Stealth Euthanasia:
Health Care Tyranny in America

(Hospice, Palliative Care and Health Care Reform)

By Ron Panzer
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What Others Have to Say About This Book

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Dedication

This book is dedicated to the vulnerable who have been targeted for stealth euthanasia.

This book is being provided free of charge online in the web version as a public service of the Hospice Patients Alliance.

This book contains the most-censored story in America and we cannot guarantee that this information will be available in the future. There are many who do not want you to learn what is contained in this web-book.

So, feel free to email links to this book to your friends. Post links to this book on your blog and websites.

Permission is granted, and you are encouraged, to post the web-book itself, mirroring it on your blog or website exactly as it is posted here: www.hospicepatients.org/this-thing-called-hospice.html

As events occurring in real-time are discussed in this book, it will be updated from time-to-time, so check back here periodically for updated versions. Let others know about this vital information!
Introduction

There are numerous books about the history of euthanasia and eugenics proposals in our society. This book is not one of those. It offers a rare glimpse from my experience within the end-of-life industry, my work as a patient advocate, and includes the revelations of hundreds and hundreds of people as they have recounted it to me. This book explains how we got where we are today and provides statements by many of our nation's leaders in health care, government and patient advocacy, that taken altogether form the pieces of the puzzle that reveal what has been hidden from the American public for decades: stealth euthanasia is being practiced throughout the United States and elsewhere.

I have many friends within the hospice industry who confirm what I recount here in this book, so I urge you to read through to the very end, as you have never heard all that I am about to share with you. Some of it may surprise and shock you. Some of it will trouble you, but all of it will affect what happens to you, your family and our society in the days to come.

This is the story of the intentionally "below-the-radar" changes that have been aggressively pursued in our society for decades. Because these changes are not covered by the major media in any coherent, connected way, or at all, the public has difficulty "putting a finger" on what is happening and why. They see changes here and there as situations arise in their lives, especially in health care. They hear stories about what is happening and mistakenly assume they are isolated incidents. Sometimes, they just can't believe the changes that have already been made. They seem so "foreign" to what American society is all about, and the reason they seem "foreign" is they do not arise from American Constitutional values.

Some people are frightened by these changes, changes that seem to be imposed upon society without the approval of the majority of citizens. They question the wisdom of abandoning the traditional values that formed the foundation for American life. They question the declining percentages of Americans who support the traditional value of a family (husband, wife and children), marriage (husband and wife), sanctity of life, faith in God, the value of work and the opportunity to get ahead in a free society. They wonder how we have strayed so far. They question whether we are still truly free to express our religious faith in a public setting, or even whether the dedication to "do no harm" within health care is the prevailing mindset. Shockingly, often it is not.

If you want to know what all that "death panel" talk is really all about, this is the book that explains exactly what is going on and will be going on.

There are no formal "death panels," but there are bureaucrats in government, HMOs, and private health insurance companies whose decisions knowingly result in denied tests, denied treatments and certain death in many cases. This has been well-documented. However, when the federal government becomes the big HMO itself, test and treatment denials will be the equivalent of death sentences for some, even many. The new health care reform law creates several methods that are likely to result in rationed care. For example, the "Independent Payment Advisory Board" ("IPAB") is supposedly not allowed to make recommendations that directly result in rationing care, but it can exert overwhelming pressure on providers by reducing how much they get paid to provide a service.

Politicians say, “we are not going to ration care.” But they will set in motion many processes
that reduce reimbursement under the guise of “limiting expenditures,” or “keeping costs
down,” and these processes will result in rationing care. Ultimately, many services will simply
not be provided, because physicians, hospitals, and others cannot afford to provide them at the
steadily decreasing reimbursement levels determined by the bureaucrats who run Medicare,
Medicaid and other government-controlled health services.

Those on Medicare and Medicaid are already on a government-run plan and are experiencing
the effects of decisions made by unelected bureaucrats in Washington, DC. We need to
remember that Medicare passed into law in 1965 and is nominally a "voluntary" program.
However, to assure participation by all seniors, then President Lyndon Johnson pressured all
private health insurers to cancel all policies available to seniors. If seniors want to completely
opt-out of Medicare, they have to give up their Social Security benefits and then pay privately
for all services they receive. Only the very wealthy can do that.

Since there is no private health insurance available for seniors in the United States, we cannot
say that participation in Medicare is truly voluntary. Seniors must accept whatever those
running Medicare decide regarding their treatment options. Certainly, there are many who
would have no health coverage without Medicare, and millions have benefited from the
program. Many seniors are comfortable with Medicare the way it has been up to the present
time. What needs to be recognized is that changes are coming no matter what political party
or agenda controls those changes, with or without the new health care reform law. One
political party will accuse the other of threatening the well-being of senior citizens and vice-
versa. But both will silently promote the stealth euthanasia already begun in this nation. The
generous benefits of Medicare over the past are going to be phased out selectively to
streamline the program and make it more "efficient." The idea that the future Medicare will be
like what we've had till now is quite mistaken and those that trust in the promises being made
by either party need to wake up to the realities.

Former Federal Reserve Chairman Alan Greenspan has said, "telling America's aging
population that its entitlement programs such as Social Security and Medicare will survive
without significant changes is dishonest." The debate about the health care reform law or
other proposals are important, but like some demonstrations of illusion and "magic," you never
see what's really happening. Misdirection and skill fool all except those trained in the art.
While we focus on the public debate, drastic changes are being made quietly without fanfare.
"The Obama administration has released a report saying that health reform will save $575
billion in the Medicare program over 10 years.” All while the number of Medicare patients
will grow exponentially. Isn’t it obvious what is happening?

The health care reform law (H.R.3590) has already modified how Medicare will be run. Under
Section 3021, "Establishment of Center for Medicare and Medicaid Innovation," the Secretary
of HHS "shall adjust the payments made to an eligible safety net hospital system or network
from a fee-for-service payment structure to a global capitated payment model." [H.R.3590
p.205] Going from a Medicare and Medicaid reimbursement system that pays fees for
each service provided to a system that has a cap on payments made for all services provided
to a patient is one of the most significant changes to Medicare ever made and will
certainly result in drastic changes. Just think about how hospitals will change what tests,
surgeries and treatments they provide if they know the amount they will be paid is capped for
each patient they serve! And if the patient has already used up the cap amount, do you think
the hospital will continue to provide services for free?

In addition, once the government takes over management of our nation's entire health care
system under H.R. 3590, as it already has in the Medicare and Medicaid programs, it acquires
control over how care is delivered, what care is available, and who receives that care or not. It
controls how much the providers are paid, and by deciding to pay providers less than service
costs and capping total costs paid out, it is driving some physicians to leave the field and will discourage the young from entering the field. Some hospitals will close their doors, reducing the total number of hospital beds available to those in the community. On average, physicians train until they're close to 30 years old, graduate with $150,000 to $250,000 in debt for their education, and are subject to being sued on any given day.

When the nation's supply of physicians lags behind the growing elderly population and hospitals have to serve that increasing number of patients, health care services will certainly be limited. According to the Association of American Medical Colleges, "America will face a shortage of more than 90,000 doctors in 10 years." There is no question that, in order to keep health care costs down, patients will see more physician-assistants and nurse practitioners providing primary care. Actually getting to see the physician will become increasingly difficult over time. For example, "employment of physician assistants is expected to grow by 39 percent from 2008 to 2018." To cut costs even more, if a patient is chronically ill with more than one diagnosis, or very elderly, and enters the hospital more than once, that patient will likely be referred for hospice or palliative care services to prevent more costly acute care hospital admissions.

You may not realize this, but leaders in government of both political parties are promoting palliative and hospice care as the destination, your destination ... the end of the road in a patient's health care journey. There is no need for something to be called a "death panel." Rationed care will result in destabilization and consequent death for many of the chronically ill, elderly and disabled. Interventions and treatment options, as well as denials, can be manipulated so that death is made to happen.

There is no one place to point the finger and say, "he" alone is responsible, or "that group" or "that government department" alone is responsible. It is much more sophisticated and complicated than that. There are webs and webs of interconnected efforts that have resulted in a massive wave sweeping over our land, something that has not happened overnight, though it may seem so. It's been coming for over seventy years. Americans have been quietly "asleep" while those who have made war on American values achieved success after success.

We don't want to think about "death and dying" even if some have been shouting the "death and dying" talk from the rooftops. There have been thousands of news articles and speakers all across the country promoting the wonders of end-of-life care, and there is much good that can be done when dedicated professionals make their best effort to relieve suffering at the end-of-life. However, there are some who have dedicated their lives to move American society away from its traditional values, and they have not been asleep. They've been very busy for over seventy years working in the background, training others and teaching in the universities, arranging to have their ideas inserted into public school curricula.

They've written sections of textbook after textbook or controlled the slant of content used to train physicians, nurses, other health care professionals, attorneys, and therefore some of the justices who eventually serve on the courts, until they have succeeded in changing how the powerful-to-be think and act ... how they view the world from deep within. And now the indoctrinated are the powerful. They've even gotten rid of the Hippocratic Oath for graduating physicians in most medical schools (contrary to what we Americans assume). They are accomplishing the last acts of their grand project: changing completely how Americans die and how Americans view death and dying.

When physicians, attorneys and judges as well as other leaders of our society no longer affirm the sanctity of life, and when leaders within health care no longer pledge to "do no harm," there is no obstacle to the devaluation of selected lives and the discarding of those...
Before the advent of widely available hospice services in the 1980s, most Americans died in acute care hospitals in a "medicalized" environment where death, just like birth, was reserved for doctors and nurses. It was hidden from view, something that otherwise has been quite unusual over the course of human history.

The modern hospice movement with its openness to caring for the dying with family present, with its recognition of the opportunity for healing in family relationships at the end-of-life, and its focus on working to do a better job at pain and symptom management has been a wonderful thing. It incorporated the very best of the latest medical advances in symptom management with a more natural atmosphere for those facing death. But this positive step has been negated in many segments of the industry due to financial or utilitarian concerns.

Although many of us would like to think otherwise, there has always been a side of American society that has had a utilitarian streak. We will explore how this has affected health care and especially end-of-life care as well as what it means for you. There has been a very slick, sophisticated and well-financed campaign to completely twist the positive contributions of hospice into something the public would never openly accept.

Because most people in our modern society do not have the background or experience within the health-care industry, they don't have the information to understand what is really planned for us when it comes to health care reform or entitlement reform. And many of those who work within health care still do not know about many of the changes that have been put in place within the end-of-life care industry. Even among those who work in hospice or palliative care, most do not know the history of the industry and who is directing its continuing development. This book contains the essentials needed to truly understand the monumental changes being planned for our society and how it is being accomplished in our time.

The issues discussed in this book will affect American society whether the health care reform law is upheld, declared unconstitutional on appeal, repealed or not, or nullified through various efforts by some of the states. How health care is provided to the elderly and disabled is being modified, significantly. Efforts to make Medicare and Medicaid services more efficient and less costly will affect many, and the changes made are not being made solely to make them more efficient. There is something else going on.

Many worry that a government-run health care system will do away with the freedom to choose one's own physician, treatment center or treatment. Others have noted that some physicians are "opting out" of Medicare and Medicaid protesting that the reimbursement is often lower than the costs of providing services. "By 2013, less than one-third of U.S. physicians are expected to remain in private practice and patients may increasingly find that being treated by physicians in private, small practice settings may be a thing of the past." Many wonder if patients will be able to find the care they need or if they will have to wait months to get to see the doctor or have a needed surgery. With the budgetary pressures on our nation, many worry how this will impact end-of-life care for the vulnerable.

Through the years, many people have called the Hospice Patients Alliance (and many other patient advocacy organizations), pleading for help, reporting problems they have encountered, like the failure of the hospice agency to provide services as needed, reporting that the staff prevented them from giving food or liquids to their loved one when he or she could still take them in and benefit. They sometimes report that their loved one was literally killed in a health care setting. I've listened and carefully thought about the depth of the problems.

Through the years, the accounts given by these family members are eerily similar. When
family members recount what hospice staff said to them, the language and phrases used sometimes are exactly the same, the actions taken exactly the same, the outcome exactly the same. The reason? The staff at different agencies across the country are being trained in the same way, and the actions taken were quite contrary to what the patient and family expected. The services and treatment provided are not what the American people have come to expect from hospice.

Those who report to us are not uneducated in the ways of medicine and health care. Many of those who call in are themselves physicians, nurses, social workers, ministers and lawyers. Yet, even with their training, some are unable to resolve problems encountered or to even prevent the hastened death of their own family member.

Those who are quite familiar with the standards of care in health care are often surprised at the wanton disregard for adherence to the standards by some hospice agencies and staff. They often cannot believe that the violation of the standards could ever be so knowingly and willingly done. This is not to say that all hospice and palliative care units violate standards. Certainly not! But, there are too many that do, and there is a reason for it. There is a reason why government regulators surprisingly do nothing about it as well.

Hospice Patients Alliance's outreach to the public was designed to bypass the media censorship and that's how we have continued to work, to get information out to the people directly and to work individually with them as problems arise. Our website has had millions of visitors through the years. Those who need information are getting it because of what we provide.

It is strange that of the thousands of websites maintained by all the hospice agencies, ours is the only one that has all the standards of care and laws set out for the public to access easily, along with easily understood explanations of what should be expected. Yet, it simply confirms what I noticed back in 1998: there was no place for the public to get complete information about what is going on in hospice and palliative care, what the standards of care are, what to do when problems arise, and what others are experiencing in this largely unregulated niche of health care. Except for our organization, there still is no place for the public to get complete access to the standards of care with easily understood explanations, honest information about what problems do exist, and what can be done about them.

Why should the realities be hidden from the patients and families that end up using these services? With about 40% of all American deaths now occurring in hospice, the public certainly has a right to know! Why do the media's editors censor the truth so people are repeatedly blind-sided and taken by surprise when their loved one is medically killed in a hospice, hospital or nursing home? I know that if you've had a positive experience with hospice and palliative care, you may be shocked and upset to read this, but just because you had a positive experience does not mean that all others will as well.

You might conclude that I am against hospice and palliative care, but that would be completely untrue. I care very much about the field of end-of-life care and have the greatest respect for those who work in this field and dedicate themselves to relieve suffering while allowing a death in its own natural timing. We've worked hard to encourage the highest standards in end-of-life care and have worked with many in the field through the years. Yet, we believe that it's important for the public to know the hidden truth about end-of-life care as well, because each of us will be confronted with these issues sooner or later.

Whether you are a person of faith, an agnostic or atheist, this book provides a rare glimpse of the realities of health care in America that you will find nowhere else. There is much material here that you do need to know so you can see exactly what is happening, how it is happening,
when it started and why.

There is a lot of material covered, but bear with me and read on, because this book explains why you have not been informed about the hidden realities in the industry, why the major media is censoring one of the most important stories of our time, and why the realities of end-of-life care are not what the media portrays them to be. This book is our way of reaching out to the public directly, bypassing the big media censorship, the government's silent complicity, and the industry's own deception.

Our nation was founded upon principles that many of us still hold dear. It is true that some ridicule these principles ... such as a right to life, free speech (which is not limited to "politically correct" speech) and freedom from an overbearing and oppressive government. Some are rejoicing that a socialized health care system may be implemented, while others are absolutely horrified.

While there are court challenges to the health reform law, changes are being implemented anyway. No law is required for government administrators to modify some of Medicare and Medicaid's internal administrative rules. The Centers for Medicare Services already has authority to change many things. With the threat of drastic changes in private health insurance, some private insurance companies may go out of business. Other insurers are making changes that drastically affect how they do business, and as the trend continues, many changes will be irreversible.

By the time some of you read this, the high court may have already ruled, however, businesses around the country have been scrambling to try to comply with the regulations of a law that will comprise thousands of pages with all the administrative regulations included. Small businesses don't know what to do and must consult attorneys, tax accountants, and other experts to plan what to do, further bogging down productivity and economic recovery. Same thing for large corporations. The uncertainty of "what the federal government will do" is like a cloud over every business in America. The certainty of changes already made is depressing business as well.

With economic pressures mounting, deficit spending completely out-of-control in a manner never before witnessed in America, and international leaders urging that the world abandon the U.S. dollar as the world's global reserve currency, citizens worry that our nation is spiraling out of control and that our basic way of life is seriously threatened. It clearly is! We live in especially "historic times," I tell my son. And, "there has never been anything similar in American history." We pray that our beautiful and inspiring American experiment in representative democracy will find its way back to the values that allowed it to create and maintain a stable and free society.

When what our elected leaders have done through the years to endanger our nation's economic security is fully known, Bernie Madoff (the convicted Ponzi scheme investment leader) will seem like a saint. Our national trade, tax and regulatory policies have decimated the manufacturing base in this country, sent jobs and corporations overseas, and made us debtors to the world. A once proud nation is imperiled, teetering on the edge of bankruptcy, and the health and economic well-being of its citizens is imperiled with it.

Nations are discussing returning to a worldwide gold standard, rather than keeping the American dollar as the global reserve currency. Even if the gold standard is not adopted, simply downgrading the U.S. dollar and "removing America's 'AAA' status would make it more expensive for the world's largest economy [the U.S.] to borrow money on the international money markets. On Aug 5, 2011 Standard & Poor downgraded the U.S. dollar to AA+. “This would trigger austerity measures in the U.S. far more drastic than its current
deficit reduction plans ...." And yes, that means cuts in health care spending of all sorts.

Threats of terrorist attacks on our people are taken very seriously, but nobody really knows what to do to stop them. We must trust the government to protect us; that is what the government is supposed to do. But when the government itself makes changes that are inconsistent with our values and Constitutional freedoms, the people become alarmed, awakened and move to block those changes and re-assert the foundational freedoms of our nation. That is the beauty of our nation's regularly and freely held elections.

When it comes to health care, there are numerous arguments about what solution can be found for the problems of rapidly rising costs, people who can't access care, and how best to distribute tax dollars for health care. Those of us who are focused on health care hear about "evidenced-based medicine," but in the major media there is little or no discussion of the potential misuse of evidence-based medicine. We hear about "comparative effectiveness research," but in the major media there is little or no discussion of the potential misuse of "comparative effectiveness research." We hear about the "complete lives system" of leading national health care advisors, as well as the rationing of health care, but the major media reports downplay any concerns being raised.

Why have we not had an open dialog about the benefits of, or problems with, the ideas that are changing the way health care will be delivered? Why do most people have no idea what these three concepts involve and how they will dramatically affect their lives and those they love?

Evidence-Based medicine is:

"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."

["Introduction to Evidence-Based Practice," Duke Univ Medical Center Library and Health Sciences Library, UNC-Chapel Hill - Dr. David Sackett, a pioneer in evidence-based practice, 1996]

Probably most physicians today want their decisions to reflect the latest medical science and the evidence. It makes sense. But anyone who knows anything about medical studies knows that different studies result in different outcomes and conclusions. The design of the studies, the number of subjects, the controls used, and so many other factors effect what conclusions are reached. Sometimes, if you want a certain result, you can be sure to get it if you design the study just so. In fact, there are well-respected physicians debating the whole idea of "evidence-based medicine. A November 2008 seminar was entitled, "The Evidence Never Lies? Critical Debates in Evidence-Based Medicine" with leading physicians, bioethicists and professors of philosophy debating the pros and cons of this whole field of endeavor. Topics included: "What's right and what's wrong with evidence-based medicine?" "What is the role of clinical research evidence in medical practice?" and "What is the patient's role in medical decision-making?"

If evidence-based medicine is used to ration care and decide what treatments are offered citizens under Medicare, Medicaid or a possible national health system, who decides what evidence and what studies are used? Who decides what the conclusions should be? Will the physician and patient decide or will a bureaucrat somewhere in the government, a PPO, HMO or other managed care company decide?

When it comes to the care of the elderly, disabled and chronically ill, many questions remain.
Even among those who respect and value life, there is a lack of information about what is going on in the end-of-life care arena, what the hospice leadership is doing, what the successor organizations of the Euthanasia Society Of America are doing, who the major players are and how they operate. I'm sorry to say that many leaders of the culture of life, pro-lifers, have no idea what is going on, really, even if many of them think they do. They have been misinformed or intentionally kept in the dark completely. I realize that may offend some, but our role is to serve and inform and provide complete information so that citizens can influence the course of our nation knowing all that is at stake.

Many supporters of the sanctity of life simply do not know how deep this all goes and how successful the heirs of the original Euthanasia Society of America have been in our nation.

**They do not know how the Euthanasia Society is connected with the largest segment of the hospice industry in America**, and when some have finally understood it, they have been shocked. Most of those who affirm the sanctity of life view hospice as the *rightful alternative to euthanasia* and assisted suicide; they would be correct in some cases, but wrong in many others! Those who affirm the value of each life have been outmaneuvered by those who hold a utilitarian worldview, and when some of them encounter a hospice that does not respect the sanctity of life and hurried death along, they realize bitterly that they have been betrayed.

**Did you know that the largest hospice organization in our nation is the successor organization to the Euthanasia Society of America?** Did you know that according to the most prominent hospice leaders in the world, many hospices in the United States today have no reservations about hastening death through a method called "terminal sedation," (also "palliative sedation" or "total sedation")? Did you know that the federal regulations governing hospice are far fewer in number than those protecting patients in nursing homes or hospitals, or that state agencies inspect hospices less frequently than nursing homes or hospitals? Did you know some hospices may go years without being inspected at all? Did you know that because of the HIPAA privacy regulations, nobody interested in researching what is actually going on in hospice can get access to the data, so hospices that have an agenda can act without any outside interference or supervision?

This is how Robin Love's [father](#) who was not terminal was hauled off to hospice, deprived of food and water and was given large doses of morphine and sedatives. He died shortly thereafter. Wendy Ludwig, RN reports that a Catholic priest she knew was [hastened to his death](#) as well. Some hospices have gone eight years without ever being inspected, except for the initial inspection when they opened their doors! What the public thinks about hospice is a carefully constructed image. In some cases, that image is fulfilled in practice, but sad to say, in many cases, it is not. We have reports of young infants being hastened to their death in [peri-natal hospice](#) because they didn't die "soon enough!"

You could say that our society has been manipulated, maneuvered, even "conditioned" to think in ways that are completely contrary to the way Americans thought for the past two centuries. And millions and millions of dollars have been spent to achieve this. The proverbial example of the frog in the pot of water applies here. Although there is debate about what really happens, if you put the frog in lukewarm water, he won't jump out. If you put him in hot water (not boiling), he will jump out, and will definitely notice that he's in "hot water." Our society is like that. Slowly, but surely, the "temperature" has been "turned up" toward "culture of death" thinking and we don't even notice how "hot" it is anymore.

You may be surprised but today, many people have adopted the "quality of life" ethic where it's "ok" to end someone's life because they are "seriously disabled," "very elderly," have dementia or any number of other reasons. In a very real sense, many of us have become numb to the killings so that we accept an increasingly larger category of lives that may be ended in a medical setting. And many times, we don't call them "killings." We say, "We let him go." "It
was time." And to "let go" is certainly appropriate when someone is truly at the end-of-life, but when someone is not imminently dying and they end up dead, it really is a "medical killing."

If there were no medical murders, books like *Caring To Death: A Discursive Analysis of Nurses who Murder Patients* (by John Field, PhD: where over 50 cases of nurse killers from around the world are discussed) would not be written. That book is about the sensational cases that leaked out into the media and the killer nurses were apprehended and convicted. Articles like, "Angels of mercy: The dark side" would not exist. *Stealth Euthanasia: Health Care Tyranny in America* is about the policies and actions that result in imposed death and are not leaked out into the media and are given the government's complete stamp of approval: death on demand, or "stealth euthanasia." In *stealth euthanasia, policymakers, nurses, doctors and others, whose actions or decisions cause death, are not apprehended and they certainly are not prosecuted.*

Not so very long ago when sanctity of life was the mainstream ethic for our society, we recognized that we are here to care for each other, not to kill each other. Now *magazine articles* promote hospice as the "other way" to make someone die on demand.

Bobby Schindler, Jr., Terri Schiavo's brother, reminds us all when he says,

"Terri and others like her should be a constant reminder to all of us that caring for the disabled is never a burden, but is instead an act of God's unconditional love."

["The dehydration death of a nation," by Bobby Schindler March 30, 2007]

We've been conditioned to think otherwise. We've been conditioned to think that caring for the disabled is an exercise in foolishness, that the disabled and very elderly are "better off dead." Over and over, we hear stories about the suffering of the disabled who are dependent on others, but rarely do we hear about the loving interaction between the disabled and those around them who care for them. We hear less and less about the blessings that come to those who serve and care for the severely disabled and dependent, the changes brought about in those who serve, or the blessings to those who are served.

Whether openly conveyed or subliminally imprinted upon us, the message for decades has increasingly been, "let them die," they are "better off dead," "let go," "kill them." The message may not be conveyed openly in those words, but that's the message, ... from health care facility staff, newspaper articles, TV shows or wildly successful movies like *Million Dollar Baby* (about the woman boxer who becomes a quadriplegic and wants to be killed) or the highly successful television series, "House." The show's main character Dr. House is portrayed as an obnoxious, arrogant, but strangely likable genius who serves as a platform for promoting the quintessential secular bioethical view; he is a skeptic and a utilitarian who ridicules people of faith, denies God and casually approves abortion and euthanasia. He exalts in his own intelligence without giving credit to anyone else for his abilities. The secular devaluation of life pervades our society and its messengers are getting shriller and less tolerant of other views each day. The major media outlets do promote hastened death in many ways.

Our society is almost "schizophrenic" when it comes to how it approaches these issues. On the one hand, almost everybody openly praises the Special Olympics, and applauded how actor Christopher Reeve fought to regain function through rehabilitation therapy after he became a quadriplegic due to a horseback riding accident. Yet, there are many who would say that Reeve should have committed assisted-suicide or that those competing in the Special Olympics should never have been born!

Killing a congenitally disabled baby before birth is applauded as the "right decision" by leaders
and especially many doctors in our society. While under existing law, killing a baby a few days after birth is technically still a homicide, many in our society view the killing of a severely disabled baby or child, or a very elderly disabled person, as a "mercy killing." We have organizations like Final Exit Network with its euthanasia proponents selling "helium hoods" and other devices for people to kill themselves, and promoting the "right-to-die." In 2011 they started putting up billboards all over the country with the message, "My Life. My Death. My Choice."

Many praise those who care for the disabled but hide their wish that many of the disabled not be alive at all. Health care reform, whether implemented through the new law or through changes to Medicare and Medicaid, will bring rationing of treatment in that spirit. It will have life-changing and life-ending effects, and we will see exactly how. Many disability advocates favor government-provided health care, universal health care, but like pro-lifers looking to hospice for an alternative to euthanasia, they will be disappointed when the government uses a heavy hand to limit expenditures for the disabled, elderly and chronically-ill.

We can get a taste of what is coming by looking at the United Kingdom's socialized National Health Service where the disability rights group, "Scope, found that 70 percent are 'concerned about pressure being placed on other disabled prematurely'" if assisted-suicide is legalized there.

Anyone who has read the book, To Kill A Mockingbird, by Harper Lee, knows it is a modern classic dealing with race relations. It portrays the struggle of attorney Atticus Finch who heroically defends a falsely-accused black man in a racist society. Yet, there is a parallel theme considering the societal attitudes toward the mentally-ill or disabled. The mentally-ill but good-hearted character, Boo Radley, shuns any public interaction, but manages to watch over and save Atticus' children from harm. Author Harper Lee says that Atticus is a model for Christian honor and conduct who treats the town recluse Boo Radley with kindness and gentleness. Her message is that we all do the same. People like Atticus Finch still exist, however there are some today who are less tolerant of the mentally-ill. Some view the mentally-ill as less than fully human and less worthy to even be here. Members of our society are quite divided in how they regard the disabled, the mentally-impaired or ill, and about how they should be treated. Not all would look upon Boo Radley with the same loving-kindness of an Atticus Finch.

The vulnerable are among us, but are often not so visible. I have written this to help us remember what it means to be a humane society, to save the vulnerable and re-establish a just society, to make a difference in your life and the lives of your friends and family. If it is not shared widely with others, then it will not have satisfied my goal to alert people throughout our nation.

We are distributing this book online for free so that all can benefit from the information being shared, and our hope is that the book or links to it will be re-distributed virally by email throughout your own circle, posted on your own websites, social-networking sites, blogs, or printed out and shared with those who do not have access to the internet. Some tell me that people won't appreciate this book if we give it away. Some tell me that I should not mention much about abortion ("it's too controversial") or have too many religious quotes in here ("people will get turned off"), and I've thought, "well, they're right, some people won't appreciate this because it's free. And some people won't read this because I have faith and share it a little here and there. And some say I should leave the controversial abortion topic till later in the text. But I've thought about it and the material is presented in the context of how changes arose in the United States historically which makes the most sense if you truly wish to understand how we got to where we are today and where we really are today.
I can't promise to please all the people, and I know if it's the truth, it will really offend some. Some people oppose euthanasia and assisted suicide yet approve of abortion. It seems that I can't help offending some. I have to "call it the way I see it." Take what you can from it, and leave the rest, as they say. I do promise to give you the truth, and give it freely as the dear Lord has given so much to me. I never set out to be where I am today, sharing this information which is so troubling to me and so many others. I just couldn't turn away and say "no" to those who were and are now suffering. I knew that I had to do something, and this book is part of that effort.

There is no question about the direction our nation's health care is being taken. Ezekiel Emanuel, MD, who our President appointed Health Advisor, promotes the "Complete Lives System" that is being implemented to ration care. Donald Berwick, who our President appointed administrator of the Centers for Medicare and Medicaid Services, is a strong proponent of Comparative Effectiveness Research which will also be used to ration care. Under the new law, "Accountable Care Organizations" are set up which will force very aggressive rationing practices by medical groups. Cass Sunstein, who our President appointed "Regulatory Czar," states that unless you specifically record your wish not to donate organs, doctors should be able to harvest your organs (should you be declared "brain dead") for donation on the basis of "presumed consent," even if you never actually give consent. He also has stated that an economic crisis can be "used to usher socialism into the United States." Susan Rice, who our President appointed Ambassador to the United Nations states that we must increase the role of the United Nations in world affairs.

Regarding end-of-life care within the health care system, as we shall see, the nation's most prominent hospice physicians (such as Joanne Lynn, MD and Ira Byock, MD) are proponents of terminal sedation to hasten death. Willard Gaylin, MD, co-founder of the Hastings Center is a proponent of euthanasia who applauds the efforts to expand the definition of "death" in order to overcome obstacles to legally performing euthanasia. Gaylin is widely accepted in the mainstream media and policymaking circles, and the Hastings Center is one of the organizations that has most influenced the modern American hospice industry to betray its original mission to care, not kill.

To top it off, our President appointed John Holdren "Science Czar." Holdren is the co-author of the 1977 book, Ecoscience that promotes ideas like forced sterilizations and abortions to limit population growth, compelling single mothers to give up their children to others, putting chemicals in water supplies to prevent births, and a planetary world government that would implement these ideas for the good of the world. Although Holdren is a man-made global warming alarmist in the present (necessitating dramatically increased government-imposed regulations), in the late 1970s he was warning about disastrous global cooling (necessitating dramatically increased government-imposed regulations). It is not a mistake that these specific leaders were chosen to shape our society and our nation's policies. Each of them has at one time or another stated that he is not what the record shows him to be: an advocate of a much bigger government role in our lives. Their public reassurances and denials of the obvious are not credible.

Taken all together, it is certain that increased government-control of our lives and health care based upon a utilitarian philosophy is being promoted. America will certainly be changed by their collective efforts. The new health care reform law has created agencies such as the Independent Payment Advisory Board (IPAB) and the Patient-Centered Outcomes Research institute (PCORI), whose main activities will result in rationed care. The role of secular culture-of-death hospice and palliative care within the health system will be expanded dramatically.

So, it is right to be wary about the changes being proposed: we are swiftly moving toward a
utilitarian-controlled and callous society that will victimize many. It is already happening to many at the end-of-life. This book will explain exactly what is happening, how it's being accomplished, who is responsible, and why it is being done. The book will also explain what must be done to truly reform the health care industry, our government and how to restore the American respect for life. We cannot rely on the government to respect the sanctity of life at any stage of life, even though respect for an individual life is central to traditional American values and our Constitutional system. Respect for life is central to preventing harm to patients, patients who could be your loved ones.

Health care professionals who have a reverence for life view their work as a mission and an opportunity to express their love for each patient. Those with faith, view their work as an opportunity to glorify the Giver of life through service to those who are most vulnerable.

However, federal law and Congressional budgetary expenditures approved by the Presidents (current and past) encourage abortion, eugenics and stealth euthanasia. You will understand exactly how after reading this book. The simple truth is that we are entering an extremely dangerous period in American history ... dangerous for those who are the most vulnerable of all and dangerous for our society as a whole. If people contemplate and really see the sanctity of life, their quality of life arguments fall away and they will understand that we are here to care for each other, not to kill each other. Caring, and not convenience, is the sign of a civilized and just society!
I - Trends in American Society

Although the health care reform law was opposed by many who value our freedoms, utilitarians know that their decades-long activities shaped the thinking of our leaders and made it possible. The "Patient Protection and Affordable Care Act's" enactment represents a coup by elites who believe they know better than most Americans what is best for Americans. Sold to many in America as a way to bring coverage to those who had none, it represents the assumption by government of 1/6 of the American economy and therefore, a huge increase in the size of government and its role in every American's life. It may be hard to believe, because nobody has been speaking about it, but it represents a "fait accompli" for the Euthanasia Society of America's descendants in this generation. You may find such a statement completely shocking, especially if you think that government is the answer to most of our society's problems. And you will reject the statement if you believe some of the
language in the law without reading all of the law.

We have to remember that it is the people who implement the technical details and interpretation of the law that will have the greatest impact on what really happens. Many segments of the law have vague language such as, "the Secretary ("Secretary of Health and Human Services") shall establish ...." "The Secretary shall promulgate regulations ...." "The Secretary shall develop standards ...." What is clear is that many of the details are going to be filled in with "administrative rules," ... regulations that are just as much "the law of the land," but which are created not by our Congressmen, but by bureaucrats in the federal government.

For example, if you read the following segment of the law, and take it literally, you may come to believe that a utopian health care heaven has suddenly emerged and taken shape in America:

"In defining the essential health benefits under paragraph (1), the Secretary shall-

.... (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

[Patient Protection and Affordable Care Act; HR p 46]

Ah, the devil's in the details. What exactly are "essential" health benefits? And who will receive them? The language is made to sound as if everyone is going to get the essential services that would reasonably be expected to be provided. Yet, the man our President appointed Health Advisor, Ezekiel Emanuel, MD, has stated,

"services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic and should not be guaranteed." [Emphasis added]

This is not surprising since Dr. Emanuel is a fellow at the Hastings Center ... the same Hastings Center co-founded by the euthanasia proponent, Willard Gaylin, MD ... the same Hastings Center whose other co-founder, Daniel Callahan, explained in 1983 that taking all food and fluid away from vulnerable patients was probably the only way to make sure certain patients actually die (without legalization of euthanasia in America). This is the same Hastings Center that has worked side-by-side with hospice industry leaders to transform hospice and palliative care into the practical laboratory where its utilitarian, pro-euthanasia ideas are implemented, practices we now know as stealth euthanasia and direct euthanasia.

Utilitarians, like Dr. Emanuel, refer to individuals who are not working, not producing goods or not providing services for society, as non-participating citizens. These are the dependent individuals who society normally cares for or assists with the activities of daily living. It is very clear that those who are brain-injured, cognitively-impaired, developmentally-disabled or very elderly fall into the category Dr. Emanuel is referring to. If there is to be no "discrimination" resulting in "denials of care based on their age," or "disability" why would Dr. Emanuel categorically state that the disabled or very elderly (those who are "irreversibly prevented from being or becoming participating citizens") should not be guaranteed services? Why would the government set up the mechanisms for rationing care known as the "Patient-Centered Outcomes Research Institute (PCORI) where "comparative effectiveness research will be done and committees will decide what treatments are appropriate or effective for different populations of patients? Shouldn't such decisions be made by a physician and the patient? Not according to the new health care reform law. Not according to
those who will run the government-run health system.

Shining a light on how services can be denied, "Dr. Richard Della Penna, M.D., a former Kaiser physician and one of America's leading medical experts in Elder Care and the treatment of Special Needs Patients (SNPS) has filed suit against Kaiser Permanente, [et. al.], ... as a result of Kaiser's calculated plan to deny legally mandated proper treatment to approximately 57,000 seriously disabled in California, Colorado and Georgia because it just didn't want to spend the money." An example of such denied treatment? Laura Shumaker, the mother of an autistic child, writes that in 2009, she "received [her] first set of denials associated with basic treatment for my son's disorder. They denied Applied Behavior Analysis (ABA), Speech therapy, and Occupational therapy. To deny these treatments to children with autism is the equivalent of denying insulin to a diabetic or chemotherapy to a cancer patient."

These are examples of the callous hand of rationing for profit in real life. When it's your loved one being impacted, you understand how evil it can get. CEOs of these corporations make millions of dollars per year, but basic treatment for many of the disabled and chronically ill is denied! All in the name of rationing or having "effective" practices. There is a difference between making health care more efficient while making a profit and unethical exploitation.

What is Comparative Effectiveness Research?

"Comparative effectiveness research is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.

There are two ways that this evidence is found:

* Researchers look at all of the available evidence about the benefits and harms of each choice for different groups of people from existing clinical trials, clinical studies, and other research. These are called research reviews, because they are systematic reviews of existing evidence.

* Researchers conduct studies that generate new evidence of effectiveness or comparative effectiveness of a test, treatment, procedure, or health-care service."

[From the U.S. Department of Health & Human Services 's Agency for Healthcare Research and Quality - Effective Health Care Program]

With the U.S. Patient-Centered Outcomes Research Institute, a non-elected committee will be making recommendations that will likely be accepted by the Centers for Medicare and Medicaid Services in deciding what treatments it will or won't cover. If treatments are not covered, they won't be available to anyone, or they won't be available to "selected" groups within the American population!

Those promoting "controlled death," "death with dignity," or outright "euthanasia," know what it all means, what the implications are for changes to come in the future, even if those on the side of life still don't fully "get it." The bottles of champagne have been uncorked by those favoring eugenics, euthanasia, assisted-suicide and utilitarian government. And while the major media produces programs and prints articles that ridicule those who criticize the law as "right wing nuts," the aggressive rationing of health care it involves will eventually, directly
and negatively impact the lives of you and your family.

The "Patient Protection and Affordable Care Act" enshrines into law a system diametrically opposed to what most Americans believe. It creates a system where government bureaucrats (not the public) determine whether care is provided or not. Its mandate that all Americans buy into the government-approved system negates the basic freedom that Americans have always had to choose whether to buy something or not. "Pro-choice" does not apply here. "No choice" is the new policy. While promising to extend health care coverage to all, they intend to limit care that is provided to the elderly, disabled and chronically ill. How do we know this is their intent? The leaders the administration has put in place to design and administer the program have told us what they think, what their goals are and how they will implement them. It is clear they will achieve some of their goals by limiting reimbursements to those who provide medical services.

We know that rationing is on its way when we see that reimbursement to medical providers will be limited severely. The American Medical Group Association, whose members provide care for "roughly 1 in 3 Americans" has analyzed the regulations regarding accountable care organizations ("ACOs") created under the new health care reform law. The AMGA's member medical groups include the Mayo Clinic, Cleveland Clinic and many other well-known leading hospital and medical group practices. The AMGA regards the regulations as, "overly prescriptive, operationally burdensome, and the incentives are too difficult to achieve." They fear that complying with the regulations will cause significant financial loss for the hospitals and medical groups. And we know that when reimbursements are limited, the medical groups will take steps to limit services and treatments to minimize their losses, i.e., health care rationing. The AMGA also warns that, "if ACOs are not successful," they are "concerned that the only alternative to future delivery system "reform" will be draconian cuts across the provider spectrum." [Emphasis added]

Government officials and bureaucrats may not target you or your loved ones individually, but they definitely will target government's reimbursements to providers for specific groups of individuals, and then, medical providers will allow or deny access to treatment based on government-designated reimbursements for these categories of the population. There is no need for the so-called "death panels" for lives to be shortened. Bureaucratic "decision trees" will guide paper-pushers (either in private medical groups or a future government-run program) who issue determinations about whether diagnostic tests, treatment, surgeries and so on will be provided, or not. Needed treatment when denied equals shortened lives.

If it is government-run, health care will replicate the "cost-efficiency" practices of private health insurers, with outright treatment denials impacting the lives of those most vulnerable. And if it is privately-run, insurers will follow managed care models of care (as they already do) and continue to evolve along these lines promoting profit beyond what can reasonably be accomplished if the members of the health plans are to be given the health care they need and pay for.

When it comes to "patient protection," protecting citizens from treatment denials, the health care reform law fails completely. The law may only make health care "affordable" for the government through aggressive rationing of care provided. It will not make it "affordable" for many. There is no protection for the patient's right to choose a private health insurance plan over the long run. In fact, over time, private health insurance as we have known it will completely end. More private insurance companies will ration care aggressively or may go out of business as time moves forward. Health insurance plans in America are already being forced to change in ways that have caused an increase in insurance premiums. In the long run, those health insurance companies that survive will be either government-run or government-
In America, we have mainly had a privately-delivered health care system along with safety nets provided for those who could not purchase health care on their own. The safety net in years past could simply have been free clinics, free services at hospital emergency rooms for those without insurance, charitable giving from the neighbors in the community, a doctor who would treat someone for free if they were unable to pay, or an extended family that stood ready to provide bedside care as needed.

Today, Medicare and Medicaid represent the biggest government-run safety net, yet the character of the services to be provided will be drastically changed. For those who are not on Medicare or Medicaid, with implementation of the health care reform law, we will see "a dramatic decline in employer-provided health insurance -- with as many as 78 million Americans forced to find other sources of coverage." Where will these employees find coverage? Clearly, the main, or only, provider will be a government-run or government-controlled program.

There certainly are problems with our current system, and there is no question it should and can be improved. Under any system there will probably always be some who "fall through the cracks." Yet, our health care system is internationally known to offer the highest quality health care in the world. People come from all over the world to get care here under the private health care system we have had.

Private charities and government programs have helped many who are in need. The state Medicaid programs provide access to health care for millions. Numerous charities provide services to the poor, hungry, and ailing. In an effort to help some (the purported aim of the health care "reform"), the ability of many to access care is likely to be destroyed, especially when it comes to the elderly and the disabled. Sure, if their illness is easily treated, they'll get care just as they always did, but when seriously ill, treatment will be hard to obtain.

As we begin to wonder if the freedoms which make up the American way of life will disappear right before our eyes, we also wonder what are the government and media not telling us about the realities of "health care reform?" Why was a bill that provided for the government seizing control of 1/6 of our economy not read before the Congress voted on it? Why wasn't there extensive open debate about the pros and cons of such reform if the best interests of America were to be determined? Why wasn't input from all sides of society on this extremely important issue reflected in the law? How has our society seemingly been split down the middle?

When it comes to our own private lives, our own health, people have good reason to ask questions about what will happen under a government-run health care system. We don't know what will result from having a government-run or privately-run health care system that is heavily-influenced to do certain things, provide certain treatments or not, and what the government's influence will have on our lives. But we can already see the direction those pushing "health care reform" are taking us. We must understand who is running the show and how they think.

Today, "quality of life" has been substituted for "sanctity of life." The short section of the law quoted above even mentioned the phrase, quality of life, not sanctity of life. When you disregard sanctity of life and focus on quality of life exclusively, in the language of the Nazis, those "unworthy of life" with a poor quality of life are, in the name of mercy, going to be hastened to an early death. In fact, the Nazis used the phrase, "giving a merciful death."

You may say, "Oh, that's going too far!" But all we have to do is look at the case of Terri Schiavo to understand that in some cases, yes, a living, human being can be made to die in a...
hospice by court order, with the approval of the federal, state and local government as well as the police in that area.

I can hear some say, "oh, here we go again." "I've heard enough about that case and don't want to hear anymore." "I already know what happened." In most cases, you didn't hear the complete truth and you don't know what happened. Some things were never published anywhere.

Of course, many said she was "brain dead," "already dead," "better off dead" and the like. And it is clear that almost everyone has a very, very strong opinion about the case and believes they know a lot about it. They may have even read dozens of articles about it and discussed it at length.

I have spoken directly with Terri's parents and family, nurses who cared for her and others who saw her themselves. And, after reading numerous letters to the editor, online posts, hearing all sorts of discussions about the case, and reading hundreds of articles, it is clear to me that most of the people in this country have no idea what her real condition was, what really happened with her so-called "collapse," what was involved in her death, who was behind it and what the agenda was.

Almost no people really think about her admission to hospice as being central to what really occurred there! Almost nobody thinks about the euthanasia movement in this country and what that has to do with her court-ordered death. But the euthanasia movement working within the hospice industry was the force that manipulated her into hospice for the purpose of imposing death upon her.

The major media stories about the case provided absolutely false information about her. By the end of this book, you will know how and why they lied. This is easily proved for anyone who takes the time to truly research the case, read the actual court and medical records as well as speak directly with some of the nurses who cared for her, doctors who examined her, and with the family as I have.

Sometimes, there is a financial motive to deny treatment to an individual. People say, "life support is too expensive." In Terri's case, like many others who today are hastened to their death, she was not on any "life support" at all but was merely getting food and water through a tube.

On the other hand, there are some very expensive medical procedures, surgeries and/or medications that do cause people to think, "We need to determine who best should receive this." Decisions are made every day about who gets an organ transplant, and that is a form of "rationing." It's something that is necessary, and because the lives of patients can depend upon it, health care decision-making needs to be done fairly, ethically, and humanely. We can all agree on that. But then the question arises, "what determines if an action is "fair"?" How do we know if the decision is "ethical" or "right?" What does it mean to be "humane?"

These questions are answered in different ways by those who hold different worldviews and values. Some who have religious faith would decide one way. Many who are agnostic or atheistic would decide another way. How do we determine what is ethical and right? If society discards the Judeo-Christian values which are the acknowledged foundations for much of America's laws as well as the Constitution, what will be substituted for them? Anyone who's been around for more than a few decades knows that one day the experts tell us it's "bad to eat this or that." A few years later, they tell us there's new research and what they told so authoritatively before no longer applies. People just don't know what to think.
In business, especially health care, every ten years it seems there's a new "system" of management being implemented in the hospitals (those who work in them know what I'm talking about), ... a new "modern," "progressive" way of doing things. The same type of regular change holds true in terms of what the latest thinking about societal issues is. With no societal "anchor" to keep us stable, we would be going through chaotic change every decade. Just think about what happened in 1960s Communist China with the Cultural Revolutions there. One moment the Red Guard was killing "counter-revolutionaries," and a few years later, another group was killing the "old" Red Guard (calling them "counter-revolutionary," and on and on it went with millions dying in the chaos. If we don't have a stable societal "anchor" in our values, then one "crackpot" philosopher, bioethicist or politician will come along and later, another will come and change it all over again.

A stable nation cannot exist without a stable system of values and traditional beliefs. Our traditional American values are founded in the Judeo-Christian traditions which have given rise to our many freedoms: freedom of religion, freedom of expression, freedom of assembly, freedom of the press and so many others that have made our nation a model for the world.

So, we need a stable set of values that help to preserve the freedoms that are part of what America is all about. When it comes to these freedoms, freedom from discrimination is a passionately-defended right, a Constitutionally-guaranteed right. Those of us who are of different ethnic groups want to be free to live our lives without being subjected to unfair discrimination. Those of us who are ill and need an organ transplant or medical procedure, also do not want to be subject to unfair discrimination. Today, transplants may be distributed to those who are waiting on the list and those who have waited longest, who are first on the list, get the organ. It seems fair and can make sense, but sometimes, decisions are made that negatively impact a patient because people believe they are less worthy of living at all.

Some people suffer much due to illness or disability, but that does not mean they are less worthy of life itself or that they want to be killed. Utilitarians do not agree; they believe some of us are expendable, better off dead, and if not dead, then relegated to the deplorable conditions found in many nursing facilities and left there to die.

In hospitals, the elderly may be treated very differently than a middle-aged or young adult. Families have told me so many times of the difficulties they have getting physicians in the hospital to treat their loved one with simple medical care that meets the standards of care. For example, a 90 year-old who has some stable but chronic condition may be under or over treated for a condition, with the intent of causing death. Sometimes, powerful antibiotics or other medications are given when they are not needed at the same time the patient is not taking in fluids, in order to damage the kidneys and cause death. Sometimes, an anti-coagulant such as Coumadin is given in a large dose while lab tests to see if the blood levels are within the acceptable range are intentionally put off for weeks, with the intent that the patient have a stroke due to bleeding and die. Sometimes the patient is kept on an I.V. solution of saline water at a very low rate with no nutrients for days on end, with the intent that the patient destabilize and eventually die.

Sometimes, blood glucose levels are not maintained in the normal range in a diabetic patient, so that the patient dies. Sometimes, something as simple as leaving the blankets off a patient overnight is done so that the patient goes into hypothermia and dies. I've heard from families where three or four of these methods have been used to make their elderly parent die. Don't believe it? Believe it!

Just as "in some instances, medical personnel in hospital emergency rooms and physicians' offices have reported parents to state child social services agencies for child medical neglect for refusing to vaccinate their children," hospital staff may threaten the family member (who
has the power-of-attorney) with a complaint against them with adult protective services if the POA doesn't go along with whatever the hospital is doing, just to intimidate them and shut them up. And we have reports that when families refuse to go along, hospital staff do use the social service agencies to get their way and remove the caring family members from the picture (even the member with the POA).

Hospital staff may intimidate family members into signing a Do-Not-Resuscitate order and then put their loved one into hospice. It happens every day, because some doctor in the hospital decided "it's time" for that patient to die. In nursing homes, neglect and abuse can cause death as well.

There have been Congressional hearings on abuse, neglect and severe harm to residents of many nursing homes for decades, yet nothing of significance is ever done to improve the conditions in these facilities. And while some facilities do a good job, too many maintain horrendous conditions. In August 2009, Congress's "investigational arm," the General Accounting Office reported that, "the Most Poorly Performing Homes, ... tend to Be Chain Affiliated and For-Profit." [GAO-09-689] Just think what happens to the patients there when they are enrolled in hospice at these for-profit nursing homes!

There have been extended, decades-long campaigns by millions of people to achieve the civil rights blacks enjoy today. There have been decades-long campaigns by millions to achieve equal rights for women. There have been decades-long efforts to stop the killings of babies in the womb and yes, decades-long efforts to continue that practice. There have been many efforts made for years to achieve rights for immigrants, illegal immigrants, gays, migrant workers and others. There have been all sorts of marches and political efforts and protests throughout our history.

Where are the millions, or even thousands, speaking out for the rights of the disabled, the very elderly, even those deemed "terminally ill?" Many do not really know how terrible the conditions are for some of the very disabled, elderly and those who are terminally ill. Many not only do not march for the rights of the disabled, elderly and terminally ill, many think they don't really have a problem. They like to believe that they are well-cared for if they think of them at all. Others, who have seen patients suffer under the conditions at some facilities, simply block out the thought of their existence and their problems. These are society's forgotten, the voiceless.

There are reams of documents detailing the abuse, neglect and harm being done to these very elderly and the disabled but no marches. Yet, the numbers of elderly and disabled individuals victimized is in the tens of millions through the years. No action. No marches. No civil rights movement. No justice.

"Civil rights" are not restricted to the struggle of any one group of people! We all have civil rights. The trend is to "write off" this group and give them a one-way ticket out of here. It is the greatest civil rights struggle in America, yet the voices of the vulnerable are censored. If their voices reach out somehow, they are quickly silenced and ignored. It as if our society is "lynching" the elderly and nobody comes to rescue them.

If a movie were made about this civil rights struggle, it might be entitled, "What if there were a civil rights struggle, and nobody came?" It could show a blank screen with intermittent flashes of some patient advocates or organizations who've dedicated their lives to speaking out on behalf of the voiceless. But very little response from the public. No "movement" to rescue the voiceless.

**While there is life, we must care for and respect it!**
We must do more. Every day, courts, guardians, people with a health care "power of attorney," doctors, nurses, agencies and others, make decisions that may result in the harm or death of some patients. Sometimes, the decisions are made in accordance with the patient's actual well thought-out wishes. Sometimes, they are not. There are many articles about such cases, some of them actually called "mercy killings."

People are beginning to see the trends. What is being planned today is unlike anything that has ever been done in America before, and we will see that the foundation for today's "reform" has quietly been built over decades while Americans simply looked the other way. We didn't pay attention when a change here and a change there occurred. A change in the law here, a court ruling there, and after a while, the changes add up. We now have a completely different approach among health care professionals and the courts. What is planned for our society is obvious to those who understand the history of the culture of death and the "flavor" of hospice and palliative care promoted by the culture of death. Most people don't realize there even is a different type of hospice and palliative care.

Talk of managing scarce health care resources must be balanced with the Constitutional rights and basic human rights of citizens living within a just and civilized society, and the vulnerable are still citizens of our nation! Their struggle is in numbers the greatest civil rights in our history. Yet, if health care rationing is carried out on a utilitarian basis, it can become the preferred "tool" for a tyrannical exercise of power, actually eliminating many individuals and threatening the basic fabric of our society.

The Fourteenth Amendment to the Constitution of the United States:

No "State [shall] deprive any person of life ... without due process of law.

Of course, the original context when that was written had to do with punishment for crimes against society. But the idea of not executing someone, not ending their life without "due process" under the law has been an obstacle that the Euthanasia Society of America had to overcome. Over the course of seventy years, the Euthanasia Society (and its successor organizations) has made war on this central Constitutional right to life expressly stated in the 14th Amendment. They have made war on the American way of life. Through like-minded legislators along with justices of the Supreme Courts of the states and of the United States, they have succeeded. It is now possible to deprive a person of life without due process in the United States! You will see how here.

The successors of the Euthanasia Society of America are now proceeding with their plan to implement stealth euthanasia for citizens whose "quality of life" is deemed "unworthy of life." These are the last acts of this lethal society. And who will be their target? The elderly and severely disabled. In every state and county. Affecting your family and you. And they don't have to be the "very" elderly or "very" disabled. I've heard of the "not-so-elderly" (even 60 years old) or disabled being placed in hospice and dying shortly thereafter, even though they had no terminal illness at all. Others have warned about these developments:

"In an era of cost control and managed care, patients with lingering illnesses may be branded an economic liability, and decisions to encourage death can be driven by cost. As Acting U.S. Solicitor General Walter Dellinger warned in urging the Supreme Court to uphold laws against assisted suicide: "The least costly treatment for any illness is lethal medication."

[USCCB, Secretariat of Pro Life Activities]
In addition to what I share with you directly from my own experience and knowledge gathered from people all around the country and around the world, I've chosen to include extensive quotes from experts in relevant fields so you are presented with a collage of ideas and information, reference sources that allow you to see how the American respect for life has been devalued over seventy years. This book is presented less as a "literary work" and more as a practical tool you can use to understand completely where we are at today when it comes to stealth euthanasia, medical killings "under the radar" that are becoming increasingly common. You will understand the real significance of the changes in health care being implemented today and what needs to be done to protect those you care about.

Because some people become extremely offended that anyone would dare to write something critical of "those wonderful hospice people," let me respond before people get worked up. I have worked in hospice and know many wonderful professionals working in the field. Through the years, some people regularly write in and suggest that we post many positive stories about hospice. There are literally thousands of websites promoting the good that is done, some of it true. And at a hospice that is run by those who adhere to the mission, there are many benefits to the patients and their families. Yes, there are extremely dedicated professionals working in the field.

And, we have hundreds of pages of information on the Hospice Patients Alliance website detailing all the helpful services that hospice and palliative care units should be providing, how good end-of-life care is provided and the regulations governing hospice agencies. We certainly know the difference that good end-of-life care can make.

For over a decade I’ve said that:

serving hospice patients and their families is one of the greatest privileges and trusts a health care professional could ever be granted. Only those staff with great love, sensitivity, and compassion understand the real mission of hospice. Really, it is a calling.

Health care professionals are taught to be detached and not get too involved. But those of us who view our work as a spiritual calling believe in simply loving them unconditionally, being with them, treating them as we would want to be treated. Unfortunately, there is another side to the story that must be presented!

This book is an urgent wake-up call to Americans and people around the world, because what is happening in the United States is also happening in other nations as well. Worldwide influences are impacting what happens here in our country and around the globe. No nation is untouched by what happens in the other parts of the world. With the internet and so many forms of communication, with the ease of traveling around the world, groups from one nation can network with those on the other side of the globe. The European Institute of Bioethics has been warning about these developments for many years.

This book is not written for any one particular group of Americans, or any one particular religious group. We are all people, and people everywhere want the same things: the ability to provide for their families, and to live a fulfilling life. All people want the lives of their loved ones to be respected and normally do not want their lives ended in an untimely and involuntary manner.

Yet, global influences and exchange can be a blessing or a curse. The World Federation of Right-to-Die Societies, for example, has had much influence on what is happening here in the United States (such as in Oregon, Washington, and other states where efforts are being made to
legalize assisted-suicide). It also promotes legalization of medical killing in other nations.

When it comes to hospice and end-of-life care, hospice and palliative care leaders from around the world network through the International Association for Hospice & Palliative Care Organization. Information about improvements in end-of-life care can rapidly be shared and implemented. And then, America's hospice trade group, the National Hospice & Palliative Care Organization helps to shape how many hospice agencies deliver care in the United States. It is the nation's main end-of-life care industry lobbying group. That would all be fine if the National Hospice & Palliative Care Organization was not the final successor organization to the Euthanasia Society of America. Unfortunately, it is!

Whether we consider end-of-life care or health care in general, how care is delivered can be shaped by worldviews that may not be in harmony with our U.S. Constitutional values. Health care reform efforts being made today in our country are very much influenced by models of health care in place (and trends) in the United Kingdom, Canada, France and other nations. And with that influence comes much talk about health care rationing, legalization of euthanasia and assisted-suicide and other problems. Health care rationing is directly linked with the end-of-life care industry, yet this connection has not been appropriately explored. Perhaps it is because those who cannot access care, who may be denied treatment, will be placed in end-of-life care clinical settings or at home, even if they are not "terminal" in the sense we have come to understand.

In the United Kingdom, Dr Howard Martin stated on February 11, 2011 that, "giving morphine to terminally-ill patients in hospital to end their lives was a regular occurrence."

At the highest levels of policy-making in government and the corporate world, stakeholders shut out those who respect the "right to life" for all citizens at any stage of life. How do we respond to this? Do we really want politicians, bureaucrats and ideologues making decisions that impact our lives and our loved ones' lives? As most Americans have little trust for what politicians say, in general, why would we ever want them to have such an intrusive impact on the most personal decisions of our families' lives? ... on our health care?

For those who must enroll in Medicare, there is no choice but to have politicians, bureaucrats and ideologues making decisions that impact their lives. On the other hand, some with private insurance may have nameless claims adjusters who seem to whimsically deny treatment in the name of "managed care," something HMOs have specialized in. Whether you call it a "treatment denial" or "rationing," it still has the same effect, and after you look at the patterns, you know that it mostly has to do with money, but sometimes there's something else going on.

Only those who are more concerned with quality of life than sanctity of life are taken seriously at the government decision-making "table." And however many committees arrive at consensus, policies that arise out of a quality of life mindset will always end up victimizing the vulnerable, often causing shortened lives.

However, we must remind ourselves what the medical missionary, humanitarian and 1952 Nobel Peace Prize recipient Albert Schweitzer's life was all about: reverence for life! He said:

"Reverence for Life is a philosophy that says that the only thing we're really sure of is that we live, and want to go on living. And this is something that we share with everything else that lives - from elephants to blades of grass. So we are brothers and sisters to all living things, and nothing else, neither race nor colour nor religion nor sex, should be more important than this one deepest, most extraordinary thing connecting us."
"The whole world, indeed the whole universe, has evolved to give us life - you and me and the rest of the living world.

"But only humans are aware of all this. This is some responsibility. Because we also have the ability to neglect, to destroy, to cause suffering and death. And indeed some suffering and death is inevitable. ....

"For life is extraordinary. Every scientific advance tells us this. We now know the billion to one chances ever since the Big Bang that have enabled life to develop and then to survive on this planet, and the extreme rarity of it in the universe. More than ever, we have good reason to feel reverence for it."

["The Discovery & Meaning of Reverence for Life" - Albert Schweitzer; Emphasis added]

We have forgotten so much. Reverence for life is the remedy we need to heal our nation's descent into the abyss of imposed death and stealth euthanasia. Reverence for life brings sanity back into the discussion of these issues. When we have reverence for life, the question of imposing death does not arise. We simply love and care, allowing for a natural death when it truly approaches on its own. We can honor life, loving all the way from life to death.
This Thing Called Hospice

Hospice is about caring for those approaching death, whether they are young or old. People say they would like to live "forever," but when illness, old age or major disability hit, the majority begin to let go of their attachments here and think about what, if anything, comes next. They go through a process of leaving behind everything they love and finishing whatever they have left to do, and then they must let go altogether. Hospice professionals help them with these transitions, the most important they will ever go through. Hospice is a hybrid of medical, spiritual and emotional caregiving for the terminally ill and his or her loved ones.

Hospice and palliative care (symptom management) services are provided when curative treatments are no longer effective, when the patient's death is foreseeable. Under the traditional Medicare hospice benefit, patients are enrolled in the hospice benefit when the physician certifies that death is likely to occur within six months or less. Often, the physician-ordered diagnostic tests reveal cancer, heart disease or other illnesses have progressed to what is called the "end-stage" and medical treatment can no longer prevent further deterioration of the patient's health.

Large percentages of those admitted to hospice care are in the winter of their lives and also experience what many elderly face: isolation, loneliness and depression. Even for those terminally ill who are younger, visitors may be infrequent if they come at all. People don't know how to act around the dying, and tend to stay away even if they wish to visit.

Elderly patients may already be "shut-in" in their homes, living off of their retirement funds (if they have any) and Social Security. They may not be well enough to travel out to the stores to shop and depend upon other family members, neighbors and programs that serve shut-ins to help them.

With failing eyesight, decreased coordination, flagging energy levels and forgetfulness on the rise, seniors struggle to do the ordinary tasks of life, the "activities of daily living" such as bathing, dressing, cooking and cleaning. Their spouse or other family members may also be frail and are often unable to help them adequately. Being terminally ill, all of these tasks become even more difficult. In the early stages, programs like "Meals on Wheels" can continue to help the elderly enjoy a cooked meal from time to time. There are also many forms of assistance available through home health agencies. Hospice agencies offer many of these same services. As disease progresses, there is a recognition that the patient will be able to do less and less.

Home care aides may help with bathing and dressing when they are available. Nurses visit to make sure patients take their medications for the week and to check on the senior's health status. Social workers inspect the overall environment, helping to make sure the senior citizen is accessing all the support networks available to make the living arrangements work. They also offer counseling to help resolve problems the senior may be experiencing and to cope with the challenge of facing approaching death.

If the patient's medical condition has interfered with their abilities to carry out the activities of daily living, physical therapists are also available to help with movement and strength conditioning, occupational therapists can help with detailed tasks involved in daily life, speech-language therapists assess and offer help with swallowing and speech problems.
Sometimes, elders may not be able to safely function on their own and need placement in a facility where more supportive services are provided. Whether elders are living in a facility or not, they may not know others around them and may experience a feeling of complete isolation. They may feel out of place, out of touch, forgotten and alone. The young staff seem like little children, even though they may be twenty to forty (or more) years old! Some elders adjust well as they age and are able to make new friends, learn new things and participate actively in the world. Others simply can't. And as they age into the very elderly category, memory problems may increasingly interfere with their lives.

Having worked with the elderly, the disabled and the dying for many years, I've seen first-hand how difficult it can be for these individuals. The smallest tasks may have become extremely difficult, and emotionally, they face the grief of losing everything, not only their possessions, friends and family, but their very lives as death approaches.

The supportive care that a good hospice provides can make a big difference to those approaching death. Knowing that you will be cared for when everything seems to be closing in and having your family with you are what most of the dying want most. They want to be able to say things that were left unsaid, to share the love they have in their hearts, to patch up problems that may have arisen over the years and to say goodbye this last time.

And while curative measures are no longer effective, there is much that good end-of-life care can do to help the patient live more fully and comfortably till the end comes. This is what has made the idea of hospice and palliative care so appealing to many. As the days pass, the patients and families may become very attached to the hospice professionals who spend time with them. There are many opportunities for staff and patients or families to speak, share stories and get to know each other. All present share a very intense, intimate and special period in their lives. Patients and family alike often have their "guard down" and speak openly about all sorts of things that normally, they'd never share with anyone. It is a time like no other, and people know that. In many societies, there is the idea of "keeping vigil" with the dying, being there for him or her, supporting them as they make the transition from this life to the next.

This is the story of hospice, palliative care, and health care reform. It is also my story, and whether you know it or not, it is your story too, because every family in our nation will be touched in one way or another by hospice, palliative care, or the reforms being implemented. The government plans on having each of us die within hospice (or palliative care) eventually. That means you and your family members. This concerns you!

Most of the public thinks there is one "thing" called hospice all over the country. Mostly, they really don't think about it, and don't know how it's set up or how it works. The hospice industry has carefully promoted this false image of the hospice industry and carefully avoided portraying themselves as separate individual business entities, i.e., "corporations," providing services.

"Hospice is a philosophy!" exclaim some websites (run by hospice business entities). "Hospice is the place" for compassionate care, exclaim many others (business entities). Is it a philosophy? Is it a place? I can tell you that for about thirty years it's been a business! It's corporate! And it's big, getting bigger every year!

Most of the public does not know that "hospice" is not that big, warm, fuzzy thing they imagine when they think of hospice. It's not what they've been led to believe.

Hospice has always been a business aside from the purely volunteer hospices that dominated the field completely in the 1970s. There are still a couple of hundred volunteer hospices in the country, but they are not what we're discussing here. The volunteer hospices in the country do
much good, and do not pose the threat that some big hospice corporations do.

In 1983, the federal government implemented the Medicare hospice benefit and that's when all the non-profit (and a very few for-profit) hospice corporations started being created around the country. Some volunteer hospice organizations simply re-formed, incorporated under their state's nonprofit regulations and started providing services while billing to Medicare for reimbursement. For-profit hospice agencies really weren't much of a factor back then. Yet, even non-profit hospice agencies (business entities) take in revenue and pay their staff and administrators salaries.

You would get the impression that there were no problems in hospice as an industry if you considered most of the articles written over the years. There are literally thousands of articles touting the wonders of hospice, the good they do, and how families and patients are so well-served. If you read any paper in the country, you must have seen some of these "feel-good" stories, promoting hospice services. The only problem is that picture is completely unbalanced. Because the major media's editors have chosen to censor the other side of the story for decades, we have chosen to provide the information the public needs.

I remember six years ago when the hospice was dehydrating Terri Schiavo to death. ABC Worldwide radio had contacted me to come on the air and be interviewed about the case. I brought my son along to the WOOD AM Radio station high up in the Monroe Center office building in downtown Grand Rapids, Michigan. It was exciting and upsetting at the same time. The radio technicians told us where to sit and counted down as we "went live" and I was on the air answering a question posed. As soon as the words were out of my mouth, they had Michael Schiavo and George Felos, his attorney, on to counter what I said, though they were not telling the truth, and there was no opportunity given for me to respond and explain that there was abundant proof to confirm what I had said. They didn't want to hear about it. They were just interested in a sound bite, not the truth.

It's similar to the ongoing cover-up in the 1995 bombing of the Murrah Federal Building in Oklahoma City. Everyone who paid attention to the news at the time knows they were looking for "John Doe #2." And then suddenly, they weren't looking for "John Doe #2." People forget, but the truth is that the investigative reporter, Jayna Davis, found him fairly quickly, even though the FBI and federal government painted the story that Tim McVeigh and Terry Nichols acted alone. They weren't interested in finding him. In her book, The Third Terrorist: The Middle East Connection to the Oklahoma City Bombing, Jayna Davis shares conclusive proof showing that Saddam Hussein's Republican Guard was behind it. It is clear that sometimes what is presented as "reality" by the government and the media is absolutely not.

The realities of hospice are just as "covered-up." Have you read any major newspaper exposé about hospice recently? I'm sure you haven't. Not every agency or facility provides that supportive care the public has been led to believe hospice is about. Not all hospices are managed with an eye on assuring the very highest standards of care for their patients. Some are run as competitive, money-making machines. Some have committed health care fraud. Some do not honor the sanctity of life. These are why I call them "rogue hospices." Rogue hospices are much more common than people think. Most people don't even know they exist. The shocking and unfortunate truth is they do, and we shall see what they have been doing in America and how that affects all of us.

Over the years, I've been interviewed by USA Today, CNN, the Washington Post, Washington Times, Chicago Tribune and many others. Yet in almost all cases, the reporters use me to educate them about hospice and end-of-life care. They question me for hours by phone and email. Then when the article comes out, they quote one sentence from me, leaving out the major thrust of what I was emphasizing. That's the reality of "news" coverage in many cases.
They have editors and an angle on a story they want to print. So, they gather material and then shape it to appear how they want it to appear, not how the reality is.

While there are some wonderful hospices, rogue hospices are something else. Like all other industries, hospice has problems of some sort. Because the mission of hospice is unique and because these patients are among the most vulnerable of all, I believe that the public needs to be informed and to know how to deal with and correct those problems. I do not want another family to go through tragedies that others endured during the most emotionally-charged time of their lives.

After witnessing serious violations of the standards of care at the Hospice of Michigan where I worked, I formed the Hospice Patients Alliance in 1998. We are a nonprofit, all-volunteer, patient advocacy organization, providing the most complete information about hospice and the standards of care on the internet, what services are to be provided, how to get the best care and how to resolve problems when they do occur. Hospice Patients Alliance promotes the type of hospice and palliative care that respects the life of those served, providing the best in professional end-of-life care till a natural death occurs in its own timing.

People often have no idea how to get help when they have real problems with a rogue hospice agency. When problems do arise, hospice administrators and staff have become expert at giving patients and families the supreme "runaround" with evasive answers, stalling techniques and even intimidation techniques to shut them up. Eventually, families search for an organization that can help them and they find us. We give them the answers they need to get the best care for their loved ones.

In my own hospice work, I have been confronted with situations at work where I had to ask myself:

What do you do when you've been shaken to your core by what you've seen, something so profoundly antithetical to everything you believe in? I saw administrators and other staff lie to the patients and families, exploit them for gain and deprive them of needed services.

I had to consider, "what will happen if I do not get involved?" I asked myself, "What will happen if I do not run to the rescue of those who are utterly defenseless?" And if I did run to their rescue, "what price will I pay?" I did act and intervene, and I have paid the price. There are many whistleblowers and patient advocates in the country like me who have paid a steep price for remaining loyal to the duty we owe to our patients. Doors close, career paths change, finances take a hit. Plans are changed.

In 1997, there was the case of Jose Alvarez who had a terminal illness. The only thing Jose wanted was to be able to die at home, and the Hospice of Michigan, seeking to gain financially, prevented Jose from staying at home or going home once they manipulated him into their facility to charge extra room and board fees. Jose's family came to all the staff for help. I helped them and they shared their concerns with the public and filed a complaint with the State of Michigan. Their complaint was corroborated by evidence that the Hospice of Michigan had violated the standards by not providing the care needed.

Since then I've received hundreds of calls about all sorts of problems in hospices around the country. Grieving families call and report that hospice staff and physicians actually yelled at them! In many cases, family members have even been banned from being at their own mother's or father's side (or other family members' side), simply because they objected to the patient receiving an overdose of morphine or other un-needed medications. I remember being called by a man who told me that he was the terminal hospice patient and was afraid they were going to kill him. He had end-stage heart failure, though he was in his late 40s. We talked quite
a while a few times, and then I heard nothing more from him. He had told me they were taking away his regular heart medications, thereby making his condition worse. He didn't want to be in hospice. He just wanted to be cared for and allowed to die a natural death when it came, not when they decided he should die.

In many cases, the Adult Protective Service system is even used to intimidate those who truly care about the patient and object to clinically unnecessary or harmful interventions. These can be as common as giving morphine when there is no pain, sedating a patient who is not agitated, depriving the patient of needed medications when they are still benefiting from them or not providing food and fluids as needed when they patient is still benefiting from them. We have received many calls from families who tell us the hospice falsely accused them of being a threat to their own loved one and called APS when they voiced their objections to the death-protocols being implemented at the hospice. So we have those who truly care about the patient being accused of being a threat, and those who hasten death in charge of the agency entrusted to care for the patient!

Back in 2001, Pam Yates called about her son Sean Reynolds who had died in hospice care. Due to a medication error, he ended up having terrible seizures when a needed medication was not given as ordered. Bob Davis of USA Today covered this story he titled "Family sues hospice over son's suffering." The problems in hospice can be from a myriad of causes, too little intervention or medication, too much intervention or medication, inappropriate interventions or medications and so on. Pam, like any mother, suffered terribly as her son came closer to death and then passed away. She wrote about a spiritual transformation that she underwent in her book, *The Gift of More: Lessons of Faith and Love from a Life Cut Short*, which tells the story in her own words. For those who doubt that miracles can still happen, read Pam Yates' book.

In other cases, staff members have berated family members who request that a patient who is not imminently dying be given food and water, or treatment for a urinary tract infection. Hospice professionals have derided family members for not believing that their loved one had "terminal cancer," because the referring physician said the patient had "terminal cancer," even though there were no lab results, biopsies or testing of any sort to confirm it, and upon autopsy no cancer at all was found. They yell at family members when they object to strong doses of morphine or sedatives being given when the patient has no uncontrolled pain or agitation.

Most families who experience the callousness, unresponsiveness and sometimes outright cruelty of some hospice administrators and staff are completely shocked. They never expected it and could never have imagined it happening to anyone, let alone to their loved one and their family. Others do not believe hospice staff could ever act this way. Many wonderful nurses and doctors, as well as others, who work with those at the end-of-life are not aware of the havoc and harm being caused by some others in the industry. They cannot imagine anyone doing what they themselves would not do, and they get very upset reading about these realities of the rogue hospices.

Anyone who has seen their own family member die knows how traumatic and upsetting it can be. With good end-of-life care it doesn't have to be that way, but sometimes it is. It is intense, and each family member has to come to grips with their own mortality, the loss of their loved one and the pain experienced when watching someone you love decline in health and die. The last thing they need is to have a palliative care or hospice professional act rudely or worse to them. Adjusting well to the dying and death of a loved one is so important to the mission of end-of-life care services, yet families whose loved one has been hastened to death against their will cannot grieve properly. They are wounded by the victimization of their loved one and suffer endlessly.
Having spoken with hospice staff, administrators, physicians, therapists, patients and families from all over the country for years, I've gained insight into what is really happening in this industry. While there are other leaders in the hospice industry who know what is truly occurring, they are not sharing that information with the public. They know very well how they are turning this industry upside down while maintaining the appearance that nothing has changed except that they are "better and improving every day." They withhold the truth from the public they serve. They won't reveal how the hospice mission has been twisted intentionally into something it was never meant to be. They especially don't share the truth with those hospice leaders and staff who are pro-life. They don't want them to know that they are infiltrating the industry.

If you read the language used by some of the hospice leaders or listen to them speak, you will quickly realize they sound almost exactly like the hospice leaders who remain committed to providing the very best end-of-life care. Probably you'll think they're the "real thing." They're slick and very convincing. Their websites sound like they promote the very best in end-of-life care. If you've ever met a really good con-man, you'll understand what I'm talking about. But these hospice leaders do not go out of their way to condemn the hastened death of the elderly or seriously disabled. They do not commit themselves to promoting the sanctity of life. Their salaries are obscene, beyond what anyone with a conscience could accept knowing that some patients are not getting the care they need so that salary can be paid out.

While the leaders of what I call "rogue" hospices withhold the truth from the public, we do reveal what is going on: the good and the bad. We think it is necessary to reveal the truth. If people are given the necessary information, they are empowered to make the best decisions for themselves and their loved ones. They are also empowered to understand what is really going on with health care reform, end-of-life care and what their own family will face soon if our nation remains on this course. Of course, we've been attacked by those who wish to hide the changes seeping into end-of-life care. We've also been attacked by pro-life hospice leaders and staff who adhere to the original mission we also support. They don't want to admit that any problems exist in the industry or that it has been heavily infiltrated by culture of death professionals with an agenda contrary to the mission they support. These professionals feel threatened by the truth and find ways of explaining away the repeated accounts of wrongdoing at the end-of-life.

Just as our society is experiencing clashes between those with different values and worldviews, the world of hospice is experiencing internal struggles that are completely unknown to the general public. There are actually two diametrically opposing visions of what hospice (and health care in general) should be and what type of services should be provided. Even though there are religious differences, traditional Judeo-Christian, Muslim, Hindu, or Buddhist individuals respect the life of the individual. They expect hospice to allow a natural death in its own timing, and when that is not done, they realize their values are being disregarded (no matter how much "talk" there is in hospice circles about respecting everyone's religious values).

I've received calls from people of several different religions who are horrified by what they've witnessed happen to their own family members. They only too late realize that respect for the sanctity of their loved one's life has been replaced with a secular utilitarian view, often mixed with an eye toward increased revenue, resulting in a hastened death. For those who think this is an issue only for Christians or Jewish people, the Koran states, for example, "...take not life which Allah has made sacred" (Chapter 6, verse 151). American physician Mahjabeen Islam, MD states, "there is no confusion about playing God for the Qur'an states clearly that it is God alone that decides the moment and the mode of death."

Whatever the religious faith of the patient, when they first receive word from the physician
that they have been diagnosed with a terminal illness, they don't suddenly decide that they want someone to kill them. They are thinking about living, and about the end of living. They're thinking about what death will steal from them, the lost opportunities to be with loved ones, to accomplish goals, to live. If they have faith, they will be thinking a lot about what comes next. For most people, they are thinking about how they might live longer, how to improve their chances, what they can do in the time they have left. The ailing need people around them who support their beliefs and affirm the value of their life.

We need to understand that when decisions about our loved ones' care and future are concerned, those coming from different worldviews and values may arrive at completely different conclusions. Sometimes, the worldview may be a secular, utilitarian one, and that is one of the main problems in how health care is delivered (or not delivered) today. A physician, nurse or even a health insurance company (and its claims adjusters) who respects and values the lives of those being served will provide or allow for better care than those physicians, nurses or health insurance company (and its claims adjusters) who look upon the patient as a number and not a person, as an excuse to bill for services, an opportunity to profit, or even an unwanted cost.

Removing the spiritual element from health care is a dangerous step that has introduced all sorts of problems into the industry. The mission to serve is truly a spiritual mission, and those who are called to serve, serve according to the gifts given to them.

When I went to Raleigh, NC to speak at the 2010 Annual Life Conference, I was asked whether hospice and palliative care is pro-life or culture of death. The short answer is that it can be both, depending upon the hospice agency or palliative care unit and staff providing care. However, the culture of death "flavor" of end-of-life care is becoming much more dominant, and we will see why.

Although a hospice agency, as a business, must assure revenue in order to provide services, when a health care agency such as a hospice views the patient as an opportunity to profit or solely to bring in revenue, it has strayed far from the original mission that was so widely well-received in this country. When the hospice agency is run by a corporation rather than an individual person, it can become unaccountable to the patients it serves. To understand what is happening today in hospice, we need to understand how the hospice movement got started and what has happened to businesses in general.

Three Hospice "Giants"

There are three individuals who have had the greatest impact on end-of-life care in America: Physician Dame Cicely Saunders, Dean of Nursing (at Yale) Florence Wald, RN, MN and Elizabeth Kubler-Ross, MD:

Dame Cicely Saunders is the visionary pioneer who founded the first modern hospice in 1967 in London, England: St. Christopher's Hospice, named after the saint who, legend has it, helped carry travelers to the other side of a dangerous river.
"Born 22 June 1918 in Barnet, Hertfordshire, Dame Cicely trained as a nurse, a medical social worker and finally as a physician. Involved with the care of patients with terminal illness since 1948, she lectured widely on this subject, wrote many articles and contributed to numerous books."

"Dame Cicely founded St Christopher's Hospice in 1967 as the first hospice linking expert pain and symptom control, compassionate care, teaching and clinical research. St Christopher's has been a pioneer in the field of palliative medicine, which is now established worldwide.

"Through her single-minded vision, and the clinical practice and dissemination of her work through St Christopher's teaching and outreach, Dame Cicely has revolutionized the way in which society cares for the ill, the dying and the bereaved. Dame Cicely is recognized as the founder of the modern hospice movement and received many honours and awards for her work.

"... Dame Cicely Saunders recognized the inadequacy of the care of the dying that was offered in hospitals. So often, patients and families were told that "there was nothing more that could be done" a statement that Dame Cicely refused to accept.

"Throughout her time at St Christopher's her watchword has been "there is so much more to be done." Pioneering research on the use of morphine as an effective drug for pain control was carried out at St Christopher's, along with other detailed studies of new approaches to symptom control. Dame Cicely also understood that a dying person is more than a patient with symptoms to be controlled. She became convinced of the paramount importance of combining excellent medical and nursing care with "holistic" support that recognized practical, emotional, social, and spiritual need. She saw the dying person and the family as the unit of care and developed bereavement services at St Christopher's Hospice to extend support beyond the death of the patient."

Saunders was dedicated to improving care for the dying and their families. She recognized the value in a person's life up till the very end, and her vision of end-of-life care is what was so inspiring to many Americans who came to embrace the new way of caring for the dying.

And so, Americans have enthusiastically accepted hospice as it was envisioned by and practiced by Dame Cicely Saunders: a service that relieves suffering at the end-of-life but does
not hasten death in any manner.

Elizabeth Kubler-Ross & Stages of Grieving

No discussion of end-of-life care and hospice would be even marginally complete without mentioning Elizabeth Kubler-Ross's contribution to society's popular understanding of the grieving process. While working at Billings Hospital in Chicago, The Swiss psychiatrist wrote her classic book, *On Death and Dying*, which describes five stages of grieving at the end-of-life: denial, anger, bargaining, depression, and acceptance. Grief is something that must be confronted and processed by the patient, the family and friends. Understanding the sometimes intense emotions being experienced and the stages some patients go through may be helpful for all those working with the dying and their families.

Elisabeth Kubler-Ross' crusade to convince Americans that the dying should be honored, rather than ignored, changed the last days of millions.

Her 1969 classic book, *On Death and Dying*, and her advocacy work following it, gave the public permission to talk about death and grieving and taught doctors that the terminally ill should not be neglected.

[Obituary: "Her work brought dignity to the dying" - August 26, 2004 St. Petersburg Times]

Kubler-Ross's work helped professionals be much more sensitive to the range of emotions patients may go through as they near death. Her work helped our society think more about the quality of life of the patient going through the dying process. Although she observed "stages" terminally ill patients experienced, these stages were later applied to families grieving the loss of their loved one.

Although her work was widely accepted, recent studies show that not all families go through her now-classic "five stages" of grieving. A 2007 Journal of the American Medical Association article, "An Empirical Examination of the Stage Theory of Grief" reported that Yale researchers found that most bereaved individuals actually accept the death of their loved one from the beginning and did not necessarily go through "anger or depression," two of Kubler-Ross's stages. See *Time Magazine*, January 24, 2011.

It may be that the widely accepted application of Kubler-Ross's stages of grief (that some patients undergo), to the grief of the bereaved, rather than just for the patient himself, is a mistaken approach not borne out by current research. In any case, hospices and palliative care units often provide bereavement counseling services, as do funeral homes and grief counseling centers that have sprung up. Bereavement counseling has been required by government regulations in all licensed hospices for decades, yet its provision may be most needed by the 15% or so who experience "prolonged grief disorder." Based on some of the latest research, most adjust quite well over time. A 2002 study published in *Journal of Personality and Social Psychology* indicated that for most of us, the worst symptoms associated with grieving diminish within six months. ["Good News About Grief," *Time Magazine*, January 24, 2011]
Florence Wald, RN, MN

The third "giant" influence on hospice in America is certainly not "third" in her impact. In 1974, Florence Wald, RN, MN stepped down as Dean of Yale University School of Nursing to create the Connecticut Hospice, the first American hospice. From that time, Wald devoted her life to hospice in America. Though she wasn't the only worker in the field, she is the most famous leader of the modern American hospice movement. As productive and influential as she was, she sharply disagreed with Saunders' life-affirming approach to end-of-life care and said:

"I know that I differ from Cicely Saunders, who is very much against assisted suicide. I disagree with her view on the basis that there are cases in which either the pain or the debilitation the patient is experiencing is more than can be borne, whether it be economically, physically, emotionally, or socially. For this reason, I feel a range of options should be available to the patient, and this should include assisted suicide."

[Emphasis added. From: "Hospice Care in the United States: A Conversation With Florence S. Wald"
M.J. Friedrich JAMA. 1999;281(18):1683-1685]

Think about that for a minute! **What does it mean that assisted-suicide should be available to patients for economic reasons?** Whose economics? Surely not the patient's. So, is assisted-suicide supposed to be made available for society's economic needs? Or the family's (who stand to inherit the estate) economic needs? We need to let that sink in and really understand the significance of her revealing statement.

The American people have had no idea that the most prominent leader of hospice in America, Florence Wald, was pro-euthanasia and pro-assisted suicide. Wald's pro-euthanasia flavor of hospice is what is being delivered in many parts of this country, though many hospice professionals will strongly deny that.

Those who do remain faithful to Saunders life-affirming vision, who relieve the suffering of the dying until a natural death occurs in its own timing, will say they do not hasten death. Those who do hasten death will say the same. The public often has no way of knowing which type of hospice their loved one will experience.

So, here you have two leaders at opposite ends of the spectrum regarding "assisting suicide" or "imposing death," etc. Saunders and Wald may have agreed on the rest of what hospice should do, but adding in a "service" to hasten death is antithetical to everything Saunders cared about and is antithetical to the very mission of hospice. If you accept the idea of hastening death, imposing death at the end-of-life, you will not make providing good services the top priority, and if you do provide services, who decides when "time is up," and services end, and assisted suicide begins?

Many hospice leaders have spoken out and voiced their opposition to assisted-suicide or euthanasia, because if you kill the patient, you clearly can't care for them in hospice while allowing a natural death in its own timing. Hospices for decades would loudly proclaim that they never hasten death. The facts today tell a different story, as we shall see.

There is one practice that is sweeping through hospices and being very widely used: terminal
or palliative sedation. This involves permanently sedating the patient, allowing the patient to dehydrate and die. It looks outwardly peaceful as the patient is made to sleep in a medically-induced coma, but the patient's death is the result.

Terminally-sedating the patient is something that can be done in hospice that doesn't outwardly appear like euthanasia where a lethal agent is given. It also doesn't outwardly appear like assisted suicide where a patient takes a lethal medication prescribed by a physician. Terminal sedation is more subtle and deceptive. It allows the hospice to keep a patient for a week or two and bill for services rendered until death occurs. With the baby-boomer generation entering the target zone (suitable for hospice), there is always another patient waiting in the wings to be served.

Surprising to many, terminal, palliative or "total" sedation is so commonly used today to hasten death (a method of stealth euthanasia) that it is defined by the pro-euthanasia Compassion and Choices's "Good to Go Resource Guide" glossary. They define it as: "the continuous administration of medication to relieve severe, intractable symptoms that cannot be controlled while keeping the patient conscious. This treatment renders the patient unconscious and relieves suffering by inducing an artificial coma. The unconscious state is maintained until death occurs."

Saunders' caring, life-affirming view is the "flavor" of hospice marketed to the public by all hospices. It's the public image of hospice and palliative care. However, there are hospices that impose death through terminal sedation or other means, like wolves in sheep's clothing; these hospices are dangerous, even lethal to approach. Once admitted to these hospices, it can be almost impossible to get a patient out. They pose as caring hospice but provide treatment with an agenda that blindsides the patient and family and results in an untimely death, to the everlasting regret of those family members that cared.

Hospices that remain true to the life-affirming mission will not hesitate to proclaim the sanctity of life while they intervene to relieve suffering at the end-of-life. Hospices that are willing to hasten death normally do not speak about the sanctity of life and they do not teach their staff to never impose death, in fact, their training results in quite the opposite.

Hospice as the industry has marketed itself as a vague, compassionate "thing" that exists all over the country, filled with angelic hospice staff that care and work the kind of wonders that Cicely Saunders encouraged. And the staff at many hospices do care. There are thousands of articles and hundreds of books about the good work these staff do. Many patients and families have benefited from them. They have Cicely Saunders to thank for that. I, and others who work with the dying and their families, we understand that to work in this field is a privilege and a sacred trust.

This is the mission so many of us care about: relieving the many forms of suffering that occur at the end-of-life, supporting the patient and family on many levels, supporting the family even after death occurs, and especially, affirming the sanctity of that life all the way till the very end when death occurs naturally in its own timing. And those who have experienced this type of hospice are deeply grateful.

However, what will happen with health care reform? Economic pressures push government officials to try to reduce health-care spending through rationing. Rationing care on a utilitarian basis means denial of certain types of care which will precipitate a medical crisis for many, especially the elderly. Where will these elderly end up? Hospice and palliative care units. Hospice corporations already in existence are gearing up for increased revenue as additional formerly chronically-ill, non-terminal patients are sent their way. Each year, new hospices are
springing up all over the country to enroll them.

The Hospice Interdisciplinary Team Approach to End-of-Life Care

Hospice care has pioneered the use of an interdisciplinary approach to providing health care. Accessing the expertise of a team of professionals, the patient's needs are discussed from a multi-disciplinary perspective and a plan of care is created and updated on a weekly basis. The interdisciplinary team (the "IDT") is composed of nurses (both registered nurses and licensed practical nurses), home health aides, home service aides, medical social workers, chaplains, counselors, dietitians, therapists, volunteers, hospice medical director (supervision of your medical care), and the pharmacist (if the hospice has its own pharmacy and pharmacist).

Any member of the hospice IDT can bring up concerns at the weekly IDT meetings and members of the team can brainstorm to find solutions to the problems that are confronting the patient and their family. While the patient's own attending physician in the community gives the orders for medications and treatments, the hospice medical director reviews these orders and can consult with the attending physician to make sure that the patient's needs are met, sometimes educating the local physician on better ways of relieving pain or other extreme symptoms that arise at the end-of-life period.

Not all physicians have experience in treating extreme end-of-life symptoms, even though most think that they can handle it. It sometimes causes terrible problems for the patients when a physician without adequate training in pain management attempts to find the right dosage for the patient and does not know the standard protocols for titrating (adjusting) these opioid medications. Nurses are often extremely frustrated if a physician refuses to order adequate pain medication.

While the team approach has its advantages, it also has some disadvantages. In a rogue hospice where corners are cut, services are not always provided and revenue is often the first priority, the team meeting can be an opportunity to intimidate or indoctrinate staff into "how things are done" at that hospice. Some members may be afraid to speak up after experiencing disapproval from the team. Prolife nurses who object to a patient getting unnecessary medications have found themselves the target of retaliation, harassment, even false accusations or outright termination. There is a wide variation in how receptive management and other team members may be to objections about the way care is being provided in the end-of-life care setting.

If the hospice management, the interdisciplinary team and especially the medical director do not respect the sanctity of life, they may prevent treatment that will help the patient live while initiating a variety of treatment decisions that will tend to hasten death. Some interdisciplinary team meetings are merely a formality to rubber-stamp whatever the director decides. For example, commonly prescribed medications that stabilize the patient are commonly removed prematurely even though the patient is still deriving benefit from them. This is all part of
"manipulating death" that shortens the lives of patients.

Volunteer, Nonprofit and For-profit Hospice Corporations

Hospice began as a completely volunteer effort in America. The first volunteer hospices were staffed by doctors, nurses, social workers and lay people who simply wished to provide care for the dying that was focused in a wholistic way to relieve the suffering at the end-of-life. They were inspired by the work of Dame Cicely Saunders and recognized that the traditional health care system was simply not responsive to the needs of the patients. They saw that it often failed to provide good pain relief, and sometimes used the patient to prove what medicine could do in an alienating acute care hospital setting, rather than focusing on respecting the patient's own wishes. They tried to bring about an awakened insight into the needs of the dying, and over time, their efforts succeeded.

Currently, the volunteer hospices belong to the Volunteer Hospice Network, which:

"is an affinity group of volunteer organizations that provide a wide variety of free services to the seriously and terminally ill, their families and those who are grieving. VHN members include volunteer hospices, grief support programs, and many other volunteer groups that care for the dying, regardless of whether they are called "hospice." A few volunteer hospices provide medical care but most focus on practical, respite, emotional and bereavement support. VHN values include respect for diversity, love of community and protection of local solutions. The VHN serves as a central communication link among these organizations - the only Forum at the national level devoted exclusively to volunteer hospices and their special needs."

Over time, volunteer hospice leaders and some of the first hospice corporations in America realized that to be able to serve a larger segment of the community, and to offer all that modern medical science can offer, they would need to operate with reliable funding sources (rather than operating on a donation-only basis as volunteer hospices do). Several hospices and their leaders worked with the government to convince them to fund end-of-life services through hospice agencies. One such hospice,

"Vitas [Hospice] was instrumental in leading a bipartisan effort to add hospice to the healthcare payment system. As a result of these efforts, Medicare pays for hospice services. Many states have established Medicaid coverage for hospice, and virtually all private insurers and managed care plans provide coverage for hospice care."

With the implementation of the Medicare Hospice Benefit in 1983, federal funding for hospice services to the dying was assured. Studies on the financial benefits of using hospice services were completed, demonstrating that overall, hospice services result in significant reductions in expenditures by the federal government. Some volunteer hospices incorporated as nonprofit
hospice agencies under their state nonprofit laws while other volunteer hospices continued to serve on a purely volunteer basis. Nonprofit hospice corporations began to spread all over the country. Over time, some for-profit hospice corporations also were formed. While the legal structure is different for the nonprofit and the for-profit agencies, the mission remains the same and the federal standards of care are the same.

"Palliative Care" and Its Approach to End-of-Life Care

Well, not only are the people confused about what hospice is, they are even more confused about what palliative care is. I've heard from people who say hospice is the greatest thing for the dying, while others say that hospice is evil and killed their loved one. Same thing for palliative care. Hospice is not the same as palliative care, but they are very closely associated.

Really, hospice is the place (whether in a home or facility) where a certain approach to caring for the dying is provided. That approach involves the total philosophical mission presented by Dame Cicely Saunders. It is an approach that affirms the life of the patient, though they are in the end-stages of a terminal illness, and it promotes the relief of distressing symptoms throughout, until a death occurs in its own natural timing.

Saunders' basic message can be summed up:

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

This is the type of care that encourages, cares for and supports those nearing death, and warms the hearts of those who think about how to care for the dying.

However, palliative care is not exclusively practiced in a hospice. It's not a place or a philosophy. It is a niche within the field of medicine that specializes in the relief of distressing symptoms of any serious illness at any stage of life, whether of the terminally ill or not. The World Health Organization states that:

"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

Palliative medicine is the field of medicine that most effectively empowers hospice professionals to be able to relieve the suffering of the dying. Palliative medicine guides the administration of medications that can relieve pain, swelling, inflammation, seizures, spasms, fever, intestinal difficulties, respiratory afflictions and many other problems encountered at the end-of-life. It is clinically precise and is administered uniquely for each and every patient that
That being said, there is something else masquerading as palliative care just as there is something else masquerading as hospice care in this country. When every patient in a facility is "sedated, because all patients who come there are agitated" (as I've heard more than once from staff around the country), that is not palliative care or the clinically-precise application of palliative medicine. It is a perversion of hospice as well as palliative care. It is a deliberate railroading of patients to an imposed death, a hastened death through what is called "palliative" or "terminal" sedation.

Many of the state organizations of hospices in the United States changed their names to "Name of State -- state-hospice and palliative care organization." This move reflects the reality that not all end-of-life care is provided in an actual hospice agency. Sometimes, care is provided in specially designated palliative care areas of a hospital or nursing home.

There has been a lengthy effort to transform and twist the way death is perceived by the public and how Americans die. The patient, loving, reverent approach that Dame Cicely Saunders practiced and gave to the world was too religious and too "pro-life" for the leaders of the industry in this country, because they did not and do not adhere to Judeo-Christian values, traditional American values, and are not pro-life in any sense.

Many leaders at the top of the American hospice industry are not like Dame Cicely Saunders, though they pretend to be. They are utilitarians mostly concerned with expanding the industry's influence and making profit in the end-of-life care arena. The leaders at the top of the National Hospice & Palliative Care Organization ("NHPCO") are the Euthanasia Society of America's heirs and benefactors philosophically. The NHPCO is legally and corporately the final successor organization of the Euthanasia Society in the very strictest sense of the terms.
From Euthanasia Society of America to the National Hospice & Palliative Care Organization (1938-2004)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>1938</td>
<td>Euthanasia Society of America formed to legalize euthanasia</td>
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<tr>
<td>1967</td>
<td>Euthanasia Educational Fund created: soon renamed the Euthanasia Educational Council (EEC) (Living Wills created to &quot;promote discussion of euthanasia&quot;)</td>
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<td>1974</td>
<td>The Connecticut Hospice (first American hospice) formed by assisted-suicide proponent, Florence Wald, RN, MSN, FAAN (and honorary doctorate from Yale), considered the most influential force in the development of hospice in America</td>
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<tr>
<td>1975</td>
<td>Euthanasia Society of America changed its name to the Society for the Right to Die</td>
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<td>1978</td>
<td>National Hospice Organization (NHO) formed</td>
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<td>1979</td>
<td>Euthanasia Educational Council became known as Concern for Dying</td>
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<td>1990</td>
<td>Society for the Right to Die + Concern for Dying announce merger and become in 1991 the &quot;National Council for Death and Dying&quot; ... later in yr. name changed to Choice in Dying</td>
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<tr>
<td>1995</td>
<td>Robert Woods Johnson Foundation begins Last Acts Program</td>
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<td>2000</td>
<td>National Hospice Organization name-change to National Hospice &amp; Palliative Care Organization (NHPCO); Partnership for Caring becomes national program office of Last Acts</td>
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<td>2001</td>
<td>Choice in Dying merges into Partnership for Caring (March 14, 2001)</td>
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<td>2004</td>
<td>(January) Partnership for Caring and Last Acts merge to form Last Acts Partnership</td>
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<tr>
<td>2004</td>
<td>(later in year) Last Acts Partnership does (due to financial &quot;anomalies&quot;), National Hospice &amp; Palliative Care Organization acquires all legal rights and copyrights of Last Acts Partnership and becomes successor organization to it and all of its predecessors (The Euthanasia Soc of America ...) and forms &quot;Caring Connections&quot; a program of the NHPCO and continues services of predecessors: all the advance care planning resources: (advanced directives, living wills, advanced care planning). There is no further need for &quot;Euthanasia Society of America&quot; (or its successors) as the NHPCO is carrying on its work.</td>
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<td>2010</td>
<td>NHPCO lobbies to have Health Care Reform Law include language instructing physicians to counsel patients about &quot;advanced care planning,&quot; to encourage advanced directives, living wills, P.O.L.S.T. forms, hospice &amp; palliative care referrals. This language is first included, then taken out due to public outcry that government should not insert itself between physician and patient. Language is re-inserted by administrator of Centers for Medicare &amp; Medicaid Services (Donald Berwick, MD)</td>
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<tr>
<td>2011</td>
<td>(Jan 2011) Language is removed again due to public outcry.</td>
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"This advanced care planning language, and all the forms created by the Euth Soc of Amer & its successor organizations, are designed to limit care and will surely be re-introduced sometime in the not too distant future."

– Ron Panzer, Pres. Of Hospice Patients Alliance

International Task Force (now "Patients Rights Council")
http://www.internationaltaskforce.org/rpt2005_1.htm

Caring Connections Timeline (NHPCO):
http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3402

Timeline provided by Hospice Patients Alliance, Inc. (2011) www.hospicepatients.org

It is this direct lineage of euthanasia-supporting organizations that gave us the Advance Directives and the Living Wills, and now the P.O.L.S.T. forms (Physician Orders for
Anyone who doubts that the Living Will which is urged upon all Americans comes from the Euthanasia Society can read the main article proposing its adoption written by attorney, Luis Kutner in 1969 entitled, "Due Process of Euthanasia: The Living Will, A Proposal." [Indiana Law Journal v. 44, 1969, p. 549] There you have it! The Living Will was written to create a due process of euthanasia. In addition, in 1970, the Euthanasia Society of America distributed 60,000 living wills. They knew where they were leading American society, even if Americans did not!

What is a patient's "due process of euthanasia" but having the government create a patient right under the law to be medically-killed. In other words, Kutner's intention in creating the Living Will was to provide a way that governmental authorities could allow a form of euthanasia. The living wills were "sold" to the public as patients determining what type of care they would or would not want, but their main effect is to limit care that might allow them to live longer, an incremental step toward open euthanasia.

Even though the public today never thinks they are agreeing to "euthanasia" when they make out a Living Will, the effect of filling one out can interfere with getting treatment if you change your mind and want care. For example, some physicians will "write off" patients who have a Do Not Resuscitate order or a Living Will and simply provide "comfort care" while refusing to treat easily-treated infections. Not treating such infections results in an early death.

While "palliative care" in its purest form is made possible by advances in medical science and practice and is applied to relieve suffering at any stage of life, there are palliative care leaders who seek to use this newer specialty within medical practice to further an agenda that takes our society further away from affirming the value of human life and "doing no harm." Ione Whitlock of The LifeTree Organization tells us that:

"Thanks to Big Death - a collection of heavily funded non-profit hospice and palliative care groups - the line between palliative care (pain relief; symptom management) and imposed death has become blurred."

Transitions in Business

Understanding what is happening in hospice and end-of-life care today can only be fully understood by considering how businesses have evolved over time. Today's hospice agencies are corporate business entities, whether for-profit or nonprofit. The change from personally-owned businesses to corporately-run businesses does affect how end-of-life care is provided.

We all know that through the years people bought from local farmers, local markets, and local shops. With industrialization came the ability to produce more goods, sometimes better goods, and cheaper goods. Buyers flocked to buy the cheaper goods. However, as a result, many small shopkeepers and makers of goods went out of business. "Progress." They had to adapt to survive. Things changed.

Over time local farmers, markets, craftsmen and shops became bigger local shops, bigger
groups of craftsmen, bigger farms, but they were still local. If a craftsman made shoddy goods, you could always go down the street to the other craftsmen for quality work. Good quality work was (and still is in many cases) rewarded by people buying those goods, foods, and services.

Competition among different providers of goods and services resulted in efforts to maintain high standards. Providers with good values and integrity keep to those standards while still trying to find ways to make things, grow food, serve at a lower price. Why not? Lower prices bring more buyers, and eventually more profit if it is done right. Nothing wrong with that -- everyone's happy.

When everyone's generally following moral, ethical guidelines, it works well. Those who violate the laws and standards eventually get caught, exposed, and punished. It's a self-correcting system. Small or big, the providers of good services or products are rewarded and the providers of lower quality are not. We've all heard this before. But what's this got to do with you? Or me? Or hospice? Plenty.

What happens if the society and providers of goods and services no longer care about the quality of what they provide, or even about dealing honestly? What if all they care about is profit? If they are a monopoly, the only source of what they have to sell, they can raise their prices, lower their quality and people will have to buy what they can get from them. They will suffer exploitation without remedy, at least for a while. And we all know that has happened at times, for ages.

What if there's no monopoly, but many or most of the providers no longer care about top quality goods? The quality available goes down. People won't be able to buy the highest quality goods or services anymore except ordering it at a high price perhaps from afar, if what they want is still available somewhere.

When a business, farm or shop is run and owned by an individual person or small group of persons, they are more directly interested in what the customer wants. They are more likely to be sensitive to complaints and want to create satisfied customers with every business transaction.

However, when the businesses are no longer controlled by individual persons, but are run by a board of directors and the business is no longer the responsibility of one man or woman (or a small group of individuals) decisions may be made for different reasons. If the businesses become legal entities with a life of their own, corporations that get funding from investors who buy stock in the corporation, the corporation's administrators no longer answer directly to the customers. The administrators answer to the stockholders, even though they will say, "the customer always comes first."

The corporation is loyal to and controlled by what the investors, or usually the most powerful investors, want. The investors' goal is a return on their investment. How much do they want and how soon do they want it? Do they want long-term growth or short-term growth? If they want short-term growth, do they care so much about it that they are willing to let the corporation's agents provide fewer services or goods, lower quality services or goods, even cheat, steal, commit fraud or worse?

If you've gotten this far, you may still be wondering what this has to do with end-of-life care, hospice or the dying. Good question!

When the hospice corporation is for-profit, clearly the investors' eye on profit controls many decisions. This leads to cost-cutting, denial of services to patients and many problems in the
end-of-life care setting, and more hospices are now run by for-profit corporations than nonprofit! When the hospice corporation is nonprofit, many problems can still arise. The hospice corporation's administrators may be there for reasons other than serving the dying, as we shall see.

In areas that have a state-limited number of hospice providers for any one geographical region, the hospice corporation has a virtual monopoly. For example, in states like Florida, there is a "certificate of need" system where the state determines how many hospices may operate in one area. Often, only one hospice is "certified" to conduct business in an area. That state-determined monopoly status allows the hospice to do things it would not do if it had competition.

On the other hand, in states where there is no "certificate of need" system, the state allows as many hospices in as wish to operate, sometimes as many as 60 hospices in a metropolitan area. Competition for patients is fierce, something the public never sees. That competition for business dollars has many consequences, often damaging to small hospices with greater dedication to the mission of hospice as envisioned by Dame Cicely Saunders, the mission people expect to be reflected in the services provided to their loved one.
II - Hospice Today

The Business of Hospice

The largest and incredibly profitable hospice corporations don't provide hospice services the same way as those who run hospices with a real dedication to the mission. Many of the CEOs of very large hospice corporations have expanded their size by using cut-throat tactics that shut out smaller hospices, sometimes stealing patients from them, sometimes putting them out of business. Some are being destroyed by shutting them out of hospice referrals or being bought up by the larger hospice corporations.

One way of "cornering" the market in an area is to find a way to get more referrals or to "grab" patients before other hospice agencies have a chance to enroll them. I've repeatedly been told about some of these big hospices placing hospice admission nurses right in the halls of acute care hospitals, literally "trolling" for terminally ill patients to enroll.

You might think that the HIPAA would prevent a hospice nurse from accessing information that her hospice is not involved in and that she does not have a direct professional relationship with; you would be wrong. There are hospitals allowing hospice nurses to access records and know who is likely to be discharged to a hospice, and these trolling hospice admission nurses scoop them up for the big hospice they serve, even though the patient has the right to choose
their own hospice.

Physicians may refer their hospitalized patient to a particular hospice because it provides really good end-of-life care, and what happens? The family that has been told a hospice representative will show up at the hospital mistakenly thinks that there is only one "thing" called "hospice." When the big-hospice agency nurse arrives, the family thinks she is from the hospice the physician wanted them to go to and signs their loved one up with the wrong hospice. This happens a lot, and many hospice administrators know about this scam.

Competition can really be fierce for hospice patients. That's what Hospice of the Sunrise Shore's CEO, Gerry Habermehl told me back in 1998. I put Chuck Babcock, investigative reporter for the Washington Post in touch with Gerry and this is what he wrote back in 1998:

"... an aging U.S. population and the financial pressures of modern health care have brought the marketing tactics of corporate America into the cancer ward and cardiology unit."

"Things have changed so much in hospice since I started 10 1/2 years ago," said Geraldyn Habermehl, manager of Hospice of the Sunrise Shore in Alpena, Michigan. "It was pure hospice then. Now it's dog-eat-dog, dirty, competitive fighting. It was a service thing before. Now it's a money deal."

The "money deal"—which has resulted in a doubling of Medicare payments for hospice care in the past four years—has lured increasing numbers of for-profit operations to a field that once was universally non-profit...."

Babcock also wrote about Vitas' marketing efforts:

"Each patient also means money for ... nearly 100 Vitas agents earning commissions by recruiting the doomed."

Vitas said that they had discontinued the practice of paying agents finder's fees for bringing in new dying patients.

["Hospices Big Business, Thanks to Medicare" "Exploitation of Some Patients is Alleged" June 14, 1998]

The 1998 Washington Post article continues:

"Small Operators at Risk

Darla Schueth [a small hospice's administrator] views change in the hospice business from a somewhat different perspective than Westbrook [head of Vitas Hospice, the largest for-profit hospice corporation], with his 4,500 patients a day and operations in nine states. As executive director of Hospice Care of D.C., Schueth is struggling to stay in business as her patient census has ebbed in recent years by more than half, to about 40. Even as hospice care grows in the United States, competition for patients and the federal money they bring in, "is driving small hospices out of business," she said.

Likewise, Ken Nicholls and Pat Kelley of the Montgomery Hospice Society said they have seen their average patient load dwindle to about 50 a day. The Montgomery hospice, begun by volunteers in a church basement in 1981, is building an in-patient facility to complement at home service. But competition
continues to increase; the Maryland licensing board has approved four new hospices for Montgomery County, three of them for-profit.

Westbrook believes economies of scale are necessary to make hospice care viable. "You can't cover costs if you have under 75 to 80 patients a day," he said. "Most hospices are under 50. A lot of them are being subsidized by philanthropic dollars."

Vistacare's Smith agreed. The hospice field, he said, has been "largely filled with moms and pops, good hearted, wonderful people who lack' the capital or information systems" needed -- and who are vulnerable to competition from bigger operations.

Andrew Parker of American Hospice Management said the for-profits will lead a necessary consolidation in the industry. A brochure from Parker's company states: "Hospice represents an excellent opportunity for providers in many areas of the country to enhance revenue, expand service profiles, and conserve resources." The key to making money in hospice is "volume, volume, volume," Parker says.

"The whole environment of health care has changed; dollars are being squeezed," said David English, president of Hospice of Northern Virginia, the largest in greater Washington, with more than 350 patients. "Each institution is trying to maximize its revenue, hold onto the patient a little bit longer."

That means competition among hospitals, physicians, nursing homes and hospices for the cash the desperately ill can bring in. In some complicated cases, including those requiring in-patient care, the federal hospice reimbursement rate is more than $400 a day."

That was then in 1998. In fiscal year 2009 the hospice reimbursements were:
$622.66 for "general in-patient" level of care, routine home care was reimbursed at $139.97, inpatient respite care at $144.79 and continuous care in the home at $816.94

For good reason: the continuous care in the home requires that an R.N. or L.P.N. provide care for the patient one-half of the hours the continuous care team is in the home, anywhere from 8 to 24 hours a day. Patients who are placed in the higher levels of care demand much more services, because they have extreme symptoms which are uncontrolled. The greater intensity of care helps get those symptoms back under control and costs a lot more to provide.

However, some hospices have refused to provide the required continuous care level of care even though they had all the staff to provide that care. After the Alvarez family filed a public complaint to express their concerns and later expressed their desire to speak with reporters, I put Babcock in touch with Jose Alvarez' family. The family's goal in going public was to prevent such problems from happening to other families in the future. Babcock interviewed Jose's family and wrote:

"Carole Alvarez of Grand Rapids, Michigan, for example, said she felt anger and guilt upon learning, too late, that Hospice of Michigan ... could have provided round-the-clock nursing service at home to her late husband, Jose, who had wanted to die there rather than in an institution. "I just broke down and started crying, asking why I didn't explore it more. I trusted them so much," Alvarez said in an interview.
"Barbara Lewis, a spokeswoman for Hospice of Michigan, said the company erred in not making the service available. The [U.S. Dept. Of] HHS Inspector General is investigating several complaints against the company, according to documents."

"Erred?" The hospice in Michigan purposely refused to provide care in the home in order to bolster their financial status. Jose Alvarez's family wanted the public to know what happened to them and wrote:

"When the hospice staff came out, they told us that Jose was so sick that they had to take him to their facility. Jose said he wanted to stay at home, and we begged the hospice to try to keep him home with us. Couldn't they bring some nurses in the home, like we had heard they do? "No," they said. They had to bring him to the hospice's own facility, because there were "no nurses available" to take care of him at home. We had no choice but to move him to the facility, ...where he didn't want to be, where he didn't want to go."

".... Every day at the hospice care facility, Jose begged to go home. "Let me go home," he said, over and over. But no one at the hospice did anything to bring him home. At least, until we spoke with one nurse [Ron Panzer]. He listened and told us he'd ask the hospice management what they could do to bring Jose home. We wrote a letter which was given to the hospice management and placed in the chart as well."

"But the hospice management never responded. They ignored us, and ignored Jose's wish to go home, even though he begged to go home every day. Did the hospice management care? No, not at all."

The hospice not only ignored the family and Jose, they ignored me even after I directly confronted them and questioned their illegal policy. I simply asked them to follow the standards of care within hospice that allow the patient to choose for himself. Dying at home is very important to many patients. Carole Alvarez was devastated and told the Washington Post:

"We felt terrible that we couldn't bring Jose home. And later we learned that the hospice had lied to us! Because Jose's symptoms were so severe, the hospice was required to help us at home and try to control his symptoms, but they never tried at all. Of course, now we know that they were billing for room and board at their facility and getting money from our insurance company for the hospice services too. It was all about money, nothing about what was right for Jose."

In Jose's case, the hospice in Michigan was making sure to keep all their beds filled at their two free-standing facilities so they could charge for room and board there. In addition, they could bill at the higher rates for patients with uncontrolled severe symptoms (either "continuous care" or "general inpatient" level of care). The hospice was attempting to acquire funds they had been ordered to repay Medicare due to past "inappropriate billing" (fraud) they had committed.

When they told Jose Alvarez and his family "there are no nurses" available for continuous care at home, they lied. I was on the continuous care team and we all knew we were available to provide care in the patient's home. It really bothered me that the hospice in Michigan cared nothing for the standards of care or the patients.

Well, money is what allows a hospice to provide services. Problems arise when money
becomes the first priority and service comes second. Aside from billing for services rendered, hospices often use fundraising campaigns to bolster their revenue. Nonprofit and for-profit hospices accept donations and bequests from the public. "Donate to hospice." "Support hospice." "Hospice: compassionate care."... That's what the public hears. They don't hear "Donate to this business" "Hospice of the so-and-so Region." The public doesn't know where all the money goes or how it is used!

Of course, those hospices that do provide the full range of required and needed services absolutely need those donations to help provide the best care. Many charitable nonprofit hospices also take in patients who do not have health insurance and cannot pay for the services. Donating to these charitable hospices helps them provide care for the most needy.

But hospice administrators who are in it for the money don't advertise that the public's donations, "go to support the administrators of this business,"' Hospice of the so-and-so Region." Top administrators can use contributions to help themselves to $200,000 or $300,000 or more as their annual salary, plus benefits and other perks. I know of administrators that not only get the big bucks, they get all the health insurance, retirement benefits, fancy cars and much more, and these are CEOs of "non"-profit hospice agencies!

For example, Hospice of the Florida Suncoast, Inc. ("Suncoast Hospice"), the largest nonprofit hospice in the U.S., reports it paid $320,347 in 2009 to its CEO, Mary Labyak.

The Hospice of Michigan, Inc., the second largest nonprofit hospice in the U.S., reports it paid $447,008 in 2009 to its CEO, Dorothy Deremo.

Hospice of the Western Reserve, Inc., the third largest nonprofit hospice in the U.S., reports it paid $323,740 in 2008 to its CEO, David Simpson.

Clearly, hospice is big business. We still hear about hospices that provide doctors with incentives of various sorts to refer patients to that hospice exclusively, just like pharmaceutical companies "wine and dine" physicians or give them all sorts of gifts, paid seminars and trips in efforts to get them to prescribe certain medications. These are forms of kickbacks and in many cases are not acceptable incentives and are not legal. Would you want your loved one to be referred to a particular hospice just because the hospice was paying your physician to do so?
You get the idea. Never in a thousand years would these hospices want the public to know about these obscene salaries. At $25 per donation each, it might take about 10,000 - 17,000 people to donate enough just to pay one of these CEO's salary! Just think about that when you think of donating to these hospices! Or willing your estate to them. Where is your money really going to? Well, now we know.

Let's get a reality check here: whether for-profit or nonprofit, the top administrators at many big hospice businesses are paid hundreds of thousands of dollars each year. But the public doesn't have a clue. The hospice agencies that really need the donations most are the nonprofit hospices that affirm the sanctity of life, abide by the standards of care and provide all the services the patients really need. There are some smaller for-profit hospices that work hard to provide good care, but not all hospices do that. Several of the really large for-profit and nonprofit hospice corporations have been found to be committing Medicare fraud by the Justice Department.

Even though hospice corporations take in donations, they are funded mostly by the federal government's Medicare and state Medicaid programs, with much less coming from private health insurance. Why would the federal government do that? Because "hospice" saves big bucks over acute hospital care. This has been proved many, many times, study after study. Hospice lobbyists brag about that to the feds so they can keep the funding flowing in:

The biggest hospice industry lobbying group is the National Hospice & Palliative Care Organization. They write:

"Does Hospice Save Money?"

"Findings of a major study demonstrated that hospice services save money for Medicare and bring quality care to patients with life-limiting illness and their families. Researchers at Duke University found that hospice reduced Medicare costs by an average of $2,309 per hospice patient. Additionally, the study found that Medicare costs would be reduced for 7 out of 10 hospice recipients if hospice was used for a longer period of time. ...." [National Hospice & Palliative Care Organization Taylor DH Jr, Ostermann J, Van Houtven CH, Tulsky JA, Steinhauser K. What length of hospice use maximizes reduction in medical expenditures near death in the U.S. Medicare program? Soc Sci Med. 2007 Oct;65(7):1466-78.]

But when hospice reaches their corporate hands to the public, they don't brag about the money they save the government's Medicare and Medicaid programs. They only talk about "compassionate care for the dying." They don't mention the obscene salaries the CEOs, VPs, and others are getting at these larger hospice businesses.

Some administrators of the "Hospice of the so-and-so Region" are more concerned about the money, i.e., "please insert your retirement accounts here and make sure to leave your estate and life-insurance payout at the door when you enter. We'd really appreciate it." And here they get real specific: "Please make your checks out to Hospice of the So-and-So," not "hospice" all over the country.

Every couple of years I get a call from someone around the country asking how to donate to "hospice," because "hospice" gave such great to care to Aunt Arlene, and they want to make sure it gets to the right people. But, they don't know who the "right people" are, and I have to explain to them that it was a unique, specific "hospice" business that provided care and they have to donate to "that" hospice. I end up looking up the information and letting them know what the hospice's address is so they can mail the check. People are just very confused, and it's
been planned to be that way as part of a long-term "feel-good about this thing called hospice" strategy of the hospice industry.

Top administrators at these large hospices are usually more interested in their own annual salary increase than an individual patient's needs. I've heard about hospices denying something as simple as a certain type of over-the-counter medication to a patient whose family had paid many thousands of dollars for room and board over a long time, all to save on the cost of medications ... while at the same time, the CEO was earning over $200,000. There's the "mission of hospice," and there's the "business of hospice." Many staff really care about the mission. The administrators of the huge hospices? Safe to say they care more about the business of hospice: revenue, profit and what they can bring home for themselves.

In the 1980s, there were a few hundred nonprofit hospices and the number of for-profit hospices was almost nonexistent. In 1992, there were about 1,000 nonprofit and a couple hundred for-profit hospices. In 2009, about 1,400 of the hospices were nonprofit and more were for-profit, about 1,800, some of these with several branches in a region.

The ratio of nonprofits to for-profits has completely switched with growth in for-profit hospices leaping far ahead. This is a clear sign that from the business perspective, hospice is looked upon as an opportunity to make money, and I know that when hospice corporations are making a lot of money, there is major fraud involved. And for-profit hospices still receive donations. Where does the money go?
Medscape Today reports that "Patients Receive Fewer Services From For-Profit Hospice Providers" than from nonprofit hospice providers. This is not encouraging news for those facing enrollment in a hospice which is more and more likely to be a for-profit hospice.

Now don't get me wrong. There are some really good hospices (hospice entities) that put their patients first and provide a full range of services to the terminally ill. I worked with some really great hospice professionals. I trained with Mary C., RN who had been a cardiac care specialist at a major big-city hospital medical system. She demonstrated the highest level standard of care for hospice nursing. And there are other wonderful nurses and doctors serving in this field.

But let's get back to the business of "hospice." "Hospice" is like an investors' dream (if we're talking for-profit hospice). And even a large non-profit can rake in the dough for the chosen few at the top. A recent article focuses on the business angle where for-profits scoop up the less demanding patients and let the smaller nonprofits deal with the more difficult cases, so the for-profits make even more profit.

"Without changes to the current reimbursement structure, coupled with measures to ensure greater accountability in the use of these benefits, we are concerned about the potential for a more dominant hospice provider to serve selectively a higher percentage of patients with a non-cancer diagnosis. The patient population at such a hospice could thereby average significantly longer and more lucrative periods of time during which the provider would realize a great return on the Medicare per diem payments for those patients, while potentially shifting a disproportionate share of the more costly short-term patients to hospice providers with a broader commitment to a community beyond those with an ownership interest.

[In the Business of Dying: Questioning the Commercialization of Hospice; J Law Med Ethics. 2011 Jun;39(2):224-34]

If you look at the "business" outlook for the United States economy or world economy, it's pretty glum right now. But if you look at the business outlook for "hospice," (i.e., "Hospice of the so-and-so Region" all across the country) it's better than finding oil on "Uncle Jed Clampett's" Tennessee swamp (think "Beverly Hillbillies"). It's a lot better than the meteoric rise of and future forecast for gold prices. No wonder that 8 out of the 9 largest hospice corporations in America are for-profit.
Gold prices through the years look like this:

![Gold Prices Chart](image1)

The number of hospice patients being served through the years looks like this:

![Hospice Patients Chart](image2)

Number of hospice agencies through the years looks like this:

In 1985, there were about 1,545 total hospices; in 1994 about 2,312; in 2004 about 3,650; now there are about 5,000 total hospice providers.

Other sources differ on the exact numbers, but the trend is there.

The expansion of hospice as an industry looked at by the number of patients served, number of agencies serving patients is much more impressive from an investors' perspective than the rise in gold prices over the past few decades!

From the government perspective:

"Expenditures for the Medicare hospice benefit have increased approximately $1 billion per year. In fiscal year (CY) 1998, expenditures for the Medicare hospice benefit were $2.2 billion, while in CY 2008, expenditures for the Medicare hospice benefit were $11.2 billion."

[Source: Health Care Information System (HCIS)]." -- Hospice Data 1998-2008 - Centers for Medicare Services

Well, if you know any other industry where the funding is increasing by $1 billion each year, let me know. The federal government obviously has big plans for hospice and its future role in the American health care system and in your life and your family's lives. Think health care reform!

"There were more than twice as many Medicare hospice patients in 2008 than in 1998." -- Hospice Data 1998-2008 - Centers for Medicare Services
With the number of patients, i.e., "customers," increasing by 10% every year, without fail, I project the likely trend for the industry could be something like this:

I'm certain it's going to be more than 10% growth in some years to come! With the baby-boomers moving into the elderly category, more and more of them are developing acute and chronic conditions. Some of them are dying. The pressure to shunt them into hospice will become massive as the health care budget is being squeezed for whatever can be gotten out of it. The federal government has refused for decades to deal seriously with rampant Medicare fraud (their protests to the contrary). Rather than stop the theft, officials will argue that services need to be slashed and people need to go into hospice much, much sooner than ever before.

In 2009, only about 40% of hospice patients were cancer patients. However, in the 1980s, almost all of them were! Think about it. Why the change?

In 2009, 13% were in hospice simply because they were weak ("debility"), 11% were in hospice because they had "dementia" of some sort (and that can be a true dementia or simply mild forgetfulness). When patients enter hospice simply because they are elderly, weak or forgetful, it is a red flag that something definitely is not right. Just because someone is elderly, weak or has dementia does not mean they are imminently dying at all, or that they are going to die naturally even within the year or a few years. Many elderly individuals are weak and have dementia to some degree. Does that mean we should kill them? Some clearly believe the answer to that is "yes." Sometimes, the elderly are neglected intentionally and not given the close attention they require. And their health declines because of that neglect. This type of neglect can occur in the patient's own home or in a nursing home.

How would you feel if it was your grandmother or grandfather, or mother or father, who was targeted in this way? Or your children's grandmother or grandfather? They still have their
dreams of seeing your children grow up or even seeing them at all. Just because they're elderly doesn't mean they don't have any dreams of their own, that they don't want to live. Who decides that this doctor or administrator has the right, the moral authority to end someone's life? ... to cancel your dreams for that life? ... to cancel his or her dreams? Why do "they" get to play God and decide?

Artwork by Graffiti artist Banksy

My own mother-in-law was neglected and malnourished, even emaciated. My wife and I took her into our home when she was visiting and cared for her, made sure she ate and bathed and got all her medications. She had not been getting her B-12 injections for pernicious anemia nor had she gotten her medications for high blood pressure where she had been living. It was a miracle she was still alive. But once we had her here, she gained about 30 pounds and was at her optimum weight and health, even though the family had told us she had "failure to thrive" and "could not gain" weight. All she needed was decent food, common medications and loving care. If she had remained where she was, she would very likely have been sent to hospice, continued to be deprived of the simple blood pressure medications she needed and her B-12 injections, and died at least three years earlier. She lived another few years with us till she died a natural death. And yes, a good hospice was involved, then, at the end.

What is happening with the change in the type of diseases that "get someone admitted into hospice" in America? It's a complete transformation of what normally happens at the end-of-life. In the past, most patients had incurable cancer as an admitting diagnosis and entered hospice. Now, dementia, the simply elderly or "weak" patients make up a large percentage, and they die sooner rather than later ... by design, and it's been in the works for a long time.

The plan is for close to 100% of Americans to die in hospice rather than an acute care hospital. Some private insurers are creating "Advanced Illness" programs where patients are admitted for care by a hospice agency even though they are not expected to die within six months. This appears to be a move to save money by having patients die sooner with fewer or no hospitalizations, thereby saving the private insurance company (and the government)
significant expenditures and increasing profit (helping to reduce the budget deficit).

They may not achieve total utilization for hospice or palliative care, but they will increasingly narrow the gap toward their goal. Hospice and palliative care will figure in almost every American's life at the end, and certainly, it will handle one or more members of every American family, your family.

If you were a betting man, you couldn't find a better bet than hospice and palliative care. As sure as anything, we know the federal government has, is, and will promote "hospice" and "palliative care." They're increasing Medicare funding for hospice alone by $1 billion each year! We know the media editors will promote "hospice." Literally thousands of heart-warming stories about hospice have been written. We know that the economic pressures of the times will force greater utilization of hospice. What form that hospice will take is being shaped by those who don't care about you and me. When you understand who has been shaping end-of-life care for their own agenda, you may be very concerned about health care reforms coming to your neighborhood. You should be.

There are disturbing trends that are washing over the industry. The largest nonprofit hospice in the country, Hospice of the Florida Suncoast immediately comes to mind. That hospice's CEO, Mary Labyak, has told her staff, "We've got to corner the market."

What kind of statement is that when hospice is supposed to be a caring place where the focus is on serving patients at the end-of-life? How does that statement jive with the idea that hospice is a philosophy of caring well for the dying as well as for their families? And Labyak? She's regularly been placed on the board of directors of the nation's largest hospice lobbying group, the National Hospice & Palliative Care Organization. She's the one with a salary of $320,347 in 2009 at her nonprofit Hospice of the Florida Suncoast.

**Why Hospice Is a "Protected" Industry**

Well, it's pretty clear that hospice is being promoted at every level of government and by every major player in society, including the major media, big business, hospitals, nursing homes, policymakers, budget analysts and others. We've seen that hospice has been proved to save money over acute hospital care. The savings amount to billions of dollars.

"In 2009, an estimated 1.56 million patients received services from hospice." "Researchers at Duke University found that hospice reduced Medicare costs by an average of $2,309 per hospice patient."

2009 figures for hospice savings:

1,560,000 hospice patients per year
X $ 2,309 (savings/patient) per year

= $ 3,600,000,000 savings per year
"Hospitals across the United States now have Palliative Care Units, where physicians and staff specialize in the care of the seriously ill. The choice to have these units has nothing altruistic about it; it is driven by the bottom line. Studies have shown that the cost incurred on a patient in the last few days of hospitalization when they are in the Palliative Care Unit is one quarter of what it is when they are in a non-Palliative Care Unit."

["Selectively Erring on the Side of Life" by Dr. Mahjabeen Islam, Toledo, Ohio April 08, 2005]

The top level policymakers have decided that people will die in hospice or palliative care units, and that they will be pushed into hospice through a wide variety of means. $3.6 billion saved in one year. Think that motivates the government? That's nothing compared to the savings when the people placed into hospice doubles in the years to come. That's the plan. If patients are hurried along toward death, the savings skyrocket!

We may not wish to think about it, but the U.S. Department of Public Health has long looked at the American population as a "herd," in other words, as a total group to be managed. They do not think of what is best for a particular person or even thousands of people. They do what they decide is best for the whole population.

For example, when the U.S. Dept. of Public Health wanted to protect the "herd" of American people from polio, they used oral polio vaccine that had been weakened, but still contained live virus. A health department physician I contacted told me the idea was to promote "herd" immunity by exposing not only those who were vaccinated to the attenuated virus in the vaccine, but also those who refused to take the vaccine to the live virus floating around in the community due to many having been vaccinated. The rate of polio cases declined dramatically shortly after the polio vaccine was introduced in the 1950s.

That some people could develop actual full-blown polio did not stop them from using the live virus vaccine. That some people had chosen not to be exposed to the live virus did not stop them from exposing them to the live virus involuntarily (through contact with others who had been vaccinated). Predictably, some people did become quadriplegics due to having been exposed to the vaccine, either directly through vaccination or otherwise. In the case of Griffin v. United States, we see that in 1963, Mrs. Griffin was vaccinated and she became a permanent quadriplegic. "Dominick Tenuto was stricken with polio in 1979 after coming into contact with his daughter's stool while changing the diaper. The infant had been given the ... vaccine, ... which contained a live virus."

Thirty years after Mrs. Griffin got polio back in 1963, they were still using live virus in the oral polio vaccine. In 1993, I had to fight the local county health department to have my own son get the inactivated, "dead" polio vaccine safely used in Europe for over a decade. I didn't want him to unnecessarily risk contracting polio. After several refusals by the health department, I stood my ground against very strong efforts to intimidate me into using the live oral vaccine. Finally, the physician "magically" produced the version of the vaccine that we wanted, that was safer individually for him, and administered it to my son. They had it all along, but only wanted to use the live oral polio vaccine as it promoted herd immunity.

We can understand the thinking behind the government's program. They wanted to expose the non-vaccinated to the live virus to help immunize the entire U.S. population. The Centers for Disease Control states:

"Polio was one of the most dreaded childhood diseases of the 20th Century in the United States. There were usually about 13,000 to 20,000 cases of"
paralytic polio reported each year in the US before the introduction of Salk inactivated polio vaccine (IPV) in 1955. Polio peaked in 1952 when there were more than 21,000 reported cases." [and]

"The last cases of naturally occurring paralytic polio in the United States were in 1979, when an outbreak occurred among the Amish in several Midwestern states. From 1980 through 1999, there were 152 confirmed cases of paralytic polio cases reported. Of the 152 cases, eight cases were acquired outside the United States and imported. The last imported case caused by wild poliovirus into the United States was reported in 1993. The remaining 144 cases were vaccine-associated paralytic polio (VAPP) caused by live oral polio vaccine."

144 people contracted polio from the live polio vaccine from 1980 to 1999. So, to prevent 13,000 to 20,000 cases, they risk 144 acquiring the disease. Seems logical, but could they do better? The 144 would not have gotten polio if they had gotten the inactivated polio vaccine, but they were given the live version due to Public Health Department policy. So, who should decide? The government or you? When it's your child, should you decide or the government? The government's leaders decided they will decide for you.

The policymakers at the U.S. Public Health Department recognize that some individuals will either die or have severe reactions to vaccines that they mandate be administered to the general population. Children are mandated to have many vaccinations to prevent the spread of disease and only those given a waiver can be excused from receiving the vaccine and still attend school. There is even a table of vaccinations and likely serious consequences some individuals may suffer. The Code of Federal Regulations's "Vaccine Injury Table" lists the time periods within which someone receiving a vaccine has to manifest symptoms in order to be compensated for their death, injury, disability or condition. If you don't manifest "death, injury, disability or some other condition" soon enough according to the table, then you're not likely to get compensation.

"The following is a table of vaccines, the injuries, disabilities, illnesses, conditions, and deaths resulting from the administration of such vaccines, and the time period in which the first symptom or manifestation of onset or of the significant aggravation of such injuries, disabilities, illnesses, conditions, and deaths is to occur after vaccine administration for purposes of receiving compensation under the [National Vaccine Injury Compensation] Program." [42 CFR, vol. 1, chapter I, Subchapter J, "Vaccines," part 100.3 Subtitle 2 of title XXI of the Public Health Service (PHS) Act]

While most people may not suffer much or at all from a vaccination, in rare cases some do suffer severe, immediate, life-changing consequences, chronic illness, disability or death. I've met people who were perfectly normal at birth, received a vaccination, and then within days had severe neurological damage and became permanently developmentally-disabled (mentally retarded). The "one-out-of-a-million" chance; it happens to someone, somewhere.

Another example of how government leaders think and the consequences of government-promoted vaccinations?

"The HPV vaccine Gardasil, which is being vigorously pushed on unsuspecting young girls and women to theoretically guard against cervical cancer still has never been proven to actually prevent cancer. On the contrary, evidence suggests that under certain circumstances the vaccine increases your risk of precancerous lesions by nearly 45 percent, and an ever increasing number of girls are being seriously injured by this unnecessary vaccine."
"As of December 13, 2010, 20,915 adverse reactions had been reported in the United States alone, including 89 deaths, 297 miscarriages or stillbirths, and 370 reports of abnormal pap smears post vaccination.

"All of this from a vaccine that has only been on the market for four years."
[Emphasis added]

and:

"Contaminated Polio Vaccine Responsible for Human Cancer Cases"

In 2002, the journal Lancet published compelling evidence that contaminated polio vaccine was responsible for up to half of the 55,000 non-Hodgkin's lymphoma cases that were occurring each year.

What was it contaminated with?

SV40, a cancer-causing monkey virus. The puzzle began in 1994, when Dr. Michele Carbone, a Loyola University researcher, found the virus SV40, which had never before been detected in humans, in half of the human lung tumors he was studying. Since then, 60 different lab studies have confirmed the results, and SV40 has been found in a variety of human cancers, including lung-, brain-, bone-, and lymphatic cancer.

At first no one could fathom how the virus had been transmitted into the human population.

But in the censored interview with Dr. Maurice Hilleman ..., Hilleman admits Merck's responsibility in unleashing this virus via their polio vaccine, as well as the likelihood that there was an importing and spreading the AIDS virus in the same manner.

Just who is Dr. Maurice Hilleman?

Now, for those of you who may think Dr. Hilleman was just another crackpot (he passed away in 2005), think again. He was, and still is, the leading vaccine pioneer in the history of vaccines. He developed more than three dozen vaccines. More than any other scientist in history and was the developer of Merck's vaccine program.

He was a member of the U.S. National Academy of Science, the Institute of Medicine, the American Academy of Arts and Sciences, and the American Philosophical Society, and received a special lifetime achievement award from the World Health Organization.

[from: "60 Lab Studies Now Confirm Cancer Link to a Vaccine You Probably Had as a Child" Dr. Mercola February 18, 2011]

But can you sue and win in court? Not really. In order to encourage manufacturers to continue to make vaccines, Congress enacted:

the National Childhood Vaccine Injury Act of 1986 [that] created a so-called "vaccine court" to address safety claims in an attempt to ease the threat of lawsuits in state courts against pharmaceutical companies and insure against them pulling out of what they claim is an unprofitable vaccine marketplace
completely.

Under the law, people injured by vaccines are eligible for compensation for medical care, rehabilitation, counseling, special education, and vocational training expenses; diminished earning capacity; pain and suffering; and $250,000 for vaccine-related deaths.

["Supreme Court Sides With Vaccine Maker" By Emily P. Walker MedPage Today February 22, 2011]

The intent here is not to scare anyone, though we do need to carefully think about what we do medically. **The intent is to show how government policy-makers think and how policy is implemented.** They are willing to sacrifice some who are healthy in order to carry out the vaccination programs. If they can prevent the spread of terrible diseases, they would argue it's worth it. They take chances with our lives and are willing to experiment upon us with what they mandate we take. There may be safer ways to do the work. And even though vaccine manufacturers take credit for the reductions in deaths from certain communicable diseases, others say that vaccination is not really the only explanation. Improved nutrition and water quality, sanitation and sewer services as well as improvements in medical care are also important contributing factors.

"Increasingly, pediatricians are refusing to treat children who are not fully vaccinated. We need to understand that this same type of thinking flourishes among the policymakers at the top levels of government. When they wish to, they use government authority to mandate the results they seek.

Aside from vaccination, government can use other methods to prevent the spread of infectious diseases. The government has "emergency powers" that set aside and void normal Constitutional procedures. When a serious epidemic threatens to spread to larger areas of the population, the U.S. Health Department, the President and the Governors in each state are involved. Decisions they make are based upon what they deem best to prevent that spread. However, it may include the imposition of martial law in specific areas. It all sounds fine theoretically until it affects you and your family. In between the rule of law and completely implemented martial law there are steps that have been taken that increase the power of the government at the expense of individual rights.

Quarantine policy is based on these same principles: what is best for the "herd" or total population. The government will sacrifice many if it saves a larger percentage of the total population. Entire cities can be quarantined, with the military surrounding the city limits to enforce the quarantine zone with threat of lethal force if necessary. While some may think these things only happen in movies, it is realistic to consider these scenarios might happen at some time in the future.

Why do I raise these issues? It's to get a rare glimpse into how the stakeholders create policy at the very highest levels of government today. How they think. It's the same type of thinking with current health care reform, reform that's already begun for Medicare and Medicaid, utilitarian rationing of health care (which already happens in managed care organizations all over the country), and the push to have patients enter hospice or palliative care units earlier. There is nothing wrong with making health care systems more efficient and doing away with truly ineffective treatments, but utilitarian rationing (which is what we're talking about in this book) has an agenda behind the decision-making.

The government and its agents and providers of care will do whatever the elite policymakers deem "best" for the entire country (not what is best necessarily for you and your family). All
the state and local county health departments will follow suit. In addition, all licensed
physicians (or any health care professionals) who wish to retain their license, will toe the line
should a federal policy tell them they have to do this or that, or not do this or that. Physicians
will be directed to order a patient into hospice under certain circumstances. Or, treatment
pathways that are open now will be closed, so hospice or palliative care becomes the only
available "treatment!" The patient's right to choose will be extremely limited.

Good and Bad Hospices

One of the more common questions that we've heard through the years is, "how can I find a
good hospice?" "How do I know which hospice will provide the care my loved one needs?"
There really is no one certain answer to these questions. Often, the recent experience of
someone in the same town or city who has used a particular hospice is very revealing, but
someone else's "wonderful" experience with a hospice is no guarantee that the next person will
have the same level of care.

Recommendations from health care professionals who are in your family or from those you
trust can be very valuable, but again, they are no guarantee. Do these health care professionals
share your values about how care should be provided? Do they value the sanctity of life or do
dey think it is "ok" to end life (one way or another) to relieve suffering? Do they believe in
quality of life as the main determinant of whether a life has value? Someone who thinks
quality of life is the main factor to consider may rate a hospice very highly even though they
hastened a patient to an early death. If you get a recommendation from someone who
recognizes the sanctity of life, that would be a good sign.

Sometimes, the patient and family simply have to call different hospices and get a feel for how
the hospices present themselves, how committed they are to the mission of service to the dying
and then, take a shot and try one. If things go well, good. If not, the patient and family need to
listen to their instincts about what is happening. When medications are given that are not
clinically indicated, when services that should be provided are not being provided, when it's
hard to get in touch with staff that can help, then we need to see these as "red flags" and have
another agency manage a transfer to their care, or get care in a home health care setting.
Sometimes, that is the only option if there are few or no other hospice agencies in the area.

Some hospice leaders are just now forming a new Hospice Life Association of America, which
will help form more pro-life hospices, where all the hospice agency members affirm the
sanctity of life and share the Hospice Life Pledge with their employees. Member agencies are
committed to the pro-life mission and will never hasten or impose death unnaturally. If you
know that a hospice agency actively promotes a pro-life message, that it honors the sanctity of
life and will not impose death, but allows for a natural death in its own timing, then that is
probably the best choice for those who wish to protect their loved one from exploitation,
inadequate service or staffing, or outright hastened death.
Hospice Reimbursement: Is it a Problem?

The Medicare hospice benefit, instituted in 1983, was a boon to the expansion of hospice in America. It provides for a per-diem payment for every day the patient is enrolled in the hospice agency. Hospice administrators have told me over the years that the reimbursement is frugal, but that with good business practices a hospice agency can break even and make enough to pay for all services required to be provided under the federal and state standards of care. The nonprofit agencies often receive donations from the public to help them provide services, but it's not always easy!

The cap on reimbursement, is it a problem? Most people have no idea there even is a "cap" or limit on how much the hospice corporations get per patient each year. Well, over 500 hospice agencies have joined together to fight the government's hospice cap formula. They call themselves the National Alliance for Hospice Access. They think reimbursement is a huge problem.

They have a lot of data showing that the cap does not pay for all the services required and are working hard to either change the formula or do away with the cap as it exists now completely. There is a lot of merit to the claims that the reimbursement system leaves much to be desired and should be updated to assure hospices have the funds to provide the very best care.

All hospice corporations would welcome increased reimbursement per patient each year. However, the per-patient reimbursement is not likely to be increased much (or at all) if the economic strains on our economy continue. Although we may wish that funding should be provided adequately for each patient's end-of-life care, other health care agencies, hospitals and corporations are going to be fighting for every federal dollar they can get. This does not mean that overall spending on hospice as an industry will not grow; it will ... due to the increase in the number of hospices and total patients served.

To admit a patient into hospice, a physician must certify a patient as "terminally ill" indicating the patient is likely to die within six months. But, physicians cannot always accurately predict how long a patient is going to live, and patients often do live beyond six months. What is the result of having a patient live longer or require services beyond what the reimbursement cap will pay? When the patient lives beyond a certain time period, the patient's cost of services becomes a "net-negative" to the corporation. Although hospices with integrity balance out the revenue from some patients to help pay for services to others, problems arise when top administrators wish to use the hospice as a vehicle to pad their own income. They twist the hospice into a "rogue" hospice.

CEOs of hospice agencies can manipulate boards of directors to raise their salaries into the hundreds of thousands of dollars, while staff struggle with increased case loads and patients suffer from fewer visits, fewer services being provided and a failure to meet their very urgent needs at the end-of-life. This is a problem common to all health care agencies, whether hospitals, nursing homes, assisted-living centers or hospice agencies. However, hospice's reimbursement is quite unique. There are four levels of care: the routine home care level, the respite level, the general inpatient care level and the continuous care level of care, all with different reimbursement payments.

As we have seen, from October 2010 through the next year, the routine Home Care level is
What does this mean? It means that at the lower level of service, routine home care, hospice agencies provide routine nursing visits 1-3 times per week, aide visits 1-5 times per week, and a social worker visit occasionally as needed, and so on. If the caregiver is exhausted from caring for the patient, the hospice can take the patient into a hospice facility and provide respite care for about five days. If the patient develops extreme symptoms out-of-control, then the hospice can provide more intensive services.

If these more intensive services are provided in the home, it's called "continuous care." If these services are provided in a facility, it's called "general inpatient care." All of this can work very well if the hospice agency is dedicated to the mission. When that happens, hospice services can be a real blessing to the patient and family. The hospice makes adjustments to the plan of care as the patient's needs change and provides those services. Good clinical intervention which is tailored to the unique needs of the patient and their very specific clinical condition can make a huge difference in the lives of the patient and his or her family.

However, a rogue hospice looks at the hospice reimbursement arrangement completely differently. They don't think, "Mission first" and "how are we going to provide all the services needed?" Rogue hospice administrators think about "cornering the market," driving other hospices out of business or reducing the other agency's slice of the local business. Rogue administrators think of how much they can earn personally if they cut this or that service. They think about how they can build a hospice "empire" and not about reasonably restricting their own pay to meet the needs of the patients. Administrators who have created a rogue hospice agency view hospice as an opportunity to exploit Medicare, Medicaid, private insurance and families as well. They plunder these resources for all the money they can seize, even committing fraud or other criminal activities.

Administrators of rogue agencies will arrange kickback arrangements with nursing homes, physicians and hospital administrators in their area. They will use their political connections to "grease the wheels" moving their agency to the top of the list in their area while working to actually harm and diminish the role of other hospices in their area. I've heard from several hospice administrators through the years who have related the dirty tactics that these rogue hospice administrators use to further their selfish ends.

Administrators of the rogue hospice agencies are basically dishonest, yet they are often hailed as very successful business leaders! The ones I've met have an incredible ability to lie to your face with a smile. They have no conscience, or appear not to have one, and they think nothing of the harm their actions cause the patients, families and the staff. The ones I've met care nothing about the standards of care, morality, or the law. They use the hospice reimbursement levels to increase the revenue to their hospice and themselves while decreasing services to the patients.

Over the years, I have heard from hospice staff around the country about "inner-circle parties" at some big hospices with the abuse of drugs, alcohol and casual sexual relations of all types among these rogue hospice administrators and some of their "inner circle" staff. They just do not respect traditional morality at all.

The administrators of rogue hospices proudly dress very professionally and outwardly appear to the public to be the very picture of dedicated public servants. We need only look at their individual salaries and actions to see the hypocrisy. When they make sure that some innocent patients will be medically killed (by using staff training to misinform them about the effects of
medications), encouraging the casual administration of morphine to COPD patients, not allowing oxygen for patients who need it, encouraging staff to remove needed medications from the patients they admit or to terminally sedate the patients, or actually sending "closers" to end their lives, they never let the public know what really is going on. In these cases, they always lie and pretend to honor the caring, supportive hospice services the public has come to respect.

Hospice and Health Care Industry Fraud

Mary Labyak's Hospice of the Florida Suncoast was cited in 1996 for overbilling $14.8 million from Medicare. The administrators: selfless servants? Hardly. The staff? Many have been dedicated nurses, many of whom leave once they see the cut-throat nature of pro-euthanasia Labyak's approach to the business of hospice.

And what kind of actions does this hospice take to create its success in Florida? I've written dozens of articles over the years about this hospice, but basically, most of what they do is hidden from the public. You have to do some digging to learn about the strange choices they make and you immediately understand who they are and what kind of people they are.

Hospice of the Florida Suncoast hired Susan Wynn, a convicted felon who embezzled $370,000 and was found guilty of over 100 counts of money laundering. Not only did they hire her, they hired her first thing, the moment she was released from jail. The St. Petersburg Times reported that:

"Wynn, ... works as administrative assistant to the nonprofit's vice president of finance."

Astounding! But true. They did hire her into the finance department! And:

"federal prosecutors in Savannah accused Wynn of writing checks to herself from 1991 to 1995 using a transit authority account. She pleaded guilty to the criminal charges."
That's not all. In June 2003, The St. Petersburg Times reported that the hospice hired yet another felon into its finance department. The paper announced, "2nd felon gets 2nd chance at hospice."

Sunday, February 06, 2011

".... Karen D. Langan [pled] guilty to felony grand theft in 2001 and [after] being sentenced to five years of probation, Langan was looking for a new job.

Hospice of the Florida Suncoast gave her one, even after learning of her criminal history. Langan now works in the hospice's payroll department."

Knowing that they hired these two felons directly into the Finance Department, Wynn (the embezzler) to assist the head of Finance, and Eckerd (the thief) in payroll, it's perfectly clear, without any exaggeration, they value felons' expertise and wanted that expertise for their own. If it were fiction it might make for an interesting story, but it is tragically true. This is how the largest nonprofit in our nation is run, and it is very revealing indeed about what kind of people run it.

This hospice is very big and powerful in Pinellas County, Florida. Founded in 1977, it's among the earlier hospices in the country. And like many hospices, its board members consist of some of the most prominent leaders in town, the executives of some local businesses, a few county commissioners and other wealthy citizens. The hospice brings in huge amounts of money from donations in addition to the government's reimbursements. While the hospice itself is nonprofit, it has a for-profit subsidiary, Suncoast Solutions that produces hospice management software. Some of the board members of the nonprofit hospice have also served on the board of the hospice foundation as well as the for-profit subsidiary.

A class action lawsuit was filed in February of 2003 against the Hospice of the Florida Suncoast. The lawsuit was brought against the hospice for disclosing private information about patients including their names, addresses, diagnoses and telephone numbers. I personally went online and saw the Suncoast Solutions "ftp" website where the data was publicly accessible (1, 2, 3) and verified that personal information was being released on the ftp site as well as within software help screens, contrary to patient privacy protections. The "publicly accessible ftp" site was not password-protected and contained files that could be downloaded that contained the
information. The lawsuit also was brought alleging that the hospice (run by CEO, Mary Labyak) diverted funds (that had been donated to the nonprofit) to the for-profit subsidiary:

"the nonprofit loaned $1.9-million in donated money to its for-profit software company in 2001, calling it an investment in hospice's financial future. Documents and interviews show the money was used to buy out a Louisiana corporation that worked with hospice to develop software. The company is headed by the son of Labyak's friend Jo-Ann Mueller."

["Hospice defends software deal" May 12, 2003 Homehealthprovider.com]

My friend, Christina Brundage, RN, a very experienced and dedicated nurse has told me and others about some of her experiences working at that Hospice of the Florida Suncoast:

"They were working on all these ways to get more patients in that weren't terminal, they were going to have all these new programs - a palliative care program, a home health program .... like they were trying to bring in more and more people and fought so hard to keep any competition out. It became money oriented rather than patient oriented."

These initiatives were done under the leadership of hospice CEO, Mary Labyak, who received "the Healthcare Architect Award from the National Hospice Foundation" in 2011. What kind of health care is she designing when she approves of euthanasia and terminal sedation? And why would the National Hospice Federation let her chair their board of trustees and honor her in this way? Is this the type of leadership our nation's hospices need to protect the vulnerable? What Christina Brundage, RN witnessed shows how Labyak has twisted the hospice mission and demonstrates what Labyak and others are doing all around the nation.

I met Christina Brundage, RN in the years when so many of us were working to try to save Terri Schiavo. Christina exemplifies the dedicated hospice professional who is horrified by the changes in the industry, just as I am. She left the Hospice of the Florida Suncoast before Terri Schiavo was enrolled there, because of what she saw, how the primary focus on caring was lost. She stepped up to become a tireless volunteer for the Schindlers, the Terri Schindler Schiavo Foundation, Hospice Patients Alliance and the pro-life movement in general. Some
time after she left the hospice, she was visiting a friend in a hospice facility and saw for herself how a patient could be hastened to his death.

American hospice as an industry, led by cut-throat corporations like the Hospice of the Florida Suncoast (that want to "corner the market"), is not the pure "thing" that they market themselves to be. We've got really huge for-profit corporations like Vitas, Odyssey, Gentiva, Vistacare, and "Golden Living" that acquired the infamous mega-corporation Beverly Enterprises in 2006.

How big are these for-profit mega-hospices like Vitas? The Vitas website tells us:

"Vitas Healthcare Corporation (Vitas), based in Miami, Florida, is the nation's largest provider of hospice services with about a 7% share of the U.S. hospice market. Vitas commenced operations in 1978 and incorporated in 1983 as a for-profit organization."

1983: ... the year Vitas and others convinced the federal government to create the Medicare hospice benefit. Vitas saw the government's Medicare reimbursement as a profit-making opportunity, just as Washington Post reporter Chuck Babcock wrote in 1998:

"Vitas Healthcare currently provides services to almost 9,000 patients from 44 hospice programs in 11 states. These areas include California, Connecticut, Delaware, Florida, Georgia, Illinois, New Jersey, Ohio, Pennsylvania, Texas and Wisconsin. Over half of Vitas' patients receive care in their homes. Approximately 40% of patients receive care in skilled nursing and assisted living facilities. ....."

"The capital required to establish a single hospice facility is currently estimated at between $300,000 and $500,000. As a result, competition notwithstanding the not-for-profit providers, which constitute more than 72% of all hospices, is significant (albeit highly fragmented)."

That "72%" figure is from 1998. And the amounts needed to start up a single hospice facility are much higher now. The current stats show there are more for-profit corporations running hospices than nonprofit corporations!

"A large number of hospice programs are owned by, or are part of, a larger healthcare delivery system, typically not-for-profit hospitals. In addition to not-for-profit service providers, the industry is also characterized by a high number of small regional operators. However, nine of the top 10 providers, as measured by average daily census (ADC), are for-profit. Average daily census refers to the total number of patients, regardless of the level of service. The major publicly traded hospice industry players, which include Vitas, Odyssey, VistaCare, and Manor Care, collectively only account for approximately 15% of the market. While the relatively low absolute capital requirements represent a low barrier to entry, the regulatory complexity associated with establishing a Medicare-licensed hospice location remains a significant barrier. In addition, hospice referral sources are largely dependent on relationships and reputations established over time through the provision of high-quality care and service."

[Emphasis added]

Vitas Hospice was acquired by Chemed, the corporation that also owns Roto-Rooter plumbing services! Notice that this thing called hospice is discussed as a "market" and that competition among hospice agency providers for patients is very intense. For-profit hospice is an
investment opportunity that is not being ignored by those who know anything about health care or making money in the stock market.

For example, Beverly Enterprises, now Golden Living, owned many, many hospices and nursing facilities around the country. Odyssey Health Care owned many hospices and has now been acquired by Gentiva Health Services, another for-profit corporation:

"August 17, 2010

"Gentiva(R) Health Services Closes Odyssey HealthCare Acquisition Company Ranks as Nation's Largest Combined Home Health and Hospice Services Provider"

"Gentiva Health Services, Inc. (Nasdaq: GTIV) ("Gentiva" or "the Company"), a leading provider of home health and hospice services, today announced the closing of its acquisition of Odyssey HealthCare, Inc. (Nasdaq: ODSY) ("Odyssey") in an all cash transaction for a price of $27 per share of Odyssey common stock, without interest, for an aggregate purchase price of approximately $1.0 billion, including fees and expenses."

"The combination of Gentiva and Odyssey creates the largest US healthcare provider of home health and hospice services based on revenue. Annualized pro forma revenues for the twelve months ended July 4, 2010 exceeded $1.88 billion, of which approximately 59% related to home health services and approximately 41% related to hospice services. The combined hospice operations of Odyssey and Gentiva provide care to an average daily patient census of approximately 14,000 in 30 states. Gentiva raised approximately $1.1 billion in new debt financing to fund the purchase price and refinance existing debt." [PRNewswire via COMTEX News Network]

$1 billion was paid to purchase Odyssey health care. $1 billion! If you think hospice is all about compassionate care for the dying, you are very mistaken. It's big business! And if you think I'm kidding when I talk about "profit" in the health care industry, take a look at Gentiva:

"Gentiva continues to expect 2010 full-year net revenues to be in the range of $1.42 billion to $1.45 billion and adjusted income from continuing operations to be $2.75 to $2.80 on a diluted per share basis."

"For 2011, Gentiva expects full-year net revenues to be in the range of $1.90 billion to $1.95 billion and adjusted income from continuing operations to be $2.70 to $2.80 on a diluted per share basis. Gentiva's 2011 outlook includes the full-year impact of its Odyssey HealthCare, Inc. acquisition...."

Gentiva: $1.42 to $1.45 billion in net revenue!

What about Beverly? Before being acquired by Golden Living, Beverly ran many hospices and nursing homes as well. Now "Golden Living" does the job. "Golden Living" sounds so wonderful. At least that's what they want us to think. There are other huge hospice corporations out there, too. Let's discuss Beverly because they were the poster boy for what's wrong with health care in America today.

Beverly, for those who know, ran one of the nation's largest chains of nursing homes around the country, and you know how "great" the care is at many nursing homes. Beverly had 82,000
employees with sales of $2.98 billion in 1994.

Beverly had some problems with the federal government, big problems. The U.S. Justice Department investigation found that Beverly had defrauded the U.S. Government to the tune of $460 million!

How? By billing for services not rendered, asking to be paid for work not done. A good scam if you ask me, one that many other health care corporations are doing as well, so don't think Beverly is the only one. When I spoke with the U.S. attorneys' office, they told me they had thousands of health care fraud cases pending that they couldn't even get to. Sometimes it takes three years to process one of these fraud cases.

It's easier to rob the federal government through Medicare than to commit what we've come to think of as the "real" crimes, like bank robbing. Why risk your life when white-collar crime pays so well, and you can be assured that the federal government will reward you for the effort? Reward you? Let me explain. The feds found Beverly had fraudulently billed:

".... Four hundred sixty million ($460,000,000), for engaging in the following conduct during the period from 1992 through 1998: submitting Medicare skilled nursing facility cost reports, for cost report years 1992-1998, that overstated the costs attributable to the facilities' Medicare certified units by allocating labor hours to the Medicare certified units that were not actually incurred ...."

In other words, Beverly requested reimbursement for services they didn't provide and got paid for six years without being caught. The U.S. Justice Department and Beverly did come to a settlement. "Beverly Enterprises agree[d] to pay to the United States One Hundred Seventy Million Dollars ($170,000,000)." I think even "little Johnny" can come to the blackboard and do the arithmetic. Department of Justice arithmetic is very simple:
Think about that again:

Beverly steals  $460 million
- Beverly pays back  $170 million

Beverly gets to keep  $290 million

Does that make sense to you? It doesn't make sense to me. When someone robs the corner store for $500 and gets sent to jail for fifteen years, you know that felon is going to be out-of-work for at least fifteen years. And bank robbers often are ordered to make restitution, paying back what they stole. A health care corporation robs close to $500 million and nobody goes to jail, plus they get to keep $290 million? You know they're going to just keep on doing it. You couldn't design a more ineffective policy at the Justice Department than what they do. It encourages the opposite of what they say they are doing: "curbing health care fraud." What could be more rewarding than raking in all that money for free and not suffering any significant consequences?

It's the same kind of thing you see with environmental protection enforcement. Say some corporation really pollutes somewhere and they get caught as well as convicted of violating the law. The law says the E.P.A. can slap them with up to a million dollar fine or something like that. The company that brings in billions every year looks at that fine as just a "cost of doing business" and pays the fine without even blinking. There's no deterrence in these fines to such huge corporations, and there's no deterrence to fraud in how the U.S. Justice Department deals with health care fraud.

In fact, let me tell you about the U.S. Justice Department. They often just don't make the health care corporations that steal from the government (our tax dollars) pay everything back. Do you wonder why?

Back in 1997 when I worked at the Hospice of Michigan, the hospice had defrauded Medicare. A year earlier, they had been ordered by the federal government to repay more than a million dollars "wrongly billed." They thought they'd get away with it of course. It was in all the Michigan newspapers at the time.

I remember speaking with Raja Mishra, Detroit Free Press reporter who later wrote in his article, "A Business of Death and Dollars," November 7, 1997:

"the federal government demanded that Hospice of Michigan repay almost $1.5 million ...."

That's obviously a huge sum of money. So what brilliant strategy did the Hospice of Michigan figure out to do in order to "correct" their "wrong" billing of $1.5 million? They fired 80 employees, cut costs and decided to commit other violations to get the money to pay the feds back. This involved depriving patients of required services while making sure all the beds in their two hospice facilities were filled, (this is why Jose Alvarez didn't get to die at home as he wished) thereby collecting more room and board.

The hospice administrators also ordered the nurses (me included) to record continuous care (a higher level of care) as being provided, even though there was no extra nursing staff on hand. When I saw this, I realized that they could receive millions of dollars more each year for services not provided if they billed at the higher rate of reimbursement. I guess they were not good at "learning" the lessons the feds wanted to teach them.
The top administrators of the large Hospice of Michigan knew they were violating the standards for hospice and so did the Vice-President of the corporation. When I confronted management first in a detailed confidential letter and later in person about the needs of the patients not being met, about the exploitation of patients and the violations of the standards, the Vice-President walked me into an office, closed the door securely and just laughed in my face and told me, "Ron, you're absolutely right! This is a violation of the standards of care, but we're not going to stop." "We will get cited, sure." "We'll get a "deficiency. But, they won't shut us down." And that's exactly what happened.

When I spoke to the U.S. attorney managing the case against the Hospice of Michigan, I asked him, "Why don't you have them pay back all the money?" I also wondered why they didn't prosecute the administrators. His answer? "Well, if we did that, the business would be shut down and we can't do that."

If the people of this country, the taxpaying people of this country, had to come up with a policy for those who commit fraud, they wouldn't say, "we can't do that." They'd shut them down if they were repeat white-collar criminals, throw the administrators who designed the fraud into jail and make them pay back 100% of what they stole. I know that the real reason health care fraud is so rampant and out-of-control is this one policy of the U.S. Justice Department.

It is extremely rare for any administrator to be prosecuted, let alone serve jail time. The so-called "corporate integrity agreements" the dishonest corporations enter into with the Justice Department only make them "promise to be good," ... show on paper a plan of how they will "prevent" fraud from happening at their business ("hospice" or other agency), and then pay back a portion of what they stole, plus or minus a few million here and there. Doubt it? Head to the Department of Health & Human Services, Office of Inspector General ("OIG") website and read them for yourself:

The Office of Inspector General ("OIG") works with the U.S. Justice Department in its investigations and eventually a settlement is often arranged with the offending business ("hospice," "hospital," or other business entity). As we've seen, the hospice industry does commit Medicare fraud, thereby bolstering the revenue they bring in. I remember the director of a state Medicaid Fraud Control Unit that called me almost ten years ago asking questions about hospice. She was just beginning her evaluation of what hospices were doing in her state. In response to her questions, I explained how hospices commit fraud and she was stunned. She didn't believe me at first, but we continued speaking on and off. Several months later, she called me to report her investigations had found widespread fraud in hospice in her state.

What about one of the largest for-profit hospice chains in the USA, Odyssey Health Care? They settled with the U.S. Justice Department by paying $13 million. In 2006, they had 82 hospice agencies located in thirty different states! I've been contacted by Odyssey hospice nurses who told me about the fraud being committed there. They felt terrible that the patients were suffering because they were not getting the care they needed.

I also got calls from some therapists that had contracted with Odyssey Hospice to provide therapy services and complained that they were just listed as the hospice therapists, but were not allowed to go out and really provide service. So, they told me, when Odyssey billed for full service, they provided less, and therefore, Odyssey made more profit. Just like at some of the other hospices committing fraud.

July 11, 2006 -- "Odyssey HealthCare, Inc. (Nasdaq:ODSY), the second largest provider of hospice care in the United States, today announced that it has entered into final agreements with the United States Department of Justice
and United States Department of Health and Human Services, Office of Inspector General ("OIG") to resolve previously-disclosed federal investigations arising from two whistleblower actions filed under the federal civil False Claims Act. As previously announced, under the terms of the Settlement Agreement, the Company agreed to pay $13.0 million without acknowledging any wrongdoing. The Company recorded the $13.0 million charge in the fourth quarter of 2005."

"As part of the settlement, Odyssey worked closely with the OIG to negotiate a corporate integrity agreement ("CIA") that will enhance the Company's already robust compliance program."

"Robust" compliance program? They make it sound like the administration never knew about the fraud going on. They make it sound as if the top administrators truly care about running a completely honest operation. Fraud of this magnitude can never occur without the knowledge of top administrators. These corporate integrity agreements allow those who initiated and then carried out the fraud to plan on paper how they will "prevent" future fraud. What would the public think if we had every bank robber write down a plan for how he is not going to rob banks in the future? And then release him from custody with half the money he stole from the bank? How many bank robberies would that stop?

We need to understand that intentional fraud committed by the administrators of these hospice corporations is really organized crime, crime intended from the top levels of the corporation with policies set in place that guarantee fraud continues. Even one of these rogue hospices steals many millions of dollars each year. This is white-collar crime on a scale that boggles the mind. I know from my own experience that some of the most well-known leaders in the hospice industry are basically white collar criminals that belong in jail. Yet, they lead the national hospice organizations and are hailed as great business "successes."

You think Odyssey and Hospice of the Florida Suncoast are the only ones? Not even close.

What about Vitas, the largest hospice provider in the country? Now, Vitas is a special case, a very interesting case.

Based in Miami, Florida and founded by Hugh Westbrook, the hospice is, as we've seen, a for-profit hospice chain (now owned by Chemed Corporation), just like Odyssey, VistaCare, Beverly (now "Golden Living") and others, Vitas was under investigation during the Clinton administration for Medicare fraud with $50 million in "disputed federal payments."

As we've seen, the reporter who broke the first national story about hospice wrongdoing in the country was Washington Post senior investigative reporter Chuck Babcock. That was the reason he called me. He was working on the story and wanted to get my reaction to the Vitas case and also to research hospice and get more information. His article, "Hospices Big Business, Thanks to Medicare; Exploitation of Some Patients Is Alleged" contains references to problems I told him about at the Hospice of Michigan where I had worked, problems that confirmed that hospice had become a big business, with the potential to create terrible problems for patients.

Who was U.S. Attorney General when Vitas was being investigated? Miami resident Janet Reno. This same Janet Reno had been a state attorney for what is now Miami Dade county and certainly knew Hugh Westbrook, CEO of the Vitas Health Care Corporation based on her home turf. Westbrook was and is a huge Democrat supporter, fundraiser and friend of Bill Clinton. And Janet Reno was a huge supporter of Democrat politics.
The Justice Department investigation of Vitas Health Care? When I contacted Chuck Babcock a few years later (now at Bloomberg News), he told me that the case was just closed, no explanation. It just mysteriously disappeared under the Janet Reno Justice Department! This is how the system works. Remember that old saying? "It's not what you know ... It's who you know....!" I guess Hugh Westbrook, Bill Clinton and Janet Reno would all agree.

This is not "being negative." It just is reality. When I was younger, I never wanted to believe it. The more you see, the more you experience, and it becomes obvious. And the crooks keep stealing when nothing serious is done to stop them. As just one example, "the Texas Attorney General's Office and U.S. Department of Justice are investigating" Vitas again for committing Medicare and Medicaid fraud.

Of course, the public doesn't think about Vitas's or Odyssey's fraud when they think about hospice. They don't think of Beverly Enterprises, the Hospice of Michigan or the Hospice of the Florida Suncoast. They just think warm, fuzzy thoughts about comfort care and relieving suffering at the end-of-life. End-of-life service should be what they are thinking, and sometimes it is, but it isn't always that way. It can be a real mess, a mixture of very good care in some cases and very bad care in other cases.

The public doesn't know that leaders at such large hospices such as Hospice of the Florida Suncoast, the Hospice of Michigan, Vitas, VistaCare, and Odyssey also serve on the board of the National Hospice & Palliative Care Organization, the largest hospice lobbying and trade organization.

But we're getting ahead of ourselves. Back to the Hospice of Michigan where I worked: just like all the big hospice corporations, it has a big law firm on retainer. I'm certain they may have told them about the Justice Department policy, that they didn't require corporations to pay everything back. It's public knowledge this is the U.S. Justice Department policy. So it pays hospices and other health care corporations to commit fraud, and then wait and see what happens.

I get some of the industry seminar and leadership conference announcements. One year I had to laugh when I saw a picture and announcement that one of the hospice in Michigan's administrators was going to give a lecture at the big conference on how to prevent fraud in hospice. I imagine that behind the scenes "tricks of the trade" are shared in how to defraud Medicare and Medicaid, but can't be sure. What the public doesn't know!

What kind of fraud is the most common in hospice? Usually it's admitting patients who don't require a lot of services, like chronically ill but stable patients with a wide variety of conditions. These are patients that are properly enrolled in home health care agency services with a visiting nurse to keep an eye on their medications and condition.

Sometimes dementia patients who are not at the very end-stage of the disease are also admitted. Why admit them? Well, the hospice agency doesn't have to send out lots of staff, but they bill every day for services. Hospice is funded on a per-diem basis. Every day a patient is enrolled is a day they can bill. The less service-intensive patients balance out for the patients who require a lot of intervention and staff.

Like we've seen, good hospice administrators I've met through the years tell me that providing all the required services can be done under the reimbursement structure, but it's "tight." Whenever I hear about a hospice corporation making a lot of profit, or paying hundreds of thousands of dollars to its administrators, I know they are committing fraud of one sort or another.
As a regular part of their work, the Medicaid and Medicare fiscal intermediaries investigate bills for reimbursement from the hospices, determining if bills should or should not be paid, whether patients qualify for hospice or not. Hospices may or may not be committing fraud when the fiscal intermediaries request further information and are looking more closely at a particular hospice. Several law firms specialize in helping hospices get out of trouble with the fiscal intermediaries or even with the OIG or U.S. Attorneys' offices.

How the hospice fraud game is played is simple: they admit non-terminal patients and bill for services for several months or longer. There are other methods as well.

Kaiser Permanente's Oregon Unit is just another example of this common method. They paid $1.8 million over "billing flaws" in 2009.

"... to settle charges of false billing brought by the federal Medicare program.

The U.S. Justice Department said Kaiser's hospice program billed for services without obtaining written certifications of terminal illness required by federal regulations."

Of course, Kaiser denies any wrongdoing, but the Justice Department investigated for a few years and found false billing had been committed. In the old days, in order to avoid detection, hospices committing fraud would actually discharge the patient from hospice after several months saying the patient was not "declining" or not showing evidence they were coming closer to death (they wouldn't because they weren't "terminal").

Nowadays, it's done differently. They're more willing to be in-your-face pushing imposed deaths upon those patients that are inconvenient to them. A patient who lives too long is a liability, a legal embarrassment. The Medicare fiscal intermediaries look at every case that's billed and if a patient has lived too long, it becomes a "red flag." They look into it, looking for possible fraud.

Well, do you think the U.S. Justice Department "solved" the problem and got these hospice businesses to shape up and stop committing criminal fraud? No way! In 2011, Vitas, Vistacare, Gentiva and other for-profit hospices are in the news again, and it just continues, with serious repercussions for patients. Peter Waldman of Bloomberg News writes, "Preparing Americans for Death Lets Hospices Neglect End of Life."

Of course, there are patients who truly are terminally ill and happen to live longer, but if the pattern is widespread, it's fraud. Killing off the patient, falsifying the medical record to show the patient died of "natural causes" "proves" on paper that the patient died of his terminal illness and that the hospice was "not" doing fraud (although they were). Simple.

**Hospice Kickback Arrangements**

The bigger the hospice, the bigger the pressure is to keep patients coming their way. In March of 1998, the U.S. Office of Inspector General (DHHS) warned a second time about fraud in hospice, but it has also warned about kickback arrangements being used. It has specifically
warned about kickbacks occurring between nursing homes and hospices, but illegal kickback arrangements can occur between hospice and other providers as well.

"Fraud and abuse in Nursing Home Arrangements with Hospices"

"... arrangements between nursing homes and hospices are vulnerable to fraud and abuse because nursing home operators have control over the specific hospice or hospices they will permit to provide hospice services to their residents. An exclusive or semi-exclusive arrangement with a nursing home to provide hospice services to its residents may have substantial monetary value to a hospice. In these circumstances, some nursing home operators and/or hospices may request or offer illegal remuneration to influence a nursing home's decision to do business with a particular hospice."

"Hospice patients residing in nursing homes may be particularly desirable from a hospice's financial standpoint. First, a nursing home's population represents a sizeable pool of potential hospice patients. Second, nursing home hospice patients may generate higher gross revenues per patient than patients residing in their own homes because nursing home residents receiving hospice care have, on average, longer lengths of stay than hospice patients in their homes. Also, there may be some overlap in the services that the nursing homes and hospices provide, thereby providing one or the other the opportunity to reduce services and costs. A recent OIG report found that residents of certain nursing homes receive fewer services from their hospice than patients in their own homes. Since hospices receive a fixed daily payment regardless of the number of services provided or the location of the patient, fewer services may result in higher profits per patient."

"However, a hospice's access to nursing home patients depends on the nursing home operator. Nursing home operators may restrict residents to one or two hospice providers."

"While an exclusive or semi-exclusive arrangement can promote efficiency and safety by permitting the nursing home operator to coordinate care, screen hospice caregivers, and maintain control of the premises, it also enhances the value of the nursing home operator's decision. In these circumstances, some nursing home operators or hospices may request or offer illegal inducements to influence the selection of a hospice."

Kickback arrangements can be made between hospices and physicians, hospices and nursing homes, hospices and hospitals, even hospices and funeral homes. Let your imagination run wild and you will be sure to figure out what benefit it would be to a nursing home or a physician to get kickbacks for referring exclusively to one particular hospice. If a particular hospice is getting all the referrals, the other hospices are financially damaged. The bigger hospice just gets bigger and bigger, and more powerful. Word of mouth spreads that this hospice is "the one" to use and it "corners the market."

What if a particular funeral home pays kickbacks to one hospice so that the hospice makes sure the dead are sent to that funeral home exclusively? Other funeral homes are shut out, and sometimes destroyed. Some of those who died that had prepaid funeral plans with one funeral home have had their bodies sent to another funeral home favored by the hospice. I've been contacted regularly by funeral home directors who report this scam occurring in their area. The public is unaware of these illegal activities.
What does the National Hospice & Palliative Care Organization have to say about this publicly? Nothing. Does the NHPCO take a stand against hospice nurses trolling the halls for patients and stealing them from the smaller hospices? No, they don't even mention it. Do they make a big fuss about kickback arrangements that are occurring? Do they specifically condemn the fraud or violations of standards of care that occurred at the Hospice of the Florida Suncoast, Odyssey Hospice, or the Hospice of Michigan? No. They elect CEOs of those hospices to the NHPCO board of directors. They certainly don't make it a mission to encourage the respect for life in the hospice industry.

Other big hospices are also playing the game:

"... the number of health care companies and individuals who are willing to try to defraud the Medicare and Medicaid"

"A recent example of hospice fraud involving a South Carolina hospice is Southern Care, Inc., a hospice company that in 2009 paid $24.7 million to settle an FCA case. The defendant operated hospices in 14 other states, too, including Alabama, Georgia, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Ohio, Pennsylvania, Texas, Virginia and Wisconsin."

Hospices are increasingly involved with nursing home patients, and some hospices have taken advantage of the opportunities for fraud that exist. Recently, a November 2010 Atlantic Information Services newsletter stated that the:

"OIG reported finding major issues with hospice claims. Specifically, 82% of hospice claims for beneficiaries in nursing facilities failed to meet at least one Medicare coverage requirement, costing a total of $1.8 billion, according to an August 2009 OIG report (OEI-02-06-00221). All but 1% of the unsupported claims pertained to plans of care, election statements, services or certifications of terminal illness." [Emphasis added]
"O divine art of subtlety and secrecy! Through you we learn to be invisible, through you inaudible; and hence we can hold the enemy's fate in our hands."

_The Art of War_ by Sun Tzu Chapter VI, verse 9

III - _The Culture of Death: Covert Operations_

_Hastening Death at the End-of-Life_

The "culture of death" that promotes imposing death through euthanasia, assisted-suicide or the Third Way in hospice (terminal sedation) views the pro-life movement as "the enemy." In fact, they view traditional American society as "the enemy," something to be manipulated and defeated so that their goals can be achieved. It is clear that traditional American values are pro-life. The Declaration of Independence mentions specifically the right to life!

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

The founders of our nation recognized, and said that everyone understood that these rights were given to us by God. Charles Galloway shows in his book, _Christianity and the American Commonwealth_ that every original colony in America had founding documents that openly give thanks to God for the blessing of being able to live in freedom here. Had they not been persecuted for their faith when in Europe, most colonists would never have risked everything to come here. The right to live free from coercion, the right to choose how they practiced their faith, and certainly, the right to life itself were sacred to them, not something taken casually at all!

Though it is convenient for some to criticize the strict codes of the Puritans and others of that time, they were much more lenient and freedom-loving than any of the societies that they left behind in Europe. We owe much to the original colonists for the freedoms we enjoy today. Because the colonists established societies that treasured the rights of individuals in a free society, the founders of our nation said that the rights were "self-evident" and needed no explanation.

Today, however, the culture of death crowd does not agree. The Jack Kevorkians of our world do not believe that society is elevated when people make their best effort to serve each other
and honor life throughout life. The Jack Kevorkian style assisted-suicide advocates of our world believe in death-on-demand. They believe suicide should not be restricted in any way! They sell their agenda by appealing to the public's concern for the suffering of the terminally-ill. However contrary to the media's portrayal of Kevorkian, he was a ghoulish and bizarre character. "At least 60 percent of Kevorkian's suicide patients were not terminal. At least 17 could have lived indefinitely and, in 13 cases, the people had no complaints of pain." Though Jack Kevorkian is dead, the harm he and other assisted-suicide proponents have done to traditional American values is only increasing over time. Where assisted-suicide has been legalized such as in Oregon, suicide rates have increased.

The inner prohibition against killing oneself is actively being eroded and many in society are just fanning the flames for those troubled souls who need encouragement, counseling and love. The suicide advocates do not respect the right to live for those they deem unworthy of life, or as they suggest, "better off dead." Many of them support the ability to access assisted-suicide for any reason. So, we find patients who are not terminal but are mentally disturbed, perhaps in deep depression, killing themselves in Oregon and elsewhere. We also find Final Exit Network groups around the country encouraging suicide and providing information to people on how to commit suicide.

Derek Humphry, founder of the former Hemlock Society and chairman of the Advisory Committee for Final Exit Network says that the reason Oregon was the first to legalize assisted-suicide is that "fewer Oregonians go to church" and more Oregonians are unaffiliated with any religion at all. Reverence for life goes along with faith, while devaluation of life and approval for assisted-suicide goes along with atheism and utilitarianism.

The assisted-suicide and euthanasia advocates are, therefore, at war with America's traditional values themselves, at war with you and those you love. Hospice, which has many representatives of both the pro-life and pro-death movements, is truly divided, though the public would never know. Mixing intentional killing with hospice is like throwing gasoline on a fire: it can only cause an explosion, injury and even death to many. Just because hospice deals with those who are dying does not mean health care workers should cause death intentionally!

I worked with reporter Susan Brinkmann, Catholic Standard & Times Correspondent who researched the topic and wrote in her March 2005 article, "Managed Death: Hospice's 'Civil War"

"Where the culture of death exerts its influence is in the potential for the misuse of pain-killers to hasten death, rather than merely to control pain.

"This practice is even considered acceptable by some ethicists and doctors, who say they consider "terminal sedation" (TS) to be a legal alternative to assisted suicide. TS is defined as a deliberate "termination of awareness" - usually with morphine - that renders the patient unconscious, so that all treatment, including food and water, can be withdrawn.

"That they should die in comfort is clearly the goal - and I would argue the legitimate goal - of terminal sedation," Erich Loewy, a medical ethicist at the University of California-Davis, contends in "Terminal Sedation, Self-starvation and Orchestrating the End of Life."

"This is not the opinion of hospice founder Dame Saunders. She has said the goal of hospice care is "to make it possible for people who are dying to live
fully until they die."

"Nor is it the Vatican's belief.

"Its 1994 Charter for Health Care Workers specifically warns against depriving the dying of the "possibility of living his own life, by reducing him to a state of unconsciousness not worthy of a human being. This is why the administration of narcotics for the sole purpose of depriving the dying person of a conscious end is a truly deplorable practice."

"According to Terre Mirsch, Vice President of Holy Redeemer Home Health and Hospice Services, a good hospice should do a lot more than administer pain medication: "Symptoms come from not just physical manifestations, but from the psychological and spiritual implications of illness and the dying process. We need to treat the whole person, not just focus on physical care or giving medications."

"Holy Redeemer's team approach addresses all of a patient's needs, so that "patients are able to die comfortably," Mirsch said. "They are able to die with dignity, and don't feel the need to request interventions such as assisted suicide and euthanasia."

"During her 15 years in hospice work, Mirsch said, she found that what patients fear most is dying in pain: "Once they see that we'll do everything in our power to alleviate their pain and suffering through appropriate medical and emotional care ... people want to live, and are able to live as fully as possible. They're able to spend meaningful time with friends and family, and focus on what's really important." [Emphasis added]

The idea of a "culture of death" contrasts starkly with the affirmation of life and its value by those who adhere to a belief in the sanctity of life. A culture of death encourages the deaths of many, whether unborn, newly born, disabled or ill, orphans, the very poor, the elderly, the otherwise "expendable." Rather than seeing life as arising from the dear Lord, with meaning at all stages of life, adherents of the culture of death view life as an accident of chance, an amalgamation of cells that give rise to "life" without any Creator or ultimate meaning at all.

To better understand the "culture of death" at the end-of-life, we need to understand the "culture of death" approach to ending life at the beginning of life. We need to understand how certain lives can be devalued, mistreated, manipulated and harmed by those with an agenda. Those who seek to promote the culture of death trade in deception, sometimes using what may seem as "sensible" language to hide their intent.

For example, in the guise of promoting "choice" and a "woman's right to choose," the culture of death has denied the right of the child to choose to live. All living things seek to live. Self-preservation is perhaps the strongest instinct of all. Biological science is filled with examples of self-preservative behaviors by animals of all sorts. Although babies at all stages of their development are dependent completely, they nevertheless show their choice of life in everything they do. Once born, they seek nourishment and warmth. Their cries alert the mother to their needs. This demonstrates the instinctive choice of life by the child throughout the day, throughout their lives. If we must speak only of "women's" right to choose, what about the little women's right to choose life? Abortion is used to end the lives of more girls than boys, so any talk of women's choice is an appalling deception.

Even before birth, babies filmed in the womb during an abortion instinctively recoil away from
lethal probes used to end their lives. In her new book, *unPlanned*, Abby Johnson, former director of a Planned Parenthood clinic tells how horrified she was when she watched the ultrasound monitor and saw a baby in the womb frantically move away from an abortionist's tool. She realized that they had lied to her when they told her that babies "feel no pain" during an abortion, or that a "fetus" is not a human being. She realized that when she had counseled others, she had also misled them into ignoring their instinctive knowledge that they were killing a real human baby, their baby.

It was the same technology that convinced one of the leading original proponents of legalizing abortion to completely change his position and come to the conclusion that a baby, in utero, was truly a complete human person.

Abortionist Bernard Nathanson, MD, "co-founder of the pro-abortion vanguard group NARAL," says,

"... as a result of all of this [new] technology - looking at this baby, examining it, investigating it, watching its metabolic functions, watching it urinate, swallow, move and sleep, watching it dream, which you could see by its rapid eye movements via ultrasound, treating it, operating on it - I finally came to the conviction that this was my patient. This was a person! I was a physician, pledged to save my patient's lives, not to destroy them. So I changed my mind on the subject of abortion."

"... In 1985, intrigued by the question of what really happens during an abortion in the first three months of a pregnancy, Nathanson decided to put an ultrasound machine on the abdomen of a woman undergoing an abortion and to videotape what happens.

"We got a film that was astonishing, shocking, frightening," he says. "It was made into a film called 'The Silent Scream.' It was shattering, and the pro-abortion people panicked. Because at this point, we had moved the abortion debate away from moralizing, sermonizing, sloganeering and pamphleteering into a high-tech argument."


Nathanson also reveals how years earlier *he and others purposefully distorted the facts in order to gain public support for legalization of abortion*. In other words, they lied to achieve their goals.

"Knowing that if a true poll were taken, we would be soundly defeated, we simply fabricated the results of fictional polls. We announced to the media that we had taken polls and that 60 percent of Americans were in favor of permissive abortion. This is the tactic of the self-fulfilling lie. Few people care to be in the minority. We aroused enough sympathy to sell our program of permissive abortion by fabricating the number of illegal abortions done annually in the U.S. The actual figure was approaching 100,000, but the figure we gave to the media repeatedly was 1 million.

"Repeating the big lie often enough convinces the public. The number of women dying from illegal abortions was around 200-250 annually. The figure we constantly fed to the media was 10,000. These false figures took root in the consciousness of Americans, convincing many that we needed to crack the
It is important for us to understand that the "big lie" strategy Nathanson mentions is used also by those using end-of-life care to end life prematurely through euthanasia, assisted-suicide and Third Way palliative sedation killing. They tell us that the patient is better off dead, that it's time to "let go," and use many other manipulative and deceptive phrases to get people to go along with their agenda. They mean something other than the "letting go" that should occur when death arrives in its own natural timing. Margaret Sanger, the founder of Planned Parenthood, lied frequently in order to achieve her goals. What were her goals?

"Margaret Sanger spoke of sterilizing those she designated as "unfit," a plan she said would be the "salvation of American civilization."

[From "The Truth about Margaret Sanger" January 20, 1992 edition of Citizen magazine], and

"It was in 1939 that Sanger's larger vision for dealing with the reproductive practices of black Americans emerged." After the January 1939 merger of her Clinical Research Bureau and the ABCL to form the Birth Control Federation of America, Dr. Clarence J. Gamble was selected to become the BCFA regional director for the South. Dr. Gamble, of the soap-manufacturing Procter and Gamble company, was no newcomer to Sanger's organization. He had previously served as director at large to the predecessor ABCL."

This is the same time that the Euthanasia Society of America was just getting started.

"Gamble lost no time and drew up a memorandum in November 1939 entitled "Suggestion for Negro Project." Acknowledging that black leaders might regard birth control as an extermination plot, he suggested that black leaders be placed in positions where it would appear that they were in charge as it was at an Atlanta conference.

"It is evident from the rest of the memo that Gamble conceived the project almost as a traveling road show. A charismatic black minister was to start a revival, with "contributions" to come from other local cooperating ministers. A "colored nurse" would follow, supported by a subsidized "colored doctor." Gamble even suggested that music might be a useful lure to bring the prospects to a meeting.

"Sanger answered Gamble on Dec. 10, 1939, agreeing with the assessment. She wrote:

"We do not want the word to go out that we want to exterminate the Negro population, and the minister is the man who can straighten that idea out if it ever occurs to any of their more rebellious members."

So, Margaret Sanger, the founder of what became Planned Parenthood, was racist, a leading eugenics opponent (having written many articles on the subject) and considered birth control the true method of eliminating those deemed "unfit" or as the Nazis said, "unworthy of life." It was the same thinking in the same time period leading up till Nazi rule in Germany and the second World War. Hitler bragged about being up-to-date on the latest eugenics ideas
circulating in America.

Sanger was willing to engage in deception to get blacks to accept birth control on a widespread basis. The goal, reduction in the black population. The result? Contrary to Sanger's plans, as birth control was more widely adopted, sexual activity actually increased. With increased sexual activity, there were more births among unmarried nonwhite women:

"In 1940, nonwhite women aged 18 to 19 experienced 61 births per 1,000 unmarried women. In 1968, the corresponding figure was 112 per 1,000, a 100 percent jump. What other factor could account for the increased rate of sexual activity than wider access to birth control, with its promise of sex without tears and consequences?"

While Sanger's promotion of birth control among the black population backfired and did not decrease the population, it did create heartache and pain for them and a huge business opportunity for her organization, later called "Planned Parenthood." What is the fruit of Sanger's efforts? Well, one merely has to look at the statistics in any large city (places where a larger percentage of blacks Sanger and Planned Parenthood targeted live). The January 7, 2011 headline from CBS New York screams,

"39 Percent Of NYC Pregnancies Result In Abortion"

"The city health department last month released statistics that showed 39 percent of pregnancies ended with induced termination in 2009.

".... In 2009, there were 225,667 pregnancies in the City with 126,774 resulting in live births and 87,273 resulting in abortions. ...."

"Forty-six percent of all births in the Bronx result in abortions - the highest among the five boroughs, according to the report.

"Blacks had the highest number of abortions with 40,798 with Hispanics having the second highest at 28,364, according to the report."

That there were more births, not fewer, was not her goal. In order to achieve her goal, she promoted abortion and specifically focused those efforts on black neighborhoods. So, what do we see today? The largest percentage of Planned Parenthood clinics are in predominantly black neighborhoods. Access to "birth control" obviously doesn't prevent pregnancies in many cases, even though that's what that access is said to do. Access to birth control increases casual sexual relations and therefore, when it eventually fails, it increases the overall pregnancy rates. "Failure rates for most of these methods are higher for teens than adults because teens are more fertile than older couples, and they are less likely to use the methods consistently and correctly."

Access to birth control certainly has increased the rate of unmarried women becoming pregnant and then having abortions, or becoming single mothers. Who provides the most abortions today? Planned Parenthood. One of its slogans is that they seek to make abortions rare by providing birth control and counseling. The reality is their efforts increase the rate of abortions, and Abby Johnson reveals that she was pressured to increase the number of abortions performed at her Planned Parenthood clinic. She realized they were a business taking in most of their revenue from abortions, so she quit.

"Abortion advocates often promote contraception by claiming that as contraception use increases, the number of "unwanted" pregnancies and
therefore abortions will decrease. But a new study out of Spain has found the exact opposite, suggesting that contraception actually increases abortion rates."

"The authors, who published their findings in the January 2011 issue of the journal *Contraception*, conducted surveys of about 2,000 Spanish women aged 15 to 49 every two years from 1997 to 2007. They found that over this period the number of women using contraceptives increased from 49.1% to 79.9%."

"Yet they noted that in the same time frame the country's abortion rate more than doubled from 5.52 per 1,000 women to 11.49." ["Contraception linked to massive rise in abortion rate" by Patrick B. Craine Jan 05, 2011 LifeSiteNews.com]

So, we get more lies from those who promote abortion, contraception as well as euthanasia and Third Way hospice killings. Planned Parenthood likes to claim it provides "many" services for "women's health," yet, "**Planned Parenthood is the nation's largest abortion provider and 96% of its services for pregnant women are abortions.**" Clearly, Planned Parenthood is almost totally about providing abortions! Seeing how Planned Parenthood and other organizations like it work helps us understand the culture of death seeking to end life at any stage of life. What does Dr. Martin Luther King's niece, Alveda King, have to say about Planned Parenthood, abortion and breast cancer?

"Planned Parenthood is the largest provider of abortions in the United States and that here is a link between abortion and breast cancer."

"I said, 'Isn't it funny that Susan G. Komen for the Cure is raising money to find a cure for breast cancer while at the same time giving millions of dollars to an organization that performs abortions on women and provides birth control both of which have been linked to breast cancer.'"

".... What a scheme. Planned Parenthood does abortions and provides birth control pills which are linked to breast cancer and then Susan G. Komen for the Cure raises money to give to Planned Parenthood to do mammograms. They make you sick then raise money to treat you and then butcher you with breast surgery. Does anyone see anything wrong with this picture?"

[and]

"Following Margaret Sanger's strategy to dupe "colored ministers" Planned Parenthood selected Dr. King and other Black Leaders for awards. Dr. King supported natural family planning, called the "rhythm method" in his day. He would never agree to mass murder by abortion, and chemical birth control that is linked to illness. Planned Parenthood also lied to me, telling me that my babies were "blobs of tissue" and that "abortion wouldn't hurt as bad as having teeth pulled." It was to be "our secret." I was abortion vulnerable, and they took advantage of that. They lied then, to my uncle and to me. They still lie. Planned Parenthood, stop using my uncle to promote your injustice!"

-- Alveda C. King
Today, the widespread killing of African American babies continues:

"It has been estimated that since 1973 Black women have had about 16 million abortions. Michael Novak had calculated "Since the number of current living Blacks (in the U.S.) is 36 million, the missing 16 million represents an enormous loss, for without abortion, America's Black community would now number 52 million persons. It would be 36 percent larger than it is. Abortion has swept through the Black community like a scythe, cutting down every fourth member."

"A highly significant 1993 Howard University study showed that African American women over age 50 were 4.7 times more likely to get breast cancer if they had had any abortions compared to women who had not had any abortions."

"In a 1921 article in the Birth Control Review, Sanger wrote, 'The most urgent problem today is how to limit and discourage the over-fertility of the mentally and physically defective.' Reviewers of one of her 1919 articles interpreted her objectives as 'More children from the fit, less from the unfit.' Again, the question of who decides fitness is important, and it was an issue that Sanger only partly addressed. 'The undeniably feebleminded should indeed, not only be discouraged but prevented from propagating their kind,' she wrote."

"Sanger advocated the mandatory sterilization of the insane and feebleminded."

The forced sterilization of the mentally ill and others deemed "unfit" was carried out in Nazi Germany, along the same lines of thinking that Sanger promoted in the United States.

Just as Sanger lied to promote birth control mostly among the black population since she wanted to eliminate them, or at least decrease the size of their population, the abortion proponents of the 1960s lied to achieve legalization in New York State in 1969 (before the Supreme Court ruling of Roe v Wade). "In 2009 60 % of the pregnancies of African-American women in New York ended in abortion."

Euthanasia and assisted-suicide proponents lie just the same. And there are many who tell people to place their elderly parents in hospice so that "they will get better care," and "access to a wide range of services." Well, that is true in some hospices, but many families who have called me have reported they didn't get better care or a wide range of services. They report that once their loved one was enrolled in hospice, his or her death was hastened even when death was not expected in the near future.

Aborting a baby in the womb, medically killing a patient through euthanasia, "assisting" a patient to commit suicide by providing a lethal drug? Medical killing is medical killing, technicalities apart. A human life is just that, something to be respected, nurtured and shared, not killed. Yet, those intent on killing keep on keeping on. They have never stopped pushing their agenda. Philip Nitschke, MD, Australia's "Doctor Death" has said,

"It is often difficult to know what constitutes assisting suicide. The best advice is to do it and say you didn't."

[Philip Nitschke]
quoted in "A practical guide to suicide" By Greg Roberts in Townsville
Hastening death at the end-of-life is done in many ways, and deception is often used, just as it is used with the promotion of contraception, abortion, and sterilization. We hear reports of hospices that take away the oxygen given to patients who are chronically ill and dependent upon the oxygen for their well-being. Years ago, and in hospices with integrity today, oxygen is considered a necessary and ordinary treatment to maintain the well-being and comfort of the patient. Take it away, and a stable patient is destabilized, falling into an acute crisis from which they are not allowed to recover. They are often chronic obstructive pulmonary disease ("COPD") patients who are especially sensitive to morphine and other opioids. When they are given these medications, they quickly fall into a medically-induced coma and their breathing is stopped due to their very weak respiratory effort. Yet, hospice staff all across the country tell these patients that "morphine will help your breathing," even though it causes the breathing to stop in these patients! The trusting family members don't understand whether their loved one died of their terminal illness, or if an overdose of an opioid medication caused the death.

Other methods of hastening death include giving medications that are not needed. "The FDA has linked off-label prescribing of antipsychotic drugs [like Zyprexa, Abilify, Risperdal, and Seroquel] to an increased risk of death in the elderly." Also, "the use of benzodiazepines [like Ativan] among elderly patients has been associated with intellectual and cognitive impairment." The elderly may never recover from these adverse effects and then be labeled "dementia" patients. "Overdose symptoms may include extreme drowsiness, confusion, muscle weakness, fainting, or coma." And what do we see when patients routinely get unneeded high doses of Ativan in many hospices? They are intentionally placed in a medically-induced coma (terminal sedation) and then die in less than two weeks.

Sometimes unneeded laxatives are given to promote uncontrolled diarrhea and contribute to life-threatening dehydration. Removing the medications used to treat chronically-ill patients precipitate an intentional acute crisis from which they are not allowed to recover. Patients with heart or blood pressure conditions no longer are given their medications and they die shortly thereafter. The lie told is that the patient "no longer needs these medications." As usual, the deception is to apply something that may be true at another time, at an inappropriate time. Patients who are already at the very, very end, active phase of dying do not need their regular medications, as these medications can no longer help at that time. The patient's organs and organ systems are already failing.

But withholding the patient's regular medications, way before the patient reaches the end, active phase of dying, pushes the patient into a crisis. The patient then appears to be "actively dying" and is then either sedated, given morphine and other opioids, or both, and that un-needed cocktail of medications completely destabilizes the patient, who then dies. The trusting family doesn't know what happened.

Manipulation of patients and families occurs by mixing some things that may be true at the wrong timing or with the wrong patient. This intentional manipulation results in hastened deaths, and there are many, many deceptions we have heard about through the years. Only an experienced hospice physician or nurse would be able to know that the professional-sounding advice was not appropriate at that time or for that particular patient. Similar deceptions happen in an acute hospital setting when the patient has been selected for stealth euthanasia. Certain patients are denied treatment, forced to sign a DNR order, and manipulated into hospice; the pattern is becoming more and more common.
When is a Person a "Person?"

It is also convenient for proponents of the culture of death to deny that in addition to having a material body and rational mind, humans have a soul. They deny the spiritual purpose of life and all life involves. In addition to denying the "soul," they often ascribe all mental processes and the experiences of life to chemical processes in the brain. In other words, there is no "love," just a chemical process in the brain. There is no "purpose," just a chemical process in the brain. For them, there is no such thing as a "person," separate from what goes on materially in the body of a human being. For them, our experiences, thoughts, feelings and relationships are just a chemical process in the brain and the result of some hormonal influence.

Proponents of the culture of death attempt to create false distinctions in a myriad of ways, using a myriad of different phrases, using bogus "science" and distortions to convince the public that imposing death or even performing experiments on innocent human beings is morally acceptable. Yet, they assert that those of faith are "unscientific" when the reality is exactly the opposite.

Science confirms what faith reveals.


"...violations of the dignity of these early human beings are usually accompanied by the use of erroneous science and deceptive linguistic jargon in the attempt to justify these immoral actions. This use of contrived rhetoric to refer to the newly created human embryo or fetus is now amazingly extensive; for example: a pre-embryo vs. an embryo; a being on the way vs. an already existing one; a seed vs. an organism; ... a possible or potential human being vs. an actual human being; a possible or potential person vs. an actual human person; an object vs. a subject; ... a ball of cells vs. an organism. Politicized terms such as spare or left-over embryos or products of conception are often used."

Each of us may not have even heard of these "bioethical" distinctions proposed by the culture of death, but enough of them may "ring a bell" to recognize that the value we place in human life has been persistently attacked by those in academia who embrace the culture of death.

Dr. Irving tells us in her article, "When do human beings (normally) begin?" "scientific" myths" and scientific facts that:

"The fusion of the sperm (with 23 chromosomes) and the oocyte (with 23 chromosomes) at fertilization results in a live human being, a single-cell human zygote, with 46 chromosomes--the number of chromosomes characteristic of an individual member of the human species."
Dr. Irving cautions that a correct understanding of scientific facts is necessary to begin to properly think about what a "human being" is and when that human being's life normally begins:

"One of the most urgent yet least discussed medical dilemmas today is access to the correct basic scientific information regarding the human embryo - scientific information which demonstrates empirically that normally every human being begins to exist at fertilization in the woman's fallopian tube as a single-cell embryo, the zygote."

"Indeed, fertilization is the beginning of the existence of the human being, the human embryo, the human organism, the human individual, and the "embryonic period." Without this correct scientific information, we are all precluded from forming our consciences correctly or making morally correct medical decisions about abortion or other related current medical and scientific issues. The use of the correct science is the starting point for thinking about all of this."

"To know that the human embryo is a personal human being is central to forming our consciences correctly, and therefore to knowing what actions are right or wrong in a specific medical or research situation. While conscience is the subjective norm in philosophical natural law theory, it must be a correctly formed conscience - one in accord with objective reality and objective truth - starting with and including this objective scientific truth."

[From Dr. Irving's speech at the International Conference: The Future of Obstetrics and Gynaecology, International Federation of Catholic Medical Associations (FIAMC) and MaterCare International in Rome, Italy, June 18, 2001, "The Impact of International Bioethics on the 'Sanctity of Life'; emphasis added]

Well, the science is not tentative. It is an accomplished, accepted fact without any scientific dispute. And of course, human life can naturally occur (asexually for the 2nd twin) during "twinning" and the zygote again has 46 chromosomes, ... human chromosomes, a human life begun. We must realize that today there are many alternative methods of scientifically manipulating life whether it be "in vitro" fertilization of egg and sperm or very high-tech methods of extracting genetic material and combining it, even cloning techniques, embryonic stem cell research and other methods. Prof. Irving has mentioned some of the following methods: "SCNT, germ line cell nuclear transfer (GLCNT), twinning (blastomere separation,
blastocyst splitting, embryo multiplication, pronuclei transfer, mitochondria transfer, and dozens of other genetic engineering techniques." The new life does not have to "wait" until implantation in the uterus to be a unique, human life.

Technology has succeeded in complicating the normal answer about when life begins and how it begins. Technology changed all that:

"... with the biological revolution and the emergence of new reproductive technologies. The development of In Vitro Fertilization technologies ["IVF"] came only after human beings grew accustomed to reproductive control through The Pill. If medical technologies could be harnessed to avoid pregnancy, surely new technologies could allow couples to have long-wanted children who had not come by natural means.

"The public was assured that the use of these technologies would not bring about a moral revolution, since the availability of these new technologies would be limited to married couples. But, of course, this was a false promise, and it should have been seen as such from the start. The Pill was at first prescribed only for married couples, but the plain fact is that a far greater demand for contraceptives existed among the non-married. By the early 1970s, The Pill was available to all.

"The same story applied to the use of IVF, as well. If there were thousands of potential users among married couples, these were vastly outnumbered by non-married persons and non-heterosexual couples. The development of IVF and the revolutions made possible by egg and sperm donation and surrogate motherhood made parenthood, though redefined, now available to virtually any adult and any couple."

["Where did I come from? - it's no longer a simple question" by Albert Mohler January 3, 2011 LifeSiteNews.com]

Dr. Irving has stated:

"International agreement and documentation by the experts in human embryology and human molecular genetics make the following perfectly clear. The new single-cell human embryo formed sexually at the beginning of the process of fertilization (when the sperm makes first contact with the oocyte) is a new living human being. The new human embryo formed asexually by various natural or artificial reproductive techniques (such as one of every two identical twins) is a new living human being. They are not 'eggs.' [Emphasis added]

["Scientific Response to Criticism of the California Human Rights Amendment as "Protecting Fertilized Eggs" by Dianne Irving, PhD and C. Ward Kischer December 9, 2009]"
However, in order to "sell" abortion, contraception (which are abortifacients in many cases by preventing implantation), embryonic stem cell research, cloning, etc., people are indoctrinated to believe the clearly mistaken idea that a human being does not exist as a person until the baby is born, or is implanted in the womb, or is a certain number of days, weeks or months old, or whatever the secular "bioethicist" fancies at the time.

Those marketing the lies necessary to accept abortion, contraception, infanticide, or experimentation on innocent human individuals do so for financial gain or because they are "true believers" in the agenda, the culture of death. These industries are huge, representing billions of dollars in revenue each year. **The motivating force behind the leaders of the culture of death is not "the good of society" but rather profit outright or death that they demand.** They truly hate that some of us are alive and they will lie to achieve their aims.

Those lies told by those promoting the culture of death have been accepted by a large portion of our society, so much so, that those who fight for the victims of this "culture of death" are mocked as extremists, even though they are upholding the basic values upon which our nation was founded.

Those marketing the lies also attack the people who respect life and accept the scientific facts about human life. They ridicule those who respect the sanctity of life. Sometimes ridicule (or the attack "ad hominem") is the only method they can use successfully, since the facts are on the side of those who respect life and understand that a human life normally begins truly, at the beginning, at the moment the sperm and oocyte merge and a unique human individual is created.

Lies are also used to promote devaluation of the lives of the vulnerable. Lies are told in arguments given to promote assisted-suicide, euthanasia and/or terminal sedation of the elderly, chronically-ill, disabled, and/or cognitively impaired.
Most of the names of these organizations are based on lies, even the phrase "right-to-die" at the end-of-life is not what it's about. At the beginning of life, "pro-choice" has nothing to do with being concerned about choice in principle; otherwise, those who are "pro-choice" would respect the baby's right to choose to live. Thus, they are more accurately called the "anti-choice to live" movement.

If the "anti-choice to live" movement cared about choice, they would not be working to eliminate a health care professional's right to choose not to perform an abortion.

If they respected everyone's right to choose, they would also respect the medical students' right to choose not to learn to perform abortions. However, they have regularly been working to make abortion training mandatory in medical schools! For example, the Abortion Rights Coalition in Canada is pressing for "mandatory education in abortion and contraception for all medical students, and mandatory training in abortion techniques for all Ob/Gyn residents." And the "medical students for choice" in the U.S. and elsewhere also is working to make abortion training "a part of standard medical education and residency training." That means that all medical students would be forced to perform abortions and those that are pro-life and refused might be thrown out of medical school.

"Right-to-die" proponents tell us that "only" those seeking assisted-suicide and/or euthanasia will be hastened to their death. Research in the Netherlands and Belgium conclusively shows the opposite: patients are involuntarily killed. We will see further on that the more frank statements of the euthanasia proponents in earlier years tell us this is their goal.

We know that involuntary medical killing occurs when euthanasia is legalized. The studies in the Netherlands reported, "There were one thousand cases [of euthanasia] without explicit and persistent request in 1990, and nine hundred cases in 1995." And that was 1,000 cases a year in such a tiny country. Just imagine how many medical killings that would equal in the United States if the same rate applied here. I believe that we are experiencing that rate of involuntary medical killings (of many sorts), all hidden behind the HIPAA privacy shield. No one should have the right to make that decision for you.

In 2007, Belgium research showed patients have been killed ("euthanized") often without their knowledge or permission. "Researchers found that a fifth of nurses admitted being involved in the assisted suicide of a patient." Of those, one-half admitted that the so-called "assisted suicide" was "without consent." If there is no consent, no permission, no knowledge on the part of the patient, how can you call that "assisted suicide?" It's involuntary medical killing, plain and simple, and 10% of the nurses in Belgium admit to doing it. 10 percent! That's where euthanasia is legal, but has "safeguards" for its strict practice only under professional guidelines. We see how effective those "safeguards" are.

"Right-to-die" proponents tell us that the reason they seek legalization of assisted-suicide and euthanasia is to end unbearable pain in the case of terminally ill patients. We know, however, that modern medical science can relieve and reduce all sorts of pain and that pain is absolutely not the reason they seek legalization. So why do they keep lying saying it's all about relief of "pain?" Achieving legalization under this pretense is viewed as a stepping-stone to complete legalization of euthanasia and/or assisted-suicide for a variety of reasons. In fact, some of these groups wish to legalize suicide outright, whether for medical purposes or not.

Prof. Peter Singer of Princeton University has made a name for himself arguing that fetuses, embryos, even newborns are not real "persons" until they develop and actually exercise higher reasoning capacity. He even suggests that some higher primates or other animals may be "more" of a person, than a newborn baby, toddler, or fetus.
Steven Ertelt wrote in 2006 for Lifenews.com that "Peter Singer Defends His Views on Killing Disabled Babies Via Infanticide" saying:

"...from the point of view of ethics rather than the law, there is no sharp distinction between the fetus and the newborn baby," Singer explained.

However, Singer's view is that, instead of legal protection, both disabled babies and the unborn deserve death.

As he wrote in Rethinking Life and Death, "Human babies are not born self-aware or capable of grasping their lives over time. They are not persons. Hence their lives would seem to be no more worthy of protection that the life of a fetus." [Emphasis added]

Singer has admitted that infanticide has always been an aspect of his work, part of what he promotes.

So, once a human being is no longer considered a "person," then it is "morally acceptable" (according to culture of death proponents) to experiment on or kill that whatever-it-is (but is not a "person").

What people believe sometimes is determined by ulterior motives. We may wish to relieve our guilt over aborting a baby by telling ourselves it wasn't a "real" baby. It's not a "person." Soldiers in war may do something similar rather than really think about killing people (the "enemy") who is the son or daughter, father or mother with a family. Often, derogatory names are given to the "enemy" that makes killing easier psychologically.

When a baby is wanted and valued, the "fetus" is considered anything but a "thing," and there is no doubt it is fully "human," and there is no question about it at all. Everybody knows this! The mental gymnastics that are necessary for people to lie to themselves, even with Supreme Court sanction, are truly monumental. Truth is truth and science shows us what the truth is. A baby, even a human at the zygote stage, is not a tadpole, not a baby dog, cat, horse or cow; it's a human, a unique person.
The same thing applies to human life at the end-of-life. Even though a person is extremely ill, they are still a "person." Even if they are imminently "dying," they are not "dead." They are always a living person from the beginning till real physical death (no heart beat, no breathing, and no organs functioning.

It is sad to say that I have seen cases where adult children stood before their dying parent and argued about who would inherit this or that possession, while the dying parent lay in bed, helplessly watching the uncaring children, unable to say, "I am still here!"

Sometimes, the patient may still be able to speak and say those words, but the patient is still ignored. The patient may no longer be considered a "person" because they can't actively reason or speak up for themselves. How cruel! Say we are recovering from surgery and are in a medically-induced coma; we can't speak for ourselves. Does that mean we are not "persons?"

What about if we are temporarily brain-injured from a car accident, for example, and cannot say a word? Are we not persons? When we can speak up later after receiving rehabilitative therapy, are we then "persons?"

What about babies, two year olds, four year olds? Where does one draw the arbitrary line?
How many times is a patient talked about as if he were not even in the room or a useful participant in a discussion? This unfortunately happens often with the dying.

We should remember that truly, we are all dying; it's just a question of when each of us will die. And that is something most people avoid thinking about. Even if a person is cognitively impaired, or a child, or imminently dying, they are still completely human and still "a person." Yet, there are those who take it upon themselves to end the lives they are supposed to care for. They believe they "know better" and act on that basis. A February 2011 Canadian Medical Association Journal article states that, "In Quebec last year, 81% of [physician] ... specialists surveyed said they had seen "euthanasia" practised...." And that is in Quebec where euthanasia is illegal.

The culture of death's fabrications and propaganda (continually presented to members of our society) have convinced many that certain categories of our population are not "worthy of life" because they are not "real" persons. This is exactly the thinking promoted by the Nazis in Germany during World War II. And the moment one mentions the example of the Nazis, the objection is raised, "how dare you compare us to those evil monsters?" I dare, because what we are doing to the vulnerable is what they did, and that is a fact. We are doing it based upon the same line of reasoning as they used.

While human history is filled with a never-ending succession of dictatorial governments, brutality, violence, and genocide, what the Nazis did was unique in recent history. They exalted involuntary experimentation on human subjects as "medical science" and perfected methods of medical killing through a variety of methods. Some of the methods of medical killing perfected by the Nazis are being used today, right here in the United States! Some involuntary medical experimentation is also being done in the United States, even today.

The dark worldview that was the basis for all they did has not been extinguished. It lives on and is being implemented today. To understand what is happening today, to the ailing, elderly and disabled, we must review what happened in Nazi Germany and understand how it began and what exactly occurred.

In Nazi Germany, the Nazis began to implement their eugenics and extermination program by executing the frail, the mentally ill, the terminally ill and other chronically ill by order of the federal German government:

"The campaign to remove unwanted children from the community was not only the result of Nazi racial biology and eugenics, it was part and parcel of the effort to impose control and conformity on the entire German population."

["Hitler" by Sally M. Rogow]

"The coming of the war made the implementation of the most radical eugenic policies possible. The demand that institutionalized patients suffering from hereditary diseases be killed had first been advocated in 1920. Such eugenic killings were called "destruction of life unworthy of life," but the euphemism mercy killing, that is, "euthanasia," was also used. But even the Nazi regime did not at first dare to execute such a radical policy. The attack on the handicapped during the 1930s thus involved only compulsory sterilization, unremitting propaganda, and a consistent reduction of all expenditures. This was, however, only the beginning. Already in 1935 Adolf Hitler had told Gerhard Wagner that if war came he would implement the killing of the handicapped."
"Nazi genocide started in the winter of 1939-1940 with the murder of the handicapped."

"... it was the chancellery official Viktor Brack who designed and directed the euthanasia killing program. ... Brack recruited administrators and physicians to evolve the method of selecting the victims. They in turn recruited the physicians, nurses, policemen, and workers needed to record, transport, and kill the victims. For the killing of infants and small children T4 installed numerous so-called children's wards at hospitals throughout Germany; there physicians and nurses killed by administering an overdose of common medications. But for the killing of the larger number of adults T4 created six killing centers ... which were to serve as prototypes for the larger extermination camps later established in the East. Each center was equipped with a carbon monoxide gas chamber to kill the victims and a crematorium to dispose of the corpses. And in these centers the T4 staff developed the technique of mass murder that would be applied later in the camps in the East." [And,]

"the T4 physicians ... [selected] persons for the killing operation. ... their life-and-death decisions were based only on ... forms and they never examined the patients. Once the decision was made, the selected persons were transported from their institution to one of the six killing centers and there gassed and cremated. But as this process had to remain secret, the T4 bureaucracy generated a vast amount of fraudulent paperwork. ... The most elaborate subterfuge involved handicapped Jewish patients who were collected at several hospitals serving as assembly centers and from there transported to their death during summer and fall 1940. .... In fact, these Jewish patients, the first Jewish victims of Nazi genocide, were all murdered in the T4 killing centers located inside the borders of the German Reich."

The numbers are astounding. According to Milton Meltzer:

"Between December 1939 and August 1941, about 50,000 to 60,000 Germans—children and adults--were secretly killed by lethal injections or in gassing installations designed to look like shower stalls. It was a foretaste of Auschwitz. The victims were taken from the medical institution and put to death... [See: Never to Forget: The Jews of the Holocaust, New York: HarperCollins, 1976:131].

Robert J. Lifton makes the following assessment:

"Of the number of people killed in the T4 and the 14f13 projects, the following statistics are usually given: adult mental patients from institutions, 80,000 to 100,000; children in institutions, 5,000; special action against Jews in institutions, 1,000; concentration camp inmates transported to killing centers (14f13), 20,000 (Klee estimated that at the end of 1941, some 93,521 'beds' had been emptied for other uses [70,000 patients gassed, plus over 20,000 dead through starvation and medication] - in other words approximately one-third of the places for the mentally ill.) But these figures may well be too low; twice these numbers of people may have perished. [Emphasis added]

"The fact is that we do not know and shall probably never know. Elements of deception, imposed chaos, and the destruction of many records make anything
like an accurate estimate impossible.

20,000 dead through "starvation and medication" in Nazi Germany! What can terminal sedation misused to impose death be other than the exact same thing? The patient is not given any nutrition. The patient is not given fluids. And the patient is medicated in a variety of ways, often using liquid morphine and a sedative like Ativan (lorazepam). Taking the mentally ill to be executed during the Nazi era is the same thing as taking the dementia patients from wards where care is provided to them and then moving them to hospice for disposal. The language seem too harsh? Please tell me how it is different.

Death was certain when Hitler ordered the extermination of the mentally ill, mentally retarded and very ill. Death is certain today for those given unnecessary medications, something as simple as antipsychotic drugs:

"The Food and Drug Administration in 2005 mandated that drug makers issue warning labels on atypical antipsychotics, noting that the drugs - which are generally FDA-approved for treating schizophrenia and bipolar disorder - increase the risk of death for elderly patients with dementia. Yet when the government examined 1.4 million Medicare claims from 2007 for atypical antipsychotics for elderly nursing home residents, the government found that 88 percent of the time, the drugs were prescribed to individuals diagnosed with dementia [Emphasis added]."

"Highlighting Drug Industry Influence, Watchdog Says Overmedication in Nursing Homes Is Troubling" by Marian Wang ProPublica May 10, 2011

Can it be any clearer? The drugs cause death in dementia patients and they are given to dementia patients ... stealth euthanasia! Death is also certain when patients are placed into hospice and terminally-sedated, as is being done all around the country already. Dying from terminal sedation or an overdose is not "dying a natural death."

And "aiding" a completely dependent, cognitively-disabled patient to commit "assisted-suicide" is nothing more than medical killing, cloaked in deceptive language. Cognitively-disabled patients who are mentally-retarded, brain-injured, in a "PVS" or "minimally-conscious" state cannot choose or agree to commit suicide. "Surrogate" decision-makers who choose "assisted-suicide" for the vulnerable are merely "choosing" to "euthanize" the same class of people that Hitler chose to exterminate. Whatever you think about the circumstances of the disabled, those with Down's syndrome or the mentally-ill, they are vulnerable people who need protection and care. Treatment denial for these vulnerable individuals is designed to encourage an early death.

A United Kingdom review of the literature tells us that "about 90 percent of pregnant women who are given a Down syndrome diagnosis have chosen to have an abortion." Maura Butler, a mother of a special-needs child, wrote in Lifenews.com, "none of us is perfect; some of us just have more visible crosses than others." "But none of us could ever imagine our life without her, without her smile, her laughter, her hugs and (extra wet) kisses.

Our courts have greased the wheels for medical killing of the vulnerable to move forward. This is how it happened: in 1997, the United States Supreme Court in Washington v Glucksberg 521 U.S. 702:

"stated that a statutory ban on assisted suicide does not infringe any constitutional privileges because the "right to commit suicide" is not a fundamental liberty interest and thereby not protected by the Due Process
Clause of the Fourteenth Amendment."

"On the same day, the Chief Justice issued a second opinion, Vacco v. Quill, which affirmed the validity of a New York statute prohibiting assisted suicide and reversed the judgment of the Second Circuit Court of Appeals. In Vacco, the Court held that the New York statute does not violate the Equal Protection Clause of the Fourteenth Amendment."

However, here is where they "greased the wheels" for medical killing to move forward. The Supreme Court in the same case (Vacco v Quill):

- tacitly endorsed terminal sedation as an alternative to physician-assisted suicide, thus intensifying a debate in the legal and medical communities as to the propriety of terminal sedation and setting the stage for a new battleground in the "right to die" controversy.

["Terminal sedation: Palliative care for intractable pain, post Glucksberg and Quill" by Rob McStay, American Journal of Law and Medicine, January 1, 2003]

That ruling allowed for the "principle of double-effect" to be used to justify terminally-sedating or giving high doses of pain medications so long as the intent is not to cause death. Well, who's checking? When the patient is terminally-sedated or given high doses of an opioid for valid clinical reasons, then fine. But if the intent is to kill, the treatment is the same but the patient has no need for the medications. What happens? The patient dies. No surprise. The "intent" of the physician or nurse is not going to be checked, so widespread use of high doses of an opioid or terminal sedation is now being practiced in hospice and palliative care units across the country.

This is the "Invisible Holocaust" I have been warning about for a decade.

"... we must be wary of those who are too willing to end the lives of the elderly and the ill. If we ever decide that a poor quality of life justifies ending that life, we have taken a step down a slippery slope that places all of us in danger. There is a difference between allowing nature to take its course and actively assisting death. The call for euthanasia surfaces in our society periodically, as it is doing now under the guise of "death with dignity" or assisted suicide. Euthanasia is a concept, it seems to me, that is in direct conflict with a religious and ethical tradition in which the human race is presented with "a blessing and a curse, life and death," and we are instructed ...therefore, to choose life." I believe "euthanasia" lies outside the commonly held life-centered values of the West and cannot be allowed without incurring great social and personal tragedy. This is not merely an intellectual conundrum. This issue involves actual human beings at risk..."

"While the terror of state-sponsored euthanasia may never grip America as it once did Germany, it is possible that the terror of the euthanasia ethic - tolerated by medicine and an indifferent public and practiced by a few physicians - may grip many invisible and vulnerable Americans. Over fifty years ago, German doctors and courts collaborated to identify millions of people who were labeled 'devoid of value'. Some Americans are labeled the same today: members of a racial or ethnic 'underclass', a sidewalk screamer ... an illegal alien ... a nursing home resident with Alzheimer's disease ... an abandoned migrant worker ... or anyone too old or weak or poor to help
himself or herself. For two millennia the Hippocratic tradition has stood for the ‘sanctity’ of human life. We can alleviate the unbearable in life better than ever before. We can do that and not eliminate life itself. As I have said many times, medicine cannot be both our healer and our killer.” -- C. Everett Koop, M.D. [Emphasis added]


At the site of the three Auschwitz death camps, a plaque reminds us that over one million people, mostly Jews, were murdered there. Additional millions were murdered throughout Europe and at other camps during the Holocaust (Shoah). As Jews, Gypsies, some homosexuals, political dissidents and the intellectually and physically disabled were selected to be murdered by the Nazis, the elderly, disabled and those deemed "better off dead" are being selected for stealth euthanasia.

The Nazis kept detailed records of every individual selected for death at the camps, but we can be sure that today's records of those victimized by stealth euthanasia are always falsified to reflect a natural death. The patient's diagnosed condition (or an improvised diagnosis) is listed as the cause of death. "Stealth euthanasia" is never listed as the cause of death. Morphine overdose or terminal sedation is almost never listed as the cause of death. In today's Invisible Holocaust, stealth euthanasia has and will result in the murders of unknowable numbers of the vulnerable, because they are killed in separate locations, by separate people, and the killings are hidden behind the privacy regulations in place. The staff who perpetrate these crimes falsify the medical records to justify whatever method was used to hasten death. I estimate that easily over 100,000 vulnerable patients may be hastened to their death through a variety of means each year in the United States alone.

Just as there have been many "Holocaust deniers" who attempt to deny the reality of Nazi genocide or minimize its impact, there are those who vehemently deny that many (or any) patients are being hastened to their death in America and elsewhere around the globe. Research definitively shows that patients are being involuntarily medically killed in the Netherlands and Belgium. In the United States, we have those who adhere to the standards of care who are deeply offended by the idea that anyone would commit these egregious crimes, and they frantically attack those who expose the realities in the end-of-life care industry, even when they repeatedly hear the same type of stories from separate sources over and over again. And we have others (who are casually implementing the culture of death and hastening death) doing everything possible to hide the truth so that their agenda can continue to be implemented and expanded. We also have many in our society who simply know the truth, that the health care system can be, and is being, "wielded" just like a gun, to medically kill some of the vulnerable. Some of them take advantage of the medications available in hospice and the terminal sedation protocol available in hospice, to impose death, and the hospice staff often go right along with the plan.

However, even though many segments of society do not want the truth to come out, as Martin Luther King has said "a time comes when silence is betrayal." The realities of the horrors committed continue to surface, no matter how hard the deniers suppress and censor the truth. Year after year, people call here and to other patient advocacy organizations, seeking recognition of the medical violence that took their loved ones from them. They seek justice and reform. Family members who cry out after a hospice or palliative care staff member imposed death upon their loved one demand justice, but the Halls of Justice have been completely shut off from them, just as it is so often shut off from those who are victimized by racism, ethnic-cleansing, war, murder and genocide. The anguish of the people who are victimized cannot be hidden forever!
The proponents of the culture of death are emboldened by these court rulings and they are brazen in their actions. They know that prosecutors will do nothing to stop them, that imposing death within a hospice will not even be investigated, let alone prosecuted. Why will prosecutors do nothing? Because they know what the Supreme Court ruled in Washington v Glucksberg as well as in Vacco v Quill. They know that they would have to be “mind-readers” to prove the physician or nurse is lying when they say they “intended only to relieve pain” when they administered the drugs. It’s a very hard thing to prove in court. When you have several hospice nurses, the social worker and the hospice medical director all swearing that the patient was in extreme pain or suffering terribly, the family's testimony is easily disregarded. In many cases, the hospice manipulates the patient and family to give up the patient's attending physician and only have access to the hospice medical director. If there ever was a conflict of interests in a rogue hospice, the hospice medical director has one: as an employee of the hospice and promoter of the hospice, he or she has to look to the financial interests of the corporation. That is what happens in a rogue hospice. The patient's needs and best interests are secondary concerns for the culture of death workers.

Prosecutors refuse to act in these medical killings for another reason: prosecutors know that the federal and state governments save many millions of dollars when people die sooner rather than later. They know that hospice is being promoted by the federal and state governments. They also know that their own political future would be damaged if they went after the local respected physician or hospice and brought negative attention to the protected industry: hospice.

Yes, you can prove that the doses of morphine are massive, that the doses of sedatives are massive, and you can have two or more doctors who swear under oath that nobody should require that high a dose. The problem? The hospice agency will hire two or ten physicians who swear just the opposite, so you have a "he said-she said" type scenario where nobody is believed for sure. Families that wish to take the case to court have no access to either the criminal or civil courts when a patient is hastened to their death. And so, stealth euthanasia continues to sweep across our nation and the Invisible Holocaust swallows up more victims.

How did this problem arise? You have two completely different worldviews, value systems, caught in a battle right in front of us. The traditional American values respecting life and the utilitarian materialistic view that devalues life. Adherents to either worldview are going to say
the exact opposite things about the exact same case!

We can say that "Hitler did this" or "the Nazis did that" and people just turn off and say, "that was then," "what they did was unheard of before and will never be heard of again," or, "that's not to be compared with what is going on now." "Hyperbole!" Well, eugenics is eugenics. Euthanasia is euthanasia. They did it then; they're doing it now. Instead of piling bodies up in mountains or mass graves or incinerators, they're separately handled one-by-one, sometimes with color-coordinated decorating at the facilities. So, if medical killing is done one-by-one, in a cheerful and relaxing setting, then it's not the same medical killing? Today, the justification is given that it's all being done for the good of the suffering patient. Guess what? The Nazis did use exactly that language!

In the Netherlands, "eugenic" medical killing of babies is practiced under the [Groningen Protocol - Euthanasia in Severely Ill Newborns:](#)

"life-ending procedures for newborns may be carried out only in rare circumstances and in accordance with very strict criteria: the prognosis and diagnosis must be certain, untreatable disease, severe and unbearable suffering that cannot be alleviated, a second medical opinion, the full consent of both parents."

"There are also a number of less objectively measurable preconditions that touch on questions such as the child's prospects for quality of life. Each case must be reported to a committee of medical, legal and ethical experts ...." [Emphasis added]

["Murder or health care: the Groningen Protocol" By Marijke van der Meer February 17, 2008]

So, doctors and the courts decide who lives and who dies, and when. In the United States, we have [peri-natal hospice](#), so we don't necessarily need the "Groningen Protocol" legalized here, and court can be avoided if the parents accept peri-natal hospice for their ailing newborn. When the newborn is truly dying, making sure the infant is kept comfortable makes sense, but nurses who work in peri-natal hospice have confessed that in some cases, "the baby just didn't die soon enough." (Maybe, the baby would have lived if cared for.) So, the peri-natal staff, "made sure the baby died using morphine." How would anyone know if peri-natal hospice has been misused to hasten death of newborns that fit the criteria used in the Netherlands for infanticide under the Groningen Protocol? Who is checking? Nobody. And the methods used in peri-natal hospice can be the same as used on adults: increasing doses of morphine and other opioids, and sedatives (if necessary), and definitely deprivation of nutrition and fluid (Third Way killing: terminal sedation).

Anita Catlin, DNSc, FNP, FAAN one of the "founders" of the peri-natal hospice work has written about "Five Incredible Babies, Five Paradigm Cases That Greatly Influenced Neonatal Ethics, What Do Their Parents Say Today?" Barbara Farlow (a mother of a child whose life was taken in peri-natal hospice) wrote about her experience in an article called "Misgivings." [Peri-natal hospice is fast becoming the "2nd net" to "catch and kill" any babies with congenital abnormalities that weren't aborted pre-birth.

The use of terminal sedation as the Third Way to medically kill (aside from direct euthanasia or assisted-suicide) began to accelerate in the 1990s and now is at an epidemic level. Of course, there are also outright overdoses administered in hospices which is direct euthanasia, but who's supervising in private settings? Nobody that cares to enforce laws prohibiting
euthanasia.

Staff who work in a rogue hospice do not think they work in a rogue hospice; they think they're providing very professional care according to the latest, "most progressive" ethics. How do the administrators regard the suffering? They are looked at as pathetic remnants of something that might have been a "person" years ago. They are looked at as a means to bill for services, a "ticket" to continued revenue, and certainly "better off dead." Let's face it, as shocking as it may be to those of you who admire the good work of many in hospice, the hospice industry is being converted, within the rogue hospices around the country, into killing fields!

In a hospice that respects the sanctity of life, these things are unheard of. That is why pro-life hospices that do not impose death work hard to educate their staff and make sure the focus is on serving the patients, relieving suffering at the end-of-life and allowing for a natural death in its own timing. However, pro-life hospices are becoming rarer as time moves on, due to competition from rogue agencies that steal patients, use kickbacks and other unethical methods to "corner the market."

Respecting Life vs. Ending Life in Hospice

While the industry may promise to provide the very best for all patients they serve, something else will be delivered at those hospices that no longer adhere to the original mission of hospice which respected life. Any hospice that is engaging in Medicare or Medicaid fraud is certainly not adhering to the original standards of care. In rogue hospices in America, it's becoming common-place for many, if not all patients, to be sedated unnecessarily.

One hospice volunteer with twenty years' experience called me in tears a while back. She had started working at a new hospice home and every patient was sleeping continuously. Being an experienced hospice volunteer, she knew this was quite unusual. Hospice volunteers can do much good for the patients, but not when they are all in a medically-induced coma. In fact, it just doesn't happen at all naturally. She was familiar with good end-of-life care and how important patient and family interactions were at the end-of-life, how much "unfinished business" could be accomplished, and what a blessing good care could be for the patients as well as the families.

When she asked the charge nurse why everyone was sleeping, the nurse said, "Everyone who comes here is agitated, so everyone is sedated." And when she said, "sedated," she meant permanently sedated. It was terminal sedation, something that used to be restricted to only those patients who had "terminal agitation" or even "terminal psychosis." These patients are in extreme distress and may also have uncontrolled pain. Sometimes, sedating them can help with control of very extreme pain and agitation. Some are having terrifying hallucinations and are actually violent or may injure themselves.

Terminally-sedating a patient who is not agitated and not psychotic is a decision to end that patient's life, because they don't take in fluids or food by mouth: they're asleep. Assisted-suicide and euthanasia are just two main categories of ways to openly and obviously impose
death, but the most prevalent form of ending life in America is the Third Way, this misuse of terminal sedation.

"A clever general, therefore, avoids an army when its spirit is keen, but attacks it when it is sluggish and inclined to return. This is the art of studying moods."

_The Art of War_ by Sun Tzu Chapter VII, verse 29

"According as circumstances are favorable, one should modify one's plans."

_The Art of War_ by Sun Tzu Chapter I, verse 17

**Euthanasia Society: Covert Operations in the Health Care & Hospice Industry**
Let's review again the succession of name changes the Euthanasia Society of America has gone through:

Anyone who looks at the history of these groups and the legal succession, one to the next, will understand how clever these organizations became. *There are legal strategies used to avoid liability in business, sometimes involving changing the structure of the corporation or even dissolving one corporation and starting another. There are also legal strategies used to avoid recognition, to create a different public "face."* Early on, the Euthanasia Society was quite open about its goals, in its name and in its proposals.

But, the Euthanasia Society of America changed names after repeated failures to legalize euthanasia from 1939 through 1975. They became "Society for the Right to Die." The
Euthanasia Society proposed killing the unfit to live, those deemed defective. "Society for the Right to Die?" That's a completely different approach. The change of names effectively confused Americans, so the euthanasia society members could operate in stealth mode, to work "under the radar" and subvert the traditional American respect for life.

Americans have been strong defenders of the "rights" of citizens. So, the Euthanasia Society/for the Right to Die tapped into this "fight for rights." Ever since then, they've framed the debate in terms of a "right" to end life at the time of one's own choosing: "death on demand."

Every name change thereafter has been even more "confusing" to the American public, with a more "compassionate ring" to it: "National Council for Death and Dying" (1991) what does that mean to most Americans? "Choice in Dying?" (1991) Again, what does that mean? What kind of choice? And Americans always want the right to choose!

Even better: "Partnership for Caring" (2001). That sounds like we're all working together and caring, nothing about euthanasia in the name. "Last Acts Partnership (2004)" That's totally unrecognizable as to what it's about. And lastly, the NHPCO's "Caring Connections" (2004). That's as far from "Euthanasia Society of America" as you can get. But the National Hospice and Palliative Care Organization's "Caring Connections" project is the successor of all these organizations! ... the final successor organization to the Euthanasia Society of America.

From the very beginning, the euthanasia, eugenics and birth control leaders were of one mind. Medical killing ("euthanasia") would be used to accomplish the eugenics proponents' goals of eliminating unwanted, "defective," "useless" individuals. Who? The elderly, disabled, and seriously ill. With economic pressures rising every day, rationing health care services is certain in a federally-run health care system or in the Medicare and Medicaid systems. Rationing care will become much more aggressive, just as it has been done by HMOs and managed care systems.

How will the change in services be presented to the public? "Choice." "The right-to-die." The freedom to decide."

In 1962,

"theologian Joseph Fletcher ... [became] the chief philosopher of the euthanasia movement ... [who] "fashion[ed] a new rationale for euthanasia based primarily on the notion of patient autonomy."

Patient "autonomy." "Patient Self-Determination." Haven't we heard that before? We have. Again, this is the language being used today to justify legalization of assisted-suicide, the "right to die," and has been one of the three principles of the federal ethics set forth by the Congressionally-created Belmont Commission in 1978.

Also, in 1962,

"Pauline Taylor became president of the Euthanasia Society of America (ESA).

"Taylor...began the ESA's soul-searching process that led to a major shift in the philosophy for the entire American euthanasia movement. She believed the ESA in the past had overemphasized the soundness of an individual's decision to have his or her life ended if terminally ill and in unbearable pain ... Taylor concluded that the time was ripe to ... begin convincing the public that
Letting someone die, instead of resorting to extreme measures, was both humane and ethically permissible." [Emphasis added]


"Letting someone die." It's become common to hear that from our own family members. People will die all on their own, naturally. It's inevitable, but what "letting someone die" really means is what the Euthanasia Society of America meant: hastening death one way or another.

We heard often from the early 1970s onwards about the "horrors" of 90 year-old patients getting cracked ribs from doctors pounding on their chest doing CPR, or being forced onto terrible machines, being on "life support" that kept them alive against their wishes, being treated by doctors who cared more about themselves and what they could prove than their patients. We heard about physicians who made decisions to treat when patients had refused, when very elderly patients were ready to die, but were not being allowed to die naturally.

The newspapers published stories about patients wrongly being kept alive under "horrible" circumstances in the hospitals. Yes, there may have been some cases, even several cases, and there was a need to care for the dying in a much more sensitive way, a way that relieved their suffering, didn't force treatment on those who truly were imminently dying. But much of it was hype. There was an agenda behind it, a method to the messages we were being fed.

Nancy Valko tells us in her Women for Faith & Family 2001 article, "Of Living Wills and Butterfly Ballots" that:

"Very few people signing "living wills" and other advance directives have any idea of how such documents became a universal aspect of health care today."

"In the early 1970s when I was a young nurse, we had never heard of the "living will". When a patient was confused or comatose and appeared to be dying, we discussed such possibilities as "do not resuscitate" (DNR) orders with families. Often, aggressive or useless treatments were discouraged because such measures were considered futile or excessively burdensome in that situation. But one thing we didn't do was offer to withhold or withdraw treatments like antibiotics or feedings to cause or hasten the patient's death."

"This all began to change with the advent of the "living will" and the increasing acceptance of the newly manufactured, so-called "right to die.""

"Actually, the "living will" was originally invented in 1967 by two groups, the Euthanasia Society of America and Euthanasia Education Council, and was touted as a first step in gaining public acceptance of euthanasia. These groups had been struggling for years to get "mercy-killing" bills (which would allow doctors to give disabled or dying patients lethal overdoses) passed in various state legislatures. The "living will" opened up the new strategy of an incremental approach."

[Nancy Valko, RN is an intensive care nurse, long-time advocate for patients with disabilities, president of Missouri Nurses for Life, and spokesman for the National Association of Pro-life Nurses]

The rest is history, our history. The living will which was designed to limit treatments
provided was widely accepted. Again, it was "sold" to the public under the guise of "patient autonomy," the patient getting to decide what treatments he or she wants or does not want. However, in the case of a patient who is not able to express their wishes at the time, what is considered "patient autonomy" by a group of secular bioethicists is not the same as what others who have reverence for life would decide.

More and more people filled out advanced directives or living wills expressing their wishes. However, all the while, the euthanasia proponents were working to expand their use, knowing that once the public accepted limitations of care at the end-of-life, it would only be a short step to limiting treatment that would end up hastening death, and then directly imposing death. The Do Not Resuscitate ("DNR") forms also became universally accepted over time, and the elderly and disabled are often pressured to sign a DNR form in health care settings.

Burke J. Balch, J.D. writes:

"In the early years, pro-euthanasia forces very effectively joined the rhetoric of respect for personal or family autonomy to that of advocating making decisions based on the quality of life. Once both voluntary and nonvoluntary denial of treatment, and food, and fluids were widely accepted, however, the autonomy argument was reversed.

Soon leading bioethicists were arguing that if a competent patient, or the guardian of an incompetent patient, wanted lifesaving treatment, food and fluids, that request should nevertheless be denied if the patient's quality of life was too poor or the cost or burden to society was too great. In 1992, Virginia became the first state explicitly to authorize health care providers to deny treatment or assisted feeding against the will of patients or their surrogates.

In 1996, the Journal of the American Medical Association published an article about hospital practices in Houston, Texas. Under the procedures it described, when two doctors agree a patient should die against his will or that of his family, the patient is given 72 hours either to transfer out of the hospital or to prepare to appear before a hospital ethics committee. After hearing both sides the committee makes the life or death decision; if it is for death, the lifesaving treatment is terminated involuntarily and immediately.

[Euthanasia In the 25 Years Since Roe] By Burke J. Balch, J.D., Director, National Right to Life Committee, Department of Medical Ethics

The adoption of Living Wills, the DNR forms and most importantly, the reclassification of food and water as "medical treatment" pushed forward the incremental steps towards legalized euthanasia. Rita Marker, PhD and Wesley J. Smith, JD, J.D. of the Patient Rights Council tell us:

"In 1983, reflecting on the possible outcome of the debate, Daniel Callahan, then director of the Hastings Center, wrote that:

"...a denial of nutrition, may, in the long run, become the only effective way to make certain that a large number of biologically tenacious patients actually die." [Daniel Callahan, "On Feeding the Dying," Hastings Center Report, October 1983, p. 22]

He further predicted, "Given the increasingly large pool of superannuated, chronically ill, physically marginal elderly, it could well become the
And it now is the "nontreatment of choice," implemented in many hospices, hospitals, and nursing homes around the country making "sure" patients who just won't die "soon enough" actually die. To make it seem more humane, sedation is added.

Note that Callahan calls the elderly "superannuated" which means "obsolete," "too old for further service," and the implication is that they are ready to be discarded, like some worn out, useless tool ... and that's exactly what he means. As a utilitarian, the old who don't contribute actively providing goods or services are "useless eaters" as we've heard before. Callahan's predicted removal of food and fluids combined with sedation is the "palliative" or "terminal sedation" practiced widely in America today.

Euthanasia advocates knew that once food and water were classified as medical treatment, then withholding it would become the easy way to impose death. The public did not truly realize the significance of this change. Those who work with the dying know that there comes a time when death is imminent, in what is called the "active phase of dying," where the patient no longer wants to eat and also cannot eat, where their system is shutting down. They begin to mouth-breathe, their breathing patterns often change, organs and systems shut down, their tongue and mouth dry up. Good end-of-life care seeks to help the dying with the discomfort that can accompany this process, and there are many things that can be done.

However, those who wished to further the agenda of legalizing euthanasia realized they could "use" what naturally happens at the end-of-life to their advantage. They realized that because patients naturally stop eating as much, and then stop altogether, they could simply move up the timeline, withholding food and fluids before the patient was actively dying and death would occur from dehydration. Marker and Smith continue:

However, by the time that [the Nancy] Cruzan [case] was decided [1990], some ethicists and right-to-die advocates had already begun to expand the boundaries of "treatment" once again -- this time to include oral feeding as a medical intervention that could be withheld or withdrawn ethically. The spotlight had now shifted from the method by which food and fluids were provided to the actual food and fluids, no matter how provided.

It is no longer unusual to observe a dispassionate discussion among ethicists and medical professionals about the withdrawal of oral feeding from frail, elderly or brain damaged, but non-dying patients. Such discussions take place at many conferences, and can also be observed on the Internet. They certainly take place in the clinical setting.

In the end-of-life care setting, the way that the provision of food and fluids is halted is quite simple: the patient is sedated, then food and fluids cannot be given orally.

Misapplying terminal sedation of the patient makes the whole process of withholding food and liquids look "peaceful" to the family at the bedside. They tell the family members that the
patient "can't" eat or drink, before the patient really is unable to eat, and so, accomplish the permission to terminally sedate and dehydrate the patient, and then impose death in this way.

I've regularly heard from families that say the hospice staff sedated the patient, then gave them food or water when they were lethargic, almost asleep, and when the patient coughed, having trouble swallowing, they say, "he can't take fluids by mouth. He has a swallowing problem." And they make the patient "NPO," which means "nothing by mouth" is to be given. And without fluids, the patient dehydrates. This could be done to anyone, including you or me. It is a prescription for death.

And it's deceptive. This is not formal euthanasia or assisted-suicide, but accomplishes death just as effectively. It is the most widely-practiced form of euthanasia in America today, and is allowed by law enforcement, the district attorneys and the courts. They have chosen not to get involved, so the killings continue.

A little lie here, a little lie there, and families are fooled. Of course, if a patient has fluid building up in their lungs or extreme swelling throughout their body, giving large amounts of fluid can cause problems. Normally, diuretics are given to relieve fluid in the lungs or body; sometimes a very low dose of morphine is given with a diuretic for end-stage heart failure with pulmonary edema. But that's not the same as giving a large dose of morphine with no diuretic when there is no pain. Giving large doses of morphine with no diuretic when there is no uncontrolled pain, but there is a fluid buildup is a sure sign that death is being hastened.

In other words, what can be done appropriately medically, if done at the wrong time, can become a method of imposing death. In health care, every intervention needs to be done in a certain way to be done safely for the patient's welfare. Done in a certain way, when actually needed, interventions relieve suffering and help the patient. Done intentionally in the wrong way, at the wrong time, and the patient dies. Hospice and palliative care staff who work to impose death are expert in manipulating the family through deceptive language and information. They are also expert in manipulating the interventions so that the patient destabilizes and dies.

Marker and Smith conclude:

"The success or failure of political or social revolutions often depends on the terms used in the debate. If the movement is in accord with accepted values as expressed by language, success is often the result.

But what if the existing lexicon and traditional understanding of words and phrases hurt the cause and bog down the movement? The answer is simple: If the people don't want to follow where you want to take them, make the destination appear more attractive. This is precisely what proponents of the "right to die" have done. By using fuzzy euphemisms, by blurring vital distinctions, by using imprecise phraseology, and by redefining well-understood concepts and ethical principles, they created an Alice Through the Looking Glass World, where previously understood concepts no longer apply. It's as if "up" were now "down" and "hot" were now "cold." Words only mean what the speaker intends them to mean, regardless of the understanding of the listener.

Terms like "killing" and "suicide" which have precise definitions but negative connotations have become outcasts, replaced by subjective, feel-good, meaningless phrases such as "gentle landing," "deliverance," "chosen death," or the ubiquitous "death with dignity." Thus the ongoing revolution in ethics
and values was preceded by a radical shift in the use of language, all intended to beckon us to embark on a journey to radical social change.

That direction may or may not be where we, as a society, will want to go. But one thing is certain. We need to use clear definitions and accurate terminology if we are to truly understand what awaits us at the end of that road.


One example of a mind-boggling changed definition is basic food and water. Everyone normally considers this just "ordinary" care. If a baby or a dependent elderly person is hungry, you feed them. You help them drink. Same thing with the disabled. If they needed a feeding tube and wanted to be fed that way, it was provided without question. However, something big happened in Florida in 1999. It has everything to do with the rogue Hospice of the Florida Suncoast.

Michael Schiavo sought out the local pro-euthanasia attorney, George Felos, who was chairman of the board of the hospice, seeking to have Terri's life ended. Attorney Felos saw to it that his client's wife, Terri was accepted to the hospice though under the law Terri could not legally have been admitted into the hospice; she didn't have any terminal illness. She was not in a persistent vegetative state. Her own physician testified she had no illness that would cause her to die in the near future. The hospice admitted her anyway, expressly for the purpose of ending her life, and we shall see exactly what was done to make it happen.

In April 1999, the state law was changed to allow Terri's life (and those like her) to be ended. Florida Statutes Title XLIV, Chapter 765.101 was changed to reclassify nutrition and fluids provided by tube feedings as a "life-prolonging procedure," not ordinary care.

"Life-prolonging procedure" means any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

Also, see: "Anatomy of right-to-die law - Proponents, hospice industry given rare authority to change Florida statute" by Diana Lynne, WorldNetDaily Reporter.

This was exactly the change desired by those promoting the euthanasia agenda within hospice and palliative care circles. Remember that back in 1983, Daniel Callahan predicted "...a denial of nutrition, may, in the long run, become the only effective way to make certain that a large number of biologically tenacious patients actually die." And finally, this pro-euthanasia movement which has worked so long to change how Americans die, got the type of law they wanted all along.

It is interesting to note that when this specific change was made, the language just "magically" appeared in the proposed bill and not one person or group stood up to say they wrote it, proposed it and were responsible! Staff in state government suggested that "it might have come from hospice," but they wouldn't go on the record about it. In any case, that language was put in, voted on, and passed into law, and Terri was killed by withholding food and water as authorized by the new law that said food and water is not "ordinary" care but "life-prolonging"
With this type of logic, all of those who are fed through tube feedings, many of them in nursing homes, may be considered to be undergoing "life-prolonging procedures," not "being fed." And "life-prolonging procedures" can be withdrawn according to one's advance directive or the guardian's or surrogate decision maker's wishes. Food and water are no longer food and water if they are given by tube feeding. This change in status was a monumental success for the stealth euthanasia movement in America, what many in the hospice industry wanted, what many in the health care community wanted and what many people wanted ... all of whom no longer believe that food and water should be provided to the disabled, the very elderly, the "unworthy of life."


The Robert Woods Johnson Foundation ("RWJF") has been involved in all sorts of end-of-life initiatives, funding projects over many years. They want the public to think that they are solely focused on "improving health care" and being a benefit to the community. But if we look closely at what they are funding and what projects they have thrown their weight behind, we get a different picture. The direction of their contributions is aimed at changing how Americans think about dying and changing how Americans die. That doesn't just mean promoting greater acceptance of hospice and palliative care, as they would like the public to think. It means really changing society from a sanctity of life culture to a quality of life culture.

**Lifetree's Timeline** lists the three pronged strategy used by Last Acts:

Daniel Callahan's 3 bullet points, modified slightly by an Institute of Medicine (IOM) recommendation, became the strategy for Last Acts Objectives and included:

- change American death-denying culture to death-accepting culture;
- normalize withholding/withdrawing nutrition & hydration;
- provide avenue for hastening death by use of opioids.

Soros [Project on Death in America] PDIA scholars were principal investigators for many of the RWJF-funded projects.

Carey Goldberg of the *Boston Globe* reported in 2003 "**After 10 years, $200m effort on dying reaches its own end**"

"The Project on Death in America, financed by billionaire George Soros and the [RWJF] poured more than $200 million over the last decade into end-of-
life programs and research.

"But now the Project on Death is itself dying, and the Robert Wood Johnson Foundation is phasing out almost all related projects and shifting toward childhood obesity and the nursing shortage.

"The great stream of money that helped bring so much more attention to the dying in hospitals, in hospice care, and in public discourse is slowing to a trickle. Specialists in end-of-life issues are concerned that though a great deal has been done, much remains to do -- and say the controversy over the Terri Schiavo case in Florida illustrates their point. They fear that progress in physician training and research could stop or even backslide.

".... The two foundations are not going to abandon the field totally: The Soros project plans to act as a resource center to encourage other donors to support death-and-dying causes; and Weisfeld said the Robert Wood Johnson Foundation plans to follow the field and watch for backsliding. From the dying patient's point of view, work is still needed on items as simple as convincing doctors that they should immediately prescribe anti-anxiety medication when they deliver a terminal diagnosis, said Laura Schmidt-Pizzarello."

The writer confuses "specialists in end-of-life care" with those who promote hastened death at the end-of-life. Even the founder of the hospice movement, Dame Cicely Saunders, would not be considered a "specialist in end-of-life care" if one has to favor hastening death or imposing death outright. There are professors of palliative medicine who strongly opposed the medical killing of Terri Schiavo. It is revealing that the culture of death specialists view those who sought to protect Terri Schiavo from being medically killed as forces opposed to "progress." Their goal is obvious: imposing death on patients like Terri should be normalized and a regular part of end-of-life care services! They say that keeping the severely disabled alive is to be discouraged. Physician Frank J. Mongillo III, M.D. says that "hospice has become abortion for the elderly", and he is only one of many physicians who know this can be the case.

Robert Woods Johnson Foundation is still making grants and supporting the work to change how Americans think about dying and how they die. They are funding the National Hospice & Palliative Care Organization's "Caring Connections" program. This is the successor to the Euthanasia Society as we've seen.

**Last Acts Rallying Points Regional Centers & What Their Selection Tells Us**

It is confusing to the public when hospice industry leaders speak about the good works they are involved in and then hear about euthanasia advocates in the hospice industry. Elizabeth Wickham, PhD, of the Lifetree Organization tells us:

"In 1996, Robert Woods Johnson Foundation ("RWJF") formed Last Acts, a coalition of over 100 professional and consumer organizations. The first Last Acts Leadership Conference on March 12, 1996 brought 140 national leaders to Washington, DC. In a special supplemental report by the Hastings Center which summarized the conference, Daniel Callahan described their three-pronged strategy moving forward:
1. Change the education of health care professionals

2. Change health care institutions and public policies and regulatory apparatus

3. Engage the public to gain support

RWJF began financing and coordinating statewide end-of-life coalitions or Community-State Partnerships using established state ethics committees, networks and centers in more than 20 states.

The National Program Office for the C-SPs (Community-State Partnerships) was Midwest Bioethics Center (now known as Center for Practical Bioethics), a bioethics "think tank" in Kansas City. Each grant recipient received a sizable $450,000 from RWJF and an additional $150,000 in matching funds. These [end-of-life] EOL statewide coalitions pursued the primary goals of educating, training, advocating and changing statutes at the state level.

It is important to note how the Hastings Center was in the thick of things, releasing the official report on the conference that resulted in concrete plans to change America. Yet, the Hastings Center was founded by Daniel Callahan and Willard Gaylin, MD in 1969. Callahan was a member of the American Eugenics. Willard Gaylin, MD was a self-proclaimed communist.

For example, Last Acts had a project called Rallying Points™ and selected the Hospice of the Florida Suncoast as a regional center representing excellence in end-of-life care. The Last Acts website said,

"Rallying Points is a major initiative of the Last Acts campaign to improve care and caring near the end of life.

Two of its other Rallying Points Regional Centers were the Life's End Institute in Missoula, Montana and the Midwest Bioethics Center (now the Center for Practical Bioethics) in Kansas City, Missouri. The Center for Practical Bioethics tells us about its mission:

Our vision: A society in which the dignity and health of all people is advanced through ethical discourse and action.

Our mission: To raise and respond to ethical issues in health and healthcare.

Our core value: Respect for human dignity. We believe that all persons have intrinsic worth, and we express this belief by promoting both autonomy and social justice in health and healthcare.

Our Guiding Principles:

* To lead and promote the leadership of others
* To think critically and listen actively
* To address ethical issues unfettered by special interests
* To collaborate with others who share our values
* To work diligently toward our mission

The only problem with all that flowery very nice sounding language is, who is considered a "person" to have "intrinsic worth?" Does "practical" bioethics mean bioethics that allows for imposing or hastening death? ... as if bioethics that respect the sanctity of life are no longer practical? Does "person" include those who are very elderly, disabled, cognitively-impaired or...
who have Down's syndrome, for example? What is meant by "autonomy?" Does that mean that a baby should have the right to choose life and to not be aborted? And what is "social justice?" Does that include not having your life snuffed out as is happening in the Netherlands and Belgium where "safeguards" written into the euthanasia laws are routinely ignored? Is their idea of "social justice" the same as your idea of "social justice" or not? It's not about the sanctity of life given as a gift from God!

The other Rallying Points regional centers were the Hospice of the Florida Suncoast in St. Petersburg, Florida and the National Resource Center on Diversity in Washington, D.C.

The National Resource Center on Diversity End-of-Life Care (NRCD) committed to improving the provision of and access to quality culturally appropriate care for all individuals with terminal illnesses.

Our goals are:

* To serve as a national clearinghouse and "gathering/ networking place" for communities and researchers as they improve care and caring near and at the end-of-life for the almost 100 million Americans who are people of color.

* To interface with networks and learn from existing EOLC initiatives which are working with diverse communities around the country.

* To create, test and help identify on-going funding support for new models/frameworks for sustainable community-based and professional leadership within minority communities.

* To provide existing EOLC programs, Last Acts Partners and Coalitions with information about culturally appropriate and effective communications materials, and other resources that they can use to increase their ability to engage diverse residents in conversations about, planning for and improving end-of-life-care in their communities.

In 2003, the Life's End Institute (the work of pro-terminal sedation physician and co-founder of Partnership for Caring, Ira Byock MD) posted an article by Dr. Byock about getting quicker access to one's living wills and advanced directives through the "Choices Bank" that was created. That may sound good. Get the documents when they are needed, but what is not mentioned is what happens if the patient requests that care be provided at the hospital or hospice and the staff members don't agree? The patient's wishes can be overridden. The documents do not protect wishes to receive care; they protect choices to limit care, a one-way street. It all sounds very professional and well-meaning.

That's the pattern: use language that many can agree with while slipping in an agenda item. People like the idea of their wishes being honored at the end-of-life and euthanasia advocates have capitalized on that. However, the "honoring of patient wishes" is tainted by efforts to make sure treatment is not provided if the hospital or hospice don't agree. "Ethics committees" can override the patient's wishes. Byock was also co-founder of the successor organization of the Euthanasia Society of America: Partnership for Caring. It's starting to make sense now, isn't it?

What does the disability rights organization, Not Dead Yet have to tell us about Last Acts? They write:
"NO APPLAUSE FOR LAST ACTS"

The Problem: Last Acts, the end of life care "experts," are increasingly influencing health care policy toward people with disabilities, but excluding the disability voice. They call it "end-of-life," but increasingly often, it's really disability policy they're talking about. Last Acts is now promoting beliefs, policies, and practices that are in direct opposition to those of advocacy organizations run by and for people with disabilities. We are especially concerned about policies pertaining to infants with life-threatening disabilities, older people with cognitive disabilities, and anyone who is technology-dependent. The problem is, the real experts on disability are excluded from Last Acts ....

The Last Acts Website - Last Act's web page also has a section devoted to pediatric issues, including two scenarios given related to "end of life" decisions for newborns. The message of these scenarios is that if a doctor tells you it's best for your child to die quickly, cooperate or you'll regret it. It perpetuates the myth that medical professionals are your best "objective" source for a prognosis in the case of newborns. This flies in the face of decades of research that indicate medical professionals are much more likely to feel that certain disabilities are fates worse than death, and feel free to manipulate parents to cooperate with the phobic recommendations they make to "let nature take its course."

It's not surprising that Last Acts is drifting this way. In recent years, organizations such as Compassion in Dying and Death with Dignity National Center have gained prominence within Last Acts. These organizations share a primary mission to promote legalization of assisted suicide and euthanasia based on disability. They've used the Last Acts Bandwagon to promote their own status and respectability. They call their agenda "compassion," but it's really contempt.

"STRAW MEN" AND THE ELEPHANT IN THE LIVING ROOM

The Midwest Bioethics Center, which is also the home for the Last Acts "Rallying Points" Regional Resource Center for the Midwest, makes it clear that disability is the "elephant in the living room" of surrogate decision-making and "ending life" care. The "elephant in the living room" dominates a room, but nobody acknowledges its presence.

The case study on the current Midwest Bioethics Center website involves a man with Down's syndrome who becomes brain-injured and experiences prolonged unconsciousness. The man did not have an advanced directive and had never discussed his health care preferences. The "case study" portrays a "worst-case" scenario of a man we might suppose is in a "vegetative state" (although that label is never used), and strongly suggests withdrawing food and water is the appropriate thing to do.

.... [There are] well-financed policy groups currently defining "end-of-life" care in a way that allows the intentional killing of disabled people, especially cognitively disabled people, through the denial of basic, non-extraordinary care such as food, water and antibiotics. Under the radar, our constitutional rights are being trampled as health care providers rule that our lives are too burdensome, while the "experts" of Last Acts deny us a place at the table.
where our rights are being negotiated away.

It's time for Last Acts Partners to end the lie that they are only addressing "end-of-life care" and admit they're taking charge of health care policy for people with disabilities while excluding disability advocate groups.

_This is discrimination without representation. Worse, it's extermination without representation._

_[Nothing About Us Without Us] from the Not Dead Yet disability rights website_

So, we've learned something about Last Acts and Last Acts Partnership, but what happened after Last Acts Partnership was absorbed by the National Hospice & Palliative Care Organization in 2004? What was the final really big "last act" of the Rallying Points center, Hospice of the Florida Suncoast? Of course, it was the implementation of their agenda: the ending of a life they deemed "unworthy of life," Terri Schiavo's life, at the hospice in front of the whole world by court order. They didn't "terminally-sedate" Terri; they just stopped giving her food and liquids and had police making sure not one drop of water or an ice chip was given to relieve her thirst. But it was essentially a Third Way killing. It wasn't direct euthanasia with a lethal drug, nor was it "assisted suicide" by providing a lethal drug. It was dehydration and the consequent circulatory collapse, and that's what happened to Terri.

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**George Soros' Project on Death in America**

Elizabeth Wickham, PhD, Executive Director of Lifetree explains how billionaire George Soros has shaped American culture:

Soros' Open Society Institute/ Project on Death in America began funding a Faculty Scholars Program which provided a leadership base for promotion of palliative care into mainstream medicine. PDIA Faculty Scholars in over 50 medical schools developed into a network of colleagues and now the second generation of scholars are committed to institutional change.

Among their first projects directed at professionals were EPEC (Education for Physicians on End of Life Care) and ELNEC (a similar program for nurses). Some of the other projects were directed at changing the general culture including RC EPEC (tailored to Roman Catholics) and APPEAL (tailored to African-Americans).

".... With funding from Soros and others, symptom management for the individual patient became broadened to a larger social dimension-ethical
decision making, conflict resolution, and spiritual guidance orchestrated by a multidisciplinary team.

The great palliative care marketing achievement is reflected in the evolving nature of the definition of palliative care. Today's officially defined palliative care is far more than managing a person's symptoms and alleviating pain. Today's palliative care is an approach or a process guided by a trained and certified palliative care team to help the family determine at what point there should be a shift in the goals of care, putting the patient on a different track, away from cure and on towards death.

Recall again what Daniel Callahan said in 1983 about solving the problem of making biologically tenacious patients actually die by withholding food and water. Imposed death is being repackaged as better quality of life.

["Repackaging Death as Life - The Third Path" By Elizabeth D. Wickham, Ph.D. Presented at the 2nd Annual Life Conference in Raleigh, North Carolina, October 23, 2010]

"Hence, when able to attack, we must seem unable; when using our forces, we must seem inactive; when we are near, we must make the enemy believe we are far away; when far away, we must make him believe we are near."

*The Art of War* by Sun Tzu Chapter I, verse 19

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**End-Run Around Right-to-Life: Hospice No Longer is Safe Alternative to Euthanasia & Assisted Suicide**

With all we've covered, it should be clearer that hospice and palliative care is not a "safe alternative" to euthanasia, unless it is an openly pro-life, sanctity-of-life protecting hospice and palliative care provider. How many are? Certainly not the majority of hospice and palliative care units in the United States today! We're having a hard time finding hospices that will openly affirm the sanctity of life and work with other pro-life hospices to serve the public as
they so desperately need.

Euthanasia proponents seemingly "went away" after decades of open warfare on American values, but they only pretended to be unable to move their agenda forward. They acted as if they were doing nothing, but they became more active than ever, focused on incremental steps that were not recognized by the general public.

They've entered the end-of-life industry. What better niche of health care to ply their trade? What better disguise than to pretend to provide the very best of care while pushing stealth euthanasia? Yet, the National Right to Life Committee has not made much comment at all about the widespread infiltration of hospice by the Euthanasia Society of America's heirs and successor organizations such as the National Hospice & Palliative Care Organization.

Why would they if the National Right to Life Committee "bought into" the lie that hospice was only run as a pro-life end-of-life care industry that allowed a natural death in its own timing? Some hospice and palliative care units do not hasten death. Some. Many do hasten death I'm sad to say. Twenty years ago, that would not have been true. But such dramatic work and millions of dollars have been poured into transforming the industry into "euthanasia heaven." "Two Decades to an American Culture of Death" is what it's taken to taint the industry.

Most "right-to-life" organizations promote hospice, work with hospice and believe that hospice just about everywhere is "pristine and pure" just as Dame Cicely Saunders talked about years ago. And so many who work in hospice pretend that there are absolutely no major problems in hospice today. They vehemently deny wrongdoing. They frantically explain away the massive evidence of stealth euthanasia in case after case. According to them, the hospice industry is staffed mostly with perfect individuals who never make efforts to hasten death and any questions that are asked are raised because people "just don't understand" what happens at the end-of-life. When physicians, nurses and others call me and tell me their loved one was medically killed in a hospice, it's very hard to write everything they say off as "not understanding." Especially, when the accounts of such medical killings continue day after day, year after year. Or are we just supposed to say, "these things couldn't be true," just as the world said when Nazis hauled off millions to the extermination camps.

Right-to-life groups act as if they are totally "in the dark" when it comes to the realities of the end-of-life care industry! They are. And their choice to blind themselves to the realities allows the killings to continue virtually unopposed!

They don't want to know the truth. Perhaps some of them experienced wonderful care at some hospices. That's great, but they need to wake up. The evidence of who's running the national scene is overwhelming, and 80 percent of hospices in the US are members of the NHPCO, the successor organization of the Euthanasia Society of America. The World Federation of Right-to-Die Societies lists the National Hospice & Palliative Care Organization See the bottom of the screen shot below showing at the bottom NHPCO listed there:
Well, clearly there's been a lot of change since the first hospices started up. You probably didn't expect to see that and don't want to believe the National Hospice & Palliative Care Organization is a "right-to-die" resource, but that is what the World Federation of Right-to-Die Societies says. And, NHPCO is the successor organization of the Euthanasia Society of America, as clear as can be!

We must realize that the "universe" of hospices is not solely pro-life like it was with Dame Cicely Saunders' St. Christopher's Hospice. It took me a long time to accept this, because it was contrary to what I had been taught. I also didn't want to believe that the mission has been hijacked by corporations that have taken over, many of them for-profit. And fraud is widespread in rogue hospices. Even worse for the patients, those who are true believers in euthanasia and assisted suicide manage many of these hospices or palliative care units. They run the National Hospice and Palliative Care Organization. They're on the board of directors. They train the staff, perpetuating twisted clinical practice and interpretations of the hospice and palliative care mission.

Hospice has become a playground for the right-to-die zealot!

Except for those of faith, the sanctity of life is viewed as nothing more than an obscure phrase
spouted by "right-wing zealots." Quality of life is almost universally promoted by those in the mainstream media, by most bureaucrats running the government, the schools and universities. If any of them were to start speaking openly about the "sanctity of life," they'd be fired for "violating the separation of church and state," something that is part of communist constitutions (as in the former USSR), or Communist China, but is not part of the U.S. Constitution. We have the First Amendment's prohibition against establishing a government-mandated religion, but we have no prohibition about individuals having a religious faith or expressing their reverence for each life. The Constitution and Declaration of Independence are based upon reverence for individual life.

For the modern secular culture, when a person's quality of life is seen to be declining, the value of that life is now also viewed as declining. When it gets bad enough, ending the life of the patient is seen by many as the best way to resolve the problem of suffering. Allowing the patient to live and go through the dying process till a natural death occurs is seen as meaningless, cruel and uncompassionate! Though they don't openly say it, killing the patient to end suffering is what is meant by "death with dignity." This is the belief of the Euthanasia Society of America's heirs who are now entrenched within our health care and hospice industry. They are more "mainstream" in health care management and policymaking circles than people of faith who honor and revere life. Pro-life health care professionals "butt heads" with these secular health care bullies every day in the workplace.

The James Bond theme song written by Paul McCartney, "Live and Let Die" expressed the transition very well:

"When you were young and your heart was an open book
You used to say live and let live ....
But if this ever-changing world in which we live in
Makes you give in and cry
Say 'live and let die'

In other words, in earlier times when you were "young and open," you forgave and turned the "other cheek" allowing the offending party to live, but now, after suffering in the world and you became bitter, you should no longer believe in the value of forgiveness. You should say, "live and let die." And in the context of the Bond films, "let die" obviously means "kill." Though the Bond films can be tremendously entertaining, the coarsening of our society is clearly reflected. People of faith do not view the suffering which comes with life as a justification to become bitter, withhold forgiveness or kill, but those who are secular and utilitarian do. They do not respect the biblical moral imperative, "you shall not murder" and think nothing about imposing death upon the vulnerable.

For those who revere the life given to each of us, "death with dignity" means respecting the sanctity of each person's life, all through life, caring for those in need lovingly, relieving suffering as best can be done, but allowing death to occur in its own natural timing. With regard to the patient, David Mills writes:

"Lying in a hospice bed, in the very last situation he would have chosen for himself, my father taught me that to die with dignity means to accept what God has given you and deal with it till the end. It means to play the hand God has dealt you, no matter how bad a hand it is, without folding. It means actually to live as if the Lord gives, and the Lord takes away, and in either case blessed be the name of the Lord.

"It's dignity of a different sort than the corruptingly euphemistic slogan 'death with dignity' suggests. There is a great - an eternal - dignity in accepting
whatever indignities you have to suffer to remain faithful to God and to do what He has given you to do. A man can be humiliated and yet noble, and the humiliations make the nobility all the more obvious. My father died with dignity, though the advocates of euthanasia and the clean, quick, controlled exit might not think so." [Emphasis added]

["Real Death, Real Dignity - Dying with dignity is not the 'death with dignity' many propose" First Things February 2011]

Many churchgoing people of faith believe, want to believe, that hospice is the alternative to euthanasia. It's the "simple" solution that seemed to answer the need of the times. It was and is too simple.

The right-to-kill crowd got to the hospice industry and overpowered the influence of those who remained true to a sanctity of life ethic. They created and duplicated rogue hospices that pretend to be like Dame Cicely Saunders' hospice but are nothing at all like what she demonstrated. They have hijacked the industry and are leading them and our society into disaster.

No, many of the hospices today model themselves after Florence Wald, RN, MN's vision where assisted suicide would be available for economic reasons or just about any other reason! The euthanasia proponents, knowing Americans' traditional opposition to medical killing, have pretended to be powerless to do anything. Yes, they have pretended to be far away, as if they weren't even acting here in America, except for the "overt" euthanasia proponents run by what some people would think were "loonies" like Derek Humphry of the Hemlock Society.

But, the euthanasia proponents have been very slick, operating behind the scenes in high places, sitting down "at the table" where stakeholders make policy for the nation, sitting down "at the table" when textbooks are written, shaping our children's worldview so that sanctity of life becomes something to be mocked or considered a "throwback" to the "dark ages" when the United States was dominated by Christian "oppressive" values. They also specifically have targeted medical and nursing students for re-education through the rewriting of textbooks. The
re-education was not restricted to simply promoting hospice and palliative care as the public expects it to be; it promoted the secular culture-of-death flavor of end-of-life care favored by Florence Wald, RN, Joanne Lynn, MD and Ira Byock, MD. They have never stopped working to make changes in our society and especially hospice, and they refuse to honor the sanctity of life. They have succeeded in perverting the practice of end-of-life care, so it is no longer a "safe" alternative. The public has no way to know who to trust when they enter a hospice or palliative care unit. Only a hospice that affirms the sanctity of life is truly safe for any patient, and how will you know which one is which?

"Hold out baits to entice the enemy. Feign disorder, and crush him."

*The Art of War* by Sun Tzu Chapter I, verse 20
"On January 16th, 1938 Charles Francis Potter announces the founding of the National Society for the Legalization of Euthanasia (NSLE), which is soon renamed the Euthanasia Society of America (ESA).

According to TIME magazine, "he and a sizable group of other notable men believe[d] so strongly in the right of an incurably diseased individual to have his life terminated gently that they... organized a National Society for the Legalization of Euthanasia... its trustees included Dr. Clarence Cook Little of the American Society for the Control of Cancer and of the American Birth Control League, and Secretary Leon Fradley Whitney of the American Eugenics Society." TIME Magazine "Potter and Euthanasia," http://www.time.com, Jan. 31, 1938

[From Euthanasia ProCon.org "History of Euthanasia and Physician-Assisted Suicide"

With hindsight, we can see that they changed their tactics. Studying their words, speeches, and activities, we see that after defeat after defeat in the late 1930s and thereafter, they decided to move incrementally, getting the public to accept changes in what was expected in health care, all in the name of "patient rights." Their "enemy," the American people's opposition to medical killing, was too strong to overcome.

The Euthanasia Society membership was relatively quite small with respect to the entire country, but they had two things on their side: their willingness to persist for decades and their willingness to deceive the American public. They avoided open confrontation with the American public when they saw they could not win.

After World War II, many around the world were so appalled by the Nazi atrocities. It is no surprise that in 1950:

"The World Medical Association vote[d] to recommend to all national medical associations that euthanasia be condemned 'under any circumstances.'"

"In the same year, the American Medical Association issues a statement that the majority of doctors do not believe in euthanasia."

"When an opinion poll in 1950 asked Americans whether they approved of"
allowing physicians by law to end incurably ill patients' lives by painless means if they and their families requested it, only 36 percent answered 'yes,' approximately 10 percent less than in the late 1930s."
Ian Dowbiggin, PhD "A Merciful End: The Euthanasia Movement in Modern America," 2003
[From Euthanasia ProCon.org "History of Euthanasia and Physician-Assisted Suicide"]

So, when the Euthanasia Society of America was formed, about 46 percent of the American public favored legalization. After World War II, support dropped precipitously. For seventy years, they have never stopped. In the 1940s and 1950s, the cultural "tides" were against the Euthanasia Society, but **they kept trying to legalize medical killing, something they call "mercy."** A Nov 2, 1946 Stars & Stripes newspaper article, "N.Y. Doctors Seek Legal Mercy Killing" tells us they kept trying. That article could have been written in 2011 just the same. The cartoon included with the story demonstrates their idea of mercy.

The dear Lord certainly did not mean the same thing when He said,

"**Blessed are the merciful, for they shall obtain mercy.**"

Sermon on the Mount: Matthew 5:7
Are we to believe the message of the Lord or the advocates of 1) assisted-medical killing, 2) direct medical killing or 3) the third way: terminal sedation killing?

The Hemlock Society and Compassion & Choices: Overt Operations in America

There have always been two main groups of euthanasia proponents: the covert operators and overt operators. The covert operators are those who used the "walk, don't run" strategy after the failure by the Euthanasia Society of America to openly legalize euthanasia in the 1930s through 1960s. They decided to work incrementally by encouraging the use of living wills and advanced directives, helping more and more people use the "DNR" forms, putting their ideas into the universities that train the doctors, nurses and attorneys that manage the health care setting. The National Hospice and Palliative Care Organization's "Caring Connections" program continues this work.

The other camp remained stuck on "kill" and went for open legalization of euthanasia and assisted-suicide in different states. In fact, the idea of "assisted-suicide" is merely an incremental step to legalization of euthanasia. By appealing to those who didn't want to suffer at the end-of-life, they have gained acceptance for the idea of killing oneself at the end-of-life when a patient has a terminal condition. They always promote their idea as the "right-to-die," but everyone dies, so it's not about the "right" to die, it's about the right to determine the timing of one's death (or the timing of the death of someone you have guardianship over as a surrogate decision-maker).

Traditionally, the timing of one's death has been recognized as within God's hands, that we have a purpose in life and a time for being brought into this world and time to pass on to the next world. The euthanasia proponents do not look on life in this way. Leaders of this movement are mostly secular, atheist, socialist and utilitarians. For them, life has no meaning other than what can be accomplished or enjoyed in this world.

The Hemlock Society is a grim organization that has promoted all sorts of ways of killing oneself. Debi Vinnedge, Executive Director of Children of God for Life, says:

In 1980, euthanasia advocate Derek Humphry founded the Hemlock Society of America in Santa Monica, California. It grew to over 50,000 members with 90 U.S. chapters. Humphry's group provided substantial financing for physician-assisted suicide legislation, including the eventual enactment of Oregon's 1997 law. But to advance euthanasia nationwide, a more subtle approach would be needed.

In 2003, Hemlock chapters across the country renamed themselves Death with Dignity, Compassion & Choices, Caring Friends, Compassion in Dying and End of Life Choices. While their names changed, their motives most certainly
did not. Consider Humphry's words from a 2004 speech:

"For too long, the Judeo-Christian religions have dominated ethical thinking in the West... Unfortunately, Anglo-American law makes no distinction on these grounds: A person cannot ask to be killed. We must get this modified."

Vinnege continues:

"In the background another quietly sinister group became formal advisors to the End of Life Panel. Known as Project Grace, their board members include none other than Mary Labyak, Schiavo attorney George Felos and one more link in the Florida corruption: Sister Pat Shirley, O.S.F., officially representing the St. Petersburg diocese.

"Project Grace's motive was to use religion and the clergy to convince the patient or family that withdrawal of medical care, including food and water, was morally acceptable, even in non-terminal patients."

[Hospice care delivers Hemlock nightcap]

Wesley J. Smith, JD says this about the Hemlock Society:

Groups like the old Hemlock Society published how-to-commit-suicide newsletters and promoted wacko suicide paraphernalia like the "Exit Bag" (which had Velcro straps sewn in to ensure "a comfortable fit"). The movement's public face was the ghoulish Jack Kevorkian....

Not that the old guard has entirely disappeared. Derek Humphry, Hemlock's founder, runs an entity called NuTech that researches and promotes various methods of suicide. He's also on the advisory board of the Final Exit Network, which counsels "hopelessly ill" people on ending their lives with helium and plastic bags [link added]. (Several FEN members were recently arrested for this activity.)

... Today, the most important assisted-suicide advocates tend to be affluent and well-tailored liberal women who travel the country pitching "aid in dying" to elite society and the mainstream media. They and their groups are well funded, by organizations such as the leftist Tides Foundation. (Compassion & Choices operates with a seven-figure annual budget.)

Changing the movement's image has made a difference in its results. Three states have legalized assisted suicide - Oregon and Washington by voter referendum, and Montana by a court ruling. States from Hawaii to Vermont have experienced protracted legislative battles over the issue, the tide in favor of assisted suicide rising incrementally with each failed attempt.

These advances would not have happened but for a powerful myth promoted by assisted-suicide advocates and helped along by a compliant media: the notion that Oregon's experiment with legalized assisted suicide has been a success, in which problems and abuses are rare or nonexistent. It is true that the annual statistical reports published by the Public Health Division (henceforth OPHD) of Oregon's Department of Human Services have revealed very few problems. But there's a reason for that: The reporting
system was designed by the authors of the assisted-suicide legislation to be incapable of vigorous policing and in-depth data gathering. [Emphasis added]

As a result, nobody knows precisely what is going on in Oregon. The data in the state-published reports are based overwhelmingly on self-reporting by death-prescribing doctors - who are as likely to admit violating the law on this matter, as they are to tell the IRS that they have cheated on their taxes.

"A Myth Is as Good as a Mile: Why the assisted-suicide movement is winning" Sept 2009

Smith explains that the success in legalization of assisted-suicide in Oregon has emboldened euthanasia advocates to push for legalization of the "Third Way" of ending life, through terminal sedation of the patient in an end-of-life care setting:

... Even as they were pushing explicit assisted-suicide legalization in Washington and Montana, advocates opened a second front in their quest to legalize death-hastening acts by doctors. Two members of the California assembly with close ties to Compassion & Choices had twice unsuccessfully attempted to legalize assisted suicide in the Golden State. Thwarted in that effort, they introduced Assembly Bill 2747, a bill they said required doctors only to inform their terminally ill patients about their end-of-life options. In actuality, as first proposed, the legislation would have permitted euthanasia by the back door.

Here's how: The bill would have transformed a legitimate but rarely required pain-control technique known as "palliative sedation" from its legitimate use - putting a patient who is near death, and whose suffering cannot otherwise be controlled, into an induced coma - into a method of intentionally causing death, by, in the words of the bill, "making the patient unaware and unconscious, while artificial food and hydration are withheld, during the progression of the disease leading to the death of the patient." It would have allowed a dying patient with months left to demand that his doctor sedate and dehydrate him to death - regardless of whether sedation was actually needed to control pain and suffering. And, again quoting the bill, if a doctor didn't "wish to comply with his or her patient's choice of end-of-life options," the doctor would be required to "refer or transfer [the] patient to an alternative health care provider" who would do the deed.

These provisions were ultimately gutted from AB 2747. But it is worth noting that the law requires physicians to provide information about all options - ranging from hospice to palliative sedation (properly defined) - to terminally ill patients, or to refer them to expert organizations - such as Compassion & Choices - capable of counseling them on these options. This may seem innocuous. It isn't: The walkback of AB 2747 marked the beginning of an attempt by Compassion & Choices to change its public image from that of a zealous assisted-suicide advocacy organization to that of a supposedly dispassionate patient-education group.

It's no coincidence that a similar provision popped up in the notorious Section 1233 of H.R. 3200, the House version of Obamacare.

As part of their compensated end-of-life counseling for Medicare recipients,
physicians and nurses could refer patients to expert outside groups. And guess which organization claims credit for playing a prominent part in creating Section 1233? From the Compassion & Choices website, on July 27, 2009: "Compassion & Choices and its supporters have worked tirelessly with supportive members of congress [sic] to include in proposed reform legislation a provision requiring Medicare to cover patient consultation with their doctors about end-of-life choice (section 1233 of House Bill 3200)."

Given its involvement in AB 2747 and Section 1233, Compassion & Choices clearly wants to become the Planned Parenthood of assisted suicide, no doubt hoping one day to receive public funds and medical referrals for end-of-life counseling, and, where legal, to facilitate assisted suicide. (It has already done the latter in Oregon.)

["A Myth Is as Good as a Mile: Why the assisted-suicide movement is winning" Sept 2009]

Although the mandatory counseling sessions for Medicare recipients has been inserted into and taken out of the law twice, something along those lines will eventually be implemented; it's in line with the direction the stakeholders are moving, promoting hospice and palliative care, reducing health care expenditures by rationing care, promoting advanced directives, DNRs, and the new P.O.L.S.T. forms.

What Wesley J. Smith, JD means by the "Compassion & Choices" organization wanting to become the "Planned Parenthood of assisted suicide" is clear when you consider that Planned Parenthood "took in $2.02 billion from government grants and programs" from 2002 - 2008; Compassion & Choices wants the federal funding and recognition as a "legitimate national player" and the consequent expanded role in our society. Societally, Compassion & Choices, a pro-euthanasia, pro-assisted suicide, pro-Third-Way medical killing organization would never be accepted as a "legitimate" player on the national scene by a large majority of the American people, especially those of faith. Yet, they're just a Congressional decision away from being funded by the federal government!

If the Congress chooses to fund Compassion & Choices in the same way as Planned Parenthood, it will show its open bias toward promoting hastened death, just as the federal government has done for Planned Parenthood.

Compassion & Choices' name itself involves deception. They promote the choice to medically kill or to medically kill oneself, but allowing suicide or euthanasia is not compassion.

"Those who advocate euthanasia do so in the name of compassion. In this they are undoubtedly sincere, but misguided. Compassion is derived from Latin and means to 'suffer with', and in the context of dying persons, it translates as walking the rest of life's journey beside them, seeking their comfort at every stage. To kill them is a form of abandonment, precisely because the journey is too tough on others...." [Emphasis added]

[Euthanasia: Should We Kill the Dying? by Brian Pollard, M.D., retired anaesthetist, founded and directed one of Australia's first palliative care services, bioethicist]

Anyone who has worked with the dying knows what is meant by "walking the rest of life's journey beside them, seeking their comfort at every stage." This is the work of hospice and palliative care: to be with them, to relieve their suffering as best we can, to encourage them, to
sit with them, to love them, to pray with them, to listen and witness ... to keep vigil and honor their life!

Compassion & Choices, the new face of the overt camp of euthanasia advocates has its own "business tagline" to push its deceptive campaign. Every page of the website shouts: "Too many suffer needlessly. Too many endure unrelenting pain. Too many turn to violent means. You have choices, and it's your decision." Their tagline really is misleading. Good end-of-life care can relieve almost all suffering and in extreme cases, can make pain bearable. Those who seek assisted-death do not choose that option because of pain.

"Edward J. Larson and Darrel W. Amundsen summarise: "As a result of work by Cicely Saunders and other experts in the field of pain management, nearly all terminally ill patients can obtain sufficient relief from their physical pain. That is the purpose of hospice - and it works. Based on her years of experience treating dying patients with proper pain management at her hospice in London, Saunders reports that none of them have asked for physician-assisted suicide or euthanasia." (A Different Death: Euthanasia and the Christian Tradition, 1998, p.188)."

No, those who seek assisted-suicide do so because of the fear of being dependent or a burden on others, as well as to choose the timing of their own death (or the death of someone who has been categorized as "not competent" to make their own decisions. Even though the Compassion & Choices organization deceives with its tagline, it (and others) has been very successful in shaping American thought. Our culture has drifted further and further away from traditional American values that affirm the respect for the sanctity of life.

**Global Influences**

While each of us may know some of the groups promoting suicide as a "choice" at the end-of-life in our state, we must recognize that there are global influences affecting our nation. When it comes to promoting euthanasia and suicide at any stage of life, we need to be aware of The World Federation of Right To Die Societies which "consists of 44 right to die organizations from 25 countries." The World Federation of Right To Die Societies states that it

"strongly believe[s] that the manner and time of dying should be left to the decision of the individual, ... and that the voluntarily expressed will of individuals, ... should be respected by all concerned as an expression of intrinsic human rights."

They make it clear that the manner and timing of one's death should be up to the individual, not God, and they cloak this dark agenda in the language of a "human right" to kill oneself or be killed. WFRTDS lists other resources that are working to make it legal for people to kill themselves or to be killed medically. Some of them include the familiar names such as "Final Exit," Oregon's "Death with Dignity" Center, but surprise, surprise, ... listed prominently is the successor organization of the Euthanasia Society of America, not Society for the Right to Die, Choice in Dying, Partnership for Caring or Last Acts Partnership, but the familiar hospice organization, the National Hospice & Palliative Care Organization!! And how do they list the largest hospice industry group in the country? As one of the "Right to Die Sites!"

Confirmation! Yes, NHPCO is the friend of the World Federation of Right to Die Societies...
and is prominently listed as such.

The World Federation of Right To Die Societies is behind some of the groups working in this country and all around the world. It is interesting to note that some of its officers are also board members of the U.S.-based pro-euthanasia organization Final Exit Network. Ted Goodwin is a co-founder of Final Exit Network and also President of the World Federation. So, when any one state has an initiative pushed forward by the local right-to-kill group (Compassion & Choices, Final Exit, or some other) they can get money from other state organizations, George-Soros organizations or the World Federation and outspend the people in the state who are pro-life and respect the sanctity of life. That's what happened in Washington where pro-lifers were outspent in the campaign to legalize assisted-suicide (killing) there.

What about other global influences? What can be more global or influential than the World Health Organization? There is no doubt that W.H.O. has promoted palliative care, but which type of palliative care is it promoting? Those health care professionals who respect life tell me about all the good expert palliative care can do for patients, however others point out the spread of "palliative sedation" among providers around the world. Which is it?

WHO's list of palliative care leadership is revealing. For example, Kathleen M. Foley, MD is the medical director of the International Palliative Care Initiative of the Open Society Foundations Public Health Program, working to advance palliative care globally. This is the George Soros-funded group that together with Robert Woods Johnson Foundation financed much of the extreme changes in end-of-life care through the 1990s and up to the present time. In fact, the booklet, "the solid facts, palliative care" edited by Elizabeth Davies and Irene Higginson, distributed by W.H.O. was supported by the Floriani Foundation with collaboration of, yes, the Soros-funded Open Society Institute! Other members of WHO's palliative care leadership team include, among others, Joanne Lynn. Elizabeth Wickham, PhD encourages us to:

"... Look back to a June, 1997 NY Times story to get a better description of what Lynn believes about total sedation "When a patient is ready to die, I can stop nutrition and hydration, I can stop insulin and ventilation, I can sedate them."

When a patient is "ready to die" is not the same as "imminently dying." When a patient is imminently dying, they naturally do not eat or drink. A patient might be "ready to die" months or even years before a natural death occurs. However, under Joanne Lynn's approach, we can terminally (totally) sedate the patient and withhold and withdraw life-sustaining treatment. We've seen this before, but notice she is talking about limiting life-sustaining treatment. And Dr. Lynn represents very mainstream medical thought in the United States today. Her suggestion that life-sustaining treatment is to be limited is exactly what's spreading across the country with the new P.O.L.S.T. forms that are physician orders limiting life-sustaining treatment. Terminal sedation plus P.O.L.S.T. equals a formidable one-two punch working to impose death on the vulnerable, elderly and disabled.

This is why pro-euthanasia Compassion & Choices promotes the P.O.L.S.T. forms as part of the incremental steps to hasten death, what they call being "Good to Go." Their Good to Go Resource Guide specifically encourages each of us to have our doctor fill out the P.O.L.S.T. form, while they admit that if the physician does not agree with our views, he may refuse to fill it out for us. In the case that you want to be treated in the hospital, and the physician disagrees, he can refuse to fill out the form designating your wishes. And because they are truly medical orders (not just a patient's statement of his or her wishes), he can write whatever he wishes to, according to his medical opinion.
So, two of the global influences that are having the most impact on American end-of-life care are the World Health Organization and World Federation of Right-to-Die Societies. W.H.O. chooses to name Kathleen M. Foley, MD (working for a George Soros organization) and Joanne Lynn, MD (who has been with the Rand Corporation). Not only does Dr. Lynn not condemn Third Way medical killing, she proudly emphasizes that she can hasten death through withdrawal of food and fluids along with implementing total sedation.

V - The Courts: Removing Barriers to the Culture of Death

While we may agree or disagree with the rulings in the following cases, it is clear that these cases form a legal foundation for changes in how our society deals with decisions that will result in death. Court rulings, changes in standards within the medical community and new laws have completely changed the landscape regarding life, death and imposing death in America. While the court rulings may make "sense" to some, they have paved the way for the widely-practiced Third Way of killing used in hospices today. It's exactly like the "camel's nose in the tent." Once you give in a little way, you lose the entire battle.

Artwork copyright Vickie Travis 2011. Design copyright Vickie Travis and Ron Panzer 2011
These court decisions have chipped away at the legal protections for life itself in America. They have paved the way for the likely eventual legalization of euthanasia in our country, unless a major restoration of American values and faith occurs. Judges who truly are committed to the values enshrined in our Constitution would never have gone down this path. We need to elect Presidents that will appoint judges who respect the Constitution and revere the life the dear Lord gives us. The founders of our nation acknowledged Him. So should we, and so should our leaders. The freedoms we have enjoyed in our nation are based on the respect for all lives, all citizens. Once that respect for life was diminished, the door was opened to health care tyranny in America.

The 1965 Griswold v. Connecticut, 381 U.S. 479 Supreme Court ruling established the "right to marital privacy" for use of contraceptives

The 1973 Roe v Wade Supreme Court Ruling expanded the prior Griswald decision to recognize Constitutional "right to privacy," determined that a fetus is not a "person" separate from the mother, therefore killing the fetus is "legal" and completely up to the mother to decide for herself.

Most people think of Roe v Wade as being about the "right to privacy" and that is what gave a legal justification for abortion. That is what those promoting the culture of death would like us to believe. No, privacy is not the problem. Although I'm not an attorney or a judge, it seems to me that clearly when the Supreme Court in the Roe decision ruled that a fetus is not a person, not separate as an individual from the mother, that is where the problem was created and set into legal stone. It's absurd for them to have stated that the unique human life, the fetus, is not a person. Yes, the life is within the mother, but just as it's said, "within the mother" indicates that it is other than the mother. And common sense tells us the fetus, the baby, is a new human life. Redefining life is a habitual technique of the culture of death in their quest to be able to kill whatever category of life they wish. They redefine the baby and say it's not a human life, not a unique individual, even though it is; therefore, killing the baby, the fetus or embryo, is not "killing."

The same thing happens when they redefine the brain-injured person and say he or she is legally dead ("brain dead") or in a "persistent vegetative state" or the quality of life is so poor that they can be "let go" and they are made dead through a variety of means.

The 1976 Quinlan case heard before the New Jersey Supreme Court.

While it is true that there are times when patients are subjected to treatments, even surgeries that are unwanted, or put on machines when they don't want them, it is also true that sometimes treatments can be helpful and patients may recover, even after physicians "determine" that the patient is "brain dead." What physicians "know" about the brain and its function however much we admire what they've learned so far) is limited and sometimes mistaken.

In the 1960s, concerns were raised about these unwanted treatments. And it certainly makes sense that patients should not be subjected to unwanted treatments. Elderly dying patients should not be subjected to treatments that have no purpose and are not going to help the patient. Everyone can understand that, but when you take something as simple as that and misuse it to hasten death by not providing helpful treatment, you've changed the entire purpose of the DNR. In one case, you are honoring the patient's wishes. In another, you can manipulate the treatments to hasten and impose death, even involuntarily or without the patient's knowledge completely.

Karen Ann Quinlan was one of the patients whose condition was used to push forward the Do
Not Resuscitate protocol and patient rights to determine their own course of treatment. In 1975, she had been drinking heavily, took some drugs and her heart and breathing stopped. She was resuscitated, taken to the hospital and placed on a ventilator. When it was clear that Karen was severely brain-injured, but not "brain-dead." Her father wanted the ventilator removed.

Quinlan's doctor refused, claiming that his patient did not meet the Harvard Criteria for brain death. Based on the existing medical standards and practices, a doctor could not terminate a patient's life support if that patient did not meet the legal definitions for brain death. According to the Harvard Criteria, Quinlan could not be declared legally dead, and medical experts believed she would die if the respirator were removed.

[From: "Court and the End of Life - The Right To Privacy: Karen Ann Quinlan]

Initially, the lower courts denied the father's requests, but in the landmark case heard by the New Jersey Supreme Court, the father's wishes prevailed and the ventilator was removed. However, she continued breathing on her own until she died of an infection in 1985.

Before the Quinlan case, such decisions about withdrawing treatment were completely between a patient and the physician.

"The decision to terminate life support, which was once a private matter between the patient's family and doctor, became an issue to be decided by the courts. The New Jersey Supreme Court ruling on this case became the precedent for nearly all right-to-die cases nationwide." [And]

"In March 1976 the New Jersey Supreme Court ruled that, if the hospital ethics committee agreed that Quinlan would not recover from irreversible coma, her respirator [ventilator] could be removed. Furthermore, all parties involved would be legally immune from criminal and civil prosecution."

[From: "Court and the End of Life - The Right To Privacy: Karen Ann Quinlan]

There were several other cases that moved the "right to die," withdrawal of treatment theme along, especially the Cruzan and Schiavo cases.

In the 1990 Cruzan Case, the Supreme Court affirmed that a surrogate decision-maker has authority to exercise a patient's right to refuse lifesaving procedures (for a patient in persistent vegetative state) consequently causing death through withdrawal of treatment. There is no difference between the withdrawal of needed treatments in passive euthanasia and this court-approved "patient refusal" of lifesaving procedures (actually decided by someone else). Death is intended and accomplished just the same.

In the 2005 Terri Schindler Schiavo Case:

Terri is said to have "collapsed" with brain-injury in 1990. Medical records show that after that night but not before, she had marked injury to her neck and an L-1 injury to her spine, a posterior rib fracture and other injuries not explainable by simply having “collapsed.” No police attempted-homicide investigation was ever done. Nobody has ever explained why not. She was later examined to be in a "minimally-conscious state by physicians," but pro-euthanasia physician Ronald Cranford, MD conveniently declared Terri was in a persistent
vegetative state which suited the agenda. Rehabilitation therapy had been forbidden for many years by order of guardian Michael Schiavo, and she was later admitted to hospice fraudulently since Terri did not meet the criteria for hospice; she was not "terminal." Her own physician testified under oath that she was in good health. Terri was not on any "life support" at all but had tube feedings.

Terri was selected by euthanasia advocate Mary Labyak (CEO of the Hospice of the Florida Suncoast) and euthanasia advocate George Felos (Chairman of the Board of the Hospice and Michael Schiavo's attorney) for the express purpose of expanding the legal foundation for medical killing and chose to do that in the hospice setting. Felos had earlier been involved in another precedent-setting case: In Re: Guardianship of Estelle M. Browning. In Terri's case, the local Judge Greer refused to hear much evidence or to have Terri tested properly, although the pretense that everything had been done was carefully orchestrated. After a long court battle, the court ordered that the guardian's wishes were to be acted upon and Terri was deprived of food and fluids. None of the appeals and other courts re-evaluated Judge Greer’s findings of fact; they simply reviewed the legal decisions flowing from his findings of fact. Her medical killing gave the public yet another example where the courts ordered the removal of simple tube feedings, forbade any oral nutrition to be given, in order to cause death within a hospice setting.

VI - Physicians: Redefining Death to Remove Barriers to the Culture of Death

From the 1960s onward, physicians have pushed newer and more permissive definitions of "death" for purposes other than scientific truth. On Aug 5, 1968, the "Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death" released their report, "a definition of irreversible coma." [JAMA. 1968 Aug 5;205(6):337-40]

"The report defines "irreversible coma" as a new criterion for death, lists steps to be taken by physicians to diagnose this condition, and mentions two early instances of the concept's appearance in judicial rulings."

Many people think of the life-saving effects of organ transplantation and remember the first heart transplant in South Africa (1967) (with another one performed three days later in Brooklyn, NY on a recently born baby).

The recipient of a donated heart goes on to live a much fuller life after coming very close to dying. It is a life-changing surgery that brings prolonged life for the recipient.

But with the proliferation of organ transplant teams, the prestige and status accorded to hospitals that perform such operations, the big money made for performing such operations, is there anything else going on here aside from a pure, altruistic motive to save the life of the desperate patient who will die without a donor organ? In some cases, there is something else
going on.

Clearly, physicians didn't want to openly state the obvious, that they kill the patient to get vital organs for transplantation (such as a heart or both lungs). In the same way that babies have been re-labeled "just an embryo" or "fetus," and "not a person," to justify "aborting," killing the baby, a patient who is seen as a prospective donor is re-labeled "brain dead" so it is easier to kill him and take the organs. Of course, many today think that is perfectly fine. They have been taught to believe that the patient is "already dead," or better off "truly dead" and think they are doing that patient a favor while saving the life of the patient who receives the organs. However, some patients would and do recover if given more time.

As we've seen above, the definition of "brain death" was set at "irreversible coma." Yet, Professor Paul A. Byrne, MD and Walt F. Weaver, MD explain that "brain death" is not "death." When everybody knew what "death" was before 1968, why talk about "brain death," and later equate "brain death" with "death?" Well, before "brain death" became a criterion for "death," states such as "Kansas defined that a person was dead once all of his or her organs were dead, making some transplants impossible."

We know that transplanting organs "saves lives," but what about the person whose organs have been taken? As Paul A. Byrne, MD has explained, a heart donor cannot truly be "dead," because that would mean the heart and all organ systems had stopped functioning, and all tissues and cells had begun already to break down. Such a heart would be unsuitable for transplantation. Obviously, donors are "alive," but considered "not alive" for transplantation purposes. What happens if a patient is determined to be "brain dead" but later recovers? According to what we've been led to believe, that should never happen, but there have been such cases. Physicians do make mistakes, and sometimes even if they haven't made a mistake, patients have still recovered. Sometimes, physicians are not really interested in whether or not the donor patient might recover.

A May 13, 2009 article by Verheijde, Rady & McGregor gets right to the point:

"Brain death, states of impaired consciousness, and physician-assisted death for end-of-life organ donation" [Emphasis added]

The title says it all. It points out, without any pretension or deception, that physicians do impose death, i.e., they kill the patient, in order to get the organs used. It's very simple to understand. So, imposing death upon patients to facilitate organ transplantation must be considered one aspect of the euthanasia movement. Whether they are considered "brain dead," in a "persistent vegetative state," organ procurement organizations want those organs. Modern society may scoff at the idea that patients are being killed, but these doctors admit it, right in the title of the article. It's what's been done all along since "brain death" became an alternative definition of actual "death.

With regard to those in what has come since 1972 to be termed a "persistent vegetative state," Professor B. Jennett states:

"this state is frequently temporary, the original term persistent vegetative state is potentially misleading as it suggests irreversibility."

[J Neurol Neurosurg Psychiatry 2002;73:355-357 doi:10.1136/jnnp.73.4.355]

What will happen to patients thought to be in a "persistent vegetative state" as the push to grab organs for donation moves into "high-speed?" It's just a small step from "brain death" being used as a justification to take organs, to using "persistent vegetative state" as a justification.
What about mental retardation, Down's syndrome, or other cognitive impairments like dementia? Some physicians already advocate taking organs from the cognitively impaired of all categories.

With the **Uniform Anatomical Gift Act** ("UAGA") Revised in 2006 and 2009, the default rule for patients who are considered "brain dead" is that the patient is presumed to have given consent to prepare his body for donation of his or her organs for transplantation. Preparing the body for transplantation is not a reversible process!

Dr. Paul A. Byrne explains in his article: *"Do Your Organs Belong to the Government?"* that once the patient's organs are deemed suitable for transplantation, and because of the "presumed consent" to prepare for harvesting of the organs, the transplant team is legally allowed to flood the body with fluids which destroys the brain and any chance of recovery, while preserving the vital organs such as the heart, lung, liver, kidneys and so on. While all of this is going on, the organ procurement team "seeks to make contact" with a relative, friend or other "class" of people who can give "consent" for the "deceased" patient to be made really dead by taking his vital organs.

What if the doctors are wrong? Are they ever wrong? Chauncey Crandall, MD is the Yale-educated chief of the cardiovascular transplant program at Palm Beach Cardiovascular Clinic, Florida. Dr. Crandall reports that on October 20, 2006 he had pronounced Jeff Markin dead forty minutes earlier and was finishing up paperwork when he felt a call to pray for the patient and try again to get his heart started. He ordered the staff to give one more shock with a defibrillator. Markin is alive today because the doctor listened, prayed and did not give up. Dr. Crandall is the author of *Raising the Dead: A Doctor Encounters the Miraculous*.

Dr. Paul A. Byrne mentioned the case of Zack Dunlap: "Pronounced dead, man takes 'miraculous' turn -- Doctors can't explain why 21-year-old Zack Dunlap recovered from accident," March 24, 2008 and Val Thomas: "Woman Wakes After Heart Stopped, Rigor Mortis Set In" May 23, 2008, both of whom were officially "pronounced" dead ("brain dead") by the doctors and who came back to life from the "dead" to full consciousness and interaction and functioning here in this world. Clearly, the docs are not infallible and may be rushing the whole "brain death" determination in many cases!

On May, 2011, the Australian Gloria Cruz was officially pronounced "brain dead" and her case "hopeless." Medical professionals pressured her husband to have the ventilator turned off immediately, but he resisted and delayed the physicians. When the ventilator was eventually turned off a few weeks later, Gloria continued breathing on her own and woke up completely three days later. Doctors were stunned and said, "it's a miracle." Perhaps doctors need some humility in realizing that they still do not understand all that there is to know.

For more information, see *"Dealing Death -- A Pro-Life Nurse Looks at Dangerous Developments in Organ Procurement"* by Deborah Sturm, R.N. Deborah Sturm is a registered nurse and serves as the secretary of the National Association of Pro-Life Nurses.

Dr. Byrne has told us about some of his own patients who were considered "brain dead" and went on to live complete and normal lives, functioning in the community, working, and raising children.

Makes you think twice about what is going on, doesn't it? It should! In July, 2011, a Quebec woman, Madeleine Gauron, woke up after being declared brain dead, and immediately recognized her family.

Texas does not require the patient's own declaration of intent to donate when it comes to non-
visceral organs. See: Texas's Health and Safety Code, Title 8, chapter 693. In Texas, "non-visceral" organs refer to something like a cornea that might be removed without consent to donate. This is the desired outcome for the organ procurement industry. Who was appointed to head the President's Office of Information and Regulatory Affairs? Cass Sunstein, "Obama Regulation Czar [who has] Advocated Removing People's Organs Without Explicit Consent."

Cass Sunstein ... has advocated a policy under which the government would "presume" someone has consented to having his or her organs removed for transplantation into someone else when they die unless that person has explicitly indicated that his or her organs should not be taken.

Under such a policy, hospitals would harvest organs from people who never gave permission for this to be done.

Outlined in the 2008 book "Nudge: Improving Decisions About Health, Wealth, and Happiness," ... Under this policy, all citizens would be presumed to be consenting donors ...."

Well, it can't be plainer where they want to take us! Earl E. Appleby, Jr. director of Citizens United Resisting Euthanasia quotes Hastings Center co-founder Willard Gaylin, MD and writes:

"Over the years, physicians have practiced euthanasia," Dr. Willard Gaylin, of the infamous Hastings Center, acknowledges in Harvesting the Dead. "They have withheld antibiotics or other simple treatments when it was felt that a life did not warrant sustaining, or pulled the plug on the respirator when they were convinced that what was being sustained no longer warranted the definition of life."

The staged debate among its sundry sects notwithstanding, the real question posed by the brain-death cult is not whether its victims are dead but whether they have a right to life. We are, in Gaylin's words, "faced with the task of deciding whether that which we have kept alive is a human being, or, to put it another way, whether that human being . . . should be considered alive." "The problem," he concludes, "is well on its way to be resolved by what must have seemed a relatively simple and ingenious method. As it turned out, the difficult issues of euthanasia could be evaded by redefining death." (emphasis added)

China has taken it a step further. The government there has ruled that the organs of those to be executed do belong to the government, and they harvest the organs at the moment of execution! The March 2009 MailOnline (U.K.) article, "China's hi-tech 'death van' where criminals are executed and then their organs are sold on black market" reveals:

In chilling echoes of the 'gas-wagon' project pioneered by the Nazis to slaughter criminals, the mentally ill and Jews, [those sentenced to death] ... will be handcuffed to a so-called 'humane' bed and executed [by lethal injections] inside a gleaming new, hi-tech, mobile 'death van.' .... [and]

According to undercover investigations by human rights' groups, the police, judiciary and doctors are all involved in making millions from China's huge trade in human body parts. Inside each 'death van' there is a dedicated team of doctors to 'harvest' the organs of the deceased. The injections leave the body intact and in pristine condition for such lucrative work. After checking that the
victim is dead, the medical team first removes the eyes. Then, wearing surgical gowns and masks, they remove the kidney, liver, pancreas and lungs. Little goes to waste, though the heart cannot be used, having been poisoned by the drugs. The organs are dispatched in ice boxes to hospitals in the sprawling cities of Beijing, Shanghai and Guangzhou, which have developed another specialist trade: selling the harvested organs.

.... With more than 10,000 kidney transplants carried out each year, fewer than 300 come from voluntary donations. ....

That's less than 3% that are voluntary donations. The rest of China's donated kidneys are harvested involuntarily! Wesley J. Smith, commenting on the latest health care trends, tells us that "once a society decides that some of its members have a life of such low quality that it is acceptable for doctors to kill them, and once these patients - many of whom already feel like burdens - learn that they can save lives by their suicides, the seductive pull of asking for euthanasia/organ harvesting could reach gravitational strength." Couple the financial motivation of physicians and hospitals who do transplants with the disdain many utilitarians hold for those who are disabled, and you have a lethal prescription for the Perfect Storm about to hit American health care settings. The vulnerable are not only suffering; they must now worry that pressure will be brought to have them end their so-called "meaningless" lives and donate their meaningful organs to others who are considered more important than they are.

You may think that what happens in China is so irrelevant to what will happen here in America, but you would be mistaken. We live in a very inter-connected world and Chinese influence in the world is only growing along with its booming financial assets which are mostly controlled by the Chinese Communist government. In the early 1970s I was taught about the hypothesized threat from Communist China as its population grew bigger and bigger over time. The reality of China's growing population has only continued, however, back in the 1970s nobody was talking about China as the financial success it has become. And closer to home, a Communist China-controlled corporation plans on buying and then building a 50 square mile property in the United States south of Boise, Idaho. What

"... they have decided to do is to buy up pieces of the United States and set up "special economic zones" inside our country from which they can continue to extend their economic domination. .... the 10,000 to 30,000 acre "self-sustaining city" that is being planned would essentially belong to the Chinese government. The planned "self-sustaining city" in Idaho would include manufacturing facilities, warehouses, retail centers and large numbers of homes for Chinese workers. Basically it would be a slice of communist China dropped right into the middle of the United States."

["China Wants To Construct A 50 Square Mile Self-Sustaining City South Of Boise, Idaho" TheAmericanDream.com June 8, 2011]

Nothing against the Chinese (or any) people, but the Communist Chinese leaders and the form of totalitarian government there do not share our American values, they prohibit the truly free exercise of religion, having imprisoned many for participating in various religions, including Christianity, and they do not have any sense of the reverence for life that is implicit in our nation's Declaration of Independence and our Constitution. "Through a system of "re-education through labour, - the Chinese government detains hundreds of thousands each year in work camps without even a court hearing. There are more Christians in prison in China than any other country in the world."

With America's economy in a man-made disastrous condition and China's government in
control of vast sums, Chinese corporations acting within the U.S. are positioned to buy up several or even many sites to build Chinese cities within the United States of America. Our Congressmen as well as state leaders are allowing these plans to move forward, though during the Cold War, we would never have thought of allowing the Soviet Union to buy up sections of America. These settlements would house mostly Chinese citizens in the U.S. and can only grow with the families living here over time. While some may doubt that these are realistic threats to American sovereignty, as years pass, the real nature of these developments will become more apparent.

How long can our nation survive as a sovereign nation when our leaders betray their duty to protect our nation from all threats to our national security? When the Chinese harvest organs involuntarily from executed prisons, they demonstrate their values. When they take aborted fetuses and use their remains to create medications they demonstrate their values. These are the same utilitarian values they will bring to America when they settle here, not to become Americans and live the American dream, but to create mini-Communist China zones here, something quite the opposite! China is not the only possible threat to the U.S. The re-establishment of something like the Soviet Union is another possible factor and moves to consider European law in our own Supreme Court decisions is a move away from reverence for life and towards utilitarian secularism.

We also have radical terrorists bent on destabilizing the West and especially the United States. It seems that as our nation responds to these threats, the government is assuming a larger and larger role in daily life, threatening the basic Constitutional freedoms it is supposed to protect. If that government is no longer dedicated to the founding principles of a citizen's right to life and liberty, how can vulnerable patients be expected to remain safe? If transplant physicians are desperate to obtain organs for their patients, they will look to euthanasia as a means to organ harvesting.

Dr. Paul A. Byrne has explained where we're at today when it comes to organ transplantation, what our own elite in the medical community and the government have been up to, and whether you are likely to keep your internal organs or not should you unfortunately be found in a modern hospital with a severe brain injury. He knows the answer to the question:

"Do Your Organs Belong to the Government?"

By Paul A. Byrne, MD

June 2008

Recent news reports of responses in persons declared "brain dead" should have alerted everyone that "brain death" is not true death. These observed responses prevented the organ transplantation protocols from going further. Zack Dunlap later reported how he could hear discussions of his death, but
he could not respond at that time. Val Thomas had flat brain waves for 17 hours before her response was observed. While these might be of only passing interest to many, it ought to be of grave concern to every citizen of the United States of America, and the rest of the world.

We are continually bombarded with ads to be an organ donor. We are told that we are giving the "gift of life" in organ donation. We are led to believe that organs are taken for transplantation after true death, i.e., after the heart and circulation stops and there is no known way to restore them. We are seldom, if ever, made aware that after true death, the heart, liver, and other vital organs are not suitable for transplantation.

True death is when the soul separates from the body. Certainly when the person is living, the soul has not separated from the body. The heart, liver and other vital organs are suitable for transplantation only when there is circulation and respiration albeit supported by a ventilator. After true death, the ventilator cannot support circulation and respiration. After true death, vital organs cannot be transplanted from a corpse.

The Federal Government is much involved with obtaining organs for transplantation. During the Clinton Presidency the Secretary of Health issued an edict that when death is imminent all medical records must be sent to the Organ Procurement Organization (OPO) to determine suitability for transplantation. The secretary's edict has been updated and placed into Statute within the HIPAA Regulations (The Health Insurance Portability and Accountability Act of 1996). While many believe that HIPAA Regulations protect your privacy, there is a list of 14 reasons why the Federal Government can obtain and use your medical information without your permission. Organ donation is one of them. [See: 45 CFR Section 164.512]

If the OPO determines that your organs are suitable, a "designated requestor" is sent to the hospital to seek permission from relatives, close friends or a government official. This is done under the Uniform Anatomical Gift Act (UAGA) that was passed in all 50 States in 1968. The Revised UAGA of 2006 has already been placed into Statute in 30 states, and has been introduced in 10 more states just this year. This current Revised Act makes everyone a "prospective donor," meaning it is presumed that you intend to be an organ donor unless you have signed a refusal.

Whenever attempts are made to add or delete words from an existing statute, someone has a reason for doing so. Previously the UAGA required you to be "of sound mind" to be an organ donor. That requirement has been removed. A person who gives any sort of medical or legal consent to anything ought to be "of sound mind" in order for the consent to be valid. So, why drop "sound mind" from the existing statute? Could it be that the drafters of the Revised UAGA are concerned that a person under the influence of sedatives, or with a brain injury, might not be considered to be of sound mind, yet they still want to be able to get his/her signature or verbal consent to organ donation?

The revised UAGA empowers 15 ½ year old persons (in some states, 14 year old persons) to sign to be an organ donor when they apply for a learner's permit to drive. This is a time when a teenager might be easily intimidated. Parents can override a minor child's refusal to be a donor prior to age 18. What
is the purpose of permitting a child to sign or refuse to give an anatomical gift
if it can be overridden? What does it mean, "if a parent is reasonably
available?" Do you think the search for a parent will be as diligent when a
child has consented to be a donor as the search for a parent of a child who has
refused to be a donor?

The Revised UAGA's Section 8 recognizes that some decisions of a donor are
inherently ambiguous, making it appropriate to adopt rules that favor the
making of anatomical gifts. Thus, the Revised Act clarifies to facilitate and
insure that suitable organs are obtained. For example, a donor's revocation of a
gift of a body part is not to be construed as a refusal for others to make gifts of
other body parts. Likewise, a donor's gift of one part is not to be construed as a
refusal that would bar others from making gifts of other parts from that same
patient, absent an express, contrary intent. Section 8 is designed to firmly state
the rule that a donor's autonomous decision regarding the making of an
anatomical gift is to be honored and implemented and is not subject to change
by others. Section 8 not only continues the policy of making lifetime
donations irrevocable but also is restated to take away from families the
power, right, or authority to consent to, amend, or revoke anatomical
donations made by donors during their lifetimes (even though alert, fully
informed relatives might make a different decision).

The Revised UAGA sets forth a prioritized list of classes of persons who can
make an anatomical gift of a decedent's body or body part if the decedent was
neither a donor nor had signed a refusal. The list is more expansive than under
previous versions of this Act. It includes persons acting as agents at the
decedent's death, "adult grandchildren, and close friends." It goes through a
descending class of persons to give permission, proceeding from one class to
the next by going through those "reasonably available." As stated in the
revised Act, "Reasonably available means able to be contacted by a
procurement organization without undue effort." Undue effort is not defined;
could it mean not getting a response to a telephone call is sufficient to go to
the next class of persons?

The revised Act has language that does not protect the life of the prospective
donor and does not benefit ordinary citizens. For instance, does this bill not
discriminate by looking so hard at facilitating the obtaining of organs for
transplantation, that it overrides the fully and explicitly informed consent of
the donor? Then there is the word "surviving" used to describe the
"decedent's" relatives who can make an anatomical gift on behalf of the
"decedent" after the so-called "decedent's" so-called "death." This is ludicrous,
since a dead relative, to state the obvious, could not be "reasonably available."

In the Revised Act, what are "measures necessary to ensure the medical
suitability of an organ for transplantation or therapy"? I am concerned about
this because the bill states that "unless the donor's declaration (living will)
expressly provides for the contrary," the proposed law "prohibits" these
measures from being withheld or withdrawn from a prospective donor. A
"prospective donor," according to this bill, may be someone who is "near
death" and yet the organ procurement medical team can initiate measures that
may actually do harm to the still living potential donor-such as increasing
fluids to a head-injured patient, administering heparin and Regitine, etc., in
order to "ensure the medical suitability of an organ." It is absolutely appalling
to think that once a person is identified as a potential donor, organs for
transplant become more important than the person to whom they belong!

The Revised Act states that a revocation of an anatomical gift "does not equal a refusal." So, if you change your mind, you not only have to revoke your prior anatomical gift, but also issue a formal refusal. Isn't this close to an opt-out or presumed consent system? Such a system presumes fulfillment of all legal requirements for consent to take organs unless a person has opted out by a formal witnessed documentation of refusal. Eight European countries have such a presumed consent, opt-out system. Such a bill has been introduced in Delaware; it has not been acted upon as yet.

In some States, the Revised Act requires that "The anatomical gift must be renewed upon renewal of each [driver's] license . . . but when a license expires and is not renewed, the anatomical gift does not expire."

Organs for transplantation are primarily obtained from those declared "brain dead." This is labeled as DBD. These are patients who have disease or injury to their brain manifested by altered functioning of their brain. They typically have a beating heart, normal blood pressure, respiration supported by a ventilator, and they move and squirm when cut into without first being administered a paralyzing drug or an anesthetic.

The Harvard Criteria (on brain death) was published in 1968. Thirty more disparate sets of criteria were published by 1978; there have been many more published since. There is no general agreement or consensus as to which set of criteria to use to declare a person "brain dead." Consequently, a person could be dead by one set, but not fulfill other sets, thus they are living! Every set includes an Apnea Test. This test is done by taking away the life-supporting ventilator for up to 10 minutes. This is medical strangulation. The patient can only get worse with this test. This test is commonly done without requesting permission. If this isn't enough to draw attention, when a patient does not fulfill any of these differing brain related criteria, but the desire is to get the organs, a Do-Not-Resuscitate order (DNR) is obtained. Then the ventilator, i.e., life support, is removed. When the patient is without a pulse (but not without a heart beat) for 2-5 minutes, this becomes the signal to take the organs. This is labeled Death by Cardiac Death (DCD).

Yes, much is being done to get your organs. For an organ to be suitable for transplantation, it must be healthy and it must come from a living person. Please wake up! Organ excision does not benefit the person from whom the organs are taken, it causes their death!

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[About the writer: Dr. Paul A. Byrne, a Neonatologist, is Director of Neonatology and Director of Pediatrics at St. Charles Mercy Hospital in Oregon, Ohio, is Clinical Professor of Pediatrics University of Toledo College of Medicine, Board Certified in Pediatrics and Neonatal-Perinatal Medicine, Member of Fellowship of Catholic Scholars.

Dr. Byrne is past-President of the Catholic Medical Association (USA), formerly Clinical]
Professor of Pediatrics at Creighton University School of Medicine in Omaha, NE, and at St. Louis University School of Medicine in St. Louis, MO. He is author and producer of the film "Continuum of Life" and author of the books "Life, Life Support and Death," "Beyond Brain Death," and "Brain Death Is Not Death." Dr. Byrne has presented testimony on "life issues" to eight state legislatures beginning in 1967.

[Note: As of February 17, 2011, 44 states have now enacted the Revised UAGA and 2 have bills in process to adopt it. See the "Revised UAGA Enactment Status Map."]

In the quest to grab organs for transplantation, physicians may withhold treatments from treatable patients who could recover. They may mislead family members about their loved one's medical condition in order to get organs for transplantation. We have already seen that some doctors are very eager to pronounce a patient "brain dead" and begin the pre-harvesting protocol, flooding the body with fluids. But new research is confirming that exactly the opposite is required for recovery:

"New data from multiple studies suggest that clinicians are pulling the plug too early in patients who suffer an out-of-hospital cardiac arrest, especially among patients treated with therapeutic hypothermia. In one study, investigators showed that arbitrarily withdrawing life support 72 hours after an out-of-hospital cardiac arrest prematurely "terminates life" in as much as 10% of patients.

"What is challenging for me, as a clinician who has spent 20 years trying to increase survival rates and to get people alive to the hospital, is to think that we are losing them because we don't know what to do with them," lead investigator Dr Keith Lurie (University of Minnesota, Minneapolis) told "Heartwire," "It suggests there is a huge opportunity to improve survival. I'm thinking, in absolute terms, of 5% to 10% for any patient who comes into the hospital with a pulse--they have a 5% to 10% greater likelihood of walking out intact if we give them time."

".... In addition to that report, Drs Shaker Eid and Nisha Chandra (John Hopkins University School of Medicine, Baltimore, MD) also provide data suggesting that care for cardiac-arrest patients treated with therapeutic hypothermia is withdrawn too soon. In that analysis, no cardiac-arrest patient who was treated with hypothermia was alert and conscious after 72 hours, whereas one-third of these patients had regained alertness by day seven.

"At this stage, the data are too premature to make any formal recommendations, but we do believe there needs to be a deliberate evaluation of these patients," Chandra told "Heartwire". "To withdraw support, or the idea of making a pronouncement about the degree of neurologic recovery on day three, needs to be revisited." ".... [a] patient, not alert and unconscious 72 hours following cardiac arrest, was sent to a nursing home, only to wake up two weeks later "feeling fine," but confused about his surroundings." ["Give It Some Time! Plug Pulled Too Soon in Hypothermia-Treated Cardiac-Arrest Patients" from "Heartwire" November 14, 2010 Michael O'Riordan]
Nancy Valko, RN, President of Missouri Nurses for Life and spokeswoman for the National Association of Prolife Nurses comments:

"... one of the biggest differences between medical care today and that of 30 years ago is time. In the "old days", critically ill or injured patients were not rushed into a determination of hopelessness soon after the illness or injury so that life-sustaining treatment could be withdrawn. Because of that gift of time, we were surprised and humbled when many of these "hopeless" patients survived and even recovered. Now, especially with non-heartbeating organ donation, the "right to die" and economics, there is a lot of pressure to determine when to quit on a patient as soon as possible. This article is an important counter to that view."

Even harvesting the organs of the injured is not enough for some physicians. They are looking to plunder the organs from disabled people who are euthanized. In Belgium, it's already been done:

"A group of Belgian doctors are harvesting "high quality" organs from patients who have been euthanized. ...."

"This seems like the ultimate in utilitarian compassion: make paralysed people feel useful by killing them for their organs."

["Belgian doctors harvest high quality organs from euthanized patients" by Michael Cook Jan 24, 2011 Mercator.net]

Here is a sampling of some of the major steps our society has taken with regard to "brain-death," organ transplantation, the "wall of silence," and devaluation of life, as well as some landmark court rulings. Even though some of these decisions may "make sense" to you, they amount to steps down the slippery slope, and we are now at the bottom of that slope as we shall see.

1965 Griswold v. Connecticut, 381 U.S. 479
Established Constitutional right to marital privacy (use of contraceptives)

1967 (Dec 1) First heart transplant: South Africa (Christiaan Barnard)
Demonstrates technical feasibility of transplanting human hearts

Dec 3, 1967, 2nd heart transplant Brooklyn, NY, USA
The beating heart was cut out of 3 day old baby and transplanted into 18 day-old baby. At end of day, 2 babies had been killed by the surgeon (KIantrowitz) These transplants were immoral and illegal, therefore Harvard Committee was appointed. See Report in JAMA 1968 (below)

1968 First "brain death"
"Irreversible coma" used as new criterion for "death," those in "irreversible coma" not alive, not persons, allow harvesting of organs
1968 Uniform Anatomical Gift Act ("UAGA") Simplified the Process of Organ Donation

1970 First "brain death"
brain-dead are not "alive" persons so "brain death" allows killing of "brain dead" to harvest organs for transplantation

1973 Roe v Wade
Supreme Court affirmed prior Griswald decision and expanded Constitutional "right to privacy" to include abortion; fetus is not a "person" separate from mother, therefore killing baby is "legal," up to the mother to decide

1972 "Persistent Vegetative State"
Set up the justification for substituted decision-making; "surrogate" such as guardian able to direct care; set the stage for brain-injured to have life-support (such as ventilator-assisted breathing) withdrawn legally

1976 Karen Ann Quinlan
N.J. Supreme Court affirms patient's right to refuse life-sustaining treatment, quotes the Pope that individuals may refuse "extraordinary means;" Ct determines removing life-support of the incompetent not considered homicide (the incompetent's wishes are determined by the "surrogate" who makes decisions on his or her behalf; case encourages adoption of advance directives; Karen lives nine more years without the ventilator (tube-fed); feeding is "ordinary care" and not to be removed

1981 Uniform Determination of Death Act ("UDDA")
made brain death a legal criterion for death in the United States, "brain dead" are not alive persons so organs can be harvested and patient killed in process

1981 Introduction of Cyclosporine
the first immunosuppressant that could effectively fight rejection of organs. Except between identical twins, kidney transplants were largely unsuccessful before introduction of this drug.

1984 National Organ Transplant Act
sets up Organ Procurement and Transplantation Network

1990 Patient Self Determination Act ("PSDA")
patient rights to informed consent, to participate in decisions, to accept or refuse treatment, to fill out an advance directive to guide decision-making should the patient become incapacitated; all facilities must note that patients are given information about advance directives

1990 Nancy Cruzan
Nancy Cruzan was brain-injured after a car accident; suffered anoxia for 12-14 minutes, heart and lungs had stopped, was resuscitated; diagnosed as being in PVS state; only on tube-feeding (no ventilator); 497 US 261, 1990; U.S. Supreme Court rules Constitution does not prohibit a state (Missouri in this case) from requiring convincing evidence that an incompetent person wants life-sustaining treatment withdrawn. 3 friends come forward with new testimony that Cruzan would not wish to live in this condition; Missouri court allows tube-feeding to be stopped and Cruzan dies 12 days later. Widely-publicized case promotes advance directives

1996 Health Insurance Portability and Accountability Act ("HIPAA")
sets up Privacy Rule, protected health information ("PHI") cannot be shared with those not involved in patient's case; sets up initial Wall of Silence; allows for sharing of PHI for several reasons including notifying the "Organ Procurement Organization" so a team can immediately
come and harvest organs from "brain-dead"

**2003 HIPAA Privacy Rule Takes Effect**
Initial Wall of Silence by individuals implemented; intimidation of health care workers strengthened

**2005 Terri Schiavo**
Terri was selected by euthanasia advocates Mary Labyak (CEO of the Hospice of the Florida Suncoast) and attorney George Felos (Chairman of the Board of the Hospice) and admitted to the hospice, though she was not terminal, then denied food and fluids which was permitted due to a new Florida law allowing removal of simple tube-feedings that reclassified them as "life-prolonging treatment"

**2006 and 2009 Revised Uniform Anatomical Gift Act ("UAGA")**
created the default rule of presumption of intent to donate organs for transplantation except for individuals with documented refusal of organ donation; allows transplant teams to "prepare body for transplantation" by flooding body with fluids (which is opposite of treatment needed to relieve brain-injury) and several other methods in order to protect other vital organs; allows for several "classes" of persons to be contacted to make sure physicians get "consent" of patient to harvest organs (if relatives not "available" then friends or others can give "consent")

**2009 Hitech Act modified HIPAA Privacy Rule: Increased Penalties**
Creates three-tiered levels of fines and punishments for violations of Privacy Rule; fines dramatically increased to $50,000 and up plus one year or more (depending upon nature of violation); Creates Wall of Silence

**2010 (Feb) HITECH Act's Increased HIPPA Violation Penalties Go Into Effect**
Wall of Silence completed; intimidation of health care workers complete.

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The word of the LORD came to Jonah son of Amittai:
"Go to the great city of Nineveh and preach against it, because its wickedness has come up before me."

[Jonah 1:1-2]

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**VII - What Happens in Rogue Hospices**

We know that leaders of rogue hospices care nothing about the standards of care. They only care about the appearance of complying with the standards of care. They commit Medicare and
Medicaid fraud regularly. Their tactics are very well-planned and staff are manipulated to carry out the administration's "dirty work." Rogue hospice leaders do not respect the sanctity of life; they promise not to impose death, but they absolutely do.

Rogue hospice administrators sometimes have two sets of "books" and sometimes more. They can have a set of books to show the internal revenue service and auditors. And they can have a set of books that shows what they are really doing financially.

They can have one set to show the state department of health when it's time to determine their "certificate of need." And they can have another set of books to record what is really occurring. If they are one of the exclusive providers to a geographic area, showing they are meeting the needs of the geographic area and that no other competing hospice is "needed" allows them to operate as a monopoly. The public has nowhere else to go. For example, Florida is a "certificate of need" state where one hospice can be approved by the state as the sole provider to serve a geographic area. In other states, many hospices may operate in a geographic area in a fiercely competitive "dog-eat-dog" clash to grab patients and patient referrals.

Rogue hospice administrators may hire people with experience in committing fraud into their finance departments. They admit patients who are not terminal to bolster their revenue stream or to kill. They fail to provide services needed by the patients and their families, and they focus above all on increasing their revenue, whether they are organized as a nonprofit corporation or a for-profit corporation.

A recent Journal of The American Medical Association article shows that for-profit hospices enroll patients who are less likely to have cancer and more likely to have dementia, requiring fewer services. This is something you may wish to think about when considering which hospices may tend to be "rogue" and which hospices are trying to perform the service it's all supposed to be about:

"Compared with nonprofit hospice agencies, for-profit hospice agencies had a higher percentage of patients with diagnoses associated with lower-skilled needs and longer lengths of stay."


The federal government has had a huge role in expanding hospice and especially rogue hospice. The creation of the Medicare Hospice benefit in 1983 was the start of the big push to increase utilization of hospice in the last year of life, the last six months. Government funding for and promotion of hospice has increased each year as we've seen. Many programs have been implemented to increase utilization of hospice and palliative care and the stakeholders who create national policy have included hospice and palliative care as part of the national strategy on health care. They view the end-of-life care industry as a vital part of the "solution" to out-of-control spending in health care. And while good end-of-life care can save compared to acute hospital treatment for patients who are terminal, there is more going on.

The U.S. Justice Department continues to refuse to make Medicare and Medicaid thieves pay back 100% of what they steal, and they refuse to put the administrators of the rogue hospices that steal millions into jail. Instead of punishing these thieves who run huge rogue hospice corporations, they encourage them to sit in on national policy-making committees and serve as consultants to the government.
**Medicare/Medicaid**

**Hospice Reimbursement Cap & Hastening Death**

Well, the **reimbursement cap on what hospices receive for services** is supposed to rein in the costs of hospice services, keeping the total government disbursement per patient down. The total cap on reimbursement is an average amount paid to the hospice agency for each patient and is roughly the daily routine home care rate times 180 (days) to equal what would be paid out in six months ... since the terminal patient is supposed to have six months or less to live. The main thing about the **cap** is that there is a limit to the total revenue a hospice takes in per patient over the course of the year. It's supposed to balance out somehow with reimbursements coming in for those patients who require fewer services allowing the hospice to use those funds to help pay for patients who require a lot of services. With a hospice that has integrity, the system works as planned, but as we have seen before, the reimbursement is not huge and a hospice will just break even if they provide all services that are supposed to be provided.

What happens in a rogue hospice is something else altogether. They see the reimbursement cap as an obstacle to their profit (or the revenue stream in a nonprofit hospice corporation). We've heard from families that tell us their loved one was in hospice for several months and then all of a sudden things changed. Years ago, if a patient was not declining, the hospice would discharge the patient as the government regulations require that the hospice be able to document "decline" in the patients health status. And in good hospices, the hospice will discharge a patient who is doing well and stabilizes. The rogue hospice often will not discharge; they often will end the life of the patient once their usefulness as a reason to bill for reimbursement ends (the cap is reached). When no more money is coming in for a particular patient, the rogue hospice sees the patient as a net-negative, and acts accordingly. New patients, who are readily available, start the flow of money again, often the same day.

With economic pressures on the horizon for many years, if hospice reimbursements are limited even more (and this may very well be the case), then many hospices will not be able to provide the services traditionally provided in hospice. Those with integrity will increasingly depend upon donations. Rogue hospices will become something else, and much worse. Our **national debt** and continued deficit spending, combined with very likely **inflation** (after about $2 trillion is "created" when the Federal Reserve "purchases" that amount in U.S. "treasuries" by June, 2011. Economics matters. For some in government, worrying about how to pay for the care of the dying will be the last thing on their list of concerns!
Hospice Can Use "Closers" to End Lives

When a patient lives "too long" with respect to the "six month rule," the hospice may be losing money due to the annual cap on reimbursement they get for each patient. Sometimes a hospice will send in a closer to take care of the problem.

If a hospice patient gets really sick and unstable, well, yes, the hospice can put them on a higher level of care like continuous care or general inpatient care to justify billing at that higher rate to get more money. But if they don't have the staff to provide Continuous care or a bed at a facility for inpatient care, what to do? Or again, if the patient has required services that equal or exceed the annual cap on reimbursement, the hospice may "allow" the patient to be hastened to death. They can assign the "closers" to the case who make sure the patient "goes peacefully in their sleep," preferably really, really soon.

In some cases, there are health insurance systems that include the full range of health care services within its own facilities, such as clinics, urgent care centers, hospitals, and hospices. Some of these are HMO systems. They take in premiums for services to be provided as needed, but do not always wish to provide expensive services, or prolonged services. Removing a patient, who requires expensive services to be provided, is a way to manage expenses and increase revenue.

Years ago, without knowing it at first, I met a "closer" at a hospice. Those of us who are just interested in providing good end-of-life care wouldn't even imagine imposing death, but these guys? That's all they're about. Standards of care mean nothing to them, and they can be very sneaky. Falsifying the medical record is an ordinary way of practice for them. Remember: the medical record is the legal record of what happens in health care.

Falsify the medical record and whatever you actually did is covered up, unless someone else can "prove it." Remember, in health care, your license to practice requires you to chart truthfully and completely. If you charted something, then that is assumed to be the truth, just as someone in court "under oath" is assumed to be telling the truth. If the "closer" lies when he charts, the lie is assumed to be the truth!

And "proving" what really happens takes an investigation, a serious sincere effort to get to the truth, the whole truth and nothing but the truth, something that is done when someone kills someone violently with a gun, for example. Justice involves just such an investigation and then a sincere effort to prosecute the criminal "closer" and hold him or her accountable. But the government officials want to promote hospice utilization. They do not want hospice wrongdoing to be widely reported or known. Therefore, there are no serious police investigations, no prosecutions by the district attorneys and no consequences for hospice "closers."

So, if the "closer" says the patient was in pain, even if she was not, then he can give huge doses of morphine, and when she dies the physician can write that she died of her terminal illness. He can write that he attempted to relieve her terrible pain (when she had none), and thereby cover his tracks, minimizing his liability. He knows that those who evaluate a case are going to look for evidence the patient was in pain. If there's lot of charting showing specifics about how she expressed her pain, they'll think the administration of morphine was appropriate.

Those who are willing to lie about anything can get away with a lot, unless someone can show
they're lying. And who's going to do that? Hospice management? The other nurses? Not going to happen. The family? Even if they testify giving all sorts of evidence with other witnesses, they can be said to be "grieving" and "in denial," or "don't understand end-of-life care." We've heard it hundreds of times through the years. And there's often a family member who wanted death imposed so he or she gets to inherit part of the estate sooner rather than later (or for some other reason). They'll back up the "closer" and say everything was done wonderfully and the patient had "terrible" pain, even though there was none.

The family members who object to what happened can (with some effort) get medical records later on after the patient dies, but then it's a "he said, she said" case of who to believe. Usually, the nurses and other professionals are going to be believed, not the family, about clinical matters. When "about half of nonphysician health professionals support euthanasia or Physician-Assisted Suicide in some circumstances," many of the hospice staff will not be willing to expose the agenda. And the police do not get involved in these cases anyway, so who's going to do anything about it? Nobody.

The "closer" I met a few times did some strange things. One time was on a case that was extremely expensive to handle for the hospice. It involved a patient getting I.V. medications. The "closer" brought out a morphine cartridge used for intravenous administration of morphine, but the concentration he brought out was over twice the concentration of what was ordered for this patient. If other nurses hadn't caught it and stopped it, the patient would have died that night. Because of several things this nurse did, all of which tended toward hastening death, I now realize it was not a "mistake" that he brought out that cartridge with double the concentration of morphine in it, especially since he normally did not work on that case. It is clear now he was sent out to end the case by ending the life of the patient.

Another time, he was probably just eager to leave a case he was assigned to. Even though the patient was clearly going to die within an hour or so, he pulled the patient up really high in bed so the blood rushed away from her heart and vital organs; she died on the spot. While that wouldn't save money for the hospice, it demonstrated his insensitivity to the family and the patient and his willingness to manipulate death.

Hospice Patients Alliance board member, Vickie Travis knows about "closers." Vickie states that on September 11, 2000 a "closer" named Dennis ____ was involved with her father's death in California.

After careful analysis of her father's case was performed by consultants (physicians, hospice experts, attorneys, and others) she knows much about how her father was medically killed. The series of mis-steps that she reports were done would make any good hospice professional's head turn. For example, she reports observing the nurse use dirty technique when sterile technique was required, giving potassium (when it was not needed according to physician consultants).
HMO/Hospice Intimidation to Force DNR Status and HMO Abuse Begins

Vickie writes,

"The hospice nurse, Dennis ____, RN, repeatedly terrified my father. Who could blame him for being afraid after the treatment that he had already received? The nurse yelled at him, "you're going to die" and "you'll never walk again." During this time, Kaiser staff intensively pressured us to make my father's status DNR, or "do not resuscitate." This was against my father's and our family's firm convictions. He, and all of us as well, wanted him to receive all medical treatment that would be appropriate when necessary and under all circumstances to resuscitate him. This was documented in writing several times."

"For the entire time my Dad was enrolled in Kaiser's hospice "program," his nurse refused to change the foley urinary catheter and he would not change the trach tube. Dennis ____, RN also told us that he was a PA (physician's assistant) which was not true. These urinary drainage catheters are usually changed a minimum of once per month and sooner if they become blocked. The nurse also told the family in the presence of our father that if we wanted the g-tube changed that he would have to stand over our father on his bed and rip it out of his stomach without any anesthesia and then use an hard object to shove in a new one. Kaiser even refused to provide an adult-size wheel chair for our father, but they did provide a small, child size one that my father was obviously unable to use."

"I repeatedly requested physical therapy assistance for my Dad and was told several times that they had been billing Medicare for physical therapy, but no one performed any physical therapy on my Dad other than myself and other family members. Kaiser said that they did in fact have a report from a physical therapist. If they had a report, it would be fiction, because no physical therapist ever came out to work with my father, even though they were billing the government for therapy services. He was also supposed to have a respiratory therapist, and they did bill for that also. But there was none."

"There was a man that came out to check the equipment twice, but that is all. As for assistance with bathing, there was a health aide that every fifteen days or so would call and say she would be out to help us. She seldom showed up. I was his bather and again it was an honor to serve my father."

"Of course we complained to Kaiser about their not honoring their contract with our father. We were always informed that they had budget and scheduling problems and "nothing could be done" to help us."

"Still, we as a family continued to go forward and our father kept getting healthier and much stronger. After one of the physically painful incidents that my father had to endure under the care of Dennis ____, R.N., I finally told him that I knew Medicare fraud was being committed and that I was going to talk. The following week Kaiser officially upgraded my father's health and they
commented that it certainly didn't look like he was going to die any time soon. He was to be transferred to the palliative section of the Kaiser/Sunset home health department, but not until they actually formed a palliative section or department, so we patiently waited while he received no medical care from Kaiser."

**HMO/Hospice Nurse Causes Fatal Septic Infection**

Vickie continues:

"When they finally got this department created for their patients, Dennis ____ , R.N. was ordered by Kaiser to finally change our father's catheter and trach in order to finalize his work and complete his reports. He came out to the house under duress, informing me that he was acting as a "Closer", and without washing his hands nor wearing gloves he proceeded to change the foley catheter immediately after using the bathroom where he did not wash his hands. Then, still without washing his hands, or wearing gloves, he attempted to change the trach tube. After a lot of blood being spread around, the nurse informed me that he was unable to change the trach tube because it was stuck and it was now a detriment to our father's health if he continued to try to change it."

"We later were informed that the HMO's rules require two nurses to change a trach tube. My father did develop an infection, and to us, it is obvious it resulted from the complete failure to follow sterile technique required to change an indwelling foley urinary catheter and the tracheostomy tube."

To stop that kind of bad ending, you have to have an expert in end-of-life care at your side just to reevaluate everything they tell you or that they did. Even then, you may fail to save your loved one. Some of these "closers" are very devious and very effective. If an agency is using them intentionally, they manage to pay them bonuses for the work they do (and the money they save the corporation)."
Hospice Can Withhold Ordinary Treatments to End Lives

There are all sorts of scenarios that play out in palliative care units and hospice agencies. While, again, not all hospices do these things, it is quite common among the type of rogue hospice promoted by the culture of death. Patients and families have regularly reported being pressured to withhold ordinary treatments for a urinary tract infection or other infections, even when the terminal illness is not thought to be likely to cause death in the near future.

A decision not to treat ordinary infections is a decision to have the patient die from that infection, not from the terminal illness. Of course, many physicians look at some infections if they occur when the patient is very elderly and weak, as a "good thing," and a way that the patient will die sooner and not have to suffer. Everyone has their own opinion, but there are many patients who do not desire to die, who just want to have pain and distressing symptoms managed, just like hospices and palliative care experts say they do.

When they don't get their symptoms managed, but are treated to a death-inducing protocol, they are terrified and families are distraught. Death can be, and often is, manipulated. Patients who need rehabilitation can be placed in hospice, denied their rehabilitation, and then killed. This is what happened in a recent 2010 case that was reported to me: "What I Saw at the Hospice House."

"My boyfriend showed none of the physical signs of impending death during his initial stay at Hospice. His heart, lungs, kidneys, respiratory system, and all important bodily functions were working well. Something had happened to his brain. In my opinion, the very quick diagnosis of Lewy Body Dementia could very well have been inaccurate, especially since there were no tests that proved he ever had it and, they never gave him a chance to recover or see how he would do."

This patient had no terminal diagnosis but was given repeated doses of morphine and Ativan till he eventually died after three months of that treatment. When he wished to eat, he was sedated so that he would sleep instead.

Robin Love reports that the same type of mistreatment occurred with her father who had Parkinson's but was not terminal:

"My father had Parkinson's disease; he had been diagnosed 5 years earlier. He had lost his ability to swallow well and had opted to have a feeding tube inserted in May of 1998. Other than that, he was quite stable and was certainly not terminal. I heard from a caregiver on the day before he was to go into hospice that my mother was considering placing him in a nursing home. I went to speak with my mother, to let her know that my father could live with us, in my home, and she became irrational and very defensive and was screaming and carrying on, so I left her house with my 9 year old who had been there over night.

"The following day I received a call that he was going to hospice in 1 hour and I went back over. My father grabbed my hand and began crying and acknowledged that he did not want to go. He feared that he would somehow
die if he went into the hospice.

".... My mother had decided to put Dad in the hospice against his wishes and mine. What was my Dads prognosis? He had Parkinson's and was stable. ....So, my father was being dehydrated and starved intentionally by the hospice, even though my Dad wasn't even terminally ill. Plus, he was sedated with Haldol to put him into a coma and then given morphine to push him over the edge and kill him by shutting down his breathing. All of this, totally against his wishes!

This horrific story is retold by many people around the country experiencing the same type of death protocol. This is not caring; it's killing, plain and simple.

Hospice Can Misinform Patients and Families to End Lives

I've had numerous calls from families as you know. Sometimes the call goes like this, "I think I killed my Dad." They go on to say the hospice nurse told them to give this medication "every two hours" or something like that "without fail." They often tell me the nurse will say things like, "you don't want him to suffer, do you?" or "it would be cruel to not give him this pain relief!" The family member will then often go on to say, "My Dad didn't really have pain issues, but I was told to give it anyway."

What happens in these cases is the manipulation of the family to be the instrument of death. When a patient has no pain issues, giving powerful opioids like morphine can rapidly kill the patient. Sometimes a patient who is only taking a Tylenol for minor aches of old age is suddenly given 20 mg or morphine every four hours, then every two hours (which doubles the circulating dose in the bloodstream). Patients who are "opioid naive," not having taken these types of medication before, react with the worst adverse effects: lowered blood pressure, coma, lowered respiratory rate, periodic cessation of breathing (apnea), complete cessation of breathing and consequent death.

When hospice or palliative care staff misinform families, they are violating the standards of care which specify that all patients (and the family member with power of attorney) have the right to "informed consent" and should be given complete information about the treatments being offered, all options available, the reason for the treatment and what consequences may arise from the treatment. Failing to provide complete information is a violation of this central principle in health care. Unfortunately, it is extremely common.

I've gotten calls from weeping 80 year-olds saying, "The nurse arrived at the home and then said she was going to give my husband something to 'help him sleep.' He was in his bedroom lying down. This morning, my husband was walking, talking, eating, drinking, and we even went shopping today. He wasn't expected to die soon at all, but one-half hour after the nurse left, I went in to check on him and he was dead!"
There is no "informed consent" here, quite the opposite. Families report overhearing conversations between two hospice nurses (who thought no family member was there to listen): "the nurse said, 'I'm just like Jack Kevorkian, but I do it with morphine and get away with.'"

**Hospice Can Ignore Your Power of Attorney and Create a New One**

We are hearing more and more about adult children who favor using hospice to hasten death, either getting the elderly parent to sign a health care power of attorney appointing them as patient advocate, or, bringing the parent to the hospice where a new power of attorney is made out at that time. This method completely subverts the legal process which would respect an individual's carefully thought-out decisions delineated in the "designated advocate" section of their health care power of attorney document, their living will or advance directive.

Just think about it! You can appoint someone you are sure will respect your rights, and then when you are frail, you can be dragged to a hospice, have a new form filled out and signed by you perhaps when you are sleepy, drugged, or confused, under duress and manipulation.

See Chapter XII, *How Things Work: Typical Hospice Scenarios for Hastening Death* for a case that demonstrates this increasingly common ploy to make sure a patient is first admitted to hospice and then hastened to his or her death.

**Hospice Can Misinform Staff to End Lives**

I can't tell how many times through the years family members will call and tell me how their loved one was overdosed with morphine. Often, they report that the hospice nurse will tell them, "Morphine helps the breathing." That specific line is repeated over and over again, all across the country, so I know the staff are being trained to believe this.

Why do hospice professionals sometimes tell patients and the families "morphine helps breathing?" Because they are being mis-educated to believe it:

Kaiser Health Plan instructs its patients and nurses that morphine helps breathing, which is false. From a [Kaiser Permanente leaflet titled and having to do with an Emergency Medical](#)
Kit provided:

".... The onset of action and ease of breathing should occur in 10-15 minutes and will persist for 4 hours. The patient may become sleepy. If the patient must arise always provide competent assistance as dizziness may occur.

CONCERNS ABOUT TAKING MORPHINE

"Overdosing, there is a good safety margin with these medicines when given in the manner described. Even a sizable accidental over dosage usually causes only sleepiness and unsteadiness."

Charles Phillips, MD, patient advocate and former Kaiser Permanente physician, comments:

"Morphine is a miracle drug to relieve pain, very effectively in most cases. However, if given inappropriately it is a loaded gun. The ... information is a recipe for MURDER!

Morphine is a deadly drug in cases of COPD or emphysema and should not be given unless specifically warranted for that patient if ordered by a physician or trusted nurse that has actually assessed the patient in person. Oxygen is the preferred treatment for shortness of breath.

No family should rely on such general instructions. Morphine is like a loaded gun which is so powerful that can kill a patient by lowering their blood pressure and stopping the breathing."

Family after family has called here through the years of just such cases where the patient was given morphine and they died very soon thereafter, even though they did not have the usual signs for being in the active phase of dying. In some cases, it is possible to differentiate between a morphine-induced death and a gradual decline from a terminal illness.

When patients have breathing difficulties, the first thing a professional would do is try to assess what's causing the problem. Sometimes helping the patient sit up more in bed is a big help. A fan in the room is sometimes used and oxygen that is provided is a big help. If there is fluid in the lungs, medications can be given to reduce that fluid in many cases. Nebulizer treatments can help open the airways for a patient who needs them. These are the main ways to help with a patient's breathing difficulties. If the patient is anxious due to their very limited ability to breathe, for example, with end-stage chronic obstructive pulmonary disease (COPD), a low dose of anti-anxiety medication can be given.

But morphine? Morphine slows down the breathing. It does not increase the respiratory effort at all. In the case of a patient who is anxious, morphine is not the right choice. Not only does it sedate, in large doses, or doses that are not needed, it shuts breathing down completely and can cause death. And conveniently for those who wish to hasten death, the signs of morphine overdosage are the same as some of the signs of imminent death: sharply decreased blood pressure and much slower breathing, sometimes stopping at times (apnea).

Those nurses who have been mis-educated to believe that morphine is the "solution" for breathing problems see the outward signs of the morphine overdosage but interpret them as showing the patient is dying. They believe in what they've been taught and give morphine freely for breathing!

Kaiser misinforms the patients and families that, in the case of "overdosing, there is a good
safety margin with these medicines when given in the manner described. Even a sizable accidental over dosage usually causes only sleepiness and unsteadiness." This is irresponsible in the worst way, because, as we have seen, morphine can be fatal when an overdose is given. Some people are even more sensitive to it than others, and so require careful monitoring to make sure they do not have tragic responses. Every pharmaceutical insert from every manufacturer of morphine says it, because it is absolutely true. Kaiser's instructions (and the similar instructions many hospice nurses are getting) encourage overdoses, and if the patient dies, the family and staff are led to believe the patient died of their illness, not the morphine (that is the last thing the hospice or Kaiser wants them to believe).

The other scenario where hospice nurses are taught to give morphine is very rapid breathing that is caused by metabolic changes at the end-of-life. Well, it is true that morphine can slow the breathing, and is given for this purpose, but in patients whose breathing is extremely fast (sometimes more than 40 breaths per minute) due to those metabolic changes, morphine is not really that effective in slowing the breathing. Usually, it's given more for the benefit of the family that is often alarmed by the very fast breathing, with the idea that "something" is being done. Sometimes, the metabolic changes of the dying process take over and there is not much to be done for the wide variety of abnormal breathing patterns observed at the end-of-life.

A Miseducated Hospice Nurse

I recently received vitriolic emails from just such a mis-educated hospice nurse. "Stephen M," a Registered Nurse with special certification in Palliative Care who works in a hospice wrote to Hospice Patients Alliance on November 29, 2010:

"Morphine is not what kills people you morons. It is their time to go and god takes them when he is ready. Liquid morphine has a halflife of 45 minutes even if it is 20mg, which is the standard dose. You or anyone could drink the entire Roxanol (liquid morphine) bottle which had 30ml in it. That is a large amount and you would not DIE!"

That, from a certified hospice professional. If it were true that morphine is not really dangerous even if misused, the baby daughter of Stephanie Greene would not have died from morphine in her mother's breast milk. That morphine "cannot be dangerous if misused" is similar to what Kaiser would have told him if he worked at their hospice (from what they say in their instructional booklets ... it just causes "sleepiness"). Hmm. I remember a nurse who spilled liquid morphine on her pants and notified the hospice. They called 911, had EMS come out and take her to the hospital for observation, because they knew morphine can kill you and the dose she received through her skin was undetermined. If it had been so "safe," why call 911 and EMS and have her observed in the hospital? And, of course, any good hospice nurse or physician will tell you that the half-life of morphine is not 45 minutes as Stephen M., R.N. says; it's 1 1/2 or 2-4 hours. They would also tell you that although it is a great pain reliever, it can cause death if given in excess.

The maker of morphine states:

"Acute overdosage with morphine is manifested by respiratory depression,
somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and, sometimes, bradycardia, hypotension and death."

In other words, if a patient is given too much morphine, when they don't need it, they die, plain and simple. Like many medications, the administration of the medication is carefully monitored by physicians and nurses to make sure it is done safely. But how many hospice nurses are out there that think like Stephen M, RN (real hospice nurse) who doesn't care what the package insert says, or what the manufacturer (Purdue Pharma L.P.) says, or what the U.S. Public Health Department says. He is not representative of all hospice nurses, but he is representative of many, perhaps hundreds of mis-educated hospice nurses.

Where did Stephen M, RN, get his ideas? From hospice management, just like in many other hospice agencies. They promote this type of misinformation which all tends toward hastening the death of the patient, and the staff who have been misinformed have no idea that they are hastening death. Proper protocols for the titration of the medication must be followed and then overdosage can be avoided. That is what good hospice professionals do; it is the clinical standard of care.

**Hospice Can Miseducate Physicians to Facilitate Ending Lives**

The system wasn't supposed to work the way it does in these cases, but clever hospice managers and administrators across the country have chosen to "game" the system by miseducating physicians. You see, originally, the patient's own attending physician was always supposed to remain involved throughout the process, giving the medical orders and supervising the care given. The nursing staff that are on the scene report back to the attending physician just as in any other niche of health care. The hospice medical director was seen as someone who oversaw the hospice from a medical point-of-view and provided input on all the cases at the interdisciplinary team meetings. The hospice medical director is specifically supposed to assure a high quality of care for the patient by serving as a check on what the attending is doing, perhaps giving input and making sure that adequate pain medication is given when truly needed and so on.

In a hospice that respects the standards of care, they are not going to force the patient's own attending physician out of the picture. However, in many cases, the hospice agencies have mis-educated the local attending physicians to believe that when a patient enters hospice, the hospice's own medical director completely takes over and has to take over. This intentional deception feeds right into the reality of most physicians' over-scheduled lives: some physicians don't have the time to make minute adjustments in medications throughout the day, and some of them like the idea that the hospice medical director will take over.

"A recent study showed that physicians often end all contact with patients
Patients whose attending physicians have been with them through thick and thin have tremendous faith in and respect for them. They often feel like they've been abandoned if their attending physicians just hands over the case to the hospice. The patients often have a difficult time making the adjustment and don't understand what happened. They shouldn't have to lose their attending physician in order to access end-of-life care and the standards of care do not require that they do so. In fact, the standards demonstrate the value in having the patient's own physician with the medical director as a backup protection. Patients that are manipulated into forfeiting their right to keep their own attending physician lose a valuable asset in assuring proper care is provided.

In any case, once the patient enrolls in hospice, whether the attending physician or hospice medical director is making the orders, there are standing orders for all sorts of medications that can be given if necessary, and nurses can impose death and the attending (or even the hospice medical director) may have no idea what went on. Nurses report the conditions of the patients to the physician and record their assessment in the medical chart. A dedicated attending physician will make efforts to ferret out a clear description of the patient's condition and sometimes speak to a family member or the patient directly, so that orders given are clinically appropriate. In rare cases today, the physician actually visits the patient, but the day-to-day supervision of the care is managed by the registered nurse who reports to the physician.

When the attending physician's essential role has been eliminated, or when the attending just acquiesces to whatever the nurse requests, a nurse with an agenda can report the patient having severe, uncontrolled pain (when the patient is not in pain) thereby justifying the use of high doses of morphine which can end the life of the patient. I've had calls from hospice nurses who believe this is the right thing to do. I remember being called not too long ago by a former hospice medical director who was enraged when he found out that he had been lied to and that his medical orders were misused to end the lives of patients. He resigned, because he felt he could not be sure that his orders would be based upon accurate reporting by the nurses in the field.

You see, nurses in hospice have a unique practice environment. The public has no idea that the nurses, armed with the long list of standing orders, can give just about anything needed, or unneeded, to the patient. The physicians are truly almost never at the bedside, and if they visit, it's just that, "a visit." Other than those extremely rare moments, the nurses are on their own, and some nurses really "get into" their independent practice. Not having a doctor or other supervisor standing over their shoulder allows them to do things they could never do in a hospital (unless management was involved).

Some nurses have "right-to-die" agendas and are true believers in the utilitarian view that when quality of life is poor, ending the life of the patient is the compassionate thing to do. A very few are serial-killer types that get a kick out of killing, plain and simple. These are in the Jack Kevorkian category, but hospice nurses don't get sent to jail. Hospice is a playground for such killer nurses.

Often, we will get calls from family members and somewhere along the way, they'll say, "our doctor was completely shocked that he (the patient) died. He wasn't that far along, and death was not at all expected this soon." And the doctors call here sometimes and say they believe the patient must have died of a morphine overdose. They would be right. Naturally, because in many hospices every patient is given a sedative like Ativan (lorazepam) and an opioid like Roxanol (liquid morphine sulfate), even if they don't need it.

If every patient, no matter what their disease process is given the same treatment, then the
clinically-precise wonderful interventions that can alleviate suffering at the end-stages of many diseases ... are all "thrown to the wind," and hospice is reduced to a death mill. Providing Ativan and Morphine to every patient is not quality care and not even close to meeting the clinical standards of care for hospice and palliative care.

If hospice is reduced to giving all patients sedatives and opioids, then there is no need for The Oxford Textbook of Palliative Nursing (with over 1,400 pages) or the End-of-Life Care Clinical Practice Guidelines. What does a hospice nurse need to know more than giving Ativan and morphine if this practice is to dominate the industry?

Most end-stage terminal illnesses have a "predictable" course, meaning you see different clinical signs and symptoms as the disease progresses. In most diseases, the patient doesn't unexpectedly die (except in the case of AIDS patients for the most part).

**Palliative Sedation or Terminal Sedation to Hasten Death**

Ira Byock, MD is one of those promoting the use of palliative sedation to intentionally end life within hospice. It is no mistake that he is one of the founders of Partnership for Caring which had merged with the successor organization of the Euthanasia Society of America (Choice in Dying). He was head of the Last Acts Rallying Points Regional Center "Life's End Institute" in Missoula, Montana. He presents himself as promoting good end-of-life care. In fact, his major book on end-of-life care is entitled, "Dying Well." He wants to re-define what "dying well" means to Americans. He may agree with many good hospice professionals about much of the treatment needed at the end-of-life, but he adds in that push toward death called "terminal sedation." When he urges more people to fill out living wills or advanced directives, many would ask, "What's the problem with that?" The problem is that his brand of end-of-life care twists what the public thinks end-of-life care is into something completely different, a vehicle to impose death without formal euthanasia or assisted-suicide.

Ione Whitlock, Lifetree Organization researcher writes about Byock in her November 2009 article entitled, “The Current Health Care "Reform" Legislation: How it will make rationing and death hastening the law of the land”

In Progressive politics, Death frequently comes in packages labeled "Life."

And so it is with legislation such as that which is now before the Senate [in 2009]. Think you are supporting pain relief and hospice legislation in order to prevent assisted suicides? Wrong. Thanks to Big Death - a collection of heavily funded non-profit hospice and palliative care groups - the line between palliative care (pain relief; symptom management) and imposed death has become blurred.

One Big Death "thought leader" who has helped create the confusion between life-affirming palliative care and imposed death is Ira Byock, Dartmouth physician and hospice guru. In a blog at the New America Foundation this
summer, he illustrated our point. He suggests, using the example of one senior citizen, that we might improve seniors' lives simply by giving them "reliable transportation ... to the local Senior Center [where they would] share nutritious group lunches and noon-time discussions on advance directives for health care". In other words, he wants to sell seniors a free trip to the Center for a fulfilling and healthy life ... to persuade them to focus on death, of course.

Ione has it exactly right when she writes about the confusion between "life-affirming palliative care and 'imposed death" which now masquerades as "palliative care." How this has come to pass is a very lengthy and complicated story, but it has been set out in all its complexity at the LifeTree website "Two Decades to An American Culture of Death." Also, see the shorter version timeline and the longer, very detailed version.

Elizabeth Wickham, PhD, founder of the LifeTree organization has written:

"some palliative care groups are now training physicians to introduce palliative care (comfort care rather than cure) very early in the diagnosis of a chronic condition or terminal illness. This trend blurs the distinction between ordinary pain control and end-of-life care (palliative care). Moreover, terminal sedation and withholding hydration (see below) are often part of the mix.

When should food and water be withheld?

Death by starvation and dehydration is painful and inhumane. Withholding food and hydration is imposed death, unless the food/water cannot be assimilated, as when death is imminent - when the patient is actively dying, and death is expected within 24 -48 hours.

Nancy Valko, RN, notes:

"When people are truly [actively] dying and the body's organs begin to shut down, we often see people lose their appetite and desire to drink much. This is a process that can protect a person from suffering from fluid overload at the end and the dying person remains comfortable. But this is very different from a deliberate decision to 'fast' to death."

Wickham continues:

"Originally billed as "symptom management at the end of life," palliative care is now aggressively marketed as everything from pain relief for the public, to a cost-saving tool for hospitals, nursing homes and insurance companies.

"Many pro-life advocates had hoped that palliative care would prove to be the ultimate antidote to the assisted suicide movement. The theory was sound: if patients are offered adequate pain and symptom relief, they will not request assisted suicide as a means to alleviate discomfort. Traditional palliative care - symptom relief when death is imminent - might have accomplished that mission.

"However, over the past ten years, palliative care training and certification has been gradually co-opted by the very same right-to-die advocates that palliative care was meant to counter."

And how does this "new" twisted version of palliative care operate? It continues to enroll
patients with the traditional "terminal" illnesses: cancer, end-stage heart failure, end-stage chronic obstructive pulmonary disease, end-stage diabetes and so on. But they also round up patients who formerly were cared for at home or in facilities: the chronically ill (but not projected to die on their own within six months or longer), those with dementia from various causes, the severely disabled, the congenitally disabled or ill. If it sounds like the type of people that Hitler would have and did round up in his eugenics and euthanasia campaigns, that's because it is.

Some may think that is an extreme statement, but patients really are being hastened to their death in many ways across this nation and elsewhere.

"In 1998, the number one diagnosis ... was lung cancer .... In 2008, the number one diagnosis was non-Alzheimer's dementia."

What does this say about what we are doing with non-Alzheimer's dementia patients? Are they getting care or they being disposed of somewhere along the way? Patients who have dementia may be cared for at home by loving spouses or adult children. It is a difficult and heart-breaking work, but one that many families undertake because they continue to love the patient. Over time, even years, it may become physically impossible for the family member to continue caring. Perhaps they have their own issues as they age; perhaps they need to work and cannot physically be there twenty-four hours a day. And with the isolation of families from other relatives, sometimes living several states away from each other, it becomes very difficult indeed. Sometimes, a transfer to a facility is unavoidable.

When dementia patients are transferred to skilled nursing facilities or even specialized care units that work with Alzheimer's' and other dementia patients, they may become even more disoriented than before. Adjustments are very difficult for many to make. Because dementia itself is not normally the "cause of death," patients may live several more years and eventually they lose the ability to feed themselves, swallow and do other common activities of daily living. These facilities that care for dementia patients usually have waiting lists that can be quite long, perhaps years long before a space opens up. What is an administrator to do?

If the administrators are ethical, they will continue to care for each patient until the time their death naturally occurs. That's the way it was done all over the country until fairly recently. Now, however, there is a move to bring in hospice or have the patients transferred to a hospice facility. One nurse called me to alert us about all dementia patients being transferred eventually to the hospice nearby, even though the patients were absolutely not terminal, not showing signs of a terminal illness, and then within two weeks, the patients were dead. The nurse was horrified about what was occurring, but didn't know who to contact, who would listen or even believe her. Remember, the police and district attorneys will not get involved in these cases as they consider them "health care matters" and leave them to the state departments of health.

What do some other hospice doctors think? They're having seminars to discuss how to help patients die who are not terminal, and where the line is between sedation and active euthanasia. They are trying really hard to make a distinction between terminally sedating someone to death and killing them with a lethal drug. The University of Wisconsin Medical School is hosting the Third Annual Bioethics Symposium on April 7, 2011 and will cover topics like, "Terminal Sedation and Active Euthanasia: What are the Boundaries?" by Gretchen Schwarze, MD, MPP, facilitator, University of Wisconsin School of Medicine and Public Health. And the familiar promoter of terminal sedation to end life, Timothy Quill, MD, will be giving a talk on "Boundary Issues in Helping Patients Die." He's interested in helping people die, not allowing a natural death in its own timing. The seminar will also feature a talk on "Helping Patients Die Who Are Not Terminally Ill," Carl by Weston, MD, Hospice Physician,
It couldn’t be more obvious that we’re talking about stealth euthanasia.

Whether they received palliative sedation or an outright overdose ("direct euthanasia"), when prosecutors refuse to act, the facilities as well as those seeking to hasten death learn that they can violate the laws against assisted-suicide or euthanasia with impunity so long as they kill within a health care setting! After doctors euthanized patients in New Orleans during Hurricane Katrina, prosecutors chose not to bring charges at all. Commenting about these medical killings, Nancy Valko, RN writes:

"Note this quote: 'The bodies of 45 patients were discovered at Memorial Medical Center after the August 2005 storm, far more than at any other hospital, and some doctors subsequently acknowledged that they had injected patients with drugs to hasten their deaths. No criminal charges were brought. Last year, a relative of a patient who died filed a civil claim of euthanasia against a Memorial doctor. It was dismissed and is on appeal.' "This is a travesty of justice and shows how that even laws to protect patients from euthanasia/assisted suicide are useless unless utilized by the authorities."

[Comment from Nancy Valko, RN regarding March 20, 2011 New York Times article, "Trial to Open in Lawsuit Connected to Hospital Deaths After Katrina"

When prosecutors refuse to act when confronted with obvious medical killing, that killing of vulnerable patients is de facto legalized! And palliative sedation assures death just as certainly as a lethal drug. A study of physician specialists in Quebec, Canada notes that "48% [of physicians surveyed] said that palliative sedation "can be likened to a form of euthanasia." Really.

"If the enemy leaves a door open, you must rush in."

*The Art of War* by Sun Tzu Chapter XI, 65

**Hospice's Third Way:**
**Quill & Byock Promote Palliative Sedation to Hasten Death**

Any discussion of terminal or palliative sedation would not be complete without mentioning Timothy Quill, MD and Ira Byock, MD. Both are experts in palliative care and are well-respected leaders in the industry. In the early 1990s, Byock voiced his opposition to legalization of assisted-suicide, but his writings and actions indicated he was not a friend of Cicely Saunders' vision of end-of-life care. He created the Partnership for Caring organization to promote changes to society and how the hospice industry operated in America, and had Choice in Dying (the successor organization of the Euthanasia Society of America) merge with
the new organization. Why would he choose to merge his organization with the successor to the Euthanasia Society if he was truly against assisted-suicide and euthanasia?

While "Partnership for Caring" sounds less threatening than "Choice in Dying" (which is obviously a "right-to-die" advocacy organization) he did choose to merge the two. His repeated protestations that he is truly against assisted-suicide ring hollow to me based on this action. Blurring the lines between openly right-to-die organizations and hospice caring at the end-of-life is something Byock has excelled at.

He has also helped confuse the public about what is good medical care at the end-of-life and what is actually harmful to the patient and destructive to the mission of hospice. I'm sure he truly believes he is doing the "right thing." But then again, so did those committing euthanasia in Belgium, the Netherlands and wartime Germany. They all believed they did the right thing, but look at the end results: involuntary medical killings.

Byock has encouraged the hospice industry to widely implement terminal sedation as a way to end life within the hospice setting. Terminal or palliative sedation does not strictly come under the prohibition of open euthanasia and it's not a direct agent to cause death that a patient might take, so it avoids both the legal prohibitions against euthanasia and those against assisted-suicide. It is a right-to-die advocate's dream solution: clever, devious, and legally "do-able" throughout the health care system, especially in "hospice."

In 2000, he co-authored an article with Timothy Quill, MD in the Annals of Internal Medicine, "Responding to intractable terminal suffering: the role of terminal sedation.” Byock, with Quill, writes:

"some of these patients request that death be hastened. [He] ... presents terminal sedation and voluntary refusal of hydration and nutrition as potential last resorts that can be used to address the needs of such patients.

In the case of assisted-suicide, the patient asks the physician for a medication that will cause death and then takes it himself or herself. In the case of the request for terminal sedation to hasten death, the patient is requesting an imposed death, just the same as assisted-suicide, only the timeframe is modified slightly to bypass the laws against intending death and imposing death (euthanasia). In this Third Way medical killing by terminal sedation, it is the physician and the nurses who give the sedatives that cause the patient to enter a medically-induced coma permanently. Death is the certain outcome and the intent is that the patient die. That is what Byock means by, "terminal sedation ... can be used to address the needs of such patients" "that death be hastened." It is simply a delayed, prolonged euthanasia, a passive euthanasia, but euthanasia just the same.

Byock and Quill's article was one of the "break-through" articles that promoted hastening death through terminal sedation. Before this time, hastening death through terminal sedation was something whispered about quietly behind closed doors. Terminal sedation was never intended for this purpose; it was intended to be selectively and extremely rarely used for clinically agitated patients at the end-of-life whose pain and agitation could not otherwise be managed. This twisting of the appropriate clinical use of terminal sedation is a perversion of end-of-life care.

To openly promote terminal sedation in this way, using it to hasten death, was a "giant leap" into the abyss of the culture of death, right-to-die agenda. But Byock is more well-known to the public as the author of his book, Dying Well. Byock does not share the vision of Dame Cicely Saunders or of the original hospice mission to relieve suffering at the end-of-life while never hastening death. He openly encourages hastening death through terminal sedation and
because of his and others' efforts, terminal sedation is widely taught and practiced in many hospices as a method of hastening death. Some nurses who are trained to sedate patients may not even realize the goal of their education and practice is to hasten the death of large numbers of elderly, disabled and chronically-ill, but the effect is just the same.

Have you heard of any studies that the National Hospice & Palliative Care Organization (or other organizations) has done to see how many hospices misuse terminal sedation to end life prematurely? Obviously, you haven't. They don't do the studies, because they don't want the answers. Their membership consists of hospice corporations that have and control the medical records. They have access to the records for study, but they won't study them for this purpose, because they already know how widespread it is, and they are pleased with the changes.

What has another end-of-life care leader, Joanne Lynn, MD said about hospice providers? As far back as 2001, she indicated very clearly that:

_Hospice providers have been supportive of discontinuing life-sustaining treatments and of providing terminal sedation, but in my experience, hospice teams generally have opposed efforts to legitimize physician-assisted suicide._

["Serving Patients Who May Die Soon and Their Families: The Role of Hospice and Other Services" by Joanne Lynn, MD; _JAMA_. 2001;285(7):925-932; Emphasis added]

Well, there it is as plain as day! One of the most influential and knowledgeable hospice and palliative care leaders in the world plainly states that most hospice providers do provide "terminal sedation," which is Third Way killing! Of course, the hospices are nominally against assisted-suicide and euthanasia! If the patient commits suicide, then they're dead immediately and there are no days and days of billing for "services rendered." It's not that rogue hospices are in principle against euthanasia or assisted suicide; it's all about the money. It's not profitable to the hospice industry to support medical killing that results in instant death.

Hospices that respect the sanctity of life do not terminally-sedate their patients, nor do they impose death in any way. They allow a natural death in its own timing. They recognize the moral boundaries for human action. They recognize that murder, intending the death of a patient is wrong. Medical killing is murder. Many in society have forgotten this simple truth. We need to remember the Lord's words and choose life, so long as it is given to us:

"... I have set before you life and death, ... therefore choose life, that both thou and thy seed may live. That thou mayest love the Lord thy God, and that thou mayest obey His voice, and that thou mayest cleave unto Him: for He is thy life, and the length of thy days"

[Deuteronomy30:19-20]

When health care professionals choose to medically kill, they are choosing to shorten the days
given to each of us by the dear Lord. At these times, they deceive family members and tell them the patient is "dying," but the innocent and vulnerable patient is actually being killed if medications that are not clinically necessary are given or if the patient is terminally-sedated when they are not agitated. These hospice or palliative care professionals do not acknowledge the Lord, nor do they acknowledge that we are not to decide when a life is to be ended. It is not our role. Yet, they persist as part of the culture of death and betray the mission others work so hard to serve.

There are six things the Lord hates, seven that are detestable to him:

haughty eyes, a lying tongue,
hands that shed innocent blood,
a heart that devises wicked schemes,
feet that are quick to rush into evil,
a false witness who pours out lies
and a man who stirs up dissension among brothers.

[Proverbs 6:16-19]

Hospice: Expanding Its Turf to the Non-terminal & Hastening Their Death

Today the hospice industry is making a huge push to expand its turf so they can get more patients, more health care "territory," so-to-speak. They want to legally be able to admit patients who are not traditionally "terminal" and to be able to "care" for them (bill for them). This is something that hospices committing fraud have already been doing. It allows them to bill for a full range of services while actually providing very minimal services to a patient that doesn't need much assistance. Patients who aren't really terminal love the extra attention they get, but it doesn't cost the hospice much to just send a nurse out once or twice a week. They get to keep more revenue from Medicare or Medicaid.

Private health insurers are getting on the bandwagon, too. Calling it an "Advanced Illness" program, these insurers are signing up hospice agencies to participate in these new programs.
The agencies admit patients who do not fit the traditional "six month" prognosis with a terminal illness. What's in it for the private insurers? Well, follow the money! If patients who are not "terminal" enter hospice and get the "hospice death protocol," they will die sooner, requiring much less reimbursement from the private insurers, whether PPOs or HMOs. And since the insurance company does not have to pay for services that would have been provided, they get to keep more revenue, too!

As we have seen, "in 1998, the number one diagnosis ... was lung cancer .... In 2008, the number one diagnosis was non-Alzheimer's dementia." We must really appreciate what this means. Originally, hospice agencies were caring only for the truly dying. Now, in addition to caring for the dying, they may be caring for those who are simply elderly, disabled, chronically ill or put into hospice for other reasons, and again, not likely to die within six months.

The hospice industry is arguing that there is a legitimate need for expanding the criteria to get into hospice. They want to include the nonterminal, those who are simply getting older, and they've been arguing this way for long.

Yet, they are not the only ones. Elected Congressional leaders and bioethicists have long promoted a type of "phasing out" of health care benefits for the elderly while shunting them over to an expanded type of "hospice benefit" with limited access to hospitals or emergency care.

Back in 1994, hospice physician, Joanne Lynn, MD was testifying before the Senate Committee on Finance. She explained that the elderly want to be:

".... protected against most surgeries unless it is going to relieve them of pain. They want to stay out of hospitals if at all possible."

"These people need something like a hospice benefit. But unlike hospice, they cannot promise to die soon. So they need a hospice benefit that is tailored to the possibility that they may live six or eight or 10 years. What we are looking for then is to work on the innovations that would allow a flexible benefit that would not make resuscitation and surgery a high priority, but would instead make supportive services and enabling services a high priority." [Emphasis added]

[Senate Hearing. 1-3-1008, "End of Life Issues and Implementation of Advance Directives Under Health Care Reform

Not having a patient go into the hospital when they are terminally ill makes sense, because curative care simply doesn't work at that point. But if you take people who might benefit from acute hospital care and deny them access to the acute hospital care, some of them will die even though a helpful treatment was available at the acute hospital center. They may die years sooner than they would have, and this is what rationing is all about.

The hospice industry leadership doesn't like having to limit admissions to just the terminal who are likely to die within six months. Why not expand their turf, their census, their business and revenue?

And they don't like the reimbursement they get for each patient being "capped." The public doesn't know that there are limits to how much the hospice corporations get for each patient. The public may know they get a certain amount each day the patient is enrolled, but there is a limit. According to the Hospice Association of America:
"Medicare payments to hospices are subject to an overall aggregate per patient "cap amount." The Medicare fiscal intermediary calculates each hospice's cap amount by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period, beginning November 1 and ending October 31 of the following year. Each hospice must refund Medicare payments in excess of this aggregated cap amount. The cap amount is adjusted annually for inflation or deflation. For the year ending October 31, 2009, the cap amount is $23,014.50."

The main thing to be understood is that if the patient lives beyond a certain period (the equivalent of the cap amount being used up) or requires services that cost more than the "cap amount" allowed each year, the hospice corporation is losing money every day the patient lives beyond that time. Dividing $23,014 by 180 days (six months times 30 days per month) equals about $128. This is roughly the level of reimbursement that is paid for the most common, routine home care level of care.

In 2009, the hospice got about $142 each day the patient is enrolled. You can see that if they live beyond six months, the hospice is paying out for services and they will not get further reimbursement. So, if the physician accurately "predicts" that the terminally ill patient will actually die within the six months period which makes him fit the definition of being "terminally ill," the hospice will do more or less, "ok" financially. If the patient's condition is service-intensive, or lives longer however, the hospice corporation will find the "cap" amount running out and begin to look upon that particular patient as a financial liability. They may even send in the "closers" to "speed things up."

Aside from getting those who have not yet reached "terminal status" into hospice sooner, the policy-makers are experimenting with getting those being treated into hospice before they "give up" and seek "comfort care" exclusively. Up till this time, patients had to give up regular benefits in order to enter hospice. If they can still undergo treatment while entering hospice, they've got one foot in the door and one outside. Eventually, they're going to decide to continue treatment or give up. With hospice personnel working with them regularly, they're going to be given messages that hospice is there for them should they decide to forego curative treatment. After a while, many will see hospice as the way to go. And if enough of them choose comfort care only, sooner, the government will save more money.

American Medical News reports on this new project: "Medicare to test allowing more than palliative care in hospice"

"The health reform law enacted in March directs state Children's Health Insurance Programs and Medicaid plans to immediately cover "concurrent care" -- a combination of curative efforts and hospice care -- for children with terminal illnesses. The Congressional Budget Office estimates that the expanded coverage will cost $200 million over 10 years.

The law also calls on the Health and Human Services secretary to conduct a three-year, budget-neutral demonstration project of concurrent care for Medicare patients at 15 hospice-care sites." [and]

"The median length of stay in hospice is less than three weeks, and one-third of hospice patients die within a week of being admitted, said J. Donald Schumacher, president and CEO of the National Hospice and Palliative Care Organization. He said that Medicare paying for concurrent care could make it easier for patients and families to move from aggressive treatment to palliative
"You go from one phase to the next phase with something to hold on to as you make that transition," Schumacher said. "Many people say, 'I wish I'd come to hospice sooner.'"

Getting patients into hospice earlier gives them access to expert advice to help decide whether curative efforts are worth pursuing further, Schumacher said. "We believe involving hospice sooner will help people forgo nonproductive treatment."

The demonstration project will test whether paying for concurrent care helps patients and saves Medicare money. Then the HHS secretary will recommend to Congress whether to change the hospice-care payment policy.

Whatever they say about better circumstances for those facing a terminal illness, if there were no projected savings to the federal and state governments, they wouldn't even be looking at expanding the admission criteria for entering hospice. Schumacher revealed the real goal, having "people forgo nonproductive treatments." They are testing whether "offering" concurrent services within hospice will get patients to switch from acute hospital care to hospice sooner. The idea of offering "concurrent" services is the enticement to draw patients and families in, while all along providing them with counseling that suggests that aggressive treatment is not the way to go. That may be true in some, or even many, cases, but knowing the history and trends involved, the stage is being set for a continuum of care throughout the health care system, and once patients' care becomes quite expensive, they will be shunted over into hospice and have no choice about it, whether they have a "terminal" illness or not. Whenever you hear about hospice utilization being expanded, or the need for that expansion, when the government budget is concerned, it's all about the money.

The benefits of forgoing aggressive treatment are real when aggressive treatments no longer help, cause much discomfort and are unwanted. And providing relief from the symptoms that accompany the end-stage of a terminal illness is the important and valuable service of palliative care at the end-of-life. Let's not confuse the benefits of hospice care or palliative medicine with the economic motivators pushing changes in our system.

**How Hospices Hide the Killings (HIPAA Misdirection & Hospice Fraud)**

People often ask, "Why would hospices kill if they are paid on a per-diem basis?" The answer is that there is a never-ending supply of elderly, chronically-ill and disabled to draw from. Hospices that are rogue hospices are not having trouble getting patients. They are having trouble getting enough staff, as there is a severe nursing shortage, and that shortage is even more severely felt in hospice agencies. However, as end-of-life care is being mainstreamed
into nursing education, that shortage may be resolved over time.

In addition, if the hospice is part of an HMO or a vertically-integrated regional health care system, money is the motive. An HMO may wish to limit services and expenditures to those who are most service intensive. A vertically-integrated regional health care system has hospitals, pharmacies, labs, nursing homes, clinics, assisted care living centers and hospices, that are all part of the same health care system. If there is any type of HMO or private insurance system in place that integrates all these services under one corporate umbrella, the early death of a patient saves the health care system a lot of money.

Then people ask, "Well, if there are so many killings, why wouldn't we have heard about them in the news?" The answer is that this is the most censored story in America. The Soviet Union's powerful censorship agency, GLAVLIT, could not have kept the truth from the people any more effectively. The major media editors and managers are supportive of hospice and pro-assisted suicide and euthanasia. I know of thousands of articles reciting the wonders of hospice services at the end-of-life. I can count off with the fingers on one hand the sum of all stories printed by the major media exposing something problematic about the hospice industry.

There is a reason the major media refuses to publish the truth about hospice, palliative care, health care reform and stealth euthanasia. Most of the major media outlets like the Washington Post, ABC News, CNN and others have direct connections to those who support the culture of death approach: George Soros and others. Soros has poured millions into the major media and active journalists are on the boards of directors of Soros-funded organizations. In addition, many journalists support the Third Way stealth euthanasia practiced in many hospice and palliative care units (just "let him go") and the legalization of euthanasia and assisted-suicide. This is clear from the regular and distorted major media coverage of cases like the killing of the abused and neglected woman Terri Schiavo and others like her as well as the regular refusal of the major media to cover the topic of stealth euthanasia and Third Way killing at all. Even though they know about it and have investigated and confirmed it exists (after contacting us here at HPA), they continue to censor coverage of this dark reality of American society.

Not part of the "major" media, the WorldNetDaily magazine, "Whistleblower," did expose what is going on in end-of-life care in their May 2005 edition entitled, "Who Lives, Who Dies? Welcome to the brave new world of euthanasia, assisted suicide and 'futile care"

**HIPAA Misdirection**

Well, people may accept that the story has been censored somewhat, but they still can't believe they wouldn't hear about it at all. Remember, HIPAA was "sold" to the public with the idea it would protect patient's private personal information.

"**All warfare is based on deception.**"

The Art of War by Sun Tzu Chapter I, verse 18

What was not emphasized is that HIPAA forms a complete wall of silence about what goes on
behind closed curtains in doctor's offices, hospitals, in hospice agencies, nursing homes, assisted living and any clinic of any sort.

In 2009, the "HITECH" Act modified the HIPAA Privacy Rule to give it dramatically increased penalties:

[42 USC Section 1320d-6(a)] 20. Wrongful Disclosures - Section 13409
Clarification of Application of Wrongful Disclosures Criminal Penalties of Section 1177(a) of the Social Security Act (42 U.S.C. 1320d-6(a)) is amended by adding at the end the following new sentence: "For purposes of the previous sentence, a person (including an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation of this part if the information is maintained by a covered entity (as defined in the HIPAA privacy regulation described in section 1180(b)(3)) and the individual obtained or disclosed such information without authorization." This provision clarifies that an individual does not need to be a HIPAA covered entity to be subject to the criminal penalties in 42 U.S.C. § 1320d-6(a)

And what might those "criminal penalties be? Absolutely devastating fines and jail time. And, to clinch it and make sure agencies report such violations, the agencies themselves face fines if they don't report and "correct" the violation within 30 days. So, you have truly terrified health care agencies paranoid about violating HIPAA, and you have truly terrified health care professionals paranoid about being accused of violating HIPAA. Even if an agency/employer wished to "go soft" on an employee who made a mistake, their attorneys will advise them that they have to report in order to avoid severe penalties for covering up an incident. In addition, HITECH creates three "tiers" or levels of fines to be imposed depending on the willfulness or knowing intent of the violator of patient privacy.

Health care professionals learned, as I did in early 2010, that we can face up to a $50,000 fine (or much more) and jail time for violating the HIPAA Privacy Rule. And the obvious: we would lose our job, our family finances would be devastated, and basically, the federal government would destroy our lives as we know them.

"The base penalty for violation is a $50,000 fine, imprisonment for not more than one year, or both. For offenses committed under false pretenses, the fine is not more than $100,000, imprisonment for not more than five years, or both. And if the offense is committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, the fine is not more than $250,000, imprisonment for not more than 10 years, or both." [Emphasis added]

The "base penalty" is $50,000! You think I'm exaggerating? In June 2010, Amednews.com reported a surgeon's "HIPAA violation leads to jail time"

The case, involving a former UCLA employee, is the first to result in incarceration for unauthorized access of patient medical records.

.... Huping Zhou, a licensed cardiothoracic surgeon in China who was working at the UCLA School of Medicine as a researcher in 2003, was sentenced in late April to four months in jail after pleading guilty to charges related to looking at patient medical records he was not authorized to view.

.... "There's no question that this is sending a message," said Stephen Aborn,
executive director of Andrews International, a Valencia, Calif.-based investigative and security services provider. That message: Health care organizations, and their employees, can't afford to be complacent about privacy of patients' electronic data.

"This would be an example of [the government] demonstrating, 'Yes, we are serious about making sure you all understand we will exercise this authority with respect to employees,'" said John Christiansen, a Seattle-based attorney who advises clients on information technology matters.

[Emphasis added]

Yes, they will exercise their authority to penalize employees. This is new. Never before have the agencies and employees felt so intimidated by the threat of fines or jail time! This is the creation of a strengthened "wall of silence," behind which the stealth euthanasia is proliferating.

I personally filed the first HIPAA complaint on April 14, 2003 against Hospice of the Florida Suncoast for violating the privacy of many patients, releasing actual patient names, addresses, phone numbers and diagnoses. The U.S. Office of Civil Rights ("OCR") that enforces HIPAA did nothing. The hospice was not an employee to be silenced, so the US Office of Civil Rights sat on my complaint for years. To this date, almost eight years later, nothing has been done. Nobody went to jail. OCR never even talked to me once.
HIPAA is not about silencing agencies. It's about silencing staff that see what goes on. Employees. Health care workers are not going to talk about problems in health care with the
public (say through a news story), unless they wish to risk everything on a casual comment. Agencies will act quickly to shut down any breach of the HIPAA Privacy Rule since the agency corporation will itself be held responsible and possibly fined if they are found to be at fault. In Tucson, the Arizona Daily Star reports, "3 [University Medical Center] workers [were] fired for records access"

"The hospital has terminated three clinical support staff members this week for inappropriately accessing confidential electronic medical records, in accordance with UMC's zero-tolerance policy on patient privacy violations," says a statement issued by UMC officials this morning."

"Zero tolerance" is what it's all about. If it's about protecting patient privacy, good. But that's not what it's about.

Ok, but I can hear you saying, "Surely a staff member can report a crime to the police if someone is killed in a hospice!" Yes, you can report it to law enforcement. Many staff and families have reported it. We know from years of speaking with nurses and families: the police will not investigate reports of killings in the hospice. They universally say, "Report it to the State Health Department." And when people report it to the State, nothing is done. The state inspectors will indicate they "could not substantiate the allegations." End of story.

With the strengthened fines and threat of jail time, employees will think twice about reporting to anyone. They are not told by their employers about the provisions that allow them to report crimes committed in the workplace. Why would an employer mention that? It just wants to make sure the agency does not run afoul of HIPAA and get fined itself!

Again, you will say, "but if you go to the police and carefully explain how serious it is, they must investigate." You would be wrong.

This is how it will play out under the new HIPAA Privacy Rule. You can report to the police if you believe a crime has been committed. The summary of the HIPAA Privacy Rule says that HIPAA allows covered entities (health care workers or agencies) to report crimes to law enforcement officials if there is a violation of the law:

(5) Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes .... [two of which are:]

"Law Enforcement Purposes. Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following ... circumstances, and subject to specified conditions: .... (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death"

The only problem with that is if a health care worker goes to the police and tells them that in the ordinary course of the agency's business, crimes are regularly being committed, or even committed once, they will absolutely be fired. Why? Because they would be acting "against the corporation's interests," damaging the reputation of the corporation, which is a common reason giving for terminating a troublemaker's employment. If a crime had taken place, the corporation will deny it anyway.

This is exactly what happened to R.N. Carla Sauer-Iyer in 1996 when she reported suspected abuse of Terri Schiavo at the nursing home where Sauer-Iyer was charge nurse. Her report was
allowed under privacy rules, but the facility terminated her employment the next day! The
lesson learned by all the nurses in the country who heard about what happened to Carla Sauer-
Iyer, RN? Intimidation. "Shut up!" "Keep your head down and just do your work!" "It's not
worth it!" Just as effective as the whips used on slaves hundreds of years ago. "If you act up,
you'll be punished!"

Two, they could be falsely accused by the employer of breaching any standard of care.
Retaliation is a well-known reaction to whistleblower employees in many industries. Nurses
have been "set up" to appear to have done wrong when they haven't done anything wrong and
have been fired. Debbie Blevins, LVN was fired August 2010 after reporting violations of
HIPAA Everybody thinks that "whistleblower protection laws" would prevent such things.
Again, you would be wrong. Health care corporations can violate the laws protecting
whistleblowers and then let the "chips fall where they may."

This is exactly what happened to two nurses in Texas. They didn't actually report to law
enforcement, but reported to the State Board of Medicine which is allowed under the HIPAA
Privacy Rule. HIPAA says it allows reports to all sorts of agencies for the welfare of society.
Two nurses trying to protect patients in Texas were allowed under state law and under the
HIPAA law to report a doctor they believed to be endangering patients.

What happened? In the September 2009 Scienceblogs.com article, "Report a bad doctor to the
authorities, go to jail?" we learn that the physician was given a copy of the complaint which
included hospital code numbers to indicate which patients the nurses had included in their
complaint information. The physician went to the local Sheriff and filed a complaint saying he
was being harassed. The sheriff, with a little bit of investigatory work, found out who had filed
the "completely confidential" complaint to the State Board of Medicine. The two nurses were
fired and arrested sixty days after the complaint went in ("less than sixty days" being the
period of time within which the employer's action could be construed (under the law) as
"retaliation" against the nurses).

Oh Yes Honey, we are VERY concerned about your welfare!

We'll get her later ... fire her as soon as you can!

Artwork (c) 2003 Vickie Travis
design by Ron Panzer and Vickie Travis
The State Board of Medicine wrote to the prosecutor's office protesting the prosecution of the nurses saying the Board relied on sometimes confidential complaints and that whistleblowers should not be prosecuted as they were protected by the laws. The nurses lost their jobs just the same, and the prosecutor's office did not withdraw their case against all of the nurses! After a period of time, however, the District Attorney withdrew charges against one of the nurses, but still pursued the case against the other, Anne Mitchell, RN.

Although the Texas Nurses Association reported February 11, 2010 that the jury acquitted the Winkler county nurse of all charges, nobody should ever have to go through such an ordeal when they are just doing their job and trying to assure good care for patients.

Many nurses all across the country heard about this case and again, the message was "Keep your head down!" "Just do your job!" "Mind your own business!" "Don't go up against the powerful!"

If a corporation wrongfully terminates an employee who reports wrongdoing, corporations are willing to gamble that either the employee won't sue or they won't have the funds to hang in there and continue the legal fight for long. The corporations also figure they'll be able to win in court somehow, even with fabricated testimony.

First, the agency has (compared to the employee) unlimited funds to hire the best attorneys and pursue their legal actions against the employee should the agency decide to make false accusations about the employee to discredit him or her. They also have virtually unlimited funds to defend against an employee-brought lawsuit for wrongful termination.

A health care professional who is out-of-work, is out of luck and will have a hard time paying for an attorney. In the case of those two nurses, the Texas State Nurses Association and the American Nurses Association raised money through a legal fund set up just for that purpose. Most employees are not going to be saved by a state or national professional organization.

If the employee scraps some money together or gets an attorney to take it on a contingency basis, it will likely be a year or more before any ruling in the case. Why? The standard tactic is for the agency to delay, delay, and delay until the employee's funds run out or they tire and want to settle for a small amount. If they hang in there and even win in court, what happens then? The corporation may appeal to higher courts, which could literally involve years, with the attorneys stalling with all sorts of delays created by the agency's attorneys. Meanwhile, the worker still does not have their former job, and other agencies may decide they don't want a troublemaker in their midst. In other words, the worker is "blackballed." It happens.

Back to HIPAA Privacy Rule violations. If you are reported to the Office of Civil Rights for a HIPAA violation, there is no jury trial where you and your attorney get to present your side and prevent immediate termination. You will probably be fired first by your employer, and then there will be a hearing (months or more later) before the administrative judge at OCR before the fine and possible jail time is imposed.

Will your case be heard with impartiality and complete fairness if you are exposing the government's own stealth euthanasia program? At your agency? I don't think so!

And while the life you've had up till then and your career rests in the hands of an administrative judge, have you considered what type of "justice" is administered in governmental administrative hearings?

I've been there. Back in 1997, I filed a complaint to the federal and state government. At the state level, the inspectors refused to even investigate several allegations I brought. I appealed
to the state Office of Legal Affairs in Lansing, Michigan (a step most complainants never make after not getting justice from the state health department). Several months later, I went to the hearing before an administrative law judge. It was absolutely a "kangaroo court" with the judge refusing to listen to my evidence and to hear the testimony of witnesses about wrongdoing at the hospice I worked at in Michigan. He even said he wouldn't even entertain several allegations. He wouldn't hear anything about them, though I had proof.

Being a whistleblower can involve going up against the agency and the government that is in collusion with the agency at the same time (which was the case in Michigan). In my whistleblower case, the administrative law judge took a recess and was standing around joking with the administrators of the corporation and then later, he refused to listen to my allegations or evidence. It was a complete mockery of "justice." The judge and the administrators laughed at me, because they knew the game was rigged. My proof, the truth, meant nothing. The only thing that mattered is what the state did, and what they did was protect the agency by covering up their fraud, patient exploitation and violations of many standards of care.

Whistle blowing under HIPAA against crimes of euthanasia at your agency? When the government is encouraging the hastened deaths of patients? They'll go after you and destroy you. In the meantime, you have no income, no job, nothing.

See: The HIPAA summary.

Privacy Rules? If it's about protecting your privacy? I'm all for it. If it's about creating an impenetrable wall of silence behind which health care tyranny can be implemented, then it's the harbinger of terrible things to come. The Nazis in Germany didn't advertise their death camps and kept a tight lid on what was really going on. Anyone who spoke out about what was going on was shot. Anyone who didn't report violations of the Nazi laws or who harbored a person considered an enemy of the state was shot. The HIPAA Privacy Rule's penalties are so severe, they are the equivalent of being "shot" career-wise! The HIPAA Privacy Rule establishes everything that is needed to carry out a stealth euthanasia campaign with no word at all getting out.

Remember, there are three branches of government and the media is supposedly like a “fourth branch” or protective mechanism to keep government hones. When the media cannot be informed properly by employees and families are either intimidated into silence or hushed-up with a settlement and gag order, the media is simply out of the picture. Stealth-euthanasia is assured to be 100% stealth.

If we're talking about a rogue hospice, it will be very difficult for employees to come forward to law enforcement and report what they've seen. Fear of losing their job, being black-balled, fines based on trumped-up charges have a very, very sobering effect on all health care workers. With the weakness of the whistleblower protections and HIPAA's imposed secrecy, there now truly is a cloak of invisibility shielding the public from learning what is going on in the health care system. By design!

The wall of silence in health care is more impenetrable than the "blue wall of silence" among the police that so many have documented as existing in some areas. It's understandable that police will protect their own, just as physicians will protect their own. But the wall of silence involved in HIPAA is not based on loyalty as the blue wall among some policemen is, or the physicians' loyalty to each other is. The wall of silence in HIPAA is based on fear, and the government officials have made sure that the fear is tangible, real, and extreme, so extreme that almost nobody except a fool would dare to violate the HIPAA Privacy Rules. The agenda cannot be completed without a wall of silence, almost absolute secrecy, and they
have accomplished that.

The Washington State "Death With Dignity Act" allows physicians to write prescriptions for a lethal drug and orders the medical examiners to falsely list the cause of death as the illness the patient was suffering from, rather than the lethal drug they took to kill themselves. Falsification of death certificates is nothing new, but openly ordering the medical examiners to lie is new. We hear about falsification of death certificates often from families who report their loved one was killed in a hospice or palliative care setting and then the cause of death is listed as cancer, Alzheimers or some other illness. Just as in the case of falsification of medical charts: whatever is officially listed (as the cause of death) is the truth, because it says so. It doesn't matter that it's all a complete lie. If everyone in government simply accepts what the record says, that is what the "official" truth is. Something that could have come right out of the Soviet Union's propaganda machine.

Of course, people still ask, "How is it possible that what you're talking about is really happening?" Can they really hide killings? "It just isn't believable." "Surely, the medical charts would show something was wrong and the state would come in and prosecute."

Well, if you've been a whistleblower like me, you'd know the state actually doesn't enforce regulations in health care that much. They make a big effort to appear to do so. Every year they may go after an especially run-down, hell-hole of a nursing home, even shutting one down from time to time, just so the state Attorney General can get a headline demonstrating how he or she is protecting the vulnerable and doing such a great job. Standards of care in health care (if they are followed) are mostly voluntarily complied with and there are huge efforts by corporations to meet the standards, but that doesn't mean there aren't violations. Some corporations, like rogue hospices, are rogue corporations. Rogue hospitals, health care systems, HMOs, managed care organizations and so on. If they want to violate standards or laws, they'll figure out a way.

If rogue hospices want to hide medical killings, they can falsify medical records. How? Simple. The staff chart what is going on. If they chart or record that the patient had pain when they didn't, the record shows the patient did have pain. And the chart is the legal medical record. I like to tell people it's something like a bank robber leaving a note saying he didn't rob the bank, even if he stole a million. And, the police (the state department of health) look at the note and say, "hmm, there is a note saying nothing was stolen, so no crime occurred." "We're shutting down our investigation." The state inspectors look mostly at the charts, but they also look at the facilities and inspect, a little. The problem is, the dates of the inspections are usually leaked to the agencies so every year or so when the inspection at a nursing home is scheduled, the facility management gets the staff to "clean up their act" and be on their toes. Hospices are inspected much less frequently.

Management often brings in extra staff to help make the care provided look much, much better than what it normally is. When I worked for a temporary staffing agency, I actually was called in to a nursing home to help out for a few days during a state inspection. It was obvious they were gearing up to make it look like the facility was "top notch." We knew better. We knew that at other times, the staffing there was terrible. During the inspection, they had many more staff on hand.

Medical charts can be falsified and the appearance of what is going on can be altered to fool the inspectors. Every health care professional who's worked for even a few years knows this kind of thing goes on. When you see the same handwriting on a chart where more than one nurse entered her notes, you know it's falsified. I saw that years ago in one of the hospice settings where I worked.
The U.S. DHHS Office of Inspector General ("OIG") specifically mentions false documentation as one of the means of committing fraud by hospices:

[Note: 26] "OIG investigations have revealed that certain hospices have falsified patient medical records and plans of care to exaggerate the negative aspects regarding a hospice patient's condition to justify reimbursement."

That would be done by rogue hospices that admit non-terminal patients to bolster their revenue stream through health care fraud.

"False dating of amendments to medical records; [see note 37]

[Federal Register / Vol. 64, No. 192 / Tuesday, October 5, 1999 / Notices 54031]

This is done for a variety of purposes, whether to "clean up" the medical record in order to make it appear to comply with the standards of care or to "cover up" wrongdoing, substandard care or worse. I remember being asked to be a "chart auditor" to look for incomplete charting and all sorts of omissions in charting at a hospice where I worked. Later on, I remember seeing someone I didn't know taking charts into a little room alone. Normally, the nurses took charts into their own office space, but never into that room. I later saw charts with entries that had one person's handwriting for several different nurses' notes on the same page. It took me a little while to figure out what was going on with the "chart auditing" they asked me to do. They probably really appreciated my diligence. Little did I know what it was being used for! Believe me, falsification of charting in health care is done, has been done for a long time and is a major way of covering up fraud, bad charting, or even medical killings in hospice, whether through overdose or terminal sedation.

How else are the medical killings hidden? Well, this is obvious for those of us who have been following the hospice industry closely. We know the U.S. Justice Department has found fraud being committed by many hospices, bringing in patients who were not terminal, so they'd be able to bill for every day a patient is enrolled in the hospice, but not have to provide much service at all. It pads the revenue stream and makes for a "healthy profit." What happens to the stats in this case?

People who are not terminal don't die on their own, for the most part. They live, and sometimes they live for a long time. When you average in a bunch of patients who live a long time, helping the rogue hospice collect more revenue, with patients who have been hastened to death, you get "acceptable" "length-of-stay" stats. You can even brag that hospice helps patients live longer, not shorter! However, only hospices that respect the sanctity of life and never impose death truly lengthen the lives of the terminally ill.

In a rogue hospice, you may have patients dying the day or week they are admitted, even when they are not clinically close to death. We've heard from numerous families about these sudden, unexpected deaths at hospices all over the country. Many attending physicians have stated that they didn't expect a patient to die, but when the patient went into hospice, "boom," they were dead. Another variation on the theme is to admit patients (terminal or even non-terminal), chart that they are on continuous care to justify billing at the higher reimbursement rates while not providing the actual continuous care services ... then medically kill them after a few days or a week or so. The death "proves" they were "terminal" to the fiscal intermediaries who review the cases looking for fraud, and the hospice gets to rake in millions if they have just a few of these non-continuous care (but billed as continuous care) cases going throughout the year. It appears that administrators of the rogue hospices decided that if they're going to commit fraud they might as well "make the most of" the opportunity and not just to commit fraud at the
minimal routine home care level of reimbursement, but to get several hundred dollars more each day while they commit fraud.

Let's do the math: $700 extra reimbursement per day (for a patient billed as continuous care for whom no extra nursing services are provided) x ten patients = $7,000 extra per day. Multiply that by 30 days gives $210,000, times 12 months = $2.52 million taken fraudulently by just one hospice in one year. A larger hospice can easily have ten cases going where they are billing fraudulently at the higher continuous care rate without providing extra services at all.

When these patients die (are medically killed), the physicians tell me and others, they know the patient must have been overdosed with morphine or terminally-sedated, because their disease process just wasn't at the very end-stage of imminent death. When this kind of thing happens over and over again, physicians and patient advocates know that deaths are being hastened. Autopsies have shown massive morphine overdoses or severe dehydration, yet district attorneys refuse to prosecute. Medicare and Medicaid fraud, where non-terminal patients are brought in to pad the revenue stream, clearly skews the stats so the hospice appears to have patients living longer than they actually do.

That is how the rogue hospice industry is hiding the killings. It's that simple. Of course, the industry groups like the National Hospice & Palliative Care Organization never point this out, even though fraud is rampant in the industry. It's too damaging to their reputation which they guard zealously. They would never wish the public to know what is going on. Of course, the government officials know all about it, are in favor of it, and do nothing about it, or at least, nothing that will stop it. The government saves billions when many die. It has a conflict of interest. Fulfill its duty to protect the citizens? Or, exploit the opportunity to reduce cost expenditures (by allowing the continued early/hastened deaths of many)? That's an easy choice the government has already made: reduce cost expenditures.

Let's look at one last reason you haven't heard about the killings: access to the courts. When families call me, they often say that they can't find one attorney to take their case. There are thousands and thousands of families that would sue if they could. They report that the attorneys say, "You have a great case, but we decline to take the case at this time." This happens all across the country, and has been like this for years. Why? When you sue in civil court, any judgment is a monetary award to "make you whole" or compensate for a wrong done.

In the eyes of the court, the value of a person's life is determined by their earning capacity and affect on other people. The terminally ill have no expected earning capacity so even if there is a ruling that the death was a "wrongful death," "they were going to die anyway." If you have autopsy and medical record evidence as well as expert testimony to prove your case, and win, you can still only expect a nominal amount to be awarded. The value of a terminally ill person is nil in the eyes of the courts.

Expert witnesses can cost several thousand dollars each. So, the cost of bringing a legal action is more than the likely award should you win the case. Attorneys know this, so they don't bring actions dealing with the terminally ill, unless a family is independently wealthy and can pay out of their own pocket for the attorney's fees. Most families cannot do that at all. No access to the courts. No justice. And, the media has no lawsuit to wrap the story around. No news coverage.

If a patient dies a week, a month, or even a year earlier than expected, nobody in the government raises an eyebrow. It's all routine now. They've heard it before and do nothing. It is the public that has not heard it before, or is powerless to do anything about it when it
happens to their loved one!

"If he is secure at all points, be prepared for him.
If he is in superior strength, evade him."

The Art of War by Sun Tzu Chapter I, verse 21
VIII - Why Hospice Became the "Sacred Cow" of Health Care

While hospice was being embraced as a great solution for end-of-life care by right-to-life organizations as well as right-to-die organizations, the Euthanasia Society's successor organizations saw it as the vehicle to advance their cause. They knew that once America changed its view of dying and changed its expectations about how people died, they would be more than half of the way to widespread practice of euthanasia, however hidden that practice would be. Their infiltration of the end-of-life care industry has been accomplished just like the Greek hero Odysseus entered the city of Troy with the famous Trojan Horse. The citizens of Troy never knew the Greeks had secretly entered the city hidden in the horse until it was too late. And, most Americans do not know that the proponents of euthanasia have entered the end-of-life care arena and are shaping it to their own purposes.

"Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy."

Proverbs 31:8-9

The Government Loves Hospice

The elected officials that control the actions of our national and state governments love this thing called hospice and want to promote hospice. The Congressional leaders chose to create the Medicare hospice benefit and help fund state Medicaid hospice benefits. It's a good way to manage the population. It helps balance the budget by providing care at a cheaper price than acute hospitals can. Even better? It will be the chosen vehicle to provide hastened deaths for the disabled, the dementia patients and others selected for end-of-life treatment. If Ezekiel Emanuel, MD's "Complete Lives System" (designed to ration organs for transplantation and vaccines that are in short supply), is applied to rationing care for the elderly, hospice will be their destination.

Daniel Callahan (with Sherwin Nuland) suggests that "less money [be spent], ... for late-life technological interventions and more for preventive measures and independent living. Some people may die earlier than now, but they will die better deaths." What is planned could not be more plainly stated. Again, hospice will be the destination of those who die earlier, but "better"
according to euthanasia-advocates like Callahan.

"Principles for allocation of scarce medical interventions" The Lancet, Volume 373, Issue 9661, Pages 423 - 431, 31 January 2009 - Govind Persad, BS, Alan Wertheimer, PhD, Ezekiel J Emanuel, MD

Denying that he is advocating widespread rationing, Dr. Emanuel stated, "I think that over the last five to seven years ... I've come to the conclusion that in our system we are spending way more money than we need to, a lot of it on unnecessary care." "If we got rid of that care we would have absolutely no reason to even consider rationing except in a few cases."

Of course, even when they deny that they will ration care, they confirm that they will. Who determines what is "unnecessary care?" It was Dr. Emanuel who offered what he called an "obvious example" of "not guaranteeing health services to patients with dementia ...." This is what he deems "unnecessary care." He has also stated:

"services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic and should not be guaranteed." [Emphasis added]

[See: "Where Civic Republicanism and Deliberative Democracy Meet" Ezekiel Emanuel, MD; The Hastings Center Report, Nov-Dec 1996)

Clearly, not providing services to those the elite decide are not worthy of care is rationing! Remember the language we saw earlier in the Health Care Reform? ... about the Secretary of Health making sure that "health benefits established as essential not be subject to denial to individuals?" Again, who determines what are "essential health benefits?" Dr. Emanuel or those trained to think like him? Yes, the President's former health advisor absolutely asserts that many services to the disabled, those with dementia or cognitive impairment should not be provided. He clearly asserts that such services are not "essential." Who else is he referring to when he mentions those of us who are "prevented from being or becoming participating citizens?" They will essentially be given a lethal "long walk off a short plank."

And of course, we know where they will be directed for "care." When federal funding for the hospice industry has increased by $1 billion every year, you know the Congress is guaranteeing the expansion of the hospice industry! And if the government builds it, "they" will come. They will be made to come, by the millions.
Several years ago, Senator Charles Grassley told one of our Hospice Patients Alliance board members that the U.S. Congressmen know about the medical killings. They are not going to stop these medical killings. He said they know that the government saves at least $100,000 for every person that dies early (and that was in 2005 or so). Today, the savings are much more!

For a long time, Senator Grassley has been a champion of patients' rights in the Congress and has worked to improve patient care in America. Yet, I must finally ask publicly, "when will he or any Senator or Representative speak out on behalf of the vulnerable who are being victimized in hospice or palliative care units? When will he, or any of them, openly admit to the country that medical killings are going on across the country?" Not one has done so!

There are many Congressmen that have a utilitarian worldview and are quite happy that there is an assisted suicide law in Oregon and Washington (and wherever else it may be legalized). They are happy that parents can medically-kill unwanted babies. They are happy that Terri Schiavo's life was ended. They don't care that she was fraudulently admitted or that she wasn't terminal at all. They believe in eliminating the "unworthy of life."

On the other hand, there may be a few Congressmen that individually respect the sanctity of life, but not one has stood up and publicly exposed what they know about the medical killings in this country. They have not said one word about the medical killings in hospice! Their silence has resulted in its continuation. I imagine that they have been told to never mention it, or their career would be finished. I guess they care more about their careers than the people of the United States!

In the end, neither side of the aisle has done anything yet of significance to stop the medical killing of the terribly vulnerable, very young, very old, or disabled and ailing. There may be hearings about conditions in the skilled nursing facilities. There may be posturing, but nothing serious has been done to protect them. And yes, these individuals are absolutely being killed in very large numbers.

The Congressmen know this, but it's like the old story of the Emperor with no clothes: nobody dares to speak the truth about the matter publicly. They hope that the "obvious goes unseen" by the public. They know it and they are glad for it. They know that the large number of lives ended will help reduce expenditures for Social Security, Medicare, Medicaid and other services to the elderly and disabled.

The Presidents have known about it but also have done nothing about it, no matter how much any of them profess their faith. No matter how powerful the Congressmen and the Presidents have been, and no matter how much talk they've given about these issues, their shiny black shoes have not walked the walk into the halls of skilled nursing facilities that hold the abandoned, desperate and utterly vulnerable.

It's the un-mentionable dark "secret" that the government officials know about, many in the media know about, many of the health care industry administrators, owners and professionals know about, yet most of the public does not know about at all! The people who most need to know about it are purposefully kept in the dark! Why? So, they can walk unprepared into the health care setting and have this happen when they are vulnerable and unable to fight back, when it's too late!

Rationed care and hastened death are here already. HMOs already ration care in order to promote "efficiency" and there are many steps where physicians are restricted as to what they are supposed to mention as options for care or what diagnostic testing or treatments they're supposed to order. The HMO/managed care organization can deny approval for requested tests and procedures. If the physicians go against the guidance of the HMO and order certain
treatments anyway, on a regular basis, they risk being disqualified from participating as an "in-network" provider with that private HMO or insurance company. If they lose their classification as an "in-network" physician, they lose patients and income, and can be financially devastated.

So, many of the physicians just do whatever the HMOs/managed care organizations say to do, never telling the patients that there are other effective medical treatments even if the treatment option is denied. If the physician had at least told the patients (or their families) they might find a way to raise the money or go elsewhere to get it, but many physicians remain in "HMO mode" and remain silent, betraying their patients in the process.

How can these treatment denials and failures to inform the patients be so effective? Well, physicians are above average in intelligence if not ethics (they're people just like anyone else). They are very good at doling out "plausible explanations" that the patients will just accept since they trust their physician. Sometimes, it may take years before a patient or family learns that a treatment had been available, but it may be too late for it to help by then.

If private insurers deny coverage or treatment to a patient (and the patient knows about it), patients can appeal to government regulators or arbitrators. If there is only a single government-controlled health system, there will be no effective place to appeal to. And as they say, "you can't fight City Hall." Try fighting the federal government. It's much worse than "not easy." It's virtually impossible. This is the situation in the United Kingdom where the National Health Service is the source of thousands of complaints and horror stories, almost all that result in no relief.

If the health care reform plan goes into full effect, "regulators," "bureaucrats," Medicare/Medicaid fiscal intermediaries will decide. These are the nameless government workers who will decide not to fund Grandma Suzie's hoped-for, needed pacemaker or medication. They're going to do their part to "balance the budget" for these government programs without any fuss or fanfare. They probably will pride themselves on what a "good" job they are doing and consider themselves "patriots."

How they do their job will be decided by elite-level management, according to a secular, utilitarian approach. And the head of that elite group will be the Secretary of Health & Human Services, Kathleen Sebelius. Secretary Sebelius is a pro-abortion rights advocate and has been endorsed by Planned Parenthood, though we should recognize she increased resources for adoption when she served as Governor of Kansas 2003-2009. What else do we know about the woman who will decide about our health care regulations? She vetoed bans on late-term abortions more than once in Kansas. Medical science allows babies who are premature to survive and live. Even though many are told that abortion "ends a pregnancy," and is just a medical procedure, there is no question abortion ends the human life carried within the womb. Science even allows us to take pictures of the clearly human features of the babies in the womb. When someone can use their power to make sure that killing a fully-formed viable baby is allowed by law, I have to question his or her morality, ethics, and basic decency. How could she veto legislation in order to perpetuate the killing of defenseless babies and then say she considers life sacred?

I realize that many of you believe that abortion should be readily available for women to end an unwanted pregnancy so that the woman does not become a mother when the circumstances are not right. And I do understand that many who support abortion rights have good intentions and believe they are protecting women from harm. Many believe that contraception leads to reduced numbers of pregnancies and reduced numbers of abortions. However, the statistics tell another story.
It is clear there are many good-hearted people on both sides of the debate. There are many reasons women choose to abort their babies, and yes, there are often many difficult situations women find themselves in. However, science clearly demonstrates to us that a woman who is pregnant and chooses to abort is *already* a mother; because the human life began at conception, the moment of fertilization as every medical embryology textbook states. I believe that many, if not all, women recognize that the baby is alive and that they are now "a mother," and this is one of the reasons there is so much hesitation and heartache for those who seek to end the life of their child. A mother instinctively acts to protect the life she carries within her, so, it is my belief, aborting a baby in the womb is contrary to the natural role of the new mother and her conscience.

I'm not writing this to debate abortion with you, but to explain that the devaluation of a baby at any stage is not far removed from the devaluation of an unwanted infant, special needs child, severely disabled, very ill or elderly person. There is a continuum of devalued lives across the *full spectrum of life*.

*When we begin to accept the devaluation and killing of one human life, it is so much easier to accept and kill another.* These are things we must think about seriously in order to understand why involuntary medical killings happen in our society. Even if you are in favor of legalized abortions, read on and see how we have gotten to where we are today: involuntary medical killings occurring all over America. When it's your loved one whose life is ended prematurely, what will you think? With health care reforms already being implemented, lives will end sooner and we shall see exactly how.

The Secretary of Health, Kathleen Sebelius, is the one who will manage the creation of many details of the health care reform law. Perhaps this is what was really meant when former Speaker of the House Nancy Pelosi said, "we have to pass the law so you can find out what's in the law!" So, to understand the law, we need to look at more than the language of the law. We need to look at the people who wrote the law, the people who are behind it and in powerful leadership positions in the Department of Health & Human Services, and the stakeholders that mold national policy proposals and their implementation.

The staff throughout the department will go about their jobs. Publicly, they will talk about the need to cut costs, reduce expenditures, and spend money "wisely." "Doesn't that make sense?" they'll argue from an entirely utilitarian approach. But their decisions may be based on what is "best" for society as *they* see it, not what is best for Grandma's survival.

When the subject of entitlement reform is raised in order to balance the budget, the President and the Congressional leaders will be looking at making changes to Medicare, Medicaid and Social Security. These entitlement programs that Americans have come to expect comprise more than 50% of the federal budget. Americans have paid taxes for both Medicare and Social Security. The public expects to receive Medicare benefits. They expect to receive Social Security payments when they are eligible. None of our elected representatives wants to be the first one who raises the idea of cutting these programs (and be blamed for cuts to needed programs). With health care reform, tens of millions of people will be added to the federal government health care program. Cuts or changes will be made to help accommodate the influx of patients, and it will especially impact the elderly, disabled and chronically ill.

When the decisions are announced, we will ask, "why?" "Who does this benefit? Grandma Suzie will have her own idea of a "wise" decision when the doc informs her "sorry, Medicare no longer will fund a pacemaker for elderly people like you." "But don't feel bad! It's not personal." "It's not discriminatory." "Everyone above 65 years is being treated the same way."

"Suzie, I'd like you to consider hospice," will be the frequent line physicians will be dishing...
out (because of the changes in Medicare coming). The doc won't tell Suzie that the government pays him to strongly encourage her to make out an Advance Directive (that limits care to be provided), to ask to be put on "DNR" status ("don't resuscitate me," "make sure I die" status) or to encourage her to consider admission to hospice.

For example, "kidney specialists are pushing doctors to be more forthright with elderly people who have other serious medical conditions, to tell the patients that even though they are entitled to dialysis, they may want to decline such treatment and enter a hospice instead."

On the physician side of health care reform, with payments to physicians being reduced by the federal, state and even private insurers, physicians are being squeezed on all sides. Medicare may pay physicians only 80% or even 50% of what a private health insurance company would pay them. You may think it's a picnic, that physicians are all "rich," but they pay huge sums just to go through school for so many years. They often have hundreds of thousands of dollars in student loans when they graduate. Some lawyers are just waiting to sue any physician who makes any mistake, or even appears to have made a mistake, so physicians have to pay huge premiums for liability insurance. (And yes, there are a small percentage of physicians that contribute to most of the malpractice in the industry who need to be stopped.) Physicians also have to pay the costs of operating their practice, the "overhead." Some close their practices and retire early. Some of those who aspire to be physicians never enter the field.

While physicians are subject to the ever-present threat of a lawsuit, how many attorneys are? With 1,180,386 licensed attorneys in the United States in 2008, and 661,400 physicians, there's about two attorneys for every physician out there. And each attorney has to find some way to bring in income in an increasingly crowded field.

Some attorneys, motivated by the hope of getting their cut of a big settlement, bring frivolous medical malpractice cases and do society a disservice. When the patient has been the victim of actual medical malpractice, the attorney's service may be the only way a family or victim can get a semblance of justice. Errors and malpractice do occur and there are many egregious mistakes that lead to permanent pain, injury or even death. An attorney's service may be the only way to prevent future harm to other patients.

Clearly, attorneys and physicians wield tremendous power in our society and their actions can dramatically change the lives of those they serve. So, they have a tremendous duty to act in accordance with the established standards for practice and to act in the public's best interest.

A really talented attorney or physician may seem to be "worth his or her weight in gold" when the need arises. However, it is not always so easy for the attorneys or physicians, as some may imagine.

Some physicians complain that there is too much "red tape" in meeting all the requirements of government-regulated health care. Others warn that prices of health care are terribly high because the physicians must practice "defensive medicine" in order to avoid becoming victimized by frivolous lawsuits.

Physicians may be forced to settle a lawsuit, even if they do nothing wrong, because the medical malpractice insurance company decides, "it's cheaper" than taking the fight to court. Physicians must follow the insurance company's decision or they are "on their own." In this way, the system rewards the plaintiffs and the attorneys who bring frivolous lawsuits with the settlement money. So, physicians continue to order those unnecessary tests and procedures that increase the cost of health care for everyone.

This is why there have been repeated calls for "tort reform" to reduce costs within the
healthcare industry. However, making it harder to bring legal actions or placing limits on monetary awards may embolden health care industry HMOs, PPOs or others. Knowing that there are limits to their liability, they may act in ways that harm patients after determining that the cost of any award is less than the cost of providing appropriate diagnostic evaluation and treatment. This type of activity has been well-documented to occur within some HMOs, managed care organizations and PPOs. Finding an answer to the problems of malpractice in health care, while also reducing those legal actions that are frivolous is a difficult task that is being worked out in the courts and legislatures around our nation.

It would be wiser for the state medical boards to take a strong stand against those physicians who do not live up to the high standards needed for safe medical practice, thereby policing their own. However, state medical boards have historically been extremely lenient with physicians. Even when they censure a physician or remove the license to practice, it is usually a temporary measure and the dangerous physician continues to practice after a relatively short "probationary" period. In some cases, a dangerous physician may simply move to another state and start up again. Each state licenses their own physicians and actions taken by medical boards in other states do not necessarily apply!

However, most physicians do meet the standards of care. Today, they struggle with the high costs of maintaining a practice. Physicians are looking for any revenue source they can get to stay afloat. If the government's Medicare or Medicaid program will pay them to push hospice, or advanced directives, that's what many will do. The doc won't tell Grandma Suzie that the administrators at the HMO or our elected leaders in government don't want to pay for services she needs or that they really prefer she just die! It's all about the numbers, budgetary numbers for the HMO, the PPO, or the state and the federal government.

When patients enter hospitals or hospices, they are required to sign forms to consent to treatment, but they are also handed advanced directives to sign that are often written in such a way as to encourage limiting care in many circumstances, even limiting food and water. One of America's more popular living wills, "Aging with Dignity's 'Five Wishes document" has vague terms like "support treatment" ... "should death be near." What is "support treatment?" And what is meant exactly by death being "near?"

As time moves on, doctors will more regularly greet every elderly patient each and every year with an "end-of-life counseling" session where they will ask him or her, "don't you think you should have a "Do Not Resuscitate" ("DNR") Form filled out, or an "Advance Directive" or "Living Will" (that limits care and does not help get care if you want it)."Let's fill out this P.O.L.S.T. form, ok?" We cannot assume that somehow the government won't require these counseling sessions in the future, just because the section of the health care reform law dealing with these counseling sessions was removed.

What the public doesn't realize is that the DNR, the Advance Directive, the Living Will, and now the P.O.L.S.T form all were promoted originally by the successor organizations of the Euthanasia Society of America such as Society for the Right to Die and Choice in Dying. And the courts have gone right along in allowing a shift in the ethics guiding American law from sanctity of life to a secular quality of life ethic. The P.O.L.S.T. form spreading around the country came from Oregon, right after people there managed to get assisted-suicide legalized in that state. It's the "next step" for all of us.

What the public doesn't realize is that one of the biggest pro-assisted-suicide groups in the country, Compassion & Choices (formerly the "Hemlock Society") helped write the language in the health care reform law that pertains to these strongly encouraged "counseling" sessions with the elderly.
Since physicians are screaming about funding cuts by Medicare, if the government does decide to fund these counseling sessions, they will be sure to provide "end-of-life counseling" to get more revenue from Medicare coming into their practices. They may suggest, "Don't you think hospice is a good option for you?" Eventually incentives will be built into the government's system (just like HMOs already do) so that doctors who order fewer tests, treatments, surgeries or other services, will get paid more each year. They will know that the government plan won't approve certain surgeries or treatments for the elderly. They will know that it won't make any sense to even try to get certain procedures approved for the elderly. They'll know that at a very advanced age, the only thing that will be approved is hospice.

Betsy McCaughey, former Lieutenant Governor of the State of New York, states that the new counseling sessions:

"Would make it mandatory absolutely that every five years people in Medicare have a required counseling session," she said. "They will tell [them] how to end their life sooner."

The proposal specifically calls for the consultation to recommend "palliative care and hospice" for seniors in their mandatory counseling sessions. Palliative care and hospice generally focus only on pain relief until death.

Well, going into hospice could be a good option if the patient is actually terminally ill. It could be a good option if the hospice that is eventually used respects life and does not hasten death through misuse of terminal sedation or other means. And yes, for those of us who have been paying attention, the advanced care planning sessions that the government said would not be included in the law was added back on November 29, 2010, taken out, then added back in and then taken out yet again after public protest.

It comes down to this: care will be rationed, whether by an HMO, PPO or government program, and those who are "rationed-care rejects" will be pushed into hospice. The government will find a way to make sure the counseling sessions or a simple conversation of some sort will take place in order to get the advanced directives or P.O.L.S.T. forms completed.

One way or another, the elderly will be told, "hospice and palliative care is the 'right' choice for you!"

**The Media Loves Hospice**

People might wonder what I mean by saying "the media loves hospice." It's clear the editors do. After seeing thousands of positive "feel good" articles written about the wonders of hospice and palliative care, and knowing personally about many of the types of problems that exist, hearing about them from families and health care professionals, knowing about so many family members who have been unable to get a newspaper to cover their complaints about hospice, knowing that there are many documentable cases that the media has refused to mention, it is clear to me that "the media" chooses to promote an unrealistically positive image of the hospice industry while completely censoring accounts of the serious problems that are
occurring all over this country.

I know there are problems in the industry just as serious as those found say, in the nursing home industry. It's not like the people in the hospice industry are "perfect" and incapable of errors or causing problems. Yet, that is the impression one would get from the major media's coverage of the industry for decades. However, knowing that the people in hospice are human, imperfect just like the rest of us in any industry, there are problems, there are errors, there are terrible problems that need to be exposed and corrected.

The media has published many, many articles detailing major problems in nursing homes. They've sent out investigative reporters to put a story together. They've done undercover investigative pieces. Why haven't they chosen to do that with hospice?

Hospice is the "sacred cow" of health care and criticism of it is discouraged, strongly. High-level editors in the media know not to release information damaging to hospice's reputation. Actually, negative news about hospice is censored by every level of the major media. Years ago, I used to try to reach the media and have them cover these urgent problems and publish stories about what's really happening in hospice. After a while, I gave up, realizing they weren't interested in investigating or covering the story. It didn't matter if we had physicians or nurses who would go on record about the issues. It didn't matter if there were autopsy results showing a morphine overdose caused death. Facts didn't matter. They weren't interested.

Yes, many reporters have called me through the years and many stories have been printed, but after they "pick my brain" for a few hours, sometimes for several days, they end up printing a "fluff piece" promoting hospice and throw in one quote of mine leaving out the main points I discussed with them.

In 1998 when I contacted them and provided detailed information, AARP's magazine editors were not interested. AARP's editors would not broach the topic of hospice fraud or imposed deaths (though they later interviewed me a couple of years ago about some other aspects of hospice care published in their AARP newsletter).

The media sometimes doesn't know what they're going to get, especially if they contact Hospice Patients Alliance. They wanted something of interest, but got more than they wanted to handle. For example, years after I gave up trying to get the media to listen, ABC TV's Diane Sawyer's Primetime Show producers had their investigative reporter (Tami Sheheri) contact me. In 2007, NBC TV producer Alan Maraynes called me. It was his idea to investigate these problems since he had seen some things for himself, and he then had his investigative reporter, Maite Amorebieta, contact me. The Washington Times had reporter Dan Gabriel contact me.

In each of these cases, the investigative reporter would interview me and several families who had their loved ones killed at a hospice. The reporters told me they had investigated and confirmed the details and were going to their editors. Dan Gabriel spoke with me many times and said he had completely written his story and was submitting it for publication. But just as in the other news outlets, after two months of investigating, more or less, the editors killed the story. They just shut it down.

As this has happened several times, and it may be hard to believe, that the media is censoring such an important story, I am showing here a copy of an email from NBC's investigative reporter, Maite Amorebieta. Here is proof that NBC, as just one example, was investigating the story:
-- Original Message --

Subject: RE: the Mary Morris case, now being investigated by the Justice Department accdg to Vickie Travis
Date: Wed, 9 Jan 2008 18:43:47 -0500
From: Amorebieta, Maite (NBC Universal)<Maite.Amorebieta@nbcuni.com>
To: rpanzer@hospicepatients.org

Hi Ron,

Thank you for all your tips. [REDACTED]

Please know I am keeping a list and will follow up with all your gracious and courageous people who are willing to share their tragic stories.

Also, this is very much a long term story that we are interested in investigating, so please continue to send along your thoughts.

We hope we can get to the bottom of this

thanks and best

Maite

-----Original Message-----
From: Ron Panzer [mailto:rpanzer@hospicepatients.org]
Sent: Saturday, December 29, 2007 1:55 PM
To: Amorebieta, Maite (NBC Universal)
Subject: the Mary Morris case, now being investigated by the Justice Department accdg to Vickie Travis

Hi Maite,

Hope you had a wonderful Christmas Holiday!

Here is some information on the Mary Morris case, forwarded to us by

Vickie Travis.
- Ron P.

********************
The family is trying to get an investigation regarding the murder of her mother - Mary Morris of Fresno, California. Mary had rheumatoid arthritis and for a short time was in Beverly Healthcare. Mary was a Private Investigator and worked with the police. She was documenting illegal activities when she was suddenly killed with muscle relaxants according to the autopsy. Mary was 61 years old. Currently the family is attempting to obtain the phone records to the Fresno PD as Mary was in contact with them prior to the overdose.
The pathologist in this case was told to not contact DEA by Detective Hernandez of Fresno PD. This is the same detective that refuses to investigate the Harmon arsenic murder case.

And here is proof that they stopped investigating the story:
Hi Ron,

I understand your frustration and oftentimes share it.

We are not pursuing this project right now at all.

If you do have significant developments, please do let me know and I can run it by my bosses again.

Thanks for reliving the heartbreaking stories for me and for all of your insight.

I wish you the best of luck
Maite

Hi Maite,

Thanks for letting us know. If it is at all possible to tell us, has the story been stopped completely, or is it that you are simply working on other topics. Do you anticipate that it may be restarted in earnest in the near future?

We have been through this so many times, and it is so sad that no major network has been willing to do the story, even though there are literally thousands of cases of problems in hospice each year, and yes, anguished complaints of loved ones being intentionally killed within hospice, or other problems. We never hear about it.

I hope that some day, the media will shine a light on this topic, as the media is the real protector of the public when the government will do nothing.

Thanks again!

Ron Panzer
Pres., Hospice Patients Alliance

Some may say that there "isn't enough proof" for the media to publish the story, but there are
families with medical records, autopsies and proof of what happened. If editors wanted more proof, they could keep investigating and get what they need. They have chosen not to! They have done exactly the opposite of what is needed. They have refused to distribute the information they already have. The managers and editors of the major media have demonstrated they don't want to find out what the truth is. They know the truth already, and are avoiding it like the third rail of journalism. I imagine they know that if they actually print the truth and let it out to the public, they may lose their job.

There are thousands who know what is going on. Any doctor in America knows what can happen. Attorneys know what can happen. Families and health care professionals stand ready to go on record. I can't imagine a more urgent public-interest story about the health care industry than this, yet the investigations are just shut down.

The well-respected Cokie Roberts is just one example of a journalist who is an annual participant in national conferences promoting hospice. One of the only news outlets to investigate and then print something negative (and true) about hospice was the Washington Post and Chuck Babcock knew what he wanted: he wanted to learn about fraud and exploitation at hospices and as we've seen, he got what he came for. The other news outlet was CBS 60 Minutes II in 1999 in their article, "A Question of Homicide." For over twelve years, nobody in the major media has even touched the topic at all, not even CBS!

**Some Surgeons and Doctors Love Hospice**

Who else loves hospice? They won't tell you, but surgeons love hospice. It's useful from time to time. Well, only if they screw up and have a potential lawsuit against them for malpractice. You don't think surgeons would lie outright to patients? Well, ethical ones wouldn't, but you know, every industry has some unethical individuals who might lie and surgeons are no different (even though we wouldn't wish to believe it).

I have witnessed surgery where the patient was sent in because another physician said he had cancer. When the surgeon opened the patient up, he muttered (and we all heard it), "oh, S____"). He saw that there was no cancer, but because he feared a lawsuit, he took part of the organ out, sent it to the pathologist who confirmed there was no cancer, and they sewed the patient back up.

His conversation with the other doctors in the surgical suite indicated that he felt, "if I don't operate, it will be something hanging over my head" and the patient might come back years later to sue him, because he "didn't get the cancer out," when he could have. It was all based upon fear of litigation, not good medicine, and it certainly wasn't good for the patient. I'm sure he didn't go out to the patient and say, "I just removed part of your____, even though there was no reason to do so." I'm sure he just said, "the surgery was a success!"

So, what do some surgeons do when things go terribly bad in a different way, when they mess up the surgery? Some lie to the patient and family and say, "we found lung cancer" or whatever, and your "Uncle Joe only has six months to live." They dump the patient into
hospice. Hospice has been a real career saver for some surgeons.

Joe goes home to hospice care or straight to a hospice free-standing facility. The hospice staff, believing Joe really has cancer, start medicating him with morphine for the certain pain his "cancer" would cause. They don't understand that the pain Joe is experiencing is from the surgery, whatever went wrong then, not from cancer. Guess what? Joe dies. No lawsuit. Problem solved.

If the family later requests the medical records and wants to sue? Charles Phillips, MD reveals that the hospital may stall for time, delaying so long that the statute of limitations is passed, or sending incomplete or improperly copied records so vital information is not disclosed. [USA Today, "Patients often struggle for access to medical records" 4/29/2008]

Through the years, I've had calls from families whose loved one was found upon autopsy to never have had any cancer. They were placed in hospice because a surgeon told them the patient had "inoperable cancer" and died supposedly from that (nonexistent) cancer there very soon. The cause of death listed on the death certificate? "Lung cancer" or something like that. The real cause of death? Hospice care. Not Cicely Saunders' hospice care. Not pro-life hospice care, but Florence Wald's and Ira Byock's and Timothy Quill's type of hospice. The type of "hospice care" the Euthanasia Society of America would endorse. The type of "hospice care" the National Hospice & Palliative Care Organization (the Euthanasia Society's successor organization) would approve and says nothing about today.

**Hospital Administrators Love Hospice**

Who else loves hospice? Those administrators running the hospitals. If hospital staff can save someone and look successful, great! Years ago, acute care hospitals did everything imaginable within the realm of medical possibility to save the patient. They were out to prove what they could do. Progress was saving the patient's life.

Now, it is, and it's not. If something goes wrong, or if they simply can't save the patient, they make sure to dump the patient into hospice care before the patient dies. Even if it's not a surgical error, perhaps a medication error that caused irreversible damage, they can use hospice to solve their "problem." "We're sorry, there is nothing we can do, but hospice can help. You've heard of hospice, haven't you?"

Why would the hospital administrators want to get rid of the patient? Can't they bill for another day or two while the patient goes downhill? In some cases they can, but if the patient represents probable unreimbursed or incompletely reimbursed services, the hospital is losing money and they'll refer to hospice. A December, 2001 NHPCO/CAPC report, "Hospital-Hospice Partnerships in Palliative Care; "Creating a Continuum of Service" admits that "Hospitals and other healthcare providers are beginning to appreciate the positive financial impact of avoiding costly end-of-life activities at their institutions, and have been more open to early admissions by hospices." In addition, when patients leave for hospice, they don't die in the hospital, improving the hospital death rate statistics. Hospital death-rate stats are important criteria in rating hospitals, even if they're bogus stats.

So, if fewer patients die in the hospital, they "must" be providing superior care. They "must"
have improved the quality of their care. They "must" be really "top-notch." At least it looks that way on paper and in marketing. Higher success rates and lower death rates translate into big bucks in donations, grants and prestige, ... all things the bigwigs running the hospital care about.

Even if there is no malpractice, hospitals may use hospices to take on patients who have been denied treatment by the hospital ethics committee (sometimes called a "futile care protocol committee." In cases where the patient wants care, but the hospital doesn't want to continue to provide care, the patient has a limited amount of time to find care at another facility. Often there is no other facility and the patient is going to be discharged. Where to? Hospice. Treatment denial equals very imminent death.

**Nursing Home Owners Love Hospice**

This may be confusing to some, but residents of nursing homes can be "enrolled" in hospice at the same time they are living at the nursing home. It actually isn't that complicated; the hospice assumes the primary provider role and coordinates the end-of-life care for the terminally ill patient. As primary provider, the hospice gives some of the funds received from Medicare, Medicaid or private insurance to the nursing home.

Why would nursing home administrators and owners love hospice? Well, nursing homes have been under a lot of scrutiny for decades. Their regulations are much stricter than hospice regulations and cover just about every aspect of running the facilities. When a patient needs higher doses of opioids like morphine, staff at a nursing home may be afraid of administering large doses, especially if they have not had much experience with the dying or managing their pain. Good hospice staff can educate the staff at the nursing home about how to give these medications and how to manage different problems that arise with patients at the end-of-life.

If a patient at a nursing home develops severe health problems, hospice can be called in. If the patient had developed severe stage IV bedsores (decubitus ulcers) due to neglect, having hospice come in can help the nursing home escape detection. If the patient dies fairly soon, the evidence (the patient) is destroyed, often through cremation.

Another reason nursing home owners love hospice? They have long waiting lists, and patients may wait two, three years or more to get into some facilities. When hospice is called in, a patient's death may be hastened, and a bed is opened up for those on the waiting list. Being able to say that they can accept new patients when needed is good public relations. Making patients on the waiting list, and their families, happy is also good public relations.

But on the financial side, nursing homes are constantly looking at their revenue stream, just like any business. While there are ways to safely "spend down" one's retirement funds to avoid having to pay them out to a nursing home, and have Medicaid pick up the tab, many people fail to make the proper arrangements. Nursing homes have private pay patients and Medicaid patients. While you will hear that there should be no difference between the care provided to private pay patients and Medicaid pay patients, the factor not mentioned is "what" facility the resident enters. Those with very large retirement accounts or adequate long-term care
insurance may be able to choose a facility that has exquisite qualities.

What happens when the resident spends enough of their private funds or insurance benefits to qualify for Medicaid? Well, Medicaid takes over. However, Medicaid payment rates are usually low, so the nursing homes rely on revenue from private paying residents and any other sources to cover costs. In other words, a resident who moves from "private pay" status to "Medicaid pay" status can change from a "revenue-positive" resident to a "revenue negative" resident. Are "revenue-negative" residents the most "desirable" type from the financial perspective? Clearly not. And with states facing:

"a collective $55.4 billion shortfall in fiscal year 2011, and a combined $136.1 billion in deficits over fiscal years 2010 to 2012." This is simply not an eldercare financing crisis that can be papered over or pushed to the policy back burner."

[From The National Association of State Budget Officers, reported by Alan G. Rosenbloom, president of The Alliance for Quality Nursing Home Care]

"...Rosenbloom observed, "The fundamental health policy dilemma requiring resolution is the fact Medicaid is almost wholly dependent upon Medicare and other funding sources to augment its increasing inability to adequately serve vulnerable populations in need of care. Coupled with federal Medicare cuts and regulatory changes totaling nearly $27 billion in funding reductions over 10 years, there is no light at the end of the tunnel for seniors and those who provide their care."

["Popular support opposes funding cuts" by Bob Gatty, August 2010; Long Term Living Magazine]

OK, so what happens? Medicaid doesn't pay enough. The residents don't have any more funds. The facility/corporation wants to "optimize" their income stream. What to do? Call in hospice if there's any possible scenario the resident qualifies. Hospice can serve as the "clean up squad" and remove residents that are no longer "desired," for whatever reason. Sounds cold, and it is, lethally.

We know that there is widespread abuse, neglect and even direct harm to residents at times, at many nursing homes. Marie-Therese Connolly, J.D. a lead prosecutor for the U.S. Justice Department, has written:

Historically, law enforcement rarely has been involved in matters relating to abuse and neglect in long term care. Reports of grave and wide-spread abuse and neglect in such facilities have persisted for decades, receiving attention in fits and starts. Despite some improvements over time, recent reports continue to cite serious ongoing problems, including that an estimated one third to one quarter of nursing homes provide seriously deficient or potentially life-threatening care; that almost one third of all nursing homes are cited for abuse-related deficiencies; and that an estimated 50% to 90% of all nursing homes are understaffed at levels that have been shown to harm residents.

["Federal Law Enforcement in Long Term Care" University of Maryland Journal of Health Care Law and Policy; 4 J. Health Care L. & Pol'y 230 (2002) by Marie-Therese Connolly, J.D., Senior Trial Counsel, U.S. Dept. of Justice, Coordinator of the Department's Nursing Home and Elder Justice
When abuse, neglect or harm to a patient is discovered by management, they have a few options. They can report their own violations of the law and standards or they can cover it up. Are they going to report themselves? Absolutely not! What to do?

As we've seen, nursing homes and hospices have been found in some cases to have kickback arrangements with each other that work out financially to their mutual benefit. Since nursing homes are subject to more scrutiny than hospices, and they are also subject to more lawsuits than hospices (hospices have almost no lawsuits against them because attorneys refuse to take these cases), what better way to cover up for abuse, neglect and actual direct harm to patients, than getting hospice in there as quickly as possible after an incident and hastening death, preferably with the patient's body being cremated to destroy evidence? There are reports of such scenarios. Some of the "nonterminal" patients that research shows are enrolled in hospice must come from this "undesired resident" group.

**Guardians Love Hospice**

There are others who love hospice. Guardians! At least the plentiful supply of estate-plundering guardians who bill at exorbitant rates for this or that and who generate a truly healthy income for themselves. Plan: get guardianship, siphon off the money, and send dear old whomever off to hospice ... time to move on to another victim. The supply of vulnerable victims is almost endless, especially now with the baby-boomers aging into senior status. **Some guardians are taking advantage of their power.**

"Over the years, a growing uncaring and unjust judicial system has helped convert guardianship/conservatorship from an appropriate law to one which, if misused, is **damaging to the general public.** At present, it operates to ensnare the most vulnerable people in a larger and larger trawling net, now including those merely physically "incapacitated"! it has become a feeding trough for unethical lawyers and other "fiduciaries" appointed by the courts to protect, but many of whom become nothing more than predators."

Wards, instead of being protected by the system, are victimized by it. Strangers are given total and absolute control of life, liberty, and property of their wards. Wards of the state lose all rights involving self-determination, including:

- the right to contract, including the right to choose a lawyer;
- the right to control their assets and make financial decisions;
- the right to remain in their own home and protect it from sale;
- the right to protect and enjoy their personal property;
- the right to choose where to live;
- the right to accept or refuse medical treatment, including psychotropic drugs;
- the right to decide their social environments and contacts;
- the right to assure prompt payment of taxes and liabilities;
- the right to vote;
- the right to drive;
- the right to marry; and
"After being stripped of all their rights, wards are left defenseless and subject to exploitation by the very people chosen to protect them; they are now invisible and voiceless."

"Uncaring/corrupt judges misuse the law and engage in blatant due process, civil/human rights violations. Victims aren't always given notice of hearings at which their competence will be adjudicated, aren't always allowed to attend, and often don't have lawyers. If the court does appoint lawyers, often they are too closely affiliated with other professionals who make their living in this special area; and do not properly represent the victims' interests. Corrupt judges do not apply the required evidentiary standards in making adjudications of incompetency, and frequently fail to obey the protective statutes, or include specific findings of fact.

Homes are sold to insiders at below market! Contents - family heirlooms, jewelry, photographs, etc. - disappear, either stolen outright or sold at auction. Estate assets are rapidly paid out to the fiduciaries in exorbitant "fees" and "commissions" until there is nothing left!

"Fiduciaries" are given power of life and death, burying their wards in nursing homes where they are kept chemically restrained with unnecessary and dangerous drugs; family members are denied any say in their care, and sometimes denied visitation, except under guard at their own expense!" From: StopGuardianAbuse.org

I have heard of similar stories for years, and I'm not the only one. Every patient advocacy organization in the country has heard about the guardianship scams and the terrible exploitation of the vulnerable. Again, the Terri Schiavo case is a classic.

Here was an abused woman who was denied rehabilitation. Nurse, Carla Iyer has testified she often:

"... witnessed Terri say, "Mommy, help me", and "pain", and would also interact with the nurses and visitors. Iyer maintained that there exists over 4 hours of videotape from '95 and '96 proving this, but that it was placed under gag-order, including her own testimony about Michael Schiavo's treatment of Terri."

"...[Iyer also] informed the police and her superiors of Palm Garden of Largo Convalescent Center in Largo, Florida that she believed Michael Schiavo attempted to kill his wife with insulin injections. She claims she discovered needle marks on Terri, and found that Terri's blood sugar was so dangerously low that her levels would not register on a glucometer."

["Nurse Who Testified Against Michael Schiavo Has Nursing License Revoked" by LifeSiteNews.com Jun 30, 2006] The nurse appealed and later the board of nursing found she had done nothing wrong. Her license was returned to her.

For years, Terri was isolated and was denied visitors except her family. The money won to provide her with lifelong care was used to pay lawyers to help have her life ended in the
I know there are major problems with the system. Friends of residents in various facilities not only grieve for their friends, but are outraged that this society tolerates these abuses and crimes. They are outraged that society, by doing nothing, in effect condones them. This is clearly understood after police, district attorneys, and the rest of the government choose to do nothing significant to change the system. The ongoing abuse of the elderly residents of nursing homes has long been documented. Article after article have been written about horrendous conditions in one facility after another. Congressional hearings have been held regularly decade after decade with no reform of the industry.

"The law protects children from neglect that results in death, but is nearly silent on similar cases involving the elderly"

The state Legislature, more than a decade ago, recognized that neglect of children that results in death is a more serious crime than a misdemeanor. Lawmakers amended the law to make such cases a second-degree felony carrying a 10-year maximum sentence. That charge would be in addition to murder or manslaughter charges neglectful adults could possibly face in such cases.

That no such protection exists for the elderly seems like a serious hole in the law. Current elder abuse laws address only neglect by caretakers paid to care for the elderly -- not family members.

Elderly people who are dependent upon others for their well-being deserve the same protection under the law as children, who are also dependent upon others for their well-being."

I've also heard from hospice nurses who witnessed the plundering of patient's estates in rogue hospices, without an actual guardian being appointed. Sometimes hospices will sign up an isolated, elderly patient without notifying the patient's family. In one case, the hospice deliberately refused to contact the patient's family, listed the physician as the "family," omitted any family contact information from the medical record, and arranged to plunder the estate of the patient. They brought in an attorney to the very elderly and wealthy patient who was not legally "competent" to sign legal documents due to her dementia. Nevertheless, the attorney, with hospice administrators at his side, had the patient sign over millions of dollars to the hospice. Only later was the patient's family notified and after legal action and a settlement arrangement, the family recovered only a portion of what had been taken from the patient's estate. The hospice got to keep millions that remained. The elderly do need the protections that are afforded to children, and families need to stay in close touch with their elderly relatives in order to effectively protect them.

But the elderly do not have the same protections as children, and the elderly often do not have regular contact with their families. They can be exploited from many sides: adult children, other relatives, court-appointed guardians, health care professionals with an agenda, owners of facilities who care more about filling beds than appropriate placements, even adult protective service representatives who have an agenda. Surprising? But true. Sometimes the agency designated to protect the elderly can harm the elderly, ripping them from a loving family member who is properly caring for them and providing all they need. If hospice is brought in when the patient is not terminal, sometimes hospice care itself is the cause of death. We know that many hospice professionals will strongly object to that, but it is the truth in some hospice locations. Undeniable.
Some Adult Children & Spouses Love Hospice

There are others who love hospice. It's like the wish-fulfilling tree that gives without taking a dime. Greedy children or spouses who can't wait to get their hands on the money, the house, the estate ... love hospice! Get a doctor to suggest hospice and bingo! ... financial problems solved. It's amazing how quick they can cash in. While there are so many adult children and relatives that truly do care about their loved ones and would never consider "wielding" hospice to hasten death, there sadly are some adult children who do manipulate the system to achieve an early death for an ailing and usually very elderly parent.

Just get the legal power of attorney and you can siphon off the retirement accounts in days. If you siphon off the money before the patient dies, there is no probate to worry about. Get the medical power of attorney and you can make sure dear old Dad, or Mom, or whomever, doesn't have an opportunity to get out of the trap. Just make sure that hospice keeps him "comfortable." "Really" comfortable. Since when does being "comfortable" mean "dead?"

Since when does, "no, I don't want any morphine" mean "inject me with morphine."

Of course, good hospice staff would never give a medication that wasn't needed or that the patient didn't want. Problem is, not all hospice businesses are good. Not all staff follow the standards of care for titrating (adjusting) the dose of opioid medications. Not all honor the patient's right to refuse a medication.

Some have an agenda and are "true believers" in the idea that patients are better off dead if their quality of life is poor (in their subjective opinion). I spoke with Hospice Director, Doug A, RN who stated: he "supports a patient's right to kill himself in hospice" and that the reason why he supports that right is because he supports that right of a patient to kill himself in hospice!" He just kept asserting his belief without a logical reason to support his position.

Adult children or spouses who wish to "hurry" their loved ones along, "letting them go" as they say, certainly appreciate the strange ideas nurses like Doug A, RN have about patients killing themselves in hospice, or Stephen M, RN (the misinformed nurse) about liquid morphine (Roxanol) not being able to kill anyone. The effect of their ideas is that patients get higher doses, more frequently, and obviously, they die quite soon.

I've heard many times from family members about hospice nurses who were dosing their loved one with morphine that was not needed since the patient didn't have pain. They report that when they objected to the unneeded morphine, the hospice nurses would loudly proclaim, even yell at the family: "He's dying," thereby denying any possibility that the morphine might be causing the outward signs that seemed to indicate the patient was dying of their terminal illness. These nurses don't recognize that their own misuse of morphine (administered just because the patient twitched a toe, raised an eyebrow, or tried to speak) was killing the patient.

Yes, there are times when family members really don't understand how opioid medications are given and how they can be given safely by good hospice professionals. But, I've heard these stories from nurses and even physicians who were not able to prevent the medical killing of
their loved one (because they didn't have the guardianship or power of attorney for decision-making). *If you've never heard a physician crying hysterically about how their loved one was killed, please listen, I have.*

Adult children, relatives or spouses of the patient get what they want: death at the cheapest price. Free. They don't even have to buy a gun. They can "wield" hospice to kill. This is their quickest pathway to strike it rich. The mal-practicing surgeon gets what he wants: escape from lawsuit hell at the cheapest price. The hospitals and health systems, HMOs and managed care systems get what they want: service at the cheapest price (more profit when they don't provide other possible treatments). The guardians get what they want: elimination of the victim (potential witnesses to the embezzlement or other crimes) at the cheapest price. Another reason court-appointed guardians get what they want? The government saves money and the guardian is sometimes appointed to do just that: **eliminate the unwanted patient.**

If someone shoots an old man? They go to jail. Death by gunshot? "Horrible!"

Someone puts an elderly person in hospice with the intent that they die, wielding hospice to kill? They hit the jackpot. Death by morphine? "He did the 'right' thing!" It was "time to let go." (even though Gramps wasn't ill at all, just old).

Scary? Yes. Is it that way in all cases? No. Does it have to be that way? No, but there is a "Perfect Storm" of economic, social and moral, i.e., "immoral" reasons why things are getting worse, real fast.

Caller: "My sister killed my father by using hospice!" That from a trained Registered Nurse with two decades of experience. "He wasn't terminal!" This is part of how I know what adult children are doing to their elderly parents. They "wield" hospice as a weapon, and hospice staff in these cases, violating everything Dame Cicely Saunders stood for, willingly comply. And so it begins again. The invisible Holocaust. Nobody knows how many are killed this way. Those who wield hospice to kill aren't going to complain. Those who complain aren't being listened to. And the hospice that did everything to help kill that vulnerable father? They're not going to admit to anything. We regularly hear of falsified notes in the medical records from the families. The staff remain silent, just as some Nazi doctors remained silent during the Nuremberg trials. They don't want to lose their jobs. Or, they will say, "I just did what I was told." As if that excuses their participation in the killings!

### The Right-to-Die/Kill Crowd Loves Hospice

At those "Hospices of the so-and-so Region" that are providing good care, it won't be this way. But the trend is there. Hospice, as the industry, has been taken over by the right-to-die ("kill") crowd, and the National Hospice & Palliative Care Organization is the successor organization to the former Euthanasia Society of America. They *are* hospice, at least that's what they would have us believe. More accurately, they represent most of the hospice corporations in the country. The public doesn't know that and they don't know the connection between euthanasia and the NHPCO. Hospice won't broadcast that. No, that would be bad marketing!
Ione Whitlock, researcher for the LifeTree Organization has laid out for all to see the many details that link the two in the Timelines posted on the Lifetree website.

The NHPCO proudly announces that it has all the successor rights to Choice In Dying/Last Acts/Last Acts Partnership (later incarnations of the Euthanasia Society of America) at its "Caring Connections" Here is a screenshot of their timeline on that page:

<table>
<thead>
<tr>
<th>Predecessors of NHPCO's Consumer Program - Caring Connections</th>
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To make sure we understand that NHPCO is the successor organization of Choice in Dying, Last Acts, Partnership for Caring and Last Acts Partnership, NHPCO proudly explains all of this on the same "Caring Connections" webpage as their timeline shown above. Here is a screenshot of NHPCO's explanation on that same page:
The National Hospice and Palliative Care Organization (NHPCO), a nonprofit organization, is the leading voice for quality hospice, palliative and the broader continuum of care for people living with a serious illness. The National Hospice Foundation (NHF), a nonprofit organization and an affiliate of NHPCO, raises funds for NHPCO to support end-of-life care.

Partnership for Caring (formerly Choice in Dying) was the national program office for Last Acts, a program that was funded by the Robert Wood Johnson Foundation. In early 2004 Partnership for Caring and Last Acts were reorganized as a merged entity entitled Last Acts Partnership. In 2004, the Last Acts Partnership ceased operations. Immediately thereafter, NHPCO acquired virtually all of the physical and intellectual assets of the Last Acts Partnership.

NHPCO continued the enduring programs of Partnership for Caring and Last Acts including all the advance care planning resources. These programmatic continuations and extension were made possible by additional funding from the Robert Wood Johnson Foundation to NHPCO. With the exception of the liabilities associated with Last Acts Partnership, for all intents and purposes, NHPCO became a successor organization of Last Acts Partnership (and its predecessor entities).

Even today, NHPCO continues this work, by providing consumers with free state-specific advance directives and offering consumer support through the Helpline (two services that Choice in Dying/Partnership for Caring had provided). In addition, NHPCO works with other national consumer groups advocating for advance care planning and improved care for dying persons and their families (see www.caringinfo.org).

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION
Support for this Web site was provided by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey. www.rwjf.org

"NHPCO continues this work." Yes. That is exactly what they're doing. We've seen the direct connection between NHPCO and the Euthanasia Society of America, but NHPCO doesn't go back that far in their timeline showing the direct legal linkage to the Euthanasia Society. They show their connections going back to "Choice In Dying," something much more palatable to the public. To let the complete corporate "lineage" out would undo the results of decades-long public relations efforts that misdirect the public (selling them on Dame Cicely Saunders' vision while providing them with Florence Wald, RN's vision including the provision of assisted-suicide even for economic or social reasons). That they are using Third Way terminal sedation rather than "assisted-suicide" makes no difference. Legalization of assisted-suicide has resulted in dozens of deaths per year in Oregon for example. Terminal sedation and other means of imposing death have easily resulted in over 100,000 deaths per year. It's "bait and switch." Truth sometimes doesn't sell well when you've got a dirty secret to hide.

The members of the World Federation of Right-to-Die Societies demonstrate their love for hospice by naming the National Hospice & Palliative Care Organization website on its list of "right-to-die" websites. It can't be more obvious that they recognize mainstream secular hospice and palliative care as working to further their goals.

With respect to the so-called "right-to-die," I see that often it is the right to end a life. In the United States, the Last Acts Regional Rallying Points center, Hospice of the Florida Suncoast was the hospice that carried out the order to end Terri Schiavo's life.
I ask, "What was Terri Schiavo's crime that her life had to be ended?" The Schindlers were willing to care for her forever. Money was not an issue since there were wealthy people who pledged to pay for her care. No, the guardian, a/k/a "husband" wanted her dead, publicly saying "she didn't want to live that way," but one girlfriend, Cindy Shook testified that Michael told her that he had no idea what Terri wanted. She also described his bizarre controlling, angry, and abusive behavior, and that he had stalked her and ran her off the road. He is described as having episodes of terrible, uncontrolled angry outbursts. That's Cindy Shook's experience with Michael Schiavo.

Trudy Capone's sworn affidavit states the same: Michael stated repeatedly that he never knew what Terri would have wanted.

I mention the Schiavo case many times, because it is the most well-known hospice killing case of our time. It contains all the elements of a typical guardianship abuse case and the use of the patient to further the aims of the euthanasia movement. It also demonstrates the role of the courts and the legislators to facilitate the killing of the vulnerable. It is the case that tipped the scale for many Americans in favor of imposing death upon the vulnerable cognitively-impaired, or others. Just look at the major media's coverage and the large percentage of the public that therefore favored ending her life. You can say that Michael Schiavo used the hospice and attorney Felos, but Felos and the hospice used him and Terri as well.

We cannot underestimate the effect the Schiavo case had on the public. People saw that and later on said to themselves, "if they did it with Terri, I can do it with dear old Dad," or "Mom" or "Grandpa," "Grandma ...." It showed them the way. A long drawn-out lethal soap opera played out for all the world to digest. It's similar to the "lesson" Bill Clinton taught the younger generation about oral sex: "it's not 'real' sex." "The President said so!" Really? Well, many young men and women today believe Bill, and their behavior reflects his casual attitude toward it all. When such widely-covered stories are imprinted on the younger generations, it affects their values and beliefs. The Schiavo case was a great victory for the euthanasia movement, legally, publicly, and generationally. The medical killing all happened within hospice! And just like Bill Clinton’s “lesson” for the world, the euthanasia proponents have taught that hospice killing is “not real killing.”

I will never forget the anguish, the sadness in Bob Schindler's voice as he spoke to me, father to father. Why should a father ever have to be put in the position of seeing his own daughter killed through dehydration and not be able to do one thing to stop it? I know that with Terri's medical killing, a part of Bob just died. He was a man of faith, but faith does not erase what was done to Terri and to her family. It helps those who remain, go on, and work to prevent such tragedies, as her family has done. The Terri Schiavo Life & Hope Network works to protect the vulnerable around our country and has helped many.

Bob Schindler died Aug. 29, 2009, but it seems like yesterday. The media never printed much of what the Schindlers really said about some of the details of Terri's condition and Michael's actions. They limited their coverage, stating as authoritative euthanasia advocate Felos' statements, and continually implying that the Schindlers were "in denial" about Terri's condition.

It seems like yesterday when the woman Terri Schindler Schiavo was executed. If I wrote, "such and such" young woman was gunned down March 31, 2005," people would be shocked and horrified. If I write that "Terri Schiavo" was gunned down March 31, 2005, people would shrug their shoulders and say, "She was brain dead." "She had a heart attack, a "collapse," an "eating disorder," "she couldn't communicate or respond." All of those statements were untrue.

We should remember what Bobby Schindler, Jr., Terri's brother, said upon seeing Terri on the
floor of her apartment February 25, 1990:

"When I got to Terri, she was face down, arms bent under her torso with her hands up by her neck, lying in the hallway. ... I could hear her breathing, almost like she was snoring ... loudly."

Yet, Michael Schiavo has stated repeatedly that he found her "face up," and held her, but the police report clearly states the paramedics found Terri face down, just as Bobby Schindler, Jr. reported. Why would she be "face down" if Michael had attempted CPR if she had had "heart failure" or if "her heart stopped" as was widely erroneously reported? Why would her hands be up by her neck? Why was Michael clearly "nervous" and terribly "frightened" when the paramedics arrived.

[from the book: Our Fight4 Terri, p 19,20; Ford & Craddock]

The only facts that are undisputed by all sides is that Terri Schindler Schiavo had no neck injury before her "collapse" on February 25, 1990 and after February 25, 1990, she had a permanent neck injury that made it impossible for her to move her head much to one side. Her father, Bob Schindler said that the "medical evidence [shows] that she had a neck injury. And as the doctor said, she had no heart attack. And her ribs and parts of her body suffered fractures." You just don't get such injuries from "collapsing" in your own apartment onto the floor.

Terri had many specific injuries, including a posterior rib fracture which is universally considered a "red flag" that abuse and trauma has occurred. Fracture of the ribs toward the back of the body ("posterior") is known to occur with abuse and trauma. After extensive medical and forensic analysis, a description of exactly how all Terri's injuries could have occurred is given starting at page 373 of the book, Our Fight4 Terri by Ford & Craddock. The explanation is the only one that makes sense taking all her injuries into consideration. It includes known behavior patterns of Michael Schiavo, such as in years past, coming from behind and putting his brothers into "head locks" with his arm bent around the neck.

One physician, "after studying the bone scan (world-renowned forensic pathologist Michael Baden) posed an explosive theory on Fox News Channel's "On the Record" hosted by Greta van Susteren. WorldNetDaily reported Baden, who is co-director of the Investigative Unit of New York State Police in Albany and former chief medical examiner for New York City, ruled out potassium imbalance and a heart attack as factors in Terri's mysterious collapse and pointed to head trauma and bone injuries as a more likely cause."

"Neurologist Hammesfahr testified in the 2002 evidentiary hearing that Terri was admitted to the hospital after her collapse with a "suspiciously rigid neck" and that he'd only seen "this peculiar constellation of injuries," referencing her rigid neck and cardiac arrest, in a case of attempted strangulation."

I've spoken with some of the nurses who cared for Terri in the years she was at the nursing home. The case is in the public domain. Everything's been discussed at some point somewhere. Some of these nurses spoke to me as well as under oath about the malevolent air around Michael Schiavo Nurse Sauer-Iyer explained he forbade basic range of motion. Like many reports I get from families around the country, he is an example of a spouse who used hospice to end his wife's life. Nurses and her parents say he attempted to end her life in the nursing homes years earlier, sometimes through refusal to treat easily-treated infections.

Nurse Carla Iyer and other staff feared losing their jobs, because the nursing directors had told
all the staff that if they did anything at all to displease him, they'd be terminated. Heidi Law, C. Johnson, LPN and Carla Sauer Iyer, RN described bizarre interactions with Michael Schiavo

In December 2003, January 2004, I interviewed nurse Carla Sauer Iyer, along with Terri's sister Suzanne Vitadamo and Cheryl Ford, RN about the "The Conspiracy to Kill Terri Schindler-Schiavo" on the Highway2Health internet radio show. Iyer found that Terri's blood glucose level was undetectable after a visit from Michael and only with her intervention was her life saved. The day after nurse Sauer-Iyer reported to the police that she found needle marks on Terri and that her glucose level was so low it didn't register, she was fired from the nursing facility! So much for whistleblower protections!

Many nurses objected to the many things he did and how he treated Terri. Even though Iyer made a report to the police about Michael's interactions with Terri, the police did nothing. She testified that Michael would be thrilled if Terri had an infection and stated he was "going to get rich." The idea of inheriting when the guardian's ward dies is common. It is also common in the case of many adult children of the vulnerable.

In 2000, when Michael had her transferred to the Woodside hospice facility of the Hospice of the Florida Suncoast, denial of rehabilitation continued. Violations of the standards of care and the law continued. I'm sorry to say that if nurses had truly objected, they could have left the hospice, but they stayed and participated in it and are therefore also partly responsible. Otherwise, you could say, "nobody" was responsible, because they were "just doing their job," just as we know that on a much larger scale, nurses and doctors actively participated in the euthanasia campaign during Nazi Germany's T-4 euthanasia campaign.

Robert Jay Lifton documents all of this in his book, "The Nazi Doctors: Medical Killing and the Psychology of Genocide. There were many Nazi physicians and nurses who said they were "just doing their job," or they "had to do it," but there also were nurses and doctors who believed in ending "lives unworthy of life."

I've got a lot of reasons to be concerned about the welfare of good staff, patients and their families in this country. There are a lot of things happening that endanger them in one way or another, and I haven't mentioned all or even most of them. With regard to the Schiavo case, some things you just don't print, and so there are other things that have never been printed anywhere about the case, that are not in any affidavit or record at all.

There are still unanswered questions. For example, what happened to the two EMS workers who originally found Terri? Where is their account of what they really saw and what they really think about the case? Why were injuries to Terri's neck and bones not investigated by the police? When I interviewed Dr. Hammesfahr, January 2004, he stated Terri never had a heart attack as widely reported in the major media, she also never even had a cardiac arrest (her heart never stopped)! Dr. Hammesfahr also stated that Terri had marked injury to her neck and an L-1 injury to her spine, which he stated is common among persons being thrown against a table. Almost nothing about the case followed what would be considered a normal police response and investigation.

Did the Associated Press ever publicize Terri's injuries? the wide range of broken bones and trauma that was noted in her medical records? The posterior rib fracture which is a clear sign of abuse and trauma? No. Or that Terri wanted a divorce and that there was a huge fight the night of her "collapse"? Or that friends saw "pinch marks" on Terri? No, the public never learned about that. Did the police ever seriously consider Michael Schiavo as a suspect in the neck injury to Terri Schiavo? No. Why not? The only source that provides all of the testimony of expert witnesses, relevant medical records and never-before revealed details about the case is included in the book by Cheryl Ford, RN and J.E. Craddock, DDS, Our Fight4 Terri. Terri's
Family has now released a moving documentary account of *The Terri Schiavo Story* on DVD, hosted by Joni Eareckson Tada.

Though the major media had access to all the police reports, medical reports, hospital medical records and sworn affidavits of numerous nurses, doctors and friends of both Terri and Michael, they went with the story line given by euthanasia proponent and attorney, George Felos, Michael's attorney. The *Associated Press* repeated literally thousands of times (considering all the articles printed) absolute falsehoods that are easily disproved upon an even cursory review of the records. Why would they do that? Isn't it obvious? The "fix" was in; she *couldn't* be allowed to live. Terri's case was the next step for attorney Felos (chairman of the board of the hospice) and hospice CEO Labyak to implement much more widely-practiced "Third Way" killing within the hospice setting, ridding society of those they deemed to be "unworthy of life." This "next step" killing was done by a hospice leader (Labyak) who sits on the NHPCO board, at the hospice named as a Last Acts regional Rallying Points leader, representing the national mainstream hospice industry and “sold” to the public with very slick and endless misrepresentation of the facts.

> "All effective propaganda must be limited to a very few points and must harp on these in slogans until the last member of the public understands what you want him to understand." - Adolf Hitler

Let's look at Bobby Schindler, Jr.'s experience with Michael:

> "One experience that I had with Michael was at the beginning of his relationship with Terri, around 1984. ... we got into a very heated disagreement in the family room ... I remember distinctly that Michael got so upset that he suddenly snapped, and grabbed me by the throat and threw me down on the couch, had one hand around my neck and the other was in the air ready to punch me in the face. I couldn't move and I don't know what would have resulted if it weren't for Terri and my girlfriend screaming at him to let me go.

> ".... I often wonder what would have happened if I would have paid more attention with what happened that day."

[Our Fight4 Terri by Ford & Craddock, p 122.]

Those who think they know about her, that she had "no brain," do not understand that experimental surgically-implanted platinum electrodes were left in her brain for several years with [per Michael Schiavo] no follow-up care or maintenance (or removal) and that contrary to all standards of care no effort was made to manage a consequent hydrocephalic condition which would tend to make her deteriorate even further through the years. Radiologist Thomas Boyle, MD states that CT scans show all the classic signs of hydrocephalus, with pressure from fluid buildup pressing on her brain, yet, her guardian chose not to have it relieved. He chose to forbid rehabilitation and to have her life ended in hospice. This type of failure to provide rehabilitation is typical of many guardianship situations.

It is exactly this type of decision to end life rather than care for the disabled that is the road the NHPCO and its leaders like Mary Labyak are taking this country down. They not only want to make it possible to end the lives of those "unworthy of life," they want to change how hospice provides end-of-life care. They want to change how Americans die, how you or I die.

Hospices involved in hastening the deaths of those they consider "lives unworthy of life" won't call it killing, but the result will be just the same: the patient will die, but not from a terminal
illness. This case has disturbed and horrified good hospice professionals all over the country. They can't believe it happened in hospice, don't want to believe it, but it happened undeniably in full view of the world.

It's something so widely known it's inescapably true that hospice can kill a non-terminal disabled woman. You wouldn't know that from the slant the media gave to this story. They never emphasized this was a hospice killing. They mentioned that she was at the Woodside Hospice facility. The implication was that Terri was on life-support when all she was "on" was food and water through a tube-feeding.

Hospice nurses who send me angry letters saying that "hospice doesn't kill" have chosen to forget Terri and that she was killed in one of the most famous, biggest, most powerful hospices in the country, the Hospice of the Florida Suncoast. They forget the anguish of her mother and father Bob & Mary, her brother Bob Schindler, Jr. and sister Suzanne. I never will. We must never forget. Otherwise, it will just get worse. It is getting worse, and we keep hearing from family members whose loved ones were killed by hospice staff, often with a family member's encouragement!

Those who say that discussing the Terri Schiavo case is "rehashing an old case," don't understand what it was all about. It was, and is, all about making the ending of patients' lives in hospice the new "normal," the routine protocol. According to the sworn affidavit of Trudy Capone among others, Michael Schiavo admitted Terri never told her she would rather die than live like that (even though Michael said he was fulfilling her wishes by having her killed). Yet, her court-ordered execution was based upon the assertion she had told him she would not wish to live in that condition. The case demonstrated that all a surrogate decision-maker or guardian has to do is say the patient "did not wish to live like that," and the courts will approve his or her execution through removal of food and water, often while sedated (Third Way killing). Euthanasia by another name, just as lethal.

**IX - HMO/Managed Care Approach to Hastening Death**

You've heard the saying, "the devil's in the details," right? Well, sometimes we have to pay attention to the details to understand how things are manipulated to reduce costs, increase profit or, in the case of Medicare and Medicaid, reduce expenditures. What has happened in HMOs hasn't stayed in HMOs. In other words, health care systems, whether PPO, HMO, or other, have been watching what HMOs have done to reduce costs. At any one time, there's only a small percentage of members in a PPO, HMO or other health system arrangement that require services for serious illness. Reducing services without the public knowing is the name of the game. How do they do it? And how does that relate to hospice and palliative care? We'll find out here, but I'm asking you to be patient and pay attention to some details, to digest them and realize how incredibly damaging some tactics of HMOs and managed care can be to you and your family. Whether you are enrolled in an HMO, PPO, or government program, you may be confronted with these tactics.
Delayed Access

Well, if you can't get in to see the doctor, that's a start. For example, "Kaiser Made It Hard to See an MD, Critics Say" Its own internal documents showed it was making it hard for patients to see the physician. Hard to believe, but: "Kaiser-Bellflower[HMO]'s policy was to keep patients waiting in the emergency room until they left without treatment," "… between 1999 and 2006, more than 5,000 patients were sent home without receiving medical screening exams." Delayed access, delayed treatment, greater likelihood of more severe illness and consequent serious, even terminal illness! That is how it works.

Fabricated "Normal Ranges" To Avoid Treating You

If you do get in to see the doctor, and he orders tests, can you rely on how he interprets the tests? Maybe, maybe not. You may need to go online or to the library to refer to a medical dictionary's reference tables for standard human lab values. Some HMO's "create" their own "normal" ranges out of thin air. Charles Phillips, MD reveals "The Manipulation of HMO Medical Testing" showing how treatment can be delayed by widening the stated "normal" ranges so high or low "normals" (actually abnormal lab values) are excuses to do nothing when the patient has a serious condition. See "Kaiser: Misinforming the Public About "Normal" Human Lab Values to Limit Treatment and End Lives" below for more details.

Business tactics Used to Limit Treatment

Linda Peeno, MD reminds us in her article, "The Second Coming of Managed Care" that "Twenty-first century managed care is best defined as the organizational practices of any health care entity using business strategies to influence or control access to and availability of medical services for economic gain. Patients can become victims of systems that lead to too much care as well as too little, and they now risk danger from corporations as much as from individual agents.

This should not surprise anyone, since the provision of health care, from for-profit insurance companies to nonprofit government organizations, still works on a simple principle: Financial success and "savings" depend on maximizing the gap between money taken in and money paid out. Its face may change, but managed care is not going away.

She adds:

"...Almost every medical treatment or service is so systematized that little independent medical judgment enters into the review for many managed care In one case, a company made the conditions for approval of a hysterectomy so narrow that they would have required conservative treatments to fail and the patient to have suffered a recurrence of invasive carcinoma before she could have the surgery. In other situations, managed care organizations applied outdated or wrong criteria and manipulated criteria inappropriately to justify a denial.

Although "evidence-based medicine" is the new buzz phrase, there is a difference between legitimate clinical criteria that have been developed through research and peer review, and proprietary protocols developed by
commercial companies using pseudo-scientific processes.

Exclusions for "experimental and investigational" treatments. When managed care was first established, health plans often relied on prevailing clinical and government standards to determine whether a requested treatment was experimental. With advancements in technology and research, the exclusion grew to include investigational procedures. Now, definitions that used to be only a couple of sentences long extend for pages. Some plans try to exclude standard therapies simply because they are part of a researcher's data collection and study.

What Linda Peeno, MD Told the Congress About Managed Care in 1996 and 2009

On May 30, 1996, Linda Peeno, MD testified before Congress and gave her testimony entitled, "Managed Care Ethics: The Close View"

[prepared for U.S. House of Representatives Committee on Commerce, Subcommittee on Health and Environment, Michael Bilirakis, Chair]

"... I have educated myself not only with the books, but with the stories of people who suffer. I have painfully dissected every experience of my own from the inside out, until I understand the ways they represent industry practice, their ethical implications, and how it is possible to go awry. I have taken every penny "earned" from my work in this and folded it back into work to benefit those affected by an increasingly heartless health care system."

"I do this because I know the system inside and out. I know where the dangers are. Although many persons are quick to extol the ease and affordability of their plan, the real tests come when someone needs something expensive. Like a bucolic pasture turn battlefield, the landmines start exploding everywhere. (I know because I have helped set more than a few.) These landmines were part of my ordinary armamentarium -- including some of the below:

* benefits restriction, or making the covered benefits as narrow as the market would allow (sneaking in a few exclusions that most consumers would not be knowledgeable enough to understand, e.g. in one of my plans we had regular meetings to determine what our highest costs were and how we could redesign benefits to control them);
* exclusions, which would multiply every year, and would rarely be known to the member or a treating physician until pulled out by plan to justify a denial;
* pre-existing exclusions, to ensure that persons with known conditions would
either forgo our plan, or give us the mechanism to avoid payment for services, creating a game of wits to figure out ways to make current needs connect with some prior diagnosis;

* evasive and uninformed marketing so individuals in groups we wanted would only know the attractive elements of the plan, but none of the potential problem areas; in addition members would never know the exact coverage limits and rules of the plan until after the enrollment period when they would receive their benefit booklet;

* underwriting, or selection of the "best" groups, which meant that medical information of individuals and groups were reviewed in detail, with projections made about economic liability to the plan; making these kinds of predictions often put me, as a physician, into the role of "bookie" for the plan;

* contract design, especially for physicians; it is common knowledge in the health care business that few physicians read, much less understand, most of the terms of the contracts they would sign for us; furthermore we would exploit their economic vulnerability by telling them they could either sign or be excluded;

* maze of rules for authorizations, referrals and network availability created in order to make "technical" denials possible (e.g. failing to go through convoluted procedures set out in a "certificate of coverage," which we knew few persons ever read, would be grounds for denial of payment);

* claims of authority to extract compliance from members and physicians for the desired economic outcomes, e.g. offering a grievance process but making it a sham in its results or eliciting certain practice patterns by threats to de-selection; and finally

* denials for "medical necessity," whether prospectively or retrospectively, determining that something is not "medically necessary," according to criteria that is non-standard and rarely developed along accepted clinical methods, becomes the ultimate weapon for the plan, the "smart bomb" for "cost-containment."

"I am the evidence that managed care is inherently unethical, in the areas of both medicine and business. Had my experiences been the result of merely local aberrations, I would not have had anything to do for the past six years. On the contrary, I discovered that my experiences are standard practice and quite ordinary for the managed care business. This fuels my work in ethics. The greatest irony to me is how the words "quality" and "outcome" have come to be industry buzz words, yet neither is ever applied to the managed care practice itself. We have enough stories of maleficence by managed care to fill tomes, and yet we continue to allow the industry to claim that these occurrences are simple anecdotes. As long as we accept that rationale, we sanction a system that is functioning with virtually no checks and balances -- ethical or legal. At a time when nearly every other human endeavor faces ethical scrutiny, how can we allow a particular industry to escape -- especially one with so much potential harm?"

In September 2009, Dr. Peeno was back in front of Congress and gave her testimony, "Between You and Your Doctor: the Private Health Insurance Bureaucracy"

"I come back here today with 13 years of additional insider experience from work on over 150 legal cases against managed care companies, as well as extensive knowledge gained by helping thousands fight for needed care. I am here today representing no special interest group, and without any agenda except to urge you to force open the black box of corporate health insurance and to hold them accountable for the practices that destroy the lives of
patients, families and communities, and the health professionals who must bear the consequences of their damaged care.

"Things have never been worse for patients. The corporate machines are well-developed and expertly operational. The methods are more insidious, covert and devious. In addition to outright denials of care, new tactics proliferate to avoid, delay, limit, substitute, and manipulate care for the maximization of profits. The difference between the kinds of denials I testified about in 1996 and the current system is akin to the difference between surgery with a kitchen knife and a scalpel. Cost-cutting, -saving, and -making tactics have never been so expert and deadly.

- There is an abyss between what insurance companies say and what they do....

- There are new "agents" of denial....

- The dirty work of denial and other cost-cutting practices are increasingly outsourced ....

- Adverse insurance actions cause harm and death to real individuals - these are not statistics or "mere anecdotes" ....

- The terms "medical necessity" and "experimental/investigational" are proprietary business tools supported through the huge medical guideline/criteria/evidence-based medicine industry ....

- Health insurance companies operate in an ethical and legal void ....

I suggest that you read the entire article for an eloquent and detailed analysis of the inner workings of the private health insurance industry affecting you and your family. Yet, while this appears to be aimed at private health insurance as an industry, the same type of cost-cutting and decision-making occurs in government-run programs. It is too easy to rail and complain about "private insurance companies" on the one hand, or the coverage denials of Medicare or Medicaid, or any government plan. Simplistic solutions will not solve anything. Lambasting "capitalistic" profiteers in health care while overlooking the failures of socialized or semi-socialized health care systems simply allows us to jump from the "frying pan into the fire." We need to understand the total picture and not succumb to the urge to find an easy "fix."

Kaiser Health Plan

More details about ways to hasten death. Vickie Travis' father was in the Kaiser Health Plan (Managed Care/HMO) out in California, and ended up in the Kaiser hospice in Los Angeles. You may have heard of the "Kaiser Family Foundation" and vaguely remember they do some good charitable work, or fund this or that, but the Foundation is a separate corporate entity. The Kaiser HMO has the reputation that they basically "own" the politicians out there; Kaiser
is so wealthy, powerful and well-connected.

Kaiser Health Plan (HMO) is the public, nonprofit front for the health care system. What most people don't think about is Kaiser Permanente, the very much for-profit physicians' group there. Kaiser Permanente is officially known as The Permanente Medical Group or TPMG. In an HMO, the physicians make the orders about what treatments are going to be done, what medications are given, and so on, so long as they toe the line of the HMO that allows them to provide physician services in the system. And that "line" can prevent them from providing appropriate and timely medical diagnostic tests or treatment or medications, with the result that patients may suffer the failure to diagnose a condition at all or a diagnosis too late to properly treat. If inadequate treatments are provided, they can have "treatment failure" with no improvement of an actually treatable condition. If they don't get the medication they need, they can be harmed or even die. Kaiser has been the subject of many legal actions, yet it has contracts with the government to run some of their public health programs in California, for example. Let's see how the HMOs in our country got their start with Kaiser.

The Nixon Administration, HMO/Managed Care and E.R.I.S.A. Legal Immunity Shield

Speaking about the idea of HMOs, Erlichman told President Nixon:

"All the incentives are toward less medical care, because-the less care they give them, the more money they make."

- [Mr. Erlichman quoting Edgar Kaiser to President Nixon on February 17, 1971 From: Miller Center of Public Affairs - University of Virginia - White House Tapes.org tape rmn_e450e]

On the very next day, Mr. Nixon had a message for Congress proposing a National Health Strategy:

"The most important advantage of Health Maintenance Organizations is that they increase the value of the services a consumer receives for each health dollar. This happens, first, because such organizations provide a strong financial incentive for better preventive care and for greater efficiency."

So, right after hearing that the HMO concept Edgar Kaiser was pushing in 1971 would
provide LESS medical care, Nixon tells the public HMOs will "increase the value of services a consumer receives for each health dollar." Exactly the opposite of what is planned by the HMOs. Well, they did create legislation to allow HMOs and we now know that many HMOs (or managed care organizations) do limit care, just as Erlichman told Nixon in private forty years ago.


This law:

"provided grants and loans to provide, start, or expand a Health Maintenance Organization (HMO; removed certain state restrictions for federally qualified HMOs; and required employers with 25 or more employees to offer federally certified HMO options if they offered traditional health insurance to employees. It did not require employers to offer health insurance. "HMOs" were defined simply, as plans that: specified list of benefits to all members, charged all members the same monthly premium, and were structured as a nonprofit organization."


What is an HMO?

"A health maintenance organization (HMO is a type of managed care organization (MCO) that provides a form of health care coverage in the United States that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. ... Unlike traditional indemnity insurance, an HMO covers only care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers."

To make matters worse, the Congress passed the Employee Retirement Income Security Act of 1974 ("E.R.I.S.A."): 29 USC chapter 18, which was signed into law by President Gerald Ford.

One organization working to make HMOs and managed care organizations more responsible to the public they serve is:

"The Health Administration Responsibility Project H.A.R.P. [which]:

"[is] ... concerned that in the headlong rush to "efficient" medical care, the organizations involved are losing sight of the "quality" of the care they provide."

"As more and more "incentives" to cut back on medical care are put in place by the new class of medical entrepreneurs, the patient often suffers. ... counter-incentives must be applied, and they must be financial. The only such counter-incentives available under our system are lawsuits for damages caused by excessive cost-cutting measures."

"However, many obstacles protect corporate providers from being held responsible for their acts. ERISA drastically limits the remedies available to
injured workers, as well as preempting State regulations designed to control the more egregious problems. Rigged Mandatory Arbitration gives injured patients the illusion of justice. Strict application of state Tort laws holds doctors responsible for actions forced on them by Managed Care Organizations, which themselves escape liability."

So, the HMO or managed care organization gets doctors to do what they require, no matter how devious or harmful to the patient, yet only the doctor or other health professionals are held responsible. How did this situation arise?

The Health Administration Responsibility Project tells us in its "E.R.I.S.A. Outline"

"If the Managed Care Organization is "related to" an Employee Benefit Plan (EBP), the requirements of ERISA ... and its regulations are of overriding importance, and severely restrict patient rights.

No employer is obligated to establish an EBP. In order to encourage them to do so, Congress has given them, their plans, their HMOs and Insurers, and their administrators substantial immunities from liability.

State Regulation of HMOs administered by self-insured EBPs is Preempted by ERISA, so employees cannot be protected by those state laws which limit the excesses of other HMOs, not subject to ERISA.

Any case 'relating to' an EBP falls under Federal Jurisdiction and may be removed from state to federal court.

There the patient will find that the usual state law Tort Claims are also preempted by ERISA, so any claims against the HMO or EBP for medical malpractice, wrongful death, fraud, etc. will be summarily dismissed.

True, he may sue for a benefit denied him, but the decision of the plan administrator may often be reversed only if it was found to have been Arbitrary and Capricious, a very difficult standard to meet.

Even if that is proven, ERISA limits damages to delivery of the benefit, but it may then be too late. If the patient has died or experienced further injury because of the wrongful denial of care, neither he nor his survivors may be compensated, nor will the HMO be punished in any way. If the plaintiff wins the case, the court has discretion to award him his Attorneys Fees.

ERISA plans are construed according to federal common law, but federal common law in the 9th Circuit borrows many California rules of interpretation, including contra-insurer. See Padfield v. AIG Life Ins. Co., 290 F.3d 1121 (9th Cir. 2002), and Kunin v. Benefit Trust and Life Ins. Co., 910 F.2d 534 (9th Cir. 1990).

In setting up or continuing the plan, the employer has no Fiduciary responsibility to its employees at all. If an employee develops AIDS, for example, it is perfectly legal, under ERISA, for the employer to subsequently amend the plan so as to eliminate coverage for AIDS. See McGann v. H & H Music. Fiduciary responsibility applies only to the Administration of the plan, not to determination of which benefits will be offered.
HMOs even produce training films to teach their claims managers that they don't have to do a reasonable investigation for ERISA claims - just deny them.

[For more information, see ... the H.A.R.P. website]

All health care today is influenced by the "managed care" style of doing business which involves "cost-efficiencies" and decision-making based upon maximizing profit. This is what Charles Phillips, MD, H.A.R.P. and Linda Peeno, MD have revealed.

HMOs and the managed care approach to administering private health insurance companies exert huge influence over how a physician practices, often giving very significant bonuses to doctors for cutting Plan costs by limiting the treatments, labs and procedures they order for their patients. In other words, a physician who does "everything possible" for a patient may be in hot water with the Plan, while a physician who does the least for his patients may be honored by the HMO for meeting his "quota" of not ordering tests and treatments, thereby reducing costs.

So, the HMOs and managed care organizations are protected in various legal ways from taking big financial "hits" when a legal action is brought. They can cut corners and their costs, injuring patients and have nothing of significance happen to them as a result. Whether nonprofit HMO or for-profit managed care, as many of them are, their cost-cutting results in what could normally be considered outright criminal negligence, yet there is little legal recourse for the public.

Even though Kaiser HMO is nonprofit, the physicians' group, Kaiser Permanente is for-profit, and that explains a lot. When you know how profit is distributed, then you will understand more about Kaiser physicians. Charles Phillips, MD explains the 50-50 split at Kaiser:

"at Kaiser Permanente ... the physicians get 50% of every dollar that is collected from patients and government and not spent. This is really the split of "profits" though Kaiser uses every possible word to cover-up the use of such a word - net revenue, operating margin, etc. .... The creation of profits for the physicians is the single most import principle at the mammoth HMO and guides every decision." [Emphasis added]

Kaiser has been involved in a lot of controversy that end up in arbitration. Patients report malpractice, abuse, wrongful deaths. You may recall that a lot of health care businesses now have "mandatory arbitration clauses" that say, "if there is a dispute that needs legal resolution" arbitration is the only remedy. It can't be litigated in court. Patients or families that seek legal recourse have been seriously damaged in one way or another. They want an honest court or arbitration process, because they seek just decisions.

Mandatory arbitration is encouraged in many industries as the courts are stretched already with too many cases to hear in a timely manner. When a case involves serious bodily harm or death in a health care setting, people really expect a just assessment of the facts and a just decision. The public expects fair arbitrations if it must seek justice, but the public is not aware of an important aspect of the Kaiser-physician contractual relationship.

When a physician comes on board at Kaiser Permanente, they also sign The "Kaiser Permanente Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan." The Plan contains some clauses that have a tremendous effect on what Kaiser physicians do, say or don't say, to a patient, to a family, to a court or arbitration committee.
Kaiser physicians don't usually have a separate practice or income to fall back upon if things go wrong. They commit to the Kaiser way and after two years, they get vested into the for-profit corporation, Kaiser Permanente. They enjoy many benefits as "Kaiserized" physicians, including very nice retirement fund arrangements and other financial incentives. Their future standard of living depends upon remaining in good standing with Kaiser. Messing that up is the last thing they want to do.

Now, just imagine you are the physician. The retirement plan contract tells you that so long as you provide services as a physician and refrain from any "improper activity" you'll get regular payments through your retirement years. And that's important for anyone on a pension.

The "Disqualification" section of the contract explains that "improper activities" occur if:

[Clause] G. 6(a) "The Participant [the physician] performs any act or engages in any activity, the principal purpose of which is to damage or discredit Health Plan or physicians serving Members [the patients], or to restrict Health Plan in the legitimate operation and expansion of the hospital and medical service plans it now offers or may hereafter offer"

"Any" act that "discredits" the "Health Plan" or "physicians serving Members." So, if a physician were to speak the truth about another physician (or other Kaiser staff member) who had made some mistakes or done something that was not up to the standards of medical practice, the physician who spoke the truth could lose his entire retirement income forever.

It's not up to him to decide what is "inappropriate" or what "discredits" Kaiser. It's up to the "Administrative Committee" appointed by the Health Plan. If they decide that a physician has "discredited" Kaiser, for any reason, that's it. Entire retirement income erased, with all the repercussions that has on his future and his family. You can imagine the absolute fear physicians have of falling into disfavor with the "Administrative Committee." They're sure to "toe the line" and be extremely cautious in anything they say or do.

Therefore, even if it is the truth, a Kaiser physician cannot speak the truth without risking everything. When a patient or patient's family goes into arbitration and a Kaiser physician is called to testify, you can count on it that he or she is not going to say anything negative about Kaiser. It doesn't mean they are going to lie outright. Maybe they'll pull the "I can't remember routine" or give some vague responses that are as positive as they can under the circumstances.

This type of "disqualification clause" which basically delists the physician from the HMO and punishes the physician in many ways is commonly used in other managed care organizations.

[Clause] G. 3: "The disqualification of a Participant [physician] cancels, forfeits and forever terminates any and every interest and claim of Interest the Participant had in or under the Plan at the time of Disqualification. On and after Disqualification of a Participant, no Retirement Income or other payment of any kind is owed to the Participant or his or her Joint retirement Income Recipient or Beneficiary ...."

"Retaliation" or "Disqualification?" Only the courts can decide. If a Kaiser physician tries to improve things by speaking out, the contract says you can be disqualified from the retirement plan or worse. Kaiser has done just that to many physicians and other staff. What happens depends upon the circumstances. The income faucet is shut off forever!

Thinking about that is like a physician having Damocles' sword hanging over his head by a thread. The only thing he can think about is that sword, ... that if he says the wrong thing, does
the wrong thing, he is going to "get it" (get "disqualified" from the Retirement plan) and all those he loves are also going to be seriously hurt financially.

It would hurt the physician's children's chances of paying for college, the wife or husband might seek a divorce, he might have a hard time getting hired elsewhere if his reputation is damaged in the process. Humiliated, shamed, and unable to do anything to stop it. The physician has worked too hard, for too many years to let that happen. He's not going to say anything negative about Kaiser, that's for sure!

Only a very few have stood up to Kaiser knowing they would risk everything in so doing. The case of Michael Martinucci, MD, a dedicated patient advocate who was terminated after he made efforts to improve the quality of Kaiser services, shows how Kaiser treats those who try to assure quality patient care (possibly reducing profits):


The fear of retaliation often looms large for physicians wanting to speak out about subpar patient care. California radiologist Michael Martinucci, MD, said
that fear was realized when he was fired from a Kaiser Permanente group after trying to make improvements at one of its radiology facilities.

He knew that proving his case would be no easy task. But his legal battle paid off when a jury in December 2008 levied an $11.4 million verdict against Kaiser, $7.5 million of which came in punitive damages.

"When you see people constantly disregarding good quality patient care, you get to a level where it's just no longer acceptable," Dr. Martinucci said. "I could have let the retribution go, but then you say to yourself, that's not what I got into medicine for."

".... Jurors ... concluded that Dr. Martinucci's advocacy efforts were a "motivating factor" in Kaiser's decision to terminate him and that hospital leaders acted with "ill will."

Another physician, Dean Kevin Lurie, M.D. filed suit against Kaiser Permanente in 2006:

"Dr. Lurie repeatedly attempted to raise the quality of care standards within the Mid-Atlantic Kaiser Permanente system. In retaliation, he was accused of padding his time records. A[n] age discrimination suit has followed his sudden termination by the Permanente with charges of padding his time. He had served the Kaiser patient population for nearly 17 years. Since leaving the Permanente Group, said Group has consistently interfered with Dr. Lurie's private practice in an attempt of further employment retaliation. Kaiser has severed his pension plan."

What if the HMO harmed you or your loved one, or if they deny treatment, what can you do? These HMOs have mandatory arbitration clauses, meaning you don't sue in a district court; you take your complaint to an arbitration hearing with one arbitrator who hears all evidence and rules on your complaint. In the "Los Angeles Lawyer Journal," Dec 2004, Attorney Michael Brown states that arbitrators sometimes do not reveal that they have major conflicts of interest in cases before them, and when they don't reveal these conflicts, it constitutes fraud and destroys the fabric of the justice system. In the case of a treatment denial or injury, it may mean you or your family don't get the medical treatment you need, even though you pay your premiums every month. It may mean you don't get any financial compensation for injuries or death to a family member, even if your claim is valid.

We could say that when Congress legalized the HMOs during the Nixon-Ford era, and passed the E.R.I.S.A. laws, they created the health care industry's way to achieve legal immunity from much wrongdoing while maximizing its profit. It's been downhill ever since. Millions of patients have been harmed in so many ways. Vickie Travis has gathered much evidence about the Kaiser Health Plan and Kaiser Permanente at the Kaiserpapers.org website.

Kaiser: A Model HMO?

Even if you don't have a Kaiser HMO plan in your area, you should know that Kaiser is an HMO of HMOs. It's not only big. It's well-connected at the state level, especially in California, and some of its administrators have visited the White House. Kaiser's health care empire
resulted from our entry into World War II:

The Japanese attack on Pearl Harbor resulted in a need to build a new Pacific Fleet, and Henry Kaiser liked a challenge and offered speed of building; the workers poured into the Kaiser shipyards and had the single choice of Kaiser clinics, the latter built by the Navy and given as a gift to Kaiser at the end of the war.

So, the connection between Kaiser and the federal government is more than "strong." We know they're being looked at to determine what they do that might be implemented under the health care reform law, just as other big HMOs and private insurance companies are consulted to provide input.

On March 4, 2009, NBC reported that Kaiser Permanente's: "Does on the clock could be key to health reform." "many experts agree that Kaiser Permanente, a giant group practice system where 14,000 salaried physicians care for 8.6 million Americans, presents a possible model for health care reform." [from NBC's Robert Bazell reports - MSNBC video] On June 21, 2010, "George Halvorson, CEO of Kaiser Permanente, the nation's largest nonprofit health plan, discussed health care with CNBC." [MSNBC video: "Revolutionizing Health Care"]

The ways Kaiser streamlines treatment in efforts to be more "efficient," i.e., cut services for patients and bring in more revenue for the Kaiser Permanente group) are reported to be very creative. Again, the public sometimes doesn't know that very creative methods used may be contrary to the standards and could be unsafe.

And the Permanente physicians of Kaiser Permanente are much more than - salaried. - They get $.50 of every $1 created in - excess income - each year, e.g. in 2007 $1 billion of the $2 billion. This is on top of a good salary with great benefits. The whole - non-profit - or - not for profit - label is a trick on a gullible public. And Kaiser’s $45 million per year “Thrive” Ads campaign keeps replacing Kaiser patients as they leave the HMO each year - many through quick hospice experiences.

**Dr. Phillips Reports that Kaiser Misinforms the Public About "Normal" Human Lab Values to Limit Treatment**

Let’s go into more detail about the "clever" and creative method reportedly used by Kaiser to make itself a lot of money by saving on treatments that would be provided. You know that medical scientists all around the world have established what are called "standard lab values" for human physiology, things like "serum creatinine," "blood urea nitrogen" or the normal number of red blood cells, white blood cells, how much hemoglobin that should be found in a
complete blood count, and so on.

These lab values are taught in all the medical schools around the world. Because the human physiology, though it varies from person to person, is pretty much the same all around the world, the ranges for these values don't vary from health system to health system, or from one doctor's office to another; they are scientific fact. They are used universally by all hospitals and physicians. Right. Of course!

Well, if you think that, you'd be wrong. Use your imagination with an eye on economics and profit-making. What would happen if the docs didn't use the standard ranges of values, but they fudged the ranges? That could make for some serious repercussions in the management of patients and what types of treatments those patients would get or not get.

For example, let's think about white blood cell counts. *If you widened the scientifically-accepted "normal" range, patients who came in with abnormal white blood cell differential counts might now be considered still "normal," at least with Kaiser lab value ranges.*

Charles Phillips, MD (former Kaiser physician) has revealed that Kaiser has arbitrarily changed what is considered normal human lab value ranges to be used in patient diagnostic lab work!

Vickie Travis states that Dr. Phillips' report, *"Manipulation of HMO"* [prepared in 2003] was prepared at the request of Senator Chuck Grassley, via his assistant Emelia DeSanto, so we know that the Congress knows all about these HMO practices! Yet, the Congress does almost nothing to outlaw such medical deception with its potential for serious harm!

Dr. Phillips has worked with Senator Grassley's Finance Committee regarding HMOs that withhold clinical testing in 2003 and Lumetra deficiencies in 2008. He was a medical consultant and reviewer for *USA TODAY* first on "pill splitting" as a prime source in 2002 and later on "Medical Record tampering after bad outcome" in 2008. Within two days after he was quoted in the medical tampering article that appeared on April 29, 2008, *Patients often struggle for access to medical records* - USATODAY.com, he was advised by two hospitals that his clinical privileges were in imminent jeopardy.

This retaliation was also reported later within ["Physicians, Legal Experts, & Advocates to Testify Before Congress" May 14, 2008]

Dr. Phillips told me that after the hospitals threatened him with retaliation for working free with the *USA TODAY*, they backed down when he asked them to consider what kind of publicity they would get nationally if they acted against him in retaliation. Now back to the Manipulation of lab testing.

*You may be tempted to quickly skim over this section because it is not immediately apparent what is going on or why it is important. Please carefully think about the details of this section, as what Dr. Phillips has revealed is one of the most sinister, deceptive and lethal tricks "in the book" to manipulate patients and assure an early death.* It could mean you or your loved one dying when you could have lived had you been given proper diagnostic testing and subsequent treatment.

Withholding of clinical testing is something the public may suspect, but may not know about with certainty. And if the withholding is done without appearing to be “withholding” or treatment denial? How would a lay person know they should have a certain test or not? They are not medically-trained. In general, the people using the HMO have no idea they are being
denied diagnostic testing, and the media is not educating the public about how their own health care providers can betray them in the very worst way, leading to deaths that could have been avoided with proper medical care. Dr. Phillips mentions he found the problem in many levels of testing: complete blood counts, kidney function testing, Lyme Disease screening, cardiac stress tests, etc. For example in complete blood counts (one of the most common tests in medicine) he says:

"White blood counts - The value of the normal white blood count should not shift in any particular hundred years. But Kaiser alters what is normal. See table below.

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<tbody>
<tr>
<td>WBC</td>
<td>4,800 - 10,800</td>
<td>4,000 - 11,000</td>
<td>4,000 - 11,000</td>
<td>3.500 - 12,500</td>
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Kaiser Permanente Blood Count Chart

This table shows that in 1995 Kaiser physicians in Southern California were using the normal range of white blood count to be 4,800 to 10,800 (Exhibit 7a).
Then, by 1998, Kaiser physicians in Southern California were using the normal 4,000-11,000 (Exhibit 7b).
The same Southern California Permanente Group kept this white blood cell count definition into 2001 (Exhibit 7c),
and presumably also at this time. This would mean that on the low side, white blood cell depression from a chemotherapeutic agent would not be noticed as early as before. And on the high side, bacterial infection would not be caught as early.

But the Permanente Medical Group, Inc. (TMPG) in Northern California got even more aggressive and changed the normal value of the white blood count from 3,500 to 12,500 ... a spread meant to discover less illness.
... Fewer low and high white blood cell changes from normal would be caught by this method.

Meanwhile, other hospitals outside of Kaiser, like Victor Valley in California, have chosen not to alter human physiology and to continue to use the 4,800 to 10,800 range. .... This is more ethical. [from the testimony of Charles Phillips]

We have also had reports of completely falsified or nonexistent lab results being used (saving the costs of actually running the tests). Another method of fraud used is the
writing of renewable prescriptions with several refills so the patient does not need to see the physician, but recording “visits” that never occurred and billing for them!

So, patients in the Northern California branch of the Kaiser HMO (The Permanente Medical Group or TPMG - the largest unit) might be told, "well, your blood count is still in the normal range" when it's not! A conscientious physician might say, "but it's at the high end; we're going to keep a close watch on that and re-evaluate at your next year's appointment."

Well, white blood cell count differentials can tell a physician a lot. They can alert the physician to problems the patient may have with certain diseases, even leukemia or cancer. Let's say the patient does have leukemia for example, treatable leukemia. If the laboratory range is wider than accepted medical ranges, the patient is not immediately started on chemotherapy, expensive chemotherapy. They wait. Things get worse. After a year, the patient obviously has something terribly wrong and then they find what? Leukemia! But it's too far gone to treat. "Sorry, I have bad news for you. Your wife has untreatable leukemia and has six months left to live."

If the patient got treatment a year earlier, expensive treatment to provide, they may have lived. Now they die, the patient never knows that they could have been treated earlier and the family never knows they were deceived. And the HMO reduces costs, increasing profit for the physicians group!

But what does the U.S. National Library of Medicine, U.S. Department of Health and Human Services, and the National Institutes of Health consider normal lab values for white blood cell counts? "4,500-10,000 white blood cells per microliter (mCL)."

That's a much smaller range from low to high than what Dr. Phillips reports Kaiser uses! It is only a matter of time before false science is used elsewhere by managed care organizations or the federal government. When you can't even trust the "normal" ranges for lab values printed on your diagnostic tests, you can't trust the system at all!

Did Congress become wary of Kaiser in light of this 2 inch thick, 2003 report by Dr. Phillips? No. In fact, Kaiser's Associate Executive Director for the Permanente Medical Group of Northern California, Sharon Levine, MD, is on the board that will run the new U.S. health system's Patient-Centered Outcomes Research Institute (PCORI). She is also on the California Medical Board in what Dr. Phillips calls the Kaiser-fornia; she is among the top ten MDs in Kaiser.

As we have seen, the PCORI Institute will conduct comparative effectiveness research (CER); They will decide what treatments or interventions shall or shall not be provided to you, me, your father, mother, grandfather, grandmother, relatives, friends and other citizens of the United States! This is just one of many reasons how we know that the federally-mandated health care system is being "Kaiserized" and will ration health "care."

Kaiser may even convince them to change normal lab values to either create or erase diseases as fits physician retirement profits, Dr. Phillips warns. Finally, Dr. Phillips has studied Kaiser into its hospice tactics and has warned people about the "ABC Kit" that can sedate patients quickly to death - Tuesday being a convenient day for the system. Occasionally, the Phenobarbital suppositories - meant for seizures - can be introduced so as to give the high morphine dose lethal effect. He also reported on one patient who had two morphine prescriptions only one of which was being charted.

CNN reports that Kaiser has admitted rigging “its electronic medical records system to conceal abnormal lab test warnings.” The obvious result of not getting notice of abnormal lab tests is
the failure by the HMO to treat the patient in a timely manner, the likelihood that the patient’s health declines and becomes untreatable and death. And the lab test ranges Kaiser uses are sometimes distorted already, as we’ve seen above. Sounds to me like a conspiracy to make sure the patient does not get treated and does die, maximizing profits.

On May 30, 1996, Linda Peeno, MD provided testimony to a subcommittee on Health and Environment of the U.S. House of Representatives entitled, "Managed Care Ethics: the Close View." She said:

"As a former medical director, I have done the dirty work of managed care. This prompted me to leave and work aggressively for health care ethics. Because I know how the "system" works, I am best able to identify its ethical transgressions and suggest corrections."

"Health care is a special category of business in that every decision, whether clinical or economic, has an ethical component. The ethical issues for "managed care" fall into four major categories of concern: professional, medical, business, and social. Some of the more important areas for attention include: the lack of professional code of ethics for physician executives; interference with the principles of informed consent and patient autonomy; violation of consumer rights; and social maleficence in obstruction to access and delivery."

"I contend that "managed care," as we currently know it, is inherently unethical in its organization and operation. Furthermore, I maintain that we have an industry which can exist only through flagrant ethical violations against individuals and the public. Based on my experience, a health plan's resistance to ethical correctives will be proportionate to its reliance on ethical transgressions for its "success." We must not sanction their unethical practices at the expense of individual rights and public good will."

"Although the "managed care" industry is quick to defend its actions with high-sounding justifications, their claims break down under examination. For example, can they really support the argument that the effects of "managed care" are necessary for the "good of society." What does this mean? Who should decide this? Can this be appropriately determined by the entity who stands to benefit the most from an economic definition of this "good?"

"The systemic ethical problems in managed care require urgent correction in several areas: the monitoring of denials of care; the elimination of certain contracting arrangements with physicians; the requirement for full disclosures of financial arrangements, cost-cutting strategies, and consumer information; the development of open and reported grievance procedures; and the mandate of ethical guides and processes. How could the industry object? After all, this is just a way for "managed care" to apply its own processes of "quality management" and "outcome analysis" to itself?"

"Nothing less than the life and well-being of our society depends upon this. We have gone too far under our current system called "managed care." How much more harm and death must occur before we have the courage to do something about it?"

When patients are harmed due to managed care treatment denials, they can be sent to hospice agencies with the line, "there is nothing we can do for you, but you may wish to consider
hospice." Many doctors who are "in-network" with an HMO/managed care company are given huge financial incentives to not disclose all medical options available to patients so that the average cost per patient in their practice is reduced, and consequently the cost to the HMO/managed care organization is reduced, maximizing revenue.

X - The Federal Government's Approach to Hastening Death

There are many ways the federal government is encouraging the hastening of death, as outrageous as that may sound to some. We've discussed some of that. The federal government has done nothing about the reports from thousands of families coming in to the Congressmen,
to the President, the various agencies entrusted with enforcing the law in the U.S. Justice Department. When imposed deaths or "medical killings" are reported, a complete run-around is given to the families who complain. I've heard from families that have literally spent years trying to get someone in government to listen. Yes, I know, many will say, "this is not believable," if it was really happening, the police would act. That's exactly the problem; the police do not act, universally. The district attorneys don't act. The state attorneys general do not act. The U.S. Attorney General does not act. The U.S. Drug Enforcement Agency does not act. I've spoken to some of the agents at the D.E.A. who admit they don't get involved. It was clear to me that they either don't want to get involved or have been told by superiors not to get involved.

In other words, the "fix" is in, the officials in government know what's going on, but the public is being kept in the dark. Hidden behind the veil of secrecy created by HIPAA's Privacy Rule, anyone can be killed in a health care setting and the police will not get involved. Of course, if there's some psycho-serial killer going around killing people in a hospital when it's not "approved" by management at the facility, and if it causes embarrassment or threat of a lawsuit (loss of dollars) for the hospital or other facility, then the police will be brought in and the psycho-serial killer nurse (usually) will be charged and prosecuted.

Some of the more famous cases include Charles Cullen, RN, a "N.J. Nurse Sentenced [in 2006] to Life for Killing 22"

Other prominent cases include

"March 1984: Nurse Robert Diaz [was] convicted of killing 12 elderly patients with lethal doses of a heart drug in March and April 1981."

"August, November 1987: Donald Harvey, former nurse's aide, pleaded guilty to at least 34 murders in Ohio and Kentucky."

["Hospitals failed to report nurse's spotty background" December 2003]

But for every psycho serial-killer out there like these, there are literally thousands of physicians and nurses who may use subtle ways of encouraging death sooner rather than later. It's common practice. And they get away with it. The "slow code" used on the elderly in nursing homes or hospitals is not the only way to assure someone dies.

The federal government saves billions when many patients go into hospice all across the country and die sooner rather than later (had they gone into the acute care hospital and been treated). And it is appropriate at a certain point to let go and allow a natural death, but the point where staff give up is arriving earlier and earlier, to the dismay of many patients and families. Sometimes, it can be as simple as intentionally not providing rehabilitation after a minor stroke or not prescribing the appropriate common medication or dosage to effectively control high blood pressure or manage a heart condition. When proper treatment is not provided, the patient ends up in the hospital, in hospice, or dies outright much sooner than they would have.

I've seen for myself (and heard of many cases where) disabled patients are given relatively weak antibiotics for very serious infections without testing for effectiveness of the medication ("culture and sensitivity" tests). Yet, had the patient been a non-disabled young patient, they would have instantly been placed into the hospital, given more effective intravenous antibiotic therapy and, of course, given the tests to determine what antibiotic would be effective. It is clear that the physicians have different standards as to how they provide services to the disabled and elderly and if the disabled or elderly die sooner, the physicians may be pleased. It is often a family member who, year after year, remains the only patient advocate standing in
the way of the disabled or elderly patient's manipulated, premature death.

There is very little difference between passive euthanasia (where a needed treatment or medication is withheld to make a patient die) and intentional rationing that the bureaucrats know will result in death. Rationing is the withholding of treatments or medications. Going even further, in the United Kingdom, the government is providing the school children with more information about euthanasia and assisted-suicide:

"School children as young as 14 are being taught about euthanasia and assisted-suicide in a new educational video featuring notorious euthanasia promoter Dr. Philip Nitschke, known by many as 'Dr. Death.'

In the 20-minute film, produced by Classroom Video, Nitschke, the Australian founder and director of the euthanasia group 'Exit International,' demonstrates the use of his suicide machine that dispenses lethal injections."

["UK Marketing Assisted-Suicide Educational Videos for 14-year-olds" by Rebecca Millette Apr 20, 2011 LifeSiteNews.com]

The United Kingdom's National Health Service, a socialized medical system, is a window into our future, should our nation's health care reform law be implemented completely. It is not difficult to see that the governments with socialized medical systems promise health "care," but increasingly promote euthanasia and assisted-suicide to limit expenditures. It is likely school children in the United States will be fed similar "educational" films promoting euthanasia and assisted-suicide as a utilitarian "rational option" at the end-of-life.

When we look to government to provide health care (as is the case for Medicare, Medicaid and with health care reform), we relinquish control to the government. When citizens lose control over their own health care options, they lose freedoms and ultimately the right to their own life. Ken Skuba asks:

"what happens under a socialized health care system that places higher value on budgets than human life.

Rationing, delays in treatment, and abuse of power (can we say murder?) are the logical outcome. In Belgium, socialized medicine and legalized euthanasia have emboldened some health care professionals to become medical vigilantes. A study found that a high proportion of deaths classified as euthanasia in Belgium involved patients who did not ask for their lives to be ended. .... Containing costs by euthanizing patients, legal or not, is tempting in a state-run, taxpayer-funded system."

["Euthanasia -- a Product of Government-run Health Care" by Ken Skuba July 15, 2010 StandardSpeaker.com]

Any rationing of health care done by a federal health system will have a certain and huge impact on the longevity of many patients. Many will simply die if they don't get treatment or an organ transplant. When the federal government promotes hospice, rogue hospice, they know that some, even many, patients will die sooner. Rationing of health care will be the biggest boost to the hospice industry ever seen. Their growth will be exponential and utilization of hospice will move as it already has, steadily upwards. Now about 40%, it will approach 100%
Physician Orders Limiting Life-Sustaining Treatments to Hasten Death

Well, I've mentioned these before, but let's get into the details. The "Physician Orders for Life-Sustaining Treatment" ("P.O.L.S.T.") forms are being implemented in many states around the country and will likely soon be made available in every state. P.O.L.S.T. is considered a "paradigm" by those promoting them. The "paradigm" is the model way of thinking about and implementing orders that limit life-sustaining treatments at the end-of-life. And that is the key thing about these forms: they are medical orders, not "a patient's wishes," and a physician is supposed to fill them out after considering the patient's wishes.

As I've titled this section, they are physician orders limiting life-sustaining treatments. But the idea that they limit life-sustaining treatments is not emphasized in the name given or the discussion with the public. The physician fills out the form which becomes part of the medical chart, just like a DNR form which is prominently noted in a medical chart. It is within the physician's power to write in whatever he wants in a P.O.L.S.T. form.

It reminds me of a call I got about seven years ago about a hospital registered nurse in a Northwestern state who noticed a physician writing "Do Not Resuscitate" "DNR" on dozens and dozens of charts all at one sitting. She knew these patients on her wing of the hospital and knew they were not dying and were certainly capable of recovering. She knew they had not requested to be placed on DNR status. When she went up to the physician to ask him what he was doing, he became infuriated and yelled at her, trying to intimidate her.

When she went up the chain of command, her complaints were ignored by the hospital and she was blackballed as a nurse and left the field. It's also very safe to say that this is not the only case where physicians have written "DNR" on patient charts without the patient's approval or request.

There is a huge opportunity for physicians who have an agenda to misuse the tremendous power a P.O.L.S.T. form gives them. Unlike years ago when more physicians respected the sanctity of life, today a large percentage of physicians are focused on "quality of life." It sounds reasonable, but the consequences can be lethal.

You see, even though the public has heard about DNR forms, Advanced Directives, Power of Attorney forms and others, they are often not actually created by many patients. People put off having these documents made. People don't like to sign away their rights and they don't like to think about their own decline and death. So, those interested in limiting treatments to the elderly, disabled and terminally ill created the P.O.L.S.T. forms so that physicians can accomplish the same thing anyway, without the patient's signature! It will be quite easy for the
physicians around the country to fill them out and have almost universal utilization of these forms.

The P.O.L.S.T. paradigm incorporates the shared values of the health care community focusing on quality of life and the need to limit care at a certain point in disease progression. Although there are spaces and boxes to indicate a patient wants "full treatment," the thrust of the entire paradigm is limiting or eliminating treatment entirely at some point. It is specifically promoted to be used for patients who have at least one of the following "medical" conditions: they are "close to death, permanently unconscious, [or have] advanced progressive illness, [or] extraordinary suffering." These are exactly the same types of conditions where the pro-euthanasia groups want the ability to impose death through direct euthanasia, assisted-suicide or Third Way killing.

Take note that these criteria are quite subjective and could be interpreted differently by different physicians, or patients or families. The P.O.L.S.T. paradigm considers "extraordinary suffering" one of the "medical" conditions, yet "extraordinary" suffering is not defined in the "guidance" provided. However, the P.O.L.S.T. website guidance clarifies when P.O.L.S.T. should be implemented with persons who have disabilities.

The P.O.L.S.T. website directs that, especially with patients who have some form of cognitive impairment, the physician should ask these questions:

"Does the person have a disease process (not just their stable disability) that is terminal; Is the person experiencing a significant decline in health (such as frequent aspiration pneumonias); Is the person in a palliative care or hospice program; and/or Has this person's level of functioning become severely impaired as a result of a deteriorating health condition when intervention will not significantly impact the process of decline?"
This is a sample P.O.L.S.T. form from Oregon, Page One:
HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for Person Named on this Form  Person's Name (print)

This voluntary form records your preferences for life-sustaining treatment in your current state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name (print)</th>
<th>Relationship (write “self” if patient)</th>
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Opt Out  [ ] Check box if you do not want this form included in the electronic POLST registry.

Contact Information

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<th>Surrogate (optional)</th>
<th>Relationship</th>
<th>PhoneNumber</th>
<th>Address</th>
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<th>Health Care Professional Preparing Form (optional)</th>
<th>Preparer Title</th>
<th>PhoneNumber</th>
<th>Date Prepared</th>
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<tr>
<th>PA's Supervising Physician</th>
<th>PhoneNumber</th>
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Directions for Health Care Professionals

Completing POLST

- Should reflect current preferences of persons with advanced illness or frailty. Encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form. Refer to Guidance for Health Care Professionals at http://www.ohsu.edu/polst/programs/docs/guidance.pdf.

Sending to POLST Registry (Required unless “Opt Out” box is checked)

- For the POLST Registry, the following information on the other side of the form must be completed:
  - Person’s full name
  - Date of birth
  - Section A
  - Physician / NP / PA Signature and date signed
- Send a copy of both sides of this POLST form to the POLST Registry:
  - Fax or eFax: (503) 418-2161 Date / /  
  - Mail: Oregon POLST Registry Date / /  
  - Mail Code: CDW-EM
  - 3181 SW Sam Jackson Park Road
  - Portland, OR 97239

Reviewing POLST

This POLST should be reviewed periodically and if:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write “VOID” in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (Required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

PUT REGISTRY ID STICKER HERE:

For permission to use the copyrighted form contact the OHsu Center for Ethics in Health Care. Information on the POLST program is available online at www.polst.org or at polst@ohsu.edu.

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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The National Association of Pro-life Nurses sums up the form:

"Sections on the paradigm are three or four (depending on the state) in which the patient can choose his or her desired medical intervention. These areas are 1) CPR, 2) antibiotics, 3) "artificially" administered nutrition, and 4) medical intervention. The medical intervention section is further divided into three choices

1) "Comfort Measures Only" is self explanatory, but does include the option of transfer to a hospital if suffering cannot be alleviated at home.

2) "Limited Medical Interventions" may also include IV fluids and antibiotics.

3) "Full Treatment". Under this section a patient may decide to limit the type of IV meds or the length of time for effectiveness of treatment.

Elizabeth Wickham, PhD, head of the LifeTree Organization states that:

"... P.O.L.S.T. is much more likely to LIMIT life-sustaining treatment. The P.O.L.S.T. form becomes part of doctor's orders and is prominently displayed in the patient's medical record wherever the patient goes."

"P.O.L.S.T. was tested in Oregon in the early 90s and was launched in 1995, one year after Oregon passed legislation legalizing physician assisted suicide. Now, in 2010, over 30 states have endorsed or are developing P.O.L.S.T. programs."

Map of the states that already have implemented or are planning P.O.L.S.T. programs.

Dr. Wickham continues:

[Some of the P.O.L.S.T. forms] ".. can override your Health Care Power of Attorney agent. The form has a lengthy series of boxes to check indicating levels of treatment. Boxes include "Comfort Measures Only," "No
Antibiotics," "No IV Fluids," and "Do Not Attempt Resuscitation"

"A trained facilitator, using carefully designed curricula such as the "Respecting Choices" program, may assist in filling out the form which then becomes part of doctor's orders, although it can come into effect with neither the patient's nor a physician's signature."

"... the "consulting sessions" between physician and patient that [were to be] federally funded [under the Health Care Reform Law] involved filling out the P.O.L.S.T. form."

Under the new health care reform law, physicians will be rated for "quality of performance" and one of the things the government is insisting on is that the physician complete the P.O.L.S.T. forms, which are the new DNR forms. Under a section called, "Physician Quality Reporting Initiative," there will be:

quality measures on end of life care and advanced care planning .... Such measures shall measure both the creation of and adherence to [Physician] Orders for Life-Sustaining Treatment."

In other words, doctors will be rated higher if they make sure the patient fills out advanced directives, living wills and/or DNR forms. The doctor will be rated higher if he or she has recommended hospice or palliative care for the elderly person. He will be rated higher if he has filled out the P.O.L.S.T.

It really doesn't matter whether the health care reform law is overturned by the courts or repealed by Congress; the P.O.L.S.T. paradigm is being welcomed with open arms in medical policymaking circles across the country. They will be implemented for Medicare recipients and made available throughout the country whether we have a private or publicly-run health care system, or a mix of those. The P.O.L.S.T. paradigm represents one of the most powerful tools those who do not affirm the sanctity of life will have to shunt elderly, disabled and chronically-ill into hospice or palliative care units and have their deaths hastened through limiting treatments that are needed.

Those who are pushing reform forward believe strongly in the need for entitlement reform. They will ration health care through the "Complete Lives System," "Cost Efficiency Research", and by encouraging physicians with financial incentives to get elders into hospice and palliative care sooner than they have been doing.

The President appointed Donald Berwick, the director of the Centers for Medicare and Medicaid Services ("CMS"). Berwick has a long history of supporting health care reform including the rationing of care. In 1994, he wrote "Eleven Worthy Aims for Clinical Leadership of Health System Reform" and suggested that:

"Most metropolitan areas in the United States should reduce the number of centers engaging in cardiac surgery, high-risk obstetrics, neonatal intensive care, organ transplantation, tertiary cancer care, high-level trauma care, and high-technology imaging."

[JAMA. 1994;272(10):797-802.]

Yes, you read that correctly! Most of us would be thinking we should be building more top-level hospital care centers. Rationers think the exact opposite. Their thinking is something like those managing a herd of gazelle that is periodically attacked by cheetahs (disease, old age,
disability) across the African Savanna. Who lags behind and is hunted down? The older, slower, ailing gazelle, and the herd is thinned, leaving the fittest to live another day. In other words, if there are fewer top regional health care centers and hospitals, then people will die sooner. This is the thought process of the appointed Director of the Centers for Medicare and Medicaid Services, Donald Berwick: reduce the quality of care and fewer people will live to old age! The opposite of what any sane individual American would want.

Eugenics proponents would have the weaker newborn removed from the human herd. It is clear that "Darwinism gave rise to the eugenics philosophy. Eugenics is 'the science of improving the stock.'" Eugenic thought existed throughout history, but Darwinism gave it a huge boost. For those at the end of life, euthanasia advocates wish to be able to legally impose death on the terminally ill.

We also need to consider the steadily growing fields of genetic research, biotechnology, nanotechnology and other technological developments that are offered as ways to eliminate many diseases and conditions. Genetic research and amniocentesis allow for prenatal testing to detect many conditions. The presumed, "approved treatment," is abortion, for those individuals who are found to have a genetically-detectable condition. In the search to improve the lives of humanity, medical scientists, eugenicists, think nothing of completely eliminating the lives of those who may not be "perfect" in their eyes. In other words, medical eugenicists prefer to eliminate life to end suffering, and mothers being intimidated to have a "voluntary" abortion is but one step away from coercive eugenics.

Kristan Hawkins, Executive Director of Students for Life cautions:
"... will prenatal genetic tests eventually move from being voluntary to mandatory, in the name of cost-savings? Down the road, will abortions be encouraged by the state or even forced on those children who will have special needs or will need life-long medical care?"

[and] "...Today, in America, this rationing is already happening to many babies born with Trisomy 18 and 13" 

"Eugenics" by Kristan Hawkins March 31, 2010 Lifenews.com

The same type of thinking dominates when it comes to the elderly and disabled: "eliminate the patient" to end their suffering. Of course, the old, ailing and disabled die, and Nature takes its course in its own timing, but we are not animals to be euthanized like dogs. A civilized society cares for its elderly, ailing and disabled; it does not go out of its way to avoid caring for them or intentionally impose death!

Well, the administrator of the Centers for Medicare and Medicaid Services, Donald Berwick doesn't agree. Obviously if Berwick gets his way, major metropolitan areas will have fewer advanced, high-tech, cutting-edge medical services, and the costs of providing care in America will be reduced (the elderly, ailing and disabled will die much sooner). Berwick's "worthy aim" to reduce the number of these regional centers would basically destroy the very excellence of medical care that America is noted for!

Not only that, Julian Pecquet wrote in his July, 2010 (The Hill) article, "GOP says Obama avoiding questions about CMS head's ties to industry."

Berwick's Institute for Healthcare Improvement received more than $9 million in "gifts" in 2008 and 2009 from unknown donors, according to Grassley's office, at the same time that Berwick was being paid a $2.4 million salary as CEO.

If anyone has questions about whether there really are "death panels" envisioned in the new health care reform law, Joe Wolverton, II entitled his July, 2010 article, "Donald Berwick" citing:

"The executive director of the National Right to Life organization, David Osteen, [who] described Berwick as a "one-man death panel."

"President Obama's appointment of this open advocate of rationing to implement his health care law underlines the need for repeal before untold numbers of vulnerable Americans suffer death from denial of life-saving treatment," Osteen continued.

Berwick stated very plainly in a 2009 interview, "Rethinking Comparative Effectiveness Research" that he supports its use to ration care and bring costs down:

"The decision is not whether or not we will ration care--the decision is whether we will ration with our eyes open."

The real question is whether decisions made by Big Government about the availability of the care you need will be in your interests or the interests of an impersonal government evaluation of what "people of your age" should have access to. Remember, "Comparative Effectiveness Research" may sound reasonable at some point, but when coupled with Ezekiel Emanuel, MD's "Complete Lives System," it's a recipe for disaster. And these types of ways of thinking, so shocking to ordinary citizens, have been promoted for many years. They will be pushed
forward by many of the elite whether or not the health care reform law is declared unconstitutional by the Supreme Court.

The Independent Payment Advisory Board (IPAB), (also mentioned in the health care reform law as the "Independent Medicare Advisory Board") with its Presidentially-appointed 15 members, can amass unimaginable power to limit care provided to Medicare recipients. Mark Hemingway has written an April 14, 2011 article, "Obama's Medicare Plan: Rationing by Bureaucrats -- The president's big plan for Medicare involves unelected bureaucrats making life or death decisions." Hemingway states that "any recommendations IPAB makes about Medicare spending automatically become law," and that "IPAB is more and more likely to be a Trojan Horse for the serious command-and-control rationing."

Prior to the enactment of the health care reform law, we had "the sustainable growth rate ("SGR")" [that] was a well intentioned effort to slow the increase in Medicare payments to more closely match the rate of inflation." The forerunner of IPAB, "MedPAC (the Medicare Payment Advisory Commission) plays an advisory role in establishing SGR, but it requires the action of Congress to institute it." Contrary to Constitutional law, the new IPAB has powers only Congress had beforehand and its directives will become law if Congress fails to get three-fifths of its members to vote to override IPAB's recommendations.

James Capretta, a former top health official at the Office of Management and Budget says:

"The only thing they [IPAB members] can really do is change what those who are providing services to the patients get paid. And of course, what they're going to get paid under this kind of proposal is less and less and less over time," Capretta said.

"When you bring payment rates down, people say, 'I can't provide that service at that price,' and they stop doing so. That's when you end up with the situation of, frankly, rationing, price rationing." [Emphasis added]

[Obama Seeks Stronger Hand for Medicare Panel by James Rosen April 22, 2011 FoxNews.com]

IPAB is part of the executive branch, but its recommendations become law and can only be countered by the Congress with that three-fifths majority vote. Some say IPAB is unconstitutional because they have a legislative function, but are in the executive branch. It is clear that IPAB could exert tremendous power to limit care and available treatments over time. Many government proposals that started very small have grown through the years. For example, the 16th Amendment was enacted in 1909 and allowed the federal government to levy an income tax with about 1% of the population paying about 1% in taxes in 1913. Now, at least 53% pay income taxes and the rates vary from about 10% to 35%. Another example? When Medicare started in 1966 it cost $3 billion, and they projected it would cost $12 billion in 1990. But it actually cost $107 billion in 1990, almost ten times what was estimated. The federal government's programs and powers just seem to keep growing every year!

The American Medical Association is strongly opposed to IPAB. The AMA writes, "The 15-member IPAB is a presidentially appointed board comprised of health care experts and economists who are tasked with developing Medicare spending cuts in years during which spending exceeds a target growth rate...."

The AMA goes on to explain one of the most revealing aspects (for our purposes here) of the IPAB cuts: "rate reductions for hospitals and hospices are explicitly excluded until 2020, yet, estimates from the Congressional Budget Office calculate a reduction in Medicare
spending of approximately $15.5 billion from 2010 to 2019, raising concerns that only a few providers, including physicians, will bear the brunt of the cuts." [Emphasis added] There could be no more obvious proof that hospice is being promoted with the full force of the federal government: the hospice industry is shielded from the IPAB cuts in reimbursements for almost ten years!

**How Government Can Work:**

**Involuntary Sterilization, Experimentation and Hastened Death**

What does involuntary sterilization have to do with hospice and end-of-life care? Well, it again demonstrates "how people in government think" and what they are capable of. It demonstrates how the eugenics and euthanasia proponents are willing to treat those they deem "unfit" and "unworthy of life." Involuntary sterilization in America? Unheard of! Not really. Involuntary sterilization actually had widespread public support in America and continued into the 1950s. The idea of eliminating the unwanted includes eugenic restrictions on who is born, sterilization to prevent the unwanted from reproducing, and euthanasia to make those who are unwanted die at any stage of life, all part of the culture of death.

"Although the eugenics movement in the United States flourished during the first quarter of the 20th Century, its roots lie in concerns over the cost of caring for "defective" persons, concerns that first became manifest in the 19th Century. The history of state-supported programs of involuntary sterilization indicates that this "surgical solution" persisted until the 1950s. A review of the archives of prominent eugenicists, the records of eugenic organizations, important legal cases, and state reports indicates that public support for the involuntary sterilization of insane and retarded persons was broad and sustained. During the early 1930s there was a dramatic increase in the number of sterilizations performed upon mildly retarded young women."


The public "face" of our federal government is something other than the reality, and while it provides many services and benefits to the public, it also is responsible for much harm. We have a dark history of performing forced sterilizations and experiments on the mentally handicapped. See "Eugenics: Compulsory Sterilization in 50 American States."

American prisoners and other people were subjected to all sorts of involuntary experiments through the years. The history of medical experimentation on prisoners, soldiers, the elderly and the general population is very well-documented. As a current example, Robert Finney, Ph.D. and patient advocate writes that "for decades, Kaiser Permanente doctors have conducted a medical 'experiment' on unwitting patients to determine the cost and progression of kidney failure and its complications, when diagnosis and treatment are intentionally withheld."
You think the government would never experiment upon our brave young men and women who enter the military? Here are just a few of many cases:

1944 U.S. Navy uses human subjects to test gas masks and clothing. Individuals were locked in a gas chamber and exposed to mustard gas and lewisite [an arsenic-based poison].

1944: Manhattan Project injection of 4.7 micrograms of plutonium into soldiers at Oak Ridge.

1947: The CIA begins its study of LSD as a potential weapon for use by American intelligence. Human subjects (both civilian and military) are used with and without their knowledge.

1953-1970: U.S. Army experiments with LSD on soldiers at Fort Detrick, Md.

What about patients to be cared for? Would the government experiment on them? Absolutely! A few cases are listed here:

1945: Manhattan Project injection of plutonium into three patients at Billings Hospital at University of Chicago.

1946-1953: Atomic Energy Commission sponsored study conducted at the Fernald school in Massachusetts. Residents [mentally-retarded children] were fed Quaker Oats breakfast cereal containing radioactive tracers.

1953 Newborn Daniel Burton rendered blind at Brooklyn Doctor's Hospital due to high oxygen study on RLF.

1953-1957: Oak Ridge-sponsored injection of uranium into eleven patients at Massachusetts General Hospital in Boston.

Involuntary experiments on the general public?

1949: Intentional release of radiodine 131 and xenon 133 over Hanford Washington in Atomic Energy Commission field study called "Green Run."

1950: U.S. Army secretly used a Navy ship outside the Golden Gate to spray supposedly harmless bacteria over San Francisco and its outskirts. Eleven people were sickened by the germs, and one of them died.

There are dozens and dozens of cases like these, but you probably think these things only happened many years ago, right? Wrong.


1998: Boston Globe (four part) series, "Doing Harm: Research on the Mentally Ill" shed light on the mistreatment and exploitation of schizophrenia patients who have been subjected to relapse producing procedures in unethical experiments.

There are many other cases, and experiments continuing into the present, sometimes now done.
on people in other countries who have nobody to protect them and don't understand what is being done to them:


2001: A biotech company in Pennsylvania asks the FDA for permission to conduct placebo trials on infants in Latin America born with serious lung disease though such tests would be illegal in U.S.

When we focus on these involuntary sterilizations, drug trials, radiation exposures, and experiments of all sorts, in most cases it is the poor, the uneducated, minority groups, foster children or mentally-ill who are victimized. These are some of the same groups that the Nazis rounded up for experimentation or elimination. The U.S. House Committee on Oversight is investigating drug manufacturer Wyeth for promoting off-label use of the anti-organ-rejection drug, Rapamune, despite the increased risk of death to recipients of the drug. Using a drug for off-label uses without properly informing the patients and getting permission amounts to involuntary experimentation on the unsuspecting patient. In addition, Wyeth is being investigated in particular for targeting African-Americans for this experimental use of the drug. You might respond by saying these are limited cases, not applied to the general population, and therefore, it "doesn't concern us." We need to remember that all people deserve respect and humane treatment and, any group that today is not subject to discrimination or mistreatment might be subject to another type of harm in the future. Remember:

"In Germany, they came first for the Communists, And I didn't speak up because I wasn't a Communist;

And then they came for the trade unionists, And I didn't speak up because I wasn't a trade unionist;

And then they came for the Jews, And I didn't speak up because I wasn't a Jew;

And then . . . they came for me . . . And by that time there was no one left to speak up."

[Martin Niemöller, prominent German anti-Nazi theologian and pastor]

Involuntary hastened death? Well, as we've seen that's already happening! We have the medical killings in the hospices, hospitals, nursing homes and elsewhere going on and government officials refuse to act, refuse to investigate or prosecute. Medical killing is de facto legal throughout the United States. The victims are not people who wanted to act upon a supposed "right to die." These are people who were deprived of life. Elderly, mentally-handicapped, disabled, even those in need of rehab... manipulated into hospice one way or another, or another health care setting, and terminally-sedated, overdosed or "made to die"
through a variety of means.

When the President, the Congress and state and local government officials choose year after year to not act on medical killings, they choose to allow involuntary medical killings. Not one Senator, Congressional Representative or one of the Presidents has spoken out about these medical killings and made a serious effort to stop them!

We need not go back to the times when our federal government supported the evil of slavery to see its brute force in action. As recently as 1972, the U.S. Public Health Service was involved in one of the most disgraceful involuntary experiments on human subjects ever conducted, the Tuskegee Syphilis Experiment. "The Tuskegee Syphilis Experiment: The U.S. government's 40-year experiment on black men with syphilis" by Borgna Brunner tells us that:

"For forty years between 1932 and 1972, the U.S. Public Health Service (PHS) conducted an experiment on 399 black men in the late stages of syphilis. These men, for the most part illiterate sharecroppers from one of the poorest counties in Alabama, were never told what disease they were suffering from or of its seriousness. Informed that they were being treated for "bad blood," their doctors had no intention of curing them of syphilis at all."

".... By the end of the experiment, 28 of the men had died directly of syphilis, 100 were dead of related complications, 40 of their wives had been infected, and 19 of their children had been born with congenital syphilis."

".... The experiment continued in spite of the Henderson Act (1943), a public health law requiring testing and treatment for venereal disease, and in spite of the World Health Organization's Declaration of Helsinki (1964), which specified that "informed consent" was needed for experiments involving human beings."

Along these lines, who did President Obama name as his "Science Czar?" John Holdren. Who is he? The Director of the White House Office of Science and Technology Policy, Assistant to the President for Science and Technology, and Co-Chair of the President's Council of Advisors on Science and Technology -- informally known as the United States' Science Czar.

Holdren co-authored the 1977 book, Ecoscience, with his close colleagues Paul Ehrlich and Anne Ehrlich, and wrote:

* Women could be forced to abort their pregnancies, whether they wanted to or not;

* The population at large could be sterilized by infertility drugs intentionally put into the nation's drinking water or in food;

* Single mothers and teen mothers should have their babies seized from them against their will and given away to other couples to raise;

* People who "contribute to social deterioration" (i.e. undesirables) "can be required by law to exercise reproductive responsibility" -- in other words, be compelled to have abortions or be sterilized.

* A transnational "Planetary Regime" should assume control of the global economy and also dictate the most intimate details of Americans' lives -- using
an armed international police force.

This was not some simple paperback "quick read." It was 1,051 pages long and was a quite serious text promoting these and other utilitarian, eugenic ideas. With the passage of the years, these elitists have not abandoned their ideas, but have slowly but surely worked to implement them incrementally. Though Holdren and the Ehrlichs now incredibly say they "never" advocated the coercive methods mentioned in the book, just "discussed" them, it is hard to swallow their denials when they continue putting forth "doom and gloom" predictions requiring governmental action. Why would they write such a serious book, over 1,000 pages long if they did not believe what they were writing? It was not a work of fiction. Holdren still is a big proponent of the man-made global warming scam and is promoting methods to "shoot pollution particles into the upper atmosphere to reflect the sun's rays and cool the earth." He is now famous for making predictions that have not come true.

Harvard-educated Jerome Corsi, Ph.D (in political science) wrote for WorldNetDaily, July 10, 2010, "Obama science czar: Surrender to 'planetary regime' Urges U.S. to give up sovereignty to U.N.-controlled world supergovernment"

And what is Susan Rice, the United States Ambassador to the United Nations saying now? Rice, appointed by President Obama, stated at the World Affairs Council of Oregon, Portland, Oregon, that "our challenge today is to strengthen [the United Nations] and in doing so, to make America more secure. Significant that she was at the "World Affairs Council" in the state that also gave us legalized assisted-suicide!

Continuing on about our Science Czar, Holdren:

"The authors argued that involuntary birth-control measures, including forced sterilization, may be necessary and morally acceptable under extreme conditions, such as widespread famine brought about by "climate change."

"They recommended the creation of a "planetary regime" created to act as an "international superagency for population, resources and environment."

and

"Holdren acknowledged the United States would have to surrender sovereignty to the planetary regime and that the regime would have to have military arms for the envisioned supergovernment to succeed.

"He clearly specified the planetary regime would be charged with global population control.

"Holdren wrote: "The Planetary Regime might be given responsibility for determining the optimum population for the world and for each region and for arbitrating various countries' shares within their regional limits. Control of population size might remain the responsibility of each government, but the Regime should have some power to enforce the agreed limits."

Those are not my words. They are the words of the Science Czar appointed by our President! Yet for all of Holdren and the Ehrlichs scare tactics, "overpopulation is a myth: plenty of food and space exists." Wars and greed create the conditions where people go hungry.

Seem a little hard to believe these views of those who are running our government? Well, let's consider "Project Paperclip," a project of the United States Government. Attorney and human
rights activist, John W. Whitehead, Esq. writes in "Nazis," December 28, 2010:

"After a lawsuit and pressure from private interest groups, the Justice Department finally released a 617-page report detailing how the American government not only welcomed but employed Nazis after World War II ... enlist[ing] them in subjecting Americans to all manner of experiments, what are they capable of doing to us now?"

"Take Project Paperclip, for example. Few have heard of it because the U.S. government has successfully concealed most of the facts surrounding the project. The government has passed it off as a short-term operation limited to an innocent investigation of Germany's scientists after World War II. In reality, Project Paperclip was the largest and longest-running operation involving Nazis in the history of the United States, and its effects are still being felt today."

[One example out of many given] ".... Kurt Blome, a high-ranking Nazi scientist, told U.S. interrogators in 1945 that he had experimented with plague vaccines on concentration camp prisoners. He was tried in the Nuremberg War Trials -- but acquitted -- on charges of extermination of sick prisoners and conducting experiments on humans. .... Blome was hired by the U.S. Army Chemical Corps to work on chemical and biological warfare."

".... Edgewood Arsenal, located near Baltimore, MD., is the most secret military base in the country. Paperclip scientists worked there between 1947 and 1966 conducting experiments on American citizens. Initially, their main efforts were to test the poison gases that had been invented by the Nazis during the war. Soon, the testing turned to LSD and other mind-control agents. Nazi science that was reminiscent of concentration camp experimentation was used as the basis for research in the United States on Americans.

"MKULTRA, for example, is the name of the mind control experiments conducted on U.S. soldiers under Project Paperclip. Reviewing the experiments in the late 1950s, one CIA auditor wrote of them: "Precautions must be taken not only to protect operations from exposure to enemy forces but also to conceal these activities from the American public in general. The knowledge that the agency is engaging in unethical and illicit activities would have serious repercussions."

".... Nazis went unpunished and federal law was violated. Worst of all, as Linda Hunt has documented, Nazi attitudes toward research on human subjects were imported and adopted by various U.S. officials."

A February 27, 2011 Washington Post article, "AP IMPACT: Past medical testing on humans revealed" reviews the history of involuntary medical experimentation in the United States. The article implies that unethical medical experimentation in the United States ended in the 1970s due to reforms here, and that scientists interested in conducting such unethical experiments went elsewhere to other countries. While that is true, some involuntary medical experimentation has continued in the United States. We hear reports of patients being injected with various substances against their wishes, often without their knowledge. This is a one of the well-censored stories in America, just like the widespread medical killings, the stealth euthanasia victimizing many, many thousands.

Although many believe otherwise, the modern origin of the eugenics and euthanasia movement
Eugenics was the racist pseudoscience determined to wipe away all human beings deemed "unfit," preserving only those who conformed to a Nordic stereotype.

Elements of the philosophy were enshrined as national policy by forced sterilization and segregation laws, as well as marriage restrictions, enacted in twenty-seven states. Ultimately, eugenics practitioners coercively sterilized some 60,000 Americans, barred the marriage of thousands, forcibly segregated thousands in "colonies," and persecuted untold numbers in ways we are just learning. Before World War II, nearly half of coercive sterilizations were done in California, and even after the war, the state accounted for a third of all such surgeries.

"California was considered an epicenter of the American eugenics movement. ...."

"Eugenics would have been so much bizarre parlor talk had it not been for extensive financing by corporate philanthropies, specifically the Carnegie Institution, the Rockefeller Foundation and the Harriman railroad fortune. They were all in league with some of America's most respected scientists hailing from such prestigious universities as Stanford, Yale, Harvard, and Princeton. These academicians espoused race theory and race science, and then faked and twisted data to serve eugenics' racist aims."

"Stanford president David Starr Jordan originated the notion of "race and blood" in his 1902 racial epistle "Blood of a Nation," in which the university scholar declared that human qualities and conditions such as talent and poverty were passed through the blood."

"In 1904, the Carnegie Institution established a laboratory complex at Cold Spring Harbor on Long Island that stockpiled millions of index cards on ordinary Americans, as researchers carefully plotted the removal of families, bloodlines and whole peoples. From Cold Spring Harbor, eugenics advocates agitated in the legislatures of America, as well as the nation's social service agencies and associations."

"The Harriman railroad fortune paid local charities, such as the New York Bureau of Industries and Immigration, to seek out Jewish, Italian and other immigrants in New York and other crowded cities and subject them to deportation, trumped up confinement or forced sterilization."

"The Rockefeller Foundation helped found the German eugenics program and even funded the program that Josef Mengele worked in before he went to Auschwitz."

"Much of the spiritual guidance and political agitation for the American eugenics movement came from California's quasi-autonomous eugenic societies, such as the Pasadena-based Human Betterment Foundation and the California branch of the American Eugenics Society, which coordinated much of their activity with the Eugenics Research Society in Long Island. These organizations—which functioned as part of a closely-knit network—published
ra
cist eugenic newsletters and pseudoscientific journals, such as Eugenical
News and Eugenics, and propagandized for the Nazis."

And who was one of the main leaders in the effort to include advance care planning "counseling" in the health care reform law? "Senator John D. Rockefeller IV of West Virginia, [who] had urged the administration to cover end-of-life planning as a service offered under the Medicare wellness benefit." Rockefeller, from the same family that (as we just read above) "helped found the German eugenics program and funded the program that Josef Mengele worked in before he went to Auschwitz."

### Utilitarian Care Rationing: Health Care Reform, The Government's "Complete Lives System" and Hastened Death

When President Obama was elected, he chose Chicago politician Rahm Emanuel as his White House Chief of Staff, and later named Rahm's brother, Ezekiel Emanuel, MD, PhD as his Health Care Advisor. Dr. Emanuel, Chair of the Clinical Center Department of Bioethics for the U.S. National Institute of Health is a leader in medicine and bioethics. A graduate of Harvard Medical School and professor of medicine there, the list of his accomplishments is truly impressive.

For many years, he has asserted his opposition to the legalization of euthanasia and assisted suicide, preferring good end-of-life care as the best choice for the terminally ill. Just as Dr. Byock has done. What could be wrong then? Why has his name been mentioned as related to "death panels?" He certainly says that he is upset that his views, in his opinion, have been misrepresented.


The discussion of the "Complete Lives System" was within the context of allocating scarce medical resources for liver transplant patients or vaccine recipients (in the case that there was not an adequate supply of vaccines or organs for transplantation). The authors explain their view that patients who are younger would benefit more from a liver transplant, have longer use of the organ and that giving the organ to the younger patient is the "right" way to go. This is not a far cry from the old, traditional cry, "women and children first" when saving passengers on a sinking ship.

Triage in a hospital or health care system also involves choosing who best will benefit from care. If there's a scarce supply of organs to donate, then doctors need to think about who gets
the organs when they become available. How to choose?

While Dr. Emanuel may assert that his "system" is intended "only" for application in the case of vaccine scarcity or organ scarcity, but can we trust Dr. Emanuel that the "system" won't be used for general rationing of health care? I don't think Dr. Emanuel can control how his "system" is used. He certainly has many accomplishments in medicine, but he may have done much harm as well.

Whatever "learned" discussion he may have among scholars, debating the ethical nature of this or that medical decision ... when it comes to implementing Obamacare or reforms to Medicare (without the health care reform law), there are not going to be long-winded debates. There will have to be entitlement reforms with the current national budget crisis. The "Complete Lives System" will not be restricted to just those cases that Dr. Ezekiel Emanuel was referring to (vaccine distribution and organ distribution). His system will be used to decide how to ration all available services for the elderly across the board in many, many situations. And even limiting it to vaccine distribution and organ transplantation may not be fair or ethical either.

With current organ transplant networks, a patient gets "on the list" for an organ transplant and waits till they arrive at the front of the line and when an organ is available, they get it. Under Dr. Ezekiel Emanuel's system, the elderly could be prevented from ever getting an organ no matter how long they wait! Using this system, the elderly would die, whereas with the current system, they could wait just like any other person and get an organ when it is available.

The Wall Street Journal's December 29, 2010 article, “Death Panels Revisited - The left won't admit that Sarah Palin had a point about rationed care” provided this assessment:

"Under highly centralized national health care, the government inevitably makes cost-minded judgments about what types of care are "best" for society at large, and the standardized treatments it prescribes inevitably steal life-saving options from individual patients."

That already happens under Medicare and Medicaid. Ask any doctor. Now, in 2011, Dr. Ezekiel Emanuel has left the administration post and gone back to work at the National Institute of Health. Why was he brought in? And why is he leaving now? It's clear that the job he was brought in to do is done. He helped shape the thinking of those implementing health care reform, whether through administrative actions in the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, or in the reform law. His input is no longer needed. Rationing will happen in Medicare, Medicaid and if implemented, a national health care system.

The New York Times published an editorial on rationing and organ transplants suggesting exactly what we've been reviewing here:

The number of kidneys available for transplants falls far short of the need, so there is no choice but to ration them. ...."

There are nearly 90,000 people on waiting lists to receive kidney transplants, and in 2009 there were only some 10,400 kidneys from dead donors to give them. And about 6,300 kidneys were transplanted from living people who donated one of their two kidneys and usually specified the recipient.

Currently the kidneys from dead donors are provided, through an organ procurement and transplantation network, to people who have been waiting the longest. That may seem fair since many transplant candidates wait for
years, and some die while waiting.

But the system has serious shortcomings. Some elderly recipients get kidneys that could function far longer than they will live and that could have done more good for a younger recipient. Some younger recipients get kidneys that will fail and will need to be replaced, using up another scarce kidney.

These problems could be eased through a proposal under consideration at the transplant network to better match the likely longevity of the patient with the likely functional life of the kidney.

The patients and kidneys would each be graded separately. About 20 percent of the kidneys predicted to have the longest functional lives would be provided to the youngest and healthiest patients. The other 80 percent of kidneys would go to patients who are no more than 15 years older or younger than the donor.

The approach seems likely to make it harder for elderly people to get a kidney. But when kidneys are already scarce and apt to get scarcer as much of the population ages and sickens it is a rational choice.


There in a nutshell is the rationing of care for the elderly argument. It's going to hit the elderly from every side, whether organs for transplantation, medications, surgeries, or diagnostic tests. Wherever the elderly turn, they're going to increasingly face this type of discrimination. If the public doesn't wake up soon, it will be legalized discrimination that results in much earlier deaths for the elderly, and it will affect all Americans as they age. It will be accomplished by suggesting this is the "rational way to go." That it is discrimination, that it will result in earlier deaths for one group of citizens, that it is contrary to the respect for the individual's rights under the Constitution (to be treated equally under law), that it is the same "logic" used by the Nazis will not be mentioned.

**Government Health Care Reform Law & the former Hemlock Society (Compassion & Choices)**

Compassion & Choices (formerly the "Hemlock Society") brags about writing the language in the health care reform law that pertains to these strongly encouraged paid physician "counseling" sessions with the elderly, counseling sessions that specifically were to include making out an advanced directive or living will, talking about hospice and palliative care, and specifically filling out the P.O.L.S.T. form.

Why would the chief "overt" pro-euthanasia organization in the country care about these
counseling sessions? Well, being that they are pro-euthanasia, they realize just as the "covert" euthanasia groups do, that any forms (advanced directives, living wills, DNRs, and the P.O.L.S.T. forms) that limit care will result in hastened deaths, the push into hospice, where the "Third Way" terminal sedation can be applied. The elite leaders of the euthanasia movement believe in the agenda: eugenics and euthanasia go hand-in-hand. Euthanasia and "culling the herd" of those "unworthy of life." Culling the herd of those whose quality of life they say is "too low."

They believe the lives of these vulnerable individuals have no value. Yet, parents of the disabled know differently. The Christian minister, Kathryn Kuhlman, relates the story of a Mrs. Fischer who gave birth to a baby with severe congenital hydrocephalus and was told by several physicians that the little girl, Billie, would without a doubt be permanently retarded if it functioned at all. The baby was completely nonresponsive, and the physicians advised her to institutionalize the baby, but Mrs. Fischer said,

"No. I can't ever send her away from me. I love her too much. And if she isn't aware of anything else in this whole world, she must somehow feel this love. As long as God gives me the strength to take care of her, I'm going to do it."

Mrs. Fischer and her 12 year-old daughter, Helen, fasted and prayed for little Billie's healing and their prayers were answered! The size of little Billie's head began to reduce in size till she became quite normal and later on became a perfectly normal girl and an "A student" in school. See I Believe in Miracles by Kathryn Kuhlman, 1965. p. 77-84.

Euthanasia advocates do not recognize the possibility of miracles, spiritual healing or the value of the lives of the severely disabled. The euthanasia advocates at Compassion & Choices know that rogue hospice which has been given a free pass to hasten death by all levels of government, will accomplish their goals of bridging the gap between where we are today and their "final solution." Now, direct euthanasia is illegal throughout the country and assisted-suicide is legalized only in a few states.

Once the P.O.L.S.T forms or advanced directives are filled in for almost all patients, and health care rationing is stepped up through the government Medicare or Medicaid systems, or rationing done by private managed-care organizations, when a personal health crisis arises, the elderly and severely disabled will have no option other than going into hospice and/or palliative care; treatment will not be available because funding will be cut off for other treatments!

Rogue hospices will accomplish what the Euthanasia Society's elite never could do: euthanize the unwanted, elderly, severely disabled and/or medically-complex chronically-ill. You won't hear about it happening, though. Thanks to HIPAA's Privacy Shield, the wall of silence will prevent widespread reporting. You will only hear about someone here or there who "went into hospice." It's all been very well thought-out to reduce public outcry.

The Euthanasia Society's representatives through the years tell us that the severely disabled and very elderly "would not wish to live" in those conditions, but research tells us differently. Even among those who are totally "locked-in" and cannot move their bodies at all (except to blink an eyelid), many have communicated that they are happy and do not wish for assisted-suicide or euthanasia.

After several years, it will be easier to pass legalization of euthanasia. Economic pressures are already mounting very quickly. States are in emergency cost-cutting mode and Medicaid is going to be cut. The federal budget is even worse. There is no question that Medicare benefits per person are going to be cut back eventually. They may not tell the public in so many words,
but it will be cut. The legalization of euthanasia will become hard to resist for Congressional Representatives struggling to balance a budget that is way out-of-control.

In fact, having a budgetary crisis that is way out-of-control gives the government the excuse to impose cost-cutting at all levels of health care, especially at the end where the elderly are concerned. As the President's former chief of staff, Rahm Emanuel (Ezekiel's brother), has said, "Never let a serious crisis go to waste." Private insurers are already famous for their treatment denials. If there is a war involving an attack on the United States, if the dollar is discarded as the world global reserve currency, if the federal government keeps printing trillions of dollars, the economic pressure to hasten the death of the vulnerable will be incalculable. The dollar will lose its status as the world's reserve currency, causing devaluation of its worth, inflationary pressures, a lowering of the standard of living in the United States, and more pressure on the federal government in paying interest on the debt. Not to alarm you, but these factors may very well cause a national emergency of some type, and there will be no alternative but to implement widespread reductions in the entitlement programs: Medicare, Medicaid, and Social Security.

As we have seen, when Germany was economically devastated after WW I, the Nazis seized control and implemented changes to get the German economy back on track. And, remember: "Already in 1935 Adolf Hitler had told Gerhard Wagner that if war came he would implement the killing of the handicapped." Of course, our economic situation would be unique, but the pressures would, in the eyes of the utilitarians, justify widespread implementation of euthanasia.

Michael Pryce, MD has read the law and has this to say about what really is in the law:

"If one carefully reads the bill, and it just may take a doctor to elucidate this, the beginnings of medical killings are clearly laid out for the future. The authors of the law cleverly and strategically placed a disclaimer in the law to head off any criticism. The disclaimer states that "individuals or institutions refusing to participate in 'assisted suicide, euthanasia, or mercy killing' may not be discriminated against by government, entities receiving federal financial assistance under this Act, or health plans created under this Act." (p. 141, section 1533). Enough said? The government and others cannot persecute or presumably prosecute a doctor or a health care institution for refusing to conduct clearly defined medical killing.

The readers must ask themselves why are those terms even included in a "health care" bill? Reading on in the law, "This protection, however, explicitly does not apply to or affect any limitation relating to (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of any item for the purpose of alleviating pain even if such use may increase the risk of death as long as such an item is not furnished with the purpose of causing, or the purpose of assisting in causing, death, for any reason." So the law unbundles the terms "assisted suicide, euthanasia, and mercy killing" into individual events that in and alone would be enough to cause death. Although they claim protection against the unbundled terms like euthanasia, they can and will persecute and prosecute if the health care providers refuse to withdraw, medications, medical treatments and procedures, fluids and/or nutrition.

["How to Get ObamaCare Repealed Overnight" By Michael Pryce, on Mar 6,
Remember, we've had decades-long civil rights marches for many causes. Nobody's marching year after year en masse for the elderly, the forgotten, the "to-be discarded." They are truly expendable in the eyes of the government policymakers and elite. And more and more, they are regarded as expendable to significant portions of our society! That's why the government has done nothing significant to change their plight. When an elder dies, the government saves money; that's it. And allowing this to continue currently has no effect on who the public votes for. If people don't object, they don't lose votes, and the elected officials are happy to continue the "status quo," business as usual.

**Government Action When There is A Question of Homicide**

Every county district attorney and police department in the country has received reports of wrongdoing, even wrongful deaths in a hospice. They almost universally refuse to even investigate, let alone prosecute medical killing at a hospice. Their inaction only demonstrates their abandonment of their duty to serve and protect the people. They say, "it's a health care matter." "Take your complaint to the state health department." I've heard this story from families across the country for years.

When hospice directors hear such complaints from families, they usually tell them, "you are clearly having a difficult time grieving, let me get you in touch with our grief counselor." Or, they'll tell the family that the patient was in pain and the morphine was given to relieve that pain (even if the family knows the patient had no uncontrolled pain). Offering to provide a hospice grief counselor to a family member who believes the hospice staff killed their loved one is a real slap in the face. It's highly condescending and offensive. The hospice directors and staff act as if they had no hand in what happened, and portray the family member as a "troublemaker" or as someone who simply "doesn't understand."

If the family members complain while the patient is being "treated" to life-ending interventions such as morphine overdoses, or, anti-psychotic and sedative medication overdoses, the hospice staff may actually threaten the family member, labeling them as "violent," or "a danger to staff and the patient." They have them escorted out of the building and sometimes banned from visiting their loved one at all. I've heard these stories numerous times through the years, and not just from lay people who do not know what is clinically-appropriate. I've heard these reports from physicians, nurses, social workers, attorneys and others who were not able to protect their loved one in a hospice setting.

What happens when the family says it was homicide and the coroners' office actually listened? Almost unheard of, but in hospice industry history there is one case. CBS 60 Minutes II reported in their June 1999 article, "A Question of Homicide" about just such a case. It occurred in Volusia County, Florida, back in 1998. The county Coroner's Office officially ruled nineteen hospice deaths as homicides through morphine overdosage, and forwarded the cases to the county district attorney for prosecution, what happened?

The district attorney refused to prosecute, contacted the state attorney general who appointed a
panel of *hospice* physicians to review the hospice cases. The panel ruled all deaths were natural. Of course! The two physicians in the coroners' office were terminated and the third forensic scientist told me that because he was a civil servant and was protected by county regulations from being terminated without cause, he was harassed until he resigned and fled the state.

It's not an easy thing for a coroners' office to formally, officially rule a case as a homicide and refer it to the district attorney for prosecution. It's even harder for them to rule 19 deaths as homicides. They had to be sure. When they're looking at cases from the local, respected hospice, those coroners went over every detail many times to be sure. They had no doubt. But it was all covered up. The prosecutors refused to enforce the laws and prosecute the cases! Hospice is a protected industry. We've seen this over and over again as in the United Kingdom where the

"Director of Public Prosecutions has declined to bring charges against at least 20 people suspected of helping others to commit suicide...."

"The disclosure provoked fury from anti-euthanasia groups. They accused [The Director of Public Prosecutions] Mr. Starmer, who is in charge of all criminal prosecution decisions, of single-handedly rewriting the law on suicide."

What happens if a nurse puts in a complaint to the state department of health? Aside from losing her job by being harassed out or retaliated against, she may be blackballed completely from the industry. **Blackballing** of nurses (making them un-hireable) happens!

Some nurses have had their licenses attacked at the state board of nursing with fabricated charges against them. And the result of their complaint? In almost all cases, the state inspectors "fail to corroborate" or fail to investigate the "allegations" in a timely manner and therefore no action at all is taken.

As an example, back in 2005, **the California "Health department was sued to force it to follow the law:***

"Exasperated by what they say are years of state indifference to nursing home complaints, two San Jose-area women and a watchdog group are suing the Department of Health Services in hopes that the courts can force the agency to follow its own rules."

"State law requires nursing home complaints -- written or oral -- to be acknowledged within two days and investigated within 10 days. That seldom happens, say critics of the department. And a department spokeswoman said Tuesday that in only about 40 percent of the less serious cases -- those that do not involve an immediate threat to life -- are investigations begun within 10 days."

"More and more complaints are not investigated at all, or not on a timely basis," said Patricia McGinnis, head of California Advocates for Nursing Home Reform, one of the plaintiffs in the lawsuit."

What happened with the lawsuit? California Advocates for Nursing Home Reform won the case.

"The Department was ordered to comply with the statutory requirements and
to complete investigation of the "backlogged" complaints within a specified period of time."

But forcing the inspectors to respond to complaints in a more timely basis has not led to better care.

"Charlene Harrington, lead author of a University of California at San Francisco study that was released [in May 2008 said]: "The study found that the number of complaints about poor quality of care increased, as did documented deficiencies and citations."

"The quality of nursing home care has been a serious problem in California and nationwide for many years," Harrington said.

Professor Harrington is correct. Problems in nursing home care as well as care in other agencies are extremely severe in many cases all over the country. When families, patients or staff complain, the state departments of health do not respond in an effective way to force compliance with regulations that protect patients.

In March 2002, Bee Becker, retired HPA Board member testified before Congress about her mother-in-law's murder in a nursing home, yet nothing has changed within the industry. The Congressional investigations confirm over and over again that patients are still abused, neglected and directly harmed, Congressman Waxman's 2001 investigation being just one of many through the decades. Here is Bee Becker's testimony to Congress, even more relevant today as conditions worsen:

Statement of Barbara Becker to United States Senate - Special Committee on Aging March 4, 2002

Mr. Chairman, Members of the Committee, I am Barbara Becker from Indiana. Thank you for allowing me to represent my mother-in-law, 83-year-old Helen Becker Straukamp, homicide victim.

According to the facility, Helen had been "injured"; the hospital was informed that she suffered a "fall", but an employee later told us of the assault. An eyewitness reported that Helen was picked up by her arms from a standing position, lifted off the floor and slammed into a wall and handrail, falling to the floor unconscious.

Helen was never even able to stand again and died 22 days later. The coroner ruled her death a homicide.

I discovered on my own in Louisville that the perpetrator of this assault was a male mental patient with a decades-long, violent history which
included 4 shootings, SWAT teams, prison time, etc. None of this was mentioned in the investigations.

I found documents signed by the nursing home showing that they knew of his history. After the assault on Helen, this resident was soon given his usual access to the entire population of the facility. He threatened to castrate a wheelchair-bound resident while a surveyor was in the facility. He attempted to assault yet another elderly female resident, and the administration of the facility did nothing. I notified a detective and the prosecutor. A judge issued an order for involuntary removal to a psychiatric unit where he had to be placed in total lockdown and charged with involuntary manslaughter, pending a competency hearing.

My experiences with regulatory agencies, law enforcement, etc., are as follows:

Due to my dogged determination for accountability, I contacted elected representatives including the Governor, the state and U.S. attorneys, CMS, HHS, and the GAO. Four investigations resulted in 42 pages covering six years of previously 'undiscovered' violations from the date of this man's admission. No immediate jeopardy level was imposed due to Helen's death. HCFA overrode the state's flat fine and imposed a $1,000/day fine, but the scope and severity level was unchanged. Still out of compliance on a revisit, the CMP continued and total fines amounted to $60,800; by not appealing, they were granted an automatic 35% federal discount to $39,520, regardless of the homicide. To this day, the facility's record on the CMS website appears very favorable. The entire experience with the state regulatory agency was adversarial from the first meeting. There was absolutely no doubt who was being protected, and it wasn't the residents. In my first meeting with an IDOH official, I was personally told "well, this wasn't like a beating"; the former assistant commissioner refused to discuss the case with me.

Law enforcement investigated, but only the perpetrator.

I contacted Adult Protective Services three times, only to be told that they don't handle nursing home cases. They are barred from investigating nursing home cases without orders from the DOH; DOH rarely uses this resource.

I contacted the Peer Review Organization, Health Care Excel and received only a letter and brochure, declining to even investigate.

The Medicaid Fraud Unit completed a very thorough investigation and validated every piece of evidence I had provided. I pushed the completed case through the AG's office (who took no action) and on to my local prosecutors. They declined to investigate or prosecute. There has yet to be any justice for a homicide.

All I hear from the industry are labels of "isolated incidents", which must by now number in the hundreds of thousands; "frivolous lawsuits", no matter how horrific the case; I hear whining for "more money", "less regulation" and what I refer to as tort 'DE-form'. The 'system' leaves no alternative for victims.
I could have provided reams of evidence today, until I realized that countless victims and family members like me have stood here before you, evidence in hand. Countless Congressional Reports, GAO Reports and studies have been presented to Congress for years. The evidence is already in....those with the power to stop these atrocities know exactly what is happening. You have seen thousands of certificates of unnatural deaths, thousands of pictures of the bodies of victims of our 'system'.

At least 15 of the 25 largest nursing home chains have been accused, found guilty or have admitted to Medicare fraud of multimillions of taxpayer dollars. To my knowledge, not one owner/operator has gone to prison. They are not even required to pay back all the defrauded funds.

Negligent homicide and elder abuse within my home or the community, is treated as criminal; not so inside a nursing home. It's a regulatory offense with no criminal accountability.

I am from a long line of patriots and veterans from W.W.I through Desert Storm. Yet veterans referred to as the "Greatest Generation" are enduring these same nursing home atrocities and treated as those least deserving of our country's respect. Yet there is considerable concern for the Afghan detainees in Cuba, and it's a felony to euthanize a mockingbird here in Washington.

Helen's homicide was included in Congressman Waxman's Report to Congress July 30, 2001, on reported abuse in one-third of our nursing homes and has received nationwide media attention.

It's long past time to restore the Civil and Constitutional Rights of nursing home residents.

Thousands are waiting to hear the results of today's hearings.

When will we have justice?

With all due respect, what will I be able to tell everyone across the country when I return home?

- Barbara Becker

And, yes, many patients are being abused, neglected and directly harmed in these facilities. If that's not enough, some are medically killed in locations around the country, and sometimes it is the adult child, spouse or guardian who puts the patient into hospice, sometimes it is a nursing home or hospital that encourages enrollment in hospice, though the patient is not terminal, and the patient dies within a week or two. The "death protocol" is well-rehearsed and 100% effective.

Just look at the changes in the hospice population of patients:
"The percentage of Medicare hospice patients with lung cancer dropped from 16% in 1998 to 9% in 2008. In addition, we are seeing a notable increase in the number of neurologically-based diagnoses. We are also seeing a marked increase in non-specific diagnoses such as "Debility, Not Otherwise Specified", and "Adult Failure to Thrive". -- Hospice Data 1998-2008 - Centers for Medicare Services

When a patient is admitted to hospice for "debility," "failure to thrive" or "not otherwise specified," I get concerned. I've seen cases where an elderly patient was labeled "failure to thrive," but when a family member got involved and made sure the patient got the medications they needed, had good food to eat that they liked, took the time to make sure they ate, and showed that they loved them, the patient came around, gained weight and returned to full health. I've also seen cases where they ended up dead, because they didn't get the kind of care that used to be common-sense and ordinary.

I remember the Jan 10, 2000 Archives of Internal Medicine study of Oregon physicians, "Attitudes and Practices Concerning the End of Life - A Comparison Between Physicians From the United States and From the Netherlands" that showed they would increase the dosage of morphine if the patient was very weak (debility), thought their life was meaningless or if they thought they were a burden on their families.

* When severe weakness and debility of the patient were involved, 36% approved of increasing the dosage of morphine; 37% approved of Physician-Assisted Suicide ("PAS"); and 14% approved of euthanasia.

* When patients felt that they were a burden on their families, 24% of the physicians approved of increasing the morphine dosage; 24% approved "PAS"; 7% approved of euthanasia.

* When patients felt that their lives were meaningless, 20% of the physicians approved of increasing the morphine dosage, 22% approved of "PAS", and 7% approved of euthanasia.

These doctors are not talking about increasing the dosage of morphine to relieve pain which is what morphine is for. This is increasing the dose when there is no need for morphine.

Increasing the dose of morphine when there is no uncontrolled pain is certain to cause all the predictable adverse effects: a lower respiratory rate, lower blood pressure, cessation of breathing and death.

So, increasing the dose of morphine when the patient has no extreme pain, but has weakness, felt his or her life is meaningless, or thought they were a burden? That is clearly a decision to end the life of the patient.

Reassuring, isn't it?

We know that in 2007, there were 2,423,712 total resident deaths recorded in the United States.

In Belgium where euthanasia is legalized, "the incidence of euthanasia in Flanders in 2007 was ... estimated as 1.9% of all deaths." if we were to estimate the number of intended, active euthanasias in the United States using this percentage, 46,050 patients would have been medically killed by outright active euthanasia. Many other imposed deaths occur through other means such as withdrawal of needed treatments, refusal to treat, failure to provide food and fluids, terminal sedation and others. Of course, any form of euthanasia is illegal in the United States. You could say there aren't "any" legal euthanasias being performed.

But I know there are euthanasias in this country. Many families have called here reporting intentional overdoses of morphine being given or patients being sedated against their will and dehydrated over the course of a week or two (terminal sedation). You could then say, "they're lay people, non-medical individuals; they don't know anything." But we've had confirmation from palliative care professionals, hospice nurses, doctors, social workers and others who testify to what they've seen.

There are many ways of imposing death, whether "actively" through a lethal medication, or "passively"
through withholding a needed treatment, food or fluids. If you don't treat an easily treatable urinary tract infection and it then goes septic, causing death, that could be seen as "passive euthanasia." If you don't provide food or liquids, that's "passive euthanasia." If you don't provide extra oxygen for a patient that needs it, and he dies, that's "passive euthanasia." If you know there are some simple measures you could take to re-stabilize a patient, but you choose not to do them, you are choosing to have that patient die.

These methods are used in the United States all the time. That's why many Associated Press articles written at the time the Terri Schiavo debate was raging quoted physicians as saying, "I don't know what the fuss is. We do this sort of thing every day."

And remember those Oregon physicians who were studied back in 2000? 20-36% of them would increase the dose of morphine for non-pain-related reasons (causing death obviously). Can we look at this objectively? Physicians are willing to end patients' lives through lethal agents like morphine.

This speaks volumes about what is going on. It's the "untold story" of physician practice. The kind of stuff that most major media outlets are not going to share with us (because they generally favor legalization of assisted-suicide, euthanasia and health care rationing).

So, when the hospice industry talks about expanding services for the non-terminal and providing them through hospice, I see "red flags" of all sorts. I think about what they're not saying. They are not talking about how the leadership has been infiltrated by those who believe in euthanasia of the terminal, the disabled, the chronically ill, those with dementia and other categories of illnesses. They are not mentioning that the ethics that will be used to provide these services will not be based on Constitutional law or rights, or based on the sanctity of life, but on secular utilitarian ethics. They will not reveal that the government officials are interested in culling the population of patients who have repeat acute hospital admissions; they don't want to pay for it.

Patients with dementia may have higher risks for injuries and complications requiring hospitalizations or surgeries of various sorts. Those who qualify as "failure to thrive" are on the way to requiring some sort of intervention at the hospital, perhaps with repeat admissions costing many tens of thousands of dollars. If they continue to go downhill, Medicare is certain to pay for a lot of services before the time comes when they are "officially" labeled "terminal" and eligible for hospice. The data shows that they want these patients to enter hospice sooner, perhaps a year or more sooner, and everyone knows they're going to die sooner, too.

**The Federal "Ethics" Used to Decide Who Lives and Whose Death is Hastened**

Dr. Emanuel and the scholarly colleagues at NIH are not going to personally make these decisions. The nameless bureaucrats running "Obamacare," under the new [*Patient Protection and Affordable Care Act* of 2010](https://www.gpo.gov/fdsys/pkg/PLAW-111publ191/pdf/PLAW-111publ191.pdf) will make these decisions. Even if the law is ruled unconstitutional by the Supreme Court, Medicare and Medicaid will include forms of rationing based upon a secular ethical system.

Those who decide will not necessarily be physicians, scholars or even "bioethicists." They will be made up of utilitarian, secular-minded bureaucrats who are only interested in doing what they are told to do. They may not even have advanced degrees or any college degrees at all. They will follow the decision-trees handed down from "above" by those at the highest levels of power within the bureaucracy.
Everything about the President's policies has been about re-shaping American society according to his vision. He shows little propensity to listen to those of faith who object to the plan.

While Dr. Emanuel is supposed to be the best, "chief" bioethicist in the country, what bioethics will he apply? When considering the effects of legalization of euthanasia or physician-assisted suicide, he writes:

"Ultimately, the ethical question we should consider is: Will legalizing-or permitting-euthanasia and PAS promote-or thwart-a good death for the 2.3 million Americans who die each year in the United States? Will people who die be helped or harmed by having euthanasia or PAS available to them? In confronting this question, we must first acknowledge that figuring out the benefits and harms of permitting euthanasia or PAS is speculative, at best."

["What is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?"
Ezekiel J. Emanuel, MD Ethics, Vol. 109, No. 3. (Apr., 1999), pp. 629-642.]

His phrasing of the question and his suggestion that "figuring out the ... harms of permitting euthanasia or physician-assisted suicide is speculative, at best" is very revealing. No matter how "learned" the discussion, it is clear that bioethicists like him have lost their way and no longer affirm the sanctity of life at all. Our nation's chief bioethicist states that we have to guess what harm may come from legalizing the killing of the patient! Obviously, the harm is that the patient is dead! And of course, there are many other ripple effects from that: family and friends who are deprived of the time with the patient at the end, the opportunities for healing relationships, the "unfinished business" that is left unfinished, the devaluing of the life given, the playing God that is done when one medically kills, the coarsening and darkening of our society if we allow such evils, the likelihood that more and more categories of those "suitable" for euthanasia will be allowed, and the likely deterioration of end-of-life care services.

Dr. Emanuel asks (in the conclusion of his article),

"Will legalization of euthanasia and PAS significantly improve the care of the 2.3 million patients in the United States who die each year? There is no compelling evidence that the answer is in the affirmative. And the focusing of so much attention and energy on debating, campaigning, litigating, and studying euthanasia and PAS is beginning to detract from the primary goal of improving end-of-life care."

If you think about it, it's quite amazing to think that killing the patient could in any way "improve the care" of that patient. Yet, this is what our chief bioethicist is thinking about. At least, let's hope that the primary goal is to improve end-of-life care, but what type of improvements will be made? While some improvements in end-of-life care are encouraged through health care reform, will they also include Third Way killing through palliative sedation? Definitely. And therefore, the "harm" Dr. Emanuel apparently "avoids" when he suggests not legalizing euthanasia and assisted-suicide remains.

Over and over again, we see physicians and bioethicists taking a stand against euthanasia and assisted suicide and promoting palliative care and hospice. And when they do, the pro-lifers enthusiastically applaud, not realizing they are not going to get what they think. These same physicians and bioethicists allow for Third Way killing in palliative care or hospice settings that accounts for many, many thousands of imposed deaths each year. The problem with Dr. Ezekiel's (and others') discussions lies in what ethical considerations and assumptions are used when deciding what reforms to implement.

And we know that the ethics to be applied to any health care reforms won't be in line with any religion: that would be "unconstitutional" according to the anti-religious mainstream today. We know what it will be. It will be run according to "Federal Ethics," established by an elite group of individuals selected by Congress (not the "people of the United States") and derived from what became known as the Belmont Report. The group was originally commissioned by Congress in 1974 to establish guidelines for research on fetuses.
"Based on the Belmont Report and other work of the National Commission, HHS revised and expanded its regulations for the protection of human subjects in the late 1970s and early 1980s. The HHS regulations are codified at 45 CFR part 46, subparts A through D. The statutory authority for the HHS regulations derives from 5 USC. 301; 42 USC. 300v-1(b); and 42 USC. 289.

"The regulations found at 45 CFR part 46 are based in large part on the Belmont Report and were written to offer basic protections to human subjects involved in both biomedical and behavioral research conducted or supported by HHS. In 1991, 14 other Federal departments and agencies joined HHS in adopting a uniform set of rules for the protection of human subjects, identical to subpart A of 45 CFR part 46 of the HHS regulations. This uniform set of regulations is the Federal Policy for the Protection of Human Subjects, informally known as the "Common Rule."

As Prof. Dianne Irving, PhD says in her article, “What is Bioethics?”

".... these bioethics principles of autonomy, justice and beneficence have been used -- as originally defined -- as the explicit basis for many major public policies, governmental regulations, private sector and industry guidelines, even international guidelines still in use today - e.g., the federal OPRR regulations on the use of human subjects in medical research, The Common Rule, Institutional Review Board Guidebooks, Hospital Ethics Committee Guidebooks, most policies for hospitals and other health care facilities, the international CIOMS/WHO [World Health Organization] Guidelines for the use of human subjects in Third World countries, etc."

"That is, these bioethics principles are explicitly defined in these documents in the same way as they were defined in The Belmont Report .... These bioethics principles also now literally redefine the "ethics" of other disciplines, e.g., business ethics, and ethics in engineering. Even our country's military schools have restructured their ethics courses and have essentially reduced them to courses in bioethics (often using many of these same bioethicists as their professors). Many colleges and universities already require a course in bioethics in order to graduate, and most medical and nursing schools have incorporated it in their curricula. Bioethics is even being taught now in the high schools. And what is being taught as bioethics are the Belmont principles, or renditions of one or more of these principles as defined in Belmont terms. ...."

"Bioethics has also influenced the law and the media."

This is not bio-"ethics" as you or I might want it. It does not conform to the Hippocratic Oath that the public has long assumed physicians affirm upon graduation from medical school, including the physician's promise:

"I will do no harm or injustice to [my patients]."

and

"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary [medical device] to cause an abortion."

[Physicians "Hippocratic Oath"]

The National Institutes of Health states that:

"Contrary to popular belief, the Hippocratic Oath is not required by most modern medical
schools, although some have adopted modern versions that suit many in the profession in the 21st century. It also does not explicitly contain the phrase, "First, do no harm," which is commonly attributed to it.

Well, we can see the slant the N.I.H. wishes to push, clearly implying "modern" medicine has "outgrown" the "obsolete" restriction of the Oath such as to "do no harm." NIH implies that the phrase "do no harm" is not in the Oath, saying the phrase, "first, do no harm" is not "explicitly" in the Oath, but we just read (from the same NIH web page) that the oath clearly includes the phrase, "I will do no harm." Yes, it does not have the word, "First," before the "do no harm," but why imply "do no harm" isn't in the oath? It is!

What do the right-to-kill groups have to say? The World Federation of Right to Die

"Although the Oath laid the foundation for the ethical ideals to which medical practitioners should aspire, its detailed wording, relevant to social conditions prevailing 2400 years ago, is not appropriate to the practice of modern medicine."

[from The World Federation of Right To Die Societies member, South Australian Voluntary Euthanasia Society]

"Do no harm" is not appropriate? "I will give no lethal drug" is not appropriate? "I will not give a woman a pessary to cause an abortion" is not appropriate? What about those "modern versions" of physician oaths the NIH mentions?

"The oath most often employed by medical schools today is "the Lasagna Oath."

That surprised me. The "Lasagna" Oath? What's that? Well, it's called the physician's "modern oath." What is most alarming about this modern version is the following section:

".... Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks.

But it may also be within my power to take a life;

this awesome responsibility must be faced with great humbleness and awareness of my own frailty.

Above all, I must not play at God."

["The Hippocratic Oath: Modern Version" Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University]

It may "be within my power to take a life...." What does that mean? I would like to think it meant that in the ordinary course of medicine, some people might die. We can all understand that, but that is not the language most carefully chosen by the author. "Take a life" is not the same as "lose" a life! And just before stating that one must "not play at God," the oath states they may "take a life." What else is "taking" a life but "playing God?" There is no prohibition against abortion or giving a lethal drug as was included in the Hippocratic Oath. There is no prohibition against "doing harm." In fact, the word, "harm" is not contained in the modern physician's oath. Of course, each medical school chooses what oath to use, and:

".... In 1993, a large-scale study of the oaths administered by almost 150 North American medical schools was undertaken to determine the popularity and content of modern oaths.

As it turns out, the oaths given in this day and age have changed substantially from the
original. Fourteen percent ban euthanasia. Eleven percent invoke a higher power. Eight percent oppose abortion.

"Is the Oath Outdated?" Jackie Rosenhek, Dec 2009, Doctor's Review

Only 14 percent ban euthanasia and only 8 percent "oppose" (but do not "ban") abortion! It used to be 100% banning abortion or doing the "harm" of euthanasia with the Hippocratic Oath. So, we've come a "long way" down the wrong way. The ethics held by physicians and other medical-legal professionals today is nothing like the clear respect for life held by physicians of old. Perhaps that is why many physicians look with contempt upon those of us who still respect life.

It was only four years after the new physicians' oath was written that in 1968, the Ad Hoc Committee of the Harvard Medical School to examine the definition of brain death" released their report, "a definition of irreversible coma." Abandoning the Hippocratic Oath to "do no harm" goes right along with creating a new definition of death and the killing of the not really dead patient to get the organs for donation.

The issue becomes clearer when we consider why in 2007, "Italian doctors want[ed] to scrap [the]'outdated' Hippocratic Oath"

"Senior medical figures in Italy are campaigning to scrap the Hippocratic Oath for doctors on the ground that the passages forbidding abortion and euthanasia are outdated."

[Richard Owen in Rome, The Times Online]

Why is Italy so far "behind the times?" While America has been sleeping, most U.S. med schools trashed the Hippocratic Oath long ago! Well, 87 percent of Italy's population is Catholic. It's been difficult for the "new" secular bioethics to move forward there with the Catholic Church's unmoveing opposition to medical killing of any form.

The secular bioethics (Professor Irving has explained to us) is nothing like the ethics supported by the founders of our nation. It is not the ethics you may have adopted as a Christian, Jew, Muslim, Hindu, Buddhist or person of some other faiths. It's secular, non-pro-life "bioethics" as the government instituted back in 1978: the "Common Rule" of the Belmont Commission. And it's not really, "new." Secular utilitarianism has been around for a very long time indeed!

Any way you look at the principles of the U.S. Congress-created Belmont Commission, they are utilitarian and an establishment of a system of ethics foreign to the founding of our nation, directly opposed to the principles embodied in the U.S. Constitution, and contrary to the faith of most Americans. "Autonomy," "beneficence," and "justice" as defined in the Belmont Report are just not in the Constitution. The insertion of these principles into most aspects of our society has been a wedge to twist much of what our government and health care institutions do and turn it toward utilitarianism. These principles are in stark contrast with our nation's life-affirming tradition of respecting the rights of "the individual" citizen under Constitutional law! In July, 2011, the National Institute of Health proposed modifying the regulations that protect human research subjects to make it easier to conduct studies. Some warn that this will allow more abuse, rather than less.

Like most hospitals in the United States today, the Flagstaff Medical Center's ethics committee in Arizona uses similar secular bioethics principles to guide its decision-making: "patient autonomy; beneficence, ... justice, involving fair use of limited resources; and nonmaleficence - the goal of doing no harm." How "autonomy, beneficence, justice and nonmaleficence" are defined depends upon your worldview. Nurses who object to the decisions being made are "encouraged" to realize they must "set them aside when needed, because other considerations in an ethics case may trump personal beliefs." Almost all hospital ethics committees use the same principles to guide their decisions. And when a staff member holds pro-life beliefs contrary to the secular and "politically correct" tyranny, they are often not invited to be or remain on these
committees.

In other words, pro-life professionals must go along with decisions that hasten or impose death, remain silent, or risk losing their jobs, because decisions made by the hospital's ethics committee represent its official policy. Any employee fighting that decision is acting contrary to the corporation's secular mission, is viewed as a troublemaker, and the corporation may use that to justify terminating the employee or finding another reason to terminate the employee.

As far as health care is concerned and its "reform," we are being catapulted ahead into a health care system administered completely by people who follow utilitarian, socialist, secular values. They do not value the lives of the elderly, disabled and chronically ill and are finding ways to deny treatments, shunt them over into hospice and have their lives ended. The elite will determine who lives and who dies sooner. It will no longer be government of the people, by the people and for the people; it will be government by secular mandates imposed on the people, especially the ailing.

The Justice Department's move to prosecute pro-life protesters who simply hand out information peacefully outside of abortion clinics is a move to stifle pro-life free speech, not just to protect the rights of individual women to access abortion clinics to end the life of their baby.

The secular utilitarian principles will govern what decisions are made about your loved one or yourself when the time comes, either when you need medical care or when you simply fit the "profile" of who is not to get certain care and who is. Interesting that "profiling" is forbidden when detecting those terrorists who would kill Americans, so all Americans have to be treated like criminals at the airport security lines.

Does this make sense? No profiling for terrorists, but profiling will be used to discriminate against all Americans of a certain type, the elderly and disabled. Why? Because according to "the elite" you have lived "complete lives," "long enough" in their estimation, and you no longer deserve services because you are a "nonparticipating citizen," no longer working or contributing to society, or your "quality of life" is poor. You no longer need treatment or care in their view; you only need "comfort care" that will peacefully end your life. Even if you do need real care, you will be denied that care. You and your loved ones will die sooner rather than later, for sure, if you needed that care! Why? Because you fit "the profile."

Economist and New York Times columnist, Paul Krugman, said:

"Some years down the pike, we're going to get the real solution, which is going to be a combination of death panels"

"and sales taxes. It's going to be that we're actually going to take Medicare under control, and we're going to have to get some additional revenue, probably from a VAT [a "value added tax"]. But it's not going to happen now." - From ABC TV's November 14, 2010 roundtable discussion on "This Week with Christiane Amanpour"

It's getting quite in-your-face and obvious what they intend to do. Even if there is all this talk of compassionate care, it's "comfort care" combined with rationing care, and that doesn't always mean clinically-appropriate end-of-life care as we would expect. Paul Krugman, Ezekiel Emmanuel, MD, PhD, many other physicians and some politicians have openly told us what to expect.

In an Aspen Institute interview, Microsoft Chairman, Bill Gates indicated:

"The access that used to be available for the middle class is just rapidly going away," Gates
said. "That's a trade-off that society is making because of very, very high medical costs."

The country has demonstrated an unwillingness to question if "spending $1 million on the last three months" of a person's life is a cost-effective direction, especially considering the same amount of money can keep 10 teachers employed. Gates called for the nation to do a better job of examining the benefits of costly end-of-life medical care.

"That's called the death panel and you're not supposed to have that discussion," Gates said, taking a jab at critics of the health care bill that Congress considered earlier this year."

Gates forgets to mention that even though "more than $100 billion may be lost in health care fraud, waste and abuse" each year, only $11 billion is used to fund all Medicare hospice payments each year. If even ten percent of the health care fraud, waste and abuse that occur each year were recovered, it would fund an entire year of care to the elderly at the end-of-life. And that is not even beginning to count all the fraud, waste and abuse of our tax dollars throughout the entire federal budget, covering many areas of the economy.

Sure, some hospital admissions are not wise, because the patient truly is dying and the acute care hospital may not be able to do anything to help. In those cases, good end-of-life care is ideal. But, the idea that we need to ration care for the elderly to the extreme is nonsense. If it is the last three months of a person's life, as Gates mentioned, we can provide good hospice & palliative care that does not impose death and that respects their life. Caring for the vulnerable, not killing, is the sign we are a civilized society. Gates clearly has a different vision for American society.

If we choose to impose death upon the elderly (one way or another), then we'll be just like the Nazis, because that's what they did with their seriously ill citizens. And they thought they were at the forefront of what was "progressive" and "civilized." Not too long after World War II, Leo Alexander, M.D. wrote in 1949 in The New England Journal of Medicine, pages: 39-47, "Medical Science Under Dictatorship" about the motivation some Nazi physicians had to commit their crimes against humanity:

"The important lesson here is that this motivation, with which one is familiar in ordinary crimes, applies also to war crimes and to ideologically conditioned crimes against humanity-namely, that fear and cowardice, especially fear of punishment or of ostracism by the group, is often more important motives than simple ferocity or aggressiveness."

Dr. Alexander continues discussing the Nazi crimes against humanity:

"The Early Change in Medical Attitudes"

"Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians.

It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived.

This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans.

But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick." [emphasis added]
This is exactly where we're at today: the rationing of care for the very elderly, disabled and chronically ill, the devaluing of their lives, the encouragement of death-hastening methods when quality of life is deemed to be inferior, the outright imposition of death through many means within the health care system.

Physicians today do not face execution if they do not follow the orders of the "Fuhrer," but they do face ostracism from their colleagues if they are openly pro-life, refuse to participate in what is considered "standard" quality of life decision-making which hastens death. Nurses, pharmacists and doctors who question what is going on all around them do stand to be blackballed, even fired from their positions in many hospitals, nursing homes, and especially hospices.

If they refuse to perform an abortion, there have been laws supposedly protecting their conscience rights. If a pharmacist refuses to dispense drugs like the "emergency contraceptive Plan B" that kill newly conceived babies, there have been conscience rights laws. These minimal protections do not always protect those who revere the sanctity of life.

Bill Saunders of Lifenews writes about the former protections:

"Under the Bush rule, recipients of federal healthcare funds are required to certify that they are in compliance with three existing federal conscience protection laws: the Church amendment, the Public Health Service Act Section 245, and the Weldon Amendment (which is passed annually as part of Congressional appropriations). Each of the laws covers different areas, but all relate to whether a healthcare professional can be required to participate in medical procedures or research activities against his or her religious beliefs or moral convictions.

"Concerned that these laws were not being honored, and that illegal discrimination was occurring, HHS proposed the conscience clause rule in August 2008 in order to provide a regulatory vehicle to enforce the three conscience laws. The rule was finalized December 19, 2008 and took effect January 20, 2009."

With the change in administration, the new protections have now been taken away just two years after they were made effective:

"... the Obama administration on Friday finally rescinded most of a federal regulation designed to protect those who refuse to provide care they find objectionable on moral or religious grounds.

"... Any weakening of conscience protections opens the door that much further to discrimination against life-affirming health-care professionals and institutions," said Jonathan Imbody, vice president for government relations at the Christian Medical Association. "With many areas already facing critical shortages of professionals and institutions, this is no time to be risking the further loss of health-care access for poor patients."

["Obama administration replaces controversial 'conscience' regulation for health-care workers" By Rob Stein Washington Post Staff Writer February 18, 2011]

The removal of the protections for pharmacists will force them to dispense the so-called "emergency contraception" called "Plan B." Is "Plan B" only a "contraceptive?" Does it only prevent conception? The drug's description clearly shows it is not:

"... This medication ... causes changes in your cervical mucus and uterine lining, making it harder for ... a fertilized egg to attach to the uterus. Levonorgestrel emergency contraceptive is used to prevent pregnancy."
Katie Walker of the American Life League writes:

"Planned Parenthood and the birth control industry would have you believe Plan B One-Step cannot cause an abortion. That is a lie."

"In 1965, the American College of Obstetricians and Gynecologists issued a Terminology Bulletin that 'officially' changed the definition of 'conception' from the union of sperm and egg to implantation. As a result, the medical establishment does not call the killing of a human being prior to implantation an abortion. But that is just semantics."

"Plan B One-Step works like any other abortifacient drug: It can alter (thin) the lining (endometrium) of the mother's uterus so that the newly-formed baby cannot implant and thus dies. Plan B One-Step's product information itself states, 'It may inhibit implantation (by altering the endometrium).' Direct abortion is the willful ending of a preborn human being's life. Plan B One-Step is thus a direct abortion method. Women should not allow themselves to be misled by sales representatives for Plan B and Plan B One-Step, who claim that these products will not terminate an existing pregnancy."

"Unfortunately, the birth control industry and Planned Parenthood - the nation's largest abortion chain - have tricked many women into aborting their tiny children. Plan B One-Step, Plan B, the birth control pill, IUD and other hormonal birth control products can all cause abortions. Period."

["Don't be Fooled: Plan B One-Step Causes Abortion" July 30, 2009 - By Katie Walker]

We need society and our elected leaders as well as those in industry to use scientifically accurate language and definitions. Redefining life so that lives can be ended is evil. By saying that conception has not occurred until implantation is ridiculous. Obviously, conception occurs when the sperm penetrates the oocyte and the two unite. Plan B does not prevent that; it kills the new life formed. We need a culture of life that does not punish those who simply wish not to kill human beings or participate in that killing in some way within a health care setting. Why should we be forced to kill, participate in killing in some way, or facilitate it, or if we refuse, lose our careers?

What will happen to nurses or doctors who refuse to participate in euthanasia, even if it is "Third Way" euthanasia. When the major media, the government and the health care administrators in the end-of-life arena do not even recognizes the medical killing as killing, how can the nurse object? How can she even assert an objection? If she is fired for objecting, who is going to care? And what legal remedy will she have? None at present. It's just like those who say no conception occurs (when it does) and therefore there is no ending of the tiny new human life.

Add to this the rationale for decision-making made by health care providers that are absolutely for-profit. The Kaiser Permanente physician group (absolutely "for" profit) has its own:

"... "group ethic," which is Kaiser's attempt to all but replace the Hippocratic Oath; suddenly the "group" of physicians have to watch out for each other financially and the "group" of patients are supposedly willing (uninformed consent) to sacrifice individual high cost care to the purpose of keeping each individual's premium down."

["Permanente Medicine: Navigating a Course to Our Sustainable Future" and "Permanente Medicine: The Permanente Medicine Map" by Jon Stewart, Assoc. Editor of the Permanente Journal, Winter 2000, vol 4, No 1]

No matter that the individual supposedly "served" by "the group" is denied care that could save their life or cure their condition or at least stabilize it properly! The profit motive in health care is not a substitution of another set of moral values; it is the substitution of no moral values, just an eye on what brings in more net
profit to "the group," the "HMO" or Preferred Provider Organization ("PPO"). Today's PPOs have come to resemble the HMOs, with the managed-care model of decision-making, treatment denials or roadblocks put in the way, incentives for physicians to decrease diagnostic tests, treatments and cost of medications. The profit motive that dominates a health insurer's policies and subsequent treatment denials (at the expense of quality care) is the equivalent of anarchists being in charge of the government.

Health "care" ceases to even be "care" if decisions are no longer based upon what is medically appropriate.

When the government controls the system, health "care" ceases to be "care," and becomes a budgetary consideration. And government controls Medicare and Medicaid, the health care systems in which the elderly and disabled find themselves.

As we have seen, the leadership of the National Hospice & Palliative Care Organization is composed of pro-euthanasia advocates like Mary Labyak, CEO of the Hospice of the Florida Suncoast. Why would this organization elect her or others like her to such prominent positions if the organization cared about promoting the sanctity of life? They don't. They are absolutely promoting a secular, utilitarian "progressive" vision that includes hastening death through the misuse of terminal sedation. Whether they admit it or not matters not. What matters is the direction they are steering health care and end-of-life care in particular.

Powerful leaders of the largest hospices in the country are in a position to dominate the national organization. When you want to understand why, remember the old maxim, "follow the money." Each hospice that is a member of the National Hospice & Palliative Care Organization pays $8 for every hospice patient they have each year. If they serve 2,000 patients per year, they pay several thousand dollars in dues while some small hospices may have 100 patients a year. There's a big difference between $800 and several thousand dollars in dues-based revenue to the national organization. The bigger hospices, often rogue hospices, pay more; they have a bigger seat at the table.

**Government Rationing Health Care through Cost Effectiveness Research**

"Overview of the Patient-Centered Outcomes Research Institute"

"The Patient Protection and Affordable Care Act, the health reform bill recently signed into law by President Obama, establishes a private, non-profit entity called the Patient-Centered Outcomes Research Institute. The Institute will spearhead efforts to prioritize and fund comparative effectiveness research (CER) using a largely stakeholder-driven process. This initiative builds upon the strong foundation laid in 2009 by the $1.1 billion in funding for CER in the American Recovery and Reinvestment Act (ARRA)."

This so-called "Patient-Centered" outcomes research and its "comparative effectiveness" research is so important to health care "reform" that:

"The Institute will be funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), which will consist of funding streams from general revenues, an annual $2 fee per Medicare beneficiary transferred from the Medicare Trust Fund, and an annual $2 fee
That's half a billion dollars! It must be important. Why would the federal government spend half a billion dollars on this? Because "Comparative Effectiveness" research will save much, much more. It's all about deciding what care will not be provided, what care is determined to be "ineffective" and therefore no longer "approved," and therefore not reimbursable by Medicare, Medicaid or any vestigial private insurance company that remains if the federal health insurance system achieves complete control.

Spending half a billion dollars could be seen as a "good investment" if it saves billions more through denials of care across the board, affecting just about every citizen of the United States! It will certainly affect the elderly and disabled on Medicare.

If you think this is all about making the health system more effective and cost-efficient while preserving quality of care, you are quite mistaken. Any treatments or interventions denied may result in earlier deaths. Any treatments not "denied" but not "approved" may result in earlier deaths. Treatments that are "not approved" won't even be considered as an option to be offered or denied.

Why will they result in earlier deaths? Because when you don't treat a condition, the condition is likely to worsen, resulting in a cascade of harmful changes. Treatments not "approved" will not be provided by private insurers (if the federal health system takes over) as well as Medicare and Medicaid. Again, treatments will not be received by patients who may need them.

Our current health care system with all its faults and wonders has never before allowed one entity to completely control who gets and who does not get a particular type of health care. People from all over the world come to the United States to get some of the best care available anywhere in the world. If the so-called health care reform is fully implemented, the finest aspects of our health care system may be dismantled. The federal government has denied that care will be rationed, or that "death panels" will be created, but we have only to look to other nationalized health care systems to see the devastating consequences of giving one entity, especially the federal government, complete control over U.S. citizens, complete control of our health care and whether we receive it or not.

The federal government will assure you that the people running P.C.O.R.I. and its cost-effectiveness research (CER) have great "integrity" and are well-intentioned. They must have "your welfare in mind" when they make their decisions. "Government knows best" is the new motto, but can we trust "Big Government?" Who is the Obama administration putting in charge of your health care? in charge of your mother and father's health care? or your relatives and friends? Or yours? Among some others:

"Who is running PCORI? The answer was revealed today. The [PCORI Board of Governors]
includes:

* Associate Executive Director for the [Permanente Medical Group of Northern California]

* CEO of Empower, LLC,

* Researchers from [among other ... universities]: Dartmouth"

Yes, they list it as "Permanente Medical Group of Northern California," but that is "KAISER" Permanente Medical Group of Northern California, the same medical group that Dr. Phillips states gives its patients devious, distorted and widened lab ranges that are not consistent with other lab values used in many other health care systems, in the medical schools or textbooks or around the world.

To review: Dr. Phillips states "... the Permanente Medical Group, Inc. (TMPG) in Northern California got
even more aggressive and changed the normal value of the white blood count from 3,500 to 12,500."

To review: what does the U.S. National Library of Medicine, U.S. Department of Health and Human Services and National Institutes of Health consider normal lab values for white blood cell counts?
"Normal Results"

4,500-10,000 white blood cells per microliter (mcL)."

So, the people who widen the normal range of lab values in order to intentionally detect disease later on, when it is almost certainly too late to treat, these are the people we should trust with our very lives under a government-mandated health "care" system??

And who is at Dartmouth University, especially overseeing end-of-life care, something the new rationed version of health care is very-much interested in? Ira Byock, MD, the same Ira Byock, MD who created the hospice lobbying group Partnership for Caring which absorbed Choice in Dying, the successor organization of the Euthanasia Society of America, and the same Ira Byock, MD who along with Timothy Quill, MD promotes wide implementation of palliative sedation (or "terminal sedation") as a means to hasten death (Third Way killing). This does not encourage me and it should not encourage you to trust the federal government's new "Patient-Centered Outcomes Research Institute."

So, who is running the Patient-Centered Outcomes Research Institute?

* Associate Executive Director for the Permanente Medical Group of Northern California

* CEO of Empower, LLC

* Chairperson of Friends of Cancer Research

* Chief Medical Officer of the Pfizer Medical Division

* Chief Science and Technology Officer for Johnson & Johnson

* Director of Strategic Partnerships and Alliances at the Xerox Corporation

* Executive Vice President of The Regence Group

* President and CEO of the American Association of People with Disabilities

* President of BJC Health Care

* Program Director for the Health Technology Assessment program at the Washington State Health Care Authority

* Principal Deputy Under Secretary for Health and National Program Director for Cardiology, Department of Veterans Affairs

* Researchers from the following universities: Dartmouth, Harvard, Mississippi, North Carolina, UCLA, and Yale

* Senior Vice President of Medtronic, Inc.

And while the feds can point to the "President and CEO of the American Association of People with Disabilities," that's just one person among dozens of other representatives of corporate interests such as Johnson & Johnson, Kaiser, Xerox, and BJC Health Care. Why isn't the list
dominated by representatives of and advocates for the elderly, the disabled, the chronically ill or just plain American citizens all across the land? Why aren't representatives from National Right to Life or church leaders included? What about all the patient advocacy groups and disability advocacy groups?

Why do the corporate interests have a major role in deciding who gets care and who doesn't (because this is what it's all about)? Does this make sense to you as an American citizen, a taxpayer, or even as a human being who needs access to health care now or in the future?

**Government Protection of Hospice and Many Health Care Facilities**

I tried back in 1997 to bring about reform and to help patients get the care the federal regulations required the hospice to provide. With inside information about terrible treatment of patients, detailed accounts and witnesses from various part of the state, the state department of health inspectors refused to even look into many of the separate violations listed. It was a shock to me, but looking back, I understand how it happened.

Due to budgetary concerns, inadequate numbers of state inspectors are hired in the first place. State inspectors are understaffed and overworked. Higher managers may be appointed by the Governor (either directly or through intermediaries who do the appointing) and these selected managers are put there for a purpose: to make sure the regulatory agencies don't get "out-of-control," don't go after friends of the Governor (or other elected officials). These managers let staff know that they do not go after "protected" corporations. And they will certainly let them know which agencies and facilities are on the "list" to be protected. We have to remember the huge sums of money industry sends to state elected officials' campaigns or PACs of various sorts.

Those nursing homes you read about every year that the state attorney general went after? Their owners probably didn't pay enough "protection money" to the elected officials' campaign funds. They are used in many states to give the public the idea that the state attorney general is really "doing his job" and making sure that "bad" facilities are either shut down or fixed. They give the impression that the elderly can rely on the State Attorney Generals (in each state) to make sure the residents of these facilities get good care. The reality is quite the opposite. Have you visited one recently? Any thinking adult in the United States has heard some horror story about what happens in these skilled nursing facilities.


"Inadequate staffing is the Achilles heel of most nursing homes, said Steve Garcia, a Long Beach-based lawyer who has sued nursing homes for providing substandard care."

"These people on the floor, they're not doing it to get rich," Garcia said. "They
could work at McDonald's and make the same amount of money. They do it because they care. But when you ask one person to do the job of three people, there is going to be problems."

And why is there inadequate staffing? In many cases, it's because the owners of the nursing homes view it as an investment opportunity to take in as much profit personally or corporately as they can, and then they move on. Sometimes, they close down one corporate owner and reopen under a new corporate ownership several times to avoid being held liable for damages in lawsuits brought by patients and families. Just a little more staffing could make the lives of patients and staff infinitely more humane, but owners simply will not budge.

When owners of facilities complain about funding, we must remember the profits being made by corporations like Gentiva Health and others. Remember, their 2010 net revenue is expected to be about $1.42 Billion! Large chains own many hospices, and even large nonprofit agencies still pay their top administrators in the hundreds of thousands of dollars range. Short-staffing is a decision made by those at the top to fill their pockets first and consider patient and staff needs last.

Now, you may say that your hospice agency provided great care and all of this is insulting and offensive to even read. Well, just because you experienced great, wonderful care for your loved one, doesn't mean there aren't problems at other hospices. I know there are good hospices and very dedicated hospice professionals all over the country. I also know there are some terrible hospice agencies and professionals, because I've seen them and met them personally.

Hospice as an industry reminds me of what it must have been like hundreds of years ago for strangers traveling in foreign lands with a language barrier.

You see a different culture, people with different values, and you don't know whether those you meet are friendly or hostile, whether they will welcome you or kill you. As you approach cautiously, they motion for you to come nearer, and you don't know what to do; you're afraid, but hungry. They make signs that they are peaceful, and they even show you the way to a tent where they motion for you to stay.

Food is brought to you and you wonder, "is this ok to eat?" or "are they going to poison me and take my money?" You really don't know. The bowl of soup looks really good, smells good, and has lots in it. But you know, the best meal with just a tiny bit of cyanide is still poisonous and will kill you! You have to throw the whole thing out and start over if there's poison in the soup!

Hospice is like that. Something that was widely provided with integrity and self-sacrifice, and real dedication to a mission is now a mixture. Some hospice businesses are run with integrity and some are not. It's a gamble today, and it is tragic that families have no idea whether they're going to get Dame Cicely Saunders' version of hospice that respects life, or if they're going to get Florence Wald's version. Remember, Wald said that "assisted suicide should be available" for all sorts of reasons including economic reasons.

When you're searching for a hospice are you going to check the U.S. Department of Justice website and see if there was a conviction of the hospice (or its administrators) you plan on using? Are you going to call the Department of Health at your state capitol and check and read all the complaints against that hospice to decide if it's a good hospice to go to?

Which kind of hospice is it going to be? Families have no idea. In fact, one of the most frequent questions we receive is, "how can I find the best hospice? one that will provide the
full range of services and not hasten death?" It's a difficult question to answer, because there is no one way to be sure about hospices all around the country. There may be hospice agencies that one hears about nearby, because your neighbor or family used their services, and this is one of the answers we give, "if you know someone who has recently used a hospice, ask them how it went." Reputation is based partly on actual experiences out there and much can be learned from others in the community.

On the other hand, just because someone else had a good experience with a particular hospice agency does not mean it will be the right one for you, or that it won't hasten death. People who are pro-assisted-suicide and have used a hospice that imposed death will rave about the hospice, how "compassionate they were," and how everything they did was "top-notch," but if you don't know their views on assisted-suicide, the recommendation will come back to bite you.

Also, a hospice that may hasten death in various ways certainly does not do that with everyone. They will be certain to provide wonderful care for those who are prominent in the community and many others, even many that are not prominent. They cannot afford to be universally-recognized as a place where patients are hastened to their death, even if they are of that mind and believe in: the elimination of patients who use scarce resources in order to save money in the health care system ... or, the elimination of patients who are better off dead because they are suffering, because their quality of life is poor.

Because finding a hospice that honors the life of the patient is becoming difficult to do, some hospice leaders are in the process of forming a new association of hospice agencies and staff around the country that respect the mission envisioned by Dame Cicely Saunders and also subscribe to the Hospice Life Pledge.
The Hospice Life Pledge

I affirm the value of all human life regardless of age, disability, or the disease process involved, and reject the prevailing notion that some lives are less worthy to be lived than others.

I reject the practice of assisting a suicide, performing euthanasia, or terminally-sedating a patient (who has no extreme agitation or extremely severe, uncontrollable pain) with the intent to impose death in health care.

I affirm that supportive medical care must be provided to all individuals.

+++*

Nutrition and hydration, and other treatments such as antibiotics, x-rays, bone-setting, etc., are basic human needs (ordinary palliative care), and provision for those needs sometimes requires medical expertise and technology.

These basic human needs should not be withheld or withdrawn unless they cannot be absorbed or are unusually burdensome for an individual, an individual is in the final stage of a terminal condition, the individual’s death is truly imminent, and not intended.

Palliative care and hospice programs that respect life and do not intentionally hasten death must address the proper care of the dying individual. Palliative care and hospice programs which serve those nearing the end-of-life should be encouraged.

These programs should provide medical, informational, emotional, psychological, and spiritual support as well as the management of symptoms in order to make that individual’s last days as normal and comfortable as possible.

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4680 SHANK STREET, NE • ROCKFORD MI 49341 • PHONE 616.866.9127
www.hospicepatients.org

Any hospice agency, staff member or professional who subscribes to this vision and wishes to promote the sanctity of life at the end-of-life should contact us by email or Dr. Cristen Krebs of the new Hospice Life Association of America for more information about this encouraging work. If you wish to start a pro-life hospice agency that demonstrates reverence for life in action yet do not know how to begin, contact Cristen. Hospice agencies are encouraged to share this pledge with all employees and use it in their own training programs. Reform and rededication to the mission begins with one person and one agency at a time. You have more
power than you know; just take a step in the direction of life with us.

**Government:**

**Controlled by Corporate Interests**

All one needs to do to understand how much government is influenced is to think about the billions of dollars that are spent overall by all industries in the country and outside the country, trying to get Congress or the President to act in ways favorable to each particular industry. Just about everyone understands that lobbying is "how it's done" in Washington and all the state capitols. Money pours into the campaign funds for elected officials every election. Just enter the name of any Congressional Representative or Senator at the Open Secrets Organization website, and you'll see that industries do have tremendous influence over what the officials do. Large industries can't afford to have seriously adverse rulings or laws put in place that might even destroy their industry. So, they lobby.

In addition, government officials who are voted out of office often end up working as lobbyists as soon as the law allows them to do so. They know the ropes, how government works. They're personal friends with those who managed to hold onto political office. They have the connections. So, the lobbyists who influence the government often were in the government.

Elected officials also know that large corporations provide jobs in their districts. Doing what is favorable to the corporation is a way of telling the public, "We're protecting jobs at home." "See how I'm working for you!" But they're protecting themselves and the corporations first. Politicians unfortunately look to retention of power as one of the single most important goals of their lives. Just imagine the effort that goes into working for years to become a Senator or Congressional Representative. You don't want to do anything that would jeopardize that. And money is the fuel that powers your campaign engine. Money from political action committees, from the political party you're affiliated with, money from donations. If the corporations can somehow deliver money to pay for ads, influence votes in your favor, you're going to help them. If they've already helped you, you will help them. It's the old "big boy network" on steroids.
Corporatism and Socialism

As the corporations gain power, becoming heavy-weight players on the national and even international scene, the government has also gained power through creeping regulation of just about every aspect of business. The "Commerce Clause," Article I, Section 8, Clause 3 of the Constitution declared:

The Congress shall have Power .... To regulate Commerce ... among the several States ...."

"Regulation-minded progressive leaders of the early twentieth century sought to evoke judicial rulings that would expand the sweep of the clause." As the decades have come and gone, the scope of Congressional action now appears to be unlimited, and states and local governments have also expanded their regulatory activity. There are so many laws and regulations that nobody could conceivably be aware of them all. More laws and regulations on the books mean that government is more and more involved in our everyday affairs, especially those of businesses across the land. While corporate influence over government has increased, the role of government has also increased. The socialists of the Frankfurt school of socialism contemplated this change:

".... The overall process, behind the state's oscillating policies of responding to over- and under-accumulation, is a greater and greater involvement, and the movement of ever larger portions of the economy from the realm of the market to the realm of state administration."

"Theoretically, there is no limit. The state can continue to solve crises of over- and under-accumulation by shifting costs and revenues from the market to the political sphere indefinitely, until the final result is a privately owned corporate economy in the same position relative to the working and taxpaying population as the ruling class in the Asiatic mode. The role of commodity exchange and realization in the market will steadily decline until the capitalists are the state, and the economy is a single giant, slave-operated latifundium. Owners of the corporate economy operate directly through the state, as in feudalism or Asiatic mode, to exploit population at large through entirely political means."

"Some members of the Frankfurt school saw fascism as an attempt to do just that. ... Nazism reflected an evolution in which capitalists increasingly acted through the state. ... such a society might, in future, altogether abandon commodity production and the law of value. At some point, in that scenario, the market would be superseded by state administration, and the capitalists would extract a surplus from labor directly through the state. When that point was reached, the market would have been completely transformed into a state-owned and state-managed economy, and the capitalists would no longer be capitalists. Instead, they would be owners of the state economy by virtue of their control of the state."
As we have seen, the people behind the corporations who are behind the politicians do control the actions of the government. And they also control hospice and health care policymaking and regulation.

Societal leaders especially from the late 1950s and into the 1960s have cultivated secular, utilitarian philosophies in an effort to spread socialism. The Frankfurt School of socialist philosophy (and others like them) had an enormous effect on this country, influencing the professors in the universities that encouraged the rejection of all traditional values in our society. The 1960s "Counterculture" movement is directly tied into the Frankfurt School of philosophers and writers as well as other socialists who achieved their goals: a greater rejection of marriage, family, religion, and a rejection of any "absolute values" of "right" and "wrong." They encouraged a secular moral relativism so that people came to believe that "if it felt ok, then it was good to do," without thinking about the long-term consequences of their actions.

Writer-philosophers like Erich Fromm, Wilhelm Reich and Herbert Marcuse were influential in transforming our society, from the university, to the students, to the culture at large. Their writings were widely read, assimilated and had tremendous impact on American culture. And part of those changes is the transformation of traditional male and female roles. Our culture no longer reinforces the traditional type of hero who demonstrates strong, "macho" decisiveness. The culture encourages "consensus" as a means of finding a solution, rather than an individual affirming his idea of what is absolutely "right" and what is absolutely "wrong."

In fact, anyone who asserts that there even are "absolute" values such as "right" and "wrong" is frowned upon as a religious fanatic, bigot, homophobe, sexist, capitalist, Christian, Jew, or whatever label they choose to affix to him. Any label but "socialist or communist" will do. Today, because of "political correctness," we are not allowed in many social situations to accurately respond and state that someone's position is "communist" or "socialist" for fear of being called a "McCarthyite" and slanderer. In other words, the moment one accurately assesses a position as "socialist," personal attacks begin.

Government officials that do not honor the Constitutional right to live do not want a people that believes in "right or wrong" or in "sanctity of life." Government officials that are utilitarian and often socialist want a people educated to believe in quality of life as the determining factor when it comes to health care decision-making. They want children educated to believe in sacrificing individual rights and freedoms for the "greater good of society." This is a position 100% contrary to the American principles of freedom that recognize the reality: only when the individual is free can a society be free and just. They want government to be able to decide when a patient dies within the health care system.

The elite leaders redesigning our society's health care system embrace moral relativism where "anything goes," so imposing death is not actually wrong and is "good" if "the quality of life" is low. That is the language of the utilitarian side of hospice and health care.

Those interested in promoting socialism, have promoted "reaching consensus," sharing information and gathering input from others. It's fine to share information, but when individuals cannot make decisions on their own in organizations, it can lead to a tyranny of the "politically correct," where nobody has the nerve to stand up and speak out against a "group" decision (which can be manipulated by individuals within the group). "Consensus" is thought to be the ideal way of making a decision-making. It's "safe," and thought to lead to a "wiser," "better," decision. That assumption is false and dangerous, because it only takes one individual with an agenda to manipulate the group in the "politically correct" direction. Others in the
group will express their "agreement," even when they don't, out of fear. We have become a nation of "sheep" where people are just afraid to say the wrong thing, do the wrong thing, or to be thought "politically incorrect."

Seeking to fulfill a "group" agenda can lead to tyranny. In Nazi Germany, independent thinkers were not only discouraged, they were executed. These were considered "troublemakers." Intimidation through violence was one of the most powerful weapons Nazis used to subjugate and control the people.

We in the United States are not at that point, but intimidation of those who object to the agenda is very intense. The intimidation of the people is the main reason problems in health care (and hospice especially) continue. People are afraid to stand up and be counted among those who protest, who speak the truth, who say, "No more!" We're not being shot on the spot as was done in Germany, but people are terrified to speak out.

I've talked to hundreds and hundreds of people over the years who promised to help, to fight the abuse that happened in their own family, and they almost universally do nothing at all. And so it continues. They will not put their name out there and say, "I experienced this. They killed my loved one, and it is wrong, and I am dedicating my life to stopping it." Even those who desperately wish to stop the killings refuse to publicly name names of the staff or hospices involved, or even have their own names used. HMOs, managed care organizations, regional medical systems and pharmaceutical companies as well as hospices count on the fear people have. They use that and profit from it.

Now, there are moves to have U.S. citizens spy on each other. Just as the governments in Nazi Germany, Communist China, Cambodia, Vietnam and the Soviet Union (and elsewhere) encouraged people to report suspicious behavior to the authorities, we are seeing the beginning of a climate of fear. We may think that it is necessary due to the threat of terrorist attacks in this country, but it is clear that we are but one step away from becoming a society tyrannized by an all-powerful government. Now there is "The iPhone 'Patriot App' to help people report others to the federal government: Who is to say what will be deemed "patriotic" in the future?

There are others who warn that attempts to protect our nation from terrorism through the Patriot Act have inadvertently given too much power to the government to violate traditional freedoms guaranteed in the Bill of Rights, such as the Fourth Amendment guaranteeing freedom from unlawful search or seizure without probable cause and a court order. Others warn about "Big Government" creating national databases on all citizens. The new database being created by the Executive branch of our government will include:

"a computerized system to track all Americans from cradle to grave by cross-linking all their school and college academic and extra-curricular records, including tests and appraisals by supervisors and peers, with health, welfare, employment and income data. .... Social Security numbers, family income, medical exams, and criminal and administrative penalties, ...[as well as] preschool experience, prenatal care, daycare, early childhood education and after-school activities. [and] information not only from the Department of Education, but also from the Department of Health and Human Services (which would include Head Start, WIC, Parents as Teachers and after-school programs) and from the Department of Labor."

["Obama's desire for data on your kid" by Phyllis Schlafly Worldnetdaily.com May 24, 2011]

Combine that kind of database with the move to have nationally-recognized state driver's
license/ID cards that include biometric identifiers and the HIPAA/HITECH Act-created national medical record database and you have government officials and numerous bureaucrats having access to and knowing an incredible amount of information about each of us that used to considered private. Under H.R. 1, The American Recovery and Reinvestment Act of 2009,

"The Secretary shall ... invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States."

It can't get clearer than that. The goal is to link databases together. State health information exchanges become national health information exchanges that follow a person wherever they are in the country. State "enhanced" ID cards become national ID cards because they will be recognized nationwide. "Whoa!" I can hear you saying to yourself right now! "This guy's gone off the deep end?" "This is too much!" But these are just the facts. There is no wild "conspiracy theory." This is what is already happening. Big government, big corporations, together controlling what happens to individuals in our society. What really is "corporatism" or "corporate fascism?" It meant one thing years ago in Italy and Germany during WW II, but for our discussion, it can mean the control of government by the very powerful and ultra-rich; today that means the corporations. It's a type of fascism that does not involve nationalism.

Whether health care corporations, hospice corporations or other, the government is clearly heavily-influenced by lobbyists who can buy time with our representatives. An ordinary citizen cannot buy that time and will not get that time with the Senator from "this-or-that state." The Senator is going to give special treatment to the lobbyist from the industry that managed to contribute the most to his political action committee, campaign fund or to the political action committee of his national political party. Big donors get big access. Small donors or non-donors do not, and if they get time, it will be minimal in most cases.

I remember back in 1997 traveling to the state capitol to meet with one the state senators about the corruption in the Hospice of Michigan where I worked. I did get to meet with Michigan State Senator Joe Schwarz for a few minutes and spoke to him about the exploitation of the patients, the violations of the standards of care, the harm being done. He listened and he ignored what I had to say, even though it was terribly important to the people of Michigan as well as United States taxpayers. He did nothing. Listening to a resident of the state (or the country) is not the same as acting for their welfare. It became clear that listening to a resident of a state has become the equivalent of humoring an uninvited and unwanted guest at the table of government! We're seen as an "annoyance" to the elected officials. And at the same time we are viewed in this way, our state and federal elected officials consistently act on behalf of the corporations and individual benefactors that helped finance their way to elected office.

Barack Obama in June, 2009 while speaking to the American Medical Association physicians about health care reform:

"no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what. My view is that health care reform should be guided by a simple principle: fix what's broken and build on what works."

But the truth is exactly the opposite:

"As many as 80 to 100 million people will not have the option of keeping the coverage they have now, contrary to President Obama's promise. According to analyst Allisa A. Meade of McKinsey & Company, they will be switched into
other policies after the insurance mandates take effect in 2014? -- whether they like it or not."

As far as nobody taking away citizens' current health care plans:

"Government has the authority to destroy the private insurance market by preventing insurers from earning a reasonable return. If companies charge "unreasonable" premiums, as determined by Health Sec. Kathleen Sebelius, she can block them from participating in a huge sector of the market -- as she already has threatened to do. Michael Barone calls this "gangster government."

And when the private health insurers are destroyed outright, so changed as to be unrecognizable compared to what they were, or taken over completely, the citizens' current health plans won't even exist. Clearly, we won't be able to "keep them," as the President promised. In addition, many employers will no longer offer health insurance when the reforms are fully implemented. Employees at these companies will have no choice but to find insurance with the government plan.

President Obama has repeated his claim that we will be able to keep our doctors and our current health plans many, many times. However, it is absolutely untrue. If it were true, why would the federal government be willing to spend half a billion dollars on the Patient-Centered Outcomes Research Institute?

Phrases such as "patient-centered outcomes" immediately bring to mind George Orwell's book, Nineteen Eighty-Four, where the Ministry of Truth deals with lies, the Ministry of Peace deals with war and the Ministry of Love deals with torture. The public relations campaign for this health care "reform" law is similar to the campaign waged to promote HIPAA. We have to repeatedly hear how HIPAA actually protects our private health information (PHI) when we know that it does not: many in government and certain corporations will have access to our health information. And when all the health records are transferred to electronic form and the connections are made between all the providers, there will be a centralized database or a way to access the information wherever it is. Good computer hackers will be able to find whatever they want, and those who can pay will get whatever information they want. It will not be "private."

"Acceleration in the use of electronic medical records may lead to an increase in personal health information theft, according to a new study that shows there were more than 275,000 cases of medical information theft in the U.S." in 2009. Weren't we told that the new electronic records and HIPAA would protect the privacy of our medical records? Exactly the opposite is occurring. As with all things, things go wrong, and so will "privacy" and "patient-centered outcomes."

"Patient-Centered?" More likely: "Corporate" and/or "Government-centered." Although the rationale for the institute sounds good: "we will research and find those treatments that are most effective and the best use of the taxpayer dollars," I can hear government representatives reciting over and over. It will be more like, "we will find ways to reduce costs by denying treatment to those individuals whose lives are not productive for society, and for the 'greater good' we will eliminate them." It is already happening.

The President's statements? Propaganda? Absolutely. The reality? The private health insurers are either going to go out of business or simply comply with the federal government regulations and control, not only of the coverage provided, but the premiums they charge. If the health reform law is not repealed and not declared unconstitutional, the private insurers
will become an extension of the federal government, not an independent business at all. And the people will not be able to keep the policies they have because they will no longer exist; the government has mandated so many changes to health care coverage that the entire industry is in turmoil, feverishly trying to adapt and comply with the massive number of regulations.

Two things are undeniable: government's role in virtually every industry in the country is expanding, and, corporate influence on government officials is also expanding.

Ralph Nader says we have been on "The Road to Corporate Fascism"

"Ralph Nader exclaims that the central political issue of our time is giant corporate power and its takeover of our government, plus the spread of commercial values into every nook and cranny of our culture including the commercialization of childhood, the universities and almost everything these large corporations touch."

and

"Nader declared that the United States is running under a corporate fascist economic system. 'We're living in a country whose democracy is beyond the breaking point. The extent of corporate control has developed into corporate fascism,' Nader said."

"He said only small businesses still practice capitalism, 'We don't have a capitalist economic system - it's corporate fascism. Every major tenet of capitalism is violated by corporate power. Only small businesses still practice capitalism. We used to be able to challenge corporate influence in Washington, but they have so much power now that we can't. The corporations are laughing at us. They're daring us to try to take away their power."

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**How Government Can Work:**

**The Food & Drug Administration & Corporate/Industry Lobbying**

Just one example of how government can work to benefit an industry is the U.S. Food & Drug Administration. They regulate the pharmaceutical industry as well as agriculture and foods. The players in the industries regulated are mega-corporations. Corporations like Monsanto, Glaxo SmithKline, and Merck ... billion dollar industries. And they're in it for profit, not that profit's bad; it's what greases the wheels of the economy. But if profit is used to pervert the regulatory obligations of the government, the public suffers.

When we're talking about "profit," we mean big profit. **Glaxo SmithKline had 9.257 billion GBP in operating profit as of 2009** (that's $14 Billion profit in U.S. dollars) Glaxo SmithKline
is the maker of Avandia that has been linked to fatal heart attacks and strokes, yet the drug is still marketed heavily to the public. GSK spends millions on lobbying the federal government. With that much money being spent on lobbying, it surely has had a major impact, on how the laws and regulations are implemented by the government's regulatory bodies, especially the Food & Drug Administration. And GlaxoSmithKline is only one of dozens of pharmaceutical corporations.

The pharmaceutical industry also pours millions of dollars into medical schools, research and ongoing physician education, definitely promoting their own products in the process. How much do physicians promote health through methods that are non-pharmaceutical? ... that may take months but really change the person's life? Or do most physicians simply prescribe a drug or do surgery?

We know that there are many studies (even done in the U.S.) that show exercise, diet and many other methods may help promote health or alleviate suffering, even lessen the symptoms of those who suffer from many conditions, but this is not emphasized. Physicians who make promotion of health a major part of their practice are sometimes viewed as quacks. Of course, natural methods may not work in all cases, but that's true of medications being ordered all over the world. Sometimes they work and sometimes they don't.

I've seen a lot, as has anyone in health care (if they were willing to tell you), and if you read the drug reference books, you'll know that every medication has adverse effects, and that some are quite severe. We are told "take this," or "take that," but often the risks are not fully shared with the patient even though the principle of "informed consent" is basic to ethical practice of health care. While the TV screens flash images of girls smiling and dancing across the screen and the announcer tells all the ladies to buy such-and-such contraceptive, I cannot forget the young woman I cared for as a nurse who lay in a bed, totally paralyzed from a severe, major stroke after taking a contraceptive years ago.

The ads from pharmaceutical companies always speak very quickly at the end and say something like: "may cause heart attack, stroke, or death." And they only have that warning, because they're forced to do so by regulations. I know all the girls will ignore the warning. 'Try 'Yazz' or whatever contraceptive entice the ads. Have fun! I remember that girl lying in the bed.

Friends say I'm being too harsh when I tell them the U.S. Food & Drug Administration has a revolving door between pharmaceutical industry scientists, lobbyists and their own members or that donations from industry to elected officials influences the FDA decision-making process. I remind them of articles like:

"FDA nears decision on genetically engineered salmon" which explains that "agribusiness has spent $350 million lobbying Washington since 2008."

or

"Daschle and Democrats to Get a Dose of Pharma's Medicine" By Lindsay Renick Mayer on January 8, 2009

"Most [pharmaceutical] industry players this year will be fighting off increased regulation and may oppose a requirement that drug companies disclose all of their gifts and payments to doctors. They'll also be trying to prevent the FDA from being able to ban direct-to-consumer advertising for new drugs. The pharmaceutical industry has been sending representatives to knock on Congress member's doors, spending $171.7 million on lobbying in
the first nine months of 2008. When the year-end lobbying reports come in for 2008 on Jan. 20, they will likely show that the industry spent more in '08 than the $225.9 million it spent the year prior."

"The health sector as a whole could find this a year of many changes, and doctors, nurses, insurance companies and hospital execs are also making sure they're heard on Capitol Hill. The health sector spent $150 million on campaign contributions in the 2008 election cycle, more than the $123.7 million it spent in 2003 and 2004. It spent $365.1 million on lobbying in the first three quarters of 2008."

The amount of money being thrown around by agribusiness, the pharmaceutical industry and others is obviously buying influence, tainting the democratic process in our nation. And when it is likely that:

"Prescription Drugs [are] More Deadly Than Cocaine, Heroin, Amphetamines" (May 06 2009)
why would an intelligent person assume that prescription drugs are truly safe or that what we are being told about them is the "whole truth?" According to "the Journal of the American Medical Association, an estimated 1.9 million adverse drug reactions occur each year, and up to 180,000 of them could be life threatening or even fatal." “58,226 American soldiers ... died in the Vietnam War or are missing in action.” Let's see, 58,226 Americans died in Vietnam and the country is up in arms, with the most divisive cultural debate in modern times. But 180,000 Americans have life-threatening or even fatal reactions to prescribed medications and there is absolutely no overall American outrage. Does this make sense?

And what happens when patients have life-threatening drug reactions that cause serious and permanent damage to the patient's health? If they can be saved from death outright, they often become chronically-ill patients who are then shunted into hospice if they are going in and out of the acute care hospital. That's what Congress created the Medicare hospice benefit for: saving the federal government by avoiding patient admissions into acute hospital care.

When I tell my friends the FDA's actions can sometimes be corrupt, allowing unsafe drugs to be marketed because they're heavily lobbied by the big Pharma industry, they think I've gone off the deep end. The facts are on my side. I point to articles like, "FDA Panel Doles Out Bad Medicine For Lobbying Heavyweight GlaxoSmithKline" By Andrew Kreighbaum on July 14, 2010 posted at Open Secrets

"A 33-member advisory panel to the federal Food and Drug Administration voted today to seriously restrict the labeling and possibly the sale of the controversial diabetes drug Avandia, the New York Times reports. The FDA will consider this recommendation when it makes its final ruling at a later date."

"A negative FDA ruling will likely affect the bottom line of a company that spent $8.7 million on federal lobbying in 2009 and has already spent $2.2 million in the first quarter of this year. GlaxoSmithKline, the drug's manufacturer, has much more than that at stake. It earned $1.1 billion from the drug in 2009, Fortune reports." A 2006 article in The New England Journal of Medicine said that patients taking Avandia had a much greater risk of heart disease than patients on alternative drugs."

"A ruling that pulled the drug from the market could result in more litigation against GlaxoSmithKline, Fortune reported, but the drug accounts for only 2
percent of the company's profits."

"GlaxoSmithKline is a major political player in Washington and ranks seventh for lobbying expenditures among all pharmaceutical and health product companies this year."

How many people have to die because they take Avandia before the FDA pulls the drug? If they don't die, but are "just" irreversibly harmed? They can be sent to hospice! I can understand the reluctance to remove a drug from the list of safe medications, because millions of dollars have gone into researching and developing that drug, but if it's not safe, it's not. Avandia is still for sale in 2011.

The evidence of collusion between the FDA and the industry is overwhelming. Drugs that are not safe continue to be sold, even though studies show the dangers are significant. Just think about the Vioxx case. For years, they knew Vioxx and other drugs like it could and did cause heart attacks, but the FDA allowed it to stay on the market.

When unsafe drugs, doctors, hospitals or other agencies harm patients and the patient sue them, they settle with the patient out of court, basically using gag orders to pay for the patient and their family's silence. And so it goes, on and on, and the public never learns the full extent of the harm done.

Has our government under any administration really acted consistently to protect the public from unsafe drugs? There's more focus on limiting care for the elderly than protecting them from drugs that harm them.

The Government's Conflict of Interest

When you have the government disbursing tax revenue to pay for Medicare, Medicaid or even health care in a nationalized single-payer health care system, it has to look directly to controlling expenditures, reducing the number of tests, treatments, surgeries and other services provided. In other words, they will become the "mother of all HMOs."

"Rep. John Conyers (D-Mich.), the ranking member of the House Judiciary Committee ... [stated] that the health-care law ... is a platform for building a single-payer health care system in the United States.

["Conyers: Obamacare Is 'Platform' for Creating Single-Payer System"
CNSnews.com March 14, 2011 By Nicholas Ballasy]

They will use the "Complete Lives System" promoted by Ezekiel Emanuel, MD and not limit its application to deciding who gets a vaccine or an organ for transplantation. They will use the "Cost-Effectiveness Research" results (interpreted however they wish) of CMS Administrator
Donald Berwick, MD. They will make sure the P.O.L.S.T. forms are universally used. They will ration care.

What does that mean for getting the care you want and need? In some cases, you may get the care you want, but when it comes to the elderly, the disabled, or even the young but very sick, you may find the recommended treatment is denied. That's the system HMO/managed care corporations have used to make sure they run "in the black" and make profit. For the government-run system, it will be about holding down costs while they dish out billions to other questionable projects for the purpose of "pork-barrel" spending to make sure the votes keep coming in.

If some form of nationalized health care system moves forward, taxes will certainly rise to cover costs. When the taxpaying public is taxed even more, they have less disposable income to contribute to charity. The nonprofit sector's contribution to society is diminished just as government's role increases. Either the money is in private hands or in the government's "hands." Either nonprofit charities are encouraged to help provide a safety net for the vulnerable or government provides whatever services bureaucrats and elected officials decide will be provided, or not.

There is no question a government-run health care system will involve a conflict of interest. Promising everything, but delivering much less, with problems hidden behind the HIPAA Privacy Rule Wall of Silence. Privately-run or government-run, palliative Care units or hospice will be the pre-determined destination for us all.

**XI - Where We are Headed**

It should be clear by now, we are already far along the way toward stealth euthanasia widely implemented for those who require costly health care services, especially the very elderly, disabled and seriously ill. Organ donation will probably be made mandatory for the brain-injured not too many years down the road. In other words, patients who are brain-injured may have organs plundered without an opportunity to recover, as is already happening in too many cases.

With health care reform, rationing of health care, comparative effectiveness research, the complete lives system, budgetary crises, the baby-boomers entering the winter of their lives, it's obvious what is going to happen and everyone knows it, but doesn't want to admit it. Just like that old story of "The Emperor's New Clothes." It just takes a little child to say the obvious: "the emperor's" "wonderful new clothes" don't exist! And everybody suddenly realizes that they've known the truth all along. Instead of "health care reform," we're going to get health care rationing and hastened death. Once you start making the federal government the "HMO of all HMOs," the conflict of interest is there, interfering with the sincere intent to provide health "care."

It's like the analogy of letting the camel's nose get into the tent: once the nose is in, the rest will follow, and then the tent will be trampled. Health care, whether run by "managed care" or government "managed care" is going to interfere with the provision of health care! They can promise the world, but they can't deliver on those promises to everyone. Many are going to
Patients who are brain-injured but not suitable for organ harvesting will be placed in palliative care and hospice to be disposed of. Others will have services withdrawn as economic pressures mount and also will be placed in hospice or palliative care. We are already seeing steep cuts in Medicaid funding for the disabled which directly threatens the viability of their obtaining needed services. Once we as a society have looked to the government for these services, other networks fade away, and it is very difficult to wean society off of government entitlement programs. We've forgotten in some ways how to provide services for ourselves. Our income is taxed to provide funds for government programs, but what happens when the government squanders much of what is taxed, allows much to be stolen through fraud, abuse and waste? What happens when due to mismanagement at the government level, services that were provided are suddenly shut down? We no longer have the extended family support, the community support or the spirit of sacrifice in large enough numbers to be willing to care for those in need without government-paid services.

The states are facing severe budgetary crises, and they're making steep cuts in funding for many programs. Talk to any parents of severely disabled children and ask them about their state's Medicaid cuts. They've been occurring regularly around the country. If the children don't get needed services, they will decline in one way or another, and may acquire illnesses they would have avoided had they been cared for well. Eventually, earlier deaths will result. Some families can carry on, but some just cannot manage on their own without extensive professional nursing help. Instead of nursing care, the states will begin offering hospice and palliative care. If budgetary crises worsen, Medicaid programs will see sharp decreases (per capita) in government funding.

The elderly will have treatments, medications and surgeries denied based upon their age, not their physical suitability for a particular treatment. With those denials will inevitably come a decline in health status, a worsening of conditions and entry into hospice or palliative care.

As J. Donald Schumacher, NHPCO president and CEO says, "The trends for increased usage of hospice are expected to continue as we see an aging generation of baby-boomers face end-of-life situations for themselves and their parents...." He should know. But it won't just "continue." It is going to be massive.

The Removal of Pro-life Physicians and Other Health Care Professionals

We will also see the removal one way or the other of pro-life physicians and other health care professionals. This is already happening as pro-life nurses and doctors are "set up" for retaliation, harassment and termination of employment when they don't go along with the agenda. When a secular government system is in full operation, physicians or nurses who don't "go along" with the system will be shown the door. There is no doubt the system will be secular and not pro-life. There will be no room for those who disagree with the agenda of the stakeholders' policies being implemented. As with the 1993 Health Security Act ("Hillary
Care") that did not pass into law, providers who are not part of the system may be outlawed.

Pro-life nurses, doctors and other professionals will have to leave the country in order to practice with respect to life when the system is fully transformed by the "culture of death" agenda. Some are already leaving nursing or the practice of medicine. Or, they can practice "under the radar," fearing that at some point, their pro-life views or actions will be discovered and their employment terminated.

And as we've seen, the current administration moved two years ago to rescind "conscience rights" laws thereby removing the protections in place for physicians and other health care professionals who refuse to participate in abortion.

What would be the consequences of removing all pro-life nurses and physicians, as well as all other pro-life staff? Clinically appropriate hospice and palliative end-of-life care could be completely eliminated. We have only to remember the Nazi T-4 program from 1939 to see what is possible:

"Between December 1939 and August 1941, about 50,000 to 60,000 Germans - children and adults - were secretly killed by lethal injections or in gassing installations designed to look like shower stalls. It was a foretaste of Auschwitz. The victims were taken from the medical institution and put to death...." (Never to Forget, New York: HarperCollins, 1976:131.)

Robert J. Lifton makes the following assessment:

Of the number of people killed in the T4 and the 14f13 projects, the following statistics are usually given: adult mental patients from institutions, 80,000 to 100,000; children in institutions, 5,000; special action against Jews in institutions, 1,000; concentration camp inmates transported to killing centers (14f13), 20,000 (Klee estimated that at the end of 1941, some 93,521 'beds' had been emptied for other uses [70,000 patients gassed, plus over 20,000 dead through starvation and medication] - in other words approximately one-third of the places for the mentally ill.) But these figures may well be too low; twice these numbers of people may have perished. The fact is that we do not know and shall probably never know. Elements of deception, imposed chaos, and the destruction of many records make anything like an accurate estimate impossible.

The same is true concerning the total number of people murdered at specific killing centers. Hartheim victims of both ordinary 'euthanasia' and 14f13 are variously estimated from 20,000 (by Dr. Georg Renno, Lonauer's successor as director), to 400,000 (by Franz Ziereis, the former commandant of Mauthausen, on his deathbed); 30,000 is believed to be the best estimate. While these figures may seem unimpressive when placed next to the millions killed in the Final Solution, they represent the murder of shockingly large numbers of people - all in places characterized as hospitals." (The Nazi Doctors: Medical Killing and the Psychology of Genocide. London: Papermac, 1986 (Reprinted 1990) p. 142).

We have to remember that the same type of thinking that justified the killing of these patients in 1939 is used by those reforming our health care system today. We know that to be true. Eugenics - selection of the "unwanted" to be aborted? That's widely promoted and practiced! Euthanasia of the "unworthy of life?" What else is happening to PVS patients, brain-injured patients, patients said to be "brain dead?" The elderly? They're being hauled off in many cases.
The disabled? We've seen that, too. Just think of Robin Love's father who had Parkinson's disease. He wasn't terminal, just disabled. No, there's too much information showing that those in charge are aligned with the same utilitarian philosophy that devalues life and is willing and able to destroy life with no reservations at all.

**Assisted Suicide and Euthanasia May be Legalized**

And yes, it is possible that we may see assisted-suicide, euthanasia and "third-way" killing legalized across the country if a return to traditional American values does not occur. I certainly hope not, but “why not?” say the utilitarians. If we don't affirm traditional values of reverence for life, anyone can be killed, anyone can commit suicide, so long as it is done through a government-approved agency. In Oregon, physician-assisted suicide is legal, yet anyone other than a physician aiding the suicide of a person commits a crime. As we know, patients may be involuntarily medically-killed as in the Netherlands, Belgium and elsewhere. Supposed "safeguards" built into the new laws written by euthanasia proponents will be violated with impunity and prosecutors will refuse to act, just as they refuse to prosecute medical killings in the end-of-life care arena (or elsewhere). And without enforcement, the practice of medical killing is applied to a wider group of victims.

When commenting on proposition 161 which was a failed attempt at legalizing euthanasia in California in 1992, California's then Attorney General Daniel E. Lungren stated,

"This measure would result in some unknown savings due to decreased utilization of the state Medi-Cal program and other public programs, including county programs."

Yes, killing the patient does save money. Dead people do not "utilize" services! Killing the patient involuntarily is monstrous, but any form of euthanasia, assisted-suicide or Third Way killing saves even more money than providing end-of-life care in a hospice or palliative care setting.

**XII - Where We're at Today**

So, can't you see what is happening? We've come full circle and our society is now acting like Germany of the 1930s and early 1940s. It is happening again. We've forgotten as a people to
love, to cherish life, to value life and savor the blessedness of each one. Now, life is cheap, expendable, and throwaway, just like paper plates. When society's done with us, it just discards us.

Sanctity of life has become a phrase that is sneered at by the elite, the media and many in government. Those of us who have faith, do consider life sacred, a gift from God. The utilitarians believe they have the right to end life at any time they deem appropriate for the "good of society." People of faith believe we do not have the right to end life, that life has a purpose, a meaning beyond what someone in a federal health system treatment board could see. If life has a meaning and purpose, then it is not even our own right to end our life. Our life is seen as resting in God's hands and its end something allowed within God's timing, not our own. Our life is seen as dedicated to the purpose of our lives, a service while on this Earth, and something that can still be useful to God, others and ourselves up till the time we take our very last breath.

"I knew you were the one,  
The day I looked into your eyes."
Oh, you are a miracle,
You're sweeter than I ever dreamed.
You're so much more than beautiful!
How can it be that you belong to me?

[from "You Belong to Me" by Michael W. Smith album: "Wonder"]

When we look at an elderly person, when we love and truly "see" the person ... we see the life, the being, just as alive and real as a newborn baby. The complete spark is still there. It may be hidden to some, but that does not mean it is not there. Till the last breath is taken, that life is there. I remember so many of the elderly patients that I worked with. I took the time when I could, each time I went in to their rooms trying to treat them with respect, speak to them with respect and look them in the eye and acknowledge them as a "person." When you do that, they recognize it and are nourished, like a wilting flower that craves water, and is revived with that love. Our elderly need the water of love, that only a caring touch can provide!

"The fundamental attitude of reverence is the basis for all moral conduct toward our fellowmen and toward ourselves. ....

"How could one really love another person, how could he make sacrifices for him, if he sensed nothing of the preciousness and plenitude which is potentially enclosed in man's soul, if he had no reverence for this being ...."

"Reverence for our neighbors is the basis for all true community life, for the right approach to marriage, the family, the nation, the state, humanity, for respect of legitimate authority, for the fulfillment of moral duties toward the community as a whole and toward the individual members of it. The irreverent man splits and disintegrates community."

[The Art of Living by Dietrich and Alice von Hildebrand, p 9-10.]
But now we've got such large corporations bent on making profit ... like HMOs, managed care
health insurance companies, regional health systems, vertically-integrated retirement
communities and pharmaceutical companies. Profit comes first, even though they have so
many services and benefits, just as the pharmaceutical companies have wonder drugs that have
saved so many lives. When patients become expensive, they may be undesirable to the
corporation. Yes, so much good is done, but much opportunity for mischief exists.

With Medicare and Medicaid cutting reimbursements for certain services, physicians feel
squeezed under the system. Some are opting out of the system completely. We are heading for
a tiered system of delivery. We've got the "Federal Employees Health Benefits Program," or
FEHBP ... [that] insures 8 million federal workers, retirees and their families and members of
Congress," the elderly on Medicare, the poor on Medicaid, and many on private insurance (if it
survives health care "reform"). However, many physicians who opt out of government-
reimbursed programs are creating a private-pay "concierge plan" system (like the old days
before Medicare and Medicaid were created) that those with extra "disposable" income can
afford.

Health care reform, rationing of health care for the elderly, the economic pressures of the
federal and state budgets, the infiltration into hospice by the euthanasia zealots, ... all of this is
hurting people. The federal government has never created a policy that would stop the fraud,
waist and abuse that rob our treasury of funds needed to provide services. The U.S. Justice
Department, though it professes to fight fraud, abuse and waste, is still controlled by political
forces behind it. Elected Presidents and Congressmen will not tolerate the Justice Department
seriously going after huge industries that contribute to their campaigns, even if they are
committing fraud. We can see that the Justice Department's ineffective policies will continue,
so those seeking to increase the funds available in the budget will look to hospice, palliative
care and euthanasia as a way out.

It's already happening. People call regularly to report that patients are being involuntarily
euthanized in America. People are dying after being inappropriately terminally-sedated or
overdosed. Their deaths: hidden behind the Privacy Rule. They cry out for help, but who is
helping them? Not the government, not the corporations, not the agencies, not the police or
others.

The elderly and disabled have nobody to save them in many cases. They need strong advocates
at their side who wield the "Power of Attorney" wisely and can navigate through the
manipulations of those who would take the patient's life.

The young adults don't want to think about the elderly, disabled or chronically ill unless they
have a career working with them. Many middle-aged adults are too busy in their own careers
to think about the vulnerable. And the elderly? They are already deprived of whatever power
they had when they were younger. A retired judge, retired physician, retired elite, retired
official has no power to order anyone about. Many of them end up being victimized by the
same system that they chose to ignore while capable of making a difference, and yes, I've
heard stories of such cases.

Seventy years ago, my people cried out and help didn't come for them. Because the world did
not want to believe the truth. It wanted to "mind its own business." It wanted to go on as if
nothing was happening. It wanted to pretend, and it believed the lies of those who said, "There
are no killings," "There are no camps," "The people are only being sent for re-education," "All
is well."
But underneath, inside, the world knew and let it happen, just as people now know that there are medical killings, and they let it happen. All sorts of excuses are spewed forth, but it doesn't justify the crimes being committed. People pretended to themselves it wasn't happening. People today pretend it isn't happening.

People, lots of people, even most people, looked the other way, didn't want to get involved. They were afraid. Even some of the police were afraid. Some of the soldiers were afraid. But they did the unthinkable, because they figured they were going to save their own "skin." If it meant sacrificing others to survive, they did it. It was "everyone for himself." And today, it's the same: people look the other way and choose not to get involved, because they're afraid. They don't want trouble. I've listened to hundreds of people over the years and so many are horrified by what is going on. On the other hand, most of them do nothing, because they are terrified of speaking out.

To speak out is an act of faith, a demonstration of one's resolve to stop the evil, an act that leads to an unknown destination.

To speak out is to express your humanity in a way that comes from deep within and transforms you.

To speak out is to risk being vulnerable yourself, to leave the comfort of the familiar.

Yet, in speaking out, we are given an inner strength so we may help another.

As young civil rights advocate, John Lewis, said in Selma, Alabama in 1965:

"If not us, then who? If not now, then when?"

In wartime Germany, many people were terrified of speaking up. They feared they would join others that Hitler's troops had shot in front of them or that they would be sent off to the "concentration camps" to die. So, they remained silent.

However, there were some who overcame their fears, decided it was time to act and that if they didn't act, lives would be lost. They risked their lives to save Jews and others being persecuted by the Nazis. Due to their efforts many were saved! Corrie ten Boom and her family in Holland created The Hiding Place in their home where people could be safe during the raids.

"By protecting these people, Casper and his daughters, Corrie and Betsie, risked their lives. This non-violent resistance against the Nazi-oppressors was the ten Booms' way of living out their Christian faith. This faith led them to hide Jews, students who refused to cooperate with the Nazis, and members of
"....Four ten Booms gave their lives for this family's commitment, but Corrie came home from the death camp. She realized her life was a gift from God, and she needed to share what she and Betsie had learned in Ravensbruck:

"There is no pit so deep that God's love is not deeper still"

and

"God will give us the love to be able to forgive our enemies."

**The HIPAA Privacy Rule: Wall of Silence**

The abuse of those enrolled in hospice or receiving palliative care is especially unlikely to be documented. Why? Because the federal and state government officials want utilization of hospice to increase each year. They don't want any negative news about hospice to see the light of day. Another reason abuse is unlikely to be documented is the Privacy Rule of the HIPAA regulations. It prevents outside organizations from accessing the necessary documents or contacting the families around the country to investigate what is really happening.

It is difficult to do any evaluation of what is happening in health care around the country, because of the Privacy Rule. The Privacy Rule supposedly protects a patients' own data, but it definitely protects health care corporations, physicians, nurses, and agencies. Who can open that impregnable safe except those who hold the keys? The federal and state government agencies could, but they don't want that type of information. Patients who die earlier save the federal and state government billions each year.

And those others who hold the keys are those who have secrets to hide, liability to minimize, risk to reduce or eliminate. That's part of what those "Risk Management Departments" do at the hospitals, hospices, and skilled nursing facilities.

"Investigating doctors' performance can cause problems of consent and confidentiality" is the title of a British Medical Journal article from April 2002. "Doctors' Dirty Little Secrets: The Dark Side of Medical Privacy" is the title of a 1998 Washburn Law Journal article. A 2001 American Journal of Law & Medicine article, "An eHealth Diptych: The Impact of Privacy Regulation on Medical Error and Malpractice Litigation." The titles say it all. It's obvious that HIPAA was not solely created to protect the privacy of the patient, even though every single business in the country is burdened with the HIPAA regulations under threat of devastating fines that could destroy individuals there or the business itself should the feds choose to act.

Fear! That's what HIPAA is all about. Employees are terrified of breaching the Privacy Rule
and losing their jobs and having devastatingly huge fines imposed. Fear was intentionally created in Nazi Germany in order to subdue and control the people. So, many became "sheep." People in our country have also become like sheep, afraid that their slightest move to speak out will find them out of a job and fined.

The North Country Gazette reported that the Florida Board of Nursing acted to revoke Carla Sauer Iyer, RN's license because she spoke publicly about the Schiavo case, yet had only mentioned matters that were already in the public domain. ["Florida DOH To Revisit License Issue of Schiavo Nurse" By June Maxam Aug 16, 2006]

This Board of Nursing action was based upon the HIPAA and state privacy rule. Nurses know that if they speak about confidential matters in public, even to protect those being victimized, they may lose their career. The board later reversed its decision in August of 2006 allowing Sauer-Iyer to continue to practice as a nurse, saying she had done nothing wrong. But many people never learned about that; they learned she had been targeted for speaking out.

Now, nurses, doctors and others are liable for fines up to $50,000 or more for certain HIPAA violations. These fines would destroy many of them financially. Some would lose their jobs.

"Be afraid to speak up!" That is the message of the Florida Board of Nursing to nurses everywhere. And the word gets around. "Look what happened to Carla Sauer Iyer, RN."

But what about the privacy rights of the patients? They should be protected. AIDS patients, cancer patients, and many other patients may not want the world to know what disease they are suffering from. Every effort should be made to protect their information, but is HIPAA really about protecting patient confidentiality?

I remember when I filed the first HIPAA complaint in the U.S., because the HIPAA law went into effect that day. I naively thought that the federal government would do something about the terrible violation of the privacy of hundreds of patients committed by the Hospice of the Florida Suncoast.

I had learned that, incredibly, its for-profit subsidiary, Suncoast Solutions, used real patient data in the help screens and elsewhere for the hospice management software they sold and distributed to many hospices around the country. They also posted this information online.

Suncoast Solutions had been warned about these violations of patient confidentiality many times, and had refused to remove the actual patient data. They could have simply changed the data to resolve the problem. It was an easy-to-fix problem, but they refused to do anything at all. When I heard about it, I really couldn't believe it. I get a lot of phone calls and not everything I hear is believable. Sometimes, people are confused. Sometimes they don't understand something or have other motives.

I investigated, saw the patient data posted on the Suncoast Solutions site (it was not password-protected), and I was floored! There, for all the world to see, were patients' real names, real addresses, real phone numbers, real diagnoses. I still could not believe it. "They can't be that stupid," I remember thinking. So, half-heartedly I called some of the patients listed as having HIV or whatever, and guess what? They were real people; actual names were used in the software. I talked to them. It was shocking!

I waited for April 14, 2003 and faxed in my complaint just after midnight April 13th, just when April 14th began, so I know it was the first complaint sent in. The United States Department of Health & Human Services, Office for Civil Rights ("OCR") is where I sent it (by mail also). I did receive acknowledgement from the OCR that they received it on April 14, 2003. Then
three years went by.

I guess OCR didn't know what to do. They probably were upset to get a complaint about an agency, not an individual, and they just filed it away to be ignored for as long as possible. It wasn't what they expected, I'm sure. And they certainly did not wish to go after that Hospice of the Florida Suncoast which is extremely politically well-connected both at the capitol in Tallahassee, Florida and the capitol of our nation in Washington, DC.

They delayed three years till 2006 when they decided to send it over to the Center for Medicaid and Medicare Services since they said they thought that would be a "more appropriate" place for the HIPAA complaint to be handled.

It didn't make sense at all, if OCR really wanted to enforce the HIPAA Privacy Rule and protect patients' privacy. I handed them a perfect case to demonstrate they were serious.

The Centers for Medicaid and Medicare Services does not investigate HIPAA complaints. OCR does! OCR is the government agency specifically authorized to investigate HIPAA complaints. That was the last I heard from them. You would think that at least the first complaint they got, they would pay attention, do something, and levy a hefty fine.

I never read about a huge HIPAA fine being levied against Suncoast Solutions. Maybe I missed it? I don't think so. OCR never even contacted me once to ask any questions about the details of the case, not even once.

And to "find" such a huge violation of the privacy of over a hundred patients, and to act to protect those patients' privacy? That would have made a great news story for OCR to tout, showing how effective they were.

But OCR was not eager to act at all in this case. Think of it; you're at OCR, entrusted with doing a great job, enforcing this new law that had been announced with so much fanfare. What do you do with such a big case? Nothing. It doesn't add up if you believe HIPAA is about privacy rights. To delay three years after obviously doing nothing at all, and then send it to CMS that has nothing to do with enforcing HIPAA?

Waiting for three years assured only one thing: all the terminally ill patients whose information was leaked would have died. If OCR had acted sooner (or at all), they would have been forced to make a "finding" that the Hospice had violated HIPAA and that could be used against the hospice, meaning hundreds of patients (or their families) would likely win their lawsuits. Waiting until they all died protected the hospice. It is a very, very well-connected business!

OCR's refusal to act on the very first HIPAA complaint where hundreds of patients' confidentiality was violated demonstrates the reality behind HIPAA. Their refusal to act only adds up if you realize HIPAA is only about keeping secrets or hiding information from the public, intimidating health care professionals and businesses and enlarging government's intrusion into the lives of every American. Everything that happens in the health care system is now hidden behind the powerful veil of privacy created by HIPAA's Privacy Rule.

When a patient is exploited or abused or even killed, the staff cannot speak out openly, for fear of being brought up on charges of violating HIPAA's regulations, charges that could cost them their job and their family's financial well-being, especially with fines over $50,000. Even though HIPAA's Privacy Rule has exceptions for staff to report to the police, and other governmental agencies, look what happened to Carla Sauer Iyer, RN who was only trying to protect Terri Schiavo from abuse that Carla reported actually endangered her life.
The feds at OCR refused to act on the case I reported to them involving over a hundred patients, but, they say they are doing a great job:

Re: HIPAA Enforcement at OCR:

[The Department of Health & Human Services,] "HHS' Office for Civil Rights is responsible for enforcing the Privacy and Security Rules. Enforcement of the Privacy Rule began April 14, 2003 for most HIPAA covered entities. Since 2003, OCR's enforcement activities have obtained significant results that have improved the privacy practices of covered entities."

Significant results? Really? Really???

We must understand that HIPAA does not completely prevent the release of private health information or your medical records. Nothing can absolutely prevent the release of this information. What HIPAA and the HITECH Act do is exert pressure to prevent individual staff or agencies from releasing information while creating the electronic database for all medical records. Many physicians state that their "immediate concern with putting all that medical data on a nationwide computer network is privacy." They rightly understand that creating the electronic database actually lends itself to release of your confidential medical information (the opposite of what you have been told).

If HIPAA were all about really assuring the privacy of our medical records, why would physicians have this concern about privacy? To make it even more obvious, consider that in December, 2010, the New York City Health and Hospitals Corporation's North Bronx Healthcare Network had a breach of private healthcare information for 1.7 million patients. A month later in January, 2011, Health Net had a breach that involved 1.9 million patients where entire computer hard drives have been lost! And there are many agencies where the confidentiality of information has been breached.

The health care agencies and providers responsible for "breaches affecting 500 or more individuals" are collectively responsible for releasing information from millions of patients. The breach of confidential information is not absolutely prevented! The nationwide electronic database is being created. With so many having access to the information (as permitted by the government regulations) comes an even greater risk for breach of confidential information, and any computer system is vulnerable to hacking and even physical theft of the hard drives, as we have seen. Under HIPAA, individual staff are prevented from revealing what really is happening to individual patients. This allows for widespread treatment denials for the vulnerable elderly and severely disabled without any specific details released by those health care professionals who see it firsthand, and it creates the environment where stealth euthanasia can be widely practiced.
Hospice Wrongdoing
May Never be Properly Evaluated

The Privacy Rule affects those of us who would like to do studies on what's really happening in the hospice industry. We would like to do research on the number of patients terminally-sedated, or overdosed with opioids that were not needed. We don't have access.

The hospices themselves will never do a study of themselves showing what they've done that is in violation of the law. They want to cover all that up. And they alone have the medical records. If a family member requests and gets the medical record for their loved one, it's "only one case." The government will not do a study of these abuses, because it is working in every way possible to encourage greater use of hospice at the end-of-life.

Any report that makes it into public view will be "anecdotal," and therefore discounted by those in power, in the "scientific" circles that evaluate what is happening in health care. They'll just be individual reports from people, over and over again, all over the country. Even if there are millions of such complaints, they will all still be considered "anecdotal," and therefore considered, unreliable reports. They will be discounted until the epidemic of "anecdotal" reports becomes the "elephant in the room" and everybody realizes the reports are true and they've been true all along.

How do I know? Because I've been receiving these anecdotal reports for years, and so has every patient advocacy, disability rights organization, and pro-life organization in the country.

We know; we've heard it all before over and over. No matter how many complaints go to the police, the district attorneys, the State legislators or State Attorney General, the federal government with all its web of thousands of regulatory bodies, nothing has been done and nothing will be done. At least, nothing will be done until something really major changes with our country's entire approach to health care, ethics and enforcement of the laws when it comes to the elderly, disabled and ailing. Only when the public becomes awakened and outraged with the epidemic of killings and abuses will the elected officials act. If they think it may affect their electability, they'll act, but not until then.

Family Members are Afraid to Speak Out

But how many people today have the courage of Corrie ten Boom and her family? Family members are afraid to speak out.
They are afraid to speak up against another family member who had the medical power of attorney and arranged for hospice to come in and make "sure" the patient was kept "very comfortable" till they died. They don't want to cause an irreversible rift in the family. They value family and hope for the best, but know what their relative did to manipulate death and impose it upon their loved one. The rift occurs anyway and families have been torn apart ever after. So, why not speak up?

Family members are afraid to speak out publicly against the hospice, fearing the hospice will sue them for slander. They know that the hospice staff may lie saying that the patient had severe pain when they did not, in order to justify the high doses of morphine or other opioid given. But no hospice is going to sue the bereaved family member. They may explain away their statements saying, "they're having a difficult time coping." But suing them? I don't think so. So, why not speak up?

Family members are afraid to speak out against any one particular nurse or doctor, again fearing they will be sued. It is a very strange thing to witness the victims being afraid to speak out against the killers. If family members spoke up about particular hospice staff members, a hospice that was run with integrity would learn about it and be able to get rid of these individuals. If the hospice approves of the "death protocol" the "closer" nurses implement, then the family members will learn that and know who they are dealing with. At least they'll have spoken the truth, tried to prevent it from happening to others and exposed the nurse and the agency for what they are. Doing nothing only allows the hospice to continue to medically kill patients.

But people are afraid.

Thwarting Appeals to Action

We can report each other to the federal government, but if health care professionals see any sort of abuse, even murder, within health care, we can't speak publicly about it due to fear of the federal government prosecuting us for violating the HIPAA Privacy Rule. We may be able to report what we believe to be a crime to our superiors in the health care system, but they won't act if they condone the hastening of death.

We may be able to contact the police or the county district attorney as well. But in just about every case around the country, the police and local prosecutors refuse to investigate or prosecute (if there is conclusive proof of the murder of a patient in hospice). Hospice is the "sacred cow" and is protected. Until a generation of our citizens objects, until the population becomes awakened and outspoken, unafraid to put their name out there and say that they object to these evils, the evils will spread and more patients will be either abused, neglected, harmed or even hastened to their death.

Nurses, who are known to go into the profession not just for money, but because they care to serve, are often afraid and intimidated in the workplace. Management knows exactly how to push the buttons of nurses who challenge the system. Even non-profit corporations running facilities can create problems for the staff. Either way, the old "divide and conquer" strategy is
used over and over again in health care whether hospitals, nursing homes or hospices.

The financial vulnerability of many nurses makes them even less likely to report problems in health care. Many nurses' incomes are essential to the financial well-being of their families, and many are single mothers who are raising a family on their own. They are terrified of losing their jobs, their health benefits (if they have any), and worry about their children. That is why the health care industry is one of the most backward and exploitive fields in America. Those with dollar-signs in their minds administer many of the facilities and those with hearts of gold perform the real work of caring for those who need so much.

Although there are some good for-profit corporations in health care, I truly believe it would be better for non-profits to dominate the health care industry. Health care is a mission of service and whatever funds are used to provide care should be going to care and services, not to others profiting off of the system. It seems that years ago, people recognized this spiritual mission of health care, but as our society has mostly assumed a secular world-view, health care has become just another industry to be exploited.

How Things Work: The Legal Environment for Nurses

That brings to mind the whole legal arena. When you're hired, management tells you that not only do they have health insurance for full-time employees (usually with significant employee contributions), and the short-term disability, the workers' comp, but they also tell you they have liability insurance. They say, "whatever happens," "we're here; we have all these benefits and you have nothing to worry about that." "We'll be there for you." "You don't need your own liability insurance." Well, again, all is not as it seems to the new, naive, trusting employee who is full of faith in the system (as I was back when I was a new nurse).

If the hospital (or other health care agency) is actually sued, the hospital's risk management department and its attorneys will size up the situation. The corporation's attorneys will assess the liability and the best course of action to protect the hospital! If that includes protecting you and defending your actions, they will protect you and help you. However, if they believe they can most easily win their case by throwing you to the wolves and "parting ways," they will not defend you and they may actual terminate you from employment. They may actually sue you as well. That's why many nurses carry their own liability insurance. If you have your own insurance, the attorneys that are hired work on your behalf, and what they do may or may not be beneficial to the corporation.

I've received tearful reports from nurses who were fired at hospice agencies, because they refused to overdose a patient with morphine in a hospice, at the express direction of the greedy adult son of the patient who did not care a bit about the patient, just how soon he could get his hands on the estate. I've received calls from nurses who spoke up about the inappropriate use of terminal sedation to impose death; they were harassed, retaliated against and were either fired or quit.
Many good nurses are leaving the field of hospice care, because they know they will be discriminated against and possibly lose their license. Some malicious managers at these hospices have gone after the licenses of the nurses who respect the sanctity of life. It is exactly the same as what happens to nurses who refuse to participate in an abortion at a hospital: they can be fired for not helping in the procedures. "Protections" for the conscience rights of the health care professionals who are pro-life are not effective. And the current administration has rescinded some of the protections that were in place and might theoretically "protect" a worker after they had been fired or discriminated against. The prohibitions against retaliation or harassment of a "troublesome" employee are not respected by management and management knows it can get away with treating an employee that way. Even if they later lose a lawsuit, they know that most employees will not sue and most cannot hang on for the long delays the corporation's attorneys will create, draining the limited resources of former employees struggling just to make ends meet.

How Things Work:
Typical Hospice Scenarios for Hastening Death

The following hospice cases represent typical scenarios used in end-of-life settings. Although many will protest that these stories are rare exceptions or anecdotal stories, after hearing similar stories from families all across the country for a decade, I know that these are widespread methods being used. Perhaps more than anyone in the United States, I know, because I've heard from families and spoken with them for hours, asking specific questions to clarify exactly what happened. Having worked in hospice and spent the last 13 years focused on end-of-life care hours every day, I don't believe everyone who calls saying this or that happened. They have to have the details of what happened, what medications were given, dosage, frequency of administration and so on. Sometimes, and even many times, I have told a family member, "I think the hospice was really trying to help your loved one; it sounds like they did the best possible and followed the correct procedures." That would surprise many, but it is true. If a patient is really in pain, giving increasing doses of the appropriate medication to be used for that type of pain is indicated.

However, the other stories about problems in hospice and palliative care units, whether in hospitals, nursing homes or elsewhere just keep coming in. Every patient advocacy group in the country has heard some of these stories. But because we are hospice and palliative-care oriented, we get calls from the staff in the industry: medical directors, nursing directors and staff working in hospice, who confirm what we are saying and sharing with you. These are the censored stories. For every story that follows below, there are hundreds, even thousands just like them all across the country. It is not an East-coast or West-coast thing. These problems exist in middle-America, the Midwest, North and South, all around.
I've heard from professionals teaching hospice & palliative care standards of care who have also confirmed serious, even criminal problems exist in this industry. I am sharing the reports of the following family members with details so you can read what happened in their own words. The details matter. Many are well-educated professionals, some with masters' degrees or other advanced degrees or training. They are speaking from experience and knowledge. These are their stories.

**Lucid, Poor, Elderly Veteran Euthanized Against His Will**

Note: the following is the account given by two daughters in the involuntary euthanasia of their father. Names have been withheld to maintain confidentiality.

December, 2000

Letter to authorities:

My sisters and I believe that the circumstances surrounding the death of our father are suspicious and unusual, and therefore fall within the criteria of deaths designated by the (name of state) Death Investigation Act which warrant investigation. We also believe an investigation into the facts and circumstances surrounding our father's death is warranted by those agencies responsible for enforcing state and federal regulation compliance and investigating criminal activity, medical malpractice, and Medicare fraud. Because of the complexities and broad scope of this matter, we are addressing this letter to U.S Attorney and the District Attorney for the __th Judicial Circuit, State of __________.

Our own investigation thus far has produced evidence supporting the allegations asserted herein, and we are concerned that the hospice, doctor, nurses and others involved may alter, destroy or otherwise dispose of any medical and-or other records in their possession and/or under their control before their records can be subpoenaed, if not already altered or destroyed. However, we have copies of medical records which prove most aspects of the fraud and other criminal allegations we will be describing in this letter. The various allegations we are asserting include criminal homicide, conspiracy to commit homicide, Medicare fraud, Title II Controlled Substance Act violations, medical malpractice and many other violations of the Code of Federal Regulations ("CFR") and the Official Code of (name of state).

I will address the Medicare fraud, i.e., our father's Hospice certification, first, not because it is the most blatant violation committed, but because it was while under Hospice care that he suffered the damages and, ultimately, his death, which are the subject of this letter. In Dr. (name of doctor)'s capacity as our father's private physician, he certified to Medicare that our father was terminally ill with lung cancer in order to qualify him for Hospice benefits through Medicare. (name of doctor), it turns out, is also the Medical Director of this Hospice, that he recommended our father to sign up with (name of corporation/hospice) Hospice. There is no medical evidence whatsoever confirming such a diagnosis - no pathology reports, no x-rays, no lab reports. Nor is there any medical evidence of any other type of cancer. (name of doctor) was well aware at the time of Medicare certification, and at all times subsequent thereto, that all tests conducted on our father for any type of malignancy returned negative or inconclusive
During the course of our father's care under (name of corporation/hospice) Hospice, the following violations were committed by (name of doctor) and (name of corporation/hospice).

1. He was given a drug for which his medical records reveal he was allergic to, although at least four alternative drugs were available on the market, resulting in his death.

2. He was given a drug which he was told was specifically for his COPD, but actually was medically contraindicated for his primary illness of COPD, resulting in his death:

Note: Of concern: All of our father's medications were obtained through the VA hospital, both those prescribed by his VA physician and (name of doctor). However, (name of doctor) obtained the morphine from a private, local pharmacy, altogether bypassing the VA. This is because my father's VA hospital records are replete with notations with regard to his morphine allergy and his diagnosis of COPD. (name of doctor) knew he would not be able to get the morphine from the VA, because it would have been red flagged by VA pharmacy.

3. His regular medications were withheld from him, against his will. This included Lasix for his COPD and his medications for blood pressure (which is evidence that the morphine could not have been administered with the intent to aid and assist his breathing). Morphine, in low dosages in combination with a diuretic such as Lasix, may be used to decrease pulmonary edema (usually in very end-stage heart failure).

4. He was denied his right to change his course of treatment when he both wrote and verbally requested that the drug be stopped. He was allergic to this drug and he stated the morphine was making him sicker. His instructions were ignored and the administering of the drug was continued by both Hospice and (name of doctor):

5. Food and water was denied him via abuse, neglect and later on, due to the comatose state caused by the above described drug (terminal sedation).

6. (name of doctor) falsified my father's death certificate by incorrectly stating the cause of death to be lung cancer, by incorrectly stating the time of death to be two hours later than it occurred (right after an IV was given), and as for the other two causes of death listed by (name of doctor), i.e., pleural effusion and COPD, it will be shown that these were causes of death only because of his intentional hastening of these illness (by not providing appropriate care) to the point of his death.

7. Several months before his death, my father was given a vial of morphine by a nurse at (name of corporation-hospice) and was told to keep it in his bedside stand to "think about". It is doubtful that this vial of morphine was prescribed and legally dispensed by a pharmacist because there was no pharmacy label on it, just the manufacturer's label. It is not legal to dispense unlabeled morphine (or medications of any kind) and especially not without a specific doctor's order. The implications of this action by (name of corporation/hospice) are in direct violation of Hospice regulations and all basic standards of care.

8. When advised by family members that our father wanted the morphine stopped, (name of doctor) failed to contact our father to verify his wishes about the morphine.

9. (name of doctor) and (name of corporation/hospice) prescribed dosages exceeding those necessary for my father's symptoms, and utilized methods of administering the morphine in contradiction to the standards of care for his condition, used excessive amounts of drug, and had them given to him by injection rather than a standard method of oral, subcutaneous or IV
10. He was illegally discharged from Hospice care and then reinstated a week later, suffering severe mental distress from such action by (name of doctor) and (name of corporation/hospice), in violation of Hospice guidelines and regulations as outlined in the CFR:

11. He was denied his final arrangements with regard to his children due to the inadequacy of the "spiritual counselor" assigned to him.

12. (name of doctor) and (name of corporation/hospice) made only one brief visit to our father during a 6-day stay at the (name of hospital) Hospital (this was only a few weeks before his death), contrary to Medicare Hospice regulations.

13. Various other violations of the laws and standards of care were committed, including, but not limited to, violations of basic standards of care and misleading family members about the effects of the morphine, causing them to submit to and assist in the assault and battery on our father, i.e., forcing him to take morphine injections against his wishes and convincing family members to ignore his wishes, as well and administer the morphine injections.

14. The hospice violated our father's wishes to remain alert and oriented. The hospice's actions placed our father in a medically induced coma, despite the fact that he stringently denied experiencing any pain whatsoever during this time. He had not been comatose until given the morphine directly against his wishes.

15. (name of doctor) and (name of corporation/hospice) did not provide continuous 24 hour nursing care for our father during the crisis symptoms resulting from the overdosage of morphine, (during the last days of his life) when he needed professional care the most. (name of doctor) and (name of corporation/hospice) rendered our father helpless through the administration of the morphine, and that is how he died, and he did not die with dignity as Hospice is supposed to provide for.

With regard to the fraudulent diagnosis and fraudulent cause of death, please be advised that we are in possession of our father's medical records from the VA Hospital (name of hospital), where any and all tests for cancer were performed. (name of doctor) advised certain family members three days before our father's death that he, himself, possessed no medical evidence of lung cancer, and that he had made his diagnosis based on the medical records of the VA Hospital and on what our father told him.

The VA Hospital could not have provided him with any evidence of lung cancer because no such records exist and secondly, physicians cannot legally or ethically diagnose and certify a terminal illness simply upon a patient's unsubstantiated fears. And the fact that the doctor admitted having our father's VA Hospital records means the doctor was fully aware of our father's allergy to morphine and also, that our father had COPD, for which morphine is generally contraindicated. Morphine depresses and slows down the respiratory rate, and especially in COPD patients can lead to death when the breathing is made to stop.

I should also mention that the doctor had treated him for his COPD during the three years he was his medical doctor, so he was aware of all his different illnesses, including renal insufficiency, which also made morphine contraindicated for him because it prevents adequate elimination of the morphine from the body.

Also not receiving his Lasix caused the fluid buildup (pleural effusion) in his lungs to escalate. The morphine induced coma also resulted in his inability to cough, preventing him clearing his
airways when in the medically induced coma. This resulted in more fluid buildup in his lungs.

When (name of doctor) prescribed the morphine, he did not prescribe an emergency kit to be kept near his bedroom which could reverse any respiratory suppression caused by the morphine. He knew he would have a severe adverse reaction: and, he knew that with his renal insufficiency, failure to get Lasix and COPD, he could overdose very quickly on the morphine and that the antagonist Naloxene should have been available in case of an allergic reaction or overdose. As it happened, he did have an adverse reaction and he did overdose...dying shortly after receiving the IV morphine.

For the reasons stated above, a copy of this letter is being forwarded to (name of State) Drugs and Narcotics Agency for further investigation into the misuse and abuse of a Title II controlled substance and the actions of (name of doctor) who is registered with the US Drug Enforcement Agency to prescribe and administer narcotics in accordance with the Controlled Substance Act.

On the first day of administering morphine to our father, the hospice nurse advised family members who were present to contact all family members so we could visit our father while he would still know us, because within a few days he would be comatose, and then he would die. In other words, the treatment plan was actually an involuntary euthanasia plan, because our father had been alert, oriented, and mobile up to this point, and demonstrated no symptoms of a person facing imminent death from illness. The Doctor literally described the onset and progression of an intentional morphine overdose.

On the third day of the morphine program, our father's wife contacted the Hospice nurse and advised that our father was unable to swallow his usual medications. She was advised by the Hospice nurse that his difficulty in swallowing was a result of the morphine and if he could not swallow his medications, not to worry about giving them to him. Our father was faithful in taking his medications, including his vitamins, because he intended to live as long a life as possible and to be as healthy as possible throughout the length of his life. Because of the dire necessity of certain medications, i.e., medications for pleural effusion, blood pressure and heart condition, it is another suspicious and unusual circumstance that these medications would be discontinued with no concern on the part of (name of doctor) or (name of corporation/hospice).

According to the pharmacist that dispensed the morphine injections, he was not aware of our father's allergy to morphine and stated that the doctor had not informed him of past adverse reactions to the morphine.

At one point, during the 10-days my father was on morphine, our father could not be awakened by family members or the Hospice nurse and (name of doctor) was notified of our father's condition by the Hospice nurse. Rather than have the hospice nurse call local emergency medical personnel, (name of doctor) traveled from his county of residence, to my father's home to examine him himself. It is more curious that during the visit, before leaving our father's home, (name of doctor) authorized the hospice nurse to increase the dosage and/or frequency of morphine injections being administered to our father and advised family members who were present at the time that his dosage could be increased. This, even though our father had no complaint of pain at all.

Our father, on another day, awoke from his comatose state, but due to his inadequate food and fluid intake and in the absence of receiving his regular medications, was extremely weak and ill. At this point, he found a pen and paper and managed to write a note of his own free will and accord, in the presence of not less than three family members stating that he wanted the morphine discontinued because it was making him sicker. The morphine was continued against
our father's will.

The family member who wanted to control daddy's treatment plan, (name of son) took the note from our father, and in a display of anger, slapped the note between his hands and told our father, "we are going to continue as planned." A local minister visited with our father that evening, and our father repeatedly told the minister that he did not want to be given any more morphine.

To ascertain our father's mental state and awareness of what he was saying, the minister asked our father a series of questions, to which he answered all correctly, e.g., "who is the President of the United States," "what is your birthday," "how old are you," etc. The minister, however, had been told by the hospice nurse emphatically that the morphine was necessary to help our father's breathing difficulties and urged our father to continue the morphine injections. This minister was made a victim, herself, in that she will have to live with the fact that she unwittingly contributed to the calculated murder of a good man for the rest of her life: Our father relied on this minister's word (who had relied on the nurse's promise that our father needed the morphine), and therefore our father subsequently submitted to the morphine (although he had previously vehemently refused them over and over again).

The following day, our father managed to sign a medical release form for his medical records from the VA Hospital, directing his medical records be sent to him in care of his daughter (name). He stated to another of his daughters that he wanted all of his children to know the truth if he died. Sadly, the records did not arrive until two weeks after his death; too late to get an injunction to stop the morphine from being administered to him, and too late to save his life.

Our father drifted in and out of consciousness for another day and was then rendered completely comatose by the morphine. For two days, at a minimum, he received no fluids or food and remained comatose. No IV fluids were administered to prevent premature death by dehydration and starvation. A statement obtained from one family member who was present at our father's bedside during the last two days of his life stated that by the last day of his life, our father was receiving morphine injections on an hourly basis. He did not revive, again, and passed away on ____________, 2000.

The following are several significant facts which should be considered in an investigation into our father's death: Our father was nearing the time when he would need to be re-certified in order to continue with Hospice. Some family members had begun to question the cancer diagnosis (which lab tests or other medically scientific tests failed to diagnose at all). Our father had related to several family members that (name of corporation/hospice) nurses had told him that the hospice was in financial difficulty and that was why they were shorthanded and could not be more available to him. (This financial difficulty was a self-created situation since the hospice was signing on more patients in order increase its profit.)

Approximately one month prior to his death, our father had called 911 and went to the hospital for breathing difficulties while under hospice care without notifying hospice in advance, allegedly contrary to their hospice rules. Our father called 911 to get emergency medical assistance because his many calls to hospice for medical assistance were not returned at all! It is my understanding that, according to Medicare guidelines, hospice would be responsible for payment of any hospital expenses incurred by our father for medical care for symptom control. If our father were to continue to use 911 as an alternate emergency avenue when the hospice failed to provide the promised 24 hour nurse on call, as it so often had in the past, it would have resulted in a great expense for the hospice.

Our father advised several of his children that immediately after his visit to (name of hospital), the hospice nurse advised him that they had a meeting and decided to discharge him, because
he had gone to the hospital against hospice rules. Actually, the hospice had been responsible to provide emergency symptom management, but failed to do so, and to retaliate against our father when he simply wanted medical care for his illness, is the opposite of what hospice is supposed to do. The mental distress this caused our father was enormous. One week later, (name of corporation/hospice) accepted him back into their care, and a few days later they started him on morphine and ten days later he was dead.

Another curiosity is that during our father's more than one week stay in (name of hospital), and subsequent overnight stay in the VA Hospital, he did not once complain of experiencing any pain whatsoever. If our father was then, two weeks later, in dire need of medication for unbearable pain associated with cancer, that seems odd indeed. Again, there was no medical proof he had cancer, no lab tests, no formal diagnosis (except on the falsified hospice enrollment forms and death certificate) and no pain.

One more curious and suspicious incident is that on the last day of our father's life, in the last hour of his life, a hospice nurse arrived with an IV pump. She said it was a morphine pump. She had great difficulty in getting the IV needle inserted properly into our father's veins because of his physical dehydration and deterioration by that time. Within a few minutes of getting the IV going, she came out of his bedroom and announced his death to the family. This incident absolutely demands investigation.

We know that nothing we do can bring our father back. We also know we are not going to let this matter rest until our father's death certificate is corrected in all respects, and those responsible for his death are held accountable.

Sadly, our father is representative of those at greatest risk of becoming victims of involuntary euthanasia - he was a veteran who proudly served his country. He was poor, elderly, disabled, and disadvantaged. Our father fought with all the abilities he had at his disposal to hold on to life. His determination to live had seen him through medical crises before, to go on to long term recoveries, but his extraordinary determination was not able to overcome the forces of a doctor and a hospice equally determined to end his life.

Our father, though elderly, ill, and, at times, very lonely, was a caring and beloved person, respected by those in the community, who never did one thing to harm anyone, yet he suffered a death less dignified and a thousand times more painful, emotionally, physically, and mentally, than a murderer on death row receives.

I hope the information contained in this letter and the enclosed medical records and statements are sufficient to initiate an investigation into the death of our father. If there is any further information you need please give me a call at the number provided at the top of this letter.

Sincerely,

(name of daughter)

[Daughter's Note: This case was reported to the State and local authorities who have to date done nothing. The state and local DA's office have had several months to investigate, but have conducted no such investigation. Further, the hospice and the hospice doctor have separate continuing business relations with the county coroner who would do part of the investigation for the DA's office. The DA's office has not investigated. They plan no action at all. We wish]
to know if hospices have a license to kill. It is evident, that in our father's case they did.]

Mother Killed by Hospice with Morphine Overdose

[Note: the following is the account given by a daughter showing how her mother was medically killed by a hospice, its medical director and its nurses: involuntary euthanasia. Names have been withheld to maintain confidentiality.]

My mother was recently a hospice patient in _________. She had chronic lung disease (C.O.P.D.) which we all expected would eventually take her life. However, while under hospice care she died of "acute morphine intoxication." This has been confirmed by an autopsy by the coroner's office, and now is being investigated by the county D.A.

Since she was under hospice, and also considered terminal, I don't know how serious it will be taken. However, I now know that this is not an isolated case, and feel that it's probably happening to others as well. What I find particularly disturbing is that my mother did not want to take the Roxanol (liquid morphine), and that's what caused her death.

The hospice nurses kept insisting that it would help her breathe, although everything we read stated that morphine would actually slow down her breathing and could even stop it completely. The nurses claimed that in small doses, morphine actually would make her breathing much easier. Consequently, she finally agreed to take it, and my brother and myself were encouraging her to do so, based on what the hospice kept telling us. We trusted them! Throughout the patient records, it mentions our concerns regarding the Roxanol.
My mom agreed to become a hospice patient primarily because she totally depended on bottled oxygen to breathe. It was difficult transporting her to and from physicians. It also appeared they actually did little besides adjust her medications.

Since hospice claims to have "physician services" available, and her attending physician appeared to be in favor of her signing up for hospice, she agreed. Initially, we began to have problems getting the proper medications. Many of the meds she took for breathing problems did not appear to be on the hospice "formulary". This appeared quite odd since the meds she took were standard for her condition. I also had been told that the hospice handled all supplies, i.e. underpads, gloves (for dressing changes), etc. Whenever, we asked for anything, they were always out. They also claimed falsely that these items were not generally covered. I finally spoke with their social worker assigned to the case for a clarification to determine what was covered. After that, they supplied all necessary items. However, I did request a written list of items covered, they could not supply.

Although my mother had difficulty breathing, she was completely alert and aware at all times. After we finally received her medical records from the hospice after her death, it was noticed that they had written "comfort measures only" to be supplied. However, they did not see to it that my mother was kept comfortable. They denied her the basic medications which would have helped her manage her C.O.P.D. symptoms!

I'm still trying to determine exactly what hospice does supply, since they supplied so little. Through the duration of her hospice care, there were many issues which we felt needed physician input. We had no contact whatsoever with either the attending or the hospice physician regarding my mom's care. (I did meet with the attending physician at his request to try to resolve who should be responsible for prescribing her medications. At the end of the meeting, he told me that the hospice has their own physicians and they should be handling her case.)

Approximately one month after we initially signed with the hospice, a home health aide who was assisting my mom get back into bed, cut her leg quite severely with her acrylic fingernails. The vein was actually exposed. We have a friend who is a dermatologist who felt the wound was bad enough that a wound care specialist should be contacted. We requested a physician visit from the hospice. They initially ignored the request. When we became persistent about having a physician evaluate the wound, they arranged for their hospice physician to stop by our home. He evidently stopped in front of the house, then received a page from the hospital and left. Throughout her care, we never saw or spoke to him.

Several weeks after the leg wound incident, her breathing became much more labored. We told the hospice nurse we suspected pneumonia since she'd had that before with similar symptoms. We were told by the nurse it absolutely couldn't be pneumonia since there was no fever present. We once again asked for a physician to evaluate our mother, but once again the request was ignored.

Approximately two weeks prior to her death, her right hand swelled and the fingers became very sore and puffy. The nurse suspected either an infection or a bite. It was extremely painful. We once again requested a physician, and once again the request was ignored. Instead, they ordered an antibiotic in case it was an infection. My mom refused to take it without speaking to a physician.

Since her breathing was becoming more labored, the hospice nurse began to really push the Roxanol. My mom finally relented and began to take small doses of 5 mg every 4-6 hours or many times less frequently. (The prescription on the bottle allowed for 10mg). Since my mom was extremely petite (she weighed approximately 75-80 lbs.), she was very concerned of
overdosing on medications.

The day before her death, the hospice nurse came into our home, and said that the attending physician said my mom could have 20mg of the Roxanol every 2 hours. That was 4 times the amount we had been giving her. Since her breathing was still labored, and the prior doses didn't appear to be helping her much, the nurse administered the larger dose (the medical records now state that she gave her 10mg, although at the time, she said it was 20). The last thing I remember my mom ever saying was "but I just had some". She had been alert and aware prior to the dose being administered.

She went into a coma that afternoon. I immediately paged the hospice nurse and was told that the coma was part of her "actively dying" and that the morphine had nothing to do with it. We wanted to call 911, but when you are with hospice, you are instructed to contact the nurse instead. We also knew that she did not want to be placed on a ventilator and were afraid that would happen if we called 911. At the time, neither my brother nor I had any idea there was a drug to counteract a morphine overdose. Nor did the nurse volunteer any such information.

The nurse never came out that day. The following morning while my mom was still in a coma, the hospice nurse returned. She insisted that my mom needed some more Roxanol. My mother's breathing rate had slowed down considerably and I vehemently said "no," telling the nurse that I still felt as though the morphine had caused the coma. She denied that and even stated that morphine can go "in and out of the system quite quickly." She said my mom was actively dying, and that it had nothing to do with the morphine. The nurse told me that "it was "inhumane" to allow her to struggle for breath as she was. The morphine would only help make her breathing easier." I finally reluctantly agreed to a very small dose. I'm not certain of the amount given, but my mom died later that evening. Now I know that the morphine killed my Mom.

The coroner was not called as is the rule in the area we live. My brother and I began looking more into the morphine issue, and contacted the coroner's office. The autopsy report took 10 weeks, but confirmed our suspicions. The coroner confirmed that my mother had bilateral pneumonia, which never was treated.

The physician who prescribed the increased morphine level to be given was the hospice physician. He had never seen or spoken to my mom. There was absolutely no contact with the family. It is my understanding that in _________, it is illegal for a physician to write a narcotic for a patient he has never evaluated. We are contacting the medical board on this issue.

I also began looking up some information on Roxanol/morphine, and how it's utilized with COPD patients. What I found in every journal I looked at was that Roxanol is "contraindicated for use with COPD patients". Consequently, we don't really know why it was given. She did not have cancer, and was not in severe pain.

I also attempted to get her records from the hospice. They have been absolutely impossible to work with. It's nearly impossible to get them to respond on any issues. They refused to release records to me until I filed a complaint about it with the county department of health services. When they did send out my Mom's records, they did not send the complete record and were careful to actually remove certain pages from the record that were particularly incriminating. When I again requested specific documents which I learned had to be part of the record, they sent some, but again, failed to send everything. They still make it extremely difficult.

This story goes on and on. The bottom line is that my mother was "euthanized" against her will and against our wishes by the hospice, its physician and nurse who were supposed to be
helping her live out her remaining days to the fullest, not kill her!

The hospice has continued to insist that the morphine had nothing to do with her death, and that my mother died from her lung disease. According to the official coroner's findings, my mother's morphine levels were extremely high. The morphine intoxication was the only cause of death. It had nothing to do with her lung disease.

This has been extremely hard on my whole family. We all had hoped and prayed that we would have Nana with us for another Christmas. The sad part is that without hospice, we probably would have. I had brought her to live with us, thinking that we could help extend her life, and allow her to be around loved ones. Instead, she was overdosed on morphine by those we entrusted to help with her care.

As I mentioned before, I don't believe this is an isolated case, and would like to do whatever I can to prevent this from happening to another nana somewhere.

signed - Name of daughter

Note: There are several issues involved in this case. The Hospice was required to provide the supplies needed for this patient's care related to her terminal illness. Also, morphine is contraindicated generally with C.O.P.D. patients and especially in an elderly patient, medications do not "go in and out of the system quickly" as the nurse incorrectly stated. Every nurse and physician knows that the elderly do not metabolize or excrete medications as quickly as the younger patients. In this case, the breathing rate became quite slow, according to the daughter's report, and yet, the hospice nurse still gave the morphine, knowing it would slow the breathing down more and then stop the breathing.

The attending physician had told the daughter that the hospice has its own physicians, and that the hospice medical director should handle the case. That is completely incorrect. Most physicians are not well informed about the specifics of hospice regulations. The hospice regulations actually envision a check and balance system with the attending physician making the orders for medical care and the hospice medical director serving as a check to make sure that the patient's symptoms are managed well.

For a hospice to remove the C.O.P.D. patient's medications for breathing management is absolutely abominable and the opposite of standard hospice care regulations. The C.O.P.D. symptoms were the symptoms that were causing discomfort to the patient, not pain, such as in cancer, so the patient would have been much more comfortable receiving the medications her attending physician had ordered. It is obvious from the daughter's account, that the hospice had no intention of managing the patient's C.O.P.D. symptoms but was bent on euthanizing her by giving her morphine when her breathing had slowed down below acceptable standards.

Hospice Patients Alliance has received this report from a daughter who is devastated by the medical killing of her mother (involuntary euthanasia). HPA does not take a position on any specific hospice, but condemns the abominable lack of even minimal compliance with the most basic of health care standards, resulting in the needless death of this family's mother and thousands of other helpless patients throughout the US. We condemn the hospice's violation of human rights and patient's rights described in this actual case history.
Father of Robin Love Killed by Hospice with Morphine Overdose

Note: the following is the account given by a daughter showing how her father was medically killed by a hospice, its medical director and its nurses: involuntary euthanasia. Names have been withheld to maintain confidentiality.

Robin Love reports:

I was the only one of the children living in the area and I would visit with my father, at home, at least twice per week. My children were very close to both of my parents so I always felt it was very important that they saw their family on a regular basis. My mother had medical power of attorney. And I believe she knew I was going to go to court to be named guardian and that is why everything had been done very sneaky and that I was kept away from hospice for the same reasons.

There were too many people who would be able to show that my mother wasn't very capable of making rational decisions on many levels, not just regarding my father's care. My father wasn't able to speak but could communicate with his eyes and hands. He had 6 caregivers (2 full time and 4 part time) who were able to understand him. And he was aware of everything going on around him. My father wasn't terminal.

My father had Parkinson's Disease; he had been diagnosed 5 years earlier. He had lost his ability to swallow well and had opted to have a feeding tube inserted in May of 1998. Other than that, he was quite stable and was certainly not terminal. I heard from a caregiver on the day before he was to go into hospice that my mother was considering placing him in a nursing home. I went to speak with my mother, to let her know that my father could live with us, in my home, and she became irrational and very defensive and was screaming and carrying on, so I left her house with my 9 year old who had been there over night.

The following day I received a call that he was going to hospice in 1 hour and I went back over. My father grabbed my hand and began crying and acknowledged that he did not want to go. He feared that he would somehow die if he went into the hospice. My husband and 3 of my father's caregivers were also there to witness his distress and obvious wish not to enter hospice. All of this planning had been done unknowingly to any other family members. I visited with my Dad twice and the third day was told that I was not allowed to be there. Nor were any of his caregivers or his own sister!

My mother had decided to put Dad in the hospice against his wishes and mine. What was my Dad's prognosis? He had Parkinson's and was stable. All of his internal organs were functioning, it was just the feeding tube that seemed to have disturbed my mother. However, with the feeding tube in place, he was not having any other medical problems.

I kept track of the cans of formula that my Dad had. The hospice didn't use any of them! My father was being starved to death intentionally, against his will. In addition, The nurses at the hospice told me my father was not being medicated at the end. However, my husband glanced at the chart and wrote down the info and I called his sister (who is a nurse) and she told me that it was morphine and the other was a sedative. In addition, I witnessed an aide administering morphine and she "accidently?" left the book open, which indicated that my father had received five doses of morphine that very day.
I just find all of this so unethical! And later on when I requested a meeting, the "Hospice Ethics Committee" meeting was re-scheduled 3 times, then completely cancelled. The hospice had no interest in speaking with me about the involuntary euthanasia they were committing.

So, my father was being dehydrated and starved intentionally by the hospice, even though my Dad wasn't even terminally ill. Plus, he was sedated with Haldol to put him into a coma and then given morphine to push him over the edge and kill him by shutting down his breathing. All of this, totally against his wishes!

Now I wonder how this can happen in the United States. I just don't understand it, and the local district attorneys have not done anything yet to bring charges against the hospice. It seems like they can do anything and nobody in authority cares to stop them. After doing research and speaking with others, I've realized that there are many other cases like my Dad's, and it is just horrifying to know that this is going on.

I have reported this to the state Attorney General's office, the state Office of Health Quality and the U.S. Drug Enforcement Administration, but none of them have acted. They all say they don't handle this type of case. I was informed that the US Drug Enforcement Administration does not deal with this issue. There is basically NO ONE to oversee what drugs are issued to hospice patients.

Father Killed by Hospice with Morphine Overdose

by Pat Bridwell and Jane Kennedy September 13, 2004

This is about a man who loved life, cherished each day as a gift, and whose iron will to live was an inspiration to all who knew and loved him. He was intelligent, a hardworking career man into his 70's, and a veteran of World War II who loved his country. He adored family and friends, and his name is Dewey __________. He is my Dad. He was 81.

In 1991 he had heart bypass and carotid artery surgery and had remained on heart and blood pressure meds since that time. Dad developed hardening of the arteries in the last few years. His blood pressure was kept extremely low. Occasionally, his legs ached due to poor circulation, but Dad kept going despite his declining health. He was never homebound or bedridden.

On July 5th Dad was hospitalized with nausea, diarrhea, vomiting, and weakness. CT scans and a colonoscopy revealed that part of his colon had died due to improper blood flow. He needed surgery but doctors chose not to operate. He was weak, and they feared he would not survive the risk. He was treated with IV fluids, antibiotics, potassium, and was also given a blood transfusion because he had some bleeding from his colon. He was released a week later, and at no time did his condition require pain medication. The only discomfort Dad ever complained about was gas pain after eating or his leg/neck aches from lying in bed.

He regained his appetite and bounced back with unusual energy. On July 28th and August 8th, the diarrhea returned. Both times he was hospitalized for dehydration and given IV fluids. He was given antibiotics again on the August 8th visit. Still, his condition did NOT require pain medication. The doctor who had seen Dad in the E.R. on August 8th told my step mom that
Dad's condition was irreversible and on a downhill spiral. He obviously felt Dad had six months or less and recommended that she seek help from Hospice. On August 10th, Dad was ready to come home and had every hope of regaining his strength and recovering. Giving up or giving in to the problem was not an option for him.

I was ignorant, naive, trusting and knew very little about Hospice. I had only heard good things about how they come to the homes of dying cancer patients in agonizing pain to provide comfort and care. I never knew in-house Hospice facilities existed before now.

Tuesday, August 10th: My step mom had Dad transported that afternoon from the hospital to ______ Hospice Facility in __________, Georgia. I went there immediately after work. Dad was sitting up bed, in very good spirits, and said he was starving. I went to the office and asked for a tray. He ate/drank most everything on the tray and sent me for another buttered roll. Afterward, he had a diet coke and candy bar for dessert. I helped him out of bed, and he walked to the bathroom. There was no light in there, but he managed. I found someone, who later turned out to be the Chaplain, and requested a light bulb be installed. Dad asked what I thought about the place, and I told him the truth. I didn't know yet. He said, "I don't know yet either." Dad was doing real well that evening.

I can only mark the following as the worst three days of my life...the darkest hours... a shocking experience, horrifying discovery.. and a devastating and painful memory.

Wednesday, August 11th: By the time I arrived after work, Dad was lying there and was definitely not himself. He was always happy to see people, greeted them with a smile, and was ready to talk. This time was different...Dad seemed agitated, not interested in conversation and just wanted to rest. This was totally out of character for him, even when he wasn't feeling well. My stepmom said he had had a busy day with a lot of visitors (his brothers and sisters). She informed me that the staff doctor would be meeting with us the next morning. I had a bad feeling... I hugged and kissed Dad, as always, and left so that he could rest. That night I called my aunt. She was elated that Dad was doing so good and knew he was feeling much better. She talked about what a good time they all had during the visit and how Dad was sitting up in bed, laughing, joking, and even singing a song.

Later that evening I called my family doctor on the phone. When I told him Dad was in that facility, he asked why. He paused for a while and then said, "if your Dad's in that place, it's only a matter of days. Those people have the license to kill." I turned sick to my stomach and called my step mom. Dad trusted her judgment completely, and I knew I had to handle the situation with caution and respect. Without repeating the words of my doctor, I told her that I was not happy with Dad being in that place and I believed they were drugging him with morphine. She said he would get better care there than in the hospital. She reminded me that she had told them not to give Dad any narcotics and had planned to bring him home when he gets stronger. All I could do was pray.

Thursday morning, August 12th: That morning I found Dad lying there like a zombie. He had a weird expression on his face and appeared not to know or care that he was in the world. His breathing was labored. I shook him and tried to make him talk, but it was useless. I marched into the nurses' room and told them who I was. This was the conversation:

"My Dad can't even speak to me today, and he was out of it yesterday when I came. What kind of medicine did you give him? "Roxanol and Ativan," she said. "For what?" I asked. She picked up his chart. "Says here that he got out of bed last night, complained with his legs aching, and he was agitated." "My step mom told you NO narcotics, I said. How much did you give him?" "20 milligrams; he's on the lower end of the dosage" she replied. "How often?" I asked. "As needed," she answered very sharply and defensively. Her behavior gave new
meaning to the word, "agitated." I walked away in anger.

Afterward, we met with the doctor. He spoke very calmly, seemed well rehearsed, and implied that he "thought" Dad had gotten worse since he arrived there on Tuesday. "How do you know?" I asked. He said he could tell that Dad was in pain because of the expression on his face and that he had started rubbing his abdomen. He "suspected" that Dad had developed a blockage in his abdomen or that he "may be developing an infection." Dad has just finished antibiotics in the hospital a few days before. I told him Dad had not mentioned any pain to me, that he had been "out of it" for the last two days, and that I wanted to be able to talk to him. He told me I was being selfish. My skepticism and objection to their agenda was obvious to them. They had the speech and the drill "down-pat." I knew I was living a nightmare, and that Dad's death was certain.

I walked into Dad's room, shook him, and aroused him long enough to ask if he was in pain. "No, he said, just pressure" and pointed to his abdomen. Dad's bowels had not moved since he arrived there on Tuesday. Despite his weakness, he was restless and moved side-to-side. He kept wanting to sit or pull himself up. Every time we raised his head, they would lower it, indicating he could breathe better lying flat!

Friday morning, August 13th: I called at 5:00 a.m. and asked to speak to Dad's nurse. She was a night nurse that I had never spoken to. She was very kind and said Dad had slept well on his own without medication. He was still weak and groggy but alert enough to speak. She put the phone to his ear. I said, "hey sweetie, it's so good to finally talk to you." I asked if he had a good night, and he said, "I think so; I just feel real tired." He said, "Pat, thank you for loving me so much." I said the same to him in tears and told him I was on my way. My sister and I arrived at 6:00 a.m. We hugged him and exchanged "I Love You's," but he kept drifting off, rather than engaging in conversation. My step mom arrived around 7 a.m.

My sister and I were in and out of Dad's room, as were the Hospice staff. We heard one of them say it would be 12 hours or less. At one point, my step mom tried to talk to him. They scolded her, telling her not to get him agitated. Each time we went back into the room, Dad was more pale and his respirations shorter. Dad was dying, as my sister and I stood over him. One of the nurses came in with morphine. We asked how often they were giving that stuff to my Dad, and she said every 15 minutes. We ran her out of the room. Dad drew his last breath at 4:30...

These were skilled morphine experts with a mission that excluded my Dad's wish to live, that denied him the right to communicate with friends and loved ones, and experience life in the time he had left - a mission that went against what every Hospice is suppose to represent. There was "no dignity" in his death, and it was "not a natural death in its own time."

I never knew about Hospice Patient Alliance until my sister located the web site. We think about the other 17 who were there in that facility. We think about the countless other victims of Hospice and their families all over the country... the stories we've read so similar to this. We are deeply grateful to know there are people like you who care about the rights and violations of vulnerable people, who expose the truth about bad Hospice, and who disclose the government for turning a blind eye to this evil, dark trend to hasten death, and who realize that every day left with a loved one is precious beyond words. Because of you, we know there is hope for others. The education came too late for my sister and I to help Dad, but we are here to help you. God Bless each of you.
What I Saw at the Hospice House

[Note: The following is the account given by a professional whose boyfriend was denied rehabilitation and death imposed upon him in a hospice house. Because she was not named as power-of-attorney for health-care decision-making, she was unable to stop the process.

The patient here was not considered "terminal" but was in need of some rehabilitation therapy. Rather than provide therapy, he was placed in a hospice agency and his life was ended prematurely. He did not choose to enter this agency and his wishes were to have rehabilitation. When patients who experience disability, confusion or illness of various sorts are hastened to death, rather than getting the therapy they need, what does this say about our society and those who directly instigated the imposed death?]

Summer, 2010

When my boyfriend retired recently, we had been together for nearly nine years. He was sixty years old and wanted to return to his home town so that he could spend time with his elderly mother who is in a nursing home. He had lived away from family for more than twenty years. He went back and moved into his sister's home temporarily, with the intention of making plans for the next phase of his life in which he also wanted to return to teaching.

In the Fall of 2009, he came to visit me. We were discussing our future plans. About 2 weeks into his visit, he received an emotionally-charged phone call from his sister saying she wanted him out of her house. Her call was baffling. He was devastated, and explained that he had never seen that side of her before. He also disclosed to me that he suspected his sister, and possibly her husband as well, was abusing prescription drugs.

In the last several years, she had regularly borrowed significant amounts of money from him for various reasons, one time supposedly to pay the mortgage, and there were other reasons she gave. He told me she had a history of mismanaging her own finances despite the fact that at one time she had a well paying job. Because he cared for her and had the money, he gave it to her.

He said they were close as children and he always willingly helped her during times of need. Because of the relationship he thought they had, he also named her as his power of attorney. My partner had a sizeable estate and as power of attorney, she had access to all his bank accounts and his lock box. He was very concerned after her call.

He then asked me to serve as his power of attorney (should anything happen). I regret not accepting his offer, but I was concerned that we were not married and wanted to avoid conflict with his family. He then decided to appoint his more stable older brother as power of attorney.

Because he was really upset by her call, he flew back right away to straighten things out legally. When he got there, his sister completely changed her behavior and said she didn't want him to leave her home.

My boyfriend had struggled with depression during his life but it never interfered with his career. He was highly successful, talented musically and theatrically, and had amazing achievements. In 2010, he suffered a Major Depressive, possibly Bi-Polar episode that put him in the hospital for 3 days and they put him on Risperidone. His older brother told me that upon his discharge, the sister took him to the lawyer's office and had him re-name her as power of
attorney. He seemed to stabilize for a while.

After a while, his sister reported that his behaviors were becoming odd and he had stopped taking his medication. She took him to the hospital and he was admitted for treatment. He signed himself into the hospital, was aware of what was happening, and had been driving earlier that week.

For reasons that are unclear, they changed his medication to Zyprexa (known for potential to cause strokes) and within 24 hours of being there, he could not articulate words, move his limbs, or swallow, and became incontinent. Initially, his sister would not tell family members which hospital he was at! His brothers were concerned about the motives of their sister and didn't trust that she would get him the proper care. After several days of testing, they had begun to diagnose him with Dementia.

The sister then told her brothers the name of the hospital, and she called me to find out more about his medical history. She told me they thought he had alcohol-induced dementia, and I said that didn't make sense since he rarely had a drink. My boyfriend was a man who had been in impeccable health, was an avid runner until he moved back to his home town, was extremely health conscious in his eating and drinking habits and did not like to take any medication at all.

Shortly after my conversation with his sister, he was diagnosed with Lewy Body Dementia. They started him on Ativan to decrease anxiety and the Exelon patch (for dementia). At the end of May, 2010 the hospital discharged him to a rehabilitation center, but when he got there he was dehydrated so they sent him back to another local hospital. I flew out to be with him and see for myself how he was doing. He recognized me immediately, was thrilled to see me, and began discussing things with me that were very relevant to our life together.

In our discussions that night he told me that he could not move his legs and that he thought he had had a stroke. The next day the family arrived at the hospital; the sister and her husband seemed very uncomfortable with me being there. They would not leave me alone with my boyfriend unless it was very late at night after they went home.

He began eating ice cream and some soft foods while he was in the hospital and spoke a bit more clearly. The hospital discharged him to the rehab center after approval by the insurance company. We arrived there in the afternoon and got him settled in a room. A doctor came to the room and I asked questions about his diagnosis and medications. His sister exploded at me and told me that I needed to stop. At that point, I learned the sister was asking for a meeting with the Hospice House Coordinator.

I was stunned and asked her why she would be considering hospice. She said that she was just getting information and promised me that she would follow through with the 30 days of rehab. Finally, they sat him up in a chair for the first time since May and the speech therapist came in to assess him for speech and his ability to swallow. She barely touched his neck and he began to swallow normally. He also had begun to move his limbs again. I felt relieved at this point that we would at least have the 30 days to assess his abilities and he was already showing slight signs of improvement.

During this time at the rehab, the sister and her husband went to meet with their lawyer about my partner's finances. She described him to me as a "fast track lawyer." She would disclose other things to me such as cutting up my partner's credit cards and closing his cell phone account, etc., all this before he had a chance to be assessed and helped at the rehabilitation center. She obviously had made some decisions about what would happen to my boyfriend.
On Friday afternoon of June 4, 2010, the brothers arranged to take me to the nursing home for a visit with their mother who had been asking to see me. The brothers were very much aware of my concerns that my boyfriend would get the proper treatment and they seemed to be on board with me.

While we were visiting their mother at the nursing home, the sister called the oldest brother and told him that she was moving my partner to Hospice House that day. I was shocked, confused, and horrified. He didn't have a terminal illness! Why would the hospital recommend rehab if he was dying? He wasn't dying!

His mother asked about him, but the family limited the information they gave to her, and told me they didn't want her upset. They forbade me from telling his mother what was really going on with him.

Upon returning to the rehab, his sister looked at me so smugly, picked up her purse and without saying a word left to go to Hospice House. Everyone followed but her husband who seemed to be keeping a watch on me with my partner. I asked him what the plan was and he told me my partner had 8 days to live. I was shocked! I told him that I felt like I was watching Perry Mason and that I never needed anything from my boyfriend but his love.

At that point, he stormed out of the room and did not talk to me the rest of the time I was there. The ambulance was busy and hospice said they were too busy to admit him that night. The staff at the rehab center said they would not move him until the next day. I was relieved.

However, shortly afterwards, a nurse came back in and said his sister insisted that he be moved that night. I began crying and my partner lifted his arm to wipe the tears from my face. The sister's haste in arranging my partner's affairs was alarming.

The ambulance arrived at 10:00 pm to move him. My partner said, "Where are they taking me now?" My heart was broken. The paramedics asked if I would be following them over to Hospice House, and I told them I did not agree with the sister's decision to take him there and I would not be going that night. They were very understanding and kept the intravenous fluids going.

I was devastated as they took him away and the nurses and staff at the rehab came to be with me. They told me they did not agree with the sister's decision. They said they have seen many miracles occur during rehab. They took me to the chapel and stayed with me until I was able to drive back to my hotel.

The next day, I called my partner's nurse at Hospice House hoping to get some support and to find out my partner's room number. I also asked if I might talk to a social worker thinking they might be able to help me. It was Saturday so the social workers were not readily available. I met with the nurse when I got to Hospice. From the beginning, it was clear that she was not going to be in my camp.

Alarms were going off inside and my instinctive sense of danger told me something was really wrong. I became mistrustful of the staff and knew that I needed to be careful of what I said. Surprisingly, the nurse said that my partner met the criteria for being there. "How could that be?" I thought. She also said that clearly there was something neurological going on. I asked her where his intravenous fluids were and she said they took the IV out. She said that hospice does not think IVs are good for patients because of the edema they cause.

The hospice nurse explained to me that he would not get any kind of rehab but that he would receive "comfort care." She told me his sister was very concerned about me and let the staff
know that I did not agree with her decision. Apparently, she had told them I was in "denial" about his so-called "terminal condition." At that point, I decided that the social worker most likely was not going to be an ally either.

I worked hard to get my partner to eat and drink to get him stronger. I went out and bought things I knew he liked and would eat. Within a week he was eating more, drinking lots of fluids, was articulating his words almost normally, and knew when he had to use the bathroom. They had put a catheter in and a pad on the bed for bowel movements.

He would ask things like, "Isn't there any real food around here?" They were primarily giving him ice cream cups and yogurt. He began to eat full breakfasts and dinners. But then the sister would say that he was agitated and ordered the drops of Ativan under his tongue even though I did not witness any agitation. It would immediately put him to sleep and then he would not eat or drink.

The hospice staff also never sat him up, dangled his legs, or got him out of the bed. I kept asking about this fearing he would get pneumonia or blood clots; everyone looked at me with a vacant stare and ignored my questions.

They were also giving him drops for pain now even though he told me he wasn't in pain except for lying in the bed. One of the young nurses said to me, "We look for the furrow in his brow and that tells us he is in pain and needs medication." It was unbelievable!

Although he may have had a minor stroke or "TIA", or even had dementia, there may have been adverse effects of the medications he had been on, and that was never investigated. Whatever his condition, he was able to have many coherent, intelligent conversations with me. He told his family three different times that he may have had a stroke and they would just negate it and tell him that he didn't.

I talked to the student doctor who was taking care of him and asked her about the need for the Ativan as it was putting him to sleep and about my concern that he could not eat or drink if he was always sleeping. Rather than respond to my concerns about his nutritional intake and need for fluids, the student doctor asked if I was unhappy with what they were doing at Hospice House. Although I had many misgivings, I told her they were probably doing what they were supposed to in hospice (I didn't know what to think) but that I thought it was very premature to put him in hospice, and that he did not belong there at all.

His sister flew out of the room and exploded in a rage at me again. I felt so shaken that I had to leave the facility for a while. I tried to ask nurses (when I would catch them without a family member present) if the medical staff noticed my partner's improvements with eating, drinking, moving his body as well as his conversation. I asked if they could recommend another placement beside Hospice. Although I had many misgivings, I told her they were probably doing what they were supposed to in hospice (I didn't know what to think) but that I thought it was very premature to put him in hospice, and that he did not belong there at all.

Other hospice staff would just react blankly and tell me he just "needs to be at Hospice." I asked another doctor who told me that because he was responding to nutrition he would probably live "a few extra days" at Hospice.

I became more and more concerned. At his sister's request, they were giving him Ativan and pain medicine (which I then learned was morphine) much more often and he was sleeping more and more, and eating and drinking less. I was very concerned!

During this time, I called Right to Life who consulted with their attorney and they told me that
I could do nothing because the sister was the legal POA. The tensions with the sister continued to get worse, plus I had a job that I needed to return to. So I flew back home with the intention that I would be back soon.

I began calling the night nursing station to avoid the family during the day and asked to talk with him almost daily. There were times he was very communicative and we had several relevant conversations. Then they began telling me he was sleeping so I couldn't speak to him.

One of the nurses let me know that they had put an intravenous port in that day so they could administer the Ativan and morphine that way rather than under the tongue. I questioned her on the need for such a severe measure in his case. Soon after that, they told me they were too busy for me to call at night and I needed to call during the day when the family was present. I was not comfortable having contact with the sister so that ended my phone communication with my partner.

My anxiety and concern increased greatly when I learned of the port for the medications. I made a series of phone calls trying to access help for my partner. I spoke with Elder Abuse and they told me they would not investigate it because the sister had the POA. I called Hospice Patients Alliance, Legal Aid, and Priests for Life (which also referred me to) the National Catholic Bioethics Center. The response was the same about the POA. They were very compassionate and supportive of my situation.

However, the man I spoke with at the Bioethics Center told me that I had to get my conscience right because this was not going to have a good outcome for my partner. He told me to make one last plea to his sister to get him the proper treatment, and I wrote her a letter asking her to do so. I also told her that I did not believe that her brother would be making this decision to go to Hospice under these circumstances.

Immediately after that, her husband sent me the most vicious letter I have ever read, telling me that I was venomous, in denial, that my partner knew not to make me POA and that I should not contact their family again.

It was a horror to be away from my boyfriend not knowing what was happening to him. I began checking the obituaries daily and thought I would try to learn from the social worker at the Hospice House about his condition only to find out that they had changed the pass code which gave them permission to discuss the patient's condition with me, so that I could no longer get any information.

A month or so later, I received an e-mail from the oldest brother's wife letting me know that my partner had passed away that night. That was it.

My beloved man had been in a bed for 3 full months with only morphine and Ativan treatment, their so called "comfort care." In my presence, I can tell you that he was anything but comfortable and he was so confused about what was happening to him.

It was agonizing to witness this and a nightmare to even think about. Whether he had Lewy Body Dementia or not, it is impossible for me to fathom that anyone who truly loved another and cared about their life would not offer them the opportunity of 30 days of rehab to assess their abilities, or try ordinary medical treatments.

I would never have imagined the collusion of the Hospice House medical staff in hastening my partner's death. There was no one there who questioned anything going on but me. My partner showed none of the physical signs of impending death during his initial stay at Hospice. His heart, lungs, kidneys, respiratory system, and all important bodily functions were working
Something had happened to his brain. In my opinion, the very quick diagnosis of Lewy Body Dementia could very well have been inaccurate, especially since there were no tests that proved he ever had it and, they never gave him a chance to recover or see how he would do.

In any case, his sister denied him the 30 days of rehab he needed to properly evaluate his condition and help him recover. His brothers would not challenge the sister's decisions. Although we were originally told he had "8 days left," my partner lived a few months longer, which tells me this man I loved was healthier than they said. And the question remains, "what medical condition, if any, ended his life?

Before this, I never would have believed that "comfort care" means we leave you to die because you no longer are "worthy" to live.

This experience has been horrifying to me. It has awakened me to the possible future of so many. To have my loved one's life snuffed out in this manner has been extremely life changing for me. I will never be the same.

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**Hospice Ignores Actual Power of Attorney Gives Drug Cocktail to Assure Death of Mother**

[Note: The following is the account given by an R.N. whose mother was placed in hospice against her will. The R.N. who was the named power-of-attorney for health-care decision-making was ignored and the hospice made a new POA document with a sibling of this R.N. Her mother was given multiple sedatives as well as morphine, Ativan and Haldol, though none of these were wanted by the patient and had been refused by the R.N. who had the POA.]

By Mary ____, R.N. October, 2010

It was not God's time...

As a Registered Nurse, I spent most of my nursing career in the specialty of Labor and Delivery. With every new life brought forth, I stood in awe of God's miraculous work.

As a nursing student, I also had the opportunity to care for a middle-aged woman dying of leukemia. She had no hospice care or family with her at that time. She died as I held her, and knew this was a chosen assignment.

Many years later, my father-in-law was also dying in an upstate New York hospital. In 1993, he was placed on a hospice floor there. He was put on a morphine drip through the night and he left us the next morning after having a violent seizure, which was agonizing for my mother-in-law to see. These were her last moments with her husband, images she carried with her the 3 years she lived without him.

Two and a half years ago, I brought my Mom to Oklahoma from New York, so that she could spend time with her older sister who lives in Texarkana. My brother had placed my Mom on hospice care in the home for several months prior, since Mom had difficulty controlling her salt intake and would have episodes of leg edema that at times required hospitalization.

Mom and Dad regularly traveled back and forth between New York, Oklahoma, and Texas,
and Mom had spent the better part of thirty years with us. Mom and Dad had seven children, but I was her main caregiver when she needed it. I brought her to Oklahoma for her aortic valve replacement six years ago, when cardiologists essentially wrote her off, in upstate New York. They told us she was "too high risk," for at that time she weighed 260 lbs as a geriatric patient.

Since I also have a disabled special needs son, who has bravely faced ten surgeries over the course of his precious life, I called my son's heart surgeon, who gave us hope. He told me to bring Mom to him, and God healed her through his gifted hands! She did beautifully, was so strong, and eventually over the course of time lost 130 lbs, which was a healthy weight for her.

In 2008, the hospice nurses in New York told us she had "less than six months to live." It wasn’t so. In two months, I was able to nurse her back to health. Mom was very sensitive to medications, as is our son. She had other medical issues that some physicians don't address, even though these are common conditions: adrenal weakness, lymphedema, and pernicious anemia to name a few. Her blood pressure ran very low and I had to exercise great caution when giving her medications.

I also had our naturopathic physician treat her with the necessary nutritional supplements we lack as we age. At this time, the only service hospice was providing for us, was some of her medications. I provided all her care including monitoring her vital signs.

One day I had a problem with what the hospice social worker did. While I was attending to our son in another room, the social worker gave my Mom a "Do Not Resuscitate" form to sign (a "DNR"). I was not happy that she chose to give this to my Mom to sign without me being present in the room. The hospice staff loved to use the line "It's the patient's decision." I told the social worker after questioning my Mom in front of her, that my Mom did not understand what she was signing.

I explained to my Mom, to have IV fluids and nutrition withheld from her, was a very painful way to die, as was the case for Terry Schiavo. I also stated to both of them, that my Mom should not be signing anything without discussing it first with my Dad. The social worker said we could rescind the form anytime.

We called my Dad that night and rescinded the form the next day. About two weeks later, my Mom fell in the bathroom fracturing her tibia & fibula (right leg), after taking half of a sleeping pill. I knew as a nurse, that if that DNR form had been in place, some physicians wouldn’t have worked hard to save Mom (or any of their patients with DNRs). This had been God's protection for my Mom.

She then spent several months recovering in the hospital and in rehab, requiring wound care and did well.

Hospice discharged her when she was admitted to rehab. A complication did arise just as we were about to get her back home. Her potassium level dropped and her heart rhythm started to fail. She then received treatment at the hospital, and a pacemaker was inserted. We were happy to learn that her heart's efficiency was back to normal. She continued to gain ground and had a strong immune system. After eleven months, she traveled back to be near Dad in New York.

Mom, like many elderly people, also suffered from some other conditions that were successfully treated. Still and all, she was a fighter at 80 years of age. At this point, her primary care physician wanted her to have rehabilitation therapy again.

My brother decided to have hospice care for her at his home instead. This was a major turning
point for Mom.

Since he worked all day and believed that hospice would provide everything she needed, he felt this was the best option to provide for her needs. The young doctor from hospice was kind, and came to see her regularly. Mom felt comfortable with the nurse and aide who cared for her. I interceded from afar when I was able to over the phone, but the communication with my brother was strained.

I soon found myself also needing naturopathic treatment for exhaustion, from years of caring for our special needs son and Mom (when she had been here), along with so many other family responsibilities. In April of this year, my Dad required emergency surgery and four days later, our daughter underwent an emergency C-section with the baby being born early. At the same time, my husband and son had viral bronchitis, and I discovered the same week that my Mom was severely dehydrated from increased diuretics hospice staff had given her.

I was able to intercede via phone and changes were made. She was then admitted to the hospice palliative care facility where she stayed for four weeks. After that, she came back to my brother's house and we were able to hire a nurse for several months to help with extra hours of care for her. She certainly didn't fit the "six months" prognosis required to be in hospice. I know she would have benefited from rehabilitation therapy.

My brother (who lives out of state), came to help my Mom and Dad as well, while I helped family members recover at our home. After six weeks, I was finally able to get away and flew up to New York for three weeks. I met with the hospice physician and nursing team while there. The hospice physician was very honest with me, telling me he was nervous about meeting me, since he heard I was a "naturalist". He thought I was against my Mom taking any medication. I explained that I was not against necessary meds for her medical conditions, but that I also embraced nutritional and naturopathic supplementation that she needed, for all the above reasons. (Our son's heart surgeon led us in this direction for our son). The hospice physician said he was fine with her taking calcium and magnesium, vitamin B12 and vitamin D, etc., but that originally she had told him she didn't want to take them" because there were just too many pills to take."

I did want the hospice physician to take her off the Wellbutrin (an anti-depressant) and Klonopin (an anti-anxiety and anti-seizure medication) he had started her on several months before. She was having tremors, which is a side effect of the Klonopin, and she almost burned herself lifting a coffee cup. He was hesitant, since she had been depressed and he said it was difficult to get patients off these meds once they are started on them. (Looking back, my husband and I believe many of her neurological symptoms she had at this time, were due to the fact she was not taking the required vitamin B12 for her pernicious anemia & staff were not making it a priority to implement).

I asked the nurses if they did patient teaching with my Mom concerning her diet and salt intake. They said they did, but ultimately (again), "it is the patient's decision." When the hospice physician said my Mom was suffering from heart failure, I told him her heart had recently been evaluated in the hospital and it was functioning normally. I also suggested that tests be done to evaluate her heart if he really felt that was a problem. He said that if they did them, Mom might not meet hospice criteria and services would end.

At this point, I also discovered my name was not listed on the hospice's health care proxy form (where the health care power of attorney was named), only my brother's name was! Mom had previously specifically appointed me to serve as power of attorney (health care agent) and I had the legal documents to prove it, but the original documents were not given to hospice by my brother. Hospice to my knowledge, did not ask if any previous proxy was in place for my
Mom & have indicated to family members in the past, they like to have someone local to confer with.

My other brother had been visiting nursing homes near Dad, looking for some that might be good for Mom, but was not pleased with the care he witnessed in any of the Medicaid facilities. Mom was requiring twenty-four hour supervision, and I believe again, it was due to her not getting her vitamin B12 supplementation for the pernicious anemia. If untreated, patients with pernicious anemia and vitamin B12 deficiency often develop dementia, but many get their memory back when B12 is provided again. The physician did tell Mom that if she got better she could go back to her primary physician and I do believe he was trying to help her get better.

Part 2:

What happens next is the hard part. By July, there was no extra money for nursing care in the home, and my brother wanted to get back home. He had been in New York three months at this point and was handling financial affairs for my Dad, including paying his bills. He didn't know what to do in light of Mom's ongoing care and was basically at a standstill.

About that time when he was hoping to return home, the Medicaid social worker called to tell him that a bed had opened up at the local hospice house. He felt this was an answer and shared with most of the family how wonderful this would be for Mom.

I was skeptical (because of my past experiences with hospice), but hospice houses are not available everywhere, so I really wasn't sure how this would go. I asked lots of questions, and my brother told me it was a beautiful place (only ten beds) and she could stay there indefinitely with one-on-one care. They told me she could even travel to come see us, working out details with the physician there. It sounded too good to be true.

The next day, my brothers packed up Mom and admitted her to this facility. She was afraid, because she never wanted to be placed anywhere but in a home with her own family. Family dynamics came into play and other siblings were unwilling or physically couldn't provide twenty-four hour care for Mom. I was torn, exhausted, wanting to have her with me, but also knowing I could not separate her from Dad again, as they needed each other. The real power-of-attorney form was also not being honored or respected, which had named me Mom's health care agent.

As I prayed and sought whatever way I could to help my Mom, it became apparent that I was in the midst of a major spiritual battle. One of the most damaging statements my brother said to my Mom when he admitted her there was: "This is where you're going to stay until the Lord takes you home."

Several days later, she told her sister over the phone: "They've put me here to die." When I heard this, I told her he should never have told her that; that she could get better and come see us and her new great-granddaughter soon with Dad. I called her often, and the first few weeks she began to tell me she just didn't feel right. She felt "off." Just a month before (when I saw her last), she still had much life in her.

I believe some of the beginning "hospice protocol" meds were already being administered to her. On the phone, the nurses told me she hadn't lost any ground the first three weeks, but at the same time I could hear my Mom in the background say she didn't want a medication she was being given.
I again questioned the nurse and learned it was Roxanol. The nurses didn't say they were giving her morphine, but that's what Roxanol is, liquid morphine. I then proceeded to get into a heated argument with the nurse. She told me she had to give it, because it was a standard ordered medication. I told her to write on her chart that the patient and the patient's family requested she not be given this. She insisted again that she had to give it. I then told her if I needed to do something legally I would, since we essentially had no rights where their protocol was concerned and that this was wrong.

That night, I faxed some important medical information to the nurse practitioner overseeing my Mom's care (concerning her meds, diet, and nutritional supplements). I was kind, grateful, and knew my Mom's medical issues better than anyone, having cared for her so many years. In the pamphlet hospice gives to patients and their families, it stated that they welcome any information from family, to better help the patient. I would soon find out: they didn't truly welcome it from me.

The hospice supervisor left a message for me the next day requesting a conference call with my two brothers and me. Instead, I flew to New York again at the request of my brothers to meet with the hospice team. At this point, my Mom was definitely showing signs of all the major side effects of the liquid morphine.

Staff members told us what I'd already figured out, that "she's not going to want to eat" "she'll be sleeping more during the day," "she will have trouble breathing," and "she won't make a lot of sense when she talks," so "talk with her while you still can." They said it was all part of the decline with her disease.

I knew as a nurse and knowing my Mom so well, these scenarios were not going to come to pass because of any hereditary disease she had, but because of the deadly effects of the drugs being given.

The meeting was very difficult. From the beginning, it was obvious the nurse practitioner disliked me and felt threatened by me, even though she had never even met me before! I shared my concerns and was direct and honest with the team.

I told them I believe older people are often "written off" too soon and that my Mom deserved the chance to get better. I told them, I wanted my Mom to go when God decided, not when a staff member expedited her death. They asked if I thought they were doing this and I said, "yes," I do, and that I had never seen this happen in any other area of medicine other than in abortion clinics and hospice, where a patient's and the family's rights were not honored.

The hospice staff became quite offended, and I clarified that I was not attacking them personally, just the hospice philosophy as I had seen it practiced. The nurse practitioner then said, "Maybe this isn't what you want for your Mom" and that "you should talk this over as a family." She did agree to stop the Roxanol at bedtime, but said my Mom's body would determine what they would give her.

At the meeting, my brother also defended his bringing Mom salted foods, which I reminded him would make her swell. I knew they would just give her even more medication for pain and the whole cycle would start all over. When the meeting ended, the nurse practitioner refused to shake my hand and unprofessionally even turned her back to me.

When the family talked afterwards, I received resistance from my brother who had been on the phone during the conference call meeting. He needed to defend his initial decision to put Mom in this facility. I wanted to move Mom to a hospital, but my brothers would not agree to work together with me, to do this. On my own, I tearfully visited a nursing facility near my parents'
house. The nursing supervisor truly wanted to help me, but had no beds available until November. All things considered, I had no choice but to spend what time I could with Mom, come home, and try to recover. I was exhausted from the lack of sleep, the tension with the hospice staff and family, and the incomprehensible resistance to get even common-sense things done for Mom. This spiritual battle I was engaged in, was intense. I prayed with Mom and put all into the Lord’s hands for the time being, trusting Him to give us strength to get through this.

As the weeks went by, it was more difficult for Mom to talk. I was desperately trying to gain some ground physically at home, as well as care for our special needs' son and beautiful new granddaughter. By October, Mom was asking to go to her own home in New York. Dad wanted this, too, but he couldn't do anything, because he was not on the "hospice-recognized" "version" of the health care proxy either.

I remember when Mom was in palliative care, the physician was not interested in what my Dad wanted, ... only what my Mom had signed. This wasn't right and only created family division, especially since the elderly can sometimes be confused and can be manipulated by suggestions from staff. "Why wouldn't a spouse have any input?" I thought. I questioned in my heart what we'd ultimately come to. While home, I had no peace in my spirit and cried out in anguish to God for my Mom. I saw our primary physician who had cared for Mom over the years, and asked him if we could safely wean Mom off the Wellbutrin and Klonopin (meds for depression). He said that we could.

I once again faxed the nurse practitioner this information in hopes of turning Mom around, and also included medical information we had recently learned through our naturopathic physician, regarding our son and the pernicious anemia most of my family have, including me. I requested that my Mom be given methylcobalamin (a specific form of B12 for the pernicious anemia). Without this, I explained her ability to metabolize medications and food would be greatly hindered and neurological damage would continue to ensue (mental clarity, inability to get out of bed, weakness, etc.)

My brother did try to give her the methylcobalamin that I had sent for her. It had been by her bedside, but she would forget to take it, or was too weak to take it on her own. The staff at this hospice agency would only be responsible for the medications. They saw no need for any supplements, which in this case was critical and something the nurse practitioner should have known.

As one might assume by the way all was unfolding, I heard nothing back from the nurse practitioner, but my Dad received a call from the hospice social worker asking him what funeral home we were planning on using for Mom. He was very upset and told her she had no business asking him such a thing and that he believed in Divine intervention. She then apologized to him.

At this point, with all the drugs they were giving her, Mom wasn't eating much and was definitely weakening. My brother kept trying to get her up into her chair and took whatever opportunity he had to encourage her to eat. She wasn't talking much and she was sleeping most of the time. After a few weeks, my Dad called and asked all of us to come and be with Mom. He said he wasn't giving up his belief that God could intervene. He just wasn't sure she was going to make it, since she was so weak. I packed once again and set off for New York with my brother (who lived out of state).

When I arrived at the hospice house, my Mom was not doing well at all. I had no time to assess her condition, for upon entering her room, the nurse practitioner pounced upon me. She was determined to prove everything I had shared with her was wrong. She claimed the blood
test she ran on my Mom showed her B12 level was too high and she didn't want us giving her anymore B12.

I tried to explain what she did not know, regarding how the body stores excess B12 and that she needed to run an MMA test which is more specific. This was all research our naturopathic physician had medical documentation to support. The nurse practitioner just shook her head and then told me she would be stopping some of Mom's meds the next day and starting some others, and walked out of the room. That was the last time I saw her.

At this time, Mom was terribly dehydrated. My brother and I tried to get anything we could into her. She actually was able to swallow some pudding and ice chips, but we were scolded by an evening nurse who said that she couldn't swallow. I knew the game and they had to chart this to carry out their ending-life protocol.

Later, the nurse (the one that I had had words with over the phone) yelled at me. I expressed my concerns again about the medications being given and how they can kill patients. I explained that I did not believe she was dying from heart failure. I knew that her heart was functioning well and had recently been tested by the cardiologist, her last hospitalization. Then the nurse yelled at me: "She's dying!" right in front of Mom!

I told her that I believe in miracles, and she told me, "well, you're not going to get one." She also told me that natural treatments do nothing, because her grandson died of cancer and suffered without drugs.

It was becoming very clear to me that the more I fought, the more they would retaliate against me, and the more they were trying to prove me wrong. They had no respect for what I knew about my Mom's condition. They had no respect for my training and experience as an R.N. They had no respect for my values or my faith, and they certainly didn't care that they were hastening my Mom's death. They did not respect the sacredness of her life, to me, our family and to God.

I finally did obtain a list of medications my Mom was being given, which had been kept from me earlier. It took twenty-four hours to obtain, for my brother had to sign a release for them to give me the list. I suspect the staff had meetings discussing how to deal with me. I told Mom that I was so sorry this was happening to her, that I was fighting for her and would continue to fight for her.

When I received the list, I was absolutely appalled by what I read!

_There were eight sedating medications (Ativan, Klonopin, Haldol, Methadone, Lortab, Restoril, Seroquel and Morphine) all being given at bedtime! She also had a Scopolamine patch in place. My Mom could normally only take half a sleeping pill, because of her normally low blood pressure. Her heart was very strong with her pacemaker, and her urine output was still adequate. They knew it would take this unbelievable lethal amount of medications to end her life. I felt as though I was in the middle of hell._

I called my dear friend who loved Mom, and is a nursing instructor. She has worked with hospice with her students (at a very different agency), and told me how she had never seen anything like this given before. I also called another friend who is an attorney, trying to see if a previous health care proxy (the original one my Mom wanted) with my name on it, could be a way I could get Mom into a hospital. This is what I wanted to do months earlier with my brothers, but they wouldn't agree to it.

At this point, I went down to the nurses' station and started calmly asking more questions. The
nurse who had yelled at me earlier that evening became very nervous. She said only the hospice health care proxy was valid, even though I then told her I was listed on my mom's prior health care proxy. This original proxy was signed by my mother when she was in good physical and mental health.

When I shared with her what my friend had told me regarding the eight medications, she said they had stopped all her meds that night. I asked: "all her meds?" Then she said, "all but the Ativan, Haldol and the Morphine." In response, I asked: "so you've started the [death] cocktail, then". I then asked where their license was posted and what agency they were under. She said the State of New York and that I would have to wait until tomorrow to get any more information that was locked up. She claimed there was no one I could talk to that night, and time was clicking away.

She then told me she was going to walk down the hall to ask my brother (who lived out of state), if she could call security on me. I was shocked and terribly hurt, especially when my brother agreed! Even though I had never raised my voice and had only asked questions because I loved my Mom, they called security.

The security guard came as I was kissing my Mom, with my Dad by my side. I told the guard I had done nothing wrong. He told me to take my time, that he didn't get involved with anything at the nurses' station and that he would even give me the name of the manager overseeing the facility that I could talk to. He was God's reminder that I wasn't entirely alone there.

I confronted my brother as he walked behind us out of the building. My youngest brother was on his way, driving from Texas. He was in total agreement with me in my fight for Mom. He called our other brother and the nurses' station in defense of me, as well. Mom knew my youngest brother was on his way and she was waiting for him...

That night, I remembered what my friend had asked me about earlier, concerning whether there was any kind of an advocacy group that could help me. It came to mind that I had read an article last year regarding Hospice Patients Alliance. I called my husband and he found their number. I called it at 3 a.m. and received a call back just an hour and a half later. It was the greatest blessing!

I was told that it was very important to implore my brother (who was on the hospice health care proxy), to get her transferred to an agency that would honor Mom's wishes; that any narcotic effect could be reversed with a medication, and that this was the best approach to try first. If not, I would have to get an attorney to show that Mom's wishes were that I be power of attorney, where her health care decisions were concerned.

I had prayed for a miracle and God had made a way to help my Mom. The next day, I didn't go see Mom, for I was working hard seeking legal advice, should I need a court order (which would take days), should my brother not be on board to move my Mom to a hospital.

God provided a young man working on my Dad's porch, whose mother was a nurse at a hospital I called. They even put me through to a Hospitalist who was very compassionate and willing to care for her. I then called my brother who was on the health care proxy but he again, still refused to work with me to get Mom to the hospital.

He told me, "no, I don't believe she can get better." It was what the hospice staff had told him. My heart sank, but I was still hopeful. My youngest brother was driving as fast as he could to get to New York, and he planned to attempt to convince my other brothers to move Mom.

He arrived in the early afternoon that next day (Sunday). He picked me up at the hotel I was
staying at and when we arrived at hospice, all my family (Dad, and five of the seven siblings) were gathered around Mom's bed. The other two were present by phone. It was obvious she had only hours to live.

As horrific as it sounds, the truth is, this wasn't my Mom. She looked like a euthanized animal, dying from the very thing I fought years before - starvation and dehydration. My youngest brother told me later he felt as though he was watching someone on death row.

We all prayed together and talked to Mom as her breathing became more difficult. There was reconciliation with family members, something Mom had wanted for some time. The last four hours she had were ones of surrender for me. Many family members left the room for a time.

My youngest brother, I and the brother who did not want her moved, along with his girlfriend, were with Mom. I told her, "I'm not leaving you!" I was determined to do spiritual warfare and not let the enemy steal anymore than he already had. I didn't allow one moment of somber silence to ensue, that she might be afraid.

I asked my brothers to hoist her up and I got into bed with her. I held her in my arms with her back against my chest. I put our special needs' son on the phone with her and he sang to her. My husband, daughter and Mom's sister and my cousin all talked to her, as well. Then I sang to her every song God gave me of praise and glory to Him.

I prayed over her and we just talked to God with every precious moment. She even received a call from Ron Panzer, of the Hospice Patients Alliance six minutes before she passed. This was a gift, as she knew people really valued her life and were fighting for her. My youngest brother said, "God told me that Mom is a picture of Jesus." She was dying for a bigger purpose, as Jesus did.

I felt as though my back was the cross. I know God shortened her last hours, as He did with His son. Like Jesus, she was a lamb that had been led to the slaughter. What our Savior said on the cross came to my mind: "Father, forgive them for they know not what they do." My younger brother cried and thanked Mom for waiting for him. That was when she took her last breath and gave up her spirit. The only comfort I could truly take at that moment was that she was no longer being harmed.

I don't know why God allowed her to go under these wrongful circumstances, especially since He did provide us the miracle I had prayed for. I only know He is not finished yet and can use it all as He sees fit to unfold His never-ending plan, for nothing can separate us from the love of Christ.

I leave you with a scripture the Lord gave me a short time before my Mom's home-going:

"Rescue those who are unjustly sentenced to death;

don't stand back and let them die. Don't try to avoid responsibility by saying you didn't know about it."
For God knows all hearts, and He sees you.

He keeps watch over your soul, and He knows you knew!

And He will judge all people according to what they have done."

Proverbs 24:11-12

I pray our story will bring hope to those who are vulnerable, and comfort to all who are suffering from this most traumatic and complicated grief. Know that you are not alone. -- Mary

Colleen Meland Reports: My Mother who had COPD Was Given Large Doses of Morphine and Terminally-Sedated to Death!

Note: Colleen Meland describes what happened to her mother August 27th through September 3, 2007. She writes that:

"I intended to forward my own testimonial before now, three years later, but my investigative undertakings, and unfruitful effort to take action against parties responsible for her mistreatment, as well as the continued emotional pain I endure reflecting on the ugly progression of events that prematurely took my mother's life, caused me to postpone sharing this information sooner. I finally feel the inclination to bring some closure to this difficult phase of my life and want to validate the work Hospice Patients Alliance pursues to educate and warn individuals about the current practices and trends in terminal and end-of-life medical care."

When I began documenting my concerns about the questionable quality of care my mother received under hospice care the last week of her life, (immediately following her release from the hospital in improved physical condition from when she was admitted) I wondered, "Are there not other individuals in my situation, feeling that a loved one's best interests were neglected, in being provided legitimate medical care to allow continued survival and a natural, more extended, digression towards death from the terminal disease?"

I did an internet search and discovered the Hospice Patients Alliance website. This website validated my fears and suspicions that my mother was likely the victim of foul hospice practices.

When I read the testimony about a "Mother Killed by Hospice with Morphine Overdose," I felt as though I was reading a commentary by someone mirroring my personal experience, but
realized that my experience actually mirrored hers because her account preceded mine. It was disturbingly unsettling to read her quoting statements made to her by hospice caretakers that verbatim reflected statements made to me by the hospice nurses caring for my mother prior to her quick death.

"My mother was recently a hospice patient in __________, she had chronic lung disease (C.O.P.D.) which we all expected would eventually take her life. However, while under hospice care she died of acute morphine intoxication."

"Since she was under hospice, and also considered terminal, I don't know how serious it will be taken. However, I now know that this is not an isolated case, and feel it's probably happening to others as well. What I find particularly disturbing is that my mother did not want to take the Roxanol and that's what caused her death."

Hospice similarly insisted that my mother, in the absence of severe pain and not gasping for air, be given routine, not "PRN" (as needed) doses of Morphine in the form of Roxanol. I trust that were my mother's body exhumed and an autopsy performed, similar evidence of morphine overdose would be presented.

Terminal Sedation of My Mother

I have become increasingly aware that deceptive means are practiced by medical caregivers, particularly within hospice organizations to end the lives of the vulnerable. Sedation without hydration is used to intentionally cause death. Misapplication of a treatment occurs imposing death without the outward appearance that killing is occurring. As was the case of my mother's hospice treatment, she as the patient was too sedated to question, and family members such as me realized within three days too late what had happened.

I have since read that sedation given with no hydration causes the circulatory system to collapse for lack of fluid. British physician Dr. Gillian Craig, MD has warned about the practices of sedation without hydration in her book, "Challenging Medical Ethics: No Water — No Life." To administer potentially lethal medication when there is no complaint of pain, even increasing its doses, is in my opinion and that of many others, an act of murder.

When my mother was released from the hospital, August 27th, she was not actively dying due to the natural disease process. Her sedation, and dehydration lending to her circulatory collapse was imposed death, involuntary euthanasia!

I have since become informed that the diet of Morphine and Ativan are a lethal combination. "If one won't kill you, the other will." (Ron Panzer, lifeissues.net) Morphine administered without food or water causes an overdose, sending the blood pressure plummeting and slowing breathing. Without water given to the patient, fluid volume in the blood decreased, blood pressure drops more and the circulatory system collapses.

My mother had not been experiencing terminal agitation, delirium, or severe anxiety related to her respiratory disease at the time the lead nurse recommended administering Roxanol, and at the time three days later when her morphine dosage was increased. I have no doubt, now, that it led to her quick physical deterioration and death within less than 72 hours.

It is my understanding that hospice is to neither hasten death, nor attempt to cure the underlying terminal illness. The Hospice Pledge (accompanying) in my opinion was violated in my mother's case.
"Hospice nurses kept insisting that it would help her breathe... The nurses claimed that in small doses, morphine actually would make her breathing much easier."

Precisely what I was told!

"Consequently, she ... agreed to take it, and" I encouraged "her to do so based on what the hospice kept telling" me. I "trusted them!"

"My mom agreed to become a hospice patient primarily because she totally depended on bottled oxygen to breathe." ... "Since hospice claims to have "physician services" available and her attending" hospital "physician appeared to be in favor of her signing up for hospice, she agreed."

My own mother's introduction of Roxanol was initiated by the first shift hospice nurse, who simply shoved it into her mouth.

My mother began having respiratory irregularities within 16 hours of the morphine regimen being introduced to her system. I was never advised that respiratory suppression and difficulties were a symptom of overdose and that the morphine administration should be discontinued in the event these conditions developed. Nor was I aware that an antidote drug to counteract a morphine overdose ["Narcan"] existed.

I had been told how very sick my mother was by the hospice nurse, so thought her decline was because of her being sicker than I perceived her to be at the time she was released from the hospital in seemingly improved, good condition. I didn't suspect or recognize my mom's declining conditions as being the symptoms of overdose. The nurses attending to my mother did nothing to counteract the effects of her overdose condition. In fact, I had been told to administer an additional dose of the Roxanol were she to exhibit respiratory distress, that it would help her through the episode.

Two days before my mother died, when her ability to chew and swallow diminished as she attempted to eat lunch, and soon after at which time the nurse discontinued any effort to continue introduction of both food and fluids to her (the reason given that she might aspirate on them). No I.V. treatment was suggested nor provided for her. It was implied to me that she was actively dying (a surprise to me, as the day before, prior to her morphine dose being increased, I was told she no longer justified continuous care support).

From information disclosed to me within days of her death, I have no doubt now that she was deliberately overdosed in the face of my naiveté and ignorance all the while being led to believe her physical decline was a natural progression because of her very sick condition.

I know now, having reviewed her hospital records from her care just prior to her release into the hospice care, that her condition was definitely stable and certainly not of serious concern to doctors Rae and Sheldon who attended to her while in the hospital. Dr. Sheldon even recommended follow-up care in his office following her release from the hospital and return home.

I feel strongly that my mother was overdosed on morphine by those I trusted to help me with her care. I am willing to have her body exhumed to verify this contention. Furthermore, I feel that I was betrayed and duped. It is personally devastating for me to realize that I unknowingly had a hand in administering the medication that contributed to my mother's premature, not natural death. It had been my ongoing effort to provide the very best medical and physical care...
for my mother. I now feel I failed her miserably.

Although I had concerns about the morphine being given to my mother in the absence of intolerable discomfort, I had no knowledge at the time the Roxanol treatment was recommended by hospice, to supposedly "help her breathe easier," that morphine tends to be contraindicated with C.O.P.D. patients, especially the elderly. Had I known this fact, I certainly would have refused its administration, and would have seriously considered terminating the agency's services at that time.

My first impression of the hospice care was negative. I had developed personal reservations about the agencies ulterior motives, after the disturbing remarks of the first shift hospice nurse who was eager to drug her up. He stated that my mother was very sick, recommended discontinuing her regular medicine regimen to go straight to the end-of-life packet, and told my mother's personal caretaker that my mother would be dead in a week. I was then erroneously reassured by the team's lead nurse, and an agency nurse I spoke to over the telephone, that it wasn't the agency's objective to intentionally push my mother to her end sooner than later.

My mother's personal caretaker (who was present daily between 8 a.m. until 6 p.m. daily throughout the entire week while hospice was present caring for my mother) can verify my assertions. I kept her informed about what I discussed at the dining room table with the hospice team leader, when she wasn't present to hear the discussion herself (times she was in the bedroom near my mother).

- Colleen Meland

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**About the Current Health Care Reform**

I think about all these things. The patient and their families, the nurses and doctors who struggle to do the right thing in often difficult circumstances. I think about those who care nothing for those same patients but look at all of this work as simply a business opportunity. They don't see the sacredness of the lives before them. There is no reverence for life as Dr. Albert Schweitzer demonstrated for all the world. They only see dollar signs.

"Death panels?" Yes, they are already here, but as we have seen, it is not like you may have imagined at all. Bureaucrats who make decisions to limit payments, deny treatments, hospital committees that deny treatment, staff who choose to hasten death in various ways .... Private insurance companies, managed care organizations and HMOs ration care when they choose to. Government health insurance programs will do the same, but you won't have anywhere to appeal to if the federal government is the only game in town. When expenditures are limited, rationing is certain. And when there is no right to appeal and no right to correct actions that are extremely harmful, even lethal, that is health care tyranny. Many of those trusting and naive citizens who supported these changes through the years will be very bitter in the end.

Congressmen and Congresswomen, Senators and the President himself all talk about health care reform. They're not interested in real health care reform. They know about the problems,
the abuse, the neglect, the rapes of some of the elderly and disabled in the nursing homes. It's well-known. The felons sometimes hired into the nursing homes who beat and terrorize the residents... Or residents who are criminally insane or violent, being housed in the same facilities as other elderly and disabled....

The abuse, neglect and direct harm to residents of skilled nursing facilities have been well-documented and it's been happening around the country for many decades. But our elected officials all get donations from the industry owners and administrators, just like Hugh Westbrook (CEO of Vitas Hospice when it was being investigated by the Justice Department) donated to Bill Clinton's campaign and the investigation just “went away.” Like they say, "don't bite the hands that feed you!" Politicians are not going to bite the hands that feed them.

Health care will never be reformed properly until the money flowing from the industry stops flowing into the election campaign accounts of those running, or re-running for office. We just had campaign finance "reform" and the money is flowing just as fast as ever.

And health care fraud will never stop until the United States government, through the Justice Department, changes its policies that reward health care fraud that accounts for over $100 billion in stolen funds:

The Justice Department informs us that:

**Health Care Fraud Schemes Are Diverse**

Health care fraud schemes can be simple or complex. Unscrupulous health care providers target public as well private health insurance plans. Billing Frauds

The Department continues to bring criminal and civil charges against those providers who knowingly submit false bills to health care payors:

* billing for services or equipment not rendered
* billing for services or equipment not medically necessary
* double billing for the same service or equipment
* upcoding (e.g., billing for a service or equipment reimbursed at a higher rate than was provided)
* unbundling (e.g., billing separately for services or equipment included in a global rate)
* billing frauds in cost reports from hospitals or nursing homes, to obtain reimbursement when not permitted or at a higher rate of reimbursement than permitted.

**Kickbacks**

Another too common fraudulent scheme is the payment and receipt of kickbacks in return for influencing the provision of health care. Kickbacks are pernicious because they corrupt medical providers' decision making, often replacing profit for patient welfare. Kickbacks can lead to grossly inappropriate medical care, including unnecessary hospitalization, surgery,
tests, and equipment.

The Consequences of Health Care Fraud Are Severe

"While no one has an exact figure, the General Accounting Office estimates that health care fraud, waste and abuse may account for as much as 10 percent of all health care expenditures. As health care expenditures now exceed one trillion dollars each year, more than $100 billion may be lost in fraud, waste and abuse annually."

If there's that much fraud, waste and abuse annually, just within the health care industry, then with a sincere effort to clean it up (meaning putting criminals in jail for once! and making the crooks in all industries pay back every dime) those funds could be used to care for those who need it most.

People say, "we can't afford to pay for services for the terminally ill." "Better off to provide assisted-suicide, euthanasia or terminally-sedate them to death." The entire amount spent by Medicare for hospice services is between $11 billion and $12 billion! The amount of health care fraud in this country is ten times that amount! The money is there to care for each and every vulnerable patient and provide the very best of end-of-life care. The money is there. It is the government's policies and its "federal ethics" that devalues life and rewards criminals sucking the system dry that are the problem. The government does not wish to truly fix the health care fraud problem. They can say otherwise forever. I will never believe that.

US DOJ JUNE 26, 2003

LARGEST HEALTH CARE FRAUD CASE IN U.S. HISTORY SETTLED
HCA INVESTIGATION NETS RECORD TOTAL OF $1.7 BILLION

WASHINGTON, D.C. - "HCA Inc. (formerly known as Columbia/HCA and HCA - The Healthcare Company) has agreed to pay the United States $631 million in civil penalties and damages arising from false claims the government alleged it submitted to Medicare and other federal health programs, the Justice Department announced today."

"This settlement marks the conclusion of the most comprehensive health care fraud investigation ever undertaken by the Justice Department, working with the Departments of Health and Human Services and Defense, the Office of Personnel Management and the states. The settlement announced today resolves HCA's civil liability for false claims resulting from a variety of allegedly unlawful practices, including cost report fraud and the payment of kickbacks to physicians."

"Previously, on December 14, 2000, HCA subsidiaries pled guilty to substantial criminal conduct and paid more than $840 million in criminal fines, civil restitution and penalties. Combined with today's separate administrative settlement with the Centers for Medicare & Medicaid Services (CMS), under which HCA will pay an additional $250 million to resolve overpayment claims arising from certain of its cost reporting practices, the government will have recovered $1.7 billion from HCA, by far the largest recovery ever reached by the government in a health care fraud investigation."

"Health care providers and professionals hold a public trust, and when that trust is violated by fraud and abuse of program funds, and by the payment of
kickbacks to the physicians on whom patients and the programs rely for uncompromised medical judgment, health care for all Americans suffers," Robert D. McCallum, Jr., Assistant Attorney General for the Civil Division said. "This settlement brings to a close the largest multi-agency investigation of a health care provider that the United States government has ever undertaken and demonstrates the Department of Justice's ongoing resolve and commitment to pursue all types of fraud on American taxpayers, and health care program beneficiaries."

"Let this case be a continuing reminder to all that in the fight against health care fraud this office will not be deterred," said Acting Principal Deputy Inspector General Dara Corrigan. "Medicare dollars paid to provide ever more expensive health care services to the country's taxpayers should never be fraudulently diverted. This is our job and our trust and we take these duties very seriously," Corrigan concluded.

We've already discussed how the industry leaders' funds are pouring into the campaigns of the elected officials. We know the US DOJ's policy is to only force the crooks to pay back a portion of what they steal. Rarely does even one executive go to jail and if so, not for very long. Senators like Bill Frist (whose family controlled Columbia/HCA, now HCA, Inc.) have millions of dollars of stock in these corporations. Their fortunes are tied to the industries. Other Senators and Congressmen's fortunes are tied to other industries. Government is often run by those who seek to protect their vested interests and certain industries. What the people want or need is often ignored and the corporate interests served first.

Some of the industry leaders and elected officials lie through their teeth while they smile, just as some of the people I've met over the years who told me they cared about the patients. With health care reform, there is no need for "death panels," or for rationing care the way it will be implemented. We are seeing, and will see, many articles promoting the idea of "letting go" when we or family members become elderly or disabled and we have a major chronic illness. If the illness or condition is expensive to treat, the pressure to "let go" is often overwhelming.

An August, 2010 New Yorker article, "Letting Go -- What should medicine do when it can't save your life?" by Atul Gawande emphasizes the distress of medical treatments: "In the previous three months, almost nothing we'd done to Sara-none of our chemotherapy and scans and tests and radiation-had likely achieved anything except to make her worse. She may well have lived longer without any of it." And that's the point: we've turned the corner in health care. We are no longer trying to prove what medicine can do in every case. We are trying to limit care and not do for patients if they fit the profile of being unworthy of medical care: the elderly, the disabled, the chronically ill. Hospice and palliative care can be a good fit for patients with incurable illnesses, but if treatments exist that could stabilize them, the move to hospice (and the decision not to treat) may be a decision to hasten their death. In other words, society has decided, "times up."

So, hospice and palliative care is a very mixed bag. And health care "reform" is a mixed bag. But there are too many negatives when we consider all of the changes being pushed ahead. We have extremely dedicated professionals doing the very best to relieve suffering at the end-of-life and have administrators raking in the dough, using hospice to fill their pockets. What to do? Round up the crooks and put them in jail; shut down the chronically fraudulent hospices that just can't get enough free money; give the money to hospices with integrity that respect life, do not impose death, and offer clinically appropriate interventions for each patient's unique condition.

Hospice is a free Medicare benefit. What kind of hospice will it be when health care reform
kicks in full-blast? As we've seen, reform to Medicare is happening whether or not the new health care law is upheld or stricken down by the Supreme Court. We don't hear much discussion at all about the reforms that will be made no matter what happens with the health care reform law.

With any reform that is likely to occur, hospice care will continue to be free to those on Medicare and Medicaid. And people think, "Oh, thank God Grandma can get all the services they promise. I get the calls from them later on when the therapy is not provided as required, nurses don't come out when needed, aides are not scheduled enough, or on the other hand, they're railroad the patient on an express train to death with terminal sedation or outright morphine overdoses.

Then, they wonder, "what happened to all those services we were promised?" And they don't know what hit them. They have been caught up in the "Invisible Holocaust." They didn't have a clue what was going to happen.

Those of us who were sold on the idea of "health care reform" and want lower health care premiums as well as eventually, "free" health care? Just like those "free" electric wheelchairs advertised on TV, nothing is truly free. "Free" to the elder, but paid for by our tax dollars. "Free" to the patient who is determined to be "terminally ill," but he may pay for it with a shortened life. We've heard about that scenario many times through the years. The following two quotes from Joanne Lynn, MD tell you in less than 30 seconds what many hospices
are willing to do and doing:

"When a patient is ready to die, I can stop nutrition and hydration, I can stop insulin and ventilation, I can sedate them." [and]

"Hospice providers have been supportive of discontinuing life-sustaining treatments And of providing terminal sedation, but in my experience, hospice teams generally have opposed efforts to legitimize physician-assisted suicide."

Yet, we are told:

"Whoever destroys a soul, it is considered as if he destroyed an entire world. And whoever saves a life, it is considered as if he saved an entire world."

from the Talmud, Sanhedrin 4:8 (37a)

I spoke with Dr. Lynn several years ago. Not knowing the history of her involvement and her approach, I thought she would be supportive of my concerns about patients being hastened to their death within hospice and palliative care settings. I really was naive, just as when I spoke with Dr. Byock. I knew they were leaders within the hospice movement and thought they would be receptive. Dr. Lynn was very courteous and respectful, patiently listening to me and even suggested that we might "do a study" to see what was going on, but nothing ever came of it. Why would she want to show that people were being hastened to their death using methods she has openly admitted occur widely in hospice and that she has proposed as suitable methods of bringing about the end of a patient's life?

We must understand that when the leaders in health care and especially end-of-life care speak, they don't use language the same way, and they don't freely explain their real views to the public. Sometimes, we can catch their meaning when they're speaking to like-minded end-of-life care industry leaders. Dr. Lynn has an organization called Americans for Better Care of the Dying formed at exactly the same time I started Hospice Patients Alliance. But I wonder, what does she mean when she says "better care of the dying?"

"Death with dignity," even "dying well," (the title of Dr. Byock's book) do not mean what we mean when we use those terms. But terminal sedation? Is this the "good death" hospice has sold to the public?
Is There An Attack Against the Pro-Life Hospices?

In Pennsylvania, Highmark Blue Cross/Blue Shield is requiring all licensed hospice and palliative care providers to become members of NHPCO in order to be approved as an "in network" Blue Cross provider of end-of-life care advanced illness services. Dues for NHPCO cost thousands of dollars, and pro-life hospices that know NHPCO is the current successor organization of the Euthanasia Society of America will object to joining. The question remains: is the National Hospice & Palliative Care Organization working with private insurance companies all around the country to make sure all hospices become members?

Even though Highmark Blue Cross in Pennsylvania has been made aware of pro-life hospices objections to its policies, Highmark Blue Cross is not backing down. Leaders of pro-life hospices say that it is contrary to their religious beliefs and that of their employees to join an organization like NHPCO due its culture of death "flavor" of providing end-of-life care services.

While such pro-life nonprofit hospices work hard to provide services that respect the sanctity of life, these hospices will be damaged, because they are being shut out of providing services to Blue Cross members. And Blue Cross members who are pro-life and want to access the pro-life hospice services are being prevented from doing so (Blue Cross won't pay if the hospice is not a member of NHPCO) by Blue Cross's arbitrary policies.

It's something like a physician being told he cannot be an "in network" provider if he doesn't join the American Medical Association which is just a trade organization, a lobbying group, just like NHPCO! In effect, Highmark Blue Cross is saying to those hospice agencies who don't join NHPCO, "we don't want you," and "if you're financially damaged, we really don't care!" In addition, Highmark Blue Cross is saying to its pro-life members, "we don't care if you can't access services at the pro-life hospices!"

Just as pro-life physicians' and pharmacists' conscience rights are being rescinded by the current administration, possibly forcing them to either participate in abortion, or lose their license if they refuse, the pro-life hospices are facing damaging financial tactics to force them to join a culture of death organization that the World Federation of Right to Die Societies labeled a "Right to Die Site," the National Hospice & Palliative Care Organization.

So, you see, the battle is being waged. Even though you're not hearing about these struggles in the major media, if you care about the sanctity of life, these are urgent matters! If Highmark Blue Cross and other private insurers continue along these lines, many of the pro-life hospice agencies will be financially damaged while culture of death, rogue hospices will be rewarded.

You may ask, "what's in it for Highmark Blue Cross?" ... or all the other Blue Crosses or other private insurers who are doing the same thing? "Why would they implement such a discriminatory policy?" Well, as they say, "follow the money!" When culture of death end-of-life care is "provided," the elderly, disabled and seriously ill die much sooner than usual, saving the private insurers millions. Highmark Blue Cross obviously cares more about saving money than having the highest quality pro life services accessible to its members from a hospice that respects the sanctity of life!

Jonah went to Nineveh and warned the city that if they didn't repent and change their ways, the
city would be destroyed in 40 days. What surprised him was that the city really did change its ways.

"When God saw what they did and how they turned from their evil ways, he had compassion and did not bring upon them the destruction he had threatened."

[Jonah 3:10]

XIII - A Purpose In My Life and Yours

You may think this description of health care reform and the hospice industry is extremely negative, but this is the dark underbelly of the industry, not all of it. There's always the good and the bad. I'm not jaded. I'm experienced, and throughout this book, I've labored to include references that confirm everything that is mentioned here. Even more than two decades ago when I worked in homes for developmentally disabled (mentally retarded) adults, I saw things that just weren't right and worked to improve conditions for the residents. There's always room for improvement in an industry and hospice and palliative care is no exception.

Yet, it's not all about the end-of-life care industry, hospice, palliative care, advanced illness programs or health care reform. What is happening with those could not happen unless something was amiss with our society, unless we had gotten "off course" and lost our way. We've all made mistakes, but when they add up collectively over the course of decades, spread across our entire land, we become something other than we have aspired to be. We can be proud of much that is American, but we cannot be proud of many things that we do as a society and as individuals. We need something more than a "New Years' Eve" resolution to "be good." We need reform within ourselves as well as in society. Where is our heart? Where is our mind? What occupies our attention? What do we value and do our actions reflect those values?

We have chances and chances to reform, to change, to return to the way that brings life. Sometimes, there is something we need to do. We feel it inside, an urging, a need, a calling. Sometimes, we are called to serve. Our work is not yet done. Will you make an effort to bring some joy into the lives of the vulnerable who are often alone? Or help to fight the culture of death? Or create an extended "family" around you that works together to help those in need? There are so many opportunities to serve and so little time left. Sometimes, there is no time left, but for God's grace.

One night after working there (February 12, 1989), coming home after the 4 p.m. to 12 midnight shift, the roads were clear, but it was freezing cold. I was coming down a hill at 45 miles per hour, just like everyone else. A car approached from the other direction and I decided to move slightly over to the right, away from the centerline. That's when I realized the entire road was covered with "black ice." My little movement to the side was enough to put my car into a total skid. I remember skidding sideways passenger door-side first across the centerline toward the left, across that lane, down a ditch, and then flipping over with the roof of my car sliding across three parked cars in the used car lot!
My car landed upside down on the other side of those three cars, and I crawled out. I felt something wet on my head and saw it was blood, and stumbled out to wave down a car. Although it was an incredible accident, and the owner of that used car lot must have just shook his head in the morning when he looked at his cars in the lot, I had just a few scratches and a small scar. I have to believe that God saved me for some reason. He later gave my wife and me our beautiful son and life went on.

I have to believe that my life was spared for a purpose, perhaps to become a nurse, form Hospice Patients Alliance and help people around the country, write this and other articles, share some of the many experiences I've had through the years, open the eyes of people around the country to what is happening. I couldn't turn my back on those who were being exploited or hurt, never imagining what a crazy ride I'd have over the years. But I've made some good friends all over, and I'm grateful for the opportunity to make a difference.

When you see people suffering and you know you can do something, can you turn your back on them? Can you walk away? While everyone has to pick their own battles, we must help each other when we can. **Anguish has many faces and inaction can only allow conditions to get worse.** That's what happened in Germany during the 1930s and 1940s. There were many warning signs of what was about to happen, and things started to happen. People didn't want to get involved. They were caught up in their own concerns, their own businesses, their own lives. What happened to someone else, of a different ethnic background didn't matter to them... until they were being hauled off to the camps.

We've been lulled into a lethargic apathy. About 10% of Americans are on antidepressant drugs. The average American spends about 4.5 hours watching TV, 1.5 to 2.5 hours using the computer, and about 1.5 hours playing video games. That's 7.5 to 8.5 hours each day. If we work 8 hours a day, and sleep 8 hours a day, then a huge amount of our "free time" is taken up with TV, computer and video games. Of course, some people use computers, TV and even video games at work, but the reality is we are not "living our own lives" in the "real" world as much today as in the past. People escape into the entertainment world rather than paying attention to what is happening right here in our country.

We need not only be concerned with our own generation and young adults, but also the children that may not be fully "integrated" into the real, physical world, who live vicarious lives on the internet.

"Children are often happier with their online lives than they are with reality, a survey has revealed. They say they can be exactly who they want to be and as soon as something is no longer fun they can simply hit the quit button."

"...Psychotherapist Peter Bradley, who is also deputy director of Kidscape, said that the desire for so many to adopt a different identity online was a cause for concern because the children were being divorced from reality. He added: 'These findings suggest that children see cyberspace as detachable from the real world and a place where they explore parts of their behaviour and personality that they possibly would not show in real life. We can't allow cyberworlds to be happier places than our real communities, otherwise we are creating a generation of young people not functioning adequately in our society.'"

["Generation net: The youngsters who prefer their virtual lives to the real world" By Liz Thomas February 8, 2011]

And "hitting the quit button" on your computer is not something you can do in the real world,
with real problems, especially when problems drag on for months and months, when you need to be a responsible adult and care for others who are ailing and dependent on you for the long term. When it comes to caring for the ailing and disabled, the impatience learned through spending much of one's time in a virtual world of gaming and internet experience will only contribute to a readiness to abandon those who are in need, making imposed death the "quick" solution the younger generation has come to expect. They may not be learning the patience needed to truly care for others long-term.

In the past, there wasn't a "virtual world" of television, computer or video gaming entertainment to escape to. When parents today look at their children, they often see individuals who do not spend as much time with friends and playmates as in the past. Or, when friends get together, they may watch TV or play video games together, rather than playing games with real things in this world. This is new and it is having a tremendous effect on society. Taken altogether (the antidepressants and other medications, the escape into TV, computer and video gaming) it is easy to come to the conclusion that we are not really focused on "this world." We're living vicariously through television, movie, video gaming and computer entertainment. Are we becoming lulled into complacency where we as a society don't really care what happens to others, especially the vulnerable? Especially with the amount of realistic depictions of horrific violence throughout the video gaming, movie and television world, people are becoming hardened to terrible things. It is almost impossible to shock people anymore; they've seen it all through entertainment. So, when people hear about people being medically killed, will they care? Not unless it's already happened to them, and then it's too late.

In his book, *Brave New World*, Aldous Huxley warned about the dangers of being lulled into a distracted state while government's power to oppress increased dramatically. He imagined a society under totalitarian rule where the citizens were lulled into a hypnotic state through the drug he called, "Soma."

"Soma is a hallucinogen that takes users on enjoyable, hangover-free "holidays", developed by the World State to provide such inner-directed personal experiences .... as a self-medicating comfort mechanism in the face of stress or discomfort, thereby eliminating the need for religion or other personal allegiances outside or beyond the World State."

"Recreational sex is an integral part of society. According to The World State, sex is a social activity, rather than a means of reproduction, and sexual activity is encouraged from early childhood. The few women who can reproduce are conditioned to use birth control ... The maxim "everyone belongs to everyone else" is repeated often, and the idea of a "family" is considered pornographic; sexual competition and emotional, romantic relationships are rendered obsolete because they are no longer needed. Marriage, natural birth, parenthood, and pregnancy are considered too obscene to be mentioned in casual conversation. Thus, society has developed a new idea of reproductive comprehension."

".... In The World State, people typically die at age 60, having maintained good health and youthfulness their whole life. Death isn't feared; anyone reflecting upon it is reassured by the knowledge that everyone is happy, and that society goes on. Since no one has family, they have no ties to mourn." [review of Brave New World, Answers.com]

Does this sound familiar? Does it remind us of what we see when we look around us at the current state of our society? And when we are lulled into a hypnotic state of complacency, when we don't care what happens to others, why would the federal and state government...
Constitutional rights, though existent on paper, matter nothing at all if there is almost no, or no, enforcement of the laws when it comes to the vulnerable elderly, disabled, acutely or chronically ill. Their rights are violated every day in one way or another throughout the country, in many of our health care settings. Do our elected officials believe that society is so complacent, they need not assure compliance with standards that exist on paper only?

When government's size, power and intrusive influence spreads like poison over the land, society has already been tainted. Your freedom and the very lives of the vulnerable are directly threatened. February 17, 2011, the Treasury Secretary, Tim Geithner said that the current proposed budget is "unsustainable," because the interest on the debt was so massive ... that we as a nation could not pay it in years to come.

"During the Senate Budget Committee hearing, Sen. Jeff Sessions (R-Ala.) asked the Treasury secretary, 'Under your budget, the interest increases each year. It was $187 billion in 2009. Under your proposal, it increases to $844 billion.'

"Geithner responded, 'Senator, absolutely, it is an excessively high interest burden, it's unsustainable.'"

[Treasury Secretary: Obama's Budget Leads to 'Unsustainable Obligations'
Feb 17, 2011 CNSNEWS.com]

Why would the administration propose a budget that borrowed so much money to spend that it literally jeopardized our nation's financial stability? Proposing a budget that absolutely must lead our nation into economic disaster is not the action of a responsible person. It is either insane or nefarious. One might theorize that those proposing such deficit levels are ignorant and unintelligent. However, we know they are not.

So, we have to understand that there is a reason for everything proposed. When a policy is proposed that when implemented would, with certainty, create a severe threat to our nation's integrity, survivability and security, it can only have been done in order to implement other radical changes. A fiscal crisis of unprecedented levels would result in a move by government to rein that crisis in through heavy-handed governmental action. It would certainly create calls for the implementation of emergency governmental measures, something akin to martial law, or if not that exactly, simply a more totalitarian government. In other words, the form of our government would be changed into something completely contrary to the Constitutional Representative Republic known as the United States of America. That is what "change" means in this context.

Recently, to illustrate how government can expand its reach, the U.S. Justice Department threatened to shut down all flights over Texas when the Texas legislature was about to pass a law that "would have made it illegal for Transportation Security Administration agents to perform hand searches at airport security checkpoints unless there was probable cause."

Normally, the federal government and Texas state government would litigate the issue in court without such threats. But the U.S. Justice Department threat, if acted upon, would have cost Texas billions of dollars and caused financial havoc in the state. Due to the federal bullying tactic, Texas legislators backed down. What is to stop a similar federal threat from being used to nullify the Constitutionally-guaranteed right of state legislatures to independently create any future state law? The same type of financial threat bullies states and local school districts into complying with federal education requirements and curricula in the schools. We have come very far from the time when the local schools, school districts, and even state departments of
education, chose their own books and curricula for the courses taught free of federal government influence.

As such bullying tactics continue, the size and reach of the federal government only increases, with individuals and state officials alike feeling intimidated. As planned financial pressures worsen with intentionally-created, unsustainable federal expenditures, the funds allocated for care of the elderly and severely disabled will be cut drastically. If we stay on the current course, conditions will only get worse for the vulnerable.

Our national "ship of state" is like a gorgeous ocean liner filled with passengers. It moves so swiftly through the water and is admired by so many. We would never wish to think that it could ever be in danger, but the ship is tilting so far over to the left that the deck is almost touching the water. A little more and the entire ship will go under in an instant. When it does, what has been the American form of government will end. The traditional American freedoms and rights enjoyed will end if they are not defended and protected at every step of the way. A little step to the left, to the left and left again, and the government will have seized control of so much that we will be stuck. There will be survivors, and those of us who are able will all need to help others find their way again. What will happen to the vulnerable will not be pretty.

Those who work in health care, and really care, know about the plight of the vulnerable. They've seen many cases, troubling cases. But what do we do? Do we wring our hands and say, "we can't do anything about it?" or escape into our work or into the virtual worlds available in video games, the computer or television? Do we turn away while people are harmed? People are being hurt. Real people's lives are being snuffed out! I get the calls and so does every patient advocacy organization in the country. They call and ask, "why did this happen to my father?" How could this happen?" They don't understand what we've reviewed here. Patient advocates know the exploitation and medical killings are really happening, but society as a whole just keeps on going as if nothing is happening.

Seventy years ago, in the Jewish ghettos in Germany and elsewhere in Europe, fathers and mothers' tears streamed down their face as their children were being ripped from their arms forever by Nazi soldiers. Do we really register and understand what happened? Children cried out as their fathers and mothers were led away. Husbands and wives were separated and then killed in groups. In our own times, the evidence of Bob and Mary Schindler's tears for daughter Terri were always evident on their faces. Look at many of the pictures taken of them when their daughter's life was on trial. Anguish, silent or screaming out loud, is still anguish, and it doesn't go away easily. The people who call me and other advocates are in terrible pain, because those they love have been taken away from them and were not allowed to die a natural death. Some are medically killed years before their time!

Listen. The dear Lord gives us life. Health care professionals should not be involved in taking life. Yet, as we've seen, contrary to what most of you have believed all along, most physicians do not swear to "do no harm." Most do not take an oath to never give a lethal drug. Most of them actually take an oath that acknowledges they may actually "take a life" (not "lose" a life). Years ago, there would be no question about how wrong these killings are. Just about everybody knew that physicians should not be medical killers. Now, people think they should. How strange a society we have become! How dark a society we have become!

Before the American counter-cultural revolution of the 60s, the mainstream medical thinking did not consider faith to contradict science. The two were viewed as being mutually beneficial to the patient and not mutually exclusive:

Dr. Elmer Hess, President-elect of the American Medical Association said that "any doctor who lacks faith in the Supreme Being has no right to practice
medicine." The Erie, PA, urology specialist assailed those practitioners who are seeking only money, saying that, "a physician who walks into a sickroom is not alone. He can only minister to the ailing person with the material tools of scientific medicine - his faith in a higher power does the rest."

[Des Moines Still College of Osteopathy & Surgery Logbook, January, 1954]

Today, any physician who, like Dr. Hess, openly professes his faith (outside of religiously-affiliated organizations) is greeted with scorn and is likely to be denied many opportunities for advancement. Some are even attacked by those with hostility to those physicians who have faith. In the United Kingdom, a member of an openly Christian medical group has had a complaint filed against him by the mother of an adult patient. Though the patient has no objections, his mother filed the complaint against Richard Scott, MD who is a Cambridge-educated British physician, for simply mentioning that he personally found faith in Jesus helpful. That the physician provided all expected and approved medical testing and procedures beforehand and had the patient's permission to discuss his faith does not matter. Now, the physician must defend his actions or risk losing his license to practice medicine. The situation in the United States is becoming similar.

What a contrast between Elmer Hess, MD, the President of the American Medical Association, affirming the need for physicians to have faith in God, and physicians (and others) now being persecuted for so much as mentioning their faith at all. Has our society become what we once detested? Has it slowly been intentionally poisoned? Are we repeating the horrific errors of years past? Clearly, our society has lost its way. We have forgotten too much!

"Remember!" survivors of the Holocaust warn us. "Never again!" they cry out. They have cried out for seventy years since the Nazi era. And now it's begun again in a time of economic uncertainty, just like in Germany. "Never again" has not lasted forever. It started there with the vulnerable, and it's starting here with the vulnerable in exactly the same way and for the same reasons.

Back in 1977, I lived in Germany for months and met Germans who were young men and women during the Nazi era.

I saw the shame and sadness in their eyes when I asked them, "did you know?" They looked away sadly. They knew.

And you know what is happening here now. Intolerance for those of the Jewish and Christian faiths is spreading around the world in many places (though you wouldn't know it from the coverage on TV). And while we fear terrorist threats from radical Muslims, many Muslims suffer violent attacks as well. We are all endangered in some ways by the lack of tolerance, the willingness to use violence and war to achieve an end, the readiness to discard some lives to achieve a goal.

Those who respect life and take stands against abortion and euthanasia are mocked, ridiculed and harassed in many ways. The atheists complain about those of faith "imposing their beliefs" on others, yet the historically-rare freedoms enjoyed in our modern society are based on respect for the individual found in the Judeo-Christian traditions. And where eugenics and euthanasia policies are legal, there is little tolerance for the vulnerable. Many are involuntarily killed, as we have seen.

The freedom to express one's faith in public is being systematically whittled away in the name of "not offending" this or that group, with the net effect that people cannot express their faith in public without being condemned. Yet, there is nothing in the American Constitution that
says nobody should ever be offended. When there is freedom of expression, real freedom to express yourself, someone is guaranteed to be offended, and they can then respond freely as well. That is the American way. Trying to assure nobody is offended is certain to offend some, and the effort to prevent offensive speech destroys freedom of speech.

In this country, some have lost their jobs because they expressed their faith. Around the world, many have lost jobs as well as their lives for expressing their faith. Intolerance for those of faith goes hand-in-hand with the ruthlessness of those who would impose death upon those they consider unworthy of life, whose quality of life is questioned.

Even in this country, people, especially the elderly, literally are taken away to be medically-killed. They're not always being transferred voluntarily. Robin Love's non-terminal father was hauled off to hospice at the direction of his wife, with tears streaming down his face, begging not to be sent there. I receive similar reports from families around the country regularly ... families using hospice to end the life of the vulnerable family member.

When someone is taken away and then finally dies, there may be a sweet obituary, even online, with a photograph: "so-and-so died peacefully on October 24, 2010." "Post your thoughts here." "Send donations to 'Hospice of the So-and-So Region."

Of course, when this thing called "hospice" or palliative care honors life, it's good, really good. But when it dishonors life, destroys life, it's bad, really bad. Ten years ago, I warned that hospice could become the "killing fields" of America. The implementation of widespread terminal sedation has made that a reality. With the HIPAA Privacy Rule's absolute wall of silence, everything is ready for that outcome, and it's already started.

"Therefore, take care to follow the commands, decrees and laws I give you today."

- Deuteronomy 7:11

"Do not seek revenge or bear a grudge against one of your people, but love your neighbor as yourself. I am the LORD."

- Leviticus 19:18
True Reform that Protects Citizens

True reform of the health care system can never occur when methods of hastening death or directly imposing death are included in the mix. Respect for the patient's life and clinically excellent end-of-life care are not possible when euthanasia, assisted-suicide and/or palliative sedation are used to impose death. They are mutually exclusive.

"Mark Boughey, director of palliative medicine at St. Vincent's Hospital in Melbourne [Australia], .... [reminds us that] under palliative care, doctors, nurses and other health professionals treat the symptoms and ease the pain of the terminally ill, making them more comfortable and helping them lead a dignified life until death. The goal is not to "cure" the patient, but it's also not to expressly hasten that person's death." [Emphasis added]

[At the 18th International Congress on Palliative Care, Oct 18, 2010 in Montreal], "he [also stated] ... that in the Northern Territory [of Australia where physician-assisted suicide was temporarily legal], [many] patients who had opted for physician-assisted suicide ... were deprived of palliative care that could have eased their suffering."

"Boughey noted that in Oregon (where the Death with Dignity Act has legalized physician-assisted suicide under certain circumstances) private HMOs are increasingly promoting the euthanasia option."

As we have seen before, efforts to increase revenue (undertaken by HMOs, for-profit corporations and even non-profit health care corporations) or reduce government expenditures, twist the provision of health care into something that uses patients as a means to a financial end, something completely contrary to what is beneficial to the patient. Paying for a lethal agent to end a patient's life is much cheaper than providing a full range of hospice or palliative care services until the patient dies a natural death. The billions in savings that hospice already provides annually to the health care budget (compared to acute care hospital admissions) are apparently now "not enough" for those exploiting patients for gain.

"Says philosophy professor Mark Foreman: "According to a study of the British Medical Association, the state of palliative care and hospice care in Holland is very poor. Where euthanasia is an accepted medical solution to patients' pain and suffering, there is little incentive to develop programs which provide modern effective pain control for patients."

Ironically,

"Ira Byock, [now] director of palliative medicine at Dartmouth-Hitchcock Medical Center in New Hampshire, urged physicians at the [same] conference to focus on suicide prevention with some of their terminally ill patients."

"Byock recounted the examples of a couple of his patients who had expressed a desire to end their lives, but who then changed their views when provided with more comprehensive palliative care."

**Byock has gone around for years and years urging the avoidance of assisted-suicide and/or euthanasia, while promoting another method, palliative sedation, that achieves the**
And the major media outlets give physicians like Ira Byock, MD and Joanne Lynn, MD the royal treatment in terms of coverage. Their words are "the voice" of hospice in America today. In the "Before I Die" television special on death and dying hosted by the late Tim Russert of NBC, Byock and Lynn are both included (representing hospice and palliative care) among the 14 presenters. Karen Stanley, RN, MSN, AOCN (from yes, Kaiser Permanente in Fontana, California) speaks as does Arthur Caplan, PhD (one of the leading secular bioethicists in America). Willard Gaylin, MD, the self-proclaimed communist, euthanasia advocate, and co-founder of the Hastings Center is also included. What does that tell you? And, the program is funded by, no surprise here: The Robert Woods Johnson Foundation that funded the Last Acts initiatives (naming Hospice of the Florida Suncoast a Rallying Points regional hospice center), that has funded many of the educational programs to change how Americans die and think about dying, promoting the quality of life ethic, not the sanctity of life ethic.

Jesus gave us the key to understand what is happening here when He said:

> Either make the tree good and its fruit good, or make the tree bad and its fruit bad; for the tree is known by its fruit.

> You brood of vipers, how can you, being evil, speak what is good? For the mouth speaks out of that which fills the heart.

> The good man brings out of his good treasure what is good; and the evil man brings out of his evil treasure what is evil.

> - Matthew 12:33-35

If the "fruit" of Byock, Quill and other renowned palliative leaders' efforts (like Joanne Lynn, MD) is hastened deaths for the vulnerable through Third Way killing, we know that however respected they may be, however knowledgeable they may be, however powerful they may be, however wonderful their words sound, it is tainted, to be thrown away and replaced with good "fruit." They "talk the talk" all the time, but they only "walk the walk" some of the time. Lay people who are not educated in the ways, and the ways, of hospice and palliative care are very easily fooled.

When hospice agencies, palliative care units and "advanced illness" provider organizations are based upon a vision that honors the life of those in their care, then they will provide wonderful services and be a true blessing to the dying and their families. This "fruit" arises from seeds planted by physician and hospice founder Dame Cicely Saunders, who loved the dear Lord, recognized the sanctity of life and based her work on respecting that life. Hospice services based upon respect for the sanctity of life are never forgotten and those who receive them are grateful for the rest of their lives.
We have to recognize that when a family member dies, that memory is etched in the mind of the surviving families' memories forever. They never forget what happened, and if hospice did everything to make those days better; the family will remember that. These family members cannot understand why anyone would ever criticize what hospice or palliative care professionals do, but they really don't understand the full scope of what hospice or palliative care really is, only what they experienced. I can understand their confusion. But you understand now, both the good and the bad. And you understand more about how the government works, how the HMOs and managed care health insurance companies work. Linda Peeno, MD has explained that:

"In order to change or resolve problems, we must have an accurate understanding of the ways in which systems work and how they influence the lives of individuals, communities and society."

With that proper understanding of everything behind what we are seeing in our society and health care, we can see the direction real reform of the system needs to move. Learning about these problems without considering how to reform the system, would simply leave us with extremely troubling information about abuse, neglect, harm and exploitation with the health care system.

So I asked myself, and I ask you: what will you do when you've been shaken to your core by what you've seen, or learned, something so profoundly damaging to the lives of patients and completely antithetical to everything you believe?

What will happen to you as a person were you to consider not getting involved? ... not running to the rescue of those who are utterly defenseless?

Have you ever seen something like that, where you asked yourself, "should I get involved?" Should I help reform the system, society, the government? Can I help with those around me in my community?

Your answer speaks to who you are as a man, as a woman, as a human being. It doesn't matter if you're black or white, "green" or "blue." What matters is what you do!

And God knows! Yes, He knows. And you know, don't you?

A civilized society cares for the poor, the cold, the needy, and the hungry. It cares for the sick and the dying.

We need to re-assert our American values: real freedom of speech, freedom to offend or not, and freedom to speak back as well. That's what we're about.

We need to re-assert our belief in the sanctity of life and be vocal, and never stop affirming it.

We need to get away from being "politically correct," because conforming to what is politically correct is equivalent to abdicating our moral responsibility to our nation and its people, to each other. The "politically correct" way is not the American way! The Supreme Court has ruled that even offensive speech is protected under the Constitution. Political correctness is intolerance of differing views. Political correctness is tyranny. Political correctness labels the pro-life view as “offensive!”

We need to re-affirm the value of the family, with a father and mother, as research shows the children do best when they live within a traditional family (political correctness does not negate this truth!). Winston Churchill said, "There is no doubt that it is around the family and
the home that all the greatest virtues, the most dominating virtues of human society, are created, strengthened and maintained." It is certain that the family meant by Churchill as an ideal to aim for was the traditional family, not a kaleidoscope arrangement so prevalent in our disintegrating society. And what the utilitarian socialists have so successfully attacked for several decades are the traditional Judeo-Christian family and values. Their idea of what is good or virtuous is the opposite of traditional American society's values. Just as they devalue biblical values, they devalue our U.S. Constitutional values.

We need to be willing to, and actually give some of our time, energy, funds, and talents, to help others.

At the beginning of this book, I mentioned "evidence-based medicine," "comparative effectiveness research," and the "complete lives system" which are being used to change how health care is delivered in this nation and around the world. They all can sound very professional and sensible, however, how these tools for optimizing care and rationing care are implemented will be affected by the worldview and ethical considerations of those at the top policy-making levels of our government. You now know what can be involved with these "high-sounding" excuses to ration care and encourage stealth euthanasia.

That worldview and those ethical considerations are not pro-life and do not affirm the sanctity of life. It is certain these nice-sounding concepts will be misused to justify limiting care to those deemed less worthy of life and therefore, less worthy of treatment and services. With all we've reviewed so far, you can see the direction it all is moving. There is no doubt about it.

Real reform of what is happening in health care can only happen when we swallow our pride and are willing to listen to others in our extended families and care for them when they need us, even if we don't always get along.

We must rebuild the safety net of a traditional American life when the immediate family, extended family and local communities all worked together to help each other. When a barn burnt down, for example, the community got together and with many laborers, a new barn was constructed in a short time. That's the spirit we need in America. Not the spirit of asking government to provide everything, do everything and be everything, because it can't. Every dollar that is taken from private citizens and businesses in taxes, are dollars that can't be used to privately benefit others. The lower the taxes, the more money there is to buy things and support the local economies, and the charities that demonstrate what is truly best in America, which is the foundation of our nation. Government does not create jobs (except government jobs).

We must demand that white-collar criminals in health care settings be prosecuted to the full extent permitted by law and then sentenced to be imprisoned for many years.

We must demand that the laws be changed to prevent private HMOs, PPOs, or any sort of managed care organization from exploiting or mistreating patients. Giving them immunity from prosecution (such as happened with the E.R.I.S.A. law and HMO laws) has only resulted in widespread exploitation and gaming of the system for revenue.

We must demand that Boards of Medicine and Nursing not be allowed to give a mere slap on the hand to physicians or nurses who seriously harm patients intentionally. If the very small percent of troublesome physicians, nurses or others are prevented from causing further harm, there would be a great decrease in the number of consequent lawsuits.

However, as we have seen, much of what has happened till now has proceeded according to the plan of those who do not respect the sanctity of life as well as those who are plundering the
system. The elitists are ecstatic that their plans for transforming our society are right on schedule and the media is cooperating 100% in "pulling the wool over the eyes" of the public.

Patients and patient advocates have something else to say. They have a different message. Will we listen to their voices? We say that in serving others, even the disabled, the chronically ill and those at the end-of-life, we receive the gift of service, the opportunity to love and care, the opportunity to grow as a human being and as a child of God. Life itself is a school with many lessons to be learned: how to love, how to care, how to humble ourselves to wash another's feet, and see to the needs of those who are truly dependent.

We must ask ourselves if we will work to help others or only be concerned about ourselves and our own families. If we abandon the concern for others, we will soon find out that we have likewise been abandoned by others to our detriment. This is the question that confronted those who tried to survive in Nazi-occupied territories during World War II while doing nothing to stop the increasing power of the National Socialist political party there.

It's not like it was there in Nazi Germany, yet, here in America. They're not shooting us on the spot, so what's stopping us from protecting the vulnerable among us? or speaking up? or caring at all?

My focus has been hospice, but you can't go around inspecting hospice agencies like a visitor to a nursing home. You won't get in, and much hospice and palliative care is provided in a patient's own home. The industry is insulated by its unique setup. It is also insulated by the HIPAA Privacy Rule which throws a veil of secrecy behind which hospices can do just about whatever they want. Enforcement in the industry is almost nil, especially compared with how hospitals or nursing homes are inspected and regulated. The rogue hospices can do much damage without any word getting out to the public at all. We've seen how that can happen. And our society is definitely being harmed by the perversion of hospice and palliative care by rogue hospices or corporations that seek to exploit end-of-life care for profit.

By now you must realize that this is something that can't be solved with a simple phone call, letter or email. Even a health care policy proposal is not enough to change this.

We need to remember what happened incrementally in Nazi Germany before the millions were killed in the concentration camps. We have to remember how it started there. There have been many tyrannical dictatorships throughout history, but Nazi atrocities were uniquely vicious, perverted, and outright evil. We have taken too many steps down a road leading to where they were and we need to turn back toward life.

We must pay attention to what is happening behind the HIPAA secrecy veil.

We must make sure our elected representatives act to protect the vulnerable.

We need to make sure everybody in America knows the truth about what is going on. And sharing the truth with others one by one may be the most important step you can take. Plant seeds of thought and inquiry. We never know what will come of it, but sharing the truth can change the world. Telling one or two other people can save lives, perhaps hundreds of lives.

You still may prefer to ascribe what I've been discussing to a few isolated incidents here and there .... and write it all off as insignificant. It's not! If you know anything about how things work, you'll know it's not isolated or insignificant. Many in hospice deny that there are any serious problems in the industry as we've seen, yet if that were true, then hospice would be unique in all of human history, and clearly, that is not the case. There are problems, epidemic problems that need to be corrected. And in the face of regular reports of serious problems in
the industry, hospice professionals that deny these problems exist must be part of the problem. They certainly cannot help resolve the problems that exist when they work so hard to stamp out the slightest bit of news about the realities in the industry from getting out.

To reach the public and get that information out, I've shared what I've learned through the years and the story of hospice and palliative care. We've read the accounts of involuntary euthanasia that occurred right here in America, in hospices from different parts of the country. We've seen together how stealth euthanasia can be done and is being done. There is a stealth attack on our American way of life. This dark cloud over our nation represents the beginnings of a health care tyranny, with or without nationalized health care and "reform!"

This threat is very real, and it's very important for everyone in our nation to recognize this. It affects every family in America. We've discussed aspects of hospice, health care and the effect of corporations on our society.

It's up to each of you to decide what to do about it, whether you'll keep on pretending it's not true or not "as bad" as some make it out to be. You may decide to do something, and if you do, I encourage you to speak up to your elected officials at every turn, at town hall meetings, at their offices (local, state and federal), to write letters and never stop speaking up. And speak with each other in your extended "families," in your "blessed communities," in your churches, mosques, and temples, in the classroom and elsewhere.

The government "coming to the rescue" is not the answer. But government changing its direction would be a big help in correcting these problems. Those directing government today really believe that rationing care, depriving patients of their lives, eliminating some or many of the vulnerable is the "solution." Like the "final solution" in Germany, we're dealing with the engineering of a population: before birth through selective abortion, at birth through infanticide and misuse of peri-natal hospice to eliminate the unwanted, at any stage in life through medical rationing and selective failure to treat or outright acts of harm and at the end-of-life through Third Way stealth euthanasia as well as active medical killing.

We need people who value the sanctity of life to enter government and represent the people with integrity and show that caring for the vulnerable is the solution. All the original American colonies had government representatives that were dedicated to the respect for life and freedom from oppression and coercion. We need not only be wary of open coercive eugenics and euthanasia as was practiced in Nazi Germany. We need also to be alert to the poisonous practice of outwardly "voluntary" eugenics and euthanasia ... where the parents choose to abort their baby or, an elderly or disabled person asks to be euthanized. What is voluntary for the parent is absolutely involuntary for the defenseless baby, and the elderly and disabled patient are among the most likely to be manipulated into assisted-suicide or euthanasia. That manipulation can come from a big private health insurer or government-run Medicare or Medicaid program, limiting the options and help available to those in need.

Big government is part of the problem, as are many big Corporations that have forgotten the customers (patients) they serve. Many have been focusing on the revenue they bring in while forgetting the customers being served, the patients. Yes, some would like to exclusively blame government. Others would like to exclusively blame big corporations and health insurers. There is enough blame to go around and certainly, everyone's right that the government and the corporations need major reform. But the answer rests in all of us. The people in government, the people in the corporations and the people wherever they live. The choices we make, wherever we are, matter. The people are the answer.

We need to establish strong families, extended families and "blessed communities" that can support and care for each other especially in the tough times that many are going through, in
the tough times that may come in the future. And out of such strong families, extended families and communities will arise strong individuals, leaders who can create true reform of health care or government, whatever shape they assume as time moves forward. The power of the people is much stronger than most people think, but it must be awakened, given voice and acted upon.

A free society is always only one step away from tyranny. A free society requires the active participation of its citizens. You, me, all of us. We can all do something and make our contribution to society. Otherwise, the vulnerable may experience the effects of tyranny in their lives the moment they enter the health care system, as many already have.

We who consider our practice as a spiritual mission remember what the dear Lord Jesus said:


For I was hungry, and you gave Me something to eat;

I was thirsty, and you gave Me something to drink;

I was a stranger, and you invited Me in;

naked, and you clothed Me;

I was sick, and you visited Me;

I was in prison, and you came to Me.'

Then the righteous will answer Him,

'Lord, when did we see You hungry, and feed You,

or thirsty, and give You something to drink?

And when did we see You a stranger,

and invite You in, or naked, and clothe You?

When did we see You sick, or in prison, and
come to You?'

The King will answer and say to them,

'Truly I say to you, to the extent that you did it to one of these brothers of Mine, even the least of them, you did it to Me.'

- Matthew 25:35-40

Who is our "neighbor?" ... that we should care? Everyone we meet. Every elderly, disabled or chronically ill patient. We must care for them.

We need to wake up! The storm is upon us. It's been planned for several decades and now we're seeing right in front of us the impact of it all. It seems like society is being transformed overnight, but it's been changing incrementally for decades.

It's time to speak up and protect the vulnerable who cannot speak for themselves. No more "Bob and Mary Schindlers" should have to suffer the untimely death of their daughters. No more "Vickie Travises" or "Robin Loves" should have to see their father's life snuffed out by a hospice "closer."

Hospice and palliative care needs renewal, and reform. Health care cannot be truly reformed if we do not address the problem of end-of-life care. While the government allows the whole-sale theft of taxpayer funds through Medicare fraud and other government payouts to the white-collar criminals, the pressure to medically kill many of the elderly is only increasing. More and more leaders are bringing up the topic:

"Medicare Bound to Bust as First Boomers Hit 65," screams the headline:

What do people who have been in charge of the U.S. government's funds have to say?

"David Walker, former U.S. comptroller general" [reports that] "the retirement of the baby boom generation will bring a tsunami of spending that will cause a severe problem for the federal government's budget over time."

".... Take Medicare, health care for the elderly and disabled:

- The number of people eligible will nearly double from 46 million to 80 million by the time all the boomers reach 65.

- It's estimated the cost will grow from $500 billion a year today to $929 billion by 2020.

- The number of workers supporting each senior will fall."
Walker cautions:

"Ultimately we're going to have to make tough choices about how much health care can we afford and sustain and how are we going to change our payment systems to make sure that it doesn't bankrupt the country .... Because if there's one thing that could bankrupt the United States, it's out-of-control health care costs."

Already, the blame for the fiscal crisis is going to health care spending, when there's been billions and billions of dollars going to "pork-barrel" spending and unidentified people or organizations. Although health care is a huge portion of the budget, there is a huge amount of fraud just in that industry, as well as fraud in many other government-funded industries. The article alerts us that "Medicare is already underfunded by at least $23 trillion. That's the difference between the benefits promised and the taxes actually being paid into Medicare. It could go bankrupt as early as 2017."

We can be sure that there will be increasingly agitated declarations that legalization of euthanasia is "absolutely necessary." And at the same time, almost nothing will be done about the billions and billions of dollars somehow "disappearing" into the pockets of hundreds of nameless beneficiaries of the government's largess and the U.S. Justice Department's failure to go after those plundering the national treasury through fraud of all sorts. Several factors are simultaneously impacting our society that will push toward imposing death upon the vulnerable. And many people will believe the lie.

What about the promised increased services under health care reform? Where will the funds for that come from at exactly the same time people are complaining about how much the elderly are costing and will cost? Services that are increased will clearly be balanced by drastic cuts in services to the severely disabled, especially Medicaid, and by drastic cuts for some of the elderly as they require care that simply will not be approved. Let's remember what the Nazis did in just the same way:

"Generous family allowances and public health care was provided from monies taken from special schools and institutions, welfare agencies, health insurance, guardianship courts, municipalities, private charities, and from families with children who had any type of disability (Aly, 1993)."

["Hitler" by Sally M. Rogow]

So, when you think of all the wonderful services that may be provided, as promised, remember the disabled and the elderly, remember what happened in the past. Extra benefits for some will come at the cost of others, and many will die much sooner than they would have because of it. Extra benefits for some will buy votes and support for the government programs and rationing, while the vulnerable are victimized. Of course, some won't care, until it happens to someone in their family.

I also think about the residents of the nursing homes. While some are receiving good care, there are so many that languish, neglected, abused, assaulted or worse. I think about the patients who ended up in hospices that condone imposed death through terminal sedation or overdoses. Listening to them crying out, hearing the reports of their families, I am reminded of the plea of David, son of Jesse:

*I cry aloud to the LORD; I lift up my voice to*
the LORD for mercy.

I pour out before Him my complaint; before Him I tell my trouble.

When my spirit grows faint within me, it is You who watch over my way. In the path where I walk people have hidden a snare for me.

Look and see, there is no one at my right hand; no one is concerned for me. I have no refuge; no one cares for my life.

I cry to You, LORD; I say, "You are my refuge, my portion in the land of the living."

Listen to my cry, for I am in desperate need; rescue me from those who pursue me, for they are too strong for me.

Set me free from my prison, that I may praise Your name. Then the righteous will gather about me because of Your goodness to me.

Psalms 142

Think about the afflicted, the vulnerable, those who are dependent on others for care. This is not just the voice of David. It is the voice of the afflicted wherever they may be. We must protect them, serve them, care for them, and love them.

We need to listen to the voice of Dame Cicely Saunders who said,

"Anything which says to the ill that they are a burden to their family and that they are better off dead is unacceptable. What sort of society could let its old folk die because they are in the way?"

When economic pressures and utilitarian philosophies are used by those running our health care agencies and insurance systems to justify what they do, we need to remind them of our heritage that affirms the value of life, the respect for the elderly, the need to care for those who are vulnerable. It will take everything we've got to battle for the lives of the vulnerable, if we are to succeed in protecting them. But, if America stood for anything, it stood for taking care
of our own, and we need to take care of the vulnerable!

No one person can fix the problems we have discussed here. The people, government officials, interests, corporations and organizations that have intentionally created this culture of death with a ready-made killing mill, hidden behind the HIPAA Privacy Rule, ... they're not going away. Those family members among us who "wield" hospice or palliative care to end the lives of the vulnerable need to hear from us. They need to remember what shame means. They think they can do anything. We need to show them that we see them for what they are. Remaining silent to "keep the peace" only allows the killing to continue on and on.

We need people from all walks of life and all sorts of professional abilities to get involved where they are, in their own community, state and on the federal level as well. All of us have different abilities, gifts and areas of influence.

As Mother Teresa of Calcutta has said,

"What I do you cannot do
but what you do, I cannot do.
The needs are great, and none of us,
including me, ever do great things.
But we can all do small things, with great love,
and together we can do something wonderful."

Yes, she showed the way. We can care for those who need care so long as we choose to care for them! We can fix the system. But "the system" is a reflection of what we, as a society, allow.

Reforming Government:
Rebuilding America

Many ask, what can I do to help? How can we fix this problem? The solution is right before us. Shining a light where formerly there was darkness is the simple answer. The darkness does not exist unto itself. The lack of knowledge about the realities in health care and especially, end-of-life care, is removed by seeing and understanding the truth. Once we have the facts, we can no longer be fooled, even if those with an agenda try. Empowered with the truth, Americans and those around the world can re-affirm their commitment to the sanctity of life and demand that the governments, elected officials and bureaucrats remove this evil from the Earth. Devaluing life is the beginning of a tragic road that has lead to this Invisible Holocaust, now revealed to you.

Stealth euthanasia can only exist when the public is uninformed and therefore allows it to continue. That is why this is the most censored story in America. It "must" remain the most
censored story in America for it to continue. You can prevent that from happening. Bypass the major media and those who would withhold the truth about end-of-life care and share this information with those around you.

People want an answer such as, "Who do I call?" "Where do I write?" "What government department handles this?" This is way beyond any one person, one official or department of the government. No one person has all the answers. These problems will only be resolved when American men and women are not afraid to stand up and say, "I believe this is wrong." "This happened to me." "This is not acceptable." And use their own name when they take a stand for life, for the vulnerable.

I cannot tell you how many people have called here or written to us complaining about what is going on. Every patient advocacy organization in the country has heard from them. They are outraged, often crying, and terribly troubled. But when I ask them if they will stand up and do something, many say:

"I want to, but I can't speak out, because I don't want to cause a rift in my family."

"I can't speak up, because I'm employed at this or that corporation."

"I can't speak up, because I work for the government."

"I can't speak up, because I'll lose my job."

"I can't speak up, because they may sue me."

"I can't speak up, because I settled with the corporation and have a gag order forbidding any discussion of what happened.

"I can't speak up, because I'm afraid."

"I can't speak up, because I don't want to dwell on this. I just want to put it all behind me and forget."

And so many times I have said to them:

"You know, I've had many others contact me, saying exactly the same things you are saying, and many of them promised to do something, but did nothing. If all the people who have called me had done something, your loved one would probably be alive today."

If you do something, others may live!

How many people have to be killed before you do something? Within your own circle, within your own community, begin where you can. Are you able to awaken the strength within you to take a stand? To contribute by caring for someone in your area?
In my humble opinion, non-cooperation with evil is as much a duty as is cooperation with good.

- Mahatma Gandhi

Decide whether you are willing to help solve this problem or not. If not, then tragically, you are contributing to the problem. When evil is on the move, we no longer have the luxury of inaction.

Silence is lethal! Silence is the same as acquiescing to the evil. Silence is what allowed the evil in Nazi Germany to grow until it was in complete control of German society, where many good people lived and lived in fear. I understand people don't want to believe things have gotten so bad. I understand people don't want to have to sacrifice a "comfortable" life. But that is exactly the point. Do what you can do.

We cannot look at the past or even the present and throw up our hands in dismay. We must look at where we are, learn from where we've been and work to create a bright future for those who are yet to come. This is our job, our sacred duty. There is terrible suffering in the world. There always has been some form of suffering in the world. We may not wish to swallow what seems to be a terribly bitter pill. Yet, we are here to spread our love and demonstrate the caring spirit that affirms each and every one's life. Wherever we are, however little we think we can contribute to the mission, let us give of ourselves for the good of all.

Even if you think there is nothing you can do, you can pray, you can share the truth, you can honor the lives of those who are now vulnerable. Pray for those who work to help the vulnerable. Pray for those who remain true to the mission of serving those at the end-of-life. For those of you who work in the pro-life work, I hope that some of you will consider helping out advocating for those at the end-of-life and for those who are disabled and vulnerable. The need is great, but the workers are very few.
Some of us have forgotten what the word "sacrifice" means and why one sacrifices. Parents sacrifice their lives to raise, care for and prepare their children for "the world." They spend time with them, love them, and raise them up in the ways of goodness. If parents are faithful to their mission, caring for the children, then their lives change irreversibly when a child is born. Children, when they become adults, go out into the world and make their own way, yet they also have a duty to their parents and their own children. So, each generation makes sacrifices to care for the other generations young and old. This is the way, from generation to generation.

We may sacrifice much of our lives or even give our life itself to save those around us. Those who do so are sometimes called "heroes," but giving of our lives in service to those around us is what makes us civilized. Giving our life for the sake of others is the testament to our love.

Jesus said:

"Greater love has no man than this, that a man lay down his life for his friends."

John 15:13

Remember why we have been a haven for people of all nations. It is not just because we have been a great power in the world. Otherwise they would be going by the millions to China. No, it is because we are the land of the free. A land of opportunity. Have we forgotten this? Have our elected officials forgotten this when they make laws that oppress the people? Have our court justices forgotten this when they make rulings that eventually result in the death of millions? (Roe v Wade, Quinlan, Vacco v Quill, Schiavo ...)

Return America to a righteous commitment to the right to life at all stages of life. Demand that the Congressmen pass a "personhood" law that affirms the scientific fact that "normally every human being begins to exist at fertilization in the woman's fallopian tube as a single-cell embryo, the zygote," or upon twinning (or when scientists clone a human life). Demand that the vulnerable be respected, cared for and allowed relief from distressing symptoms at the end-of-life while allowing a natural death in its own timing. Protest the killings! Picket the district attorneys in every county that refuse to prosecute the medical killings. Picket the state legislators and governors who do nothing! Picket the state attorney generals who do nothing.

One essential part of the answer to these widespread medical killings is something most of us may find difficult to accept. It has to do with the dwindling number of traditional families as well as extended families. When there are strong traditional families and extended families, there are many family members able to help with the children, to help with anyone who is sick, especially the elderly and disabled. One of the things I hear so often is, "We just don't know what to do. We have to work." "I'm taking care of my kids, working, but caring for "Mom" or "Dad" is just too much." "We've had to consider putting him or her in a facility." Hospice staff cannot always be there, so, what do families do? They put their loved one in a facility or in some cases, they hasten his or her death at home, because they don't want to be "burdened" with caring for the patient anymore. How did we get to this point?

It began with industrialization and the move to the big cities for employment in the factories. As we all know, people left the local village or town, often leaving behind their extended families. And when they did that, they abandoned their natural safety net, the extended family. The original solution. Sometimes, men or women would travel alone to the city and work, so they did not even have the traditional family as a safety net. Without the safety net of the traditional or extended family, who could one turn to? Charities or the government. As time
has moved on, it's mostly the government. The government became the provider of the safety net, the resource people turn to. And once you turn to government as the safety net, you give power to the government over your life and the lives of those you love. And then, the elite policymakers can decide, who gets care and who doesn't and consequently "who lives and who dies."

Something as simple as your entire extended family staying near to each other and being there for each other when needed can make a world of difference! If that's not possible, creating an extended "family" of friends and others of a like mind can accomplish the same thing. It may not always "take a village," but it does take an extended family or community to provide the "round the clock" attention that a terminally ill, very elderly or severely disabled person may need.

Help to create that community! Where you are. In your community, your circle. It's not that the vulnerable always need constant intervention, but they need someone to be accessible to provide help at any time, to be available to assist them. To be there. Create your extended family now. Get together with those of a like mind, in your church, temple or other group. Speak about these things and agree to help each other and count on each other, and you'll find that you can "weather the storm" and get through trying times with each other's support. You can count on each other and pro-life professionals, but you cannot count on the NHPCO-controlled hospices or palliative care units to provide the care you need and allow a natural death in its own timing. When it comes to support, you need an extended "family," whether they are your own relatives, a "family" of believers or simply like-minded friends.

Remember, Karl Mark and Frederick Engels described the goals they had in the Communist Manifesto, and abolition of the traditional family is one of the major goals they listed. They knew that when there is a strong family life, the allegiance people feel is to their family, to God, to country, but not "country first" at the expense of love for God, family and the respect for the individual. Marx and Engels wanted individuals to be loyal to the government first and foremost. That is why what we see encouraged today in our modern society is "family" defined as anything involving children, but specifically not restricted to the "traditional family" described by Marx as "bourgeois," something to be discarded in his socialist utopia.

When our children are often not warned about the dangers of communism and socialism through history, we must ask why not? Why is it not "politically correct" to teach the dark history of communism and socialism wherever it has been practiced? We have to at some point ask ourselves, "whose politics is deciding what is "politically correct?" That's the key to understanding all of this. It's not just because of the endless investigations by Joe McCarthy into "who is a communist?" back in the 1950s. It's that there really are those who want America to become socialist or communist, and many of them are already in government. Some may not openly use these terms, but the goals are the same. And some in the labor movement and unions openly denounce capitalism and the free market economy of the United States.

They truly do not support the sacrament of marriage between a man and a woman or, of having a traditional family with one father and one mother as the "ideal," even though research study after research study has shown that children do best when they have a loving father and mother in the home, a traditional family. Many of those who push socialist agendas forward edit the major media newspapers and television programming. It is clear, when we look at the policies they promote, at their editorial "opinion" pages and the programming they create, and the messages within the programs that are transmitted to our children, you find that Marx and Engels would be pleased.

What was another major goal listed in the Communist Manifesto? Public education, nationally-
controlled education with indoctrination of the children. And we have that today. Nominally, the states have control of the public schools within their borders, however the federal government has tremendous influence through many laws and programs and initiatives. The public school system is only nominally under local school board control.

The federal government manipulates the states to comply with the current administration's agenda by threatening to withhold funds from the states unless they buckle under and agree with whatever the federal government is pushing. For example, the Indiana state government recently passed a law that cuts off funding for Planned Parenthood, the nation's largest abortion provider, through any state-run Medicaid program. In response, the current administration has threatened to cut off the $5.3 billion federal contribution to the state's Medicaid program unless the state allows the money to go to kill babies. This is just one example of many in which states are fighting to retain some semblance of states' rights and in this case, stop supporting taxpayer-funded baby killing.

In addition, the editors of public school textbooks shape how American history is taught (and not taught) and what values are transmitted (and not transmitted) to the children. Often, the public school "message" is contrary to the instruction the children receive at home and church or temple, and eventually, the public school system's agenda wins over many to a moral relativism. The universities are full of those who promote a secular, utilitarian worldview, along with secular bioethics, all of it contrary to the American spirit, to our roots and our faith. And research has shown that a majority of college graduates end up more socialist-leaning than when they entered college.

While the evils of unrestrained capitalism may result in exploitation, and we have seen what it does when applied to health care, HMOs, managed care and even PPOs, there are other things we need to beware of. Public school students are frequently reminded of the problems with unrestrained capitalism, but the evils of communism, socialism and Nazi socialism are often not explored at length. Are our schools teaching about the evils of Nazi Germany or what America stands for? A survey of 17 year-olds in America conducted by Common Core finds that:

"Nearly a quarter cannot identify Adolf Hitler, with ten percent thinking Hitler was a munitions manufacturer."

".... A third do not know that the Bill of Rights guarantees the freedom of speech and religion." ["Survey of 17-Year-Olds Finds a Nation Still at Risk, Students Earn "D" When Tested on History and Literature," February 20, 2008 Common Core Press Release]

If students don't know who Adolf Hitler was, what do they know about the Nazis? They certainly don't know much about the atrocities committed by the Nazis or the Communists under Stalin in the former U.S.S.R. Many students in the U.S. think our country is the enemy, that we are "the bad guys." They often think that our brave young soldiers are the "enemy," rather than realizing that it is our soldiers who have given their lives for centuries so that we all enjoy the freedoms so unique to our American experiment in representative democracy. They believe that free enterprise is an evil, rather than a vehicle for the free "pursuit of happiness" within a free society. Many believe that an expanded government role is the answer to most of society's problems, rather than a threat to the freedoms all oppressed peoples seek, and which we have enjoyed for so long.

I ask why? And immediately, the answer becomes obvious. A secular, utilitarian and socialist agenda is being promoted throughout our society: in the public schools, universities, the major media, government and health care. There are many individuals and groups that are working
separately to accomplish these goals. When the public (especially the young) forgets the
millions killed by the "National Socialists" in Nazi Germany or the communists in the
U.S.S.R. (Union of Soviet Socialist Republics), Vietnam, Cambodia, North Korea and China,
then they may be rallied to socialist causes in our nation. They may also be deceived into
believing that utilitarian methods of dealing with the elderly, the disabled and terminally ill are
the "efficient" way to "handle" them, just as was done by the Nazis. It is no mistake that many
of the goals of the Communist Manifesto have been implemented in the United States already.
It is no mistake that many who would have been called "communists" decades ago simply call
themselves people who are interested in "progress." In most cases, they don't go around
announcing themselves.

When these covert socialists mean "progress," they mean leaving behind the Judeo-Christian
values of traditional America and embracing the big government models used in Europe and
elsewhere. Respect for the individual and his or her rights is one thing that is central to our
Judeo-Christian values in traditional America. Many of the socialist governments in Europe
simply place the government's power and interests higher than the individual. While one can
point out a benefit here and there of the European governments, none of them provide the full
range of freedoms enumerated in our Constitution, our Bill of Rights, our Representative
Democracy and free enterprise system. That's why people from all over the world have come
to America knowing that they can make a better life for themselves and that their children can
have an even better life than they do. That's why we have been known as the land of the free.

President Ronald Reagan reminded us:

"You know, four years ago on the 40th anniversary of D-Day, I read a letter
from a young woman writing of her late father, who'd fought on Omaha
Beach. Her name was Lisa Zanatta Henn, and she said,

"We will always remember, we will never forget what the boys of Normandy
did."

Well, let's help her keep her word. **If we forget what we did, we won't know
who we are.**

["Ronald Reagan's Farewell Address to the Nation," January 11, 1989]

Many young people today have forgotten what those "boys of Normandy did," and they don't
know who we are! They've been helped to forget. They've been helped to have never even
known what those boys of Normandy did. They have been helped to not know who we are. We
must remind ourselves, remind all of us, collectively, who we are as a people. Remind
ourselves what we are, as the best of what we've been, not the worst. Every country has its
faults. We need to remember the ideals we hold dear in our unique American experiment with
representative democracy. We've striven to correct our errors through the Civil War and the
civil rights movement and its successes. We must carry on!

When we fought the Nazis during World War II, we weren't just fighting a warmongering
nation; we were fighting a worldview filled with evil. As we have seen so thoroughly here, that
worldview has come to our shores. Now we have to fight it again!

With the baby-boomer generation just entering the elderly range, with more to come, with the
economic crisis being worsened by out-of-control deficit spending, elimination of the elderly,
disabled and terminally ill will be, and already has been, suggested as "necessary" by those
who hold the utilitarian worldview. We are looking at a "T-4" program much larger than
Hitler's. Our government may not be rounding up an ethnic group, but government programs
like Medicare, Medicaid and a possible nationalized health care system will funnel the vulnerable into the NHPCO/euthanasia-flavored "end-of-life care" with "Third Way" killing widely practiced, and conveniently hidden by the HIPAA wall of silence.

In order to create more and more supporters of the utilitarian agenda, proponents call for earlier and earlier "pre-school" programs, just the type of "education" Marx and Engels would applaud. Early pre-school reduces the parental role in educating (indoctrinating) the children. The goal for socialists is to indoctrinate the children at so early an age that they would not acquire "bourgeois" religious faith, morality and Judeo-Christian values. They end up disrespecting all traditional values and know nothing but self-indulgence and think nothing of acting in ways that hurt others if it furthers their own momentary focus. It ends in anarchy that government elites can manipulate and exploit to their own ends.

"Give me the child for seven years, and I will give you the man." is the famous quote attributed to the Jesuits. Many have recognized this truth. Plato wrote:

"And when children are born, the offspring of the brave and fair will be carried [off]; .... care however must be taken that none of [the mothers] recognise their own offspring;

[The Republic, by Plato]

Plato suggested that the nation's indoctrination could be most successful when the parental influence was removed. However, just because we are taught to admire Plato's philosophical achievements and intellect, his ideas and proposals are not necessarily "right," fair or humane. Some of his ideas clearly clash with the values that have made for our American way of life. Marx and Engels agreed with Plato, though. So did Hitler and his National Socialist collaborators:

"Schools were a primary target for control and their administration was placed in the hands of the party faithful. By 1938, the German school system was brought under the total control of the central government and removed from the jurisdiction of the individual states ... (Huebner, 1962). .... The entire educational system was politicized, but primary and special schools received the most attention, secondary schools reached only about a quarter of German students and were more difficult to change (Mayer, 1966). New textbooks and curriculum guides were full of Nazi propaganda, hateful racist stereotypes and myths of Aryan superiority (Mosse, 1966). .... Early childhood and kindergarten systems were also brought under government control and church and privately sponsored kindergartens were banned. .... It was a common sight to see three year olds marching and waving flags in a military parade."

["Hitler's Unwanted Children" by Sally M. Rogow]

Just because the open language of Marx and Engels, or Plato, or the Nazis, is no longer used, doesn't mean that the same goals are not being pursued incrementally, whether in kindergarten, pre-school and now even in "early preschool." What is our country's Secretary of Health & Human Services doing? "She has teamed up with [others] to raise the quality of early childhood education programs." And while it all sounds great "for the sake of the children," there is something else going on. It is absolutely not all about the children. It's about growing government's role in controlling people's lives, the lives of our children, the indoctrination of our children and reducing the parental role.
There are state-approved "birth to three" programs being implemented around the country, and while parents have a role, it's one more incremental step that may be used to lessen parental influence while increasing governmental influence in a child's development, beliefs, values and faith (or lack of faith). A little change to the curriculum here and there, year after year, shapes the mind and conscience of the young. Parents have been protesting some of the content of public school curricula for years. We know what it's about, and it has nothing to do with supporting the parents' values or worldview!

The founders of our nation envisioned free public schooling for children provided at the local community level, with local community values, not nationally-imposed values. When the federal government began providing funding to the states for education and many other programs, the states ceded control of their schools and programs to the federal government to a large extent. And when local schools started accepting funding from the state, they ceded control to the state. To a large extent, local control of the public school curriculum has been eliminated, no matter how much parent teacher councils and local school boards do; their choices are limited.

Homeschooling, private schools and the school voucher program (to give parents a choice) are some of the solutions to the indoctrination going on in public schools. There may be wonderful teachers in the public schools, yet the textbooks and curricula used are often designed by those wishing to shape the attitudes of the next generation of leaders. Parents who are actively involved with their children and regularly discuss the issues with them will be better able to raise independent-minded children who will blindly accept the values and beliefs shared with them in school.

It's clear that the ever expanding sphere of Big Government in our society is absolutely contrary to the limited role envisioned by our founders. When it involves early education, it is antithetical to the faith-based upbringing that can be provided by a traditional family with the support of an extended family. It is antithetical to the upbringing given to Americans for most of our history. Again, there is no need for state-influenced early preschool or preschool when the traditional family, extended family and local community is there as a support network for all sorts of purposes, including education of the children at an early age. The bigger the role of government, the more parental rights are violated and nullified. "Schools [even] arrange secret abortions" without notifying the parents at all.

What will our children be taught, and how will it affect our society as a whole? We need not look far:

"Law, morality, religion, are ... so many bourgeois prejudices ...."

[The Communist Manifesto by Karl Marx and Frederick Engels]

They're not talking about the "law" they would institute. They're talking about law based on Judeo-Christian principles. "Morality" according to the Communist Manifesto is just a "bourgeois prejudice." Clearly, they reject all scriptural instruction regarding values that are considered absolute. On the other hand, what would Marx and Engels think about today's moral relativism? Where "anything goes?" What would they think about public school sex education that promotes the idea that "everybody's doing it" (when research shows that is not true), and children can be given birth control without a parent's consent, where a child can be operated upon to kill her baby without even informing a parent?

What would they think about entertainment where sexual promiscuity is elevated and shown every night on TV, where those of faith are mocked as "fanatics," where the hero figures of days gone by are mostly nonexistent, where men are ridiculed as ineffective, stupid and
unfaithful, where woman are portrayed as mostly unfaithful, uncommitted, against marriage, where suicide is considered a "right," even though expressly forbidden by natural law, Judeo-Christian ethics as well as the ethics of many major faiths? Marx and Engels would be pleased. We've come a long way down the path they showed the world. Cass Sunstein, the communist-leaning administration-appointed "Regulatory Czar," says that marriages should not be recognized by the government, rather they should be "strictly private matters."

Many have assumed that the "communist threat" is no longer a factor in America. The truth is quite the opposite. The American way of life has been attacked from within by several forces. Those promoting euthanasia, eugenics, utilitarianism as well as socialism have never stopped working to shape the young in the schools, the universities and society as a whole. Our society has largely abandoned traditional Judeo-Christian values, American values, even though lip service is given in order to continue the collective self-delusion. This is part of the poison that has allowed our society to go so far astray.

Remember Willard Gaylin, MD? The co-founder of the Hastings Center that had a pivotal role in shaping how Last Acts worked to change America's view of death and dying and changing how Americans die? Right. Gaylin is a "clinical professor of psychiatry at Columbia College of Physicians and Surgeons, specializing in the private practice of psychiatry and psychoanalysis. He is presently serving on the board of directors of several organizations including: Planned Parenthood Federation of America, Inc., ... and The Hastings Center." So, one of the leaders who has shaped how America dies and thinks about dying (and helped twist Dame Cicely Saunders' vision of hospice into the culture of death) sits on the board of the largest killer of babies in the world, Planned Parenthood.

Those who promote a secular, utilitarian view of the world are in charge of our government's approach to health care. We've discussed several influential leaders and advisors shaping how our society moves steadily toward a culture of death. One memorable example is Daniel Callahan, PhD, the other founder of the Hastings Center:

Dr. Callahan an elected member of the Institute of Medicine, National Academy of Sciences; a former member of the Director's Advisory Committee, the Center for Disease Control and Prevention, and of the Advisory Council, Office of Scientific Responsibility, Department of Health and Human Services.

Yes, the same Callahan who was a member of the American Eugenics Society, founder of the Hastings Center that worked with Last Acts to change how Americans think about dying and how they die, and, most famous for his quote, "a denial of nutrition, may, in the long run, become the only effective way to make certain that a large number of biologically tenacious patients actually die." This is the guy that advises the United States Department of Health and Human Services "Office of Scientific Responsibility." How does that strike you? Is he the person you would want to decide whether you live or die, or whether your loved one lives or dies?

The contrast between those pushing the culture of death and those who affirm the sanctity of life is like night and day. To fix the problem, we've got to simply turn around, get off this road, a path designed by the utilitarian, socialist, anti-life culture of death. Many of them control what is happening at the government level, both state and federal. They know about the medical killings. They want them to happen. But we must remember that they are not wiser, smarter, better qualified in any sense to decide that America must resemble Nazi Germany in how it treats the most vulnerable of us all. You are wiser and together the people can be more powerful than any elite group. Whatever they set out to destroy: religion, family, traditional
values and morality... these are the things that we need to strengthen.

I know that many of you (if you have experienced tragic medical killings in your family) have hoped that you could call or write to some person, organization or government agency to get justice for your loved one or prevent it from happening to others. It is clear that the answer is not so simple. Many have tried to get justice or have the problem corrected by government without any response at all. Some have tried for years. The answer to these problems is simple, but it is not going to happen by calling any person or by contacting any governmental department. This is a societal problem that now exists in just about any level of government and a large percentage of our society, even throughout the world. These problems will only be corrected through great effort applied over time, as long as it takes for our elected officials, judges, physicians and a majority of the people honor life and understand how precious it is. This is what we have collectively forgotten.

Do not despair! Do not give up! Whenever all hope seems lost, remember He is there to see us through. May the Lord bless us all and keep all of us safe from those who would do harm.

There have always been challenges, fears and threats to our nation and its people. Do not think for a moment that we cannot turn our nation around. Each of you, each of us, has a power within that knows no bounds. Simply start with what you can do and see where it leads. You may be afraid. You may doubt, but with faith you can achieve wonders! It may be the "boy scout" in me (yes, I was in the scouts for a few years, but my brother was the Eagle scout), but as I was taught, we need to leave the world a better place because we passed through here. Each of us can do that. The new generation of Students for Life of America is working to make our society a better place. Others are also joining the work.

Together, we must fight the corporatism dominating our government, influencing our elected officials. They are elected to represent us. They are not elected to act as puppets for the corporations, whether multinational or not.

We must elect leaders who remember their duty to the people! We cannot afford to sit back any longer.

We must elect leaders who remember all the people, even the tiniest of emerging lives and the fading elders who should be respected and cared for.

We must demand that the U.S. Justice Department start enforcing the full force of the anti-fraud statutes and require 100 percent repayment of all funds stolen from the U.S. government, from the people! We must demand that the U.S. Justice Department prosecute and imprison those who defraud the government. We can no longer afford to reward those who steal millions!

Once we do, and once our elected representatives know how strongly we feel about life, they will have no choice but to return to the right path. Those who are pro-life have remained silent for far too long about end-of-life matters. We can no longer sit back and assume that government is going to "do the right thing," or that we can just "trust them." Our collective silence has cost many, many thousands of lives! Our silence and apathy has come at a terrible cost, one that will eventually touch every family in America. We must speak out loudly! We must not back down!

Perhaps most of us have been too comfortable in this nation having relatively little concern that someone we love may be taken away from us through illness. Due to improvements in water quality, hygiene and sanitation as well as advances in medicine, most of our children no longer die from formerly lethal childhood diseases. We have forgotten how dear and fragile
life is and apparently can only learn the lesson when it is too late. When there are tragic losses of life, the people will regain their understanding of what life is all about. We must proclaim the sanctity of life again and again, never stopping to think that "that's all we need to do." It is something that must be taught to our children and to all the generations, otherwise our nation is lost. We must reclaim America's heritage and reaffirm our collective reverence for and gratitude for life.

During the widely publicized battle to save Terri Schiavo's life, thousands of people protested, wrote letters, emails, went to Washington and the state capitol in Florida, protested outside the Woodside hospice facility of the Hospice of the Florida Suncoast. After all the legal wrangling and court decisions were done, Terri was killed. Many thought that was the end of it, but as we've seen, her execution was the public "show" execution put on for the "benefit" of the world, to demonstrate that the disabled can be killed and should be killed. That image, deliberately imprinted onto our minds, was the desired result of the "show" execution. The major media writers did not give voice to those disability rights activists who protested for years. They parroted the words of the euthanasia advocates in the hospice industry.

After Terri's death, many went "away," back to their regular lives. For others, the work to save the vulnerable has never stopped. Day after day, night after night, we labor to save the vulnerable in whatever way we can. Getting the truth out is one of the biggest tools we have to fight back. That is why the overall context of what we've discussed in this book has been omitted from the major media coverage of the issues. This book contains the most-censored story in America, the story the editors of the newspapers refused to share with you. The story that liberal newspapers refused to print. The story that even conservative newspapers refused to print! The story that officials in government, health care, and policymaking circles do not want you to know.

Since Terri's death, there have been thousands of "Terris" put to death out there, some of them very elderly, some them disabled, some brain-injured, some just vulnerable in one way or another. As Dr. Byrne cautions, patients who are brain-injured are being looked upon as donors, rather than patients in some cases and being treated to preserve the organs, not to help the patient recover. It is important to make sure that you advocate for the patient so they get care that optimizes their chances for recovery.

Terri's family, brother Bobby, sister Suzanne, mother Mary and Bob, Sr. continued the work to help others and prevent future imposed deaths through the Terri Schiavo Life & Hope Network. Other patient advocates have been watching the developments unfold through the years, and we are alarmed by what we see. If I could ride through the streets of America shouting, "the redcoats are coming," I'd do that, but there are no "redcoats" coming. There is, however, a tidal wave of death-dealing coming our way. This book is my way of warning you and your loved ones. There is no more time to "sleep."

Even a small light on the shore can alert sailors guiding our ship of state to the dangers of running aground. It is in this spirit that I offer this to you, to our nation, and to people everywhere.

March 31, 2011 marks six years since Terri died. Her death was a wakeup-call to America. And it still matters! We cannot forget. The Lord cares what happens to the ailing, the poor, the disabled, elderly and abandoned:
"This is what the Sovereign LORD says:

"You have not strengthened the weak or healed the sick or bound up the injured."

"Therefore, .... I myself will search for my sheep and look after them.

"I will bind up the injured and strengthen the weak"

Book of Ezekiel 34:2,4,7,11,16

H.A.L.O. - Hospice Advocacy & Leadership Organization

Dr. Cristen Krebs, DNP has started an end of life advocacy organization called HALO (Hospice Advocacy & Leadership Organization) to begin educating patients and their families about their end of life rights, the Medicare hospice benefit, and the standards of care before patients are admitted to hospice. She says, "a little education can go a long way to encouraging the very best in end-of-life practices and outcomes." The HALO project will create local end-of-life support groups starting in Pittsburgh and elsewhere around our nation. This is an integral part of renewing the pro-life end-of-life care mission in America.

Hospice Life Association of America: Respecting Life at the End-of-Life

Some dedicated, visionary leaders in the hospice industry are beginning the formation of a new organization to restore the mission Dame Cicely Saunders brought to the world and to renew the industry from within and without. A new Hospice Life Association that promotes respect for life at the end-of-life will create a safe haven for those hospice and palliative care providers and staff that honor the lives of the vulnerable. It will promote a renewed industry more in line with traditional American values. End-of-life providers, whether "hospice" or "palliative care" or even the new "advanced illness" providers, all of those who recognize the sanctity of life can join and promote a professional, clinically advanced service for those needing care. My friend and one of my inspirations, Dr. Cristen Krebs, DNP is the founder of the Catholic
Hospice of Pittsburgh. She is fighting the fight for the needy.

The Catholic Hospice of Pittsburgh is one shining example of a pro-life hospice that affirms the sanctity of life and the Hospice Life Pledge. They are currently raising money to build a pro-life hospice facility and expand their services to the public, so they can serve many patients and families from all over who come there for end-of-life care, ... care that affirms the value of each and every patient. This is the type of hospice we need to support and encourage around the country, wherever we may find them.

Cristen Krebs is also a co-founder of the new Hospice Life Association of America. Through the new Hospice Life Association of America, people will be able to find a place that will provide the services they expected and need so desperately ... hospices or palliative care providers who will say, as did Dame Cicely Saunders.

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

Hospice and palliative care administrators, agencies, professionals, and lay people, any who are pro-life, can get more information about joining the new Hospice Life Association of America from Cristen at the Catholic Hospice in Pittsburgh, PA. The Association is a membership organization that will provide a safe haven for those working to provide end-of-life care that affirms the sanctity of life. People can also get information about the pro-life hospice services and the new pro-life hospice facility they are planning by telephoning: 866-933-6221.

Those of you who wish to get involved and help out, contact pro-life groups that you know about, support them with your time, energy and donations for their nonprofit mission. Together, we can change our society for the better!

For those family members who are in anguish because you witnessed the medical killing of your loved one: do not blame yourself! Now you understand how and why it happened. Help prevent it from happening to other patients and their families.

The culture of death has infiltrated many aspects of society, but there are still rays of light peeking out, burning brightly. There are many who recognize the sanctity of life and we must join together. We must remember that those who were concerned about similar changes in pre-war Nazi Germany faced horrific obstacles, yet they stood true to life, to our God and saved many. Ultimately, the Light prevails dispelling all darkness. Accurate information itself is a source of great power. That is why what we've reviewed here has been the most-censored story in America. No more! This book is a gift to you and people around the world, to empower you so you may help the vulnerable around you. Share it with those around you.

Applying this knowledge, guided by your caring heart, conditions will certainly improve over time. Turning our society toward life will not be an easy task, but with prayer and dedication, a way will be found. Many will come to join us in the affirmation of life. Young and old from all walks of life will reach out to help. It is no small matter. This is all about our survival as a moral society that respects the lives of the vulnerable. It's most directly and urgently about their survival. As long as we are here, alive, we can do something in our own lives to make a difference. This is our mission.
Perhaps, Terri said it best,

"Where there’s life, there’s hope."
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Lisa Brenner, HPA Board member, prolife advocate

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Joanne Lestone, HPA Board member, prolife advocate

Barbara "Bee" Becker, retired HPA Board member for several years, long-term nursing home patient advocate, testified before Congress regarding her mother-in-law's murder in a nursing home, Bee has helped locate thousands of articles about patient issues through the years, sharing them with all. She has worked tirelessly for many years to improve the conditions of the vulnerable.

Christina Brundage, RN, dedicated prolife volunteer, former hospice nurse, one of the few hospice nurses in this country willing to speak the truth openly.

Paul A. Byrne, Director of Neonatology and Director of Pediatrics at St. Charles Mercy Hospital in Oregon, Ohio, Clinical Professor of Pediatrics University of Toledo College of Medicine, head of the Life Guardian Foundation, prolife patient advocate, pioneer in the field of neonatology, former President Catholic Medical Association, author, inventor of one of the first oxygen masks for babies, an incubator monitor, and a blood-pressure tester for premature babies, which he and a colleague adapted from the finger blood pressure checkers used for astronauts

Charles Phillips, MD, patient advocate, testified before Congress, prepared testimony for Senator Grassley's Finance Committee" Manipulation of HMO," emergency and family physician, whistleblower, author

Prof Dianne Irving, PhD, Professor of the History of Philosophy, and of Medical Ethics (Georgetown University, Catholic University of America, and The Dominican House of Studies), Christian Bioethicist, author of numerous articles on bioethical issues, career-appointed bench research biochemist/biologist (NIH, NCI, Bethesda, MD), who has dedicated her life to providing the world with scientifically-pristine and logically-sound analysis of the bioethical issues that confront our world. I am grateful she has managed to teach me just a
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Matt Abbott, pro-life journalist,

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Dr. Cristen Krebs, DNP, founder and administrator of the prolife - Catholic Hospice of Pittsburgh, co-founder of the new pro-life national hospice agency and professional organization: Hospice Life Association of America, co-founder of the H.A.L.O. Project (Hospice Advocacy and Leadership Organization, a patient and family hospice support network)

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Rita Marker, JD, Exec. Director - Patients Rights Council (formerly International Task Force on Euthanasia and Assisted Suicide, attorney, author and patient advocate. The Patients Rights Council has a wealth of information on assisted-suicide and euthanasia, their history in the United States and legislative efforts in America.

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I also must thank all the wonderful friends who make up the Hospice Patients Alliance around the world who have shared so much with us through the years: their comments and encouragement, insights, experiences, news articles and the problems they've observed. We could not do the work without you, your support and encouragement!

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About the Author:

Ron Panzer is President of Hospice Patients Alliance, a patient advocate and member of the National Association of Pro-life Nurses. More information about Mr. Panzer can be found at the Hospice Patients Alliance website.
"Ron Panzer's knowledge of the health care industry -- and its dark side -- is exceptional. Equally exceptional is his dedication to authentically pro-life hospice care. Every person who works in health care, and particularly those who deal with end-of-life issues, would do well to read Ron's new e-book Stealth Euthanasia: Health Care Tyranny in America. Dare I say that many of them are in for a wake-up call!" - Matt Abbott, Catholic pro-life journalist

This book is being provided free of charge online as a public service of the Hospice Patients Alliance.

This book contains the most-censored story in America and we cannot guarantee that this information will be available in the future. There are many who do not want you to learn what is contained in this web-book.

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Note: The people of our nation urgently need this information to understand what is happening to our society and how their way of life is being threatened. We encourage everyone to share it. Some names and/or details have been changed to protect the privacy of some individuals mentioned. If you believe that any account given here reflects something that happened in your family or a case that you know about, the similarities are coincidental. There are thousands and thousands of cases like these each year in the United States.

Hospice Patients Alliance is a charitable nonprofit organization working to promote the very best in end-of-life care and renew the pro-life mission of hospice that encourages people to live their lives fully until they die. Hospice Patients Alliance is only supported by donations from the public, people like you.

We need your donations to continue our work.

Please donate to support this vital mission!