



SOUNDING THE ALARM

1. What happens when the highest levels of the executive, legislative, and judicial branches of the government of the United States of America cannot stop the gruesome starvation and dehydration of a severely disabled female, even with national and international focus?

The female dies a cruel unjust death, the death peddlers become emboldened, the Church becomes more entrenched in its atrophy, civilization becomes more deeply corroded, and thousands more suffer the same with no end in sight.

This was the clarion call to action that was never answered by the Church and still today.

Blessed are your eyes, for they see, and your ears, for they hear.” Matt. 13:16

2. *Recognize and remember the killing is a two-sided coin.* One side is assisted suicide. The other side, euthanasia and its methodology, is carefully disguised now and ensconced in Catholic health care settings.
3. To answer the silent pleas of the helpless you must prioritize:

Expelling from all Catholic health institutions any persons paid or volunteering who are promoting palliative care.

Expelling from all Catholic health institutions any persons fully accredited or actively seeking accreditation from the Academy of Hospice and Palliative Care Medicine.

Stopping all recruitment of palliative care personnel.

Disbanding the Supportive Care Coalition and, as with safeguards for minors, restrict members from management and the delivery of direct health care services to any population.

Immediately disentangling all Catholic health care facilities from the unholy alliance with community groups which support and advocate palliative care.

Speaking out against the POLST, MOLST, living wills and any other advance directives crafted and promoted by pro-euthanasia groups which do not uphold the life-affirming principles of Catholic doctrine.

Reviewing all state forms for advance directives and speak out and work to change any which do not uphold the life-affirming principles of Catholic doctrine.

Reviewing state bans on assisted suicide, crafted by pro-euthanasia groups, and speak out against and work to repeal such bans which allow safe harbors for euthanasia to be committed by health care workers.

Reaffirming the traditional definition of death while refuting without equivocation “brain death” and set up new safeguards for any patient who is cognitively or sensory impaired or both.

Reasserting the Church’s understanding of true “natural death”, words now co-opted and used by the pro-death zealots to manipulate patients to their desired end.

Disavowing wholeheartedly the death industry’s jargon “vegetative state”.

Recognizing now that clerics and their entourage are by and large insulated from the predatory tactics waged against the average patient to hasten death. Like drones, these zealots hover over patients seeking their confidence and then prey upon their fears and ignorance of ordinary care and acute medical practice. And when the patient is won over and ready to accept being steered away from all acute care or directly overcome, therein lies one more victory for the healthy and the strong for how these dollars are better spent.

Resisting the urge to write position papers which, though truthful and eloquent, are read by few and save no lives.

Stealth Death

4/3/17

Euthanasia must be understood both spiritually and tactically.

Spiritually it is evil and like all evil it will appear as something virtuous where no virtue exists.

Tactically, persons who have researched this over one or more decades, tell me it has a defined history in this country going back to the Hemlock Society (1930s) and defined tactics.

See www.lifetree.org

From this beginning, by the 1980s, two opinions/strategies emerged.

The Oregon side wanted a militant approach in assisted suicide.

The New York side wanted to do things in a more nuanced way.

This “new” eugenics movement is all about influence over the minds and hearts of the people who care for the dying-caregivers, physicians, nurses, chaplains, social workers to name just a few- so that they can control the timing and place of death.

Alphabet Soup

The Oregon side, the militants, rebranding themselves from the Hemlock Society to Compassion and Choices to Death with Dignity all pushed for legal assisted suicide. 7/1/16 New Mexico Supreme Court Rules There is No Right to Assisted Suicide reported by LifeNews.com. A recent defeat for Compassion and Choices and the ACLU which brought the suit.

The New York side became the Euthanasia Society of America morphing into the Society for the Right to Die and Concern for the Dying in the 70s and 80s, Choice in Dying in the early 90s, Partnership for Caring in the late 90s and Last Acts Partnership in the early 2000s. This wing claimed to be against physician assisted suicide. Beware. These so called moderates have tried to distinguish themselves as offering the moral high ground. See enclosed June 5, 2016 WSJ “Canada Debates Right-To-Die Limits by Paul Vieira.

In 1987, Dr. Josefina Magno of Washington DC and Dr. Gerald Holman of St. Anthony’s Hospice in Amarillo, Texas called a meeting of hospice physicians in Granby, CO to form what would later become known as the American Academy for Hospice and Palliative Care Medicine (AAHPM), the professional organization for palliative care physicians.

A pivotal event-took place in 1998 when Ira Byock, then President of the AAHPM joined with Choice in Dying to form Partnership for Caring and therein was born a major public relations campaign to gain public support and a political mandate for their agenda. **Then they *seemed* to disappear, but the evidence shows they have quietly filtered into the new field of palliative medicine.** In her 2005 book *Terri’s Story: The Court Ordered Death of an American Woman*, author Diana Lynn describes it as **the “third path” to death**, not wholly natural, not suicide, but something in between. The “moderates” insist there is a big difference between withholding and withdrawing medical treatment and giving someone access to a lethal dose of barbiturates.

The Never Satisfied Elites

In November 1995, George Soros called 20 foundations together who were committed to transforming the culture of dying. See enclosed Participants at Soros Meeting, 11/1995. In addition to Soros’ Project on Death in America and his Open Society Institute, attendees included AARP, Commonwealth Fund,

Greenwall Foundation, Mayday Fund and Cornfield Foundation, Milbank Memorial Fund, Nathan Cummings Foundation, the Rockefeller Family Office, and the Gerbode Foundation.

Also in 1995, the Robert Wood Johnson Foundation began a big communications and outreach effort called Last Acts. Last Acts worked at the grass roots level. They held their first Leadership Conference in March 1996. 140 national leaders came to Washington, D.C. See enclosed Participants at first Last Acts Conference, 3/1996. Representatives of bioethics (Hastings Center, Center for Practical Bioethics in KC and Park Ridge Center in IL), providers (American Hospital Foundation, American Nurses Association, Hospice Foundation of America, National Association for Home Care) and euthanasia (Concern for Dying) and many foundations were all there. All told 140 national leaders met in Washington,DC.

Two major funders stand out: the Robert Wood Johnson Foundation funded research and infrastructure and George Soros' Project on Death in America funded a cadre of professionals.

In the last 20 years these two foundations have provided several hundred million to **advance THEIR VERSION OF PALLIATIVE CARE into our American health care system and worldwide.** From its beginning, the RJW Foundation acted like a quasi-university, allowing intellectuals to test ideas with the Foundation's money. The Foundation is notorious for funding pilot projects so that it can later convince government to replicate them on a much grander scale. After the Clinton attempt at health care failed, their message became: "The way we care for people who are dying and their families is dreadful. But with adequate communication we could change all that...just get people to fill out living wills and forego treatment." But it didn't work. Fewer than 20 percent of us signed living wills.

Daniel Callahan described the Last Acts three-pronged strategy moving forward.

Change the education of healthcare **professionals**

Change health care **institutions** and **public policies** and the **regulatory apparatus**

Engage the **public** to gain support.

The first Soros scholar led projects were directed at professionals-EPEC was for physicians and ELNEC was for nurses. Other projects were aimed at changing the **general** culture including RC EPEC for Roman Catholics and APPEAL for African-Americans. Soros' Project on Death in America provided the physician leaders to integrate RWJ projects into mainstream America. His PDIA Faculty Scholars were quickly in place in many of the country's medical schools.

The Big Enchilada

All roads lead to palliative care. **The "third path" is totally committed to "upstreaming" or changing the American healthcare system so that palliative care is integrated with traditional care early on.** See the table contrasting the present "old model" of end of life care with their expanded model. The *traditional (old)* view of palliative care was associated with volunteer hospice care for cancer patients. The current (*new*) view of palliative care is not only for cancer patients. See the diagram of Traditional and Current Views of Palliative Care. This diagram shows that the new view is to introduce palliative care at the time of diagnosis, and **then increase the PROPORTION of symptom management "palliative" treatments to traditional "curative" treatments to the point of death.** **Note that palliative care includes a period of managed grief.**

Eight Palliative Care Training Centers (PCLCs) are run by Dr. Diane Meier's Center to Advance Palliative Care. They are training people who work in all healthcare settings- hospitals, rehab centers, nursing homes, assisted living centers, outpatient clinics, senior centers, volunteer respite caregivers, volunteers at healthcare community centers, ... The list goes on.

2001 to 2004, the National Consensus Project for Quality Palliative Care, with the collaboration of four major palliative care organizations and Partnership for Caring, develops and issues the National Consensus Project Guidelines.

In 2006, hospice and palliative medicine became an *official* medical subspecialty.

In 2007, the National Quality Forum established its National Framework and Preferred Practices for Palliative Care and Hospice Care. There are 38 Preferred Practices within 8 Domains. Here is one example:

Preferred Practice 22: Specialized palliative care and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.

Put another way, they are educating your priests, ministers and rabbis. The Florida Clergy Ending-of-Life Education Enhancement Project is a model program to educate the clergy about accepting hastened death.

For only four years- **2008-2012** - no palliative care fellowship is required for anyone to sit for the certification exam to become board certified.

Starting in **2013**, only fellowship-trained palliative professionals are allowed to sit for the certification exam. It is very significant that you can no longer be grandfathered in without official fellowship training!

In summary, they created the standards, got the specialty officially recognized, and now require that you complete one of their fellowships before you can even sit for the board exam- all in 12 years!

The CAPC-SOROS-RWJ version of palliative care is about coordination of care by an interdisciplinary team (IDT). The main members of the IDT are physicians, nurses, social workers and chaplains. Nutritionists, respiratory therapists, physical therapists, music therapists and caregivers can also be part of the team.

“Features commonly associated with hospitals that provide a palliative care consultation service are:

- JCAHO accreditation

- Cancer program approved by the American College of Surgeons

- COTH member hospital (Council of Teaching Hospitals)

- Catholic church operated**

- Large size (i.e., over 250 beds)

See <http://web.archive.org/web/20080512081253/http://www.capc.org/news-and-events/releases/news-release-4-14-08>.

The palliative care team helps develop relationships. It is designed to promote and then help implement advance care planning. The team communicates risks and benefits of various treatments with an emphasis on “realistic” expectations, discusses the patient’s concerns— all with the objective of helping the patient develop *goals of care*. The underlying problem is that they emphasize supportive rather than “real” medical services, and they base their analysis on a quality of life index. The palliative care team will insert itself into the family dynamic and try to bring consensus that it is time to “let go”!

Under the direction of Dr. Diane Meier CAPC has become a well-oiled training and marketing machine. Among its projects was to develop a list of triggers for recommending palliative care consultation in the presence of a serious or chronic illness. This is an all encompassing list that considers not only the medical state of the patient but the dynamic between the patient and the physician and also the family relationships. Several of those triggers indicate clearly how the new palliative care does not wait to enter at the end of life like it used to! The universe of hospitals and other care facilities presently under

the influence of this new palliative care, where a palliative care team can be found, and the list of triggers for adult and pediatric patients to be referred for a palliative care consult is available at www.getpalliativecare.org. Practically everyone and their cousin will qualify. Here are a few examples of the triggers:

Declining ability to complete activities of daily living

Weight loss

Multiple hospitalizations

Difficult to control physical or emotional symptoms related to serious medical illness

Patient, family or physician uncertainty regarding prognosis

Patient, family or physician uncertainty regarding goals of care

Patient or family requests for futile care

DNR order conflicts

Use of tube feeding in cognitively impaired or seriously ill patients

Limited social support and a serious illness (e.g., homeless, chronic mental illness)

Patient, family or physician request for information regarding hospice appropriateness

Patient or family psychological or spiritual distress

These triggers will introduce the palliative care process into patient populations which may be declining, but are not dying. Note especially that those with limited social support and/or declining abilities are identified as ripe for palliative care.

Box 'Em

Polst

Not enough people signing living wills? Enter the POLST or MOLST, a living will with teeth. Once it is completed, all medical personnel must obey it. The Physician's Order for Life Sustaining Treatment has been crafted to scare and intimidate patients away from acute surgical or medical care using technical medical jargon and through persons trained to present the document or via video. Moreover, the creators of such forms nowhere include food and water under comfort care or any other level of care for that matter. They bend over backwards to make the form more clinical and sterile. In later iterations they prefer the wording Comfort-Focused Treatment over Comfort Care. Has caring become anathema? How voluntary is the form when a patient is being manipulated to sign it and nudged to check the boxes that will hasten their death? The designers use words like natural death as a moving target placing them where they will best steer the patient toward refusing treatment.

Food and water provided in any manner are merely ordinary care but the POLST creators make it medical care to induce withholding of what is essential for life. They even propose a trial period! Why would anyone who can eat or drink suddenly stop because they surpassed the trial period on the form? There is no goal for the trial period and there are no parameters to continue it or discontinue it.

These forms, when introduced and completed by other parties, create a wedge between patients and their doctors. These forms fail informed consent when all the variables surrounding a future medical condition are unknown. These forms lack a conscience clause for health care professionals who may have concerns about medical orders they are asked to fulfill.. Many states don't even require that the patient sign the form! In Oregon, it's only *recommended* that the patient sign it. See the enclosed Oregon POLST. Later in some versions they dispensed with the word *recommended* altogether.

State Bans on Assisted Suicide

Fifteen states now have bans on assisted suicide that contain safe harbors for health care workers to starve/dehydrate/terminally sedate a patient.

State Threats to Patient-Chosen Advance Directives

Covered in full in the Robert Powell Center for Medical Ethics of the National Right to Life Committee report originally issued 4/2005 and revised in 7/2015.

Equations and Matrixes

Under the Affordable Health Care Act , the new healthcare imperative is to improve value V where $V = \text{Quality}/\text{Cost}$. So how is quality defined in healthcare?

See the National Quality Forum definition of healthcare table.

There are six goals.

- Patient-centered
- Beneficial
- Safe
- Timely
- Equitable
- Efficient

Notice that we are no longer talking about health care that is essential for living, but rather that which is deemed important as reflected in the 4 principles of bioethics- autonomy, non-maleficence, benevolence and justice.

The importance of electronic health care records to the “third path” movement cannot be overestimated. They plan to use EHRs to segment the population as a tool for guiding clinicians IN FUTURE DECISIONS ABOUT CLINICAL CARE. Dr. Joanne Lynn has outlined eight categories of health to separate out the curable from the not curable. See 8 Categories of Health.

- 1) Healthy
- 2) Maternal and Infant
- 3) Acutely ill but mostly curable
- 4) Chronic condition, normal function
- 5) Stable but significant disability
- 6) Short period of decline near death
- 7) Organ system failure
- 8) Long dwindling course (frailty, dementia)

In 2007, Dr. Lynn was the lead author of a Center for Medicare Services (CMS) article proposing a “Bridges to Health” model. That model specifically marries the six NQF bioethics quality goals to these eight patient categories and proposes that the planner shift to a matrix model of “resource allocations” over the 48 cells in the matrix, and away from the traditional model of tailoring services to each patient’s situation which is said to be too difficult and costly. Make way for the army of planners.

It Takes a Community to End a Life

Last Acts focused on communities—Community-State Partnerships. As part of Last Acts, RWJ funded an \$11.25 million national framework for statewide activities called Community-State Partnerships. The

National Program Office was at the Center for Practical Bioethics in Kansas City. Grants which averaged \$450,000 were given to set up 25 statewide coalitions, often tapping into **established** bioethics networks. See the list of Community-State Partnerships.

These state-wide coalitions acted as “social entrepreneurs” at the grassroots level. You may recognize some of their advocacy activities at the state level. They advocate 1) for required professional training in palliative care, 2) for POLST legislation, 3) for better reimbursement for palliative care, 4) to reduce restrictive requirements for pain policy boards, and 5) to **mandate** honoring of patients’ advance directive choices. What the proponents of euthanasia want is access to kill, the freedom to kill without fear of prosecution, and to be paid to kill all under the guise of patient advocacy.

We call your attention to a new coalition which has been “under the radar” these last couple of years. The Last Acts Partnership people have come together again for round two by forming a new, much larger coalition to manage the news media. The director of the Center for Practical Bioethics and a former head of AARP joined forces with a former chairman of Partnership for Caring for form the Coalition to Transform Advance Care (C-TAC). C-TAC is a unique group of 120 members or “stakeholders” across the world of healthcare including the same five groups identified earlier (the original euthanasia/eugenics people, bioethics centers, providers of healthcare, “grassroots”/community organizations and private foundations). See the list of C-TAC members.

This new “third path” juggernaut is deep into our society, working to “create change in normative and expected behavior regarding advance illness”, working to change our moral sentiments and avoid any future “death panel” hysteria. Their guiding principle is not DO NO HARM but rather consensus based on “communitarian” ethics-what is the greatest good for the community, rather than the good of the patient.

The recurring theme is best expressed by Dr. Joanne Lynn of the Center for Practical Bioethics. According to Lynn, “We have overinvested in medical care. We have had the wrong set of priorities. What we need is more community volunteers to give companionship, food and keep people safe.” Lynn argues that hospice manages those who die within a short period of time, but our system lacks a well-funded program to address those with multiple chronic conditions. (the expensive ones!) She is saying that better quality healthcare means more community healthcare organizations and fewer hospitals! See Joanne Lynn’s series of short videos on the Care Transitions Program Initiative at <http://www.youtube.com/watch?v=qb46VHuaJLA&list=PLBCFE9967989A6F5E>.

RWF infused over \$200 million into the caregiving industry. In 2001 alone the Foundation gave \$112 million to develop Faith in Action (FIA) which **trains community volunteers** who are available to offer free respite care to family caregivers, home care and other supportive services. One of the “third path’s” strategies is to “mobilize” family caregivers to apply pressure for policy reform. National standards for the caregiving industry are popping up all over the place. Recently the US Department of Labor mandated that “direct care” workers must be paid the minimum wage. Will all this political activity in the caregiving industry benefit the patient or will the increased cost of regulated caregiving make families more willing to concede to the pressures of palliative care?

Search and Seizure

Partial Transcript of Paul Byrne, M.D. www.lifeguardianfoundation.org

“The first patient that I encountered with these questions was a patient by the name of Joseph in 1975 and Joseph was on a ventilator for several weeks and a brain wave test was done and it was

interpreted as being consistent with cerebral death. And I saw death on his chart and I saw Joseph and it seemed like these things...that something was seriously wrong because Joseph was not dead. There's a lot of different terms that gets used and there's a lot of different criteria that gets used. None of them are for true death. They're all for designating some kind of condition that is not true death but something so it becomes a signal to do something else like get the cut out the organs or turn off the life support.

It was suggested to stop treating Joseph but I continued to treat him and eventually he went home from the hospital. He went to school, he got good grades, ran track, played baseball. He's married and has 3 children. But he was the patient that started my study of the subject of brain death.

Brain death is fake death. It's not true death. It's just fake death. It's what they made up primarily to get organs but it's also used to stop treatment. And what makes somebody dead is the action that's taken and their...the declaration like if you turn off the ventilator or cut out the beating heart then of course no one recovers after they've had their beating heart cut out.

People that are called brain dead are alive. It's just made up to get organs. Every organ that's transplanted is a healthy organ and it comes from a living person. There are essentially no organs that can be transplanted from a cadaver. A cadaver is a dead body and everybody realizes that when death occurs there's destruction and of course there's destruction of the vital organs and it occurs quickly when there is no oxygen supplied to those organs.

So organ transplantation involves getting someone who is living and doing...coming to some conclusion so they can get organs. When people go to the license bureau and they're asked the question 'Do you wish to be an organ donor?' those who say 'yes' are surmising that the organs will be taken after their death when in fact there are no organs that are suitable for transplantation after true death. Now I know this might be difficult for people to hear because they might not have ever heard it before yet it's the kind of things that if they just think about it it would make sense to them because most people can tell the difference between life and death and then the other thing that adds to the mix up about the situation is the only thing you hear about is the recipient of the organs.

People concentrate on the recipients and of course we're happy when we see someone who continues to live after they've received a heart but on the other hand we know that the one that they took the heart out of was killed in the process.

New Definition of Death

Definition of Irreversible Coma "The Harvard Criteria" 1968

Between 1968 and 1978 there were 30 different sets of criteria published each less strict.

"I looked at the Harvard criteria and asked 'Is it based on science?' They published this set of criteria. The common denominator to all the criteria is that the patient is unconscious. Of course, unconscious is a strong word but all that it means is that they cannot demonstrate that they are conscious. The only function of the brain that's tested is the function of taking in a breath and they determine that the person can't take in a breath by taking away their ventilator. These persons are on ventilators. A ventilator is a machine that we use to help people to breathe but the only thing the machine does is pushes air in. It doesn't even make it come out and it only works when the lungs are healthy and the heart is healthy and the heart is circulating and the liver's functioning and the kidneys are functioning and that means it only works when someone is alive.

They take the ventilator away and there's no breath, no breath not just for 30 seconds or a minute or two minutes but for 10 minutes they suffocate the patient. They make the carbon monoxide go up. When the carbon monoxide goes up that makes the brain swell and makes them get worse. That's known as the apnea test and the apnea test incidentally is not a test for sleep apnea."

Presumed consent of organ donation

- a. DMV-no recording of the "no"
- b. "Accepted medical standards are all set up to get your organs." Byrne
Uniform Anatomical Gift Act now legal in 47 states presumes everyone intends to be an organ donor.
Is this a violation of the 13th amendment?
Is this not involuntary servitude when the government is setting us up to be organ donors?
- c. HIPAA-14 ways the government can get our information without our permission and use it including to use our organs
- d. Apnea test-no law to obtain consent and who would give consent if relatives knew it would be suffocating their loved one and who would consent to their loved one having their organs cut out of their bodies, even with a paralytic (to keep the patient from moving) and still with no anesthesia?

Coerced Consent... "brain washing"

"What happens in the hospital is that it's set up so that as soon as somebody is unconscious and on a ventilator especially if they are under 40 years of age, the organ transplant people are contacted immediately. Furthermore your doctor or the doctors and nurses at that hospital are not allowed to request permission to get your organs. The organ transplant people employ designated requesters is what they are called and they know how to be nice to you and we've watched them work. They will bring you a cup of coffee. They will be very kind and then they will find out if there's a mother or a father who might be more likely to give in. And then they separate them and then they get the weaker one to say yes and their job is to get the others to say yes to get the organs. All of this is set up to get your organs. You have to understand that the organ transplant industry and that's what it is. It's an industry. **It's a multi-billion dollar industry. It's completely dependent on getting health organs from living persons.** They can't get organs from a cadaver. Furthermore, it's set up by the Federal Government. The Federal Government is the one that supplies much of the money for organ transplantation. You know that Medicare is was started out to provide health care for persons who were 65 and older. Yet Medicare participates in paying for almost all organ transplantation procedures. You know a body is worth probably at least \$5 million dollars for their organs for the organ transplant industry!

And so it isn't that I'm opposed to people living longer. Of course, I want them to live longer but the case of heart transplantation they really don't do as many as they formerly did because they realize that if you just gave them better treatment to the heart that's there they do better than if they get a transplant so they don't do so many transplants anymore. They used to do more partial liver transplants but then a brother in Colorado gave part of his liver to his brother and in about 5 or 6 days the donor was dead and in about 6 months the recipient was dead and then they looked around and they found 5 other cases like that where partial liver transplant resulted in the death of the participants so they don't do as many as they formerly did and of course you can't do a whole liver transplant unless you kill the donor. And then there are things that we find out that with better nutrition and vitamins that livers that weren't able to heal are now able to heal. And of course, kidney disease, dialysis, people can live a long time on dialysis. Of course, it's not as convenient as the kidneys that we were born with and don't have to use dialysis but on the other hand to get a kidney for transplant the donor either becomes dead or becomes weaker..."

Regulatory Lollipops

See the Belbury Review "Death Facilitators Being Sneaked in Over Labor Day Weekend" 9/05/15 detailing the implications of the newly created and now in effect CPT codes 99497 and 99498. These codes provide financial reimbursement for professional services directed at controlling the timing of death.

Legislative Wish List

The "third path" movement is highly organized in the United States at the state and local levels and has made great inroads internationally. By and large, the last levers to push are at the federal level. It is the only hope of stopping them and saving the innocents of every age from unjust and tortuous death. The other side is rabid for the passage of H.R. 1666 The Patient Centered Quality Care for Life Act and H.R. 1339 The Palliative Care and Hospice Education and Training Act. No doubt there are other initiatives.

A key is to see they have separated out the words hospice and palliative care giving way to their goal of a separate "universe" of palliative care for the masses. One can easily observe hospices changing their names where XYZ Hospice becomes XYZ Hospice and Palliative Care and boasts of the number of their clients now receiving palliative care.

In summary, evil, having no mass of its own, must occupy a good. Thus, the purveyors of death seek to occupy healthcare. Evil seeks entry. Thus the proponents of euthanasia seek access to the innocent. Evil seeks to exert its own will in defiance of God's will. Death peddlers want immunity. Finally, evil seeks its own glory. So too the "third path" seeks adulation for their misguided charity.

An Independence Day Prayer

We pray you, O God of might, wisdom, and justice,
through whom authority is rightly administered,
laws are enacted, and judgement decreed,
assist with your Holy Spirit of counsel and fortitude
the President of these United States,
that his administration may be conducted in righteousness,
and be imminently useful to your people,
over whom he presides;
by encouraging due respect for virtue and religion;
by a faithful execution of the laws in justice and mercy;
and by restraining vice and immorality.

Let the light of your divine wisdom direct
the deliberations of Congress,
and shine forth in all the proceedings and laws
framed for our rule and government,
so that they may tend to the preservation of peace,
the promotion of national happiness,
the increase of industry, sobriety, and useful knowledge;
and may perpetuate to us the blessing of equal liberty.

We pray for the governor of this state,
for the members of the assembly,
for all judges, magistrates, and other officers
who are appointed to guard our political welfare,
that they may be enabled by your powerful protection
to discharge the duties of their respective stations
with honesty and ability.

We recommend likewise, to your unbounded mercy,
all our fellow citizens throughout the United States,
that we may be blessed in the knowledge
and sanctified in the observance of your most holy law;
that we may be preserved in union,
and in that peace which the world cannot give;
and after enjoying the blessings of this life,
be admitted to those which are eternal.

Grant this, we beseech you, O Lord of mercy,
through Jesus Christ, our Lord and Savior. Amen.

Archbishop John Carroll, first bishop of the United States

Canada Debates Right-to-Die Limits

By PAUL VEIRA

OTTAWA—A political stalemate over right-to-die legislation is stirring legal questions about who can seek a doctor's help to die and under what conditions doctor-assisted suicide is lawful in Canada.

A 2015 Supreme Court of Canada ruling decriminalizing doctor-assisted suicide will take effect Tuesday, giving Canadians who have "grievous and irremediable" conditions the constitutional right to seek a physician's help to die. The ruling had been suspended to give lawmakers time to craft legislation defining who fits the court's criteria.

But while Prime Minister Justin Trudeau's government introduced legislation in April, its bill has yet to be approved.

The proposed law would narrow the criteria to restrict physician-assisted suicide to those with a terminal disease or to when death is "reasonably foreseeable."

Since the Supreme Court ruling is taking effect before the legislation, medical professionals and legal experts say health-care providers and patients are entering an unusual gray zone.

"Canada will become the most liberal country in the world with respect to death-hastening policies" in the absence of legislation, said Harvey Chochinov, a palliative-care expert at the University of Manitoba in Winnipeg. Dr. Chochinov, a critic of having no law in place to govern doctor-assisted death, last year led a government panel on addressing right-to-die policy.

The proposed legislation, which has been passed by Parliament's lower house and is now being debated in the Senate, is similar to laws in some U.S. states with right-to-die regimes, such as Oregon and California.

To avoid so-called suicide tourism, it limits doctor-assisted suicide to people who

are eligible for government-funded health services in Canada.

Some senators oppose limiting doctor-assisted suicide to those with terminal illnesses and say that limit contravenes the Supreme Court ruling. That debate is part of what is holding up passage of the law.

Citizens with 'grievous' conditions can seek a doctor's help as of Tuesday.

Justice Minister Jody Wilson-Raybould told senators in testimony last week that without legislation, there would be a legal vacuum that would act as a barrier to right-to-die services, since some doctors might shy away from acting.

A national physicians' group echoed that concern. "Physicians across the country remain uncertain, and in that

climate of uncertainty Canadians will be left to languish—exactly what the Supreme Court of Canada ruling sought to avoid," said Cindy Forbes, president of the Canadian Medical Association.

It is unclear when both chambers of Parliament will agree on legislation. The Senate is expected to hold a final vote this week. Should the upper chamber make amendments, the legislation would head back to the lower house for a new round of debate.

Anticipating the risk that legislation wouldn't be ready, regional medical authorities have issued guidelines to doctors that they say are in accord with the Supreme Court's ruling. But Ms. Wilson-Raybould, along with some medical experts, warn that this won't be enough because the protocols fail to impose limits on who can seek a doctor's help to die.

—Kim Mackrael
contributed to this article.

Participants at Soros Meeting, 11/1995

AARP Andrus Foundation: John Feather, Dir.
American Suicide Foundation: Herbert Hendin, Ex. Dir.
Colorado Collective for Medical Decisions, Inc.: Donald Murphy, Pres.
Columbia Foundation: Susan Clark, Ex. Dir.
Commonwealth Fund: Karen Davis, Pres.
Council on Foundations: Mary Ann Zehr
Greenwall Foundation: William Stubing, Pres.
Mayday Fund and Kornfeld Foundation: Fenella Rouse, Ex. Dir.
Milbank Memorial Fund: Christine Cassel, chair of the Department of Geriatrics and Adult Development at Mt. Sinai Medical School
Nathan Cummings Foundation: Charles Halpern, Pres; Andrea Kydd, Dir., health program New York Community Trust; Len McNally, Sr. Prog. Off.
Non-Profit Management Associates, Inc.: Thomas Bryant, Chm.
Open Society Institute: Aryeh Neier, Pres.; Liz Lorant, Dir., Medical and Health Programs in Eastern Europe
Project on Death in America: Kathleen Foley, Dir., and chief of pain service at Memorial Sloan-Kettering Cancer Center Susan Block, board member, Dir. of the Faculty Scholars Program, and professor, Harvard Medical School and Harvard Community Health Plan Joanne Lynn, board member, and Dir., Center to Improve Care of the Dying, The George Washington University Patricia Prem, board member, and social worker David Rothman, board member, and Dir., Center for the Study of Society and Medicine at Columbia University's College of Physicians and Surgeons
Robert Wood Johnson Foundation: Lewis Sandy, VP; Rosemary Gibson, program officer; Paul Tarini, communications officer
Rockefeller Family Office: Charles Terry, Dir. of philanthropy
United Hospital Fund: David Gould, VP for program
Wallace Alexander Gerbode Foundation: Thomas Layton, Ex. Dir.

Source: <http://web.archive.org/web/20070210230310/http://www2.soros.org/death/news1.htm>

Participants at the first Last Acts Conference, 3/1996

Laury L. Adsit	National Academy of Elder Law Attorneys	Gatherine Ehlen	American Association of Health Plans
Madalon Amenta	Hospice Nurses Association	Michelle Grant Ervin (F)	Howard University Hospital
Paul Armstrong (F)	Timinus and Associates	John Feather	AARP Andrus Foundation
Lynn Beauregard	Alliance for Aging Research	Betty R. Ferrell	Oncological Nursing Society/City of Hope Med Center
Lois Bergeisen	Association of American Medical Colleges	Marilyn Field	Institute of Medicine
Linda Blank	American Board of Internal Medicine	Linda Fink	National Consumers League
Susan Block	Harvard Medical School & Project on Death in America	John C. Fletcher	Center for Biomedical Ethics, UVa School of Medicine
Diane Blum	Cancer Care, Inc.	Kathleen Foley (S, F)	Memorial Sloan-Kettering Cancer Center/PDIA
Carmella Bocchino	AAHP/AMCRA	Robert B. Friedland	National Academy on Aging
Anne Boling	Center to Improve Care of the Dying	Arnold Golodetz	American Health Decisions/Vermont Ethics Network
Lynn Brallier	Consciousness Connections Foundation	David A. Gould	United Hospital Fund
Thomas E. Bryant	Hospice Foundation of America	Joan Greco	Fred Friendly Seminars
Roger J. Bulger	Association of Academic Health Centers	Beatrice Greenbaum	New York Citizens Committee-Health Care Decisions
Michael Burch	The American Legion	Charles Halpern	Nathan Cummings Foundation
Phyllis Byard	Funeral and Memorial Societies of America	Bernice Catherine Harper	National Hospice Organization
Daniel Callahan (S)	The Hastings Center	Joan K. Harrold (F)	Center to Improve Care of the Dying
Lisa Carlson	Funeral and Memorial Societies of America	Amy Harvell	Joshua's Tent
Ellie Carper	Center to Improve Care of the Dying	Hannah L. Hedrick	American Medical Association
Mike Christenson	Allina Foundation	Thomas Hoyer	The Center for Social Gerontology
Myra Christopher	Midwest Bioethics Center	John W. Hoyt	Health Care Financing Administration
Elizabeth Clark (F)	National Coalition for Cancer Survivorship	John Iglehart	Society of Critical Care Medicine
Chris Cody	National Hospice Organization	Bruce Jennings	Health Affairs
Ruth C. Cohen	National Association of Professional Geriatric Care Managers	Kay E. Jewell	The Hastings Center
Mary Ellen Courtright	Retired physician	Sandra H. Johnson	Health Care Financing Administration
John B. Crosby	FHP Foundation	Diane Jones	Center for Health Law Studies SLU
Neal E. Cutler	American Medical Association	Stanley B. Jones	Hospice Association of America
Thomas Delbanco (S)	Boettner Center of Financial Gerontology	Annette Kane	Health Insurance Reform Project
Steven Devlin	Beth Israel Hospital/Picker Institute	Suzanne J. Kieffer	National Council of Catholic Women
Virginia Dizer	Boettner Center of Financial Gerontology	Aaron J. Kissel	Hospice Association of America
Richard Doerflinger	National Association of State Units on Aging	William Knaus (S)	Alzheimer's Association
G. Kevin Donovan	National Conference of Catholic Bishops	Barbara Koenig (F)	University of Virginia School of Medicine
	Oklahoma Bioethics Center/American Academy of Pediatrics		Stanford Center for Biomedical Ethics

Cont'd LA Participants, 3/1996

Austin Kutscher	Foundation of Thanatology	Daniel Perry	Alliance for Aging Research
Andrea V. Kydd	Nathan Cummings Foundation	Linda Peterson	American Hospital Association
Elaïne Locke	American College of Obstetricians & Gynecologists	Susan M. Pethey	American Medical Directors Association
Karen Lomax	National Center for Clinical Ethics, Dept. of VA	Anne Pritchett	American Medical Women's Association
Jonathan Lord (S)	American Hospital Association	Susan Prokop	American Society of Internal Medicine
James Lubitz	Health Care Financing Administration	Rosemary Quigley	American Medical Association
Joanne Lynn (S)	Center to Improve Care of the Dying	Thomas Reardon (S)	American Medical Association
John J. Mahoney	National Hospice Organization	Don Reynolds	Midwest Bioethics Center
Richard Mandelbaum	American Association of Retired Persons	Fenella Rouse	Emily Dave & Joseph S. Kornfeld Foundation/Mayday Fund
Dacosta R. Mason	American Association of Retired Persons	Cindy Hyton Rushton	The Johns Hopkins University
Karen R. Matherlee	National Health Policy Forum	Charles R. Sabatino	ABA Commission on Legal Problems of the Elderly
Stephen McConnell	Alzheimer's Association	Colleen Scanlon	Center for Ethics & Human Rights, American Nurses Assoc.
Catherine McDermott	Granmakers in Health	Charles Scott	Population Communications International
Alixé McNeill	National Council on the Aging	Andrew Smith	American Association of Retired Persons
Galen Miller	National Hospice Organization	Lois Snyder	American College of Physicians
Alicia Mitchell	American Hospital Association	Mildred Solomon (F)	Education Development Center, Inc.
Christine I. Mitchell	The Children's Hospital, Boston	Deborah Solove	Colorado Collective for Medical Decisions
Kathi Mooney	Oncology Nursing Society	Barbara Spring	Missoula Demonstration Project
Anna Moretti	Choice in Dying	John Stanley	Lawrence University Program in Biomedical Ethics
Rebecca Morgan	National Academy of Elder Law Attorneys	Ellen Stovall	National Coalition for Cancer Survivorship
Pat Murphy	Newark Beth Israel Medical Center	Gerald O. Strauch	American College of Surgeons
Naomi Naimeran	American Hospice Foundation	Mary S. Strong	American Health Decisions
Janet Neigh	National Association for Home Care	William C. Stubing	The Greenwall Foundation
William Nelson	Department of Veterans Affairs	Joan Teno	Center to Improve Care of the Dying
Herbert Nickens	Association of American Medical Colleges	H. James Towey	Consultant to Governor Lawton Chiles
Laurence O'Connell (S)	Park Ridge Center for the Study of Health, Faith & Ethics	Ann Morgan Vickers	National Hospice Organization
Mary O'Malley	The Prudential	Bruce Viadeck (S)	Health Care Financing Administration
Kevin O'Rourke	Center for Health Care Ethics, St. Louis University	Sandra M. Walker	Business & Professional Women/USA
Mark D. Olshan	B'nai B'rith	Tracey M. Watton, Jr.	National Medical Association
Karen Orloff Kaplan	Choice In Dying	Anne Werner	United Seniors Health Cooperative
Henry Pacheco (F)	Center for Health Promotion, National Council of La Raza	Anne Wilkinson	Center to Improve Care of the Dying
Esther Park	Older Women's League	C. Roy Woodruff	American Association of Pastoral Counselors
		Edmund H. Worthy	United Seniors Health Cooperative

Old Model vs. Expanded Model of End of Life Care

Figure 1

Characteristics of a Shift in the Conception of Health and Health Care

OLD MODEL

Definition: Health as physical health and the absence of disease

Goal: To find a cure for disease

Context: Acute episodic illness and treatment of disease

Value: Defeat death

EXPANDED MODEL

Definition: Health as wellness, including mental, social, spiritual, and physical health

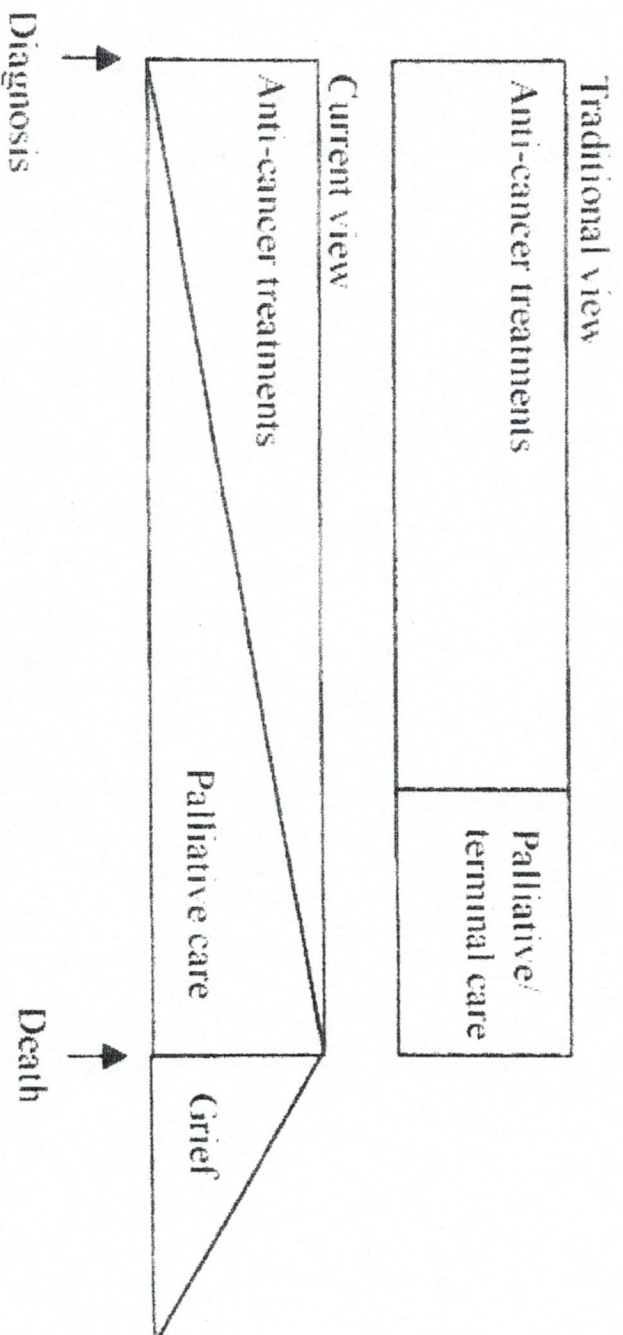
Goal: To promote functional capacity and well-being

Context: Includes chronic illness and treatment of the whole person as well as acute illness and treatment of disease

Value: Prevent illness, injury and untimely death, relieve suffering, and care for those who cannot be cured

Source: *Transforming Death in America: A State of the Nation Report*, Prepared for Last Acts by Metzger and Kaplan, June 2001, Figure 1, p. 7
<http://web.archive.org/web/20030817094653/http://lastacts.org/files/publications/stateofthenation.pdf>

Traditional and Current Views of Palliative Care



Source: *Journal of the Royal Society of Medicine*, September 2001
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1282181/>

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.
 For more information on Oregon POLST visit: www.orpolst.org

Patient Last Name:		Patient First Name		Middle Int.
Date of Birth: (mm/dd/yyyy)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Last 4 SSN: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address: (street / city / state / zip)				

A CARDIOPULMONARY RESUSCITATION (CPR): *Patient has no pulse and is not breathing.*

Check One

- Attempt Resuscitation/CPR
 Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B MEDICAL INTERVENTIONS: *If patient has pulse and/or is breathing.*

Check One

- Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Maximize comfort through symptom management.
- Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital if indicated. Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.
- Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
Treatment Plan: Full treatment including life support measures in the intensive care unit.

Additional Orders: _____

C ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible.*

Check One

- No artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.

Additional Orders: _____

D DOCUMENTATION OF DISCUSSION:

- | | |
|---|--|
| <input type="checkbox"/> Patient (Patient has capacity) | <input type="checkbox"/> Health Care Representative or legally recognized surrogate |
| <input type="checkbox"/> Parent of minor | <input type="checkbox"/> Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.) |
| <input type="checkbox"/> Court-Appointed Guardian | <input type="checkbox"/> Other: _____ |

Signature of Patient or Surrogate

Signature: <u>recommended</u>	Name (print):	Relationship (write "self" if patient):
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This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box

E SIGNATURE OF PHYSICIAN / NP / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.

Print Signing Physician / NP / PA Name: <u>required</u>	Signer Phone Number:	Signer License Number: (optional)
Physician / NP / PA Signature: <u>required</u>	Date: <u>required</u>	Office Use Only

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

Information for patient named on this form PATIENT'S NAME: _____

The POLST form is **always voluntary** and is usually for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Oregon Advance Directive is recommended for all capable adults, regardless of their health status. An Advance Directive allows you to document in detail your future health care instructions and/or name a Health Care Representative to speak for you if you are unable to speak for yourself.

Contact Information

Surrogate (optional):	Relationship:	Phone Number:	Address:
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Health Care Professional Information

Preparer Name:	Preparer Title:	Phone Number:	Date Prepared:
----------------	-----------------	---------------	----------------

PA's Supervising Physician:	Phone Number:
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Primary Care Professional:

Directions for Health Care Professionals

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- Should reflect current preferences of persons with advanced illness or frailty. Also, 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/documents/Guidebook.pdf>.

Sending to Oregon POLST Registry (Required unless "Opt Out" box is checked)

<p>For the Oregon POLST Registry the following must be completed:</p> <ul style="list-style-type: none"> • Patient's full name • Date of birth • Section A • MD / DO / NP / PA signature • Date signed 	<p>Send a copy of both sides of this POLST form to the Oregon POLST Registry.</p> <p><u>FAX or eFAX:</u> 503- 418-2161</p> <p><u>or</u></p> <p><u>Mail:</u> Oregon POLST Registry CDW-EM 3181 SW Sam Jackson Park Rd. Portland, OR 97239</p> <p><u>Registry Phone:</u> 503-418-4083</p> <p>*Please allow up to 10 days from receipt for processing into the Registry. Mailed confirmation packets may take four weeks for delivery.</p>	<p>Date Submitted _____ / _____ / _____</p> <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 10px auto;"> <p>MAY PUT REGISTRY ID STICKER HERE:</p> </div>
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Reviewing POLST

- This POLST should be reviewed periodically and if:
- The patient is transferred from one care setting or care level to another, or
 - There is a substantial change in the patient's health status, or
 - The patient's treatment preferences change, or
 - The patient's primary care professional changes.

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.

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.orpolst.org or at polst@ohsu.edu.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

NQF Defines Quality Healthcare

Quality healthcare meets six goals:

- Patient-centered (based on the patient's wishes and goals)
- Beneficial (likely to help the patient)
- Safe (not likely to harm the patient)
- Timely (delivered when it is appropriate, not too early and not too late)
- Equitable (available and applied to all who could benefit)
- Efficient (not wasteful of health resources and patient's time and effort)

Source: "The Development, Status, and Future of Palliative Care," by Diane Meier (Ch. 1, p. 55), *Palliative Care: Transforming the Care of Serious Illness*, March 2010, <http://www.rwjf.org/content/dam/web-assets/2010/03/the-development--status--and-future-of-palliative-care>. From National Quality Forum, <http://www.qualityforum.org>

8 Categories of Health

1. **Healthy**
2. **Maternal and Infant**
3. **Acutely ill but mostly curable**
4. **Chronic condition, normal function**
5. **Stable but significant disability**
6. **Short period of decline near death**
7. **Organ system failure**
8. **Long dwindling course (frailty, dementia)**

Source: Lynn, et al., <http://belburyreview.com/wp/using-health-records-to-segment-society>

Community- State Partnerships

Alabamians for Better Care at Life's End

University of Alabama at Birmingham (Birmingham, AL)

California Coalition for Compassionate Care

California Health Foundation and Trust (Sacramento, CA)

Connecticut Coalition to Improve End-of-Life Care—Better Endings

Sage Services of Connecticut (New Haven, CT)

District of Columbia Partnership to Improve End-of-Life Care

DCHA Program Services Company (Washington, D.C.)

Florida Partnership for End-of-Life Care

Florida Hospices and Palliative Care (Tallahassee, FL)

Kokua Mau Project

State of Hawaii (Honolulu, HI)

Iowa Partnership for Quality Care in Dying with Dignity

University of Iowa (Iowa City, IA)

Kansas LIFE Project: Living Initiatives for End-of-Life Care

Life Project Foundation (Wichita, KS)

Journey's End: A KY Partnership for Quality End-of-Life Care:

Kentucky Hospital Research and Education Foundation (Louisville, KY)

Maine Consortium for Palliative Care and Hospice

Maine Hospice Council (Manchester, ME)

Michigan Partnership for the Advancement of End-of-Life Care

Michigan Hospice Organization (Lansing, MI)

Minnesota Partnership to Improve End-of-Life Care

Metropolitan Area Agency on Aging (St. Paul, MN)

Nevada Center for Ethics and Health Policy

University of Nevada (Reno, NV)

New Hampshire Partnership for End-of-Life Care

Foundation for Healthy Communities (Concord, NH)

Establishment of a Statewide Program to Improve End-of-Life Care

Carolinas Center for Hospice and End of Life Care

Carolinas Center for Hospice and End-of-life Care (Cary, NC)

Matters of Life and Death Project

North Dakota Medical Research Foundation (Bismarck, ND)

Oklahoma Alliance for Better Care of the Dying

Oklahoma Association for Healthcare Ethics, Inc. (OKC, OK)

Improving Quality of Care for Our Most Vulnerable Population

Brown University (Providence, RI)

Partnership to Improve End-of-Life Care in Utah

HealthInsight (Salt Lake City, UT)

West Virginia Initiative to Improve End-of-Life Care

West Virginia University Foundation (Morgantown, WV)

Project closed early:

Health Research (Albany, NY)

Planning grants only:

Indiana University (Bloomington, IN)

University of Texas Medical Branch at Galveston (Galveston, TX)

C-TAC Member S

- AARP
- Aetna
- Alliance for Home Health Quality and Innovation
- Allina Health
- Alzheimer's Association
- Amedisys
- America's Health Insurance Plans (AHIP)
- American Academy of Hospice and Palliative Medicine (AAHPM)
- American Academy of Nursing (AAN)
- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Association of Colleges of Nursing (AACN)
- American Association of Colleges of Pharmacy
- American Association of Critical Care Nurses
- American Cancer Society
- American Cancer Society Cancer Action Network
- American Diabetes Association
- American Dental Education Association
- American Geriatrics Society
- American Heart Association
- American Hospital Association
- American Society of Clinical Oncology (ASCO)
- The Arc of the United States
- Ascension Health
- Association of American Medical Colleges (AAMC)
- Aurora Health Care
- Baylor Health Care System
- Belvedere Health Services
- Brown University
- C-Change
- California State University Institute for Palliative Care at Cal State San Marcos
- CancerCare
- Capital Caring
- Care Continuum Alliance
- Care Support of America
- CareFirst BlueCross BlueShield
- Caregiver Action Network
- Caring Foundations
- The Holding Group
- Honoring Choices Massachusetts
- Honoring Choices Minnesota
- Honoring Choices Wisconsin
- Hospice Foundation of America
- Hospice and Palliative Nurses Association (HPNA)
- Humana
- Institute of Medicine (IOM)
- Intermed
- Jewish Healthcare Foundation
- Kaiser Permanente
- Kansas City Hospice and Palliative Care
- Kendal Corporation
- LeadingAge
- Long-Term Quality Alliance
- Mintz Levin Center for Health Law & Policy
- MyDirectives
- National Academy of Elder Law Attorneys (NAELA)
- National Alliance for Hispanic Health
- National Business Group on Health
- National Center for Medical-Legal Partnership
- National Coalition on Health Care
- National Council on Aging
- National Healthcare Decisions Day Initiative
- National Hospice and Palliative Care Organization (NHPCO)
- National Hospice Work Group
- National Partnership for Women & Families
- National Retail Federation
- Partners HealthCare System
- Pfizer
- Positive Medicine
- Premier Healthcare Alliance
- Progressive National Baptist Convention
- RAND Health
- REACT
- The Rest of Your Life (RoYL) Planning
- Roundtable on Critical Care Policy