

# "Transforming Traditional Care to Palliative Care - Repackaging Death as Life"

Watch the video here: <https://youtu.be/iMLxNJqkdxg?si=rdL7rjSAquNncBxU&t=186>

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## (Slide 01)

Today, in the next hour, we will describe how our society has been duped by those who wish to control the time and place of dying. Their successes were gradual as planned. Before people would accept a death model of "health" care a profound change in our moral sentiments was necessary. These transformers took charge of the language and began an education campaign to change our view on death. Passage of the Affordable Care Act greatly strengthened their cause. The harsh reality today is that, unless we are healthy and then suddenly die in our sleep, ALL of us will be impacted because these social surgeons have fundamentally transformed our healthcare system!

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## **Their Business Model of Healthcare -- think sustainability**

(Slide 02 -- Dr. Diane Meier, Director of the Center to Advance Palliative Care, speaks at Madison-Dean Initiative 3/28/11)

Do you remember that those who pressed for health care reform warned that health care spending was the primary threat to the American economy? Soon after passage of the Affordable Care Act Dr. Diane Meier, Director of the Center to Advance Palliative Care, spared no words in criticizing traditional fee-for-service care, calling it a threat to the American economy:<sup>1</sup>

*"It's not fair to expect the US government to be able to change the US's addiction to fee-for-service overnight. Those of us in medicine know you don't take an addict cold turkey ...; you have to taper, or the patient will die... It has to be a gradual process of change. And that gradual process is what's built into the health reform bill. Very gradual increases in paying people for quality, helping people to get used to working under a fixed budget, which we used to call capitation, but now we call it accountable care organizations, patient-centered medical homes and bundling strategies. Now, that was very effectively bashed both during and after health reform, as rationing and euthanasia... **but the fact remains that unless we are able to think about both quality and costs, we will become a third world nation ourselves, just because of healthcare spending.**"*

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<sup>1</sup> **"Palliative Care: A Cure for Meaningless Suffering"** featuring Diane E. Meier, MD, FACP, video at <http://www.vnacares.org/health-care-services/end-of-life-care/madison-deane-initiative>

Really? Two questions immediately come to mind. Who now is defining quality and value. Why do we need to ration healthcare expenditure anyway? Why not focus on **growing the economy** and let healthcare expenditures **grow** accordingly? Fundamental to what she says is a unique "value equation" that has become so much a part of the implementation of the ACA.

We must very carefully listen to what they say because we are dealing with gnosticism where black is white....and life is death. We must be like our forefathers who deduced that the earth was round by watching the ships disappear from the harbor. Over the last half century through legislation and policy changes we have directed healthcare spending away from medical research and high-tech medical care to programs that emphasize supportive and comfort care only by non-medicals. Slowly, by incremental change, we watched as "lifecare" has become "deathcare."

Ione Whitlock of [belburyreview.com](http://belburyreview.com) has summarized the chronology of this gradual change over the last 4 decades. The names of individuals, organizations and coalitions, together with their funding, are available at [www.lifetree.org/funding](http://www.lifetree.org/funding).

The earth-is-round issue in healthcare can only be understood by observing who is limiting "access" to traditional care -- who is encouraging us to withhold and withdraw, who is setting futility guidelines, who is advocating the generous use of opioids. These are the people who want mandated universal healthcare and rationing.

Be careful about using the phrase "natural death." Years ago, the right-to-die people elected to define it to include withholding or withdrawing food and water from patients who are not actively dying and who are in "palliative" sedation. They have co-opted the language. Decisions that were once controversial, decisions to withhold and withdraw ordinary medical treatment, are now commonly accepted.

[\(Slide 03](#) -- Leadership Circles by Ione Whitlock)

This "new" eugenics movement began several decades ago with the coming together of several groups: 1) the original euthanasia/eugenics people, 2) bioethics centers, 3) healthcare providers, 4) "grassroots" / community organizations and 5) private foundations.

The low profile movement represented by these groups has created a market for its "services." To do so it had to change minds and hearts. First, of the suppliers of healthcare -- caregivers, physicians, nurses, chaplains, social workers to name just a few --- and second, of the consumers -- the patients and their families. The objective has been about building a new system of care -- deathcare -- that controls the timing and place of death. All this while we fail to observe and analyze why the ship leaving the harbor disappears over the horizon.

The incremental system changes were given a big boost by the Affordable Care Act. Now the "social engineers" **are very close to achieving their ultimate goal which is to make their version of EOL care MANDATORY here in America while exporting "deathcare" into a One World Order.**

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## A brief history

The modern euthanasia movement in America emerged in the 1930s and was known as the Euthanasia Society of America. Euthanasia proponents sold themselves as pain relief for the dying.

Their original strategy was an attempt to secure legalization of *passive* euthanasia or the withholding and withdrawing of medical treatment as a way to change public opinion to accept *active* euthanasia, commonly known as physician assisted suicide. But there were conflicts within the movement and by 1980 there came to be two distinct wings when the more militant elements broke off.

We are all very familiar with the militants, their various organizations over the years -- Hemlock Society, Compassion and Choices, Death with Dignity -- and their successes in a few states now including California.

The moderates wear the mantle of acceptability but beware! Become educated. They have successfully distinguished themselves by claiming to be on the moral high ground above those who offer physician assisted suicide. This more nuanced wing called itself the Society for the Right to Die and then Concern for Dying in the 70s and 80s, Choice in Dying in the 90s, Partnership for Caring in the late 90s, and finally Last Acts Partnership in the early 2000s. **Then they seemed to disappear, but the evidence shows they have quietly filtered into the new field of palliative medicine...**

For fifteen years we at LifeTree have researched this Third Path Movement. In her 2005 book about Terri Schiavo *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. It is the healthcare analogy to the Fabian "Third Way" political movement in England.

These moderates insist there is a big difference between withholding and withdrawing medical treatment and giving someone access to a lethal dose of barbiturates. The more militant, on the other hand, see little or no difference. Professor Dowbiggin relates in his book *A Merciful End-- The Euthanasia Movement in Modern America* how pro-assisted suicide advocates point out the hypocrisy of those who would outlaw physician-assisted suicide, while permitting the practice of physicians drugging dying patients into comas and then removing hydration and nutrition so that the patients die of starvation and dehydration.<sup>2</sup>

What were the benchmarks in this transformation? In 1987 Dr. Josefina Magno of Washington DC and Dr. Gerald Holman, director of St. Anthony's Hospice in Amarillo, Texas called a meeting of hospice physicians in Granby, CO to form what later became known as the American Academy

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<sup>2</sup> "Conclusion: The 1990 and beyond" (Chapter 6, p. 175), *A Merciful End: The Euthanasia Movement in Modern America*, Ian Dowbiggin, Oxford University Press, 2003 which cites Humphry and Clement, Freedom to die, 190; author's telephone interview with Timothy Quill, 2001

for Hospice and Palliative Medicine (AAHPM), the professional organization for palliative physicians.

This professional group joined forces with Choice in Dying to form the RTD group Partnership for Caring.<sup>3</sup>

Dr. Ira Byock of AAHPM and Karen Kaplan of Choice in Dying described the purpose of the merger in the Partnership for Caring newsletter: "Partnership for Caring will engage in high visibility, high impact activities on both national and grassroots community levels to meet two basic goals. The first ... is to raise awareness in patients, families, and their providers -- about the kind of care that every person in this nation deserves at life's end. The second ... is to create a chorus of informed demand among consumers for improved end-of-life care that cannot be ignored."<sup>4</sup>

In other words, Partnership for Caring would conduct a major public relations campaign to gain public support and a political mandate for their Right-to-Die agenda.

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**Let's take a brief look at the early strategies, people, projects and funders of the "third path"**

Many foundations funded this low profile euthanasia movement, but two stand out because of their overall impact. The Robert Wood Johnson Foundation funded research and infrastructure and George Soros' Project on Death in America (PDIA) funded a cadre of professionals. In the last 20 years these two foundations have provided billions of dollars to advance **THEIR VERSION OF PALLIATIVE CARE into our American health care system and worldwide.**

From its beginning, the RWJ Foundation acted like a quasi-university, allowing intellectuals to test ideas with the Foundation's money. The RWJ Foundation is notorious for funding pilot projects so that it can later convince government to replicate them on a much grander scale. For a recent example, in 2002 the Foundation began funding a community coalition of healthcare pseudo "professionals" with access to healthcare records in Camden, NJ. Camden Coalition of Healthcare Providers (CCHP) is a revolutionary model to ration care for the high-utilizing patients and it is now being tested in 10 communities.

Starting in 1989, RWJ launched a six-year SUPPORT study of how 10,000 patients were cared for at the end of their lives. Dr. Joanne Lynn, who is currently Director of the Altarum Institute's Center for Elder Care and Advanced Illness (CECAI), led the study. It found that fewer than 20 percent of us had signed living wills or had other advance directives. They knew that advance care planning was a highmark prerequisite to legalizing the control of death. Getting people to codify their "goals of care" has been a major strategy for the last 20 years.

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<sup>3</sup> Partnership for Caring materials were distributed in faith-congregations including the Diocese of Raleigh in the mid-2000s at a Catholic Charities/Respect Life meeting.

<sup>4</sup> "Partnership for Caring-- The Voice for the Dying", by Karen Orloff Kaplan and Ira Byock, *Choices*, vol 7, No 4, Winter, 1998

Enter George Soros in the mid-90s and the momentum changed! His 1994 speech at Columbia Presbyterian Medical Center announcing the formation of Project on Death in America included this summary statement: "The mission of the Project is to promote a better understanding of the experiences of dying and bereavement and by doing so help transform the culture surrounding death."

(Slide 04 -- list of participants at Soros meeting in Nov. 1995)

In November of 1995 Soros called 20 foundations together who were committed to transforming the culture of dying.<sup>5</sup> In addition to officials from Soros' Project on Death in America, part of his Open Society Institute, and RWJ officials, the list of attendees include people from many other foundations ---- AARP, Commonwealth Fund, Greenwall Foundation, Mayday Fund and Kornfeld Foundation, Milbank Memorial Fund, Nathan Cummings Foundation, the Rockefeller Family Office, and the Gerbode Foundation.<sup>6</sup>

Also in 1995 RWJ began a big communications and outreach effort called Last Acts. Last Acts worked at the grassroots level. They held their first Leadership Conference in March, 1996. One hundred forty national leaders came to Washington, DC.<sup>7</sup> They produced "challenges" (objectives) and "opportunities" (tactics).

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

- Change the **education** of health care **professionals**
- Change health care **institutions** and **public policies** and the **regulatory apparatus**
- Engage the **public** to gain support

Two prominent Catholic lay people were present at this meeting. They have since become the experts who articulate the American Church's views about End of Life decision making.

Choice in Dying's Karen Kaplan had this to say about Advance Directives:<sup>8</sup>

*Advance directives are tools, like staples, shovels or irons. They are very good tools, but unless you pick them up and use them correctly, they won't work for you.*

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### **Agents of change from the top down and the bottom up ...**

They needed some bridges with two way traffic between those working on the big picture at the institution level and those advocates and activists working within communities.

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<sup>5</sup> [http://web.archive.org/web/2001062207225/http://www.soros.org/death/george\\_soros.htm](http://web.archive.org/web/2001062207225/http://www.soros.org/death/george_soros.htm)

<sup>6</sup> <http://web.archive.org/web/20070210230310/http://www2.soros.org/death/news1.htm>

<sup>7</sup> [https://web.archive.org/web/20030716044919/http://www.lastacts.org/la\\_ala/la\\_abt\\_conf-d.htm](https://web.archive.org/web/20030716044919/http://www.lastacts.org/la_ala/la_abt_conf-d.htm)

<sup>8</sup> [http://web.archive.org/web/20030521082659/http://www.lastacts.org/la\\_ala/levintro.htm](http://web.archive.org/web/20030521082659/http://www.lastacts.org/la_ala/levintro.htm)

Soros' Project on Death in America provided the physician leaders to integrate RWJ projects into mainstream medicine. 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.

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### **Their institutional engine of change was a new view of palliative medicine ...**

([Slide 05](#) -- *Newsweek* cover)

So said *Newsweek* in its cover story on October 9, 2006 titled "Fixing America's Hospital Crisis." This is what it had to say:<sup>9</sup>

"Determined people .... are transforming the way U.S. hospitals care for the most seriously ill patients. **The engine of change is palliative medicine.** "

What is this engine of change? We have identified some of the organized, determined people. Let's take a closer look at their version of palliative medicine.

([Slide06](#) -- Traditional view vs current view of palliative care )

Today's palliative care is much more than symptom management. It is a PROCESS. In the beginning palliative care applied to near death cancer patients. See the contrast between old and new pictured in a 2001 article in the *Journal of the Royal Society of Medicine*.<sup>10</sup> 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 but for those of us with multiple chronic conditions including dementia and anyone with a serious illness.

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 over traditional "curative" treatments to the point of death. Note that palliative care includes a period of managed grief and a before death period of anticipatory grief.**

**The "third path" is totally committed to "upstreaming" or changing the American healthcare system so that palliative care is integrated into traditional care early on.**

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<sup>9</sup> "Fixing America's Hospital Crisis, *Newsweek*, October 9, 2006 at <https://web.archive.org/web/20070823051240/http://www.msnbc.msn.com/id/15175919/site/newsweek/>

<sup>10</sup> See "UK strategies for palliative care" by Llorca Finlay, *J R Soc Med*, 2001; 94: 437-441 at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1282181/>

The official definition of palliative care is still a work in progress, but this much is certain. **Palliative care is critical to the success of health care reform! So if we are unhappy with the Affordable Care Act WE NEED TO UNDERSTAND PALLIATIVE CARE; several parts of ACA were written by palliative professionals.**

One of the original Soros scholars Dr. Diane Meier began the Center to Advance Palliative Care (CAPC) with Soros funding shortly after her "change of heart" speech disclaiming physician assisted suicide was reported by the NY Times. At first CAPC focused on bringing palliative inpatient units into the healthcare system. Now CAPC and their followers are training people to sustain palliative care programs across all health settings: hospitals, rehab centers, nursing homes, assisted living centers, outpatient clinics, volunteer respite caregiving and community healthcare organizations and to encompass all clinicians including the generalists.<sup>11</sup>

The CAPC-SOROS-RWJ version of palliative care is about coordination of care by an interdisciplinary team (IDT). The main members of the interdisciplinary team are physicians, nurses, social workers and chaplains. They are working hard to educate caregivers to become part of the team. More on that later.

The palliative care team helps to develop relationships. They are taught to be supportive rather than offer "real" medical services. They are taught to base their comments on the quality of life argument. They try to bring consensus that it is time to "let go"! Diane Meier describes the work of the palliative care team this way. "...a major ---if not the largest -- part of the team's work is to help patients clarify values and treatment preferences in the face of advancing illness and prognosis and in light of "realistic options" for care. The process of goal clarification requires intense, time-consuming, face-to-face conversations with patients and/or family members..."<sup>12</sup>

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## Progress to "maturity" of palliative medicine

[\(Slide 07](#) -- timeline of the steps to palliative care maturity)

The rapid rollout of palliative medicine as a board certified specialty has been nothing short of phenomenal.<sup>13</sup> From 2001 when four major palliative care organizations and RTD Partnership for Caring began to develop National Consensus Project Guidelines for Quality Palliative Care... to the first board certifying examination in hospice and palliative medicine in 2008... to a requirement that all palliative professionals have one year of fellowship training in 2012, palliative "services" have become part of regular medical "services." These social engineers created the official guidelines for

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<sup>11</sup> Their upcoming annual meeting in San Antonio in November, 2015 features a Pre-Con "community" bootcamp session the night before the main conference to teach community organizers how to be effective in this healthcare revolution.

<sup>12</sup> POLST offers next stage in honoring patient preferences", Meier, D.E. and L. Beresford, 2009, J Palliative Medicine 12(4):291-5. At present, the framework to pay for these conversations with medicare patients is being developed.

<sup>13</sup> "The Development, Status, and Future of Palliative Care" by Diane Meier (Chapter 1), *Palliative Care: Transforming the Care of Serious Illness*, March 2010 at <http://rwjf.org/files/research/4558.pdf>

the new sub-specialty, got it recognized officially by the AMA, and now require that you complete one of their fellowships before you can even sit for the board examination --- all within 12 years! <sup>14</sup>

Not only do they intend to pass legislation to subsidize specialists in palliative medicine but they intend to regulate the continuing education of the generalists so they become familiar with the palliative philosophy of care.

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**(Slide 08 -- The Value Equation)**

We hear a lot about "quality" and "value-based" care. They define value of a treatment by the value equation  $V = \text{Quality}/\text{Cost}$ . They are building the business case for palliative care.

So the bureaucrats at the National Quality Forum propose to tie payment to value. They propose to scientifically identify the value of care given by the many providers who care for individuals with multiple chronic conditions based on some sort of value equation. Can this really be done? How will they be able to link cost with quality measures? How will the bureaucrats go about defining the science of a performance measurement for quality? Can you imagine the number crunching that will be needed! Never fear.... Robert Wood Johnson is hard at work funding much of this research.<sup>15</sup>

Second, and more basic, they must define quality!

**(Slide 09 -- NQF definition of quality)**

They look to the National Quality Forum, a national membership organization created by RWJF to develop and implement national quality measures of improvement. NQF has adopted the Institute of Medicine's six quality goals.<sup>16</sup>

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

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<sup>14</sup> Clinical Practice Guidelines for Quality Palliative Care, Third Edition, National Consensus Project for Quality Palliative Care, 2013, [www.nationalconsensusproject.org](http://www.nationalconsensusproject.org). See [http://www.hpna.org/multimedia/NCP\\_Clinical\\_Practice\\_Guidelines\\_3rd\\_Edition.pdf](http://www.hpna.org/multimedia/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf). Also see <http://www.qualityforum.org> and <http://216.122.138.39/publications/reports/palliative.asp>

<sup>15</sup> Barenson, Robert A., Pronovost, Peter J., Krumholz, Harlan M. *Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues*. Robert Wood Johnson Foundation: May 2015. Available at [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf406195](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406195) (or [here](#)).

<sup>16</sup> National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org); Institute for Healthcare Improvement [www.ihl.org](http://www.ihl.org) referred to on p. 55 of "The Development, Status, and Future of Palliative Care" by Diane Meier (Chapter 1), *Palliative Care: Transforming the Care of Serious Illness*, March 2010 and Institute of Medicine (IOM), 2001), *Crossing the Quality Chasm*, Washington, D.C. National Academy Press.



- Efficient (not wasteful of health resources and patient's time and effort)

Notice that we are NOT talking about health care that is focused on protecting and preserving life, rather that which is deemed important as reflected in the 4 principles of bioethics -- autonomy, non-maleficence, beneficence and justice.

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### **Categories of health and CAPC Triggers for Palliative Care: More Tools for the Planners.**

([Slide 10](#) -- Lynn's eight categories of health)

The importance of electronic health 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. Here is a model from one of the leading Third Path gurus.

Dr. Joanne Lynn outlined eight categories of health to separate out the curable from the not curable --- 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, and 8) Long dwindling course (frailty, dementia).

In 2007, Dr. Joanne Lynn was the lead author of a Center for Medicare and Medicaid Services (CMS) article proposing a "Bridges to Health" model. That model specifically ties the six NQF bioethics quality goals to her eight patient categories and proposes that the planners 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.<sup>17</sup>

Make way for the army of planners. In one of her [www.belburyreview.com](http://www.belburyreview.com) postings, Ione Whitlock has more fully described that most of Dr. Lynn's work has been about constructing more efficient "bridges to death."

([Slide 11](#) -- CAPC Triggers)

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 illnesses.<sup>18</sup> 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. Fully integrated palliative care targets those with multi-chronic conditions, the expensive ones.

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<sup>17</sup> "Using Population Segmentation to Provide Better Health Care for All: The 'Bridges to Health' Model", by Joanne Lynn, Barry Straube, Karen Bell, Stephen Jencks, and Robert Kambic, for Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *The Milbank Quarterly*, Vol. 85, No. 2, 2007, pp. 185-208.

<sup>18</sup> <http://www.getpalliativecare.org/resources/clinicians/>

Note especially from the list,

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

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**They talk about "Patient-centered" Decision Making, but their argument is more like The Tragedy of the Commons. Whose autonomy is it anyway?**

The traditional understanding of medical decision making was based on a patient/family consultation with the specialist or general physician who was trained to "DO NO HARM". Today we hear more about informed consent and that it leads to patient-centered decision making. We hear that palliative care is about matching the care provided to what a patient wants.

However, if you read carefully what they say, the Interdisciplinary Team (IDT) is trained to find consensus based on "communitarian" ethics -- a mini-version of bioethics. Decisions are based on what is the greatest good for the community, rather than the good of the patient!<sup>19</sup>

According to the principles of communitarianism, if there are social consequences or the community suffers from allowing people to obtain the service they want, then someone has to say "NO!"

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<sup>19</sup> See Dianne Irving's "What is Bioethics?" at <http://www.all.org/learn/stem-cells/bioethics/what-is-bioethics/> for bioethicist Daniel Callahan's statement on the importance of communitarianism: "The Hastings Center's Daniel Callahan conceded in the 25th anniversary issue of The Hastings Center Report celebrating the "birth of bioethics," that the principles of bioethics simply had not worked. But not to worry, he said, we might try communitarianism now: 'The range of questions that a communitarian bioethics would pose could keep the field of bioethics well and richly occupied for at least another 25 years.'" For Callahan's quote see Daniel Callahan, "Bioethics: Private Choice and Common Good," Hastings Center Report (May-June 1994), 24:3:31

Listen to what the then president and CEO of the National Quality Forum, Dr. Christine Cassel, had to say in 2007 about managing medical resources for the **population's health, rather than the individual's health.**<sup>20</sup> (She said) "Physicians must be committed to managing medical resources. This responsibility is controversial largely because it can be seen as in conflict with the more traditional altruistic commitment of the physician to the patient..." She continues, "The fee-for-service model does not allow physicians to affect where saved resources go, so why would they try to avoid costly interventions in the name of helping other patients?..." It's the old Tragedy of the Commons argument.

In the same journal, the command to good doctors and hospitals by Rationer-in-Chief Dr. Ezekiel Emanuel is more emphatic.<sup>21</sup> He gives physicians the ultimatum: "Physician autonomy and leadership can only be affirmed if accompanied by acceptance of responsibility and accountability. Unless physicians want to be marginalized -- unless they are willing to become just another deckhand-- they must accept and affirm that they are responsible for controlling health care costs."

Stuart Altman, Professor of National Health Policy at Brandeis University, was asked at a public meeting of providers and consumer advocates in Winston Salem, "Why are we getting penalized when we take care of the patient?" Altman said, "I tell them, 'you are big, rich and powerful, and you have the ability to resolve the problem but you will be part of the solution whether you like it or not.'"<sup>22</sup>

A friend recently reminded me of Judge Robert Bork's comment in *Slouching Towards Gomorrah* where he wrote "It is ironic that our supposed 'freedom' to choose death has made it far easier for others to choose our death as the autonomy is often theirs, not ours."

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## **From Last Acts to the Coalition to Transform Advance Care! Think global!**

([Slide 12](#) -- C-TAC member organizations)

We call your attention to the new Coalition to Transform Advance Care (C-TAC) which operated "under the radar" for a couple of years starting in 2010, just after the passage of the Affordable Care Act.

C-TAC is now very much a part of the lobbying scene in Washington, DC. We will discuss their legislative agenda in more detail this afternoon.

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<sup>20</sup> "Managing Medical Resources Return to the Commons?" by Christine Cassel, MD and Troyen Brennan, MD, JD, , *Journal of the American Medical Association*, June, 13, 2007, Vol 297, No 22

<sup>21</sup> "Will Physicians Lead on Controlling Health Care Costs?" by Ezediel Emanuel, MD, PhD and Andrew Steinmetz, BA, *Journal of the American Medical Association*, July 24/31, 2013, Vol 310, No 4

<sup>22</sup> [http://www.journalnow.com/business/business\\_news/local/experts-improved-communication-can-cut-hospital-readmissions/article\\_4ec0334e-82d6-11e2-ae34-0019bb30f31a.html](http://www.journalnow.com/business/business_news/local/experts-improved-communication-can-cut-hospital-readmissions/article_4ec0334e-82d6-11e2-ae34-0019bb30f31a.html)

What happened is that the Last Acts people active in the mid 90s have come back together to form a much larger coalition. C-TAC now has over 120 members -- patient and consumer advocacy groups, health care professionals and providers, private sector stakeholders, faith-based organizations, academia, the payer community, and others. Their goal is to carry out the Last Acts agenda, manage the news media, promote new legislation to accompany the Affordable Care Act, and help community groups become part of the culture of death. C-TAC is co-chaired by former AARP president Bill Novelli and former chairman of the RTD group Partnership for Caring Tom Koutsoumpas.<sup>23</sup>

They knew that advance care planning, if done correctly, would be their main tool. As their name implies they are the Coalition to Transform Advance Care. They want advance illness planning to result in "goals of care" easily found in the **electronic health record**. Examples of these forms are the living will, the POLST form, a health care power of attorney, and an appointed surrogate for the patient.

The POLST form is their most important tool. Community facilitators are being trained in how to coax patients into making limiting choices for curative treatment on the POLST form. C-TAC wants the government to fund these discussions and to pay these "facilitators", who are often social workers. Sarah Palin called these government-paid EOL discussions "death panels." Because of the uproar, government funding for these sessions was dropped from the Affordable Care Act in order to gain passage, but they have patiently been working to bring them back. Currently the government is about to implement two new CPT reimbursement codes with which to document these discussions with a doctor or "other qualified professional."

Keep your eye on C-TAC! If you wonder about their long term aspirations, **think global!** It is not by accident that Brad Stuart, a board member of C-TAC, just returned from Rimini, Italy where he presented at the Communion and Liberation meeting in August a revealing talk titled "HEALING WHEN THERE IS NO CURE AT THE BEGINNING AND END OF LIFE."<sup>24</sup> **Note the use of the word "healing", not curing!** Healing does not mean bodily healing or preserving and protecting a person's life. Healing in the palliative care lingo means a healing of the "spirit" as defined by New Age.

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### **How to achieve a revolution -- develop a "Caring" Community!**

RWJ infused over \$200 million to develop a network across the country of interfaith volunteer caregivers. Faith in Action begun in 1983 is now the Interfaith Volunteer Caregivers Program. This program trains **community volunteers** who offer free respite care to families. They are trained in how to advise on treatment choices, become a patient advocate, and encourage organ/tissue donations. They especially work within faith-based communities so look in your Church bulletin. Here's what you might find:

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<sup>23</sup> <http://advancedcarecoalition.org/2013/03/upcoming-webinar-featuring-bill-novelli-tom-koutsoumpas-ann-monroe/>

<sup>24</sup> [http://www.meetingrimini.org/eng/default.asp?id=677&id\\_n=12079](http://www.meetingrimini.org/eng/default.asp?id=677&id_n=12079).

(Slide 13 -- Church bulletin)

Joanne Lynn calls for a Caregiving Corps, similar to the Peace Corps.<sup>25</sup>

One campaign to bolster volunteer activities and infiltrate faith-congregations is directed by Caring Connections at National Hospice and Palliative Care Organization. Their booklet called "It's about How You Live, In Faith, Community Outreach Guide" is a manual on how to partner with congregations and is designed for use by hospices and the Community-State Partnership "end-of-life" coalitions. Another booklet available on that site to help organize communities is called "The Naturally Occurring Communities (NOC) Toolkit."<sup>26</sup> John Kretzmann on the board of Gamaliel Foundation which is an Alinskyite group describes how to **organize caregivers in faith communities.**

National standards for the caregiving industry are popping up all over the place. The US Department of Labor recently mandated that "direct care" workers must be paid the minimum wage.<sup>27</sup> California is considering a law that would require all home care aides to be certified and licensed to meet government guidelines.<sup>28</sup> Will all this political activity in the caregiving industry benefit the patient? Or will the increase in the cost of regulated caregiving make families be more willing to concede to the pressures of palliative care?

(Turn off slide 13)

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### **The Third Path and Faith-Community groups Are Intertwined ...**

You may wonder what happened behind the scenes in the year before passage of the Affordable Care Act. Families USA developed by The Villers Foundation in Massachusetts and its Boston counterpart Community Catalyst helped the Obama administration get "across the finish line." In Community Catalyst Kate Villers had developed strong consumer organizations in every state which were linked into a collective and powerful voice.<sup>29</sup>

After the special election in Massachusetts which elected Scott Walker when the great momentum toward passage of ACA seemed about to stop, this important consumer health group sponsored an off-the-record call to a huge number of community activists all over the country. One can listen to Ron Pollack, Executive Director of Families USA explain a strategy to "bring health reform across the finish line" after the "week that sucked."<sup>30</sup>

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<sup>25</sup> "Caregiving Corps: Tapping a Nation of Caring People." Altarum Institute. <http://altarum.org/our-work/caregiver-corps-tapping-a-nation-of-caring-people>

<sup>26</sup> See [www.caringinfo.org](http://www.caringinfo.org). Both booklets are written by Rev. James Brooks who founded Project Compassion in Chapel Hill to train respite caregivers.

<sup>27</sup> <http://belburyreview.com/wp/new-dept-of-labor-ruling-minimum-wage-for-home-health-in-all-50-states/#.UnFhf3LD9Mw>

<sup>28</sup> [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB322](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB322)

<sup>29</sup> <http://www.communitycatalyst.org/about/our-history-impact>

<sup>30</sup> [http://sas-origin.onstreammedia.com/origin/infiniteconferencing/FamiliesUSA/Families\\_012210\\_2pmET.wa](http://sas-origin.onstreammedia.com/origin/infiniteconferencing/FamiliesUSA/Families_012210_2pmET.wa)

Alinsky had favorable relationships with the Catholic Church in Chicago. It is no surprise that faith-communities were also a major source of the momentum in those last days. In April, 2009 over 40 national religious organizations signed up to discover how they could support comprehensive health care reform. They formed the "We Believe Together -- Health Care for All (WBT)" movement. Their message was that American faith traditions support affordable health care coverage for all.<sup>31</sup>

Some of you are well aware that the Catholic Campaign for Human Development (CCHD) at the USCCB funds groups that adhere to principles which are inconsistent with Catholic Church doctrine. Sadly, it is true that CCHD is involved in the Culture of Death at End of Life as well.

The number one recipient of all CCHD grants is the Industrial Areas Foundation (IAF) which was founded by Alinsky himself. IAF is his lasting contribution to those who wish to radicalize. IAF recruits local churches and teaches how to challenge the power structure.<sup>32</sup> Catholic writer Paul Likoudis wrote that CCHD was created to be a permanent funding source for IAF. IAF spawned several faith-community groups including PICO, Gamaliel and DART.

Take one example. CCHD money goes directly to the PICO National Network.<sup>33</sup> A partial list of PICO activities makes it clear that CCHD has joined the list of private philanthropies who fund deathcare. PICO is a key partner at the C-TAC InterFaith and Diversity Workshop. PICO has ties to APPEAL, a RTD program to change the care of African Americans at End of Life, and to Rev Jeremiah Wright who was on the board of RTD Last Acts Partnership.<sup>34</sup> PICO lobbied heavily for healthcare reform.<sup>35</sup> With Robert Wood Johnson funding PICO is helping to redefine the healthcare delivery system in Camden, NJ to be used as a national model of community accountable care organizations (ACOs).<sup>36</sup>

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### **Reduce the *Gap* Between Mainstream Medicine and Community Health Services ...**

In a interview with the Center for Practical Bioethics Dr. Joanne Lynn calls for more community involvement. 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.<sup>37</sup> She is also saying that better quality healthcare means a community health workforce and fewer hospitals!

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<sup>31</sup> <http://www.discoverthenetworks.org/printgroupProfile.asp?gpid=7481>

<sup>32</sup> "The Uses of Confrontation", Rev. John Newhaus, April 2002, <http://www.firstthings.com/article/2009/-2/scandal-time-12>

<sup>33</sup> <http://www.catholicsun.org/2013/03/06/cchd-awards-800000-to-three-groups-working-on-immigration-reform/>

<sup>34</sup> Rev. Jeremiah Wright is involved with the APPEAL project. See <http://web.archive.org/web/20040610114234/http://www.appealproject.org/>

<sup>35</sup> <http://www.piconetwork.org/bringhealthreformhome>.

<sup>36</sup> <http://www.piconetwork.org/pages/0061>

<sup>37</sup> See video of Lynn's interview at the Center for Practical Bioethics at <http://www.youtube.com/watch?v=yJszGpAq1WQ>

Calling it improved quality care, the Third Path Movement is permanently restructuring the entire health care delivery and payment system. Using more community services the traditional separation between primary providers and public health professionals is eroding. The public health model will soon dominate the health scene as community-based palliative care takes over.

Section 3026 of the Affordable Care Act allocates \$500 million over 5 years to test models in the Care Transitions Program. The stated goal is to prevent hospital readmissions, prevent patients from "bouncing back." Care "managers", with transition coaching training and experience, will be paid to monitor symptoms and work on advance care planning.

Since October 1, 2012 hospitals have been taxed for readmitting certain medicare patients within 30 days of discharge. The transitions program in Akron has a social worker set to follow the patient home, often to work with a palliative care team. The Akron story is just one of the public/private partnerships the Center for Medicare and Medicaid Services (CMS) has awarded as part of the Community-Based Care Transition (CCTP) program. Over 100 CCTP grants have been awarded to partnerships among special, approved Community Based Organization (CBO) and a consortium of acute care hospitals.

It is no coincidence that Dr. Joanne Lynn and Eric Coleman had the foresight, even before the passage of the Affordable Care Act, to develop a year-long "Organizing the Health" project in Colorado to build power among communities for collective action, i.e. to help build these Community-Based Organizations who could apply for the new CCTP grants.<sup>38</sup> Interesting also that they brought in expert faith-based community organizer Marshall Ganz and two of his prodigys with connections to George Soros as they developed their models.<sup>39</sup>

These CCTP partnerships seek to standardize the way people move across care settings using a trained "Community Support Navigator" (CSN) who coaches the patient and family to make sure the patient has decided on *goals of care* (mainly a completed POLST form), and who looks for "red flags" when the patient's condition worsens so as to notify a palliative care team.

It is disturbing, yet not surprising, to find out that Catholic Charities in the Archdiocese of Chicago was approved to be the CBO for one of these grants.<sup>40</sup> Will Catholic Charities become part of our nation's network of community healthcare rationers?<sup>41</sup>

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<sup>38</sup> See Joanne Lynn's series of short videos on the Care Transitions Program Initiative at <http://www.youtube.com/watch?v=qb46VHuaJLA&list=PLBCFE9967989A6F5E>

<sup>39</sup> Ella Auchincloss and Kate Hilton helped in Colorado. Ms. Auchincloss was director of the Harvard Kennedy School's Hauser Center, a leading change network. Not so coincidentally, the new leader of Soros' Global Foundation Open Society Institute was formerly faculty director at the same center.

<sup>40</sup> <http://innovation.cms.gov/initiatives/CCTP/CCTP-Site-Summaries.html>

<sup>41</sup> In the 1980s Catholic Charities was on the bandwagon for the right to health care. See "1985 Issues of Concern," *Charities USA* 13, no 2 (February 1986): 29.

The CCTPs are paid a flat rate per beneficiary served in the target population, but the **CCTP is able to allocate funds WITHIN that population as they wish, determining who will get more services and go the hospital and who will get less and be referred to palliative care.** These CCTPs will have access to your Electronic Health Records to guide their decisions. As Dr. Joanne Lynn said, "These are organizations with CLOUT!"

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I know you have heard this one before, but Listen to how Daniel Callahan, a major "third path" proponent, described a problem back in 1983: "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 (he observed that) a "deep seated revulsion" exists over the prospect of withholding or withdrawing nutrition and hydration.

In late 1984, a story appeared in the *New York Times*. It is important because it reported how **both wings** of the right-to-die movement and emerging **bioethics think tanks** such as the Hastings Center, led by Daniel Callahan, were working **TOGETHER** to change attitudes and behavior...working to change the culture...painting the issues in terms of **compassion versus technology**.<sup>42</sup>

We have described how all of this has played out to you today in some detail.

We ask you to carefully examine the new field of palliative medicine that has a planned set of triggers to initiate an palliative care consultation, downplays the curative power of technology, gives us more federal bureaucracy with access to our electronic health records to categorize the population, employs lavish use of morphine, and times our death based upon a team-coached decision.

Palliate means to reduce violence of a disease. Palliative care used in the right hands can make the truly dying patient's experience more tolerable. Palliative care should enhance the remainder of each individual's life, not rush them to death.

If you are being offered palliative care today, the chances are that it is the (CAPC) version. The number of professionals practicing the old palliative care is in decline. Soros- and RWJ- funded people have established the guidelines and regulations for palliative care as it is officially practiced and paid for by Medicare now. Each day physicians, nurses, chaplains and social workers are being exposed to their propaganda and then required to practice it.

Today's palliative medicine has become the vehicle of those who wish to transform good, traditional healthcare into deathcare. Take heed of Isaiah's warning: "Woe to those who call evil good and good evil, who put darkness for light and light for darkness, who put bitter for sweet and sweet for bitter." (Isaiah 5:20)

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<sup>42</sup> "It's a ripple-in-the-pond effect. You've got to change attitudes and behavior, not legislation." Statement of A.J. Levinson, executive director of Concern for Dying, "Movement Seeks to Advance Rights of the Dying", *New York Times*, Dec 12, 1984



We pray that this message falls on fertile ground. We are all called to become better informed. People who want to understand will be like watchmen in the night, guarding and defending their loved ones from stealth attacks in the later chapters of life.