The Linacre Quarterly

Volume 64 | Number 4 Article 2

November 1997

"Now that Dr. Lejeune is Dead, Who Will Protect Me?" The Case for a Comprehensive Strategic Plan to Stop Assisted Suicide

Anne G. Thunder

James M. Thunder

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by

Anne G. and James M. Thunder

Mrs. Thunder, a nurse by training, has served on the boards of the Wisconsin Right to Life Political Action Committee and the School Sisters of Notre Dame (SSND) Lay Volunteer Program. Mr. Thunder also served with his wife on the board of the SSND program and has served as general counsel of Americans United for Life Legal Defense Fund. They presently reside with their children in McLean, VA.

Overview

Demographic, social, and economic trends and the fears they engender are pushing Americans up near the top of a great divide on the question of assisted suicide. One fear, larger than the rest, however, keeps us from going up and over the divide. It is the fear expressed by a man with Down syndrome to his new doctor after his previous doctor had died: "Now that Dr. Lejeune is dead, who will protect me?"[1] The death of this man's doctor, Dr. Lejeune, a pro-life protector of the disabled, left the man feeling alone and vulnerable. His fear is that of every man and woman who fears the divide's other side with its slippery slope[2] where human lives will be subjectively evaluated for their quality and no life intrinsically protected.

Based on what we have observed, those who would work to

protect innocent human life from assisted suicide need to develop a comprehensive strategic plan with goals, objectives, and measurable results. We believe that, in executing any plan, we must make clear who we are and what we stand for, but we must also address fears, real or perceived, that are driving people to assisted suicide. We believe there is an opportunity during the next two to three years to gain the upper hand. If we fail to work effectively during this window of opportunity, executing a turnaround will be exceedingly difficult.

Near the Top

The evidence that we are near the top of this great divide includes the following:

1) Michigan prosecutors have been unable to persuade a jury of our peers to convict Kevorkian, a pathologist suspended from the practice of medicine, who has participated (as of October 24, 1996) in 44 assisted suicides;

2) Two federal appeals courts, consisting of some of the most learned men and women in our land, have struck down as unconstitutional state laws forbidding assisted suicide;[3]

3) The passage by referendum of Oregon Ballot Measure 16 (also known as the Oregon Death with Dignity Act) in November, 1994;

4) Poll data showing general sympathy with assisted suicide;

5) The growth of organizations supporting euthanasia, e.g., the Hemlock Society, and increasing sales of books espousing it.

The American people have been informed about these, and other events, but by and large show no alarm. If we do not help the American people to recognize the problem and wake up, we will further constrict our ability to change the outcome.

Demographic, Social and Economic Facts & Trends

There are facts and trends and fears pushing the American people to the top of this great divide. We possess a limited ability to change the facts and trends; we have, however, the wherewithal to change the fears.

The facts and trends are demographic, social, and economic.

They include:

1) the lengthening life expectancy in America;

2) the lengthening or elimination of retirement age;

3) the "baby boomer" bulge, now aged 28 to 50;

4) the growing need for health care facilities of all types for the baby boomer generation;

5) the low birth rate in the United States (and other developed countries) and the relative and absolute growth in the population of the elderly;[4]

6) the growth in the population of widows;[5]

7) the rise in the number of elderly poor;[6]

8) the growth of retirement communities and retirement homes;[7]

9) the increasing numbers of people who die in hospitals rather than at home and, therefore, die in unfamiliar surroundings and are subject to aggressive and unwanted medical care;

10) the increasing incidence of cremations;[8]

11) the ability of modern medicine to maintain life support;

12) the growing number of people with disabilities;

13) the growing ability to detect tendencies for, or diagnose, disease or disability, especially of those having no cure (e.g., Huntington's Disease, Lou Gehrig's Disease) rendering these person's "terminally ill" years before death (indeed, before birth);

14) the increasing ability of medicine to "harvest" healthy tissue and organs, allowing some elderly and disabled people to prove their value by yielding their tissue and organs before nature takes its course;

15) the growing numbers of people in a "persistent, vegetative state";

16) the perception by some that medicine has grown "increasingly mechanistic, commercial, and soulless";[9]

17) the increasing incidence of depression and other forms of mental illness;[10]

18) increasing dependency on, and costs of, drugs;

19) the lack of medical insurance coverage;[11]

20) recognition that the financial condition of the Social Security System and of Medicare/Medicaid threatens the ability of the American people, through their government, to offer a safety net to millions of elderly, sick, and disabled citizens;[12]

21) insufficient pension and retirement funds;

22) the change to health maintenance organizations (HMOs) with its cost-cutting anonymity;[13]

23) the failures of insurers to reimburse for hospice care or for pain relief;

24) the changing attitudes of physicians toward assisted suicide.[14]

People's Fears

These facts and trends engender fears for the future. People fear:

1) loneliness and isolation in their lives, in retirement communities, retirement homes, or high-rise apartments, but especially in hospitals;

2) pain and the inability or unwillingness of medical personnel to end it;

3) that effective pain treatment necessarily hastens death or that pain relief will lead to addiction;

4) being subject to aggressive and unwanted medical care;[15]

5) loss of control over their lives;

6) the financial burden of medical care;

7) the inability or unwillingness of a diminishing number of youthful taxpayers, through the government, to care for them;

8) the financial burden of meeting their needs, not just medical, of living ever longer lives placed on themselves and their descendants;

9) the restructuring of the American health care system so that impersonal bureaucrats override medical opinion to deny necessary or wanted health care;[16]

10) the regression of the quality of their lives as they age or become disabled;

11) the devaluation of their lives as they age or become disabled.

Fears of Those Who Oppose Assisted Suicide

Many, other than potential victims of assisted suicide, fear assisted suicide. For their part, doctors and other medical personnel, especially pro-life personnel, fear having requests made of them that

they conscientiously must refuse.[17]

Pro-lifers, whether they are medical personnel or not, share the following fears:

1) How can we stop assisted suicide where most initial victims will be seriously ill and may have lived a long life when we have not stopped abortion where the victims have been largely healthy unborn children with a full life to give ahead of them?

2) When we cannot stop abortion where the victim has harmed no one and sounds and looks pure, how can we stop assisted suicide where the victim may have a history of offenses and looks old or disabled?

3) How can we stop assisted suicide where many victims are allegedly exercising their choice and actively seek death when we have not stopped abortion where the victims are not exercising choice, are silent, and do not seek death?

4) When we cannot stop abortion where the cost of pregnancy and child-rearing is finite and may result in a "payback" in the form of a taxpaying adult who will care for his or her parents, how can we stop assisted suicide where the costs of illnesses or disability mount with each passing day and cannot be paid back?

5) If we cannot stop abortion when all human beings have survived their birth and should value existence, how can we stop assisted suicide when all living human beings recognize that death is inevitable but the fact of existence after death is not a proven fact?

6) When we cannot stop abortion where pregnant women by and large go out of their homes and face pro-life vigils to obtain the abortion at a clinic, how can we stop assisted suicide where even a non-medical person can provide death services to the victim in their or the victim's home?

7) When we cannot succeed in having persons who identify themselves as Catholic declare their opposition to abortion in any greater numbers than the general population, how can we succeed in having these same people understand, appreciate, and declare their support for Catholic principles on assisted suicide?

Above all else, while there are all of the fears enumerated above pushing us up to the great divide, there is, for now, a greater countervailing fear, the fear of being killed against one's wishes by medical personnel or relatives or friends.[18] In the Netherlands,

"(c)oncern that their lives might be ended without their consent has led some to join the Dutch Patients' Association (60,000 members), a group organized by religious Protestants opposed to both euthanasia and abortion, which gets inquiries from people wanting to know if a particular hospital is 'safe'."[19] In the poignant words of the man with Down syndrome who had been a patient of Dr. Lejeune, the first president of the Pontifical Academy for Life, to his new doctor after a clinical examination, "Now that Professor Lejeune is dead, who will protect me?"[20]

Window of Opportunity

A window of opportunity to protect innocent life does exist and it exists because:

1) The Supreme Court has accepted two cases for decision by summer, 1997. On the one hand, it is not expected that the Court will find a federal constitutional prohibition of state laws allowing assisted suicide. On the other hand, it is not expected that the Court will accept the result or the rationale of either court of appeals and find a federal constitutional right to assisted suicide. Instead, it is expected that the Court will leave the question to the states.[21]

2) Few states have addressed the issue. Thus, the Supreme Court's ruling will give us room to maneuver and plan. It will be a state-by-state fight and any strategic plan should target certain states for necessary victory.

3) The practice of assisted suicide has not yet gotten a strong foothold.[22]

4) For now, the American Medical Association is opposed to assisted suicide.[23]

5) Over time, the opinions of Catholics may be expected to conform with those of the typical American,[24] as they do now with abortion.

6) As noted, American health care is being restructured. While there are numerous problems associated with this restructuring, including a market that yields incentives for providers to discourage expensive medical care and combining Catholic and non-Catholic organizations, there can be an opportunity to influence newly created organizations to act in a manner that comports with Catholic beliefs.

There is a window of opportunity, but only a window. The late Cardinal Bernardin stated, "[W]e cannot afford to wait to renew the covenant with patients and society until some indefinite time in the future. The future is about to inundate us. If we do not reset the moral compass before the flood arrives, our opportunity may be washed away."[25] Father O'Rourke, director of the Center for Health Care Ethics of St. Louis University Health Sciences Center, recently quoted French novelist Leon Bloy in a way that will be helpful here: "The great gift of the present time is that no one can afford to be lukewarm."[26]

We must not be lukewarm. But how should we be hot? We must use the time afforded by this window of opportunity to influence American public policy on assisted suicide. There appears to be general support among Catholics to engage in such outreach or community education, [27] but the Catholic population is unaware of any specific program.[28]

There are occasional statements by the bishops or single bishops. There are occasional op-ed pieces. There has been some legislation on living wills and powers of attorney. But the public's level of confusion and anxiety remains high and is increasing.

To influence American public policy, we believe that we must not focus on assisted suicide alone. We believe we must begin identifying, by articulating, the fears felt by the American people - as we have just done. Then we must address these fears before we can persuade people to oppose assisted suicide.[29]

A Strategic Plan that Includes Informing the Lay Catholic

In September, 1996, Bishop Keating, the bishop of the Diocese of Arlington, Virginia, issued a pastoral letter on courage. In this pastoral, he referred to the number of times that the Gospels recount that Jesus declared, "Be not afraid." We must identify and articulate the fears of our brothers and sisters in the Faith. Then we must address each and every one of them. We must not wait until they are at the hospital and faced with decisions about themselves or their loved ones. We must not wait until there is a referendum or an election at the state legislature. The fears they feel are real to them now and it is now, not later, that we should address their fears - informing their consciences and their opinions.[30]

We recognize that, in the final analysis, heartfelt, intimate conversation about these fears will ultimately turn to fundamental issues of character, such as:

- "What constitutes meaningful life?
- "How should I want to live in order to die well?
- "What kind of person do I want to be in the face of suffering?
- "How much suffering am I willing to bear and for what reason?
- "Do I have to be the kind of person who insists on controlling everything as the only way to find meaning and fulfillment?
- "What do I owe others in my dying?"[31]

The answers to any character issues would be difficult to evaluate, but it would seem that, at minimum, we would want our fellow believers, first, and all citizens, second, to 1) know how to identify Catholic health care institutions and personnel; 2) know how Catholic health care institutions and personnel and Catholic lawyers have addressed and are addressing their fears; and 3) know, respect and support Catholic medical ethics and therefore the ethical standards of Catholic health care institutions and personnel. In its most graphic form, all of the American people should know whether an institution and its personnel will or will not kill them, will or will not listen to their cries of pain, will or will not treat their pain, will or will not recognize depression and aggressively treat it, and will or will not abide by their advance directives.

Thus, any comprehensive strategic plan should include:

1) ensuring communication to the general public about health care ethics, pain management, and rights under the law;

2) ensuring the education of health care professionals in pain management and the ethics and law of caring for seriously or terminally ill or disabled people;

3) ensuring education of attorneys on advance directives and wills and the prosecution of mercy killers;

4) ensuring that the number of autopsies is increased, the number of hospices is increased, and respite care becomes more available;

5) polling;

6) monitoring and influencing state and federal legislation, and participating in court cases; and

7) setting measurable objectives and monitoring progress toward them.

Conclusion

We see a pressing need to respond to the fears that are driving us to the divide of assisted suicide. We have begun discussions with groups and individuals concerned about assisted suicide to ensure that there is a strategic plan to respond to these fears - a plan with a message, a plan to communicate that message, a plan to coordinate and manage that message, and a plan to test the success of that message.

We are aware that any plan must have broad support among medical personnel, including doctors, nurses, administrators, and hospice workers; the elderly and disabled and their advocates; priests and hospital chaplains; ethicists and lawyers.[32]

References

1. Marie A. Peeters, M.D., "Quo Vadis? Professor Lejeune's Legacy, *The Linacre Quarterly,* Nov. 95, 86.

2. The former abortion doctor, Bernard Nathanson, objects to the image of slope, preferring instead "a spiralling staircase descending into unfathomable depths of evil. At every step one has the opportunity to rest, to survey the moral landscape critically, to look back, to contemplate with great care the next step, and even to climb back up if the occasion warrants.", Nathanson, "Beyond Meaning", *First Things*, June/July 1995, 48,50 (a review of John J. Michaldzyk, ed., *Medicine, Ethics, and the Third Reich*).

3. The U.S. Supreme Court heard oral argument on these cases on January 8, 1997 and, as of this writing, has not yet issued its decision.

4. Many supporters of birth control and abortion sought to achieve population control. Now that the birth rate is low, and in many countries is below replacement rate, they may want to achieve "population balance" by increasing the death rate.

5. It would seem that the majority of victims of assisted suicide in the United States are older women. Nancy Osgood and Susan Eisenhandler, "Gender and Assisted and Acquiescent Suicide: A Suicidologist's Perspective", *Issues in Law & Med.*, 9 No. 4 (1994), 361. There are many reasons why this is so. Dr. Hendin, professor of

psychiatry and executive director of the American Suicide Foundation, notes one of them. He observes from his own clinical experience that "in most (suicide) pacts (between elderly husband and wife) a man who wishes to end his life coerces a woman into joining him to prove her love." Herbert Hendin, M.D., "Seduced by Death: Doctors, Patients, and the Dutch Cure", *Issues in Law & Med.,* 10, No. 2 (1994), 123, 133.

6. While the absolute numbers of elderly poor grow, we are told that the number of poor children, as a percentage of the entire population, is growing faster than the percentage of elderly poor.

7. The existence of retirement homes and communities would seem to cut both ways on this problem. On the one hand, members of retirement communities are less isolated from members of their generation; on the other hand, they are more isolated from members of other generations. In which community would deeds by doctors like Kevorkian more likely go unnoticed and engage in mischief? Could a Jim Jones-like figure persuade a retirement community to engage in mass suicide?

8. Cremation is important to the problem because it reduces or eliminates evidence of foul play.

9. Joseph Cardinal Bernardin, "Renewing the Covenant with Patients and Society", *The Linacre Quarterly*, Feb. 1996, 3,5 (address delivered to the AMA House of Delegates, Washington, D.C., Dec. 5, 1995).

10. Hendin, 167. Dr. Hendin discusses the 1993 acquittal in Assen, the Netherlands, of a psychiatrist who had assisted in the suicide of a patient, a physically healthy 50-year old woman, recently divorced, whose sons had just died. He states that it is characteristic of suicidal people to wish "to control and to make demands on life that life cannot fulfill." Ibid, 129. "Determining the time, place, and circumstances of death is the most dramatic of such demands." Ibid, 126. He observes that "The acceptance of euthanasia for psychiatric patients who are suicidal is simply bad psychiatry...Seriously suicidal patients want suicide. In a society that makes euthanasia accessible for them they will be harder to treat, not easier." Ibid, 164.

11. "Many Uninsured Struggle to Get Adequate Care, Study Concludes; Finding Contradicts Popular Belief that Needs are Met", *The Washington Post*, Oct. 23, 1996, sec. A, p. 2 (reported in JAMA).

12. We refer to citizens. The welfare and immigration laws enacted in 1996 force us to focus on the problem of providing care for legal permanent residents.

13. See, e.g., George Anders, *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (Boston: Houghton Mifflin, 1996); Burke J. Balch, "Managed Care: Will It 'Manage' Your Death?", *Nat'l Right to Life News,* Aug. 5, 1994,9. The trade association for HMOs issued a policy in December, 1996, in response to these

concerns.

14. Lee, M.D., et al, "Legalizing Assisted Suicide - Views of Physicians in Oregon", *N Eng. J. Med.* 334, Feb. 1, 1996, 310; Correspondence, "Physician-Assisted Suicide", *N. Eng. J. Med.* 335, Aug. 15, 1996, 518. While the AMA filed briefs in the Supreme Court in 1996 opposing assisted suicide, an association of medical students filed briefs *supporting* it.

15. The pro-euthanasia literature abounds in stories such as these: "The letter told of a doctor of 68 who was admitted to the hospital with advanced cancer of the stomach. An operation revealed that the liver was also affected. Another operation followed for the removal of the stomach, and there was evidence of further complications. The patient was told of his condition and, being a doctor, he fully understood. Despite increasing doses of drugs, he suffered constant pain. Ten days after the operation he collapsed with a clot in a lung artery. This was removed by another operation. When he sufficiently recovered he expressed his appreciation of the good intentions and skill of the doctor who had performed the operation. But he asked that, if he had a further collapse, no steps should be taken to prolong his life, for the pain of his cancer was now more than he should needlessly continue to endure. He wrote a note to this effect in his case records, and the staff of the hospital knew of his feelings. Two weeks later he collapsed with a heart attack, and despite his expressed wish, he was resuscitated. The same night his heart stopped again on four more occasions and each time it was restarted artificially. He lingered on for three more weeks, with violent vomiting and convulsions. A whole series of medical techniques was then employed to keep him alive. Preparations were made for using an artificial respirator but the heart stopped before this could be done." Robert N. Wennberg, *Terminal Choices* (Grand Rapids, Michigan: Eeardmans, 1989) 112 (reported in the July 1974 issue of *The Humanist*, reprinting a letter from the February 17, 1968 issue of the *British Medical Journal*).

These are the types of stories that filled Dutch Dr. van den Berg's book, according to Dr. Fenigsen. Richard Fenigsen, M.D., "Euthanasia in the Netherlands", *Issues in Law & Med. 6,* No. 3, 1990, 229. Such accounts appear in the American press. E.g., "Ohio Justices Reject Extended-Life Suit, *Washington Post*, Oct. 13, 1996, sec. A, p. 10 (when Edward H. Winter was hospitalized with heart problems in 1988 he told his doctor he did not want to be resuscitated since his wife had deteriorated after such a procedure and he did not want any extraordinary lifesaving measures. After his heart slipped into a potentially fatal rhythm, a nurse revived him with a defibrillator, steadying his heartbeat. Two days later, he suffered a stroke that paralyzed his right side. He remained incapacitated until he died two years later at age 82.).

16. See n. 13.

17. Aside from prohibiting euthanasia, another method to fulfill this societal duty is the enactment of legislation to protect medical personnel exercising their conscience. Lynn D. Wardle, "Conscience Clauses Offer Little Protection", *Health Progress,* July-Aug 1993, 79.

18. Both fears can occur in the same person in close order. Dr. Herbert Hendin wrote the following account of a doctor and her uncle in the Netherlands: "Dr. Johanna Groen-Prakken, a psychoanalyst and euthanasia advocate...told me of her concern that too many physicians were unaware of how patients' moods can fluctuate in the course of their treatment. After a colostomy necessitated by colon cancer, her own uncle, a retired physician, had been acutely depressed, stopped eating, and asked her to assist in his suicide. She told him that he could always end his life but that he should get healthy first, and she arranged to have him discharged from the hospital to a more cheerful setting in a nursing home. When she visited him in the home a few days later, he was smoking a cigar and no longer talking of suicide. Two years later his cancer had metastasized. But now her uncle, no longer wanting an assisted suicide, feared involuntary euthanasia. He was afraid his family would give him pills to hasten his death in order to collect their inheritance. His relatives assured him that they all wanted him to live. In the course of his treatment, this man had gone from wanting an immediate death to fearing that he would be deprived of the chance to die naturally." Hendin, 160-1.

19. Ibid., 161

20. Marie A. Peeters, M.D., "Quo Vadis? Professor Lejeune's Legacy", 86.

21. Until there is general agreement among the states on euthanasia, people may take state laws and policies on euthanasia into consideration in deciding where to live and certainly where to retire and die.

22. Once it does it will be harder to turn the tide. For example, in the *Casey* abortion case, the Supreme Court mentioned again and again how people had relied on the *Roe v. Wade* decision to order their lives. It is a characteristic common to those who conspire to kill the innocent and have blood on their hands. The same occurred in the Netherlands: "There is...a particular feature inherent in the euthanasia debate [in the Netherlands] that favors the suppression of contrary statements. Impartial discussion on euthanasia is only possible so long as it is purely theoretical. As soon as the first patients die by euthanasia, an editor, or any public figure who had once endorsed euthanasia, finds himself at a point of no return: he can no more afford to be wrong, lest he be held morally responsible for wrongful killings." Fenigsen, 234.

23. We say "for now" because (1) the AMA was at one time opposed to abortion; (the Hippocratic Oath did not stop the AMA from supporting abortion and it will not stop the AMA from supporting assisted suicide if it believes the circumstances warrant it); and (2) while the AMA filed briefs in 1996 before the Supreme Court opposing assisted suicide, an association of medical students filed briefs supporting it.

24. Dr. Fenigsen says that the "pro-euthanasia movement [in the Netherlands] is supported by all major Dutch political parties and by the majority of Dutch Catholics [and] Protestants..." but he does not cite sources. Fenigsen, 243.

25. Bernardin, 9.

26. The Rev. Kevin D. O'Rourke, O.P., "Making Mission Possible: A Response to Rev. Richard A. McCormick's Article on the Preservation of Catholic Hospitals", *Health Progress*, July-Aug. 1995, 45,60.

27. *E.g.*, Adam Cardinal Maida, "A Spirituality for Families for the Third Millennium", *Columbia*, Oct. 1996, 8, 9 (keynote address at the 114th Annual Supreme Council Meeting of the Knights of Columbus) ("Last month...I announce[d] that the archdiocese [of Detroit] will be working with many Catholic and non-Catholic agencies in the [Detroit] metropolitan area to offer counseling and financial assistance to people who might be contemplating an abortion or euthanasia...The response and support have been absolutely overwhelming...[A]pproximately 10 to 15 calls per day are looking for assistance, particularly in the area of euthanasia and pain management...There is a great need for education in this regard, especially as many of our Catholics have a rather naive impression that our tradition requires them to accept all pain without any palliative treatment."); Catholic Health Association's Task Force on Pain Management, "Pain Management: Theological and Ethical Principles Governing the Use of Pain Relief for Dying Patients", *Health Progress*, Jan-Feb. 1993, 30, 38 ("[K]ey strategies that will be instrumental in formulating effective responses [include:] Through community education programs, promote public education about pain, pain treatments, drug addiction, and ways to discuss pain with health care professionals for patients, their families, and the general public."); Catholic Health Association "Care of the Dying: A Catholic Perspective, Part II, Social and Political Context - Catholic Providers Must Exemplify a Caring Community", *Health Progress,* April 1993, 16, 19 (excerpts) (we must acknowledge the influence of the media and seize opportunities for public education on fundamental human and religious values; the first effort has to be directed toward educating members of the media) (our proposal does not focus on members of the media).

28. Much needs to be done. For example, Cardinal Bernardin cited the fact that one-fourth of American medical schools do not have formal courses in medical ethics. Bernardin, 8.

29. It might be useful to research how the Catholic Church in the Netherlands and Catholic medical and legal professionals responded over the last 20 years to euthanasia in that country - if only not to imitate their failure.

In our research, the only statement referring to church bodies in the Netherlands we have found relates to a very successful (in numbers sold and influence) 1969 book by Dr. Jan Hendrik van den Berg, *Medical Power and Medical Ethics*, in which he rejected traditional medical ethics' respect for life and pronounced a duty to terminate meaningless lives, including those of "defective" children. Fenigsen, 229-230. There were a number of formal statements applauding the work, including those of Protestant ministers, Protestant church authorities, and Catholic intellectuals. Ibid., 230, nn. 8-10.

30. This language combines the language of traditional Catholic morality (informing consciences) with the modern social science language of modern media (opinion polls).
If the byword in real estate is "location, location, location", then it would seem our byword must be "educate, educate, educate."

31. Rev. Richard M. Gula, "Character Witness: Walking the Talk on Euthanasia", *Health Progress*, Jan-Feb. 1995, 35, 36. The late Cardinal Bernardin taught us much when he answered these questions with his words and his example.

On these questions, permit us to repeat another example: "I remember a mother who had lost her six-year-old son. She told me that when her son was three and a half years old, he had been struck down by a paralysis of his legs which, little by little, invaded his whole body, and he became blind. Some months before he died, his mother was weeping at his side. Her little one said to her: 'Don't cry, mummy. I still have a heart to love my Mummy.'" Jean Vanier, *Man and Woman He Made Them* (New York: Paulist Press, 1985), 25.

32. One observer of the effort to defeat Oregon Ballot Measure 16 stated the importance of: 1) having a number of mainstream religious groups perceived by the public as early and strong opponents, 2) keeping the Democratic party at all levels at least as neutrals, 3) pressing the ethical dimension of the issue within religious communities and in the mainstream culture, and 4) focusing on states that are less libertarian than the Western states. J.P. Kenney, "The Suicide State", *First Things*, April 1995, 16.