**Stealth Euthanasia** 4/7/17

**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 us it has a defined history in this country going back to the Hemlock Society (1930s) and defined tactics.

See [www.lifetree.org](http://www.lifetree.org)

Euthanasia is imposed death. It is rooted in Greek: *eu* means good; *thanasia* means death. A better term is Epivalothanasia.

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

Ruled 5-0 unanimously that there is No Right to Assisted Suicide reported by [LifeNews.com](http://lifenews.com). This was a 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 Woods 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.

1. Change the education of healthcare **professionals,**
2. Change health care **institutions,** **public policies** and the **regulatory apparatus,**
3. Engage the **public** to gain support.

The first Soros scholar-led educational projects that 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. (PDIA: Problem Interactive Adaptation) Note the focus: physicians, nurses, Catholics, and African American persons. All can be identified as caring for those who are weak and vulnerable.

**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” care to traditional “curative” treatments to the point of death. Note that palliative care includes an additional 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, pastoral care workers 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 was 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](http://web.archive.org/web/20080512081253;%20http://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*](http://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=Quality/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 this is 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-malfeasance, 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 (first widely recognized as implementer of the mendacity of “brain death”) 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 that 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**](http://www.lifeguardianfoundation.org)

“The first patient that I encountered with these questions was a patient by the name of Joseph in 1975. Joseph was on a ventilator for several weeks; a brain wave test was done; it was interpreted as being “consistent with cerebral death.” I saw death on his chart and I saw Joseph. It seemed like these things…that something was seriously wrong because Joseph was not dead.

There’s a lot of different terms that are used; there’s a lot of different criteria that are 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 cut out the organs or turn off the life support.

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

**“Brain death” is fake death. “Brain death” is a mendacity. 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 after zthe 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 dioxide go up. When the carbon dioxide goes up, this makes the brain swell and makes the patient’s condition get worse. That’s known as the apnea test.** The apnea test incidentally is not a test for sleep apnea.” The apnea test is a procedure that includes taking the life supporting ventilator away for 10 minutes. The patient is suffocated for 10 minutes.

**Presumed consent of organ donation**

1. DMV-no recording of the “no”
2. “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 HIPPA-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 $1-5 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*