

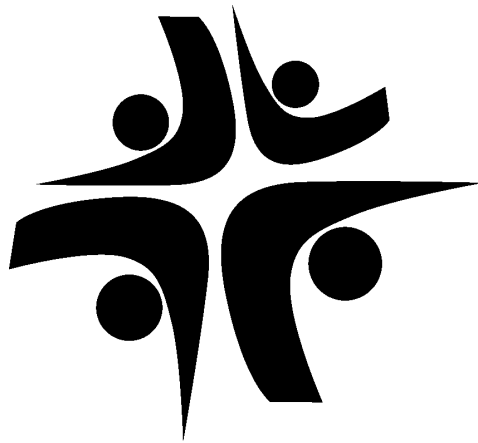
# **“NEVER AGAIN”**

**REPORT ON THE SECOND INTERNATIONAL SYMPOSIUM  
ON EUTHANASIA AND ASSISTED SUICIDE**

**Lansdowne, Virginia  
May 29-30, 2009**

**Catholic Organization for Life and Family**

**June 16, 2009**



The Second International Symposium on Euthanasia and Assisted Suicide was held near Washington DC, in Lansdowne (Virginia), on May 29-30, 2009. It was preceded by a Strategy Meeting (May 28) attended by 38 leaders of groups opposed to euthanasia and assisted suicide.

Both events were organized by Mr. Alex Schadenberg, executive director of the Euthanasia Prevention Coalition (Canada) and chair of the International Euthanasia Prevention Coalition, and co-sponsored by EPC, Not Dead Yet (USA), Physicians for Compassionate Care (Vermont), Care Not Killing (UK), No Less Human (UK), The Compassionate Health Care Network (Canada), the International Task Force on Euthanasia and Assisted Suicide Terri Schiavo Foundation (USA), ALERT (UK) and the Institute for the Study of Disability and Bioethics (USA).

During two full days, some 140 participants heard some of the most prominent experts on these critical issues and discussed among themselves the most effective arguments and strategies developed to counter the world-wide, extremely well organized, pro-euthanasia / pro-assisted suicide lobby. It soon became obvious that “our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms” (Eph. 6:12). This is truly spiritual warfare.

For an overview of the symposium, the list of speakers and their short biographical notes, please see the attached schedule (Annex 1). The following were the conference themes:

- *Where we are – The history to the present*
- *Palliative Care – Current issues*
- *The Washington I-1000 assisted suicide Initiative*
- *Recent campaigns and experiences*
- *A personal story*
- *Culture change and culture shift*
- *Euthanasia by dehydration – real stories*
- *The disability perspective*
- *The fear of suffering*
- *Working together*

Among the participants were lawyers, physicians, nurses, hospice consultants, pro-life movement representatives, university professors, specialists from the disabled community, activists, journalists, members of the clergy, diocesan representatives, students and two delegates from the pro-euthanasia/assisted suicide lobby. They also heard the personal stories of people living with disabilities or accompanying loved ones living with a disability.

This event was a privileged occasion to network with people from other countries where assisted suicide and euthanasia are already legalized. Their experience, and the knowledge of those who continue to combat reoccurring initiatives to legalize these deadly practices, will be useful to the CCCB and COLF as we elaborate effective strategies in Canada.

Reviewing all presentations would have made this report excessively long. We have instead identified some of the main ideas gathered from certain presentations and from conversations with the speakers which appear to be the most appropriate in our cultural context. For more clarity, we will present them in point-form format.

### **LATEST DEVELOPMENTS IN THE UNITED KINGDOM**

***Dr. Peter Saunders, MB, FRACS, is the General Secretary of the Christian Medical Fellowship and the Director of the Care Not Killing Alliance, United Kingdom.***

- In the United Kingdom, assisting suicide is a crime and intentionally killing is also a crime. In 2005, the Mental Capacity Act made advanced directives legally binding.
- In its February 17, 1994 Report, a House of Lords Select committee recommended:
  - No change in the law to allow euthanasia
  - Competent patients may refuse treatment
  - Development of Palliative Care Services
  - Research into pain relief and symptom control
  - Treatment-limiting decisions *not* to be determined by resource availability

Lord Walton of Detchant explained: *“We concluded that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death.”*

- Between 2003 and 2005, Lord Joffe introduced three bills. The first ran out of time; the second led to Lords' Select Committee Reports; and the third came to the vote.

- Faced with the 2006 Assisted Dying Bill, which promoted assisted suicide but not euthanasia (including nurses' involvement and worrying definitions, e.g. "terminally ill" and "unbearable suffering"), disability rights groups, professional groups, healthcare providers, pro-life groups, faith based organisations and concerned individuals got together and formed an alliance: *Care Not Killing*. It took six months to do so. The Catholic Bishops Conference, the Church of England and the Christian Medical Fellowship were involved from the beginning and provided the 12 000 pounds necessary to launch this initiative.
- Care Not Killing membership comprises 18 core organizations and 30 associate organizations. Among its core members are: ALERT, the Association for Palliative Medicine of Great Britain & Ireland, the United Kingdom Disabled People's Council, CARE, the Catholic Bishops Conference of England and Wales, the Catholic Union, the Christian Medical Fellowship, the Church of England, the Evangelical Alliance, the Heythrop Institute, the Lawyers' Christian Fellowship, LIFE, the Northern Ireland Hospice Association, RADAR and Right to Life.
- All these partners, and many more who often do not share the same views on abortion or other divisive issues, agree on three common aims:
  - Promoting more and better care (palliative care)
  - Opposing assisted dying
  - Changing public opinion

Their common strategy includes:

- A website – [www.carenotkilling.org.uk](http://www.carenotkilling.org.uk)
  - A powerful slogan – "Care Not Killing"
  - Resources – leaflets/DVDs/papers
  - Spokespeople
  - Evidence-based research
- Very careful not to use religious arguments which would marginalize its message, Care Not Killing uses secular language and the following arguments and sound bites... Euthanasia and assisted suicide are:
    - Unnecessary - Requests for euthanasia are extremely rare when patients needs are fully met – therefore we need good palliative care. You can kill the pain without killing the patient
    - Dangerous – A change in the law would place vulnerable people under pressure to request early death – therefore it should not be changed for a few persistent cases. The right to die can so easily become the duty to die.

Its spokesperson is an agnostic Labour Member of Parliament. When approached by the media, individual members use the agreed upon arguments, always referring to euthanasia and assisted suicide as public health and public safety issues. Again, from the start, Care Not Killing made the conscious decision not to use spokespeople who could be accused of being Christian or pro-life, and therefore rejected.

The Conference of Catholic Bishops of England and Wales has mobilized the faithful and encouraged them to use secular arguments in the public arena. In the parishes, of course, the Church has also taught Catholic arguments against these practices.

- Launched on January 30, 2006, Care Not Killing distributed 500,000 leaflets, 15 000 copies of the DVD “Doctors speak on assisted dying”, participated in a major public debate against Dignity in Dying, organized a petition and a major letter writing campaign to Peers and MPs, and a major media campaign (patients, doctors and disabled people spoke out against the bill; faith leaders united; demonstrations were held outside parliament and peers turned out in force to oppose the bill. It was defeated by 148-100 at second reading on May 12, 2006.
- On June 29, 2006, the British Medical Association voted overwhelmingly to oppose euthanasia: 65% against voluntary euthanasia, 65% against physician assisted suicide, and 94% against non-voluntary euthanasia.
- At the present moment, the law remains unchanged and the medical profession is united against euthanasia and assisted suicide, though public opinion polls remain in favour of a change in the law. Dignity in Dying has regrouped (12 staff and over £1million turnover) and is promoting advance refusals, more well-funded court cases and physician assisted suicide as part of “end of life care”. They are using more spokespeople and celebrity support, and promoting high profile “Dignitas” suicides.
- Care Not Killing’s strategy includes:
  - Highlighting those more extreme agendas
  - Highlighting positive role models
  - Highlighting abuses in Oregon and the Netherlands
  - Emphasizing small numbers and public safety issues
  - Lobbying within Parliament
- For the media, Care Not Killing has become the reference. It is a Limited Liability Non Charitable Company and its five directors meet every two months. Core organization representatives sit on Its Advisory Board to develop strategies.

## OREGON UPDATE – AN EROSION OF CONSCIENCE

*Dr. William Toffler, MD, is Professor of Family Medicine and National Director of Physicians for Compassionate Care in Portland (Oregon).*

A review of the status of assisted suicide in Oregon shows that

- The Oregon “model” legislation is seriously flawed (despite shroud of secrecy)
- It has had an impact on national and international events
- There has been an erosion of traditional medical ethics and trust
- Conscience protection has emerged as a critical front

An academic review of six cases (Hendin H, Foley K. Physician assisted suicide in Oregon: a medical perspective. Mich Law Rev 2009;106: 1613-45) reveals:

- The failure to ensure palliative care alternatives
- The inadequacy of “safeguards”
- An emphasis on protecting physicians
- Deviation from accepted medical practice
- Inadequate monitoring

So why say no to assisted suicide?

- It is dangerous for patients
  - *Pressures due to health care costs*
  - *Fails to protect depressed or mentally ill*
  - *Families can be left out, not notified*
  - *No oversight of quality of patient care*
- Advocates want to expand the law

Many pressures and fears are based on Health Care costs...

- Limits on healthcare spending
  - *OHP won't pay for chemo, radiation, surgery if the patient's survival is estimated less than 5 years*
  - *BUT will pay for assisted suicide as “comfort care”*
- Most expensive time of life is expendable
- Expensive life is not as “worthy”
  - *Disabled adults are concerned*
  - *Some disabled newborns euthanized in Holland*

The Founder of the Hemlock Society (now Compassion and Choice), Derek Humphry, clearly said that “*Physician-assisted Suicide and Euthanasia can help solve the problem of rising health care costs*” (12/2/1998).

Pain is not the reason for suicide according to Oregon family members. No physical symptoms were rated higher than 2 on scale of 1-5

- The most important reasons are:
  - wanting control over circumstances of death

- fear of loss of dignity
- preferring to die at home
- concerns about independence, ability for self care and quality of life

Depression is untreated...

- Depressed or mentally ill persons are considered “**competent**” unless they have an “**impaired judgment**”
- The word “capable” is used on Oregon doctor forms to describe a person who “has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating, if those persons are available”
- Mental health referrals are not required

The Oregon model has:

- Legalized a “shroud of secrecy”
  - Doctors are required to *falsify the death certificate* (Sec. 4 (l)(ii)(B)(2) by listing the underlying terminal disease as the cause of death
  - Administratively required documentation regarding compliance is collected, but the information may not be made available for inspection by the public (Sec. 15)
- Institutionalized bad medical practice where
  - Focus shifts away from relieving distress
  - There is no peer review or medical quality oversight
  - The absence of medical standards means that doctors who participate “*in good faith*” **cannot** be: disciplined for bad practice (lose their license), expelled from their job, medical organization, or business relationship, be criminally prosecuted (sent to jail) or sued for medical malpractice

So-called “death with dignity” has become death on demand:

- The right to choose death when you want it becomes the right of other people to choose for you when you are unable
- Autonomy and control by a few becomes abuse of the vulnerable many
- The plan for use in exceptional circumstances becomes death on demand and the elimination of “worthless undignified lives.”

Because the proponents of assisted suicide have been very careful, the reported evidence does not show strong empirical evidence of a slippery slope. But the Barbara Wagner story confirms the slippery slope argument... She was a 64 year old retired school bus driver and her metastatic lung cancer was back after 2 years remission. Her oncologist prescribed chemotherapy to slow cancer growth, reduce symptoms and extend her life. Barbara received a letter from the Oregon

Health Plan saying that chemotherapy was not covered, but ...assisted suicide drugs were 100% covered! (*Eugene Register-Guard*, June 3, 2008).

Choice for physicians is under attack as they are being told that exercising their right of conscience might “constitute an imposition of religious or moral beliefs on patients” (ACOG Committee on Ethics Opinion No. 385: Nov, 2007).

- The patient’s well being is paramount
- Where conscience causes physicians to “deviate from standard practice”, they must give “prior notice” to patients
- They have a duty to refer in a timely manner
- In “emergency” cases, they need to provide care regardless of their personal moral objections
- In “resource poor areas”, the law insists that “providers...should practice in proximity to individuals who do not share their view...”

### THE WASHINGTON I-1000 ASSISTED SUICIDE INITIATIVE

*Margaret Dore is an attorney in the Seattle area. She was admitted to practice in 1986 and represents clients in guardianship, probate and trust matters. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section.*

Because of her preoccupation regarding elder abuse, she has studied many pro-euthanasia and pro-assisted suicide bills and has come to the conclusion that they essentially all say the same thing. Here is the overview she presented at the symposium:

- The Death with Dignity Acts are STATUTES.
- The first issue is therefore, what do they say? Moreover, all of them say essentially the same thing:
  - They are closet euthanasia bills. The new Canadian bill (C-384) is the exception, which is upfront about being a euthanasia bill. With the American versions, you can’t call it euthanasia because euthanasia, mercy killing, etc. are defined out of the statutes.
  - The bills have relaxed competency requirements so that it’s easier to get people signed up.
  - The bills specifically allow behavior that allows a patient to be coerced by other people.
  - Liability for the actions of other people is generally illusory.
  - Once the person is signed up, no more patient consent is required despite proponents’ representations to the contrary. Patients have a right to revoke the prior request, but this is not consent. An

incompetent, sedated or sleeping patient would not have the ability to revoke a prior request.

- Overall, the statutes are a fraud and/or “choice” is a lie.
- What the statutes actually say is a weak point for proponents and therefore a STRONG POINT FOR US.
- With what the statutes say being a weak point for proponents, they like to start all sorts of distracting arguments, especially regarding religion. They also like to talk about PAIN.
- DON'T FEED THE TROLL: Bring the arguments back to what the statute says and/or other arguments that go against their “choice” argument. Do NOT talk about faith and values or the subject gets moved to faith and values. Do not respond with arguments that emphasize pain (go very light on hospice); do not use slogans that implicitly concede that DWD promotes “choice”. It doesn't.
- Conclusion: Death with dignity Acts are not about dignity and choice. They are about enabling people to pressure others to an early death or even cause it. They also encourage patients with years to live, to give up hope.

### **“CULTURE CHANGE AND CULTURE SHIFT”**

*Wesley Smith (USA) is a senior fellow at the Discovery Institute, an associate director of the International Task Force on Euthanasia and Assisted Suicide, and a special consultant for the Center for Bioethics and Culture. He left the full time practice of law in 1985 to pursue a career in writing and public advocacy. His book “Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder” (1997) has become a classic in anti-euthanasia advocacy.*

Here are some of the points he made in his presentation:

- Health has become the primary good in society today. The defining ends of society are now no longer justice, equality and mutual caring, but that no one should suffer. We have become paralyzed by the fear of suffering. When society's first goal is quality of life and making sure that no one suffers, the principles of right and wrong no longer matter. Some may decide that others' best interest is to die.
- With the collapse of moral judgment and critical thinking in society, we need to get involved to help depressed people wanting to die. We need to become once more a caring and compassionate society. We must not allow abandonment, but work to alleviate the suffering. This takes time and effort.

- The solution is hospice care and pain control. The power of palliative care, the power of love and the power of compassion are immense.
- Our role as a human race is to get a person from the “I want to die” stage to the “I’m ready to die” stage.
- People are victimized by the assisted suicide movement; they kill the sufferer and create suffering. We have a better way: LOVE and COMPASSION... BEING WITH...

### THE DISABILITY PERSPECTIVE (1)

*Diane Coleman (USA) is a person with significant disabilities and the Founder and President of “Not Dead Yet”, a grassroots disability rights organization opposing euthanasia and assisted suicide. It is a secular, single issue group.*

- The central themes and messages of this organization are that:
  - The medical system resists accountability
  - Financial constraints pose a threat in the medical system
  - Bias against people with disabilities permeate society and medical providers
  - Fear of disability drives pro-euthanasia advocacy
- A central demand of the disability rights movement is: “NOTHING ABOUT US, WITHOUT US”
- What does disability have to do with assisted suicide? The disability experience is that people who are labeled "terminal," based on a medical prediction that they will die within six months, are — or almost inevitably will become — disabled.
- “When patients ask for death to be hastened, the following areas should be explored: the adequacy of symptom control; difficulties in the patient's relationships with family, friends, and health workers; psychological disturbances, especially grief, depression, anxiety,” (Block SD; Billings JA, Patient requests to hasten death. Evaluation and management in terminal care. Archives of Internal Medicine. 154(18):2039-47, 1994 Sep 26).
- “The desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self. . . . Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: ‘I'm inconveniencing, I'm still inconveniencing other people who look after me

and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't, I wouldn't. No, I'd rather die.'

"Participants frequently used the notion of dignity to describe the experiences associated with disintegration: . . . 'You've become a bag of potatoes to be moved from spot to spot, to be rushed back and forth from the hospital, to be carried to your doctors' appointments or wheeled in a wheelchair, and it really does take away any self-worth, any dignity, or any will to continue to live.'

". . . Loss of community entailed the progressive diminishment of desire and opportunities to initiate and maintain close personal relationships, owing to loss of mobility, exclusion and alienation by others, and self-isolating actions by participants. . ." Lavery, J.M., Boyle, J., Dickens, B.M., Maclean, H., & Singer, P.A. (2001). Origins of the desire for euthanasia and assisted suicide in people with HIV-1 or AIDS: A qualitative study. *Lancet*, 358 (9279), 362-7.

- "These are quintessential disability issues, and your disability *amici* are here to say that these feelings are not inevitable, that their causes can be successfully addressed and that, most importantly, these emotions do not justify a lethal response." (from the Not Dead Yet Amicus Brief in the Montana Case).
- In 1997, the National Council on Disability (USA) issued a declaration titled "Assisted Suicide: a Disability Perspective" which was reissued in 2005. It states that "Current evidence indicates clearly that the interests of the few people who would benefit from legalizing physician-assisted suicide are heavily outweighed by the probability that any law, procedures, and standards that can be imposed to regulate physician-assisted suicide will be misapplied to unnecessarily end the lives of people with disabilities . . . . At least until such time as our society provides a comprehensive, fully-funded and operational system of assistive living services for people with disabilities, this is the only position that the National Council on Disability can, in good conscience, support."

The following excerpts from the Not Dead Yet Amicus Brief in the Montana Case illustrate more preoccupying trends...

- "Assisted suicide advocates use the term 'death with dignity' to justify assisted suicide, but when asked what 'indignities' concern them, they invariably describe the need for assistance in daily activities like bathing and toileting, and other disability realities, as reasons everyone should accept for setting up a societal double standard for who gets suicide assistance while everyone else gets suicide prevention. Like derogatory racist and sexist language, the equation of disability and indignity is anti-

disability, or 'able-ist,' thinking. Not surprisingly, these negative assumptions are sometimes shared by people whose disability status has not been life-long, but has been acquired by traumatic accidents and chronic diseases. However, people with disabilities rate our own quality of life as high or higher than the general public rates their own."

- "By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a disabled person to do so, the law assumes that the non-disabled person's life is intrinsically more valuable and worthwhile than a disabled person's life. For *amici*, perhaps no other attitude strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, surrounding barriers and prejudices do so."
- "Providing assisted suicide only for people with disabilities and denying them suicide prevention services, based on a doctor's prediction of terminal status or other justification, violates the ADA because the presence or absence of disability determines whether state and local governments:
  - enforce laws requiring health professionals to protect individuals who pose a danger to themselves;
  - respond to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities;
  - investigate and enforce abuse and neglect and homicide statutes in cases reported as assisted suicides."
- "At issue is nondisabled peoples' intense fear of becoming disabled. When a person with a disability states a desire to die, nondisabled people believe the request is reasonable because they project their own biases and believe that living with a severe disability is a life of dependency, indignity and helplessness; in short, worse than death. The wish to die is based on the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids."
- "When medical professionals and the media use phrases like 'imprisoned by her body,' 'helpless,' 'suffering needlessly,' and 'quality versus quantity of life,' purportedly in a humanistic and compassionate way, they are really expressing fear of severe disability and a very misguided condemnation, 'I could never live like that.' Society translates these emotions into a supposedly rational social policy of assisted suicide. Whenever permanent disability is [defined] as the problem, death is the solution.... [T]he wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from [the same] emotional disturbance or illogical despair [that nondisabled persons

face].” (C.J.Gill, Suicide Intervention for People With Disabilities: A Lesson in Inequality, 8 *Issues in Law & Med.* 37, 39 (1992).)

- Finally, here are things people with disabilities know that others spent millions to research about individuals and families:
  - People change their minds about what is acceptable as disease/condition progresses
  - Family members don’t consistently or correctly predict individual choices
  - Family members have conflicts of interest and project personal disappointments onto their family member
  - Lack of adequate home and community-based services is a big issue
  - Healthcare providers say things to influence/pressure individuals and families to withhold treatment
  - Healthcare providers push public policies to avoid accountability
  - Healthcare providers are not consistently accurate in predicting terminality
  - Healthcare providers devalue people with disabilities and serious health impairments

## **THE DISABILITY PERSPECTIVE (2)**

**Alison Davis** (UK) runs “No Less Human”, a group for disabled people, their families and care-givers which campaigns to achieve the right to life of all disabled people, from conception to natural death. She has spina bifida, hydrocephalus and various other disabling conditions, and uses a wheelchair full time.

Attached is her talk (Annex 2) at the Second International Symposium on Euthanasia and Assisted Suicide. The last section is particularly moving as it is her personal witness.

## **STRATEGIC THINKING**

**Rita Marker** (USA) is a practicing attorney, educator and speaker. She has been the Executive Director of the International Task Force on Euthanasia and Assisted Suicide since it began in 1987. She is the author of the critically acclaimed book “Deadly Compassion”.

**Alex Schadenberg** (Canada) is the Executive Director of the Euthanasia Prevention Coalition (Canada) and chair of the International Euthanasia Prevention Coalition.

Together, they concluded the symposium with strategic ideas, some of which are listed here and are the fruit of the experience of the proponents of life in different countries:

- The legalization of euthanasia and assisted suicide is not about autonomy, dignity and choice. It is about giving some of us the right to kill others.
- We need to effectively work together: build a coalition, get organized ahead of time and stay united on a simple issue basis. If we work apart, we will not be effective. We must be inclusive. We have a problem if we let our differences divide us. It is not wrong to disagree, but it is wrong to let ourselves be divided. We need unity in diversity.
- We must build a “social barrier” against these unjust laws which allow the killing of people. We are trying to protect people, not principles.
- We need to find “stories” – people who will witness to their choice for life, and in doing so will mobilize other people.
- Social engineering is always preceded by verbal engineering. It is important to use precise language, calling things by their name.
- We need to individualize the message, personalize the message and humanize the message. People must understand how assisted suicide and euthanasia will impact their life.
- We may not have much money and time, but we must do what we can, as little as it may be. We can be tremendously effective with very little time by
  - Writing a letter to the editor
  - Phoning a talk show
  - Suggesting speakers to the groups we belong to
  - Discussing these issues with family and friends
  - Posting our thoughts on You Tube
- We need to empower people by forming them and giving them confidence to become involved, even if they are not experts. We must be very accurate about what we know and say.
- Just like the proponents of assisted suicide and euthanasia, we need to work everyday.

## CONCLUSION

Our country is now facing a third attempt by Bloc Québécois MP Francine Lalonde to legalize euthanasia and assisted suicide: Bill C-384 (*An act to amend the Criminal Code – Right to die with dignity*). Whether it is adopted or not remains to be seen. But one thing is absolutely sure: this issue will not go away. The Canadian pro-euthanasia and pro-assisted suicide lobby is working in close collaboration with the world-wide lobby promoting these deadly practices. Until they achieve their goal, they will not rest.

In reflecting on possible conclusions that can be drawn from the Second International Symposium on Euthanasia and Assisted Suicide, it has become quite obvious that:

1. This is a social justice issue, a public health issue and a public safety issue. That should be our focus.
2. A national coalition needs to be created in Canada to counter any bill aiming to legalize assisted suicide and euthanasia. Because reinventing the wheel is never a good idea, perhaps a good look at the British *Care Not Killing* experience might be very useful.
3. We must use secular language and arguments.
4. We must carefully choose our spokespeople, so that they are not rejected as Christian or pro-life.
5. We need to identify good “stories”: people from the medical and political spheres, along with people who are ill, disabled and elderly, and have chosen life.
6. Money makes the difference between winning and losing. In Washington State, Emily’s list said it all: Early Money Is Like Yeast.

For now, COLF is preparing a Parish Kit, which will be available in electronic format only, and will include:

- A parish bulletin insert summarizing Bill C-384 and its foreseeable impact: *“Legalized Euthanasia and Assisted Suicide – What Would It Mean for You?”*
- Another parish bulletin insert proposing arguments to be used when writing to or meeting one’s MP, or the media: *“Stop Bill C-384 – Speak Up Now!”*
- A list of excerpts from Church documents called “The Church Speaks Out,” to help priests prepare their homilies on euthanasia and assisted suicide.

- The brochure entitled *“Euthanasia and Assisted Suicide: Urgent Questions”* (questions and answers)
- And the leaflet entitled *“Living, Suffering and Dying... What for?”*, on the Christian meaning of life and suffering.

The members of COLF’s Board of Directors met in June 2009 and discussed these issues. A plan to counter Bill C-384 will be brought to the attention of the CCCB over the summer.

**June 16, 2009**