

# reflections

Magazine

## A NEW WAY OF LOOKING AT LIFE

**DON'T GO THERE!  
A WARNING FROM  
THE NETHERLANDS 2**

**INSIDE  
THIS ISSUE:**



*Reflections* takes an in depth look at the issues of assisted suicide and euthanasia as they unfold across Canada.



**THE QUEBEC EXPERIENCE 7**  
**IN CONVERSATION WITH  
CHARLES LEWIS 10**



## Editor's Corner

**E**uthanasia and assisted suicide advocates have been pressing the issue of legalization of the practice for decades. I recall the Sue Rodriguez case in 1993 when the Supreme Court of Canada upheld the Criminal Code forbidding Rodriguez to die by assisted suicide.

In 2012, the battle became decidedly pronounced when the Quebec National Assembly's Select Committee on Dying with Dignity issued their recommendations for a kind of "euthanasia on demand." LifeCanada wrote extensively about this issue.

Since that Committee report, Canada has witnessed a sudden turning of the tide among media, and by extension, the general population. Quebec has led the charge.



By the time you read this Magazine, the practice of killing patients may already be realized in Canada through a Supreme Court decision in the Carter Case.

Education will be of paramount importance. We trust that our readers will make good use of this resource to assist people in understanding what is at stake in the battle to live and die with true dignity.

Sincerely for Life,

*Natalie Sonnen*

Editor, Reflections Magazine

# ASSISTED DYING: DON'T GO THERE

BY THEO BOER

**M**In 2001 the Netherlands was the first country in the world to legalize assisted dying. Safeguards were put in place to show who should qualify and doctors acting in accordance with these safeguards would not be prosecuted. Five regional review committees were installed to assess in hindsight every case and to decide whether it complied with the law. For five years after the law became effective, such physician-induced deaths remained level - and even fell in some years. Together with most of my colleagues in ethics, I concluded that there didn't need to be a slippery slope when it comes to assisted dying. A good law, in combination with the review procedure, provides the warrants for a stable and relatively low number of assisted deaths.

However, beginning in 2008, the numbers started to rise at an annual rate of 15%, year after year. Whereas the numbers were 1,882 in 2002, the annual report of the committees for 2013 recorded 4,829 cases and there are no signs of stabilization yet. In the case of cancer, euthanasia is clearly on the way to become a 'default' mode of dying. Other developments include a shift in the type of patients who receive these treatments. Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved. Some of these patients could have lived for years or decades. In 2012, under the name 'End of Life Clinic,' the Dutch Right to Die Society (NVVE) founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away. On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic.

Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting towards considering them rights, with corresponding duties on doctors to act. A new law is in the making that obliges doctors who refuse to provide assisted dying to refer their patients to a 'willing' colleague. Pressure on doctors to conform to patients' (or in some cases relatives') wishes can be intense. Pressure from relatives, in combination with a patient's concern for the wellbeing of his beloved, is in some cases an important factor behind a request. There is a serious risk that patients and their doctors, once assisted dying is made legal, will no longer seriously consider the palliative alternatives. Not even the Review Committees, despite hard and conscientious work, have been able to halt these developments.

If there is anything that can be learnt from the Dutch experience, it is that a law that legalizes assisted dying not only reflects a change in public morality, but in its turn causes such changes. For the NVVE, the Dutch law is not the end of a process, but the beginning of the next step towards a full right of every citizen to have his life terminated at his discretion. I used to be a supporter of legislation. But now, with twelve years of experience, my mind has changed. As long as we do not know where the Dutch road will end, and as long as we do not know what could have prevented the slide that we have witnessed in the past years, my advice to other countries is: don't go there.

Theo Boer is professor of health care ethics at the Theological University in Kampen and senior lecturer of ethics Protestant Theological University at Groningen. For nine years, he was a Member of a Regional Review Committee for the Dutch Government. Five such committees assess whether a euthanasia case was conducted in accordance with the Law.



Photo Credit:

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**... WE DO NOT KNOW WHERE THE DUTCH ROAD WILL END...**

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# HOW QUEBEC CITIZENS RESPOND TO A POWERFUL PRO-EUTHANASIA LOBBY



## THE QUEBEC EXPERIENCE:

It is no secret that the international lobby for legalization of euthanasia and assisted suicide has been active for many years. But it was still a shock to discover a fully-grown, well-connected and aggressive pro-euthanasia lobby in Quebec in 2009, after the College of Physicians began to advocate publicly for legal euthanasia. Most of us were only marginally involved in the public debate until then. The time had come to act, here in Quebec, and quickly.

A group of concerned Quebecers founded the citizen network *Vivre dans la Dignité* (Living with Dignity) in 2010, just before the Quebec Government's "Select Committee on the Question of Dying with Dignity" began its public hearings.

Many of our friends and colleagues gave cogent presentations before the Special Committee, demonstrating the value of life to its very end and the dangers inherent in giving doctors the right to end patients' lives, even at a patient's request. Overall 60% of submissions opposed euthanasia. The Special Committee nonetheless recommended in March 2012 not only that euthanasia, under the euphemism "medical aid in dying" become legal, but that it be part of health care for patients suffering from a serious incurable disease with no chance of improvement and meeting certain other conditions but not necessarily being terminally ill ("The Committee recommends that relevant legislation be amended to recognize medical aid in dying as appropriate end-of-life care..." excerpt from Recommendation No 13 at p. 82). This anti-democratic outcome renewed our energy to continue fighting.

Convinced that a strong medical voice against euthanasia was necessary, medical colleagues formed the *Collectif des médecins contre l'euthanasie* (Physicians' Alliance against Euthanasia) in September 2012. We wrote a declaration de-

scribing high-quality end-of-life care and the reasons why euthanasia should never be part of it. We immediately received support from many doctors, including prominent advocates for terminally ill patients, such as Dr. Balfour Mount. Our numbers grew steadily and we are now nearly 700 doctors. But in spite of all our efforts the Quebec Government was moving steadily forward toward tabling the euthanasia bill.

The Alliance and Living with Dignity multiplied their efforts: letters to the media, interviews, conferences, contacts with politicians and advertisements in the newspapers and on television. Other groups joined the battle: the *Rassemblement québécois contre l'euthanasie* organized a march in front of the Quebec National Assembly, rallying 1700 citizens of all ages. The Coalition of Physicians for Social Justice brought speakers from countries where euthanasia is legal, to explain its dangers. Our voice was being heard to some extent but this still did not prevent the Government from tabling Bill 52 in June 2013.

As drafted, the Bill aimed at legalizing euthanasia by categorizing it as health care. But a province cannot simply take a criminal act, prohibited by the Criminal Code of Canada, and call it health care to make it fall under its jurisdiction. No state and no medical association in the world consider euthanasia to be health care.

We presented our objections before the Government Committee studying the proposed law, at the same time realizing that given the political situation, the Bill was almost certain to be adopted. Along with our political lobbying we started planning our court challenge.

The next few months were one long roller-coaster ride. The Bill came close to being adopted several times. This continued through the provincial election and change of government in April 2014. The new premier, Philippe Couillard, had earlier expressed opposition to euthanasia, but his new government adopted the Bill as its second piece of legislation, on June 5, 2014. The Bill received assent a few days later, on June 10, and according to its provisions, the new Act will come into force on December 10, 2015 "or any earlier date set by the Government".

On July 17, 2014, Living with Dignity and the Physicians' Alliance against Euthanasia filed a court action before the Quebec Superior Court seeking to have all sections of Bill 52 dealing with "medical aid in dying" declared invalid as falling under the exclusive legislative federal competence over criminal law. The case is scheduled to be heard in September 2015.

What is it like for ordinary citizens to turn suddenly into political activists? It is a school of deep reflection on the human condition and the meaning of vulnerability and of caring. We have learned to speak in public and to meet influential people without worrying about how we appear, to work hard without knowing whether this particular effort will bear fruit or seem wasted, not knowing what will happen tomorrow, next week or next year. We have challenged friends, acquaintances and strangers to give time, energy and money to help defend

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vulnerable people, and have witnessed exemplary acts of generosity. We have become shameless in asking for financial support for our legal costs, knowing that we are not working for ourselves. We are frequently touched by the insistent and ongoing support of many, many Quebecers and other people who are concerned about protecting the most vulnerable among us. They inspire us to continue working and trusting that we can succeed against seemingly insurmountable odds.

Please help us: <http://vivredignite.org/en/donations/>.

Nicolas Steenhout  
Director, Living with Dignity Network

Catherine Ferrier  
President, Physicians' Alliance against Euthanasia



LIVING WITH DIGNITY



# PALLIATIVE CARE:

Care for the whole patient;  
addressing “total pain”

BY MARGARET COTTLE, MD



In the 1960's, British physician Cicely Saunders was inspired by her Christian faith to found the modern hospice movement, bringing creativity and rigorous science to end of life care. In the 1970's, Dr. Bal-four Mount from Montreal introduced hospice medicine to Canada. The name was changed to palliative care because “hospice” has a negative connotation in French. The term comes from the Latin pallium, a cloak, since palliative care seeks to cover what cannot be cured. Acceptance of palliative care grew slowly through the hard work of these visionar-ies, but the unmet needs continue to be substantial.

During the past 25 years I have been privileged to work in palliative care. Our focus is to care for the whole patient, acknowledging the family as the unit of care. We work very hard – and do a great job – in relieving pain and other symptoms in hospitals, in hospices and at home, but our treatments go well beyond physical concerns. Dr. Saun-ders coined the term “total pain” to refer to the interaction between physical, social,

psychological and spiritual factors in how we all experience pain. Patients with spir-itual distress may have physical pain that is hard to control until these issues have been addressed. A young woman thought her pelvic pain was a “curse from God”. Once our team and her pastor had reas-sured her of God's unconditional love for her, her pain was fully controlled with less medication. Familial or social issues also have an impact. A widow was restless and in pain, but her hidden anguish was for her only child, a son with a developmental disability for whom she had been caring for 40 years. Once she trusted us enough

*“In the tender compassion of our God the dawn from on high shall break upon us, To shine on those who dwell in darkness and the shadow of death, and to guide our feet into the way of peace.”*  
- Luke 1:78-9

to share this concern, we found an excellent group home for her son and our patient needed half the previous amount of medica-tion to control her pain completely.

One major frustration for Canadian palliative care profes-sionals is highlighted in the findings of the Parliamentary Com-mittee on Palliative and Compassionate Care: less than one in three Canadians has access to adequate palliative care. Almost three quarters of Canadians are suffering needlessly due to lack of resources. Another frustration is that a small group within our profession—with a misguided sense of compassion—has been supporting euthanasia and physician assisted suicide. This is very dangerous and utterly unnecessary. Do not be deceived. Patients do not need hastened death; they need excellent care and a deep understanding of their difficult situations. They need all of us to be present with them in profound solidarity. They need the resources that 70% do not have.

In fact, where euthanasia and assisted suicide is legal there has been rapid expansion and a total lack of enforcement of so-called “safeguards”. Patients with mental illnesses, early stage eye disease and even ringing in the ears (tinnitus) have been euthanized. Children and patients with dementia have also been targets, neither of whom can provide meaningful “consent”. In one study published in the Canadian Medical Association Jour-nal in June of 2010\*, the physicians who reported that they had caused the death of the patients admitted anonymously that one in every three of those patients had never given explicit consent.

Every doctor knows that it is frighteningly easy for patients to die – keeping them alive is the hard work, and caring for them respectfully and compassionately in the process is even tougher. It takes courage and hope to treat patients, especially when the outcome is far from certain. Agreeing with patients

that their lives are not worth living and helping them to die not only destroys the trust between patients and physicians, it also reveals a distinct lack of imagination. Real creativity is shown by finding ways to reach people in despair, both at the end of life and in other circumstances, and to make it clear that they matter to us, that their lives are important and that we will be with them in their troubles.

Our team members will confirm that there is a deep joy that comes from helping patients and families by relieving pain—physical, psychological, social and spiritual, and that journeying with our fellow-travelers in their dark times brings richness to the lives of everyone involved and a new appreciation for the depth of the human spirit.

Look around! The world is overflowing with evidence of the Lord's limitless creativity, His delightful imagination, His gracious provision and His loving kindness – even in difficult circumstances. He is inviting us to join Him as He cares for His children. What a privilege. Let's not miss it!

Dr. Margaret Cottle is a Palliative Care physician in Vancouver, BC. For over 25 years Dr. Cottle's practice has been exclusively dedicated to the care of dying patients and their loved ones. She is a clinical instructor at the UBC medical school where she teaches clinical skills and palliative care. She serves on the board for the Euthanasia Prevention Coalition of Canada.

\*CMAJ. 2010 Jun 15;182(9):895-901. Epub 2010 May 17. Physician assisted deaths under the euthanasia law in Belgium: a population based survey.

**Every doctor knows that it is frighteningly easy for patients to die - keeping them alive is the hard work, and caring for them respectfully and compassionately in the process is even tougher.**

*“And God is able to make all grace abound to you, so that in all things at all times, having all that you need, you will abound in every good work.”*  
- 2 Corinthians 9:8 (NIV)



# A CANADIAN CONTRADICTION:

## Preventing Suicide Among the Able-Bodied, Administering it to the Sick and Disabled

BY MARK DAVIS PICKUP

In October of 2012, Canada's Parliament gave unanimous support to the idea of a National Suicide Prevention Strategy. It's rare to get all party support on anything but it happened, to much acclaim from the media and public, including me. My gladness soon died away when I realized that the suicide prevention strategy idea was meant for suicidal healthy and able-bodied Canadians not the incurably ill or severely disabled, like me.

After more than 30 years with aggressive multiple sclerosis, let me tell you something about death with dignity: It is not an event but a process the end result of having lived with dignity. Dignity is not achieved by injecting poison into a person's bloodstream, or starving and dehydrating them to death, when they are at their lowest point. That is abandonment not dignity.

Assisted suicide is a new aberration of human liberty and dignity. For more than 700 years Common Law discouraged or punished assisted suicide. Moderns of the Brave New World of the 21st Century hold up personal autonomy as the highest right. The idea of independent personal autonomy is diametrically opposed to the concept of interdependent community. One person's actions don't affect just them. They never do. No man is an island. Words like family, community, nation, attest to our interdependence.

If I choose suicide (assisted or otherwise) it will affect my wife, my children and my grandchildren. It will affect my doctor because I will ask her to stop being a healer and become my killer. My suicide will affect my community and, in a small way, it will affect my nation by helping to entrench the notion there is such a thing as a life unworthy to be lived. No matter how sick I may yet become I still have a responsibility to the Common Good of society and posterity. I have a right to expect the best palliative care available and those things that foster life with dignity, even at its end.

Euthanasia and assisted suicide lobbyists say Canada's laws against assisted suicide are discriminatory against the incurably sick and disabled because they are denied the ability to commit suicide like able-bodied Canadians. That argument is deeply flawed and I suspect it hides an anti-disability prejudice. Just because someone can commit suicide does not mean they have a right to do it. There is no "right" to suicide in Canada. If there was a right to suicide, why would Canada's Parliament



unanimously support the idea of a National Suicide Prevention Strategy as they did in 2012?

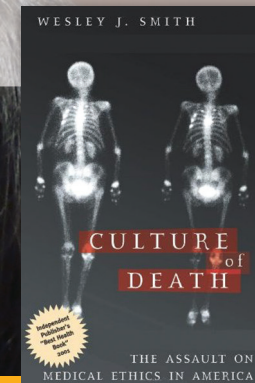
I dream of a return to a life-affirming nation not a life-denying nation. Perhaps I am naïve: I still believe Canada can turn its course to protect and embrace all who have sunk beneath the waves of their circumstances and have become suicidal. That is what civilized societies do.

Mark Davis Pickup is a disability rights advocate and popular blogger at Human Life Matters: [www.humanlifematters.org](http://www.humanlifematters.org). He has been married to his wife of 41 years. They have two children and five grandchildren.

## THE READING CORNER

LifeCanada recommends the following books and papers to help our readers deepen their knowledge and understanding of this important international issue.

Contact us if you have other recommended reading at [info@lifecanada.org](mailto:info@lifecanada.org).

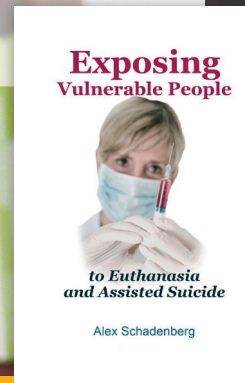


**CULTURE OF DEATH:  
THE ASSAULT ON MEDICAL  
ETHICS IN AMERICA**

By Wesley J. Smith  
Illustrated by real-life stories, Wesley J. Smith explains in his ground-breaking book, *Culture of Death: The Assault on Medical Ethics in America* that American medicine "is changing from a system based on the sanctity of human life into a starkly utilitarian model in which the medically defenseless are seen as having not just a 'right' but a 'duty' to die.

Smith's *Culture of Death*, a warning about the dangers of the modern bioethics movement, was named one of the Ten Outstanding Books of the Year and Best Health Book of the Year for 2001 (Independent Publisher Book Awards).

Available at [www.amazon.com](http://www.amazon.com)

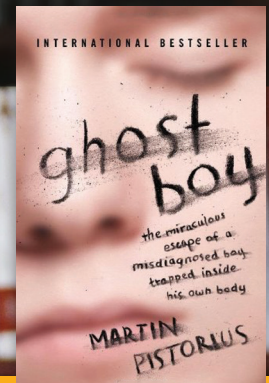


**EXPOSING VULNERABLE PEOPLE  
TO EUTHANASIA AND ASSISTED  
SUICIDE**

By Alex Schadenberg,  
RANDOM HOUSE | 2002

Published in 2013, this book examines the data concerning involuntary euthanasia deaths and the experience of nurses with euthanasia in Belgium. It exposes how false reports are being used in other jurisdictions to support the legalization of euthanasia and assisted suicide.

Of special interest is an exposé of how Justice Smith in the Carter case in British Columbia "avoided the truth in order to establish false and dangerous recommendations for the legalization of euthanasia and assisted suicide in Canada" and how the Quebec Commission on Dying with Dignity 2012 report may purposefully ignore key studies.



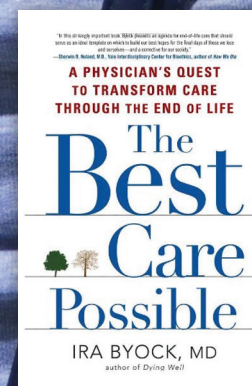
**GHOST BOY**

By Martin Pistorius  
[www.ghostboybook.com](http://www.ghostboybook.com)

In January 1988 Martin Pistorius, aged twelve, fell inexplicably sick. Martin's parents were told an unknown degenerative disease had left him in a "vegetative state."

Ghost Boy is the heart-wrenching story of one boy's return to life 12 years later, through the power of love and faith. In these pages, readers see a parent's resilience, the consequences of misdiagnosis, abuse at the hands of cruel caretakers, and the unthinkable duration of Martin's mental alertness betrayed by his lifeless body.

Martin's emergence from his own darkness invites us to celebrate our own lives and fight for a better life for others.



**THE BEST CARE POSSIBLE**

by Ira Byock, MD

Dr. Ira Byock, one of the foremost palliative-care physicians in the US, argues that end-of-life care is among the biggest national crises facing us today.

He puts a human face on the issues by telling richly moving, heart-wrenching, and uplifting stories of real people during the most difficult moments in their lives. It is a compelling meditation on medicine and ethics told through page-turning, life or death medical drama. It is passionate and timely, and it has the power to lead a new kind of national conversation.



## SPEAKING WITH CHARLES LEWIS

## 1. How did you first get involved in this issue?

Before covering religion for the National Post I was opposed to legalized assisted suicide but didn't think much of it. As a reporter I got interested in the issue so I was able to probe more deeply. What I learned was horrifying. Holland and Belgium originally legalized euthanasia as a way to end the awful suffering of those at death's door. But it eventually morphed into dispatching those who had depression, chronic pain or who felt they had lost their quality of life. In Belgium there is no longer a minimum age. In Holland if a doctor won't kill you, death vans can be dispatched for your convenience.

Because of my own illness I can no longer hike or cycle and what used to take a few hours to write can take days. But I would hate to think my life was so devoid of meaning that I would kill myself because I couldn't cycle. Being sick takes creativity and heart. It means finding other ways to enjoy life.

Now we have Quebec's Bill 52 enacted into law. It purports to be safe and only for those in terrible pain and at death's door. Anyone who says otherwise is accused of fear mongering. Yet I've met bio-ethicists and lawyers who say the wording as it stands now can be interpreted in a much broader way to encompass many more people. But don't take their word for it: Before the bill was passed in the spring, the Quebec College of Physicians and Surgeons admitted that when Quebecers get used to legalized euthanasia, the bill will have to be expanded to reach more people with more ailments and at an even younger age. I have yet to read a pro-euthanasia editorial that acknowledges what the College itself has said.

BEING SICK  
TAKES  
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AND HEART.  
IT MEANS  
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## 2. What is the danger to the rest of the country?

Quebec says it hasn't broken the Criminal Code with the passage of Bill 52. It says that ending people's lives for compassionate reasons is a health care matter and health care is controlled by the province and therefore the Criminal Code ban gets in the way of what is a provincial prerogative. To date, the federal government has not challenged Quebec, and I don't believe other provinces have pushed for Ottawa to take on Quebec either. Let's face it, 70% of Canadian say they're in favor of some form of state-sanctioned suicide. It's not a long stretch to say politicians may not want to get in the way of something so popular.

Right now, Quebec is putting together procedures for how Bill 52 will work practically. My fear is that by then voters in other provinces will start to push their provincial governments to follow Quebec.

And then there is the Carter Case that was heard in the Supreme Court of Canada. There is a strong chance the court will say that bans on assisted suicide and euthanasia are unconstitutional. **At that point, the nightmare will begin.**

## 3. You mentioned to me that the use of language can mislead people. Give us some examples.

You'll notice that supporters of state-sanctioned suicide rarely ever call it suicide or killing, even though that's exactly what it is. They call it "compassionate care," or "medical aid in dying" or "death with dignity." I once asked an official in Oregon, in charge of their assisted suicide regime, and he said they don't use the word "suicide" because it has too many negative connotations. "Foolish me," I thought.

## 4. There were also personal reasons for your opposition, correct?

In December 2011, I was heading out the door for a birthday lunch when this pain hit me that felt like I was being stabbed in the back. That started an odyssey that continues to this day. A year after this started I had surgery to repair my spine. It helped but didn't do what I had hoped. I'm still on morphine, with its nasty side effects, and I have had to give up many of the activities I once loved, including writing about religion for the National Post.

I'm not saying any of this to prove how tough I am but to explain that this is not a theory to me.

And I was relatively lucky. We have our home paid off and we have no debts. I have good insurance and my wife has a good job. She has been compassionate and we have gone through this together. I'm also a devout Catholic and that is a blessing. What I worry about is that many people without that kind of security may say it's time to check out because the pressure is too much.

## 5. What can the ordinary Canadian do?

What Canadians can do is to start writing letters. It's a simple act and with e-mail you don't even have to lick envelopes. Keep what you write and send them again every week or so. Write to the Prime Minister, his ministers, your MP. Write to religious leaders like local bishops. Encourage more and better palliative care and pain management. This is crucial moment in our history. Later you could either say, "I did everything to stop it" or you could say, "I was busy watching reruns that night on TV."

Charlie Lewis was a journalist for 33 years, including seven years as religion reporter and editor of the paper's religion blog, Holy Post. He retired last year due to illness.

EUTHANASIA  
IN CANADA:  
WHAT CAN YOU DO?

LifeCanada has put together a page of resources covering this important issue. It comes complete in both French and English, with templates of letters to your Member of Parliament, explanations of the Quebec situation, our eleven question Abingdon Research poll, and several relevant articles.

Also included is a "talking points" page that helps you formulate quick and easy arguments to use in discussions with others.

Euthanasia and PAS are important issues that require your immediate attention.

Go to  
<http://www.lifecanada.org/ea>  
for LifeCanada's euthanasia and PAS resource page





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LifeCanada provides several ways in which individuals can help us raise funds without spending a penny of their own money.



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You can participate in our Real Estate for Life Program. Before you or someone you know buys or sells a house, contact us to find out how 75% of the referral fee can be donated to LifeCanada.



Consider making LifeCanada a beneficiary of your estate or of a life insurance policy. Leave a legacy of life that will help us to continue in our valuable educational work. Contact us for more information.

# Thank you

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In the coming months, LifeCanada will launch one of our biggest and most wide-reaching projects ever. Stay tuned for details.

*Thank you for your generous support.*

