Sample Letter: Bill C-41

Make your voice heard—write to your Member of Parliament

Join the CCCB's letter-writing campaign to ask your MP to:

- Keep the mental-illness exclusion in place through separate legislation.
- Remove the advance-request provisions from Bill C-41.

Personalize and send your letter using the CCCB template. Given time constraints, we encourage you to **send your communication by email** but it can also be sent by post. Find your MP's contact information.

Subject: Bill C-41 Medical Assistance in Dying Safeguards Act

Dear *[MP's name]*,

As a constituent, I am writing about Bill C-41, the *Medical Assistance in Dying Safeguards Act*. Please support maintaining the exclusion from euthanasia and assisted suicide where mental illness is the sole underlying medical condition, and oppose the expansion of euthanasia through advance requests.

The bill combines these two very different measures. Please work to separate them so that Parliament can maintain the mental illness exclusion without legalizing advance requests for euthanasia.

The government had planned to allow euthanasia for mental illness alone. Following sustained examination of evidence from experts and people directly affected, a joint parliamentary committee recommended retaining the exclusion indefinitely. Advance requests, however, have not received the same sustained, wide-ranging federal scrutiny. Please insist on an equally thorough examination of the evidence. Parliament must be willing to confront the reasons for rejecting this expansion, rather than assuming that safeguards can make advance requests acceptable.

An advance request would allow euthanasia after a person has lost the capacity to understand and reconsider that decision. What someone fears about future illness may differ from how they experience it. Memory loss and dependence do not diminish a person's dignity or necessarily make life unbearable.

An advance request would also leave others to determine whether the circumstances it describes have arisen and to interpret the person's expressions or behaviour. These are profound

responsibilities for practitioners, families, and caregivers. Beyond the possibility of mistakes, an earlier request can never make deliberately ending a person's life morally acceptable.

People facing illness need confidence that they will receive care and will not be abandoned. Please advocate for better access to geriatric care, home and community support, suitable accommodation, caregiver respite, and palliative care. These services cannot remove every hardship, but no one should feel driven towards euthanasia because adequate care is unavailable. Euthanasia cannot substitute for that care.

I therefore ask you to:

- Support separating the two measures in Bill C-41.
- Support maintaining the exclusion where mental illness is the sole underlying medical condition.
- Oppose the advance request provisions and advocate for care that upholds the dignity of people living with illness or disability.

These requests do not depend on agreement about euthanasia as a whole. I oppose euthanasia and assisted suicide, but people with different convictions can share the concerns raised here and support measures that prevent further expansion.

Thank you for considering my concerns and for your service to our community. I would appreciate a response explaining your position and the steps you intend to take.

Sincerely,

[Full name]
[Street address]
[City, province, postal code]

Canadian Conference of Catholic Bishops

Advance Requests for Euthanasia

What Catholics Need to Know About Bill C-41

What our faith asks of us

Every person possesses dignity simply by being a unique person created in the image and likeness of God. Illness, memory loss, and dependence do not diminish it. The Church opposes euthanasia and assisted suicide. Following Christ and a long Christian tradition of care, we are called to accompany people who are sick, frail, or marginalized. Caring for a person can never include deliberately ending their life.

Mental illness exclusion and advance requests for euthanasia

Canadian law calls euthanasia and assisted suicide "medical assistance in dying" (MAID).

Canadians have reason to be worried about Bill C-41, the *Medical Assistance in Dying Safeguards Act*. The bill would keep the exclusion where mental illness is a person's only underlying medical condition. That is welcome. But it would also allow euthanasia through advance requests after a person can no longer understand or reconsider their decision.

Unless Parliament acts, euthanasia for mental illness alone will become legal on 17 March 2027. Bill C-41 would prevent this expansion, as a parliamentary committee recommended after extensive consultation with experts and those affected. But the same bill would also allow advance requests for euthanasia—a separate expansion with no corresponding deadline and so far without the same sustained, wide-ranging federal scrutiny.

Parliament should separate the two measures. The urgency of preventing one expansion must not become a reason to rush another.

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How advance requests for euthanasia would work

Under Bill C-41, an advance request would involve two stages:

1. A person with a serious, incurable illness expected to cause loss of decision-making capacity, such as Alzheimer's disease, signs a request while still able to make informed decisions. It describes the circumstances in which they would want euthanasia after losing that capacity.
2. Euthanasia could take place years later. The person would no longer be able to reconsider the request in light of their actual experience.

Other reasons why advance requests for euthanasia should be rejected

Some people support advance requests because they fear future dependence. Yet research and clinical experience show that memory loss or dependence does not necessarily mean that a person finds their life unbearable. What someone fears beforehand may differ from how they experience life with illness.

An earlier request is not the same as informed consent at the time euthanasia takes place. Doctors and nurse practitioners would have to assess suffering and interpret the request and the person's responses. Families and caregivers may be asked to help determine whether the conditions for ending their loved one's life have been met. An earlier request can never make deliberately ending a person's life morally acceptable.

Fundamental objections cannot be resolved by safeguards

The proposed expansion of euthanasia for mental illness alone underwent sustained expert and parliamentary reviews. The legalization of advance requests has not undergone the same level of detailed federal review. People facing loss of decision-making capacity deserve equally careful attention to their safety and well-being.

Advance requests would not be limited to people near death. They would allow euthanasia when the person is not at the end of life and can no longer make an informed choice. Parliament must confront the reasons for rejecting this expansion, rather than assume safeguards can make it acceptable.

In 2025, the UN Committee on the Rights of Persons with Disabilities urged Canada not to expand euthanasia through advance requests.

What this means in Quebec

Euthanasia following an advance request already takes place in Quebec under provincial law. Quebec's prosecution service has a policy against criminal prosecution when specified conditions are met. Bill C-41 would expressly change federal criminal law to permit this practice. Catholics in Quebec should also speak out. Anyone who has witnessed problems can share their concerns with their MP while respecting patients' privacy.

Refusing overly burdensome treatment

The Church teaches that a person may refuse treatment when its burdens are disproportionate to its expected benefits. The intention must be to forgo that treatment, not to cause death. An advance directive refusing such treatment is not an advance request for euthanasia. Ordinary care remains due, including food and fluids while these remain beneficial and do not impose excessive burdens on the patient.

Care that people can count on

The response to fear and suffering must be care and accompaniment:

- Appropriate treatment, including geriatric care for older people's health needs.
- Help at home, suitable housing, and practical support and respite for caregivers.
- Palliative care provided as soon as it is needed, rather than only in the final weeks of life, to relieve pain and other forms of suffering and to address the emotional, social, and spiritual needs of those who are ill or dying.

Families and parishes can offer companionship and spiritual support. No one should be made to feel that dependence makes them a burden or their life less worthy of protection.



Further reading:

cccb.ca/billc41

What you can do now

- **Pray** for people who are ill, those who care for them, and for an end to euthanasia in our country. Consider fasting as your health permits.

- **Share this fact sheet** and encourage respectful discussion in your parish and community.

- **Make your voice heard—write to your Member of Parliament.**

  Join the CCCB's letter-writing campaign to ask your MP to:

  - Keep the mental-illness exclusion in place through separate legislation.
  - Remove the advance-request provisions from Bill C-41.

Personalize and send your letter using the CCCB template.

- **Help build a community in which people can count on one another.**

  Visit people who are sick or frail, and support their caregivers. These works of mercy bear witness to Christ's love and affirm that everyone deserves care and companionship until natural death.

The Canadian Conference of Catholic Bishops (CCCB) brings together Canada's Catholic bishops to address matters of shared pastoral concern and contribute to public life in the light of the Gospel.

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Advance Requests for Euthanasia (called MAID)

Parliamentary Brief on Bill C-41

Canadian Conference of Catholic Bishops

This parliamentary brief presents the response of the Canadian Conference of Catholic Bishops (CCCB) to Bill C-41, the *Medical Assistance in Dying Safeguards Act*, which the government introduced on 27 October 2026.[1]

"Medical assistance in dying" (MAID) includes both "voluntary euthanasia" (the administration by a physician or nurse practitioner of a substance that will cause a person's death at that person's request) and "assisted suicide" (the prescription or provision by a physician or nurse practitioner of medication that a person could self-administer to cause their own death).[2] Bill C- 41 focuses on advance requests for euthanasia (referred to in shorthand by some erroneously as Advanced Medical Directives or AMD)[3] made after diagnosis of a serious and incurable illness or disease that is expected to cause irreversible loss of capacity to consent to euthanasia. Such requests could be acted on after the person has lost capacity, potentially years later.

If enacted, Bill C-41 would decriminalize euthanasia by advance request in certain circumstances if administered in a Province that has enacted legislation to create a repository for requests.[4] The proposed route therefore depends on enabling provincial or territorial legislation.

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1 Bill C-41, *Medical Assistance in Dying Safeguards Act*, 1st sess., 45th Parl., first reading October 27, 2026 (hereafter "**Bill C-41**"), cl. 5 (proposed *Criminal Code* subsecs. 241.21(1), (2)(b), (8)(d), and (10)), https://www.parl.ca/DocumentViewer/en/45-1/bill/C-41/first-reading. References to Bill C-41 below are to its first-reading text; its proposed provisions are not yet enacted law.

2 Department of Justice Canada, *Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, June 2016, "Part 1," "Part II," "Definitions," https://justice.canada.ca/eng/rp-pr/other-autre/adra-amsr/p2.html.

3 In Quebec, advanced medical directives and advance requests for euthanasia are governed by distinct statutory provisions; the concepts are not interchangeable. Gouvernement du Québec, "Requirements to Issue Advance Medical Directives," last modified March 8, 2019, under "Clinical Situations Covered" and "Treatments Covered," https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/advance-medical-directives/requirements; "Advance Request for Medical Aid in Dying," accessed October 27, 2026, https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/medical-aid-in-dying/advance-request-medical-aid-dying.

4 Bill C-41, cl. 5 (proposed *Criminal Code* subsec. 241.21(10)).

Bill C-41 would also extend the existing prohibition on MAID where mental illness is the sole underlying medical condition,[5] which is otherwise scheduled to expire on 17 March 2027.[6] This aligns with recent guidance from the UN Committee on the Rights of Persons with Disabilities.[7]

In 2025, the UN Committee on the Rights of Persons with Disabilities recommended that the Canadian government maintain the mental illness exclusion and reject proposals to allow advance requests for MAID.[8] Consistent with UN policy guidance, the CCCB recommends that the advance-request for euthanasia provisions be removed from Bill C-41 and the mental illness exclusion be advanced independently.[9]

Further diligence regarding advance requests is required. This issue requires parliamentarians to carefully examine the evidence and hear from affected persons and relevant experts, without treating acceptance of advance requests as a foregone conclusion. To that end, the CCCB asks that Bill C-41 be split into two separate parts, with the first part on the mental illness exclusion voted upon prior to the March 17, 2027 deadline, and the second part on advance requests for euthanasia voted upon separately after adequate study and debate. Addressing the two measures separately would allow Parliament to maintain the mental illness exclusion without rushing its examination of the distinct ethical, clinical, and legal questions raised by advance requests for euthanasia. There is no principled reason to hold a single vote on these two separate issues.

The CCCB also calls for greater investment in the care and support needs of people facing illness and loss of independence. These practical measures are essential, but neither their provision nor procedural safeguards to MAID provision would resolve the CCCB's moral objection to intentionally ending human life.

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5 Bill C-41, cl. 4(2) and 5 (proposed *Criminal Code* subsec. 241.2(2.1), and 241.21(9)). The subsections provide that persons cannot meet the three requirements of a grievous and irremedial medical condition "on the basis of a mental illness" Another condition must independently satisfy the requirements of being serious and incurable, such that the person is in an advance state of irreversible decline in capability, and which causes them enduring physical pain or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

6 *An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2*, S.C. 2024, c. 1, s. 1, https://laws.justice.gc.ca/eng/AnnualStatutes/2024_1/page-1.html.

7 Committee on the Rights of Persons with Disabilities, "Concluding Observations on the Combined Second and Third Periodic Reports of Canada," Convention on the Rights of Persons with Disabilities (CRPD/C/CAN/CO/2-3), April 15, 2025 (hereafter "**UN Observations**"), paras. 19(d) and 20(a), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FCAN%2FCO%2F2-3&Lang=en.

8 UN Observations, paras. 19(d) and 20(a)–(b).

9 The statutory deadline of 17 March 2027 applies only to the exclusion of mental illness from MAID eligibility; it does not impose any obligation or deadline on Parliament to authorize advance requests.

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The issue addressed here is euthanasia assessments and provision after loss of decision-making capacity, rather than advance medical directives, which specify the medical treatments a person wishes to receive or refuse if they lose decision-making capacity,[10] or assisted suicide, in which the person self-administers a substance that causes their death.[11] The CCCB's opposition applies to both assisted suicide and euthanasia but not advance medical directives. While Canadian law continues to permit euthanasia and assisted suicide under certain circumstances, the CCCB advocates for measures that limit their harm and prevent further expansion. Its support for maintaining the mental-illness exclusion must also be understood in that light.[12] Although much of the research discussed here concerns dementia, the ethical questions raised by advance requests for euthanasia extend to other conditions involving loss of decision-making capacity.

These considerations draw on Catholic moral and social teaching,[13] together with other sources including Health Canada's 2025 national conversation, clinical studies, philosophical and bioethical scholarship, Canadian law, and Quebec's framework for advance requests. This brief also benefited from review by physicians, other health-care professionals, ethicists, and legal experts. Responsibility for the positions expressed herein nevertheless remains with the CCCB. Catholic moral reflection appeals to reason and to the goods of human life shared by all. Its concerns are therefore offered for public examination, not as claims dependent solely on religious belief.[14]

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10 Gouvernement du Québec, "Requirements to Issue Advance Medical Directives," last modified March 8, 2019, under "Clinical Situations Covered" and "Treatments Covered," https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/advance-medical-directives/requirements.

11 *Criminal Code*, R.S.C. 1985, c. C-46 (hereafter "***Criminal Code***"), s. 241.1, https://laws-lois.justice.gc.ca/eng/acts/C-46/section-241.1.html; The *Criminal Code* permits both practitioner administration and self-administration. Bill C-41, cl. 5, proposed subsec. 241.21(15), expressly limits provision under an advance request to practitioner administration; Health Canada reports that all cases of MAID in 2024 involved practitioner administration (Health Canada, *Sixth Annual Report on Medical Assistance in Dying in Canada*, November 2025, sec. 2.2, https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2024.html).

12 Canadian Conference of Catholic Bishops, Permanent Council, *Statement by the Permanent Council in Support of Bill C-218: "An Act to amend the Criminal Code (Medical Assistance in Dying),"* February 4, 2026, 1, https://www.cccb.ca/wp-content/uploads/2026/02/2026-02-04-Statement-by-CCCB-PC-Support-of-Bill-C-218.pdf.

13 *Catechism of the Catholic Church*, nos. 2276–2279, https://www.vatican.va/content/catechism/en/part_three/section_two/chapter_two/article_5/i_respect_for_human_life.html; Pontifical Council for Justice and Peace, Compendium of the Social Doctrine of the Church (Vatican City: Libreria Editrice Vaticana, 2004), no. 155, https://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_compendio-dott-soc_en.html; Congregation for the Doctrine of the Faith, *Samaritanus bonus: On the Care of Persons in the Critical and Terminal Phases of Life*, July 14, 2020, secs. V.1 and V.4, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html; Dicastery for the Doctrine of the Faith, *Dignitas infinita: On Human Dignity,* April 2, 2024, nos. 51–52, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_ddf_doc_20240402_dignitas-infinita_en.html.

14 Cf. Leo XIV, *Magnifica humanitas*, encyclical letter, May 15, 2026, no. 56, https://www.vatican.va/content/leo-xiv/en/encyclicals/documents/20260515-magnifica-humanitas.html.

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The thirteen considerations below are grouped into five parts:

I. Legislative boundaries and equal protection
II. Interpreting advance requests after capacity is lost
III. Understanding suffering and ensuring appropriate care
IV. Ethical distinctions and responsibilities of care
V. Evidence and parliamentary scrutiny

I. Legislative boundaries and equal protection

In 2015, the Supreme Court of Canada declared *Criminal Code* provisions prohibiting access to MAID to be unconstitutional.[15] In response, Parliament amended the *Criminal Code* to allow MAID to be administered by physicians and nurse practitioners to eligible adults suffering from a grievous and irremediable medical condition where natural death was reasonably foreseeable.[16]

In 2019, the Superior Court of Quebec decided *Truchon c Procureur général du Canada*, which declared federal and provincial provisions restricting MAID to persons "at the end of life" or whose natural death was reasonably foreseeable to be unconstitutional.[17] The Court in *Truchon* expressly declined to decide issues related to expanding euthanasia to allow advance requests.[18]

Neither the Attorney General of Canada nor the Attorney General of Quebec appealed the *Truchon* decision. Instead, Parliament responded by amending the *Criminal Code* in 2021 to broaden MAID eligibility requirements, including by removing the requirement that a person's natural death be reasonably foreseeable.[19] The amendments also prevented persons whose sole medical condition is a mental disorder from accessing MAID (known as the mental illness exclusion).[20] The mental

15 *Carter v. Canada (Attorney General),* 2015 SCC 5 at para. 147, https://canlii.ca/t/gg5z4#par147.

16 *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, S.C. 2016, c. 3, s. 3 (the "***2016 Amendment***"), https://laws.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html.

17 *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 at paras. 734–736, https://canlii.ca/t/j4f8t#par734.

18 *Truchon* at para. 16. The Court was not asked to decide the constitutionality of excluding persons whose sole medical condition is a mental illness. The express exclusion on that basis was subsequently introduced into the *Criminal Code* in 2021: 2021 Amendment, s. 1(2) (enacting *Criminal Code* subsec. 241.2(2.1).

19 Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd sess., 43rd Parl., assented to March 17, 2021, S.C. 2021 c 2 (hereafter "***2021 Amendment***"), https://www.parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent; Government of Canada, "Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision," last modified September 1, 2021, https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/p1.html.

20 *2021 Amendment*, s. 1(2).

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illness exclusion was set to expire automatically after two years, but was extended by further amendments in 2023 and 2024.[21]

In response to *Truchon*, the Province of Quebec ceased applying its statutory requirement that a person must be "at the end of life" to qualify for MAID.[22] In 2023, Quebec formally amended its *Act Respecting End-of-Life Care* to remove the end-of-life requirement and to authorize advance requests for euthanasia in certain situations,[23] becoming the first and only Canadian province to do so to date.[24] Like the federal amendments in 2021, Quebec's 2023 amendments prevent persons whose sole medical condition is a mental disorder from accessing MAID.[25]

Further expansions of MAID availability engage both Parliament's constitutional authority over criminal law (and peace, order, and good governance) and provincial constitutional authority over health care.[26] Bill C-41 would permit advance requests for euthanasia only in provinces that have enacted legislation to regulate and establish a repository for such requests. Consequently, the circumstances in which a human life can legally be taken will vary across Canada. Given the fundamental constitutional interests at stake, including respect for human dignity, the protection of vulnerable persons, and the rights of persons with disabilities, Parliament has an essential role to play in establishing national protections that uphold respect for human life and the dignity of the person, rather than promote the expansion of euthanasia.

1. Maintain the mental-illness exclusion through separate legislation

Under the law currently in force, the mental illness exclusion is scheduled to end on 17 March 2027. This statutory deadline does not require Parliament to authorize advance requests for euthanasia,

21 *2021 Amendment*, ss. 1(2.1) and 6; Bill C-39, S.C. 2023, *An Act to amend an Act to amend the Criminal Code (medical assistance in dying)*, 1st sess., 44th Parl., assented to March 9, 2023, cl. 1, s. 1, https://www.parl.ca/DocumentViewer/en/44-1/bill/C-39/royal-assent; Bill C-62, SC 2024, *An Act to Amend an Act to Amend the Criminal Code (medical assistance in dying), No. 2*, 1st sess., 44th Parl., assented to on February 29, 2024, cl. 1, s 1, https://www.parl.ca/DocumentViewer/en/44-1/bill/C-62/royal-assent.

22 Gouvernement du Québec, "Requirements for receiving medical aid in dying following a contemporaneous request," last updated 5 March 2025, https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/medical-aid-in-dying/requirements.

23 *An Act to amend the Act respecting end-of-life care and other legislative provisions*, SQ 2023, c 15, https://canlii.ca/t/565mm (hereafter "**2023 Quebec Amendment**"); Gouvernement du Québec, "Advance Request for Medical Aid in Dying,"https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/medical-aid-in-dying/advance-request-medical-aid-dying.

24 Cf. Jesse Feith, "Explainer: A Look at Advance Requests for MAID in Quebec," *Montreal Gazette*, 30 October 2024, https://montrealgazette.com/news/provincial-news/explainer-a-look-at-advance-requests-for-maid-in-quebec/..

25 *2023 Quebec Amendments*, s 16.

26 *Constitution Act, 1867*, 30 & 31 Victoria, c. 3 (U.K.), ss. 91(27) and 92(7), https://canlii.ca/t/56g8v.

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nor does *Truchon* require the expansion of euthanasia to persons lacking decision-making capacity or under an advance request. As drafted, Bill C-41 would maintain the mental illness exclusion and specify that mental illness cannot be used to establish any of the three medical criteria for a grievous and irremediable medical condition.[27] We urge Parliament to advance those provisions independently of the provisions pertaining to advance requests. The advance-request provisions should be removed from Bill C-41 to permit further study without delaying legislation maintaining the mental illness exclusion.

The history of Canada's euthanasia and assisted suicide legislation shows a pattern of successive expansion. The 2016 framework required that natural death be reasonably foreseeable and that the person expressly consent immediately before the procedure.[28] The 2021 amendments broadened the eligibility requirements in several ways. For those with a reasonably foreseeable death, a limited waiver of final consent was introduced—the first departure from the principle of contemporaneous consent.[29]

Bill C-41 would take that departure even further: a person's life could be ended after they have lost decision-making capacity, by a request made earlier. The CCCB is concerned that the limits of legal authorization will continue to shift. We ask the government to explain the principled basis on which it would resist or allow further expansion.

2. Equal protection must endure after loss of capacity

Bill C-41 would permit individuals to make advance requests for MAID that can only be acted upon if they later lose their capacity to consent.[30] This raises a concern that advance requests could be motivated by the prospect of losing capacity, rather than by the anticipation of intolerable suffering.

Human dignity belongs to every person throughout life and is not diminished by changes in cognition, capacity, or independence.[31] Dependence is not an exceptional condition confined to a

27 Bill C-41, cl. 4(2) (proposed *Criminal Code* subsec. 241.2(2.1).

28 2016 Amendment, s. 3 (enacting *Criminal Code* paras. 241.2(2)(d) and 241.2(3)(h)), and s. 9.1, https://laws.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html. Section 9.1 required an independent review of issues relating to advance requests; it anticipated further examination but did not require their subsequent authorization.

29 2021 Amendment, s. 1(1) (repealing *Criminal Code* para. 241.2(2)(d)) and s. 1(7) (enacting *Criminal Code* subsecs. 241.2(3.1)–(3.5)), https://laws.justice.gc.ca/eng/AnnualStatutes/2021_2/FullText.html. The limited waiver of final consent appears in subsection 241.2(3.2). Subsection 241.2(3.1) establishes a separate set of safeguards for persons whose natural death is not reasonably foreseeable..

30 Bill C-41, cl. 5.

31 Dicastery for the Doctrine of the Faith, *Dignitas infinita*, declaration on human dignity, April 2, 2024, nos. 24 and 51–54, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_ddf_doc_20240402_dignitas-infinita_en.html.

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separate class of persons; *it is a universal feature of human life, differing in form and degree over time*.[32] A person who has lost decision-making capacity therefore remains someone to whom care is owed. Loss of decision-making capacity does not diminish the value of that person's life. Permitting the intentional ending of a person's life when that person can no longer understand, confirm, or reconsider the decision would further weaken the legal protection afforded by requiring contemporaneous consent, precisely when that person's dependence on others is greatest.

Interdependence involves more than a need for services. People who have lost decision-making capacity remain members of families and communities. They may continue to give and receive affection in ways that change as illness progresses. Our responsibility is to sustain those relationships, including when reciprocity is no longer apparent. Human dignity does not depend on being able to return the care one receives.[33]

3. International disability rights concerns require a response

The UN Committee on the Rights of Persons with Disabilities expressed in a 2025 report that it "is extremely concerned" about Canada's removal of the "reasonably foreseeable death" criterion for MAID.[34] The Committee further "note[d] with concern" Canada's decision not to challenge the *Truchon* decision, as well as evidence from the Office of the Chief Coroner for Ontario indicating that the expanded MAID provisions have been disproportionately accessed by women with disabilities and other persons with disabilities in marginalized situations.[35]

The Committee expressly recommended against further expansions of MAID eligibility criteria to include advance requests or persons whose sole underlying medical condition is a mental illness.[36] It also encouraged the federal government to invest in more care and social supports and to establish a federal independent oversight mechanism to monitor, regulate and handle complaints in relation to MAID.[37] The Committee also called for stronger consultation processes led by Indigenous communities and responsive to the distinct Peoples involved, including Indigenous persons with disabilities who are non-status or live off reserve, while respecting self-determination.[38] These are recommendations of a treaty-monitoring body and warrant a reasoned government response.

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32 Alasdair MacIntyre, *Dependent Rational Animals: Why Human Beings Need the Virtues* (Chicago: Open Court, 1999), 82, 100, 127–28, 130.

33 Leo XIV, *Magnifica humanitas*, nos. 50 and 75; Dicastery for the Doctrine of the Faith, *Dignitas infinita*, no. 26.

34 UN Observations at para. 19.

35 UN Observations at paras. 19(a) and (c).

36 UN Observations, paras. 19(d) and 20(a)–(b).

37 UN Observations, paras. 20(c) and (e).

38 UN Observations, paras. 20(d).

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II. Interpreting advance requests after capacity is lost

4. Advance requests leave others to make potentially mistaken interpretations

A written advance request cannot determine when its conditions have been satisfied or how the patient now experiences those conditions. Clinicians and others must interpret advance requests in light of the patient's medical circumstances and any present words, behaviour, or responses.

A Dutch study of 14 cases involving advance euthanasia directives and dementia documented continuing difficulties in assessing patients' current wishes, suffering, and possible alternatives.[39] The reliability of such interpretations is uncertain. It is also unclear how a request should proceed when those responsible for the assessment disagree. An advance request is necessarily based on anticipated circumstances, yet the circumstances in which it is later invoked may differ materially from those anticipated. The advance request document records earlier wishes, but cannot remove the need for others to decide whether and how its terms apply after the patient has lost the capacity to give an informed judgment.[40] Parliament must confront the possibility that the interpretation on which the patient's death depends may be mistaken.

The interpretive responsibility also falls on families, care teams, and institutions. Disagreements may arise regarding what the person intended, whether the specified conditions have arisen, or how to understand current responses. Making end-of-life treatment decisions for others can impose significant and lasting emotional burdens, which could be exacerbated by interpretive uncertainty or disagreement.[41]

Parliament should examine who may raise a concern, how disagreements would receive independent review, and how the person would remain protected pending their resolution.

5. Unforeseen circumstances can undermine an earlier judgment

Someone making a request can understand a diagnosis but cannot know how later care, relationships, treatments, or adaptation to illness will affect their daily life. Hayden P. Nix's analysis

39 Djura O. Coers et al., "Euthanasia in Advanced Dementia: An Empirical Study of the Decision-Making Process Based on Advance Directives," *Age and Ageing* 55, no. 6 (2026): afag170, https://doi.org/10.1093/ageing/afag170. First published online June 22, 2026.

40 Catherine Ferrier, "MAiD by Advance Request: Vulnerability, Stigma, and the Myth of Free and Informed Advance Consent," *Unravelling MAiD in Canada: Euthanasia and Assisted Suicide as Medical Care,* ed. Ramona Coelho, K. Sonu Gaind, and Trudo Lemmens (McGill-Queen's University Press, 2025), 456–61, https://doi.org/10.2307/jj.29357373.18. Ferrier's discussion is an ethical and clinical analysis, not a representative study of advance-request outcomes.

41 Council of Canadian Academies, "The State of Knowledge on Advance Requests for Medical Assistance in Dying" (Ottawa: CCA, 2018), 73, 142–143; David Wendler and Annette Rid, "Systematic Review: The Effect on Surrogates of Making Treatment Decisions for Others," *Annals of Internal Medicine* 154, no 5 (2011): 336–346, https://doi.org/10.7326/0003-4819-154-5-201103010-00008.

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identifies the difficulty of predicting which future impairments a person will experience as intolerable.[42] A person may make a serious and considered judgment about the future without accurately anticipating how it will be experienced. Clinical experts describe how people living with dementia may adapt to changes in their lives, emphasizing the importance of appropriate care and support.[43] Research also shows that people with dementia may assess their quality of life more positively than family members or care staff do.[44] We should therefore not assume that their experience will match what they feared beforehand. Further, new therapies, improved care, or changed relationships may alter the circumstances in which the request is later considered. It is likely that these differences may become apparent only after the person has been assessed as no longer capable of reconsidering the request.

6. An earlier request is not contemporaneous free and informed consent

Existing *Criminal Code* provisions require that individuals be given an opportunity to withdraw their request for euthanasia and consent expressly immediately before euthanasia is administered.[45] A limited exception allows certain people whose natural death is reasonably foreseeable to waive this final confirmation if they have already been assessed as eligible and have made a written arrangement with their practitioner for euthanasia on a specified day, anticipating that they might lose capacity beforehand.[46] This differs from an advance request intended to apply if specified circumstances arise, potentially years after the request is made.

42 Hayden P. Nix, "Operationalizing the Intolerable Suffering Criterion in Advance Requests for Medical Assistance in Dying for People Living with Dementia in Canada," *Cambridge Quarterly of Healthcare Ethics* 35, no. 2 (2026): 94–100, https://doi.org/10.1017/S0963180124000264. First published online May 22, 2024.

43 Romayne Gallagher, testimony before the Special Joint Committee on Medical Assistance in Dying, *Evidence*, no. 6, 44th Parl., 1st sess., May 9, 2022, https://www.parl.ca/DocumentViewer/en/44-1/AMAD/meeting-6/evidence; Ramona Coelho, "Canada's MAiD Consultation Misleads the Public in Its Framing," Macdonald-Laurier Institute, November 3, 2025, https://macdonaldlaurier.ca/canadas-maid-consultation-misleads-the-public-in-its-framing-ramona-coelho-in-national-newswatch/; Ramona Coelho, "Is Our MAiD System Safe for Canadians with Dementia?," Macdonald-Laurier Institute, October 2, 2025, https://macdonaldlaurier.ca/is-our-maid-system-safe-for-canadians-with-dementia-ramona-coelho-in-national-newswatch/.

44 Christopher Beer et al., "Factors Associated with Self and Informant Ratings of the Quality of Life of People with Dementia Living in Care Facilities: A Cross Sectional Study," *PLoS ONE* 5, no. 12 (2010): e15621, https://doi.org/10.1371/journal.pone.0015621.

45 *Criminal Code* ss 241.2(3)(h), (3.1)(k). https://laws-lois.justice.gc.ca/eng/acts/C-46/section-241.2.html.

46 *Criminal Code*, s 241.2(3.2)-(3.5). https://laws-lois.justice.gc.ca/eng/acts/C-46/section-241.2.html. Subsection (3.5) provides a separate exception allowing a practitioner, under a prior written arrangement, to administer a substance to cause death if the person has self-administered a substance but has lost capacity and has not died within the agreed period.

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Bill C-41 requires professional assistance and information from a practitioner with expertise in the requestor's illness or disease.[47] The bill requires the person to be told that new treatments or other ways of relieving suffering may become available before euthanasia is carried out.[48] It also treats the advance request as including the person's informed consent to euthanasia.[49] These requirements cannot establish whether a person would still choose euthanasia in the circumstances that actually arise.

Informed consent requires decision-making capacity, freedom from coercion, and adequate information about the proposed intervention, its material risks, and the available alternatives.[50] Once capacity has been lost, the person cannot weigh that information in light of their actual experience or reconsider the request. Giving the earlier request legal authority does not ethically substitute informed consent at the time of assessments or when euthanasia is administered.[51]

Parliament would do well to debate how concerns about pressure, misunderstanding, or changed circumstances would be examined when the person can no longer clarify the request.

7. Present responses must not be overridden by an earlier request

Proponents of advance requests argue that people should be able to request euthanasia in advance precisely because they expect to lose the capacity to decide later. Bill C-41 nonetheless recognizes that the person's later responses matter. Words, sounds or gestures demonstrating refusal or resistance would prevent euthanasia from being provided on the basis of that request thereafter.[52] Where a practitioner is in doubt about whether a response constitutes refusal or resistance, administration would be prohibited at that time and for the following 30 clear days.[53] The bill

47 Bill C-41, cl. 5, proposed *Criminal Code* subsecs. 241.21(8)(e)–(f).

48 Bill C-41, cl. 5, proposed *Criminal Code* subsecs. 241.21(8)(g).

49 Bill C-41, cl. 5, proposed *Criminal Code* subsecs. 241.21(8)(i).

50 Canadian Medical Protective Association, *Consent: A Guide for Canadian Physicians,* 4th ed., revised October 2024, under "Requirements for Valid Consent," "Disclosure of Information," and "A Consent Form Itself Is Not Consent," https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians. The guide explains ordinary consent requirements; it is not cited as endorsing the ethical critique of advance requests.

51 Ferrier, "MAiD by Advance Request," 456–61; Catherine Ferrier, "Opinion: MAID Is Not a Solution for Dementia," *Montreal Gazette*, October 22, 2026, https://montrealgazette.com/opinion/op-eds/opinion-maid-is-not-a-solution-for-dementia/.

52 Bill C-41, cl. 5, proposed *Criminal Code* s 241.21(5). The statutory text does not qualify refusal or resistance with the word "clear."

53 Bill C-41, cl. 5, proposed *Criminal Code* ss 241.21(3)(d) and (6). The 30-clear-day prohibition concerns doubt, not a request that can no longer be relied on because refusal or resistance has been demonstrated.

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excludes involuntary words, sounds or gestures made in response to contact from both the refusal and the doubt provisions.[54]

These safeguards depend on practitioners interpreting the responses of a person who can no longer explain them. While some clinical guidance is emerging, distinguishing expressions of refusal or resistance from involuntary responses or manifestations of an underlying illness remains a significant challenge for practitioners.[55] Health Canada's 2025 consultation recorded the concern that wishes expressed earlier could govern a person's later life.[56] A person's earlier statements may help caregivers understand what matters to them. Such statements, however, neither settle how that person now experiences their circumstances nor justify disregarding present signs of resistance, engagement with loved ones, or distress. Values and sources of meaning may persist or change as cognition declines; relationships continue even when the person can no longer describe their significance. Neither apparent contentment nor distress should be treated as an unambiguous statement of the person's wishes.

III. Understanding suffering and ensuring appropriate care

8. Fear of inadequate care calls for improved care and accompaniment

The Catholic principles of solidarity and the common good require practical care and accompaniment for patients and those who support them.[57] In Canada, provinces and territories are primarily responsible for delivering health care. However, they face substantial pressures in providing comprehensive care. This bears directly on Bill C-41: Health Canada's consultation recorded concerns that gaps in care could lead some people to make advance requests out of fear that adequate support would be unavailable once they could no longer advocate for themselves.[58] Instead of expanding euthanasia, dedicated federal funding could help expand timely assessment and management of cognitive disorders, geriatric services, home and community care, suitable accommodation, and respite and practical training for caregivers. For people facing dementia and other cognitive

54 Bill C-41, cl. 5, proposed *Criminal Code* s 241.21(7).

55 Canadian Association of MAiD Assessors and Providers, *Clinical Considerations for Advance Requests for MAiD* (December 2024) at pp 27–28, https://camapcanada.ca/wp-content/uploads/Clinical-Considerations-for-Advance-Requests-for-MAiD-FINAL-December-2024-1.pdf.

56 Health Canada, *What We Heard: National Conversation on Advance Requests for Medical Assistance in Dying*, October 29, 2025 (hereafter "**Health Canada National Conversation**"), secs. 1–2 under "Key Themes," https://www.canada.ca/en/health-canada/programs/consultation-advance-requests-medical-assistance-dying/what-we-heard.html. The report summarizes participants' views; it does not adopt recommendations.

57 Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (Vatican City: Libreria Editrice Vaticana, 2004), nos. 166, 182, and 193; Congregation for the Doctrine of the Faith, *Samaritanus bonus,* July 14, 2020, V.4–5; *Catechism of the Catholic Church*, no. 2211.

58 Health Canada National Conversation, "Key Themes," sec. 4, under "Broader Health and Social Supports for End of Life, Not Just for MAID".

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diseases, these services address daily dependence and safety, not only end-of-life needs. Palliative care should also be available throughout a life-limiting illness, including early in its course, according to need.[59] Families' exhaustion and grief deserve attention, but cannot simply be equated with the patient's suffering. Unequal access to palliative care in many Indigenous communities, including those in rural and remote regions, calls for services developed in partnership with these communities that are responsive to their traditions and priorities. Any influence of these inequities on advance requests requires investigation.[60] Parish communities also have a role: the CCCB's *Horizons of Hope* offers a resource for understanding palliative care and accompanying patients, families, and caregivers.[61] These supports cannot remove every hardship, but their absence should not be allowed to narrow the choices people believe are open to them. Euthanasia and assisted suicide cannot substitute for the care and accompaniment owed to every person.

9. Observable impairment does not establish experienced suffering

Dependence on others for personal care or difficulty recognizing relatives do not, by themselves, establish that a person is experiencing intolerable suffering that cannot be relieved. Equally, losing the ability to communicate verbally does not make clinical assessment impossible. Guidance on dementia care from the National Institute for Health and Care Excellence recommends considering structured observational tools alongside clinical assessment when a person cannot report pain. It also recommends investigating and addressing clinical or environmental causes of distress, including pain, delirium, or inappropriate care.[62] The first step must be to understand the person's experience, assess their needs, and provide appropriate treatment and support, not to end their lives.

To date, Quebec is the only Canadian province with legislation to facilitate advance requests for MAID. Bill C-41 would adopt minimum requirements that substantially reflect the requirements adopted in Quebec, including the requirement that two independent practitioners confirm MAID

59 Ferrier, "MAiD by Advance Request," 465–67; Ferrier, "Opinion: MAID Is Not a Solution for Dementia"; World Health Organization, "Palliative Care," August 5, 2020, under "Key Facts" and "What Can Countries Do?," https://www.who.int/news-room/fact-sheets/detail/palliative-care.

60 Muhammad Saim, "Rooted in Community, Guided by Tradition: Reimagining Palliative Care for Indigenous Peoples," ehospice, August 26, 2025, https://ehospice.com/canada_english_posts/rooted-in-community-guided-by-tradition-reimagining-palliative-care-for-indigenous-peoples/.

61 Canadian Conference of Catholic Bishops, *Horizons of Hope: A Toolkit for Catholic Parishes on Palliative Care*, accessed October 27, 2026, under "Why Promote Palliative Care in Our Parishes?," https://www.cccb.ca/faith-moral-issues/suffering-and-end-of-life/horizons-of-hope-a-toolkit-for-catholic-parishes-on-palliative-care/.

62 National Institute for Health and Care Excellence, *Dementia: Assessment, Management and Support for People Living with Dementia and Their Carers*, NICE guideline NG97, June 20, 2018, recommendations 1.7.1–2 and 1.8.3–5, https://www.nice.org.uk/guidance/ng97/chapter/Recommendations. See also Catherine Ferrier, "Opinion: MAID Is Not a Solution for Dementia," *Montreal Gazette*, October 22, 2026, https://montrealgazette.com/opinion/op-eds/opinion-maid-is-not-a-solution-for-dementia/.

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eligibility.[63] Both the federal and Quebec regimes require the person to have lost capacity to consent as a result of the qualifying illness, exhibit the clinical manifestations specified in their advance request on a recurring basis, be in an advanced state of irreversible decline in capability, and experience enduring and intolerable physical or psychological suffering that cannot be adequately relieved. [64] Both regimes also require practitioners to assess the person's actual suffering, rather than relying solely on the appearance of the manifestations described in the advance request.[65]

These requirements fail to establish how reliably intolerable suffering can be identified after decision-making capacity has been lost. However carefully conducted, clinical assessments cannot substitute for a present, informed decision by the person that their life should be ended. Uncertainty about suffering provides an additional reason not to authorize euthanasia after incapacity; our objection in principle to euthanasia does not depend on that uncertainty.

10. Advance requests could influence decisions about other care

In a 2002 study using hypothetical cases, physicians reported less willingness to offer some treatments unrelated to resuscitation when a do-not-resuscitate (DNR) order was present.[66] Although the study did not examine advance requests for euthanasia, it gives reason to investigate whether such requests could influence decisions about other care. An advance request might be interpreted, without sufficient grounds, as a refusal of otherwise beneficial treatment. If treatment were withheld on that basis, the patient's condition might worsen, and that deterioration might then be taken as a reason to carry out the request. This possibility also warrants examination.

IV. Ethical distinctions and responsibilities of care

11. Refusing disproportionate treatment is not equivalent to requesting euthanasia

A refusal of life-sustaining treatment by advance medical directive and an advance request for euthanasia may both lead to irreversible consequences. The decisive moral distinction is therefore not irreversibility, but what is being chosen. Catholic teaching permits withholding or withdrawing treatment that is excessively burdensome or otherwise disproportionate to its expected benefits. In such cases, the decision to forgo a particular intervention allows the underlying illness to take its

63 Bill C-41, cl 5 (proposed Criminal Code, subsecs 241.21(2)–(3)); *Act respecting end-of-life care*, CQLR c. S-32.0001, ss 29(3) and 29.19, https://canlii.ca/t/8t49.

64 Bill C-41, cl 5 (proposed Criminal Code, subsecs 241.21(2)–(3)); *Act respecting end-of-life care*, ss 29.1(2), 29.19, However, Bill C-41 would additionally require that the loss of capacity itself be irreversible, a requirement not expressly imposed by Quebec's legislation.

65 Bill C-41, cl. 5, proposed *Criminal Code* ss. 241.21(2)–(4); *Act respecting end-of-life care*, ss 29.5(1)–(2), 29.18–29.19.

66 Mary Catherine Beach and R. Sean Morrison, "The Effect of Do-Not-Resuscitate Orders on Physician Decision-Making," *Journal of the American Geriatrics Society* 50, no. 12 (2002): 2057–61, https://doi.org/10.1046/j.1532-5415.2002.50620.x.

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course. Death may be foreseen and accepted, but it is neither the purpose of the decision nor the means of relieving suffering. As the 1980 *Declaration on Euthanasia* explains, "Such a refusal is not the equivalent of suicide."[67]

Ordinary, proportionate care remains a requirement, including nutrition and hydration where these continue to be beneficial and do not impose excessive burdens. The question in a legitimate refusal is whether a treatment remains appropriate, not whether the person's life remains worth protecting. Euthanasia, by contrast, deliberately causes death as the means of ending suffering. It does not treat the suffering; it ends the person's life on the assumption that this will end their suffering. An advance request asks a practitioner to carry out that act once specified circumstances arise. The right to refuse disproportionate treatment therefore does not establish a justification for euthanasia.[68]

12. Conscience protections must be effective in practice, including for institutions

Even if the person requested euthanasia beforehand, the practitioner remains morally responsible for deciding to carry it out. According to Catholic teaching, Catholic health care professionals and institutions have the right and duty of conscientious objection and the obligation to refuse cooperation in euthanasia and assisted suicide.[69] Authorizing advance requests through Bill C-41 would increase the need for robust conscience protections for health care workers and institutions.

These concerns already arise under existing rules. The *Criminal Code* expressly states that nothing in section 241.2 compels an individual to provide or assist in providing MAID.[70] Nevertheless, Ontario's medical regulator requires physicians who decline to assess or provide MAID for reasons of conscience or religion to make an effective referral.[71]

The *Criminal Code* does not include conscience protections for institutions. Quebec law prohibits palliative care hospices from excluding MAID from the care that they offer.[72] Providence Health

67 Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, May 5, 1980 ("**Declaration on Euthanasia**"), sec. IV, "Due Proportion in the Use of Remedies," https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

68 Declaration on Euthanasia, sec. IV, "Due Proportion in the Use of Remedies,"; John Paul II, *Evangelium vitae*, March 25, 1995, no. 65, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html; Congregation for the Doctrine of the Faith, *Samaritanus bonus: On the Care of Persons in the Critical and Terminal Phases of Life*, July 14, 2020, V.2–3 and V.8, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html.

69 Congregation for the Doctrine of the Faith, *Samaritanus bonus*, V.2 and V.9.

70 *Criminal Code*, s. 241.2(9).

71 College of Physicians and Surgeons of Ontario, "Medical Assistance in Dying," updated December 2023, policy 1(b), https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying.

72 *Act respecting end-of-life care*, s. 13, as amended by S.Q. 2023, c. 15, s. 10

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Care, the Catholic organization that operates St. Paul's Hospital in Vancouver, is a defendant in a lawsuit challenging policies that allow faith-based institutions to decline to provide MAID.[73]

Inadequate conscience protections for institutions may threaten the continued operation of faith-based hospitals.[74] These hospitals, many of which have a long and venerable history in our country, continue to make substantial contributions to Canada's healthcare system, including by serving vulnerable and marginalized populations that face barriers to treatment elsewhere.[75] Some commentators have observed that these institutions provide a "sanctuary" for patients who wish to receive end-of-life care in an environment where MAID is not offered, including those who may be concerned about being pressured to consider it.[76]

Bill C-41's individual non-compulsion clause does not expressly address institutional protections or referral obligations arising under provincial law or professional regulations. These questions require a coordinated response rather than reliance on the federal clause alone. The federal government should work with provinces, territories, and professional regulators to secure effective protection against compelled participation or cooperation, including referrals, while ensuring that practitioners and institutions can continue to offer appropriate treatment, symptom relief, and accompaniment.

V. Evidence and parliamentary due diligence

13. Parliamentary scrutiny must address unresolved evidence and safeguard failures

Health Canada's 2025 report records support for advance requests alongside significant concerns about their application. The report brings together an open online questionnaire, a separate public-opinion survey of a random sample of 1,000 Canadians, and roundtable discussions. The questionnaire results were not intended to be statistically representative; these components should be distinguished when assessing the report's findings.

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73 *O'Neill v. British Columbia (Minister of Health)*, 2025 BCSC 601 at paras. 1–6, https://www.jccf.ca/wp-content/uploads/2025/04/Chief-Justice-Skolrood-re-ONeill-v.-British-Columbia-Minister-of-Health-04-01.pdf. That decision concerns applications for intervenor status and describes the constitutional challenge. The trial on the merits concluded in April 2026 before Chief Justice Skolrood. Judgment is on reserve.

74 Brian Bird, "Ending Catholic Health Care in B.C. over Euthanasia Would Be a Tragedy" (26 July 2023), Vancouver Sun, https://vancouversun.com/opinion/op-ed/brian-bird-ending-catholic-health-care-in-b-c-over-euthanasia-would-be-a-tragedy.

75 Gail Johnson, "St. Paul's Hospital Leads in HIV-AIDS Treatment and Research" (29 March 2011), The Georgia Straight, online: https://www.straight.com/article-383801/vancouver/st-pauls-hospital-leads-hivaids-treatment-and-research; Elizabeth Dogherty et al, "Implementation of a Nurse-Led Overdose Prevention Site in a Hospital Setting: Lessons Learned from St. Paul's Hospital, Vancouver, Canada" (2022) 19 Harm Reduction Journal 13, DOI: https://doi.org/10.1186/s12954-022-00596-7.

76 Brian Bird, "Sanctuaries from Euthanasia Must Be Protected," *National Post*, February 19, 2024, https://nationalpost.com/opinion/brian-bird-sanctuaries-from-euthanasia-must-be-protected/.

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In its letter of 18 March 2025 to the Minister of Health, the CCCB criticized the online questionnaire's emphasis on conditions for permitting advance requests, which gave inadequate scope to objections to the practice itself.[77] Parliamentary scrutiny should allow those objections to be fully examined. Moreover, as an account of an initial national conversation, the report does not provide a comprehensive assessment of the consequences of authorizing advance requests.[78]

General support for euthanasia should not be mistaken for informed approval of the law's full scope and practical implications. In a 2024 survey of 2,140 Canadian adults, 73.3% supported Canada's euthanasia and assisted-suicide law overall. Yet only 32.0% supported euthanasia for a patient who refused potentially curative treatment. Support was lower still (23.2%) for a patient unable to obtain suitable, affordable housing to alleviate symptoms. Parliament should therefore look beyond headline support for advance requests and examine whether the questions and information provided to the public adequately convey the legal, clinical, and ethical issues involved.[79]

Concerns about compliance and oversight arise across Canada. In its 2024–2025 report, Quebec's *Commission sur les soins de fin de vie* identified 19 cases of non-compliance, including failures concerning eligibility, second opinions, and consent.[80] In Ontario, investigative reporting has described hundreds of compliance concerns recorded by the Chief Coroner; a regulatory decision also documented serious failures in one physician's euthanasia practice.[81] British Columbia's 2024

77 William T. McGrattan, letter to the Honourable Kamal Khera, Minister of Health, on behalf of the Permanent Council of the Canadian Conference of Catholic Bishops, March 18, 2025, 1, https://www.cccb.ca/wp-content/uploads/2025/03/CCCB-Letter-to-the-Honourable-Kamal-Khera-P.C.-M.P.-Minister-of-Health_MAID-Advanced-requests.pdf.

78 Health Canada National Conversation, "Introduction," "A National Conversation on Advance Requests" (subsections "Online questionnaire," "Public opinion research," and "Virtual roundtables"), and "Key Themes."

79 William J. W. Choi et al., "When Medical Assistance in Dying Is Not a Last Resort Option: Survey of the Canadian Public," *BMJ Open* 14, no. 6 (2024): e087736, https://doi.org/10.1136/bmjopen-2024-087736; see also Ramona Coelho, "Ottawa Keeps Mucking Up MAID," Macdonald-Laurier Institute, October 16, 2026, https://macdonaldlaurier.ca/ottawa-keeps-mucking-up-maid-ramona-coelho-in-the-national-post/.

80 Commission sur les soins de fin de vie, *Rapport annuel d'activités du 1er avril 2024 au 31 mars 2025* (Québec: Gouvernement du Québec, 2025), 8–9, sec. 3.1 and table 3.1, https://csfv.gouv.qc.ca/fileadmin/docs/rapports_annuels/csfv_rapport_activites_2024-2025.pdf.

81 Alexander Raikin, "A Pattern of Noncompliance," *The New Atlantis*, November 11, 2024, https://www.thenewatlantis.com/publications/compliance-problems-maid-canada-leaked-documents.College of Physicians and Surgeons of Ontario, Inquiries, Complaints and Reports Committee, summary of decision concerning Dr. Eugenie Ulrica Tjan, July 11, 2018, secs. 1 and 4, available under "Other Notifications," https://register.cpso.on.ca/physician-info/?cpsonum=63892.

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oversight report recorded 353 errors requiring education about legal requirements or professional standards.[82]

Health Canada's national data raise additional questions about vulnerability. In 2024, among recipients whose natural deaths were not reasonably foreseeable, practitioners reported the "perceived burden on family, friends or caregivers" as a source of suffering in 50.3% of cases, and "isolation or loneliness" as a source of suffering in 44.7% of cases.[83] While these figures alone do not establish coercion or non-compliance, they reinforce the need to examine whether appropriate care and support were available and highlight the risk of potential pressures on the decision to euthanize a patient.

Considering the evidence above, Parliament should not authorize further expansion. Identified failures in existing eligibility requirements and safeguards point in the opposite direction. The government, working with provincial authorities and regulators, should provide a public account of investigations and corrective measures, including evidence that those measures reduce the risk of recurrence. However, resolving these practical failures would not remove the Catholic Church's moral objection to euthanasia.

A thorough and transparent parliamentary examination of Bill C-41 would give fair consideration to all relevant evidence and perspectives, including objections to advance requests in principle. It would examine the reliability of judgments about suffering and present responses after capacity has been lost; conflicts between an earlier request and the person's current circumstances; the possible influence of an advance request on other treatment decisions; and the effects of inadequate care, social isolation, and pressure from others. It would also examine how the circumstances in which a request was made are documented, how its voluntariness is assessed, and how concerns about pressure or misunderstanding can be investigated after capacity is lost. It would assess systematically the experience in Quebec and other jurisdictions that permit advance requests, including requests carried out, declined, or deferred, the reasons for those decisions, and disagreements among those involved, including the use of independent review or court proceedings to resolve them. People living with conditions that may impair decision-making capacity, their representative organizations, their families, and those who care for them would have a meaningful opportunity to contribute. Its findings would distinguish clearly between what the evidence establishes and what remains contested or uncertain.

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82 British Columbia Ministry of Health, MAiD Oversight Unit, *Medical Assistance in Dying (MAiD) Oversight: 2024 Year End Report*, 8, disclosed under freedom-of-information request HTH-2026-60677, https://canadiancatholicnews.ca/wp-content/uploads/2026/07/HTH-2026-60677.pdf; see also Ramona Coelho, "It's Time for Parliament to Legislate Proper MAiD Oversight," Macdonald-Laurier Institute, July 16, 2026, https://macdonaldlaurier.ca/its-time-for-parliament-to-legislate-proper-maid-oversight-ramona-coelho-in-national-newswatch/.

83 Health Canada, *Sixth Annual Report on Medical Assistance in Dying in Canada*, November 2025, sec. 3.4, fig. 3.4a, https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2024.html.

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Parliament has a responsibility to examine these questions before considering a change with irreversible consequences for people who can no longer give informed consent. The CCCB calls for thorough, public examination of the evidence, but does not support adoption of the advance-request provisions. We ask that those provisions be removed and that legislation maintaining the exclusion where mental illness is the sole underlying medical condition proceed separately. The CCCB requests an opportunity to appear before the parliamentary committee entrusted with examining Bill C-41.[84]

Approved by the Permanent Council of the
Canadian Conference of Catholic Bishops
before submission to Parliament on
12 November 2026.

The Canadian Conference of Catholic Bishops (CCCB) is the national assembly of approximately 80 Catholic bishops in Canada, who work together on matters of common pastoral concern. Its Permanent Council, currently comprising 14 bishops from across Canada, oversees the work of the Conference between its annual plenary assemblies. Its membership includes bishops elected by the Plenary Assembly and four *ex officio* members: Cardinal Gérald Cyprien Lacroix, Archbishop of Québec and Primate of Canada; Cardinal Frank Leo, Archbishop of Toronto; Archbishop Christian Lépine of Montréal; and an Eparchial Bishop representing the Eastern Catholic Churches in Canada.

84 Congregation for the Doctrine of the Faith, *Samaritanus bonus*, V.1, https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html.

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