Legislated Ableism: Bill C-7 and the Rapid Expansion of Medical Assistance in Dying in Canada

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This paper explores the recent expansion of medical assistance in dying to disabled people who are suffering intolerably but are not at the end of their lives. The paper argues that it is impossible to separate suffering caused by an irremediable disability and suffering caused by the impacts of systemic ableism, which include high rates of poverty, social isolation, and exclusion for people with disabilities. The paper suggests that this legislative expansion raises constitutional issues under s. 15 and s. 7 of the *Charter* because it is premised on a view that portrays disability as potentially worse than death and thus denies people with disabilities the protection of the criminal law that is provided to other Canadians. The paper concludes that there is no safe way for the state, through the medical system, to be involved in ending the lives of people with disabilities who are not otherwise dying.

Cet article explore l'extension récente de l'aide médicale à mourir aux personnes handicapées qui souffrent de manière intolérable, mais ne sont pas en fin de vie. Cet article soutient qu'il est impossible de distinguer la souffrance causée par un handicap irrémédiable de la souffrance causée par les impacts du capacitisme systémique, incluant, mais sans en restreindra la portée, des niveaux élevés de pauvreté, d'isolement social et d'exclusion vécus par les personnes handicapées. Cet article suggère que l'extension législative soulève des questions constitutionnelles en vertu des articles 15 et 7 de la Charte, puisqu'il est fondé sur une perspective qui dépeint l'handicap comme étant potentiellement pire que la mort, et refuse donc aux personnes handicapées la protection du droit pénal qui est accordée aux autres Canadiens. Cet article conclut qu'il n'existe aucun moyen sécuritaire pour l'État, par l'intermédiaire du système médical, de mettre fin à la vie des personnes handicapées qui ne sont pas en train de mourir.

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I. Introduction

Early in 2022, a 31-year-old woman in Ontario (using the pseudonym "Denise") was approved for a medically assisted death.[1] Denise, who uses a wheelchair due to a spinal cord injury, was diagnosed with Multiple Chemical Sensitivities (MCS), which causes rashes, difficulty breathing, and severe headaches.[2] Denise applied for medical assistance to die in part because she could not tolerate her smoke- and chemical-filled apartment and could not afford accessible housing on the monthly $1,169 she received from the Ontario Disability Support Program (ODSP).[3] In response to media coverage,[4] disability organizations and private citizens rallied to raise enough money to keep Denise alive in the short term.[5] Denise was able to move to a hotel temporarily to continue her search for appropriate housing.[6]

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1 See Avis Favaro, "Woman with disabilities approved for medically assisted death relocated thanks to 'inspiring' support", *CTV News* (28 May 2022), online: <ctvnews.ca> [perma.cc/VYU9-Z2W6] [Favaro, "Support"].

2 *Ibid*.

3 *Ibid*. She appears to have also received $50 per month for a special diet (*Ibid*). Advocates have pointed out that roughly $1,100 per month does little to help a person with disabilities reach the poverty line of $2,028 per month (if they live in Toronto), especially considering that it costs approximately 40% more to live with a disability (see e.g. Ian Brown, "Disability advocate Al Etmanski wants Canada to make history with a new guaranteed-income policy", *The Globe and Mail* (2 January 2022), online: <theglobeandmail.com> [perma.cc/2VTU-QDG9]). Another advocate noted that "[t]he federal government set the precedent by stating that those who couldn't work during the pandemic were given the $2,000 [a month for] CERB. [ODSP] should at least be doubled" (see "What's wrong with ODSP? Advocate says rates must be doubled, support should be election issue", *CBC News* (4 May 2022), online: <cbc.ca> [perma.cc/E6L3-BEDM]).

4 See e.g. Avis Favaro, "Woman with disabilities nears medically assisted death after futile bid for affordable housing", *CTV News* (4 May 2022), online: <ctvnews.ca> [perma.cc/KB66-PYBH]. For more on these cases, see also Kayla Wiebe & Amy Mullin, "Choosing death in unjust conditions: hope, autonomy and harm reduction" (2023) J Medical Ethics 1 at 1 [Wiebe & Mullin, "Choosing death"].

5 See Favaro, "Support", *supra* note 1.

6 See Favaro, "Support", *supra* note 1. See also Zahraa Hmood, "'Hunger Games style social Darwinism': Why disability advocates are worried about new assisted suicide laws", Niagara This Week (19 September 2022), online:

"Sophia"—who was diagnosed with MCS and had spent years searching and pleading with all levels of government for safe housing—received a medically assisted death only months earlier.[7] In a video Sophia made eight days before her death, she stated: "[t]he government sees me as expendable trash, a complainer, useless, and a pain in the ass."[8]

This paper examines the legal developments in Canada that have led to medical assistance in dying (MAiD) being available as a solution for the suffering of people like Denise and Sophia, who have disabilities but are not at the end of their lives. The provision of MAiD to people who are not dying is commonly referred to as Track 2 MAiD, whereas MAiD for those whose natural death is reasonably foreseeable is referred to as Track 1. This paper challenges the argument that Denise and Sophia were simply exercising their individual autonomy in seeking MAiD. Rather, this paper posits that the state offering death as a solution to the suffering of disability for those not at the end of life is inherently ableist and based on the discriminatory premise that disability can be worse than death and, therefore, that death is a benefit for this group of Canadians. This is not to deny that some people with disabilities support MAiD, and of course that individuals with disabilities were the face of court challenges leading to expanded MAiD. This paper takes no position on the difficult decision made by any individual to die through MAiD. Rather, this paper argues that the state, through the medical profession, should not participate in ending the lives of people who are not otherwise at the end of life.

<niagarathisweek.com> [perma.cc/FT26-8QZ9]. The author describes Denise as having been on a waiting list for seven years for affordable housing in Toronto.

7 See Avis Favaro, "Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing", *CTV News* (24 April 2022), online: <ctvnews.ca> [perma.cc/G6QE-P3EV].

8 *Ibid* (the video was shared with CTV News before Sophia's death). See also Leyland Cecco, "Are Canadians being driven to assisted suicide by poverty or healthcare crisis?", *The Guardian* (11 May 2022), online: <theguardian.com> [perma.cc/6C7Z-9RAF]. The media is full of stories of people seeking access to MAiD for reasons related to poverty or access to services – for example, a Montréal man with quadriplegia sought MAiD because of changes in the provision of his home care (Lillian Roy & Angela MacKenzie, "'I can't live that way': Montreal man seeking medically assisted death due to home care conditions", *CTV News* (3 October 2022), online: <montreal.ctvnews.ca> [perma.cc/V59X-WZPZ]).

In 2021, the federal government expanded MAiD to provide for medically assisted deaths for people who are not facing death but are suffering intolerably from an irremediable medical condition or disability and in an advanced state of decline.[9] This legislative process took place at the height of a global pandemic, which had taken a particularly harsh toll on people with disabilities.[10] Thousands of Canadians with disabilities died during the pandemic due to the inadequacies of long-term care, while others were left neglected and uncared for.[11] Some even accessed MAiD to escape the misery of lockdown in long-term care.[12] People with intellectual disabilities were more likely to die of COVID-19 yet were not consistently prioritized for vaccines unless they were immunocompromised or institutionalized.[13]

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9 See Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021, preamble (assented to 17 March 2021) [Bill C-7].

10 See generally Statistics Canada, *Impacts of COVID-19 on persons with disabilities*, Catalogue No 11-001-X (Ottawa: Statistics Canada, 27 August 2020) online (pdf): <www150.statcan.gc.ca> [perma.cc/JWA8-HASK]; Tom Shakespeare, Florence Ndagire & Queen E Seketi, "Triple jeopardy: disabled people and the COVID-19 pandemic" (2021) 397:10282 Lancet 1331 at 1331.

11 See e.g. Ontario, Long-Term Care COVID-19 Commission, *Final Report* (Toronto: Queen's Printer for Ontario, 2021) (Chair: The Honourable Frank N Marrocco) at 1, 16-20, 40, 212, 185-6; Nora Loreto, "The COVID outbreaks that Ontario wasn't counting", *Maclean's* (1 July 2021), online: <www.macleans.ca> [perma.cc/VY3P-HDFK]; Taylor Blewett, "COVID-19 death rate more than double for Ontarians with intellectual, developmental disabilities, study finds", *Ottawa Citizen* (17 August 2021), online: <ottawacitizen.com> [perma.cc/3WSB-4XZT]; Karen Howlett, "Patients died from neglect, not COVID-19, in Ontario LTC homes, military report finds: 'All they needed was water and a wipe down'", *The Globe and Mail* (11 May 2021), online: <theglobeandmail.com> [perma.cc/9NFH-MHCF].

12 See e.g. Avis Favaro, Elizabeth St Philip & Alexandra Mae Jones, "Facing another retirement home lockdown, 90-year-old chooses medically assisted death", *CTV News* (19 November 2020), online: <ctvnews.ca> [perma.cc/HJ9G-DRXQ]. See also Sera Whitelaw, Trudo Lemmens & Harriette GC Van Spall, "The Expansion of Medical Assistance in Dying in the COVID-19 Pandemic Era and Beyond: Implications for Vulnerable Canadians" (2022) 17:2 Can J General Internal Medicine 17 at 19.

13 An American study found that people with intellectual disabilities were more likely to die of COVID than others; COVID was the leading cause of death for people with intellectual disabilities in 2020 and the third leading cause of death for those without intellectual disabilities (see Scott D Landes, Julia M Finan

COVID-19 triage protocols did not just consider whether patients would survive the acute illness but rather whether mortality overall was impacted, which clearly had a disproportionate impact on people with disabilities.[14] Mask mandates were dropped before it was safe for those with "pre-existing conditions", forcing many people with disabilities into further social isolation in order to survive the ongoing pandemic.[15] Government benefits were provided least and last to those with disabilities living in poverty.[16] A long-promised federal disability support program was repeatedly delayed

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& Margaret A Turk, "COVID-19 mortality burden and comorbidity patterns among decedents with and without intellectual and developmental disability in the US" (2022) 15:4 Disability & Health J 1 at 3). See also Annette Majnemer et al, "Time to be counted: COVID-19 and intellectual and developmental disabilities—an RSC Policy Briefing" (2021) 6:1 Facets 1337 at 1344; Yona Lunsky et al, "COVID-19 positivity rates, hospitalizations and mortality of adults with and without intellectual and developmental disabilities in Ontario, Canada" (2022) 15:1 Disability & Health J 1 at 3; Jeremiah Rodriguez, "'It's devastating' disabled people not prioritized in vaccine rollout, advocates say", *CTV News* (9 February 2021), online: <ctvnews.ca> [perma.cc/UM7J-STHM].

[14] See Roxanne Mykitiuk & Trudo Lemmens, Letter to the Editor, "Assessing the value of a life: COVID-19 Triage orders mustn't work against those with disabilities", *CBC News* (19 April 2020), online: <cbc.ca> [perma.cc/LFS3-WQSJ] ("Guidelines that go beyond a prognosis of survival of the acute COVID-19 related event tend to disproportionately affect people with disabilities. They also facilitate 'ableist' presumptions about survival chances or quality of life after ICU treatment seeping into clinical evaluations ... Progressive cognitive impairment, neurodegenerative diseases such as Parkinson's and ALS, and clinical frailty due to a progressive illness, are given scores that deprioritize people with those conditions as candidates for ventilation"). Gabrielle Peters describes how one of the doctors working on the Ontario triage protocol was a former member of the physicians advisory committee for Dying with Dignity, an organization that promotes MAiD for people with disabilities (see Gabrielle Peters, "Dying for the right to live", *Maclean's* (12 November 2020), online: <macleans.ca> [perma.cc/N3YY-EMDS] [Peters, "Right to live"]).

[15] See Nadine Yousif, "'Every man for himself': Confusion reigns on how to behave in a pandemic wave void of guidelines", *Toronto Star* (21 April 2022), online: <thestar.com> [perma.cc/6H6F-CJCW]; Sarah Trick, "Saying 'the vulnerable should just isolate' doesn't count as a plan" Editorial, *TVO Today* (14 February 2022), online: <tvo.org> [perma.cc/4U5S-B5GM].

[16] While the CERB benefit provided thousands of dollars to many Canadians, including university students, people with disabilities who were unemployed received a one-time $600 benefit, and only if they qualified for the federal disability tax credit. See also Rosa Saba, "CERB and CRB discriminated against

by the Trudeau government.[17] Most recently, Ontario passed Bill 7 that allows hospitalized patients to be sent to long-term care facilities without their consent, sometimes far from family members, under the threat of daily fees if they refuse.[18] These realities for people with disabilities highlight their social inequality in Canada and provide a context for understanding why MAiD is an existential threat to disabled lives.[19]

Canadians with disabilities, new Charter challenge claims", *Toronto Star* (26 November 2021), online: <thestar.com> [perma.cc/Y9S3-8457].

17 Bill C-22 has now been passed into law and given royal assent (see Bill C-22, *Canada Disability Benefit Act*, 44th Parl, 1st Sess, 2023 (assented to 22 June 2023) [Bill-22]). This is after the Liberal government rejected a Senate amendment which would prevent clawbacks from private insurance companies (see Bill Curry, "Employment minister Carla Qualtrough rejects key Senate amendment to government's disability bill", *The Globe and Mail* (15 June 2023), online: <theglobeandmail.com> [perma.cc/J2WY-PV5D]). It is important to note that Bill C-22 is a framework for developing a disability benefit with details like "who qualifies" and "how much" to be worked out over the coming year (see Bill C-22, *supra* note 17, cl 11(1.1)(1.2)). See also The Canadian Press, "Bill to create Canada Disability Benefit reintroduced but with few details", *CTV News* (2 June 2022), online: <ctvnews.ca> [perma.cc/94U9-59UB]; Erika Ibrahim, "Liberals leave disability benefit bill in limbo as Parliament breaks for summer", *National Post* (24 June 2022), online: <nationalpost.com> [perma.cc/4PK3-BTHL]. Members of the Joint AMAD Committee asked witnesses whether enacting a guaranteed minimum income program for people with disabilities would deter them from requesting MAiD (see House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 29 (25 November 2022) at 9:35 (Honourable Marie-Françoise Mégie) [AMAD Evidence No 29]. Two witnesses, both speaking about the impact of Track 2 MAiD on people with disabilities, said no (see AMAD Evidence No 29, *supra* note 17 at 9:36-9:38 (Isabel Grant, Megan Linton)).

18 See Bill 7, *An Act to amend the Fixing Long-Term Care Act, 2021 with respect to patients requiring an alternate level of care and other matters and to make a consequential amendment to the Health Care Consent Act*, 1996, 1st Sess, 43rd Leg, Ontario, 2022 (assented to 31 August 2022), SO 2022, c 16, s 2(3). The explanatory note accompanying the legislation and section 2(7) of the legislation itself offer reassurance that the Bill does not authorize the use of restraints on those who resist a transfer without their consent. See also Desmond Brown, "Ontario hospital patients who refuse pre-arranged long-term care spot will now be charged $400 a day", CBC News (20 November 2022), online: <cbc.ca> [perma.cc/ 7WE8-X6PY].

19 See e.g. Vulnerable Persons Standard, "Feb 24 Open Letter", online: <vps-npv.ca> [perma.cc/Y2XM-F4V6] [Stop C-7].

In this paper, I use the phrase medical assistance in dying and the corresponding acronym MAiD to describe a process through which a physician or nurse practitioner administers a fatal combination of drugs to an individual, or provides those drugs for self-ingestion, after that individual has met the criteria set out in the legislation. Usually, those drugs are delivered intravenously by a medical practitioner (euthanasia); other times they are provided by prescription for the patient to ingest themselves (assisted suicide).[20] Canada has legalized both euthanasia and assisted suicide. The term *medical assistance in dying* may be appropriate for those who are accessing medical assistance at the very end of their lives— MAiD is easing people into a death that is already close in order to alleviate suffering in the process of dying. The question in this context is not whether someone is dying but rather when and how. However, this term must be contested when applied to those who are not otherwise dying, such as Denise or Sophia described above. We are not easing such individuals into a less painful death but rather actively ending their lives through a lethal injection, often years or decades before they are on the brink of natural death.[21] This distinction has led some researchers to suggest that "medically administered death" or MAD is a more appropriate label for Track 2 deaths.[22] Nonetheless, for ease

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20 For the conceptual distinctions between euthanasia and assisted suicide, see World Medical Association, Press Release, "WMA Declaration on Euthanasia and Physician-Assisted Suicide" (23 November 2021), online: <www.wma.net> [perma.cc/ XK74-R4QR]. The intravenous drugs used for euthanasia are typically midazolam, lidocaine, propofol, and rocuronium, in that order and in quick succession. Of 7,595 MAiD deaths in Canada in 2020, fewer than 7 involved self-administration of drugs (see Sharon Kirkey, "How can doctors be sure a medically assisted death is a 'peaceful' death?", *National Post* (1 July 2022), online: <nationalpost.com> [perma.cc/QLL3-P8WQ]). Some doctors challenge whether the drugs used to facilitate MAiD actually result in a peaceful death (see e.g. Joan Bryden, "Doctors offer duelling views of what it's like to receive an assisted death", *Toronto Star* (3 February 2021), online: <thestar.com> [perma.cc/LCV4-53VH]).

21 As psychiatrist Dr. Mark Sinyor explained to the Superior Court of Québec, where death is reasonably foreseeable "the choice is not whether or not to live, but solely about when and how the death will occur"; where death is not reasonably foreseeable, he testified that MAiD is indistinguishable from suicide (see *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at para 330 [*Truchon*]).

22 See e.g. K Sonu Gaind et al, "Canada's Medically Administered Death (MAD) Expansion for Mental Illness: Targeting the Most Vulnerable" (2022) 71:4 World Medical J 72 at 72.

of communication, I will use MAiD in both contexts throughout this paper because it is the widely recognized language in Canada.

This paper focuses on the expansion of MAiD to end the lives of people with disabilities who are not at the end of life and does not address the constitutionality of Canada's current MAiD regime for those who are at the end of their lives. My focus on Track 2 in this paper should not be taken as an endorsement of Track 1 as it is currently applied.[23] Whether Canadian law has adequate safeguards for people whose death is reasonably foreseeable is an issue that I leave to others to explore.[24] In this paper, however, I argue that there is a principled difference between allowing a medical practitioner to end the life of someone who is suffering in the process of dying and allowing them to end the life of someone who is not close to death. An end-of-life requirement at least, in theory, provides a coherent line for

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[23] See e.g. *AB v Canada (AG),* 2017 ONSC 3759 at para 89, where a judge held that an 80-year-old woman with osteoarthritis had a reasonably foreseeable natural death in order to qualify her for MAiD prior to Bill C-7.

[24] Perhaps most notably, unlike the Netherlands, Canada does not require that MAiD be a last resort in the sense that patients are not required to exhaust reasonable medical treatment (see Brian L Mishara & Ad JFM Kerkhof, "Canadian and Dutch doctors' roles in assistance in dying" (2018) 109:5-6 Can J Pub Health 726 at 726). Dr. Madeline Li describes giving MAiD to a young man with cancer who, with treatment, had a 65% chance of full recovery (see Madeline Li, as told to Liza Agrba, "I am a MAID provider. It's the most meaningful—and maddening—work I do. Here's why", *Maclean's* (13 February 2023) online: <macleans.ca> [perma.cc/22GD-B8X3]). There have been reports of individuals receiving MAiD under Track 1 that raise the question of whether the existing safeguards are adequate (see e.g. Avis Favaro & Jeremiah Rodriguez, "Advocates urge better safeguards after medically assisted death of BC man", *CTV News* (25 September 2019), online: <ctvnews.ca> [perma.cc/XD52-CW3Q]). While accessing MAiD under Track 1, which was limited to those with a foreseeable death, Alan Nichols' MAiD application cited hearing loss as the reason for seeking MAiD. Alan's sister testified before the Joint Committee, stating: "On Alan's MAID form, hearing loss was stated as the reason for application. How can doctors accept, approve, and administer a death for this when Alan did not have a terminal illness and his hearing had been corrected, and all the while he had been involuntarily admitted for suicide protection?" (see House of Commons, Special Joint Committee on Medical Assistance in Dying*, Evidence,* 44-1, No 13 (16 June 2022) at 18:45). For a damning investigative report on how Canada's safeguards are working for both Track 1 and 2, see Alexander Raikin, "No Other Options", *The New Atlantis* (16 December 2022), online: <thenewatlantis.com> [perma.cc/24J2-R6CU].

medical practitioners to draw between cases where death cannot be avoided and cases where suicide prevention measures should be provided. Most of the cases described in this paper refer to Track 2 MAiD on the basis of a physical disability because MAiD is not yet allowed solely on the basis of mental illness.[25] The same arguments apply with particular force to cases where MAiD is given for mental illness alone.[26]

The paper begins with a brief history of MAiD in Canada from the decision in *Rodriguez v British Columbia (AG)*,[27] which upheld the absolute prohibition on MAiD, through to *Carter v Canada (AG)*,[28] where the Supreme Court reversed itself and held that the absolute prohibition violated the *Canadian Charter of Rights and Freedoms*.[29] *Carter* precipitated Bill C-14, which introduced Canada's first MAiD regime and became law in 2016.[30] In 2019, the Superior Court of Québec's decision in *Truchon v Canada*[31] prompted a significant expansion of the initial MAiD regime, enacted through Bill C-7 in 2021.[32]

The paper then explores why this legislation has raised such profound concerns among disability organizations and activists, many of whom have denounced this expansion of MAiD.[33] These concerns must be heard and

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25 *Criminal Code*, RSC 1985, c C-46, s 241.2(2.1) [*Code*] ("For the purposes of paragraph (2)(a), a mental illness is not considered to be an illness, disease or disability"). Note that on February 29, 2024, a bill was passed to extend for a further three years the delay of MAiD on the sole basis of mental illness (see Bill C-62, *An Act to amend the Criminal Code (medical assistance in dying), No. 2*, 1st Sess, 44th Parl, 2024 (assented to 29 February 2024) [Bill C-62]).

26 See *Truchon, supra* note 21 at paras 442–43.

27 1993 SCC 75 at 615 [*Rodriguez*].

28 2015 SCC 5 at 147 [*Carter*].

29 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

30 See Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Act (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016), SC 2016 c 3 [Bill C-14].

31 See *Truchon, supra* note 21.

32 See Bill C-7, *supra* note 9.

33 See Stop C-7*, supra* note 19.

understood in the social context of systemic ableism, and in a legal context that guarantees people with disabilities equal protection of the law under section 15 of the *Charter* and an equal right to life under section 7.[34] The paper argues that the expansion of MAiD to people with disabilities—who are not otherwise at the end of life—devalues and endangers disabled lives by making suicide more readily available than the social supports they need to alleviate their intolerable suffering. As such, this expansion is constitutionally suspect. Track 2 MAiD unduly medicalizes the suffering associated with disability, portrays death as a form of medical treatment, and ignores the social and political contributors to suffering. The fact that a medical condition is irremediable does not necessarily mean that intolerable suffering cannot be alleviated.

Through Bill C-7, the government has abdicated its responsibility to respond to that suffering through means other than helping people die.[35] Many Canadians with disabilities are suffering intolerably and much of that suffering could be alleviated through government action such as, for example, accessible housing, home care, decreased reliance on institutional care, and improved financial support. To suggest that the state, through the medical profession, has an obligation to provide access to death but no obligation to make life tolerable for a *Charter*-protected group positions MAiD as a cheaper and quicker escape route rather than as true equality.

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[34] See *Charter, supra* note 29, ss 7, 15.

[35] For example, Sathya Dhara Kovac accessed MAiD in October 2022 when she was unable to get the additional home care she needed to live with ALS. In an obituary she wrote before her death she stated: "It was not a genetic disease that took me out, it was a system" (see Bryce Hoye, "Winnipeg woman who chose to die with medical assistance said struggle for home care help led to decision", *CBC News* (4 October 2022), online: <cbc.ca> [perma.cc/YN5D-LSGJ]). Reports of Kovac's death surfaced at the same time a Montréal man announced he was applying for MAiD after changes were made to his home care (see Roy & Mackenzie, *supra* note 8; see also Wiebe & Mullin, "Choosing death", *supra* note 4 at 4 ("Of particular concern are persons with disabilities who choose MAiD, the worry being that such persons might choose MAiD for social, rather than strictly medical reasons, because they cannot access alternative means of reducing their suffering, such as housing compatible with their condition or sufficient hours of paid care")).

II. The Road to Expansion of MAiD

Many Canadians are familiar with the case of Sue Rodriguez, which brought MAiD into public view in the early 1990s. Ms. Rodriguez was diagnosed with amyotrophic lateral sclerosis (ALS), a debilitating progressive condition from which she was slowly losing the ability to speak and swallow; she could not walk, move her body, or breathe without assistance.[36] The Supreme Court of Canada acknowledged that her death was likely to take place in the next two to fourteen months.[37] She sought permission for a physician to assist her in ending her life if she became "physically unable to terminate her life without assistance."[38] Because of Canada's absolute prohibition on aiding suicide, a physician would risk criminal prosecution for helping her end her life. The argument in *Rodriguez* was focused on the idea that those who were physically unable to end their own lives because of disability were discriminated against by a law that denied them help to do so, and thus were made to suffer unnecessarily through the absolute prohibition.[39] Other Canadians—who were able to end their lives without assistance —were free to choose suicide.[40]

The Court was deeply divided in *Rodriguez*, with a narrow 5:4 majority, penned by Justice Sopinka, upholding the blanket prohibition.[41] The majority stressed the longstanding nature of the prohibition on assisted suicide, its role in protecting the vulnerable, and the sanctity of life as an important section 7 *Charter* right.[42] It did find a deprivation of security of the person under section 7, holding that state interference with bodily integrity and serious state-imposed psychological stress were caused by denying access to a physician's assistance in dying.[43] However, it went on to decide that

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36 See *Rodriguez*, *supra* note 27 at 531.

37 *Ibid*.

38 *Ibid* at 531.

39 *Ibid* at 544.

40 *Ibid* at 550.

41 Concurred by Justices La Forest, Gonthier, Iacobucci, and Major. Separate dissenting judgments were written by Justices McLachlin (as she then was) and L'Heureux-Dubé, Chief Justice Lamer, and Justice Cory.

42 See *Rodriguez*, *supra* note 27 at 585–86, 590, 595, 597.

43 *Ibid* at 588–89.

the violation was consistent with the principles of fundamental justice.[44] The majority considered the longstanding and widespread criminalization of aiding suicide in Western democracies and the importance of the state interest in protecting the lives of people who might be vulnerable to abuse.[45]

The dissent of Justice McLachlin and Justice L'Heureux-Dubé found a violation of section 7 of the *Charter* that could not be justified under section 1 because any fears about lifting the prohibition were insufficient to trump a person's "entitlement under s. 7 of the *Charter* to end her life in the manner and at the time of her choosing."[46] Justice Cory's dissent went further, finding that section 7 entitles a person to a right to "die with dignity."[47] Chief Justice Lamer, also dissenting, was the only member of the Court to rely on section 15. He found that while the prohibition was neutral on its face, it had an unjustifiable adverse effect on persons with disabilities who were physically unable to end their own lives when others were free to do so.[48]

The prohibition on physician-assisted suicide was again before the courts in *Carter*.[49] This case involved applicants, Gloria Taylor, who had been diagnosed with ALS, and the surviving family members of Kay Carter, who had previously travelled to Switzerland where she received a physician-assisted death. In her trial reasons, Justice Smith differentiated *Rodriguez* both on its legal analysis under section 7, and on the basis of the different record before her. The majority in *Rodriguez* had not considered the right to life under section 7, and overbreadth, gross disproportionality, and arbitrariness had not yet been developed as principles of fundamental justice under section 7. With respect to the different record, Justice Smith explained:

> The most notable difference between the records in this case and in *Rodriguez* is that the record in this case includes: evidence pertaining to the experience with legal physician-assisted death in Oregon, Washington, Belgium, Luxembourg and the Netherlands and with assisted death in Switzerland; opin-

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44 *Ibid* at 608.

45 *Ibid* at 596–97.

46 *Ibid* at 626–27.

47 *Ibid* at 630.

48 *Ibid* at 549.

49 *Carter v Canada (AG)*, 2012 BCSC 886 at para 1 [*Carter* BCSC].

> ion evidence of medical ethicists and practitioners informed by the experience in jurisdictions with legalized assisted death; specific evidence pertaining to current palliative care and palliative or terminal sedation practices; and evidence regarding prosecution policies in British Columbia and the United Kingdom formulated since *Rodriguez*.[50]

Justice Smith found that the prohibition violated section 7 because it was overbroad and grossly disproportionate.[51] The absolute prohibition was overbroad because "a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death."[52] The prohibition was found grossly disproportionate because its severe effect on the plaintiffs outweighed "its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life."[53]

Justice Smith ultimately also found that the prohibition was discriminatory under section 15 and failed the minimal impairment and proportionality analyses under section 1.[54] Relying on evidence from other jurisdictions that allowed some form of MAiD, Justice Smith concluded that there were other, less impairing means of achieving the government's objective of protecting vulnerable persons from death. With a system of safeguards in place, there was no evidence that "since the legalization of physician-assisted death, there has been a disproportionate impact, in either Oregon or the Netherlands, on socially vulnerable groups such as the elderly or persons with disabilities."[55] When comparing the absolute prohibition to a general prohibition with specific exceptions, Justice Smith was "unconvinced" that it

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50 *Ibid* at para 944.

51 *Ibid* at paras 1371, 1378.

52 *Ibid* at para 1367.

53 *Ibid* at para 1378.

54 *Ibid* at paras 1161, 1244, 1285.

55 *Ibid* at para 1242.

had "salutary effects in preventing wrongful deaths, or in preventing abuse of vulnerable people."[56]

A majority of the British Columbia Court of Appeal overturned Justice Smith's decision, with then Chief Justice Finch dissenting, holding that it was bound by the sections 7, 15, and 1 analyses in *Rodriguez*.[57] Chief Justice Finch agreed with the trial judge that *Rodriguez* could be distinguished because the Supreme Court of Canada failed to expressly consider the "right to life" in its section 7 analysis.[58]

On further appeal, the Supreme Court of Canada agreed with the trial judge in *Carter*, holding that the complete prohibition on physician-assisted suicide was overbroad and contrary to section 7 because it was unnecessary to criminalize medical practitioners aiding suicide for those with "grievous and irremediable" illnesses:

> Section 241(*b*) and s. 14 of the *Criminal Code* unjustifiably infringes s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[59]

The Court did not address section 15.

A key difference between *Rodriguez* and the *Carter* decision rendered two decades later is the Court's understanding of the principles of fundamental justice in section 7. In *Rodriguez*, there was room within those principles to consider compelling state interests, like protecting the lives of those who were at risk through the decriminalization of assisting suicide.[60] By the time of *Carter*, those interests were relegated entirely to the section

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56 *Ibid* at paras 1267–68.

57 See *Carter v Canada (AG)*, 2013 BCCA 435 at para 316.

58 *Ibid* at para 89.

59 *Carter*, *supra* note 28 at para 147.

60 See *Rodriguez*, *supra* note 27 at 595.

1 analysis,[61] which has never been used by the Supreme Court to uphold a violation of section 7. If a violation of section 7 cannot be justified under section 1, and the interests of disabled people who may be at risk are only considered under section 1, those interests become largely invisible in the constitutional analysis.[62]

In *Carter*, disability interveners and Canada argued that allowing MAiD for those at the end of life would inevitably lead to further expansion of MAiD, thus endangering people with disabilities.[63] The Court considered this argument most directly under section 1, in the context of whether the state had a legitimate basis for putting an absolute prohibition on aiding suicide in the name of ensuring protection of the "vulnerable."[64] The Court accepted the position of Justice Smith at trial that there was no basis to believe that extending MAiD would create a risk to older or disabled persons or that it would create a slippery slope:

> As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying. She thus rejected the contention that unconscious bias by physicians would undermine the assessment process. The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization. She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized. Finally, she found no compelling

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61 See *Carter*, *supra* note 28 at para 79.

62 *Cf R v Brown*, 2022 SCC 18 at paras 70–71 (the Supreme Court of Canada clarified this analysis, distinguishing cases where the legislation directly implicates competing rights of more than one party). See also *Cambie Surgeries Corporation v British Columbia (AG)*, 2022 BCCA 245 at para 327, where the majority of the Court of Appeal for British Columbia built on the shift in *Brown* to allow a consideration of competing rights under section 7 where those rights were implicated by the state action.

63 See *Carter*, *supra* note 28 at para 107.

64 *Ibid* at paras 99–107.

> evidence that a permissive regime in Canada would result in a "practical slippery slope."[65]

The Court explicitly indicated that its judgment did not deal with issues such as "euthanasia for minors or persons with psychiatric disorders or minor medical conditions."[66]

The section 1 analysis is important because it speaks to what the Court was addressing in *Carter*: "end-of-life treatment." *Carter* was dealing with the constitutionality of *Criminal Code* provisions that prohibited doctors, on threat of criminal sanction, from assisting anyone to end their life.[67] In this specific context, the Court rejected the argument that allowing physician-assisted death at the end of life would somehow leak into ending the lives of people with disabilities in other contexts. Yet the *Carter* Court did not hold that there is a constitutional right to demand MAiD from our state-funded medical system; rather, it held that providing MAiD could not be criminal-

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65 *Ibid* at para 107 (media coverage of problematic deaths, like that of Sophia, stands in stark contrast to Justice Smith's "high degree of certainty" that the vulnerable could be protected and the Supreme Court's assertion there is "no evidence" of increased risk for people with disabilities).

66 *Ibid* at para 111. *Cf* Canada, Parliament, House of Commons, Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada: Choices for Canadians*, 44-1, No 2 (February 2023) (Joint Chairs: Hon Marc Garneau and Hon Yonah Martin) at 3, 54–74, online (pdf): <parl.ca> [perma.cc/J6UV-TLUB] [*Choices for Canadians*] (as of March 2027, Canada will extend MAiD to mental illness and a Joint Committee of Parliament has recommended extending it to mature minors). See also Canada, Parliament, House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence,* 44-1, No 19 (7 October 2022) at 9:54 (Dr. Louis Roy) (an extreme example of this slippery slope, which suggests that MAiD should be available to end the lives of infants "from birth to one year of age who come into the world with severe deformities and very serious syndromes for which the chances of survival are virtually nil"); Jacob J Kon, AA Eduard Verhagen, & Alexander A Kon, "Neonatal Euthanasia and the Groningen Protocol" in Nico Nortjé & Johan C Bestered, eds, *Pediatric Ethics: Theory and Practice* (Berlin: Springer, 2022) 291 (a potential source of inspiration for MAiD in infants is the Netherlands Groningen Protocol, where "neonatal euthanasia has been lawful for infants who are […] suffering unbearably with no hope for improvement" since 2005).

67 See *Carter*, *supra* note 28 at para 5.

ized in the context of the case before it.[68] The *Carter* Court suspended the declaration of invalidity for one year to give the government time to amend the *Criminal Code* in response to the decision[69] and later extended that suspension for a further four months.[70]

In 2016, in response to *Carter*, Parliament passed Bill C-14,[71] which amended the *Criminal Code* to decriminalize MAiD for persons with irremediable medical conditions or disabilities, in an advanced state of decline who are suffering intolerably, and whose natural deaths are reasonably foreseeable.[72] The reasonable foreseeability of death requirement was included in the legislation to serve as a safeguard to protect vulnerable individuals from being coerced into suicide. It was part of a compromise reached after consultations with the disability community. A Department of Justice background document on Bill C-14 noted that allowing MAiD "in circumstances where a person is not approaching natural death could be seen as undermining suicide prevention initiatives and normalizing death as a solution to many forms of suffering."[73] Bill C-14 was found to be consistent with the *Charter* by the Québec Court of Appeal in *Saba c Procureure générale du Québec.*[74]

Meanwhile, in 2014, Québec had passed its own legislation, the *Act respecting end-of-life care*,[75] which came into force in December 2015. It

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68 See *Carter*, *supra* note 28 at para 63.

69 See *Carter*, *supra* note 28 at paras 127–28.

70 See *Carter v Canada (AG),* 2016 SCC 4 at para 7.

71 See Bill C-14, *supra* note 30, cl 3.

72 *Code*, *supra* note 25, s 241.2.

73 Canada, Department of Justice, *Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)* (Ottawa: DOJ, 23 January 2017), part 1, online: <justice.gc.ca> [perma.cc/DWK9-7VGJ]. See also House of Commons, Standing Committee on Justice and Human Rights, *Evidence*, 43-2, No 12 (3 May 2016) at 19:53 (Dr Michael Bach).

74 2018 QCCA 1526 at paras 29, 33.

75 See *Act respecting end-of-life care*, RLRQ, c S-32.0001, art 26(3) (the Québec Court of Appeal held that permanency does not apply once federal legislation has been found to be of no force or effect as was the case after *Carter*). See also *Québec (PG) c D'Amico*, 2015 QCCA 2138 at para 34 (MAiD is an area of concurrent federal and provincial jurisdiction).

provided a regulatory framework for medical assistance in dying in Québec and included an end-of-life requirement (which would later be struck down by a Québec trial court).[76] In January 2020, Québec's Minister of Health and Social Services announced that there was an indefinite postponement of MAiD on the sole basis of mental illnesses in Québec.[77] In December 2021, the *Commission spéciale sur l'évolution de la loi concernant les soins fin de vie* convened by the Québec National Assembly, published its report recommending that MAiD not be extended to mental illness.[78] Legislation passed in 2023 excludes mental illness as a basis for MAiD and repeals the end-of-life requirement.[79] That same legislation provides for advance requests for people who have lost the capacity to consent.[80]

In 2019, just three years after the enactment of Bill C-14, a Quebec Superior Court judge held in *Truchon* that the new MAiD regime was itself unconstitutional.[81] The judge found that the reasonable foreseeability of natural death safeguard in the federal legislation was contrary to sections 7 and 15 of the *Charter* precisely because the safeguard limited MAiD to those who were at the end of life and denied it to other persons with disabilities who were suffering intolerably.[82] The end-of-life requirement in the Québec legislation was also found to violate section 15.[83]

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[76] See *Truchon*, *supra* note 21 at 764–67.

[77] See "Québec repousse l'accès à l'aide à mourir pour ceux qui souffrent de troubles mentaux", *Radio-Canada* (27 January 2020), online: <ici.radio-canada.ca> [perma.cc/CXM4-6N7U]; Quebec, Select Committee on the Evolution of the Act respecting end-of-life care, *Report of the Select Committee on the Evolution of the Act Respecting End of Life Care* (December 2021) (Chair: Nancy Guillemette) at 18, online: <assnat.qc.ca> [perma.cc/K97J-ZN9Q] [Report of the Select Committee].

[78] See Report of the Select Committee, *supra* note 77 at 57.

[79] See Bill 11, *An Act to amend the Act respecting end-of-life care and other legislative provisions*, 43rd Leg, 1st Sess (assented to 7 June 2023), s 14 (providing that "a mental disorder other than a neurocognitive disorder is not considered to be an illness" for the purposes of accessing MAiD) [Bill 11].

[80] *Ibid*, s 15.

[81] See *Truchon*, *supra* note 21 at 638.

[82] See generally *ibid* at paras 587, 683, 734.

[83] *Ibid* at paras 735.

The *Truchon* decision involved two plaintiffs. The first, Jean Truchon, was 51 years of age and had cerebral palsy, degenerative spinal stenosis, and spinal cord necrosis.[84] He experienced severe pain and needed assistance with all the activities of daily life.[85] Truchon met all of the criteria under the legislation to qualify for MAiD except that his death was not reasonably foreseeable.[86] The court did not mention that Truchon had been coping in the community and, after his deterioration following the stenosis diagnosis in 2012, he applied for additional home care that would have allowed him to continue living in his home with adequate supports.[87] He needed 70 hours of support per week in order to stay at home.[88] He was denied this funding by the provincial government, which necessitated his move to a nursing

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84 *Ibid* at paras 17, 23.

85 *Ibid* at para 25–26.

86 *Ibid* at paras 41–42.

87 See Senate, Standing Senate Committee on Legal and Constitutional Affairs, Bill C-7, *An Act to Amend the Criminal Code (medical assistance in dying) Evidence*, 43-2, No 1 (1 February 2021) at 17:35 (Jonathan Marchand) [Jonathan Marchand testimony] ("I was prepared to do anything to get out of this medical hell, but just like Jean Truchon, I was denied the home care support that I needed. I complained to the highest instances. I was told that it was a political issue as living in the community with the necessary support is not a right in Canada. After two and a half years in the hospital, I ended up in a long-term care facility. This place is a medical prison." Jean Truchon was seeking death due to Home Care and Social Inclusion Service not being offered to him by the government which cast him into a state of relentless oppression. Roger Foley's evidence references Jean Truchon's Wednesday, August 17th, 2016 email communication to Jonathan Marchand where Jean Truchon states: "En réponse à ta question concernant le maintien à domicile, je pense qu'effectivement s'il y avait des services 70 heures et plus, j'aurais préféré rester à domicile et possiblement que je n'aurais pas eu le même désir de mourir." (translation: "To answer your question concerning home care, I actually think if I had 70 hours or more, I would have preferred to stay in my home and possibly I would not have had the same desire to die.") (see Senate, LCLJ Standing Committee: Legal and Constitutional Affairs, *Briefs and Other Documents,* 43-2 (1 December 2020) at 3 (Roger Foley)) [Truchon email].

88 See House of Commons, Standing Committee on Justice and Human Rights, *Evidence*, 43-2, No 6 (10 November 2020) at 11:10 (Roger Foley) ("I read an email from Jean Truchon prior to his death revealing all he needed was 70 hours of home care per week to live. Instead, he was wrongfully assisted to die by your health and legal systems").

home.[89] It was evident from an email correspondence with his friend, Jonathan Marchand, that Mr. Truchon only developed a desire to die after his increased home care was denied.[90]

The second plaintiff was Nicole Gladu, a 73-year-old woman who experienced polio as a child and then developed degenerative muscular post-polio syndrome in her 40s, with consequent deteriorating health thereafter.[91] The trial judge accepted her evidence that she was: "worn out and at the end of her rope, a prisoner of her body and her disease. In her eyes, life is active, it has momentum and energy. She has displayed a formidable appetite for life during her entire existence, and she cannot resign herself to simply existing...like [TRANSLATION] 'a plant'."[92] Ms. Gladu was also described as meeting all the criteria except that her death was not reasonably foreseeable. Ultimately, even though given access to MAiD, she died a natural death in March 2022.[93] Unlike Mr. Truchon, who did access MAiD, she had the financial means to remain in her 14th floor condominium.[94]

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89 See Jonathan Marchand testimony, *supra* note 87.

90 *Ibid*. See also Truchon email, *supra* note 87. See also Myriam Lefebvre, "Crise dans les CHSLD: Jonathan Marchand lance un cri du cœur", *Le Journal de Montréal* (8 April 2020), online: <journaldemontreal.com> [perma.cc/E9LP-P6NX].

91 See *Truchon*, *supra* note 21 at paras 51, 55.

92 *Ibid* at para 62 [translation in original] (the quotation is notable because the judge fails to realize that comparing someone who is inactive because of disability to a plant is deeply ableist and offensive even if the person has used that language themselves). Fiona Kumari Campbell discusses the concept of internalized ableism in Fiona Kumari Campbell, "Exploring internalized ableism using critical race theory" (2008) 23:2 Disability & Soc 151 at 157 ("Internalized ableism means that to assimilate into the norm the referentially disabled individual is required to embrace, indeed to assume, an 'identity' other than one's own").

93 *Cf* The Canadian Press, "Nicole Gladu, Quebec advocate of medical aid in dying, dies of natural causes", *CTV News* (1 April 2022), online: <montreal.ctvnews.ca> [perma.cc/7Y6V-7PVW].

94 *Cf* Lisa Fitterman, "MAID Advocate savoured life 'until her last breath'", *The Globe and Mail* (17 April 2022), online: <theglobeandmail.com> [perma.cc/NS9B-3XXE].

The *Truchon* court found that Bill C-14 violated section 7 of the *Charter*,[95] holding that the reasonably foreseeable natural death clause was overbroad and grossly disproportionate to its objective of protecting "vulnerable persons who might be induced to end their lives in a moment of weakness."[96] The court held that the natural death requirement was overbroad because it prevented competent and grievously ill people from requesting MAiD, forcing them to make a "cruel choice" to either take their own lives or to suffer intolerably for an unknown period of time.[97] The court held that the requirement denied "the applicants of their fundamental choice regarding appropriate care, of their self-determination and of their right to decide the time of their death,"[98] thus equating death with "care". The court went further, holding that the natural death requirement created "an actual state-imposed obligation to live."[99]

Truchon also found that section 15 guarantees people with disabilities the choice to say their lives are not worth living and to rely on the state to help end their lives. Because people with disabilities whose deaths were not foreseeable could not exercise this choice under Bill C-14, the law discriminated against them on the basis of disability.[100] The court dismissed the argument that MAiD was denied to everyone who was not dying, not just people with disabilities, holding that this reasoning was premised on formal equality without explaining that conclusion.[101]

The judge held that the reasonable foreseeability of natural death requirement failed to consider "the applicants' personal circumstances, characteristics and actual needs in a manner that respects their value as human beings as compared to other people to whom the law grants medical assistance in dying or recognizes the right to legally commit suicide,"[102] thus turning suicide into a constitutional right. People who are suffering based

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95 See *Charter*, *supra* note 29, s 7.

96 *Truchon*, *supra* note 21 at para 556.

97 *Ibid* at para 574.

98 *Ibid* at para 582.

99 *Ibid* at para 583.

100 *Ibid* at para 663.

101 *Ibid* at para 655.

102 *Ibid* at para 673. It should be noted that while attempted suicide is not crimina-

on disability, who meet the other eligibility requirements, must be given access to MAiD "not only at the end of life, but also at any moment during their life"[103] because to do otherwise would be paternalistic and deny them the autonomy to make the choice that death was preferable to life with a disability.[104] The court did not elaborate on why other Canadians who suffer intolerably, for reasons unrelated to disability, can be denied access to MAiD. The court also found that the end-of-life requirement in the Québec legislation violated section 15 of the *Charter* but did not assess the Québec legislation under section 7.[105] The court suspended its declaration of invalidity for six months, which was extended for a total of fifteen months and two weeks.[106]

The approach to section 15 in *Truchon* allowed unfettered access to MAiD for people with disabilities "at any moment during their life."[107] The suggestion that only people with disabilities who were not dying were excluded from Canada's first MAiD regime in Bill C-14 is inaccurate because everyone whose natural death was not foreseeable was denied access to MAiD. It is only accurate if one assumes that only people with disabilities would suffer intolerably, and that only they would "need'" access to a medically assisted death. Arguably, the *Truchon* analysis could be applied to any protected ground in section 15: what if someone is suffering intolerably and wants to end their life because of the intergenerational trauma of residential schools or a long history of sexual violence victimization? By extending a right to MAiD, *Truchon* may have effectively held that there is a constitutional right to a medically assisted death for intolerable suffering based on any enumerated or analogous ground in section 15, thus going far

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lized in Canada (see *Carter supra* note 28 at para 78), that does not necessarily make it "a right".

103 *Ibid* at para 682.

104 *Ibid* at para 680.

105 *Ibid* at paras 732–33.

106 See *Truchon c Procureur général du Canada*, 2020 QCCS 772 at para 9 (the first extension was for four months and was granted in March 2020). See also *Truchon c Procureur général du Canada*, 2020 QCCS 2019 at para 26; *Truchon c Procureur général du Canada*, 2020 QCCS 4388 at para 98; *Truchon c Procureur général du Canada,* 2021 QCCS 590 at para 101 (three additional extensions of five months and one week, two months and one week, and one month, respectively, were later granted by the Quebec Superior Court).

107 *Truchon, supra* note 21 at para 682.

beyond the Supreme Court of Canada's decision in *Carter*. Unless there is a coherent way to differentiate disability from other prohibited grounds of discrimination under section 15, this is the logical extension of *Truchon*.

Disability groups had urged the government to appeal *Truchon* to a higher court and to defend its legislation that had been enacted after careful consultation.[108] Instead, the Liberal government, championed by then Justice Minister David Lametti, expanded MAiD through Bill C-7 in a process that was rushed in part because of the lower court-imposed deadline.[109] On March 17, 2021, Bill C-7 became law.[110]

III. The Legislative Scheme

Bill C-7 repealed the reasonable foreseeability of death requirement from the 2016 MAiD law and set up what are now referred to colloquially as two tracks to access MAiD.[111] Track 1 applies to those for whom natural death is reasonably foreseeable and Track 2 applies to those who are not at the end of their natural lives. Track 2 has a few additional safeguards, including a 90-day period between the first assessment and the provision of MAiD.[112] Bill C-7 originally denied MAiD on the sole basis of mental illness but, following a Senate amendment, was passed with a sunset clause such that on March 17, 2023, intolerable suffering from irremediable mental

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108 See e.g. "Advocates Call for Disability-Rights Based Appeal of the Quebec Superior Court's Decision in Truchon & Gladu" (4 October 2019), online: *Inclusion Canada* <inclusioncanada.ca> [perma.cc/W39Z-7426].

109 *Cf* Joan Bryden, "David Lametti's appointment as Justice Minister raises hope for less restrictive assisted-dying law", *The Globe and Mail* (16 January 2019), online: <theglobeandmail.com> [perma.cc/5LSG-XHJE] (as a Member of Parliament, David Lametti voted against Bill C-14 because he considered it to be too restrictive). See also *Truchon, supra* note 21 at para 741.

110 See Bill C-7, *supra* note 9.

111 *Ibid*, cl 1(7).

112 *Ibid* (although this waiting period can be waived).

illness would be a sufficient basis to obtain MAiD.[113] That sunset clause was

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[113] See Camille Bains, "Canada should delay MAID for people with mental disorders: psychiatrists", *CTV News* (1 December 2022), online: <ctvnews.ca> [perma.cc/4XBQ-NJED] (the government was under considerable pressure to extend the sunset clause); Erin Anderssen, "Medical experts call on government to delay expansion of MAID for mental illness", *The Globe and Mail* (1 December 2022), online: <theglobeandmail.com> [perma.cc/N26Z-CZ67]. See also, House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 3 (25 April 2022) at 21:26 (Dr K Sonu Gaind) [AMAD Evidence No 3]; K Sonu Gaind, Letter to the Editor, "New assisted dying law threatens vulnerable citizens" *The Hamilton Spectator* (17 August 2021), online: <thespec.com> [perma.cc/K5SP-JB55]; Dr Mark Sinyor, Letter to the Editor, "Lack of evidence-based medicine in debate around new MAID law should concern Canadians" *CBC News* (4 March 2021), online: <cbc.ca> [perma.cc/542R-S6PR]; Mona Gupta et al, Letter to the Editor, "Enough with misinformation about MAID and mental illness" *Toronto Star* (8 March 2021), online: <thestar.com> [perma.cc/7DD7-RRNE]; Jacques Gallant, "Psychiatrists are divided on assisted death for people with mental disorders", *Toronto Star* (9 March 2021), online: <thestar.com> [perma.cc/MY27-BY92] (MAiD for mental illness has led to a great deal of disagreement in the psychiatric profession).

There are two arguments that underpin the criticisms of MAiD on the basis of mental illness in addition to the arguments against Track 2 MAiD generally. The first relates to the requirement that someone must have an irremediable medical condition to qualify for MAiD. Experts testified before the Joint Committee that, while there may be people whose mental illness is irremediable, psychiatrists do not have the ability to identify who those people are (see Canada, Parliament, Special Joint Committee on Medical Assistance in Dying, *Evidence,* 44-1, No 9 (26 May 2022) at 14:02 (testimony of Dr John Maher); Erin Anderssen, "Medical experts call on government to delay expansion of MAID for mental illness" *The Globe and Mail* (1 December 2022) online: <theglobeandmail.com> [perma.cc/N26Z-CZ67]). The second argument is that there is no clear way to differentiate MAiD on the basis of mental illness from suicide particularly when dealing with conditions like depression for which suicidality may be a symptom. Kim and Lemmens have observed that while depression is the most common reason for psychiatric MAiD, "[i]n Belgium and the Netherlands, medical assistance in dying has been provided to people with chronic schizophrenia, posttraumatic stress disorder, severe eating disorders, autism, personality disorders and even prolonged grief" (Scott YH Kim and Trudo Lemmens, "Should Assisted Dying for Psychiatric Disorders Be Legalized in Canada" (2016) 188:14 Can Medical Assoc J E337). The British media reported that a 23-year-old Belgian woman obtained MAiD as a result of the

extended twice such that MAiD for mental illness would become available on March 17, 2027[114]

The purpose of Bill C-7 was to provide access to MAiD for people with disabilities who are suffering intolerably and to decriminalize the medical practitioners who cause or assist in their deaths.[115] The underlying premise was that a medically assisted death was preferable to requiring such individuals to continue suffering. The phrase "death with dignity" is often used to describe MAiD whereas a life with suffering is depicted as undignified.[116] The assumption is that making MAiD available somehow brings dignity to these lives and, potentially, reduces suicide by giving people an easier path to a death within their control.[117]

In Canada, deliberately administering a drug for the purpose of causing the death of another human being would normally constitute murder under section 229(a)(i) of the *Code*.[118] Providing that drug to another person for the purpose of assisting them in ending their own life would constitute the

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trauma resulting from a terrorist incident (see Lucy Skoulding, "Woman, 23, who survived 2016 Brussels airport terror attack 'euthanised' in Belgium", *The Independent* (10 October 2022) online: <independent.co.uk> [perma.cc/87ZL-RJ88]).

114 In March 2023, Parliament passed a bill extending this exclusion until 2024 (see Bill C-39, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2023, cl 1 (assented to 9 March 2023)). Conservative MP Ed Fast's Private Member's Bill C-314 sought to cancel the expansion of MAiD to those with mental illness. The Bill was defeated by 17 votes in the House, 150–167, with the majority of Liberals and Bloc Québecois voting against it. While the NDP had initially supported the expansion of Bill C-7, they voted with the Conservatives against expansion to mental illness (see *House of Commons Debates,* 44-1, No 234 (18 October 2023) at 16:35 (The Deputy Speaker)). See also Bill C-62, *supra* note 25.

115 Bill C-7, *supra* note 9 at preamble, paras 2–3, 6–8.

116 See e.g. Anna Vargo, "Death with Dignity in Canada: No Longer Limited to the Terminally-Ill" (28 May 2022) 8:1 Voices in Bioethics 1 at 1.

117 As will be discussed, however, if this were correct, one would expect the suicide rate to go down in jurisdictions with permissive MAiD regimes. This is not, in fact, happening (see the text accompanying note 227).

118 See *Code*, *supra* note 25, s 229(a)(i).

crime of aiding suicide contrary to section 241(b) of the *Code*.[119] Section 14 of the *Code* provides that no one can consent to their own death and that consent is not a defence to the criminal responsibility of the person inflicting it.[120] All of these provisions collectively recognize the seriousness of deliberately taking someone's life or of helping them to commit suicide. These provisions offer protection from death through the deterrent and denunciatory force of criminal law. Section 227 now provides an exemption from culpable homicide offences for medical practitioners providing MAiD. The government has acknowledged that the MAiD regime involves the "creation of an exemption for certain medical practitioners from the criminal offences of culpable homicide (i.e., murder, manslaughter, or infanticide) and assisting suicide."[121]

The *Code* sets out the MAiD criteria in section 241.2(1):

> (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
>
> (a) they are eligible—or, but for any applicable minimum period of residence or waiting period, would be eligible—for health services funded by a government in Canada;
>
> (b) they are at least 18 years of age and capable of making decisions with respect to their health;
>
> (c) they have a grievous and irremediable medical condition;
>
> (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

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119 *Ibid*, s 241(b).

120 *Ibid*, s 14 (the government chose not to amend this provision but, after *Carter*, it must be read down to exclude MAiD).

121 See Permanent Mission of Canada to the United Nations and World Trade Organization, *Response of Canada to the Joint Communication from the Special Rapporteur on the Rights of Persons with Disabilities, the Independent Expert on the Enjoyment of All Human Rights by Older Persons, and the Special Rapporteur on Extreme Poverty and Human Rights*, No. GENEV-7208 (Ottawa: PMCUNWTO, 2021) at para 14, online (pdf): <spcommreports.ohchr.org> [perma.cc/J9LW-6HAG] (because MAiD is not manslaughter or infanticide, this exemption can only be referring to murder. Sections 241(2)–(5.1) and 245(2) of the *Code*, *supra* note 25, also create exemptions from aiding suicide and administering a noxious thing, respectively).

> (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.[122]

Someone is considered to have a grievous and irremediable medical condition under section 241.2(2) if:

> (a) they have a serious and incurable illness, disease or disability;
>
> (b) they are in an advanced state of irreversible decline in capability; and
>
> (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.[123]

Section 241.2(3) sets out a number of safeguards for when natural death is foreseeable, and section 241.2(3.1) provides safeguards for when death is not foreseeable: the request must be in writing and witnessed; the person must understand their right to withdraw the request at any time; and another practitioner must have confirmed that the individual meets all the criteria.[124] If neither of those two physicians/nurse practitioners has expertise regarding the individual's condition, they must consult with another practitioner who does.[125] Advocates before Parliamentary committees urged the additional safeguard that a medical practitioner not be allowed to raise MAiD with a patient—rather the idea had to be initiated by the individual.[126] This

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122 *Code*, *supra* note 25, s 241.1(1).

123 *Ibid*, s 241.2(2) (the requirement that a condition be irremediable sits awkwardly with the absence of a requirement that the person exhaust medical options. If a particular treatment option exists that might remediate the condition, but it is not acceptable to the individual, the law arguably allows access to MAiD for a condition that is not irremediable). See also Li, as told to Agrba, *supra* note 24 (Dr. Madeline Li describes a patient as having a 65% chance of a cure had they undergone treatment).

124 See *Code*, *supra* note 25, ss 241.2(3), 241.2(3.1).

125 *Ibid*, s 241.2(3.1)(e.1).

126 See e.g. House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 10 (30 May 2022) at 19:44 (Dr Ramona Coelho) ("There is no safeguard in Bill C-7 that forbids raising MAID, and the related

was rejected and there is no such limit on healthcare workers raising the option of MAiD.[127]

Subsection 241.2(3.1)(i) requires that at least 90 days have passed between the first assessment and the day on which MAiD is provided. However, if the assessor and the provider are both of the opinion that a loss of capacity is imminent, this period can be shortened at their discretion.[128] There is no check on the exercise of that discretion. There is also the possibility that someone who qualifies under Track 2 can avoid the waiting period by being switched to Track 1 if, for example, they stop eating. The Canadian Association of MAiD Assessors and Providers explicitly states in their publication that a "clear and serious intent to take steps" to "voluntarily cease eating and drinking" would make natural death reasonably foreseeable.[129]

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amendment was voted down by the Senate ... Inadequate safeguards suggest that this has been packaged and thinly veiled as a medical procedure. If this is not the case, I ask the government to reconsider its MAID regime").

127 See Maria Cheng, "'Disturbing': Experts troubled by Canada's euthanasia laws", *AP News* (11 August 2022), online: <apnews.com> [perma.cc/GD68-BWRX]. The Canadian Association of MAiD Assessors and Providers (CAMAP) states that physicians and nurse practitioners have an ethical obligation to raise MAiD if a patient might be eligible (see "Bringing up Medical Assistance in Dying (MAiD) as a clinical care option" (February 2022) at 1, 6, 7, online (pdf): *Canadian Association of MAiD Assessors and Providers* <camapcanada.ca> [perma.cc/3QRK-V8W]). *Cf* "The Interpretation and Role of 'Reasonably Foreseeable' in MAiD Practice" (February 2022) at 7, online (pdf): *Canadian Association of MAiD Assessors and Providers* <camapcanada.ca> [perma.cc/FS2X-B52M] [CAMAP].

128 See *Code*, *supra* note 25, s 241.2(3.1)(i).

129 CAMAP, *supra* note 127 at 1 ("[a] person may meet the 'reasonably foreseeable' criterion if they have demonstrated a clear and serious intent to take steps to make their natural death happen soon or to cause their death to be predictable. Examples might include stated declarations to refuse antibiotic treatment of current or future serious infection, to stop use of oxygen therapy, or refuse turning if they have quadriplegia, or to voluntarily cease eating and drinking." I cite this passage not as an endorsement of this position, which I believe is contrary to the intent of Track 1 MAiD, but rather to show how broadly Track 1 is being applied by the very organization that provides guidance to MAiD providers).

Subsection 241.2(3.1)(g) requires that before administering MAiD, the physician or nurse practitioner must ensure that the person knows what services are available. They are required to confirm that the person has received information and been offered consultations regarding the means available to relieve their suffering including, where appropriate, "counselling services, mental health and disability support services, community services and palliative care."[130] Where those services are not "available", there is no requirement in the legislation that they be made available or that actual attempts be made to alleviate suffering before administering MAiD. The MAiD provider must also "have discussed with the person the reasonable and available means to relieve the person's suffering" and must agree that the person has given "serious consideration" to those means, but there is no legislative obligation for the state to pay for those means when the person cannot afford them.[131] Following a review of these safeguards, an expert panel commissioned by Health Canada concluded that MAiD solely on the basis of mental illness could be administered "without adding new legislative safeguards to the *Criminal Code.*"[132]

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130 *Code*, *supra* note 25, s 241.2(3.1)(g).

131 *Ibid*, s 241.2(3.1)(h).

132 Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (Ottawa: Health Canada, 2022) at 49 [*Final Report*] (The panel rejected the term "mental illness" because it does not have a standard definition, so it used the language of "mental disorder" in its report instead); Jeff Kirby, Letter to the Editor, "MAiD expert panel recommendations are inadequate, contends panel member who resigned" *The Hill Times* (16 June 2022), online: <hilltimes.com> [perma.cc/AJ9R-XAU9] (one member of the panel, a psychiatrist, resigned because he felt members were being discouraged from raising issues); Ellen Cohen, "Why I resigned from the federal expert panel on medical assistance in dying", *The Globe and Mail* (14 October 2022), online: <theglobeandmail.com> [perma.cc/7YC2-MXDR] (a member of the panel with lived experience of mental illness also resigned).

IV. Preliminary Data on MAiD

In 2022, there were 13,241 MAiD deaths in Canada totaling 4.1% of all deaths.[133] This was an increase from 10,092 MAID deaths in 2021.[134] Four hundred and sixty-three of those deaths were Track 2 deaths, comprising 3.5% of all MAiD deaths.[135] While we had only nine months of data from 2021 under Track 2, this is more than double the 223 reported for that year.[136] The number of Track 2 cases varies across jurisdictions. In 2021, for example, 4% of MAiD cases on Vancouver Island were Track 2 cases; this percentage was "much higher than in Ontario."[137] In 2022, people accessing Track 2 were generally younger than those accessing Track 1, with 41.5% between the ages of 18 and 70[138] as compared to 28.9% falling into this age group for the overall MAiD population.[139] For the first time, we now have some data on Track 2 and gender indicating that "[t]here was a greater percentage of females than males (59.0% vs 41.0%) whose death was not

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133 See Health Canada, *Fourth Annual Report on Medical Assistance in Dying in Canada, 2022* (Ottawa: Health Canada, October 2023) at 21 [Fourth Annual Report]. In response to the more than 30% increase in the number of MAiD deaths in 2022, the Globe and Mail editorial board has called on the government to take a step back on MAiD concluding that "Ottawa needs to withdraw its amendments that include mental illness in the law for MAID. There are too many uncertainties, most crucially the inability to determine who is suffering from a truly irremediable mental disease and who will recover given enough time, treatment – and hope." (see "It's time to take a step back on assisted death" Editorial, *The Globe and Mail* (4 November 2023), online: <theglobeandmail.com> [perma.cc/B4VU-CAXK]).

134 Fourth Annual Report, *supra* note 133 at 21. See also Health Canada, *Third Annual Report on Medical Assistance in Dying in Canada 2021* (Ottawa: Health Canada, July 2022) at 18 [Third Annual Report].

135 Fourth Annual Report, *supra* note 133 at 34.

136 *Ibid*; Third Annual Report, *supra* note 134 at 28. The Fourth Annual Report actually reports the number of Track 2 deaths for 2021 at 223, but the Third Annual Report reports the number of Track 2 deaths as 219.

137 Kevin O'Keefe & Avis Favaro, "A rare look at Canada's growing demand for medical assistance in dying", *CTV News* (11 April 2022), online: <ctvnews.ca> [perma.cc/L4LD-ZUH6].

138 See Fourth Annual Report, *supra* note 133 at 35.

139 *Ibid*.

naturally foreseeable in 2022."[140] This disproportionate number of women is not seen in Track 1 where there are slightly more men than women accessing MAiD (51.8% vs 48.2%).[141]

There is very little information on diagnosis for Track 2, with 50% of cases attributed to "neurological conditions", 37.1% to "other conditions", and 23.5% to "multiple comorbidities"[142] which include things like chronic pain, diabetes, and "frailty."[143] The number of MAiD requests where the applicant is found ineligible has consistently gone down with 8% in 2019 and a low of 3.5% in 2022.[144]

It is important to bear in mind when looking at MAiD statistics that, for many categories of statistics, Track 1 and Track 2 are not disaggregated. Because there are so many more deaths classified as Track 1, those deaths will inevitably overshadow the Track 2 deaths in terms of numbers alone. For example, when looking at the nature of the suffering for people who received MAiD in 2022, both tracks are combined together. Thus, it is impossible to say with any certainty what the nature of the suffering was for those 463 Track 2 deaths specifically. Similarly, with respect to the individuals who received palliative care or disability supports, the annual report does not provide data on Track 2 specifically. We know that 19.6% of people who accessed MAiD did not receive palliative care, although 87.5% of this number had access to palliative care.[145] Additionally, 89.5% percent of people received disability support services, but 39.8% of those people received disability support services for less than six months.[146] Again, Track 1 and Track 2 are not disaggregated.

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140 *Ibid*.

141 *Ibid.*

142 *Ibid* at 34 (this is particularly striking given that very detailed information is provided on gender and diagnosis for the overall sample).

143 *Ibid* at 27 (Chart 4.1D includes other comorbidities including very common conditions such as osteoarthritis, osteoporosis, and hearing and vision loss. These numbers led the Globe and Mail editorial board, *supra* note 133, to ask whether "Canadians [are] being approved for a medically assisted death simply because they are old?").

144 *Ibid* at 48.

145 *Ibid* at 32.

146 *Ibid* at 33 (note that being a recipient of provincial social assistance qualifies as

Experience from other jurisdictions would suggest that the equivalent of Track 2 cases tend to increase over time which is consistent with the early Canadian data. In Belgium, for example, where MAiD is available for those not at the end of life, there has been a steady increase in the number of cases where death was not reasonably foreseeable. In 2003, death was not foreseeable in 8.1% of deaths.[147] In 2013, death was not foreseeable in 14.7% of the deaths.[148] There was also a steady increase during that time period of cases linked to a neuropsychiatric disorder diagnosis, such as major depressive disorder, schizophrenia, or bipolar disorder. In 2005, for example, 0.8% of medically assisted deaths were linked to a neuropsychiatric disorder.[149] In 2013, 3.9% of cases were linked to such a disorder.[150]

Experience from other jurisdictions also suggests that women will be overrepresented in Track 2 cases involving psychiatric disabilities. In one study, researchers found that of a sample of 100 patients who requested MAiD in Belgium on the sole basis of at least one psychiatric disorder, 77% were women.[151] Those individuals were, on average, 47 years old.[152] Other researchers have demonstrated that the preponderance of women seeking MAiD for mental illness is a consistent finding with "women [accounting]

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receiving disability support services).

147 Sigrid Dierickx et al, "Euthanasia in Belgium: Trends in Reported Cases Between 2003 and 2013" (2016) 188:16 Can Medical Assoc J E407 at E410 [Dierickx, "Euthanasia in Belgium"]. See also Trudo Lemmens, "Charter Scrutiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice" (2018) 85 SCLR (2nd Series) 459 (an examination of Canadian law in the context of Belgium and the Netherlands prior to Bill C-7).

148 Dierickx, "Euthanasia in Belgium", *supra* note 147.

149 *Ibid*.

150 *Ibid*.

151 Liev Thienpont et al, "Euthanasia Requests, Procedures and Outcomes for 100 Belgian Patients Suffering from Psychiatric Disorders: A Retrospective, Descriptive Study" (2015) 5:e007454 BMJ Open 1 at 6 (the researchers point out at 6 that: "[Having a majority of women in their sample] is in line with other reports in the literature, which indicate that women fulfil the diagnostic criteria for mental disorders more often men, except in the case of substance use disorders").

152 *Ibid* at 6–7.

for the majority (69–77%) of persons who request and receive euthanasia based on a psychiatric condition."[153] One study found that 36% of those who died from psychiatric MAiD had a history of trauma.[154] Even before MAiD for mental illness becomes legal, we already see a disproportionate number of women in Track 2 MAiD deaths (59%).[155] It is likely that this overrepresentation will increase when MAiD for mental illness becomes available.

Track 2 MAiD has galvanized disability organizations and disability activists across the country.[156] The bill was described by Krista Carr, Executive Director of Inclusion Canada, as the disability community's "worst nightmare."[157] Disability organizations and advocates argue that this law violates the rights of disabled Canadians by devaluing and stigmatizing disabled lives, portraying disability as something to be avoided at all costs, even through death.[158] A group of disabled Canadians started a "Disability Filibuster"—an online forum to celebrate disability culture and to talk about the impact of the expansion of MAiD on disabled lives.[159] In order to understand these critiques it is necessary to understand why they see Bill C-7 as a function of widespread and systemic ableism in Canada.

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153 Marie E Nicolini, Chris Gastmans & Scott Y H Kim, "Psychiatric Euthanasia, Suicide and the Role of Gender" (2022) 220 British J Psychiatry 10 at 10 [Nicolini, Gastmans & Kim, "Role of Gender"] (It has been suggested that women in coercively controlling and otherwise abusive relationships may be particularly vulnerable to coercion in this context and that a history of violence may contribute to accessing psychiatric MAiD). See also, Sonia Sodha, "Assisted dying seems humane, but can we protect the vulnerable from the malign?", *The Guardian* (1 January 2023), online: <theguardian.com> [perma.cc/QP45-H3KS].

154 See Marie E Nicolini et al, "Euthanasia and Assisted Suicide of Persons with Psychiatric Disorders: The Challenge of Personality Disorders" (2020) 50 Psychological Medicine 575 at 577.

155 Fourth Annual Report, *supra* note 133 at 35.

156 See Stop C-7*, supra* note 19.

157 House of Commons, Standing Committee on Justice and Human Rights, *Evidence*, 43-2, No 6 (10 November 2020) at 4 (Krista Carr) online (pdf): <ourcommons.ca > [perma.cc/PB4L-HM57].

158 See Stop C-7, *supra* note 19.

159 See Disability Filibuster*,* "Homepage", online: <disabilityfilibuster.ca> [perma.cc/PF8W-3AYY].

V. Ableism in Canada

Despite the growing awareness of systemic racism and sexism in mainstream social and political life, ableism has not yet received the same level of attention in public discourse. Yet it is impossible to examine the disability community's concerns about MAiD without understanding the pervasive nature of ableism in Canada and the degree to which the medical profession has been complicit in that ableism. The former UN Special Rapporteur on the Rights of Persons with Disabilities described ableism as follows in her report drafted after her visits to Canada and Norway:

> [Ableism is] a value system that considers certain typical characteristics of body and mind as essential for living a life of value. Based on strict standards of appearance, functioning and behaviour, ableist ways of thinking consider the disability experience as a misfortune that leads to suffering and disadvantage and invariably devalues human life.[160]

Fiona Kumari Campbell goes further and suggests that ableism includes the view that disability makes one less than "fully human" as being "fully human" is to be "able"; therefore having a disability is "tolerated" but ultimately "inherently negative."[161]

Ableism is so deeply embedded in our social structures as to be largely unrecognizable or invisible. As Dr. Heidi Janz argues, what makes ableism so insidious is that it has been transformed into "common sense."[162] James Cherney posits that the rhetoric of ableism has become so reified and accepted as common sense that it "denies its own rhetoricity."[163] Ableism does not exist outside of our laws and legal processes but rather is a deeply

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160 Special Rapporteur on the Rights of Persons with Disabilities, *Rights of Persons with Disabilities*, UNGA, 43rd Sess, UN Doc A/HRC/43/41 (2020) at para 9, online: <documents-dds-ny.un.org> [perma.cc/U3C7-UFPG], citing Ron Amundson, "Disability, ideology, and quality of life: A bias in biomedical ethics" in David Wasserman, Jerome Bickenbach & Robert Wachbroit, eds, *Quality of Life and Human Difference* (New York: Cambridge University Press, 2005) [*2020 UN Special Report*].

161 See e.g. Campbell, *supra* note 92 at 151.

162 Heidi L Janz, "Ableism: The Undiagnosed Malady Afflicting Medicine" (2019) 191:17 Can Medical Assoc J E478 at E479.

163 James L Cherney, "The Rhetoric of Ableism" (2011) 31:3 Disability Studies

embedded part of them. Ableism often intersects with racism, as can be seen in the sterilization of disproportionately Indigenous women and girls with disabilities.[164] Other laws and policies that sustain and promote systemic ableism include: the institutionalization of people with intellectual disabilities[165] or those with mental illness;[166] limits on the ability to immigrate to this country based on disability;[167] welfare rates that force disabled people to live below the poverty line;[168] removal of children from parents with disabilities;[169] and prioritizing able-bodied people for access to medical

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Q, online: <dsq-sds.org/index.php/dsq/article/view/1665/1606> [perma.cc/WMU5-2BRR].

164 See e.g. Susan M Brady, "Sterilization of Girls and Women with Intellectual Disabilities: Past and Present Justifications" (2001) 7:4 Violence Against Women 432 at 432; Robert A Wilson, "Eugenics, Disability, and Bioethics" in Reynolds & Wieseler, *infra* note 199 at 21; *2020 UN Special Report*, *supra* note 160 at para 10; *E (Mrs) v Eve*, [1986] 2 SCR 388 at 393–94.

165 In Nova Scotia, for example, people with disabilities have been on the waitlist for community-based residential services for nearly 20 years (see *Nova Scotia (AG) v MacLean*, 2017 NSCA 24 at para 10; *Disability Rights Coalition v Nova Scotia (AG)*, 2021 NSCA 70 (Factum, Appellant) at para 48, online (pdf): <disabilityrightscoalitionns.ca> [perma.cc/B6QU-2W87]).

166 See e.g. Katherine Warburton & Stephen M Stahl, "Balancing the Pendulum: Rethinking the Role of Institutionalization in the Treatment of Serious Mental Illness" (2020) 25:1 CNS Spectrums 115 at 115.

167 See e.g. Judith Mosoff, "Excessive Demand on the Canadian Conscience: Disability, Family, and Immigration" (1999) 26:2 Man LJ 149 at 149.

168 See e.g. Rabia Khedr & Emily Macrae, "Disability should not equal poverty" Editorial, *The Hamilton Spectator* (7 March 2022), online: <thespec.com> [perma.cc/VY3G-4FAY]; Statistics Canada, *Low Income Among Persons with a Disability in Canada*, by Katherine Wall, Catalogue No 75-006-X (Ottawa: Statistics Canada, 11 August 2017) at 2–3, 6 online (pdf): <statcan.gc.ca> [perma.cc/R2J9-LW2Y]; Statistics Canada, *A Demographic, Employment and Income Profile of Canadians with Disabilities Aged 15 Years and Over, 2017*, by Stewart Morris et al, Catalogue No 89-654-X2018002 (Ottawa: Statistics Canada, 18 November 2018), at 19, online (pdf): <statcan.gc.ca> [perma.cc/4D8M-9FV3]; *2020 UN Special Report*, *supra* note 160 at para 10. *Cf* Katie Raso, "Disability and the job churn" (1 July 2018), online: <policyalternatives.ca> [perma.cc/D5FN-4ARU] (people with disabilities face employment discrimination, resulting in higher rates of unemployment and lower wages, which will only worsen with the normalization of the "job churn").

169 See e.g. *Nova Scotia (Community Services) v CKZ*, 2016 NSCA 61 at paras

care.[170] Disabled writer and policy analyst Gabrielle Peters describes ableism as the "rebar in our economy, politics and culture."[171]

The medical model of disability is central to sustaining ableism both in medicine and in legislative policy.[172] The medical model of disability constructs disability as a medical shortcoming or a flaw, and as something needing to be fixed or ameliorated.[173] If the medical profession's *raison d'être* is to cure or eradicate illness and disability, those living with chronic disabilities represent its failures: those they have failed to fix or make whole. Thus, it is not surprising that doctors consistently rate the quality of life of their disabled clients as lower than the ratings disabled individuals give their own lives.[174]

The medical model also puts doctors in a central role as gatekeepers to resources and supports, which gives them enormous power to name and label who is included in and excluded from particular categories that are linked to resources and supports.[175] These labels also affect other legal

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1–7. See also Judith Mosoff et al, "Intersecting Challenges: Mothers and Child Protection Law in BC" (2017) 50:2 UBC L Rev 435 at 460–68.

170 See Mykitiuk & Lemmens, *supra* note 14; Peters, "Right to live", *supra* note 14; World Health Organization, News Release, "Disability" (2 December 2022), online: <who.int/news-room> [perma.cc/8MJ2-X4ZF]; *2020 UN Special Report*, *supra* note 160 at para 10.

171 Peters, "Right to live", *supra* note 14.

172 See Joel Michael Reynolds, "'I'd Rather Be Dead than Disabled': The Ableist Conflation and the Meanings of Disability" (2017) 17:3 Rev Communication 149 at 153 [Reynolds, "Better Dead than Disabled"]; Justin Anthony Haegele & Samuel Hodge, "Disability Discourse: Overview and Critiques of the Medical and Social Models" (2016) 68:2 Quest 193 at 196; Bradley A Areheart, "When Disability Isn't Just Right: The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma" (2008) 83:1 Ind LJ 181 at 193.

173 See Areheart, *supra* note 172 at 186; Reynolds, "Better Dead than Disabled'" *supra* note 172 at 153.

174 See Lisa I Iezzoni et al, "Physicians' Perceptions of People with Disability and their Health Care" (2021) 40:2 Health Affairs 297 at 304. For a description of physicians' perspectives on caring for people with disability, see Tara Lagu et al, "'I Am Not the Doctor for You': Physicians' Attitudes about Caring for People with Disabilities", (2022) 41:10 Health Affairs 1387 at 1391.

175 See Haegele & Hodge, *supra* note 172 at 195–196.

statuses such as who is capable of making medical decisions, marrying, entering a contract, or consenting to sexual activity.[176] When doctors are the gatekeepers, we tend to insist on fewer safeguards than when, for example, police or judges are making these profound decisions about life and death. The benevolence we implicitly attribute to doctors obscures the need for procedural safeguards.[177]

Professor Joel Reynolds identifies one way in which the medical model has maintained its pre-eminence through what he describes as the ableist conflation of disability, suffering, and death.[178] Reynolds asks the critical question: "What if a vast range of medical thinking and communication about disability is based not in its lived experience, but in misguided aversion to and fear of it?"[179] As he identifies, "[i]t is this bold-faced linking of disability with pain, of which death is ultimately a species, that achieves such a spectacle of uncritical thinking about disability."[180]

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176 See Janine Benedet & Isabel Grant, "A Situational Approach to Incapacity and Mental Disability in Sexual Assault Law" (2013) 43:1 Ottawa L Rev 1 at 10–12. See also Michael Bach, *Right to legal capacity under the UN Convention on the Rights of Persons with Disabilities: key concepts and directions from law reform* (Toronto: Institute for Research and Development on Inclusion and Society, 2009) at 1, 9–11.

177 For example, we require fewer procedural safeguards to civilly commit someone under mental health legislation than we do to incarcerate them through the criminal justice system. In British Columbia, a person can be detained and have that detention renewed for months without access to a hearing. The onus is on the detained individual to apply for that hearing (see *Mental Health Act*, RSBC 1996, c 268, ss 22–25 [BC *Mental Health Act*]). Isabel Grant and Peter Carver have discussed the degree to which judges recognize the coercion in the criminal justice system more readily than in the mental health system in *PS v Ontario*, 2014 ONCA 900 (see Isabel Grant & Peter Carver, "*PS v Ontario*: Rethinking the Role of the Charter in Civil Commitment" (2016) 53:3 Osgoode Hall LJ 999 at 1015, 1017. See also Isabel Grant, "Mental Health Law and the Courts" (1991) 29:4 Osgoode Hall Law Journal 747 at 783).

178 See Reynolds, "Better Dead than Disabled", *supra* note 172 at 150.

179 *Ibid*.

180 *Ibid* at 152–53 (Reynolds also argues at 150 that the reason that the medical model remains "so gallingly entrenched is because of [what he calls] the 'ableist conflation': the conflation of disability with pain and suffering").

Nowhere has the conflation between disability and suffering been more starkly illustrated than in the Joint Committee hearings reviewing Canada's MAiD laws. Committee members and witnesses described that they would rather be dead than be incontinent,[181] live in long-term care,[182] or lose their mental acuity.[183] Disabled Canadians have listened to their legislators discuss whether it would be better to be dead than to be like them.[184] Gabrielle Peters, for example, tweeted that the MAiD hearings "broke her in new

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[181] This evidence was given by British Columbia psychiatrist Derryck Smith, who stated that that "if you wait too long to apply for MAID, you're going to become incompetent. If you become incompetent, then you are sentenced to five years of sitting around in a home in adult diapers." (see House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 8 (25 May 2022) at 9 (Derryck Smith) online: <parl.ca> [perma.cc/KA8M-5N7Q].) This statement led to a thread on Twitter with the hashtag "whileincontinent", started by Gabrielle Peters, where disabled Canadians tweeted about their impressive accomplishments while they were experiencing incontinence (see Gabrielle Peters, "If it feels safe to you - and I completely understand why it might not - and you have or have ever been incontinent, could you consider tweeting #WhileIncontinent and what you did?" (25 May 2022), online: <twitter.com> [perma.cc/3TSD-5K9V] [Peters, "#whileincontinent"]).

[182] See House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 6 (9 May 2022) at 28 (Alistair MacGregor), online: <parl.ca> [perma.cc/E9G6-L9MF] [AMAD Evidence No 6] (Alistair MacGregor noted that "we've often heard during this committee about the stigma that many people have—i.e., 'Oh, my goodness, if I were to get a diagnosis of Alzheimer's, my life would essentially be over.' They look at the state of long-term care in Canada, and there's a very real fear there"). See also AMAD Evidence No 3, *supra* note 113 at 21:38 (Audrey Baylis states: "I haven't nursed for a number of years, because I had three careers, but I am a registered nurse. Most of the people whom I have been knowledgeable with are 100% behind MAID, because none of us are going to go into a nursing home, one way or another. Right now I still do not qualify to have MAID in Canada because I don't have anything really medically serious at the moment. I don't qualify").

[183] In asserting the importance of enacting advance directives for MAiD, Senator Kutcher described people with dementia as "smear[ing] their feces on the wall or eat[ing] them" and "spend[ing] their whole day sitting in front of a television set, laughing and singing, clapping at TV shows, and moving their body in time to the music" (AMAD Evidence No 6, *supra* note 182 at 28 (Senator Kutcher)).

[184] See AMAD Evidence No 29, *supra* note 17 at 09:01 (Isabel Grant); see also *ibid* at 08:54 (testimony of Catherine Frazee).

and terrible ways."[185] Peters started the Twitter hashtag "#whileincontinent" where disabled Canadians tweeted about their many accomplishments while experiencing incontinence after a witness suggested that incontinence might be a reason to access MAiD.[186]

In contrast to the medical model, the social model of disability highlights the social and political realities of living with a disability in a world where ableism is the common-sense norm.[187] Much of the suffering associated with disability is imposed by stigma, discrimination, and exclusion from full participation in social and political life. These models are not necessarily mutually exclusive nor is either a comprehensive description of disability. A person with a disability may experience as negative both the actual physical impairments and the social stigmatization of disability and barriers to participation.[188] But the pro-MAiD movement relies exclusively on the medical conception of disability and of suffering while ignoring the social components. Only when something is characterized as medical in nature, and medically unfixable, is MAiD available.

Dr. Shelley Tremain describes the rush to expand MAiD in Canada as a form of "disaster ableism."[189] Relying on the works of Kyle Whyte and

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185 Gabrielle Peters, "In case you don't know, the MAID hearings in 2021 broke me in new and terrible ways and this description was/is very much me." (25 November 2022), online: <twitter.com> [perma.cc/6NBY-5B6Z].

186 See Peters, "#whileincontinent", supra note 181.

187 The Supreme Court has acknowledged the importance of the social model in understanding disability, exclusion, and marginalization in *Granovsky v Canada (Minister of Employment and Immigration)*, 2000 SCC 28 at paras 30, 34.

188 See Sara Goering, "Rethinking Disability: The Social Model of Disability and Chronic Disease" (2015) 8:2 Current Reviews Musculoskeletal Medicine 134 at 135. Tom Shakespeare rejects what he describes as a "strong" social model of disability that rejects the reality of actual impairment in favour of what he calls an agenda for disability equality which recognizes "both the diversity of illness and impairment experiences and contexts, and the breadth of everyday life" (see Tom Shakespeare, *Disability Rights and Wrongs Revisited*, 2nd ed, (London: Routledge, 2013) at 1, 4).

189 Shelley Tremain, "My Virtual Presentation to PhiloSOPHIA, June 3, 2022: Disaster Ableism, Assisted Suicide, and Bioethics" (Presentation delivered at the Philosophy of the Limit: Risk, Disaster, and Infrastructure virtual panel), online (transcript): <biopoliticalphilosophy.com> [perma.cc/KB9P-DCVR] [Tremain, "Disaster Ableism"]. Tremain develops this concept from Naomi Klein's

Naomi Klein, she describes this distortion as "presentism," which "leads people to obscure or minimize how their actions relate to the persistence of colonialism, capitalism, ableism, racism, and other forms of power."[190] She argues that Bill C-7 has been framed within this presentist narrative:

> By framing Bill C-7 as a unique and urgent new procedural corrective, Canadian [proponents of MAiD] have, again, reconfigured and obfuscated the incremental normalization of eugenic practices in precisely the way that Whyte describes, that is, according to the presentist orientation of an epistemology of crisis. This presentist orientation positions the notions of personal autonomy and quality of life as existing outside of any temporal location, as timeless and universal, and in doing so, conceals the historically contingent and culturally specific character of these politically motivated ideals, as well as the way that these constructs emerged from and reproduce the liberal settler state itself.[191]

The medical model foregrounds the medicalization of suffering as if it can be compartmentalized and distinguished from the social and political factors contributing to suffering. Professor Ameil Joseph has criticized the ableist way these realities of disability have been obscured in the MAiD debate:

> Historical context is critical to this discussion yet almost nowhere is it being included in the debates. In the Senate hearings, in the media coverage and even in the advocacy, much of it has ignored the long history of eugenics and discrimination of persons with disabilities in Canada.
>
> If we listen to persons with disabilities, we'll learn that so much of their day-to-day suffering is a result of systemic discrimination that denies them the basic needs for robust

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writing about "disaster capitalism", a component of neoliberalism that allows for the exploitation of social disaster crises to expand unregulated economic markets (see generally Naomi Klein, *The Shock Doctrine: The Rise of Disaster Capitalism* (Toronto: Vintage Canada, 2009)).

190 Tremain, "Disaster Ableism", *supra* note 189.

191 *Ibid*.

> living. Disability itself is not a consignment to suffering and misery. That's an ableist lens.[192]

Joseph continues by explaining that this medicalization of disability and suffering is a political strategy employed as a tactic to further eugenic and ableist policies:

> These omissions are not accidents, they are coherent with the historical trajectories of ableism and eugenics that attach ideas of compassion to institutionalization, eradication and exclusion. We have a body of historical evidence that shows we have treated people with disabilities as burdensome and unworthy of adequate incomes and services.
>
> We have permitted a medicalized idea of suffering to persist in persons with disabilities by omitting the social contexts of suffering, while erasing the historical contexts, and turning our gaze away from the systemic racism and discrimination that we know is persistent and pervasive across systems and services.[193]

Peters similarly argues that MAiD is a rebranding of the eugenics movement.[194]

Ableism underlies the idea that the suffering associated with disability is not only inherent to disability but is also distinct from other human suffering. Only the intolerable suffering of people with disabilities is responded to with an offer of death. The exceptionalizing of disabled suffering as warranting death is evident throughout the decision in *Truchon*. Yet if one examines the reasons people give for seeking MAiD, many of them are neither directly caused by disability nor unique to disabled suffering: loneliness and isolation, loss of dignity, and being a burden on loved ones

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192 Ameil J Joseph, "Expanding MAiD could worsen discrimination against people with disabilities", *QUOI Media* (22 February 2021), online: <quoimedia.com> [perma.cc/TB6Z-FU4E].

193 *Ibid.*

194 See Gabrielle Peters, "Canada is NOT as Advertised. MAiD Is Eugenics" (16 June 2022), online: <mssinenomineblog.wordpress.com> [perma.cc/E9BK-S2SX].

are not unique to disability.[195] The suggestion that the dignity of a life is diminished if one lacks full independence is also ableist. Many people with disabilities depend on family or caregivers to manage various aspects of their lives. Their dignity is not diminished through this dependence; rather, their dignity is diminished because society repeatedly tells them it should be, and often denies them the supports to ensure that their needs are met.[196]

Recognizing the degree to which ableism is embedded in law and social policy is a necessary step to understanding the *Charter* arguments against Bill C-7. In debate about MAiD, these arguments are pitted against more traditional liberal autonomy and formal equality arguments, which are portrayed as being racially and disability neutral.[197] These arguments presume that everyone has the same access to the same opportunities to alleviate intolerable suffering. The concept of choice in the abstract is prioritized without any scrutiny given to the range of choices available to people with disabilities. The medical model is co-opted to obscure the degree to which intolerable suffering is socially enabled and facilitated. Former human rights lawyer and now Senator Marilou McPhedran, in her powerful speech in the

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195 See Fourth Annual Report, *supra* note 133 at 31.

196 See Goering, *supra* note 188 at 137 (Harriet McBryde Johnson describes her morning ritual of having assistance in washing: "I sometimes think how strange it would be to do these morning things in solitude as non-disabled people do, and to regard, as many of them do, a life like mine as a dreadful and unnatural thing. To me it is so natural to feel the touch of the washcloth-covered on flesh that is glad to be flesh, to rejoice that other hands are here.") For a critique of our understanding of vulnerability see Gabrielle Peters, "Vulnerability is Not a Swear Word" (27 December 2022), online: mssinenomineblog <ms sinenomineblog.wordpress.com> [perma.cc/9P5Y-A55E]; Joshua Briscoe, "Dying, But Not Alone" *The New Atlantis* (Summer 2021), online: <thenewat lantis.com> [perma.cc/R36R-KYDF]:

> Many of my patients tell me they don't want to become a burden. Who taught them that? They learned it from a culture that values fictional autonomy of the individual. The argument that a patient who feels she has lost autonomy should have a medical option to end her life does not just leave matters up to the individual, but solidifies this cultural myth, telling everyone that the life lacking full autonomy is not worth living. Sadly, some of the most vulnerable people are ready to believe that – not by their own choice, but by the choice of a culture declaring that dependence is undignified.

197 See Wiebe & Mullin, "Choosing death", *supra* note 4 at 2–3.

Canadian Senate against Bill C-7, summed up what is wrong with offering special access to death for disabled Canadians:

> Disabled Canadians have not found separate housing in institutions to be a benefit. They have not found separate entries through back doors or freight elevators to public buildings to be dignified. They have not found separate employment in unpaid sheltered workshops, or separate education in segregated schools, or separate transportation to be adequate, where inclusion and equality are goals. What could possibly be the rationale for a separate right to assisted death exclusively for people with a disabling condition? Ableism, maybe? It is no small thing, no mere formality to reframe death as a benefit for the living rather than a harm, but only for some, not for all who might desire it.[198]

The following section turns to section 15 and section 7 of the *Charter* and how Track 2 violates those rights. This analysis does not provide a comprehensive constitutional analysis but rather lays the groundwork for others to build on these arguments.

VI. Charter Arguments Against Bill C-7

The constitutional analysis in this paper is premised on the assumption that everyone who can access Track 2 MAiD has a disability as that term is understood in law. While this point should be obvious, its importance to the constitutional analysis requires that this assumption be addressed explicitly.

A. Disability as the Unifying Principle for Track 2 Eligibility

The definition of disability is a complex issue.[199] Not all people who satisfy a particular legal definition of disability necessarily self-identify

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198 "Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)", 3rd reading, *Debates of the Senate*, 43-2, No 27 (11 February 2021) at 1620 (Hon Marilou McPhedran) [McPhedran].

199 See Joel Michael Reynolds, "Theories of Disability" in Joel Michael Reynolds

as disabled,[200] but they would still be considered legally disabled for the purposes of, for example, bringing a claim of discrimination under human rights legislation.

This is not an issue that has been fully developed in the context of the pro-MAiD literature. Professors Jocelyn Downie and Udo Schuklenk make the contrary assertion—that disabled and nondisabled people alike have access to MAiD—by contrasting disability with chronic illness: "It is not only persons with disabilities who are now eligible as a result of the removal of the eligibility requirement of 'natural death has become reasonably foreseeable', but also people with chronic illness."[201] They later make a distinction between persons with disabilities and those with mental illness.[202] My point is simply that grievous and irremediable chronic illness (or mental illness) coupled with an irreversible decline in capability and intolerable suffering constitutes a disability in law, whether or not someone self identifies as disabled. The *Ontario Human Rights Code*, for example, explicitly includes illness and mental disorder in the definition of disability.[203]

There is no uniform definition of disability in federal law or under the *Charter* and different legal instruments use different definitions with a core of similarity among them.[204] I provide two examples to make this point, one from federal legislation, the other from the UN *Convention*

& Christine Wieseler, eds, *The Disability Bioetchics Reader* (London: Routledge, 2022) 30 at 31–32, citing Fiona Kumari Campbell, "Inciting Legal Fictions: 'Disability's Date with Ontology and the Ableist Body of Law (2001) 10:1 Griffith L Rev 42 at 43.

200 See Campbell, *supra* note 92 at 157–88.

201 Jocelyn Downie & Udo Schuklenk, "Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada" (2021) 47 J Medical Ethics 662 at 665 [Downie & Schuklenk, "Social determinants of health"].

202 *Ibid* ("[i]n many—if not all—jurisdictions, many people with disabilities as well as people with mental illnesses suffer from a disadvantage not inherent in their illness").

203 RSO 1990, c H19, s 10(1)(d).

204 See Human Resources and Skills Development Canada, *Federal Disability Reference Guide* (Ottawa: Human Resources and Skills Development Canada, 2013) at 2, online (pdf): <canada.ca> [perma.cc/RNR8-L795].

on the Rights of Persons with Disabilities (*CRPD*),[205] both of which support the contention that everyone who has access to MAiD is disabled. For example, the *Accessible Canada Act* uses the following definition:

> Disability means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment — or a functional limitation — whether permanent, temporary or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person's full and equal participation in society.[206]

The UN *CRPD* uses an inclusive definition in its purpose statement: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[207]

While not every disabled person will meet the criteria for Track 2 MAiD, this analysis starts from the position that everyone who meets the criteria would be considered legally disabled.

B. Section 15 Argument

Section 15 of the *Charter* guarantees everyone equal protection and benefit of the law without discrimination based on grounds that include physical and mental disability.[208] Recall that Canada's MAiD regime operates as an exemption from the crimes of aiding suicide and murder. Is it discriminatory to decriminalize the ending of life for people based on their disabilities?

There are two steps to an analysis under section 15 of the *Charter.* To prove a *prima facie* violation of section 15(1), a claimant must demonstrate that the impugned law or state action: (a) on its face or in its impact, creates

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205 *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) [*CRPD*].

206 SC 2019, c 10, s 2.

207 *CRPD*, *supra* note 205, art 1.

208 See *Charter*, *supra* note 29, s 15.

a distinction based on enumerated or analogous grounds; and (b) imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage.[209]

1. Step 1: Does the Law Make a Distinction Based on Enumerated or Analogous Grounds?

While the courts no longer require that there be a mirror comparator group against which to conduct the section 15 analysis,[210] the majority decision in *R v Sharma* highlights that comparison is still an important part of the section 15 analysis.[211] The MAiD legislation makes a distinction based on a subset of people with disabilities, which is an enumerated ground under section 15. The legislation decriminalizes ending the lives of people with irremediable medical conditions or disabilities, a decline in capacity, and intolerable psychological or physical suffering, even if they are not otherwise dying. As described above,[212] all individuals who qualify for Track 2 MAiD fall within the enumerated ground of physical disability as protected by section 15. Mental disability is also a prohibited ground of discrimination under s. 15.[213] Members of other groups who are suffering intolerably but are not disabled do not qualify for MAiD. The Supreme Court of Canada has made clear that one need not establish discrimination against every member of a class to establish a section 15 violation and that violating the rights of a subset of that class will suffice.[214]

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209 *Fraser v Canada (AG),* 2020 SCC 28 at para 27 [*Fraser*].

210 See *Quebec (AG) v Alliance du personnel professionnel et technique de la santé et des services sociaux,* 2018 SCC 17 at para 27 [*Alliance*]. See also Jonnette Watson Hamilton & Jennifer Koshan, "The Supreme Court of Canada's Approach to the Charter's Equality Guarantee in its Pay Equity Decisions" (2018), online: <ablawg.ca> [perma.cc/5D9N-7AK6].

211 2022 SCC 39 at para 41.

212 Please refer to the discussion of the definitions of disability, *supra* notes 199 to 207 and accompanying text.

213 See *Charter, supra* note 29, s 15.

214 See *Brooks v Canada Safeway*, [1989] 1 SCR 1219 at 1247–48; *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624 at paras 56-58 [*Eldridge*]; *Fraser*, *supra* note 209 at para 72.

2. Step 2: Is the Distinction Discriminatory?

The discrimination inquiry is based on whether a law has "the effect of reinforcing, perpetuating or exacerbating . . . disadvantage, including 'historical' disadvantage."[215] The impugned law need not be the primary source of the social or political disadvantage: "If the law reinforces, perpetuates, or exacerbates [a group's] disadvantage, it violates the equality guarantee and thereby gives discrimination the force of law."[216] If the law furthers the gap between people with disabilities and the rest of society, it is discriminatory:

> The root of s. 15 is our awareness that certain groups have been historically discriminated against, and that the perpetuation of such discrimination should be curtailed. If the state conduct widens the gap between the historically disadvantaged group and the rest of society rather than narrowing it, then it is discriminatory.[217]

The lived reality for people with disabilities in Canada continues to be one of marginalization and the devaluing of disabled lives. In *Eldridge*, the Court identified how discrimination against people with disabilities has been perpetuated by portraying disability as a flaw or something that needs to be fixed:

> This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able-bodied norms.[218]

More recently, the Supreme Court of Canada recognized the ongoing systemic discrimination based on disability in 2020 in *G*: "In our society, persons with disabilities regrettably 'face recurring coercion, marginalization, and social exclusion' . . . As this Court has recognized, '[t]his historical disadvantage has to a great extent been shaped and perpetuated by the

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215 *Ontario (AG) v G*, 2020 SCC 38 at para 40 [*G*].

216 *Ibid* at para 42.

217 *Quebec (AG) v A*, 2013 SCC 5 at para 332.

218 *Eldridge*, *supra* note 214 at para 56.

notion that disability is an abnormality or flaw.'" [219] Justice Karakatsanis went on to describe the role of section 15 in alleviating this disadvantage:

> Section 15's promise of respect for "the equal worth and human dignity of all persons" requires that those with disabilities be considered and treated as worthy and afforded dignity in their plurality. And s. 15's guarantee that discrimination not be given the force of law requires careful attention to the diverse impacts that government action will have on those with disabilities.[220]

Singling out the suffering associated with disability in a way that portrays it as different from all other human suffering, and as the only suffering that warrants death as a solution, is based on an ableist stereotype that life with a disability may be worse than death. Senator McPhedran made this point in her speech rejecting Bill C-7: "A worse stereotype could not be institutionalized in law; that disability-related suffering, often caused by inadequate health and social supports, and entrenched inequality, justifies the termination of a person's life."[221] One might argue that physical pain differentiates the suffering of disability from other suffering. However, in Canada, unmanaged pain is not even the leading reason provided by individuals seeking MAiD. For example, in the Fourth Annual Report on MAiD in Canada, 59.2% of people who requested MAiD cited uncontrolled pain, or *concern about* controlling pain, as a cause of intolerable suffering, thus making it the third most common type of suffering described.[222] This information was not broken down between Track 1 and 2 and obviously includ-

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219 *G*, *supra* note 215 at para 61 (citations omitted).

220 *Ibid*.

221 McPhedran, *supra* note 198 at 1620.

222 See Fourth Annual Report, *supra* note 133 at 31 (many of the reasons cited were things experienced by many people not at the end of life—86.3% cited a lack of meaningful activities, 53.1% a loss of dignity, 35.3% being a burden on family members and 17.1% loneliness or isolation). The opioid crisis has led many doctors to refuse to prescribe narcotics to manage pain for people who are not terminally ill, leading MAiD as a possible response to untreated pain (see Ann Marie Gaudon, "Waiting and Wanting to Die in Canada" *Pain News Network* (28 July 2022), online: <painnewsnetwork.org> [perma.cc/5ZNL-PZ99]. See also Brian Goldstone, "The Pain Refugees: the forgotten victims of America's opioid crisis", *Harper's Magazine* (April 2018), online: <harpers.org> [perma.cc/Z8B2-HFV5]; Adam Zivo, "So now we're going to euthanize

ing the *concern about* controlling pain, as compared to pain itself, muddies this data even further; the fact that one fears uncontrollable pain does not mean one will experience it. The legislative criteria explicitly include psychological pain as a basis for MAiD, which undermines the argument that physical pain might be a reason for treating disability differently.

Criminal law plays an important expressive function in messaging what behaviour is acceptable in society and what behaviour is condemned.[223] By allowing medical professionals to provide death to people with disabilities, the *Code* sends the message that these disabled lives are less worthy of saving through suicide prevention efforts than the lives of those without disabilities. The expressive role of this legislation goes well beyond those who actually access MAiD. This legislation risks normalizing death as a response to the suffering associated with disability, which is stigmatizing for all people with disabilities.[224]

There is research that demonstrates when suicide is more accessible, suicide rates increase.[225] Contrary to the assumptions referenced in *Carter* and *Truchon* that restricting MAiD could force people to take their own lives,[226] recent studies demonstrate that access to MAiD does not in fact reduce suicide rates in jurisdictions that allow it; rather there is some sug-

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drug addicts?" Editorial, *National Post* (26 October 2023), online: <national post.com> [perma.cc/H3EK-YGGK]).

223 See generally Joel Feinberg, "The Expressive Function of Punishment" (1965) 49:3 The Monist 397 at 409.

224 Thomas Healy in Thomas Healy, "Stigmatic Harm and Standing" (2007) 92:2 Iowa L Rev 417 at 450 notes that there is nothing inherent in particular traits that are stigmatizing, "[instead], attributes become stigmatizing as a result of cultural beliefs that develop through a process of social learning. This process generates a collective understanding about what traits are desirable and what traits are discrediting."

225 See e.g. N Kreitman, "The coal gas story: United Kingdom suicide rates, 1960-71" (1976) 30:2 British J Preventive & Soc Medicine 86 at 92; Shu-Sen Chang et al, "Factors associated with the decline in suicide by pesticide poisoning in Taiwan: a time trend analysis, 1987-2010" (2012) 50:6 Clinical Toxicology 471 at 471; D Gunnell et al, "The impact of pesticide regulations on suicide in Sri Lanka" (2007) 36:6 Intl J of Epidemiology 1235 at 1240.

226 See *Carter*, *supra* note 28 at para 30; *Carter* BCSC, *supra* note 49 at para 17.

gestion those rates might even increase, particularly among women.[227] The relationship between assisted suicide and the rates of non-assisted suicide is a complex subject and it is too early to assess empirically whether the expansion of MAiD has had an impact on Canadian non-assisted suicide rates.

Further discriminatory impacts will likely be felt by other groups such as women and Indigenous people with disabilities. Even in its first full year, Track 2 MAiD was disproportionately accessed by women (59%).[228] Similarly, international data tells us that psychiatric MAiD is disproportionately accessed by women.[229] One explanation for the gender paradox in suicide—the fact that more women attempt suicide but more men complete it—is that men choose more violent means that are more likely to be successful (e.g., use of firearms) whereas women, at least in Western countries, tend to choose less violent methods (e.g., drug ingestion), which are less likely to be fatal.[230] Many people who survive suicide attempts will receive treatment and not die from suicide.[231] One recent study suggests that the data on the gender divide for psychiatric MAiD maps almost perfectly onto the data on gender relating to attempted suicide.[232] By providing women with a nonviolent means that is socially acceptable and 100% effective, the provision of

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227 See e.g. Anne M Doherty, Caitlyn J Axe & David A Jones, "Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: systematic review" (2022) 8:4 British J Psychiatry Open 1 at 7 (in a comprehensive meta-analysis, the authors conclude that there is no evidence to support a decline in non-assisted suicide rates in European jurisdictions with MAiD and that further study is necessary to determine whether there is in fact an increase). See also Silvia Sara Canetto & John L McIntosh, "A Comparison of Physician-Assisted/Death-with Dignity-Act Death and Suicide Patterns in Older Adult Women and Men" (2022) 30:2 Am J Geriatric Psychiatry 211.

228 See Fourth Annual Report, *supra* note 133 at 35.

229 See Nicolini, Gastmans & Kim, "Role of Gender", *supra* note 153 at 10.

230 *Ibid* at 11.

231 *Ibid*. See also Council of Canadian Academies, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition* (Ottawa, The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, 2018) at 89.

232 *Ibid* at 12.

MAiD for mental illness ensures that these women succeed in ending their lives.[233]

It is also notable that Indigenous witnesses before the Senate opposed this expansion of MAiD.[234] Many Indigenous communities are already experiencing a crisis in suicides, particularly among youth, and Indigenous people have significantly higher rates of disability than other communities in Canada.[235] Indigenous witnesses urged fulsome consultation with Indigenous communities before the enactment of Bill C-7.[236] However, the federal expert report on MAiD for mental illness acknowledges that "[t]o date, engagement with Indigenous peoples in Canada concerning MAiD has yet to occur."[237]

The discrimination in Bill C-7 is both direct and indirect, producing an adverse impact on disabled lives. The law deliberately targets a subset of people with disabilities for whom the aiding of suicide and even the intentional killing will be decriminalized, thus denying them the protection of criminal law. But the discrimination is also indirect, by depicting MAiD as a form of "treatment." This depiction permits medical professionals to offer MAiD to persons who are not otherwise seeking it, which may undermine a person's trust in their doctor and send a signal that the physician has lost hope.[238] This change in the relationship between doctors and persons

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233 *Ibid* (the authors note that women's social and economic inequality includes high rates of gender-based violence, which is a risk factor for women's mental illness and suicidality and could contribute to these alarming numbers).

234 See House of Commons, Special Joint Committee on Medical Assistance in Dying, *Evidence*, 44-1, No 25 (4 November 2022) at 9:45 (Neil Belanger). See also Senate, Standing Senate Committee on Legal and Constitutional Affairs, *Evidence,* 43-2 (2 February 2021) (Lisa Richardson).

235 See Statistics Canada, *Indigenous people with disabilities in Canada: First Nations people living off reserve, Métis and Inuit aged 15 years and older*, by Tara Hahmann, Nadine Badets & Jeffrey Hughes, Catalogue No 89-653-X2019005 (Ottawa: Statistics Canada, 12 December 2019) at 3, online: <www150.statcan.gc.ca> [perma.cc/G3Y4-KHV3].

236 See Neil Belanger's testimony, *supra* note 234.

237 *Final Report*, *supra* note 132 at 72.

238 See Cheng, *supra* note 127. See also CAMAP, *supra* note 127 (CAMAP has recommended that doctors have an ethical responsibility to raise MAiD with a patient who might qualify).

with disabilities may deter people from either seeking medical support in their most vulnerable moments or from fully disclosing the extent of their suffering. It also could discourage doctors from pursuing every possible treatment option where MAiD is an easier, fully funded, and more readily accessible option.

The trial judge in *Carter* talked about MAiD as "an insurance policy" that brings comfort to dying Canadians such that if the dying process gets too difficult, they have the emotional security of knowing that there is an escape route.[239] This language needs to be contested for those who are not dying. Rather than an insurance policy, some perceive Track 2 MAiD as a "monkey on their back" constantly throughout their struggle to deal with the realities of chronic illness and disability in Canada.[240] They are constantly in a position of re-evaluating whether their lives are worth living in a social context where the state is offering to end those lives. This is a burden other Canadians do not bear.

3. Is MAiD a Benefit for People with Disabilities?

Advocates of extending the MAiD regime to those not at the end of their lives argue that it provides a benefit to people with disabilities, not that it discriminates against them.[241] It allows them to exercise a choice to die when their lives are perceived as no longer worth living. This is the essence of the government's *Charter* statement justifying Bill C-7 and is the language used to justify extending MAiD to people with mental illness—i.e., that it would be discriminatory to deny this "benefit" to people on the basis of mental illness.[242]

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239 See *Carter* BCSC, *supra* note 49 at para 1329.

240 See e.g. BrvHrt09, "K, I get it. The MAiD monkey on my back, whispering in my ear has a lot of past and present pain to exploit. But a lot of ppl have survived trauma. Why should only disabled people, people with mental illness have ours met w/ an invitation or encouragement to be killed by the state?" (16 May 2022), online: <twitter.com/BrvHrt09> [perma.cc/8BU2-G8A9].

241 See e.g. Wiebe & Mullin, "Choosing death", *supra* note 4 at 5. For a more detailed discussion of this argument, see text accompanying notes 310–315, *below*.

242 Canada, Department of Justice, *Charter Statement: Bill C-7: An Act to amend*

In order to portray MAiD as a benefit, proponents work to distinguish it from suicide because most people agree that easier access to suicide is not generally considered a benefit and that suicide prevention is an important social goal.[243] One recent article describes the benefit as a form of harm reduction.[244] Characterizing MAiD as a benefit for people with disabilities who are not dying is the legislative entrenchment of the "I would rather be dead than disabled" narrative that Reynolds identifies as being at the heart of ableism.[245] There is no context in which we characterize death as a benefit for any other person who is not dying. Presenting MAiD as a benefit in these circumstances allows society to deny the actual benefits that might reduce the intolerable suffering experienced by Canadians with disabilities.

If the state has an obligation to alleviate intolerable suffering, and to alleviate the risk that people will take steps to end their own lives in more violent ways, why is this only a benefit for people with disabilities? Disabled people are not the only people who suffer intolerably nor are they the only people who contemplate ending or attempt to end their lives. For others, we assume that people can and should be dissuaded from suicide; that with adequate resources and supports, life can be made tolerable.

Section 15(2) of the *Charter* does allow for legislation that targets disability in order to ameliorate conditions of disadvantage.[246] Thus, for ex-

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the Criminal Code (medical assistance in dying) (Ottawa: DOJ, 2021) online: <justice.gc.ca> [perma.cc/D6CC-2JQ2].

243 See Jocelyn Downie, David Wright & Mona Gupta, "What's the relationship between suicide and MAiD?", *Policy Options* (15 February 2021), online: <policyoptions.irpp.org> [perma.cc/TA5E-S268] (the authors describe "rational suicide" or suicide with "justifiable reasons," which appear to be those based on significant disability, and seem to distinguish these suicides from those which are presumably considered irrational although that language is not used explicitly. They link MAiD with rational or understandable suicide. They conclude that suicide and MAiD are different but concede some overlap and they suggest that the language of "physician-assisted suicide" is largely responsible for the confusion that may exist around the overlap). See also Naomi Richards, "Old age rational suicide" (2017) 11:3 Sociology Compass 1 at 2 (I would argue that rational suicide is itself an ableist term – we see them as rational because we think we would rather be dead than disabled).

244 See Wiebe & Mullin, "Choosing death", *supra* note 4 at 5.

245 See Reynolds, "Better Dead than Disabled", *supra* note 172 at 153.

246 See *Charter*, *supra* note 29, s 15(2).

ample, a financial benefit that is only available to people with disabilities could be insulated from challenge by a nondisabled person through section 15(2). However, the Supreme Court has held that this section is meant to protect ameliorative state action only from claims of reverse discrimination by those who are not included in the legislation.[247] In other words, section 15(2) "cannot bar s.15(1) claims by the very group the legislation seeks to protect."[248] Section 15(2) cannot insulate legislation from claims that it violates the rights of people with disabilities.

The UN Special Rapporteur on the Rights of Persons with Disabilities, the Special Rapporteur on Extreme Poverty and Human Rights, and the Independent Expert on the Enjoyment of All Human Rights by Older Persons formally wrote to Canada expressing "grave concern that provisions contained in the Bill may be contrary to Canada's international obligations to respect, protect and fulfil the core right of equality and non-discrimination of persons with disabilities."[249] They noted a real risk "that those without adequate support networks of friends and family, in older age, living in poverty or who may be further marginalized by their racialized, indigenous, gender identity or other status will be more vulnerable to being induced to access MAiD."[250]

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247 Hamilton & Koshan, *supra* note 203 at 10, citing *Centrale des syndicats du Québec v Quebec (AG)*, 2018 SCC 18 at paras 37, 39.

248 *Alliance*, *supra* note 210 at para 32.

249 *Mandates of the Special Rapporteur on the rights of persons with disabilities; the Independent Expert on the enjoyment of human rights by older persons; and the Special Rapporteur on extreme poverty and human rights*, UNHCR, 2021, UN Doc OL CAN 2/2021 (2021) at 4, online (pdf): <spcommreports.ohchr.org> [perma.cc/H2QR-VCGC] [Mandates]. The Special Rapporteur on the Rights of Persons with Disabilities testified against Bill C-7 before the Senate committee considering the legislation (see Senate, Standing Senate Committee on Legal and Constitutional Affairs, Bill C-7, *An Act to Amend the Criminal Code (medical assistance in dying) Evidence*, 43-2, No 1 (1 February 2021) at 10:58 (Chair: Mobina S.B. Jaffer), online (pdf): <sencanada.ca> [perma.cc/EEV5-WKEH]). Nonetheless, the government invoked the Convention on the Rights of Persons with Disabilities in enacting Bill C-7 (see Bill C-7, *supra* note 9 at preamble).

250 Mandates, *supra* note 249 at 3.

C. Section 7 Argument

Section 7 of the *Charter* guarantees the right not to be deprived of life, liberty, and security of the person except in accordance with the principles of fundamental justice.[251] These principles are found in the basic tenets of our legal system[252] and reflect "basic values underpinning our constitutional order."[253] In *Bedford*, the Court described section 7 as "concerned with capturing inherently bad laws: that is, laws that take away life, liberty, or security of the person in a way that runs afoul of our basic values."[254]

Section 7 has played an important role in the development of MAiD; it was both the basis on which the *Carter* Court struck down the absolute prohibition on MAiD as being overbroad, and one of the grounds on which the *Truchon* court struck down the reasonable foreseeability of death requirement.[255] Thus, the scope of *Carter* is particularly important for assessing the constitutionality of Bill C-7.

The *Carter* Court was not clear on the scope of its judgment. The Court did not explicitly limit access to MAiD to people at the end of their life, but referred throughout the judgment to those "during the passage to death"[256] or at the "end-of-life."[257] For example, the Court acknowledged that "s. 7 recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life."[258] The Court explicitly limited its judgment to the named plaintiffs: "[t]he scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronounce-

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251 See *Charter*, *supra* note 29, s 7.

252 *Re BC Motor Vehicle Act*, [1985] 2 SCR 486 at para 31 [*BC Motor Vehicle Act*].

253 *Canada (AG) v Bedford*, 2013 SCC 72 at para 96 [*Bedford*].

254 *Carter*, *supra* note 28 at para 95, citing *Bedford*, *supra* note 253 at para 96.

255 *Carter*, *supra* note 28 at para 147; *Truchon, supra* note 21 at para 638.

256 *Carter, supra* note 28 at para 63.

257 *Ibid* at paras 10–11, 22–23, 106, 115. See also *Canada v FE*, 2016 ABCA 155 at para 41 (where the Court of Appeal of Alberta held that *Carter* did not require the applicant to be terminally ill to benefit from an exemption during the suspension of the declaration of invalidity).

258 *Carter*, *supra* note 28 at para 68.

ment on other situations where physician-assisted dying may be sought."[259] The Court also indicated that the declaration "simply renders the criminal prohibition invalid" and does not go further.[260] There is nothing in *Carter* that speaks to the constitutionality of extending that access to those not at the end of life, but the Court was explicit that its judgment does not extend to MAiD for mental illness.[261] *Carter* says nothing about whether a MAiD regime could go too far or whether Bill C-7 does just that.

Unlike in *Carter*, the section 7 analysis in *Truchon* is so expansive that it is difficult to see how any limit on MAiD could be upheld if that decision were followed. *Truchon* found that, at least for people with disabilities, a "right to decide the time of [one's] death" is part of the right to life.[262] The *Truchon* court held that it would be paternalistic to deny people with disabilities the right to make choices about ending their lives.[263] Yet it is always "paternalistic" to intervene in suicide, not just when a person has a disability. Nonetheless we invest significant resources to deter and intervene in suicide because we believe that saving people's lives is a social good that justifies the paternalism of intervention.

Truchon does not discuss why this intervention is only unduly paternalistic when someone has a disability. The unspoken premise is that suicide is a benefit and a social good for people with disabilities whereas for others it is something to be deterred. If limiting MAiD to people whose death is foreseeable increases the risk that they will take matters into their own hands "in a degrading or violent manner,"[264] why does this not apply to all individuals who are suicidal? By singling out disability in this way, *Truchon* is a judicial manifestation of the ableist "better dead than disabled" rhetoric.

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259 *Ibid* at para 127.

260 *Ibid* at para 132.

261 *Ibid* at para 111.

262 *Truchon*, *supra* note 21 at para 582.

263 *Ibid* at paras 309, 635.

264 *Ibid* at para 521.

1. Life, Liberty, and Security of the Person

a. Life

In *Carter*, the Supreme Court of Canada established that "the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly."[265] Providing MAiD to persons with disabilities outside of end-of-life circumstances and exempting medical practitioners from the criminal offences of murder and aiding suicide directly increases the risk of death of disabled individuals. It is reasonable to assume that most medical practitioners would not help people die without this immunity from prosecution, and that at least some disabled people will choose MAiD who would not have attempted suicide because the option of MAiD is presented as a pain-free and infallible path to ending one's life.[266]

The Court in *Carter* found a deprivation of life on the basis that the absolute prohibition forced people "to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable."[267] Six hundred and eighty-six people with disabilities who were not at the end of their lives have died through MAiD in the first year and nine months since passing this legislation in March 2021.[268] Some of those people might have ended their own lives through suicide, but if there were complete overlap between the groups, we would expect suicide rates to decline significantly in jurisdictions with MAiD, which they have not.[269] Some of these deaths, including Sophia's, could have been prevented if the state provided the resources people need to live. Sathya Dhara Kovac wrote in her obituary that she accessed MAiD much earlier than she wanted to die because of the failure of the system to support her.[270] Track 2 MAiD undoubtedly increases the risk of death for a subset of people with disabilities.

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265 *Carter*, *supra* note 28 at para 62.

266 See generally *supra* note 20 and accompanying text.

267 *Carter, supra* note 28 para 57.

268 See Fourth Annual Report, *supra* note 133 at 34.

269 Doherty et al, *supra* note 227 at 5.

270 See Hoye, *supra* note 35.

b. Liberty and Security of the Person

Both *Carter* and *Truchon* looked at the rights to liberty and security of the person together rather than separating them. Both rights were interpreted in *Carter* in negative terms, focusing on the right to be left alone by the state, and the right to make choices about one's bodily integrity and medical decision-making independent of state interference.[271] This negative conception of liberty does not create an entitlement to MAiD, but rather limits the state's ability to prohibit it through criminal sanction. The *Truchon* court was brief on security of the person and liberty but concluded that the reasonably foreseeable natural death requirement "directly interferes with [the] physical integrity [of disabled persons whose death is not foreseeable], causes them physical and psychological pain and deprives them of the opportunity to make a fundamental decision that respects their personal dignity and integrity."[272]

Laws that increase the risk of death also implicate physical security of the person by denying persons with disabilities the protection provided by the law of murder and aiding suicide. Psychological security of the person is also implicated through the severe psychological stress that is imposed on people with disabilities through the stigmatization of their lives. When a person asks for support, they may be met with an offer of MAiD.[273] News stories of war veterans being offered MAiD when they sought supports and MAiD being suggested to a woman seeking urgent psychiatric care illustrate the impact of this law on people who simply want the supports to live.[274]

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271 *Carter, supra* note 28 at paras 64–69.

272 *Truchon*, *supra* note 21 at para 534.

273 CAMAP, *supra* note 127. See e.g. Rob Gibson, "Kelowna man exasperated as elderly friend struggles to receive healthcare at home", *Castanet* (2 June 2022), online: <castanet.net> [perma.cc/PFW2-ZAS8].

274 See e.g. Jessica Doria-Brown, "'Horrifying' that Veterans Affair worker raised assisted suicide with troubled veteran, group says" *CBC News* (24 August 2022), online: <www.cbc.ca> [perma.cc/BS4Z-KRYF]. See also Tom Yun, "Paralympian trying to get wheelchair ramp says Veterans Affairs employee offered her assisted dying", *CTV News* (2 December 2022), online: <ctvnews.ca> [perma.cc/FE33-VD3A]. Kathrin Mentler went to Vancouver General Hospital amid a psychiatric crisis seeking support. Instead, she was asked if she had ever considered MAiD because the psychiatric system was "completely overwhelmed" (see Michelle Gamage, "She Sought Help in Crisis and Was Suggested MAID Instead" *The Tyee* (9 August 2023), online: <thetyee.ca> [perma.

While some persons with serious and irremediable disabilities may welcome the choice to die because of lack of access to resources to alleviate their suffering, others find this choice deeply stressful and stigmatizing. Offering death as an option for people who are suffering and struggling to live may lead them to constantly reassess whether their lives are worth living. They lose the benefit of living in a society (and dealing with a medical profession) that takes for granted that their lives are worth saving.[275] As Professor Martha Minow has noted "[t]he option of medical assistance in dying would alter the menu for all involved. It would turn the continuation of living into a question, open for debate, doubt, and persuasion."[276] Dr. Joshua Briscoe describes this as follows:

> [The person], even if they never face the overt inquiry from others, must nevertheless settle the matter in their own mind: why am I still trying to live? Can I come up with sufficient reasons? Is society helping me find a reason to live? The mere offer—even the existence—of [MAiD] forces them out of default territory. Now they *must* choose. …This exacerbates suffering rather than relieves it. It adds to the burdens of those who already perceive themselves to be a burden. The desiccated imagination of our modern age does not offer to help bear this burden; rather, it offers reasons why some have a duty to die.[277]

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cc/D4L8-ESNZ]; Jennifer Gauthier, "Vancouver hospital defends suggesting MAID to suicidal patient as risk assessment tool" *The Globe and Mail* (9 August 2023), online: <theglobeandmail.com> [perma.cc5Y4Q-Y723]).

275 See J David Velleman, "Against the Right to Die", (1992) 17:6 J of Medicine & Philosophy 665 at 674 (Velleman argues that constantly having to justify one's life, both to oneself and to others, is an enormous burden that can make that life not worth living. He describes the important benefit of the status quo being that your life is worth living). See also Joshua Briscoe, "Dying", *supra* note 196; Joshua Briscoe, "Affirming Dignity: Arguments Against Medical Aid in Dying**"** *Psychiatric Times*, (21 December 2022), online: <psychiatrictimes.com> [perma.cc/5WPK-TX8K] [Briscoe, "Affirming Dignity"].

276 Martha Minow, "Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases" (1997) Sup Ct Rev 1 at 22.

277 Briscoe, "Affirming Dignity", *supra* note 275.

2. Principles of Fundamental Justice

The principles of fundamental justice have developed in a way that focuses on arbitrariness, overbreadth, and disproportionality.[278] None of these existing principles work particularly well in the context of a law that decriminalizes the killing of people with disabilities who are not at the end of life. In this paper, I focus only on two potential principles of fundamental justice: the established principle of gross disproportionality and a proposed new principle of fundamental justice that people with disabilities cannot be denied the protection of criminal law on the basis of their membership in a *Charter*-protected group.[279]

a. Gross Disproportionality

Gross disproportionality targets laws that may be rationally connected to their stated purpose but whose *effects* are so disproportionate that they cannot be supported.[280] Gross disproportionality applies only in extreme cases where "the seriousness of the deprivation is totally out of sync with the objective of the measure."[281] Gross disproportionality does not consider the beneficial effects of the law for society, since balancing the law's beneficial and deleterious effects is a function more properly reserved for section

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[278] *Bedford, supra* note 253 at paras 96–97.

[279] I have not included an analysis of overbreadth because while Track 2 MAiD is very broad, overbreadth focuses on whether legislation captures people who are beyond the scope of its intended purpose. I believe that the very purpose animating Bill C-7 is itself unconstitutional. However, there may well be cases where MAiD is being authorized for people who are outside of the scope of its purpose. That argument, however, would require careful examination of an individual case that is beyond the scope of this paper. One could also argue that Bill C-7 is arbitrary in targeting only disabled suffering, but the case law on arbitrariness makes it an extraordinarily high threshold requiring *no* connection between the effect and the purpose of the law (see *Bedford*, *supra* note 253 at para 98 where the Supreme Court held that arbitrariness requires that "there is no connection between the effect and the object of the law").

[280] *Bedford, supra* note 253 at para 103.

[281] *Ibid* at para 120. See also *Canada (AG) v PHS Community Services Society*, 2011 SCC 44 at para 133.

1 of the *Charter*.[282] Gross disproportionality requires an assessment of the government's purpose in enacting the law.[283]

The *Truchon* court identified the purpose of the reasonably foreseeable natural death provision as "to protect vulnerable persons who might be induced to end their lives in a moment of weakness, by preventing errors when assessing requests for medical assistance in dying."[284] This framing is problematic; drawing the line between people who are dying and disabled people who are not does not directly protect people in a moment of weakness as people in both categories have moments of weakness. Furthermore, framing suicide as always simply being a moment of weakness ignores the reality that many suicides have a significant element of planning.[285] This paper suggests that the government's purpose in enacting Bill C-7 was to provide people with disabilities who are not at the end of their lives the option to escape intolerable suffering through death, while immunizing medical practitioners from criminal responsibility for assisting them.

It is difficult to imagine a more grossly disproportionate effect than a death that could have been avoided had proper supports been provided. In explaining why the death penalty is contrary to our fundamental values, the Supreme Court of Canada in *United States v Burns* stressed the fallibility of existing systems to prevent wrongful convictions and correspondingly, wrongful deaths: "[w]hat is important is the recognition that despite the best efforts of all concerned, the judicial system is and will remain fallible and reversible whereas the death penalty will forever remain final and irreversible."[286] A medical system that is under-resourced to the breaking point, with far fewer safeguards than a judicial system, is fallible in the extreme.[287]

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282 See *Bedford, supra* note 253 at paras 120–22.

283 *Ibid* at paras 120–21.

284 *Truchon*, *supra* note 21 at para 556.

285 See Nicolini, Gastmans & Kim, *supra* note 153 at 11; Michael D Anetsis, Kelly A Soberay & Peter M, "Reconsidering the Link Between Impulsivity and Suicidal Behavior" (2014) 18:4 Personality & Soc Psychology Rev 366 at 377.

286 2001 SCC 7 at para 129 [*Burns*].

287 See e.g. John Paul Tasker, "'This is a crisis': Head of medical association warns that the health-care system faces 'collapse'", *CBC News* (21 September 2022), online: <www.cbc.ca> [perma.cc/WA5S-2FRQ].

Because MAiD is portrayed as beneficent for people with disabilities not at the end of life, and because we trust doctors implicitly, we fail to recognize the fallibility of the systems in place to ensure wrongful deaths do not happen. It may be easier to describe a wrongful death in the context of the death penalty than in the context of Track 2 MAiD. At the very least, a death where the intolerable suffering could be made tolerable through adequate social supports, such as housing in Sophia's case or better home care for Sathya Dhara Kovac, fits the criterion for a "wrongful death." Bill C-7 does not require that resources be made available to alleviate intolerable suffering; instead, it simply requires that the individual be informed of and consider what resources are already available.[288] Given our imperfect medical and social support systems, wrongful deaths are inevitable and are already happening. Ending the life of someone who is not dying could also be fairly cast as a wrongful death because of the systemic impact of the devaluing of disabled life.

The *Burns* court made no exception for the convicted offender who wanted to choose the death penalty over life in prison—the death penalty was seen as morally repugnant to the values protected by the *Charter*.[289] This clarity about the death penalty begs the question why Canadians are so comfortable with doctors ending the lives of people with disabilities who are not otherwise dying? No court would uphold MAiD if it were only available to alleviate the intolerable suffering of Indigenous or racialized persons in Canada, or members of any other section 15 protected group. The Supreme Court in the death penalty context highlighted that one wrongful death was one too many.[290] How many wrongful deaths of people with disabilities are we willing to tolerate to provide able-bodied Canadians the "insurance policy" of knowing that if they become disabled, they will have an exit ramp?[291]

b. Equality as a Principle of Fundamental Justice

It is not surprising that our existing principles of fundamental justice fall somewhat short given the unprecedented nature of Bill C-7; Canada has never before passed a law allowing for the killing of only members of a

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288 *Supra*, text at notes 130 to 132.

289 *Burns*, *supra* note 286 at para 78.

290 *Ibid* at para 102.

291 See *Carter* BCSC, *supra* note 49 at para 1329.

Charter-protected group, other than those already at the end of their natural lives.[292]

In *Carter*, the Court confirmed that "the principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person."[293] For a rule or principle to be recognized as a principle of fundamental justice, it must be: (1) a legal principle; (2) about which there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate; and (3) it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty, or security of the person.[294]

A new principle that the criminal law cannot selectively decriminalize harm committed against a protected group based on stereotypes about the value of their lives fulfills all three criteria. First, it is a normative "legal principle" rather than a mere description of "an important state interest" or "general public policy."[295] A victim's membership in a protected group should never be the basis for denying them the protection of criminal law, especially where it is based on stereotypes that have fed systemic discrimination against members of that group.

Second, there exists significant societal consensus that this principle is "vital or fundamental to our societal notion of justice."[296] The principle that the criminal law cannot selectively decriminalize harm on the basis of stereotypes about a protected group recognizes essential assumptions in our

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[292] It is well established in Canada that competent patients can refuse life-saving treatment even where that refusal may result in death (see *Malette v Shulman*, [1990] OJ No 450, 67 DLR (4th) at para 19 [cited to DLR], which was cited with approval by the SCC in *Carter, supra* note 28 at para 67). The analogy between MAiD and the right to refuse treatment, however tenuous, only applies to track 1 MAiD because anyone for whom refusing treatment would lead to death would satisfy Track 1.

[293] *Carter*, *supra* note 28 at para 81, citing *BC Motor Vehicle Act*, *supra* note 252.

[294] See *R v Malmo-Levine,* 2003 SCC 74 at para 113; *Canadian Foundation for Children, Youth and the Law v Canada (AG)*, 2004 SCC 4 at para 8; *R v DB*, 2008 SCC 25 at para 46.

[295] *Canada (AG) v Federation of Law Societies of Canada*, 2015 SCC 7 at para 89.

[296] *Rodriguez*, *supra* note 27 at 590.

criminal system—namely, the belief in the equal dignity and worth of every human person and our understanding that the criminal law must be applied fairly, impartially, and consistently with the *Charter*'s equality guarantees. In making decisions about who to criminalize or decriminalize, those decisions must be free of stereotypes about the value of particular victims' lives.

Other scholars have developed the argument that equality must be incorporated into the principles of fundamental justice in much more depth than this paper allows.[297] There is also case law support for this principle. In *Andrews*, Justice McIntyre described the section 15 "guarantee [as] the broadest of all guarantees. It applies to and supports all other rights guaranteed by the *Charter*."[298] Justice Wilson, in her minority decision in *Morgentaler*, held that "a deprivation of the section 7 right which has the effect of infringing a right guaranteed elsewhere in the *Charter* cannot be in accordance with the principles of fundamental justice."[299] A unanimous Court of Appeal for Ontario stated that it had "no doubt that the equality rights created by s. 15 are principles of fundamental justice."[300] In her concurring minority opinion in *New Brunswick (Minister of Health and Community Services) v G(J)*,[301] Justice L'Heureux-Dubé held that the section 7 analysis must "[take] into account the principles and purposes of the equality guarantee in promoting the equal benefit of the law and ensuring that the law responds to the needs of those disadvantaged individuals and groups whose protection is at the heart of s. 15."[302]

It is a basic tenet of our legal system that the lives of all Canadians are equally valuable. At the very least, then, section 7 must mean that the right to life and security of the person for persons with disabilities, a section

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297 See Kerri Froc, "Constitutional Coalescence: Substantive Equality as a Principle of Fundamental Justice" (2011) 42:3 Ottawa L Rev 411 at 411; C T Sheldon, Karen R Spector, & Mercedes Perez, "Re-Centering Equality: The Interplay Between Sections 7 and 15 of the *Charter* in Challenges to Psychiatric Detention" (2016) 35:2 NJCL 193; Suzy Flader, "Fundamental Rights for All: Toward Equality as a Principle of Fundamental Justice under Section 7 of the *Charter*" (2020) 25:43 Appeal L J 43 at 45.

298 *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143 at 185.

299 *R v Morgentaler*, [1993] 3 SCR 463 at 175.

300 *Philippines (Republic of) v Pacificador,* (1993), 64 OAC 344 (CA) at para 55.

301 [1999] 3 SCR 46 at para 115.

302 *Ibid* at para 100.

15 protected group, cannot be given less value and less protection by the criminal law than the right to life and security of the person for other Canadians. The reasonable foreseeability of death requirement could arguably change this analysis for Track 1 because that person is already dying, and the state is simply easing the suffering of that dying process. Track 2 MAiD, by contrast, kills disabled people who are not in the process of dying. This argument is clear in the context of other protected groups. The government surely could not, for example, exempt men from the crime of aggravated assault, but only where the victim is their female intimate partner, or decriminalize robbery, but only if committed against a person of a particular race.[303]

Third, the principle that the criminal law cannot selectively decriminalize harm against a *Charter*-protected group is precise enough to yield a manageable standard. It is easy to determine whether a provision falls afoul of the legal standard. Those with irremediable medical conditions or disabilities are not the only Canadians who suffer intolerably, yet they are the only Canadians who are denied protection of the criminal law prohibitions on ending life (i.e., murder and aiding suicide). This denial undermines the value of their lives and signals to all persons with disabilities the lack of priority on protecting their lives.

D. The Centrality of Choice in the Sections 15 and 7 Analyses

The choice argument is central to both the section 15 and the section 7 analysis. Proponents of Bill C-7 stress that all the legislation does is provide one more choice in the arsenal of treatment options available to a person with a disability: how could legislation that simply gives people more choices be in violation of their rights?[304] The concept of choice presupposes

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303 It is notable that the marital rape exemption did exactly this. It decriminalized husbands who raped their wives. See *Criminal Code*, RSC 1970, c C-34, s 143 ("[a] male person commits rape when he has sexual intercourse with a female person who is not his wife (a) without her consent…"). This provision was repealed in 1983 to bring the criminal law into compliance with the *Charter* (see *An Act to amend the Criminal Code in relation to sexual offences and other offences against the person and to amend certain other Acts in relation thereto or in consequence thereof*, SC 1980-81-82-83, c 125, s 6).

304 For support of this view, see Jocelyn Downie & Udo Schuklenk, "Disability, mental illness, and medical assistance in dying in Canada: Recent slippery slope and social determinants of health arguments miss the mark" (9 August

the existence of social conditions required to make a non-coerced choice and the availability of alternative courses of action.

Choice is complicated in the MAiD context where the only choice provided by the legislation is between intolerable suffering and death. Looking at the story of Sophia, she exercised her choice to die but that choice, like her intolerable suffering, was shaped by her inability to obtain what she needed to live: accessible housing. Sophia's disability may have been irremediable, but her suffering could have been reduced through adequate government supports to help her escape poverty. By conflating her suffering with her disability rather than with her poverty, we obscure the state's obligation to provide the bare necessities of life. The fact that Denise ultimately obtained the money to live in a hotel temporarily and delay MAiD demonstrates the starkness of this choice. Sathya Dhara Kovac chose MAiD because she was denied adequate home care to manage her ALS.[305]

Where choices are driven by inescapable poverty, social isolation, stigma, loneliness, or perceiving oneself to be a burden on others, it is problematic to construct state inflicted death as an autonomous choice.[306] Such marginalization in this context may be a form of coercion.[307] While no one

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2021) *Journal of Medical Ethics*, online (blog): <blogs.bmj.com> [perma.cc/QG4U-SC2N] [Downie & Schuklenk, "Slippery slope"].

[305] See Hoye, *supra* note 35. Media reports on Rose Finlay – a young mother living with quadriplegia after an accident as a teenager – indicate that she has qualified for Track 2 MAiD as she struggles to obtain adequate disability supports. As one newspaper account describes: "Finlay says the government has created the perfect storm for people living with disabilities in Ontario. 'Starve them, cut them off from participating in society and then offer them death'" (see Sam Riches, "Quadriplegic Ontario mother says her only option is assisted suicide due to lack of support" *National Post* (22 June 2023), online: <nationalpost.com> [perma.cc/6CW3-85W8]). Rose has also written a blog post detailing her experience (see Rose Finlay, "the wall." (n.d.), online: <wheelchair1derwoman.com> [perma.cc/Y389-7LLK]).

[306] Of the people who requested MAiD in 2022, 35.3% cited being a burden to their families as one of the causes of their intolerable suffering (see Fourth Annual Report, *supra* note 133 at 31).

[307] See Brennan Leffler & Marianne Dimain, "How poverty, not pain, is driving Canadians with disabilities to consider medically-assisted death", *Global News* (8 October 2022), online: <globalnews.ca> [perma.cc/2WCT-CVZ8] (as palliative care physician Dr. Naheed Dosani told Global News: "When people are living in such a situation where they're structurally placed in poverty, is medi-

can access MAiD solely on the basis of poverty, for many Canadians, disability, social marginalization, and poverty are inextricably linked.[308]

A recent article by bioethicists Kayla Wiebe and Amy Mullin argues that even where people live in "unjust" social conditions, and where those conditions impact a decision to seek MAiD, autonomy requires that we respect that choice if they meet the eligibility requirements for Track 2 MAiD.[309] They go so far as to label Track 2 MAiD in unjust social conditions a form of "harm reduction."[310] A harm reduction approach "acknowledges that the recommended solution is necessarily an imperfect one: a 'lesser evil' between two or more less than ideal options." [311] They argue that people seeking Track 2 MAiD in unjust social conditions are taking an active role in responding to their situation and are motivated to realize a goal: "The fact that this goal is arguably grim and reflects a severely unjust social landscape does not detract from the legitimacy of their agency. It is an indictment of the options available, not of the status of their autonomy, given the options they have to work with."[312]

The same authors wrote a short follow-up to their own paper, which sums up their argument clearly:

> It is tragic and unjust when people with chronic conditions lack adequate social supports to make living with their conditions tolerable and elect to receive MAiD. However, targeting and problematizing the autonomy of persons making these decisions, even if intended to protect people presumed to be collectively vulnerable, is a mistake. When social conditions combine with chronic health problems to lead people who

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cal assistance in dying really a choice or is it coercion? That's the question we need to ask ourselves").

308 According to Statistics Canada, the percentage of persons with disabilities who are considered low income is nearly double that of persons without disabilities in 2019 and 2020 (see Statistics Canada, *Poverty and low-income statistics by disability status* (Ottawa: Statistics Canada, 7 September 2022), online: <stat can.gc.ca> [perma.cc/3JQU-EURA]).

309 Wiebe & Mullin, "Choosing death", *supra* note 4 at 5.

310 *Ibid.*

311 *Ibid*.

312 *Ibid* at 3. See also Downie & Schuklenk, "Slippery slope", *supra* note 304.

> sought other alternatives, without relief, to request MAiD, the least harmful approach is to evaluate their requests as we do any other.[313]

This passage begs the question of what "chronic health problems" add to the equation to justify a response of death. Aside from the direct invocation of the "better dead than disabled" ideology, the authors fail to engage with the role of the state in the creation of the unjust social conditions, the refusal (not inability) to remediate those conditions,[314] and the ready availability of a state-funded death. We go beyond individual autonomy when the state gets involved in approving, funding, and providing death through the use of its criminal law power and its healthcare system. In other words, by making death the only solution to intolerable suffering, the state is facilitating and encouraging disabled deaths, a role that stands in direct conflict with its obligations under articles 10, 12 and 17 of the *CRPD* and sections 7 and 15 of the *Charter*.[315] Wiebe and Mullin attempt to differentiate what they refer to as "substantive justice" from autonomy, linking Track 2 MAiD only with the latter.[316] This paper argues that the *Charter* makes no such distinction and that it demands substantive justice.

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313 Kayla Wiebe & Amy Mullin, "Decision-making in injustice: MAiD in Canada after Bill C-7" (28 April 2023) J Medical Ethics, online (blog): <blogs.bmj.com> [perma.cc/4UNG-HGVB]. For examples of the many critiques of this position, see Shelley Tremain, "Are Amy Mullin and Michael Cholbi Experts on MAiD?" (14 June 2023), online (blog): <biopoliticalphilosophy.com> [perma.cc/Z7NY-DCGV]; Christopher Lyon, "Kevorkian's ghost: A response to Wiebe and Mullin's argument for MAiD for the oppressed" (14 May 2023), online (blog): <jme.bmj.com> [perma.cc/A8X3-SQGX]; Quentin IT Genius, "Hopeless hope, autonomy, and anthropology: a response to Wiebe and Mullin", (11 May 2023), online (blog): <jme.bmj.com> [perma.cc/AUE2-EHAE]; Thomas Koch, "harm reduction" for harmful ethics", (10 May 2023), online (blog): <jme.bmj.com> [perma.cc/G5JU-BSR6].

314 Mullin herself accepts that it is a refusal to remediate these conditions (see Sharon Kirkey, "Canada shouldn't deny assisted suicide if social conditions made life intolerable: bioethicists" *National Post* (9 May 2023), online: <nationalpost.com> [perma.cc/4P2Z-PF9V] ("[t]he public 'may be shocked to realize that some people's lives become intolerable to them — not simply because of their health condition, but because of something that, as Canadians, we have the power to change,' Mullin said")).

315 *Charter, supra* note 29; *CRPD, supra* note 205, art 17; Mandates, *supra* note 249 at 4.

316 See Wiebe & Mullin, "Choosing death", *supra* note 4 at 3.

The importance of putting the choice argument in context finds support in the majority decision of Justice Abella in *Fraser*, where she acknowledged that the courts have consistently held that "differential treatment can be discriminatory even if it is based on choices made by the affected individual or group."[317] This is particularly the case where those choices are constrained by the kinds of systemic inequalities faced by people with disabilities. Justice Abella explained the importance of understanding constrained choices when applying a standard of substantive equality: "In contrast to formal equality, which assumes an 'autonomous, self-interested and self-determined' individual, substantive equality looks not only at the *choices* that are available to individuals, but at 'the social and economic environments in which [they] pla[y] out.'"[318] She cited with approval the scholarship of Professors Margot Young and Sonia Lawrence, both of whom have demonstrated that the choice narrative has impeded women's equality.[319] As Lawrence indicates:

> [A] contextual account of choice produces a sadly impoverished narrative, in which choices more theoretical than real serve to eliminate the possibility of a finding of discrimination. ... The result is a jurisprudence which almost mocks a more nuanced version of the what and how of discrimination, through frequent recourse to the idea that any harm to the claimant was actually the result of her choice, or her unwise exercise of her own judicially protected liberty.[320]

Justice Abella emphasized Lawrence's argument that the structural conditions in which people exist mean that some choices are made more often by people with "particular 'personal characteristics.'"[321] This is especially true

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317 *Fraser*, *supra* note 209 at para 86.

318 *Ibid* at para 88 [emphasis in original], citing *Nova Scotia (AG) v Walsh*, 2002 SCC 38 at para 342.

319 *Fraser*, *supra* note 209 at paras 89–91.

320 Sonia Lawrence, "Choice, Equality and Tales of Racial Discrimination: Reading the Supreme Court on Section 15" in Sheila McIntyre and Sanda Rodgers, eds, *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Markham, ON: LexisNexis Canada, 2006) at 115–16, cited in *Fraser*, *supra* note 209 at para 90.

321 *Ibid* at 124–25, cited in *Fraser*, *supra* note 209 at para 90 [emphasis removed].

with MAiD where the only people to whom MAiD is accessible are those with the personal characteristic of disability.

A central weakness of a formal equality approach is its failure to recognize the particularities of disabled people's lives. Young explains how formal equality is underpinned "by an idealized vision of the liberal individual: autonomous, self-interested and self-determined. The individual is otherwise unencumbered by particularity of history, social location or circumstance."[322] This vision of formal equality posits maximizing the choice of the individual as paramount and, correspondingly, the individual becomes responsible for those choices. Substantive equality, by contrast, requires us to interrogate the range of choices available and the social and economic contexts in which they play out.[323]

An understanding of section 7 that focuses on unencumbered autonomy ignores the role of social location and the corresponding constraints put on the range of available choices. The choice to live in woefully inadequate institutional care, isolated from loved ones, or to die is no choice at all. UN Special Rapporteurs acknowledged this danger in their formal letter to Canada expressing concern about Bill C-7:

> It is not beyond possibility that, if offered an expanded right as *per* Bill C-7, persons with disabilities may decide to end their lives because of broader social factors, including loneliness, social isolation and lack of access to quality support services. Indeed, persons with disabilities, particularly older persons with disabilities, may be vulnerable to explicit or implicit pressures arising from their context, including expectations from family members, financial pressures, cultural messages.
>
> [and]
>
> The accumulated disadvantages that flow from disability may give rise to indirect pressure for persons with disabilities to make their choice one way rather than another under the proposed Bill. This would apply in particular for those lacking adequate family and network support, and effective restrictions that arise from their circumstances on their access to

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322 Margot Young, "Unequal to the Task: 'Kapp'ing the Substantive Potential of Section 15" (2010) 50 Sup Ct L Rev (2d) 183 at 190–91.

323 *Fraser*, *supra* note 209 at para 42.

> health services, such as suicide prevention, on an equal basis with others. In this regard, safeguards provided in Bill C-7 would appear to not be adequate or far-reaching enough to guard against the dangers that vulnerable persons with disabilities, including older persons with disabilities, would face should it become law.[324]

Consider what choice looks like in the context of people with disabilities who are incarcerated through the criminal justice system. The Correctional Investigator testified before the Senate that he opposed making MAiD available to anyone who is living behind prison walls,[325] indicating that Canada is an outlier in allowing MAiD in prisons: "Hopelessness, despair, lack of choice, denial of community alternatives are all conditions imposed by the reality of incarceration. A prisoner's ability to choose how, when and where to end one's life is mediated through the exercise of state power."[326] Yet MAiD is available to incarcerated individuals with disabilities even when compassionate release may not be.[327] Their so-called autonomous choice may be between a life of intolerable suffering at the hands of the state or death at the hands of the state. This "choice" will be particularly problematic when MAiD becomes available for mental illness, given the very high

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[324] Mandates, *supra* note 249 at 5–7.

[325] See House of Commons, Standing Committee on Public Safety and National Security, *Evidence*, 43-2, No 5 (2 November 2020) at 20:05 (Shannon Stubbs) ("[i]n the latest correctional investigator's report, he raised serious concerns about euthanasia in prisons. He called on the government to stop the practice altogether. Today he was at the committee and said he is deeply disturbed by three instances that he said should never have happened"). See also Kathleen Martens, "MAiD in prison: Inmates are 'dying to get out' says senator", *APTN News* (15 May 2023), online: <aptnnews.ca> [perma.cc/H4Yz-PDMX]; Avis Favaro, "The number of medically-assisted deaths in Canada's prisons a concern for some experts", *CTV News* (3 May 2023), online: <ctvnews.ca> [perma.cc/Y8BQ-DJUZ] [Favaro, "Concern"].

[326] House of Commons, Standing Senate Committee on Legal and Constitutional Affairs (2 February 2021) at 15:00 (Ivan Zinger), online: <oci-bec.gc.ca> [perma.cc/TQ82-AGML].

[327] See generally Alexander IF Simpson, Jason Tran & Roland M Jones, "Ethical considerations regarding mental disorder and medical assistance in dying (MAiD) in the prison population" (2022) 63:1 Med Sci Law 1 at 1; Adelina Iftene, "The Case for a New Compassionate Release Statutory Provision" (2017) 54:4 Alta L Rev 929 at 929.

rates of mental illness and the overrepresentation of Indigenous persons in prisons.[328]

Involuntary detention through the civil or forensic mental health systems raises similar concerns. The expert panel reviewing MAiD for mental illness has recommended that MAiD be available to persons who are involuntarily detained in psychiatric facilities for six months or longer, or for those who face repeated periods of detention of less than six months.[329] The only additional safeguard recommended is that the assessment be conducted by persons outside of the institution.[330] In all Canadian jurisdictions, those who are civilly detained cannot leave the facility at will and may lose the right to refuse psychotropic medication.[331] They may be held in seclusion or restrained physically or chemically.[332] They may have no choice about what treatment to undergo, whether to leave the facility, what clothes to wear, or who they are allowed to see or contact.[333] Yet we feel safe offering them the "choice" of death.[334] These examples highlight the fraught nature of choice in the lives of people who have no tolerable choices available to them and the very tenuous line between coercion and choice.

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328 Senator Kim Pate has already spoken about receiving letters from incarcerated individuals wanting MAiD as a way of escaping the conditions of confinement and their isolation from loved ones (see Martins and Favaro, "Concern", *supra* note 325).

329 See *Final Report, supra* note 132 at 14–15.

330 *Ibid* at 67.

331 See e.g. BC *Mental Health Act*, *supra* note 177, s 31 (consent to treatment is deemed to exist when in designated facility).

332 See Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System,* by Laura Johnstone (Vancouver: Community Legal Assistance Society, November 2017) at 14.

333 *Ibid* at 15, 23, 80–81.

334 See *Final Report*, *supra* note 132 at 67. It is particularly noteworthy that a person can be civilly detained precisely because they are a danger to themselves as a result of their mental illness (see e.g. BC *Mental Health Act*, supra note 177, s 22(3)(c)(ii), which provides for civil commitment on the basis of protecting the individual from themselves).

VII. Conclusion

Canada now has one of the broadest MAiD regimes in the world.[335] While the regimes in Belgium and the Netherlands are currently broader in terms of already allowing MAiD for mental illness, Canada's absence of a requirement that reasonable medical options be exhausted sets us apart from these jurisdictions.[336]

If suffering is cast as an entirely medical matter, and medical practitioners say it cannot be fixed, then they inevitably become the gatekeepers to determine whose lives are worth saving and whose lives are not. The suffering of disability is exceptionalized as different and inherently worse than other suffering. This medicalization of suffering, and the atomized construction of autonomy obscures the coercive role of the state and its own wilful failure to address the social inequalities that many people with disabilities face on a daily basis in Canada.

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335 Concerns have been raised about the scope of our legislation from Canadian and international experts. See e.g. Charles Lane, "Will future Canadians owe the disabled an apology for euthanasia?" *The Washington Post* (17 August 2022), online: <washingtonpost.com> [perma.cc/YTL8-VRB9]; Yuan Yi Zhu, "Why is Canada euthanizing the poor?" *The Spectator*, (30 April 2022), online: <spectator.co.uk> [perma.cc/R98C-KEUT].

336 Unlike in Canada, in the Netherlands, there is a "due care criteria," where a physician must ensure all methods to alleviate the suffering have been tried before approving a MAiD request (see Mishara & Kerkhof, *supra* note 24 at 727). As Lemmens, *supra* note 147 at 470 indicates, "[g]enerally, patients can request euthanasia if all of the following criteria are fulfilled: (1) they have a medical condition; (2) which causes unbearable (physical or psychological) suffering; (3) the situation is medically hopeless (Belgium) or there is no prospect of improvement (Netherlands); and (4) the suffering cannot be alleviated (Belgium) or there is no reasonable alternative solution (Netherlands)."

Belgium and the Netherlands both allow for MAiD on the basis of mental illness, for mature minors and based on an advance directive thus making those regimes broader in terms of who can access MAiD. In Canada, the Special Joint Committee on Medical Assistance in Dying has recommended the expansion of MAiD on similar grounds (see Special Joint Committee on Medical Assistance in Dying, *Choices for Canadians, supra* note 66 at 3, 54–63 (recommending the expansion of MAiD availability to mature minors), 73-4 (recommending advance requests)).

This paper has argued that Track 2 MAiD is unconstitutional and that it should be repealed or struck down by a court. It is true that if Bill C-7 were found to be unconstitutional or repealed, some disabled people who are suffering would be unable to access a medically-administered death if their natural death was not reasonably foreseeable. Able-bodied Canadians who are worried about future disability will lose the benefit of this "insurance policy." As Catherine Frazee notes: "To walk in solidarity with disability rights defenders on the issue of medically hastened death, most of us will have to accept some limits on our privileged autonomy. Many will have to abandon the hubris of full control in life."[337] It is equally true that if Bill C-7 is ultimately upheld, disabled people will die even though their suffering could have been rendered tolerable through adequate supports. For Sophia, state-sanctioned poverty and social marginalization led to MAiD; her disability was simply the gateway through which she accessed it.[338]

We need to decide as a country which results in a graver injustice: denying state-provided death to disabled Canadians who are suffering but not at the end of life, or facilitating state-provided death for someone whose suffering could have been alleviated? How we answer that question says a lot about the kind of country in which we live and the value we put on each disabled life. It is not the role of the state to ensure that those individuals have access to death when the state is not willing to ensure that they have access to a life without intolerable suffering.

It is very important to give people with disabilities more choices and more autonomy in how they live their lives. But offering autonomy over death to those who may not have access to what they need to live does not enhance equality or autonomy; it simply provides an exit ramp from the state sanctioned misery of their lives—an exit ramp that will save the state millions of dollars in healthcare and social supports.[339] It is striking

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337 Isabel Grant et al, "A Conversation on Feminism, Ableism and Medical Assistance in Dying" (2023) 34:3 CJWL [forthcoming in 2024].

338 Wiebe and Mullin acknowledge this fact and specifically refer to Sophia's situation without naming her (see Wiebe & Mullin, "Choosing death", *supra* note 4 at 1).

339 Even before Track 2 MAiD was introduced, the savings to the healthcare system were estimated to be between $34.7 million and $136.8 million annually (see Kelly Malone, "Medically assisted deaths could save millions in health care spending: Report", *CBC News* (23 January 2017), online: <cbc.ca> [perma.cc/QZR5-VHL8]). Track 2 MAiD could add to this considerably when one

that MAiD is fully covered by state-provided healthcare in Canada when so many of the supports needed to live are not.[340]

We must cede to the lessons of history that, even with the best of intentions, the altruism of the medical profession can be invoked to carry out the eugenic policies of the state. Any law that authorizes the killing of people with disabilities must therefore be subjected to the highest level of scrutiny. Quite simply, there is no safe way for the state or the medical profession to be in the business of killing people who are not otherwise dying. I end with the words of Gabrielle Peters:

> [I]n many ways it comes down to whether you believe in the infallibility and absolute integrity of the institutions of our society or not. If you don't, then – at minimum – you draw the line at the state delivering lethal injections to people not near the end of life.[341]

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considers potential years of social welfare payments and healthcare costs, plus end-of-life care.

340 A recent cost analysis suggests that MAiD in Canada could save millions annually for the healthcare system in savings for end-of-life care (see Aaron J Trachtenberg & Braden Manns, "Cost analysis of medical assistance in dying in Canada" (2017) 189:3 Can Medical Assoc J E101 at E103). As the numbers of Track 2 cases expand, including those based on mental illness, there is also the potential for savings in social welfare spending.

341 Gabrielle Peters, "MAiD – Marginalized Against Institutionalizing Death – The Opposition to the Expansion of MAiD is About faith, but just not the religious kind" (7 September 2022), online (blog): <mssinenomineblog.wordpress.com> [perma.cc/3CDK-SNCC].