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Feminist Alliance for International Action
L'Alliance Féministe pour l'Action Internationale
CANADA

Women with Disabilities, Medical Assistance in Dying (MAiD), and Canada's Implementation of the Convention on the Rights of Persons with Disabilities Articles 5, 6, 8, & 10

Submission to the Committee on the Rights of Persons with Disabilities

From the Canadian Feminist Alliance for International Action (FAFIA)

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I. Preface

1. The Canadian Feminist Alliance for International Action (FAFIA) is an alliance of Canadian women's organizations founded following the Fourth World Conference on Women, Beijing 1995. One of the central goals of FAFIA is to ensure that Canadian governments respect, protect, and fulfill the commitments to women that they have made under international human rights treaties and agreements. FAFIA has made submissions regarding Canada's compliance with its human rights obligations to United Nations treaty bodies since 1997.

2. This report was authored by Isabel Grant (Professor, Allard School of Law), Elizabeth Sheehy (Professor Emerita, University of Ottawa, Faculty of Law), and Janine Benedet, K.C. (Professor, Allard School of Law). It is based largely on their prior collaborative research (with Catherine Frazee) and on Isabel Grant's sole-authored research. The authors of the report thank Shelagh Day, Catherine Frazee, Maria Sokolova, and Katie Woodcroft for comments and assistance.

II. Introduction

3. In 2021, the Canadian government extended Medical Assistance in Dying (MAiD) to people with disabilities whose natural deaths are not reasonably foreseeable, thus solidifying its support for an ableist regime built on the premise that some disabled people are better off dead. This new dimension of Canada's euthanasia regime, known as "Track 2" MAiD, is a modern form of eugenics.

4. Canada has also legislated for the further extension of MAiD to people whose sole underlying condition is a mental illness, with implementation scheduled for 2027.

5. Although MAiD is currently only available to adults eighteen years of age and older and to those with capacity to make health care decisions, a joint parliamentary committee has recommended expanding Track 1 MAiD to "mature minors," and the federal government has already begun a "national conversation" seeking feedback on expansion to "advance

requests," such that doctors would be exempt from the criminal law for killing an individual who is no longer capable of giving consent if the person made a request while competent.

6. With these laws and practices targeted specifically and solely at people with disabilities, Canada is violating the UN *Convention on the Rights of Persons with Disabilities* ("*CRPD*" or "the Convention"), namely Article 5, the right to equality and non-discrimination and Article 10, the right to life. Canada's Track 2 MAiD regime has a particularly devastating impact on women with disabilities, in violation of Article 6. Moreover, the direct and indirect impacts of Track 2 MAiD in Canada infringe Article 8, in that they perpetuate the devaluation of the lives of people with disabilities, and normalize the deprivations and discriminatory practices that entrench the social and cultural disadvantage of people with disabilities in Canadian society.

7. This submission will focus on the impact of Track 2 MAiD on the lives and deaths of women with disabilities, a group who also experiences the intersecting oppressions of misogyny, racism, ageism, and poverty, creating the "perfect storm" for this deadly, ableist policy. Canada has abandoned its state obligations regarding women with disabilities even though their grave endangerment through Track 2 MAiD was entirely foreseeable, violating their rights to non-discrimination and equality, their right to life, and their right to be treated fairly as women, thwarting progress toward an inclusive Canada in which their equal dignity and worth is secure.

III. Legislative Background

8. In Canada, deliberately administering a lethal drug for the purpose of causing the death of another human being would normally constitute murder under section 229(a)(i) of the Criminal Code. Providing that drug to another person for the purpose of assisting them in ending their own life would constitute the crime of aiding suicide contrary to section 241(b) of the *Code*. Section 14 of the *Code* provides that no one can consent to their own death and that consent is not a defence with respect to the criminal responsibility of the person inflicting it. 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.

9. In 2015, the Supreme Court of Canada in *Carter v Canada* found that the offence of assisting suicide was unconstitutional for violating s. 7 (the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice) of the *Canadian Charter of Rights and Freedoms*, which is part of the Constitution of Canada. The *Carter* Court held that an absolute prohibition on physician-assisted death was overbroad. Its conclusion was premised on the assumption that "properly designed and administered safeguards" were feasible (at para 105) and the conclusion that there was "no evidence" that "socially vulnerable populations" would be at particular risk, nor was there any compelling evidence that a "slippery slope" would result (at para 107).

10. Parliament responded in 2016 with Bill C-14, which created exceptions to the offences of aiding suicide, culpable homicide, and the administration of a noxious thing for those doctors and nurse practitioners who provide medically assisted dying for people who have a grievous and irremediable medical condition, and for other practitioners who assist. A grievous and irremediable medical condition was defined as a serious and incurable illness, disease or disability, with an advanced state of irreversible decline in capability, intolerable physical or psychological suffering and a reasonable foreseeability of natural death (RFND). This is what has come to be known as "Track 1" MAiD. While the focus of this submission is on Track 2, it should not be taken as endorsement of the ableist underpinnings or the abuses recorded under Track 1.

11. In 2016 when introducing the law, the Department of Justice reassured the disability community that the RFND criterion was an important safeguard because "in circumstances where a person is not approaching natural death, [MAiD] could be seen as undermining suicide prevention initiatives and normalizing death as a solution to many forms of suffering."

12. However, in 2019 a single judge of a Quebec trial court found that the RFND criterion was unconstitutional under the *Charter* for denying access to MAiD for people with disabilities who were suffering intolerably but not dying (*Truchon v Canada (Attorney General)*). That court held (at para 574) that the RFND requirement was overbroad, grossly disproportionate, and discriminatory 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. The judge found (at para 682) that people who were suffering based on disability must be given access to MAiD "not only at the end of life, but also at any moment during their life", (at para 680) 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.

13. In spite of earlier reassurances about the importance of holding the line at those persons whose natural deaths were reasonably foreseeable, the Canadian government took the extraordinary decision not to appeal *Truchon*. Instead, in February 2020, just as Canada was entering the most significant public health crisis in its history with the COVID-19 pandemic, Bill C-7 was introduced in the House of Commons.

14. Disability organizations, scholars, and advocates testified in opposition to this expansion in Parliament, urging the government not to extend MAiD to people with disabilities who were not dying. The UN 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 also wrote to Canada setting out their concerns in a Mandate Letter. They argued that this legislation may be contrary to the CRPD and in particular to state party obligations to respect, protect and ensure the right to life (Article 10), the right to non-discrimination (Article 5), and the obligations to promote positive perceptions and greater social awareness towards people with disabilities and to combat stereotypes and prejudices (Article 8).

15. This law, which came into force in March 2021, fundamentally changed the nature of MAiD in Canada by adding "Track 2". The definition of grievous and irremediable medical

condition was amended to remove the RFND requirement. Conditions like chronic pain, cerebral palsy, autism, spinal cord injury, frailty, hearing or vision loss, arthritis, and multiple chemical sensitivities can now be approved as the sole basis for MAiD.

16. The *Criminal Code* sets out the MAiD criteria, which must be met for exemption from criminal liability, 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*
> *(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.*

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.*

Canadian law is explicit that a person need not exhaust treatment options before accessing MAiD, making Canada's regime one of the most expansive in the world.

IV. Track 2 MAiD Violates the Convention on the Rights of People with Disabilities

17. Track 2 of Canada's MAiD regime violates multiple Articles of the Convention. Violations of Articles 5, 6 and 10 will each be discussed in turn in this submission. Effects and practices that contravene Article 8 are cross-cutting in nature, and will be highlighted at various points throughout the submission. These violations occur not only through

disproportionate impacts supported by data, but are also inherent in the targeting of people with disabilities for Track 2 MAiD. They are borne out through the incalculable burdens placed upon people with disabilities, and most particularly, women with disabilities, in Canada.

Article 5: The Right to Equality and to Non-Discrimination

18. The expansion of MAiD to people with disabilities who are not at the end of life violates the principle of non-discrimination through both direct and indirect discrimination.

19. General Comment No. 6 (2018) on equality and nondiscrimination expresses concern about States relying on a medical model of disability, which is incompatible with the Convention: "Under the medical model of disability, persons with disabilities are not recognized as rights holders but are instead 'reduced' to their impairments" (para 8).

20. The Convention is based on "inclusive equality," which "embraces a substantive model of equality that includes a redistributive dimension to address socioeconomic disadvantage, a recognition dimension to combat stigma and prejudice, a participative dimension, and an accommodation dimension to make room for difference (para 11). Substantive equality "seeks to address structural and indirect discrimination and takes into account power relations" (para 10).

21. Track 2 MAiD is premised entirely on a medical model of disability that portrays disability as a flaw that, when it is medically irremediable, warrants ending someone's life. It is assumed both that the suffering is inherent to the disability (rather than the social barriers that cause and compound suffering for people with disabilities) and that the suffering associated with disability is uniquely different than all other human suffering. Physicians and nurse practitioners are set up as the gatekeepers to the procedure, effectively deciding whose life is worth saving and whose is not, something that is not a medical decision but rather a normative one about the value of disabled lives.

22. The Mandate Letter sent by the Special Rapporteur to Canada is informed by these principles, noting that equality is grounded "*inter alia*, on a recognition of the inherent equal worth of each person with a disability – equal personhood. This element of recognition of the equal human agency, personhood and inherent worth of all persons with disabilities is said by the Committee to underpin its conception of 'inclusive equality' in the CRPD."

23. Track 2 MAiD denies people with disabilities equal protection of the law and equality before the law and constitutes both direct and indirect discrimination. Direct discrimination occurs when people are treated less favourably than others because of their disability. Indirect discrimination arises where "laws, policies or practices appear neutral at face value but have a disproportionate negative impact on a person with a disability" (para 18b). Track 2 discriminates directly against people with disabilities and indirectly against women with disabilities.

24. Rather than Canada eschewing ableism, as required by Article 5 and as is implicit in Article 8, Track 2 MAiD entrenches it by exempting medical practitioners from the criminal law. Canada engages in direct discrimination in violation of Article 5 by declaring that people with disabilities are the only Canadians not near death who are eligible for state-provided euthanasia and whose lives are not protected in the same manner as other Canadians.

25. While not every disabled person will meet the criteria for Track 2 MAiD, no one who satisfies the criteria would fail to come within the definition of disability, whether or not they self-identify as disabled.

26. The CRPD uses an inclusive definition of disability 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.

27. Similarly, under domestic law, those with grievous and irremediable medical conditions would be considered disabled for the purposes of federal and provincial human rights legislation and the *Accessible Canada Act* .

28. 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 (at para 9):

> [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.

29. Singling out the suffering associated with disability so as to suggest it is different from all other human suffering and 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.

30. Because over 99% of MAiD deaths in Canada occur through the administration of a lethal injection, the exemption from criminal responsibility is for first degree murder (an intentional killing that is planned and deliberate), the most serious crime under Canadian law. Quebec, the province with the highest rate of MAiD deaths, prohibits self-administration, thus ensuring that MAiD deaths are always caused by medical practitioners in that province.

31. Through Track 2, the government has withdrawn the protection of the criminal law prohibition against murder for people with disabilities who experience suffering that they subjectively find intolerable and has thereby abdicated its responsibilities, including under multiple Articles of the Convention, to respond to disabled suffering by providing accessible housing, appropriate home care, decreased reliance on institutional care, improved financial support, and by ensuring that laws and policies do not entrench disability stigma or prejudice.

32. By medicalizing the suffering associated with disability, portraying death as a form of "medical treatment," and ignoring the social and political contributors to suffering, Track 2 endangers people with disabilities by normalizing suicide and making it more readily available than the social supports people with disabilities need to end or mitigate their intolerable suffering. The fact that a medical condition is irremediable does not necessarily mean that intolerable suffering cannot be alleviated. However, Track 2 MAiD is cheaper and easier than providing adequate supports. As the Minister of Employment, Workforce Development and Disability Inclusion, Carla Qualtrough stated, "it should not be easier to access a medically assisted death than to get a wheelchair – but it is."

33. The Canadian Association of MAiD Assessors and Providers, an Association that is funded by the federal government to develop curriculum and training around MAiD, has asserted that doctors and nurse practitioners have an ethical obligation to raise MAiD where a patient might be eligible. This direction effectively normalizes a practice that can have lethal consequences for patients with disabilities, by urging medical professionals to offer MAiD to persons who are not otherwise seeking it. By sending a signal that their physician has lost hope for any relief from their suffering, relationships of trust that are crucial to healing and recovery can be compromised or severely undermined. This change in the relationship between practitioners and persons 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 practitioners from pursuing every possible treatment option where MAiD is an easier, 100% effective, fully funded, and more readily accessible option.

34. Offering death as an option for people who are suffering and struggling to live requires them to question and reassess whether their lives are worth living. Contrary to the inclusive measures mandated in Article 8, Track 2 MAiD robs people with disabilities of the benefit of living in a society (and dealing with a medical profession) that takes for granted that their lives are worth saving. As Professor Martha Minow has noted "[t]he option of medical

assistance in dying … alter[s] the menu for all involved. It turns the continuation of living into a question, open for debate, doubt, and persuasion."[1]

35. Dr. Joshua Briscoe describes this burden 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.

36. That normalization of MAiD is occurring is evident from the data. The number of deaths effected through MAiD is large and expanding. Since 2016, Canada has seen a considerable increase every year, with a total of 60,301 people having died from MAiD. In 2023, 15,343 Canadians died from MAiD, amounting to 4.7% of all deaths. While most deaths are Track 1, the percentage of MAiD deaths qualifying under Track 2 is also increasing. In the nine months of 2021 when Track 2 was available, there were 219 Track 2 deaths and in 2022 there were 463. In 2023, 622 disabled people died under Track 2 MAiD, constituting 4.1% of all MAiD deaths and a 34% increase from the previous year.

37. Section 241.2(3.1) attempts to provide some prerequisites for cases 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 two independent practitioners must have confirmed that the individual meets all the criteria. If neither of those two physicians/nurse practitioners has expertise regarding the individual's condition, they must consult with another practitioner who does. However, if a person is found ineligible by a medical practitioner, there is no limit on the number of practitioners to whom they can apply.

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

38. The discrimination perpetrated through Track 2 MAiD cannot be alleviated through legislated "safeguards." None of these prerequisites are an answer to the discriminatory ableism that underpins Track 2. They are simply designed to validate that the people medical practitioners kill meet the formal statutory criteria. They are not intended to and do not uphold the equality of persons with disabilities, but rather operate as a cover for ableism. It is therefore unsurprising that attempts to add additional requirements have been rejected, and that the existing prerequisites are decried by some practitioners and advocacy groups as barriers to be circumvented.

39. For example, the Parliamentary committee was urged to add 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. This safeguard was rejected, and there is no such limit on healthcare workers raising the prospect of MAiD. In fact, as noted above, the Canadian Association of MAiD Assessors and Providers states that physicians and nurse practitioners have an ethical obligation to raise MAiD if a patient might be eligible.

40. In Quebec, when the oversight body raised concerns about the widespread use of MAiD, reminding doctors of their legal obligation to obey the guidelines, its concerns were dismissed and labelled as "intimidating" by the president of the Quebec Association for the Right to Die in Dignity. When legal guidelines are treated as merely annoying formalities by the providers of MAiD, there is a serious risk of widespread disregard for those prerequisites. For example, one report examining MAiD deaths since 2018 found 428 cases of possible *Criminal Code* violations, none of which were reported to police.

41. The potential for abuse was demonstrated recently by two cases in Vancouver and one in Calgary: one where an interim injunction was granted to stop the MAiD death of a woman diagnosed with bipolar disorder; a second involving a wrongful death claim by the family of a man with bipolar disorder who was given MAiD while on a day pass from a psychiatric committal; and a third in Calgary where a young woman with autism was approved for MAiD despite the well-founded objections of her immediate family. All of these cases raise concerns over practitioners disregarding Track 2 eligibility criteria and safeguards.

42. 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. There is no check on the exercise of that discretion. Someone who qualifies under Track 2 can avoid the 90-day waiting period by being switched to Track 1 if, for example, they stop eating or refuse routine medical treatment, circumventing this requirement.

43. Although Track 2 requires that before administering MAiD, the physician or nurse practitioner must ensure that the person knows what services are available to them, there is no requirement that these services actually be provided or made available in a particular jurisdiction. There is also no mechanism to ensure that practitioners are even aware of non-medical services and supports that are beyond their own scope of practice, thus increasing the likelihood that peer-based and other innovative forms of support may be overlooked. The MAiD provider need only confirm that the person has 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."

44. 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. There are many examples reported in Canadian media where individuals have resorted to Track 2 MAiD when they have been denied adequate home care or other supports.

45. There is no safeguard that protects people with disabilities when MAiD is disconnected from end-of-life. The prerequisites that do exist are utterly unenforceable because there is no pre-death oversight mechanism to validate or contest a practitioner's expertise or assessment, to inform family members who might have additional information or resources

regarding the request, or to ensure that needed services and supports are discussed or facilitated.

46. The existing oversight mechanisms, such as a complaint to a medical regulatory body or to police, are only practically available after the person has died. Any attempts to enforce statutory prerequisites prior to death are often thwarted by privacy claims, such that family members may find out only after their loved one is dead that their relative had been planning, with a medical practitioner, to kill themselves. Privacy has also been used as a justification for denying family members access to health records after a family member has died, making it impossible to investigate whether there was coercion or whether other care options were presented.

47. Further, in some provinces in Canada, such as Ontario and Québec, the cause of death on the death certificate is listed as the underlying condition, not as MAiD. Thus, the death certificate may list chronic pain or hearing loss as the cause of death rather than the lethal combination of drugs that are injected into the person. This practice renders even more complex any search for accountability. Despite findings of numerous irregularities in both Ontario and Québec, no practitioner has ever been charged with violating the *Criminal Code* prerequisites for exemption from criminal responsibility in Canada.

48. Additional so-called safeguards are not an answer to the violations of the CRPD that flow from Track 2. These defects in the administration of the statutory requirements are structurally "baked in" to the eugenicist premise underlying Track 2 – that some people with disabilities do not have the right to suicide prevention and adequate social supports, and instead are better off dead. While transparency, oversight, and accountability are important so long as this system continues to exist, strengthening and enforcing safeguards cannot change this fundamental premise of Track 2 MAiD – that state-funded euthanasia is an appropriate solution to the suffering of people with disabilities who are otherwise not near natural death.

Article 6: Women with Disabilities

49. Beyond the direct discrimination that Canada is perpetrating against people with disabilities through Track 2 MAiD, it is also committing indirect discrimination against women with disabilities, in violation of Article 5 as well as Article 6. Article 6 requires States to refrain from discrimination and to take active steps to promote the empowerment of women and girls with disabilities. The General Comment acknowledges that in order to accomplish this, it is important to understand the social structures in which women and girls with disabilities live:

> Ensuring the human rights of women requires, first and foremost, a comprehensive understanding of the social structures and power relations that frame laws and policies, as well as of economic and social dynamics, family and community life, and cultural beliefs (para. 8).

50. The structural realities of women's lives, as well as the current data on who accesses Track 2 MAiD, clearly show a discriminatory impact on Canadian women with disabilities. This submission is not solely based on a claim that at the end of the day more women than men will die from Track 2 MAiD, but also on what drives women to access it, what motivates medical practitioners to offer it to women, and what prompts policy-makers to push ahead, believing that some women with disabilities are better off dead.

51. Government policy analysts do not appear to have examined how Track 2 MAiD will affect women and girls with disabilities. This is despite the fact that the federal government has said it is committed to a "Gender Plus" screening analytic for both law and policy. Yet it is entirely predictable that Track 2 MAiD bears heavily upon the lives of women with disabilities due to multiple structural features of women's lives. Canadian society profoundly devalues aging women, and especially aging women with disabilities.

52. According to paragraph 12 of General Comment 3:

> Article 6 is a cross-cutting article related to all the other articles of the Convention. It should remind States parties to include the rights of women and girls with disabilities in all actions aimed at implementing the Convention. In particular, positive measures need to be taken in order to ensure that women with disabilities are protected against multiple discrimination and can enjoy human rights and fundamental freedoms on an equal basis with others.

53. This paragraph implies that compliance with Article 6 requires compliance with other articles of the Convention and that specific positive measures must be taken to ensure the equality of women and girls with disabilities. This oligation includes compliance with Article 4(2) of the Convention, which requires state parties to progressively realize the economic social and cultural rights of persons with disabilities, without prejudice to those obligations that are immediately applicable according to international law. Economic and social rights in the CRPD include, among others, the rights to education (Article 24), health (Article 25), and an adequate standard of living and social protection (Article 28). These rights are also set out in *the International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3 [ICESCR].

54. Women made up approximately 59% of all Track 2 deaths in 2022 and 2023. It is notable that 65.3% of all women who died were listed as having "other conditions," (2023 at 25) as compared to only 34.7% of men. These conditions include diabetes, frailty, autoimmune conditions, chronic pain, and mental disorders. Unlike with Track 1, people accessing Track 2 are more likely to live alone than with family members. A study by Ontario's Death Review Committee, which reviews MAiD deaths after they take place, found that MAiD Track 2 recipients, 61% of whom were women, were more likely than Track 1 recipients to be living alone, more likely to not have family members as next of kin, and more likely to live in the most marginalized neighbourhoods.

55. Beyond this current Track 2 MAiD data, there are at least four structural factors that bear unequally upon women with disabilities: women's poverty, the intersection of sexism and ableism within the medical profession, women's socialization as caregivers and the prevalence of male violence against women and girls and its contribution to suicide. Finally, this submission will examine what the 2027 expansion of Track 2 MAiD to persons whose sole underlying condition is a mental illness holds for women.

56. *Women's Poverty:* Women are more likely than men to experience disability; rates of disability increase with age; and women tend to live longer than men. This means that,

among the older population of people with disabilities, women predominate. Furthermore, 23% of women with disabilities live on low income.

57. Canada's failure to meet its international obligations to secure the social and economic rights of people with disabilities has disastrous effects for women with disabilities. The same social and economic factors that have impeded women's equality in Canada for decades remain in place: (1) poverty, income inequality, unequal pay, unpaid and precarious work (2) inadequate childcare, (3) lack of adequate housing, and (4) men's violence against women and girls. There is no national, coordinated strategy to counteract these interlocking causes of women's inequality.

58. The poverty of women with disabilities is further perpetuated by Canada's notoriously inadequate social assistance rates and disability supports, which have gendered impacts. Provincial, territorial, and federal social assistance rates are too low and associated programs are insufficient to lift women out of poverty.

59. Older women have less access to private wealth to fill the gaps left by disintegrating health care in Canada and a tattered social welfare safety net. Women are over-represented among low-income families/individuals in Canada and are more likely to experience food insecurity. Among those over 65 years of age, more women than men live on low incomes. These disparities are heightened for women with disabilities, Indigenous women, and racialized women, and further compounded when Indigenous or racialized women experience disabilities.

60. Disability rights advocates have lobbied for years for adequate disability-related social assistance, and in 2022 the Government of Canada announced a new Canada Disability Benefit with the aim of "lift[ing] hundreds of thousands of working-age Canadians with disabilities out of poverty". Despite the hope that came with the announcement of this program, advocates have been disappointed with its roll-out. While 1.6 million Canadians receive disability-related social assistance, only 600,000 are eligible for the Canada Disability Benefit. Even if individuals are able to overcome the significant barriers inherent

in the Canada Disability Benefit application process, they will only receive a maximum of $200 per month. At this rate of funding only 25,000 of them (4.2% of those receiving the benefit) will be lifted above the official poverty line.

61. It is therefore entirely predictable that women with disabilities who are poor will be offered or driven to MAiD because they cannot find stable, accessible, and safe housing, home care, palliative care, or appropriate health care.

62. Despite the secrecy shrouding so many women's deaths, there are examples showing the role of poverty, inadequate home care, and unsafe housing in women's Track 2 MAiD applications. Early in 2022, a woman who had been diagnosed with Multiple Chemical Sensitivities, accessed Track 2 MAiD after spending years searching and pleading with all levels of government for safe housing. In a video she 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." By contrast, a 31-year-old woman in Ontario, who uses a wheelchair due to a spinal cord injury and who was diagnosed with Multiple Chemical Sensitivities, was able to withdraw her MAiD application when disability organizations and private citizens rallied to raise enough money to allow her to move to a hotel temporarily to continue her search for appropriate housing. She had been on a waiting list for affordable housing for seven years.

63. Rosina Kamis lived with fibromyalgia and chronic leukemia and struggled with food and housing insecurity, loneliness, and poverty. She asked her friends to keep secret that it was her emotional suffering that precipitated her MAiD application, not her physical suffering. Sathya Dhara Kovac wrote in her obituary that she accessed MAiD much earlier than she wanted to die because of the failure of the social welfare system to support her, not because of her illness. Other examples of women driven to MAiD by systemic failures of social and economic support are described in Canadian media.

64. There are also examples of women seeking medical and other support who are instead offered MAiD. Kathrin Mentler, who lives with chronic depression, went to Vancouver

General Hospital to seek psychiatric support when she was in a crisis. Instead, she was told that there was a long wait list for psychiatric help and was asked whether she had considered MAiD. Christine Gauthier, a military veteran and former Paralympian, was offered MAiD by a caseworker when she pursued her five-year long wait for a wheelchair lift. Heather Walkus went for physiotherapy for a bruised hip, where the therapist suggested she consider MAiD.

65. The rights to life and to equality are indivisible from the full realization of economic and social rights guaranteed under the ICESR and the CRPD. Canada's failure to fulfill its commitments to protect these rights, as well as the failure to require assurance that those accessing MAiD are not doing so because of their poverty and the consequent inability to secure their medical, health care, and housing needs, will inexorably lead to MAiD disproportionately being offered to, or accessed by, persons with disabilities, especially women.

66. Canada's failure in this regard does not, however, mean that remedying social and economic inequality would render Track 2 MAiD acceptable or consistent with the CRPD, because Track 2 MAiD is targeted only at people with disabilities on the ableist premise that people with disabilities may be better off dead.

67. *The Medical Profession:* Doctors and nurse practitioners are the ones who serve as gatekeepers in deciding whether MAiD is authorized for a person even though this is a legal decision that requires skills and insights well beyond those that are purely medical in nature. Women's historical relationship to the medical profession has often been one of oppression.

68. Practices of sexism, racism, and ableism continue to show up through patterns of sexual abuse, misdiagnosis, and systemic abuse of patients. Women's symptoms of illness may not be recognized because they differ from men's; women may be diagnosed later than men for the same conditions, and women's physical unwellness may be attributed to women's mental or psychiatric conditions, and left undiagnosed or untreated.

69. Racism too affects the kind of care that Indigenous and racialized women receive, whereby pernicious beliefs about patient motivations and experiences disrupt appropriate treatment. Members of the LGBTQ community with disabilities, and especially those who are transgender, also face unique challenges in accessing appropriate healthcare and supports.

70. There is also an emerging literature demonstrating that ableism is prevalent in the medical profession. A 2022 US study of physician attitudes reports that doctors find patients with disabilities burdensome to their practices and assert that the remuneration they receive for care is inadequate; some physicians describe important structural barriers to providing appropriate care, such as time limits on appointments and a lack of accommodations, while others display attitudes of resentment towards their patients with disabilities or refuse them care.

71. Doctors also evaluate the quality of the lives of people with disabilities considerably lower than those individuals rate their own lives. People with disabilities often face unwanted suggestions of "do not resuscitate" orders, reduced priority through triage protocols, and are now offered MAiD when they are seeking treatment and supports.

72. These practices feed into how medical practitioners evaluate the suffering of women with disabilities and assess whether they would be "better off dead." These practices suggest that women with undiagnosed, untreated, or under-medicated conditions might believe MAiD is their only option; that doctors might be more likely to assess women with disabilities as qualifying for Track 2 death and less likely to offer them treatment; and that doctors might pay less attention to the role of failed social welfare support in a woman's decision to seek MAiD since these are not medical problems that they can solve.

73. *Women's Socialization under Patriarchy:* Women with disabilities are more likely to be socially isolated, with fewer supports. Men are not socialized to care for dependents, especially their wives, nor are they expected to do so. For example, a 2009 study reports that, when a patient is diagnosed with a serious illness, men are six times more likely to

abandon their female partners with disabilities than are women to abandon their male partners. At a societal level, men are not expected to care for their female partners with disabilities; the burdens of caregiving for men are seen as somehow exceptional.

74. Further, women's socialization as caregivers rather than receivers of care may make women more anxious about being a burden to others. In 2023, the Fifth Annual Report shows that 49.2 percent of all Track 2 recipients expressed being a burden on loved ones or caregivers as one of their reasons for accessing MAiD, and 47.1 percent cited loneliness. No doubt, there are men who elect MAiD because they do not wish to burden others. Yet one might fairly worry that more women will elect Track 2 MAiD because they either have no family support or do not wish to "burden" others. A woman's perception that they are a burden then forms part of the intolerable suffering that is a prerequisite for MAiD eligibility.

75. Beyond the gendered oppression that "perceived burdensomeness" places on women, this experience is also driven by social class and ableism. When the state fails to provide adequate disability supports, such as home care, caregiving is privatized and can be inaccessible for many people with disabilities. The whole notion of being a burden on society or loved ones is grounded in ableism, and the depiction of dependence on others as somehow undignified and contrary to the notion of autonomy is discriminatory.

76. *Men's Violence against Women:* The relationship between MAiD, disability, and male violence is complex. Male violence is disabling for women and girls, and men target women and girls with disabilities for both physical and sexual violence. One study found that women with disabilities are at four times the risk of sexual assault as women without disabilities and at least 50 percent more likely to experience abuse from an intimate partner.

77. With intimate partner abuse and rape may come isolation, fear, anxiety, chronic pain, the risk of brain injuries, PTSD, and depression—all of which can exacerbate whatever the woman is already coping with, be it pain, poverty, or limited care options. Being a victim of intimate partner or sexual violence significantly increases the risk of women's suicide

attempts. A recent English study found that women who have experienced domestic abuse were four times more likely to have attempted suicide than other women and three times more likely to have done so in the past year. In addition to the usual challenges around reporting male violence, women with disabilities may face additional barriers to reporting, particularly where the abuser is in a caregiving position.

78. Finally, the issues of perceived burdensomeness and violence against women are interwoven. Being constructed as a burden may well be part of a pattern of a coercively controlling relationship, which can put undue pressures on women with disabilities to access MAiD. Women with disabilities in abusive relationships may be pressured into seeking MAiD and may be coerced by their abusers into believing their lives are worthless and burdensome. MAiD assessors and providers may have no ongoing relationship with the person seeking MAiD thus making full disclosure of abuse even less likely.

79. A further impact of Track 2 MAiD as a response to women's disability and suffering is the normalization as "mercy killing" of the acts of violent men who kill their wives with disabilities. For example, in 2023, Francois Belzile, who deliberately gave multiple insulin injections to his female partner who lived with disabilities and caused her death, was initially charged with first-degree murder. However, the prosecutor was willing to accept a guilty plea to manslaughter, and the judge sentenced him to house arrest because he allegedly suffered from "caregiver burnout." The UK experience suggests that "mercy killing" as a justification is raised almost exclusively by men who kill women, not the reverse. In these cases, even the pretense of choice has been discarded in favour of reframing male violence as "compassion."

80. All of these structural features of women's lives suggest that Track 2 MAiD is likely to be perceived as the only solution for some women with disabilities, yet they are rendered invisible in the MAiD discourse and data collection. We are left with a comforting but false narrative about women with disabilities peacefully accessing MAiD to alleviate their suffering.

81. *Mental Illness: An Additional Threat*: The sex discriminatory impact of Track 2 will reach dire proportions in 2027 when MAiD on the sole basis of mental illness becomes available. The *Criminal Code* currently states that mental illness is not an illness, disease, or disability for the purposes of MAiD. However, under the current regime, if a woman has a mental illness in addition to any grievous and irremediable medical condition, she will qualify for Track 2 MAiD. Many people with mental illness have one or more coexisting physical disabilities that will qualify them under Track 2.

82. Track 2 MAiD can already be sought and approved even though mental illness may play a major role in the woman's decision and may compromise capacity to consent. For example, Christie and Alicia Duncan testified before the Parliamentary Committee regarding the death of their mother Donna Duncan who, after suffering a concussion in an accident, accessed MAiD while experiencing depression and soon after a suicide attempt. Furthermore, experts caution that the request by a patient with a personality disorder for euthanasia to their doctors "may be a request for communication about loneliness or mental suffering, or an attempt by the patient to find a reason to continue living through eliciting a dialogue with his/her doctor or mental health worker."

83. In 2027, when MAiD will become available for persons whose sole underlying medical condition is mental illness, there is no doubt that the results will be deeply gendered. Depression is the leading underlying condition for psychiatric euthanasia in other countries and —women are more than twice as likely as men to be diagnosed with depression. Other psychiatric conditions such as PTSD, borderline personality disorder, and anorexia are more commonly diagnosed among women and have been linked to trauma.

84. These conditions have all been the basis for psychiatric euthanasia deaths in the Netherlands and Belgium, where women are grossly over-represented. In one study, researchers found that of a sample of 100 patients who requested MAiD in Belgium on the basis of at least one psychiatric disorder, 77% were women. Those women were, on average, just 47 years old. Other researchers have demonstrated that women account for "the majority (69–77%) of persons who request and receive euthanasia based on a

psychiatric condition." One study reports that 36% of those who died from psychiatric MAiD had a history of trauma, for example, physical and sexual abuse. Canada collects no data on the role of trauma in its MAiD requests.

85. MAiD on the sole basis of mental illness raises fundamental questions that Canada has failed to address. To qualify for MAiD, one's condition must be irremediable. The Centre for Addiction and Mental Health has indicated that "[t]here are no established clinical guidelines that health care practitioners can use to determine if a person's mental illness is grievous and irremediable." Leading Canadian psychiatrists have published a statement indicating that it is impossible to identify whose mental illness is irremediable.

86. While some mental illnesses may in fact be irremediable, according to testimony by Dr John Maher before the Parliamentary committee, psychiatrists do not have the ability to predict who will and who will not improve at a rate better than chance. The majority of MAiD providers are family doctors without psychiatric expertise. In 2022, for example, 67.7% of MAiD deaths were administered by family physicians. Another issue is whether MAiD assessors can differentiate between suicidality in individuals experiencing mental illness, as opposed to an "appropriate" MAiD death based on mental illness. MAiD proponents argue that doctors can distinguish someone who wants to commit suicide from someone who wants MAiD yet there is a lack of clarity about how this will be done or what the difference is between these two states of mind. Some try to differentiate suicide and MAiD on the basis of impulsivity—suicides are impulsive and not planned—what the Supreme Court of Canada in *Carter* characterized as "a moment of weakness" — whereas MAiD deaths are allegedly considered and deliberate.

87. In fact, research suggests that many suicides are not impulsive but rather are planned, particularly those that are a result of intractable depression, substance abuse, and/or childhood trauma.

88. There is also some suggestion in the literature that completed suicides will increase as a result of MAiD, particularly among women. In Canada, as in many other Western

jurisdictions, men are more likely to die from suicide but women are almost twice as likely to attempt suicide. One possible explanation for this paradox is the fact that men tend to choose more violent means to end their lives than women and, therefore, that women are more likely to survive and potentially go on to live full lives.

89. In the only study of psychiatric euthanasia and gender, researchers demonstrated that the gender breakdown for psychiatric euthanasia maps almost perfectly onto the gender breakdown of attempted suicide. In other words, by providing a sanitized, socially acceptable means of suicide, promoted as painless and peaceful, that is 100 percent fatal, we may be effectively turning many of the high number of attempted suicides for women with mental illness into completed suicides through Track 2 MAiD.

90. It is well known that suicide is a particular problem in Indigenous communities, especially among youth. Indigenous communities also have higher rates of disability. Indigenous women are at an elevated risk of male violence, and male violence increases the risk of suicide significantly. The extension of MAiD to the sole basis of psychiatric disability risks establishing a potentially deadly vicious cycle between disability, violence, trauma, and death.

91. MAiD is available in Canada to incarcerated persons. People with disabilities, and especially mental illnesses, are vastly overrepresented in Canadian penitentiaries. Approximately 90% of federally sentenced women have a history of trauma or past abuse. Indigenous women face the highest rates of overincarceration and make up 50% of the population of incarcerated women while only comprising 4-5% of the general population of women in Canada. Indigenous women comprise 96% of federally sentenced women who are in Structured Intervention Units (segregation). Canada has adopted the *UN Declaration on the Rights of Indigenous Peoples* and yet Canada has failed to ensure that MAiD will not endanger Indigenous women with disabilities who end up incarcerated.

92. The Correctional Investigator has taken the position that no one should receive MAiD inside prison walls, yet there are troubling reports that MAiD has been incentivized for

prisoners who cannot otherwise leave prison to be with their families. Inexplicably, MAiD deaths are the only deaths in penitentiaries that do not have to be reported to the Office of the Correctional Investigator.

Article 10 The Right to Life:

93. The right to life has not yet been the subject of commentary under the CRPD, but is also found in other international instruments to which Canada has long been a party, such as the *Universal Declaration of Human Rights* and the *International Covenant on Civil and Political Rights* (ICCPR). The commentary on the right to life under the ICCPR notes that "the right to life is a right that should not be interpreted narrowly. It concerns the entitlement of individuals to be free from acts and omissions that are intended or may be expected to cause their unnatural or premature death, as well as to enjoy a life with dignity."

94. The UN Human Rights Committee has noted that the right to life for people with disabilities includes the enjoyment of the right on an equal basis with others. This includes the provision of "reasonable accommodation when necessary to ensure the right to life, such as ensuring access of persons with disabilities to essential facilities and services" and measures to combat stigmatization that may deny access to health care.

95. The Mandate Letter sent to Canada by the Special Rapporteur about Track 2 MAiD acknowledged that Canada does have latitude in introducing a legislative regime for MAiD. However, the concern raised was that the right to life of people with disabilities was not being protected *on an equal basis* with others because Track 2 MAiD targets people with disabilities who are not dying.

96. In *Carter v Canada* the Supreme Court of Canada established (at para 62) 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." 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 increase the risk of death for individuals

with disabilities. Medical practitioners would not help people die without this immunity from prosecution. 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, certain and celebrated path to ending one's life.

97. Killing does not alleviate suffering; it eliminates the sufferer. This is why we see cases of people accessing MAiD because they cannot afford accessible housing or home care, or because they do not want to live in woefully inadequate long-term care facilities. While one cannot receive MAiD on the sole basis of poverty, when poverty accompanies disability, MAiD is, according to some, entirely defensible.

98. The concerns raised in the Mandate Letter regarding the impact of Track 2 on Article 10, the Right to Life, were prescient:

> It is not beyond possibility that, if offered an expanded right as *per* 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.

99. 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 or denies them their right to life. It allegedly allows the individual to exercise a choice to die when they perceive their lives as no longer worth living.

100. Explicit analogies are often made to reproductive choice, specifically women's access to abortion. Superficially, these arguments may seem to align with the interests of the disability rights movement, which has often focused on the ways in which people with disabilities have and continue to be denied the same autonomy that others have about fundamental life choices and day to day preferences. The analogy to abortion is, of course, gendered and suggests that the push to expand MAiD is a battle for the autonomy of women with disabilities.

101. Access to safe, legal abortion is important to women's equality because control of women's reproductive capacity by men is a practice of sex inequality. Forcing women to become pregnant (through coerced intercourse and lack of access to contraception), and forcing them to give birth (through lack of access to abortion) are all tools of male control that limit women's social and economic equality. Other than through the bare appeal to choice, MAiD has nothing to do with securing women's economic and social equality or their full participation in public and private life.

102. The core premise of this argument is the framing of killing someone as a kind of "medical treatment" for people with disabilities. MAiD is not a treatment for disability; it only appears that way because it is administered by medical practitioners. It is the only "treatment" in the history of medicine whose sole aim is to kill the patient. In other settings, such as punishment for criminal activity, we recognize the fundamental difference between penalties such as incarceration and the death penalty. Death is final and irreversible – there is no opportunity to correct regrets or mistakes. It is the ultimate denial of life and liberty. Yet in the context of Track 2 MAiD, this essential truth is obscured. A human rights approach to disability focuses on the rights of persons with disabilities to live with equal autonomy, not the right to be dead.

103. The characterization of MAiD as a benefit for people with disabilities who are not dying is the legislative entrenchment of "it is better to be dead than disabled" narrative that is at the heart of ableism. It is only a benefit to be dead if being dead is accepted as preferable to life with a disability. The Mandate Letter sent to Canada raises this concern:

> From a disability rights perspective, there is great concern that, if assisted dying is made available for all persons with a health condition or impairment, regardless of whether they are close to death, a social assumption might follow (or be subtly reinforced) that it is better to be dead than to live with a disability. Therefore, a major concern must be that persons with a disability (and perhaps especially those with newly acquired impairment) may opt too readily for assisted dying, based on the internalisation of prejudices, fears and low expectations of living with a disability, even before having the chance of coming to terms with and adapting to their new disability status.

104. The presentation of MAiD as a kind of medical treatment that enhances individual choice misses the ways in which choice is socially constructed in systems of ableism, intersecting with ageism and sexism, among other forces. The result is a simplistic analysis, suggesting that more "choice" is always better, whereby each limitation on MAiD is seen not as a life-saving measure but rather as an obstacle to choice-maximization.

105. Within Canadian society, the extreme and dehumanizing measure of ending the lives of people with disabilities by Track 2 MAiD is now embraced as reasonable and normative. At the same time, systemic remedial measures at the policy and program levels to remediate suffering by non-lethal means remain entrenched as extraordinary, unreasonable, and not feasible. This ascendant cultural narrative runs completely contrary to the core tenets of inclusive equality, as expressed in the CRPD broadly, and in particular Article 8.

V. MAiD's Continuing Expansion in Canada Threatens All People with Disabilities, Particularly Women and Girls

106. The Canadian government has initiated a "national conversation" on advance requests for MAiD, following the lead of the province of Quebec. The government defines an advance request as "a request for MAID made by an individual who still has the capacity to make decisions, before they are eligible or want to receive it."

107. This formulation obscures the fact that advance requests involve providing MAiD to people who can no longer give contemporaneous consent, such as persons with advanced dementia. The person who lacks the capacity to consent is robbed of any humanity in this framework and is seen only through the lens of their prior competent self. They will be killed even where they do not understand what is happening to them. This fundamentally changes the role of caregiving in Canadian society and the role of the medical profession vis-à-vis people with dementia. Someone will have to make the decision about when MAiD is to be provided, and it is a small step from advance requests to MAiD by substituted decision-making.

108. This expansion of MAiD to "advance requests" has profound implications for women with disabilities and their rights under Articles 5, 6, and 10. Since women's life expectancy continues to be longer than men's, women make up the majority of older adults, with the gender gap widening with age. Women make up approximately 65% of those residing in long-term care settings in Canada. In 2020, women made up approximately 62% of all Canadians with dementia. This means that women who are pressured or induced into signing an advance request for MAiD to be given at a time when they will not know what is happening to them are more likely than men to one day have that authorization carried out.

109. While researching the sexual assault of older women, we encountered calls for the availability of advance directives that would authorize a man to have sex with his wife after she has lost the capacity to consent owing to dementia or other sources of cognitive decline. We were reassured that this dehumanizing expression of male sexual entitlement was prevented by Canadian law, which has held that consent to sexual activity must be given contemporaneously by a person with the present capacity to do so. If this principle is abandoned for the most serious crime of murder, it is not a big step to abandon it for sexual assault of the most vulnerable women with disabilities.

110. It appears inevitable that the next expansion beyond advance requests will be to the use of substituted decision-making, in which family members or other designated persons will be authorized to consent to MAiD on behalf of another person who did not make such a request at the time they had capacity, or who may never have had capacity to make such a decision.

111. Substitute decision-making would permit parents to authorize the killing of their children with disabilities or a husband to authorize the killing of his wife with Alzheimer's disease, on the basis of his assessment that she "never would have wanted to live that way" and that she should not be denied the same "choice" other Canadians have. If so, this will further demonstrate the degree to which death has been normalized as the best way to alleviate the

suffering of disability, and the degree to which even the most basic safeguards – like informed consent – are so rapidly cast aside.

112. Article 12 of the CRPD requires state parties to eliminate all forms of substitute-decision making. Canada has a reservation to this aspect of Article 12, which means it can continue to adopt such decision-making models. However, expanding the practice would be a further, deliberate form of noncompliance with the Convention.

VI. Recommendations

113. Canada must repeal Track 2 MAiD.

114. In addition, so long as MAiD on any track continues to be offered in Canada, FAFIA supports these additional recommendations, consistent with those made by Canadian disability organizations:

i) MAiD must not be extended to persons on the sole basis of mental illness;

ii) MAiD must retain the fundamental requirement of contemporaneous informed consent and not be extended to advance requests or substitute decision-making; and

iii) MAiD must not be extended to children under the age of 18.

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