



Women with Disabilities, Medical Assistance in Dying (MAiD), and Canada's Implementation of the International Covenant on Civil and Political Rights

Submission to the UN Human Rights Committee

A joint submission by: the Canadian Feminist Alliance for International Action (FAFIA); DAWN Canada; and Inclusion Canada

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I. Acknowledgements

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 (University Killam Professor, Allard School of Law) and Elizabeth Sheehy (Professor Emerita, University of Ottawa, Faculty of Law). The analysis relies on their [prior collaborative research](#) with Janine Benedet, K.C. (Professor, Allard School of Law) as well as Professor Grant's solely authored work.¹ The authors of the report thank Shelagh Day, Catherine Frazee, 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](#).

1. "A Conversation on Feminism, Ableism, and Medical Assistance in Dying (2024) 34:3 CJWL 31; " Legislated Ableism: Bill C-7 and the Rapid Expansion of MAiD in Canada" (2024) 15:2 McGill JL & Health 259 and "Why Track 2 MAiD is Discriminatory" (2025) 8:4 Canadian Journal of Bioethics 45.

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 completed a “national conversation” on expansion to “advance requests,” which would allow doctors to 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. Advance requests are already allowed in Québec contrary to Canadian criminal law.
6. According to the [Concluding Observations](#) of the UN Committee on the Rights of Persons with Disabilities, Track 2 MAiD, which targets people with disabilities for death, violates the UN *Convention on the Rights of Persons with Disabilities* (CRPD), namely Article 5, the right to equality, and Article 10, the right to life.
7. The Committee on the Rights of Persons with Disabilities, found that the MAiD regime is premised “on the basis of negative, ableist perceptions of the quality and value of the life of persons with disabilities, including the view that ‘suffering’ is intrinsic to disability, without recognition that inequality and discrimination cause and compound ‘suffering’ for persons with disabilities.” (Concluding Observations, para 19(a))
8. The Committee addressed the claim that the MAiD regime does not violate rights because it merely offers “choice” to people with disabilities. The Committee describes the choice argument as “a false dichotomy, setting up the premise that if persons with disabilities are suffering, it is valid for the State Party to enable their death without providing safeguards that guarantee the provision of support, and on the basis of ableist assumptions that de-emphasize the myriad of support options that could allow persons with disabilities to live dignified lives, and [without considering] the systemic failure of the State Party to address the social determinants of health and well-being with regard to poverty alleviation, access to healthcare, accessible housing, prevention of homelessness, prevention of gender-based violence, and the provision of community-based mental health support and employment support.” (Concluding Observations, para 19(b))

9. The Committee recommended that Canada repeal Track 2 MAiD, including the pending changes scheduled for 2027 that will make Track 2 available on the sole basis of mental illness. The Committee also recommended that Canada not support any further expansion to mature minors or advance requests. It recommended that Canada invest in comprehensive measures to ensure that the systemic failures in relation to the social determinants of health and well-being are addressed, with regard to poverty alleviation, access to healthcare, accessible housing, prevention of homelessness, prevention of gender-based violence, and the provision of community-based mental health support, care services at home and personal assistance, and employment support. Finally, the Committee recommended community-led consultation processes with Indigenous Peoples, and Indigenous persons with disabilities, respecting the principle of self-determination and the establishment of a federal independent oversight mechanism to monitor, regulate and handle complaints in relation to medical assistance in dying. Canada has yet to provide any response to these recommendations.
10. Canada's Track 2 MAiD regime has a particularly devastating impact on women with disabilities, in violation of both Article 6 of the ICCPR, the right to life, and Article 26, the right to non-discrimination. Moreover, the direct and indirect impacts of Track 2 MAiD in Canada 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.
11. 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 and their right to life, thwarting progress toward an inclusive Canada in which their equal dignity and worth is secure.

III. Track 2 MAiD Violates the ICCPR, Articles 6 and 26

12. In addition to violating the *Convention on the Rights of Persons with Disabilities*, Track 2 MAiD violates two Articles of the ICCPR: Articles 6 and 26. These violations occur because of the targeting of people with disabilities, at the cost of their lives, and because of the disproportionate impact that the regime has on women with disabilities.
13. [General Comment No. 36 on Article 6, the right to life](#), is particularly pertinent here. It 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.” (para 3)
14. The General Comment (at para 9) outlines the state’s obligation to take adequate measures to prevent suicides, particularly among vulnerable individuals. With respect to ending the lives of terminally ill patients, states “must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patients, with a view to protecting patients from pressure and abuse.”
15. According to the General Comment, States Parties must take measures to ensure that people with disabilities enjoy the right to life on an equal basis with others. (para 24) This may require measures of protection to ensure access to “essential facilities and services.”
16. State Parties must take positive steps to ensure access to “food, water, shelter, health care, electricity and sanitation, and other measures designed to promote and facilitate adequate general conditions, such as [...] effective emergency health services [...] and social housing programmes. State Parties should also develop strategic plans for advancing the enjoyment of the right to life, which may comprise measures to fight the stigmatization associated with disabilities and diseases.” (para 26)

17. State Parties are obligated to investigate and use the power of the criminal law (as opposed to administrative measures) to prosecute unlawful deprivations of life. (para 27) These investigations must be “independent, impartial, prompt, thorough, effective, credible, and transparent.” (para 28) States Parties are also obligated to take steps to prevent similar violations in the future.
18. Lastly, the right to life must be “respected and ensured without distinction of any kind,” including based on sex, disability, and socioeconomic class” as well as “multiple and intersectional forms of discrimination.” (para 61)
19. FAFIA submits that in light of these observations, Canada’s Track 2 MAiD regime clearly violates Articles 6 and 26.

IV. Recommendations

20. Canada must repeal Track 2 MAiD, including the planned expansion of MAiD on the sole basis of mental illness, by reinstating the requirement of a reasonably foreseeable natural death for all MAiD deaths.
21. In addition, so long as MAiD on any Track continues to be offered in Canada:
 - i) MAiD must retain the fundamental requirement of contemporaneous informed consent and not be extended to advance requests or substitute decision-making; and,
 - ii) MAiD must not be extended to children under the age of 18.

V. Legislative Background

22. 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 at a minimum 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.

23. In 2015, the Supreme Court of Canada in [Carter v Canada](#) found that the offence of aiding 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).
24. 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 required a reasonably foreseeable 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 documented under Track 1.
25. 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.”

26. 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.
27. 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.
28. 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 the proposed 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).

29. 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](#), diabetes, cerebral palsy, autism, spinal cord injury, “frailty”, [hearing or vision loss](#), arthritis, and [multiple chemical sensitivities](#) can now qualify a person for MAiD.
30. The *Criminal Code* sets out the MAiD criteria, which must be met for exemption from criminal liability, in section 241.2(1). The person must be 18 years of age and eligible for government health services. They must have a grievous and irremediable medical condition and have made a voluntary request for MAiD. They must provide informed consent after having been informed of the means that are available to relieve their suffering, including palliative care.
31. The definition of a grievous and irremediable medical condition under section 241.2(2) remained unchanged except that the RFND requirement was removed:
- (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.*
32. Canadian law does not require that a person [exhaust treatment options](#) before accessing MAiD, making Canada’s regime one of the [most expansive in the world](#).

VI. Track 2 MAiD Violates Article 6, the Right to Life

33. 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 even celebrated path to ending one’s life.

34. Killing does not alleviate suffering; it eliminates the sufferer. This is why there are 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.
35. The concerns raised in the [Mandate Letter](#) regarding the impact of Track 2 on 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.
36. 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.](#)”
37. 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 Article 6 of the ICCPR, 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.”²
38. 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

² Martha Minow, "Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases" (1997) Sup Ct Rev 1 at 22.

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.

39. 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.
40. 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 medical practitioner 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 overworked practitioners from pursuing every possible treatment or support option where MAiD is an easier, 100% effective, fully funded, and more readily accessible option.
41. 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 76,475 people having died from MAiD as of the end of 2024. In 2024, 16,499 Canadians died from MAiD, amounting to 5.1 % of all deaths. While most deaths are Track 1, the percentage of MAiD deaths qualifying under Track 2 is also consistently 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. In 2024, the most recent year for which data is available, **732 Canadians utilized Track 2 MAiD** comprising 4.4% of all MAiD deaths.

VII. Arguments Made to Justify MAiD Track 2

42. 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.
43. 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 would be the only “treatment” in the history of medicine whose sole aim is to kill the patient. A civil rights approach to disability focuses on the rights of persons with disabilities to live with equal autonomy, not the right to be dead.
44. The characterization of MAiD as a benefit for people with disabilities who are not dying is the legislative entrenchment of the “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 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.
45. 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.

VIII. “Safeguards” Cannot Protect People with Disabilities from MAiD

46. There is no safeguard that can protect the right to life of people with disabilities once MAiD is disconnected from end-of-life. None of these prerequisites are an answer to the 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 rights of persons with disabilities, but rather operate as a cover for ableism.
47. Further, the prerequisites that do exist are utterly unenforceable because exceptions are provided for many requirements; there is no pre-death oversight mechanism to validate or contest a practitioner’s expertise or assessment; there is no obligation to inform family members who might have additional information or resources regarding the request; and there is no mechanism to ensure that needed services and supports are discussed or facilitated.
48. Section 241.2(3.1) of Canada’s *Criminal Code* 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.](#)
49. 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, thereby [circumventing this](#) supposed safeguard.

50. 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.”
51. 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 examples reported in Canadian media where individuals have resorted to Track 2 MAiD [when they have been denied adequate home care, accessible housing](#) or other supports.
52. Attempts to add safeguards have been rejected. For example, the Special Joint Parliamentary Committee on MAiD in 2022 was urged to add the 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.
53. 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.³

54. The potential for abuse is demonstrated 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.
55. 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 can be 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 is often 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, [whether other care options were presented, or whether the criteria were even met](#).
56. 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 in Canada.

³ Is there a reference for this report.

57. Additional so-called safeguards are not an answer to the violations of the ICCPR 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.

IX. Track 2 MAiD Violates the Right to Non-Discrimination, Article 26

58. 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, targeting people with disabilities, and particularly, women with disabilities.
59. General Comment No. 6 (2018) with respect to the *Convention on the Rights of Persons with Disabilities* and the right to equality and nondiscrimination expresses concern about States relying on a medical model of disability: “Under the medical model of disability, persons with disabilities are not recognized as rights holders but are instead ‘reduced’ to their impairments” (para 8).
60. That 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). We urge the Human Rights Committee to adopt a similar interpretation of the right to non-discrimination for people with disabilities under the ICCPR.
61. 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 and stigma that cause and compound suffering for people with disabilities) and that the suffering associated with disability is uniquely different than all other human suffering.

62. 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” (CRPD, para 18b). Track 2 discriminates directly against people with disabilities and indirectly against women with disabilities.
63. Rather than Canada eschewing ableism, Track 2 MAiD entrenches it by exempting medical practitioners from the criminal law. Canada engages in direct discrimination in violation of Article 26 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. Other Canadians are entitled to suicide prevention.
64. 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.
65. All of the widely-accepted definitions of disability would include anyone who qualifies for Track 2 MAiD. The CRPD, for example, 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.
66. 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*](#).
67. 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.

68. 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 international human rights law, 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.
69. 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 compassionate. At the same time, systemic remedial measures at the policy and program levels to remediate suffering by non-lethal means are viewed as extraordinary, unreasonable, and economically infeasible. This discriminatory cultural narrative runs completely contrary to the core tenets of the right to life for people with disabilities, as expressed in ICCPR broadly, as well as in the CRPD.

X. Track 2 Discriminates Against Women with Disabilities

70. Beyond the direct discrimination that Canada is perpetrating against all people with disabilities through Track 2 MAiD, it is also committing indirect discrimination against women with disabilities, in violation of Article 26.
71. 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.

72. Government policy analysts do not appear to have examined how Track 2 MAiD [affects 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.
73. Women made up approximately 59% of all Track 2 deaths in 2022 and 2023 and 57% in 2024. It is notable that [65.3% of all women who died were listed as having vaguely defined “other conditions,”](#) (2023 at 25) as compared to only 34.7% of men. The same disparity was also [seen in 2024](#) with 57.8% of women found to have “other conditions” as compared to only 45.7% of men making these cases even harder to scrutinize. 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.
74. 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.

A. Women's Poverty

75. [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](#).
76. 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.
77. 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.
78. 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.
79. 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.](#)

80. It is therefore entirely predictable that women with disabilities [who are poor](#) will be offered or driven to request MAiD because they cannot find stable, accessible, and safe housing, [home care](#), [palliative care](#), or appropriate [health care](#).
81. 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.
82. 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](#).

83. 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](#).
84. The rights to life and to non-discrimination are indivisible from the full realization of the civil and political rights guaranteed under the ICCPR, as well as the 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.
85. 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 ICCPR, because Track 2 MAiD is targeted only at people with disabilities on the ableist premise that people with disabilities may be better off dead.

B. Sexism and Ableism in the Medical Profession

86. Women's historical relationship to the medical profession has often been [one of oppression](#). 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.

87. 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.
88. 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.
89. 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.
90. 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.
91. 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.

C. Women's Socialization under Patriarchy

92. 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.
93. Further, women's socialization as caregivers rather than receivers of care may make women more anxious about being a burden to others. In 2024, the [Sixth Annual Report](#) indicates that 50.3% of Track 2 recipients reported perceiving themselves a burden on loved ones or caregivers as one of their reasons for accessing MAiD and 44.7% reported loneliness or social isolation. 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.
94. 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.

D. Men's Violence against Women

95. 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.

96. 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 or the woman is financially dependent on him](#).
97. 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.
98. 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.”

99. A [recent Vancouver Island case](#) reveals a man who pressured his wife with Alzheimer’s into seeking MAiD and threatened to kill her if she did not qualify. No criminal charges were laid and [his threatened actions were described by the judge as potentially contrary to Canada’s MAiD law rather than as contrary to Canada’s murder laws](#).
100. 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.

E. Mental Illness: An Additional Threat

101. 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](#) and are already qualifying under Track 2.
102. 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.”](#)

103. 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.
104. 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.
105. 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.
106. 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. 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.

107. 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.
108. 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.
109. 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.
110. 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.

111. 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.
112. 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](#).

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

113. The Canadian government 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.”
114. 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.

115. This expansion of MAiD to “advance requests” has profound implications for women with disabilities and their rights under Articles 6 and 26. 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.
116. 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.
117. 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.

XII. Recommendations

118. Canada must repeal Track 2 MAiD, including the planned expansion to MAiD on the sole basis of mental illness by reinstating the requirement of a reasonably foreseeable natural death for all MAiD deaths.
119. In addition, so long as MAiD on any track continues to be offered in Canada:
 - i) MAiD must retain the fundamental requirement of contemporaneous informed consent and not be extended to advance requests or substitute decision-making; and
 - ii) MAiD must not be extended to children under the age of 18.

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