

## Does Allowing Track 2 MAiD Harm Disabled People?

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### Article abstract

In 2021, in response to the Superior Court of Quebec's decision in *Truchon v. Canada*, the Canadian Parliament amended the Criminal Code to allow Medical Assistance in Dying (MAiD) for some people who don't have a "reasonably foreseeable natural death." Debate rages over this amendment. In particular, some academics and activists argue that it should be repealed because it discriminates against disabled people. In 2024, these arguments appeared in a Canadian court proceeding; two disabled individuals and four disability rights organizations filed a lawsuit in the Ontario Superior Court of Justice, challenging the amendment. In this paper, I critically analyze the harm-centric arguments in the applicants' notice of application (which crystallizes the broader opposition to the amendment). In doing so, I draw on analysis from both sides of the ethical debate over the amendment. Ultimately, I conclude that the applicants' arguments — and those from other opponents of the amendment — don't succeed. Some of my recurring objections include that the alleged harmful effects of the amendment are either 1) harmful only if the applicants' dubious ethical assumptions are true, 2) not attributable to the amendment, or 3) nonexistent, negligible, or unlikely. In defence of the amendment, I discuss how it respects people's autonomy and avoids instrumentalization.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

## Does Allowing Track 2 MAiD Harm Disabled People?

Nicholas J. Abernethy<sup>a</sup>

### Résumé

En 2021, en réponse à la décision de la Cour supérieure du Québec dans l'affaire *Truchon c. Canada*, le Parlement canadien a modifié le Code criminel afin d'autoriser l'aide médicale à mourir (AMM) pour certaines personnes qui n'ont pas de « mort naturelle raisonnablement prévisible ». Cette modification fait l'objet d'un vif débat. Certains universitaires et militants soutiennent notamment qu'elle devrait être abrogée car elle est discriminatoire à l'égard des personnes handicapées. En 2024, ces arguments ont été présentés dans le cadre d'une procédure judiciaire canadienne ; deux personnes handicapées et quatre organisations de défense des droits des personnes handicapées ont intenté une action en justice devant la Cour supérieure de justice de l'Ontario, contestant la modification. Dans cet article, j'analyse de manière critique les arguments centrés sur le préjudice présentés dans l'avis de demande des requérants (qui cristallise l'opposition plus large à la modification). Pour ce faire, je m'appuie sur l'analyse des deux côtés du débat éthique sur la modification. En fin de compte, je conclus que les arguments des requérants — et ceux des autres opposants à la modification — ne sont pas recevables. Certaines de mes objections récurrentes sont que les effets néfastes allégués de la modification sont soit 1) néfastes uniquement si les hypothèses éthiques douteuses des requérants sont vraies, 2) non attribuables à la modification, soit 3) inexistantes, négligeables ou improbables. Pour défendre la modification, j'explique en quoi elle respecte l'autonomie des personnes et évite l'instrumentalisation.

### Mots-clés

aide médicale à mourir, discrimination, handicap, Canada, autonomie

### Abstract

In 2021, in response to the Superior Court of Quebec's decision in *Truchon v. Canada*, the Canadian Parliament amended the Criminal Code to allow Medical Assistance in Dying (MAiD) for some people who don't have a "reasonably foreseeable natural death." Debate rages over this amendment. In particular, some academics and activists argue that it should be repealed because it discriminates against disabled people. In 2024, these arguments appeared in a Canadian court proceeding; two disabled individuals and four disability rights organizations filed a lawsuit in the Ontario Superior Court of Justice, challenging the amendment. In this paper, I critically analyze the harm-centric arguments in the applicants' notice of application (which crystallizes the broader opposition to the amendment). In doing so, I draw on analysis from both sides of the ethical debate over the amendment. Ultimately, I conclude that the applicants' arguments — and those from other opponents of the amendment — don't succeed. Some of my recurring objections include that the alleged harmful effects of the amendment are either 1) harmful only if the applicants' dubious ethical assumptions are true, 2) not attributable to the amendment, or 3) nonexistent, negligible, or unlikely. In defence of the amendment, I discuss how it respects people's autonomy and avoids instrumentalization.

### Keywords

medical assistance in dying, discrimination, disability, Canada, autonomy

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## INTRODUCTION

Since 2016, Medical Assistance in Dying (MAiD) has been legal in Canada for some people whose "natural death has become reasonably foreseeable" (alongside other eligibility criteria) (1). In 2021, the Canadian Parliament amended the *Criminal Code* to allow MAiD for some people whose "natural death is not reasonably foreseeable" (2). Since then, many academics and activists have argued that this change should be undone because it discriminates against disabled people, in the sense of constituting harmful differential treatment. Some critics have gone as far as saying that "MAiD for people not at the end of their lives... is a modern form of eugenics against people with disabilities" (3, p.39).

In September 2024, two disabled individuals and four disability rights organizations filed a lawsuit in the Ontario Superior Court of Justice, challenging the amendment to the *Criminal Code* (4). In this paper, I will critically analyze the applicants' arguments in their notice of application, which crystallizes the broader academic and activist opposition to the amendment. However, it is beyond the scope of this paper to determine whether the applicants' arguments are legally strong, i.e., whether they succeed in showing that the amendment violates the *Canadian Charter of Rights and Freedoms*. Instead, I explore whether they are strong merely as arguments about harmful differential treatment (although, of course, this exploration will have legal relevance). In doing so, I draw on analysis from both sides of the ethical debate over the amendment. Ultimately, I conclude that the arguments made by the applicants — and other opponents of the amendment — don't succeed.

## LEGAL BACKGROUND

In 2016, in response to the Supreme Court of Canada's decision in *Carter v. Canada*, the Canadian Parliament passed Bill C-14, which legalized providing MAiD to people who meet the following eligibility criteria:

being an adult (at least 18 years old) who is mentally competent (“capable”) to make health care decisions for themselves; having a grievous and irremediable medical condition (as defined under subsection 241.2(2)); making a voluntary request for medical assistance in dying which does not result from external pressure; giving informed consent to receive medical assistance in dying; and, being eligible for health services funded by a government (1).

Subsection 241.2(2) defines “having a grievous and irremediable medical condition” as follows:

having a serious and incurable illness, disease or disability; and, being in an advanced state of irreversible decline in capability; and, experiencing enduring physical or psychological suffering, due to the illness, disease, disability or state of decline, that is intolerable to the person and cannot be relieved in a manner that they consider acceptable; and, where the person’s natural death has become reasonably foreseeable (1).

The notion of a reasonably foreseeable natural death has been the subject of some interpretative disagreement, but, in practice, it means that “there is sufficient temporal proximity to death (it is coming soon), and/or that the trajectory towards death is predictable from the person’s combination of known medical conditions and potential sequelae” (5, p.1). A precise timeline is unnecessary. When MAiD is provided to someone who satisfies all of Bill C-14’s eligibility criteria, this is known as Track 1 MAiD (4).<sup>1</sup> For this track, the most common medical condition is cancer (6).

In 2021, in response to the Superior Court of Quebec’s decision in *Truchon v. Canada*, the Canadian Parliament passed Bill C-7, which changed MAiD eligibility to no longer require a reasonably foreseeable natural death (4). When MAiD is provided to someone whose natural death isn’t reasonably foreseeable, this is known as Track 2 MAiD (4). For this track, the most common medical conditions are “Neurological conditions and ‘other’ conditions (such as diabetes, frailty, autoimmune conditions, chronic pain)” (6).

## EXPOSITION AND CRITICAL ANALYSIS

Perhaps the most important claim made by the applicants in the 2024 lawsuit is that all grievous and irremediable medical conditions (as defined by Bill C-7) are disabilities, so everyone who is eligible for either Track 1 MAiD or Track 2 MAiD is disabled (4). Some academics make the same claim (7,8). By contrast, Bill C-7 seems to define “disability” more narrowly. It says that a grievous and irremediable medical condition is an illness, a disease, or a disability, so it implies that not all grievous and irremediable medical conditions are disabilities.<sup>2</sup> Also, as I will discuss later, most MAiD recipients don’t self-identify as disabled. However, for the sake of argument, I concede that the applicants are correct about the non-legal meaning of the word “disability.” Given this, allowing Track 2 MAiD straightforwardly constitutes differential treatment vis-à-vis disabled people; it changes the MAiD eligibility of a subset of them, and it doesn’t change the MAiD eligibility of anyone without a disability (4).<sup>3</sup> So, the real question is whether this differential treatment *harms* disabled people.

The applicants say yes. Specifically, they say that “Bill C-7’s addition of MAiD Track 2 imposes a burden and denies a benefit in a manner that has the effect of reinforcing, perpetuating, and exacerbating the disadvantages faced by persons with disabilities” (4, p.12). The applicants identify many ways in which allowing Track 2 MAiD supposedly harms disabled people. I have sorted the harms into five bundles: 1) causing premature deaths, 2) legitimizing death as an appropriate response, 3) demeaning disabled people, 4) decreasing healthcare options, and 5) decreasing trust in the healthcare system. For each bundle, I will critically analyze the applicants’ associated argument. Some of my recurring objections to these arguments include that the alleged harmful effects are either i) harmful only if the applicants’ dubious ethical assumptions are true, ii) not attributable to allowing Track 2 MAiD, or iii) nonexistent, negligible, or unlikely.

Throughout my critical analysis, I will assume that Canadian MAiD providers follow the legal and professional requirements regarding MAiD (e.g., discussing the possibility of MAiD only with people who may be eligible) (9). This is for two main reasons. First, the available evidence strongly suggests that violations of these rules are vanishingly rare in Canada (10). Granted, there have been news stories of alleged rule violations, but such allegations have been repeatedly debunked (10-13). Second, in cases where MAiD providers don’t follow the rules, there may well be discrimination against disabled people, but it seems incorrect to attribute this discrimination to allowing Track 2 MAiD (rather than attributing it to the rule violators and/or the rule enforcers who failed).<sup>4</sup> With this in mind, let’s turn to the bundles of supposed harms.

<sup>1</sup> To be clear, the notion of “tracks” came after *Truchon*.

<sup>2</sup> This implication follows from the presumption against interpreting statutes as including redundancy.

<sup>3</sup> By this logic, allowing Track 1 MAiD also constitutes differential treatment vis-à-vis disabled people.

<sup>4</sup> Furthermore, I agree with the following point made by Eric Mathison: “we also know that unethical acts transpire in other forms of end-of-life care, or in other aspects of health care, and it would be a mistake to conclude that those other forms of health care should be banned because of rare problems. By analogy, the existence of drivers who break the law doesn’t justify banning driving” (12).

## Bundle #1: Allowing Track 2 MAiD Causes Premature Deaths

The applicants argue that allowing Track 2 MAiD “increases the risk that [disabled people] will end their lives prematurely” (4, p.13). The applicants’ conception of premature death seems to include any deaths caused by Track 2 MAiD; they assert that “Death should not be a solution for disabled people who experience intolerable suffering but are otherwise not at the end of their lives” (4, p.9). Similarly, “There is no deprivation that is more serious and more irrevocable than causing someone who is not otherwise dying to die” (4, p.14). According to the applicants, the risk of premature death is exacerbated by both 1) how Track 2 doesn’t make MAiD eligibility contingent on exhausting all available treatment options, and 2) how MAiD is — or is portrayed as — easier, less painful, more accessible, and more effective than other options (4).

There are many different conceptions of premature death inside and outside the academic literature (14), and the applicants don’t specify which they have in mind. Fortunately, all that matters for my purposes is that they seem to believe that premature deaths are *harmful*. So, for the sake of simplicity, I will engage with their premature death argument as an argument about harmful death. Essentially, what the applicants are saying is that people who choose to receive Track 2 MAiD are making a choice that is bad for them, so Track 2 MAiD should be disallowed.

I have two main objections to this argument. The first is that it is very unclear whether the deaths caused by Track 2 MAiD are actually harmful. The second is that what would be much *more* harmful is violating currently eligible people’s autonomy by preventing them from being able to choose Track 2 MAiD.

### Objection #1: Are the Deaths Themselves Actually Harmful?

The main reason why it is very unclear whether the deaths themselves are harmful is because people who receive Track 2 MAiD were experiencing intolerable suffering. In 2023, over 70% of these people reported suffering from a “loss of dignity,” and over 95% reported suffering from a “loss of ability to engage in meaningful activities” (6).<sup>5</sup> In most (if not all) cases, eligible patients request Track 2 MAiD because they judge that their life is very low-quality. They have unique epistemic access to their quality of life, so we should believe that this judgment is probably correct. Thus, receiving Track 2 MAiD deprives them of the continuation of a harmful life; arguably, such deprivation is beneficial (so long as it is consensual).<sup>6</sup> Furthermore, as bioethicist Udo Schüklenk contends, “not terminal patients are arguably worse off than those who do suffer from a terminal illness, because potentially they could be forced to suffer unbearably for many decades” (16, p.611).

In the Track 2 literature, there are two main arguments that can function as responses to this objection. The first holds that because Track 2 recipients are disabled, it is ableist to say that death may be better for them than continuing to live with their condition. According to legal scholar Isabel Grant, “the state offering death as a solution to the suffering of disability for those not at the end of life is inherently ableist and based on the discriminatory premise that disability *can be* worse than death [emphasis added]” (7, p.262). In the same vein, she condemns “an ableist stereotype that life with a disability *may be* worse than death [emphasis added]” (7, p.307). Almost identically, legal scholars Quinn et al. claim that it is “reiterating [an] ableist stereotype” to say that “significant disability *can be* worse than death [emphasis added]” (8, p.6).

This response has unacceptable implications. Both Grant and Quinn et al. share the applicants’ view that a grievous and irremediable medical condition is a disability (7,8). So, Grant and Quinn et al. would have to affirm that an intolerably suffering late-stage cancer patient is reiterating an ableist stereotype and a discriminatory premise when they say that life with their condition (a significant disability) is worse than death because of their extreme pain.<sup>7</sup> However, affirming this would be deeply implausible. Furthermore, Grant and Quinn et al. would have to affirm similarly counterintuitive things about some people who are eligible for Track 2 MAiD (e.g., someone with severe transverse myelitis, causing paralysis and extreme pain).

Fortunately for the applicants, the second possible response to my doubting of the harmfulness of the deaths themselves is more *prima facie* plausible. According to this response, the deaths caused by Track 2 MAiD are harmful because even if the recipients’ lives were very low-quality at the time, their lives would have improved if they had stayed alive. Thus, receiving Track 2 MAiD deprives them of beneficial futures. In the literature, Track 2 opponents provide two main reasons for why people’s lives would improve if they were denied access to Track 2 MAiD.

The first reason is that many of the people in question would adapt to their disability. As Quinn et al. argue, “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... even before having the chance of coming to terms with and adapting to their new disability status” (8, p.5). For example, physician and bioethicist Quentin Genuis highlights a case where “a previously able-bodied individual experienced sudden, inexplicable neurological illness that caused significant disability and chronic pain” (17). This individual was “paternalistically” denied access to Track 2 MAiD, so he stayed alive, and he is now grateful for this denial (17). Similarly, Track 2 opponents Coelho et al. adduce how “In a recent Canadian study, which followed patients with spinal cord injuries, half of the participants reported suicidal ideation during the first 2 years of experiencing their injury. However, in retrospect... none wanted MAiD after they had time to adjust to living in the community” (18, p.874). Presumably, after adapting, these people’s lives were no longer very low-quality.

<sup>5</sup> Later I discuss the argument that this suffering is caused by systemic ableism, but what matters for this section is that suffering is harmful regardless of its cause.

<sup>6</sup> For debates on this topic, see the philosophy of death (15).

<sup>7</sup> Saying that one’s own disability is worse than death directly entails that disability can be worse than death.

The main problem with this reason is that it seems to apply to only a small subset of people who receive Track 2 MAiD. In 2023, more than 50% of Track 2 recipients had lived with their grievous and irremediable medical condition for over five years, and fewer than 5% had lived with their condition for under a year (6). This evidence suggests that Track 2 recipients generally aren't people who haven't had the time to get used to their condition; recall that MAiD eligibility requires "enduring" suffering (2). As an aside, note that someone would be ineligible for Track 2 MAiD if the newness of their condition precluded confirming that they have decision-making capacity, enough information for informed consent, an irreversible decline in capability, suffering that can't be alleviated in a way they consider acceptable, etc.

The second reason provided for why eligible patients' lives would improve if Track 2 MAiD was disallowed is that eligible patients who have refused some of the available treatment options would try these options if they were denied access to Track 2 MAiD (19). For example, researcher Alexander Raikin points to "patients who become fixated on MAiD, who under different circumstances, before MAiD was a part of our culture, would have... pursued treatment options with a reasonable chance of success even though doing so would be temporarily unpleasant or uncomfortable" (20). Furthermore, Track 2 opponents Lemmens et al. argue that such cases are especially concerning vis-à-vis Track 2 because "In the non-end-of-life context, combining treatment refusal with a request to active ending of life raises the stakes" (21). Presumably, on average, such requesters risk losing more years of post-successful-treatment high-quality life (compared to Track 1 requesters who have refused some treatment options). In a similar vein, bioethicists Martin Gundersen and David Mayo say that "there is a much greater likelihood that a nonterminal patient who wishes to die could be restored to a meaningful existence, and hence a much greater chance that physician-assisted death would be a mistake for that patient, than would be the case for a patient near death" (22, p.22).

There are two main problems with this second reason, both of which flow from the fact that eligibility for Track 2 MAiD requires trying all available treatment options that one considers acceptable (1). The first problem is that, for eligible patients who have refused some treatment options, it is highly uncertain whether they would try these options if they were denied access to Track 2 MAiD. This is because there are four other things that they might do instead. The first is continuing to consider the options unacceptable, continuing to refuse them, and continuing to experience intolerable suffering (perhaps for many more years). The second alternative is suicide. Tragically, some people resort to this option when they are denied access to MAiD (23). Thus, allowing Track 2 MAiD may avoid some severe harms that some people would experience during suicide attempts and/or afterwards (in the event of a failed attempt) (24).<sup>8</sup> The third alternative is dying via methods like requesting the withdrawal of life-sustaining treatment or voluntarily stopping eating and drinking.<sup>9</sup> Again, such deaths can be more harmful than deaths caused by Track 2 MAiD (26). The fourth alternative is becoming eligible for Track 1 MAiD (and then receiving it) by expressing the intention to engage in the third alternative. As legal scholar Jocelyn Downie explains,

patients can meet the "reasonably foreseeable" criterion if they have demonstrated a clear intent to take steps to make their natural death happen soon or to cause their death to be predictable... For Julia Lamb [a B.C. woman with spinal muscular atrophy], this means indicating a certain intent to stop BiPAP [a sleep breathing machine] and then refuse antibiotics for the pneumonia that will inevitably result from the lack of ventilatory support. By logical inference, for others it will mean indicating a certain intent to refuse regular turning, then refuse skin care for the inevitable bedsores, and then refuse antibiotics for the infections that will inevitably result from the untreated bedsores. For still others, it will mean indicating a certain intent to refuse all food and liquids (27).

Track 2 opponents fail to show that people would choose to try treatment options that they consider unacceptable rather than one of the above four alternatives.

The second main problem with the "people would try more treatment options" reason is that even for people who would do so if Track 2 MAiD was disallowed, it is uncertain whether these options would improve their quality of life to such an extent that living would become better for them than death, so it remains uncertain whether receiving Track 2 MAiD would harm them. As Downie and Schüklenk explain, "some decisionally capable persons with disabilities... reject the treatments, supports and services proposed by their clinicians (because they view life with them as worse than death)" (28, p.666), and it is questionable whether these people are incorrect in viewing things thusly. After all, MAiD eligibility requires being informed about all rejected treatment options.

For illustration, imagine a treatment option with a low chance of a significant increase in quality of life and a high chance of severe adverse effects (on top of prolonging pre-existing intolerable suffering). Understandably, someone seeking Track 2 MAiD might refuse this option because they consider it unacceptable. Would it harm this person to receive Track 2 MAiD rather than suffer through this other option? Track 2 opponents fail to show that the answer is yes.

There is one remaining criticism of Track 2 MAiD that is worth considering in this section on the deaths themselves. Namely, Coelho et al. condemn that, for Track 2 eligibility, "There is no requirement that standard best-practice treatments... are accessible" (18, p.874). The main problem with this criticism is that it has no bearing on whether the deaths caused by Track 2

<sup>8</sup> For more on this in the context of Track 1 MAiD, see *Carter*.

<sup>9</sup> By putting Voluntarily Stopping Eating and Drinking (VSED) in this third category rather than the second category, I am implying that it isn't suicide. I recognize that this is a controversial view (25). Fortunately, nothing in my argument depends on whether VSED counts as suicide.

MAiD are harmful. As Schüklenk explains, for a “patient who is failed by an unresponsive health care system,” “The health care system will be no more responsive if they are denied access to MAiD” (16, p.612). For reasons I will discuss later, disallowing Track 2 MAiD wouldn’t make standard best-practice treatments more accessible.

In summary, the applicants (and other Track 2 opponents) fail to show that the deaths caused by Track 2 MAiD are harmful.<sup>10</sup>

## Objection #2: Disallowing Track 2 MAiD Would Violate People’s Autonomy

In this section, I argue that disallowing Track 2 MAiD would harm the people who would otherwise receive it because denying them access to Track 2 MAiD would violate their human right to autonomy over their lives. This right covers choosing Track 2 MAiD over other options (even more beneficial ones) as well as choosing Track 2 MAiD based on considerations like ease, painlessness, and efficacy.<sup>11</sup> The autonomy argument for MAiD in general has been made many times (and affirmed by the Canadian courts) (26,29), so I won’t repeat it. Instead, I will rebut objections that hold that the autonomy argument doesn’t work in the case of Track 2 MAiD.

But before doing so, it is worth explaining how the autonomy argument interacts with the previous section on the deaths themselves. Consider the following three possibilities. First, suppose that the previous section managed to show that the deaths caused by Track 2 MAiD aren’t harmful. If so, one should believe that denying people access to Track 2 MAiD definitely harms them — because of the harm of the autonomy violation. Second, suppose that the previous section managed to show merely that it is *unclear* whether the deaths caused by Track 2 MAiD are harmful. If so, one should believe that denying people access to Track 2 MAiD probably harms them, on balance, because of the clear and severe harm of the autonomy violation. Third, suppose that the previous section was utterly unsuccessful in resisting the view that the deaths caused by Track 2 MAiD are harmful. If so, one should believe that whether denying people access to Track 2 MAiD harms them, on balance, depends on the relative severity of the harm of the death vs. the harm of the autonomy violation. Although it is beyond the scope of this paper to rehash old debates over the following, my stance is that the latter harm would outweigh the former harm, so denying people access to Track 2 MAiD would harm them, on balance, even if the deaths themselves are harmful.

One might complain that the above paragraph is insufficiently granular. Perhaps the previous section managed to show that *some* of the deaths caused by Track 2 MAiD are probably harmless, whereas others are probably harmful. For example, perhaps one thinks that the deaths are probably harmless in the >50% of cases where a Track 2 recipient had lived with their condition for over five years, and probably harmful in the <5% of cases where a Track 2 recipient had lived with their condition for under a year.

The problem with this perspective (*vis-à-vis* the aim of the applicants) is that *at most* it could justify something like disallowing Track 2 MAiD for people who have lived with their condition for under five years.<sup>12</sup> Among other reasons, this perspective couldn’t justify disallowing Track 2 MAiD across the board because, in the words of philosopher Lawrence Nelson, disabled people should be “treated as unique individuals and not as some anonymous ‘disabled person’ lacking a character or personal history” (30, p.3).<sup>13</sup> Indeed, even some Track 2 opponents condemn “failure to recognize the particularities of disabled people’s lives” (7, p.329). However, one of the starkest examples of such failure would be disallowing Track 2 MAiD for all currently eligible patients on the basis that receiving Track 2 MAiD would be harmful for a subset of them.

With all of the above in mind, there are two main objections that contend that the autonomy argument doesn’t work in the case of Track 2 MAiD. The first is the Internalized Ableism Objection. According to this objection, denying someone access to Track 2 MAiD often wouldn’t violate their autonomy because people who choose Track 2 MAiD often do so non-autonomously, driven by internalized ableism (8,31).<sup>14</sup> In the words of disability ethicist Heidi Janz, “The prevalence of... ableist medical and social messaging is resulting in increasing numbers of... disabled people ‘choosing’ MAiD as a final capitulation to ableism” (33, p.138). More specifically, as summarized by Track 2 defenders Kayla Weibe and Amy Mullin, the concern is that disabled people are choosing death in large part because “they have internalised an incorrect belief that life with a disability is less worthy than life without one” (34, p.410). On philosopher Danny Scoccia’s reconstruction of the Internalized Ableism Objection,

What makes [such beliefs] tainted, inauthentic, or nonautonomous is their origins in an oppressive society, not their falseness per se. The reason why the option of [assisted dying] provides only the illusion of freedom is that the preferences it allows disabled people to satisfy were molded under conditions of unfreedom (35, p.485).<sup>15</sup>

<sup>10</sup> This failure is especially damning because, if Track 2 MAiD was disallowed, then a practitioner who provides Track 2 MAiD regardless would be guilty of murder. They could be given a life sentence for causing a harmless (and consensual) death, and this punishment seems unjust.

<sup>11</sup> If someone is misinformed about the degree to which MAiD possesses such features, then they can’t provide informed consent, so it would be illegal to provide MAiD to them.

<sup>12</sup> To be clear, I deny that the perspective would actually justify this, given the harm of the autonomy violation.

<sup>13</sup> This was affirmed in *Truchon*.

<sup>14</sup> For an example that shows that not all people who choose Track 2 MAiD are driven by internalized ableism, I encourage the reader to research the story of artist and disability advocate April Hubbard, who intends to receive Track 2 MAiD because of her increasingly debilitating disabilities (32). She would reject, in the strongest possible terms, that life with a disability is less worthy than life without one.

<sup>15</sup> As Scoccia correctly observes, “saying that preferences are nonautonomous if they rest on normative error [would be] fundamentally dishonest” (35, p.484).

There are three main problems with the Internalized Ableism Objection. The first is that even if many disabled people are choosing Track 2 MAiD because of internalized ableism, preventing them from doing so would still be a violation of their autonomy (so long as they have decision-making capacity). By analogy, it seems that it would be a violation of someone's autonomy to prevent them from dieting (or prevent someone else from helping them diet), even if this prevention was done on the basis that their desire for dieting is driven by internalized fatphobia. Similarly, it would be a violation of a woman's autonomy to prevent her from getting a facelift, even if this prevention was done on the basis that her desire for the surgery is driven by internalized ageism (and/or internalized sexist beauty standards).<sup>16</sup> The same would be true for preventing a homophobic bisexual man from dating only women, even if this prevention was done on the basis that his desire for doing so is driven by internalized homophobia.

The second main problem with the Internalized Ableism Objection (as reconstructed by Scoccia) is that its underlying assumption — that beliefs and preferences are inauthentic when they originate from oppression — is utterly untenable. For example, experiencing oppression can make someone develop an authentic preference for fighting oppression. Feminist theorist Serene Khader adduces how “a Salvadorian anti-poverty activist called ‘Maria’ describes the hunger and extreme poverty in which she grew up as motivating her to fight these conditions” (36, p.183). Obviously, it would be a severe violation of Maria's autonomy to prevent her from fighting poverty, even if this prevention was done on the basis that her preference for fighting poverty was molded under conditions of unfreedom.

The third main problem with the Internalized Ableism Objection is that it has implausible implications. Suppose that it is correct that denying a competent person access to a way of dying wouldn't violate their autonomy if their desire for death is driven by internalized ableism. This entails that involuntarily treating an intolerably suffering disabled person (or even force-feeding them) wouldn't violate their autonomy if their desire to refuse life-sustaining treatment (or to stop eating and drinking) is driven by something like internalized contempt for dependence on others. However, this conclusion seems false. As Downar et al. explain, “while many patients request MAiD today for reasons that are criticized as ‘ableist,’ [e.g., a loss of independence] the same rationale is accepted without comment or judgment when used to justify withdrawal of life support or a discontinuation of life-prolonging therapies” (37, p.896).

In summary, the above three problems show that the Internalized Ableism Objection fails to prove the existence of cases where denying a currently eligible patient access to Track 2 MAiD wouldn't violate their autonomy. Even for eligible patients suffering from internalized ableism, denying them access to Track 2 MAiD would be a severe violation of their autonomy (and thus highly harmful).<sup>17</sup> Of course, it would be a different story for patients whose internalized ableism impairs their decision-making capacity.

The second main objection to the autonomy argument in the context of Track 2 MAiD is the Structural Coercion Objection. This objection holds that denying someone access to Track 2 MAiD often wouldn't violate their autonomy because people who choose Track 2 MAiD often do so non-autonomously, driven by structural coercion to die (7, 18, 39). According to physician and advocate Ramona Coelho, this is because “societal structures, such as governments, create and sustain the predicaments that can make death an attractive choice for those who would have instead benefitted from greater resources and care” (40). More specifically, the applicants say that disabled people often experience intolerable suffering because of various forms of marginalization (including poverty, homelessness, and isolation), and disabled people often lack access to societal supports (particularly state-funded supports) that could make their suffering tolerable (4).<sup>18</sup> According to the applicants, this is especially true for disabled people who are also female, trans, non-binary, or indigenous (4). For a typical explanation of why the structural states of affairs in question are coercive, consider the following quote from Quentin Genuis about the aforementioned individual with a neurological illness, who was denied necessary mobility supports:

He was clear that his “higher” desire was to live; his request to die would be retracted if his circumstances changed. His request for MAiD was not the choosing of a preferred option. He requested MAiD because, in his unjust context, it seemed to be his only choice. He felt as if he had no choice. His circumstances were straightforwardly coercive (17).

There are three main problems with the Structural Coercion Objection. The first is that it has implausible implications like those of the Internalized Ableism Objection. Suppose that the Structural Coercion Objection is correct that denying a competent person access to a way of dying wouldn't violate their autonomy if their desire for death is driven by structural coercion. This entails that involuntarily treating an intolerably suffering person (or even force-feeding them) wouldn't violate their autonomy if their desire to refuse life-sustaining treatment (or to stop eating and drinking) is driven by a societally-caused lack of acceptable alternatives. However, this conclusion seems false.

<sup>16</sup> It is beyond the scope of this paper to engage with the feminist literature on adaptive preferences.

<sup>17</sup> A better approach to dealing with internalized ableism can be found in Khader's work: “Noncoercive interventions, such as those involving... incitements to question prevailing beliefs, seem appropriate public responses to agents... who experience local value distortion... without fully compromised autonomy” (38, p.313). In the context of Track 2 MAiD, such interventions could involve checking for signs of internalized ableism and connecting afflicted patients with professionals who could help with eliminating their internalized ableism.

<sup>18</sup> It is beyond the scope of this paper to determine whether, for example, a disability causing homelessness that causes intolerable suffering legally counts as the disability causing the suffering. So, I will focus on cases where it seems that a disability causes intolerable suffering but could be prevented from doing so via societal supports.

The second main problem with the Structural Coercion Objection is that its framing of marginalization and lack of support paints a misleading picture. As Downar et al. explain, “In every country with available data, [assisted dying] is more common in people with higher income and education,” and “relatively few people from socioeconomically disadvantaged demographics pursue [assisted dying]” (10, p.1175, 1177). The available evidence suggests that this trend is holding true for Track 2 MAiD in Canada (41). Furthermore, in 2023, across both tracks, “In a small number of cases (n=5) disability support services were required but were not accessible to the person” (6). Even if all five of these cases were Track 2 rather than Track 1 (which is exceedingly unlikely), this would still be fewer than 1% of all Track 2 cases in 2023. Moreover, it is unclear how often societal mistreatment is the *tipping point* for making someone’s suffering intolerable.

The third main problem with the Structural Coercion Objection is that thought experiments show that denying freedom of choice is a severely anti-autonomous way to respond to structural coercion in analogous cases. Consider the following two.

I present the first using the language of the Structural Coercion Objection. Imagine someone who wants to flee their home country (and become a refugee) because the government oppresses their ethnic group, causing them extreme suffering.<sup>19</sup> Their “higher” desire is to stay in the country they love; their desire to flee would change if their circumstances changed. Their desire to flee isn’t the wanting of a preferred option. They want to flee because, in their unjust context, it seems to be their only choice. The government made fleeing an attractive choice for them, even though they would have benefitted from the cessation of oppression. Their circumstances are straightforwardly structurally coercive. Now imagine that the government — via walls and border patrol — prevents them from fleeing. If someone said that denying them the option of fleeing doesn’t violate their autonomy because their desire to flee is driven by structural coercion, this would be absurd.

The second thought experiment comes from philosopher Eric Mathison. As he explains, many women choose to get abortions because of financial considerations (e.g., the high cost of childcare) (11). Some socioeconomically disadvantaged women would no longer desire an abortion if they were wealthier; the socioeconomic system makes them see abortion as their only choice. Again, there is a sense in which this is structural coercion, and again it would be a severe violation of their autonomy if the government denied them access to abortion on the basis that their desire for abortion is driven by structural coercion (11).

The counterintuitiveness of the Structural Coercion Objection can also be shown by thought experiments involving non-structural coercion.<sup>20</sup> Consider the following three.<sup>21</sup> The first comes from Danny Scoccia. He asks us to imagine that

The Gestapo has captured a British spy, whom it will torture and then execute soon unless he swallows a capsule in his possession that will kill him instantly and painlessly. His choice to swallow the capsule is “forced” and involuntary; the alternative to not swallowing it is horrible. There is a priest in the same holding cell as the spy, concerned that the spy will go to hell if he commits the mortal sin of suicide. He cannot free the spy, but he can take the capsule away from him. Surely if he does that for what he thinks is the spy’s own long term good, he violates the spy’s autonomy (35, p.489).

Suppose the spy wants to swallow the capsule. He wants to die because, in his unjust context, he sees death as his only choice. Nevertheless, it would be a severe violation of his autonomy if the priest prevented him from swallowing the capsule, even if this prevention was done on the basis that his desire to die is driven by coercion.

The second thought experiment also comes from Scoccia. He asks us to imagine a cancer patient with a bleak prognosis who volunteers for a clinical trial involving an experimental cancer drug (35). They see trying this drug as their only choice.<sup>22</sup> Nevertheless, it would be a violation of their autonomy to prevent them from trying the drug, even if this prevention was done on the basis that their desire for the drug is driven by coercion (in some sense).

The third thought experiment comes from bioethicist Daryl Pullman. It is designed to be anti-Track-2, but, as I will argue, it fails in this regard. Pullman sets the stage as follows:

Imagine you are a parent and a ruthless criminal has taken you and your child hostage. The criminal offers you a tragic choice. She will let either you or your child go free, but only on the following condition; you must kill either yourself or your child. If you kill your child, you will go free; if you kill yourself, your child will go free. If you choose to do neither your deranged tormentor will kill both you and your child. You decide to kill yourself (43).

<sup>19</sup> Assume that fleeing would be irreversible for one reason or another.

<sup>20</sup> Although I believe that the thought experiments involving structural coercion are sufficient to prove my point, I am providing additional thought experiments to show the universality of my point.

<sup>21</sup> In his illuminating article on the topic, Brent Kioussis considers similar thought experiments, but he reaches conclusions that are less pro-MAiD than mine (42). Most relevantly, he says that “Whether MAiD should be permitted depends, too, on how easily law and policy can be changed in order to ameliorate the injustices in question” (42, p.421). Although I disagree with this view, I won’t rebut it because Kioussis would probably agree with me about the cases that I am considering in this section. According to him, “Law and policy could change now, making circumstances better. But the effects of these changes may not be realized for years, even decades, and so are not likely to reduce the suffering of persons who have been harmed by these injustices so far. The fact that this injustice cannot be remedied in a way that quickly improves their circumstances suggests that they should still be permitted to access MAiD” (42, p.421).

<sup>22</sup> If the reader thinks that the following matters, suppose that the patient has cancer because of an injustice (e.g., illegal dumping of toxic waste).

Pullman's main takeaway is that this choice isn't meaningfully autonomous; although he doesn't use the language of coercion, this is clearly what he has in mind (43). He claims that the choice in the thought experiment is analogous to "individuals opting for MAiD when they are unable to find adequate social supports to relieve the burden of their day-to-day existence" (43).

I agree that these two cases are to some degree analogous, but this analogy provides no intuitive support for the Structural Coercion Objection's claim that denying a structurally coerced eligible patient access to Track 2 MAiD wouldn't violate their autonomy. This is because it seems that somehow merely preventing the parent from killing anyone (in which case the criminal would kill both innocents) would be much worse, autonomy-wise, than allowing the parent to kill themselves (and thereby save their child). In large part for this reason, it seems that preventing the parent from killing themselves would harm them (on the supposition that the innocents won't be rescued in time). This provides intuitive support for my claim that denying a structurally coerced eligible patient access to Track 2 MAiD would harm them by violating their autonomy (on the realistic assumption that Canadian poverty, homelessness, isolation, etc. won't disappear anytime soon).<sup>23</sup>

In summary, the Structural Coercion Objection fails to prove the existence of cases where denying a currently eligible patient access to Track 2 MAiD wouldn't violate their autonomy. As shown, disallowing Track 2 MAiD would violate people's autonomy, so, for previously discussed reasons, it would harm them. Furthermore, given that people who desire Track 2 MAiD because of structural coercion have already had their choices restricted in a wide range of ways, it would be especially harmful to violate their autonomy by narrowing down their options even more. Track 2 opponents are right that the cases in question are deeply tragic, but their proposed solution would only make things worse. Ultimately, neither the Internalized Ableism Objection nor the Structural Coercion Objection can save the applicants' premature death argument from the autonomy argument for MAiD.

## Bundle #2: Allowing Track 2 MAiD Legitimizes Death as an Appropriate Response

Next, the applicants argue that allowing Track 2 MAiD "has legitimized the idea that death is an appropriate response to" the following experiences: 1) some disabled people's intolerable suffering, 2) losses of things like dignity and the ability to engage in meaningful activities, and 3) feeling like a burden (4, p.10, 14). In some places, the applicants use the phrase "reasonable solution" in lieu of "appropriate response" (4, p.10). For the purposes of this paper, I assume that "legitimizing" means "making something seem true or permissible." With this in mind, I have two objections to this argument (and one objection to a related argument).

### Objection #1: Is There Actually Legitimization?

My first objection is that it is doubtful whether allowing Track 2 MAiD has legitimized that death is an appropriate response to experiences 1 to 3. This is for two main reasons. The first is that the available evidence suggests that, between Bill C-7's passage and now, there hasn't been an increase in the number of Canadians who think, for example, that death is an appropriate response to the intolerable suffering of people who are eligible for Track 2 MAiD. Between the month after Bill C-7's passage (in 2021) and June 2023, Ipsos polls found a 4% increase in the number of Canadian adults who *oppose* allowing Track 2 MAiD (44,45). If anything, this suggests an increase in the number of Canadians who think that death is an *inappropriate* response to the intolerable suffering of people who are eligible for Track 2 MAiD. Of course, this type of evidence is inconclusive,<sup>24</sup> so what really matters is that it definitely doesn't support the applicants' legitimization argument.

The second main reason for doubting the alleged legitimization is that both inside and outside the context of MAiD, when Canadian law allows competent people to choose a treatment option, it doesn't seem that the law legitimizes the option as an "appropriate response" or a "reasonable solution." For example, Canadian law allows competent people to refuse blood transfusions (usually done for religious reasons) (46), but it doesn't seem that, in doing so, the law legitimizes refusing blood transfusions as appropriate. Instead, it seems that if the law legitimizes anything, it legitimizes that it is appropriate that competent people get to decide how they are treated (within some limits), even if their decisions are objectively unreasonable (or seem unreasonable from a practitioner's perspective).

Besides, even if allowing Track 2 MAiD *does* contribute to legitimizing that death is an appropriate response to experiences 1 to 3, the margin of change (relative to allowing only Track 1 MAiD) would be unclear. For example, because over 95% of Track 1 recipients reported suffering from a "loss of ability to engage in meaningful activities" (6), if allowing Track 2 MAiD legitimizes death as an appropriate response to this loss, then so does allowing Track 1 MAiD. Given that over 95% of MAiD deaths are Track 1 (6), it would be implausible to say that allowing Track 2 substantially increases the degree to which Canadians buy into a message that, if sent, is sent by both tracks.

### Objection #2: Is There Actually Harm?

My second objection to the applicants' legitimization argument is that even if allowing Track 2 MAiD *has* legitimized that death is an appropriate response to experiences 1 to 3, it is doubtful whether this would be harmful because it is doubtful whether death is an objectively inappropriate response to these experiences. As a general rule (though not an exceptionless one), if X

<sup>23</sup> Recognizing that Canadian society's structural coercion will almost certainly continue into the near future doesn't constitute endorsing this. To use the uncharitable words of Track 2 opponent Isabel Grant, I am not actually "suggest[ing] that the state, through the medical profession, has an obligation to provide access to death but no obligation to make life tolerable for a Charter-protected group" (7, p.269). Like many other Track 2 defenders, my view is that the state has both obligations.

<sup>24</sup> The polls' credibility intervals are both  $\pm 1.9\%$  (44,45).

is an objectively appropriate response to Y, it isn't harmful to legitimize X as an appropriate response to Y. So, it seems that the applicants are implicitly relying on assumptions that hold that death is an objectively inappropriate response to each of the three experiences. All three assumptions are dubious.

Let's begin with 1 and 2. Whether death is an objectively inappropriate response to some disabled people's intolerable suffering — and losses of things like dignity and the ability to engage in meaningful activities — depends on the correctness of parts of the applicants' premature death argument. However, I have already problematized these parts. Regarding 3, it is doubtful whether death is an objectively inappropriate response to feeling like a burden in cases where this feeling is correct. For example, imagine an altruistic Track 2 requester who wants to die partly to decrease the strain on the Canadian healthcare system. The applicants provide no reasons for why this type of ethical decision-making would be inappropriate.

However, in the disability studies literature, a reason is provided: choosing death to stop being a burden is based on the false ethical premise that life isn't worth living when one is dependent on others (47).<sup>25</sup> Against this, psychiatrist and bioethicist Brent Kioussis shows that being merely dependent on others is different from being a burden on others (which involves imposing severe net harms), so "it could sometimes be reasonable for a person to choose to hasten her death to avoid being a burden" (49, p.15). Ultimately, choosing death to stop being a burden on others isn't based on the premise that life isn't worth living when one is dependent on others; as many disability scholars emphasize, everyone is dependent on others.

Some Track 2 opponents would reply by arguing that death is an objectively inappropriate response to feeling like a burden because it is a non-autonomous response (for a heretofore undiscussed reason).<sup>26</sup> Namely, they would argue that choosing this response involves two types of anti-autonomous "felt pressure" (50, p.2). The first comes from burdened caregivers pushing someone to choose MAiD (7,8,51). However, the existing eligibility criteria and safeguards deal with this. As Eric Mathison explains, "MAiD assessors spend a lot of time going over the reasons someone has for wanting MAiD, including looking for evidence of coercion or undue influence" (52). Besides, some people are pushed by their families to *refuse* MAiD — and some people "refuse MAiD because they perceive it as a burden on their families" (50, p.4) — but we don't react to this by disallowing MAiD refusals.

The second type of alleged felt pressure comes from mere knowledge of the burdening (51). However, it is unclear why we should think about this any differently (autonomy-wise or otherwise) from how, for example, mere knowledge of extreme poverty can engender felt pressure to donate to charity. Against this, bioethicists Stoll et al. would say that "a person's preference for MAiD should not be driven by external factors" (50, p.2), but we don't hold other major life decisions to this high standard. As Eric Mathison and philosopher Jeremy Davis argue, "not all autonomous choices have to be self-regarding or self-interested. The decisions we make affect others, and we often make our most important decisions with consideration toward its effects on those we care about most" (53, p.346). Besides, feeling like a burden has an internal dimension; as Stoll et al. observe, "the patient's perception that they are a burden for caregivers may form part of the intolerable suffering" (50, p.2). In fact, the external vs. internal distinction arguably breaks down in many of the cases in question. As disability scholar Michael Gill argues (albeit not in the context of Track 2 MAiD),

Consider, for instance, a patient's desire for her loved ones' memories to be mainly of her as vibrant, engaged, loving, and caring, rather than for their memories to be dominated by thoughts of her going through an agonizing dying process in a significantly compromised condition. That desire could be described as self-oriented and unrelated to burden: she does not want people to think a certain way about her. Or it could be described as burden-based and altruistic: she does not want her loved ones to carry burdensome memories. But probably the more accurate thing to say is that the distinction between self-oriented and burden-based is in this case inapt (48, p.319).

Now, regarding cases where the feeling of being a burden is *incorrect* (e.g., someone falsely believes that they are a burden on their family), I have three comments. First, it is unclear how common such cases are. As Michael Gill notes, "Recent studies have also found that there is generally moderate correspondence between patients' self-perception of burden and actual caregiver burden" (48, p.321).

Second, as Stoll et al. explain, "When these unrealistic perceptions [of burdensomeness] contribute significantly to the individual's understanding of relevant information in deciding to seek MAiD, it can be argued that their competence to make that decision is impaired" (50, p.3). Thus, they may be ineligible for MAiD.

Third, regarding cases where someone's competence is unimpaired despite falsely believing that they are a burden, I would have to fall back on my earlier objection that questions whether there is legitimization. Specifically, I maintain that allowing Track 2 MAiD doesn't legitimize anything harmful in the cases in question because allowing Track 2 MAiD doesn't legitimize that death is an appropriate response to feeling like a burden. Recall my earlier objection's discussion of the lack of evidence of legitimization, as well as the analogy to blood transfusion refusals.

<sup>25</sup> Michael Gill thoroughly refutes the associated arguments, largely by showing that they are guilty of the naturalistic fallacy (48).

<sup>26</sup> Some Track 2 opponents (e.g., legal scholar Elizabeth Sheehy) would say that "the whole notion of being a burden on society or loved ones is grounded in ableism" (3, p.59). Against this, I would repeat my responses to the Internalized Ableism Objection.

### Objection #3: Is There More Rumination?

To conclude this section on legitimization, I explore another alleged harm of the legitimization: unhealthy rumination. According to Isabel Grant, “some perceive Track 2 MAiD as a ‘monkey on their back’ constantly throughout their struggle to deal with the realities of... disability in Canada. They are constantly in a position of re-evaluating whether their lives are worth living” (7, p.311). In the words of legal scholar Martha Minow (as quoted by Grant), this is because “the option of medical assistance in dying would alter the menu for all involved. It would turn the continuation of living into a question, open for debate, doubt, and persuasion” (7, p.318). Of course, there is a sense in which the discontinuation of living is always “on the menu” — regardless of whether Track 2 MAiD is allowed — for anyone capable of unassisted suicide, but the alleged key difference (as I understand it) is that allowing Track 2 MAiD has made more people see the discontinuation of living as a reasonable solution for them (and thus a live option, which triggers rumination).

However, Grant fails to show that the unease that allowing Track 2 MAiD may engender in some people outweighs the ease it engenders in others. As Ian Ball (the medical chair of a hospital MAiD committee) and Scott Anderson (a MAiD provider) observe,

A recurring theme is that patients’ moods are tremendously improved with the knowledge that MAiD gives them control over their disease... the availability of MAiD has improved the outlook of many patients who have not chosen the procedure. The knowledge that MAiD is an option, should symptoms become unbearable, is very reassuring for patients (54, p.372).

In fact, making MAiD available to people can comfort them so much that they see their life as worth living again. For example, in a 2015 study of Belgian patients with psychiatric disorders,

Among all 48 patients whose euthanasia requests were accepted... 11 patients decided to either postpone or cancel the euthanasia procedure. Of the latter 11 patients, 8 explained (by phone or mail) that knowing they had the option to proceed with euthanasia gave them sufficient peace of mind to continue their lives (55, p.5).

Given such evidence, the burden of proof is on Track 2 opponents to show that, on balance, allowing Track 2 MAiD harms eligible patients’ mental health. They fail to show this.

In summary, the applicants (and other Track 2 opponents) fail to show that allowing Track 2 MAiD has perniciously legitimized death as an appropriate response.

### Bundle #3: Allowing Track 2 MAiD Demeans Disabled People

The applicants argue that allowing Track 2 MAiD “devalues the lives of people with disabilities” (4, p.14). Although the applicants make this claim multiple times, they do little to flesh it out, so I will steelman<sup>27</sup> them by drawing on legal scholar Deborah Hellman’s demeaningness-centric theory of wrongful discrimination, which aligns with how some other Track 2 opponents (e.g., Isabel Grant) develop the devaluation argument (7). According to Hellman’s theory, discrimination is wrongful when it demeans someone, i.e., when it treats them “in a way that denies [their] equal moral worth” (56, p.29). Whether drawing a distinction between people is demeaning depends on this distinction’s socially understood meaning, which in turn depends largely on culture and context (56). In particular, drawing a distinction based on traits that define a mistreated and disadvantaged group is more likely to demean because of the distinction’s social significance (which emerges largely from how such distinctions have been drawn in the past) (56).<sup>28</sup>

Returning to MAiD, the applicants could argue that allowing Track 2 MAiD devalues disabled people’s lives by demeaning them because killing disabled people is socially understood to connote treating them as lesser, given the mistreatment of disabled people by Canadian society, especially the Canadian healthcare system. For an example of this mistreatment, consider how the rate of unmet healthcare needs is much higher for Canadians with disabilities than Canadians without disabilities (57). It would be understandable for such mistreatment to colour the ways in which people interpret how Canadian society treats disabled people differently (e.g., by making more of them eligible for MAiD).

The main problem with this argument is that a fuller picture of the history of the mistreatment of disabled Canadians reveals that it is doubtful whether allowing Track 2 MAiD is socially understood to connote treating them as lesser. In particular, this is because one of the main manifestations of this mistreatment has been the violation of the autonomy of disabled Canadians, especially by the Canadian healthcare system. Examples include forced sterilization and mass institutionalization (58,59). So, giving more disabled Canadians more control over their lives represents a repudiation of this historical mistreatment rather than a continuation of it. These considerations lend credence to the view that *disallowing* Track 2 MAiD would demean disabled people by being socially understood to connote treating them as “incompetent, easily coerced, and inclined to end their lives” and thus “plac[ing] them in the roles to which they have been confined by disability discrimination” (60, p.684). As philosopher

<sup>27</sup> A steelman is the opposite of a strawman. In other words, I am strengthening their argument before rebutting it.

<sup>28</sup> Also, Hellman says that demeaning someone requires having more power or status than them (56). This is because demeaning someone puts them down, so the demeaner has to be in a position such that their expression of disrespect can subordinate the victim (56).

Christopher Riddle argues, “Denying people with disabilities the right to exercise autonomy over their own life and death says powerfully damaging things about the disabled, their abilities, and their need to be protected” (61, p.487). Importantly, such ideas were key in *Truchon*; as Justice Christine Baudouin emphasized, “society often perceives the disabled as being incapable, due to their physical disability, of making the... ‘right decisions’ concerning their body and their life, hence their vulnerability and need for state protection from their... ‘poor choices’, including, for example, a request for medical assistance in dying motivated by the disability” (26, para.672).

The above problem with the demeaningness argument is even more acute vis-à-vis disabled Canadians who are also female, trans, non-binary, indigenous, or part of any other marginalized community because Canadian history is full of violations of the autonomy of members of these groups, especially by the Canadian healthcare system. Examples include non-consensual medical experiments and examinations, as well as barriers to accessing reproductive healthcare and gender-affirming healthcare (62-65).

Furthermore, the socially understood meaning of allowing Track 2 MAiD is presumably shaped partly by the context of the modern philosophy of the Canadian healthcare system. Specifically, given the triumph of patient autonomy over practitioner paternalism (66), allowing some disabled Canadians to choose Track 2 MAiD may be socially understood to connote treating them as morally worthy agents free to exercise self-determination over their lives. For illustration, Nicole Gladu (one of the disabled applicants in *Truchon*) interpreted the pro-Track-2 ruling as follows: “Now, it’s really a matter of personal decision. It’s up to me or it’s up to Mr. Truchon or other people like us to decide if we prefer the quality of life to the quantity of life” (67). As previously discussed, allowing Track 2 MAiD may legitimize that it is appropriate for people like Gladu to decide how they are treated.

This charitable interpretation is further supported by two legal provisions: 1) it is illegal to “discuss MAiD with a patient with the aim of inducing, persuading, or convincing the patient to request MAiD” (9, p.1) and 2) MAiD eligibility requires “making a voluntary request... which does not result from external pressure” (1). Arguably, these provisions express that disabled Canadians’ lives are valuable (and thus worth protecting from deaths that aren’t fully voluntary).<sup>29</sup> As Justice Baudouin put it in *Truchon*, “Respect for their individual freedom that is expressed thoughtfully, freely and clearly also contributes to the affirmation of the inherent value of their lives” (26, para.310).

Moreover, even if allowing Track 2 MAiD *did* demean disabled people, the margin of change (relative to allowing only Track 1 MAiD) would be unclear. Because everyone who is eligible for Track 1 MAiD is disabled (according to the applicants and others), if allowing Track 2 MAiD demeans disabled people, then so does allowing Track 1 MAiD (given my above steelman). So, because over 95% of MAiD deaths are Track 1, it would be implausible to say that allowing Track 2 MAiD substantially increases the degree to which disabled people are demeaned. It shouldn’t be forgotten that some disability rights groups (e.g., Not Dead Yet) have argued that limiting assisted dying eligibility to terminally ill people is ableist (35).

The applicants would probably respond to this margin-of-change challenge by arguing that allowing Track 2 MAiD is uniquely demeaning to disabled people because

The exemptions carved out by MAiD Track 2 are based on a distinction between those who are disabled and those who are not. In contrast, the distinction between those who are eligible for MAiD Track 1 is based on a distinction between those who are dying (their natural death is reasonably foreseeable) and those who are not dying (4, p.9).

For context, the “exemptions” in question are exemptions to the *Criminal Code* sections on murder and aiding suicide (4). So, what the applicants seem to be saying in the above quote is that eligibility for Track 2 MAiD is determined by whether one is disabled, whereas eligibility for Track 1 MAiD is determined by whether one’s natural death is reasonably foreseeable.

However, there is no meaningful sense in which this is true. Yes, eligibility for Track 1 MAiD requires that one’s natural death is reasonably foreseeable, but it also requires that one is disabled (according to the applicants and others), and it requires many other aforementioned things (e.g., adulthood and decision-making capacity). Similarly, eligibility for Track 2 MAiD does require that one is disabled, but it also requires these many other things.<sup>30</sup> The applicants are arbitrarily setting aside most but not all of the eligibility criteria that the two tracks share. Moreover, both tracks’ eligibility criteria show that the Canadian approach to MAiD is individualized, rather than expressing sweeping generalizations about all disabled people or all disabled Canadians.

Now, some Track 2 opponents would respond to all of my demeaningness-centric analysis thus far by accusing me of missing the bigger picture. Sure, they would say, allowing Track 2 MAiD isn’t demeaning in isolation. However, it is demeaning *in conjunction with* something else.

<sup>29</sup> Arguably, a similar thing is true for the eligibility criterion that requires that the patient’s suffering can’t be relieved in a way they consider acceptable.

<sup>30</sup> Justice Baudouin emphasized this in *Truchon*.

## The Conjunction Argument

The Conjunction Argument holds that allowing Track 2 MAiD (only for some disabled people) while disallowing MAiD — and offering suicide prevention — for all non-disabled people demeans disabled people by expressing that their deaths and their suffering are fundamentally different from those of non-disabled people.<sup>31</sup> Isabel Grant sets the stage as follows:

if [MAiD] is about autonomy, why do we only care about disabled autonomy? Those with disabilities are not the only people who may want to die. Why do we not offer death on demand to all competent adults who wish to end their lives? Why only disabled lives?... Others argue that MAiD is fundamentally about alleviating suffering... But disabled people do not have a monopoly on intolerable suffering, especially when one includes in the definition of “suffering” factors like loneliness and being a burden to others. Why do we only offer death for disabled suffering? (3, p.42).

Grant’s answer to such questions is that “The unspoken premise is that suicide is a benefit and a social good for people with disabilities whereas for others it is something to be deterred” (7, p.315). In other words, the Track 2 MAiD system rests on the assumption that, for disabled people and disabled people only, dying would be good for them and good for society. Thus, the system is “portraying disability as something to be avoided at all costs, even through death” (7, p.292). In the words of Heidi Janz, allowing Track 2 MAiD “enshrine[s] into law the quintessential ableist stereotype that it’s better to be dead than disabled” (39, p.299). In a similar vein, disability activist Catherine Frazee argues the following:

The foundational logic for Track 2 — that the suffering of disabled people warrants a special easing of eligibility thresholds for MAiD — builds from an ableist premise — namely, that disability suffering is inexorable, categorically distinct from the suffering of any non-disabled person, and remediable only by extreme medical intervention (3, p.70).

According to Frazee, allowing Track 2 MAiD doesn’t just build from such premises; it also socially entrenches them (3).

There are two main problems with the Conjunction Argument. The first is that Bill C-7 made only a tiny percentage of disabled Canadians newly eligible for MAiD, so, if the law expresses anything about whether it is better to be dead or disabled, it expresses that it is better for the vast majority of disabled Canadians (who are eligible for neither track) to be alive.<sup>32</sup> The same goes for what the law expresses about disabled people’s suffering. The vast majority of disabled Canadians are eligible only for non-MAiD remedies, including suicide prevention programs (if applicable) and non-extreme medical interventions such as standard pain management, so the law expresses that their “disability suffering” isn’t “inexorable” or “remediable only by extreme medical intervention” (3, p.70).<sup>33</sup> Also, note that people who are eligible for Track 2 MAiD are still eligible for non-extreme remedies.

The second main problem with the Conjunction Argument is that whether a demeaning message is sent by the conjunction of allowing Track 2 MAiD and disallowing MAiD for non-disabled people depends on how this allowance and disallowance are socially understood. Grant, Janz, and Frazee implicitly assume (for reasons that will become clear soon) that Canadians generally agree that everyone with a grievous and irremediable medical condition has a disability. However, this assumption seems false; Canadian society seems to have a narrower conception of disability. Consider the following two pieces of (admittedly inconclusive) evidence. The first is that, as previously discussed, the Canadian government says that a grievous and irremediable medical condition is an “illness, disease *or* disability [emphasis added]” (1). The second is that, in 2023, “33.5% of Track 1 respondents self-identified as having a disability compared to 58.3% of Track 2 respondents” (6). This amounts to over 65% and over 40%, respectively, believing that *their own* grievous and irremediable medical condition *isn’t* a disability. To be fair, it is possible that the rest of Canadian society understands disability much more broadly than both the Canadian government and Canadian MAiD requesters. However, if most Canadians have even a somewhat similar conception of disability, they wouldn’t think that all grievous and irremediable medical conditions are disabilities. This matters because it means that, if they thought about it, they would probably think that both Track 1 and Track 2 make some non-disabled people eligible for MAiD. Thus, they probably wouldn’t see either track (in isolation or in conjunction with anything else) as singling out disabled people, their deaths, or their suffering. Therefore, the Conjunction Argument fails to show that the conjunction in question expresses that disabled people’s deaths and suffering are fundamentally different from those of non-disabled people. To be clear, I am not abandoning my earlier concession that all grievous and irremediable medical conditions *are* disabilities; I am just exploring the implications of the fact that most Canadians would probably disagree.

However, let’s suppose for the sake of argument that I’m wrong. Perhaps most Canadians really do think that all grievous and irremediable medical conditions are disabilities. In this case, the Conjunction Argument could be correct that it is demeaning

<sup>31</sup> Parts of this argument can be found in the notice of application.

<sup>32</sup> This is why it is absurd to criticize Bill C-7 by saying, in the words of Quinn et al., 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” (8, p.5). Assisted dying hasn’t been made available for all people with a health condition or an impairment!

<sup>33</sup> Furthermore, many (if not most) *suicidal* disabled Canadians are eligible only for non-MAiD remedies. This is because many (if not most) suicidal disabled Canadians lack at least one of the following: decision-making capacity, an irreversible decline in capability, and suffering that can’t be alleviated in a way they consider acceptable. After all, suicidality correlates with impaired decision-making capacity (68), and many disabilities (e.g., paraplegia and down syndrome) usually don’t involve a continuous decline in capability (let alone an irreversible one), and many suicidal disabled Canadians’ suffering can be alleviated in an acceptable-to-them way that they either haven’t tried yet or are in the process of trying. Therefore, the law doesn’t express that suicidal disabled people’s deaths and suffering are fundamentally different from those of other people.

to limit MAiD eligibility to a subset of people with grievous and irremediable medical conditions. This would entail that the status quo system is in some sense problematic. Then the question would be what is the proper solution to this problem? There are three main options.

The first is merely disallowing Track 2 MAiD. However, this wouldn't solve the problem because, in a Track-1-only system, MAiD eligibility would still be both limited to a subset of disabled people (according to the applicants and others) and socially understood as being so (given what I have just supposed for the sake of argument). So, if allowing Track 2 MAiD demeans in conjunction with disallowing MAiD for all non-disabled people, then allowing only Track 1 MAiD would also demean in conjunction with this disallowance. Arguably, Isabel Grant implicitly admits this when she says that "By allowing medical professionals to provide death to *people with disabilities*, the [Criminal] Code sends the message that these disabled lives are less worthy of saving [emphasis added]" (7, p.308). Clearly, Track 2 isn't the real issue here.

Legal scholar Jonas-Sébastien Beaudry would probably respond by rejecting that a Track-1-only system would be demeaning. On the better-dead-than-disabled front, he makes the following argument:

By limiting medical assistance in dying to patients whose death is due to occur soon... the state could in principle avoid making or condoning problematic quality-of-life judgments. This is because MAiD could be considered not as a kind of suicide, but as a modality of dying. Death being inevitable, MAiD patients would be perceived as choosing the modality of their death rather than as choosing to forego years of existence (69).

The fundamental flaw of this argument is that death is *always* inevitable, so choosing MAiD always constitutes both choosing a modality of death and choosing to forgo some duration of existence. Furthermore, despite Beaudry's claim to the contrary (69), allowing only Track 1 MAiD wouldn't limit MAiD eligibility to patients whose deaths are due to occur soon; some patients who are eligible for Track 1 MAiD could live for many more years (5).

So, what are the two options that could actually solve the problem that the Conjunction Argument identifies (if this problem exists)? The second option is disallowing MAiD altogether, and the third option is adding a third track by expanding MAiD eligibility to include some intolerably suffering people who are non-disabled (and socially understood as such). The applicants provide no reasons for favouring the second over the third option, and besides, the second option is a non-starter because it would violate the *Charter* (29). So, if anything, the Conjunction Argument may be more promising as an argument for further expanding MAiD eligibility.<sup>34</sup> By (loose) analogy, when Canada made voting available only to men, this was demeaning, but the proper solution was making voting available to more people rather than less.<sup>35</sup>

In summary, the applicants' demeaningness argument fails (even when buttressed by the Conjunction Argument).

#### **Bundle #4: Allowing Track 2 MAiD Decreases Healthcare Options**

The applicants argue that allowing Track 2 MAiD "narrows the range of options that are available... for dealing with suffering [disabled people] are finding intolerable" (4, p.11). According to the applicants, this is because practitioners may not pursue all available non-MAiD treatment options for people who are eligible for Track 2 MAiD (4).

The main problem with this argument is that it is highly doubtful whether practitioners are pursuing fewer non-MAiD treatment options for people who are eligible for Track 2 MAiD. After all, Track 2 MAiD providers are legally required to do the following:

ensure that the person has been informed of [and has given serious consideration to] the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care (72).

Furthermore, withholding or withdrawing treatment options to induce a patient to request MAiD would be illegal (for the aforementioned reasons). The applicants identify no incentives for practitioners to violate these requirements, and the applicants ignore the strong disincentives (e.g., the risk of imprisonment and losing one's license to practice). Besides, even if there are some violations, the harm would be attributable to the rule violators and/or the rule enforcers (rather than the eligibility change). Ultimately, it seems much likelier that allowing Track 2 MAiD expands — rather than narrows — disabled people's range of options for dealing with intolerable suffering (by giving some of them the option of Track 2 MAiD).

In response, the applicants could argue that allowing Track 2 MAiD has led (or will lead) to Canadian federal or provincial *governments* doing less to ensure that eligible patients can access non-MAiD treatment options. As Coelho et al. claim, "The rapid expansion of MAiD offers cost-savings for governments, creating arguably perverse incentives not to address the inadequacies of the healthcare system" (18, p.876). However, there is no evidence of such fears coming true in Canada (34), and similar predictions made about other jurisdictions that have legalized assisted dying (e.g., Belgium and Oregon) have

<sup>34</sup> For some arguments in this direction, see the work of Udo Schüklenk (70).

<sup>35</sup> One might respond to this entire demeaningness section by arguing that it sets the bar too high and that allowing Track 2 MAiD clears the lower bar for being merely offensive. However, Brent Kiouss shows that such offensiveness would be insufficient to justify denying people access to MAiD (71).

been proven wrong (28,48,60). For example, opponents of assisted dying in general predicted that it would lead to governments doing less to ensure that eligible patients can access palliative care, but, as philosopher Ben Colburn notes, “assisted dying tends to go hand in hand with greater support for palliative care, financially and otherwise” (60, p.685). Importantly, this trend has held true in Canada (28,73). Around the world, governments don’t react to assisted dying eligibility expansions by doing less to ensure that eligible patients can access non-assisted-dying treatment options. The burden of proof is on Track 2 opponents to show that Track 2 MAiD is an exception to this rule, but they have failed to do so.

Furthermore, even if disallowing Track 2 MAiD would *eventually* lead to more access to non-MAiD treatment options, this wouldn’t make it permissible. Most Track 2 recipients are over 75 years old (6), so, if Track 2 MAiD was disallowed tomorrow, most of the people who would be denied access wouldn’t live long enough to reap the rewards of more access to non-MAiD treatment options if this progress came, say, ten years down the line (34). So, denying them access would constitute violating their autonomy and prolonging their intolerable suffering for the sake of other people’s access to non-MAiD treatment options. Arguably, this would be impermissible instrumentalization (12,34,74). Justice Lynn Smith correctly condemned this type of “hostage-taking” in *Carter* (75, para.1274).

### Bundle #5: Allowing Track 2 MAiD Decreases Trust in the Healthcare System

The applicants’ fifth and final argument is that allowing Track 2 MAiD has decreased disabled Canadians’ trust in the Canadian healthcare system (4). This is for three main reasons. First, Track 2 MAiD being allowed “can undermine the trust a person should have in their service providers” because “Death is presented as a form of medical treatment but only because they have a disability” (4, p.10). Second, many disabled people fear that a practitioner will recommend death to them, and this discourages them from accessing healthcare services (4).<sup>36</sup> Third, being offered MAiD communicates that the healthcare system won’t help you because it doesn’t care about you (4). Consequently, allowing Track 2 MAiD “narrows the range of options... that persons with disabilities may *perceive* as available... for dealing with suffering they find intolerable [emphasis added]” (4, p.11). Importantly, this could be true even if my previous section is correct that allowing Track 2 MAiD expands the range of options that are *actually* available.

The main problem with this argument is that it is doubtful whether allowing Track 2 MAiD has decreased many disabled Canadians’ trust in the healthcare system. I have three justifications for this claim. The first is that the applicants’ above reasons are weak so long as practitioners are following their legal and professional requirements. For example, it is doubtful whether someone would perceive that being “offered” Track 2 MAiD communicates (or evinces) that the healthcare system won’t help them — or doesn’t care about them — so long as the practitioner fulfills their professional obligation to discuss MAiD with the patient in a way that makes it clear that MAiD is just one option among all the “medically effective and legally available treatments” (9, p.4). Furthermore, it is doubtful whether someone would perceive that the practitioner is recommending death, so long as the practitioner heeds the ban on trying to induce, persuade, or convince patients to request MAiD. Note that some regulators (e.g., the British Columbia College of Nurses and Midwives) explicitly interpret the law as making it illegal for practitioners to “encourage... advise, [or] recommend” MAiD (76). Also note that a rule-following practitioner would bring up Track 2 MAiD for the first time not by literally *offering* it but by saying (or implying) that the patient *may* be eligible for it. As Eric Mathison explains, “Typically, providers don’t say ‘would you like MAiD?’ Instead, they offer info or to connect the patient with the MAiD team” (52). Among other reasons, this is because the process for determining eligibility is long and complex (especially for Track 2).<sup>37</sup>

My second justification is that the available evidence conflicts with the applicants’ trust argument. For example, a 2023 Ipsos poll found that over three quarters of disabled Canadians support allowing Track 2 MAiD (45). This would be hard to explain if a large percentage of disabled Canadians believed claims like the following: 1) death should never be a form of medical treatment for a disability (even a grievous and irremediable medical condition), 2) being “offered” Track 2 MAiD communicates (or evinces) that the healthcare system doesn’t care about you, or 3) allowing Track 2 MAiD narrows disabled Canadians’ range of options for dealing with intolerable suffering.

My third justification is that even if the applicants’ reasons were plausible, the margin of change (relative to allowing only Track 1 MAiD) would be unclear. For example, imagine a disabled Canadian who loses some amount of trust in the Canadian healthcare system because of Track 2 MAiD presenting death as a form of medical treatment for some disabilities in some cases. Before Track 2 was allowed, this person probably already distrusted the Canadian healthcare system because of Track 1. After all, if Track 2 presents death as a form of medical treatment for some disabilities in some cases, then so does Track 1. For another example, imagine a disabled Canadian who uncharitably interprets being “offered” Track 2 MAiD as communicating (or evincing) that the healthcare system doesn’t care about them. Before Track 2 was allowed, this person may well have already distrusted the Canadian healthcare system. After all, this pre-existing distrust would explain why they

<sup>36</sup> Isabel Grant adds that this may also “deter people from... fully disclosing the extent of their suffering” (7, p.311).

<sup>37</sup> My points in this paragraph are a large part of why I reject hope-centric arguments for disallowing Track 2 MAiD. For context, Coelho et al. claim that “Offering MAiD to a patient who has not raised it could be interpreted as an indication that their suffering will likely become intolerable, and that MAiD is the recommended way out, impacting patient hope” (18, p.873). Beyond what I have already said, there are two main problems with this argument. The first is that it couldn’t justify disallowing Track 2 MAiD; it could only justify disallowing “offering” MAiD to patients who haven’t raised it. The second is that in a world without Track 2 MAiD, patients who are told about it in the status quo would still be told if their suffering is likely to become intolerable (which, in practice, means “extreme”) (77, p.20). Similarly, they would still be told if their condition is irremediable (or likely to be so). This is because these patients would still be making treatment decisions, and informed consent requirements would make practitioners give these patients the information in question. Thus, disallowing Track 2 MAiD probably wouldn’t increase these patients’ hope.

interpret the “offer” uncharitably. This pre-existing distrust could have many sources, including Track 1 and previous negative experiences with the healthcare system, which are much more common for disabled people (78,79).

The applicants could respond by arguing that even an unclear margin of change in how much the Canadian healthcare system is trusted by a small minority of disabled Canadians would be a major issue (given the severity of the harms associated with forgoing healthcare services).

I have two counter-responses. The first is that this alleged decrease in some disabled Canadians’ trust in the healthcare system could be outweighed by an increase in *other* disabled Canadians’ trust in the healthcare system (such that, on balance, allowing Track 2 MAiD increases disabled Canadians’ trust in the healthcare system). This is for two main reasons. First, many disabled Canadians may feel empowered by being given more control over their lives (see my earlier arguments for why allowing Track 2 MAiD is empowering and sends an empowering message), and this may help build — or rebuild — trust after infantilization by the Canadian healthcare system (and/or other systems). Second, some disabled Canadians want Track 2 MAiD or believe that they may want it eventually, and it is generally easier to trust a system that is willing to give you what you want. Many of these people would desire death — or foresee desiring death — because of their suffering-causing disability, so, contrary to what the applicants say, they probably wouldn’t mind death being presented as a form of medical treatment (or perhaps “medical intervention”) for some disabilities in some cases.

My second counter-response is that even if there has been an overall decrease in disabled Canadians’ trust in the healthcare system after the passage of Bill C-7, this harm may be overwhelmingly attributable to false or misleading information about MAiD (rather than to allowing Track 2 MAiD). For context, misinformation about MAiD is common on social media (80,81), and many MAiD cases have been misrepresented by the media (often to the dismay of the patients involved). For example, one patient said that his case was “hijacked by the right trying to spin it into their own agenda” (10, p.1176). It is certainly possible that some disabled Canadians’ understandings of how Track 2 works have been distorted by op-eds and news stories overgeneralizing from a select few cases in which practitioners *may* have violated their professional obligations. Here I have in mind the widely publicized case of a clinician who allegedly “discussed MAiD in positive terms” with one of the individual applicants (4, p.5), who was in a mental health crisis at the time (82).

By analogy, imagine a country in which misinformation convinces some of its disabled inhabitants that, because of a newly elected party, the healthcare system is providing much less support for disabled people. If this decreases the disabled inhabitants’ trust in the healthcare system and narrows their perceived range of treatment options, these harms are attributable to the misinformation rather than to the election of the party.

In summary, the applicants fail to show that allowing Track 2 MAiD has decreased disabled Canadians’ trust in the Canadian healthcare system.

## CONCLUSION

One might object to this entire paper by arguing that it hasn’t *definitively* disproven that allowing Track 2 MAiD has caused premature deaths, perniciously legitimized death as an appropriate response to some experiences, demeaned disabled people, decreased their healthcare options, and decreased their trust in the healthcare system. This is true. As legal scholars Sarah Lazin and Jennifer Chandler correctly observe, there is a “lack of detailed information about the consequences of expanding MAiD access” (83, p.114), so it is probably currently impossible to conclusively prove or disprove the existence of these harms. However, all that this paper needs to have shown is that these harms are highly uncertain. If it is very unclear whether allowing Track 2 MAiD has caused these harms, then the Canadian government should default to respecting disabled people’s human right to autonomy over their lives. Furthermore, even if disallowing Track 2 MAiD would benefit some disabled people by mitigating some of these harms, the instrumentalization issue would arise again. Would this benefit justify violating many disabled people’s autonomy? The applicants — and other Track 2 opponents — fail to show that the answer is yes.

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**REFERENCES**

1. Department of Justice. [Legislative Background: Medical Assistance in Dying \(Bill C-14, as Assented to on June 17, 2016\)](#). Government of Canada. 2 Feb 2023.
2. Department of Justice. [Charter Statement: An Act to amend the Criminal Code \(medical assistance in dying\) \(C-7\)](#). Government of Canada. 21 Oct 2020.
3. Grant I, Benedet J, Sheehy E, Frazee C. [A conversation on feminism, ableism, and medical assistance in dying](#). Canadian Journal of Women and the Law. 2023;35(1):31-72.
4. [K.C., Kathrin Mentler, Inclusion Canada, Indigenous Disability Canada / The British Columbia Aboriginal Network on Disability Society, Council of Canadians with Disabilities, and Disabled Women's Network of Canada v. Canada \(Attorney General\)](#). 2024 OSCJ CV-24-0072847-0000.
5. Canadian Association of MAiD Assessors and Providers. [The Interpretation and Role of "Reasonably Foreseeable" in MAiD Practice](#). CAMAP. Feb 2022.
6. Health Canada. [Fifth Annual Report on Medical Assistance in Dying in Canada 2023](#). Government of Canada. 11 Dec 2024.
7. Grant I. [Legislated ableism: Bill C-7 and the rapid expansion of medical assistance in dying in Canada](#). McGill Journal of Law and Health. 2024;15(2):259-335.
8. Quinn G, Mahler C, De Schutter O. [Mandates of the Special Rapporteur on the rights of persons with disabilities; the Independent Expert on the enjoyment of all human rights by older persons; and the Special Rapporteur on extreme poverty and human rights](#). Office of the United Nations High Commissioner for Human Rights. 3 Feb 2021.
9. Canadian Association of MAiD Assessors and Providers. [Bringing up Medical Assistance in Dying \(MAiD\) as a clinical care option](#). CAMAP. Feb 2022.
10. Downar J, MacDonald S, Buchman S. [Medical assistance in dying, palliative care, safety, and structural vulnerability](#). Journal of Palliative Medicine. 2023;26(9):1175-9.
11. Mathison E. [Assisted dying and abortion are connected](#). Value Judgments. 1 Jun 2023.
12. Mathison E. [Assisted dying in Canada is working great](#). Value Judgments. 16 Aug 2022.
13. Mathison E. [Lack of housing is a housing issue](#). Value Judgments. 19 Oct 2022.
14. Sørheim P, Barra M, Norheim OF, Gamlund E, Solberg CT. [Premature death as a normative concept](#). Health Care Analysis. 2024;32(2):88-105.
15. Luper S. [Death](#). In: Zalta EN, Nodelman U, editors. The Stanford Encyclopedia of Philosophy. Winter 2024 Edition. 25 Aug 2021.
16. Schuklenk U. [Argumenta ad passiones: Canada debates access thresholds to MAiD](#). Bioethics. 2022;36(6):611-2.
17. Genuis QIT. [Hopeless hope, autonomy, and anthropology: a response to Wiebe and Mullin](#). Journal of Medical Ethics. 22 May 2024.
18. Coelho R, Maher J, Gaidn KS, Lemmens T. [The realities of medical assistance in dying in Canada](#). Palliative and Supportive Care. 2023;21(5):871-8.
19. Coelho R, Gaidn KS, Lemmens T, Maher J. [Normalizing death as "treatment" in Canada: Whose suicides do we prevent, and whose do we abet?](#) World Medical Journal. 2022;70(3):27-35.
20. Raikin A. [No other options](#). The New Atlantis. 16 Dec 2022.
21. Lemmens T, Shariff MJ, Herx L. [How Bill C-7 will sacrifice the medical profession's Standard of Care](#). Policy Options. 11 Feb 2021.
22. Gunderson M, Mayo DJ. [Restricting physician-assisted death to the terminally ill](#). Hastings Center Report. 2000;30(6):17-23.
23. Fichten L. [As Canada delays medically assisted dying in mental illness cases, some find relief, others fear consequences](#). CBS News. 19 Nov 2024.
24. Moawad H. [The effects of self-inflicted neck trauma](#). Verywell Health. 29 May 2022.
25. Downie J. [An alternative to medical assistance in dying? The legal status of voluntary stopping eating and drinking \(VSED\)](#). Canadian Journal of Bioethics / Revue Canadienne de Bioéthique. 2018;1(2):48-58.
26. [Truchon v. Canada \(Attorney General\)](#). 2019 QCCS 3792.
27. Downie J. [A watershed month for medical assistance in dying](#). Policy Options. 20 Sep 2019.
28. Downie J, Schuklenk U. [Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada](#). Journal of Medical Ethics. 2021;47(10):662-9.
29. [Carter v. Canada \(Attorney General\)](#). 2015 SCC 5, 1 SCR 331.
30. Nelson LJ. [Respect for the developmentally disabled and forgoing life-sustaining treatment](#). Mental Retardation and Developmental Disabilities Research Reviews. 2003;9(1):3-9.

31. Lemmens T. [How Canada's medical assistance in dying law turned euthanasia and assisted suicide into a quasi-universal therapy for suffering](#). *Journal de Droit de la Santé et de l'Assurance Maladie*. 2024;39:110-22.
32. Chisholm C. [Saying goodbye to April](#). CBC News. 17 Nov 2024.
33. Janz H. [Plagued to death by ableism: what the COVID-19 pandemic and the expansion of eligibility for MAID reveal about the lethal dangers of medical and systemic ableism in Canada](#). *Canadian Journal of Bioethics / Revue Canadienne de Bioéthique*. 2023;6(3-4):137-41.
34. Wiebe K, Mullin A. [Choosing death in unjust conditions: hope, autonomy and harm reduction](#). *Journal of Medical Ethics*. 2024;50(6):407-12.
35. Scoccia D. [Physician-assisted suicide, disability, and paternalism](#). *Social Theory and Practice*. 2010;36(3):479-98.
36. Khader SJ. [Adaptive preferences and procedural autonomy](#). *Journal of Human Development and Capabilities*. 2009;10(2):169-87.
37. Downar J, MacDonald S, Buchman S. [Medical assistance in dying and palliative care: shared trajectories](#). *Journal of Palliative Medicine*. 2023;26(7):896-9.
38. Khader SJ. [Must theorising about adaptive preferences deny women's Agency?](#) *Journal of Applied Philosophy*. 2012;29(4):302-17.
39. Janz H. MAID to die by medical and systemic ableism. In: Kotalik J, Shannon DW, editors. *Medical Assistance in Dying (MAID) in Canada: Key Multidisciplinary Perspectives*. Cham, Switzerland: Springer; 2023. p. 299-308.
40. Coelho R. [Medical assistance in dying overused in Canada even before expansion](#). The London Free Press. 9 Jul 2022.
41. Mathison E. [MAID and marginalization](#). *Value Judgments*. 28 Oct 2024.
42. Kious BM. [Hard choices: how does injustice affect the ethics of medical aid in dying?](#) *Cambridge Quarterly of Healthcare Ethics*. 2024;33(3):413-24.
43. Pullman D. [Moral and intellectual gymnastics in defense of Canada's out-of-control MAiD regime](#). *Impact Ethics*. 19 May 2023.
44. Ipsos. [Support for Medically-Assisted Dying in Canada](#). Dying With Dignity Canada. 9 May 2022.
45. Ipsos. [Support for Medically-Assisted Dying in Canada](#). Dying With Dignity Canada. 30 Jun 2023.
46. Banerjee S. [Quebec coroner says Jehovah's Witnesses had right to refuse blood transfusions](#). Toronto Star. 14 Nov 2017.
47. Kittay EF. [When caring is just and justice is caring: justice and mental retardation](#). *Public Culture*. 2001;13(3):557-79.
48. Gill MB. When is self-perceived burden an acceptable reason to hasten death? In: Cholbi M, Varelius J, editors. *New Directions in the Ethics of Assisted Suicide and Euthanasia*. 2nd ed. Cham, Switzerland: Springer; 2023. p. 315-36.
49. Kious B. [Burdening others](#). *Hastings Center Report*. 2022;52(5):15-23.
50. Stoll J, Ryan CJ, Trachsel M. [Perceived burdensomeness and the wish for hastened death in persons with severe and persistent mental illness](#). *Frontiers in Psychiatry*. 2021;11:532817.
51. Box G, Chambaere K. [Views of disability rights organisations on assisted dying legislation in England, Wales and Scotland: an analysis of position statements](#). *Journal of Medical Ethics*. 2021;47(12):e64.
52. Mathison E. [A look at the recent Charter challenge to track two MAID](#). *Value Judgments*. 3 Oct 2024.
53. Davis J, Mathison E. [The case for an autonomy-centred view of physician-assisted death](#). *Journal of Bioethical Inquiry*. 2020;17(3):345-56.
54. Ball IM, Anderson S. [Availability of medical assistance in dying can be therapeutic](#). *CMAJ*. 2017;189(9):e372.
55. Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K, De Deyn PP. [Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study](#). *BMJ Open*. 2015;5(7):e007454.
56. Hellman D. *When Is Discrimination Wrong?* Cambridge, Massachusetts: Harvard University Press; 2008.
57. Casey R. [Disability and unmet health care needs in Canada: a longitudinal analysis](#). *Disability and Health Journal*. 2015;8(2):173-81.
58. Hopper T. [The time when Canada's elite wanted to sterilize "insane" and disabled people](#). National Post. 16 Aug 2023.
59. Brown I, Radford JP. [The growth and decline of institutions for people with developmental disabilities in Ontario: 1876-2009](#). *Journal on Developmental Disabilities*. 2015;21(2):7-27.
60. Colburn B. [Disability-based arguments against assisted dying laws](#). *Bioethics*. 2022;36(6):680-6.
61. Riddle CA. [Assisted dying & disability](#). *Bioethics*. 2017;31(6):484-9.
62. Burnett M. [A history of abortion in Canada: The quest for women's reproductive rights](#). *Journal of Obstetrics and Gynaecology Canada*. 2019;41(supp. 2):S293-5.
63. James-Abra E. [The road to inclusion: transgender health care in Canada](#). *The Canadian Encyclopedia*. 29 Jul 2014.
64. MacDonald NE, Stanwick R, Lynk A. [Canada's shameful history of nutrition research on residential school children: The need for strong medical ethics in Aboriginal health research](#). *Paediatrics & Child Health*. 2014;19(2):64.
65. Gibson E, Downie J. [Consent requirements for pelvic examinations performed for training purposes](#). *CMAJ*. 2012;184(10):1159-61.
66. Kilbride MK, Joffe S. [The new age of patient autonomy](#). *JAMA*. 2018;320(19):1973-4.
67. The Canadian Press. [MAID litigant says disability doesn't make her vulnerable to pressure to end her life](#). CTV News. 16 Dec 2020.

68. Sastre-Buades A, Alacreu-Crespo A, Courtet P, Baca-Garcia E, Barrigon ML. [Decision-making in suicidal behavior: A systematic review and meta-analysis](#). *Neuroscience and Biobehavioral Reviews*. 2021;131:642-62.
69. Beaudry J-S. [Bill C-7, assisted dying and "lives not worth living."](#) *Policy Options*. 14 Dec 2020.
70. Schuklenk U. [Time to rethink assisted dying?](#) *Bioethics*. 2024;38(4):273-4.
71. Kious BM. [Disability, offense, and the expressivist objection to medical aid in dying](#). *Journal of Medicine and Philosophy*. 2024;49(6):532-46.
72. Health Canada. [Model Practice Standard for Medical Assistance in Dying \(MAID\)](#). Government of Canada. Mar 2023.
73. Canadian Institute for Health Information. [Access to Palliative Care in Canada, 2023](#). CIHI. 2023.
74. Mathison E. [The better world argument](#). *Value Judgments*. 17 Nov 2022.
75. [Carter v. Canada \(Attorney General\)](#). 2012 BCSC 886.
76. British Columbia College of Nurses & Midwives. [FAQs](#). BCCNM.
77. Downie J, Chandler J. [Interpreting Canada's Medical Assistance in Dying Legislation](#). Institute for Research on Public Policy. Mar 2018.
78. Stainton T. [Disability, vulnerability and assisted death: commentary on Tuffrey-Wijne, Curfs, Finlay and Hollins](#). *BMC Medical Ethics*. 2019;20:89.
79. Riddle CA. Medical aid in dying: the case of disability. In: Cholbi M, Varelius J, editors. *New Directions in the Ethics of Assisted Suicide and Euthanasia*. 2nd ed. Cham, Switzerland: Springer; 2023. p. 225-41.
80. Roley G. [CBC headline on assisted suicide expansion is fake](#). AFP. 31 Jul 2024.
81. Goldin M. [Canada isn't pushing minors to end their lives. Current euthanasia laws don't apply to them anyway](#). AP Fact Check. 24 Jul 2023.
82. Gamage M. [She sought help in crisis and was suggested MAID instead](#). *The Tyee*. 9 Aug 2023.
83. Lazin SJ, Chandler JA. [Two views of vulnerability in the evolution of Canada's medical assistance in dying law](#). *Cambridge Quarterly of Healthcare Ethics*. 2023;32(1):105-17.