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Discrimination and Socially Embedded Suffering: Extending Grant's Critique of Track 2 MAID to Mental Illness

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Article abstract

In her paper entitled "Why Track 2 MAiD is Discriminatory," Isabel Grant offers a compelling disability justice-based critique of Canada's evolving MAID regime. She argues that Track 2 MAID, which concerns persons who are not approaching the end of life, is premised on a medical model of disability that obscures structural ableism and therefore discriminates against persons with disabilities. In this commentary, I show that Grant's analysis becomes even more urgent when extended to current debates about the expansion of MAID eligibility for individuals with mental illness as the sole underlying medical condition.

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RÉPONSE À - ARTICLE / RESPONSE TO - ARTICLE

Discrimination and Socially Embedded Suffering: Extending Grant's Critique of Track 2 MAID to Mental Illness

Nicholas Dunn[a]

Texte discuté/Text discussed: Grant I. Why Track 2 MAiD is Discriminatory. Can J Bioeth/Rev Can Bioeth. 2025;8(4):45-55.

Résumé
Dans son article intitulé « Why Track 2 MAiD is Discriminatory », Isabel Grant propose une critique convaincante du régime évolutif de l'AMAD du Canada, fondée sur la justice en matière de handicap. Elle soutient que la voie 2 de l'AMM, qui concerne les personnes n'étant pas en fin de vie, repose sur un modèle médical du handicap qui occulte le capacitisme structurel et, par conséquent, est discriminatoire à l'égard des personnes handicapées. Dans ce commentaire, je montre que l'analyse de Grant devient encore plus urgente lorsqu'elle est étendue aux débats actuels sur l'élargissement de l'éligibilité à l'AMM pour les individus souffrant de troubles mentaux en tant que seule condition médicale sous-jacente.

Mots-clés
AMM, aide médicale à mourir, troubles mentaux, discrimination

Abstract
In her paper entitled "Why Track 2 MAiD is Discriminatory," Isabel Grant offers a compelling disability justice-based critique of Canada's evolving MAID regime. She argues that Track 2 MAID, which concerns persons who are not approaching the end of life, is premised on a medical model of disability that obscures structural ableism and therefore discriminates against persons with disabilities. In this commentary, I show that Grant's analysis becomes even more urgent when extended to current debates about the expansion of MAID eligibility for individuals with mental illness as the sole underlying medical condition.

Keywords
MAID, medical assistance in dying, mental illness, discrimination

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INTRODUCTION

In a recent paper in this journal, "Why Track 2 MAiD is Discriminatory" (1), Isabel Grant offers a compelling disability justice-based critique of Canada's evolving MAID regime. Grant argues that Track 2 MAID, which concerns persons who are not approaching the end of life, is premised on a medical model of disability that obscures structural ableism and therefore discriminates against persons with disabilities.

In this commentary, I show that Grant's analysis becomes even more urgent when extended to current debates about the expansion of MAID eligibility for individuals with mental illness as the sole underlying medical condition (MI-SUMC). My aim is not to dispute Grant's conclusions but rather to build on them to show that they apply with equal force to the case of psychiatric MAID, where the conceptual and ethical stakes are arguably even greater.

I begin by briefly reviewing Grant's argument that Track 2 MAID is discriminatory (section 1), and elaborate on the social model of disability, which is implicit in Grant's discussion (section 2). I then discuss two further theoretical frameworks that Grant does not engage with, but which, when brought into dialogue with her argument, reveal why the discrimination she identifies becomes even more acute in the case of mental illness. These are: the *Externalist Model of Mental Illness* from the philosophy of psychiatry (section 3), and theories of *Structural Injustice and Substantive Equality* from political philosophy (section 4). These frameworks highlight the limitations of internalized and individualistic ways of conceiving of psychiatric suffering, and instead suggest a shift toward social, relational, and structural approaches to analyzing how mental illness is both experienced and constituted. I conclude by observing how these perspectives, in turn, challenge standard discrimination-style arguments regarding MAID MI-SUMC, which frame it in terms of "equal access." I also consider the implications for ongoing policy debates (section 5).

1. GRANT ON WHY TRACK 2 MAID IS DISCRIMINATORY

When MAiD was first legalized in 2016, only individuals with 'grievous and irremediable' medical conditions whose deaths were 'reasonably foreseeable' could qualify. Amendments to the law in 2021 removed the end-of-life requirement, making it possible for those with non-terminal illnesses to be eligible, provided their suffering is 'intolerable' and their condition 'irremediable'. As noted, Grant focuses her discussion on these cases (1).

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Grant's central claim in the article is that Track 2 MAID is "discriminatory against people with disabilities" (1, p.47). One of the primary reasons for this, she argues, is that MAiD policy in general is premised on a medical model of disability that treats the suffering associated with disability as something that is inherent to the individual and arises solely from a physical impairment. Consequently, death is put forward as a form of medical treatment that is suitable for disability-related suffering. As Grant notes: "This medical construction of human suffering may obscure the social factors that often contribute to and shape one's perception of suffering" (p.46). Further, it operates on the assumption that the kind of suffering experienced by those with a disability is worse than other forms of human suffering, inviting the belief that such lives may no longer be worth living. According to Grant, Track 2 MAiD reinforces ableist assumptions that see disability-related suffering as uniquely intolerable and disability itself as a deficit located within the individual rather than a product of social and structural conditions.

While Grant's argument is compelling, her discussion focuses squarely on physical illness and the structural inequalities affecting individuals with physical disabilities. What Grant does not explore, however, is the case of mental illness, where the line between medical and social suffering is not only blurry but where the issue of social determinants and structural conditions is particularly salient (1).

2. THE SOCIAL MODEL OF DISABILITY

Implicit in Grant's critique of the medical model of disability is an alternative put forth by disability ethicists, namely, the social model of disability. This model emphasizes that many of the hardships experienced by disabled people arise not from physical impairments themselves but rather from various social conditions and external barriers. To this end, disability ethicists distinguish between *impairment*, variations or differences in an individual's body or mind, and *disability*, obstacles caused by society that prevent full participation (2).

Grant's analysis presupposes three important commitments of the social model of disability. First, disability-related suffering is not solely caused by impairments but can be exacerbated or heightened by social and environmental factors. Second, autonomy is socially conditioned and cannot be analyzed apart from material realities, including structural ableism and histories of disadvantage and inequality. Third, equality requires changing social structures, not merely applying existing rules and norms to everyone in the same way.

Applying the social model of disability to the issue of MAID MI-SUMC suggests that we must confront the societal barriers that contribute to psychiatric suffering, such as stigma, poverty, under-funded services, or long wait times. Moreover, it suggests that determinations about whether one's mental disorder is 'irremediable' or request for MAID is 'autonomous' cannot be made without first addressing these structural conditions.

3. THE EXTERNALIST MODEL OF MENTAL ILLNESS

Recent work in the philosophy of psychiatry regarding the ontology of mental disorders supports claims made by those who adhere to a social model of disability. Traditional approaches locate psychiatric disorders squarely within the affected individual, as merely a dysfunction of the brain. Against these internalist models, externalist models of mental illness understand it not as something that is simply "in the head," but rather as something that emerges from an ongoing and dynamic relationship between a person and their world. In other words, mental illness is partly constituted by factors that lie outside the individual, that is, their environment, opportunities, and supports (3).

When applied to MAID MI-SUMC, externalism destabilizes the view that mental pain and suffering can be viewed in isolation from an individual's social context. Maung (4,5) discusses the ethical implications of externalism, namely, that there may be certain social and environmental interventions that could alleviate psychiatric suffering — and that these interventions may make a difference for whether an individual ends up requesting MAID. To date, however, the parallels between the social model of disability and externalist models of mental illness have yet to be observed. This is striking, as both treat suffering as socially embedded rather than purely individual.

4. STRUCTURAL INJUSTICE AND SUBSTANTIVE EQUALITY

Iris Marion Young was the first to theorize structural injustice — the idea that many forms of social injustice are not the result of individual bad actors but are rather built into social structures (6). In this way, harms are unevenly distributed, often disproportionately affecting certain groups simply through the normal operation of our systems and institutions. Moreover, responsibility for injustice is shared by all who participate; the ordinary actions of individuals contribute to the persistence of various forms of inequality, even if unintentionally.

Young further distinguished between formal and substantive equality (7). The formal conception of equality sees it as simply a matter of everyone living under the same rules. Yet this ignores how the rules were made in the first place; sameness of treatment in a context in which the system was set up unfairly ends up perpetuating inequality. Hence, a commitment to substantive equality requires thinking about the kinds of opportunities and outcomes that are available to individuals. Bringing these two strands together, Young argued that truly addressing inequality requires changing those structures that systematically disadvantage some people.

Applying this to the issue of MAID MI-SUMC suggests that there is a danger in treating it as simply about equal access. While many pro-expansion arguments operate on the basis of formal equality, Young warns us that sameness of treatment can further entrench inequality when background conditions are unjust. Viewing eligibility criteria for MAID identically in the case of physical and mental illness, respectively, may not ensure equal protection under the law if the suffering involved in the latter is socially embedded. Incorporating concerns about substantive equality requires that we understand how structural injustice hinders autonomy. In other words, options are only meaningful when there are viable and genuine alternatives. Moreover, our ethical evaluation of MAID MI-SUMC cannot be reduced to questions of informed consent or procedural fairness. Instead, a commitment to substantive equality means addressing the structural injustices faced by many people with mental illness.

5. DISCRIMINATION, EQUAL ACCESS, AND THE FUTURE OF MAID MI-SUMC POLICY

Proponents of MAID MI-SUMC argue that denying it to individuals with mental illness constitutes discrimination as it bars them from equal access to a legal right (8). Since those with physical illnesses are able to seek MAID, they argue that preventing those with mental illness from requesting it is arbitrary and unjust. On this view, if we truly respect autonomy, then we must offer the same end-of-life options to everyone, regardless of their diagnosis. I suggest that we might run the discrimination argument in the other direction. In other words, under present circumstances in which there exist significant barriers to adequate mental health care and supports, it might in fact be discriminatory to allow those with mental illness to be eligible for MAID.

Stepping back, we can say that something is discriminatory if it results in unequal treatment on the basis of arbitrary (i.e., morally irrelevant) differences. What seems to be overlooked by those who make discrimination-style arguments on this issue is the salience of social and external factors for how mental disorders are both experienced and constituted. Arguably, these factors make it different, in important ways, from physical suffering. If the social model of disability is correct, then we risk medicalizing a despair that is, at least in part, socially produced. If externalism is correct, then psychiatric conditions may resist separation from their social context in ways that physical conditions do not. Moreover, if we examine the issue through the lens of structural injustice, then we can see how framing the debate as simply a matter of inclusion risks obscuring the conditions that produce or exacerbate the very suffering that expansionist policies aim to alleviate. Thus, well-intentioned policies can inadvertently reproduce structural inequalities when they overlook the social conditions that shape mental illness. Expanding MAID for MI-SUMC without addressing social determinants mistakes sameness in treatment for fairness in outcome. And what is presented as compassion may inadvertently be a form of discrimination.

What I have tried to show here is how Grant's argument can be extended to the case of MAID for mental illness. Doing so underscores the ethical inadequacy of a framework that assesses psychiatric MAID through a strictly medical model. If psychiatric suffering is partly socially constituted, then assessments of 'irremediability' require taking into account systemic barriers to care, access to therapy and treatment, housing instability, poverty, stigma, and social exclusion. Where individuals face severe structural barriers to care and other social supports, presenting MAID as an available option risks transforming neglect into what appears to be an individual medical choice. As Grant shows, Track 2 already "posits death as…[a] convenient response to the suffering of people with disabilities" (1, p.52), especially to the extent that it is framed as simply a matter of choice. Allowing MAID for MI-SUMC risks deepening the patterns of discrimination that she identifies by treating it as a remedy for a suffering that is more tightly bound to social determinants than many physical disabilities. The present debate about expansion for MI-SUMC needs to address the question of what supports the state must provide to those with mental illness before eligibility for MAID could be considered ethically permissible.

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