AUTONOMY, CAPACITY, AND THE RIGHT TO EXIT

A Policy Framework for Non-Terminal Medical Aid in Dying

Master Policy Packet — For Distribution to Legislative, Clinical, Academic, and Advocacy Audiences

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Author's Note

This framework emerges from lived contradiction: at eighteen, I survived a serious suicide attempt with full intent and means. Nearly twenty years later, I choose life—not out of fear or social obligation, but because the conditions became tolerable.

That trajectory does not invalidate the argument; it exposes the lie that forced preservation is benevolence. The state that resuscitates without consent does not save a life; it claims ownership of one. This paper insists the right to exit belongs to the person whose life it is. Only when the door stands unlocked does the choice to remain carry moral weight. Anything else is conscription.

This packet is the source document for four audience-specific briefs: Legislative, Clinical/Medical Ethics, Academic, and Advocacy. All derive from the argument presented here.

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Executive Summary

Current Medical Aid in Dying (MAiD) frameworks predicate eligibility on terminal illness, irremediable suffering, or analogous threshold conditions. This paper argues that these criteria are philosophically insufficient and practically counterproductive. The operative criterion for eligibility should be **decisional capacity**—and nothing more.

This framework proposes a shift from a **Protectionist Model**—which treats eligibility as a concession granted when suffering becomes sufficiently legible to clinicians and legislators—to a **sovereignty model** grounded in four claims:

1. **Capacity is the only gate.** Suffering is a proxy; capacity is the principle. A person without pain who has formed a settled, informed preference for death presents an equal autonomous claim to one in persistent agony. The state has no legitimate interest in ranking whose suffering is sufficiently legible.
2. **Process serves as the filter.** A rigorous two-stage assessment and mandatory waiting period distinguishes crisis response from stable autonomous preference. Procedure is not a barrier; it is the mechanism of verification.
3. **Capability does not create obligation.** An individual's value to family, community, or society does not function as a statutory prohibition on exit. Persons are not public assets. Continued existence is not a debt owed to the collective.
4. **The Right to Exit as forcing function.** An enforceable exit right compels the state to treat livability as a deliverable rather than a platitude. Where socioeconomic conditions drive MAiD uptake, those conditions become documented public record. The moral and political cost of that record creates structural incentive for investment in life. This is not advocacy for death; it is the most consequential structural argument for dignified living.

> **On the disability rights objection:** This framework directly engages, rather than dismisses, the critique advanced by organizations such as DAWN Canada and ADAPT. The principal concern—that expanding MAiD eligibility enables the state to offer death as a substitute for adequate supports—is treated as *partially valid and structurally important*. The forcing function argument presented in Section V is offered as the substantive answer to that concern, not a circumvention of it. See Section IV for full engagement.

I. The Problem with Current Frameworks

1.1 The Suffering Criterion

Jurisdictions that permit MAiD typically require proof of "unbearable" or "intolerable" suffering. This framing conflates sympathy with rights. It suggests that a person must first be visibly broken before they are permitted to leave.

The suffering criterion creates a perverse dynamic: the more articulately a person can describe their distress to an evaluator, the more likely they are to receive access. Conversely, a person who has formed a settled, informed, philosophically coherent preference for death—but who presents as calm and functional—may be denied on the grounds that their suffering is insufficiently demonstrable. This is not a clinical standard; it is a performance requirement.

A more fundamental problem is definitional. "Unbearable" is not a clinical category. It is a subjective threshold that varies with individual psychology, cultural background, pain tolerance, and access to support services. To adjudicate on it requires evaluators to override the applicant's own report in favor of external assessment—precisely the paternalism this framework rejects.

1.2 The Terminal Illness Requirement

The United States model, operative in ten states and the District of Columbia, restricts eligibility to persons with a terminal prognosis of six months or fewer. This restriction has no coherent philosophical foundation.

The relevant moral question is not *how soon* a person will die, but whether they possess the autonomous capacity to determine when and how. A person with a terminal prognosis of five months is not meaningfully different, in terms of self-determination, from a person with a non-terminal but severely degenerative condition who will live twenty years in declining function. To treat them differently is to make a rights determination on the basis of prognosis rather than personhood.

1.3 International Comparators

1.4 Liability Theater

Psychiatric response to suicidal ideation frequently functions as institutional liability management rather than therapeutic care. The operational priority is avoiding documented responsibility for a death "on our watch," not resolving the conditions that produced the crisis. The result is a sequence that is coercive in substance if not in name: involuntary or pressured hospitalization, coerced safety contracts of no demonstrated clinical value, premature discharge into the same unlivable conditions, and the restarting of the cycle.

Biology persists; autonomy is suspended. The patient is held as a hostage to the provider's liability exposure and the state's moral discomfort with the existence of the preference. This

Jurisdiction	Eligibility	Suffering Req.?	Non-Terminal?
Canada (2026)	Grievous & irremediable condition; Track 2 for non-foreseeable death	Yes	Yes (Track 2; 732 provisions in 2024; 61.5% disability)[†]
United States	Terminal ($\leq$6 months); 10 states + DC	No	No
Belgium / Netherlands	Unbearable suffering including psychiatric	Yes	Yes (psychiatric review)
Switzerland	Any (assisted suicide organizations)	No	Yes (existential cases)
Proposed	**Decisional capacity only**	**No**	**Yes (stable preference)**

[†] Health Canada, *Sixth Annual Report on Medical Assistance in Dying* (2024 data, released November 2025). Mental illness as sole underlying condition delayed to March 2027. Track 2 year-over-year growth: 17% from 625 (2023) to 732 (2024).

Table 1: MAiD Eligibility Models, 2026

is not a treatment model. It is an administrative loop designed to defer, not resolve.

II. The Philosophical Foundation

2.1 Bodily Self-Determination

Medical jurisprudence across Western democracies has established, without serious remaining controversy, that competent adults may refuse any medical treatment—including life-sustaining treatment—without requiring justification, without being required to attempt it first, and without the consent of family members or treating clinicians. The foundation of this right is bodily self-determination: the principle that a person's physical existence is their own domain, not the state's.

If this right is recognized—and it is, in law, in every relevant jurisdiction—then the question is not whether persons possess the right to determine the boundaries of their existence, but why that right is suspended the moment the determination is self-directed rather than treatment-directed. The moral logic that permits a patient to refuse a ventilator and die by suffocation also supports permitting that patient to choose a swifter and less distressing death by other means. The distinction the law currently draws is not principled; it is aesthetic.

2.2 The Informed Refusal Principle

Medicine already recognizes, without controversy, that a patient may decline any treatment—including life-sustaining treatment—without first attempting it. A patient may refuse chemotherapy without a single round. A patient may decline dialysis without trial. The sole requirement is that the refusal be *informed*: the person must understand what the treatment is, what outcomes it realistically offers, and what declining means.

This framework applies that principle consistently and without exception.

An individual seeking MAiD assessment need not have attempted psychiatric treatment, exhausted pharmacological options, or completed a course of psychotherapy. They must know that these interventions exist, understand their realistic outcomes and risks, and—knowing this—decline them. The criterion is **informed awareness**, not **attempted compliance**.

> **The clinical interview's role under this framework:** The evaluating clinician tests comprehension, not compliance history. The relevant questions are not "Have you tried an SSRI?" but "What do you understand about SSRIs, what outcomes do the literature suggest, and what led you to decline them?" An honest, documented refusal following full disclosure is more epistemically transparent than a coerced trial producing performative compliance.

Requiring prior exhaustion of treatment for psychiatric or existential cases imposes a double standard that medicine has abandoned everywhere else. It encodes a covert hierarchy: the state's preferred interventions become mandatory prerequisites for autonomy in the categories it deems "weak-minded." This is not diligence. It is diagnostic disenfranchisement.

2.3 Capability Does Not Create Obligation

A persistent objection is that an individual's value to others—family, society, their professional community—prohibits their exit. This view is structurally identical to the claim that a person's labor value prohibits their resignation. Both treat the person as a resource to be retained by others' need rather than a subject with sovereign interest in their own existence.

Relationships are vital. They are, for many people, primary reasons to remain. But they cannot function as statutory chains. The fact that a person *can* contribute does not mean they *must*. Continued existence is not a debt owed to the collective, to one's family, or to the state.

2.4 The Depressive Capacity Objection

A targeted form of the paternalist objection holds that persons with treatment-resistant depression cannot satisfy the "appreciation of alternatives" criterion for capacity, because hopelessness functions as a cognitive filter that makes alternatives appear unavailable even when they are formally understood.

This objection deserves direct engagement. The informed refusal framework dissolves it by clarifying what appreciation requires. The question is not whether the person *feels* the alternatives to be viable—this would make the capacity standard dependent on the very symptom being assessed—but whether they *understand* what the alternatives are and what they offer.

A preference that survives full informed disclosure is the operationalization of capacity. To permanently exclude persons with depressive histories on the grounds that their refusals cannot be trusted is to convert a diagnosis into a lifetime disqualifier. This is the paternalism this framework rejects, made explicit.

III. The Two-Stage Capacity Assessment

To distinguish authentic autonomous preference from crisis-state decision-making, this framework proposes a two-stage protocol with a mandatory assessment period.

3.1 Stage 1: Decisional Capacity

The evaluating clinician must assess and document that the applicant demonstrates:

- **Understanding of consequences.** The applicant understands the permanent and irreversible nature of death. This must be assessed, not assumed.
- **Informed awareness of alternatives.** The applicant has received documented presentation of all available alternatives—medical, psychiatric, financial, social, palliative—and understands their realistic outcomes and associated risks. Prior utilization of any alternative is *not* required. Informed refusal of alternatives, following full disclosure, must be respected.
- **Absence of acute distortion.** The applicant is not in an active psychotic state or transient crisis condition that materially undermines comprehension. This is a state assessment, not a diagnostic exclusion: a person with a history of psychosis who is currently stable is not disqualified.
- **Preference stability.** The preference is stable across time and is not reducible to a situational or episodic response to a transient condition. This is assessed through the waiting period and multiple evaluations, not through a single interview.

3.2 Stage 2: Process Comprehension

The applicant must demonstrate willingness to engage with the assessment process itself, including understanding *why* the safeguards exist and accepting them as legitimate. This functions as a mechanical filter for impulsivity.

A person in acute crisis will rarely tolerate a 90-day bureaucratic process with multiple independent evaluations. A person with a resolved, stable autonomous preference can. The process itself is evidence of resolution—not because endurance proves rationality, but because the capacity to engage with a structured procedure across time reflects precisely the stable, reflective orientation that distinguishes autonomous preference from reactive crisis.

> **Diagnostic logic of Stage 2:** A person who claims Stage 1 capacity while refusing to engage with Stage 2 process requirements likely fails Stage 1. Genuine understanding of why safeguards exist—as protections for the applicant, not obstacles—is itself a component of the comprehension required for autonomous decision-making.

IV. Principal Objections and Responses

4.1 The Disability Rights Critique

> Expanding MAiD eligibility, particularly to non-terminal and socioeconomically disadvantaged applicants, does not extend autonomy—it provides the state with a cheaper alternative to adequate supports. Disabled people, people experiencing poverty, and people who are isolated are not choosing death freely; they are choosing death because the state has failed to make life livable. An expanded eligibility framework legitimizes that failure by processing it as autonomous preference.

Response: The critique is partially correct, and that is precisely why this framework does not stop at expanding eligibility.

The disability rights organizations advancing this objection have identified a real phenomenon. Health Canada's 2024 data shows that Track 2 recipients are modestly more likely to reside in lower-income neighborhoods than Track 1 recipients, and that disability and social isolation are prominent documented drivers of "intolerable suffering" claims. The Ontario Chief Coroner's reviews have documented cases in which inadequate housing, income insufficiency, and care gaps appear as primary conditions motivating MAiD requests.

This is not acceptable. The question is what follows from that finding.

The Protectionist position—restrict access, close the exit door—does not resolve the underlying conditions. It adds legal coercion to material deprivation. The person who lacks housing, adequate care, and social connection, and who finds life intolerable as a result, is not made better off by being denied the right to act on that assessment. They are made worse off in a way that is now compelled by the state.

The forcing function argument in Section V of this paper is the substantive answer to the disability rights concern, not a deflection of it:

1. Under the proposed framework, evaluators are *required* to present all available alternatives—housing, income support, disability services, community connection—with sufficient specificity for genuine comprehension. This presentation must be documented.
2. Where an applicant cites inadequate access to these supports as a condition of their preference, the administering authority is *required* to transmit a formal report to relevant government ministries documenting this as a driver of the provision.
3. That documentation creates a public record of state failure. Not a private administrative note—a documentable, aggregable, politically legible record.

The disability rights organizations are right that the state should not offer death as an alternative to adequate care. This framework makes that explicit and structural. Where they

are wrong is in the conclusion: that the remedy is to remove the exit rather than to document, publicize, and politically weaponize the conditions that drive people toward it.

The Protectionist Model has governed most jurisdictions for decades. In those same decades, housing supports have eroded, disability services have been underfunded, psychiatric wait times have grown. Closing the exit has not produced the dignified conditions its defenders claim it would compel. There is no evidence that coerced existence creates political pressure for better lives. There is evidence that documented, state-recorded deaths attributable to inadequate supports create that pressure.

4.2 The Slippery Slope Objection

The concern is that expanding eligibility criteria leads inevitably to expansion of the eligible population in ways that cannot be controlled—that "capacity only" becomes "effectively anyone."

This objection is empirically testable. The relevant data comes from Belgium and the Netherlands, which have operated under broad eligibility criteria—including psychiatric cases—for over two decades. Neither jurisdiction has experienced the predicted exponential expansion or the predicted collapse of safeguards. Utilization has grown modestly and measurably; the demographics of recipients have shifted somewhat; the procedural requirements have been tightened in response to specific case-by-case concerns.

The slippery slope argument proves too much. Applied consistently, it would prohibit any extension of any right on the grounds that extension is logically unlimited. The answer is not to prohibit extension but to design the procedural architecture carefully—which this framework does.

4.3 The External Coercion Objection

The concern is that persons—particularly disabled people, elderly people, and people who experience themselves as burdens—may choose MAiD under subtle or explicit coercive pressure from family members, caregivers, or financial incentives.

This is a legitimate concern and is addressed procedurally rather than by restricting eligibility:

- Every assessment includes a confidential interview with a social worker or independent advocate unaffiliated with the care team.
- Financial and dependency circumstances are reviewed as a standard component.
- Mandatory offer of independent legal assistance for advance planning.
- Revocation is absolute and available until the final moment.

The coercion concern is an argument for robust process, not for categorical exclusion. Categorical exclusion on the basis that coercion *might* be present is itself a coercive act: it over-

rides the expressed preference of the many to protect against the hypothetical victimization of the few.

V. Systemic Consequences: The Right to Exit as Forcing Function

The most profound implication of this framework is not the death of the individual but the reformation of the society that remains.

5.1 From Coercion to Alliance

In a system where the patient possesses the legal right to exit, the clinician loses the power of coercive retention. They cannot function as a custodial jailer mandating existence. Instead, the clinician must become an ally—working to make the patient's life subjectively worth continuing. Therapy shifts from preventing death as an administrative outcome to incentivizing life as a collaborative project. Custodial becomes restorative. This is not a small shift; it is a complete reorientation of the therapeutic relationship.

5.2 The Mandate for Livability

Health Canada's 2024 data already shows the dynamic in embryonic form: Track 2 provisions reached 732 in 2024, up 17% year-over-year, with 61.5% of recipients reporting disability. Total MAiD provisions reached 16,499 in 2024, representing 5.1% of all Canadian deaths. Documented cases cite unaffordable housing, inadequate disability supports, and social isolation as core drivers. These are not anomalies. They are early signals.

Under capacity-based eligibility, the signal becomes undeniable. The state must either document systemic abandonment as a cause of death or prevent it. If a citizen chooses MAiD because they lack housing or adequate care, the administering authority records that failure. Aggregated across a population, that record is a political instrument of the first order.

> **The Survivor's Dividend:** Resources reallocated to ensure that the choice to remain is supported by dignity, not merely permitted by default. The Right to Exit functions as a consumer protection standard for existence: the product must be good enough to retain the user, or the state must explain, on public record, why it was not.

5.3 Correction by Consent

It must be acknowledged directly: this framework will result in what may be termed a *correction by consent*. Some individuals will choose to exit rather than wait for societal improvement that may not arrive in time for them. This is the price of a free society—and the price of having failed them earlier.

The alternative is to compel their continued existence while continuing to fail them. That is not a moral position. It is a policy of managed despair with administrative gatekeeping.

A society that remains by consent rather than by conscription is not a depleted society; it is a more honest one. And it is a society with an undeniable structural incentive to improve the conditions under which the consent to remain is given.

VI. Procedural Architecture

6.1 Mandatory Resource Presentation

Evaluators must present, in sufficient specificity for genuine comprehension, every realistic alternative: housing assistance, income support, disability services, community connection, palliative care, psychiatric intervention, peer support programs. Presentation must be documented. Referral must be offered and, if declined, that declination must be recorded with the applicant's stated reasons.

Informed refusal of any alternative, once its nature and realistic outcomes are understood, must be respected without condition.

6.2 Waiting Periods as Diagnostic Instruments

A minimum assessment period of 90 days applies to all non-terminal applications. This period is not a delay tactic; it is a diagnostic instrument. A preference that cannot survive 90 days of reflection, multiple independent evaluations, and genuine engagement with alternatives is not the settled autonomous preference this framework is designed to recognize.

The period serves a second function: it is the interval during which alternative supports may be arranged and tried. Persons who accept alternative support during this period may withdraw the application without prejudice or stigma at any point.

6.3 Independent Coercion Screening

Every assessment includes:

- Confidential interview by a social worker or independent patient advocate unaffiliated with the treating team and with no institutional stake in the outcome.
- Structured review of financial circumstances, dependency relationships, and any indicators of external pressure.
- Mandatory offer of independent legal assistance for advance planning: wills, powers of attorney, care directives.

6.4 Documentation of Socioeconomic Drivers

Where an applicant identifies inadequate access to housing, income, disability supports, or social connection as a primary or contributing condition of their preference, the administering authority **must** transmit a confidential formal report to the relevant government ministry, documenting these conditions as a driver of the provision. This is not optional. This is the mechanism by which the forcing function operates.

6.5 Revocation

The right to revoke the application is absolute. It may be exercised at any point in the process, for any reason, without explanation, without stigma, and without effect on future access to services. No “death day locked-in” mechanism is permissible.

VII. Model Statutory Language

The following provisions are offered as draft model language for legislative consideration. They are not jurisdiction-specific and require adaptation to local constitutional and statutory frameworks.

Provision	Proposed Language
Eligible Person	Any adult who demonstrates decisional capacity as assessed under this Act. Terminal diagnosis and proof of suffering are not required.
decisional capacity	The demonstrated ability to: (a) understand the permanent and irreversible nature of death; (b) demonstrate informed awareness of available alternatives including medical, psychiatric, financial, and social supports; (c) express a preference stable across the assessment period; and (d) be free from acute psychotic or crisis states that materially distort comprehension. A history of psychiatric diagnosis does not constitute disqualification. Stability is assessed at the time of evaluation.
Informed Refusal	An applicant need not have utilized any alternative prior to application. Documented informed awareness of alternatives and reasons for declining them shall satisfy this element. Evaluators shall assess comprehension of alternatives, not compliance history.
Assessment Period	A minimum of 90 days from first application for non-terminal provisions. Multiple independent evaluations are required within this period. Applications may be withdrawn at any point without prejudice.
Coercion Screening	Every application shall include: (a) confidential assessment by an independent social worker or patient advocate unaffiliated with the care team; (b) structured review of financial and dependency circumstances; (c) mandatory offer of independent legal assistance for advance planning.
Socioeconomic Documentation	Where an applicant identifies inadequate housing, income, disability support, or social connection as a primary or contributing basis for their preference, the administering authority shall transmit a formal report to the relevant ministry documenting these conditions as a driver of the provision.

Provision	Proposed Language
Revocation	The right to revoke is absolute, available without condition or explanation until the moment of provision, and has no adverse effect on future access to services or applications.
Clinician Conscience	No clinician is required to participate in MAiD assessment or provision. Conscientious objectors must provide timely referral to a willing provider. Refusal to refer constitutes patient abandonment.
Standard of Proof	Decisional capacity must be established by clear and convincing evidence across the full assessment period, consistent with the standard applied in guardianship and high-stakes competency determinations. The burden rests on the assessment record.
Evaluator Disagreement	Where independent evaluators reach divergent conclusions on capacity, the matter is referred to an independent Clinical Ethics Committee within fourteen days. Capacity requires reasoned concurrence of at least two evaluators. Unresolved disagreement triggers administrative review.
Review and Appeal	Any applicant whose request is denied has the right to: (a) a fresh independent evaluation by a new panel within 30 days; (b) expedited administrative tribunal review; and (c) judicial review of any adverse tribunal decision. All denials must be in writing with reasoned findings. The administering authority bears the burden of justification on review.

Conclusion: Life as an Opt-In System

This is not advocacy for death.

It is a refusal to treat adult sovereignty as conditional on suffering thresholds, clinical legibility, or social utility. The argument does not require that exit be easy; it requires that exit be possible—and that the conditions under which people choose to remain are documented, legible, and subject to political accountability.

Bar the exit, and presence is conscription: silent, coerced, stripped of moral weight. Unlock it, and presence becomes deliberate affirmation. Every person who remains does so as a choice, not a default. That is the only condition under which the choice means anything.

The alternative is gentler rhetoric concealing a rising body count that we already refuse to name honestly. Replace sanctity-of-life dogma with sovereignty of the living, or acknowledge that the dogma was always about the comfort of those who remain rather than the welfare of

those who suffer.

The door must stand unlocked. What happens next—individually, socially, politically—is then a matter of genuine choice. That is where moral life begins.

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