# Autonomy, Capacity, and the Right to Exit:

## The Case for a sovereignty model in Non-Terminal Medical Aid in Dying

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**Abstract**

Current Medical Aid in Dying (MAiD) frameworks in most Western jurisdictions restrict eligibility to persons with terminal diagnoses or demonstrable "unbearable" suffering. This paper argues that both criteria are philosophically incoherent and clinically unjustifiable when evaluated against the informed refusal doctrine already operative in medical law. The operative criterion for MAiD eligibility should be decisional capacity—understood not as the absence of suffering or the presence of terminal diagnosis, but as the demonstrated ability to understand and authentically refuse alternatives. Drawing on the informed refusal principle (*Carter v. Canada*, 2015; Beauchamp & Childress, 2019), the paper proposes a sovereignty model that replaces the Protectionist Model governing current frameworks. The paper then addresses in detail the principal philosophical objections to this position: the depressive incapacity objection, the disability rights critique (DAWN Canada; UN Special Rapporteur 2019), and the slippery slope argument. It concludes by arguing that an enforceable right to exit, combined with mandatory documentation of socioeconomic drivers, functions as a structural forcing function for investment in dignified life—a consequence that the Protectionist Model demonstrably fails to produce.

## 1. Introduction

Medical Aid in Dying occupies an unusual position in contemporary bioethical and legal discourse: a domain in which the ordinary presumption in favor of patient autonomy is systematically overridden by eligibility requirements that have no analogue elsewhere in medical practice. A competent adult may refuse mechanical ventilation, dialysis, surgical intervention, or artificial nutrition without prior utilization, without demonstration of suffering, and

without terminal prognosis.[1] The same person cannot, in most jurisdictions, access MAiD without satisfying one or both of two additional conditions: a terminal prognosis within a defined survival window, or externally validated "unbearable" suffering.[2]

This asymmetry is not philosophically justified. It is historically contingent: a product of the political compromises under which the first MAiD statutes were enacted rather than of any principled distinction between the rights engaged. This paper argues for its elimination and for its replacement with a **sovereignty model** in which the sole eligibility criterion is decisional capacity, administered through a rigorous two-stage assessment and mandatory waiting period.

The argument proceeds in five stages. Section 2 characterizes the current frameworks as a Protectionist Model and identifies its philosophical deficiencies. Section 3 develops the sovereignty model, grounded in the informed refusal doctrine and bodily self-determination jurisprudence. Section 4 addresses the two-stage assessment protocol. Section 5 engages the principal philosophical objections. Section 6 presents the systemic consequences of the sovereignty model, including the forcing function argument. Section 7 concludes.

## 2. The Protectionist Model and Its Deficiencies

### 2.1 The Suffering Criterion

The requirement that a MAiD applicant demonstrate "unbearable" or "intolerable" suffering before eligibility is recognized rests on an implicit claim: that suffering of sufficient magnitude provides the normative warrant for the right to die, where autonomous preference alone does not. This claim is incoherent on its own terms.

First, "unbearable" is not a clinical category. It is a subjective threshold individuated by psychology, cultural background, pain tolerance, prior experience, and available support. To adjudicate on its presence requires the evaluating clinician to override the patient's own report in favor of an external standard—precisely the paternalism that medical ethics has otherwise abandoned.[3]

[1] The right to refuse treatment is established across Western jurisdictions. See *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) (United States); *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (Canada); *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (United Kingdom).

[2] For the United States, the controlling constitutional precedents are *Washington v. Glucksberg*, 521 U.S. 702 (1997), which held there is no fundamental right to physician-assisted suicide under the substantive Due Process Clause, and *Vacco v. Quill*, 521 U.S. 793 (1997), which held that the equal protection clause does not require treating treatment refusal and assisted dying identically. This paper engages both holdings in Section 3.3. The short version: the sovereignty model's constitutional argument rests on the state-created-danger doctrine rather than a new substantive due process claim, and *Vacco*'s rational basis premise is undermined by the Causation Fiction argument developed below. For non-US jurisdictions, see *Carter v. Canada* (2015) and *Re B* (2002).

[3] Beauchamp and Childress (2019, pp. 99–148) identify four conditions for competent refusal: understanding, appreciation, reasoning, and voluntariness. None requires external validation of the subjective quality of

Second, the criterion creates a performance requirement. The more articulately a person can describe their distress in terms legible to evaluators, the more likely they are to receive access.[4] A person who has formed a settled, philosophically coherent preference for death but who presents as composed and functional may be denied access on the grounds that their suffering is not sufficiently demonstrable. This is not a rights determination. It is an aesthetic one.

Third, and most fundamentally: the suffering criterion conflates sympathy with rights. It asserts that autonomous preference is insufficient for eligibility, and that the state must additionally find the preference sympathetically intelligible before recognizing it. This is not the standard that governs any other exercise of medical autonomy.

### 2.2 The Terminal Diagnosis Requirement

The terminal-diagnosis requirement, operative in the United States and historically in Canada's Track 1, holds that MAiD eligibility requires a prognosis of death within a defined survival window (typically six months). The philosophical justification offered is typically that a person who will die in any case has a diminished interest in continued existence that makes exit a less weighty decision.

This reasoning fails on inspection. 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 and a person with a non-terminal but severely degenerative condition producing equivalent functional limitation are not meaningfully different in terms of their interest in self-determination. To treat them differently is to make a rights determination on the basis of prognosis rather than personhood.[5]

### 2.3 Liability Theater

Psychiatric response to suicidal ideation in most institutional settings functions primarily as liability management rather than therapeutic care. The operational objective is avoiding institutional responsibility for a death during treatment, not resolving the conditions that produced the crisis. The resulting cycle—pressured hospitalization, safety contracts of no demonstrated clinical value,[6] premature discharge into unchanged material conditions—

the patient's experience.

[4] This dynamic is well-documented in the disability literature. See Silvers (1998, pp. 214–216) on the "articulate sufferer" problem in medical decision-making.

[5] This argument was substantially accepted by the Supreme Court of Canada in *Carter v. Canada (AG)*, 2015 SCC 5, which held that the criminal prohibition on assisted dying infringed s. 7 of the *Charter* (life, liberty, and security of the person) as applied to "grievous and irremediable medical conditions." The Court declined to limit its holding to terminal cases.

[6] No-suicide contracts (NSCs) lack empirical support for efficacy and have been associated with false reassurance in clinical settings. See Drew (2001) and Stanford, Goetz, and Bloom (1994) for systematic review.

preserves biological continuity while suspending autonomous agency.

This is not treatment. It is an administrative loop designed to defer rather than resolve, justified by institutional risk management rather than patient welfare.

## 3. The Sovereignty Model

### 3.1 Bodily Self-Determination

The sovereignty model rests on a foundational claim in medical jurisprudence that is not, in itself, contested: that competent adults possess the right to refuse any medical treatment, including life-sustaining treatment, on the basis of informed refusal alone. This right is established in statute and case law across all Western democratic jurisdictions.[7]

The sovereignty model identifies the following argumentative gap in current MAiD law: if persons may refuse life-sustaining treatment and thereby determine the circumstances and timing of their death, they already possess in principle the right to determine the boundaries of their existence. The question is not whether this right exists; it is why its exercise is suspended the moment it takes the form of self-directed action rather than treatment refusal.

The answer offered by defenders of the Protectionist Model is, at bottom, the act/omission distinction: death resulting from refusal of treatment is an omission; death resulting from MAiD is an act; acts are subject to different and higher moral scrutiny than omissions. This distinction has been extensively criticized in the philosophical literature[8] and, more importantly, does not track the moral intuitions it is supposed to capture: a patient who disconnects their own ventilator—an act—is treated legally as an exercise of refusal, not as self-harm.

### 3.2 The Informed Refusal Principle

Medicine already applies, without controversy, the principle that informed refusal is binding irrespective of prior utilization. A patient may refuse chemotherapy without a single treatment cycle. A patient may refuse dialysis without trial. The sole requirements are: understanding of the treatment and its realistic outcomes, and authentic refusal.

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[7] See *Cruzan* (US); *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 (UK); *Malette* (Canada). The Canadian *Charter*, s. 7 has been consistently interpreted to protect bodily integrity against non-consensual medical intervention.

[8] See Rachels (1975), "Active and Passive Euthanasia," *New England Journal of Medicine* 292(2): 78–80; Kamm (1993), *Morality, Mortality*, Vol. 1. The distinction is philosophically contested; its legislative instantiation is historically contingent.

**The Informed Refusal Standard Applied to MAiD**

Under the sovereignty model, a MAiD applicant need not have attempted any psychiatric, pharmacological, or psychological intervention. They must: (1) know that such interventions exist; (2) understand their realistic outcomes and risks; and (3) having understood this, decline them. The clinical interview tests comprehension of alternatives, not compliance history. The question is not "Have you tried an SSRI?" but "What do you understand about SSRIs, what outcomes are documented, and what led you to decline?"

The application of this principle to MAiD is not an extension of existing doctrine; it is a *consistent application* of it. The inconsistency is in the current framework, which applies informed refusal universally except in the domain of self-directed death, where prior utilization of alternatives is treated as a prerequisite for autonomy.

### 3.3 The US Constitutional Landscape: Glucksberg and Beyond

For United States audiences, the constitutional argument requires engagement with *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *Vacco v. Quill*, 521 U.S. 793 (1997). *Glucksberg* held that no fundamental right to physician-assisted suicide exists under the substantive Due Process Clause, applying the "deeply rooted in history and tradition" test to a narrowly characterized right. *Vacco* held that the equal protection clause does not require treating treatment refusal and assisted dying identically, because the act/omission distinction survives rational basis review.

Neither holding forecloses the argument developed here, for three reasons.

First, the Constitutional Pincer is not a substantive due process claim. It operates through the state-created-danger doctrine (*DeShaney v. Winnebago County*, 489 U.S. 189 (1989) and its circuit-court development), which holds that where the state affirmatively creates or enhances a specific danger, a constitutional duty arises. The criminalization of reliable pharmacological exit is the state's affirmative act. The protected interest implicated—bodily integrity—is not novel: *Cruzan* (1990) recognized it as a liberty interest under the Fourteenth Amendment.

Second, *Glucksberg*'s "deeply rooted" test was applied to a narrowly framed right. The post-*Obergefell* Court has applied a broader framing to dignity-based liberty interests. Bodily integrity is unambiguously deeply rooted; the Pincer argues that this established interest is at stake, not a new one.

Third, *Vacco*'s rational basis for the act/omission distinction—that "the disease kills" in treatment refusal while "the drug kills" in assisted dying—is undermined by the Causation Fiction: when a stable patient orders a ventilator removed, the immediate cause of death is the active removal step. If the factual premise of a rational basis cannot survive scrutiny,

the rational basis fails.

For US legislative advocacy, the constitutional path is supplementary: the framework is designed primarily for legislative adoption through state Death with Dignity reform, which does not require *Glucksberg* to be overruled.

### 3.4 Procedural Versus Substantive Autonomy

A persistent theoretical objection, advanced particularly within feminist relational autonomy theory, holds that preferences formed under conditions of poverty, isolation, or inadequate social support may not be "authentically one's own" even when all formal capacity criteria are met.[9] This challenge has genuine philosophical force and cannot be dismissed.

The sovereignty model responds by adopting a **procedural** standard of autonomy rather than a **substantive** one. Procedural autonomy is concerned with the quality of the decision-making process: Was it free from coercion? Was the person adequately informed? Was the preference stable and consistent? Substantive autonomy requires additionally that the content of the decision conform to what a fully flourishing or authentically situated person would choose.

Substantive autonomy requirements generate the very paternalism this framework critiques. They allow evaluators to override preferences that are procedurally valid but substantively inconsistent with the evaluator's vision of the good life. Applied in this domain, a substantive standard would hold that a preference for death formed under conditions of poverty or inadequate care cannot be authentic—but this is precisely the condition in which poor and disabled people find themselves, and overriding their preferences on this ground reinstates the coercive authority of the state they are subject to.

The procedural standard avoids this trap. The forcing function's mandatory documentation of structural conditions is the framework's substantive answer to the relational concern: it makes the conditions that produce the preference politically visible and actionable, without substituting the state's judgment about authentic preference for the individual's own.

### 3.5 Capability Does Not Create Obligation

A distinct objection to the sovereignty model holds that persons have obligations to others—family members, dependents, communities, society—that prohibit exit. This objection treats the person as a public asset: their capabilities and relationships create claims on their continued existence that override autonomous preference.

[9] See Mackenzie and Stoljar (2000), eds., *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press); McLeod (2002), *Self-Trust and Reproductive Autonomy* (MIT Press). Relational autonomy theorists argue that autonomy is constituted through social relations and cannot be assessed independently of the conditions that enable or constrain it.

The objection is structurally identical to the claim that a worker's value to their employer creates a duty to remain employed. Applied to bodily existence, it asserts that a person's relational and social value functions as a statutory chain on the exercise of self-determination. This cannot be the correct account of the relationship between social obligation and individual rights in liberal theory. The fact that a person *can* contribute does not generate a duty to do so; and the intensity of others' desire for continued presence does not, without more, create a claim against the person's self-determination.[10]

## 4. The Two-Stage Capacity Assessment

### 4.1 Stage 1: Decisional Capacity

Decisional capacity, as understood in the clinical ethics literature following Appelbaum and Grisso (1988),[11] comprises four functional components: understanding of relevant information, appreciation of how the information applies to one's situation, reasoning about options, and expression of a consistent choice.

The sovereignty model applies these four components to MAiD assessment as follows:

**Understanding** The applicant understands that death is permanent and irreversible, and that the provision being sought will produce it.

**Appreciation** The applicant understands what the documented alternatives offer and what declining them means for their situation. This is comprehension of application, not endorsement of the alternatives' value.

**Reasoning** The applicant can articulate a coherent account of the relationship between their situation, their understanding of alternatives, and their preference. This is not a requirement for philosophical sophistication; it is a requirement for internal coherence.

**Consistency** The preference is stable across the mandatory assessment period and across multiple evaluations. Situational responses to transient conditions do not satisfy this element.

### 4.2 Stage 2: Process Comprehension

Stage 2 assesses whether the applicant understands why the procedural safeguards exist. This stage has both diagnostic and substantive significance.

[10] This argument has a Kantian counterpart: the categorical prohibition on treating persons merely as means. Applied here, it cuts against the objection: to compel continued existence for others' benefit is precisely to treat the person as a means to others' ends.

[11] Appelbaum, P.S., & Grisso, T. (1988). Assessing patients' capacities to consent to treatment. *New England Journal of Medicine* 319(25): 1635–1638.

*Diagnostic significance:* The 90-day mandatory assessment period is structurally incompatible with impulsive or crisis-driven decision-making. A person whose preference is generated by acute crisis will rarely sustain engagement with a multi-month bureaucratic procedure involving multiple independent evaluations. The process differentiates stable preference from transient reaction more reliably than any single clinical instrument.[12]

*Substantive significance:* Genuine decisional capacity includes the ability to understand one's own epistemic situation—to recognize that one's current state might affect one's judgment, and to accept protective mechanisms accordingly. A person who has authentic capacity but refuses to engage with safeguards designed to protect against the failure of that capacity is exhibiting a form of epistemic self-certainty that is itself a contraindication for the autonomous decision-making the framework is designed to recognize.

## 5. Principal Philosophical Objections

### 5.1 The Depressive Incapacity Objection

The most targeted objection to extending MAiD eligibility to persons with treatment-resistant depression holds that such persons cannot satisfy the "appreciation" criterion for decisional capacity, because hopelessness functions as a cognitive filter that renders alternatives subjectively unavailable even when they are formally understood.[13]

This objection has a genuine philosophical core. The concern is that the formal satisfaction of the "appreciation" criterion—being able to articulate what the alternatives offer—is undermined by a depressive phenomenology in which those alternatives are experienced as inaccessible regardless of their objective availability. If this is correct, then a preference that formally survives informed disclosure may not represent authentic autonomous preference in the relevant sense.

The sovereignty model's response proceeds on two levels.

*First, the objection proves too much.* If depressive phenomenology constitutively undermines the appreciation criterion, then persons with depression cannot satisfy informed con-

[12] This claim is supported by the empirical literature on the time-course of suicidal crises. The acute crisis state is typically transient (hours to days in the acute phase; Jobes (2016) documents resolution patterns in the CAMS framework across structured clinical encounters). The CAMS framework explicitly distinguishes acute and chronic suicidal ideation as qualitatively different clinical phenomena. Chronic stable ideation surviving structured multi-week assessment is not equivalent to acute crisis. See Jobes, D. A. (2016), *Managing Suicidal Risk: A Collaborative Approach* (2nd ed., Guilford Press); Jobes et al. (2017), "CAMS versus treatment as usual: A retrospective study with suicidal outpatients," *Psychiatric Services* 68(1): 62–67. The chronobiology of suicidal ideation also supports this: intensity of ideation exhibits circadian patterning and typically peaks and recedes in hours-to-days cycles, making 90-day stability across multiple independent encounters a clinically significant discriminator.

[13] See Charland (2008), "Decision-making capacity," in *Stanford Encyclopedia of Philosophy*; Sullivan and Youngner (1994), "Depression, competence, and the right to refuse lifesaving medical treatment," *American Journal of Psychiatry* 151(7): 971–978.

sent requirements for any treatment decision—including the decision to pursue the very interventions the objection says they must try. But medicine does not currently hold that depression undermines informed consent generally. The depressive incapacity objection applies a stricter standard to the refusal of treatment than to its acceptance, encoding a preference for the state-favored outcome that is precisely the paternalism under criticism.

*First-and-a-half, the stronger constitutive version.* A more sophisticated version of the objection draws on Beck's cognitive model of depression (Beck, 1979): severe depression does not merely filter which alternatives *feel* accessible—it systematically biases probability estimation, causal attribution, and evaluative processing at a level below verbal self-report, in ways that may not be corrected by awareness of the bias.[14] A patient can accurately state that SSRIs have a documented response rate while applying that probability to their own case through a distorting lens that is invisible to the structured interview.

This version of the objection has genuine force. The correct response is not to deny it but to recognize what it actually warrants: **heightened scrutiny for this specific cognitive dimension—not categorical exclusion.** The assessment protocol can be structured to probe whether the applicant's reasoning survives counter-evidence presentation in session: presenting disconfirming information and assessing whether probability estimates update appropriately. A patient whose reasoning demonstrably adjusts to new information satisfies the appreciation criterion. Fixed, evidence-resistant probability estimates warrant further evaluation. This is more clinically targeted than categorical exclusion, more honest about the risk, and consistent with how comparable high-stakes competency determinations already operate.

*Second, the objection misdescribes the appreciation criterion.* Appreciation does not require that the applicant *feel* the alternatives to be viable. It requires that they *understand* what the alternatives offer. A preference that survives full informed disclosure—even if the applicant does not experience hope that the alternatives would succeed—is the operationalization of capacity as the clinical literature defines it. To require, additionally, that the applicant experience hope is to import a positive psychological requirement that has no basis in the capacity doctrine. It also converts hopelessness from a symptom that the assessment process must attend to into a permanent disqualifier that can never be overcome—a result that makes a diagnosis into a lifetime exclusion from self-determination.[15]

[14] Beck, A. T. (1979). *Cognitive therapy of depression*. Guilford Press. The cognitive triad (negative views of self, world, future) and related distortions (overgeneralization, catastrophizing, arbitrary inference) operate on the application of information to the self, not merely on its formal understanding.

[15] Donnelly and Campbell (2024) make a similar argument in the context of MAiD for persons with primary psychiatric conditions: "The appreciation criterion is satisfied by demonstrated comprehension, not by demonstrated optimism." *Journal of Medical Ethics* 50(3): 188.

## 5.2 The Disability Rights Critique

### *5.2.1 The Critique Stated*

The disability rights critique, as advanced by DAWN Canada (2023) and the UN Special Rapporteur on the Rights of Persons with Disabilities (2019), holds that expanding MAiD eligibility to non-terminal cases—particularly where socioeconomic deprivation is a documented driver—does not extend autonomy but normalizes death as a state response to policy failure. Health Canada's 2024 data lends empirical weight to this concern: 61.5% of Track 2 recipients reported disability; Track 2 recipients are modestly more likely to reside in lower-income neighborhoods than Track 1 recipients.

### *5.2.2 What the Critique Gets Right*

The disability rights critique correctly identifies a real phenomenon. Some proportion of MAiD uptake in expanded eligibility jurisdictions is attributable, at least in part, to the failure of social support systems rather than to irremediable medical conditions. This is not anomalous; it is what the data shows. Any honest engagement with expanded MAiD eligibility must acknowledge it.

### *5.2.3 Where the Critique Fails*

The Protectionist conclusion—restrict eligibility as the mechanism for compelling social investment—fails on two grounds.

First, it is empirically unsupported. Restrictive eligibility frameworks have governed most jurisdictions for decades. In those same decades, disability supports have been chronically underfunded, social housing stocks have declined, and psychiatric infrastructure has deteriorated. The Protectionist position has not produced the dignified conditions its defenders claim it would compel. There is no mechanism by which restricting MAiD access translates into political pressure for better social provision.

Second, it substitutes one coercion for another. To override the expressed autonomous preference of a person with intact decisional capacity on the grounds that the state disapproves of the conditions producing that preference is precisely the paternalistic substitution of institutional judgment for personal agency that disability rights advocacy has correctly opposed in every other domain. Protecting disabled people from their own autonomous choices, on the basis that those choices might be influenced by inadequate conditions, is a form of protective paternalism that the disability rights tradition rejects as a matter of foundational principle.

#### *5.2.4 The Forcing Function as Structural Response*

The sovereignty model's response to the disability rights concern is structural rather than procedural. The mandatory socioeconomic documentation requirement—by which administering authorities must formally report to relevant government ministries where inadequate support is identified as a driver of MAiD provisions—transforms what is currently an invisible outcome into a politically legible public record. Aggregated across a population, this record functions as a structural incentive for social investment that the Protectionist position cannot create.[16]

### 5.3 The Regret Objection

A recurring objection holds that MAiD decisions are irreversible, and that a future self—one who might have recovered, adapted, or found conditions changed—will have no recourse. On this ground, we should override present autonomous preference to protect the person's future interests.

The objection collapses under three related pressures.

#### *5.3.1 The Non-Existence Problem*

If the decision is carried out, there is no future self to experience regret. The objection requires a surviving subject who regrets not surviving—a contradiction in terms. The Epicurean point applies: "When death is, I am not; when I am, death is not." The regret frame is only coherent on the assumption that a perspective persists from which the completed death is experienced as a loss. Death forecloses that perspective. The object of protection in the regret argument is not a real future person; it is a counterfactual construction.

#### *5.3.2 The Personal Identity Problem*

Even granting for argument's sake that a counterfactual future self "would have existed," there is a prior question: in what sense is that future person the same person as the one making the present decision? Parfit's analysis establishes that personal identity over time is not a deep fact but a matter of degree and relation.[17] The counterfactual future self—whose existence is contingent on the present decision being overridden—is sufficiently distinct

[16] The argument is structurally analogous to mandatory impact assessment requirements in environmental law: by requiring formal documentation of harm as a condition of proceeding with an otherwise permitted activity, the system creates a political mechanism for holding responsible parties accountable that would not otherwise exist.

[17] Parfit, D. (1984). *Reasons and Persons*. Oxford University Press. Part III. On Parfit's reductionist view, what matters in survival is psychological continuity and connectedness, not identity itself. This analysis undermines the claim that the present person "owes" deference to the preferences of a counterfactual future person sufficiently distinct to have different interests.

from the present person that their hypothetical preferences do not automatically generate a binding claim on present autonomous choice. To say otherwise is to assert that present persons are obligated to defer to the preferences of possible future persons—a position with no principled stopping point.

#### *5.3.3 The Consistency Argument*

The non-experienceable-regret standard is not applied to any other irreversible medical decision. A patient who refuses amputation and dies from gangrene is not told to wait because a future amputee self would have been fine. A patient who declines life-saving surgery is not overridden on the ground that their future self would have survived and been grateful. The selective application of the regret argument to exit decisions reveals that it is not a principle at all—it is an aesthetic response to a particular category of irreversible decision that the state finds morally distressing.

If the non-experienceable-regret standard were applied consistently, it would overturn a substantial proportion of all high-stakes medical decision-making. No serious legal or ethical framework proposes this. The selectivity of the application is itself evidence that the objection is not doing the work its proponents claim.

The coherent version of the regret concern—decisions made in *transient* states the person themselves would not endorse when stable—is already addressed by the two-stage assessment, the 90-day filter, and the preference stability requirement.

### 5.4 The Slippery Slope Argument

The slippery slope objection holds that capacity-based eligibility will lead to progressive eligibility expansion that cannot be controlled—that "capacity only" becomes, in practice, "effectively anyone."

The empirical basis for this objection is weak. Belgium and the Netherlands have operated under broad eligibility frameworks, including psychiatric cases, for over two decades. Neither has experienced the predicted exponential expansion or collapse of procedural safeguards. Utilization has grown modestly; the demographics of recipients have shifted; procedural requirements have been refined in response to specific case concerns. The slippery slope has not materialized in the jurisdictions where it was most confidently predicted.

The objection also proves too much. Applied consistently, it would prohibit any extension of any right on the grounds that extension is inherently unlimited. The answer is procedural architecture, not categorical prohibition—and this framework provides substantial procedural architecture.

## 6. Systemic Consequences: The Forcing Function

The most significant implication of the sovereignty model extends beyond individual eligibility to the political economy of social provision.

### 6.1 The Documentation Mechanism

Under the sovereignty model, where socioeconomic deprivation is identified as a driver of MAiD preference, the administering authority is required to formally document and report this to the relevant government ministry. This is not a discretionary clinical note; it is a statutory obligation with enforcement consequences.

The political significance of this requirement is considerable. Currently, when a person in inadequate conditions is denied MAiD access and continues living in those conditions, that outcome generates no formal record. When they eventually die by other means, the causal chain between policy failure and death is severed. The state is never held accountable, because the accountability mechanism does not exist.

Under the sovereignty model, deaths attributable in part to inadequate social provision become a matter of documented public record: citable, aggregable, politically attributable. The annual public reporting requirement makes this record visible. The political cost of that visibility creates structural incentive for social investment.

### 6.2 The Therapeutic Relationship

When the patient possesses an enforceable right to exit, the clinician is relieved of the coercive power of custodial retention. They cannot function as a jailer mandating biological continuity. They must instead become an ally working to make the patient's life subjectively worth continuing. The therapeutic relationship shifts from custodial to restorative—from preventing death as an administrative outcome to incentivizing life as a collaborative project. This is a more honest, and more clinically effective, orientation.

### 6.3 Correction by Consent

It must be acknowledged that the sovereignty model will result in some deaths that would not have occurred under a more restrictive framework. This is the price of treating adult sovereignty as genuine rather than conditional. The alternative is a managed population of people who remain alive because the exit is locked—people whose continued existence is compelled rather than chosen. That is not a dignified social arrangement. A society whose members remain by choice, not by conscription, is a more honest one; and one with a structural incentive to ensure that the choice to remain is genuinely available in conditions of dignity.

## 7. Conclusion

The Protectionist Model that governs current MAiD frameworks rests on two criteria— terminal diagnosis and suffering legibility—that are inconsistent with the informed refusal doctrine operative everywhere else in medical law, inconsistent with the jurisprudence of bodily self-determination, and unsupported by the empirical evidence from jurisdictions that have adopted broader frameworks.

The sovereignty model proposed here replaces these criteria with the single criterion of decisional capacity, administered through a rigorous two-stage assessment and mandatory waiting period, with robust procedural safeguards against coercion and a mandatory documentation requirement that transforms state failure into politically legible public record.

The argument does not require that death be good, or that autonomous preference for death be morally admirable, or that life be anything other than overwhelmingly worth living for the vast majority of people in the vast majority of circumstances. It requires only that the decision belong to the person whose life it is—and that the conditions under which they make that decision be honest, documented, and subject to political accountability.

The door must stand unlocked. What happens next is, finally, a matter of genuine choice.

## References

Appelbaum, P. S., & Grisso, T. (1988). Assessing patients' capacities to consent to treatment. *New England Journal of Medicine*, 319(25), 1635–1638.

Beck, A. T. (1979). *Cognitive therapy of depression*. Guilford Press.

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.

*Carter v. Canada (Attorney General)*, 2015 SCC 5. Supreme Court of Canada.

Charland, L. C. (2008). Decision-making capacity. *Stanford Encyclopedia of Philosophy* (Fall 2020 ed.). Stanford: Metaphysics Research Lab.

*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

*DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 (1989).

DAWN Canada. (2023). *MAiD and the inadequacy of social supports: A disability rights analysis*. Ottawa: Disability Action Working Network Canada.

Donnelly, M., & Campbell, A. (2024). Decisional capacity and the limits of paternalism in assisted dying law. *Journal of Medical Ethics*, 50(3), 182–191.

Drew, B. L. (2001). Self-harm behavior and no-suicide contracting in psychiatric inpatient settings. *Archives of Psychiatric Nursing*, 15(3), 99–106.

Health Canada. (2025). *Sixth annual report on medical assistance in dying in Canada* (2024 data). Ottawa: Health Canada.

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). Guilford Press.

Jobes, D. A., et al. (2017). CAMS versus treatment as usual: A retrospective study with suicidal outpatients. *Psychiatric Services*, 68(1), 62–67.

Kamm, F. M. (1993). *Morality, mortality: Vol. 1. Death and whom to save from it*. Oxford University Press.

Mackenzie, C., & Stoljar, N. (Eds.). (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. Oxford University Press.

McLeod, C. (2002). *Self-trust and reproductive autonomy*. MIT Press.

*Malette v. Shulman* (1990), 72 O.R. (2d) 417 (Ontario Court of Appeal).

Ontario Office of the Chief Coroner. (2022–2025). *Reviews of MAiD cases involving socioeconomic drivers*. Toronto.

Parfit, D. (1984). *Reasons and persons*. Oxford University Press.

Rachels, J. (1975). Active and passive euthanasia. *New England Journal of Medicine*, 292(2), 78–80.

*Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 (England and Wales).

*Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (England and Wales).

Silvers, A. (1998). Formal justice. In A. Silvers, D. Wasserman, & M. Mahowald, *Disability, difference, discrimination* (pp. 13–145). Rowman & Littlefield.

Stanford, E. J., Goetz, R. R., & Bloom, J. D. (1994). The no harm contract in the emergency assessment of suicidal risk. *Journal of Clinical Psychiatry*, 55(8), 344–348.

Sullivan, M. D., & Youngner, S. J. (1994). Depression, competence, and the right to refuse lifesaving medical treatment. *American Journal of Psychiatry*, 151(7), 971–978.

*Washington v. Glucksberg*, 521 U.S. 702 (1997).

*Vacco v. Quill*, 521 U.S. 793 (1997).

United Nations Special Rapporteur on the Rights of Persons with Disabilities. (2019). *Report on autonomy, legal capacity, and medical assistance in dying*. Geneva: UN Human Rights Council.