AUTONOMY, CAPACITY, AND THE RIGHT TO EXIT

A Clinical and Medical Ethics Brief on Capacity-Based MAiD

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Author: Justin Bogner
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Document Suite

This document is one of five in the *Autonomy, Capacity, and the Right to Exit* policy suite (Bogner, 2026). The Master Policy Packet contains the complete philosophical argument, all data, and full procedural architecture. Audience-specific briefs are available for Legislative, Clinical/Medical Ethics, Academic, and Advocacy audiences.

Purpose and Audience

This brief is written for clinical ethics committees, psychiatrists, psychiatric nurses, hospital administrators, and medical associations engaged with Medical Aid in Dying policy. It addresses: (1) the clinical coherence of a capacity-based eligibility standard; (2) the assessment protocol proposed under this framework; (3) the empirical record from existing capacity-based regimes; (4) the implications for the therapeutic relationship; (5) professional liability considerations; and (6) specific clinical objections, including the depressive incapacity objection.

I. The Clinical Incoherence of Current Frameworks

1.1 The Informed Refusal Doctrine and Its Inconsistent Application

The foundational principle of modern medical ethics is informed consent: a competent patient may refuse any treatment, including life-sustaining treatment, on the basis of their understanding of the treatment and its outcomes, without prior utilization and without justification to the

treating clinician.[1]

The clinical inconsistency in current MAiD frameworks is notable: this same doctrine is not applied to the decision to seek self-directed death. A patient may refuse chemotherapy without trial; they may not, in most jurisdictions, access MAiD without demonstrating terminal prognosis or externally validated suffering. The asymmetry is not clinically justified. It reflects historical and legislative contingency, not principled medical ethics.

1.2 Suffering as a Construct Lacking Clinical Operationalization

"Unbearable suffering" is a legislative construct that clinical staff are asked to operationalize without the validated instruments and inter-rater reliability that capacity assessment has achieved. The Dutch SCEN protocol and the Belgian regional review commissions have produced working definitions, but these have not yielded the kind of standardized assessment frameworks that exist for decisional capacity. The result is that eligibility assessment under suffering-based frameworks is: (a) subject to inter-rater unreliability; (b) sensitive to clinician bias toward or against MAiD provision; (c) dependent on the applicant's ability to articulate subjective distress in terms intelligible to the evaluator.

Capacity, by contrast, is a clinical concept with an established empirical literature, validated assessment instruments, and cross-disciplinary consensus.[2] Replacing suffering with capacity as the eligibility criterion does not lower clinical standards; it *raises* them by substituting a measurable, clinically grounded concept for a legally constructed but clinically unmoored one.

II. The Capacity Assessment Protocol

2.1 Operationalizing Capacity for MAiD Assessment

The sovereignty model applies the four-element Appelbaum-Grisso framework to MAiD:

Understanding The applicant can accurately describe what death involves (permanent, irreversible cessation), what the proposed provision entails, and what the realistic outcomes of all presented alternatives are. Understanding is assessed through structured interview, not assumption.

[1] This principle is codified in legislation across jurisdictions (*Health Care Consent Act*, Ontario, 1996; *Patient Self-Determination Act*, US, 1990) and affirmed in case law. See *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (right to refuse emergency treatment); *Re B* [2002] 2 All ER 449 (right to refuse ventilator).

[2] Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med* 1988;319(25):1635–1638. Moye J, Marson DC. Assessment of decision-making capacity in older adults: an emerging area of practice and research. *J Gerontol B Psychol Sci Soc Sci* 2007;62(1):P3–P11.

Appreciation The applicant understands how the general information applies to their specific situation. Appreciation does not require optimism about alternatives; it requires demonstrated recognition that the information is relevant to their case. The evaluating clinician distinguishes between a patient who says "SSRIs don't work for anyone" (failure of understanding) and one who says "SSRIs have a documented response rate of approximately 50% for moderate depression; my history includes two adequate trials without response" (appreciation satisfied).

Reasoning The applicant can articulate a coherent account of how their understanding of their situation, the alternatives, and their values leads to their expressed preference. The reasoning need not be philosophically sophisticated; it must be internally coherent and free from gross logical errors or fixed false beliefs.

Expression of a Consistent Choice The preference is stable across the assessment period and across multiple evaluation contexts. Contextual variation (presenting differently to different evaluators) is diagnostically relevant. Persistent stability across 90 days and multiple independent evaluations satisfies this element.

2.2 The Evaluating Clinician's Role

The role of the evaluating clinician under this framework is fundamentally different from the role assigned under suffering-based frameworks.

Dimension	Protectionist Model	Sovereignty Model
Primary question	Is this person suffering enough?	Does this person understand what they are deciding?
Role	Gatekeeper / adjudicator of suffering	Assessor of comprehension and stability
Treatment history	Required; exhaustion of alternatives typical prerequisite	Irrelevant to eligibility; comprehension of alternatives is assessed
Clinical instrument	None standardized; clinician judgment on suffering	Appelbaum-Grisso framework; standardized capacity assessment
Liability orientation	Institutional (avoid death on our watch)	Patient-centered (assess authentic preference)
Therapeutic role	Custodial retention	Restorative alliance

Table 1: Comparison of clinician roles under Protectionist and Sovereignty models.

2.3 Why 90 Days

The minimum 90-day assessment period is calibrated to clinical reality rather than legislative convenience. Three considerations support it. First, an adequate antidepressant trial requires 6–12 weeks; a stability assessment that runs shorter than this cannot meaningfully evaluate whether the preference survives a fluctuation cycle. Second, 90 days spans typical episodic variability in mood disorders, allowing evaluators to observe the preference across periods of relative improvement and relative worsening. Third, the 90 days is a floor, not a ceiling: complex presentations warrant longer assessment, and the framework specifies no maximum. The Dutch and Belgian regimes use "durable wish" language without numerical anchors; the proposal here trades some flexibility for procedural clarity, on the judgment that a published minimum is more defensible than an unspecified "stability" standard, which is subject to evaluator variance.

2.4 Treatment-Resistant Depression: A Moving Landscape

The alternatives presentation requirement is dynamic, not static. The clinical landscape for treatment-resistant depression has changed materially since the frameworks governing most MAiD statutes were drafted. Evaluators must present the current state of the field, not its 2016 equivalent. Response rate figures below are taken from the conservative end of the available meta-analytic and pivotal-trial estimates.

Esketamine (Spravato) FDA-approved March 2019 for treatment-resistant depression. Intranasal administration; rapid onset (hours rather than weeks); response rates in TRD populations approximately 50–60% in short-term trials, with statistically significant superiority over placebo plus active oral antidepressant (NNT for response approximately 6).[3] Durability at 6–12 months is less established. REMS certification required for prescribers and dispensing facilities. An applicant who has not been presented with esketamine as an option has not received an adequate alternatives presentation for a TRD assessment.

Repetitive Transcranial Magnetic Stimulation (rTMS) FDA-cleared for major depressive disorder; pooled response rates approximately 29% in primary meta-analytic samples, with consistent statistical superiority over sham (NNT approximately 5).[4] More recent network meta-analyses confirm efficacy with somewhat higher point estimates depending on stimulation

[3] Fedgchin M, Trivedi M, Daly EJ, et al. Efficacy and safety of fixed-dose esketamine nasal spray combined with a new oral antidepressant in treatment-resistant depression: results of a randomized, double-blind, active-controlled study (TRANSFORM-1). *Int J Neuropsychopharmacol* 2019;22(10):616–630. Pooled meta-analytic estimates: response RR 1.28 (95% CI 1.12–1.46), remission RR 1.39 (95% CI 1.18–1.63).

[4] Berlim MT, van den Eynde F, Tovar-Perdomo S, Daskalakis ZJ. Response, remission and drop-out rates following high-frequency repetitive transcranial magnetic stimulation (rTMS) for treating major depression: a systematic review and meta-analysis of randomized, double-blind and sham-controlled trials. *Psychol Med* 2014;44(2):225–239.

parameters. Non-invasive; no anesthesia required; outpatient protocol. Growing evidence base for accelerated TMS protocols (intensive daily sessions).

Electroconvulsive Therapy (ECT) Remains the highest-response-rate intervention for severe depression: pooled response rates approximately 74% in unipolar major depressive episode, with remission rates of approximately 52% overall.[5] Efficacy is reduced but still substantial in TRD specifically: remission rates of approximately 48% in patients with prior pharmacotherapy failure compared with 65% in patients without.[6] Underutilized due to stigma and access limitations, not efficacy. Durability requires continuation strategies; relapse without continuation pharmacotherapy or maintenance ECT is substantial. Evaluators presenting alternatives must include ECT with accurate efficacy and risk information, not a stigma-inflected summary.

Ketamine (IV) Off-label; rapid antidepressant effect; response rates in TRD approximately 50–65% in short-term trials. Access variable; mechanism distinct from conventional antidepressants; evidence base growing.

The framework's response to this landscape is precisely the one that avoids paternalism: the question is not whether the applicant has tried these modalities, but whether they understand what each offers and have declined following genuine comprehension. Informed refusal of esketamine is as valid as informed refusal of a second SSRI. The evaluator's obligation is to ensure the refusal is genuinely informed—which requires knowing that esketamine exists.

2.5 What the Clinical Interview Is Not

The clinical interview under the sovereignty model is not:

- A session designed to persuade the patient to choose differently. The clinician presents alternatives in sufficient specificity for genuine comprehension; they do not advocate for any alternative.
- An assessment of whether the clinician agrees with the patient's values or finds their reasoning compelling. Clinicians routinely work with patients whose values differ from their own without this constituting an eligibility barrier.
- An opportunity to require trial of interventions the patient has declined. Informed refusal of alternatives is binding. The clinical interview's role is to assess whether the refusal is informed, not to override it.

[5] Bahji A, Hawken ER, Sepehry AA, Cabrera CA, Vazquez G. ECT beyond unipolar major depression: systematic review and meta-analysis of electroconvulsive therapy in bipolar depression. *Acta Psychiatr Scand* 2019;139(3):214–226.

[6] Heijnen WT, Birkenhäger TK, Wierdsma AI, van den Broek WW. Antidepressant pharmacotherapy failure and response to subsequent electroconvulsive therapy: a meta-analysis. *J Clin Psychopharmacol* 2010;30(5):616–619.

III. The Empirical Record from Capacity-Based Regimes

Any clinical brief proposing a capacity-based standard must engage with the empirical record from the jurisdictions that already operate one. The relevant data come primarily from the Netherlands and Belgium.

3.1 The Kim 2016 Findings

The most-cited empirical analysis of psychiatric MAiD outcomes is Kim, De Vries, and Peteet's 2016 review of 66 Dutch psychiatric euthanasia cases from 2011 to 2014.[7] The findings are not flattering to the Dutch regime as practiced and must be addressed directly.

The study found that 56% of psychiatric EAS recipients were described in case reports as socially isolated or lonely; 32% had been refused EAS by at least one physician before ultimately receiving it, with most of the redirected cases handled by a single mobile End-of-Life Clinic; in 11% of cases there was no independent psychiatric consultation; and physician disagreement about eligibility was common but the regional review committees generally deferred to the judgments of the providing physicians. The companion analysis of capacity evaluations specifically (Doernberg, Peteet, and Kim, 2016) reached similar conclusions about variability in how the four-element framework was applied.[8]

3.2 What the Sovereignty Model's Protocol Is Designed to Address

These findings are the procedural failure modes the protocol specified in this brief is designed to prevent. The mapping is direct.

The Kim findings show that a substantial minority of cases were redirected to a single willing-provider clinic after refusal elsewhere. The sovereignty model's response is the multi-evaluator concurrence requirement (§4.3): a finding of capacity requires reasoned concurrence on each functional element by at least two independent evaluators, not a workaround through a willing third party.

The Kim findings document that 56% of cases involved social isolation or loneliness as a reported feature. The sovereignty model's response is the independent coercion screening by an unaffiliated social worker or advocate, the financial and dependency circumstances review, and the explicit socioeconomic documentation requirement where inadequate support is identified as a driver. These are not optional. They are required elements of every assessment.

[7] Kim SYH, De Vries RG, Peteet JR. Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry* 2016;73(4):362–368. doi:10.1001/jamapsychiatry.2015.2887.

[8] Doernberg SN, Peteet JR, Kim SYH. Capacity evaluations of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics* 2016;57(6): 556–565. doi:10.1016/j.psym.2016.06.005.

The Kim findings document that 11% of cases proceeded without independent psychiatric consultation. The sovereignty model's response is that independent psychiatric evaluation is mandatory, not advisory.

The Kim findings document that review committees deferred to physician judgment rather than examining contested decisions de novo. The sovereignty model's response is the graduated review structure: explicit documentation of any divergent findings, mandatory Clinical Ethics Committee referral within fourteen days for unresolved disagreement, and administrative review with documented reasoned findings if the disagreement persists.

A clinical reader should not read the Dutch experience as evidence against capacity-based assessment. The Dutch regime is not a controlled implementation of the sovereignty model; it is a different regime, with documented procedural gaps, and it shows precisely where a more rigorous protocol must close those gaps.

IV. The Depressive Incapacity Objection: Clinical Analysis

This is the objection most frequently raised in clinical contexts, and it deserves careful clinical analysis rather than brief dismissal.

4.1 The Objection

Persons with treatment-resistant depression cannot satisfy the "appreciation" criterion for decisional capacity because hopelessness functions as a cognitive filter: alternatives are formally understood but experienced as inaccessible. On this account, a capacity assessment that returns "capacity present" in a person with severe depression is a false positive—the capacity criteria have been formally satisfied, but the authentic preconditions for autonomous preference are absent.

4.2 The Clinical Response

4.2.1 Depression does not uniformly impair capacity

The empirical literature does not support the proposition that depression, including severe depression, uniformly impairs the functional elements of decisional capacity. The MacArthur Treatment Competence Study found that significant impairments in decisional abilities affected only a minority of patients with major depression, with deficits less pronounced than among patients with schizophrenia.[9] Vollmann et al. (2003) found that on physician clinical assessment

[9] Grisso T, Appelbaum PS. The MacArthur Treatment Competence Study. III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior* 1995;19(2):149–174.

2.9% of depressed inpatients were judged incompetent, rising to approximately 20% under formal MacCAT-T administration with stricter cut-offs—meaning that even on the most demanding formal standard, four out of five depressed inpatients retained capacity.[10] The 2013 systematic review by Hindmarch, Hotopf, and Owen reaffirmed that capacity impairment in depression is variable, correlated with severity, and not reliably predicted by diagnosis alone.[11] Across studies, the consistent finding is that the majority of patients with depression—including inpatient samples—retain decisional capacity for treatment decisions on rigorous formal assessment.

The implication is direct: a categorical "depression negates capacity" inference is not supported by the data. Capacity is decision-specific, varies by severity, and must be assessed individually rather than presumed absent on diagnostic grounds.

4.2.2 Appreciation does not require experiential access

The appreciation criterion requires that the patient understand how the information applies to their situation. It does not require that they *experience* alternatives as accessible. A patient who accurately states that SSRIs have a documented response rate for their condition, that two adequate trials without response are in their record, and that they decline further trials because the probability of benefit does not, in their assessment, justify the cost—satisfies the appreciation criterion. The criterion is epistemic, not phenomenological.

To require, additionally, that the patient *feel hope* that alternatives might succeed is to import a positive affective requirement that has no basis in the Appelbaum-Grisso framework and no precedent in clinical capacity doctrine. It also creates an impossible standard: hopelessness is a symptom of the condition being assessed; requiring its absence as a precondition for capacity makes the capacity determination circular.

4.2.3 The double standard problem

The depressive incapacity objection, applied consistently, would require that persons with depression satisfy a higher capacity standard than persons without depression for all medical decisions. But medicine does not currently impose this: a patient with severe depression who accepts pharmacological treatment does not have their capacity for that decision specially scrutinized. The heightened scrutiny applies only when the decision is to refuse the state-preferred intervention—revealing that the objection is not about capacity at all, but about the outcome.[12]

[10] Vollmann J, Bauer A, Danker-Hopfe H, Helmchen H. Competence of mentally ill patients: a comparative empirical study. *Psychological Medicine* 2003;33(8): 1463–1471.

[11] Hindmarch T, Hotopf M, Owen GS. Depression and decision-making capacity for treatment or research: a systematic review. *BMC Medical Ethics* 2013;14:54. doi:10.1186/1472-6939-14-54.

[12] This asymmetric scrutiny is well-documented. See Astrachan IM, Keene AR, Kim SYH. Questioning our presumptions about the presumption of capacity. *J Med Ethics* 2024;50(7):471–475. doi:10.1136/jme-2023-109199. See also Owen GS, Szmukler G, Richardson G, et al. Mental capacity and psychiatric in-patients: implications for

4.3 The Clinical Protocol Response

The sovereignty model does not ignore the depressive incapacity concern. It addresses it procedurally. A preference that is generated by acute depressive crisis is unlikely to be stable across 90 days of assessment. A preference that survives the assessment period—including periods of relative improvement and relative worsening—and that is articulated consistently across multiple independent evaluations, has survived the procedural filter that the objection is concerned about. The process is the response.

V. Evaluator Disagreement: Clinical Governance

The multi-evaluator requirement raises a governance question that must be addressed explicitly: what happens when independent evaluators reach different conclusions about the presence of decisional capacity?

5.1 Why Disagreement Occurs

Capacity assessments in complex psychiatric presentations are clinically challenging. Reasonable evaluators applying the same criteria to the same patient may weigh the functional elements differently: one assessor may find the applicant's appreciation criterion satisfied while another finds evidence of cognitive distortion affecting probability estimation. Pretending this does not occur is not clinical honesty.[13]

5.2 The Protocol

The proposed governance protocol for evaluator disagreement operates in three steps:

1. **Documentation of disagreement.** Each evaluator produces a written assessment documenting their findings on each of the four functional elements. Disagreement is recorded explicitly, with reasoned findings on each element. A "capacity present" finding must be reasoned; an unexamined concurrence is not sufficient.
2. **Clinical Ethics Committee referral.** Where evaluators reach divergent conclusions, the case is referred to an independent Clinical Ethics Committee (CEC) within fourteen days. The CEC's function is not to conduct a new capacity assessment but to review the divergent findings and identify whether the disagreement reflects a genuine clinical difference or a

the new mental health law in England and Wales. *Br J Psychiatry* 2009;195(3):257–263.

[13] Appel JM. Legal and ethics considerations in capacity evaluation for medical aid in dying. *J Am Acad Psychiatry Law* 2024;52(3):311–326. doi:10.29158/JAAPL.240038-24.

procedural gap. The CEC may recommend additional evaluation on a specific element (e.g., further assessment of the appreciation criterion using counter-evidence presentation).

3. **Administrative review for persistent disagreement.** Where CEC review does not resolve the disagreement, the matter is referred to the administrative review panel. This is a legal and governance step, not a clinical one. It creates a documented record of the dispute and a reviewable administrative decision— which is accessible to the applicant via appeal.

5.3 What Capacity Requires

A finding of capacity requires reasoned concurrence by at least two independent evaluators on each of the four functional elements. Majority rule on a binary question ("capacity present / absent") is insufficient; reasoned concurrence on each element is the standard. This is consistent with the clear and convincing evidence standard governing the assessment and protects both the applicant and the clinical assessors.

VI. Liability Considerations

6.1 The Current Liability Model

Current clinical practice around suicidal ideation is oriented primarily around institutional liability management: documenting that intervention occurred and that the clinician met the standard of care for suicide prevention. This orientation produces defensive practice patterns documented in the existing literature: coerced safety contracts of no demonstrated efficacy, pressured hospitalization optimized for administrative rather than therapeutic outcomes, and discharge into unchanged conditions.

This orientation often prioritizes liability reduction over the therapeutic alliance. This has consequences for the therapeutic relationship, for patient trust, and for clinical outcomes.

6.2 The Sovereignty Model and Liability Reform

Under the sovereignty model, the clinical liability framework shifts. Clinicians who conduct rigorous, documented capacity assessments following the protocol specified in this framework—multiple independent evaluations, documented alternatives presentation, independent coercion screening, 90-day assessment period—are operating within a structured and documentable standard of care. Liability exposure is reduced by procedural compliance, not by preventing death at all costs.

The conscientious objection provision is critical here: no clinician is required to participate in MAiD assessment or provision. The only obligation imposed on objectors is timely referral

to a willing provider. This protects clinical autonomy while ensuring that patient access is not foreclosed by institutional objection.

6.3 The Therapeutic Consequence

The most significant clinical consequence of the sovereignty model is the reorientation of the therapeutic relationship. When the patient possesses an enforceable exit right, the clinician loses the coercive power of custodial retention.

This constraint is not a limitation on clinical effectiveness; it is the precondition for a different kind of clinical effectiveness. The therapeutic relationship becomes genuinely collaborative. The clinician's role is to make the patient's life worth continuing—to address the conditions that are driving the preference, to connect the patient with resources they may not know exist, to work on the quality of the life rather than the fact of its continuation. This is a more honest, and ultimately more effective, clinical orientation.

VII. Assessment Protocol Summary

Stage 1 — Decisional Capacity Assessment (multiple independent evaluators)

- Understanding: permanence of death; realistic outcomes of all alternatives
- Appreciation: application of information to own situation
- Reasoning: coherent, internally consistent account
- Expression: stable preference across assessment period
- State assessment: no acute psychosis or crisis-state distortion *currently*

Stage 2 — Process Comprehension

- Applicant understands why safeguards exist and accepts them
- Demonstrates sustained engagement across 90-day minimum period
- Failure to engage with Stage 2 is diagnostically relevant to Stage 1

Required Elements of Every Assessment

- Documented alternatives presentation with referrals offered; declinations recorded
- Independent coercion screening by unaffiliated social worker or advocate
- Financial and dependency circumstances review
- Offer of independent legal assistance
- Socioeconomic documentation where inadequate support is identified as a driver

Revocation: Absolute, unconditional, available until the moment of provision.

VIII. Clinical Objections: Summary Responses

"We cannot assess capacity reliably in psychiatric populations"

Response: Capacity assessment in psychiatric populations is a well-established clinical practice with validated instruments (MacArthur Competence Assessment Tool; Aid to Capacity Evaluation). The empirical record demonstrates that the majority of patients with depression retain capacity on rigorous formal assessment (Grisso & Appelbaum, 1995; Vollmann et al., 2003; Hindmarch et al., 2013). The proposed framework applies these instruments to a new context; it does not require new clinical methodology. The challenge of assessing capacity in complex cases is an argument for rigorous multi-evaluator assessment, not for categorical exclusion of psychiatric populations from eligibility.

"Psychiatrists will face pressure to approve requests against their clinical judgment"

Response: The conscientious objection provision protects clinicians who decline to participate. The multi-evaluator requirement means no single clinician carries the assessment alone. The documented capacity protocol creates a professional standard of care that protects clinicians who conduct rigorous assessments, regardless of outcome. The pressure concern is addressed by process, not by maintaining a categorical prohibition.

"This will normalize suicide and undermine suicide prevention"

Response: Suicide prevention is directed at crisis-state, impulsive, and untreated-pathology-driven deaths. The sovereignty model is addressed at a categorically different population: persons with stable, long-considered, informed preferences who have survived a 90-day assessment process. These populations do not overlap clinically. Indeed, the explicit, documented nature of MAiD provision—as distinct from unassisted suicide—may reduce rather than increase the broader social normalization concern, since it is administered within a visible, regulated, documented clinical process.

"The Dutch experience shows capacity-based regimes fail"

Response: The Dutch experience documented in Kim et al. (2016) illustrates specific procedural failure modes—redirected cases through a single willing provider, high rates of social isolation among recipients, occasional absence of independent psychiatric evaluation, deferential review committees. The sovereignty model's protocol addresses each of these directly: multi-evaluator concurrence on each functional element, mandatory independent coercion and socioeconomic screening, mandatory independent psychiatric evaluation, and graduated administrative review with reasoned findings. The Dutch data are evidence for a more rigorous protocol, not against capacity-based assessment as such.

Key Clinical References:

Appel JM (2024), *J Am Acad Psychiatry Law* 52(3):311–326;
Appelbaum PS & Grisso T (1988), *N Engl J Med* 319(25):1635–1638;
Astrachan IM, Keene AR, Kim SYH (2024), *J Med Ethics* 50(7):471–475;
Bahji A et al. (2019), *Acta Psychiatr Scand* 139(3):214–226;
Beauchamp TL & Childress JF, *Principles of Biomedical Ethics* (8th ed., 2019);
Berlim MT et al. (2014), *Psychol Med* 44(2):225–239;
Doernberg SN, Peteet JR, Kim SYH (2016), *Psychosomatics* 57(6):556–565;
Fedgchin M et al. (2019), *Int J Neuropsychopharmacol* 22(10):616–630;
Grisso T & Appelbaum PS (1995), *Law and Human Behavior* 19(2):149–174;
Health Canada, *Sixth Annual Report on MAiD* (2025);
Heijnen WT et al. (2010), *J Clin Psychopharmacol* 30(5):616–619;
Hindmarch T, Hotopf M, Owen GS (2013), *BMC Medical Ethics* 14:54;
Kim SYH, De Vries RG, Peteet JR (2016), *JAMA Psychiatry* 73(4):362–368;
Moye J & Marson DC (2007), *J Gerontol B Psychol Sci Soc Sci* 62(1):P3–P11;
Owen GS et al. (2008), *BMJ* 337:a448;
Owen GS et al. (2009), *Br J Psychiatry* 195(3):257–263;
Vollmann J et al. (2003), *Psychological Medicine* 33(8):1463–1471.