Canadian Association of MAiD Assessors and Providers

Association canadienne des évaluateurs et prestataires de l'AMM

Assessing Incurability For Requests For Medical Assistance In Dying

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Canadian Association of MAiD Assessors and Providers (CAMAP)

The Canadian Association of MAiD Assessors and Providers (CAMAP) is the unique association of professionals involved in the delivery of medical assistance in dying (MAiD) care in Canada. Founded in 2016, the mission is to support MAiD professionals in their work, educate the health care community about MAiD, and provide leadership on determining standards and guidelines in MAiD practice. CAMAP members strive to achieve the highest level of care for our patients and to model this care for a national and international audience. CAMAP works with governments in Canada at all levels, provincial medical and nursing regulatory bodies, national medical and nursing colleges, national professional groups, medical and nursing colleagues, and national organizations supporting MAiD.

Process

CAMAP established the Working Group on Assessing Incurability For Requests for Medical Assistance in Dying to produce a document to assist MAiD assessors and providers in determining whether a person has an incurable illness, disease, or disability (one of the required elements of a grievous and irremediable medical condition). The Working Group included MAiD providers who specialize in (1) family medicine and (2) psychiatry. It also included an academic expert in health law and ethics. A draft was circulated to national stakeholders for comment. They were invited to submit feedback and revisions were made to the guidance in response to their comments. The resulting draft was submitted to and approved by the CAMAP Board of Directors for publication on the CAMAP website. This guidance will be updated as circumstances warrant.

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Introduction

To be eligible for MAiD, a person must have a “grievous and irremediable medical condition.” This criterion is explicitly defined in the Criminal Code of Canada as follows:

> **241.2(2)** A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
>
> **(a)** they have a serious and incurable illness, disease or disability;
>
> **(b)** they are in an advanced state of irreversible decline in capability; and
>
> **(c)** that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.[1]

Similarly, the Québec MAiD legislation includes the requirement that a patient must “suffer from a serious and incurable illness and be in a medical state of advanced, irreversible decline in capability.”[2]

Some clinicians have expressed uncertainty about how best to assess incurability in the context of MAiD, particularly in light of Track 2 in the federal legislation and the removal of the requirement for being at the end of life in the Québec legislation.[3]

This guidance document is intended to assist clinicians with their understanding and assessment of the incurability element of the Canadian MAiD eligibility criteria (including MAiD for mental illness as the sole underlying medical condition (MI-SUMC[4]) as of March 2027 in Canada but not Québec).[5]

This guidance sits in a broader context of all of the eligibility criteria, and it must be emphasized that a finding that a person’s illness, disease, or disability is incurable does not automatically mean that they have a grievous and irremediable medical condition. The other two requirements of this eligibility criterion must also be met (i.e., advanced state of irreversible decline in capability and their illness, disease or disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable).

It must further be emphasized that a finding of curability or incurability of an individual’s condition is the determination of the assessing clinician (hereafter, “clinician”) using their professional judgment at the time and in the context of all of that particular individual’s medical

circumstances. In some situations, this will be challenging. It is the clinician's responsibility to exercise their best judgement and to be able to defend it.

Background

The term “incurable” is not defined in the Criminal Code, nor has it been given an authoritative interpretation by any court, which is the only legal mechanism to obtain such an interpretation of an undefined term in a statute. Clinicians have thus had to apply this term without an authoritative and specific interpretation. Over time, there have been efforts to propose interpretations based on court decisions and established legal principles and these efforts have informed clinical assessments.

The Supreme Court of Canada (SCC) made a comment on the meaning of the related term “irremediable” in its decision in Carter v. Canada (the leading case on MAiD in Canada):

> “Irremediable”, it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.[6]

When discussing Bill C-14 (the first legislative framework for MAiD in Canada), Senior Counsel of the federal Department of Justice said:

> I would conclude that the criminal law itself prohibits administering a medical substance to a person against their wishes. That is the crime of assault. The criminal law has to be interpreted consistently, as a whole. So it’s not possible to interpret “incurable” in Bill C-14, were it to pass, as though it would require a person, compel a person, to undertake a medical treatment that they otherwise don’t consent to. That is one section of the Criminal Code compelling what is criminally prohibited by virtue of another section of the Criminal Code.[7]

A report published by the Institute for Research in Public Policy (IRPP) on interpreting MAID eligibility criteria suggested that “incurable” should not be interpreted in such a way as to require patients to accept unwanted treatments in order to meet this eligibility requirement for MAiD. When offering a justification for this interpretation of the Criminal Code provision, the authors of the report relied upon the law on consent to medical treatment:

> First, the proposed interpretation is consistent with the well-established law on consent to medical treatment (in the area of criminal assault as well as the tort of battery). With very few exceptions (such as patients with certain communicable diseases), the law allows capable patients to refuse medical treatments for any reason whatsoever, regardless of the potentially fatal consequences of the refusal and regardless of whether others consider their refusal reasonable. As noted by the Senior Counsel of the Department of Justice:

> In other words, a person has the right to refuse any kind of treatment. A person can have an illness for which there is a potentially effective treatment, but if the person refuses to be treated, even to save their life, the illness will be, for all intents and purposes, incurable.[8]

Of course, while suggestive, the SCC statement in Carter is not a judicial comment on the meaning of "incurable" as that term was not in front of the SCC (the Carter decision predated Bill C-14 which introduced this term). Furthermore, Bill C-14 added a requirement that a person's "natural death" be "reasonably foreseeable."[9] The Quebec legislation included a requirement that a person must be "at the end of life."[10] The IRPP interpretation that "incurability" does not require treatment was developed in that restricted context. However, Bill C-14 was subsequently amended by Bill C-7[11] in response to the Truchon decision.[12] This Bill removed the requirement that a person's natural death had become reasonably foreseeable.[13] Similarly, Bill 11 in Quebec removed the requirement that a person be "at the end of life."[14]

Both before and after these legislative changes, there were questions about whether a patient's condition could be said to be "incurable" if there remained treatment options that had not been tried.

At present, any of the following scenarios could arise in the context of a request for MAiD:

1. the pathophysiology of the person's condition is understood, including its persistence over time, and it is known that it cannot or is highly unlikely to be eliminated or reversed (e.g., ALS, glioblastoma).
2. the pathophysiology is understood and is persistent but does not necessarily correlate well with symptoms (e.g., degenerative disc disease, spinal stenosis).
3. the pathophysiology is understood but its persistence in time and the evolution of symptoms over time is highly variable (e.g. multiple sclerosis).
4. the pathophysiology is not well understood (for example, post-Covid syndrome) or the condition is defined primarily by symptom profiles (e.g., fibromyalgia).

In an effort to facilitate the development of guidance for clinicians, Health Canada convened the Task Group on MAiD Practice Standards to draft a model professional regulatory standard relating to the Criminal Code provisions that could be adopted or adapted by regulatory authorities of physicians and nurses through their regulatory standards and guidance documents.The Task Group's mandate was to develop a broad framework for the understanding and application of the terms used in the legislation, including those directly related to the eligibility criteria, such as "incurability."

According to this Model Practice Standard:

> Incurable means there are no reasonable treatments remaining where reasonable is determined by the clinician and person together exploring the recognized, available, and potentially clinically effective treatments/interventions in light of the person's overall state of health, beliefs, values, and goals of care.[15]

Although many, or even most, assessments of incurability may not be difficult, clinicians must make also determinations of incurability in more complicated situations. This guidance document is intended to further support clinicians in applying best clinical practices within the existing legal framework.

Assessing Incurability

Basic Legal Requirements

There are some basic legal requirements relevant to the assessment of incurability:

> A person who requests MAiD may believe that they have a serious and incurable illness, disease, or disability. However, to find a person eligible for MAiD, the assessor and provider must be of the opinion that the person has a serious and incurable illness, disease, or disability. If a clinician is not able to form the opinion that the person's condition is incurable, then the patient cannot be found eligible for MAiD by that clinician.[16]
>
> If a person requesting MAiD on Track 2 does not give serious consideration to the means available to relieve suffering they cannot be found eligible for MAiD.[17] However, disagreement with a patient's informed refusal of indicated and accessible treatments is not in and of itself evidence of a lack of serious consideration and is therefore not necessarily grounds for finding the patient does not meet the incurability criterion.

For Track 2 cases, if neither of the two assessors has expertise in the condition causing the person's suffering, the law requires that one of the MAiD assessors involved in an assessment must consult a physician or nurse practitioner with that expertise.[18] This may be done via email, phone, virtually, or in person. The assessor (and/or consultant) may also determine that the patient needs to be seen by a consultant, depending on the clinical issues to be addressed. Care should be taken to be clear in documentation about the nature of the consultations with other clinicians (was it to fulfil the procedural safeguard of consulting with a clinician with expertise in the condition causing the person's suffering? and/or was it to assist in the gathering of all information needed to perform the assessment of incurability (which could include information beyond the condition causing the person's suffering)?)

Working Definitions

For the purposes of assessing incurability in their practice, clinicians can draw on the following working definition of "incurable":"'Incurable' means there are no reasonable treatments remaining where reasonable is determined by the clinician and person together exploring the recognized, available, and potentially clinically effective treatments/interventions in light of the person's overall state of health, beliefs, values, and goals of care."[19]

For the purposes of assessing "incurable", "clinically effective" means able to reverse or eliminate the underlying pathophysiology. For conditions defined by symptom profiles or those

where underlying pathology and symptoms correlate poorly, “incurable” refers to the inability to sufficiently and enduringly relieve the symptoms.

Best Practices

Best practices for establishing incurability within the MAiD assessment process include the following:

1. Competence

   “[*Physicians and Nurse Practitioners*] who choose to assess eligibility for or provide MAiD, must have sufficient training, experience, and qualifications to safely and competently do so in the circumstances of each case.”[20] When assessing a request grounded in a condition with which they have relatively little familiarity, they should seek assistance from colleagues and/or obtain medical documentation and/or consult clinicians who have relevant expertise.

2. Essential information

   Access. The assessor should obtain all information that is necessary for the assessment of incurability. If the patient refuses access to essential information from one source, clinicians should attempt to obtain it from another source. If the person refuses access to essential information from any source, then the assessor must tell the patient that the assessment cannot be completed and they cannot be found eligible.[21]

   Diagnosis.[22] Particular attention should be paid to scientific knowledge about the underlying pathophysiology of the condition(s), where it exists. Where there are diagnostic challenges, it is important for MAiD practitioners to review all available information from relevant specialties in order to be aware of the likely diagnosis.

   Treatment attempts[23] that have been made up to the point of the assessment should be reviewed, including their duration, delivery, intensity, and outcomes.

   Treatment options.[24] *Indicated* treatment options are treatment options that would be indicated in light of the person’s condition(s). These may already be well-documented in recent treatment notes or consulting specialists’ reports. The full range of treatment options may be found in recognized clinical practice guidelines (CPGs) for the specific condition(s) underlying a person’s MAiD request, or, where guidelines do not exist, the scientific literature. In some circumstances, identifying all of the possible treatment options indicated might require that the assessor consult with specialists or have the patient seen by specialists or other clinician(s) with expertise in the relevant discipline(s). The latter consultation is not itself an eligibility assessment (that remains the

responsibility of the assessor). Rather, it is a consultation in order to provide expert opinion and insight needed for the assessment.

Assessors should be alert to the fact that thorough discussions of the options with the patient may reveal that treatments being refused are not indicated for the particular patient (e.g., a treatment may be shown to be efficacious in clinical trials, but the individual patient cannot tolerate the side effects).

Available treatment options. Once the treatment options that would be indicated are known, assessors should determine which are available to the patient, i.e., what can be obtained by and for the patient. Establishing the incurability of the illness, disease, or disability in such situations does not require that a person attempt treatments/interventions that exist somewhere in the world but that are unavailable to them.

Acceptable treatment options.[25] Once the indicated and available treatments have been identified, assessors should determine which are acceptable to the patient. To do this, clinicians should explore the patient's beliefs, values, and goals of care with them. **It is essential to prevent a situation in which a patient is refusing potentially effective treatments/interventions because they have misconceptions or unaddressed fears about the options.**

Reasonable treatment options. "Reasonable" is determined by the clinician and person together exploring the recognized, available, and potentially clinically effective treatments/interventions in light of the person's overall state of health, beliefs, values, and goals of care.[26]

3. Determination of incurability[27]

Incurability should be established with regard to the totality of the patient's circumstances. A diagnosis alone does not determine incurability or eligibility for MAiD. Incurability must be assessed on a case-by-case basis considering all of the person's circumstances, including but not limited to consideration of the interactions and synergies of their comorbid conditions.

The assessor may find the person's condition to be incurable:

a) when knowledge of the pathophysiology allows predictions about death, and at the time of the MAiD assessment, no reasonable intervention will reverse the pathophysiological process; OR

b) when knowledge of the pathophysiology allows predictions about progression of the disease process over time, and at the time of the MAiD assessment, no reasonable intervention will reverse the pathophysiological process; OR

c) when knowledge of the pathophysiology allows predictions about the persistence of the pathology over time, and at the time of the MAiD assessment no reasonable intervention will reverse the pathophysiological process or its associated symptoms; OR

d) when the condition is defined by a symptom profile and is treatment refractory. A condition is "treatment refractory" when it is non-responsive to treatment (all or most available treatment).[28] The range of treatment options is reflected in condition-specific clinical practice guidelines (where they exist) and subspecialty practice.

4. Treatment refusal

There may be situations where at the time of the MAiD request there are interventions that might reverse the pathophysiological process or alleviate a condition's symptoms but the person refuses such interventions. The clinician may still find the condition incurable and they should clearly document their reasoning and the patient's reasons for this refusal.

Assessors should be alert to the possibility that a person has a comorbid condition that is contributing to suffering even if it is not the stated reason for the MAiD request (e.g. adjustment disorder following catastrophic diagnosis, pain stemming from another physical condition, or comorbid chronic mental disorder).[29] In such circumstances, assessors should confirm that the person has explored options for treating the comorbid condition(s) (or request that their MRP refer them to other clinicians who are equipped to provide this information). This is indicated because the suffering related to the secondary or comorbid condition (e.g. adjustment disorder or pain) may lead a patient to refuse treatment and/or other interventions for the primary condition that led to the MAID request. Relieving this suffering may lead a person to want to continue treatment for the primary condition. The clinician must also determine whether the comorbid condition is affecting the person's decision-making. If it is, the person may not be eligible for MAiD.

Assessors should also be alert to the possibility that socioeconomic, or other issues are contributing either to the patient's symptoms or their experience of suffering and to the person's willingness to try treatments for the condition leading to the request for MAiD. Addressing these issues (where possible) might lead a person to want to continue treatment for the primary condition.[30] In such circumstances, assessors should explore

additional options for addressing these issues (or refer to other professionals who are equipped to do this).

However, if a patient continues to refuse indicated and accessible treatments, the assessor must consider further what is known about that person's condition, specifically:

a) where the person has a condition in which the pathophysiology or its associated symptoms is still potentially reversible, and where one does not have confidence in the patient's refusal being maintained with the passage of time (whether because there are indications of the decision being unsettled or because there is considerable time before the pathophysiology would cease to be potentially reversible), the condition cannot be considered incurable (e.g. a young person with early stage breast cancer).

b) where the person has a condition for which the pathophysiology or its associated symptoms is still potentially reversible, even if there is considerable time before it would cease to be so, but there is confidence that the refusal will be maintained over that time, the condition can be considered incurable (e.g. refusal of liver transplantation for MASH - metabolic dysfunction-associated steatohepatitis-based on longstanding religious commitments).

c) where the pathophysiology is known but the evolution of the condition or its associated symptoms is unpredictable (e.g., degenerative disc disease) the clinician should weigh up the treatment options. Where a person has refused a majority of treatments at least some of which are likely to reduce symptoms, the condition should not be said to be incurable. Where the person has tried many treatments and is refusing the few remaining options, the condition can be said to be incurable.

d) where the pathophysiology is poorly known and/or the condition is defined by symptom profile (e.g., fibromyalgia) the clinician should weigh up the treatment options.Where a person has refused a majority of treatments which are likely to reduce symptoms, the condition should not be said to be incurable. Where the person has tried many treatments and is refusing the few remaining options, the condition can be said to be incurable.

   In between "a majority" and "the few", the clinician meets the limits of clarity of the boundary between curable and incurable in relation to some chronic conditions and the clinician will have to exercise their best judgment based on the totality of the clinical circumstances and the specificity of the situation, in order to make a decision.[31] Case discussion with experienced colleagues is encouraged to solicit other perspectives and test one's own reasoning.

5. Documentation

   The steps above and the clinician's reasoning leading to their conclusion(s) should be well-documented in the clinical record.

Key Practice Points for Assessing Incurability

- There is a broad range of illnesses, diseases, and disabilities for which people might request MAiD. Establishing incurability requires a clinical reasoning process that is appropriate to the person's condition(s). Namely, the clinical reasoning must take into account the level of clinical and scientific knowledge known about the condition(s).

- Knowing the diagnosis or diagnoses as precisely as possible will inform the kinds of information an assessor will need to gather about the patient. However, a diagnosis alone does not determine incurability or eligibility for MAiD. Incurability must be assessed on a case-by-case basis considering all of the person's circumstances, including but not limited to consideration of the interactions and synergies of their comorbid conditions.

- In all cases, assessors must:

    - be informed about the severity and duration of the person's condition
    - be informed about the disease trajectory according to clinical knowledge and the individual's disease trajectory through a detailed history of present illness, the recognized treatments undertaken prior to the assessment and the accessibility of any other treatments
    - discuss with the patient the relevant information about their condition(s), treatment options, means of relieving suffering, etc. (and for Track 2 cases, ensure that the person has given serious consideration to these means)
    - understand the person's overall state of health, beliefs, values, and goals of care and how these relate to the MAiD request and any remaining indicated, available, acceptable, and reasonable treatment options
    - document the above in their clinical notes

- As a general principle, conditions can be considered incurable when there is no reasonable intervention that can reverse the condition's underlying pathophysiological process or its associated symptoms. "Reasonable" is determined by the clinician and person together exploring the recognized, available, and potentially clinically effective treatments/interventions in light of the person's overall state of health, beliefs, values, and goals of care.

- With respect to conditions for which the pathophysiology is unknown or unpredictable, assessors should document the treatment attempts made up to the point of the assessment (including their duration and intensity, outcomes of those treatments/interventions) as well as what options remain. Such conditions can be considered incurable when they are treatment-refractory.

- If applicable, assessors should explore reasons a person has declined to accept/trial any remaining treatment options. It is essential to prevent a situation in which a patient is refusing potentially effective treatments/interventions because they have misconceptions or unaddressed fears about the options. Assessors should be alert to any issues - apart from their grievous and irremediable medical condition - that are contributing to the patient's experience of their suffering and thus their request for MAiD.

- Treatment refusal does not preclude a finding of incurability subject to specific considerations (see section 4).

About the Authors

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Endnotes

1. Criminal Code, RSC 1985, c C-46, s.241.2(2).

2. An Act respecting end-of-life-care CQLR c S-32.0001, s.26(3(a).

3. Canada: Bill C-14 An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), 1st Session, 42nd Parliament, 2016 (Bill C-14); Bill C-7 An Act to Amend the Criminal Code (Medical Assistance in Dying), 1st Session, 43rd Parliament, 2020 (Bill C-7); Bill C-39 An Act to amend An Act to amend the Criminal Code (medical assistance in dying) 1st Session, 44th Parliament, 2023 (Bill C-39); and Bill C-62 An Act to amend An Act to amend the Criminal Code (medical assistance in dying, No. 2, 1st Session, 44th Parliament, 2024 (Bill C-62). Québec: Bill 11 An Act to amend the Act respecting end-of-life care and other legislative provisions, 1st Session, 43rd Legislature, 2023 (Bill 11). Note that there are some significant differences between the federal and Québec legislation (e.g., Québec allows for some advance requests for MAiD and has a permanent exclusion of "mental disorder other than a neurocognitive disorder" as the sole underlying medical condition (s.26) while Canada does not allow for requests made in advance of meeting all of the eligibility criteria (s.241.2(3)(h) and 3.1(k)) and it has a temporary exclusion of "mental illness" as the sole underlying medical condition) (s.241.2(2.1)). However, the laws do not differ on "incurability."

4. While it is common to use the expression "mental disorder as the sole underlying medical condition (MD-SUMC)", this is inaccurate as the law excludes "mental illness" not "mental disorder" and so the accurate expression with respect to federal law is "mental illness as the sole underlying medical condition (MI-SUMC)".

5. Under s.241.2(2.1) of the Criminal Code, a "mental illness" cannot be considered a "serious and incurable illness, disease, or disability" for the purposes of MAiD eligibility. By operation of s.1 of Bill C-62, this exclusion clause will be automatically repealed in March 2027. Québec's exclusion has no repeal provision.

6. Carter v. Canada (Attorney General), 2015 SCC 5 at paragraph 127.

7. Proceedings. 42nd Parliament, 1st Session, issue no. 10, "Evidence," June 6, 2016. https://sencanada.ca/en/Content/Sen/Committee/421/LCJC/10ev-52666-e

8. Downie J, Chandler JA. Interpreting Canada's Medical Assistance in Dying Legislation. Institute for Research on Public Policy. [Internet]. Canada; 2018; Available from: https://irpp.org/wp-content/uploads/2018/03/Interpreting-Canadas-Medical-Assistance-in-Dying-Legislation-MAiD.pdf at pp.17-18.

9. Bill C-14 An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), 1st Session, 42nd Parliament, 2016 (Bill C-14), s.3.

10. Bill 52 An Act respecting end-of-life care, s.26(3). This law was adopted by the National Assembly in June 2014, prior to the Supreme Court's decision in Carter. The Act's

eligibility requirement of “end of life” was unrelated to the Federal Government’s addition of the requirement for reasonably foreseeable natural death.

11. Bill C-7 An Act to Amend the Criminal Code (Medical Assistance in Dying), 1st Session, 43rd Parliament, 2020.

12. Truchon v. Canada (AG), 2019 QCCS 3792.

13. Bill C-7 An Act to Amend the Criminal Code (Medical Assistance in Dying), 1st Session, 43rd Parliament, 2020, s.1(1).

14. Bill 11 An Act to amend the Act respecting end-of-life care and other legislative provisions, 1st Session, 43rd Legislature, 2023, ss.2-3.

15. Health Canada, Model Practice Standard for Medical Assistance in Dying. 2023 [Internet] Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.33.

16. It must be emphasized that the standard is “be of the opinion”, not certainty. Criminal Code, RSC 1985, c C-46, ss.241.2(3)(a) and (3.1)(a). It must also be noted that if another clinician is of the opinion that the person’s condition is incurable, then they can find the person eligible (assuming they meet the other eligibility criteria).

17. “Serious consideration to those means” is a legal safeguard for MAiD requesters under Track 2. Criminal Code, RSC 1985, c C-46, s.241.2(3.1)(h). While the interpretation of “serious consideration” lies outside the scope of this guidance, the following was proposed in the Model Practice Standard: “10.3.6 Serious consideration of the reasonable and available means to relieve the person’s suffering (only Track 2) 10.3.6.1 Before a [*physician/nurse practitioner*] provides MAID, they must ensure that they and the assessor have discussed with the person the reasonable and available means to relieve the person’s suffering and they and the assessor agree with the person that the person has given serious consideration to those means. 10.3.6.2 Serious consideration must be understood to mean: a) exercising capacity, not merely having it; b) exhibiting careful thought; and c) not being impulsive.” Health Canada, Model Practice Standard for Medical Assistance in Dying. [Internet] Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.17.

18. Criminal Code, RSC 1985, c C-46, s.241.2(3.1)(e.1).

19. Health Canada, Model Practice Standard for Medical Assistance in Dying. 2023 [Internet] Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.33.

20. Health Canada, Model Practice Standard for Medical Assistance in Dying. 2023 [Internet] Available from:

https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.5.

21. "Where a capable person refuses consent to obtaining health record and personal data necessary for the completion of a MAID assessment, the assessors and providers must explain that, without such information, the assessment cannot be completed and therefore the person cannot be found eligible." Health Canada, Model Practice Standard for Medical Assistance in Dying. 2023 [Internet] Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.16.

22. Individuals may have more than one condition which together lead to the request for MAiD but, for readability, we will use the singular.

23. Simply for the sake of readability, we include "interventions" in the word "treatment".

24. Throughout this document we use the plural form 'options' but recognize that there may be some conditions for which there is only one option.

25. As in all clinical care, individuals are free to choose treatment based on their state of health, values, beliefs, and goals of care.

26. Health Canada, Model Practice Standard for Medical Assistance in Dying. 2023 [Internet] Available from: https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html at p.11.

27. This analysis draws upon Gupta M and Downie J, "Interpreting and operationalizing the incurability eligibility criterion in the Canadian assisted dying legislation" Front. Psychiatry, 16 March 2025, Sec. Public Mental Health, Volume 16 - 2025 | https://doi.org/10.3389/fpsyt.2025.1549289

28. Treatment refractoriness in this context must be distinguished from the use of the expression "treatment resistant" applied to specific conditions. Howes OD, McCutcheon R, Agid O, de Bartolomeis A, van Beveren NJ, Birnbaum ML, Bloomfield MA, Bressan RA, Buchanan RW, Carpenter WT, Castle DJ, Citrome L, Daskalakis ZJ, Davidson M, Drake RJ, Dursun S, Ebdrup BH, Elkis H, Falkai P, Fleischacker WW, Gadelha A, Gaughran F, Glenthøj BY, Graff-Guerrero A, Hallak JE, Honer WG, Kennedy J, Kinon BJ, Lawrie SM, Lee J, Leweke FM, MacCabe JH, McNabb CB, Meltzer H, Möller HJ, Nakajima S, Pantelis C, Reis Marques T, Remington G, Rossell SL, Russell BR, Siu CO, Suzuki T, Sommer IE, Taylor D, Thomas N, Üçok A, Umbricht D, Walters JT, Kane J, Correll CU. Treatment-Resistant Schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) Working Group Consensus Guidelines on Diagnosis and Terminology. Am J Psychiatry. 2017 Mar 1;174(3):216-229. doi: 10.1176/appi.ajp.2016.16050503. Epub 2016 Dec 6. PMID: 27919182; PMCID: PMC6231547. For example, the expression "treatment-resistant depression" typically refers to major depressive episodes that do not respond satisfactorily after two trials of antidepressant monotherapy; however, the definition has not been standardized. Thase M Connolly KR. (2023) Unipolar

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29. MAID Death Review Committee, MAID Death Review Committee (MDRC) Report 2024-2 Complex Medical Conditions with Non-Reasonably Foreseeable Natural Deaths. Ministry of the Solicitor General, Office of the Chief Coroner of Ontario. 2024 [Internet] Available from: https://valuejudgments.substack.com/p/the-ontario-chief-coroners-reports at pp 16-18.

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31. This is akin to the classic sorites paradox: “The sorites paradox originated in an ancient puzzle that appears to be generated by vague terms, viz., terms with unclear (“blurred” or “fuzzy”) boundaries of application. Because the predicate ‘heap’ has unclear boundaries, it seems that no single grain of wheat can make the difference between a number of grains that does, and a number that does not, make a heap. Therefore, since one grain of wheat does not make a heap, it follows that two grains do not; and if two do not, then three do not; and so on. This reasoning leads to the absurd conclusion that no number of grains of wheat make a heap.” Hyde, Dominic and Diana Raffman, "Sorites Paradox", The Stanford Encyclopedia of Philosophy (Summer 2018 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/sum2018/entries/sorites-paradox/>.