



Standards without standardization

A review of Canada's Track 2 MAiD safeguards and ethical-legal ambiguities

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Abstract

Background: Track 2 medical assistance in dying (MAiD) in Canada, introduced through Bill C-7, increases reliance on bedside interpretation of indeterminate legal-clinical concepts and heightens the need for governable safeguards.

Purpose: To review how Track 2 safeguards are defined, operationalized, and overseen, and to identify where ambiguity produces practice variability that is difficult to audit.

Approach/Methods: Narrative review of statutory and federal interpretive materials, professional regulatory guidance, peer-reviewed scholarship, and federal monitoring reports, organized using a colour-coded rubric (LS, OG, CE, EV, MP, DL, EQ) applied across core safeguards and cross-cutting governance lenses.

Findings/Argument: Across domains, safeguard strength is limited by “standards without standardization,” including under-specified documentation expectations and limited administrative auditability for inferential judgments in capacity, voluntariness and undue influence, irremediability, and serious consideration of reasonable and available means.

Implications: Strengthening Track 2 governance requires minimum, reviewable documentation surfaces mapped to each safeguard, coupled with risk-informed chart audit and feedback, and explicit equity stress-testing where service constraints narrow feasible alternatives.

Keywords: medical assistance in dying; MAiD; Track 2; safeguards; capacity assessment; voluntariness; undue influence; irremediability; oversight; governance; health equity; Canada

Introduction

Canada's medical assistance in dying regime is structured around eligibility criteria that are legal in origin but clinical in application. Since the Supreme Court's recognition that an absolute prohibition infringed section 7 rights in *Carter*, lawmakers have relied on statutory thresholds that must be interpreted at the bedside, including grievous and irremediable medical condition, voluntariness, and capacity (*Carter v. Canada (Attorney General)*, 2015). Bill C-7 reshaped that interpretive landscape by distinguishing between Track 1 cases where natural death is reasonably foreseeable and Track 2 cases where it is not, thereby creating a pathway in which the legal justification for access depends more heavily on the quality, consistency, and governability of safeguards rather than proximity to end of life (Government of Canada, 2021).

Track 2 is best understood as a high discretion environment. The statutory criteria remain formally uniform, but their application depends on evaluative judgments that have no single clinical metric, particularly when assessing irremediability, intolerability, and the authenticity of voluntariness in complex circumstances (Barbour, 2025; Gay, 2025). This is not a claim that Track 2 is inherently unsafeguardable, nor that clinicians act without integrity. It is a claim about system design. When the law delegates decisions to clinical judgment under indeterminate terms, ethical and legal risk is concentrated in the variance that emerges across assessors, institutions, and provinces, especially when oversight is largely administrative and retrospective (Close et al., 2025).

Federal reporting underscores why Track 2 governance cannot be assessed through access counts alone. In 2024, Health Canada received 22,535 reports of MAiD requests and recorded 16,499 MAiD provisions (Health Canada, 2025). Within this total, Track 2 provisions were a small minority, yet Track 2 accounted for a disproportionate share of ineligibility outcomes, a pattern consistent with greater contestability at the eligibility boundary (Health Canada, 2025). In other words, the fact that Track 2 is numerically smaller does not reduce its ethical and legal stakes. It may instead indicate that Track 2 decisions are more sensitive to interpretation, making safeguards and standardization more consequential rather than less.

This review advances the thesis that Track 2 has standards without standardization. Canada has eligibility criteria and safeguards on paper, but the operative question is whether the key safeguards are sufficiently specified to produce consistent, auditable practice in the domains that matter most: capacity, voluntariness and undue influence, irremediability, and the assessment of reasonable alternatives (Barbour, 2025; Close et al., 2025). The Sixth Annual Report provides examples of why proxy indicators can be misleading. For instance, most MAiD recipients accessed palliative care, but the track breakdown differs sharply, reflecting that Track 2 is not governed by the same end of life care pathway and therefore requires different governance logic when evaluating alternatives and supports (Health Canada, 2025). Similarly, disability self-identification is substantially higher in Track 2 than Track 1, which makes the integrity of voluntariness and the meaningfulness of alternatives a central equity stress test, not an ancillary social policy discussion (Grant, 2023; Health Canada, 2025).

The aim of this paper is to synthesize peer reviewed scholarship, regulatory guidance, and federal reporting to clarify where Track 2 safeguards are conceptually under-specified, variably operationalized, and weakly overseen, and to identify concrete targets for standardization that preserve lawful access while strengthening protection in high ambiguity cases (Barbour, 2025; Close et al., 2025; Health Canada, 2025). We do not treat administrative reporting as a substitute for safeguard validity, nor do we treat isolated public cases as dispositive evidence of system performance. Instead, we frame Track 2 as a governance problem of delegated discretion: the ethical and legal question is not only what the criteria say, but whether the system can reliably demonstrate, case by case, that capacity, voluntariness, irremediability, and alternatives were assessed in a manner that is consistent, transparent, and accountable (Society of Canadian Psychiatry, 2023; Health Canada, 2025; Gay, 2026).

Background

Canada's MAiD framework has developed through a sequence of constitutional and legislative decisions that progressively redefined eligibility and the associated safeguards. In *Carter*, the Supreme Court held that a total prohibition was unconstitutional in defined circumstances, while also emphasizing the continuing state interest in preventing error and protecting vulnerable persons (*Carter v. Canada (Attorney General)*, 2015). Parliament's initial legislative response, Bill C-14, established a federal scheme in the Criminal Code that included eligibility criteria and procedural safeguards, including the requirement that natural death be reasonably foreseeable (Government of Canada, 2016; Library of Parliament, 2019).

This framework was subsequently modified following Truchon, which found that end of life eligibility restrictions were unconstitutional as applied to the plaintiffs and contributed to Parliament's decision to amend the federal scheme (Truchon v. Procureur général du Canada, 2019; Department of Justice Canada, 2020; Government of Canada, 2021). Bill C-7 removed the reasonably foreseeable natural death requirement as a general eligibility condition and introduced a two track safeguards model. Track 1 applies when natural death is reasonably foreseeable and Track 2 applies when it is not (Department of Justice Canada, 2020; Government of Canada, 2021). Track 2 is therefore a distinct policy and clinical category because eligibility determinations depend more heavily on clinical assessments of capacity, voluntariness, and grievous and irremediable medical condition in circumstances that are not anchored to end of life care processes (Department of Justice Canada, 2020; Government of Canada, 2021).

Several legally decisive concepts in MAiD are clinically evaluative and can be applied with meaningful variation. Capacity is a legal threshold, but in practice it requires assessors to document understanding and appreciation in contexts where preferences may be stable yet shaped by suffering, fear, or value conflict (Barbour, 2025). Voluntariness is similarly defined in law, but it can be difficult to assess where decisions are formed in contexts of dependency, relational pressure, or constrained options, even when no direct coercion is present (Grant, 2023). Irremediability adds a further interpretive burden because it requires a judgment about whether the condition and suffering can be relieved by reasonable means acceptable to the person, a judgment that necessarily depends on clinical prognosis, treatment uncertainty, and the person's evaluative commitments (Gay, 2025). These features do not imply that the concepts are unusable. They indicate that safeguard validity depends on how these constructs are operationalized, documented, and reviewed.

Implementation in Canada occurs within a polycentric regulatory context. Federal law sets eligibility criteria and some procedural requirements, but provincial and territorial delivery systems and professional regulators issue standards and guidance that shape assessment practices and documentation expectations. A review of practice standards and guidance documents across Canadian jurisdictions reported meaningful variability in how requirements and expectations are framed, which supports the conclusion that statutory uniformity does not necessarily produce procedural uniformity (Close et al., 2025). For Track 2, such variability has direct ethical and legal relevance because it can affect how assessors interpret evidentiary sufficiency and how consistently safeguards are recorded in the clinical record (Close et al., 2025).

Legislative developments related to MAiD where mental illness is the sole underlying medical condition illustrate the system's recurring emphasis on assessment reliability under high ambiguity. Parliament extended the temporary exclusion through Bill C-39 and later extended it again through Bill C-62 to March 17, 2027, citing the need for additional time to prepare and to support consistent practice (Department of Justice Canada, 2023; Library of Parliament, 2024; Department of Justice Canada, 2025). While this exclusion is distinct from Track 2 more broadly, it highlights how policy decisions have repeatedly turned on whether safeguards can be applied in a manner that is consistent, clinically defensible, and publicly accountable (Department of Justice Canada, 2023; Library of Parliament, 2024; Department of Justice Canada, 2025).

Federal monitoring reports provide a complementary system level account of MAiD activity, but they are not direct evaluations of safeguard quality. The Sixth Annual Report summarizes volumes, track distributions, demographic variables, and contextual indicators, and it documents important limitations related to jurisdictional data practices and to the interpretation of neighbourhood level measures (Health Canada, 2025). These features make federal reporting valuable for describing patterns and identifying areas for further scrutiny, while also clarifying that administrative indicators are not equivalent to evidence that core safeguards were applied consistently and thoroughly in individual cases. This distinction motivates a safeguards centered review of Track 2 practice and oversight (Health Canada, 2025).

Aims, Purpose, and Scope

The purpose of this review is to examine how Canada's Track 2 MAiD safeguard requirements are interpreted and implemented in practice and to identify where ethical and legal ambiguity produces variability that is difficult to govern, audit, or justify transparently. Track 2 cases, by definition, lack the reasonably foreseeable natural death condition that previously served as a limiting criterion and a practical reference point for many clinical processes, thereby placing greater weight on the quality and consistency of safeguard application (Department of Justice Canada, 2020; Government of Canada, 2021). This paper treats safeguards not as abstract ideals but as operational requirements whose legitimacy depends on whether they can be applied in a consistent, evidence-supported manner across assessors and jurisdictions (Close et al., 2025; Health Canada, 2025).

The primary aim is to synthesize and evaluate the literature and policy guidance relevant to four safeguard domains that carry direct ethical and legal significance in Track 2: capacity, voluntariness and undue influence, irremediability, and the

assessment of reasonable alternatives. These domains are emphasized because they are legally decisive yet clinically evaluative, and they are therefore the locations where the gap between statutory language and case-level reasoning is most likely to emerge (Barbour, 2025; Close et al., 2025; Gay, 2025). A secondary aim is to analyze the governance and oversight environment in which these assessments occur, including variation in regulatory guidance and the limits of federal monitoring indicators as proxies for safeguard quality (Close et al., 2025; Health Canada, 2025).

The scope of the review is intentionally bounded. First, the paper focuses on Track 2 MAiD in Canada and does not attempt a comprehensive normative argument for or against MAiD. The analysis is concerned with the governability of safeguards, not with adjudicating individual cases. Second, structural vulnerability is addressed as a focused analytic subtopic where it bears directly on safeguard interpretation, particularly voluntariness and alternatives, rather than as a general social policy discussion (Grant, 2023; Health Canada, 2025). Third, MAiD where mental illness is the sole underlying medical condition is not treated as the central object of review; however, the repeated legislative delays in that domain are considered as policy evidence of ongoing concern about assessment reliability under high ambiguity and as a relevant comparator for safeguards discourse (Department of Justice Canada, 2023; Library of Parliament, 2024; Department of Justice Canada, 2025).

Review Questions

This paper is organized around the following questions:

How are Track 2 safeguards for capacity, voluntariness, irremediability, and reasonable alternatives defined across key scholarly and regulatory sources, and where do these definitions leave clinically material ambiguity (Barbour, 2025; Close et al., 2025; Gay, 2025)?

What forms of inter-jurisdictional and practice-level variability are described in guidance and scholarship, and what mechanisms are available to reduce unwarranted variance while preserving lawful access (Close et al., 2025; Health Canada, 2025)?

What can federal monitoring reports credibly indicate about Track 2 safeguard pressure points, and what do their documented limitations imply for interpreting system performance and equity-related claims (Health Canada, 2025)?

In what ways does structural vulnerability function as a stress-test for voluntariness and alternatives, and what safeguard specifications would be necessary to make those determinations more transparent and reviewable (Grant, 2023; Health Canada, 2025)?

Evidence Base and Inclusion Boundaries

This is a narrative review with structured policy and guidance analysis. It draws on: peer-reviewed ethics, legal, and clinical scholarship; regulator standards and practice guidance; federal monitoring reports; and selected parliamentary and Justice Canada materials used to clarify legislative intent and policy framing (Department of Justice Canada, 2020; Government of Canada, 2021; Close et al., 2025; Health Canada, 2025). The review does not attempt to estimate causal effects, quantify incidence of safeguard failure, or infer motivations from administrative variables. Its contribution is analytic and governance-focused: to clarify where ambiguity sits, how it is managed, what is currently measurable, and what would need to be specified to support defensible, auditable safeguard practice in Track 2 (Close et al., 2025; Health Canada, 2025).

Approach and Methods

This paper is a narrative review with structured analysis of policy, regulatory guidance, and federal reporting. We use a safeguards-centered analytic frame to examine how Track 2 eligibility and procedural requirements are interpreted, operationalized, and monitored in Canada (Department of Justice Canada, 2020; Government of Canada, 2021). The unit of analysis is not the individual MAiD case. It is the set of safeguard constructs that determine eligibility in Track 2 and the governance conditions that shape how those constructs are applied in practice (Close et al., 2025; Health Canada, 2025).

Sources and Document Types

We draw on four categories of sources. First, we include statutory and quasi-legal materials that define or clarify the Track 2 framework, including federal legislation and Justice Canada materials that describe the safeguard model and related policy rationales (Department of Justice Canada, 2020; Government of Canada, 2021; Department of Justice Canada, 2025). Second, we include regulatory practice standards and guidance documents issued by professional bodies and synthesized in peer-

reviewed analysis to characterize inter-jurisdictional variation in expectations and documentation norms (Close et al., 2025). Third, we include peer-reviewed ethical, legal, and clinical scholarship that addresses capacity, voluntariness, irremediability, and risk-relevant decision dynamics in MAiD contexts (Barbour, 2025; Gay, 2026). Fourth, we use federal monitoring reports to describe national patterns and to identify the limits of administrative indicators as proxies for safeguard quality, with explicit attention to the report’s documented constraints and data caveats (Health Canada, 2025).

Analytic Framework and Coding Domains

The analysis is organized around four safeguard domains that are legally decisive and practically interpretive in Track 2: capacity, voluntariness and undue influence, irremediability, and reasonable alternatives. These domains were selected because they concentrate the main ethical and legal ambiguity in Track 2 and because they are the locations where practice variance is most consequential (Barbour, 2025; Close et al., 2025; Gay, 2026). A fifth cross-cutting governance domain addresses oversight and accountability, including the relationship between regulator guidance, clinical documentation practices, and federal monitoring fields (Close et al., 2025; Health Canada, 2025). Structural vulnerability is treated as a bounded subtopic within voluntariness and alternatives, limited to contexts where it materially affects the interpretation of safeguard requirements rather than as a generalized social policy discussion (Grant, 2023; Health Canada, 2025). The analytic rubric used to classify the function of each source type across safeguard domains is summarized in **Figure 1**.

Figure 1

Analytic rubric matrix: Primary function of each source type for each analytic domain in a Track 2 MAiD safeguards review

| | Federal reports | Peer reviewed | Regulator guidance | Statute and Justice |
|-----------------------------------|-----------------|---------------|--------------------|---------------------|
| Capacity | MP | CE | OG | LS |
| Voluntariness and undue influence | DL | CE | OG | LS |
| Irremediability | MP | CE | OG | LS |
| Reasonable alternatives | DL | CE | OG | LS |
| Oversight and accountability | MP | EV | OG | LS |
| Structural vulnerability | EQ | EQ | OG | LS |

Key: LS legal standard and threshold; OG operational guidance; CE conceptual and ethical analysis; EV empirical variability; MP monitoring proxy; DL data limits; EQ equity stress-test.

Synthesis and Evidentiary Limits

Findings are synthesized by comparing how each safeguard domain is defined and justified across sources, how it is operationalized in practice guidance, and how it is indirectly represented or omitted in federal monitoring. We treat variability as analytically relevant when it concerns threshold concepts, documentation expectations, or reviewability, and we distinguish between descriptive reporting, normative argument, and empirical inference (Close et al., 2025; Health Canada, 2025). This review does not estimate incidence of safeguard failure, infer motivations from administrative categories, or treat isolated cases as proof of system-wide performance. The aim is to clarify where ambiguity sits, how governance currently attempts to manage it, and what standardization targets would be necessary to make Track 2 safeguards more consistent, transparent, and auditable (Department of Justice Canada, 2020; Close et al., 2025; Health Canada, 2025).

Analytic Orientation and Roadmap

The analysis that follows is organized by safeguard domains rather than by stakeholder positions or by broad normative claims. This structure reflects the central premise of Track 2 governance: eligibility depends on a small number of legally decisive determinations that must be made under interpretive discretion and recorded in a way that permits oversight (Department of Justice Canada, 2020; Government of Canada, 2021). Accordingly, each section examines one safeguard domain and asks a consistent set of questions: what standard is required, what guidance exists for applying it, what ambiguities recur in the literature, what variability has been documented, and what can and cannot be inferred from federal monitoring indicators (Close et al., 2025; Health Canada, 2025).



The sections proceed in the order of the main safeguard determinations that structure Track 2 practice: capacity, voluntariness and undue influence, irremediability, and reasonable alternatives. A subsequent section addresses oversight and accountability as a cross-cutting governance domain. Structural vulnerability is then considered as a bounded stress-test lens focused on how background conditions of disadvantage can affect the interpretation of voluntariness and alternatives and can complicate claims of procedural consistency when access to supports is uneven (Grant, 2023; Health Canada, 2025). Throughout, the paper does not assess individual cases or infer intent from administrative variables. The goal is to clarify where ambiguity sits, how it is currently managed, and what would be required to improve transparency and reviewability in Track 2 safeguards (Close et al., 2025; Health Canada, 2025).

Capacity

Capacity in Track 2 functions as a legal eligibility threshold and as a governance object that must be demonstrated through assessable reasoning in the record. Canadian law requires that the person has decision-making capacity to make the request and to provide informed consent, and Track 2 adds procedural features that increase the importance of documenting how capacity was established over time, including the 90 clear days assessment period with a permitted shortening when loss of capacity is imminent (Department of Justice Canada, 2020; Government of Canada, 2021; CPSO, 2024). In a safeguards review, the central question is not whether capacity can be assessed, but whether Track 2 capacity assessments are sufficiently specified and consistently documented to support credible retrospective review across jurisdictions and assessors (Close et al., 2025; Health Canada, 2025).

Capacity is typically evaluated as task-specific and time-specific rather than global, and most clinical-legal frameworks converge on functional abilities: communicating a choice, understanding relevant information, appreciating the situation and consequences, and reasoning about options (Grisso, 1997; Appelbaum, 2007; Palmer & Harmell, 2016). In MAiD, these elements intersect with distinctive decisional content. The person must demonstrate understanding and appreciation not only of the intervention and its irreversibility, but also of the nature of their condition, the sources of suffering, and the foreseeable consequences of choosing MAiD relative to other options, including symptom relief and social supports where relevant (CAMAP, 2020; Health Canada, 2022). This decisional content is one reason Track 2 capacity has a tighter linkage to process: the quality of the safeguard depends on whether assessors can show, in writing, how understanding and appreciation were tested rather than presumed.

Operational guidance in Canada increasingly frames capacity in Track 2 as a potentially longitudinal assessment problem. Professional guidance emphasizes that capacity can fluctuate and that serial assessment may be appropriate in some circumstances, alongside consultation when the capacity question is complex (CPSO, 2023; CPSPEI, 2024). CAMAP's capacity white paper similarly positions MAiD capacity assessment as a structured functional judgment that should be supported by explicit documentation, particularly in scenarios involving communication barriers, cognitive impairment, psychiatric symptoms, or decisional instability (CAMAP, 2020). Empirical work describing Canadian clinician practices suggests that assessors often rely on conversational evaluations and clinical judgment, with variability in the use of structured tools and in what is recorded as evidence of capacity, which creates an obvious standardization target for Track 2 governance (Wiebe et al., 2021).

Two ambiguity points are particularly salient for Track 2 governability. First, Track 2 requires that assessors ensure the person has been informed of "means available to relieve suffering," including counselling, disability supports, community services, and palliative care, and that they have seriously considered those means (Department of Justice Canada, 2020; Government of Canada, 2021). This creates a capacity-relevant documentation burden: when a person declines options, the record should distinguish an informed, values-consistent refusal from a refusal driven by misunderstanding, unrealistic expectations, treatability misconceptions, or a narrowed decisional horizon shaped by despair or social constraint (Appelbaum, 2007; CAMAP, 2020). Second, the 90 clear days safeguard is often interpreted as time for exploration and stabilization rather than a passive waiting period, which implies that capacity documentation should be treated as an evidentiary thread across the assessment interval, especially when symptoms, supports, or living conditions shift (CAMAP, 2020; CPSPEI, 2024; Health Canada, 2025). From a governance perspective, Track 2 capacity is therefore not only "met or not met," but "met through what reasoning, supported by what observations, documented in what way, and revisited under what triggers."

Federal monitoring can describe Track status, timelines, and some process indicators, but it cannot validate capacity assessment quality because it does not capture how appreciation and reasoning were tested, how inconsistencies were resolved, or whether reassessment occurred when circumstances changed (Health Canada, 2025). This is a structural limitation of administrative monitoring: it is well-suited to counting and classifying events, and poorly suited to auditing the internal logic of a complex clinical-legal judgment. A safeguards review should therefore treat federal monitoring as a pattern-

detection layer that can motivate scrutiny, not as evidence that the capacity safeguard is being applied consistently or robustly across Track 2 practice.

Standardization targets follow directly from these gaps. A governance-focused approach would prioritize (1) minimum documentation elements that map onto functional abilities, including explicit evidence of appreciation and reasoning; (2) defined triggers for serial capacity reassessment in Track 2 (for example, medication changes affecting cognition, delirium risk, unstable psychiatric symptoms, or major social transitions); and (3) clearer expectations for documenting how the person understood and evaluated “reasonable and available” alternatives, including what information was provided and how refusals were explored (Appelbaum, 2007; CAMAP, 2020; CPSO, 2023). These targets do not alter the legal threshold. They increase reviewability, reduce unwarranted variance, and make it more feasible to distinguish conscientious clinical discretion from documentation thinness that is difficult to govern.

Voluntariness and Undue Influence

Voluntariness is a statutory eligibility requirement, framed in the Criminal Code as a “voluntary request” that, in particular, was not made as a result of external pressure (Department of Justice Canada, 2026). In Track 2 governance terms, voluntariness is not best treated as a binary checkbox but as an evidentiary conclusion that must be supported by explicit assessor reasoning in the clinical record. This is because Track 2 cases more often unfold in contexts where dependence, social vulnerability, and service gaps can shape preferences without producing overt coercion, increasing both the discretion burden on assessors and the retrospective review burden on oversight systems (Close et al., 2025).

Canadian practice guidance generally reiterates the legal requirement while leaving substantial latitude in how it is operationalized. Health Canada’s Model Practice Standard requires assessors and providers to be satisfied that the person’s decision has been made freely, without undue influence, and related guidance explicitly notes that undue influence can reflect current pressure or the residual effects of past abusive dynamics, while also cautioning against assuming that trauma exposure alone negates voluntariness (Health Canada, 2023a; Health Canada, 2023b). Provincial regulator guidance similarly emphasizes private conversations with the person and a reasoned conclusion that the request is free from external pressure, but across jurisdictions the degree of procedural specificity varies, which can reduce comparability and auditability across Track 2 practice settings (CPSO, 2023; CPSNL, 2023).

A safeguards review benefits from separating two analytically distinct pathways to non-voluntariness. The first is interpersonal coercion or exploitation, where another party exerts control through intimidation, threats, manipulation, gatekeeping access to clinicians, or leveraging dependency. The second is “options constrained” voluntariness, where the person experiences MAiD as the only tolerable exit because adequate supports are inaccessible, unaffordable, or practically unavailable. The Criminal Code test targets external pressure, but regulators and monitoring bodies still require assessors to identify and respond to both interpersonal risk and structural constraint, because both can undermine meaningful freedom in decision-making, even if only the first cleanly resembles classic coercion (Department of Justice Canada, 2026; Health Canada, 2023a).

Tools and concepts from the undue influence literature can strengthen the operational clarity of this safeguard without importing a foreign legal test. Adult protective services frameworks commonly organize undue influence around a small number of domains: vulnerability and dependency, influencer power or authority, tactics (for example isolation, intimidation, deception), and outcomes that appear incongruent with the person’s long-standing values or interests. These domains can be repurposed as a structured inquiry guide for MAiD assessors, with the aim of standardizing what is explored and documented rather than dictating a conclusion (National Adult Protective Services Association, 2019; Quinn et al., 2017). For Track 2, the value is governance-oriented: a shared “assessment grammar” increases consistency across clinicians and creates documentation that is more reviewable for quality assurance.

Operationally, a minimum-standard approach to voluntariness in Track 2 can be specified in documentation terms. At minimum, the record should show that the assessor met with the person privately at least once, assessed for relational pressure and gatekeeping, explored the person’s perceived alternatives and fears, and documented the basis for concluding the decision was free of undue influence. When concerns are detected, the record should show what actions were taken (for example additional private interviews, collateral information where appropriate, involvement of safeguarding resources, or pausing the process) and how concerns were resolved or why they remained non-disqualifying (CPSO, 2023; Health Canada, 2023a). This is a standardization target that preserves clinical discretion while reducing the risk that voluntariness becomes an under-documented inference.

Monitoring limits are central to the safeguards review because voluntariness is difficult to audit using administrative reporting fields. Federal reporting can describe counts, timelines, and some contextual variables, but it does not capture whether private interviews occurred, whether family members shaped access, how potential coercion cues were evaluated, or how structural constraints were weighed in the assessor's reasoning. As a result, monitoring can identify patterns that merit scrutiny but cannot validate the internal quality of voluntariness assessments, which makes documentation expectations and selective chart audit strategies the practical levers for governance improvement in Track 2 (Close et al., 2025; Health Canada, 2023a).

Irremediability

In Track 2, irremediability is the most governance-sensitive eligibility element because it sits at the boundary between legal threshold language and inherently clinical, value-laden judgment. The Criminal Code's "grievous and irremediable medical condition" test is operationalized through constituent elements including a serious and incurable illness, disease, or disability, an advanced state of irreversible decline in capability, and enduring suffering that is intolerable to the person and cannot be relieved under conditions the person considers acceptable (Department of Justice Canada, 2020; Government of Canada, 2021). Track 2 adds that the person's natural death is not reasonably foreseeable, which shifts irremediability away from a near-term trajectory anchor and toward longer-horizon judgments about decline, suffering, and the role of acceptable relief.

Regulatory and practice guidance typically translates this legal language into documentation expectations without fully standardizing how the inferential step is made. Health Canada's Model Practice Standard and provincial regulator guidance emphasize that assessors must be satisfied that eligibility criteria are met, that they must apply reasonable clinical judgment, and that they should document the rationale supporting their conclusions (Health Canada, 2023a; CPSO, 2023). From a safeguards-review perspective, the core issue is not whether irremediability can be judged, but whether the decision pathway is consistently reconstructible from the record across clinicians and jurisdictions. When the reasoning is implicit rather than explicit, the safeguard becomes difficult to govern because disagreement or drift cannot be detected without intensive case-level review (Close et al., 2025).

A key conceptual complication is that irremediability, as used in MAiD law, is not a simple biomedical predicate. It is a composite judgment that integrates prognosis, response to interventions, burden and acceptability of further interventions, and the person's evaluative stance toward relief options. This is precisely why Track 2 irremediability becomes tightly coupled to the "means available to relieve suffering" safeguard. In practice, assessors must show not only that the illness or disability is serious and incurable, but that the pattern of decline and suffering is unlikely to be meaningfully altered by reasonable and available measures that the person would consider acceptable (Department of Justice Canada, 2020; Health Canada, 2023a). Governance implications follow directly: if "acceptability" functions as a major determinant, then the record must show what was proposed, what was feasible, what was declined, and why the assessor still concluded that the condition is irremediable in the MAiD sense rather than merely currently unrelieved.

Track 2 also concentrates practice variability in how "irreversible decline" is interpreted in non-terminal contexts. Decline may be medical (progressive disease), functional (loss of capability), relational (increasing dependence), or environmental (loss of housing or supports). While law foregrounds capability, the lived structure of suffering is often multi-domain, which can lead to inconsistent emphasis across assessors if a shared operational frame is absent (Government of Canada, 2021; Close et al., 2025). For rubric purposes, this is where conceptual and ethical analysis is load-bearing: the safeguard is at risk of drifting into a broad "life is intolerable" formulation unless records consistently anchor the conclusion to the statutory elements and demonstrate the reasoning bridge between observed decline and the determination that relief is not realistically attainable under acceptable conditions.

This safeguard is also where monitoring proxies and data limits are most likely to be misinterpreted. Federal reporting can summarize Track 2 volumes, timelines, and some service indicators, but it cannot validate the internal logic of irremediability determinations because it does not capture the evidentiary basis for incurability, the operational definition of decline applied in the case, or the decision rationale regarding acceptability of relief (Health Canada, 2025). As a result, system-level signals can support pattern detection, but they cannot adjudicate whether irremediability is being applied consistently or whether it is absorbing structural constraints that properly belong in an equity analysis. Governance therefore depends on standardization at the documentation layer and targeted audit capacity rather than on routine administrative fields (Close et al., 2025; Health Canada, 2025).

A further governance pressure point involves conditions where prognosis and treatment response are uncertain or heterogeneous, particularly when mental disorder is prominent in the clinical picture. Even without taking a position on future eligibility for mental disorder as the sole underlying medical condition, the broader lesson for Track 2 safeguards is that

“irremediability” becomes least standardizable precisely where outcomes are most variable and where the person’s tolerability of interventions is most central. Canadian expert synthesis has highlighted that uncertainty about prognosis and about treatment response, and variability in defining treatment adequacy, create predictable disagreement in irremediability judgments when psychiatric conditions are central (Council of Canadian Academies, 2018). This reinforces a general Track 2 safeguard implication: when uncertainty is structurally high, governance must shift from expecting uniform conclusions to expecting uniform transparency, including explicit articulation of uncertainty, rationale, and the steps taken to test key assumptions.

For the rubric and for practical safeguard improvement, the most defensible standardization target is a minimum “irremediability reasoning set” that makes determinations reviewable without making them mechanical. At minimum, the record should (1) specify the serious and incurable condition(s) considered relevant, (2) describe the advanced and irreversible decline in capability as it was interpreted in this case, (3) link the person’s suffering to that condition and decline, (4) document the relief options discussed that were reasonable and available in the person’s circumstances, (5) document what was tried or declined and why, and (6) state the assessor’s rationale for concluding that suffering cannot be relieved under conditions acceptable to the person, while explicitly noting major uncertainties where present (Department of Justice Canada, 2020; Health Canada, 2023a). This preserves clinical discretion while creating a common governance surface for Track 2 auditing, quality improvement, and inter-jurisdictional comparability.

Reasonable Alternatives and Serious Consideration

In Track 2, the “reasonable and available means to relieve suffering” safeguard is a statutory requirement embedded in the Criminal Code eligibility and procedural framework. It requires that the person be informed of means available to relieve suffering, including where appropriate counselling services, mental health and disability support services, community services, and palliative care, and that they be offered consultations with relevant professionals who provide those services. Track 2 further requires that the assessor and provider agree with the person that the person has given serious consideration to those reasonable and available means (Department of Justice Canada, 2020; Government of Canada, 2021).

Operationally, this safeguard is not satisfied by listing services. It is satisfied by a documented process showing what was discussed, what consultations were meaningfully available in the person’s context, how feasibility barriers were addressed, and how the assessor reached an agreement with the person that serious consideration occurred. The governance problem is that national and provincial guidance often restates the requirement while leaving wide variation in what counts as sufficient inquiry and sufficient documentation, which reduces inter-case comparability and makes audit judgments unstable (Health Canada, 2023a; Close et al., 2025). In practical terms, the minimum documentation surface for review should include the domains discussed, what was offered, what was feasible, what was tried or declined, and the stated rationale for concluding serious consideration, including how the assessor handled access barriers.

Conceptually, Track 2 “serious consideration” is a safeguard against options-constrained requests, not a requirement that the person must accept interventions. The safeguard asks assessors to distinguish an informed, values-consistent refusal of interventions from a refusal driven by misunderstanding, unrealistic expectations, untreated symptoms that distort appraisal, or an avoidable collapse of options under conditions of social or service deprivation. This is the point where the safeguard links directly to capacity and voluntariness, because what looks like stable preference can reflect decisional narrowing under constraint even when basic decision-making abilities are intact (Health Canada, 2023a; Health Canada, 2025). In governance terms, the safeguard is doing its work when the record shows that alternatives were explored as real options with real constraints, and that the conclusion was reached through explicit reasoning rather than inference-by-form.

Monitoring proxies can indicate that the safeguard is under strain, but they cannot validate its quality. System-level indicators such as low uptake of palliative care or disability supports among Track 2 recipients, regional variation in service access, or clustering of Track 2 cases among a small number of practitioners can signal where further oversight attention may be warranted, but they do not show whether serious consideration occurred or whether the agreement requirement was met through robust dialogue (Health Canada, 2025). For the rubric, these are pattern-detection signals that should trigger targeted review rather than reassure compliance.

Administrative reporting cannot capture the content and quality of the “serious consideration” process. Reporting fields do not record what information was provided, the realism of the options discussed, the person’s understanding of trade-offs, or the steps taken to mitigate access barriers, so routine monitoring cannot adjudicate whether the safeguard functioned as intended in a given case. This creates a governance dependency on documentation standards and selective chart audit capacity, because the safeguard is primarily evidenced by narrative reasoning rather than by countable events (Close et al., 2025; Health Canada, 2025).

This safeguard is an equity stress-test because “reasonable and available” is not evenly distributed. Where counselling, home care, disability supports, accessible housing, or palliative services are practically unavailable, the safeguard risks becoming nominal, and the assessment record must show how the assessor evaluated availability and how structural barriers were handled in the reasoning process. Track 2 governance therefore requires a disciplined way to document when suffering is being shaped by remediable service gaps versus enduring suffering that persists despite realistic supports, without collapsing that distinction into moral judgment. When the system cannot provide core supports, the record must still make clear what was feasible, what was offered, and why the assessor concluded that serious consideration occurred under those conditions (Health Canada, 2023a; Health Canada, 2025).

Structural Vulnerability

Track 2 eligibility requires voluntariness, capacity, and satisfaction of the grievous and irremediable condition criteria, but the statute does not separately define “structural vulnerability” as an exclusion or modifier. Instead, structural vulnerability enters governance through how assessors interpret and document voluntariness, serious consideration of reasonable and available means, and the acceptability boundary in relief options (Department of Justice Canada, 2020; Government of Canada, 2021). The safeguards question is therefore indirect but unavoidable: whether Track 2 processes can reliably distinguish autonomous requests made in enduring, irremediable suffering from requests meaningfully shaped by remediable deprivation, exclusion, or service failure.

Operationally, structural vulnerability should be treated as a required inquiry domain that informs, but does not replace, the core eligibility determinations. A governance-consistent approach is to specify minimum documentation elements that make structural constraints visible and reviewable, without turning the safeguard into an adversarial test of deservingness. At minimum, the record should identify salient constraints that affect options in practice, such as housing precarity, inability to access disability supports, lack of home care, barriers to pain and symptom management, social isolation, or safety concerns, and should document what was offered, what was feasible, and how feasibility constraints were handled in the serious-consideration reasoning (Health Canada, 2023a; Health Canada, 2025). This is a documentation standardization move: it increases comparability and permits audit of whether “reasonable and available” was treated as an empirical access reality rather than a theoretical menu.

Conceptually, structural vulnerability is best understood as layered and situational, not as a stable attribute of persons. In this framing, vulnerability is produced when social position and system design create predictable exposures and constraint, and it can intensify or recede as conditions change. This matters for Track 2 because the safeguard-relevant question is not whether a person is “vulnerable,” but whether identifiable constraints are narrowing the person’s perceived and real alternatives in ways that could distort voluntariness and the interpretation of intolerability. A layered vulnerability model provides a disciplined governance vocabulary for discussing constraint without collapsing into stigma or paternalism, and it supports a consistent approach to documenting how constraints were explored and addressed (Luna, 2009; Rogers et al., 2012). It also clarifies why equity cannot be handled as an afterthought: when constraints are materially unequal, the same procedural safeguard can have unequal protective strength.

Monitoring proxies for structural vulnerability are necessarily indirect. Federal reports can summarize neighbourhood-level income patterns, remoteness distributions, broad service contact indicators (for example palliative care or disability support services), and some request outcomes, which can surface where constraints may be concentrated and where Track 2 uptake may diverge from baseline patterns (Health Canada, 2025). These proxies are useful for triage and hypothesis generation, including identifying jurisdictions or settings where “reasonable and available” may be structurally thin. They are not measures of whether constraint influenced the request, because constraint influence is a case-level inference that depends on narrative evidence and clinician reasoning.

Administrative data are poorly suited to measuring lived constraint. Even when neighbourhood-level indicators are reported, they are ecological and cannot identify individual-level access barriers, informal caregiving pressures, experiences of discrimination, or the practical availability of services in the person’s immediate context. Likewise, fields indicating that a service was “received” or “accessible” cannot establish adequacy, timeliness, cultural safety, or whether the service addressed the person’s priority suffering. For safeguards governance, this implies that structural vulnerability cannot be meaningfully audited through reporting fields alone. It requires documentation expectations that capture feasibility and barriers in a structured way, and it may require targeted chart audit methods that explicitly sample cases where proxies suggest higher constraint risk (Close et al., 2025; Health Canada, 2025).

Structural vulnerability is an equity stress-test because it probes whether Track 2 eligibility processes are robust under unequal conditions of support and access. The governance aim is not to disqualify people who live under constraint, but to

prevent silent substitution of MAiD for supports that are nominally “available” yet practically unattainable. This is why Track 2 standardization should emphasize consistent recording of (1) which alternatives were realistically accessible, (2) which barriers were identified, (3) what mitigation was attempted, and (4) how the assessor concluded that serious consideration occurred despite constraints, or how the process was paused when the request appeared materially driven by remediable deprivation. The equity function of the safeguard becomes auditable only when this reasoning surface is consistently present in the record (Health Canada, 2023a; Health Canada, 2025).

Cross-Cutting Governance Synthesis and Standardization Levers

Across Track 2 safeguards, the recurring governance problem is not the absence of legal standards, but the absence of standardized, reviewable reasoning surfaces that allow consistent oversight under high clinical discretion. The statutory elements define what must be true, and regulator standards describe what clinicians should do, but most safeguards ultimately live or fail in the quality of documentation that links observations to conclusions in a way that is reconstructible by a third party. This is the shared structural feature across capacity, voluntariness, irremediability, and serious consideration: each requires a defensible inference, and each becomes difficult to audit when that inference is not made explicit in the record (Department of Justice Canada, 2020; Close et al., 2025).

A governance-oriented way to specify “what needs standardizing” is to distinguish structure, process, and outcome layers. Track 2 oversight already has substantial structure, including eligibility elements, procedural requirements, and reporting obligations. The weakest and most variable layer is process, meaning the observable work of assessment, consultation, documentation, and reassessment over time. Outcomes, by contrast, are not a substitute for safeguard quality because Track 2 outcomes do not reveal whether safeguards were applied with robust inquiry, particularly where coercion risk, access barriers, or decisional narrowing are plausible. This structure process outcome framing clarifies why documentation standardization is not bureaucratic excess in Track 2, but the primary mechanism by which safeguards become governable (Donabedian, 1988; Health Canada, 2025).

From the rubric perspective, the most actionable lever is a minimal common dataset embedded in clinical notes, not expanded reporting fields. A minimal dataset would consist of safeguard-specific documentation elements that map to the inferential burden of each safeguard and that are stable across settings. For capacity, this means functional evidence and reassessment triggers. For voluntariness, it means private interviews and inquiry into pressure and gatekeeping. For irremediability, it means explicit linkage between condition, irreversible decline in capability, intolerable suffering, and the acceptability boundary in relief. For serious consideration, it means what was discussed, what was feasible, what was tried or declined, and how barriers were handled. For structural vulnerability, it means documenting feasibility constraints and mitigation efforts in a way that is reviewable rather than moralized (Health Canada, 2023a; Health Canada, 2025).

Because routine administrative monitoring cannot validate inferential quality, the second lever is risk-informed chart audit. This does not require universal, intensive review. It requires a sampling strategy that uses monitoring proxies to identify where safeguards are most likely to be under strain and then examines the reasoning surface in the record. Examples of defensible triggers include shortened assessment periods, unusually rapid timelines, high practitioner concentration, repeated patterns of minimal documentation in serious consideration, and cases with prominent access barriers that raise equity stress-tests. The governance rationale is aligned with established quality improvement logic: audit works when it targets modifiable processes, uses explicit criteria, and is linked to feedback and learning rather than solely punitive action (Ivers et al., 2012).

Audit alone is insufficient if it is not paired with feedback mechanisms that clinicians can use to improve practice and documentation. The evidence base on audit and feedback in healthcare suggests that effects are typically modest but meaningful, and stronger when baseline performance is low, feedback is delivered by a credible source, targets are explicit, and actions are practical rather than abstract. Track 2 is an unusually high-stakes domain for applying this logic because documentation is both a clinical tool and an accountability artifact. A governance model that treats documentation as a learning target, rather than merely a compliance artifact, is more likely to reduce variance and improve reviewability across settings (Ivers et al., 2012; Close et al., 2025).

Finally, the rubric highlights a recurring interpretive risk: conflating data availability with safeguard adequacy. Federal reports are essential for system surveillance, but they are not evidence that safeguard reasoning was robust in individual cases. This is particularly salient for voluntariness, serious consideration, and structural vulnerability, where the decisive facts are narrative and contextual. Governance improvement therefore depends on aligning the oversight tool with the nature of the safeguard. Where the safeguard is inferential and narrative, the oversight tool must examine inferential documentation, not just count events (Health Canada, 2025; Close et al., 2025).

Figure 2 summarizes the cross-walk between Track 2 safeguard domains and our rubric codes (LS, OG, CE, EV, MP, DL, EQ), consolidating the key governance-relevant points raised across capacity, voluntariness and undue influence, irremediability, serious consideration of reasonable and available means, oversight and accountability, and structural vulnerability.

Figure 2
Track 2 safeguards rubric summary matrix (LS, OG, CE, EV, MP, DL, EQ)

| | LS | OG | CE | EV | MP | DL | EQ |
|---|---|---|---|---|---|--|---|
| Capacity (Track 2) | Decision specific, time specific capacity threshold; informed consent required; Track 2 90 clear days rule interacts with capacity loss | Minimum documentation set; explicit appreciation and reasoning evidence; reassessment triggers; consult thresholds | Autonomy supported by functional capacity; risk of decisional narrowing mistaken for incapacity or vice versa | Variable use of structured approaches; variability in documentation depth and reassessment practice | Shortened 90 clear days; rapid trajectory; multiple assessor notes; frequent revisions in plan | Administrative fields cannot audit appreciation and reasoning; record quality drives reviewability | Communication barriers; disability and cognitive fluctuation; unequal access to supportive assessment resources |
| Voluntariness and undue influence | Voluntary request; not a result of external pressure; undue influence prohibited | Private interview documented; inquiry domains and gatekeeping checks; actions and resolutions when concerns | Relational influence versus undue influence; options constrained context can undermine meaningful freedom | Variable screening and recording of coercion and exploitation cues; variable responses to concerns | High dependence contexts; caregiver gatekeeping patterns; repeat notes about family presence in visits | Reporting cannot capture private interview, gatekeeping, coercion cues, or resolution reasoning | Poverty, dependence, isolation, disability, discrimination can amplify pressure and reduce real alternatives |
| Irremediability (Track 2) | Grievous and irremediable condition elements; NREFD context increases inferential burden | Minimum reasoning set: condition, decline, suffering link, options discussed, acceptability logic, uncertainty stated | Composite judgment; acceptability central; risk of drift to broad intolerability without statutory anchoring | Variable interpretation of irreversible decline and acceptability; heterogeneity under uncertainty | Clusters of rapid Track 2 trajectories; repeated patterns of minimal rationale across cases in a region | Reporting cannot validate incurability, decline interpretation, or acceptability rationale | Unequal access to interventions shifts acceptability and feasibility uncertainty can bias determinations |
| Reasonable alternatives and serious consideration | Inform of means to relieve suffering; offer relevant consultations; agree serious consideration occurred | Document domains discussed, offers, feasibility, what tried or declined, barrier handling, rationale for agreement | Not coercion to accept care; safeguard against substitution of MAiD for remediable suffering under constraint | High variability by service availability, clinician knowledge of resources, and local feasibility | Low service uptake in Track 2; regional feasibility gaps; clustering by a small set of clinicians | Reporting cannot capture content and quality of serious consideration dialogue or barrier mitigation | Reasonable and available not evenly distributed; safeguards weaken where services are practically unattainable |
| Oversight and accountability | Layered regime: Criminal Code, regulators, institutions, federal reporting obligations | Pre controls plus post review; standardize documentation; risk informed chart audit; feedback loops | Do not treat form completion as evidence of robust reasoning; oversight must match safeguard epistemics | Practitioner concentration and regional variability shape norms; uneven oversight intensity across settings | Track 2 volumes, timelines, concentration; repeated minimal documentation patterns in sampled audits | Monitoring good for surveillance, weak for case quality; requires documentation standards plus audits | Oversight must be proportionate where constraints concentrate; ensure fairness and non stigmatizing review |
| Structural vulnerability | Not a separate statutory exclusion; enters through voluntariness, serious consideration, acceptability boundary | Treat as required inquiry domain; record constraints, feasibility, mitigation, reasoning link to safeguards | Layers not labels; vulnerability is situational and produced by constraints; avoid stigma and paternalism | Constraints unevenly distributed; predictable differential access across disability supports, housing, care | Neighbourhood level income or remoteness patterns; service contact indicators; local access constraints | Ecological indicators not individual access; service received not adequacy; narrative constraints not captured | Core equity stress test: prevent silent substitution of MAiD for supports; require feasibility documentation |
| Cross-cutting governance synthesis | Standards exist; governability depends on reviewable reasoning surfaces under discretion | Define safeguard specific minimum datasets; embed into notes; align audit criteria to inferential safeguards | Separate structure, process, outcome; process is weakest; documentation is the main governance surface | Audit and feedback effects modest but meaningful; strongest where baseline performance is low | Use proxies to triage chart audit rather than to infer safeguard quality | Avoid equating data availability with safeguard adequacy; treat reporting as pattern detection | Embed equity stress testing into audit triggers and documentation expectation |



Conclusion

Track 2 MAiD safeguards in Canada are anchored in clear statutory eligibility criteria and procedural requirements, but their practical protective strength depends on how consistently those requirements are operationalized and documented across jurisdictions and clinical contexts (Department of Justice Canada, 2020; Government of Canada, 2021; Close et al., 2025). Across the safeguards reviewed, the principal governance vulnerability is not the absence of standards, but the absence of standardized, reviewable reasoning surfaces that allow independent reconstruction of how key determinations were reached under conditions of high clinical discretion (Health Canada, 2023a; Health Canada, 2025).

A safeguards-forward governance response should prioritize standardization that preserves clinical discretion while improving auditability and inter-case comparability. First, implement a minimum documentation set for each safeguard, explicitly mapped to the inferential burden of the legal criteria, including capacity evidence and reassessment triggers, voluntariness inquiry elements and private interview confirmation, irremediability reasoning anchors, serious consideration documentation under feasibility constraints, and explicit recording of structural barriers and mitigation efforts where relevant (Donabedian, 1988; Health Canada, 2023a; Health Canada, 2025). Second, pair documentation standardization with risk-informed chart audit and structured feedback loops, using monitoring proxies to target review where safeguards are most likely to be strained and where learning value is highest, rather than relying on administrative reporting fields to validate safeguard quality (Ivers et al., 2012; Close et al., 2025; Health Canada, 2025). Third, embed equity stress-testing into oversight routines by requiring that constrained options and access barriers be documented as feasibility realities rather than treated as background context, supporting consistent differentiation between enduring suffering and remediable deprivation in the safeguard reasoning record (Luna, 2009; Rogers et al., 2012; Health Canada, 2025).

These recommendations do not propose changes to eligibility thresholds. They aim to strengthen governance by making safeguard reasoning more transparent, comparable, and reviewable, and by aligning oversight tools with the nature of Track 2 safeguards, which are often narrative, contextual, and inferential rather than readily reducible to countable events (Health Canada, 2025; Close et al., 2025). On the current monitoring architecture, federal reporting can support system surveillance and pattern detection, but it cannot adjudicate the internal quality of safeguard application in individual cases. The most defensible path to improved accountability is therefore to standardize documentation surfaces, audit them selectively and proportionately, and treat monitoring data as a triage layer rather than as proof of safeguard robustness (Health Canada, 2025; Close et al., 2025).

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