Legal and Ethics Considerations in Capacity Evaluation for Medical Aid in Dying

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Evaluating decisional capacity for patients seeking medical aid in dying (MAID) raises challenging legal, logistical, and ethics questions. The existing literature on the subject has been shaped largely by early disagreements over whether effective capacity assessment for such patients is ever possible, which in turn stemmed from debates over the ethics of MAID itself. In attempting to establish meaningful criteria for assessments, many jurisdictions have sought either to apply or to adapt models of capacity evaluation designed for other forms of medical decision-making, such as the widely used "four skills" model, failing to account for the fundamental differences in kind between these other decisions and MAID. This article seeks to reexamine these questions with a focus on two logistical matters (the appropriate credentialing for the evaluator and the potential liability of the evaluator) and three clinical matters (level of understanding, clinical scrutiny and certainty, and impairment) in an effort to raise legal and ethics concerns that remain unresolved, even as MAID is permitted in an increasing number of jurisdictions.

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Medical aid in dying (MAID) refers to the process in which physicians or other health care professionals provide patients with means, usually prescription medications, that enable these patients to terminate their own lives.[1] The practice remains prohibited throughout much of the world, but in the past 25 years, the trend has been toward increasing legalization.[2] At present, MAID is legally permitted in 11 jurisdictions within the United States (California, Colorado, District of Columbia, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington) and 13 other nations. Nine nations have legalized the process by statute, one (Switzerland) via the absence of a statutory prohibition and another three through court order (see Table 1).[3–28] Each of these jurisdictions lays out specific criteria for patient eligibility, usually limiting the practice to individuals with terminal or intractable medical conditions or otherwise poor medical prognoses. (Of note, a literature proposing the concept of "terminal" psychiatric illness has recently emerged but remains controversial and has not yet been accepted in either statutory law or by courts in the United States, and the use of the term with regard to anorexia nervosa has raised objections from a subset of patients and providers.[29–35]) The vast majority of these jurisdictions, although not all, also require that a patient demonstrate decisional capacity, or its legal equivalent, before proceeding with MAID. Although some of these statutes, particularly those in the United States, offer general criteria for determining capacity, these criteria often mirror those used for other medical decisions, ignoring the fundamental differences between choosing MAID and consenting to a routine clinical intervention, such as a surgical procedure or a diagnostic test. In addition, although considerable attention in the literature has been devoted to the theoretical implications of capacity evaluation in MAID, such as whether it can be assessed impartially, logistical questions regarding the process itself have

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Table 1 Capacity in State and National MAID Statutes

State/Country	Year	Evaluator(s)	Capacity Standard
California	2016	Two physicians must determine that the patient is capable. "If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment," defined as either a psychiatrist or a psychologist, to determine whether "the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder."[3]	"'Capacity to make medical decisions' means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist,. . . the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers."[3]
Colorado	2016	Two physicians must determine that the patient is capable. "If the attending physician believes that the individual may not be mentally capable of making an informed decision" then the physician must "refer the individual to a licensed mental health professional for a determination of whether the individual is mentally capable."[4]	"Mental capacity" or "mentally capable" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, the individual has the ability to make and communicate an informed decision to health care providers.[4]
District of Columbia	2017	Two physicians must determine that the patient is capable. "If either physician believes the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient to counseling to determine that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[5]	"'Capable' means that, in the opinion of a court or the patient's attending physician, consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers."[5]
Hawaii	2019	Hawaii requires two physicians or advanced practice registered nurses determine that patient is capable and also that a psychiatrist, psychologist, social worker, or marriage or family therapist has also determined that the patient "does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision."[6]	"'Capable' means that in the opinion of the patient's attending provider or consulting provider, psychiatrist, psychologist, or clinical social worker, a patient has the ability to understand the patient's choices for care, including risks and benefits, and make and communicate health care decisions to health care providers."[6]
Maine	2019	Two physicians must determine that the patient is "competent"; if either physician believes the patient is "suffering from a psychiatric or psychological disorder or depression causing impaired judgment," then the patient shall be referred for counseling until such time as the counselor determines that "the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[7]	"'Competent' means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available."[7]
Montana	2009	Capacity in Montana is determined by any health care provider.[8] No distinct statutory guidance or regulation for MAID.	Montana defines "decisional capacity" more generally as "the ability to provide informed consent to or refuse medical treatment or the ability to make an informed health care decision as determined by a health care provider experienced in this type of assessment."[8] The right to MAID was established in *Baxter v. Montana*,[9] which requires patients approved for MAID be "competent" but does not offer a definition of this term.
New Mexico	2021	Two physicians must determine that the patient is capable. "If an individual has a recent history of a mental health disorder or an intellectual disability that could cause impaired judgment with regard to end-of-life medical decision making, or if, in the opinion of the prescribing health care provider or consulting health care provider, an individual currently has a mental health disorder or an intellectual disability that may cause impaired judgment with regard to end-of-life medical decision making, the individual shall not be determined to have capacity to make end-of-life decisions until the: A. health care provider refers the individual for evaluation by a mental health professional with the training and expertise to assess a person with such a disorder or disability; and B. mental health professional determines the individual to have capacity to make end-of-life decisions after evaluating the individual during one or more visits with the individual."[10]	"'Capacity' means an individual's ability to understand and appreciate health care options available to that individual, including significant benefits and risks, and to make and communicate an informed health care decision."[10]

Table 1 Continued

State/Country	Year	Evaluator(s)	Capacity Standard
New Jersey	2019	Two physicians must determine that the patient is capable. "If, in the medical opinion of the attending physician or the consulting physician, a patient. . . may not be capable, the physician shall refer the patient to a mental health care professional to determine whether the patient is capable."[11]	"'Capable' means having the capacity to make health care decisions and to communicate them to a health care provider, including communication through persons familiar with the patient's manner of communicating if those persons are available."[11]
Oregon	1994	Two physicians must determine that the patient is capable. If either physician believes the patient is "suffering from a psychiatric or psychological disorder or depression causing impaired judgment," then the patient shall be referred for counseling until such time as the counselor determines that "the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[12]	"Capable" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. In addition, the patient cannot be "suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[12]
Vermont	2013	Two physicians must determine that the patient is capable. The attending physician must either verify "that the patient did not have impaired judgment" or refer the patient to a "psychiatrist, psychologist, or clinical social worker licensed in Vermont" to make this verification.[13]	"'Capable' means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available. . . .'Impaired judgment' means that a person does not sufficiently understand or appreciate the relevant facts necessary to make an informed decision."[13]
Washington	2018	Two physicians must determine whether patient is "competent"; if "a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment," then a qualified mental health provider must determine that "the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[14]	"'Competent' means that, in the opinion of a court or in the opinion of the patient's attending qualified medical provider, consulting qualified medical provider, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available."[14]
Australia (New South Wales)	2019-2023	Each Australian state has its own MAID statute, but the New South Wales statute (2023) is reasonably representative. One practitioner is required to determine whether the patient has "decision-making capacity in relation to voluntary assisted dying" but must refer to a second physician for assessment if uncertain.[15]	NSW law states that a "patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to (a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and (b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and (c) understand the matters involved in a voluntary assisted dying decision, and (d) understand the effect of a voluntary assisted dying decision, and (e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and (f) communicate a voluntary assisted dying decision in some way." A "patient is (a) presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and (b) presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity."[15]
Austria	2021	"The establishment of an advance directive must be preceded by clarification by two medical professionals, one of whom must have palliative medical qualifications. They must independently confirm that the person willing to die is capable of making decisions and has expressed a free and self-determined decision. . . .If, during the course of medical clarification, an indication arises that the person willing to die may have a clinically significant mental disorder, the result of which could be the desire to end their life, an assessment of this disorder, including consultation by a specialist in psychiatry and psychotherapeutic medicine or a clinical psychologist, must be arranged. . . .; That specialist must determine that "the person willing to die must be of legal age and decision-capable both at	The statute does not define capacity.

Table 1 Continued

State/Country	Year	Evaluator(s)	Capacity Standard
		the time of clarification and at the time of establishing the advance directive Their capacity to make decisions must be indisputably present."[16]	
Belgium	2002	Law requires that patient be "legally competent and conscious at the moment of making the request," also that "the request is voluntary, well-considered and repeated, and is not the result of any external pressure."[17]	The statute does not define capacity or "legally competent."
Canada	2014-2016	Two medical providers (either physicians or nurse practitioners) must determine that the patient requesting MAID is "capable of making decisions with respect to their health."[18] A more recent statute (2021) also allows for MAID for "dying persons who have been found eligible to receive medical assistance in dying and are awaiting its provision to obtain medical assistance in dying even if they lose the capacity to provide final consent, except if they demonstrate signs of resistance to or refusal of the procedure."[19]	The statute does not define capacity.
Luxembourg	2009	A physician must determine that "the patient is a capable and conscious adult at the time of his or her request."[20]	The statute does not define capable.
Netherlands	2001	The statute requires that the decision to choose MAID be "well-considered" and that the physician exercise "due care" in assessment but does not directly address capacity or competence.[21]	Neither capacity or competence are defined or addressed in the statute.
New Zealand	2021	Patient must "be competent to make an informed decision about assisted dying" as assessed by two medical practitioners. If either or both question whether competence is "established to satisfaction," a psychiatrist must conduct an independent assessment.[22]	"Competent to make an informed decision about assisted dying" is specifically defined by four criteria in the statute. The person must be able to "(a) understand information about the nature of assisted dying that is relevant to the decision; and (b) retain that information to the extent necessary to make the decision; and (c) use or weigh that information as part of the process of making the decision; and (d) communicate the decision in some way."[22]
Portugal	2023	"The opinion of a doctor specializing in psychiatry is mandatory, whenever there is a one of the following situations: a) The guiding physician and/or the specialist physician have doubts about the capacity of the person who requests medically assisted death revealing a serious, free and enlightened will; b) The guiding physician and/or the specialist physician admit that the person has a mental disorder or medical condition that affects [the patient's] ability to make decisions." That psychiatrist then makes a determination of capacity.[23]	The statute does not define capacity.
Spain	2021	The statute requires "factual capacity" and states that "factual incapacity" is to be determined by a physician "in accordance with the operating protocols determined by the Interterritorial Council of the National Health System."[24]	The statute defines "situation of factual incapacity" as "a situation in which the patient lacks sufficient understanding and will to govern themselves autonomously, fully, and effectively, regardless of whether measures of support for the exercise of their legal capacity exist or have been adopted."[24]
Switzerland	Officially legal since 1937, but practice emerged in 1980s	Swiss law does not prohibit assisted suicide except in cases where the motive is profit or self-interest.[25] The Swiss Academy of Medical Sciences lays out guidelines for MAID that are the standard of care in Switzerland. These state that "the self-determination of a patient with capacity must be respected" with regard to MAID.[26]	The Swiss Academy of Medical Sciences offers extremely detailed guidance on capacity assessment for MAID but relies on the following four elements: "Cognitive ability: the ability to grasp at least the fundamental elements of the information relevant for the decision; Evaluative ability: the ability to assign a personal meaning to the decision situation, in the light of the various options available; Decisional ability: the ability to make a decision on the basis of the information available and one's own experience, motives and values; Expressive ability: the ability to communicate and defend this decision."[27]

MAID, medical aid in dying; NSW, New South Wales

Notes: MAID became legal in Quebec in 2014 but was not legalized until 2015 in the remainder of Canada. MAID for patients with psychiatric illness has been placed on hold in Canada until 2027.[28] Various Australian states legalized the practice over a four-year time period, with the first, Victoria, legalizing MAID in 2019, and the last, New South Wales, in 2023; the practice was previously legal in the Northern Territory (1996-97) but is not at present. Colombia, Germany, and Italy have all legalized MAID through judicial opinions, but statutory regulation has not yet codified capacity standards.

received far more limited consideration. This article seeks to address these gaps by examining both the logistical questions that arise in capacity assessment for MAID, the distinctive features of MAID that may render the process unsuited for traditional assessment mechanisms, and the difficulties with current approaches to these considerations.

Capacity

Although evaluating patients for capacity to render medical decisions occurred intermittently in an earlier era, the process became increasingly formalized in the United States during the 1970s and 1980s.[36] (Of note, this article uses the terms "capacity evaluation" and "capacity assessment" for clarity, as these remain the convention in the existing literature, but concerns have been raised that this terminology understates the impact of these interactions on patients, particularly those with limited social capital, and that the term "capacity challenge" may be preferable.[37]) Building on earlier work by Loren Roth and James Drane, Paul Appelbaum and Thomas Grisso proposed a widely accepted "four skills" model in 1988 that emphasized the importance of rational decision-making.[38–40] They developed this framework in the wake of the dramatic shift from a parentalistic model of health care delivery, which dominated American medical culture into the 1950s and 1960s, to one a generation later that placed primacy on the autonomous wishes of patients.[41] Their approach was patient-centered and focused on restoring patients to capacity to maximize autonomy. Unfortunately, in the ensuing years, Appelbaum and Grisso's framework has been applied to a range of cases for which it is less well suited, including to patients who do not believe in allopathic medicine at baseline, those volitionally unwilling to communicate, and those using denial as a coping mechanism. This has necessitated exceptions to their rules.[42] The four skills model has also faced challenges for its overemphasis on rationality (as opposed to values), the potentially deleterious impact of the evaluation process on patients with limited social capital, racial bias in its application, and considerable interrater variability.[37,43–47] In addition, the Committee on Professionalism and Ethics of the Group for the Advancement of Psychiatry has emphasized the importance of including emotional capacity as part of the overall assessment.[48]

To what degree these concerns apply specifically to MAID is unclear. For example, although interrater reliability is a well documented problem in decisional capacity assessment generally, data suggest that it may not be so with regard to MAID.[49] In any case, the purpose of this article is not to claim that the four skills approach, especially when used in conjunction with Buchanan and Brock's "decision relative" (or sliding scale) model, does not have a place in capacity assessment but rather that caution must be used when applying its principles to a situation far removed from those for which it was originally intended.[50] Although some scholars have "argued that the standard for capacity should be no different for [MAID] than for any other medical decisions," (Ref. 51, p 101627) this argument has generally been advanced by those scholars who favor MAID for patients with psychiatric illnesses when arguing that laws governing MAID should not treat medical and psychiatric illness differently. Yet such an approach conflates two distinct concerns. One might make a strong case that both patients with medical and with psychiatric illnesses ought to be eligible for MAID yet still believe that the overall capacity standards for MAID and for other medical decisions should be approached differently.

MAID was not legal in any American jurisdiction at the time when the four skills model developed. Nevertheless, these four skills (communicating choices, understanding relevant information, appreciating the situation and its consequences, and manipulating information rationally) have loosely been incorporated into many of the current MAID statutes in the United States (see Table 1), often with limited advance consideration of how they may apply specifically to MAID and how they may be operationalized.[40] The "validity" of this approach "can rarely be tested because the patient, if found competent, will presumably be dead" (Ref. 52, p 394). This difficulty in assessing validity does not mean that the current methods should be presumed to be effective without careful examination. Adapting the model to MAID may prove less fruitful than designing an alternative model from the outset that addresses the distinctive features of MAID.

Logistical Considerations

The Appropriate Evaluator

The initial logistical consideration in assessing the decisional capacity of patients seeking MAID is determining who will conduct the evaluation. All 11 U. S. jurisdictions that permit MAID assign this task to one or two physicians, although nine require a

mental health professional to be involved under narrower circumstances (see Table 1). Assessing the frequency of such referrals is difficult because jurisdictions generally report the number of patients who require referral and ultimately die from MAID, but not those who are found to lack decisional capacity and die from other causes. For instance, although Weithorn reports that "5 percent of the patients who ultimately died from [MAID]" in Oregon "had been referred for mental health evaluation and found competent by the consulting mental health professional," the lack of a known denominator makes these data challenging to interpret (Ref. 53, p 82). In any case, the absence of a legal mandate does not mean that individual hospitals cannot, or should not, require the involvement of psychiatrists, psychologists, or others with specialized training. For example, policy at the University of California San Francisco Medical Center (UCSFMC) requires that all patients seeking MAID be evaluated by a mental health provider even though state law does not require this additional safeguard.[54] In this regard, statutes serve merely as a floor, and health care institutions may be well advised to set more stringent requirements.

Even assigning the responsibility to a mental health professional or a psychiatrist does not fully resolve the question of what is the appropriate credentialing and training for the evaluator. In particular, when these cases arise in the hospital setting, the initial point of contact with behavioral health services is usually the consult-liaison (CL) psychiatry team. CL psychiatrists are generally well trained in decisional capacity assessment using the four skills model, but that does not mean they are necessarily the providers best suited for capacity assessment in MAID, especially if doing so were to require a different set of assessment criteria and tools. Alternatively, an outside psychiatrist with forensic training might be tasked with this distinctive form of assessment. Of note, that is the process that most hospitals use regarding capacity assessment for nonclinical matters, such as assessing a hospitalized patient's testamentary capacity to execute a will. Such an approach would help ensure a truly independent evaluation, as the CL team may also be involved in providing treatment and emotional support to patients, which may be perceived as inconsistent with evaluating for MAID. In addition, separating evaluative and therapeutic roles facilitates open communication between patients and CL psychiatrists; patients might otherwise fear that complete honesty in pursuit of care (for example, regarding symptoms of cognitive decline) could impede their ability to pursue MAID. On the other hand, the CL team is more likely to be familiar with the patient's personal narrative and the context for the patient's decision and to have engaged in the sorts of conversations "about how that individual had come to choose MAID" that clinicians find most helpful in making such determinations (Ref. 48, p E360). A third option, entirely theoretical at present, might involve the use of a novel class of professionals (whether medical doctors (MDs), psychologists, or nurse practitioners (NPs)) who have undergone clinical training specifically in the field of MAID capacity assessment, a niche that will potentially expand in coming years as more jurisdictions consider legalization. Whichever approach is ultimately adopted, care should be taken in advance to ensure that the parties charged with such assessments feel both competent and empowered to conduct them.

Evaluator Liability and Consequences

A second logistical consideration is whether, and under what circumstances, evaluators may face either legal or professional consequences for conducting capacity evaluations for MAID. This is a subject that arises in clinical practice but has received short shrift in the existing medicolegal literature. Many jurisdictions that do permit MAID offer statutory protection to shield individuals participating in the practice from these consequences. Oregon's Death with Dignity Act, for instance, states that "[n]o person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith" in MAID and also that "[n]o professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith" in MAID.[19] Whether the "loss of membership" provision is constitutional, in light of the U.S. Supreme Court's decision in *Boy Scouts of America v. Dale*, remains unclear.[55] In that case, the Court faced the question of whether the Boy Scouts of America (BSA) might exclude a gay Eagle Scout and assistant Scoutmaster, James Dale, based on their sexual orientation.[55] In a five-to-four decision, the Court ruled that even a "public accommodation" like the BSA might exclude an individual from membership if "the presence of that person affects in a significant way the group's ability to advocate public or

private viewpoints," regardless of any state law to the contrary (Ref. 55, p 648). Arguably, the same legal principle would allow a professional organization opposed to MAID to expel members with contrary viewpoints or engaged in MAID-related conduct, but Oregon's statutory provision has not yet been challenged.

In addition to Oregon, other jurisdictions offer more limited protections. For instance, Vermont's statute prevents "civil or criminal liability or professional disciplinary action," but not loss of membership in professional organizations.[20] Montana, which legalized MAID via judicial decision, does not protect physicians from professional consequences at all, although that state also does not yet require formal capacity assessment either.

In jurisdictions where MAID is legal, establishing protection from professional consequences, such as expulsion from medical organizations, may prove essential to availability. Otherwise, providers may be reluctant to provide capacity evaluations for MAID for fear of running afoul of organizations to which they belong. For instance, prior to November 2023, the American Medical Association's Code of Ethics objected to MAID on the grounds that the practice, which it termed "physician-assisted suicide," was "fundamentally incompatible with the physician's role as healer."[56] But, as early as 2019, the American Medical Association (AMA) also issued guidance that providers might provide MAID "according to the dictates of their conscience without violating their professional obligations."[57] More recently, in 2023, the AMA agreed to review both its use of the term physician-assisted suicide (PAS) and its position on MAID.[58] At present, the AMA officially objects to the practice. Many state medical associations stand opposed as well. The Montana Medical Association's position statement on MAID, for example, states that the organization "does not condone the deliberate act of precipitating the death of a patient," which may deter providers from involving themselves in any aspect of the practice, including capacity assessment.[59] Physicians and psychiatrists engaging in capacity evaluations for MAID in states where the practice is permitted should know the extent to which they are protected from legal and professional consequences. If the goal is to ensure the availability of MAID, expansive "good faith" protections, such as Oregon's, should be adopted. None of these protections, of course, can protect physicians from potential reputational damage or the possibility that other providers will decline to provide referrals to colleagues they perceive to be pro-MAID.

Far more legally complicated are capacity assessments for MAID for patients in jurisdictions in which the practice is not legal who are seeking to travel to other jurisdictions, whether domestic or abroad, where MAID is permitted to end their lives. In fact, many states have statutes that specifically criminalize facilitating suicide (see Table 2).[60–97] In New York State, for example, "a person is guilty" of a class E felony "when he intentionally causes or aids another person to attempt suicide" and "a person is guilty" of a class C felony, "when he intentionally causes or aids another person to commit suicide."[98] Conducting a capacity assessment for MAID for a patient who seeks to travel elsewhere to end his own life legally may constitute a form of manslaughter in New York State and prove similarly criminal in many other states. In a number of jurisdictions, the law on this subject remains uncertain, depending on such factors as whether capacity assessment for referral is considered a "physical act" related to the patient's subsequent death. These vague statutes create the hypothetical potential for severe penalties, even if they do not appear to be widely enforced against capacity evaluators. Moreover, because these capacity assessments rarely if ever come to the attention of law enforcement authorities, if enforcement would occur in a high-profile case remains unknown.

In practice, CL psychiatrists are frequently asked to conduct such assessments in states where MAID remains illegal, as patients may be reluctant to travel abroad for the procedure without prior documentation ensuring eligibility. Some psychiatrists, at least, apparently do perform such evaluations. In doing so, these providers may open themselves up to civil, as well as criminal, liability. In addition, the possibility exists that private employers, including medical schools, may be able to rely on violations of the AMA Code of Ethics as a basis for terminating faculty. This possibility arose in the matter of Bandy Lee, a psychiatrist fired by Yale for allegedly violating the "Goldwater rule" of the American Psychiatric Association (APA) that essentially prohibits diagnosing public figures whom one has not personally examined.[99–101] Although the APA does not enforce its "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" on nonmembers, that does not necessarily prevent other institutions from courts to academic employers from relying

Table 2 Potential Legal Liability for Capacity Assessment for MAID by State

State	Is MAID Legal?	Potential Liability for Assessing Capacity for MAID	Statutory Language
Alabama	No	Yes	"Any person who deliberately assists another person to commit suicide or provides aid in dying is guilty of a Class C felony. (b) Any physician or health care provider who prescribes any drug, compound, or substance to a patient deliberately to aid in dying or assists or performs any medical procedure deliberately to aid in dying is guilty of a Class C felony."[60]
Alaska	No	Yes	"A person commits the crime of manslaughter if the person. . . intentionally aids another person to commit suicide"[61]
Arizona	No	No	Law only applies if providing "physical means" for suicide.[62]
Arkansas	No	Unclear	"It is unlawful for a physician or healthcare provider to commit the offense of physician-assisted suicide by: (1) Prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient's life; or (2) Assisting in any medical procedure for the express purpose of assisting a patient to intentionally end the patient's life."[63]
California	Yes	No	NA
Colorado	Yes	No	NA
Connecticut	No	Yes	"A person is guilty of manslaughter in the second degree when. . . he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide."[64]
Delaware	No	Yes	"A person is guilty of promoting suicide when the person intentionally causes or aids another person to attempt suicide, or when the person intentionally aids another person to commit suicide."[65]
District of Columbia	Yes	No	NA
Florida	No	Yes	"Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree. . . "[66]
Georgia	No	Unclear	Georgia's statute states: "Any person who publicly advertises, offers, or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose is guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than one nor more than five years." Whether a hospital psychiatrist conducting a capacity assessment for MAID referral would be considering to be "holding himself or herself out" is uncertain.[67]
Hawaii	Yes	No	NA
Idaho	No	Yes	"A person is guilty of a felony if such person. . . [p]articipates in a physical act by which another person commits or attempts to commit suicide." Whether a capacity assessment constitutes a physical act is undetermined.[68]
Illinois	No	Unclear	"A person commits inducement to commit suicide when he or she. . . [w]ith knowledge that another person intends to commit or attempt to commit suicide, intentionally (i) offers and provides the physical means by which another person commits or attempts to commit suicide, or (ii) participates in a physical act by which another person commits or attempts to commit suicide." Whether a capacity assessment constitutes a physical act is undetermined.[69]
Indiana	No	Unclear	"A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following commits assisting suicide, a Level 5 felony: (1) Provides the physical means by which the other person attempts or commits suicide. (2) Participates in a physical act by which the other person attempts or commits suicide." Whether a capacity assessment constitutes a physical act is undetermined.[70]
Iowa	No	Yes	"A person commits a class 'C' felony if the person intentionally or knowingly assists, solicits, or incites another person to commit or attempt to commit suicide, or participates in a physical act by which another person commits or attempts to commit suicide."[71]
Kansas	No	Unclear	"Assisting suicide is. . . participating in a physical act by which another person commits or attempts to commit suicide." Whether a capacity assessment constitutes a physical act is undetermined.[72]
Kentucky	No	Unclear	"A person commits a Class C felony when the person. . . [p]articipates in a physical act by which another person commits or attempts to commit suicide." Whether a capacity assessment constitutes a physical act is undetermined.[73]
Louisiana	No	Yes	"Criminal assistance to suicide is: (1) The intentional advising or encouraging of another person to commit suicide or the providing of the physical means or the knowledge of such means to another person for the purpose of enabling the other person to commit

Table 2 Continued

State	Is MAID Legal?	Potential Liability for Assessing Capacity for MAID	Statutory Language
			or attempt to commit suicide. (2) The intentional advising, encouraging, or assisting of another person to commit suicide, or the participation in any physical act which causes, aids, abets, or assists another person in committing or attempting to commit suicide."[74]
Maine	Yes	No	NA
Maryland	No	No	Statute only makes it a crime to "knowingly provide the physical means by which another individual commits or attempts to commit suicide with knowledge of that individual's intent to use the physical means to commit suicide; or. . . knowingly participate in a physical act by which another individual commits or attempts to commit suicide."[75]
Massachusetts	No	No	No statutes in Massachusetts directly addressed MAID, and although the state Supreme Court has found no right to MAID, there do not appear to be grounds for criminal liability for capacity assessments for referral.
Michigan	No	Yes	"A person who knows that an individual intends to kill himself or herself and does any of the following with the intent to assist the individual in killing himself or herself is guilty of criminal assistance to the killing of an individual, a felony punishable by imprisonment for not more than 5 years or a fine of not more than $10,000.00, or both: (a) Provides the means by which the individual attempts to kill himself or herself or kills himself or herself. (b) Participates in an act by which the individual attempts to kill himself or herself or kills himself or herself. (c) Helps the individual plan to attempt to kill himself or herself or to kill himself or herself."[76] Of note, the Michigan statute does not preempt common law principles that may also prohibit such assessments.
Minnesota	No	Yes	Statute reads "Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000, or both."[77] Subsequent to its passage, the Minnesota Supreme Court in *State v. Melchert-Dinkel* (2014) declared the "encourages" and "advises" provisions to be unconstitutional but also held that assistance can consist solely of speech.[78]
Mississippi	No	Yes	"A person who willfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of felony and, on conviction, shall be punished by imprisonment in the penitentiary not exceeding ten years, or by fine not exceeding one thousand dollars, and imprisonment in the county jail not exceeding one year."[79]
Missouri	No	Yes	"A person commits the offense of voluntary manslaughter if he or she. . . [k]nowingly assists another in the commission of self-murder."[80]
Montana	Yes	No	Of note, providers may still face sanction from employers and professional associations.
Nebraska	No	Yes	"A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide."[81]
Nevada	No	No	No statutes in Nevada directly addressed MAID.
New Hampshire	No	Yes	"A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide"; "Causing or aiding suicide is a class B felony if the actor's conduct causes such suicide or an attempted suicide. Otherwise it is a misdemeanor."[82]
New Jersey	Yes	No	NA
New Mexico	Yes	No	NA
New York	No	Yes	"A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony."[83]
North Carolina	No	No	No statute appears to apply to MAID in North Carolina.
North Dakota	No	Yes	"Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide, or who provides to, delivers to, procures for, or prescribes for another person any drug or instrument with knowledge that the other person intends to attempt to commit suicide with the drug or instrument is guilty of a class C felony."[84]
Ohio	No	Unclear	"No person shall knowingly cause another person to commit or attempt to commit suicide by. . . [p]articipating in a physical act by which the other person commits or attempts to commit suicide."[85] Whether a capacity assessment constitutes a physical act is undetermined.

Table 2 Continued

State	Is MAID Legal?	Potential Liability for Assessing Capacity for MAID	Statutory Language
Oklahoma	No	Yes	"Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide."[86]
Oregon	Yes	No	NA
Pennsylvania	No	Yes	"Aiding or soliciting suicide as an independent offense. A person who intentionally aids or solicits another to die by suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor of the second degree."[87]
Rhode Island	No	Yes	"An individual or licensed health care practitioner who with the purpose of assisting another person to commit suicide knowingly. . . [p]articipates in a physical act by which another person commits or attempts to commit suicide is guilty of a felony and upon conviction may be punished by imprisonment for up to ten years, by a fine of up to ten thousand dollars ($10,000) or both."[88]
South Carolina	No	Unclear	"It is unlawful for a person to assist another person in committing suicide. A person assists another person in committing suicide if the person. . . participates in a physical act by which the other person commits or attempts to commit suicide."; "The licensing agency which issued a license or certification to a licensed health care professional who assists in a suicide in violation of subsection. . . shall revoke or suspend the license or certification of that person" on conviction.[89]
South Dakota	No	Yes	"Any person who intentionally in any manner advises, encourages, abets, or assists another person in taking or in attempting to take his or her own life is guilty of a Class 6 felony."[90]
Tennessee	No	Unclear	"A person commits the offense of assisted suicide who: (1) Intentionally provides another person with the means by which such person directly and intentionally brings about such person's own death; or (2) Intentionally participates in a physical act by which another person directly and intentionally brings about such person's own death." Whether capacity assessment for referral might be considered "intentionally participates in a physical act" is unclear.[91]
Texas	No	Yes	"A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide."[92]
Utah	No	Yes	"An actor commits manslaughter if the actor. . . intentionally, and with knowledge that another individual intends to commit suicide or attempt to commit suicide, aids the individual to commit suicide."[93]
Vermont	Yes	No	NA
Virginia	No	Yes	Civil liability and professional misconduct. "Any person who knowingly and intentionally, with the purpose of assisting another person to commit or attempt to commit suicide, participates in a physical act by which another person commits or attempts to commit suicide shall be liable for damages as provided in this section and may be enjoined from such acts."[94]; "A licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority."[94]
Washington	Yes	No	NA
West Virginia	No	No	No statutes in West Virginia directly addressed MAID, although it is mentioned in passing in the state's advance directive law.[95]
Wisconsin	No	Yes	"Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class H felony."[96]
Wyoming	No	Unclear	"A person is guilty of criminally negligent homicide if he causes the death of another person by conduct amounting to criminal negligence."[97]

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on these principles as professional standards.[99] The potential impact of the codes of voluntary professional associations, some of which proscribe participation in MAID, has significant practical implications. State civil and criminal law in nearly all jurisdictions in which MAID is not yet legal remains unresolved on these complex subjects. Providers operating in Veterans Affairs facilities and other federally run institutions may face additional restrictions and consequences. Physicians and psychiatrists engaging in capacity evaluations for MAID in jurisdictions where the practice is not authorized for patients planning to obtain MAID elsewhere may be entirely unaware of the legal and professional risks involved in conducting such assessments.

Clinical Considerations

Historical Context

The passage of Oregon's Death with Dignity Act in 1994 led to a dialogue in the medicolegal literature between those authorities who believed that impartial capacity assessment for MAID was possible and those who remained dubious. In the former camp, the team of psychologist James Werth at the University of Akron, G. Andrew H. Benjamin at the University of Washington, and Tony Farrenkopf of Portland, Oregon offered extensive guidelines for how to conduct capacity assessments for MAID consistent with the Oregon statute.[102] These included use of the MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR), initially designed by Appelbaum and Grisso, although Werth and colleagues acknowledged that the data for this measure largely stemmed from research settings and that the designers had pointedly avoided addressing its applicability to decisional capacity related to choosing death.[103] Of note, the MacCAT-CR has never "been validated specifically for MAID," (Ref. 49, p E359) and in practice, Canadian family physician Ellen Weibe and colleagues report that "experienced MAID assessors do not routinely require formal capacity assessments or tools to assess capacity in patients requesting MAID" (Ref. 49, p E362). In response, law professors Susan Martyn and Henry Bourguignon described capacity assessment in MAID as a "Trojan Horse" in that "the final determination of capacity" in MAID cases "will usually be a product of the hidden values and subjective judgment of the physician" (Ref. 52, p 395). Martyn and Bourguignon examined Dutch MAID practices and concluded that "Dutch doctors routinely report the degree of suffering or the perceived quality of life of a patient as the primary factor in determining when a request is granted" and that "in practice, physicians ignore capacity and voluntariness, occasionally listen to relatives or other third parties rather than the patient, and consistently perform euthanasia or PAS when they, the physicians, deem the patient's quality of life miserable" (Ref. 52, p 398). They expressed concern that shifting standards of capacity based on the evaluating physician's perception of the patient's quality of life risked confusing PAS with euthanasia and turning MAID into "the physician's prescription, not the voluntary and competent choice of the patient" (Ref. 52, p 399).

The contours of this debate, although of considerable importance in the ethics and policy questions regarding whether MAID should be legal, are not particularly relevant to clinicians once MAID has in fact been authorized by law. Arguably, many of Martyn and Bourguignon's concerns may be accurate but may still not prove dispositive for legislatures and voters with regard to MAID's legal status. Other considerations related to patient autonomy or the mitigation of human suffering may simply override these concerns. Unfortunately, the existential debate over MAID has transpired at the expense of a more nuanced discussion of three important concerns related to operationalizing capacity evaluation for MAID, which remain unsettled and insufficiently examined: the depth of understanding required to satisfy capacity for MAID, the levels of scrutiny and certainty required for a determination of capacity for MAID, and the conceptual challenge of "impairment" in MAID cases.

Level of Understanding

The level of understanding in clinical capacity evaluation refers to the evaluator's assessment of the degree to which the patient fully understands the situation, its consequences, and the potential risks and benefits of any additional interventions (as well as choosing against any interventions at all). Even with the most sophisticated tools, such assessment is inherently subjective. Understanding differs from the objective factor of how much information must be provided by physicians to patients prior to rendering a clinical decision, a matter addressed in most American MAID statutes, often with considerable precision. Although capacity generally requires a threshold determination of whether a patient meets a particular standard, understanding occurs along a continuum.[104] After

all, both the average college physics student and Albert Einstein may understand the theory of relativity, but their levels of understanding clearly differ. Establishing an operational model of capacity assessment requires determining where to locate the threshold for capacity on this continuum.

Although the four skills model is widely used when evaluating capacity for most clinical decisions, some jurisdictions have chosen a different standard for certain forms of decision-making. For instance, Utah and Vermont establish distinct standards for capacity to appoint health care proxies, an approach followed in practice by many physicians elsewhere as well.[19,94,105] In addition, capacity to consent to voluntary admission to a psychiatric hospital requires a different standard in some jurisdictions, an approach endorsed by a task force of the APA in 1993.[106] In practice, most physicians use a lower standard when a patient seeks to appoint a close relative as a temporary decision-maker, such as the emergency room patient who states, "Doctor, I don't understand my medical condition, but I've been married for many years, and I trust my spouse to make all of my decisions right now." In short, the principle that certain clinical decisions are best served by a different approach to capacity assessment has been widely accepted in medical practice for many years. A compelling case exists for including MAID in this category of interventions requiring a distinct approach. The four skills model is designed to assess capacity for treatment and to consider "the values that patients place upon the risk and benefit of each treatment in question" (Ref. 40, p 1636). These risks are generally measured in terms of "probabilities" of mortality and morbidity.[40] Yet, in the case of MAID, mortality is not the risk to be avoided but rather the benefit being sought. Although one might ultimately decide that the same level of understanding is necessary for MAID as for other medical procedures, this conclusion is not at all intuitive. Because MAID is at least arguably different in kind from most other medical interventions, one might reasonably argue that novel approaches are needed for capacity assessment in this area. The intent here is not to suggest that the MacArthur Competence Assessment Tool does not have important value in the research setting, or that it does not offer helpful guidance in developing tools for capacity assessment for MAID in the clinical setting, only that it ought to be thought of as a starting point and not the only possible approach.

One line of reasoning favors a higher level of understanding and appreciation to consent to MAID. Requiring an increased degree of understanding for high stakes decisions has strong backing in the literature, including in the early works of Drane and of Buchanan and Brock.[39,50] Werth and colleagues have noted that "many commentators have suggested that as the consequences of the capacity decision become more severe, the test should become more stringent" (Ref. 102, p 356). Arguably, because the result of MAID is death, the stakes are extremely high. (Of course, in jurisdictions that only permit MAID for terminally ill patients, the stakes might be considered lower for MAID than in cases of medical decision-making in which the patient has a meaningful choice between death and long-term survival, such as forgoing chronic dialysis.) Another line of reasoning, probably more persuasive, argues for a lower standard of understanding for patients seeking MAID. A full appreciation of the details and nuances of one's medical condition, although often essential for comprehending the risks and benefits of various proposed interventions, seems superfluous when the question before patients is straightforward, stark, and binary. Indeed, rejecting a lower standard may reflect parentalistic tendencies that have since been rejected in other areas of decisional capacity assessment.[107] Although awareness of alternative options, such as palliative care, may certainly help inform the patient's decision regarding MAID, and disclosure of such other measures is required by several state statutes, the ultimate matter to be decided by the patient is whether the patient wishes to die via MAID or not die via MAID. Appreciating the clinical risks of MAID may not have a meaningful impact on patient decision-making, as the risk is the benefit. That is not to say that patients should not be informed that the MAID process might in theory result in discomfort or pain or that self-administered medications might not function as attended, but these outcomes are extremely rare, and no reports appear available in the literature. Nonclinical risks, such as the impact of choosing MAID on interpersonal relationships and finances, may indeed exist and prove highly consequential, but these consequences are generally not considered in any decisional capacity evaluations.

The choice of MAID may be emotionally fraught but is generally easier to understand than most medical procedures, which do involve various potential risks, side effects, and outcomes of different likelihoods.

In the absence of psychiatric factors that may diminish capacity, as discussed below, confirming that the patient recognizes that MAID will lead to a volitional death and seeks this outcome appears to be a sufficient standard of understanding for capacity. The alternative, erring excessively on the side of caution, risks letting "a fair number of patients suffer" (Ref. 108, p 590). Obviously, understanding is not the only factor to be considered; concerns for duress or psychiatric impairment may prove relevant, as discussed below, but none of these factors bear on the level of understanding required for MAID capacity itself. Although society may be wise to create safeguards against abuses of MAID, relying on artificially elevated capacity standards is neither the most effective or consistent mechanism for achieving these ends.

Finally, as noted by Mirza and Appel, the capacity evaluation process itself is "far from benign" for some patients, "especially those from racial and ethnic minorities" (Ref. 37, p 36). Carpenter and Merz have argued that the burden may be exacerbated in patients seeking MAID who "are likely to be quite ill" and "may have limited tolerance for lengthy conversations" (Ref. 1, p 252). In light of these concerns, simplifying the process furthers the goal of improving patient welfare and more intrusive explorations of capacity should only occur when they are clinically necessary.

Levels of Scrutiny and Certainty

The levels of scrutiny and certainty required in capacity assessment are distinct both from the underlying question of understanding and from each other. Scrutiny refers to how carefully the evaluator endeavors to ensure that the patient meets the predetermined capacity standard. In clinical practice, high stakes decisions usually result in more careful scrutiny of a patient's decisional capacity. Certainty, closely related but distinct, refers to how confident the evaluator is that the evidence obtained in the assessment establishes that the patient has met that standard. American law does not dictate a specific standard for certainty in capacity assessment, so considerable variation exists between evaluators.

The practice of applying increased levels of scrutiny and demanding levels of certainty in capacity evaluations for high stakes medical decisions has generally been applied to MAID. For example, John Peteet has observed that, in the context of MAID, "assessment of a patient for 'capacity' requires the psychiatrist to go beyond checking off the four criteria [of the 'four skills' model] to actively working to help expand the patient's capacity for envisioning other options."[109] Merely checking off that the four criteria have been formally met, which is all too common, is conceptually problematic. As Susan Stefan has cogently observed that whether or not "there should be heightened standards around a decision to die," these should exist independent of "requiring a higher bar for competence" (Ref. 110, p 44). A case can certainly be made that physicians should require a patent to envision alternatives to MAID, but that bears on the understanding required, not on the scrutiny or certainty required. Unfortunately, evaluators often conflate these distinct elements of the process. A higher level of scrutiny and certainty may be deemed preferable in high stakes, irreversible decisions, such as choosing MAID, but it does not logically follow that increased requirements for scrutiny and certainty cannot exist simultaneously with a lower standard for understanding. In fact, such an approach may prove desirable. Although the underlying ethics concern is complex and controversial, a first step in establishing an effective capacity evaluation process for MAID is distinguishing these distinct elements and determining appropriate standards for each independently.

The Challenge of Impairment

The most fraught concern in operationalizing capacity assessment for MAID relates to the consideration to be afforded patients whose choices are influenced by psychiatric conditions. Most American statutes specifically require a behavioral health evaluation under such circumstances, presumably with the goal of determining whether capacity is impaired by the patient's psychiatric state. Such a distinction may provide a false sense of assurance for legislatures but, barring rare cases of psychosis, likely obfuscates more than it clarifies. As Lois Weithorn has saliently noted, "persons in the later stages of terminal disease experience emotional suffering to a greater extent than do persons in the general population" and investigators "report challenges of distinguishing between the presence of a mental disorder and the psychological distress attendant to the grief, loss, and suffering that often accompanies the dying process" (Ref. 53, p 82). Depression in response to a terminal diagnosis may certainly be distressing and may merit treatment in situations where the patient consents. (Involuntary psychiatric treatment for patients with depression may also be indicated in some cases but is beyond the scope

of this article.) Still, why such depression should invalidate a choice for MAID, if all other criteria are met, remains unclear to some.[107] For instance, patients with "poor medical prognoses and/or low quality of life (PMP/LQL)" may experience depression "yet voice a desire for death under circumstances in which they would prefer death even if not depressed" (Ref. 111, p 360). Although a values-based capacity assessment tool might prove more help in such cases than the four skills model, neither approach fully resolves the underlying phenomenological problem of determining whether the choice for MAID is true to the patient's authentic self or is a product of pathology.[43] This question is of great significance in moral philosophy and ethics, but as the underlying distinction is theoretical rather than empirical, it is not one that any capacity assessment method or tool, no matter how precise, can ever resolve. Rather, to operationalize capacity assessment for MAID, the best approach is to accept that this distinction will remain unresolvable in most cases. In some cases, however, a clear determination between an authentic desire and one diminished by psychiatric pathology is possible. In such cases, having a clear policy is important. In cases where such a determination cannot be made, having a default policy may also prove highly useful. Yet, although establishing such a default standard is important, doing so should not be conflated with traditional capacity questions related to understanding and impairment.

Conclusion

This article likely raises more questions than it answers. The goal is not to present a universal model for capacity assessment in MAID. Rather, the purpose is to raise a series of questions about current approaches to the topic, including logistical concerns not yet addressed in the literature and difficulties with the current assessment mechanisms, which have largely been adapted from general clinical decision-making with insufficient consideration for the distinctive features of MAID. One of the reasons that MAID remains controversial, both within and outside the medical community, is that helping patients choose to end their life actively, even when done to maximize autonomy in cases of terminal illness, strikes many physicians and ethicists as a practice fundamentally different in kind from other medical interventions. That distinction may or may not bear on the ethics of the practice or whether it ought to be legal. But that difference in kind does justify a more rigorous examination of methods for ensuring capacity beyond merely adapting those used for other, essentially dissimilar matters. As the legality of MAID expands, the moment is ripe for a novel approach to these challenging dilemmas.

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