Subjectivity, Suffering, and Epistemic Injustice in MAID

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Abstract

The expansion of MAID (Medical Assistance in Dying) to Canadian patients suffering primarily from mental health conditions raises many practical and ethical challenges. This paper examines the potential threat of epistemic injustice in the accurate assessment of mental health patients seeking MAID. The MAID assessment process relies heavily on medical practitioner knowledge of patient suffering, which is difficult when the suffering is primarily psychological. These difficulties are compounded by the threat of epistemic injustice: the injustice to one's status as a knower, including one's knowledge of their own suffering. By using Miranda Fricker's (2007) framework of epistemic injustice, this paper identifies areas where testimonial and hermeneutical injustices may negatively impact the assessment process. It concludes by suggesting a number of ameliorative interventions.

Introduction

Claire Brosseau had been anticipating the day she could receive Medical Assistance In Dying (MAID) for years. She had said her goodbyes, planned the details, and prepared herself for when MAID would become available to those with a mental illness. Claire's suicidal ideation had been present since early childhood. Decades of treatment had proven ineffective. MAID was the only option that made sense. However, some of Claire's friends and family deemed her overly dramatic or accused her of attention seeking. Even Claire's mother, now one of her biggest advocates, had been skeptical at the start (Rinaldi, 2025). Still, Claire's suffering was genuine. Her reasons for requesting MAID were legitimate. Claire is the victim of epistemic injustice: the injustice to one's status as a knower. Her pursuit of MAID was constantly misread and discounted because of the difficulty in understanding the full extent of her experience. As I'll argue, Claire's justification for wanting MAID, the very nature of her suffering, are deemed less credible because of deep-rooted biases about mental illness, suicide, and what counts as a sufficient reason to end a life. While Claire is just one example, the same dynamics shape the broader debate over MAID access for patients with mental illness.

Beginning on March 17, 2027, Canada will expand MAID eligibility to patients whose sole condition is a mental illness (Government of Canada, 2024). This change is set to broaden access to MAID, and to support patient autonomy and agency. This change also means that assessments will rely even more heavily on subjective judgment in judging access to MAID. In this paper, I will explore how epistemic injustice may affect assessments guiding access to MAID in the Canadian framework. By deploying Miranda Fricker's conceptions of testimonial and hermeneutical injustice, I will explore how credibility deficits can distort the evaluation of patient suffering. My approach will illustrate how fairness and equality can be compromised even when MAID's formal assessment criteria appear to be met.

The paper begins by outlining MAID's current eligibility criteria. I then turn to focus on the particulars of MAID's assessment criteria, highlighting the centrality of communication and interpretation as crucial parts of the process. Importantly, communicative and interpretative elements of MAID assessment are highly susceptible to forms of epistemic injustice. I explain how testimonial and hermeneutical injustice threaten MAID assessments, in part by drawing on examples from broader healthcare contexts. Finally, I propose strategies for mitigation.

MAID Criteria Expansions

In this section, I outline the current eligibility criteria and assessment for MAID. Adults in Canada may receive Medical Assistance in Dying if they are at least 18 years old, have “decision-making capacity”, are “eligible for publicly funded health care services”, make a voluntary request, give informed consent after considering alternatives, and suffer from a grievous and irremediable condition (Canada, H, 2025; Gupta & Blouin, 2022). This illness, disease, or disability must be “serious and incurable”, cause an “advanced state of irreversible decline in capability”, and cause intolerable and enduring suffering that cannot be relieved under conditions they deem acceptable (Canada, H, 2025). These criteria, which are current as of 2025, reflect an expansion of MAID access since its initial decriminalization in 2016 (Government of Canada, 2024). Although MAID is still relatively new, legislative changes are indicating a movement toward more freedom of choice. Health Canada has stated its commitment to “ensuring our laws reflect Canadians' needs, protect those who may be vulnerable, and support autonomy and freedom of choice” (Government of Canada, 2024).

Previous expansions of MAID access shifted the assessment process drastically. The 2020 passage of Bill C-7 removed the requirement that a patient’s death must be reasonably foreseeable (Government of Canada, 2024). This change broadened MAID access, but also introduced more complex procedural safeguards. The law now follows a two track system. These tracks both require a written and signed request, assessments by two independent practitioners, and assurance that the patient can withdraw their request at any time. However, the second track for cases where death is not reasonably foreseeable adds safeguards such as condition specific expertise, in depth discussion of available alternatives, and a minimum 90 day assessment period (Government of Canada, 2024). This change demonstrates how eligibility expansions can both increase access and necessitate new protective measures.

The next MAID expansion will extend eligibility to those whose sole medical condition is a mental illness, which will be effective on March 17, 2027 (Canada, H, 2025; Government of Canada, 2025). It will include conditions primarily within psychiatry such as depression and personality disorders. It does not include neurocognitive disorders like Alzheimer's and dementia (Government of Canada, 2025; MAID for Mental Illness, 2021). Advocates note that this change aligns with Section 15(1) of the Canada Charter of Rights and Freedoms, which guarantees “equal protection and equal benefit of the law without discrimination”-- including on the basis of mental disability (Government of Canada, 2025; Dying with Dignity, 2021). While this expansion is aimed at advancing patient autonomy and equality, it also leads to new interpretive and practical challenges, especially when assessing psychological suffering. These challenges include difficulty judging the legitimacy of patient suffering and interpreting subjective testimonies. The federal government seems to have recognized these challenges, as the original 2023 and 2024 implementation dates were delayed to 2027 to allow more time for practitioner training, development of guidelines, and further study to ensure that the appropriate safeguards are in place. It is evident that MAID is continuously expanding, and will likely continue to do so in ways that broaden patient autonomy and equality. However, the new frameworks require a higher degree of interpretive judgment about the legitimacy of patient suffering and the authenticity of patient testimony. Thus, as eligibility expands further into areas which rely heavily on subjective interpretation, it is necessary to examine with greater care the specific elements of the MAID assessment process susceptible to epistemic injustice.

Communication and Interpretation in Assessment

Patient-physician communication is a vital aspect of the assessment process. While legislation provides the formal criteria for MAID, ethicists Rosalind J. Mcdougall and Danielle Ko point out that practitioner interpretation of those criteria also has a significant impact on access to MAID (McDougall & Ko, 2021). One challenging element of the MAID criteria is the assessment of suffering. Suffering in this context is complex because it can encompass not only physical pain, but also psychological and existential suffering. According to the Fifth Annual Report on MAID in Canada, primary reasons for requests include loss of dignity (65%-70%), perceived burden on loved ones (45%-49%), and existential suffering (35%-39%) (Health Canada, 2024b). It is evident that even when reporting MAID, the reasons provided are often based on existential matters rather than purely clinical reasons.

Some scholars, such as philosopher and bioethicist Jukka Varelius (2014), argue that existential suffering is not too vague to assess. Varelius claims that if physicians who are trained in relevant sub-specialties can already assess suffering due to illness or injury, then they would also be able to assess existential suffering provided they have expertise on existential matters (p. 104-107).

However, many disagree and argue that choices in death are fundamentally personal and should be dictated by one's own view of the world. Therefore, such choices should be deeply informed by personal circumstances traditional methods may have difficulty capturing. For example, the biophysical perspective views suffering as a personal experience shaped by a person's specific values, beliefs, and life experiences (Henry et al., 2023). In the *Journal of Bioethical Inquiry*, Jeremy Davis and Eric Mathinson's autonomy-only perspective argues that because suffering is subjective, MAID judgements should be based fully on the patient's own perspective of their life and suffering, making even the requirement of having a diagnosed illness seem futile (Davis & Mathinson, 2020). While this perspective does not reflect the current legal criteria, it illustrates the extent to which many scholars see suffering as a matter that can only be meaningfully evaluated from the patient's perspective. Furthermore, this raises the question of what it even means to be ill. Philosophers such as Fredrik Svenaeus describe illness as "an unhomelike being in the world," (p. 211) and Havi Carel characterizes it as "a fundamental disruption of the body's transparency to the familiar habits and routines of everyday life" (p. 211) (Kidd & Carel, 2018). Both definitions are interpretive and grounded in personal experiences which cannot be measured using objective measures. Together, these perspectives highlight why communication should be the most emphasized element of MAID assessment. Even though the criteria provide the legal boundaries, dialogue and interpretation determine how they are applied. This is where the risk of epistemic injustice arises. Fully understanding what a patient is going through requires a serious effort to explore the full range of their experiences.

Epistemic Injustice

Patients need to be fully understood in order to receive appropriate care through MAID, but what if they are not? Instances where physicians fail to fully listen to patients and dismiss their concerns are well documented in healthcare (Carel & Kidd, 2014), and this connects directly to the concept of epistemic injustice. Epistemic injustice occurs when the credibility afforded to a speaker is affected by bias or prejudice, whether implicit or explicit (McKinnon, 2016). Philosopher Miranda Fricker identifies two main forms of epistemic injustice: testimonial injustice and hermeneutical injustice. Both provide useful frameworks for examining potential risks within MAID assessments.

Fricker defines testimonial injustice as "a kind of injustice in which someone is wronged specifically in her capacity as a knower" (Fricker, 2007 p. 20). She explains how testimonial injustice is a result of identity prejudices rooted in stereotypes. These prejudices lead to a credibility deficit where the hearer (medical practitioner) gives the speaker's (patient) testimony less credit than it deserves. Fricker uses the example of Marge Sherwood in *The Talented Mr. Ripley* to illustrate this. Her testimony for Tom Ripley being Dickie's murder is dismissed as 'female intuition'. Her knowledge and reasons are overlooked simply because she is a woman (Fricker, 2007 p. 9).

Fricker continues to argue that not only is testimonial injustice an epistemic harm, but it is also a moral harm as it undermines a person's ability to fully participate in sharing knowledge (Fricker, as cited by Mckinnon). Furthermore, when the speaker recognizes that the hearer may be prejudiced toward them and not fully trust their say-so, this may result in what Kristie Dotson calls testimonial smothering– when the speaker chooses not to speak or leave out information due to perceived prejudice (Dotson, 2011). In the context of MAID, a practitioner may already harbour a bias against the patient, and recognizing this, the patient may be more hesitant to speak up. As Sanford Goldberg (2013, 2015)(as cited by McKinnon) notes, someone may appear less credible based on how they say something, so if the patient seems less confident about their testimony due to testimonial smothering, they will continue to be seen as less credible. As a result, communication and clarity is impeded on both sides in a reinforcing cycle.

Fricker defines hermeneutical injustice as "the injustice of having some significant area of one's social experience obscured from collective understanding owing to persistent and wide-ranging hermeneutical marginalization" (Fricker, 2007 p. 154). Hermeneutical injustice arises from hermeneutical marginalization, which is when certain groups do not have access to the hermeneutical resources to communicate and make sense of their own experiences. Fricker uses the example Carmita Wood, a woman whose experiences with sexual harassment in the workplace were dismissed as harmless flirting. Her suffering was misunderstood due to a lack of shared language to recognize sexual harassment as legitimate harm (Fricker, 2007 p. 152-153). In the context of MAID, this form of injustice may look like simply not having the medical terminology to explain their situations, but it can also be complex in the sense that the specific progression of life experiences the patient has experienced is too personal and nuanced to put into words the hearer can fully make sense of (Fricker, 2007). Although any difficulty in explaining experiences may not always be an instance of hermeneutical injustice, many challenges in communicating suffering can stem from deeper structural gaps in how we view pain, illness, or disability. In such cases, the problem is not just an individual's struggle to find words, but the lack of shared concepts available for their experiences to be validated.

Epistemic Injustice in Healthcare

Epistemic injustice is particularly a serious threat in healthcare because the patient's own testimony is crucial in making accurate judgments about diagnosis and treatment (Carel & Kidd, 2018). In MAID cases, especially with mental illness, mitigating epistemic injustice is even more crucial because much of the evidence is less objectively measurable and comes directly from what a patient communicates about their experience. Furthermore, if patients feel dismissed, this impedes upon the epistemic relationship between them and the practitioner which can further undermine the accuracy of medical decisions (Kidd & Carel, 2018). This risk is well documented and discussed in healthcare more broadly. Davis and Mathinson point out that ill people are more vulnerable to hermeneutical injustices because illness can lead to unique and extreme experiences that are even harder to communicate (Davis & Mathinson 2020). They can only be understood by those with a similar viewpoint or experiences. Kidd and Carel (2018) support this viewpoint, arguing that illness can alter how one views their daily life and surroundings, so existing hermeneutical resources become more challenging to use effortlessly.

A documented case of testimonial injustice in healthcare can be seen in the 2011 documentary *Voices from the Shadows*, where directors Josh Biggs and Natalie Boulton interviewed patients with encephalomyelitis/chronic fatigue syndrome (ME/CFS). The patients described symptoms such as pain, sensitivity to light and noise and extreme fatigue. But because the legitimacy of ME/CFS is still up for debate, the patient's testimonies were often not believed or reinterpreted in other ways, like saying the person had a mental illness or was suffering from abuse (Kidd & Carel, 2018). In this case, credibility is downgraded because the patient's testimony doesn't fit into the dominant medical knowledge or provide the kind of evidence the system values most. Thus, as Kidd & Carel observe, what counts as believable is commonly based on a naturalistic view, which ignores personal stories about one's experiences. Although there is little direct research documenting epistemic injustice in MAID, its presence in healthcare generally makes it unsurprising that it would also be relevant in MAID assessments, especially considering the high degree of subjectivity involved in evaluating suffering. This is even more critical for mental illness cases because the assessment process depends even more heavily on communication and interpretation.

Epistemic Injustice in MAID

There are several instances in the MAID assessment process where epistemic injustice may occur. These instances include the assessment of capacity, incurability, and treatment refusal. Attention should be paid to these instances because fully understanding a patient is the best way a medical practitioner can make a confident and ethical judgement. To illustrate this importance, we can use the example of the criterion which requires patients to have "enduring and intolerable physical or psychological suffering" (Health Canada, 2024a). In assessing suffering, Mona Gupta, chair of the expert panel on MAID and mental disorder at Dying with Dignity and Samuel Blouin outline an ethical dilemma medical practitioners may face: On the dilemma's first horn, it is unjust to simply determine whether or not the patient is suffering. Suffering is subjective to the patient's worldview, and for a practitioner to deem genuine testimony to be insignificant can be viewed as an act of dismissal. On the dilemma's other horn, the practitioner still has a professional responsibility to make the life-altering final judgement (Gupta & Blouin, 2022, Dying with dignity, 2023; Barnikol, 2018 as cited in Gupta & Blouin, 2022). Resolving this dilemma is no easy task. Indeed, Barnikol claims any satisfying resolution is nearly impossible. Instead, the best thing a practitioner can do is ensure they understand the patient as deeply as possible in order to make a fully informed decision. By identifying and drawing out where epistemic injustice may hinder genuine understanding in the assessment process, we can work towards ensuring fairer assessments that respect patient dignity.

1. Capacity

The requirement for a patient to have decision-making capacity is vital in assessing eligibility. However, like much of the criteria, assessments of capacity are subject to interpretation and can result in epistemic injustice. The eligibility criteria state that patients must be “at least 18 years old and mentally competent”. Much like decision-making capacity, competence is understood as the patient being able to make their own healthcare decisions (Health Canada, 2024a). Capacity is primarily assessed by the two primary independent practitioners, but can also be evaluated by additional clinicians who are asked to do so (CAMAP, 2020). Especially with the new expansion, appropriately evaluating capacity is crucial. If legislation aims to expand MAID with a greater consideration for patient autonomy, then competence must be met because autonomy presupposes competence (Young, 2024). However, this also means that if a patient is wrongly deemed incapable, then they lose their right to make that autonomous choice.

The Canadian Association of MAID Assessors and Providers (CAMAP) outlines the frameworks followed by assessors when evaluating capacity. Practitioners are trained to assess the patient's ability to understand and appreciate relevant information, reason about treatment options, and communicate a choice (CAMAP, 2020). However, these evaluation frameworks may also allow implicit biases to distort how a practitioner understands the patient. For example, a patient may have aphasia– a language disorder which makes it difficult to communicate effectively with others (Aphasia). Although patients with aphasia have trouble expressing their thoughts and understanding others, it does not always mean they lose their decision-making capacity (Johns Hopkins; CAMAP, 2020). CAMAP acknowledges that technically, practitioners should not undermine a patient's decision-making capacity solely due to aphasia. CAMAP also outlines other related factors that may cause unfair assessments– such as hearing loss, motor speech disorders, and English as an additional language. Despite these factors being recognized, fairness is not always as straightforward because epistemic injustice often arises from implicit biases.

A patient with a communication barrier may suffer from testimonial injustice because the practitioner subconsciously believes a person struggling to form sentences is less credible to make a life-altering testimony. This bias may also lead to testimonial smothering and further perpetuate testimonial injustice. Additionally, a patient may also suffer from hermeneutical injustice when lack of language hinders their ability to fully communicate their ability to understand and reason. Both forms of injustices would lead a practitioner to believe a patient is less capable than they truly are, and thus, deny them fair access to MAID. To mitigate this potential harm, Health Canada emphasizes the importance of paying close attention to body language cues and adapting assessments to individual needs, though assessing body language can be vulnerable to the same injustices (e.g. older person with a tremor) (Health Canada, 2024b). CAMAP outlines specific adaptations such as including translators and technological devices to help patients communicate effectively. Ultimately, potential injustices must first be recognized before adaptive measures can be put in place.

2. Incurability

In cases of mental illness, assessing incurability is particularly difficult, raising the potential harm of epistemic injustice. The MAID criteria requires a patient's condition to be “serious and incurable”, but there are currently no set guidelines to determine if a mental illness is incurable in the context of MAID (CAMH, 2024). There is current debate over the distinction between mental and physical illnesses. Some health professionals argue that mental illness is easier to be controlled as it is more dependent on the patient's will rather than objective conditions (Kendell, 2018). Whether or not these claims are true, it emphasizes the uncertainty that still exists surrounding the curability of mental illness. As mental illnesses seem to be more ambiguous than physical illnesses, it is challenging to objectively confirm curability. Medical practitioners would need to pay closer attention to how patients express their experiences with mental illness to make a well-informed judgement.

Hermeneutical injustice may occur when patients lack the terminology to express how their mental illness impacts them. Health Canada notes that even if a patient believes their condition is incurable, only the medical practitioner can decide if it truly is (2024). Nonetheless, patients may have a difficult time conveying the severity of their symptoms in a way practitioners will take seriously. Patients may also be subject to expressive restrictions, where they are limited to using language and forms of expression that are confined to medical norms (Carel & Kidd, 2018). Even so, their experiences with illness may already be difficult enough to express using everyday language. These hermeneutical restrictions also perpetuate testimonial injustice and testimonial smothering, as patients are generally already viewed as being less credible to make medical assertions.

3. Treatment Refusal

As part of the incurability requirement, patients must deeply consider and be well informed of alternative options to relieve their suffering (Canada, H, 2023). Although the Charter of Rights and Freedoms upholds an individual's autonomous right to refuse medical treatment, a patient cannot simply refuse all options to automatically render themselves eligible for MAID (Government of Canada, 2025; Canada, H, 2023). Thus, if a practitioner is deciding whether or not a refusal should be warranted, they must fully understand and accept the patient’s personal reasons for refusal. As patients and physicians must work together in close dialogue to determine the correct course of action for alternative treatments, the discussion of treatments is another instance where epistemic injustice may occur.

In discussion, a patient may face testimonial injustice when their reasons for refusal are dismissed to be irrational or uninformed. Even if a patient is well informed, a practitioner likely still harbours implicit biases, subconsciously viewing them as less competent. Clinicians report that because patients are understandably upset and therefore seen as irrational, it is difficult to make sound decisions based on their testimonies (Carel & Kidd, 2014). As a result, patients may be epistemically harmed when their reasons for refusal are not fully respected and taken seriously. In the context of general medicine, Darren E. Lund, a professor of social justice at the University of Calgary argues that interfering with a patient’s decision to refuse treatment is not justified because no matter how irrational it may seem, a patient should still be able to make any decision for themselves so long as they are competent (Lund, 2018). In MAID however, the stakes are different because a patient technically can still refuse, but it would result in more hesitance and conflict in the discussion of MAID eligibility, whether that hesitance is explicit or implicit.

Additionally, patients may not have the hermeneutical resources to explain their reasons for refusal. Whether they are existential, moral, or cultural, such reasons may be challenging to precisely convey. A well-known example is Jehovah's witnesses' refusal of blood transfusions. Put simply, Jehovah's witnesses believe accepting blood transfusions is against God's will and will lead to ostracisation from their religious communities (Medical Protection). Consequently, many would rather die than receive a blood transfusion. In such cases of treatment refusal, Jehovah's witnesses have received pushback and skepticism about their beliefs (Lund, 2018). Although Jehovah's Witnesses can explain their religious reasons for refusal, practitioners may never fully internalize let alone understand why this belief matters so much. Hermeneutical injustice in treatment refusal arises when there is a lack of resources to convey why a refusal feels significant to a central part of a patient's life's purpose or identity. Practitioners assessing MAID must also be well informed on the complexities of treatment refusal within the eligibility criteria.

Strategies to Mitigate Harm

Fully eliminating epistemic injustice in MAID is nearly impossible because epistemic injustice in healthcare is a broader and pervasive issue owed to extant conceptions of health and illness and broader, problematic, and insidious social inequality. Eradicating epistemic injustice in MAID would be only possible with large-scale structural reforms that go 'all the way down' to the histories that lead to current biases and conceptions (Carel & Kidd, 2014). However, it is still possible to mitigate the risk of epistemic injustice occurring in MAID assessments; I will suggest two strategies to alleviate its potential harm.

The first strategy is education concerning epistemic injustice sensitivity in training. Currently, MAID assessors' training covers "cultural safety and humility", but epistemic injustice is not directly addressed (Canada, H, 2023). Similarly to current implicit bias training models, By specifically educating on testimonial injustice, hermeneutical injustice, testimonial smothering, and outlining the instances where they may occur, medical practitioners can better identify when their biases impact patients.

I argue that this is more effective than solely educating on eliminating biases, because the idea of epistemic injustice is more patient centered. Hermeneutical injustice addresses the patients inability to communicate their experiences, forcing practitioners to learn to empathise with and consider the patient's full perspective. Framing biases around testimonial injustice is also more patient-centered because it is understood as a direct injustice to their ability to share their experiences. Outlining specific instances forces practitioners to step into the patients perspective to identify injustices. By educating practitioners this way, it emphasizes the structural nature of injustices rather than only individual attitudes, which would create a stronger, patient-centered understanding amongst practitioners.

The second strategy is to diversify the assessment process. Although epistemic injustice is a structural issue, individual practitioners will still hold different biases. Increasing the number of practitioners assessing each case means there are people with varying life experiences who can empathize with a patient's testimony. Currently, one preliminary assessor will determine if all criteria is met before the two primary practitioners can confirm eligibility (Health Canada, 2025). Although the eligibility criteria is seemingly objective, it is evident that much of the criterion is up to interpretation. Even in the early stages, cases of epistemic injustice can be reduced by simply adding another perspective.

If a patient is approved in the preliminary assessment, they are evaluated by two independent practitioners (Health Canada, 2025). Additionally, a qualified independent witness must confirm the patient's understanding of the request (Canada H, 2025). If a primary assessor lacks expertise in a patient's specific diagnosis or condition, they must also reach out to experts in the given area. These experts are not MAID assessors (Canada, H, 2023). Currently, the assessment process does include varying perspectives which should be sufficient in straightforward cases. However, with the expansion to mental illness, and with more ambiguous cases, patients may benefit from a broader assessment team. I suggest that along with the two primary practitioners, there be a committee of trained professionals in assessing MAID. In cases where the primary assessors are uncertain or deny MAID, reporting of discussions can be additionally evaluated by the committee. This way, the patient gains multiple new opinions from people of different relevant backgrounds who can either vouch for or resist their eligibility. This committee would also make it easier for those in rural areas to access fair and diverse assessments by using virtual evaluations. In conversation amongst the professionals, practitioners can bring new insights about the patient's testimony that may have been initially overlooked.

Limitations

This paper identifies the potential existence of epistemic injustice in the MAID assessment process. The methods used involved drawing on existing sources, applying the framework of epistemic injustice to the complex regulations governing Canadian MAID, and developing and defending philosophical arguments concerning epistemic injustice in healthcare. These perspectives were synthesized to examine the potential issue of epistemic injustice in MAID with the new expansion to mental health patients. However, these contributions are of primarily theoretical import, and set the stage for further empirical investigation to fully understand the extent of the threat and the efficacy of potential solutions. Additionally, the information on MAID discussed is germane to the Canadian context. While MAID bears a broad resemblance to physician assisted suicide programs in other countries, the results here should be understood as pertaining in the first to MAID. Applying solutions for MAID to programs in other countries would stand to provide further insight and additional meaningful perspectives on the threat epistemic injustice poses.

Conclusion

Medical Assistance in Dying eligibility is a complex ethical topic and will continue to be, especially as regulations expand to include those whose sole condition is a mental illness. Using Miranda Fricker's framework of epistemic injustice, this paper argues that testimonial and hermeneutical injustice pose threats to fair discussion-based MAID assessments. While these risks cannot be fully eliminated, they can be mitigated by familiarizing assessors with the nature and threat of epistemic injustice, and diversifying the assessment process. Instances where epistemic injustice may occur in the assessment process must be taken seriously to create a system that mitigates suffering, manifests fairness, and respects autonomy.

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