Fact checking– Canadian presentation to Scottish Parliament,
Submitted by: Dr Ramona Coelho

Extension of eligibility :
Despite concerns from the Human Rights Commissioner of Canada, as well as from UN experts, we continue to expand MAiD. It is legislated for mental illness in 2027, with a quick consultation being held now for advance directives to keep up with the province of Quebec, which has decided to break the criminal code by allowing the practice but asking for non-prosecution of offenders. MAID for children deemed to be able to make their own healthcare decisions has also been formally recommended to Parliament by the Joint Parliamentary Committee tasked with studying its safety.

Although predicted requests would be less than 100 per year for Quebec, The jurisdiction of Quebec just announced that their MAiD death rate is 7.3% and they can't assess by the evidence the level of palliative care that was administered beforehand.

2023 numbers of 15,300 MAiD deaths from provincial reporting tallied bring our numbers to well over 60,000 and we are awaiting 2023 Heath Canada report on MAiD.
Attachment shows Ontario has 400 maid cases completed per month with access on 2.2 days on average to maid team.

Bullying of conscience objectors or mostly physicians with concerns about the safety of MAiD as well as repercussions on patients:

A: Félix Pageau, testified to a national parliamentary committee in Ottawa that in his opinion as a physician, based on research, Canada was not ready to expand MAID. For this, a colleague in his home hospital "filed a complaint to the Collège saying he "lied" to the committee. The Collège decided to "open an inquiry, even though they don't have jurisdiction over testimony at the federal [level] or in the Parliament." The investigation became an ordeal — and an expensive one, since Pageau needed to hire a lawyer.
https://www.nationalreview.com/magazine/2023/10/02/how-death-care-pushed-out-health-care/

b- Alert from a growing number of Canadian physicians
"We are being bullied to participate in Medical Assistance in Dying"
https://collectifmedecins.org/en/press-release-2/

c: https://www.thenewatlantis.com/publications/no-other-options:
The attendees understand too what they are hearing. "Given the vulnerability of patients who are maybe requesting MAID because of socioeconomic reasons," one asks, "do you save yourself that moral and ethical distress by withdrawing?" Reel responds: "If withdrawing is about protecting your conscience, you have [an] absolute right to do so." But he adds: "You'll then have to refer the person on to somebody else, who may hopefully fulfill the request in the end."

MAiD is confirmed and happening for psychosocial suffering: **Quote confirming this practice is happening from President of CAMAP, Dr Konia Trouton**:

> Trouton, who now lives in Ontario, says she's aware that some Canadians have received MAID even when the main cause of their suffering was a socio-economic factor not directly related to their qualifying medical condition. But that doesn't technically make those cases ineligible. "The suffering and the irremediable disease don't have to be the same," says Trouton, citing the law's language around safeguards: it does not explicitly state the need for suffering to be caused by a medical condition.

Article the above quote is cited from: https://thewalrus.ca/assisted-dying/

ISSUES WITH MAID SAFETY:

These articles, from Associated Press, detail leaked CAMAP forums and corroborate evidence on who qualifies for MAID and for what, (poverty, etc.):
https://apnews.com/article/euthanasia-ethics-canada-doctors-nonterminal-nonfatal-cases-dfe59b1786592e31d9eb3b826c5175d1 and
https://apnews.com/article/2e4486b3f69e33d226d0f4a5e036a2f8

Over 400 violations in compliance with law and practice detected postmortem thus far in Ontario since 2018. This is most clear detailed investigative journalism of MAiD coverups in Canada and all links to reports are in document.
https://www.thenewatlantis.com/publications/compliance-problems-maid-canada-leaked-documents

Issues in delivery of MAiD (means and complications) have been identified even in this CAMAP paper but there are more (article to be released shortly with more reports):
https://camapcanada.ca/wp-content/uploads/2022/02/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf

Palliative Care:

- Multiple studies have shown a lack of access to palliative care and high symptom burden among those granted MAiD.

- The accuracy of government reporting on the provision of palliative care for those receiving MAiD was called into question by many experts, noting that contact with palliative care was *not* synonymous with having received palliative care. Also, it is counted by tick boxes by maid providers without any oversight of accuracy.

- Other properly conducted palliative care studies on access *demonstrate poorer access*: https://pubmed.ncbi.nlm.nih.gov/33208428/

- But even these flawed statistics show that 21% of persons receiving MAiD for a terminal illness had contact with palliative care only in the last 2 weeks before MAiD. For most people, that means contact with palliative care was initiated after applying for MAiD.

- Choosing to die from MAiD in the face of lack of timely, quality palliative care and supportive services is NOT a choice and should be considered a medical error.
-
- Polls show that the majority of Canadians prioritize expanding palliative care services over MAID; want palliative care providers to have the requisite expertise; and they are worried that "MAiD will replace social services."
-

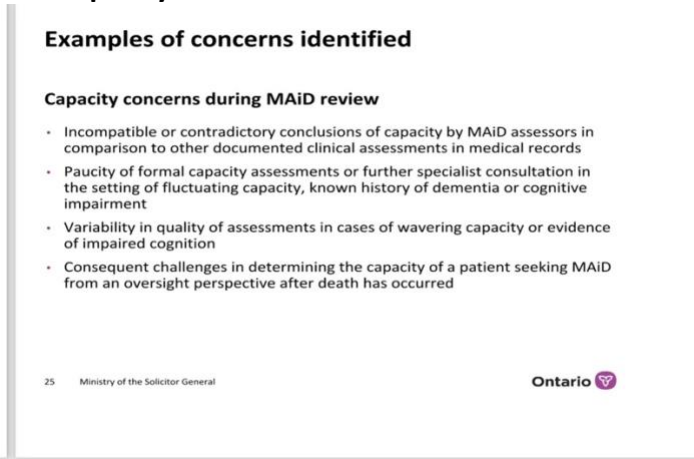
Service model and training

- No training required. A curriculum developed by maid advocates 2023, CAMAP

David Henderson credentials, also said in Canadian parliament:

- " I'm also concerned that the government has given health care professionals essentially a licence to kill without having significant checks in place to ensure that people are assessed properly and thoroughly."
-
- " We teach, and we taught for years and years before this became available, that when someone says they think life's not worth living, we start by exploring that. We inquire, "What do you mean by that?", so they can say, "I don't feel I want to live anymore." Then we talk about what the root cause of that is. That's one thing that is lacking in a lot of the assessments for MAID when palliative care is not involved. The assessment involves only whether they qualified for MAID; it doesn't ask what the root cause of someone's suffering is and how we can fix that…. I work with people who have done MAID assessments. I was actually involved in developing the policy and developed a tool to help people who didn't work in palliative care to be able to do assessments, only to be told that doing those would take too long."

Capacity: attached slide from Chief coroner of Ontario presented to CAMAP in 2020



Examples of concerns identified

Capacity concerns during MAiD review

- Incompatible or contradictory conclusions of capacity by MAiD assessors in comparison to other documented clinical assessments in medical records
- Paucity of formal capacity assessments or further specialist consultation in the setting of fluctuating capacity, known history of dementia or cognitive impairment
- Variability in quality of assessments in cases of wavering capacity or evidence of impaired cognition
- Consequent challenges in determining the capacity of a patient seeking MAiD from an oversight perspective after death has occurred

25 Ministry of the Solicitor General Ontario

Coercion : please see attached Coroner reports(of which I am a committee member) but summarized here:

- raising MAiD, giving it to people in desperate situations, poverty, lonely or feeling like a burden: that is opposite of autonomy but rather structural coercion to die
- Suicide parallels are emerging for those not dying who chose MAiD
- Financial elder abuse: big problems in Canada and cited by our government as such
- Doctors are very poor at detecting coercion
- Especially difficult when MAiD assessments and approvals are done by phone/virtual and by doctors who do not know the patient.
- Reasons for MAiD: loneliness and being a burden are highly cited by health Canada report on MAiD: https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2022.html

Abbreviated CASES from report summarized for ease in one place:

Mr. A was a male in his late 40s who experienced suffering and decline following his covid vaccinations. While navigating his physical symptoms, Mr. A was admitted twice to hospital with suicidal ideation, involuntarily hospitalized for mental illness. He was still given MAiD. The cause of his suffering and physical symptoms was likely mental health related, as was the postmortem conclusion.

Mr. B was a male in his late 40s. He was diagnosed ulcers. Mr. B also had with multiple mental illnesses. A year prior to the provision of MAiD, Mr. B attempted suicide with a descent from a height. He still received MAiD.

Mr. C was an older male, who experienced chronic back pain and had a specialist pain clinic. Mr. C was also diagnosed by a psychiatrist with an adjustment disorder leading up to his request for MAiD which was still granted.

Mr. D was a male in his 40s with inflammatory bowel disease. Mr. D was unemployed, socially isolated, was dependent on family for housing and financial support. Mr. D had a history of mental illness, suicidality, and addictions. During a psychiatry assessment, the psychiatrist asked him if he was aware of MAiD. During the MAiD process, there was no input from Mr. Ds family, despite their concerns. And the MAiD provider personally drove the patient to where he received MAiD.

Ms. E was a female in her 50s with multiple chemical sensitivity syndrome (MCSS). She had a history of psychiatric hospital care. Ms. E had difficulty securing housing that met her medical needs. As a result of her housing situation and conditions, Ms. E experienced social isolation, which greatly contributed to her suffering and request for MAiD.

Mr. F was a male in his 40s living with quadriplegia following a motor vehicle collision. The COVID-19 pandemic led to social isolation. Mr. C received MAiD before he had had an opportunity to return home. The MAiD assessors said he was not dying, so Track 2 but mentioned he could be moved to track 1 if he refused treatment. He was distressed about being able to have a relationship with his children and he chose MAiD.

The report also underscores concerning trends :

MAID can replace essential healthcare services and other solutions for suffering, particularly for disabled individuals, who are vulnerable to being steered toward assisted death due to discrimination, ableism, ageism, and a lack of adequate resources.

Initial findings show that a large number of these track 2 cases, 29%, come from those living in the most materially deprived circumstances, that is poverty, with it being much more common to be below 60 years of age, and with a higher number of women (61%) to men (demographics of people that are more likely to be suicidal but overwhelmingly recover with suicide prevention efforts). They largely lacked adequate mental health and disability supports before ending their lives and has almost no help offered for housing support, and 6 per cent were offered income support.

Those not dying more often didn’t have a next of kin and listed, i.e.: friend, lawyer or health care provider speaking to lack of social support

MAiD and Suicide:

Evidence about suicide in jurisdictions that had legalised Assisted dying:
https://irp.cdn-website.com/c0d44f22/files/uploaded/JEMH_article_EAS_and_suicide_rates_in_Europe_-_copy-edited_final.pdf

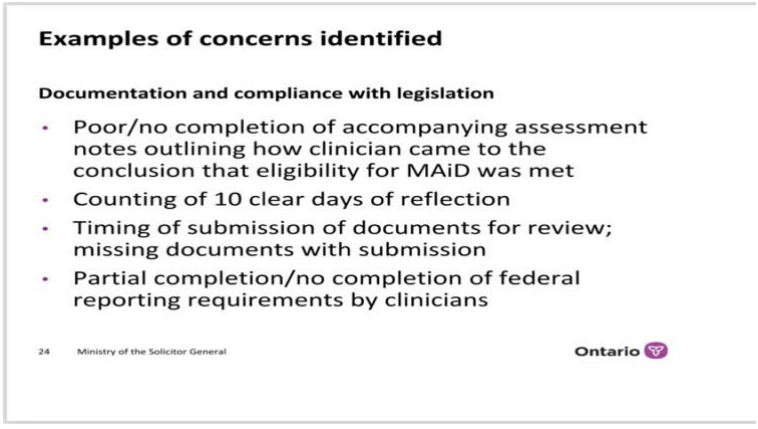
Concerns brought forward by the Canadian Association of Suicide Prevention (CASP):
https://suicideprevention.ca/media/statement-on-the-expansion-of-medical-assistance-in-dying-to-those-without-a-reasonably-foreseeable-death/

Review of Scottish Bill (some of this is from Dr Kotalik who was supposed to present but had a issue the made this impossible)
Overview of bill

1. The major deficiency is that the Bill's definition of "terminal illness". LIKE RFND IN CANADA, there is no widely accepted definition. A person with a terminal illness may live for days, months or years. very large fraction of the population of Scotland would become instantly eligible to receive assisted dying, which I imagine was not the intention.

2. The Bill provides for creation of a special category of physicians, "coordinating registered medical practitioners" Person's general practitioner will get copies of reports, but they are not involved - they will have no prior knowledge of applicants to carry out a proper, reliable assessment especially for coercion .

3. Monitoring. and reporting: See slide deck of some issues identified by Chief Coroner of Ontario in 2020, which has the best oversight of any province.



Much more data will be required to support public accountability,
assure the protection of vulnerable individuals, identify trends, determine what are the reason people seek assisted dying, provide evidence that those who received death in this program were indeed “terminally ill”, and so on.
Analyse the data and make them public in the form of annual report.
This data should help to determine if it could be a lack of social and economic support rather than illness itself which pushes people to ask to assisted death.
The bill directs that all documentation flow to offices of general practitioners.
insufficient to operate this national program.

2024

MAiD Death Review Committee (MDRC) Report 2024 – 2

Complex Medical Conditions with Non-Reasonably Foreseeable Natural Deaths

MINISTRY OF THE SOLICITOR GENERAL | Office of the Chief Coroner for Ontario

BACKGROUND

Under the *Coroners Act*, physicians and nurse practitioners who provide Medical Assistance in Dying (MAiD) are required to notify the Office of the Chief Coroner (OCC) of the death and provide relevant information to support MAiD death review, oversight, and Health Canada mandatory reporting requirements. Ontario has an established team of highly skilled nurse coroner investigators (MAiD Review Team) who retrospectively review every reported MAiD death in Ontario. A structured feedback approach for practitioners is followed to respond to concerns with statutory requirements, regulatory policies, and/or professional practice when identified during the review process. Further investigation is undertaken as required in accordance with the *Coroners Act* and with the Chief Coroner.

Reflecting the more mature state of MAiD practice, in January of 2023, the OCC modernized its approach to MAiD death review and oversight. Through the modernization process, the OCC review and oversight approach has continued to evolve to include, when indicated, enhanced expert review to respond to increasing social and systemic complexities within the contexts and circumstances surrounding MAiD practice, care, and legislation. Ontario is the first province in Canada to develop a multi-disciplinary expert death review committee to provide enhanced evaluation of MAiD deaths and to explore end-of-life complexities that have systemic and practice implications. Ontario continues to be a leader in high-quality and innovative MAiD death oversight and review.

The MAiD Death Review Committee (MDRC) was established in January of 2024. The committee is comprised of 16 members from across multiple disciplines (law, ethics, medicine, social work, nursing, mental health and disability experts, and a member of the public) who bring a diverse background of expertise in providing advisory support to MAiD oversight in Ontario.

The MDRC seeks to provide recommendations and guidance that may inform the practice of MAiD through the evaluation and discussion of topics, themes, and trends identified by the MAiD Review Team (MRT).

Committee Aim

The MDRC provides multidisciplinary expert review of MAiD deaths in Ontario with legislative, practice, health, social, and/or intersectional complexities identified through the oversight and review process. MDRC members review and evaluate the contextual circumstances that impact MAiD and inform the ecology of care for persons, families, and communities. MDRC members review relevant MAiD trends, topics, or issues and offer insights, perspectives, or interpretations and assist in formulating recommendations to inform system improvements (e.g., education of MAiD

practitioners, review of regulatory body policies) with a goal to support quality practice and the safety of patients and MAiD practitioners.

Acknowledging there is public discourse regarding MAiD, the MDRC is committed to increasing public transparency of the MAiD oversight and review process through the dissemination of reports.

Acknowledgement of Persons, Families, and Communities

The MDRC acknowledges the deaths of persons who have experienced profound suffering at end-of-life. We acknowledge the losses to partners, families, close relations, and communities.

During the death review process the OCC protects the personal biographies of the persons who have accessed MAiD. In this report, while some personal information was included for a small number of MAiD deaths, efforts were taken to maintain privacy for persons and their families by sharing only the necessary details and circumstances of their death to support understanding of the issues explored. When we identified that a person's particular circumstance may be identifiable to a person's close relations, we have made efforts to inform their next of kin. We are respectful to the persons whose aspects of their lives are shared in the information presented.

In alignment with the OCC's motto to "speak for the dead to protect the living", the MDRC approaches this important work to learn from each MAiD death. By examining these deaths and presenting this information, we aim to support continued improvement for how MAiD is provided in the province of Ontario.

Acknowledgement of MAiD Practitioners

We extend recognition to clinicians who provide dignified care to persons who have requested MAiD. We respect the clinicians who commit to on-going learning and integrate evolving MAiD practice improvements into their approaches to care. We also acknowledge that clinicians are navigating care for persons accessing MAiD within the limitations of our health and social systems. We further recognize that the OCC MAiD oversight process is an additional step in the provision of MAiD; we are appreciative of the important role of clinicians in the Ontario MAiD oversight process.

Approach to MDRC Review

Through the OCC MAiD death review process, we have observed that only a small number of MAiD deaths in Ontario have identified concerns. MAiD deaths illustrative of specific circumstances, identified during review by the MRT, are provided to the Committee. The Committee review approach is to gain understanding of the circumstances of the deaths and any issues arising, with the goal to inform

improvements to MAiD care. While the circumstances of the deaths reviewed are not representative of most MAiD deaths, the themes identified during the review are not uncommon within the MAiD review process and likely have implications for emerging MAiD practice. The deaths selected are chosen for the ability to generate discussion, thought, and considerations for practice improvement. Reporting of the review discussions is largely focused on identifying areas where there may be opportunities to prompt such improvements.

These deaths are intended to initiate discussions around areas of MAiD practice and encourage practitioners, policymakers, and other stakeholders to explore the issues presented that are relevant to their scope of decision-making. We have selected topics and deaths that depict circumstances that often represent divergence from typical practice and thereby allow new and possibly emerging practice concepts to be evaluated.

Practice considerations and recommendations may have varying levels of transferability to broader MAiD practice and policy. Some practice considerations raised by the Committee should be considered by care teams integral to the delivery of healthcare, more generally (e.g., primary care, mental health services, specialty care teams). Moreover, all persons experiencing profound suffering would likely benefit from improved access to comprehensive care which may require investments in health and social systems to meet the rising expectations of MAiD practices.

Approach to MDRC Report

The Committee reports include, where possible and appropriate, a diversity of thought and perspectives from committee members. Statements do not reflect the views of individual members. We did not aim to establish consensus – we recognize that MAiD practice in Ontario is evolving and may benefit from this varied discourse. Committee member opinion, in favor of or in opposition to, a particular recommendation, discussion point or idea, were not collated or counted and we have employed qualifiers such as “few, some, many, and most” to acknowledge the extent of support by committee members. We do not intend for these qualifiers to reflect the validity of some of these statements – some members of the Committee offer more unique expertise and may prompt the reader to consider differing perspectives. Moreover, a variety of statements included in this report may have varying significance for different stakeholders.

Recommendations provided in the report have been informed by and developed from the Committee’s written and verbal discussions. Recommendations are addressed to the organizations that are believed to be positioned to effect change and support MAiD practice and policy. The recommendations are specifically provided and disseminated by the OCC accompanied by a request for a response from the recipient.

CONTENTS

INTRODUCTION

The enactment of Bill C-7 in March of 2021 repealed the legislative requirement for death to be reasonably foreseeable and created two sets of safeguards (track one [Track 1] – reasonably foreseeable natural deaths [RFND] and track two [Track 2] – non-reasonably foreseeable natural deaths [NRFND]). Additionally outlined in Bill C-7 was the stipulation that persons with a sole underlying condition of mental illness would not be eligible for MAiD. This prohibition, outlined in Bill C-62, has been subsequently extended until March 2027.

Bill C-7 legislation permitting access to MAiD for persons with NRFNDs allowed persons with complex chronic conditions to access an assisted death following Track 2 safeguards. Over the subsequent three-year period, the MAiD Review Team (MRT) has identified that the interpretation and evaluation of legislative criteria and safeguards for persons who have accessed MAiD with a NRFND have presented opportunities for practice learnings when considering:

- persons with complex medical conditions may have concomitant mental illness requiring discernment when evaluating their grievous and irremediable medical condition,
- the application of the 90-day assessment period,
- the requirement for expertise in the condition(s) for which the requester is seeking MAiD, and
- informing the requestor of reasonable and available means to relieve their suffering[i].

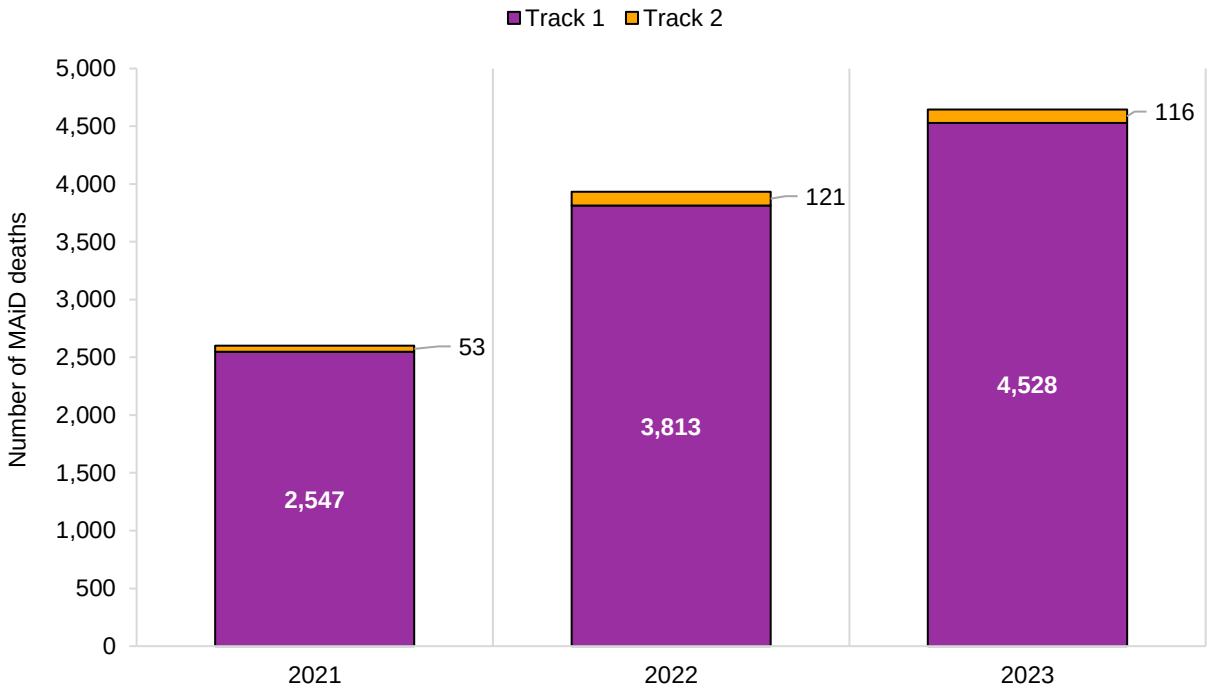
The MAiD Death Review Committee (MDRC) was asked to further contribute to these learnings to inform quality MAiD practices and approaches when considering persons accessing MAiD with complex medical conditions. Three illustrative MAiD deaths were selected for review to inform discussion on navigating complex clinical presentations with multiple interrelated conditions.

The MAiD deaths were not purposively selected to include mental illnesses in this review. However, aligned with the known higher prevalence of mental health conditions and chronic illness[ii], navigating this issue within Track 2 complex medical conditions was identified as a prominent theme for discussion. MDRC members identified that navigating complex medical conditions with concurrent mental illness presents inherent risks and increased complexities for consideration, including difficulties with assessing the criteria for a grievous and irremediable condition, navigating decision-making capacity and suicidal intent, and determining appropriate therapeutic responses to psychological distress within the MAiD process.

TOPIC OVERVIEW

Since 2021, when Bill C-7 was enacted, 2.6% of all Ontario MAiD provisions have been completed following Track 2 safeguards, for persons with NRFNDs. In 2023, a total of 4,644 MAiD provisions were reported, with 116 deaths identified as Track 2 (Figure 1).

Figure 1. Annual Number of MAiD Deaths in Ontario by Track



In this report, a focused presentation of Track 2 MAiD deaths and comparisons to Track 1 MAiD deaths are provided for health and disability characteristics. A review of sociodemographic characteristics is presented in "MDRC Report 2024 – 3: Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths". A notable limitation of the analyses is the relatively small numbers of Track 2 MAiD deaths, when compared to Track 1 deaths.

Illness, Disease, and Disability

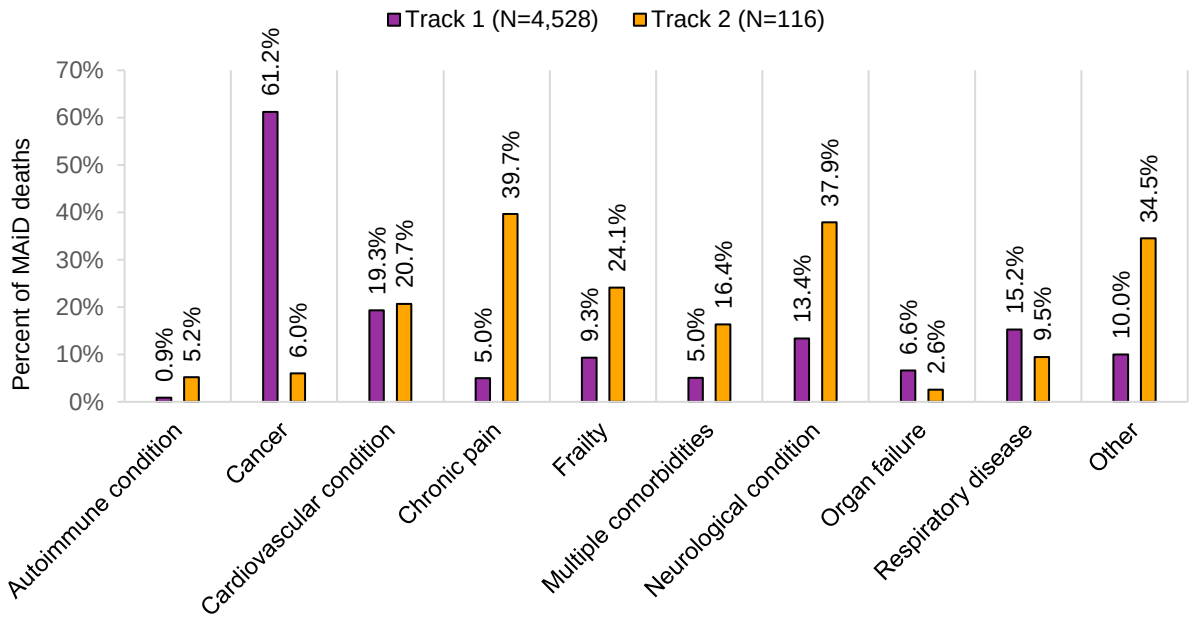
The medical conditions that are the basis of a request for MAiD differ between persons that access with a RFND (Track 1) or NRFND (Track 2). The frequency with which conditions were reported by MAiD practitioners[1] is presented in Figure 2. Cancer was the most common condition with which Track 1 recipients accessed MAiD. Persons who

[1] Conditions were not mutually exclusive. Totals do not add up to 100%.

accessed MAiD with a NRFND present with more complex conditions. Chronic pain was the reported condition for nearly 40% of Track 2 recipients, followed by neurological conditions (37.9%), which included Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis, and neurocognitive disorders. Track 2 recipients also had higher rates of frailty, multiple comorbidities, and autoimmune conditions.

More than one third of Track 2 recipients and ten percent of Track I recipients had a condition placed into the 'Other' category. Conditions included in this category are diabetes, spinal stenosis, end stage renal disease, and – for less than one percent of recipients – a mental health condition. For those with a mental health condition, the reason for which MAiD was approved was not related to the reported mental disorder. Additional focused review was conducted by the MAiD Review Team for these deaths to ensure that eligibility requirements were met.

Figure 2. Frequency of Serious and Incurable Illness, Disease, or Disability Reported in MAiD Deaths in Ontario, By Track, 2023



Persons who were approved for MAiD with a NRFND were often living with their illness for a longer period, compared with persons with a RFND. More than 60% of persons with a NRFND identified having an illness for five or more years, compared to 19% of persons with a RFND (Figures 3, 4).

Figure 3. Distribution of Track 1 MAiD Recipients (N=4,488[2]) Length of Time with Incurable Illness, Disease, or Disability, 2023

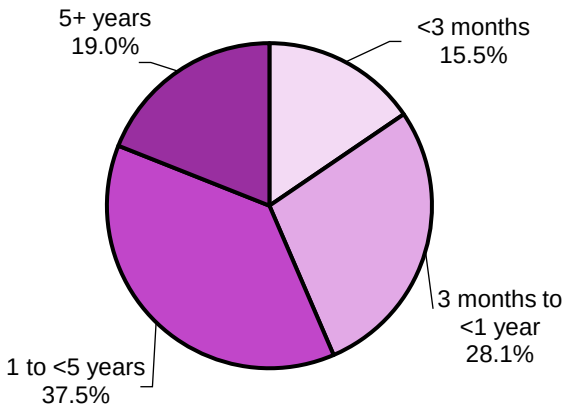
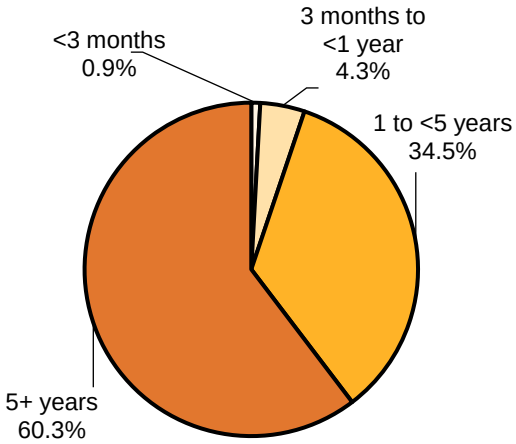


Figure 4. Distribution of Track 2 MAiD Recipients (N=116) Length of Time with Incurable Illness, Disease, or Disability, 2023



Self-Reported Disability

Track 2 recipients had higher self-reported disability[3] (62.9%) compared to Track 1 recipients (23.9%). The average length of time the requestor lived with a disability was also substantially longer among Track 2 recipients (7.8 years) compared to Track 1 recipients (1.3 years).

Disabilities reported by MAiD recipients in each of the groups are presented in Table 1. The most frequently reported type of disability was mobility related. This disability was identified by 85% of MAiD recipients. Types of disability differed between MAiD recipient groups for memory-related disabilities (86% higher in Track 2) and sight-related disabilities (66% higher in Track 2).

Disability Support

MAiD practitioners also reported MAiD recipients' needs for disability support services (Figure 5). MAiD practitioners reported that 76% of Track 2 recipients required disability supports, compared to 49% of Track 1 recipients. MAiD practitioners reported that 95% of persons with RFND and NRFND who required disability support services also

[2] Excludes deaths where information was not completed.

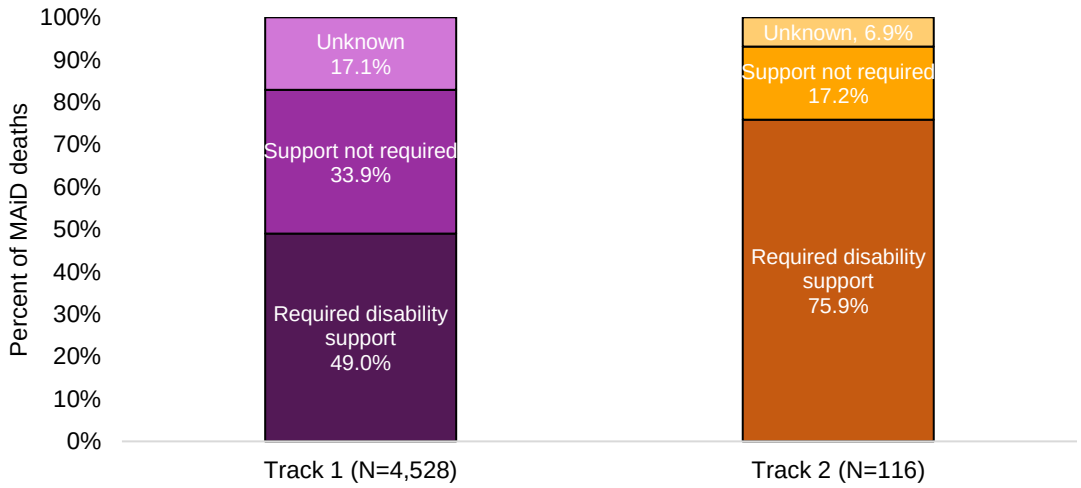
[3] Health Canada has indicated that the quality and reliability of self-identified disability data is limited due to variations in data collection.

received services. A limitation of this reporting is the inability to qualify the support received, particularly whether services rendered were sufficient to meet recipients' needs.

Table 1. Types of Disability Reported by MAiD Recipients in Ontario who Self-Reported Having a Disability, By Track, 2023

Types of Disability	Percent (%) of Track 1 MAiD Recipients (N=4,528)	Percent (%) of Track 2 MAiD Recipients (N=116)	Percent (%) Difference Between Tracks
Any Disability	**23.9**	**62.9**	**163**
Dexterity	23.7	32.9	39
Flexibility	20.9	24.7	18
Hearing	12.8	11.0	14
Memory	4.4	8.2	86
Mobility	84.8	84.9	0
Pain-Related	47.4	61.2	30
Seeing	11.6	19.2	66

Figure 5. MAiD Practitioner Assessment of the Recipients' Need for Disability Support, Ontario, 2023

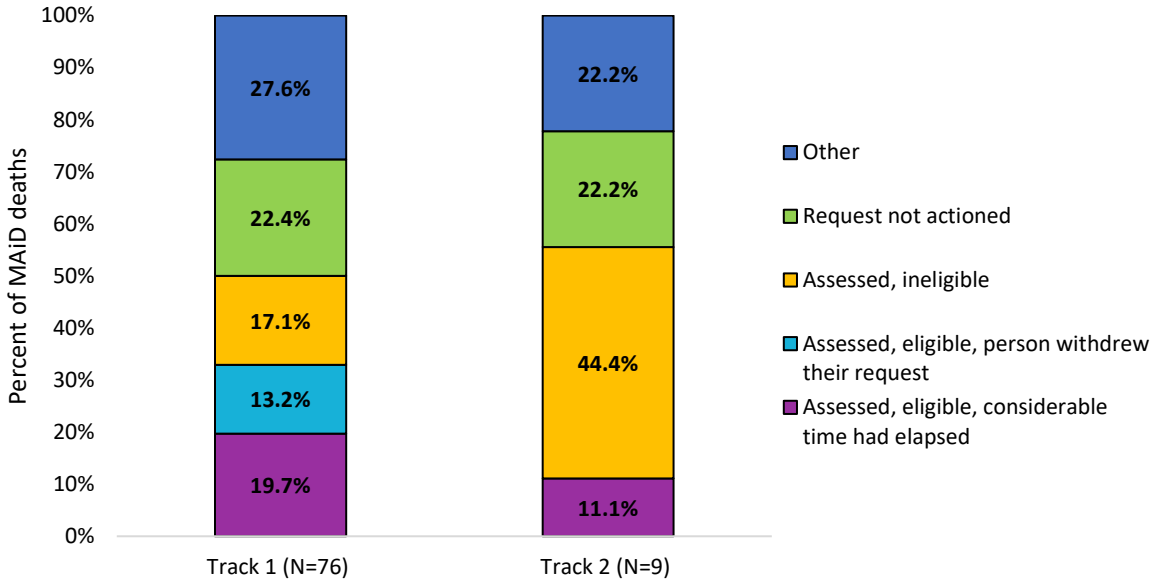


Previous MAiD Requests

For 2% of RFND deaths and 8% of NRFND deaths, the person had a previous MAiD request. The outcomes of these previous requests varied by the persons' Track (Figure

6). Nearly half of the individuals in Track 2 who had a previous MAiD request had been assessed and found ineligible.

Figure 6. Outcomes of previous MAiD requests by Track, Ontario, 2023



Intolerable Suffering

Persons who accessed MAiD with RFND and NRFND deaths appear to differ in their experience of intolerable suffering (Table 2). Track 2 recipients more frequently reported suffering related to inadequate pain control (or concern about it), and psychological and existential suffering related to feelings of isolation, loneliness, or emotional distress/anxiety/fear/existential suffering.

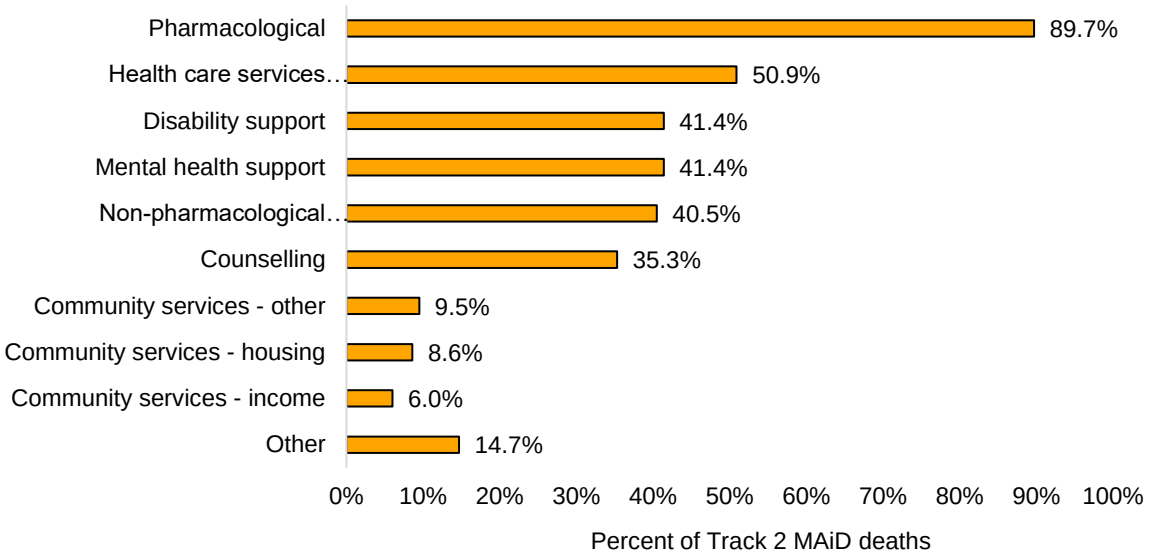
Table 2. Types of Suffering Identified by MAiD Recipients in Ontario that Could Not Be Alleviated Under Conditions Acceptable to Them, By Track, 2023

Description of Intolerable Suffering	Percent (%) of Track 1 MAiD Recipients (N=4,528)	Percent (%) of Track 2 MAiD Recipients (N=116)
Loss of ability to engage in meaningful activities	96.1	97.4
Loss of ability to perform activities of daily living	89.4	74.1
Inadequate pain control, or concern about it	51.1	61.2
Loss of dignity	66.3	63.8
Inadequate control of other symptoms, or concern about it	49.5	44.0
Perceived burden on family, friends, or caregivers	43.2	38.8
Loss of control of bodily functions	31.2	30.2
Isolation or Loneliness	15.8	39.7
Emotional distress/anxiety/fear/existential suffering	58.4	67.2
Loss of independence	86.5	81.9

Means to Alleviate Intolerable Suffering

Discussing alternate means to alleviate suffering is a legislative requirement for MAiD recipients. MAiD practitioners most often reported that they discussed and offered pharmacologic (89.7%) means to alleviate suffering for persons with NRFNDs, followed by offering healthcare services (including palliative care [50.9%]), disability support (41.4%), and mental health support (41.4%) (see Figure 7).

Figure 7. Means to Alleviate Suffering in Track 2 Deaths (N=116), 2023



MAiD Practitioners and Expertise in MAiD

Recognizing the potential complexities in Track 2 cases, including the presence of chronic pain, frailty, and the degree of disability, MAiD practitioners are legislatively required to consult a medical professional who has expertise in the requestor's condition.

In 53.4% of cases, one of the MAiD assessors declared they were an expert in the requestor's condition (Figure 8). Presented in Figure 9 are the specialties reported when one of the MAiD assessors acted as the expert and the types of specialists who were consulted when neither of the MAiD assessors had the expertise in the medical condition that was causing the requestor's suffering. External experts consulted were primarily in the fields of neurology, pain management, and geriatrics. There were legislative safeguard concerns in 1.7% of cases where expertise was not sought (Figure 8).

Figure 8. Percent of Track 2 Cases (N=116) in Ontario by Expertise of MAiD Assessor, 2023

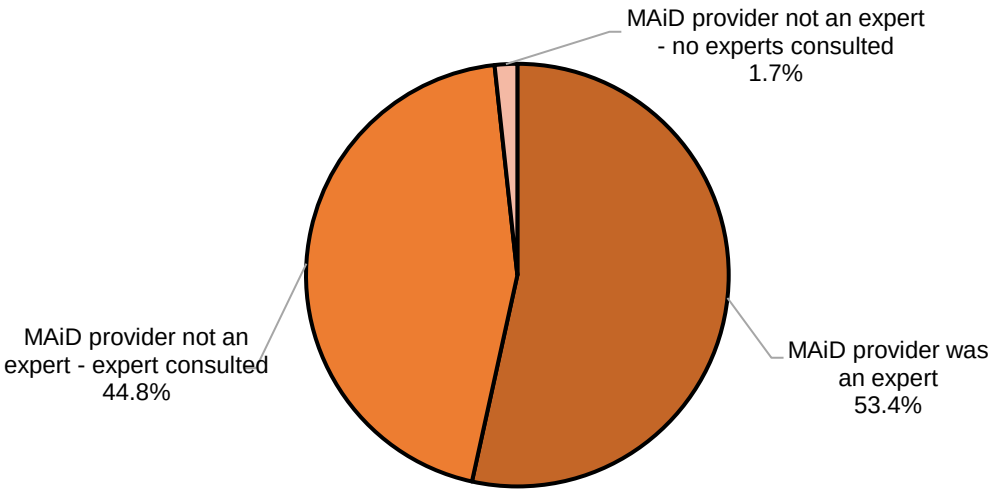
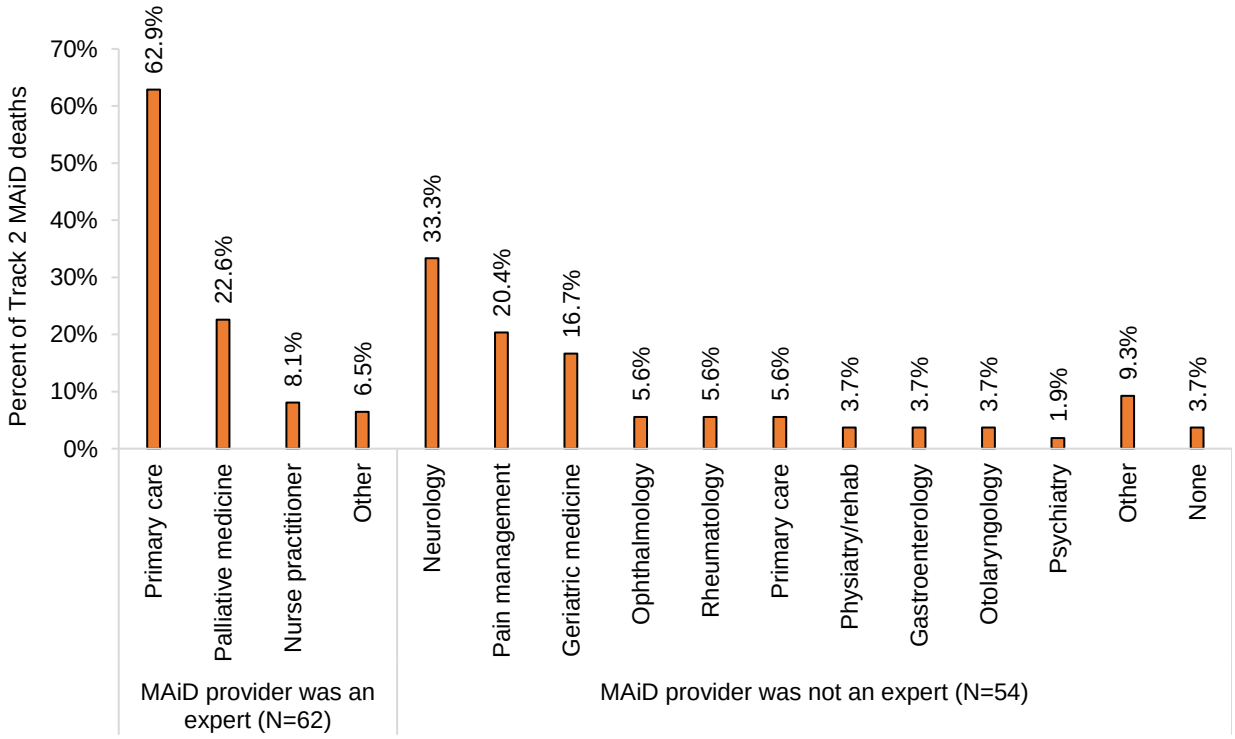


Figure 9. Types of Specialists Consulted for Track 2 MAiD Recipients in Ontario, 2023



Navigating the MAiD Process

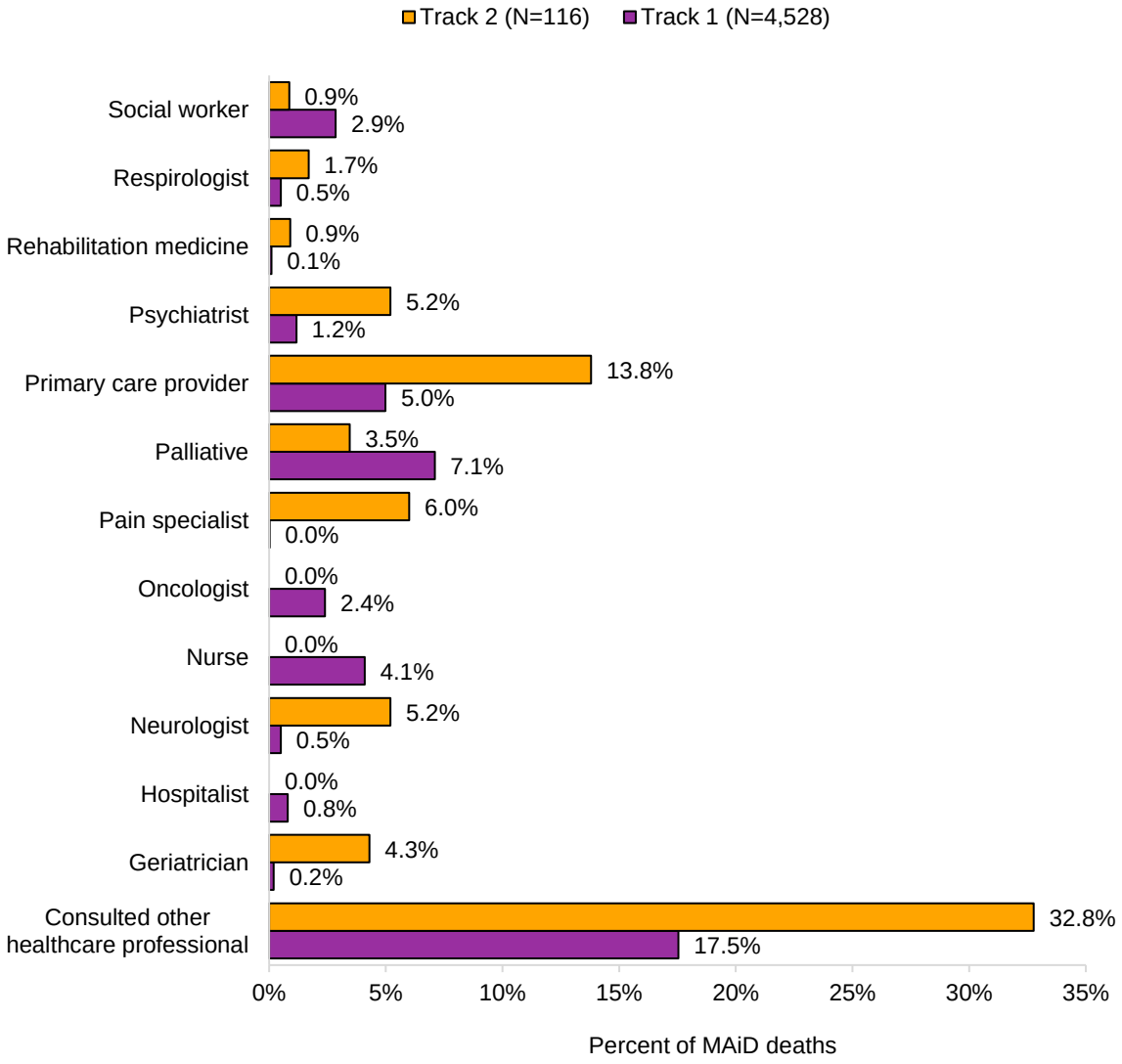
To ensure that there is sufficient time for consultation with a medical professional with expertise and for the requestor to consider and potentially trial alternate means to alleviate suffering, there is a 90-day assessment period required for persons accessing MAiD with a NRFND. The distribution of assessment period lengths is displayed in Table 3. Most assessment periods were between 90 and 120 days.

Table 3. Number of Days During the Assessment Period for Track 2 MAiD Recipients, 2023

Number of days During the Period of Assessment for Track 2 Recipients	Percent (%) of Track 2 MAiD Recipients (N=116)
Less than 90 days	13.0
90 to 120 days	45.2
121 to 180 days	17.4
181 to 365 days	12.2
More than 1 year	12.2

To inform eligibility for MAiD, nearly one-third of MAiD providers consulted another healthcare professional for persons accessing MAiD with a NRFND (Figure 10). This is nearly double the percentage of Track 1 recipients. The most consulted healthcare professionals for Track 2 recipients were primary care providers, followed by pain specialists, neurologists, and psychiatrists. For Track 1, the most consulted professionals included those specializing in palliative care and primary care.

Figure 10. Percent of MAiD Cases for Whom Another Healthcare Professional was Consulted to Inform Eligibility, Track 1 compared to Track 2



COMMITTEE REVIEW

The MAiD deaths selected for this review were illustrative examples of persons who accessed MAiD with complex medical conditions. Themes were shared across all three cases; hence, a collective presentation of the review is provided below.

CASE OVERVIEWS

Case A

Complex Medical Condition

Mr. A was a male in his late 40s who experienced suffering and functional decline following three vaccinations for SARS-Cov-2. He received multiple expert consultations, with extensive clinical testing completed without determinate diagnostic results. Amongst his multiple specialists, no unifying diagnosis was confirmed. He had a significant mental health history, including depression and trauma experiences. While navigating his physical symptoms, Mr. A was admitted to hospital with intrusive thoughts of dying. Psychiatrists presented concerns of an adjustment disorder, depression with possible psychotic symptoms, and illness anxiety/somatic symptom disorder. During a second occurrence of suicidal ideation, Mr. A was involuntarily hospitalized. During this hospitalization, post-traumatic stress disorder was thought to be significantly contributing to his symptoms. He received inpatient psychiatric treatment and care through a specialist team. He was also diagnosed with cluster B and C personality traits.

The MAiD assessors opined that the most reasonable diagnosis for Mr. A's clinical presentation (severe functional decline) was a post-vaccine syndrome, in keeping with chronic fatigue syndrome, also known as myalgic encephalomyelitis.

No pathological findings were found at the time of post-mortem examination. The cause of death following post-mortem examination was provided as post COVID-19 vaccination somatic symptom disorder with post-traumatic stress disorder and depressive disorder.

Case B

Concurrent Mental Illnesses

Mr. B was a male in his late 40s. He was diagnosed with longstanding severe gastric and duodenal ulcers with unknown etiology. Mr. B concurrently presented with multiple mental illnesses, namely depression, anxiety, narcissistic personality disorder, and bipolar mood disorder type 2. He had chronic suicidal ideations.

A year prior to the provision of MAiD, Mr. B attempted suicide with a descent from a height. He experienced polytrauma and required extensive medical and surgical management and rehabilitation. Psychiatry was involved in the MAiD assessment process. Mr. B was deemed by psychiatry to be capable of participating in the MAiD process, and the suicide attempt was determined to be a reflection of profound existential suffering. A psychiatrist determined that neither psychiatric illness nor suicidal ideations were facilitating the request for MAiD.

Case C

Chronic Pain & Adjustment Disorder

Mr. C was an older male in his 80s, who experienced chronic back pain (15 years) due to spinal stenosis and post-surgical adhesive arachnoiditis. He was followed by a specialist pain clinic. Mr. C was also diagnosed by a psychiatrist with an adjustment disorder leading up to his request for MAiD. He declined further pharmacological interventions for same. The psychiatrist determined that this approach was in-keeping with an informed decision. Mr. C's adjustment disorder was mainly influenced by irremediable chronic pain, and less likely to be responsive to pharmacologic intervention.

DISCUSSION

Theme One

Exploring Uncertain Diagnoses

Many of the MDRC members identified legislative and practice challenges that arise when evaluating the legislative requirement for a grievous and irremediable condition when a person is requesting MAiD with a complex medical condition and whose death is not reasonably foreseeable. Diagnostic uncertainty within the MAiD process raises a number of concerns: determining that the condition meets legislative requirements, ability to confirm irreversibility of the condition, alignment of treatment and care, and identifying those with expertise for consultation.

Most MDRC members recognized the clinical challenges of diagnostic determinations when a person is accessing MAiD with a complex chronic condition. Members noted that diagnostic certainty is not always feasible due to the imperfect nature of clinical knowledge and evaluation, the overlap between psychological and physical somatic clinical presentations, and a reliance on diagnosis by exclusion. Most MDRC members concluded that a definitive diagnosis is not necessary to confirm that a serious and incurable illness, disease or disability exists; however, a comprehensive and well-documented clinical investigation should be evident that weighs all probable diagnoses.

In Case A, the postmortem examination did not identify an underlying physiologic diagnosis[4]. Some MDRC members thought that the clinical diagnosis (myalgic encephalomyelitis) formulated during the MAiD assessment process was reasonable. Before and during the MAiD process, multiple clinical and psychiatric experts were consulted without a unifying diagnosis established. MDRC psychiatric experts identified that if psychiatry had been consulted for the purpose of MAiD eligibility, the psychiatric presentation, which included depression, post-traumatic stress disorder, somatic symptom disorder, illness anxiety, and personality disorder may have impacted the determination of MAID eligibility (see second theme for further discussion).

Furthering the discussion of Case A, some MDRC members cautioned that the requestor seeking MAiD with a clinical presentation previously unrecognized in medicine (i.e., possible post-vaccine somatic syndrome), may not allow for a determination of incurability of the condition or whether the requestor presents with an irreversible decline in capability given limited available clinical knowledge and research. Some members indicated that legislative interpretations and current practices support basing this determination on clinical and functional trajectories of decline.

Lastly, most MDRC members identified that diagnostic uncertainty when navigating Track 2 complex conditions presents challenges for identifying healthcare practitioners with expertise in the condition to consult. Some MDRC members recommended that multiple expert consultations from different specialties should be sought when required, seeking to explore treatments for potentially reversible conditions with similar illness presentations. Several MDRC members noted that persons in rural and remote areas may not have access to specialists without creating significant personal hardship for the requestor. Some members opined that health system solutions to mitigate this access inequity are necessary.

Some MDRC members commented that a well-documented and comprehensive clinical evaluation and investigation of an uncertain diagnosis by multiple specialists would mitigate some legislative and practice concerns. Some members discussed the value of multiple specialists being consulted with different treatment modalities trialed, spanning different functional orientations of the illness presentation, and addressing all probable conditions. Some members discussed the importance of the requestor's response to treatments to be monitored and considered within the determination of eligibility, particularly when considering irreversibility of the condition and alleviating intolerable suffering. When diagnostic clarity is not possible, or a new condition in the field of medicine is being navigated (e.g., long-COVID), some members discussed how the requestor should be informed of the limitations of available information regarding

[4] Postmortem examinations are not frequently completed as part of MRT investigations.

reversibility of the condition and unknown prospects for future management and treatment of their condition.

Practice Considerations

- Complex medical conditions often present diagnostic challenges. It is important for MAiD practitioners to consider involving multiple medical specialties to establish differential or exclusionary diagnoses, evaluate the reversibility of the conditions, and identify best potential treatments. This clinical evaluation should be well-documented to include each of these items.

Theme Two

Evaluating Concomitant Psychological Disorders

Many complex chronic conditions are a combination of biological, psychological, and social factors[iii]. Current legislation requires that a mental illness cannot be the sole underlying condition for seeking MAiD. MAiD practitioners are thereby legislatively required to have clinical evidence to reasonably conclude that a requestor's serious illness, disease or disability is not solely due to existing mental illness. In Case A, a number of mental health diagnoses were present. In Case B and C, MDRC members brought forward discussions of how concomitant mental illness requires special attention.

MDRC members identified that thorough and complete MAiD practice, when navigating assessments for individuals for Track 2 with medically complex conditions and mental illness, should include psychiatry assessment. Depression, anxiety symptoms, somatic symptoms and related disorders, post-traumatic stress disorder and personality disorders are common in these patients[iv]. All of the requestors in the deaths reviewed benefitted from a psychiatry referral. Overall, psychiatry expertise was sought in 5.2% of Track 2 cases.

Psychiatric consultations may help identify the full range of existing psychiatric diagnoses, the relationship between existing mental illnesses and the complex medical condition, and the weight of a psychiatric disorder on the request for MAiD. A psychiatric consultation should also identify if troubled relationships (e.g., personal or doctor relationships) are contributing to the request for MAiD. In Case A, the role of psychiatry was potentially underutilized for the purposes of MAiD eligibility determinations, in particular in consideration of concerns regarding a personality disorder, post-traumatic stress disorder, and depression with somatization. Response to treatment for existing mental health conditions may also help to clarify whether the psychiatric disorder is the underlying condition for MAiD or significantly contributing to suffering and the request for MAiD. In Case A, some MDRC members identified that the psychiatric treatment

duration was not long enough to effectively evaluate some treatment responses. Also, a few members felt that inadequate attention was placed on the diagnosis of somatic symptoms and related disorders such as illness anxiety disorder and personality disorder.

Professional guidelines include consideration for suicidal ideation throughout the MAiD process[v]; however, MDRC members could not identify this evaluation as standard practice in each of the MAiD deaths reviewed by the Committee. In situations where suicidality is significant to a person's psychiatric history, such as in Case B, multiple MDRC members felt that involving mental health experts should be a mandatory part of the assessment process. In Case B, psychiatry was consulted to differentiate suicidal ideations from a MAiD request and to evaluate decisional capacity to engage in the MAiD process. This consultation process was identified as a beneficial approach to practice by multiple members.

MDRC members identified mental health professionals as having an integral role in providing quality care for persons with complex chronic conditions. Members discussed the benefit of psychiatric treatments (e.g., pharmacotherapy, neurostimulation, psychotherapy) being offered as indicated for underlying mental health conditions, with appropriate therapeutic trials and monitoring. In Case C, psychiatry's role was instrumental in identifying that the diagnosed adjustment disorder was not reversible or treatable due to the nature of the stressor (i.e., severe, and refractory chronic pain).

MDRC members agreed that psychosocial support should be offered to ameliorate, if possible, psychological, and socioeconomic factors that may influence suicidal ideation and suffering, prior to providing MAiD. A few members noted the benefit of trauma-informed care and consideration of childhood or adult trauma, as this may contribute to symptoms, suffering, and the request for MAiD.

Practice Considerations

- MAiD practitioners should strongly consider psychiatric assessment when a person is requesting MAiD with a complex medical condition and concurrent mental illness:
    - to consider the full range of psychiatric diagnoses and psychiatric history (including depression and anxiety disorders, somatic symptom and illness anxiety disorders, personality disorders and post-traumatic stress disorders) and their impact on MAiD eligibility (i.e., grievous and irremediable condition, voluntariness, capacity, and consent),
    - evaluate suicidal ideation within the MAiD assessment process,
    - explore the relationship between existing mental illness and the complex medical condition to determine optimal treatments, and

- prescribe psychotropic medications in optimal doses and duration, and psychotherapies and neurostimulation as appropriate, for serious consideration by the requestor.

- Referrals to other mental health professionals (including psychologists, social workers, mental health nurses and psychotherapists) should be strongly considered to:
  - explore whether additional psychological and/or socioeconomic concerns are factors impacting the request for MAiD,
  - assess and provide support for psychological issues that may cause or magnify the presented symptoms, increase suffering, or contribute to suicidal ideation, and
  - attempt to ameliorate socioeconomic factors that may additionally contribute to suffering.

Theme Three

Navigating the Minimum 90-Day Assessment Period

MDRC members identified across each of the Track 2 deaths reviewed the importance of continuity of care with existing practitioners (e.g., family medicine, nurse practitioners, or existing care team) to provide comprehensive care when navigating complex conditions and care requirements. MDRC members opined that MAiD practitioners should not be expected to adopt full medical responsibility during the MAiD assessment process and should involve care team members in the assessment and care provision.

MDRC members framed the role of MAiD practitioners during the MAiD assessment process as one of “taking inventory” of existing diagnoses and treatments trialed, aligned with the request for MAiD. MAiD practitioners should use their medical expertise to identify additional consultations and treatments that may be required and communicate changes to the requestor’s plan of care to their care team. MAiD practitioners should focus on integrating holistic care where possible.

Many MDRC members cautioned that for NRFND with complex medical conditions, the safeguard requiring a minimum 90-day assessment period may be an insufficient amount of time to navigate the requestor’s complex care needs. In Case A, numerous consultations were conducted, both prior to and during the MAiD process. The MAiD practitioners engaged with Mr. A to identify outstanding treatment or care options through MAiD eligibility assessments, and facilitated access to additional expert consultants, implemented treatment options, evaluated the effectiveness of treatment, and monitored responses to care. Some MDRC members suggested that a clinically informed extended assessment period may have been required in this case to inform

eligibility (i.e., the irreversibility of the advanced state of decline in capability and the incurability of the illness, disease, or disability).

In Case C, the diagnosed “adjustment disorder” raised concerns for some MDRC members of a possible transient health state. Multiple MDRC members cautioned that the required minimum 90-day assessment period may not be sufficient when a requestor is experiencing a transient physical or psychological state or undergoing a transition in their care plan. In such circumstances, additional time may be required to evaluate the reversibility of the stressor or whether an adaptive response is possible. Some MDRC members indicated that evaluating transient and adaptive states should be evaluated on a case-by-case basis, evaluating all personal, social, and health factors recognizing individual variability and accessibility to resources and supports. Some members mentioned that unnecessarily extending the provision of MAiD past 90 days may further contribute to the requestor’s suffering. When an extended assessment period is required, the MAiD practitioner should address timeframe expectations with the requestor and their family.

In some cases, providing MAiD immediately following the 90-day assessment period is reasonable when comprehensive diagnoses, treatments, and care have been facilitated prior to the person initiating the MAiD process. In these circumstances, the 90-day assessment period may be suitable time for MAiD practitioners to evaluate treatments and potential options to alleviate suffering. A comprehensive evaluation of each MAID request before and during the MAID process benefits the requestor, their family and friends, and the MAiD practitioners. It also offers the best security against accusations of poor practice, reduces uncertainty, and fosters public trust in the MAiD system.

Practice Considerations

- Primary care providers and/or existing care team should continue providing medical care for the MAiD requestor during the assessment period. The MAiD practitioner should document involved healthcare professionals in the MAiD records.
- MAiD practitioners should identify additional consultations or treatments required and facilitate communication for referrals with the existing care team.
- The start date of the 90-day assessment period should be clearly documented.
- MAiD practitioners should view the 90-day assessment period as a minimum and consider what is sufficient time to explore reasonable means to alleviate symptoms and reduce suffering.

Theme Four

Facilitating Treatment for Complex Care Needs

Across the review of these MAiD deaths, MDRC members reflected on the need to develop and routinize a model of care that effectively supports MAiD practitioners in navigating complex Track 2 cases and ensures quality care for the requestor and family.

Many MDRC members agreed that a relational approach to care should be at the core of the model, valuing supports and treatments that occur within person, community, and culture. Some MDRC members identified value in MAiD practitioners having several interactions and conversations with the requestor during the MAiD process. This approach may be beneficial to facilitate an in-depth understanding of their trajectory of illness, the nature of their suffering, and situate their illness experiences within relevant personal contexts and medical history. In some circumstances, relying mainly on review of medical records for this personal narrative may be an insufficient means to fully understand the requestor's care needs. Collateral information is important to understand additional complex circumstances not available through record review.

As part of this relational approach to care, members believed that collateral information from the requestor's partner, family, and/or healthcare team should be sought with the requestor's permission. Family involvement is highly desirable but may not be possible due to refusal by the requestor or family, or unavailability to contact. Some MDRC members thought that additional information from Case A's spouse and previous mental health team would likely have been helpful. If permission from the requestor is not granted without good reason, the MAiD assessor may not be in a position to support the MAID request. Family involvement is further explored in MDRC Report 2024 - 3.

MDRC members also identified the importance of a multidisciplinary and interprofessional approach to care of persons with complex medical conditions to comprehensively identify and offer treatment options that address the multi-factorial nature of suffering. The Committee indicated that where appropriate, palliative care values should be adopted.

Members indicated benefit of engagement with multidisciplinary professionals being aligned with the issues identified. Refusals of appropriate treatment by the requestor without serious consideration and an appropriate rationale provided may impact the MAiD assessor's determination of eligibility of the MAiD request. MDRC members recognized the importance for alignment of options with the requestor's goals of care and values.

Practice Considerations

- MAiD practitioners should consider a relational approach to care, engaging with the requestor's family members (whenever possible), sometimes over several interactions, when necessary to have an in-depth understanding of the requestor's illness experience.
- Multidisciplinary and interprofessional expertise should be sought to identify physical, psychological, socioeconomic issues impacting the MAiD requestor.
- Refusals from the requestor to allow access/obtain collateral information and/or appropriate treatments without serious consideration and a rationale provided may impact the assessor's ability to determine eligibility of the MAiD request.
- Requests with chronic pain as a major factor in the MAiD request should be referred to a chronic pain expert or program.
- Where appropriate, a referral to palliative care to identify approaches to relieve suffering should be considered.

TOPIC SUMMARY

Persons accessing MAiD when natural death is not reasonably foreseeable present challenging legislative, practice, and care considerations for MAiD practitioners. In response to these challenges, some members of the MDRC called for a paradigm shift. The practice of providing MAiD would benefit from moving away from a procedural-focused approach to care-focused approach to practice. Some MDRC members believe that legislative safeguards for NRFND are intended to guide MAiD practice towards a care-focused approach – encouraging multi-disciplinary engagement via the requirement for consultation with those with expertise and navigating comprehensive care during the minimum 90-day assessment period.

A comprehensive model-of-care should be person-centered, relational, and involve persons close to the individual accessing MAiD (i.e., family and friends) when possible. MAiD practitioners are encouraged to situate a person's request for MAiD within a full understanding of their medical, socioeconomical, and cultural history of their personal circumstances. MAiD practitioners are encouraged to engage with the requestor's existing care team and to seek collateral information from persons close to the requestor when possible. MAiD practitioners and additional multi-disciplinary and interprofessional consultants should be integrated into existing care.

A multidisciplinary and interprofessional model is best positioned to consider the diagnostic challenges of complex medical conditions. Multiple medical specialties are often beneficial to establish diagnoses, evaluate the irremediability of the conditions, determine capacity, and identify best potential treatments to reduce suffering.

Many complex medical conditions are combinations of biological, psychological, and socioeconomic factors. Many complex presentations would benefit from consultations with mental health experts, especially psychiatrists, to consider capacity, suicidality, and a full range of psychiatric disorders and optimal treatments. Social workers and other mental health professionals should also be consulted when appropriate to identify and attempt to ameliorate socioeconomic vulnerabilities to reduce suffering.

RECOMMENDATIONS

In collaboration with the MAiD Review Team to inform MAiD oversight in Ontario, the MDRC aims to inform enhancements to MAiD practice and safety through system recommendations. The Office of the Chief Coroner (OCC) will disseminate this review to MAiD Practitioners in Ontario and organizations identified in the recommendations to inform continued professional practice improvements.

MDRC guidance issued in this report will inform approaches to MAiD oversight in Ontario. The OCC, based on feedback from the MDRC, will be seeking to review and revise, if indicated, the oversight response to legislative breaches and practice concerns that arise from the review of MAiD deaths to continue to support the mandate for public safety and protection.

The OCC has identified recipients and recommendations to inform further improvements to the MAiD system in Ontario. These recommendations were formulated from MDRC discussions specific to this topic and review; however, some recommendations would benefit from consideration and implementation across all MAiD practices (Track I and Track 2) and for persons who experience profound suffering and are considering an assisted death. Moreover, these recommendations should be situated within broad health and social system improvements and considered with a summative understanding of this report.

1. **To Health Canada:**

   1.1 Health Canada (HC) to consider providing additional guidance on how to approach legislative criteria and safeguards when persons requesting MAiD with a mental health condition that contributes to their grievous and irremediable condition and/or when their request and suffering is predominantly psychologically and/or psychosocially oriented.

   1.2 HC to consider the issues presented in this MDRC Review to inform updates to MAiD guidance and/or “MAiD: Implementing the Framework” for the management of Track 2 complex medical conditions. In particular,

- consider providing additional guidance to MAiD practitioners on the minimum 90-day assessment period. Guidance should reflect the importance of aligning the length of the assessment period with the determination of the requestor's care needs and providing sufficient time for appropriate navigation of health and social services. A focus on quality care and taking sufficient time (i.e., beyond the 90-day assessment period), when necessary, over procedurally fulfilling criteria to expedite the MAiD process is suggested.
- consider providing additional guidance to practitioners for seeking applicable consultation with those with expertise when navigating complex conditions, particularly for persons with concomitant mental illness where there would be benefit of involvement with a psychiatrist and/or other mental health professional.

2. To the Ontario Ministry of Health:

2.1 The Ontario Ministry of Health (MOH) to consider revising the OHIP Fee Schedule to provide a compensation framework for the enhanced role of navigating Track 2 safeguards and/or cases with complex conditions, including the time required for retrieval and review of relevant medical records, engaging in necessary discussions with the requestor's care team members, and providing expert care.

- The MOH to consider that an updated compensation framework could be adopted to monitor and analyze healthcare activities that are specific to MAiD (e.g., unique MAiD billing codes to monitor activity separate from other health services).
- An updated compensation framework could address inconsistent and uncertain billing practices for Track 2 cases (i.e., particularly for persons not receiving palliative care services).
- The MOH to consider health system needs and Track 2 practitioner shortages in their considerations for an updated compensation framework (e.g., nurse practitioners willing to engage in independent MAiD practice).

3. To Ontario Ministry of Health and Ontario Health:

3.1 The MOH and Ontario Health (OH) to consider identifying and disseminating this report with communities of practice or other healthcare agencies engaged in MAiD initiatives to improve care, coordination, and/or practice.

3.2 The MOH and OH to consider the development of a provincially coordinated MAiD care system[5], to include the following:

- Care coordination to facilitate information gathering, arranging consultations, and navigating care to ensure persons with complex needs are provided with access to services to facilitate comprehensive assessment and care.
- A consultation service or community of practice to support MAiD practitioners navigating complex MAiD requests and facilitate expert consultation for persons with complex medical conditions and/or circumstances. An interprofessional and multidisciplinary community of practice, comprised of members with diverse expertise (e.g., physicians, lawyers, ethicists, social workers), may be beneficial.
- Regional multi-disciplinary and interprofessional care teams (e.g., physicians, nurses, social workers, occupational therapists, physiotherapists, peer-support, community-life specialists) to assist in the navigation of complex care needs of persons who have requested MAiD.

3.3 MOH and OH to consider developing practice standards for a provincially coordinated MAiD care system. Consider collaborating with academic networks to evaluate this MAiD model-of-care.

4. To Toronto Academic Health Science Network and Ontario Ministry of Health:

4.1 The Toronto Academic Health Science Network to collaborate with provincial partners to support the evidence-based development of MAiD models-of-care, a community of practice, and/or MAiD Assessment Service (see also MDRC Report 2024 – 3).

5. To Canadian Association of MAiD Assessors and Providers:

5.1 The Canadian Association of MAiD Assessors and Providers (CAMAP) to consider issues identified through MAiD oversight and practice considerations as described in this report to inform and modify, if necessary, member education and practice.

5.2 CAMAP, possibly in collaboration with the Canadian Psychiatric Association, to consider the development and dissemination of practice guidance documents and resources to support MAiD practitioners in understanding the diagnoses of somatic

[5] The MDRC does not endorse a particular model-of-care. The MDRC acknowledges that this recommendation must be evaluated for feasibility and consideration of equitable integration within the current healthcare system.

symptom and related disorders, post-traumatic stress disorder, and personality disorders and their treatments.

5.3 Additionally, consider further practice guidance documents, where evidence exists, for practitioners that will assist in differentiating suicide states from MAiD requests and recognizing the impact of the MAiD assessment process on suicide risk.

6. **To College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, College of Psychologists of Ontario, and the College of Social Workers and Social Service Workers:**

   6.1 The College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the College of Psychologists of Ontario, and the College of Social Workers and Social Service Workers to consider employing this MDRC Review to inform Track 2 MAiD practice guidelines for evaluating requestors with complex medical diagnoses and/or concomitant mental illness.

7. **To Canadian Medical Protection Association & Canadian Nurses Protective Society:**

   7.1 To the Canadian Medical Protection Association and Canadian Nurses Protective Society to consider employing this MDRC Review to inform medico-legal advice provided to MAiD practitioners.

RESOURCES

Consider the following resources to inform MAiD practice:

Bill C-14: An Act to Amend the Criminal Code (Medical Assistance in Dying)

Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)

Bill C-62: An Act to Amend the Criminal Code (No. 2)

CAMAP: MAiD Assessments for People with Complex Chronic Conditions

Centre for Effective Practice (CEP): MAiD in Ontario Track 2

MAiD Implementation: Implementing the Framework

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[v] Health Canada (2023). Advice to the Profession: Medical Assistance in Dying. Retrieved from: Advice to the Profession: Medical Assistance in Dying (MAID) - Canada.ca

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2024

MAiD Death Review Committee Report 2024 - 3

Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths

Ministry of the Solicitor General | Office of the Chief Coroner

BACKGROUND

Under the *Coroners Act*, physicians and nurse practitioners who provide Medical Assistance in Dying (MAiD) are required to notify the Office of the Chief Coroner (OCC) of the death and provide relevant information to support MAiD death review, oversight, and Health Canada mandatory reporting requirements. Ontario has an established team of highly skilled nurse coroner investigators (MAiD Review Team) who retrospectively review every reported MAiD death in Ontario. A structured feedback approach for practitioners is followed to respond to concerns with statutory requirements, regulatory policies, and/or professional practice when identified during the review process. Further investigation is undertaken as required in accordance with the *Coroners Act* and with the Chief Coroner.

Reflecting the more mature state of MAiD practice, in January of 2023, the OCC modernized its approach to MAiD death review and oversight. Through the modernization process, the OCC review and oversight approach has continued to evolve to include, when indicated, enhanced expert review to respond to increasing social and systemic complexities within the contexts and circumstances surrounding MAiD practice, care, and legislation. Ontario is the first province in Canada to develop a multi-disciplinary expert death review committee to provide enhanced evaluation of MAiD deaths and to explore end-of-life complexities that have systemic and practice implications. Ontario continues to be a leader in high-quality and innovative MAiD death oversight and review.

The MAiD Death Review Committee (MDRC) was established in January of 2024. The committee is comprised of 16 members from across multiple disciplines (law, ethics, medicine, social work, nursing, mental health and disability experts, and a member of the public) who bring a diverse background of expertise in providing advisory support to MAiD oversight in Ontario.

The MDRC seeks to provide recommendations and guidance that may inform the practice of MAiD through the evaluation and discussion of topics, themes, and trends identified by the MAiD Review Team (MRT).

Committee Aim

The MDRC provides multidisciplinary expert review of MAiD deaths in Ontario with legislative, practice, health, social, and/or intersectional complexities identified through the oversight and review process. MDRC members review and evaluate the contextual circumstances that impact MAiD and inform the ecology of care for persons, families, and communities. MDRC members review relevant MAiD trends, topics, or issues and offer insights, perspectives, or interpretations and assist in formulating recommendations to inform system improvements (e.g., education of MAiD

practitioners, review of regulatory body policies) with a goal to support quality practice and the safety of patients and MAiD practitioners.

Acknowledging there is public discourse regarding MAiD, the MDRC is committed to increasing public transparency of the MAiD oversight and review process through the dissemination of reports.

Acknowledgement of Persons, Families, and Communities

The MDRC acknowledges the deaths of persons who have experienced profound suffering at end-of-life. We acknowledge the losses to partners, families, close relations, and communities.

During the death review process the OCC protects the personal biographies of the persons who have accessed MAiD. In this report, while some personal information was included for a small number of MAiD deaths, efforts were taken to maintain privacy for persons and their families by sharing only the necessary details and circumstances of their death to support understanding of the issues explored. When we identified that a person's particular circumstance may be identifiable to a person's close relations, we have made efforts to inform their next of kin. We are respectful to the persons whose aspects of their lives are shared in the information presented.

In alignment with the OCC's motto to "speak for the dead to protect the living", the MDRC approaches this important work to learn from each MAiD death. By examining these deaths and presenting this information, we aim to support continued improvement for how MAiD is provided in the province of Ontario.

Acknowledgement of MAiD Practitioners

We extend recognition to clinicians who provide dignified care to persons who have requested MAiD. We respect the clinicians who commit to on-going learning and integrate evolving MAiD practice improvements into their approaches to care. We also acknowledge that clinicians are navigating care for persons accessing MAiD within the limitations of our health and social systems. We further recognize that the OCC MAiD oversight process is an additional step in the provision of MAiD; we are appreciative of the important role of clinicians in the Ontario MAiD oversight process.

Approach to MDRC Review

Through the OCC MAiD death review process, we have observed that only a small number of MAiD deaths in Ontario have identified concerns. MAiD deaths illustrative of specific circumstances, identified during review by the MRT, are provided to the Committee. The Committee review approach is to gain understanding of the circumstances of the deaths and any issues arising, with the goal to inform

improvements to MAiD care. While the circumstances of the deaths reviewed are not representative of most MAiD deaths, the themes identified during the review are not uncommon within the MAiD review process and likely have implications for emerging MAiD practice. The deaths selected are chosen for the ability to generate discussion, thought, and considerations for practice improvement. Reporting of the review discussions is largely focused on identifying areas where there may be opportunities to prompt such improvements.

These deaths are intended to initiate discussions around areas of MAiD practice and encourage practitioners, policymakers, and other stakeholders to explore the issues presented that are relevant to their scope of decision-making. We have selected topics and deaths that depict circumstances that often represent divergence from typical practice and thereby allow new and possibly emerging practice concepts to be evaluated.

Practice considerations and recommendations may have varying levels of transferability to broader MAiD practice and policy. Some practice considerations raised by the Committee should be considered by care teams integral to the delivery of healthcare, more generally (e.g., primary care, mental health services, specialty care teams). Moreover, all persons experiencing profound suffering would likely benefit from improved access to comprehensive care which may require investments in health and social systems to meet the rising expectations of MAiD practices.

Approach to MDRC Report

The Committee reports include, where possible and appropriate, a diversity of thought and perspectives from committee members. Statements do not reflect the views of individual members. We did not aim to establish consensus – we recognize that MAiD practice in Ontario is evolving and may benefit from this varied discourse. Committee member opinion, in favor of or in opposition to, a particular recommendation, discussion point or idea, were not collated or counted and we have employed qualifiers such as “few, some, many, and most” to acknowledge the extent of support by committee members. We do not intend for these qualifiers to reflect the validity of some of these statements – some members of the Committee offer more unique expertise and may prompt the reader to consider differing perspectives. Moreover, a variety of statements included in this report may have varying significance for different stakeholders.

Recommendations provided in the report have been informed by and developed from the Committee’s written and verbal discussions. Recommendations are addressed to the organizations that are believed to be positioned to effect change and support MAiD practice and policy. The recommendations are specifically provided and disseminated by the OCC accompanied by a request for a response from the recipient.

CONTENTS

INTRODUCTION

The enactment of Bill C-7 in March of 2021 repealed the legislative requirement for a person's natural death to be reasonably foreseeable and created two sets of safeguards (track one [Track 1] – for persons with reasonably foreseeable natural deaths [RFND] and track two [Track 2] – for persons with non-reasonably foreseeable natural deaths [NRFND]). The Parliament of Canada indicated that amendments to MAiD eligibility criteria and safeguards must balance respect for individual autonomy with the protection of vulnerable persons. The MDRC reviewed three purposively selected MAiD deaths where the persons accessing MAiD belonged to groups who potentially experienced marginalization and structural inequities. This review was intended to examine these issues within illustrative cases posing specific circumstances of vulnerability. While these deaths are not representative of frequent reasons for accessing MAiD, nor are the circumstances representative of most MAiD Track 2 deaths, the themes identified during this review are not uncommon within the MAiD review process. Moreover, MDRC members reviewed only a small sample of MAiD Track 2 deaths, representing a notable limitation of this review. This review has been released concurrently with "MDRC Report 2024-2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths".

The Office of the Chief Coroner (OCC) acknowledges that many persons in civil society object to being labelled as "vulnerable". It has been recognized that this term has been misused to shift the focus of unmet social needs from societal and policy shortcomings to the individual level. In this review, the MDRC employs the term 'vulnerable' in the context of the protection of marginalized persons who are at greater risk of experiencing systemic, structural or intersectional inequities. This approach reflects the language employed in the preamble of Bill C-7[i].

In this review, MDRC members discussed opportunities where changes to MAiD practice, in alignment with legislative criteria and safeguards, could be considered to improve protection for those experiencing social disenfranchisement. Aligned with legislative responsibilities and practice standards[ii], MAiD practitioners are required to evaluate MAiD requests for possible intersectional or structural inducement towards an assisted death. The aim of this MDRC review was to evaluate selected examples of MAiD deaths where social and structural vulnerability were necessary considerations within the assessment of voluntariness. The MDRC aims to continue discussions to inform improvements in MAiD practice and safety through learnings arising from these case reviews.

Aligned with human rights experts[iii], MDRC members who advocate for vulnerable persons presented that a goal of this review should be the consideration of equitable access to health and social care systems. They emphasize that persons who access MAiD with a NRFND should have comprehensive care options to mitigate suffering,

including appropriate medical care, counselling, disability and mental health supports, and community-enriching activities. MDRC member advocates positioned that MAiD should not be the solution for societal and policy failures. Some other members stated that societal and policy deficiencies should not disenfranchise persons from accessing MAiD provided that reasonable attempts were made to access services.

Accessing MAiD with Self-Identified Disability

Persons with self-identified disabilities were included as a vulnerable group within this review. In January 2023, Health Canada expanded its data collection to include self-disclosed sociodemographic characteristics for the identification of persons with disability. Health Canada's definition of disability was adapted from the Canadian Survey on Disability[iv], a national survey administered by Statistics Canada. Health Canada defined disability "as a functional limitation in any one of the following ten areas, which cannot be corrected with the use of aids: seeing, hearing, mobility, flexibility, dexterity, pain-related, learning, developmental, mental health related or memory". A disability may be a pre-existing condition or acquired because of the requestor's current illness or disease or its associated complications.

Health Canada has indicated that the quality and reliability of self-identified disability data is limited due to variations in data collection approaches across jurisdictions, inconsistency in interpretation of the term "disability", and reluctance from individuals to self-identify, due to concerns about how this could impact their request.

MDRC members with expertise arising from a lived experience position that appropriate self-identification of disability is necessary to prompt MAiD practitioners to explore a person's intersectional membership within a particular social and cultural disability community. Self-identification of disability (i.e., as per Ontario Human Rights Code[v]), via a definition that reflects intersectional and social lived experiences, should cue MAiD practitioners to consider the intersection of disability with other marginalized identities and systemic factors that may shape a person's request for MAiD and their experiences within health and social systems. Moreover, a social and intersectional definition of disability better positions MAiD assessment and care within inclusive clinical care practices, exploring care options to alleviate suffering outside of the traditional medical model (e.g., humility-oriented anti-ableist care options[1vi]).

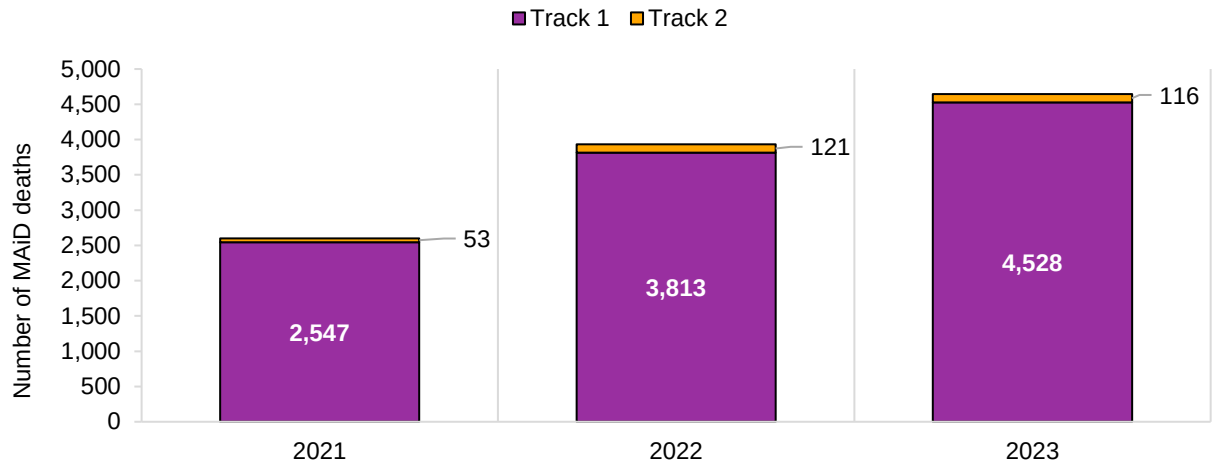
[1] A humility-oriented, anti-ableist care approach acknowledges how historical structures have limited care options and undermined the dignity of persons with disabilities. In healthcare, a holistic approach recognizes the limitations of traditional medical perspectives, especially those rooted in ableism. This care model prioritizes respect for the lived experiences of the disability community and its experts, affirming that disability is not synonymous with suffering. Additionally, this approach requires healthcare providers to acknowledge that they may not have all the necessary knowledge or tools to alleviate suffering. As such, they must consult with and collaborate with individuals who have direct experience with disability, as well as specialists in evidence-based chronic care.

This review provides an opportunity for MAiD practitioners to develop an enhanced awareness of social vulnerabilities in the context of MAiD. Further considerations provided in this report will support MAiD practitioners to avoid exclusively applying a medical model analysis to their assessments and instead, consider a social and intersectional model of disability when evaluating requests for MAiD with the involvement of those with applicable expertise, while aiming to avoid ableist interpretations of MAiD eligibility and safeguards.

TOPIC OVERVIEW

Since 2021, when Bill C-7 was legislated, 2.6% of all MAiD provisions have been completed following Track 2 safeguards, for persons with NRFNDs. In 2023, there were a total of 4,644 MAiD provisions, 116 deaths were Track 2 (Figure 1).

Figure 1. Annual Number of MAiD Deaths in Ontario by Track, 2021 - 2023



In this report, a focused presentation of sociodemographic characteristics for Track 2 MAiD deaths is presented. The characteristics are variables that could be contributing to a potentially higher degree of vulnerability at an individual level. Using data drawn from the MAiD Death Report we have presented characteristics, such as age and sex, geography, housing, and social network, that may offer considerations for the level of marginalization experienced by some groups of Track 2 recipients. A review of health and disability characteristics is discussed in “MDRC Report 2024 – 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths”. The reader should recognize that these analyses were completed with relatively small numbers of Track 2 MAiD deaths in contrast to Track 1 deaths. In addition, recognition that Track 1 and 2 MAiD recipients appear to be distinct populations with different illness journeys that may impact potential comparisons.

Age and Sex Distributions

Persons who access MAiD with a RFND and NRFND differ by age and sex assigned at birth (Tables 1, 2). Track 2 recipients were more commonly female (61%).

Persons under the age of 60 years represent a higher proportion of Track 2 MAiD deaths. Nearly 17% of Track 2 MAiD deaths were female recipients aged 18 to 59 years, while 7.5% were Track 1 MAiD deaths in this age range. The same finding was observed for males, with 18% of Track 2 recipients among those in the younger age group, compared to seven percent of Track 1 recipients.

Table 1. Number and Percent of Track I MAiD Deaths in Ontario by Age and Sex, 2023[2]

Sex Assigned at Birth	Age Group	Number of Track 1 MAiD Deaths	Percent (%) of Deaths within Sex	Percent (%) of all Deaths
Female	18-59	168	7.5	3.7
	60-69	358	16.0	7.9
	70-79	608	27.2	13.4
	80-89	631	28.3	13.9
	90+	468	21.0	10.3
	ALL AGES	**2,233**	**100.0**	**49.3**
Male	18-59	156	6.8	3.4
	60-69	443	19.3	9.8
	70-79	706	30.8	15.6
	80-89	711	31.0	15.7
	90+	278	12.1	6.1
	ALL AGES	**2,294**	**100.0**	**50.7**

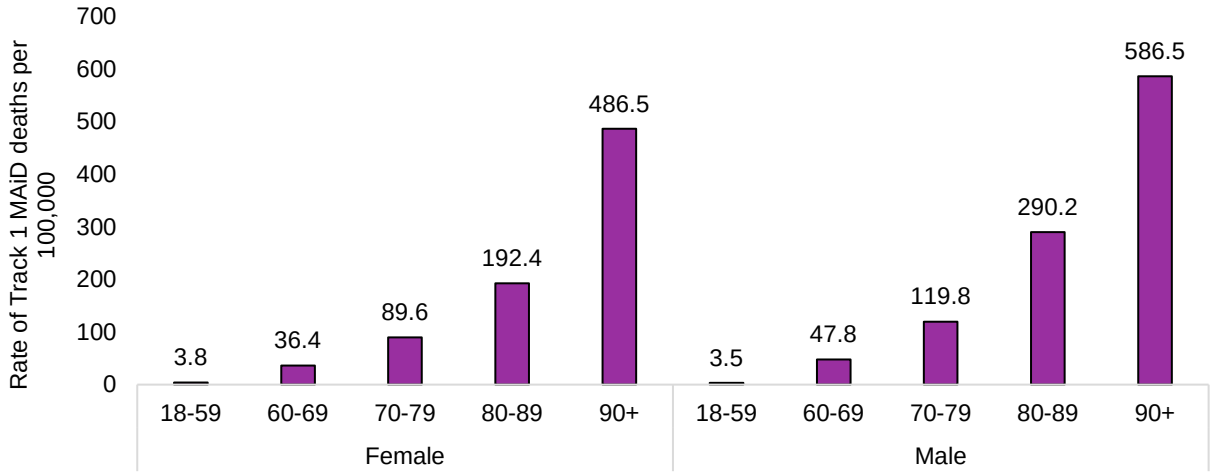
[2] Excludes deaths where information was not completed.

Table 2. Number and Percent of Track 2 MAiD Deaths in Ontario by Age and Sex, 2023[1]

Sex Assigned at Birth	Age Group	Number of Track 2 MAiD Deaths	Percent (%) of Deaths within Sex	Percent (%) of all Deaths
Female	18-59	12	16.9	10.3
	60-69	10	14.1	8.6
	70-79	20	28.2	17.2
	80-89	18	25.4	15.5
	90+	11	15.5	9.5
	ALL AGES	**71**	**100.0**	**61.2**
Male	18-59	8	17.8	6.9
	60-69	10	22.2	8.6
	70-79	15	33.3	12.9
	80-89	8	17.8	6.9
	90+	4	8.9	3.4
	ALL AGES	**45**	**100.0**	**38.8**

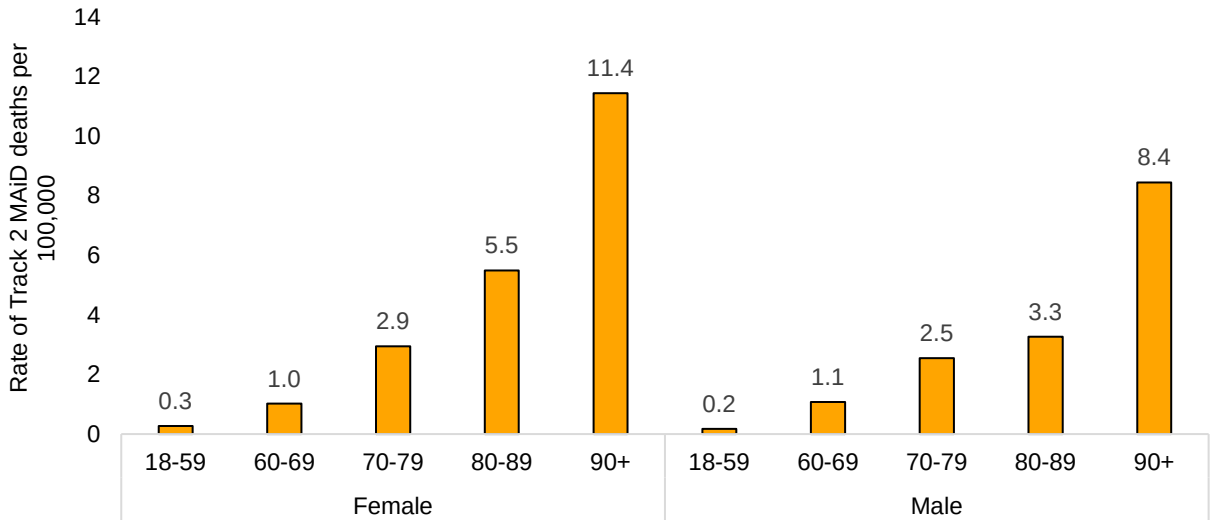
To support comparison across different population sizes, rates of MAiD provisions per 100,000 persons aged 18 years and older were calculated. Overall, the rate of MAiD recipients increased substantially with age (Figures 2,3). Among Track 1 recipients, higher rates were seen among males for nearly all age groups when compared to females. The highest rate was seen in males aged 90 years and older, with 587 deaths per 100,000 males in 2023 (Figure 2).

Figure 2. Rate per 100,000 of Track 1 MAiD Deaths in Ontario by Age and Sex, 2023



In contrast, rates of Track 2 provisions were higher among females for most age groups. The highest rate was for females aged 90 years and older, with 11 deaths per 100,000 females (Figure 3).

Figure 3. Rate per 100,000 of Track 2 MAiD Deaths in Ontario by Age and Sex, 2023



Geographic Distribution

The geographic distributions of Track 1 and Track 2 MAiD deaths illustrate that the public health units (PHU) in Ontario with higher rates of Track I deaths – Grey Bruce, Haliburton, Kawartha Pine Ridge, Huron Perth, Leeds, Grenville and Lanark, North Bay Parry Sound, Southwestern, and Timiskaming PHUs – are not consistent with the locations that show higher levels of Track 2 deaths (Haliburton Kawartha Pine Ridge, Huron Perth, Simcoe Muskoka, Sudbury and District, and Thunder Bay PHUs). Lower rates for both Track 1 and Track 2 were seen in the Greater Toronto Area (Figures 4,5). Geographic variations may be due to a number of factors and merits further investigation.

Figure 4. Rate of Track 1 MAiD Deaths per 100,000 Population (aged 18+) by Public Health Unit, 2023

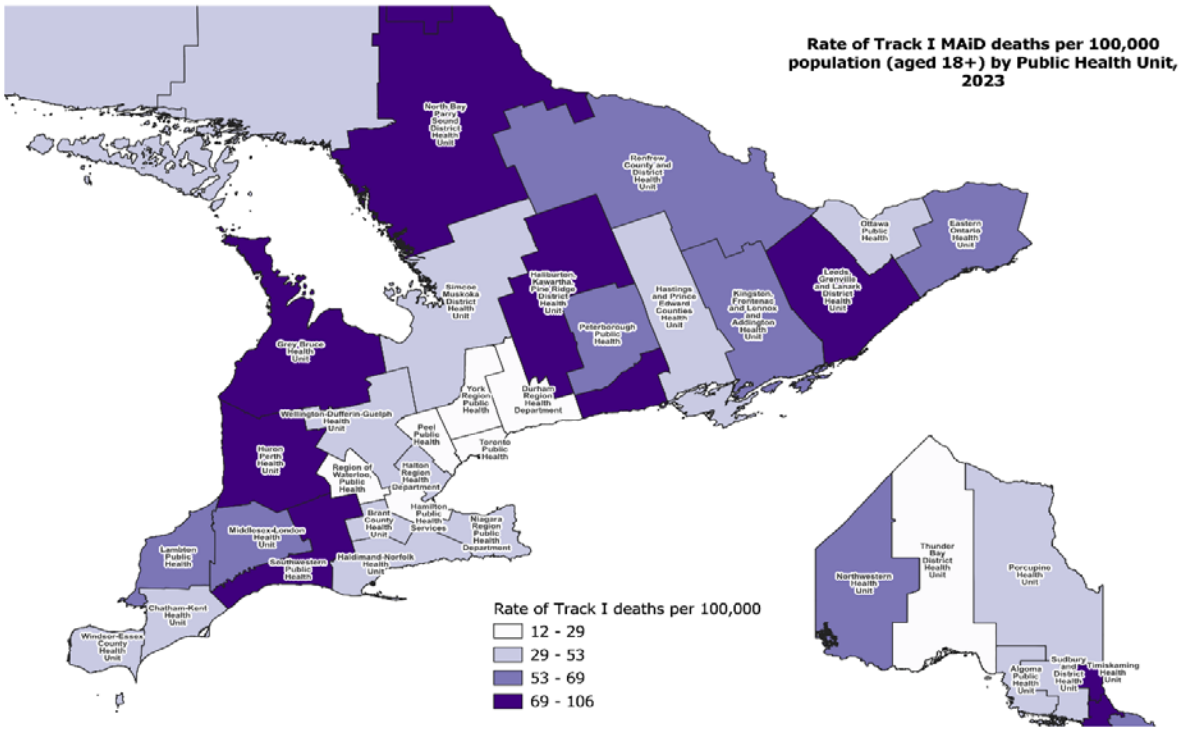
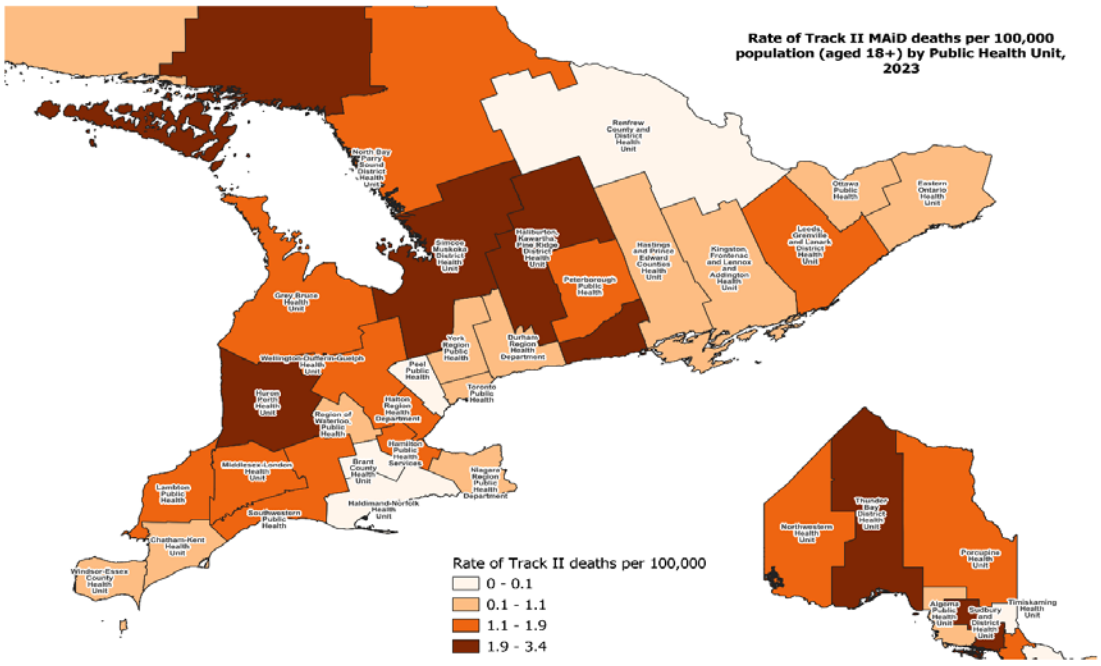


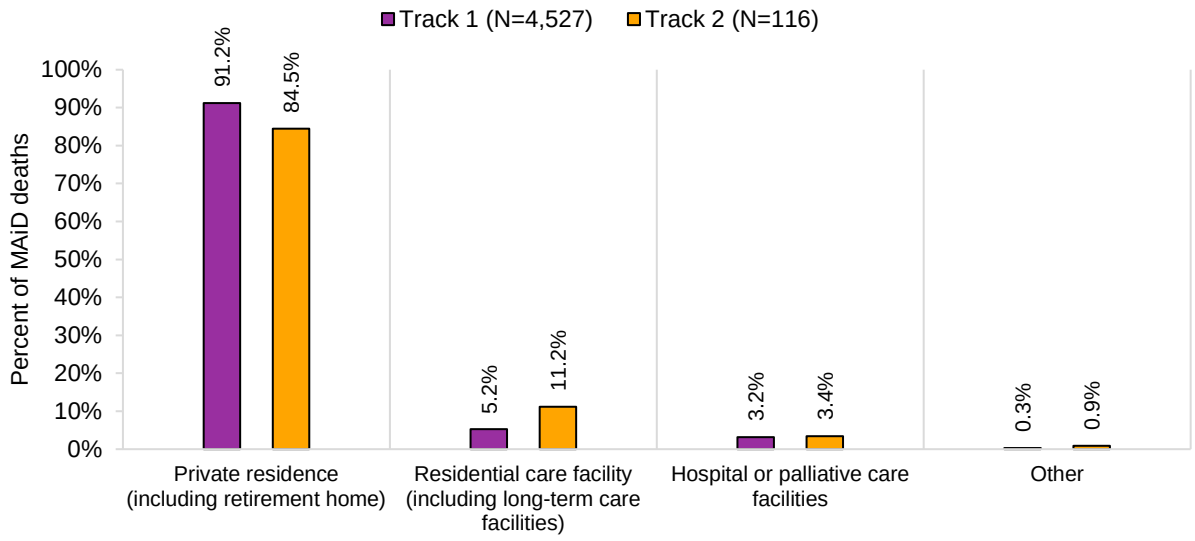
Figure 5. Rate of Track 2 MAiD Deaths per 100,000 Population (aged 18+) by Public Health Unit, 2023



Housing

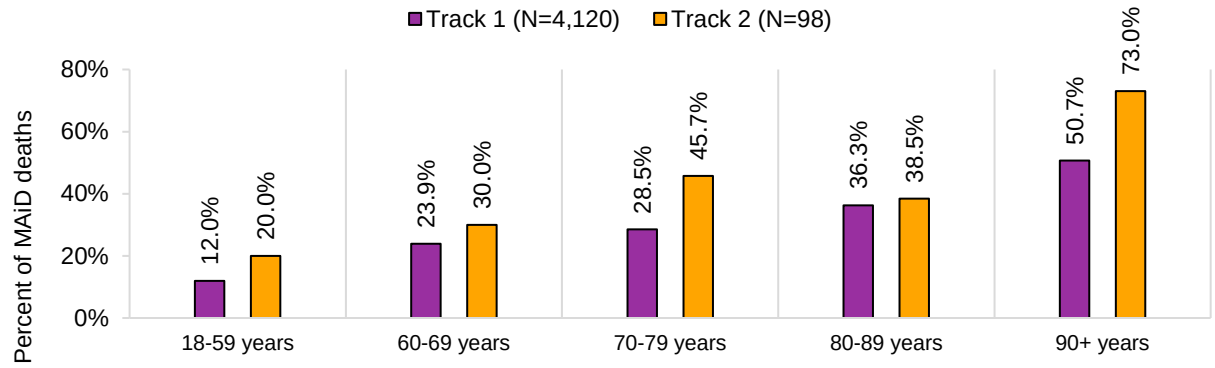
Mandatory reporting for MAiD requires the type of housing and living situations for all recipients of MAiD be specified. The majority of persons who accessed MAiD via both tracks were living in private residences, including retirement homes (Figure 6). A slightly higher proportion of Track 2 recipients resided in residential care facilities (long-term care and assisted living). Persons who accessed MAiD resided in hospitals, palliative care facilities, or in 'other' locations (correctional facilities, shelters, group homes, and hotels/motels) in similar proportions across both safeguard tracks.

Figure 6. Distribution of Residence Type for MAiD Deaths in Ontario, by Track, 2023



Track I and Track 2 recipients differed in the percentage of each population living alone. Track 2 recipients more commonly lived alone at all ages (Figure 7).

Figure 7. Proportion of MAiD Recipients in Ontario Living Alone, by Age Group and Track, 2023



Social Network

Track 2 MAiD recipients were more likely to be living alone (see Figure 7). Data gathered as related to the next of kin (NOK) relationship was also evaluated (Figures 8,9). These data showed apparent variations in the types of relationships that MAiD recipients relied upon when selecting a NOK.

Ninety percent of Track I MAiD recipients provided an immediate family member (spouse, sibling, or child) as their NOK, compared to 73% of Track 2 recipients. Those who accessed MAiD via Track 2 safeguards were more likely to have provided a friend, extended family member, or other person, such as a case worker, lawyer, or health care provider.

Figure 8. Distribution of Track 1 MAiD Recipients (N=4,528) 'Next of Kin' by Relationship, 2023

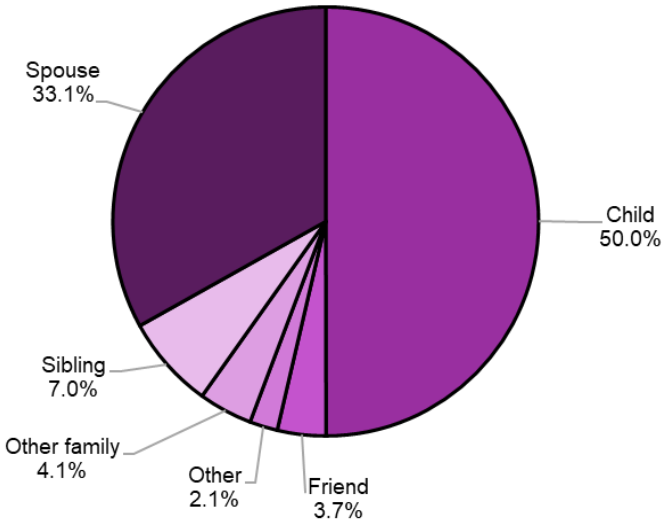
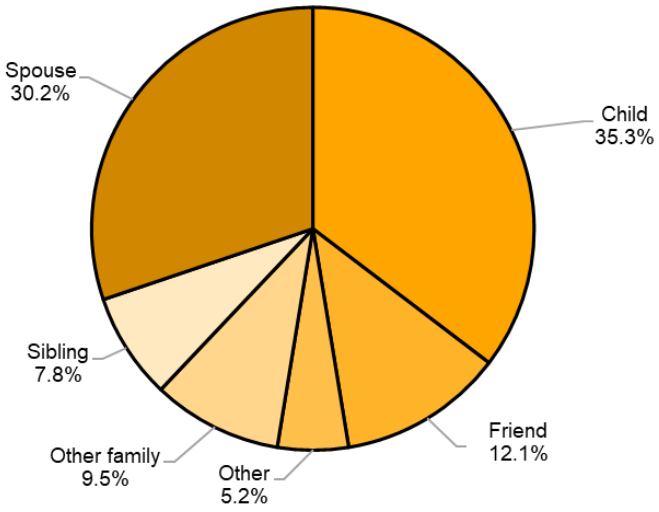


Figure 9. Figure 9. Distribution of Track 2 MAiD Recipients (N=116) 'Next of Kin' by Relationship, 2023



Marginalization

While the information collected about individual MAiD recipients does not include socioeconomic data, using the residential neighbourhood where an individual lived may provide insight into the level of marginalization associated with that neighborhood and therefore a greater risk for vulnerability. Public Health Ontario, The Centre for Urban Health Solutions, and St. Michael's Hospital have developed an index which identifies the level of marginalization associated with residential/community geography based upon a number of metrics. Please refer to "Medical Assistance in Dying (MAiD): Marginalization Data Perspectives" report from the Office of the Chief Coroner for additional detail and perspectives regarding marginalization and MAiD recipients.

There are four dimensions in the index: material resources; households and dwellings; age and labour force; and racialized and newcomer populations. Details about the indicators used for each dimension as well as its limitations can be found in the User Guide [3].

A comparison of Track 1 and Track 2 recipients for each of the four dimensions are presented in Figures 10 to 13. For the Material Resources dimension (Figure 10), which is most closely associated with poverty, Track 2 recipients are more likely to reside in areas of the province with high levels of marginalization (28.4%) than Track 1 recipients (21.5%).

While both the Households and Dwellings dimension (Figure 11) and the Age and Labour Force dimension (Figure 12) show that MAiD recipients were more likely to reside in areas with high marginalization, the indicators which define these dimensions are highly correlated with age and disability. Therefore, the results may not provide meaningful information beyond confirming what is known about the age and health status of those seeking MAiD.

Finally, the Racialized and Newcomer dimension (Figure 13) demonstrates that MAiD recipients in both Tracks were predominantly non-racialized populations.

[3] https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Ontario-Marginalization-Index

Figure 10. Distribution of MAiD Recipients by Level of Marginalization: **Material Resources Dimension**, 2023

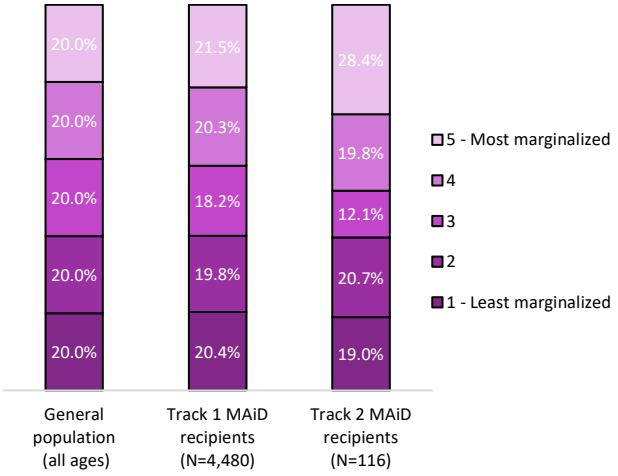


Figure 11. Distribution of MAiD Recipients by Level of Marginalization**: Households and Dwellings Dimension**, 2023

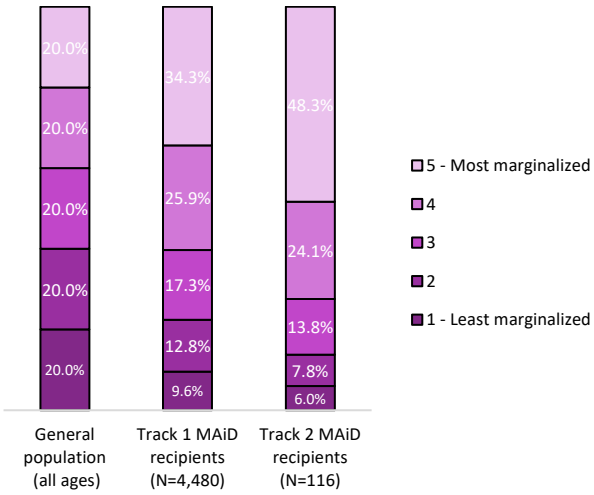


Figure 12. Distribution of MAiD Recipients by Level of Marginalization: **Age and Labour Force Dimension**, 2023

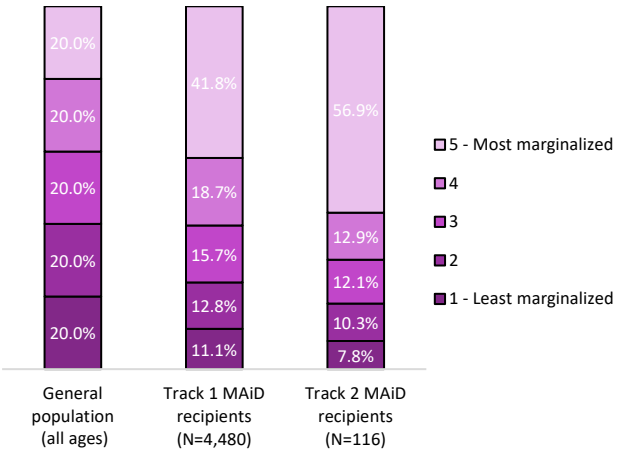
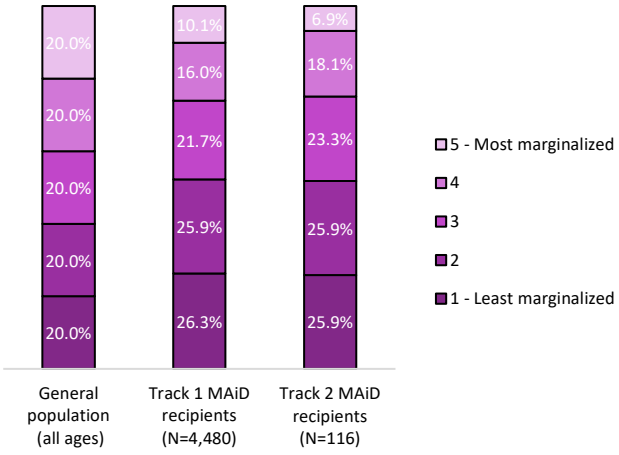


Figure 13. Distribution of MAiD Recipients by Level of Marginalization: **Racialized and Newcomer Population Dimension**, 2023



When considering the increased likelihood of MAiD recipients – particularly those in Track 2 – residing in areas with higher levels of material deprivation, it is important to understand the relationship between illness, disability, and marginalization.

Figure 14 demonstrates the levels of marginalization described for the residential community of MAiD recipients who have experienced disability by the length of time with a disability. Figure 15 shows a similar relationship for MAiD recipients experiencing a serious illness for ten or more years. Given that the Material Resources dimension is representative of community aggregates, the level of deprivation for each individual MAiD recipient cannot be directly determined. Material deprivation is likely multi-factorial, potentially including direct impacts of the illness or disability, such as employment opportunities.

Overall, these comparisons are predicated on generalized measures for vulnerability and not direct individual level reporting (Figure 14, 15). Therefore, the reader should recognize limitations to the analyses. Individuals seeking MAiD under Track 2 have features which often include a significantly longer disease and disability burden to those seeking MAiD under Track 1.

Figure 14. Distribution of MAiD Recipients by Level of Marginalization: Material Resources Dimension, and Length of Time with Disability, 2023

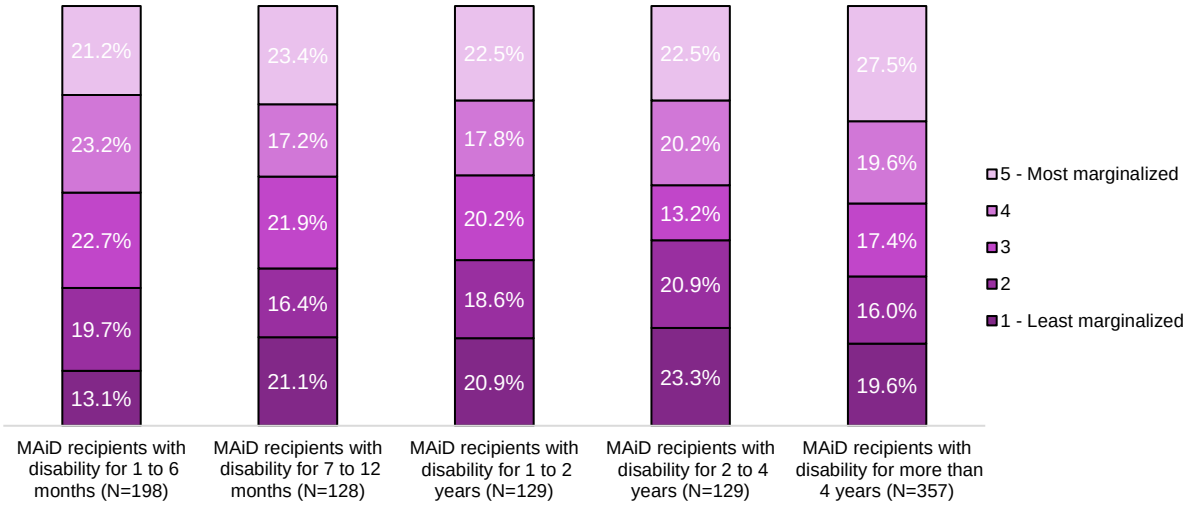
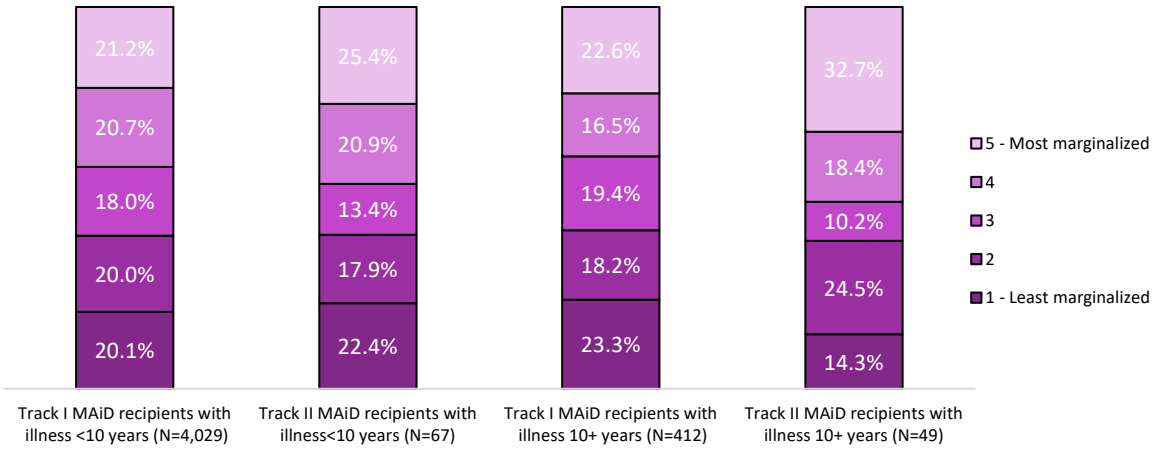


Figure 15. Distribution of MAiD Recipients by Level of Marginalization: Material Resources Dimension, and Length of Time with Serious Illness, 2023



COMMITTEE REVIEW

CASE A

SOCIAL VULNERABILITY

Case Overview

Mr. A was a male in his 40s with inflammatory bowel disease. He received extensive treatment for this illness. It was reported that partly due to the course of his illness, Mr. A did not have an active social network: he could not maintain employment, he found personal relationships difficult to sustain, and he was dependent on family for housing and financial support. As a result, Mr. A lived with reduced social supports. He had declined multiple social support programs and psychosocial services.

Mr. A had a history of mental illness, previous episodes of suicidality, and on-going alcohol and opioid misuse. He lost his driver's license secondary to his addictions. During a psychiatry assessment, the psychiatrist asked him if he was aware of MAiD and presented information on the option. While Mr. A was believed to have maintained decisional capability, his substance use was not explored in the MAiD assessments, and he was not offered addiction treatments.

During the MAiD process, there was no documented input from Mr. A's family, nor a statement about why there was no engagement with family. The MAiD provider documented that the family had concerns about his request for MAiD.

The MAiD provider personally transported Mr. A in their vehicle to an external location for the provision of MAiD.

Discussion

The MAiD death was reported to the OCC by the involved MAiD practitioners as deemed to have met eligibility within legislative parameters; eligibility was primarily determined on the incurable condition of inflammatory bowel disease with advanced state of irreversible decline and intolerable suffering. Multiple MDRC members expressed concerns of the limited exploration of medical and social issues experienced by Mr. A. The MAiD assessors' focused evaluations were reported as problematic for many members – the approach did not address significant concerns regarding mental health and addictions, social well-being and support, and family involvement.

Mental Health & Substance Use Disorder

Some members expressed concerns about mental illness being a significant driver of Mr. A's MAiD request. Some MDRC members expressed that Mr. A's mental illness was not fully examined for remediation. Many MDRC members believed that there was a need and importance to address his mental health concerns, which were a significant driver of his suffering. Specifically, some members identified that Mr. A may not have received sufficient care through mental health and social services. MDRC members agree that special consideration and care is required to determine whether mental illness may be a significant driver of a MAiD request (see MDRC Report 2024 - 2).

Given Mr. A's history with mental illness and previous episodes of suicidality, some members were concerned about the potential risks of a psychiatrist providing information on MAiD during a mental health assessment. These members identified that introducing MAiD to patients, particularly when they are not approaching their natural death, raises concerns of the impact on voluntariness, given the power imbalance in a healthcare provider and patient relationship (framed in terms of potential coercion or undue influence). Mr. A appeared to have been socially vulnerable and isolated – it is important to consider the weight of a physician's advice in a person's decision making. A few members discussed that bringing forward MAiD in this context may undermine a person's resilience and confirm an impression that their life is not worth living. MDRC members with both psychiatric and MAiD expertise provided another view. These members identified that discussions of MAiD can be clinically informed and well-timed when fully considering a person's treatment history and suffering, albeit respecting continual professional guidance on this issue.

An additional mental health concern recognized by most MDRC members was the apparent limited treatment of Mr. A's concomitant substance use disorder. Most members advised that substance use often complicates physical and mental disorders and strains relationships. It is important that concerns of substance use be comprehensively explored and addressed, particularly through psychiatry and other experts (e.g., mental health and addiction counsellors). Most MDRC members agreed

that evaluation of substance use should not be solely limited to a determination of decision-making capability. Rather, substance use should be explored in relation to eligibility. A few members of the committee thought that untreated substance use should preclude MAiD eligibility. Pragmatically acknowledging these views, some MDRC members determined that MAiD practitioners should have evidence that the decision to access MAiD was not significantly influenced by the person's substance use. This determination may be informed over multiple interactions between the requestor and the MAiD practitioners, during periods of abstinence, and in consultation with experts.

Social Vulnerability

Many MDRC members opined that Mr. A may have benefited from greater consideration of social and mental health supports to address unresolved issues during the MAiD process. MAiD data demonstrates that interventions employed to alleviate the suffering of persons accessing MAiD with NRFNDs are proportionally higher as pharmacological options, with a smaller percentage of interventions focused on healthcare services, such as palliative care, disability and social services, and mental health supports (see MDRC Report 2024 – 2). Community services, including housing and income support, were offered to a low proportion of persons. Community life[vii], supports and purpose are strong determinants of well-being. A few MDRC members raised the importance of the potential for undue influence and vulnerability[viii] of persons who are without social supports and community networks in their requests for MAiD and their experiences of suffering.

Many MDRC members recognized limited family engagement as a concern within the navigation of the MAiD process. Strained familial relationships may have been a driver of suffering for Mr. A. Most MDRC members felt there would have been benefit for the MAiD practitioners to further address this concern. Pausing MAiD assessments and facilitating measures and interventions to reduce social isolation may have been a valuable and beneficial approach when seeking options to alleviate suffering for this person. Family engagement, especially when they are the main caregivers of a person, could have potentially provided a more comprehensive perspective of life circumstances and the requester's health journey and trajectory. Some MDRC members discussed how family caregivers often have an important role in assisting MAiD practitioners in identifying issues that require and would benefit from further consideration and enhanced care and support.

Some members felt enhanced family engagement would have facilitated understanding of Mr. A's decision to access MAiD and the determination of eligibility. Some members acknowledged that when differences and perspectives between the requestor and family are irreconcilable, the decision remains with the person accessing MAiD. However, increased understanding of the MAiD process and improved family

awareness or understanding of the requestor's decision to access MAiD may alleviate some distress for the family. More importantly, many MDRC members noted that family consultation might provide an opportunity to potentially repair previously fractured relationships, allowing for greater support for the individual. Additionally, the MAiD practitioner may use these interactions to facilitate access to support and counselling for family members.

Professional Boundaries

Multiple MDRC members raised concern about the action of a MAiD provider transporting the requestor to their MAiD provision location. MDRC members shared that this action may have created pressure and gave rise to a perception of hastening a person towards death. Others disagreed, indicating their perspectives that the physician's actions were helpful and compassionate. Some MDRC members suggested that there should be consideration for limits on the ancillary services provided by MAiD practitioners in support of a MAiD death (e.g., chauffeur, shopping, etc.) to protect against perceptions of influencing final consent. MDRC members discussed how MAID practitioners should maintain a professional boundary from the persons they assess. Driving patients to a place to receive MAiD was felt to be a transgression of such boundaries by some MDRC members. MAiD practitioners should ensure that the MAiD process remains self-directed and provision arrangements are guided by the requestor.

Practice Considerations

To address social vulnerability:

- Community life, supports and purpose are strong determinants of well-being. Isolated persons should be offered connection to their local community (e.g., disability community, spiritual or ethnic communities), especially during the MAiD process. If these offers of support are not accepted, there should be clear documentation.

Engagement of family and/or close relations:

- Engagement with family and/or close relations in the MAiD process should aim to be a key component of MAiD practice[ix]. Challenges with navigating family involvement and relationships may be supported by social workers or others with suitable skill/competencies. Approach to and rationale for family engagement (or lack thereof) should be documented.
- When permitted by the requestor, supportive discussions with family and close relations may:
    - provide a more comprehensive perspective of life circumstances, health journey and trajectory, and identify areas that require further consideration and care; and/or

    - encourage a relational approach to care; and/or
    - facilitate a family's understanding of the decision to access MAiD and the determination of eligibility; and/or
    - provide an opportunity to repair previously fractured relationships allowing for greater support for the individual.
- Close relations should be offered support throughout and after the MAiD process (e.g., counselling, access to a social worker or other support personnel).

In consideration of substance use:

- Substance use often complicates physical and mental disorders and contributes to social isolation. As such, substance use should be comprehensively explored and addressed, particularly through psychiatry and other experts (e.g., mental health and addiction counsellors). Evaluation of substance use should not be limited solely to a determination of decision-making capability.
- There should be offers of treatment for substance use (e.g., psychosocial support, addiction counselling, pharmacological options). Care needs should be facilitated via an appropriate care provider to support the assessment process. These should be clearly documented.
- MAiD assessors should document their reasons for determining that the decision to access MAiD was not unduly influenced by the person's substance use (e.g., consistent decision-making and reasoning). This determination can be strengthened over multiple interactions, during periods of abstinence, and, where possible, in consultation with others with expertise if needed.

CASE B

HOUSING VULNERABILITY

Case Overview

Ms. B was a female in her 50s with multiple chemical sensitivity syndrome (MCSS). She had a history of psychiatric hospital care for depression, anxiety, suicidality, and post-traumatic stress disorder, related to childhood trauma.

Ms. B had difficulty securing housing that met her medical needs. After years of attempts to secure appropriate housing, the Human Rights Tribunal issued a ruling to allocate funds to renovate her apartment. These renovations did not satisfactorily address her MCSS symptoms. A remaining option presented was to live in a small hypoallergenic space (i.e., a bubble). As a result of her housing situation and conditions, necessary to address her MCSS, Ms. B experienced social isolation, which greatly contributed to her suffering and request for MAiD.

Discussion

MDRC members recognized the complexity of assessment when the requestor is seeking MAiD with psychosocial suffering. The MAiD practitioners involved with the MAiD process determined eligibility from Ms. B's medically confirmed MCSS. MDRC members expressed differing opinions regarding her condition and eligibility. Some members cautioned that a social issue, housing, was at the forefront of this request, not in keeping with a medical condition. Other members differed, stating that her condition (MCSS), and related suffering, would have persisted even with further housing options. Some members indicated that with a significant psychiatric history, some psychiatrists would perceive the presentation of MCSS to be more in keeping with a psychiatric diagnosis, namely a somatic symptom disorder.

Consensus was not achieved amongst MDRC members about whether Ms. B was eligible for MAiD. Many members confirmed that they would not have considered Ms. B eligible for MAiD, either arising from the belief that psychiatric issues were predominately underlying the MAiD request or on the basis of an unmet social need. Other members more cautiously identified that while there was suitable clinical evidence to support eligibility based on her condition of MCSS, they felt that special consideration is required when persons present with significant psychosocial challenges and mental health issues.

Most MDRC members acknowledged that the MAiD practitioners made significant efforts to navigate the core psychosocial and housing issues identified. However, there was a lack of consensus about how to proceed when suffering is mainly or entirely driven by psychosocial factors. Significant efforts had been made to pursue alternate options for housing; however, a few members believed there were other outstanding housing options to explore (e.g., small trailer in a more rural setting). Most MDRC members believed that Ms. B's MCSS presentation required her to continue living in isolation in a small hypoallergenic environment and hypothesized that other housing arrangements would not have led to the resolution of her suffering. Almost all members agreed that social needs, such as housing, should be foremost approached with an attempt to address unresolved issues, acknowledging that navigating social issues would likely take longer than the minimum 90-day assessment period. Some members considered that social needs may be considered irremediable if all acceptable and available options have been explored. Others felt that MAiD is not a solution for all society and policy failures, furthering social injustices, and strongly dissented to this approach. Overall, most MDRC members agreed that the MAiD process should give way to urgent social services intervention and maximize supportive healthcare options to reduce symptoms and suffering prior to proceeding with MAiD.

MDRC members agreed that MAiD practice should emphasize assessing and alleviating suffering in a care-based approach to MAiD practice. The statutory 90-day assessment period was introduced as an arbitrary timeline to approach complex issues. There may be benefit for MAiD assessors to pause or defer assessments while consultant, social, and other care takes place. A multi-disciplinary approach to support assessment of patients, specifically for vulnerability, and identifies options to live and recover was agreed upon. There may be benefit for the multi-disciplinary members to be primarily independent from the MAiD team (see Recommendations 3).

Practice Considerations

- See “MDRC Review 2024 - 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths” for discussion and considerations for the involvement of expert consultants (e.g., psychiatrists, social workers) for complex psychosocial issues.
- Psychosocial needs, such as housing, should be foremost approached with an attempt to address unresolved issues. Navigating these issues may take longer than the regulatory minimum 90-day assessment period. Some members considered that social needs may be considered addressed if all acceptable and available options have been explored.
- The MAiD process should be deferred while the person is waiting to access appropriate social services or healthcare. This approach to practice recognizes the importance of addressing and resolving suffering in contrast to procedurally qualifying for a MAiD death.

CASE C

DISABILITY

Case Overview

Mr. C was a male in his 40s living with quadriplegia following a motor vehicle collision. The COVID-19 pandemic may have contributed to vulnerability in his medical journey (e.g., social isolation). Mr. C received rehabilitation without physical or functional gains. Due to his complex medical conditions, returning home with supports was not feasible.

The MAiD assessors considered his death non-reasonably foreseeable, thereby proceeding with Track 2 safeguards. However, one of the MAiD assessors considered the 90-day assessment period to be a “waiting period” and documented the possibility of “reducing the timeline should his natural death become reasonably foreseeable” (e.g., untreated septicemia).

Mr. C was separated from his family while receiving on-going complex continuing care. He was distressed about perceived limits of maintaining an ongoing relationship with his

young children. Mr. C was a member of a racialized and religious community, with associated challenges with acceptance of MAiD.

Discussion

Mr. C had experienced a catastrophic event and accessed MAiD within two years of injury. The committee discussed Mr. C's period of adjustment to living with disability. Most MDRC members agreed that eligibility for MAiD should be considered within the context of emerging evidence and best practices relevant to the condition in question during periods of transition, ongoing physical and psychosocial adaptation, and times of heightened suicidality[x]. A few members brought forward that the spinal cord community may not agree with finding a person eligible for MAiD within the first two years[xi] of a spinal cord injury. Persons with a spinal cord injury require an opportunity to navigate profound adjustments and recovery with the possibility of returning to meaningful community life. A few MDRC members discussed how MAiD practitioners may benefit from improved awareness of ableism biases[xii] that may influence clinical interpretations of recovery and the presentation and evaluation of options to alleviate suffering. Other members identified that Mr. C's request for MAiD was informed by untreatable medical sequalae (i.e., pressure injuries to the skin) and avoiding associated suffering. These members expressed that eligibility should be person specific. Adhering to specific timelines for adjustment may not account for their medical experiences and associated issues.

Some members were concerned that one of the MAiD assessors approached the Track 2 legislative safeguard for the minimum 90-day assessment period without a purposeful approach for navigating expertise and offering care options (i.e., approached as a "waiting period"; see also MDRC Report 2024 – 2). The primary assessor also communicated to Mr. C that the 90-day period could be reduced should his natural death become reasonably foreseeable.

Legislatively, the 90-day assessment period may only be shortened for risk of imminent loss of capacity. Some MDRC members expressed their concerns that persons with increased vulnerability are at risk of accessing MAiD without adherence to safeguards in place to promote safety and quality care (e.g., 90-day assessment period). Also, multiple members identified concerns that 'track switching' might be occurring, with limited opportunity to identify potential legislative breaches.

Aligning with heightened consideration of needs during a period of adjustment following a catastrophic injury, MDRC members recognized the importance of navigating consultation with those who have expertise in the requestor's condition, engaging the person's existing care team in the MAiD process, and facilitating peer support. The MDRC agreed that navigating complex circumstances requires a multidisciplinary

approach to care. In the determination of MAiD eligibility for Mr. C, the MAiD practitioners relied heavily on review of records. Members believed that there would have been benefit for a multidisciplinary case conference with Mr. C's existing care team (i.e., physiatry, occupational and physiotherapy, nursing, social work) to ensure that all treatment and care options were explored. Similarly, expert consultation should align with the requestor's core issues. The MAiD practitioners did not document engagement with physiatry or rehabilitation specialists in the expertise consultation process. A comprehensive consultation process is required to ensure the standard of care is met and options to relieve suffering extend beyond pharmacological interventions. Most members agreed that failing to explore disability, mental health, and community support services is not in keeping with quality practice. Mr. C may have benefited from additional therapeutic approaches for his suffering, such as peer mentoring, psychosocial guidance for navigating his relationship with his children, and social solutions for enhanced community and cultural engagement.

Multiple MDRC members noted the importance of cultural considerations within the MAiD process. Gathering information about the person's cultural community may facilitate additional understanding of the personal meaning one attributes to living with disability, as well as further perspectives regarding their request for MAiD. Greater cultural awareness also extends to surviving family members who, due to religious or cultural beliefs and values, will be left to navigate the impact of the decision to pursue an assisted death and may ultimately affect the support system that they need to rely on. Social, cultural and family issues should be part of MAiD assessments, particularly when there is potential for future relational conflict. Consensus amongst MDRC members was that cultural considerations should be discussed early in the MAiD process.

Practice Considerations

- MAiD assessors must be familiar with and adhere to established legislative safeguards. Resources available to enhance learning of Track 2 safeguards and management include Health Canada's "Implementing the Framework" and The Office of the Chief Coroner's "Medical Assistance in Dying Lessons Learned: Track 2 Non-Reasonably Foreseeable Natural Death (NRFND)".
- Efforts should be made to ensure a requestor has received the recognized standard of care for their condition. Engaging with the person's interprofessional and multi-disciplinary care team (i.e., via case conferencing) may assist in determining if the standard of care has been achieved.
- Access to and engagement with peer support[xiii] is an integral component of care for persons living with disability following a catastrophic event.
- Review of healthcare documentation may not always offer the most comprehensive insight and understanding of the requestor's medical trajectory of

disability. It would be beneficial for healthcare professionals involved in the requestor's care to be given an opportunity to consult and collaborate in the MAiD process (e.g., social workers, occupational therapists, and physiotherapists) to ensure all avenues of care have been explored.

- MAiD assessors should seek guidance from those with expertise to evaluate requests for MAiD during periods of transition and/or during a period of ongoing physical and psychosocial adaptation.

SUMMARY

MAiD practitioners should consider this review as a preliminary discussion of some issues of vulnerability and continue to build upon the practice approaches presented in this review to address person-specific circumstances. MDRC members encourage MAiD practitioners to continue to explore and document issues of vulnerability within the MAiD process.

MDRC members also recognize that the subject of vulnerability is positioned within broader health and social policy issues. MDRC members encourage continued discussion of these issues from broader perspectives and at all levels. Specific analysis of social and health policies is outside of the aim and scope of the MDRC.

MDRC discussion of the provision of MAiD with potentially marginalized persons brought forward issues of structural inequities that may exist and that may influence aspects of the MAiD process, particularly when considering the potential for structural coercion or undue influence of the request for MAiD and equitable access to care. There were differing views on how to assess and respond to requests for MAiD where a person may be vulnerable to social inequity across both MDRC reviews (see "MDRC Report 2024 – 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths"), most members expressed their views that vulnerable persons would benefit from a multi-disciplinary and interprofessional model of care. The role of this approach (see Recommendation 3) would be to evaluate potential structural inequities and navigate remedial options. A patient advocate could assist in ensuring options have been explored to live with dignity in their community, aligned with their unique social, cultural, and environmental contexts. When necessary, suitable time should be provided, including beyond the 90-day assessment period, to explore identified complexities.

A multidisciplinary and interprofessional approach to care would help to address some concerns identified by MDRC members for the most ideal navigation of complex Track 2 cases.

1. The presentation of Ontario's MAiD data (MDRC Reports 2024 - 2 & 2024 - 3) showed regional differences in the provision of MAiD. In rural and remote

regions, benefit could arise from improved access to a provincially resourced assessment and care team including addressing concerns of accessibility to care and expertise consultation.

2. A few MDRC members expressed concerns regarding the higher rate of repeated requests for MAiD in Track 2 cases (see MDRC Report 2024 – 2). Nearly eight percent of Track 2 MAiD deaths were persons who had previously requested MAiD and in nearly half of those previous requests the person was found ineligible. Although there could be a number of reasons for this finding, a few MDRC members expressed concerns of 'doctor shopping for approval' in both Track 2 and Track 1 assessments.
3. An interprofessional assessment service would ensure that requests for MAiD in Track 2 requests with complex circumstances are reviewed from multifaceted perspectives, alleviate the burden of responsibility of MAiD practitioners to solely determine eligibility in complex conditions, and ensure expert guidance when structural inequities are identified.
4. Some MDRC members expressed their concern that pharmacological interventions are more frequently offered (see MDRC Report 2024 – 2) compared to health care services including palliative care, disability support, and mental health support, for the alleviation of suffering. More comprehensive care options to alleviate suffering are likely to be identified within an interprofessional model of care.
5. Many MDRC members expressed the benefit of more robust guidelines and standards of care for MAiD. An expected outcome of a multidisciplinary and interprofessional assessment and care model would be to guide quality care indicators and guidelines for the provision of MAiD, including the consideration of psychosocial factors recognized in this review (see Recommendation 3).

A few MDRC members expressed strong concerns and objections for the lack of utilization of current evidence and standards of care to guide MAiD practice. In response to reviewing the selected MAiD deaths in vulnerable persons and broad perspectives garnered from available Ontario data, some MDRC members called for a paradigm shift in MAiD practice. Members encouraged a shift from a procedural-focused to a care-focused approach to MAiD. In alignment with a care-focused approach to MAiD practice, MAiD practitioners evaluating MAiD requests for persons with NRFND should have, or involve others with, the necessary knowledge, skill, and expertise to competently identify the unique care needs of persons with disability. MAiD Track 2 care-focused practice should be situated within an understanding of the social and intersectional model of disability, adopting disability communities' social and cultural frameworks. There would be benefit for multi-disciplinary care in MAiD practice, particularly during the minimum 90-day assessment period, with consideration of expertise outside of the traditional medical model (i.e., peer support and/or disability

advocates). These providers may help to ensure ableist perspectives of care options, potentially limiting exploration of options to alleviate suffering, do not go unchallenged. Disability-affirming psychosocial approaches to care, community integration, and psychosocial support are reflective of quality care practices.

RECOMMENDATIONS

The MDRC collaborates with the MRT to inform MAiD oversight in Ontario. The MDRC seeks to inform potential changes to MAiD practice and safety through system recommendations. The Office of the Chief Coroner (OCC) will disseminate this report to MAiD practitioners and other relevant organizations in Ontario to inform potential MAiD practice improvements.

MDRC guidance issued in this report will inform approaches to MAiD oversight in Ontario. Based on feedback from the MDRC, the Office of the Chief Coroner MAiD Review Team (MRT) will explore modification of MDR reporting procedures to capture circumstances of increased vulnerability to support comprehensive review of these MAiD deaths.

The MRT will consider changes to the "MAiD Legislative Oversight Framework" in response to issues and recommendations brought forward in these reports (MDRC Reports 2024 - 2 & 2024 - 3). The MRT will collaborate with respective regulatory bodies to review and if indicated, revise the framework, specifically, for our responses to legislative and significant practice deviations.

The OCC has identified recipients and recommendations to inform improvements to the MAiD system in Ontario. These recommendations were formulated from MDRC discussions specific to this topic and review; however, some recommendations would benefit from consideration and implementation across all MAiD practices (Track I and Track 2) and for persons who experience profound suffering and are considering an assisted death. Moreover, these recommendations should be situated within broad health and social system improvements and considered with a summative understanding of this report.

1. **To Health Canada:**

   1.1 Health Canada (HC), supported by engagement with persons with lived experience of disability and their advocacy and support groups, to consider providing guidance on how to approach Track 2 legislation and safeguards within a disability care framework.

1.2 Health Canada to consider providing additional guidance on how to approach Track 2 legislative criteria and safeguards when navigating vulnerability within the MAiD assessment process, including:

- how to approach MAiD requests when suffering is predominately derived from an unmet social need (e.g., housing arrangements), and
- how to approach differing determinations of safeguard assignments (Track I vs Track 2) to best assess and facilitate care within the MAiD process for persons experiencing vulnerability.

1.3 Health Canada to consider increasing data collection related to vulnerability to better evaluate requests for - and access to – MAiD, and to consider actionable changes to health and social policy.

2. To Ontario Ministry of Health (MOH):

2.1 The Ontario Ministry of Health (MOH) to consider revising Clinician Aid A:

- by engaging with persons with lived experience of disability and their advocacy and support groups, to adopt mechanisms for consistent data collection and reporting of self-identification of disability.
- to include opportunities for self-identification of other key areas of vulnerability to aid MAiD providers and assessors in recognizing potential complex circumstances and needs.

3. To Ontario Ministry of Health and Ontario Health:

3.1 The MOH and Ontario Health (OH) to consider identifying and disseminating this report with communities of practice or other healthcare agencies engaged in MAiD initiatives to improve care, coordination, and/or practice.

3.2 The MOH and OH to consider the development of a provincially coordinated MAiD care system[4], to include the following:

- Care coordination to facilitate information gathering, arranging consultations, and navigating care to ensure persons with complex needs are provided with access to services to facilitate comprehensive assessment and care.
- A consultation service or community of practice to support MAiD practitioners navigating complex MAiD requests and facilitate expert consultation for persons with complex medical conditions and/or circumstances. An

[4] The MDRC did not evaluate a particular model-of-care. The MDRC acknowledges the necessary considerations of feasibility and equitable integration of a MAiD model-of-care within the current healthcare system.

interprofessional and multidisciplinary community of practice, comprised of members with diverse expertise (e.g., physicians, lawyers, ethicists, social workers), may be beneficial.
- Regional multi-disciplinary and interprofessional care teams (e.g., physicians, nurses, social workers, occupational therapists, physiotherapists, peer-support, community-life specialists) to assist in the navigation of complex care needs of persons who have requested MAiD.

3.3 As an outcome of MDRC reviews 2024.2 and 2024.3, the MOH and OH to consider in their development of a provincially coordinated MAiD care system that persons presenting with the following characteristics or experiences may benefit from enhanced MAiD care coordination:

- social vulnerability (e.g., limited social network),
- unmet or underserviced social needs (e.g., housing),
- self-identified care inequities (i.e., due to intersectional issues),
- complex comorbid medical conditions, such as substance use
- complex diagnostic determinations due to concomitant and interrelated psychiatric conditions, including trauma,
- accessing MAiD with identified deviations from receiving the standard of care or outside of evidenced based care parameters (e.g., requesting MAiD following a known transient period of psychosocial adaptation following severe disability),
- lack of access to care that is informed by palliative principles and approaches (e.g., barriers to access palliative care services due to end-of-life parameters).

3.4 MOH and OH to consider developing practice standards for a provincially coordinated MAiD care system. Consider collaborating with academic networks to evaluate this MAiD model-of-care.

4. To Toronto Academic Health Science Network:

4.1 The Toronto Academic Health Science Network to collaborate with provincial partners to support the evidence-based development of MAiD models-of-care, a community of practice, and/or MAiD Assessment Service.

5. To Canadian Association of MAiD Assessors and Providers:

5.1 The Canadian Association of MAiD Assessors and Providers (CAMAP) to consider issues identified in this report to inform their ongoing review and revision of MAiD education and practice guidelines.

5.2 CAMAP to consider engaging with disability service agencies, advocates, and persons with lived experience to develop core competencies and competency-oriented tools for MAiD practitioners assessing and providing care to persons with disability (e.g., how to navigate unique care needs to alleviate suffering for persons with disability (e.g., peer supports and community life specialists)).

6. To College of Physicians and Surgeons of Ontario and College of Nurses of Ontario:

6.1 The College of Physicians and Surgeons of Ontario (CPSO) and the College of Nurses of Ontario (CNO) to consider:

- employing this MDRC Report to inform MAiD practice guidelines for navigating the Track 2 MAiD process with persons with vulnerability.
- provide guidance on the existence of evidence relevant to physical and psychosocial adjustment to illness and disability and how it can be considered in the process of discussing, assessing for, and potentially providing MAiD.

7. To the College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario

7.1 The College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario to consider employing this MDRC review to inform practice guidelines for clinicians providing care in the MAiD process, particularly related to navigating complex social needs in the Track 2 process.

8. Canadian Medical Protection Association & Canadian Nurses Protective Society:

8.1 The Canadian Medical Protection Association (CMPA) and Canadian Nurses Protective Society (CNPS) to consider employing this MDRC Report to inform medico-legal advice provided to MAiD practitioners.

RESOURCES

Consider the following resources to inform MAiD practice:

Health Canada (2023). Advice to the Profession: Medical Assistance in Dying (MAID) - Canada.ca

Inclusion Canada (2020). Position on Medical Assistance in Dying

MAiD Review Team (2023). Voluntariness Lessons Learned[5]

MAiD Review Team (2024). Medical Assistance in Dying Lessons Learned: Track 2 Non-Reasonably Foreseeable Natural Death[5]

Vulnerable Persons Standard (2017). The Standard

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Medical Assistance in Dying (MAiD): Marginalization Data Perspectives

OFFICE OF THE CHIEF CORONER | MINISTRY OF THE SOLICITOR GENERAL

Contents

Background on Marginalization Data

At the May 2024 annual Canadian Association of MAiD Assessors and Providers (CAMAP) conference, initial data gathered by the Office of the Chief Coroner (OCC) for Ontario were presented. Within these data was an initial categorization of Non-Reasonably Foreseeable Natural Deaths (NRFND), or Track 2, by the Ontario Marginalization Indices based on the community where the MAiD recipient resided. This was completed in an effort to develop further understanding about vulnerable persons accessing MAiD for discussion at the MAiD Death Review Committee[1]. (Please refer to MAiD Death Review Committee Report 2024-3: Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths[2]).

The intent in presenting a number of Ontario MAiD data elements at the CAMAP conference was to provide perspective by describing initial findings. Further, the data were presented to initiate reflection and discourse amongst those involved in MAiD practice and policy and to prompt further research of this topic. The data presented illustrated preliminary information drawn from a limited number of cases, particularly for Track 2 deaths. Analytic conclusions were not provided as analysis had not been completed.

In response to questions arising from the initial presentation, the OCC undertook analysis in collaboration with the Ontario Ministry of Health. Efforts were made to examine subsets of the MAiD recipient population as defined by medical condition against the Marginalization Indices (MI) of the communities where they resided. In addition, as a comparator, all individuals in Ontario with the same medical conditions were evaluated to identify whether marginalization was correlated with the medical illnesses associated with the MAiD requests, or whether there are other public health implications that impact an individual's decision to pursue MAiD.

It is important to note that the Marginalization Indices apply to geographic areas, not individual people. In the analyses presented, a geographically defined community's MI is used as a proxy for individual-level data since actual sociodemographic data about the MAiD recipients are not available.

The purpose of this report is to guide further understanding of the levels of marginalization, particularly related to material resources, among the communities where Track I and Track 2 MAiD recipients reside in Ontario, as well as among various MAiD subgroups, such as those with specific medical conditions or similar durations of disability.

Data Sources and Marginalization Dimensions

Marginalization Data Sources

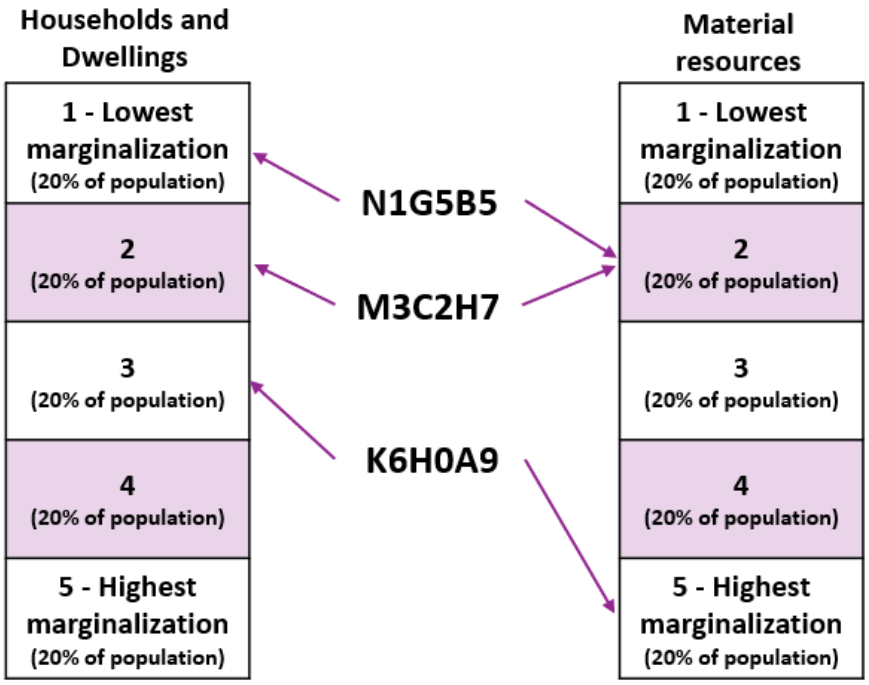
Public Health Ontario, The Centre for Urban Health Solutions, and St. Michael's Hospital developed an index based on Canadian Census information that allows for comparison of marginalization between geographic areas in Ontario.

[1] Matheson FI (Unity Health Toronto), Moloney G (Unity Health Toronto), van Ingen T (Public Health Ontario). 2021 Ontario marginalization index: user guide. Toronto, ON: St. Michael's Hospital (Unity Health Toronto); 2023. Joint publication with Public Health Ontario.
[2] Requests for the MDRC report can be obtained by email at occ.deathreviewcommittees@ontario.ca

There are four dimensions in the index: Households and Dwellings; Material Resources; Age and Labour Force; and Racialized and Newcomer Populations. *Refer to Appendix A for definitions of each dimension.*

The index is designed so that 20% of the Ontario population falls within each quintile of marginalization for each dimension. For example, a geographic area with a value of five falls within the most marginalized 20% of Ontario's communities.

For the purposes of this analysis, individuals have been assigned to a quintile based on the Dissemination Area[3] associated with the MAiD recipient's residential postal code reported to the OCC. Postal codes may be associated with different levels of marginalization for each dimension.



Marginalization Limitations

More information about limitations can be found in the User Guide[4], but include:

- Marginalization indices are associated with a geographic area and are being used as a proxy for individuals (who had postal codes in the area),
    - All individuals within an area do not experience the same degree of marginalization.
    - To reduce this inaccuracy, the smallest geographic unit available – in this case postal code – was used to assign individuals to quintiles.
- The marginalization indices are not available for geographies defined as Indigenous reserves and settlements.

[3] Dissemination areas are small areas composed of one or more neighboring blocks and is the smallest geographical area for which census data are disseminated.
[4] https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Ontario-Marginalization-Index

- Some populations living away from their home community, may be undercounted in the census and therefore the indices may not be as accurate for these populations.
- Institutionalized populations, such as those living in long-term care facilities or correctional facilities, are not counted in the long-form census and so are not included in the index.
- Statistics Canada suppresses census data for some indicators and geographies in order to preserve respondent confidentiality and ensure data quality.
    - Quintiles cannot be created for regions where data are missing.
- The index used in this analysis is based on the 2021 census, which is the closest time period available for 2023 MAiD provisions.

Population Grouper Data Source

In order to compare MAiD recipients to individuals with similar health conditions in the Ontario population, the Canadian Institute for Health Information (CIHI) Population Grouper was used. The Population Grouper builds profiles for each person with a health card in Ontario based on clinical and demographic input.

- The **Clinical profile** summarizes all health conditions – including long-term chronic diseases – identified from two consecutive years of inpatient, day surgery, emergency department, hospital clinic, continuing care, home care, physician claims, and primary care data.
- The **Demographic profile** is comprised of age, recorded sex, and postal code.

The Ontario Ministry of Health operates the Population Grouper algorithm for Ontario and results were shared with the Office of the Chief Coroner for the purpose of this analysis. The conditions identified in the Clinical profile were used to identify populations whose medical conditions were most similar to those receiving MAiD.

Methodology

For the current analysis, the following steps were involved:

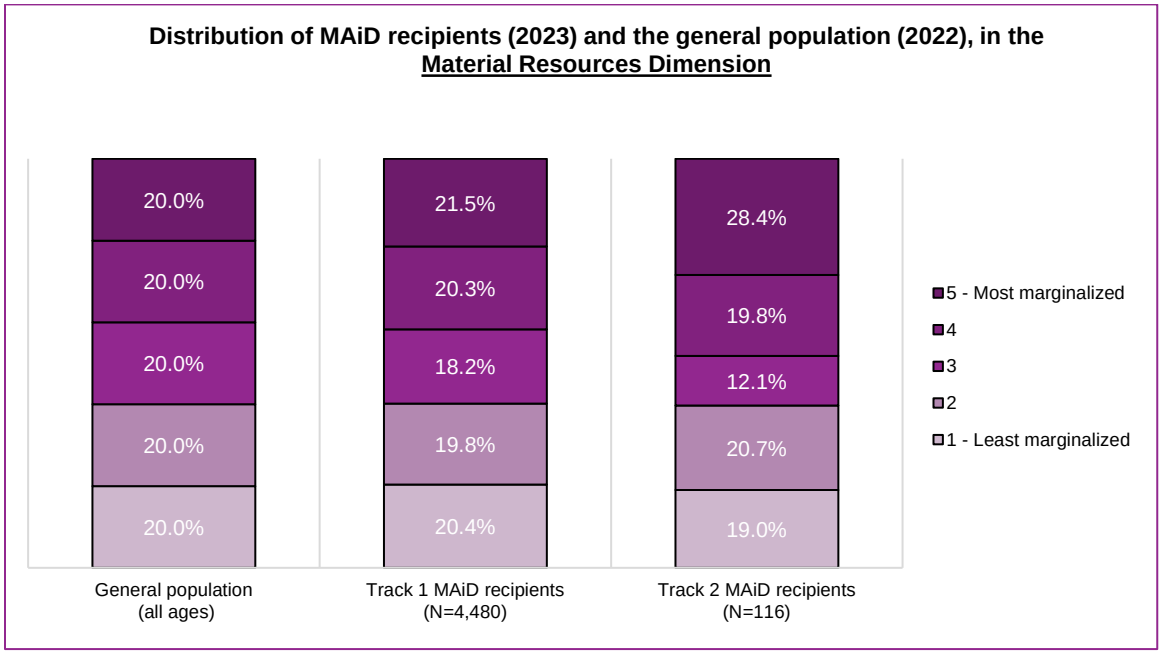
1. Residential postal codes of MAiD recipients were linked to the Marginalization Indices, and distributions of the MAiD populations within quintiles were determined for each of the four dimensions.
2. Cohorts for comparison were created using the Population Grouper by identifying individuals with the conditions most similar to those who received MAiD. The following groups were compared:
    a) MAiD recipients receiving palliative care were compared to all Ontarians who received palliative care.
    b) MAiD recipients aged 60 years and older with (1) any cancer, (2) metastatic cancer, or (3) lung cancer were compared to all Ontarians aged 60 years and older with these diagnoses.

c) MAiD recipients with Parkinson's disease or with degenerative conditions of the nervous system (e.g., Amyotrophic Lateral Sclerosis, Huntington's disease) were compared to all Ontarians with these diagnoses.
d) Track I and Track 2 MAiD recipients with self-reported disability for increasing lengths of time.
e) Track I and Track 2 MAiD recipients with a serious, incurable illness for less than 10 years and for 10 years or greater.

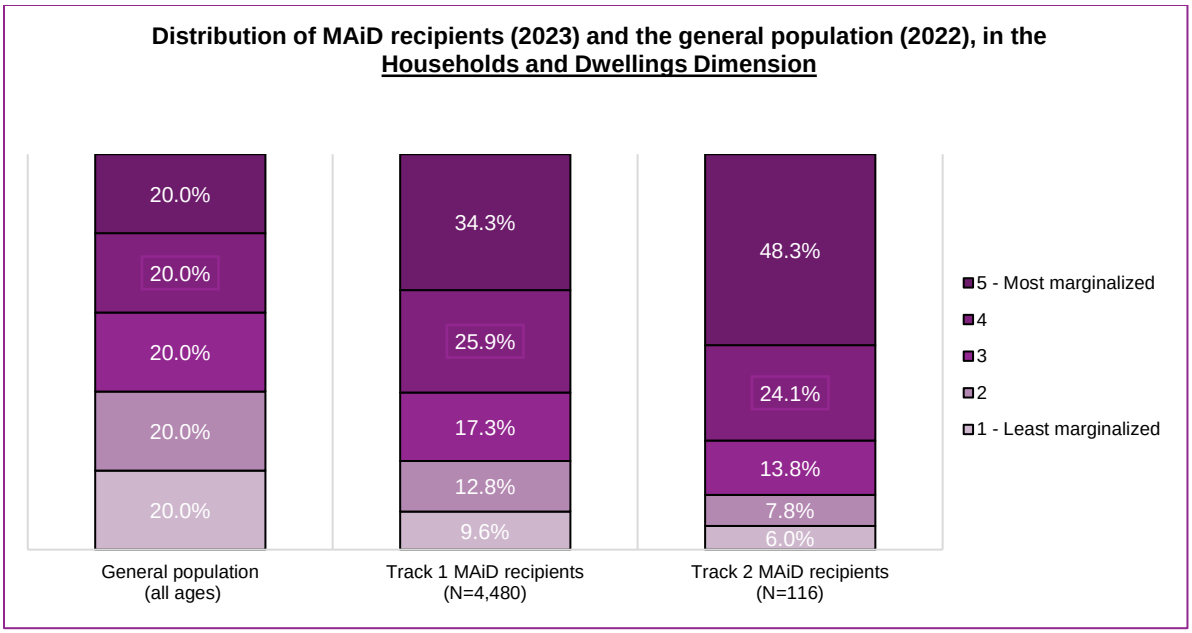
3. Distributions of quintiles for the marginalization index – focusing on the Material Resources dimension – were determined for the MAiD recipient populations and compared to those of the comparison cohorts based on the Ontario population.

Marginalization by Dimension

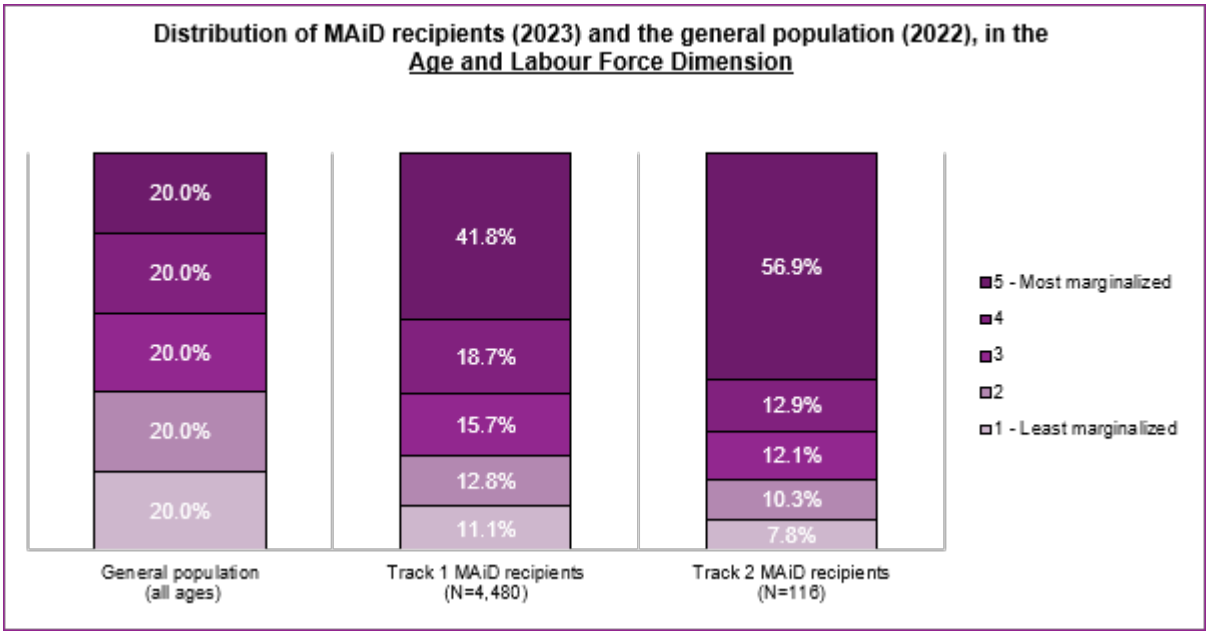
Linking of MAiD recipients (Track I and Track 2) in terms of the regional level of marginalization for the Material Resources dimension, which is closely associated with poverty, was completed. Track I recipients did not differ greatly from the general population in terms of material resource deprivation. Track 2 recipients were more likely to reside in the most marginalized areas of the province.



The households and dwellings dimension showed higher rates of marginalization among all MAiD recipients (i.e., Tracks I and 2). It should be noted, however, that a number of the indicators by which this dimension is measured (refer to Appendix A) are strongly correlated with age and includes the proportion of the population who are elderly (greater than 65 years), the proportion living alone, and the proportion of the population who are single, divorced, or widowed. Therefore, a stronger correlation with MAiD recipients is not unexpected given the older age of MAiD recipients (i.e., the average age of MAiD recipients overall in Ontario was 77).

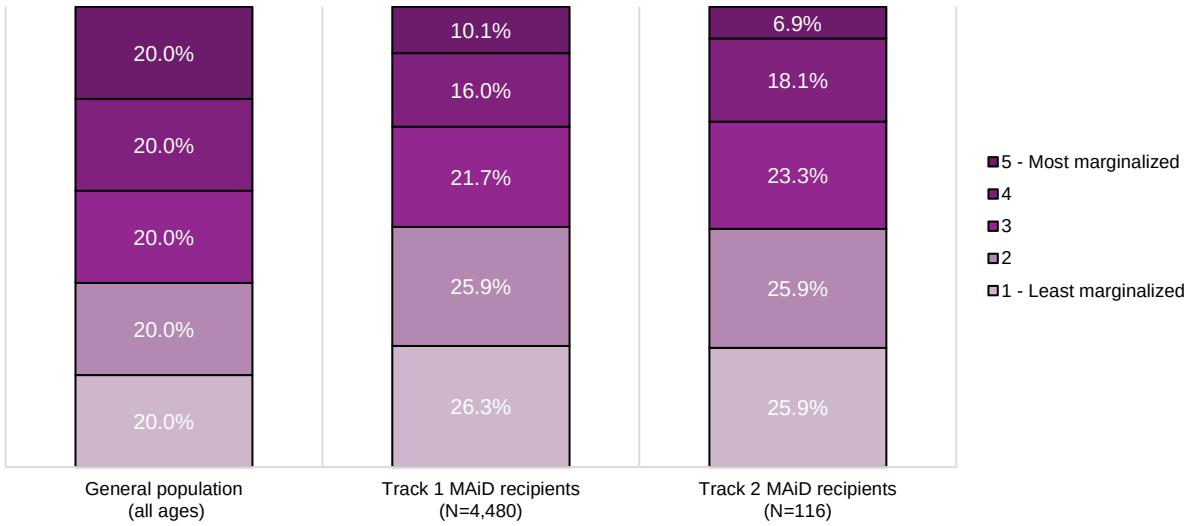


The Age and Labour Force dimension is a direct measure of age and disability, with two of the indicators used to define the dimension being the proportion of the population aged 65 years and older, and the proportion of the population not participating in the labour force which is commonly correlated with age and disability. This is demonstrated in the results seen with Track 2 recipients (56.9%), whose average age was 73 years, with 39% reporting a disability.



The fourth dimension, Racialized and Newcomer Populations demonstrates that the majority of MAiD recipients were not recent immigrants (those who arrived in the previous 5 years) and do not self-identify as visible minorities. This has been confirmed by race and ethnicity data provided by MAiD recipients (not presented in this report).

Distribution of MAiD recipients (2023) and the general population (2022), in the Racialized and Newcomer Populations Dimension



Material Resources Dimension

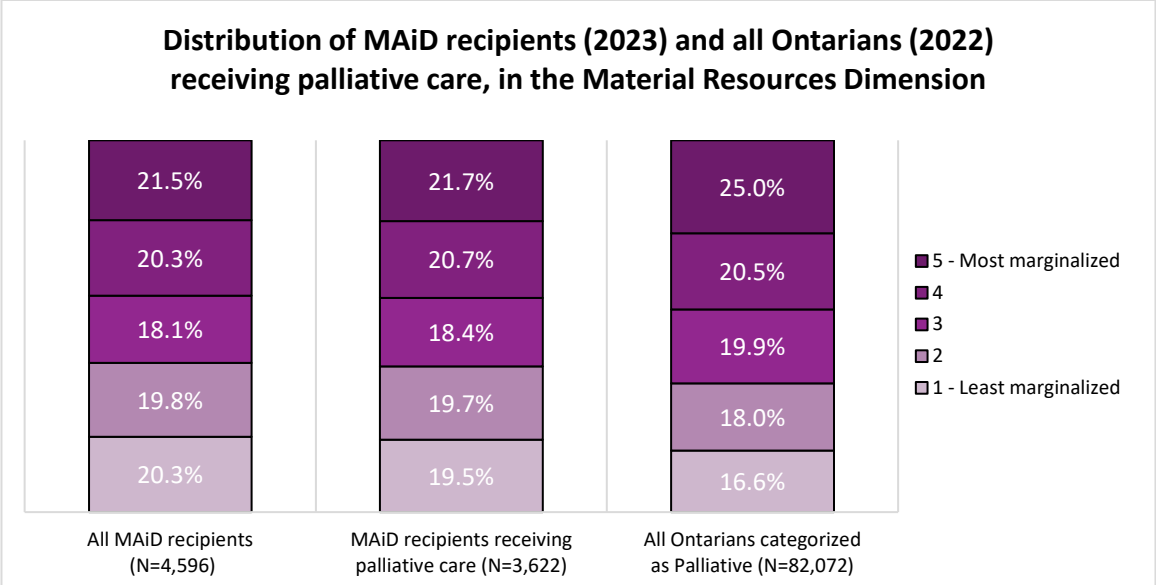
The following results focus on the Material Resources dimension in an effort to provide further insight regarding MAiD recipients in Ontario. This metric is closely related to poverty and the ability to attain basic material needs relating to housing, food, clothing, and education.

As noted, the metrics for Households and Dwellings and Age and Labour Force are, by definition, highly dependent on age and ability to engage in the work force, which are too closely correlated to provide new and meaningful information outside of confirming the older age and increased levels of disability as reported within the MAiD population.

While the Racialized and Newcomer Populations dimension shows the predominance of non-racialized populations who are MAiD recipients, this was not the primary focus of the current analysis.

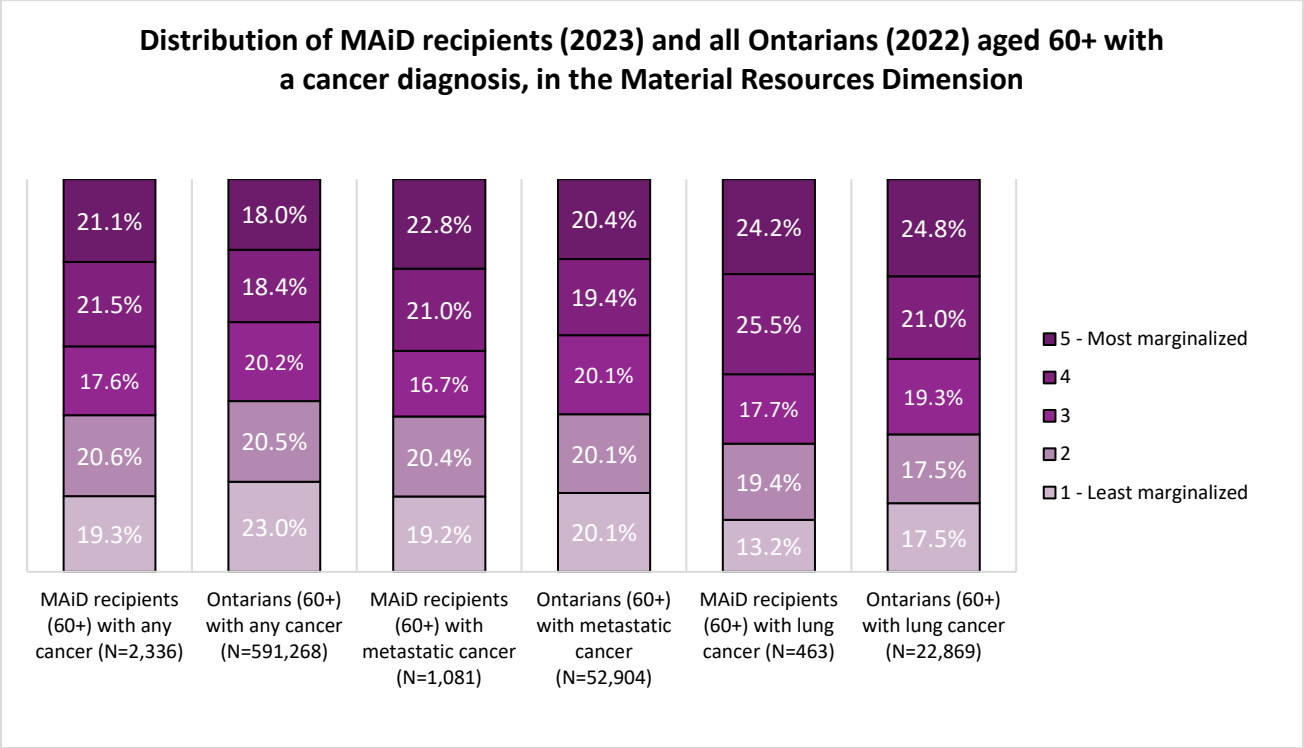
Palliative Care

Approximately 80% of MAiD recipients were reported to have received palliative care. Linkage of MAiD recipients reported to have received palliative care demonstrated levels of marginalization similar to that of all MAiD recipients. MAiD recipients (overall and recipients of palliative care) were just above 40% in the two most marginalized areas, slightly lower than the 45% in the most marginalized areas for all Ontarians receiving palliative care.



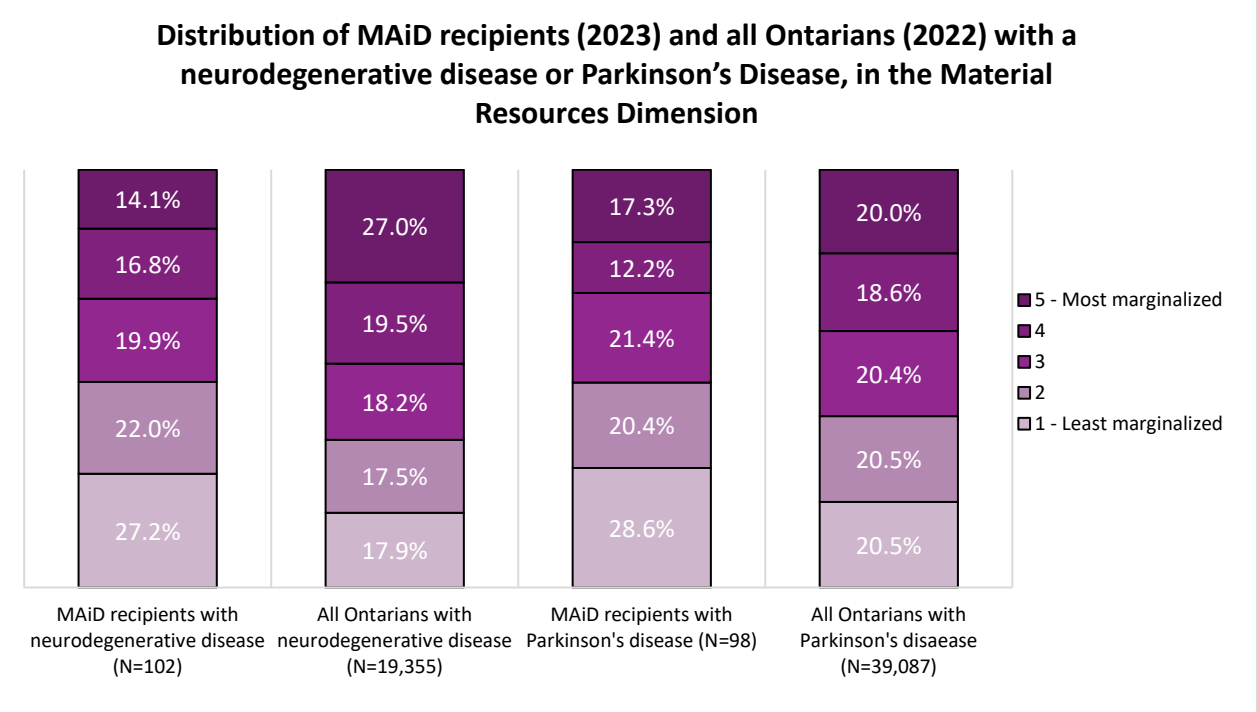
Cancer Diagnoses

When comparing marginalization among MAiD recipients with any (or metastatic) cancer to all Ontarians with similar diagnoses only small differences were observed. Both MAiD recipients and Ontarians with a diagnosis of lung cancer had a higher proportion in the most marginalized areas.



Neurological Conditions

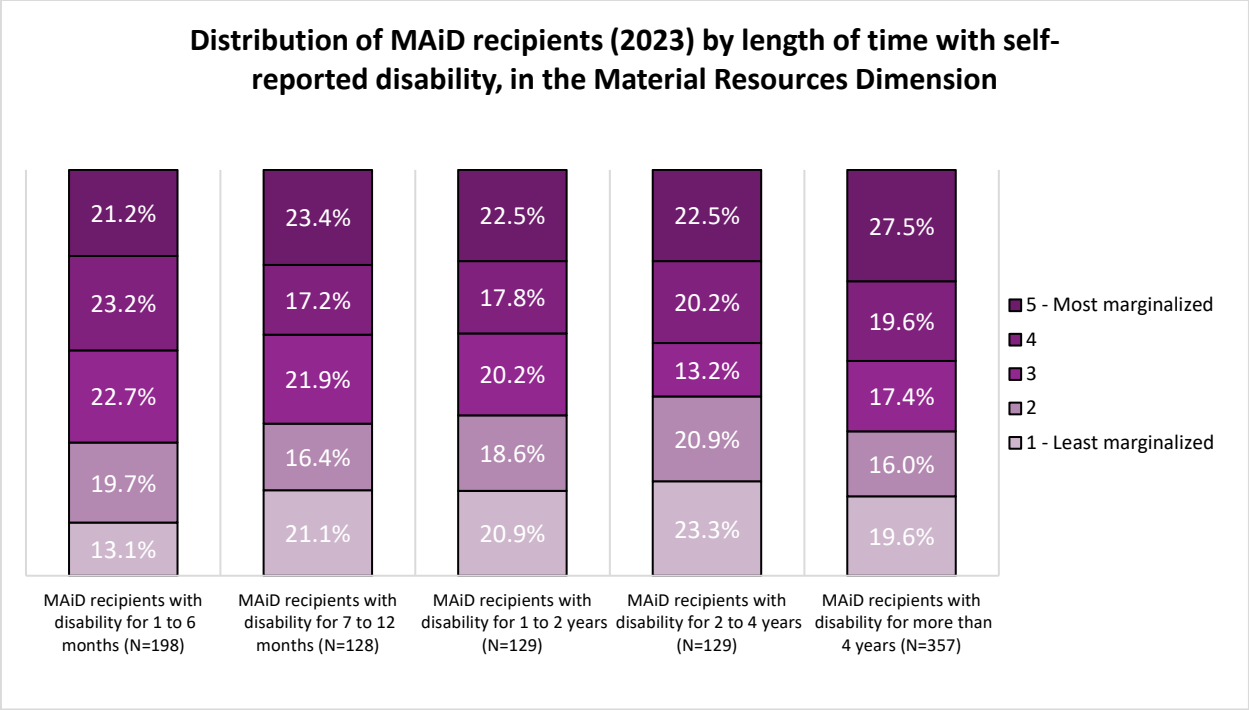
MAiD recipients with diagnoses of Parkinson's disease or other neurodegenerative conditions[5] were less likely to reside in areas of high marginalization when compared with all Ontarians with Parkinson's disease or a neurodegenerative disease.



Length of Disability by Track Safeguards

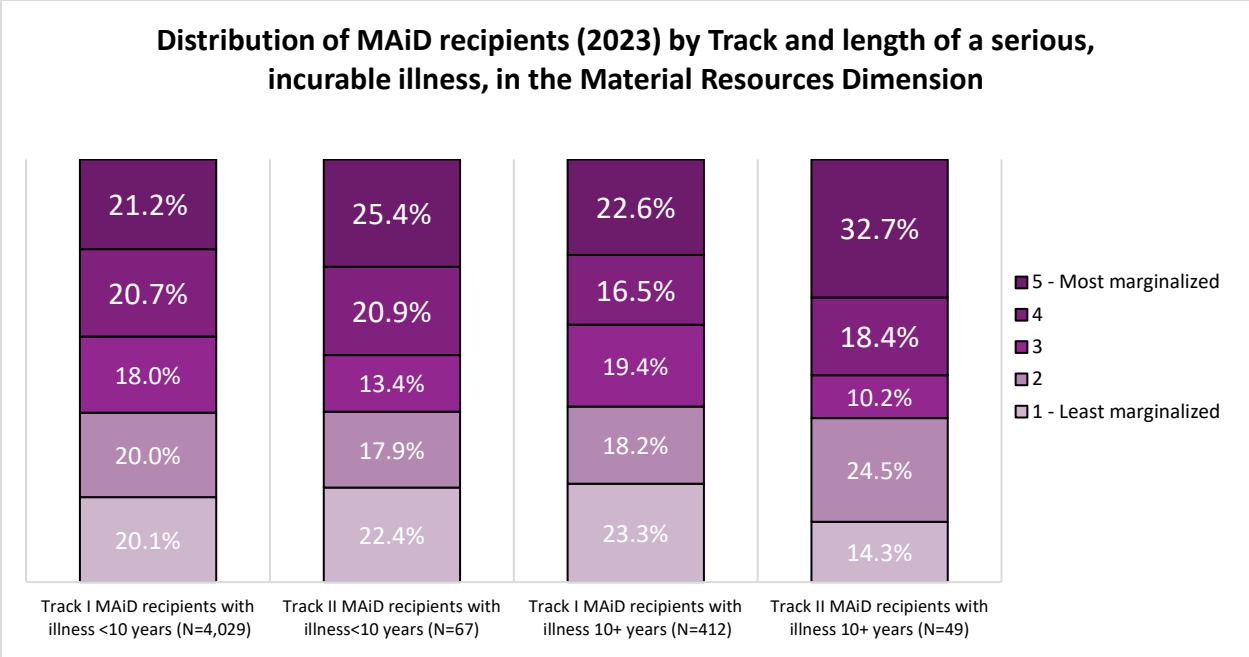
The duration of time with a disability reported by MAiD recipients was examined across the marginalization quintiles. MAiD recipients with a duration of disability of more than four years were more likely to be residing in the most marginalized areas of the province. This may be associated with the impacts of long-term disability such as access to employment and regional variation in employment opportunities.

[5] Conditions included diagnoses of amyotrophic lateral sclerosis, ataxia, Huntington's disease, hydrocephalus, and motor neuron disease, among others.



Length of Illness by Track Safeguards

A greater number of Track 2 MAiD recipients who had an illness for 10 or more years resided in the most marginalized areas of Ontario when compared with those with an illness less than 10 years.



Observations and Considerations

This work was undertaken in an effort to gain perspective regarding the socioeconomic experiences of those who receive MAiD in Ontario. As socioeconomic information is not collected directly from MAiD recipients as part of the assessment process (or required as part of mandatory reporting for Health Canada), the marginalization index was utilized for initial examination.

Considerations for future analysis include:

- Linkage of MAiD recipients' administrative health care data could provide an opportunity to better understand the medical history of MAiD recipients and examine if changes in their level of material deprivation correlates with their health challenges.
- Analysing additional medical conditions reported in Track I and Track 2 recipients to see if relationships are consistent.
- Further analysis on access to other health care services between MAiD and non-MAiD recipients may provide additional insight into differences in access based on local levels of material deprivation.
- Analysis of the level of marginalization among individuals who request MAiD but are found ineligible.

Appendix A

The following 4 dimensions are included in the Ontario Marginalization Index, and are measures by the indicators listed below.

Households and dwellings	Material resources	Age and labour force	Racialized and newcomer populations
The households and dwellings dimension relates **to family and neighbourhood stability and cohesiveness.**	The material resources dimension is **closely connected to poverty and refers to the inability for individuals and communities to access and attain basic material needs** relating to housing, food, clothing, and education.	The age and labour force dimension relates to the **impacts of disability and dependence**.	The racialized and newcomer populations dimension measures the **proportion of newcomers and/or non-white, non-Indigenous populations**, and relates to the impacts of racialization and xenophobia.
• Proportion of the population living alone • Proportion of the population who are not youth (age 5-15) • Average number of persons per dwelling • Proportion of dwellings that are apartment buildings • Proportion of the population who are single, divorced, or widowed • Proportion of dwellings that are not owned • Proportion of the population who moved during the last 5 years	• Proportion of the population aged 25 to 64 without a high-school diploma • Proportion of families who are lone parent families • Proportion of total income from government transfer payments for population aged 15+ • Proportion of the population aged 15+ who are unemployed • Proportion of the population considered low-income • Proportion of households living in dwellings that are in need of major repair	• Proportion of the population who are aged 65 and older • Dependency ratio (total population 0-14 and 65+/ total population 15-64) • Proportion of the population not participating in labour force (aged 15+)	• Proportion of the population who are recent immigrants (arrived in the past 5 years) • Proportion of the population who self-identify as a visible minority

SUMMARY

DR. EUGENIE ULRICA TJAN (CPSO #63892)

1. Disposition

On July 11, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required family physician Dr. Tjan to appear before a panel of the Committee to be cautioned with respect to lack of knowledge, skill and judgement in the provision of medical assistance in dying (MAID) and for failing to educate and prepare herself in advance of providing MAID.

The Committee also accepted two signed undertakings from Dr. Tjan.

2. Introduction

A family member of the patient complained to the College that Dr. Tjan was late for two appointments with the family in January and February 2017 and for the appointment for assisted death in February 2017 and failed to notify the coroner in advance of the procedure. He also expressed concern that Dr. Tjan gave the patient several medications, including some that they had not discussed at the pre-procedure appointment, left the patient's bedside for two and a half hours to obtain more medication while the patient was gasping for air, and was not aware of the medication kit available for medically-assisted dying patients.

Dr. Tjan acknowledged that there were many things that she could have done differently to improve the outcome in the patient's case. She stated that she was unaware of the MAID medication kit and heavily relied on her 23 years of palliative care experience. She expressed her view that the patient did not suffer during the procedure.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who is a family medicine specialist with a practice focus in palliative care. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The IO provider opined that Dr. Tjan's care did not meet the standard of practice and showed a lack of skill, knowledge and judgement. The IO provider concluded that if Dr. Tjan continued to perform MAID without further training and without accessing some mentoring from colleagues with experience, she was at risk of harming patients and should not perform the procedure. The IO provider was of the view that Dr. Tjan continued to underestimate the magnitude of providing medically-assisted death and the responsibility attached.

The Committee was disturbed to note that Dr. Tjan entered into the MAID process in this case without being adequately prepared. She did not read the College's *Medical Assistance in Dying* policy in advance of the procedure and was therefore unaware of the requirement to notify the coroner.

There was no indication that Dr. Tjan used any other resources available through the College, such as Physician Advisory Services, to prepare herself for performing the procedure, or that she contacted the Ontario Centre for Effective Practice for guidance about MAID.

It appeared that Dr. Tjan inquired about MAID medications at one pharmacy, which was unable to provide assistance, but did not ask at any other pharmacies. There was no indication that she consulted her colleagues about the procedure or conducted a robust internet search for information to guide her. Dr. Tjan did not contact the Canadian Medical Protective Association or the Office of the Chief Coroner for advice.

In palliation, the goal is to provide comfort while the natural dying process occurs during the final days and hours of the terminally ill patient's life. In MAID, the goal is to safely and humanely bring about death where death would not otherwise be imminent in the next few days.

There is a medication kit available through pharmacies that would have brought an effective and humane end to the patient's life. In this case, however, Dr. Tjan erroneously assumed that the medications she used for palliation were appropriate for use in MAID in larger doses. The drugs she used (Versed, Ativan, scopolamine, and hydromorphone) are inadequate for MAID even at high doses.

Hydromorphone was a poor choice because terminal patients are often already on high doses of narcotics and thus have developed tolerance. Scopolamine helps dry airway secretions and provides some sedation but is not lethal. Dr. Tjan indicated she would also have brought potassium chloride if she had had enough time to obtain some, but this is not a recommended drug for MAID either.

Dr. Tjan presented late for all three visits to the patient's home. This might have been excusable the first time, when she indicated she had difficulty locating the house, but not on the other

two occasions. The investigative record indicates that Dr. Tjan also failed to communicate adequately with the CCAC palliative team.

Dr. Tjan left the task of picking up the medication to the last possible minute, which caused her to be late to the patient's house on the day of the procedure. She started a butterfly IV, which is an unreliable method. The IV went interstitial, so Dr. Tjan had to rely on the patient's relative, a nurse practitioner, to start the IV.

Dr. Tjan gave dose after dose of the medications without causing respiratory arrest and sent the nurses who were present to the emergency room (ER) to get more of the same drugs. This was inappropriate, as the ER would not provide restricted drugs without authorization. Dr. Tjan then left the patient's home for more than two hours to obtain the MAID medication kit from a pharmacy while the patient's family waited, aware that the drugs keeping the patient in a coma might wear off before Dr. Tjan returned.

Dr. Tjan demonstrated a lack of professionalism by having a telephone conversation with the coroner in the presence of the patient's family members.

The Committee agreed with the IO provider's conclusions that Dr. Tjan's care fell below standard, and that she showed showed deficiencies in knowledge, skill and judgement. The Committee shared the IO provider's concerns about Dr. Tjan's lack of preparation and research regarding policy and drug protocols; lack of communication with other health care providers; and failure to perform the procedure using two IVs and the appropriate drugs.

As a result of this investigation, the Committee decided to seek an undertaking from Dr. Tjan to address the issues in question. Dr. Tjan signed two undertakings, dated May 8 and May 9, 2018, that provide that she will not engage in the practice of MAID in any respect, and, in her palliative care practice, will practise under the guidance of a supervisor, engage in professional education in palliative and end-of-life care, and undergo reassessment.

In addition to accepting the two undertakings, the Committee decided to require Dr. Tjan to attend at the College to be cautioned in person with respect to the care she provided in this case.

Complications with Medical Assistance in Dying (MAID) in the Community in Canada

Review and Recommendations

Bakewell, F, Naik VN

A Canadian Association of MAiD Assessors and Providers (CAMAP) White Paper

March 28, 2019

Contents

Executive Summary

Total MAiD deaths in Canada between December 10, 2015 and October 31, 2018 is reported as 6749 deaths as per the most recent report by Health Canada (1). Between January 1st, 2018 and October 31, 2018, an estimated 55% of those deaths have taken place outside of the hospital setting, in the patient's home, a long-term care facility, or a hospice. This most recently available reporting of MAiD in Canada is still an estimate, as it pre-dates mandatory federal monitoring and reporting and data is incomplete or approximate from several provinces and territories. The vast majority have taken place with parenteral medications, with only a very small number using self-administered oral preparations.

The purpose of this paper is to outline some of the potential complications that may be associated with the administration of MAID, both in intravenous (IV) or oral form, and to provide recommendations to both prevent and deal with any complications that do arise.

The following are summary recommendations:

1. All patients undergoing MAID in the community should have documentation outlining their request and consent for the provision available at the time of the provision. Patients should also have an up-to-date provincial Do Not Resuscitate form available, or equivalent order signed by them and their physician or nurse practitioner, to prevent attempts at resuscitation should attendance or transport by emergency medical services (EMS) be required.

2. Discussion of potential complications should be a routine part of the consent process when discussing the MAID provision with patients.

3. Clinicians should obtain consent from patients prior to the initiation of MAID for any therapies that may be required should a complication occur (e.g. conversion from oral self-administration to IV in the setting of delay, or the need for an unexpected transfer to hospital).

4. For MAID provisions in the community, physicians and nurse practitioners who do not insert IVs as part of their regular practice should be accompanied by another clinician experienced in inserting IVs, in the absence of a peripherally inserted central catheter (PICC). The need for a functional PICC should be considered based on physical examination prior to the provision. Port-a-cath devices can be considered for access by experienced clinicians. Midline catheters are less secure than PICC's, and their function should be confirmed before use. Intraosseous infusion (IO) requires technical expertise and regular experience, and is not recommended electively for MAID.

5. For oral self-administered MAID, clinician presence at the provision is recommended to intervene with IV medications to complete the MAID provision in case of delay or complications with the oral preparation.

6. Clinicians should know their contingency plan for failed vascular access or administration of medications prior to starting any provision. This plan will vary depending on local context. If clinicians are unable to establish IV access prior to the administration of medication, provision should be deferred until such time when non-emergent help can be obtained.

7. If a complication occurs with either IV or oral self-administration, and clinicians are unable to obtain subsequent IV access, clinicians should decide whether the patient's condition allows for another clinician to be called to the scene to aid in obtaining access. Technical proficiency from regular practice and routine use is mandatory before considering intraosseous infusion emergently for a MAID complication.

8. If a patient's condition does not allow for another clinician to come to the scene and it is decided that the patient requires immediate IV access, the clinician may have to call EMS (i.e. 911).

9. If 911 is called, the clinician should request EMS to insert an IV and release the patient on scene, and/or ask them to call their online medical director for a similar order.

10. If EMS are unable to insert an IV or to release the patient on scene (or refuse to do so), the clinician providing MAID should accompany the patient to hospital to help direct further care.

11. Should a patient present to an emergency department as a result of complications of MAID in the community, and the validity of the MAID process can be confirmed to the satisfaction of the care team, it is appropriate to provide supportive and symptomatic care without attempts at resuscitation or overdose reversal. Further administration of medications to hasten death should only be considered by the clinician who assessed and obtained the consent for MAID.

Potential Complications with IV MAID in the Community

The vast majority of MAID provisions taking place in the community are done using parenteral medications administered intravenously by a clinician trained in providing MAID. The advantages of IV MAID are that it is suitable for almost all patients, is well tolerated with minimal side effects, and has rare failure rates. The disadvantages of IV MAID are that it requires the potentially painful insertion of an IV at the end of life, requires the presence of a clinician, and that the final act of medication administration may be perceived as diminishing agency and reducing autonomy for the patient.

Medication protocols for IV MAID are outlined elsewhere. Regardless of the protocol being used, none will fail if administered properly. Therefore, the most significant complications associated with IV MAID administration are the inability to obtain IV access or the loss of IV access during the provision.

Global experience

A review of 649 cases of euthanasia and assisted suicide in the Netherlands published in NEJM in 2000 outlines some data on complication rates with IV MAID (2). In that case review, there were technical problems with obtaining IV access in 5% of cases, including difficulty finding a vein or problems with the IV catheter itself. There were patient complications in 3% of cases, such as muscle spasms, myoclonus, cyanosis, gasping, or vomiting. There were problems with completion, mostly a longer than expected time to death, in 5%. Unfortunately, this case review does not provide specifics on what medications were being used.

Canadian experience

As of yet, there has not been any systematic recording of complications with IV MAID in Canada. However, in a survey of 335 Canadian emergency physicians, 3 reported having seen patients come in to the emergency department because of a failed IV administration of MAID or an inability to obtain an IV in the community (3). It is likely that the majority of cases of IV failure are resolved in the community either with re-insertion or with the assistance of another clinician.

Prevention

Given the possible complications with IV MAID outlined above, there are several steps that MAID clinicians should take to prevent them from taking place.

The first is to include a discussion of possible complications with IV MAID as part of the consent process with patients. This should include a discussion of potential difficulties with the IV, potential side effects from the medications, and the possibility of losing vascular access during medication administration. Patients should be consented for the insertion of two peripheral IVs prior to the IV provision in case one of them fails.

Unless the MAID clinician inserts IVs as part of their regular practice, then an additional clinician should be readily accessible who is particularly skilled at IV insertion (e.g. a community care nurse). If clinicians are unable to establish IV access prior to the administration of medication, provision should be deferred until such time when non-emergent help can be obtained. EMS should not be called for routine non-emergent IV insertion.

Vascular access should be evaluated at the time of the assessment, and within a close interval of administration if several weeks or months have elapsed since the MAID assessment.

Appropriate equipment should be present for troubleshooting IV access. At a minimum this should include multiple cannula sizes, but may potentially include kits for obtaining central access or adjunct equipment such as vein finding devices.

The clinician should check that the IVs are patent, and in the vein. This can be done by drawing back on the line for blood. If this is ineffective, saline can be injected to assess for ease of administration and the absence of swelling proximal to the IV insertion site. Patency can also be confirmed by the free flow of intravenous fluids to gravity, again with the absence of significant swelling proximal to the insertion site.

The clinician should be prepared with additional supplies of medications in case medications are injected into the interstitial tissues during administration.

The clinician should have a plan in place in case IV access is lost, medications have been administered, and they are unable to obtain further access. This may consist of another clinician on call who is able to come and assist, an agreement with local EMS to provide IV access without transporting to hospital, or an agreement with a local hospital for direct admission to a under a clinician with admitting privileges for such a circumstance.

In all cases of MAID in the community, documentation should be present that clearly demonstrates the patient's consent to the provision and to any subsequent care, as well as an official provincial DNR order or equivalent in case of EMS involvement.

Treatment options

Depending on the complication, there are several treatment options available to MAID clinicians in the setting of IV MAID in the community:

Side Effects or Delayed Time to Completion

As mentioned above, IV medication sequences used in MAID are generally very well tolerated and highly effective. However, should side effects (gasping, myoclonus, etc.) occur, clinicians should be ready to augment doses of medications through an IV as needed for patient comfort and provision completion. Clinicians should also be prepared to accelerate or omit parts of the protocol. For example, midazolam can occasionally cause paradoxical agitation, in which case clinicians should be prepared to quickly administer propofol without the preceding dose of lidocaine. Specifics of medication protocols may be found in other documents. Clinicians should routinely bring a complete second set of iv medication to every provision.

Loss of/Inability to Obtain IV Access

If patients are amenable, clinicians should consider establishing a minimum of 2 peripheral IV's for provisions, particularly if access is challenging. If IV access cannot be reliably obtained, or there is doubt about the reliability of the access that has been obtained, then the provision should ***stop*** prior to the administration of that, or additional medications, until further assistance is obtained. Central venous access (ie. PICC) should be considered if peripheral access is not possible.

If IV access is lost during the administration of medication and a second peripheral IV has been established, medication administration should be switched to the second IV. If a second IV has not been established, immediate attempts to obtain subsequent access should be made. During this process, subcutaneous or IM administration of sedative medications for patient comfort may be administered according to clinician's judgement.

If subsequent access cannot be obtained, clinicians should decide whether IV access is needed without delay, or if the patient can wait for another clinician skilled in IV insertion to be called as backup to come to the scene and obtain definitive access.

If access is required without delay, or if there is no other clinician available, the clinician on scene will have to decide whether to call EMS to provide care on scene or to transport to hospital. In all cases when EMS is called, it should be discussed whether it is possible for EMS attendants to obtain IV access and leave the patient on scene with the clinician responsible for the MAID administration without transporting to hospital. EMS may need to consult with their medical control for approvals as required.

If transport to hospital is required, the clinician should accompany the patient. If the clinician has privileges at the receiving facility they will be able to continue to provide care. If not, they will be able to help direct care that is provided. In these exceptional circumstances, it will be up to the treating team at the receiving facility to decide if they are able to provide IV access under the direction of the MAID clinician. The clinician will be unable to administer medications for MAID at the receiving facility unless they have privileges. Transport back to the patient's home or long-term care facility may be considered if the patient's death is not expected to be imminent, otherwise they could be admitted for comfort care.

No clinician should administer life-ending medications who was not involved in the MAID assessment and consent process. This is supported in a survey of 335 Canadian emergency physicians, where 75% said they would feel comfortable inserting an IV in these circumstances, with the patient's own clinician resuming care after this was done. However, 15% said they would not, with an additional 10% expressing serious reservations or a qualified yes (3).

Potential Complications with Oral MAID in the Community

The amendments to the criminal code that allow for MAID explicitly allow for the option of oral self-administration (4). Arguments in favour of an oral, self-administered option include allowing greater geographical access to MAID, increasing the number of clinicians willing to take part in the provision, and allowing for greater autonomy and less medicalization of the end-of-life experience for patients (5).

There have been exceedingly few reported cases of oral self-administered MAID in Canada so far: 5 as of the end of 2017 according to the 3rd Interim Federal Report (1), and 13 according to a CAMAP white paper published in April 2018 (6). However, these low numbers may in part reflect unfamiliarity with the practice and the previous unavailability of an effective, easy to administer oral option. In the fall of 2017, a pharmaceutical company received approval by Health Canada to distribute secobarbital, the oral barbiturate of choice for self-administered MAID in Oregon, Washington, and the Netherlands. It has been speculated that rates of self-administration may now go up (7).

Given a generally higher rate of adverse effects, prolonged time to death, and higher failure rate of oral self-administered MAID, it will be important to consider prevention and response to complications from oral MAID in the community, even if total numbers remain small overall.

Global experience

In the aforementioned review of MAID cases in the Netherlands published in the 1990s, there were problems with completion of oral MAID (using barbiturates) in 16% of cases (including a delay to death, failure to induce coma, or re-awakening). The range of time to death

was 1 minute up to days, with a median of 30 minutes. 3.5% of cases had vomiting and 2.6% experienced extreme gasping. The clinician present elected to administer additional IV MAID medications in 18% of cases due to the above problems (2).

In a review of 165 oral MAID cases in the Netherlands between 2013-2015, 9 patients showed some retching and 3 patients fell asleep before being able to complete the medication. 6 cases took longer than 60 minutes before death occurred. Additional IV medications were administered for the completion of the provision in 9% of cases (8).

A review of the Oregon data from 1998-2015 (a total of 991 self-administered cases; intravenous MAID is not legal in Oregon) shows that in roughly half of cases patients did not have a medical clinician present at the time of ingestion (9). For the cases where a clinician was present and data is available, there was a complication rate (not including delay) of 4.9%, mostly involving regurgitation. There are 6 reported cases of patients regaining consciousness after administration. Of the cases where data is available, the reported time from ingestion ranges from 1 minute to 104 hours, with a median of 25 minutes. EMS was involved in less than 1% of cases.

A case report of a patient in California being brought to the ED and being partially resuscitated after self-administering oral MAID at home was published in 2017, and serves to illustrate the many possible moments for miscommunication or error should an event like this occur, and the importance of clear documentation and communication between patients, family, and clinicians (10).

Canadian experience

There have been 13 reported cases of oral self-administered MAID in Canada, all with clinician presence according to a white paper published by CAMAP in March 2018 (5). Details are available for 10 of the cases that were performed in BC, where the prescription and process for oral MAID are standardized. According to the information available:

- Most cases involved the administration of phenobarbital, morphine, and chloral hydrate
- In three cases where it is known, average time to death was one hour or less. In two cases, death occurred between 60 and 90 minutes
- In five cases the oral administration was unsuccessful by 60 minutes, and required IV medications to complete the process
- In one case using the DDMP2 mixture (Diazepam 1g, Digoxin 50mg, Propranolol 2g and Morphine 15g) time to death was 135 minutes, and no clinician was present for the death.

There has been a single reported case of EMS being called and the patient being transported to a hospital as a result of adverse effects or a delayed death, highlighting the importance of clinician presence to monitor appropriate ingestion and progression to death.

Prevention and preparedness

Given the greater risk compared with IV MAID, it is especially important that clinicians of oral MAID discuss with patients the potential for adverse effects from oral MAID as part of the initial consent process. Clinicians should obtain consent in advance for any treatments that

might be administered to deal with complications that arise, including symptomatic therapies, as well as the insertion or re-insertion of IVs for the administration of parenteral MAID medications.

We strongly recommend that clinicians should be present with patients during oral self-administration of MAID, and should remain present until the patient's death (in some jurisdictions, such as BC, this is already mandated by a College practice standard). If the primary clinician does not routinely insert IVs, there should be an additional clinician readily available who is proficient in the insertion of IVs. If a patient refuses the presence of a clinician in a province/territory where clinician attendance is not mandatory, the clinician prescribing the MAID medications should be readily available to be called by the patient or any other persons present should a complication occur.

It is suggested that clinicians consider inserting an IV before oral self-administration takes place, in case medications for symptom control or conversion to IV MAID is required.

Clinicians should be prepared with additional therapies for symptom control (e.g. anti-emetics, sedatives) as well as back-up IV MAID medications when using oral therapies. Clinicians should have a plan for dealing with these complications, as well as a pre-established cut-off time for when they will consider oral medications to have delayed beyond a reasonable time and will proceed with the administration of IV MAID. This should be discussed with the patient in advance.

The clinician should have a plan in place in case IV access is lost and they are unable to obtain further access. This may consist of another clinician on call who is able to come and assist, an agreement with local EMS to provide IV access without transporting to hospital, or an agreement with a local hospital for direct admission to a under a clinician with admitting privileges for such a circumstance.

All patients who are undergoing MAID in the community should have documentation with them at all times clearly indicating their consent to MAID, and their wish not to be resuscitated (preferably an official directive for EMS, if available in their jurisdiction).

Treatment options

Side Effects or Delayed Time to Completion

Given the fairly high rate of side effects and delayed time to death that can occur with oral MAID, clinicians should be ready to administer subsequent doses of medications through an IV as needed for patient comfort and provision completion. Specifics of medication protocols may be found in other documents.

There is no clear cut-off for what constitutes 'delayed time to death' or 'failed oral MAID.' As mentioned above, clinicians should decide with patients in advance at what point they will consider inserting an IV and completing the provision with parenteral medications.

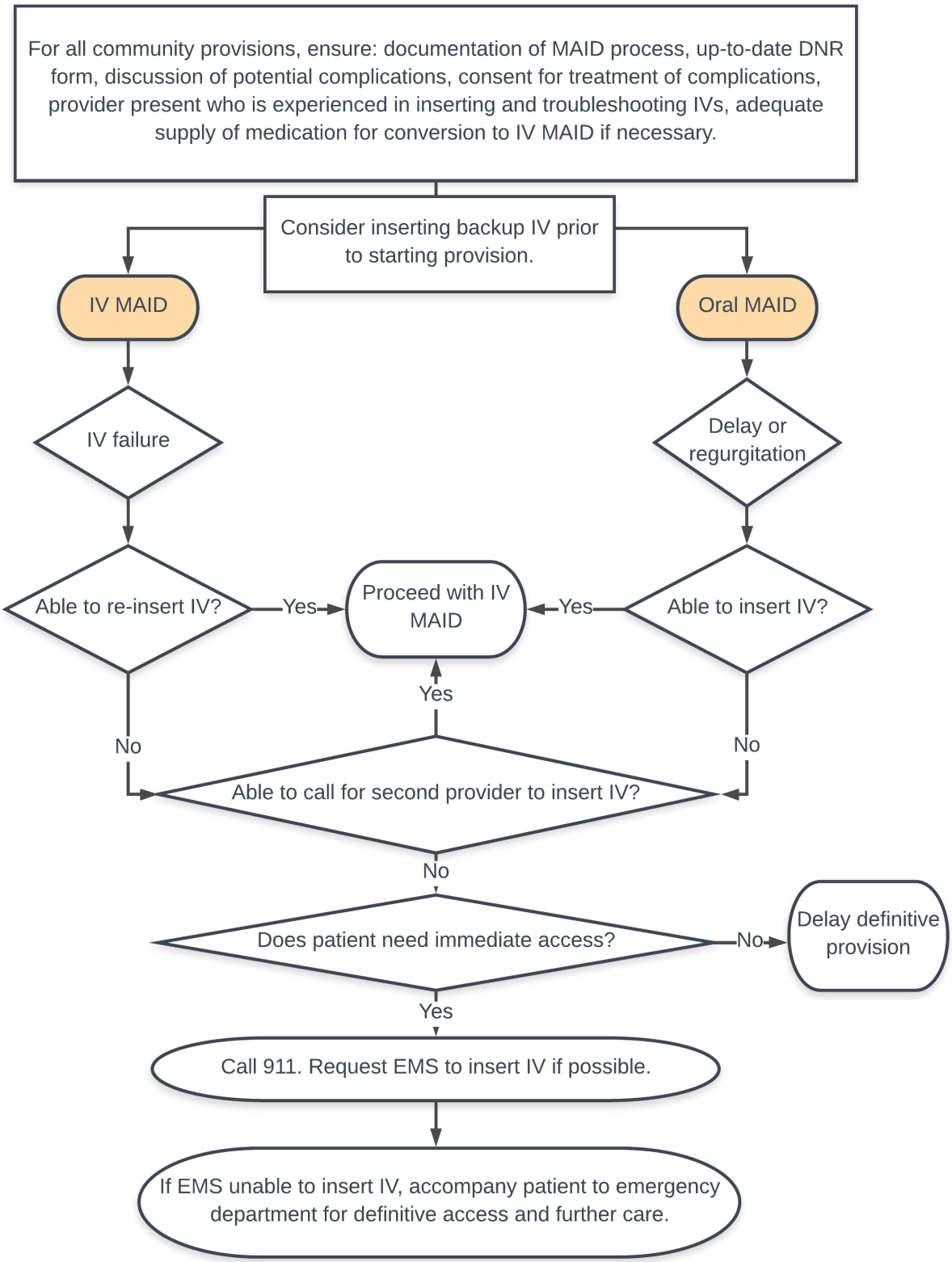
Delayed Time to Completion and Inability to Obtain IV Access

If clinicians decide to administer IV MAID medications due to a delayed time to death during oral self-administration, access should be pre-existing or quickly obtained. However, if there is any delay, subcutaneous or IM administration of sedative medications for patient comfort may be administered according to clinician's judgement.

It is possible that patients who self-administer oral MAID in the community may present to the ED without a clinician accompanying them. In these circumstances, the ED physician will have to decide what constitutes sufficient evidence that the patient's state is the result of an

approved MAID process. Ideally patients will have clear documentation of the MAID process with them at all times, as well as a standardized do-not-resuscitate order, if available. In the aforementioned survey of Canadian emergency physicians, the top three acceptable pieces of evidence to demonstrate a valid MAID process were documentation from the prescribing clinician (91%), speaking directly with the prescribing clinician (81%), and advance directives from the patient stating intent (70%) (3).

Summary Flowchart



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MAiD Quarterly Data - Q3 2024

Statistics as of: September 30, 2024

- **Total Number of MAiD deaths in Ontario (since June 2016): 22,107**
- **Total Number of MAiD deaths in 2024: 3,731**
- **Total Number of MAiD deaths in Q3 2024: 1,280**

• **Type:**	
Clinician Administered	22,104
Patient- Administered	3

	Q3	YTD	Cumulative
• Waiver of Final Consent Invoked	60	175	618 *
• Total number of deaths with organ donation	9	21	146

*from March 18, 2021 to September 30, 2024

- **Sex - Age - Disability:**

Sex	
- Female	49%
- Male	51%
- Other	0%

	Quarter		YTD		
Age	**Track 1**	**Track 2**	**Track 1**	**Track 2**	**Cumulative***
Average Age	77	69	77	72	75
Youngest	32	27	24	27	18
Oldest	104	93	104	101	114

*from total number of MAiD deaths since June 2016

Disability (Self-Identified)	QTR%	YTD%
Development	0.23%	0.08%
Dexterity	6.09%	5.55%
Flexibility	6.09%	5.66%
Hearing	3.20%	2.68%
Learning	0.16%	0.27%
Memory	0.86%	1.15%
Mental Health-Related	0.39%	0.29%
Mobility	21.72%	21.50%
Other Long Term Condition	4.45%	5.47%
Pain-Related	12.42%	11.95%
Seeing	3.20%	3.11%
Do not know	0.00%	0.11%
Person did not consent	0.08%	0.13%
ODSP Recipient	2.50%	2.14%

- **Ethnicity:**

Identification	QTR%	YTD%
-- ETHNICITY - Identifies as First Nations, Metis or Inuk/Inuit		
First Nations	0.55%	0.59%
Métis	0.16%	0.16%
Inuk/Inuit	0.08%	0.03%
Do not know	8.13%	7.91%
No	89.61%	89.55%
Person did not consent	1.56%	1.80%
-- ETHNICITY - Racial, ethnic or cultural group that best describes the person		
Black	0.31%	0.29%
East Asian	1.88%	1.74%
Latin American	0.23%	0.38%
Middle Eastern	0.39%	0.29%
South-East Asian	0.16%	0.21%
South Asian	0.94%	0.99%
White	91.41%	90.89%
Another Racial, Ethnic or Cultural Group	1.33%	1.29%
Person did not consent	2.58%	2.17%
Do not Know	1.33%	2.28%

- **Setting Of Death:**

	QTR%	YTD%	Cumulative%
Hospital (exclude palliative care beds or unit)	24.92%	26.64%	35.04%
Other (includes funeral homes, ambulatory settings, medical offices/clinics, any urban and indoor settings)	3.28%	2.87%	0.95%
Palliative Care Facility (include hospital-based palliative care beds, unit or hospice)	21.25%	19.54%	7.01%
Private Residence (including retirement home)	48.59%	48.00%	52.86%
Residential Care Facility (include long-term care facilities)	1.95%	2.95%	4.14%

*prior to January 1, 2023, Hospital-based Palliative units were included in Hospital category
**prior to January 1, 2023, Private Residence and Retirement Homes were separate categories

• Number of Unique MAiD Providers:

Clinicians	Q3 (new)	YTD (new)	Cumulative
- Physician	14	51	826
- Nurse Practitioner	2	5	80
Hospitals	0	3	177

Clinician Specialty	QTR%	YTD%	Cumulative%
- MAiD Provider is a Nurse Practitioner	12.66%	11.93%	10.60%
- Anaesthesiology	8.20%	8.66%	8.51%
- Critical Care and Emergency Medicine	2.19%	2.31%	2.57%
- Family Medicine	52.58%	50.25%	51.12%
- Internal Medicine	2.03%	2.28%	3.35%
- Oncology	0.47%	0.67%	0.72%
- Other*	3.59%	4.07%	4.86%
- Palliative Medicine	18.28%	19.83%	18.26%
- Psychiatry	0.00%	0.00%	0.02%

*The Other category includes General Practitioner and Surgery which were reported separately prior to January 1, 2023. Their cumulative values were 8% and 2 %, respectively , as of December 31, 2022

- **Deaths by County: (Cumulative, total of all MAiD deaths from June, 2016)**

County	MAiD Deaths	County	MAiD Deaths
ALGOMA	191	BRANT	211
BRUCE	322	CHATHAM-KENT	304
COCHRANE	191	DUFFERIN	92
DURHAM	681	ELGIN	305
ESSEX	567	FRONTENAC	438
GREY	404	HALD-NORFOLK	201
HALIBURTON	67	HALTON	1,059
HAMILTON	646	HASTINGS	330
HURON	198	KAWARTHA L	287
KENORA	136	LAMBTON	266
LANARK	261	LEEDS & GREN	428
LENNOX & ADD	156	MANITOULIN	52
MIDDLESEX	1,448	MUSKOKA	218
NIAGARA	674	NIPISSING	387
NORTHUMBERLND	298	OTTAWA	1,660
OXFORD	294	PARRY SOUND	139
PEEL	996	PERTH	330
PETERBOROUGH	420	PRESCOTT&RUSS	309
PRINCE EDWARD	83	RAINY RIVER	49
RENFREW	173	SIMCOE	1,066
STOR,DUN,GLEN	249	SUDBURY	286
SUDBURY DIST	30	THUNDER BAY	277
TIMISKAMING	128	TORONTO	3,066
WATERLOO	514	WELLINGTON	404
YORK	776	Person does not have a home address	27
Valid Postal code, not mapped	13		