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].

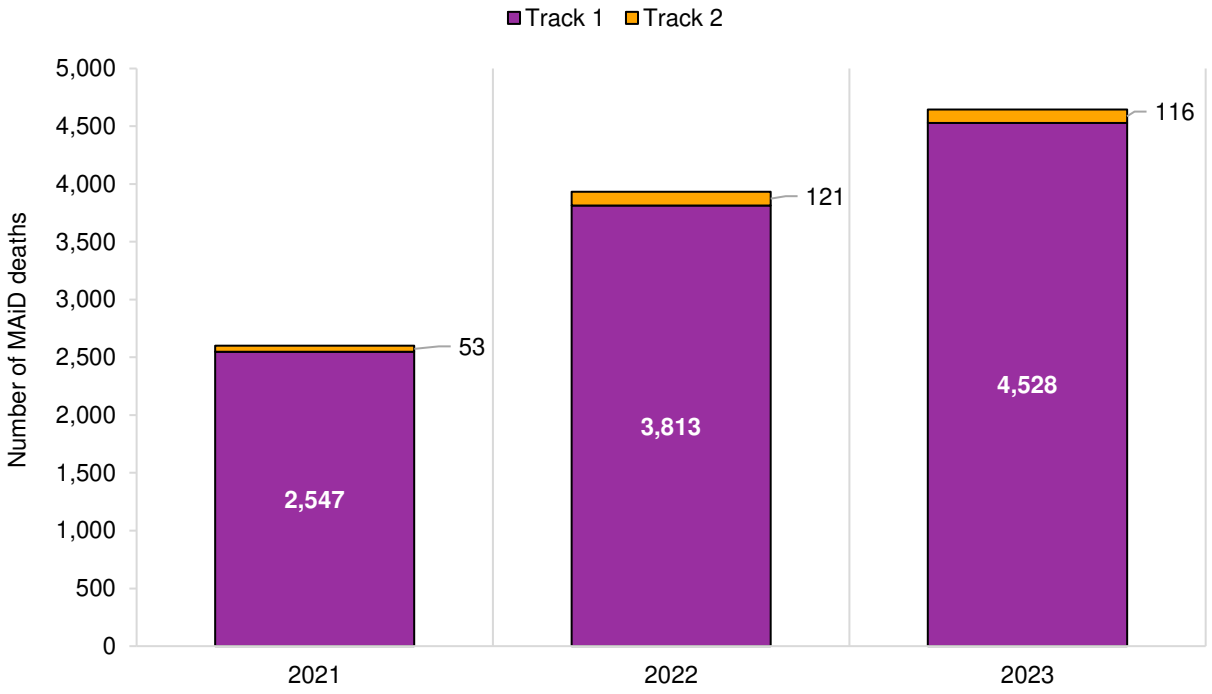
The MAiD Death Review Committee (MDRC) was asked to further contribute to these learnings to inform quality MAiD practices and approaches when considering persons accessing MAiD with complex medical conditions. Three illustrative MAiD deaths were selected for review to inform discussion on navigating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

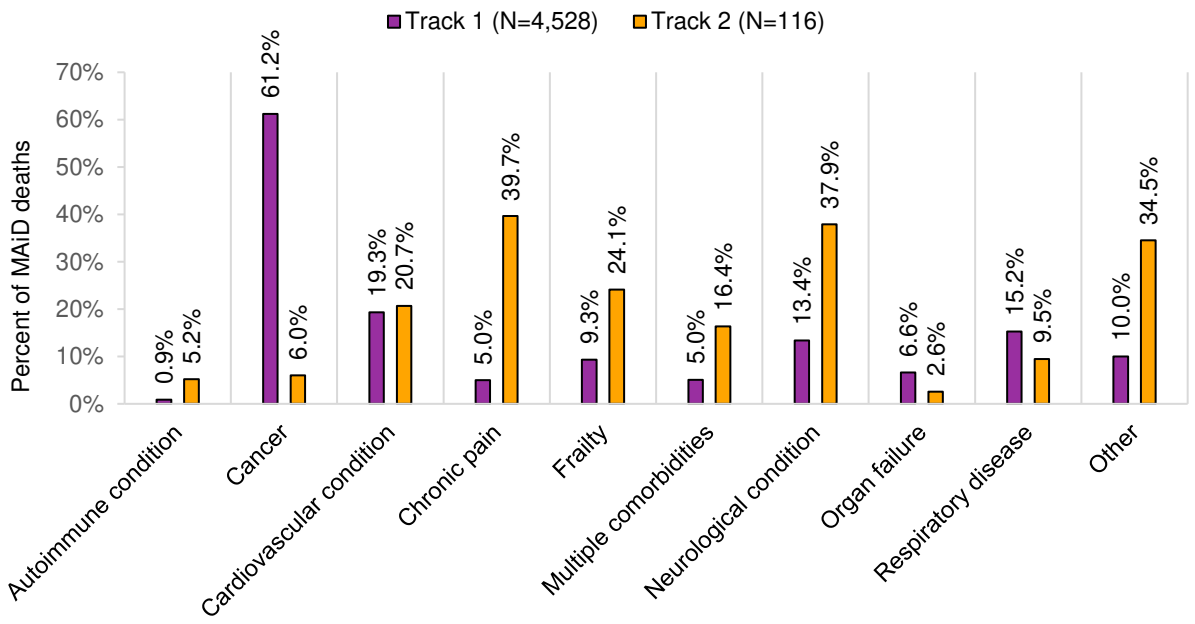
The medical conditions that are the basis of a request for MAiD differ between persons that access with a RFND (Track 1) or NRFND (Track 2). The frequency with which conditions were reported by MAiD practitioners[1] is presented in Figure 2. Cancer was the most common condition with which Track 1 recipients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

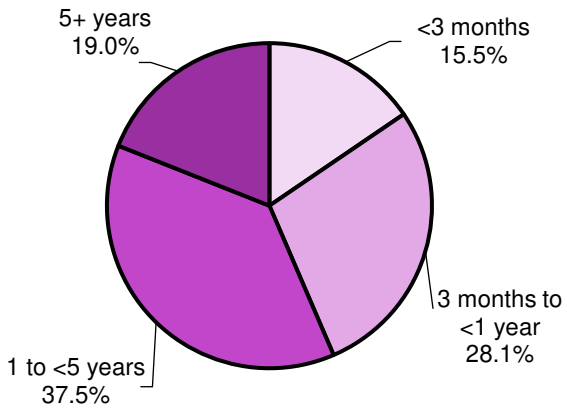
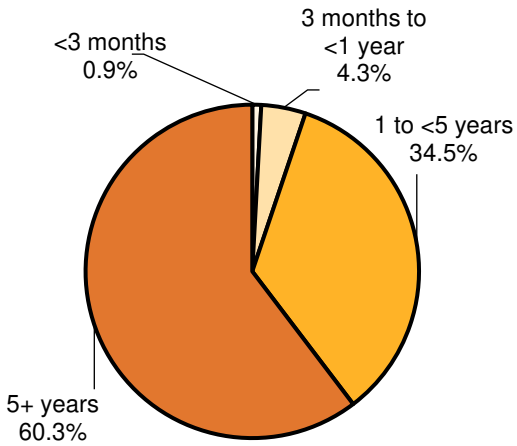


Figure 4. Distribution of Track 2 MAiD Recipients (N=116) Length of Time with Incurable Illness, Disease, or Disability, 2023



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.

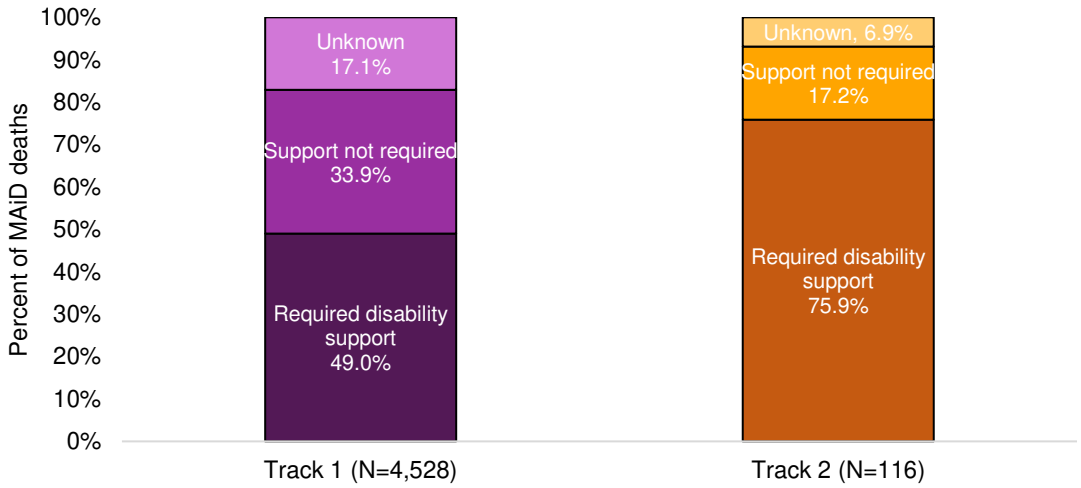
[3] Health Canada has indicated that the quality and reliability of self-identified disability data is limited due to variations in data collection.

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

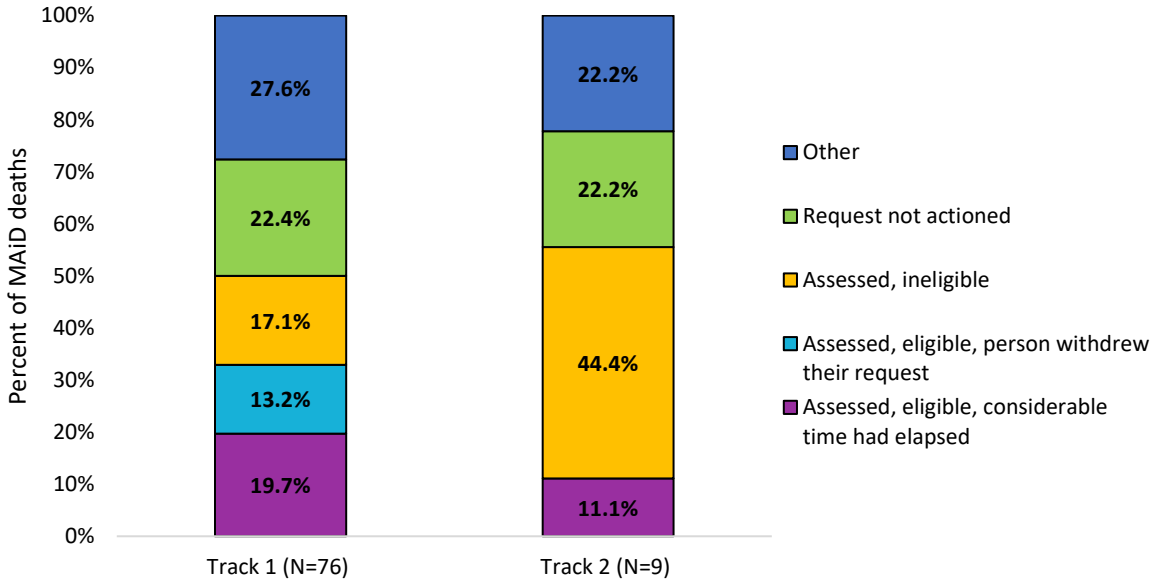


Previous MAiD Requests

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.

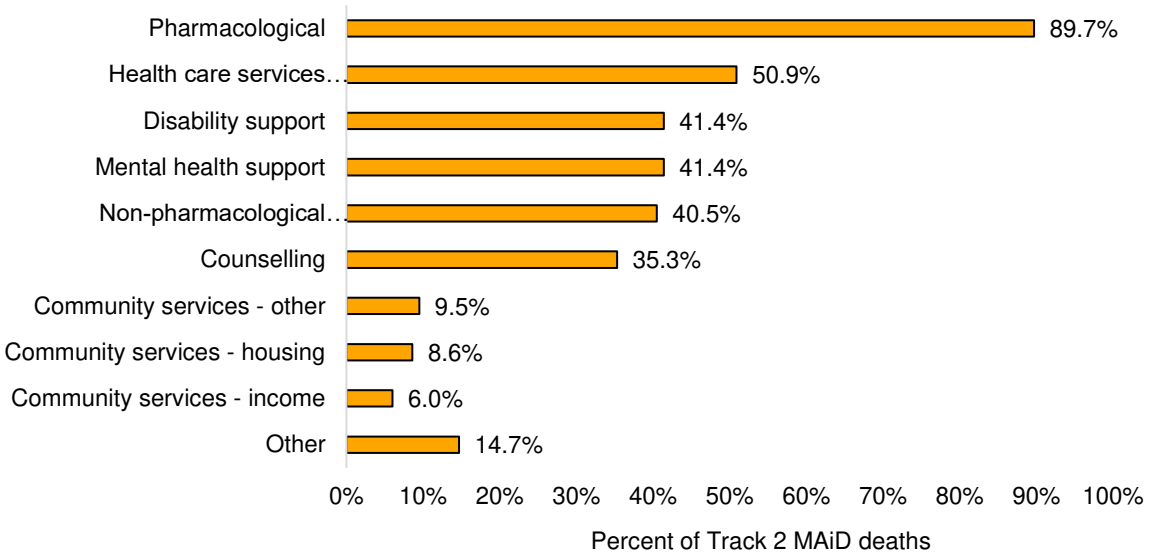
Table 2. Types of Suffering Identified by MAiD Recipients in Ontario that Could Not Be Alleviated Under Conditions Acceptable to Them, By Track, 2023

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

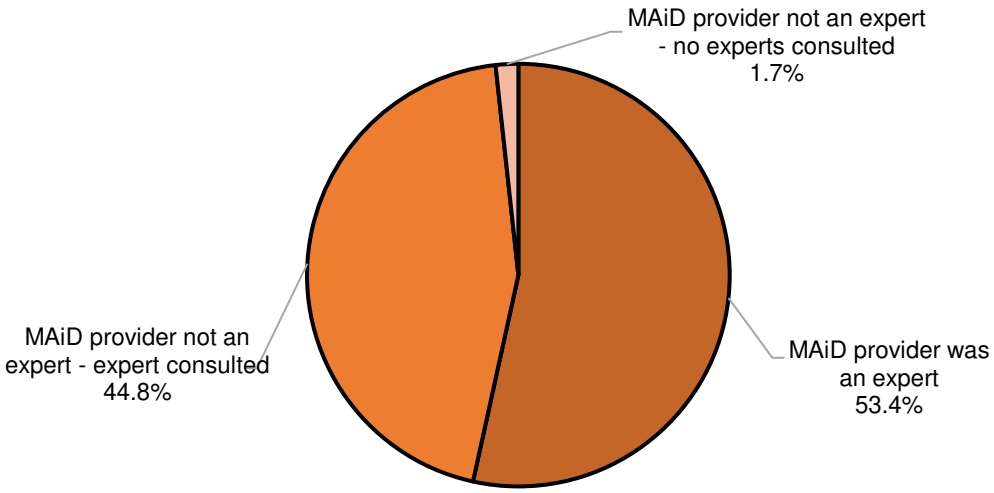
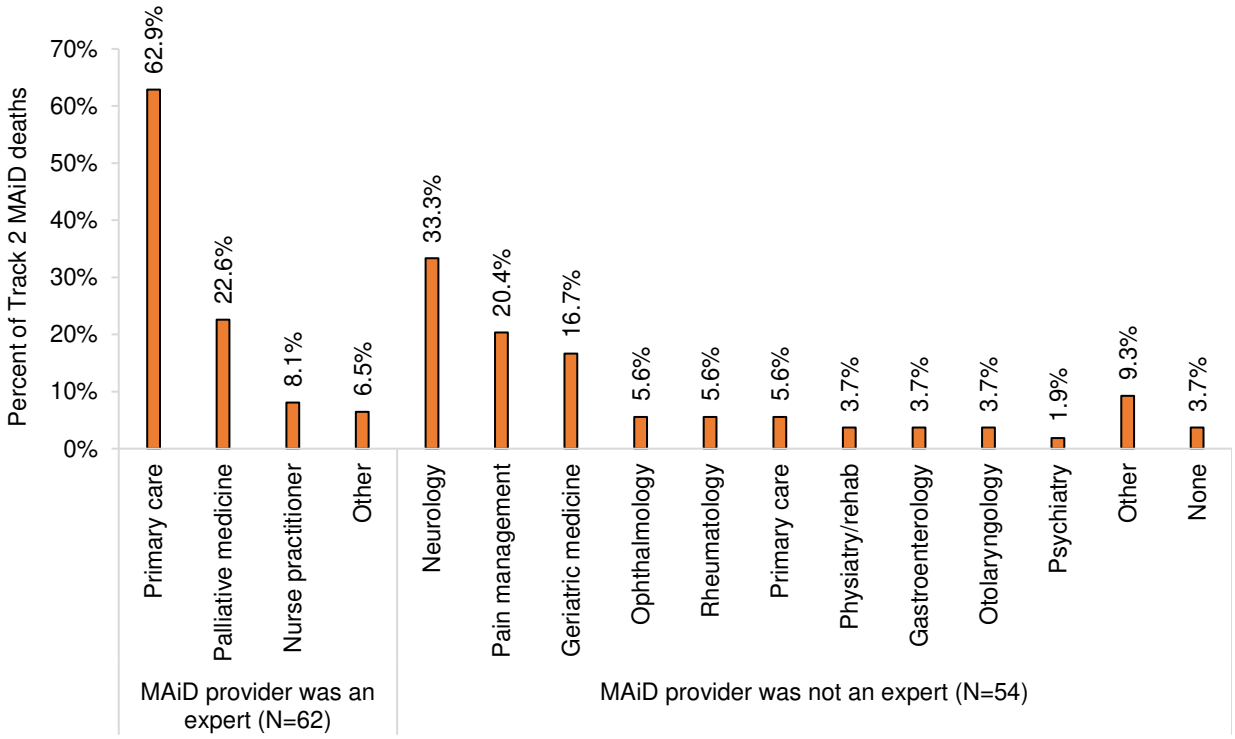


Figure 9. Types of Specialists Consulted for Track 2 MAiD Recipients in Ontario, 2023



Navigating the MAiD Process

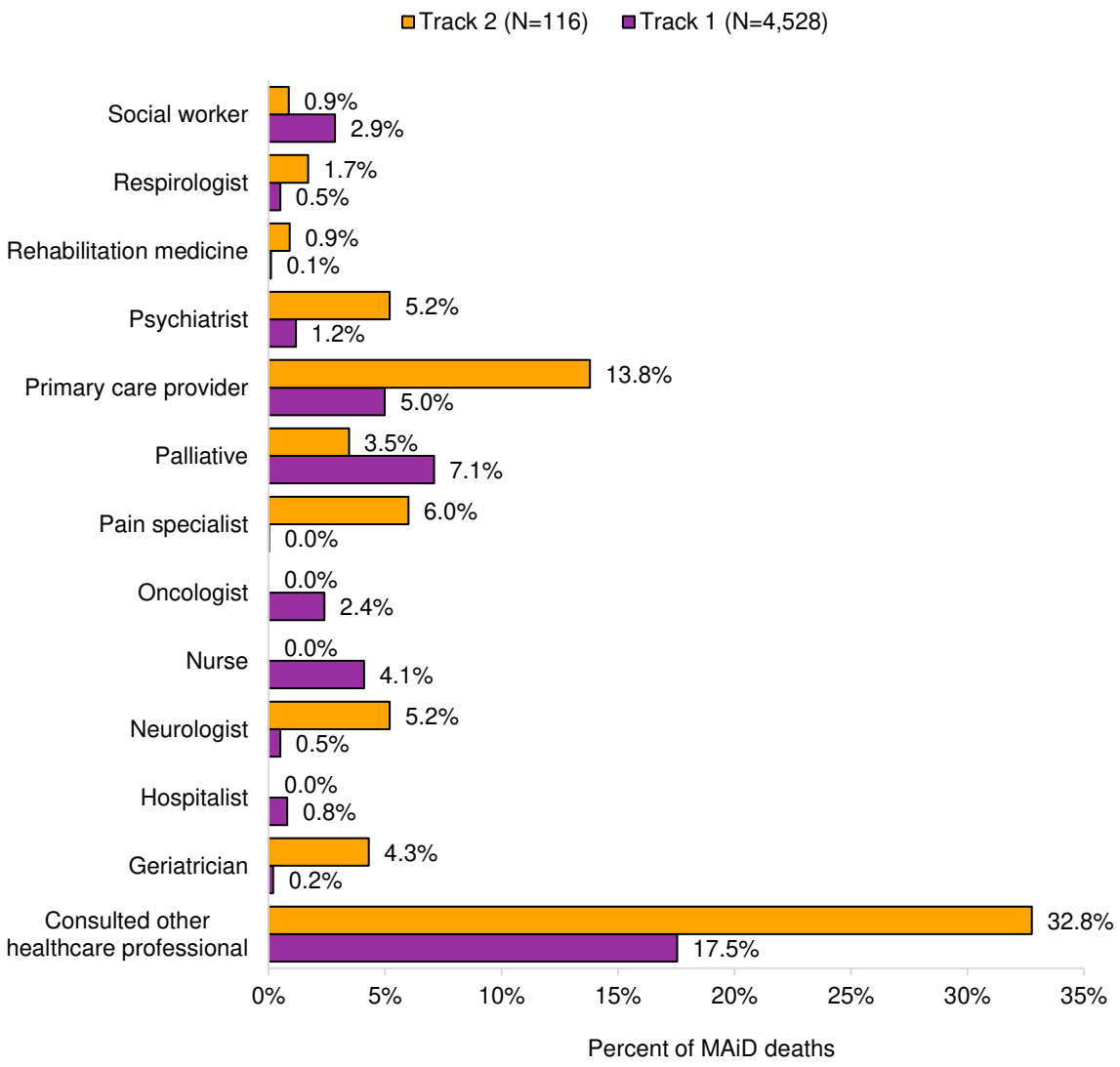
To ensure that there is sufficient time for consultation with a medical professional with expertise and for the requestor to consider and potentially trial alternate means to alleviate suffering, there is a 90-day assessment period required for persons accessing MAiD with a NRFND. The distribution of 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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