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]).

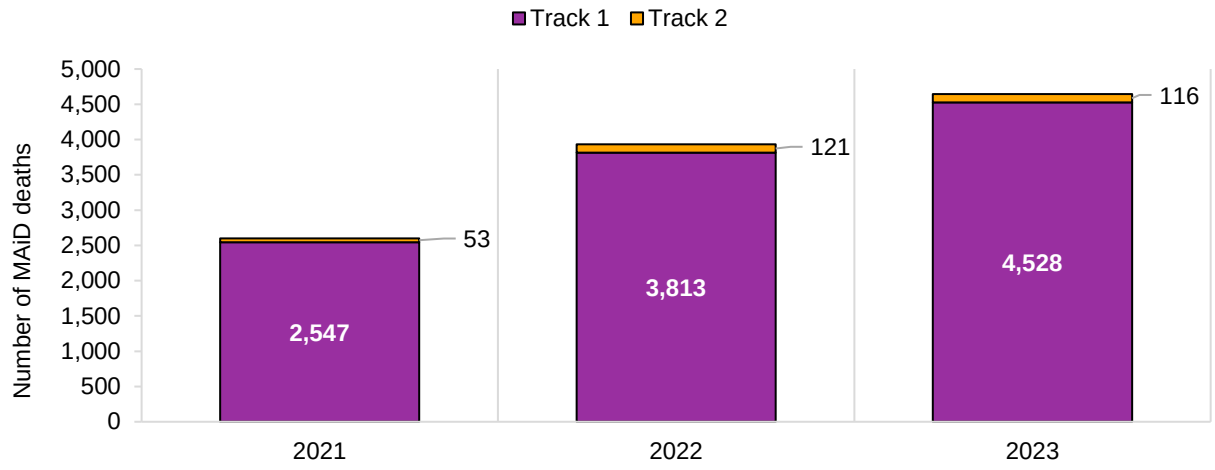
[1] A humility-oriented, anti-ableist care approach acknowledges how historical structures have limited care options and undermined the dignity of persons with disabilities. In healthcare, a holistic approach recognizes the limitations of traditional medical perspectives, especially those rooted in ableism. 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**

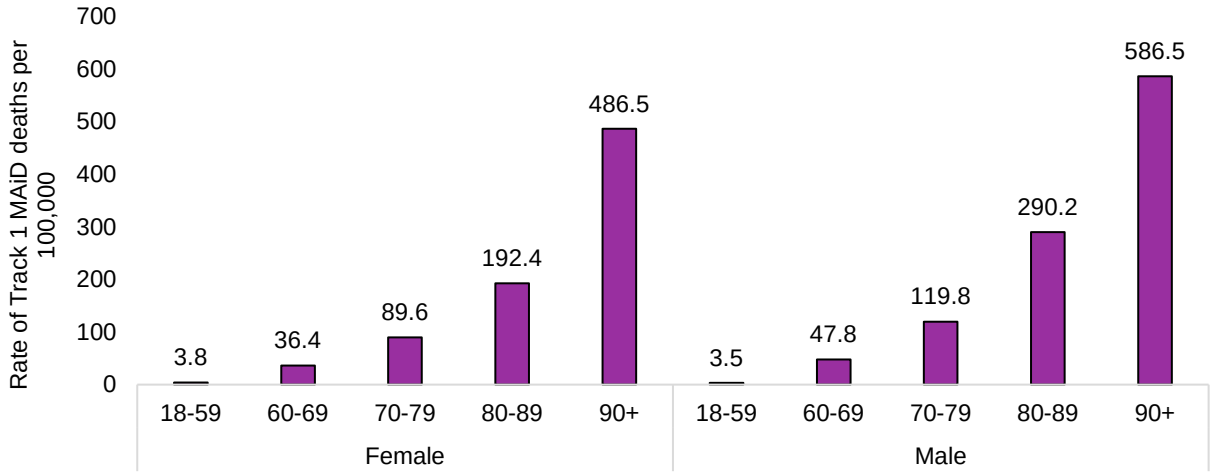
[2] Excludes deaths where information was not completed.

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**

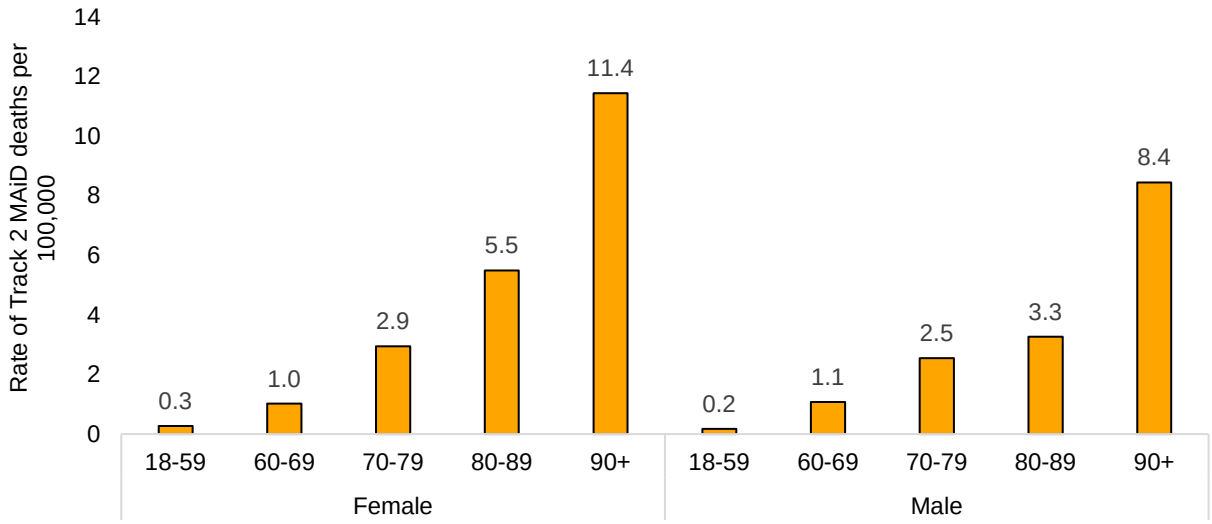
To support comparison across different population sizes, rates of MAiD provisions per 100,000 persons aged 18 years and older were calculated. Overall, the rate of MAiD recipients increased substantially with age (Figures 2,3). Among Track 1 recipients, higher rates were seen among males for nearly all 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

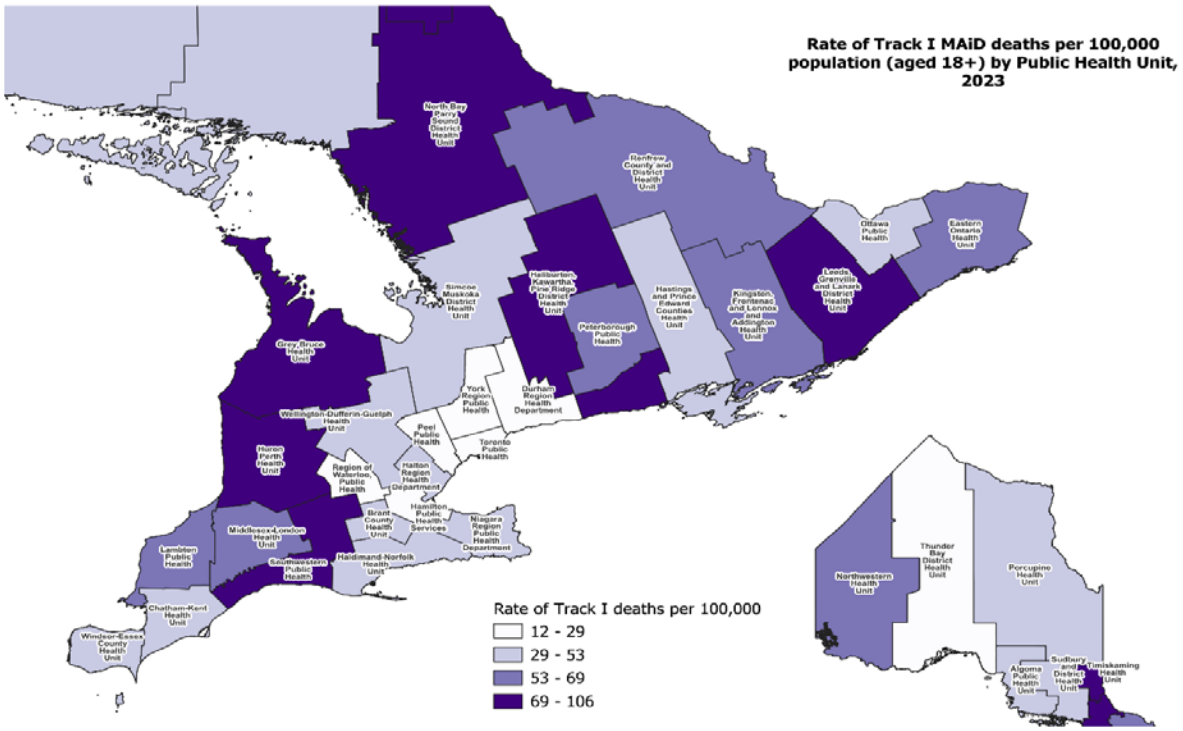
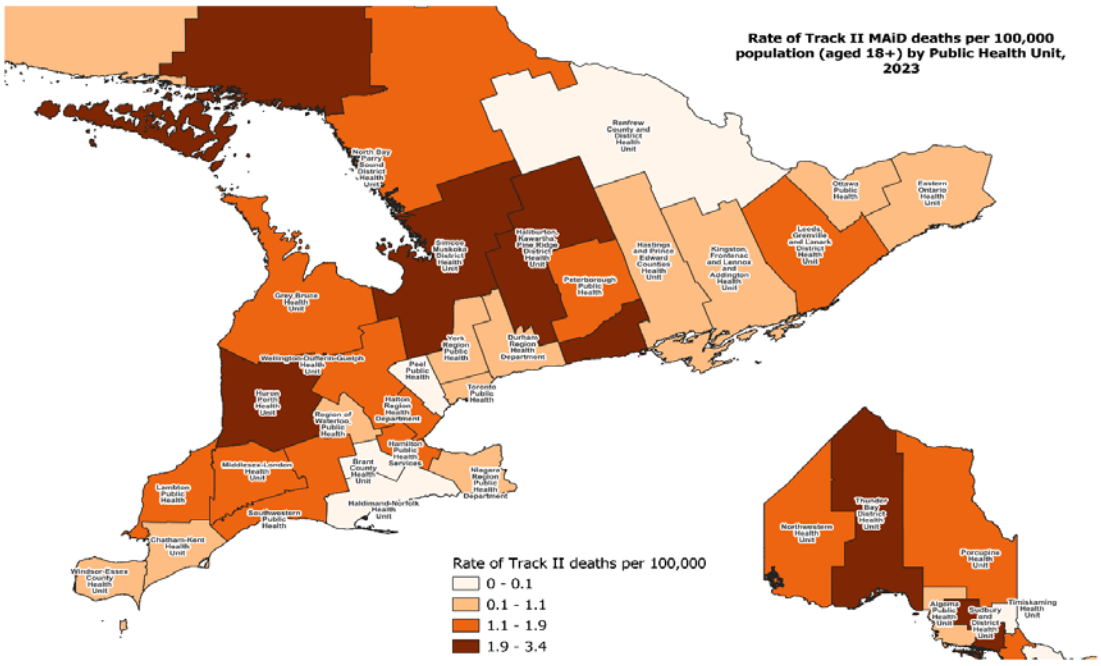


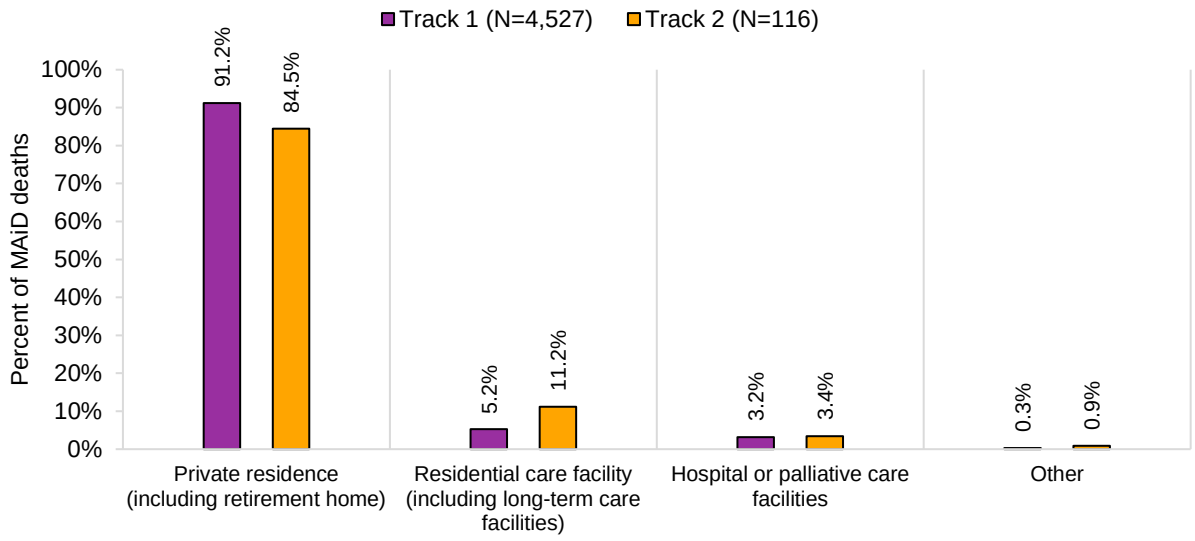
Figure 5. Rate of Track 2 MAiD Deaths per 100,000 Population (aged 18+) by Public Health Unit, 2023



Housing

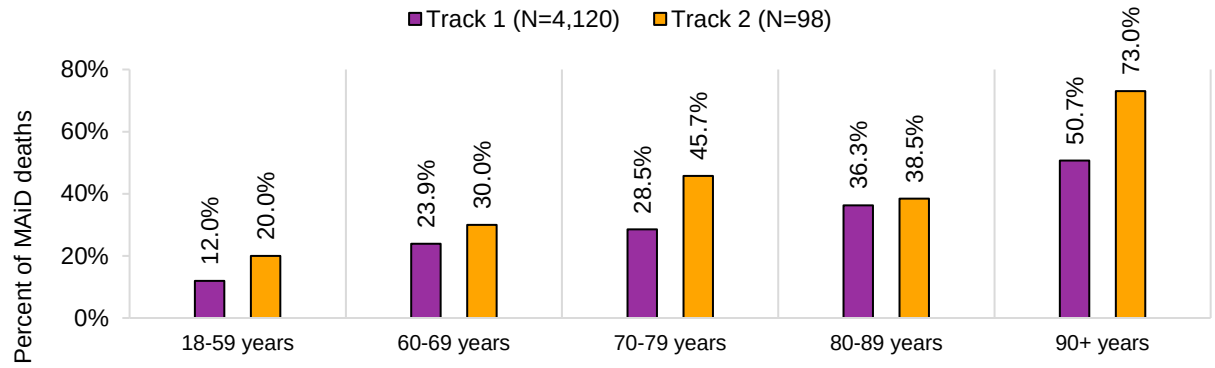
Mandatory reporting for MAiD requires the type of housing and living situations for all recipients of MAiD be specified. The majority of persons who accessed MAiD via both tracks were living in private residences, including retirement homes (Figure 6). A slightly higher proportion of Track 2 recipients 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

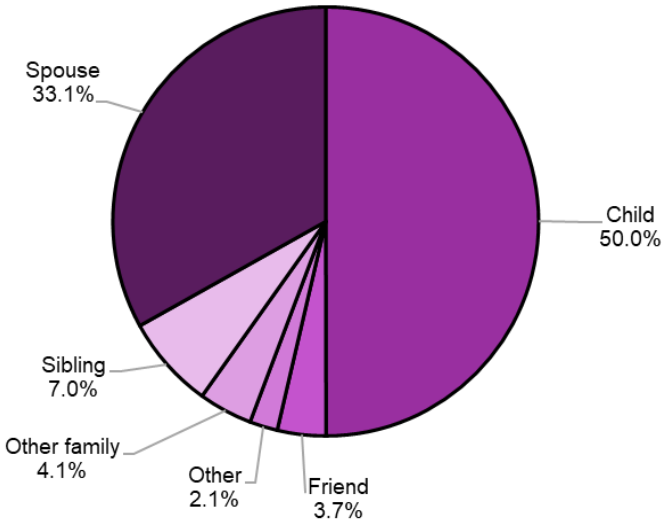
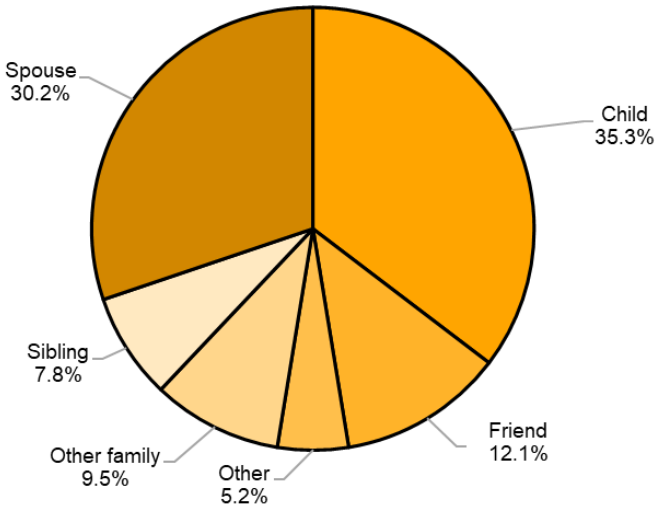


Figure 9. Figure 9. Distribution of Track 2 MAiD Recipients (N=116) 'Next of Kin' by Relationship, 2023



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

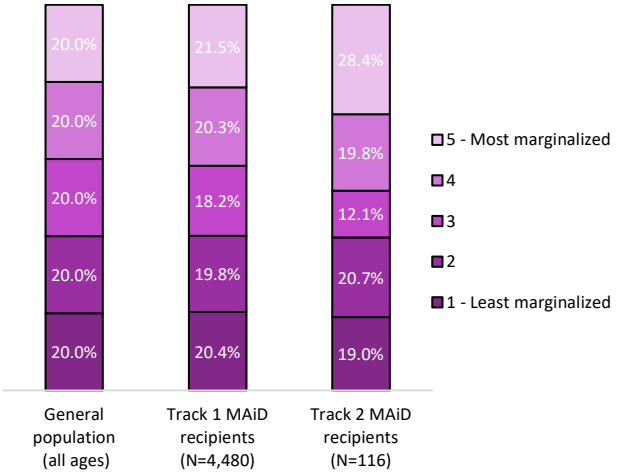


Figure 11. Distribution of MAiD Recipients by Level of Marginalization**: Households and Dwellings Dimension**, 2023

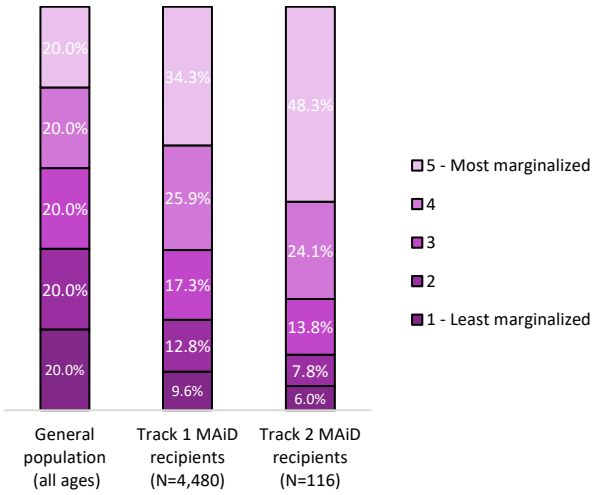


Figure 12. Distribution of MAiD Recipients by Level of Marginalization: **Age and Labour Force Dimension**, 2023

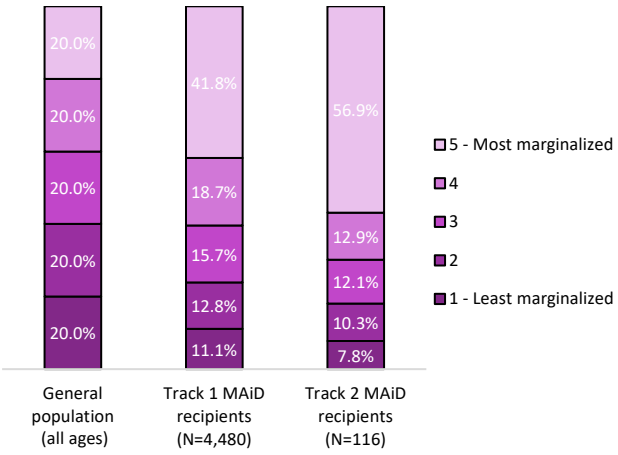
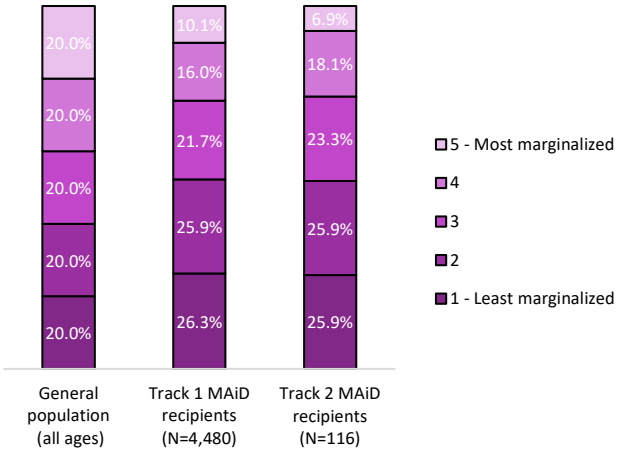


Figure 13. Distribution of MAiD Recipients by Level of Marginalization: **Racialized and Newcomer Population Dimension**, 2023



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

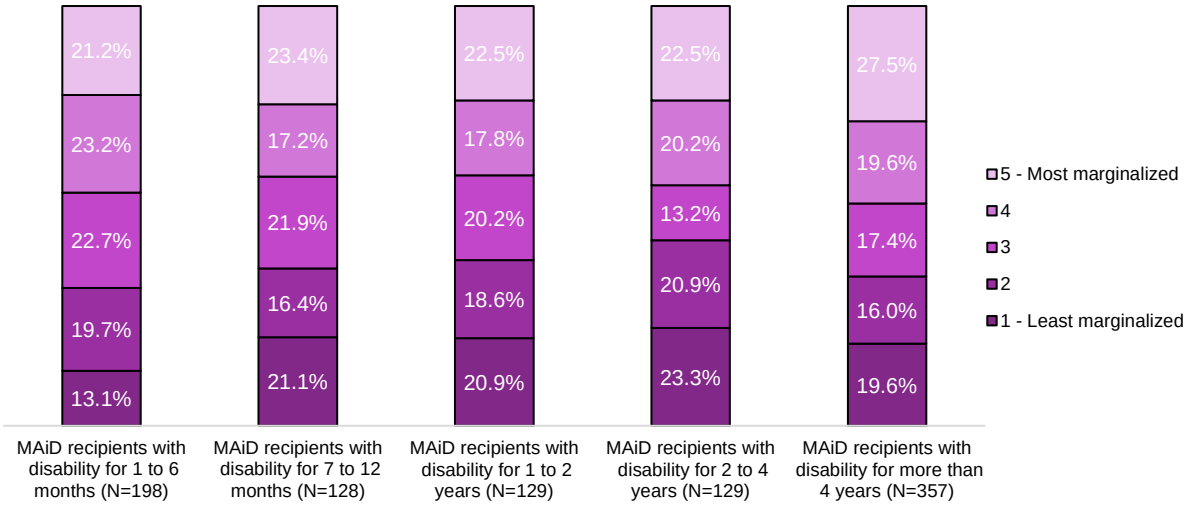
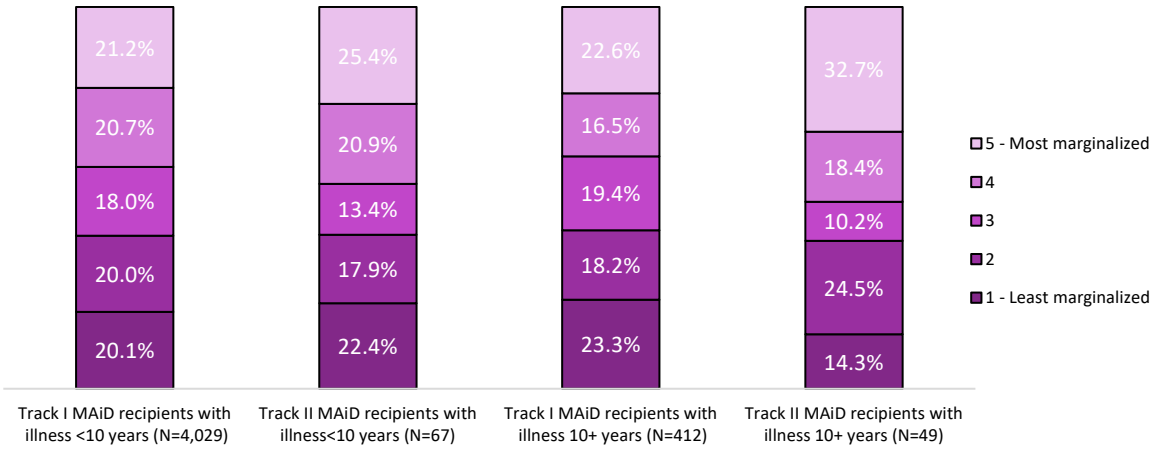


Figure 15. Distribution of MAiD Recipients by Level of Marginalization: Material Resources Dimension, and Length of Time with Serious Illness, 2023



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

[5] For copies of this document, please email occ.maid@ontario.ca.

REFERENCES

[i] Government of Canada. (2021). Bill C-7. Retrieved from: Bill C-7: An Act to amend the Criminal Code (medical assistance in dying) (justice.gc.ca)

[ii] Health Canada (2023). Advice to the Profession. Retrieved from: advice-profession.pdf (canada.ca)

[iii] United Nations. (2021). Disability is not a reason to sanction medically assisted dying – UN experts. Retrieved from Disability is not a reason to sanction medically assisted dying – UN experts | OHCHR.

[iv] Statistics Canada. (2023). Canadian Survey on Disability, 2017 to 2022. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/231201/dq231201b-eng.htm

[v] Ontario Human Rights Commission (2016). Policy on Abelism and Discrimination based on Disability. Retrieved from: Policy on ableism and discrimination based on disability | Ontario Human Rights Commission (ohrc.on.ca)

[vi] See further discussion: Shakespeare, T.Lezzoni, L., Groce, N. (2009). Disability and the training of health professionals. *The Lancet (374)*9704, P1815-1816. Retrieved from Disability and the training of health professionals - The Lancet

[vii] Health Canada. (2015). First Nations Mental Wellness Continuum Framework. Retrieved from: 24-14-1273-FN-Mental-Wellness-Framework-EN05_low.pdf (thunderbirdpf.org)

[viii] Live Work Well Research Centre. (2021). Disability Inclusion Analysis of Lessons Learned and Best Practices of the Government of Canada's Response to the COVID-19 Pandemic. Retrieved from: Disability Inclusion Analysis of Lessons Learned and Best Practices of the Government of Canada's Response to the COVID-19 Pandemic (liveworkwell.ca)

[ix] See article on family involvement: A complicated grief: Living in the aftermath of a family member's death by MAID - The Globe and Mail

[x] Nafilyan, Vahe et al. (2023). Risk of suicide after diagnosis of severe physical health conditions: A retrospective cohort study of 47 million people. The Lancet Regional Health, 25, 1-10.

[xi] Tchajkova, N., Ethans, K., & Smith, S. D. (2021). Inside the lived perspective of life after spinal cord injury: a qualitative study of the desire to live and not live, including with assisted dying. *Spinal cord*, *59*(5), 485–492. https://doi.org/10.1038/s41393-021-00619-3

[xii] Lezzoni, L. I., Rao, S. R., Ressalam, J., Bolcic-Jankovic, D., Agaronnik, N. D., Donelan, K., Lagu, T., & Campbell, E. G. (2021). Physicians' Perceptions of People With Disability And Their Health Care. *Health affairs (Project Hope)*, *40*(2), 297–306. https://doi.org/10.1377/hlthaff.2020.01452

[xiii] Mental Health Commission of Canada. (2024). Peer Support. Retrieved from: Peer Support - Mental Health Commission of Canada

REPORT AUTHORS

REPORT ISSUED ON BEHALF OF THE MAID DEATH REVIEW COMMITTEE:

Dirk Huyer, MD

Naomi Kasman, MSc

Marie Loughnane, NP, MScN

Melissa Tuinema, RN, MSc(AH)

ACKNOWLEDGEMENTS:

MAiD Review Team (MRT)

Data Analytics for Safety and Health (DASH) Unit

MAID DEATH REVIEW COMMITTEE:

Ramona Coelho, MDCM, CCFP

Katherine Kortes-Miller, MSW, PhD

Trudo Lemmens, LicJur, LLM (spec. bioethics), DCL

Paul Links, MD, FRCPC

Julie Maranda, MDCM, MHSc, (F)CCFP, MBA

Paula Pequegnat, NP

Melissa Pretty, RN, BScN

Kevin Reel, OT Reg (Ont), MSc (medical ethics)

Sarah Rogers

David Shannon, C. M., O. Ont., LLM Barrister-and-Solicitor

Osmaan Sheikh, MD, CCFP

Donna Stewart, CM, MD, FRCPC

Eric Thomas, MD

Konia Trouton, MD, MPH, FCFP

Marissa Weiler, NP

Bill Wong, MD, FRCPC