2024

MDRC Report 2024 – 4: Complex Same Day / Next Day Provisions

Navigating Complex Issues within Same Day and Next Day MAiD Provisions

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. The majority of reported MAiD deaths in 2024 (N=4,356 or 88% of all MAiD deaths) reviewed by the MAiD Review Team were evaluated to have met all legislative requirements, with no additional complexities identified requiring further evaluation. Approximately 602 MAiD deaths in 2024 required further in-depth review (N=321) or went on to require an investigation (N=281).[1]

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 legislation, practice, and care. 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).

[1] Preliminary overview of 2024 data. A small number of MRT reviews are pending final review outcomes.

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 or 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.

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INTRODUCTION

Prior to March of 2021, legislation (Bill C-14) for Medical Assistance in Dying (MAiD) included a safeguard for a 10-day reflection period, starting the day after a person completed their written request for MAiD. This safeguard was intended to provide persons with time to consider their request and provide insight into the consistency of their request for MAiD. However, there were some unintended consequences associated with adhering to this safeguard, including implications for ongoing symptom management to avoid a loss of capacity to provide final consent. As such, with the enactment of Bill C-7, the safeguard requirement for a 10-day reflection period was removed. Accordingly, for persons with a reasonably foreseeable natural death (RFND), MAiD is legislatively permitted to occur once eligibility criteria and safeguards are met.

The MDRC reviewed a selection of Track 1 MAiD deaths where the request and the provision of MAiD occurred close together, typically within a 24-to-48-hour period. Same day or next day provisions only occur in a small proportion of Track 1 MAiD deaths (219 (4.8%) of Track 1 MAiD deaths in 2023). Most often, the provision of MAiD within the same day or next day of a written request are completed for persons who present with profound intolerable suffering, severe clinical and functional decline (i.e., imminent death), and/or when there is a risk for loss of decisional capacity to provide informed consent[2]. With appropriate resources and expertise to provide MAiD safely and in accordance with legislation, most MDRC members opined that this practice was likely in-keeping with quality care when aligned with a requestor's decision for same. More conservatively, some MDRC members opined that navigating same day or next day provisions should remain an exception in MAiD practice.

For this MDRC review, three same day or next day MAiD deaths were selected for having complex medical presentations and circumstances, potentially benefiting from additional consideration within the MAiD process. These complex presentations were illustrative of unique circumstances that may occur when providing same day or next day provisions. MDRC members aimed to share learnings that may assist MAiD practitioners with identifying practice or legislative considerations when navigating complex same day or next day requests for MAiD.

TOPIC OVERVIEW

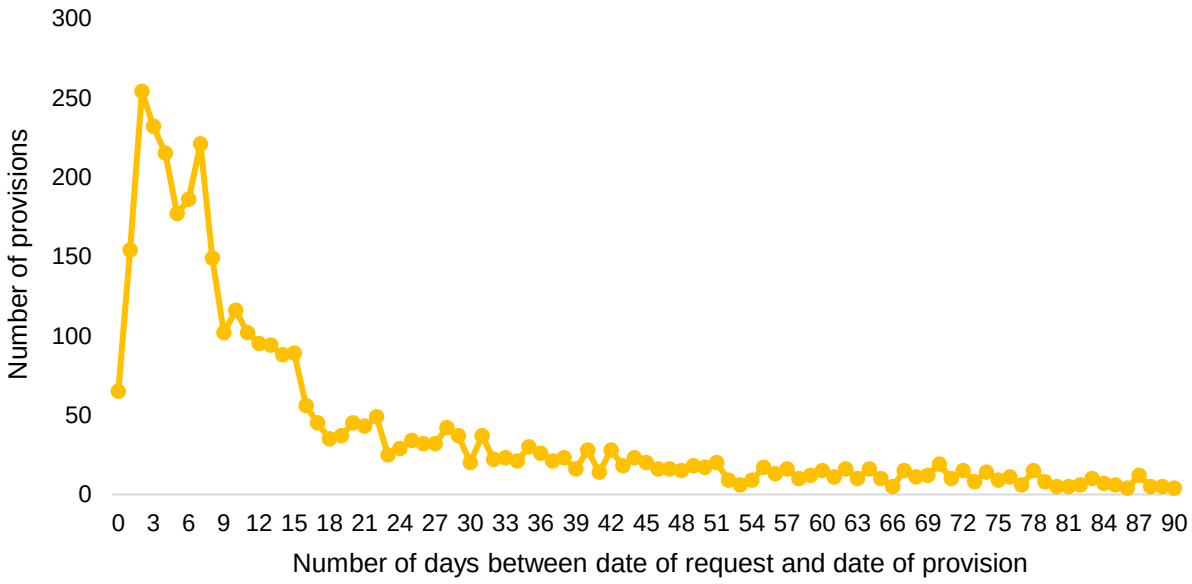
In 2023, 4,528 MAiD provisions were reported via Track 1 safeguards for a Reasonably Foreseeable Natural Death (RFND). Most Track 1 deaths occurred within 90-days of a

[2] MAiD Review Team (MRT) reviewed available documentation from a sample (n=67) of same day MAiD deaths reported in 2023.

request[3] for MAiD (N=3,749; 82.8%). The distribution of these deaths in the first 90 days is presented in Figure 1.

A small proportion (4.8%) of all Track 1 MAiD deaths occurred on the same day or next day of a request for MAiD. In 2023, 65 MAiD provisions (1.4% of Track 1 MAiD deaths) occurred on the same day of a request and 154 MAiD provisions (3.4% of Track 1 MAiD deaths) occurred on the next day of a request.

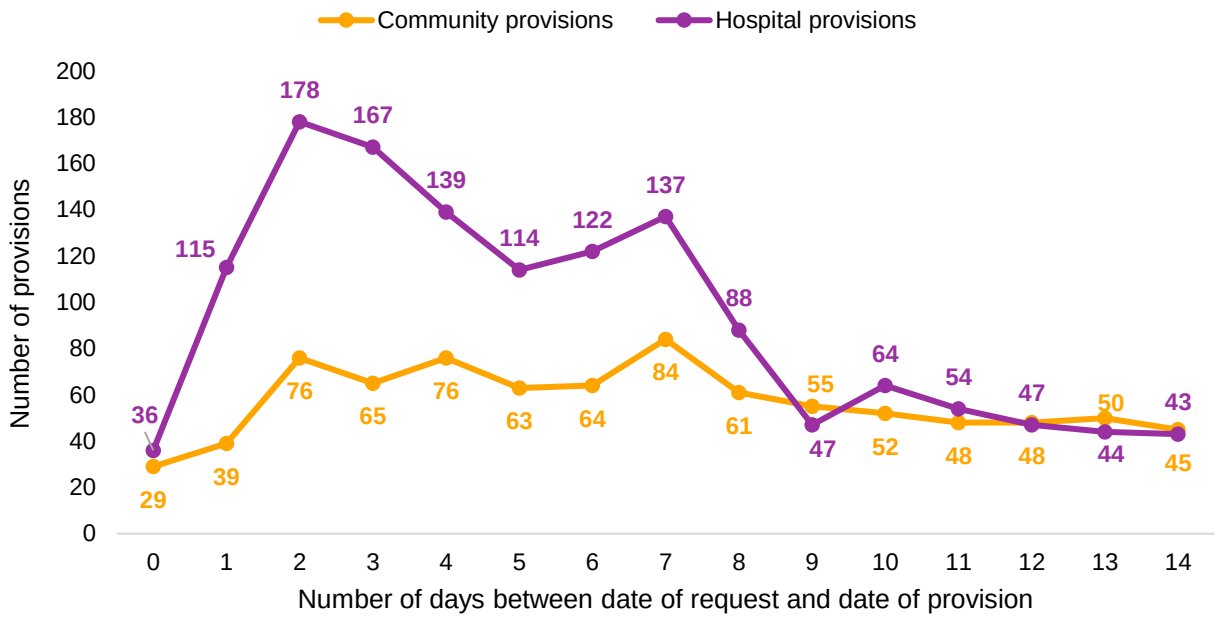
Figure 1. Number of Track 1 Provisions in Ontario in the 90 Days Following Request for MAiD, by Time Since Request, 2023



When accessing MAiD within 14 days following a MAiD request, MAiD provisions occur in hospital more frequently than in the community (Figure 2). Specifically, 7.1% of Track 1 provisions completed in hospital occurred on the same or next day after a request, compared to 2.8% of Track 1 provisions completed in the community that occurred on the same or next day after a request.

[3] The written/verbal request date is required reporting for Health Canada. The date of the request does not always reflect the date of a formal written request (i.e., Clinician Aid A).

Figure 2. Number of Track 1 Provisions in Ontario in the 14 Days Following a Written Request for MAiD, by Time Since Request and Location of Provision, 2023



The causes of death (as reported on the Medical Certificate of Death) for same day and next day provisions are presented in Table 1. Two-thirds of requestors of same day or next day MAiD provisions had a cancer-related illness. The next most common cause of death was a cardiovascular condition, at 14.6%. Less than 1% of same day or next day provisions were for persons who had been diagnosed with complex chronic conditions, musculoskeletal conditions, and autoimmune conditions. None of the same day or next day provisions that occurred for persons with a neurodegenerative condition involved a diagnosis of dementia.

Table 1. Distribution of all Provisions and Same Day or Next Day Provisions in Ontario by Cause of Death, 2023

Cause of Death (Medical Certificate of Death)	# Same Day/Next Day Provisions	Distribution of Same Day/Next Day Provisions	Distribution of all Track I Provisions
ALL CAUSES	219	100.0%	100.0%
Cancer-related	147	67.1%	57.1%
Cardiovascular	32	14.6%	11.0%
Other	14	6.4%	6.7%
Respiratory	13	5.9%	9.8%
Gastrointestinal disorder	8	3.6%	1.9%
Neurodegenerative	3	1.4%	9.0%
Complex chronic	1	0.5%	2.6%
Musculoskeletal	1	0.5%	1.4%
Autoimmune	0	0%	0.4%

In addition to differences seen in the underlying cause of death among those who received MAiD on the same day or next day after their request, there were differences in how persons who accessed MAiD described the nature of their suffering (Figure 3) and the nature of their functional decline (Figure 4). Additional detail regarding these figures can be found in Table A1 of the Appendix.

Figures 3 and 4 demonstrate that persons with same day or next day provisions were more likely to report the loss of control of bodily functions and inadequate pain control as reasons for their suffering than those with longer periods prior to their provisions. More commonly, reduced oral intake or difficulty swallowing, cachexia, and persistent or escalating chronic pain were reported as the main contributors to their decline in capability. Those with same day or next day provisions less commonly reported that their suffering was related to being a perceived burden on family or friends, and isolation or loneliness.

Figure 3. Nature of Suffering Among Track 1 Provisions in Ontario by Time Between Request and Provision, 2023

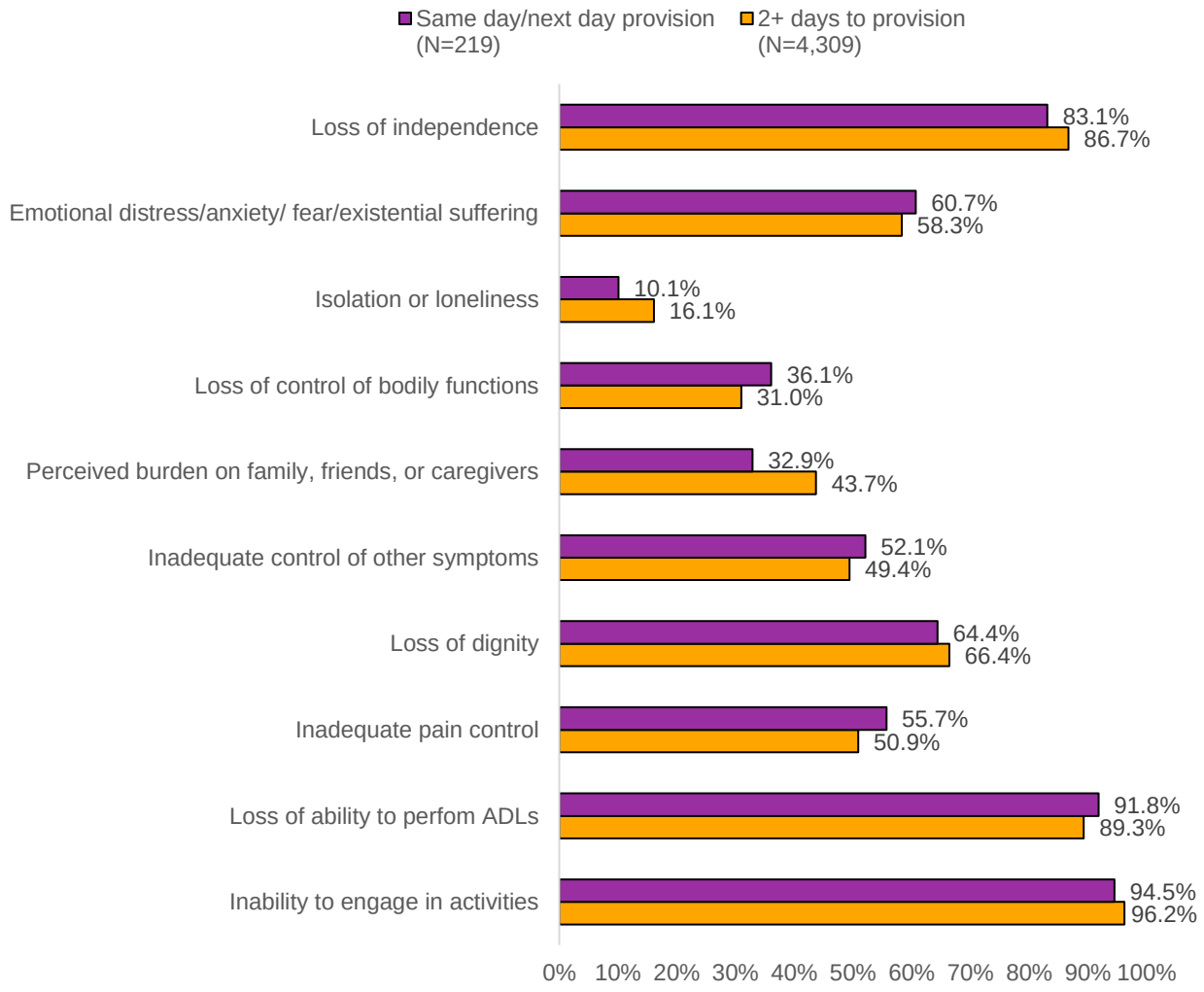
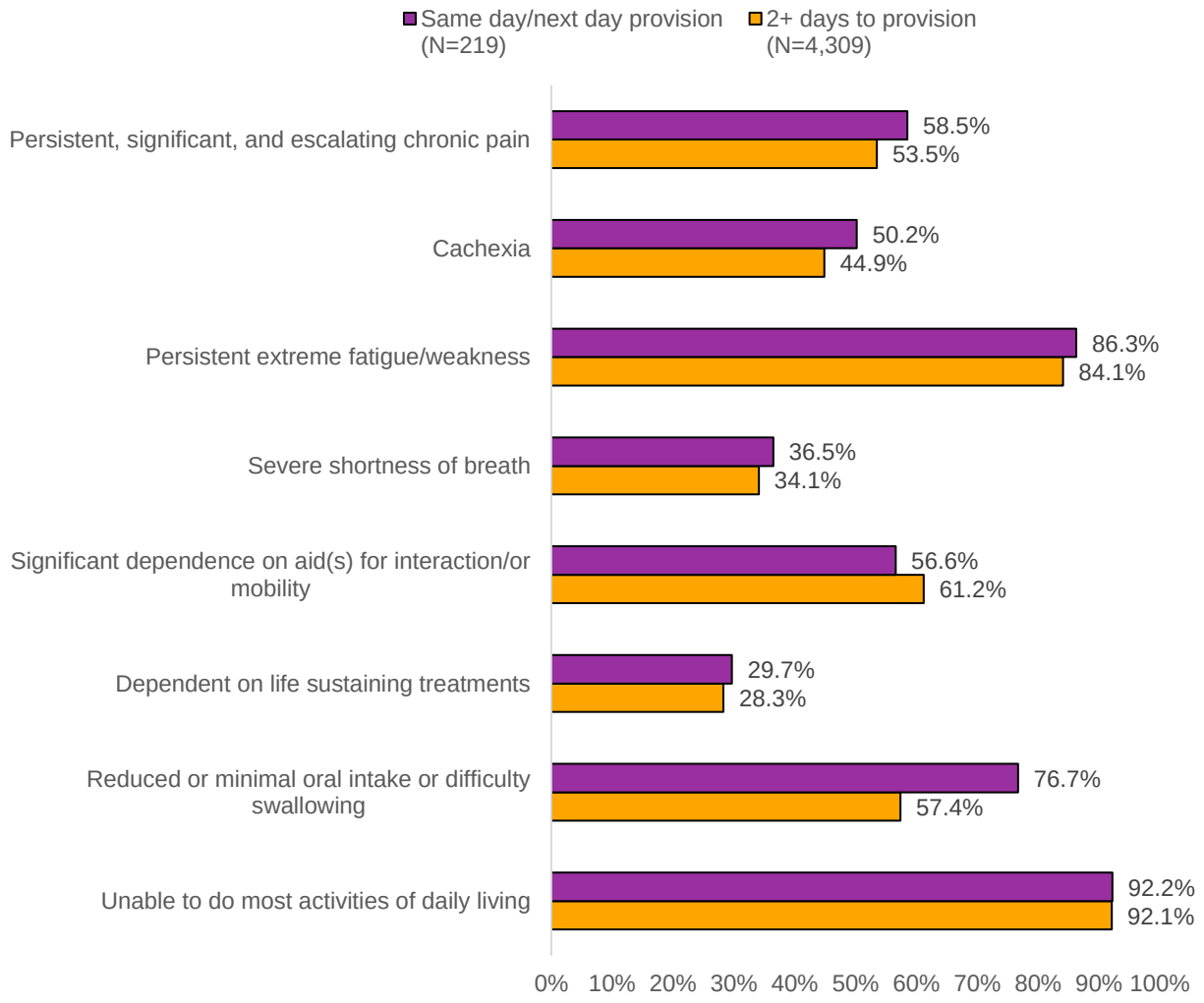


Figure 4. Nature of Functional Decline Among Track 1 Provisions in Ontario by Time Between Request and Provision, 2023



A greater number of MAiD providers (N=360) facilitated hospital-based MAiD provisions than community-based provisions (N=293), with a total of 463 unique providers across both hospital and community settings. A larger proportion of hospital-based practitioners have completed same day or next day provisions, in contrast to community-based practitioners (Table 2). There was a total of 97 unique providers who offered same day or next day provisions in either a hospital or community setting; however, ten of the 97 MAiD providers completed 40% of these same day or next day provisions.

Table 2. Number and Percent of Providers Offering Same Day or Next Day Provisions in Ontario, 2023

Provider Metrics	Hospital Provisions	Community Provisions	All Provisions
Total MAiD providers	360	293	463
MAiD providers with same day/next day provisions	83	23	97
Percent of all providers with same day/next day provisions	23.1%	7.8%	21.0%

Table 3 outlines care, disability, and provider metrics for same day or next day provisions. The timing of the request to provision of MAiD did not illustrate any notable differences for those receiving palliative care. In contrast, persons accessing MAiD via a same day or next day provision were less likely to self-report a disability or require disability supports.

The majority of same day or next day provisions were provided by physicians. Only 5% of same day or next day provisions were provided by nurse practitioners, compared to nearly 12% of provisions provided by nurse practitioners two or more days following a request. There were no differences observed among practitioners when a person accessing MAiD had a previous request, or a previous healthcare interaction with the MAiD provider.

Table 3. Palliative care, Disability Metrics, and Provider Metrics by Time Between Request and Provision, 2023

Care, Disability, and Provider Metrics	Same Day/Next Day Provision (N=219)		2+ Days to Provision (N=4,309)	
	Number	Percent	Number	Percent
Received palliative care	181	82.6%	3,445	79.9%
Self-reported disability	25	11.4%	1,059	24.6%
Disability support received	83	37.9%	2,038	47.3%

Previous MAiD request	4	1.8%	72	1.7%
Previous healthcare interaction with MAiD provider	40	18.3%	713	16.5%
Provider was a physician	208	95.0%	3,812	88.5%
Provider was a nurse practitioner	11	5.0%	497	11.5%

Regionally, the West region of Ontario had the most Track 1 MAiD provisions (37.4%), and more than half of all same day or next day provisions (Table 4). The fewest same day or next day provisions occurred in the North West region, which also had the lowest overall proportion of Track 1 provisions.

Table 4. Regional Distribution of MAiD Provisions in Ontario by Time Between Request and Provision, 2023

Region	All Track 1 Provisions	Proportion of all Track 1 Provisions	Number of Same day/next day provisions	Proportion of all same day/next day provisions
Central	867	19.4%	37	17.1%
East	1,264	28.3%	35	16.1%
North East	288	6.5%	15	6.9%
North West	76	1.7%	6	2.8%
Toronto	298	6.7%	13	6.0%
West	1,668	37.4%	111	51.2%

Some variations for the source of the MAiD request were also observed (Table 5). Persons with same day or next day provisions were much more likely to have directly requested MAiD from the MAiD provider, rather than navigating their request through a care coordination service.

Table 5. Distribution of MAiD Provisions in Ontario by Source of Request and Time Between Request and Provision, 2023

Source of MAiD Request	Same day/next day provision (N=219)		2+ days to provision (N=4,309)	
	Number	Percent	Number	Percent
Person directly	73	33.3%	1,053	24.4%
Care coordination service	87	39.7%	1,983	46.0%

Another practitioner or preliminary assessor	57	26.0%	1,102	25.6%
Another third party	2	0.9%	171	4.0%

COMMITTEE REVIEW

CASE 4A

CASE OVERVIEW

Mr. A was a male in his 90s who had requested MAiD, approximately four months prior to his death. At the time, Mr. A was found ineligible. He did not meet the legislative criteria for a grievous and irremediable condition. Mr. A's spouse had passed during the time between the findings of ineligibility and his subsequent request for MAiD.

Approximately a month after his denied MAiD request, Mr. A developed a SARS-Cov-2 infection. He medically recovered after a short illness period. Mr. A reported some residual weakness, although there was no significant impact to his function or ability to live independently.

During this period, Mr. A experienced a relapse of alcohol use disorder, possibly attributed to complicated grief from the loss of his spouse. He had poor oral intake of fluid and nutrition.

A month later, Mr. A presented to urgent care with a three-day history of falls and weakness, diarrhea, and pain. He was assessed to have deconditioning from his previous SARS-Cov-2 infection and dehydration. He was discharged home after treatment. Approximately a week later, he was admitted to hospital for weakness and falls. The attending practitioner assessed his falls to be precipitated by alcohol use and decreased oral intake of other fluids. He was rehydrated. He was also referred to psychiatry due to sustained suicidal ideation and periods of self-administering increased doses of pain medications.

Approximately a week after his admission to hospital, he was voluntarily admitted to a psychiatric unit in a religiously affiliated acute care institution. Upon assessment by a psychiatrist, he was converted to an involuntary admission. Shortly after transfer to the psychiatric unit, Mr. A expressed significant pain to his upper arm. He was assessed to have a probable muscle injury (i.e., strain) and treated with opioid analgesia. Opioid analgesic had to be subsequently discontinued due to respiratory depression. Mr. A continued to report unresolved pain.

Mr. A's involuntary psychiatric admission was extended via a Form 4 under the Mental Health Act. He did not have continuity of care with his treating psychiatrist (planned absence). During this admission, Mr. A continued to express a desire for MAiD.

During Mr. A's psychiatric admission, he experienced marked functional decline. He required assistance with all activities of daily living; he was bedbound and required a Hoyer lift for transfers.

Due to his continued desire for MAiD and experience of functional decline, Mr. A's family liaised with the previously involved MAiD practitioner (who had periodically received communication from Mr. A) for another MAiD assessment to be completed. A MAiD assessment was planned to occur outside of the mental health facility at a partner hospital due to institutional policies (religious affiliation) restricting MAiD assessments and provisions. The MAiD assessment at the partner hospital was cancelled due to lack of meeting room availability.

The MAiD provider elected to complete a virtual assessment facilitated by family via phone the same day while Mr. A. was still admitted to the acute care facility under psychiatry. This assessment was not made known to the in-patient treatment team. The MAiD practitioner found Mr. A to be capable during the assessment and he was able to articulate his suffering in the context of pain, shortness of breath, functional decline, and loss of independence. A second MAiD practitioner completed an assessment virtually, immediately following the first MAiD practitioner's assessment. During these assessments, Mr. A reported stabbing pain in his leg, shortness of breath, wheezing, and poor energy. He was given a presumptive diagnosis of complications related to his SARS-Cov-2 infection and possible heart failure. No additional clinical investigations were undertaken.

During the assessments, the secondary assessor observed that Mr. A had a bulge in his left shoulder. Following the MAiD assessment, the family advised the treatment team. The treatment team transferred him to the partner hospital for assessment. In urgent care, Mr. A was found to have a dislocated shoulder. He received multiple reductions, and the urgent care team immobilized the joint for stability.

While Mr. A was in the emergency department, the MAiD provider attempted to facilitate discharge from hospital and arrange necessary transportation. The emergency physician declined a request for discharge, and returned Mr. A to the psychiatric care team (due to Form 4 via Mental Health Act).

The next day the MAiD provider spoke with the treating psychiatrist who agreed to discharge Mr. A home for MAiD. The psychiatrist offered clinical perspective that Mr. A's clinical presentation of functional decline was inconsistent day-to-day and between activities (e.g., could not hold utensils, but could reposition self). The MAiD provider did

not document further considerations regarding these perspectives or provide additional assessment as part of the MAiD process. Mr. A received MAiD the same day he was discharged home.

DISCUSSION

Discussion of Urgency

Multiple members identified that they would not define this MAiD death within the parameters of a same day or next day provision. These members offered that there was an existing relationship between the MAiD provider and the requestor. The MAiD practitioner had a baseline understanding of Mr. A's request for MAiD; he had been previously assessed by this same provider and found ineligible. These members also believed there was an established continuity of care attributed to some on-going communication.

Despite this existing relationship, most members agreed that the short period between the virtual assessments where Mr. A was found eligible for MAiD and the next day provision did not promote a quality approach to MAiD. Namely, most members opined that this next day timeframe did not allow for necessary investigation of Mr. A's conditions, collaborating with the treatment team, nor offering alternate treatment and care. Moreover, most members identified that there was not a clearly documented need for the urgency.

A few members shared that in their experience it is not uncommon for requestors to identify a preference for a same day provision. However, some members offered that sufficient opportunity was required to understand how Mr. A's cognitive and mental state may have influenced his request and decisional capacity. Other members noted that the final mental status exam by the hospital psychiatrist identified little concern.

Some members familiar with MAiD practice identified a possible pattern where the exploration of MAiD starts much earlier than the formal assessment process. Persons often wish to delay their formal request until they are closer to their decision to access MAiD. In many of these cases, the relationship and assessment for MAiD has begun long before the formal written request. In the case of Mr. A, the relationship had been initiated following a prior request with that assessment leading to a finding of ineligibility.

Grievous and Irremediable Condition & Safeguards

Some members questioned the evaluation of the grievous and irremediable criteria due to a complex clinical presentation. In particular, these MDRC members identified that Mr. A had previously been found ineligible for MAiD due to a lack of a grievous and irremediable condition. MDRC members discussed that a comprehensive approach to

documenting Mr. A's diagnosis, in particular, the diagnostic evaluations undertaken to confirm and communicate a grievous and irremediable condition that confirmed eligibility was not evident in the documentation reviewed. In particular, the MAiD practitioner identified Mr. A's cause of death as "congestive heart failure"; however, there were no diagnostic tests, medications, or clinical symptoms typical for this condition.

Most MDRC members recognized Mr. A's presentation as complex with multiple conditions and issues contributing to his functional decline and suffering: acute pain from a dislocated shoulder, frailty with possible cognitive impairment (not yet diagnosed), and possible mental health concerns impacting his initial admission to hospital. Due to the complex presentation, some members expressed concern that the MAiD practitioners' approaches to the evaluation of legislative criteria for a grievous and irremediable condition could not be understood. Specifically, many members stated that the documentation of Mr. A's grievous and irremediable condition was not adequately described. Moreover, many members opined that a comprehensive approach to assessment, treatment and care was necessary to address his clinical presentation and offer alternate options. These members suggested that sufficient opportunity was required to facilitate expert consultation with a psychiatrist, a geriatrician, and an occupational therapist. Other members noted that the eligibility assessment outlined Mr. A's unwillingness to have further investigations.

Some members presented uncertainty regarding whether death was reasonably foreseeable, apart from Mr. A's advanced age. These members questioned whether Mr. A should have been found eligible via track 2 safeguards for a non-reasonably foreseeable natural death. They offered that reports of Mr. A's clinical presentation were inconsistent; hence, his end-of-life functional trajectory was difficult to predict. Other members noted that the MAiD provider had known Mr. A previously and may have been observing (although not clearly documented) a decline, as well as new symptoms following an acute illness.

This theme was not discussed in further detail due to alignment with a previous report. Practice considerations for exploring complex medical conditions can be explored further within MDRC Report 2024.2: Navigating Complex Conditions in Non-Reasonably Foreseeable Natural Deaths.

Concurrent Mental Health Issues and Capacity

Some members offered their perspectives that diagnosis, treatment, and care for mental health issues experienced by Mr. A (e.g., substance use, possible but unconfirmed complicated grief, suspected depression) were necessary considerations within the MAiD eligibility process. These members opined that these mental health issues

required evaluation of possible and on-going treatments for Mr. A to be found eligible for MAiD. A few members stated their opinion that the mental health conditions solely or largely contributed to Mr. A's condition and suffering. In contrast, a few members did not view mental health conditions as impacting the MAiD request and eligibility.

Some MDRC members expressed views of insufficient evaluation and documentation of capacity given possible concerns with insight and judgement that could be associated with an involuntary admission under the Mental Health Act. Others noted that Mr. A was discharged home by the attending psychiatrist with some questions about physical functional status, but no documented concerns about capacity.

Some MDRC members questioned whether the psychiatric care process influenced Mr. A's request and decision to access MAiD. Some members opined that the involuntary psychiatric admission, in addition to possible continuity of care issues (i.e., availability of the treating psychiatrist) contributed to Mr. A's distress. Some members discussed that Mr. A may have experienced a loss of control that informed his request for MAiD.

This theme was not discussed in further detail due to alignment with a previous report. Practice considerations for concomitant mental health conditions can be explored further within MDRC Report 2024.2: Navigating Complex Conditions in Non-Reasonably Foreseeable Natural Deaths.

Institutional Processes (Religious Affiliation)

Multiple members opined that institutional processes (religious affiliation) presented barriers to facilitating timely and quality MAiD assessment and care. Specifically, for this case, the following areas of MAiD care were discussed: requirement to complete a virtual assessment for a person presenting with a complex clinical presentation, perceived or actual inability for the requestor, family or MAiD assessors to collaborate or communicate with the inpatient care team, and need for covert MAiD assessment processes due to the person's and family's awareness of the institution's MAiD policies. Most members recognized that navigating MAiD within the religious affiliated institution caused distress for the requestor and family, and thereby was not aligned with quality MAiD care. Moreover, some members identified that institutional processes may have also, in-part, necessitated a next day provision due to Mr. A's likely inability to function independently upon discharge. Some other members felt that the health care providers in the institution may have appropriately prioritized the need to provide quality care for a person dealing with significant mental health and physical issues. Other members reflected that those same health care providers may have been largely unaware of the ongoing MAiD assessment process, rather than acting in a manner that would appear to be preventing access to MAiD.

Comprehensive Medical Care

Some MDRC members were concerned that Mr. A did not receive appropriate geriatric care. During his initial presentation, these MDRC members offered perspective that Mr. A's functional decline may have been reversible with appropriate access to geriatric care to address geriatric domains or syndromes (i.e., physical deconditioning, pain). Some members were concerned that Mr. A's decision to access MAiD was thereby informed, in part, by a condition that was potentially reversible. Some members identified possible quality-of-care issues, such as: limited screening, assessment, and treatment of functional decline; and access to and continuity of medical and rehabilitative care. These members offered their clinical perspectives that Mr. A's presentation was multi-factorial, in keeping with frailty. The psychiatric care team may not have had the knowledge and skills to effectively provide a geriatric approach to care. Some MDRC members questioned whether institutional barriers may have prevented Mr. A from receiving the care necessary to treat his physical decline (i.e., psychiatric care team's ability to communicate and consult with a medical or rehabilitative care team). From the documentation, it is unclear if the MAiD practitioners evaluated (or had the opportunity to evaluate) whether Mr. A was informed of the possibility that his functional decline was potentially reversible and presented with the option for transfer to a rehabilitative care facility.

Professional Boundaries

A few members identified concerns regarding the nature of the relationships between the MAiD practitioner, requestor and family. These members presented concerns that maintaining on-going informal communication, outside of clinically arranged follow-up, may present risk for undue influence within MAiD practice. MAiD practitioners are required to report MAiD requests that do not result in a provision; hence, some opined that further follow-up was not necessary. Other members noted that some clinicians are available to their patients more informally than others. Such informal communication may support avoiding rushed provision timelines through the facilitation of a more coordinated administrative process for arranging MAiD assessments and provisions and assist patient and family end-of-life decision-making.

A few members identified that a MAiD practitioner should not have a role in arranging transportation for a provision. MAiD provision arrangements should be self-arranged or supported by family to avoid perceptions of external influence. Others held the opposite opinion that this was illustrative of a patient-centered and compassionate clinician.

Practice considerations for professional boundaries can be explored further within MDRC Report 2024.3: Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths.

PRACTICE CONSIDERATIONS

Complex Diagnoses and Concomitant Mental Health Conditions:

- Please see MDRC Report 2024.2: Navigating Complex Conditions in Non-Reasonably Foreseeable Natural Deaths for practice considerations.
- MAiD practitioners should ensure, when possible, the MAiD assessment process allows time for comprehensive clinical evaluation of diagnoses, including arrangements for diagnostic testing/imaging and involvement of experts where indicated. MAiD practitioners may have to facilitate further investigations for the purposes of determining MAiD eligibility.
- MAiD practitioners should consider that adequate time is needed to ensure a requestor is informed of options to alleviate suffering, and that these options are appreciated, to provide informed consent.
- MAiD practitioners to consider coordinating in-person assessments, where possible, to facilitate a comprehensive approach to complex assessments (e.g., in-person interactions may be needed to complete a targeted physical assessment for uncertain diagnoses).
- MAiD practitioners should ensure that where the above practice considerations have been taken into account, their clinical documentation reflects it in adequate detail to convey to reviewers that their approach was comprehensive.

Approach to Same Day / Next Day MAiD Assessments and Provision:

- When considering urgent requests for MAiD, MAiD practitioners should evaluate the feasibility of facilitating quality care within the short time period. Communication with the requestor and family may be required to manage expectations and inform patient and family end-of-life decision-making.
- MAiD practitioners to recognize the importance of documenting the clinical and/or circumstantial rationale for facilitating an urgent provision (e.g., self-directed patient preference, outline specific circumstances necessitating urgency, or clinical presentation).
- MAiD practitioners should clearly and thoroughly document their approach to meeting legislative criteria and safeguards, attending to the possible considerations and challenges of providing MAiD in a short period of time (e.g., consistency of request, evaluation of potential reversibility of condition, consideration of alternate options to address suffering).
- MAiD practitioners to consider that adequate opportunity be given for reflective practice and contemplation of MAiD eligibility criteria and safeguards, in conjunction with clinical decision making, when evaluating urgent requests from persons accessing MAiD.

- MAiD practitioners and other concurrent treating teams should recognize the importance and benefit of effective communication and collaboration to achieve goals-of-care.

CASE 4B

Case Overview

Mrs. B was a female in her 80s who had a challenging medical trajectory following coronary artery bypass graft (CABG) surgery. She experienced several post-operative sequelae, including wound dehiscence, osteomyelitis, and respiratory failure. She required specialized care in hospital, including additional surgical procedures. Due to physical and functional decline, Mrs. B elected for a palliative approach to care. She was discharged home with palliative supports (i.e., palliative care team and home care support services, including adaptive aids and personal support services).

Mrs. B reportedly expressed her desire for MAiD to her family. In response, and on the same day, her spouse contacted a referral service on her behalf. The following day, a MAiD practitioner assessed her for MAiD eligibility. She reportedly told the MAiD assessor that she wanted to withdraw her request, citing personal and religious values and beliefs. She communicated that pursuing in-patient palliative care/hospice care and palliative sedation was more in-keeping with her end-of-life goals.

The next morning, Mrs. B presented to the emergency department (ED) of her local hospital. Her spouse was noted to be experiencing caregiver burnout. Mrs. B was assessed to be in stable condition, and thereby discharged home with continued palliative care. Her palliative care physician completed a referral for in-patient palliative care / hospice care due to her social circumstances (i.e., caregiver burnout). Her request was denied for not meeting hospice criteria for end-of-life, and a long-term care application was offered.

On the same day, Mrs. B's spouse contacted the provincial MAiD coordination service requesting an urgent assessment. A different MAiD assessor from the previous day completed a primary assessment and determined Mrs. B to be eligible for MAiD. The former MAiD practitioner was contacted. This MAiD practitioner expressed concerns regarding the necessity for 'urgency' and shared belief for the need for more comprehensive evaluation, the seemingly drastic change in perspective of end-of-life goals, and the possibility of coercion or undue influence (i.e., due to caregiver burnout). The initial MAiD practitioner requested an opportunity to visit with Mrs. B the following day to re-assess; however, this opportunity was declined by the MAiD provider due to their clinical opinion that the clinical circumstances necessitated an urgent provision. An additional MAiD practitioner was arranged by the MAiD coordination service to complete

a virtual assessment. Mrs. B was found eligible for MAiD by this third assessor. The provision of MAiD was completed later that evening.

Discussion

Discussion of Urgency

Some members positioned that an evaluation of a clinical rationale of ‘urgency’ is not a required consideration to inform the MAiD process. A reflection period is no longer a legislative requirement (Bill C-7); hence, clinical considerations and/or additional parameters around a request-to-provision timeline are not required. Same day and next day provisions are appropriate when legislative criteria and safeguards can be met, the timeline is directed by the requestor without external influence, and quality MAiD care and processes can occur within the timeframe.

Nonetheless, most members were concerned that there was no clinical indication for the MAiD assessments and provision to occur within the same day, with identifiable complex circumstances that may have benefitted from additional opportunity to explore and navigate. Contrastingly, a few members identified that there was some evidence of urgency due to declining function and palliative performance scale score (20% Palliative Performance Scale [PPS]) that may have indicated she was at risk for death or a loss of capacity. A few other MDRC members cautioned that a PPS score should be carefully considered and may not be an appropriate measure to inform a decision to facilitate MAiD urgently. Specifically, Mrs. B’s PPS score may have been reflective of her personal decisions (i.e., declined physiotherapy, choice to remain in bed), rather than representing an irreversible trajectory of decline.

Most members believed the short timeline did not allow all aspects of Mrs. B’s social and end-of-life circumstances and care needs to be explored. Members indicated areas that required further opportunity to explore or navigate as: the impact of being denied hospice care, additional care options, caregiver burden, consistency of the MAiD request, and divergent MAiD practitioner perspectives.

Access to Palliative Care

Many members identified that barriers to accessing inpatient palliative or hospice care (i.e., prognosis or PPS derived) was a likely factor contributing to the reason for accessing MAiD. Moreover, many members opined that poor quality end-of-life care potentially impacted the request for a brief MAiD provision timeline (i.e., concerns of burnout went unaddressed, advocacy for the necessity of admission to in-patient palliative care or hospice was not evident). Some members expressed their concern that access to MAiD was more easily organized and accessible in this circumstance than the previously requested and preferred option for end-of-life care.

Approach to MAiD Practice and Care

Divergent MAiD Assessor Perspectives

Most members agreed that divergent views of eligibility between MAiD assessors should be explored. Many MDRC members believed that the preferred approach for this circumstance may have been for the involved MAiD practitioners to consult an expert (e.g., potentially with psychosocial expertise), to assist them in exploring areas of divergent views and to facilitate continuity of care.

A few members believed that facilitating assessment by a third MAiD practitioner introduces risks associated with involvement of additional MAiD practitioners at a time of dissatisfaction with the involved practitioner, described by some as ‘doctor shopping’. In contrast, a small number of members with practice experience stated that the involvement of a third practitioner to facilitate a timely MAiD provision, in the context of profound suffering, was a reasonable approach to quality MAiD practice.

Spiritual Care

Some members brought forward concerns regarding the approach to discussions regarding religious beliefs within the MAiD process. A few members believed the approach to religious discussions (i.e., potentially influencing the requestor’s religious and personal values) raised concerns about professional boundaries. Multiple members identified that many churches and their members have perspectives on MAiD where this choice does not conflict with religious beliefs and values[i]. The MAiD provider may have been knowledgeable of varied thinking amongst faith-based groups (unconfirmed), and shared information that may have been valuable to the requestor and family.

Comprehensive MAiD Eligibility Assessments

Some members identified concerns of the ability to conduct a comprehensive MAiD eligibility assessment in the short timeframe. A few members raised findings consistent with potential cognitive impairment that was not documented as a potential consideration in the MAiD assessment.

Multiple members identified that the virtual assessment conducted by the second assessor may have been an insufficient approach to understanding the complete circumstances to determine eligibility. There was also uncertainty whether the third assessor had sufficient opportunity to access and review medical records for the completion of their MAiD eligibility assessment.

Provincial and Regional MAiD Coordination

Some members presented concerns that the provincial and regional MAiD coordination processes may not be effectively positioned within the healthcare system to coordinate preferred choices for end-of-life care. Some MDRC members discussed the implications of coordinating MAiD separately from other end-of-life care options, such as navigating and accessing MAiD more quickly than alternate, and possibly preferred, care options (i.e., hospice or in-patient palliative care). These members advocated for changes to the existing provincial care coordination system to respond to the evolving care needs of persons who are suffering. Other members asserted that changes to care coordination, such as the adoption of integrated care, is not a priority when the choice for MAiD, and consideration of alternate options, is a person-led choice.

A few members discussed potential conflicting approaches to MAiD care when guidance from the involved MAiD practitioners operates separately from MAiD coordination processes. In Mrs. B's case, the initial MAiD practitioner was available to re-assess Mrs. B the following day, maintaining continuity of care within the MAiD process. In contrast, the MAiD coordination service responded to a request from the new practitioner to facilitate coordination of the MAiD assessment process. There may need to be better understanding of the role of MAiD practitioners and MAiD coordination services during different phases of the MAiD process (e.g., coordinating a request for MAiD assessments vs on-going management of the assessment process).

Voluntariness

Many members brought forward concerns of possible external coercion arising from the caregiver's experience of burnout and lack of access to palliative care in an in-patient or hospice setting. Members noted that Mrs. B's spouse was primary in advocating and navigating access to MAiD with limited documentation of the process being self-directed. Moreover, the MAiD assessments were completed with the spouse present. These members discussed that the MAiD practitioners who confirmed eligibility for MAiD should employ and document strategies for evaluating concerns of external coercion or undue influence. Other members recognized there could be varying interpretations of the circumstances for accessing MAiD. However, without clear documentation of the approach and evaluation of voluntariness, this context cannot be understood for the purposes of MAiD review and oversight.

As a potential indicator of voluntariness, some members opined that the MAiD practitioners did not document that they had established consistency of the request for MAiD. These members opined that Mrs. B's apparent abrupt change in her request or decision to access MAiD should have been discussed, understood, and documented.

Some members discussed the complex role of families in MAiD assessment and care. These members questioned whether family members should be permitted – or under

which circumstances it is appropriate – to refer a person for MAiD assessment. The concern outlined was that a referral from a family member for MAiD presents risk that the request was not self-directed and introduces issues such as external pressure. Other members offered that family support for MAiD system navigation is often required by the requestor at end-of-life. Some members offered that additional details of the referral source and request may assist MAiD practitioners in identifying areas of potential undue influence that need to be specifically evaluated and addressed within MAiD discussions and eligibility determinations.

Many members agreed that exploring concerns of external pressure should not distract from the critical role of family informing MAiD care. A few members suggested that direct conversations about possible sources of external pressure (e.g., caregiver burnout) and openly evaluating these issues with care and discernment assists in the identification and navigation of alternate avenues for care (e.g., informing involved healthcare practitioners to support care coordination).

PRACTICE CONSIDERATIONS

- MAiD practitioners to consider maintaining continuity of care within the MAiD assessment process (e.g., consistent relationships with involved MAiD practitioners).
- When a person has been found ineligible for MAiD or divergent opinions of eligibility arise, MAiD practitioners to consider consulting with other health care professionals or care team members to offer additional perspectives that may assist in clarifying the evaluation of eligibility (e.g., ethical expertise, expertise in the person's condition, etc).
- MAiD practitioners should ensure they have necessary competencies to recognize and evaluate possible sources of external pressure (see MAiD Review Team Report: Voluntariness in Dual Provisions). MAiD practitioners may consider involving a professional with expertise to assess and evaluate sources of external coercion and/or provide perspective of the assessment (e.g., social worker).
- MAiD practitioners to consider strategies for determining whether a request for MAiD is consistent over time: arrange for MAiD eligibility assessments to occur on separate days and when there are identified concerns, each practitioner should consider follow-up and re-assessment.
- MAiD practitioners to comprehensively consider care needs, such as addressing caregiver burden, that may be informing a decision to access MAiD. This approach to MAiD care may inform the understanding and appreciation of alternate options for end-of-life care.

CASE 4C

CASE OVERVIEW

Mr. C was a male in his 70s, who presented to hospital with a six-week history of physical and functional decline. Investigations revealed metastatic cancer. Mr. C accepted in-hospital palliative care.

Approximately five days following his admission, Mr. C formally requested MAiD. A referral was made through an internal hospital referral process. On the same day, the palliative care coordinator discussed end-of-life options, including MAiD. The palliative care coordinator returned the next day to facilitate Mr. C's completion of a written request for MAiD (Clinician Aid A), and a referral to a community MAiD navigator was completed to request MAiD eligibility assessments. The hospital palliative care coordinator documented on the referral a risk for loss of capacity due to brain metastases and opioid analgesia.

Aligned with end-of-life pain and symptom management, Mr. C was administered opioid analgesia and medications for sedation. Over the course of two days, Mr. C experienced a decline in cognitive capability illustrating an altered state of consciousness and loss of his ability to communicate, followed by being responsive to painful stimuli only (opened eyes).

Given his cognitive and functional decline, Mr. C was deemed incapable of consenting to healthcare decisions by his palliative care team. Mr. C's substitute decision maker agreed to a same day transfer to hospice.

On this same day, a MAiD practitioner arrived at the hospital to complete a MAiD eligibility assessment. The MAiD practitioner was advised by the medical care team that Mr. C had an altered cognitive state and likely had lost capacity for healthcare decisions. Due to a previous expressed request for MAiD, the MAiD practitioner proceeded to vigorously rouse Mr. C, who opened his eyes and mouthed "yes" to the MAiD practitioner's inquiry of his request for MAiD. After withholding his opioid analgesia and medications for sedation for 45-minutes, Mr. C was documented to be more alert (observed to have "eyes open"). The MAiD practitioner completed the initial MAiD assessment through a series of short verbal statements ("yes") and non-verbal (documented 'head nods and blinking') confirmatory responses. The MAiD practitioner facilitated a virtual second assessment, where the first MAiD practitioner was present and provided the medical history and illness trajectory. The second MAiD practitioner also found Mr. C eligible for MAiD. The provision of MAiD occurred following confirmation of final consent via "mouthing the word 'yes'" and nodding his head in [presumed] agreeance".

DISCUSSION

Discussion of Urgency

Overall, many MDRC members discussed that an effective and timely referral process to the provincial MAiD coordination service when a requestor expresses an informal (e.g., request for information) or formal request for MAiD provides opportunity for quality MAiD processes to occur (e.g., earlier MAiD eligibility assessments, collaboration with existing care team, use of a waiver of final consent, and greater involvement with person and family). These members discussed that if Mr. C had been provided with information of MAiD during end-of-life goals of care discussions following diagnosis there may have been opportunity for an earlier referral to the MAiD coordination service for information sharing, less urgent navigation of the MAiD process, and consideration of local MAiD practitioner availability.

Many members acknowledged the need to facilitate an urgent approach to MAiD assessment and provision given Mr. C's advanced functional decline. An earlier approach to MAiD coordination may have eliminated the need for the assessments and provision to occur within the same day.

Some members recognized challenges experienced by MAiD practitioners in similar circumstances: potential interpersonal pressures to adhere to previously expressed requests and end-of-life goals to access MAiD, facilitating urgent requests due to the timing of the referral and the requestor's clinical presentation, and addressing the complexities of maintaining the autonomy of the person requesting MAiD at end-of-life, who is no longer capable to direct their care.

Decisional Capacity and Informed Consent

MDRC members presented mainly convergent views of concerns regarding the documented approach for evaluating decisional capacity and obtaining informed consent for MAiD. Many MDRC members expressed concerns that the documented evaluation of capacity and informed consent did not comprehensively illustrate how these eligibility criteria were met.

Some members discussed the approach to confirming Mr. C's cognitive capability to participate in MAiD eligibility assessments. These members discussed that withholding opioid analgesia and medications for sedation for 45-minutes was insufficient time for medication clearance. Some members expressed consideration for holding sedating medications for upwards of four hours. This approach may promote opportunity for clearer cognition and increased communicative and interactional engagement for the MAiD assessment. However, there was some recognition amongst a few MDRC members that withholding palliative pain management may also contribute to profound suffering. Thereby, MAiD practitioners should inform the requestor of the approach to care (e.g., withholding sedation) required to confirm eligibility and facilitate MAiD.

Many members identified that a rigorous evaluation of capacity was not evident from the submitted MAiD documentation. A structured approach to evaluating capacity was not documented, including the use of a capacity evaluation tool when verbal communication was limited, or adopting an approach to validating the limited verbal and non-verbal responses through the use of positive and negative statements.

As a result of the limited documented approach to confirming decisional capacity, most members had concerns about Mr. C's cognitive capabilities to provide informed consent. A few members brought forward that determining Mr. C's appreciation of his decision to access MAiD, as a necessary component of capacity, via a "nod of the head", was an insufficient approach to a capacity evaluation. There was also no documentation of Mr. C's understanding and evaluation of alternate care options (e.g., transfer to hospice). Also, family members, identified as substitute decision makers, had previously been involved in end-of-life decision making, informing the decision to transfer Mr. C to hospice.

A few members also expressed that a previously documented 'wish for MAiD' or a completed formal written request (Clinician Aid A) is not equivalent to evidence of informed consent for MAiD. As such, these members commented that there was a possible over-reliance on the completed written request and family perspectives to evaluate informed consent for MAiD. A few members highlighted the critical issue of current MAiD legislation and practice: a requestor cannot communicate an advance request or involve a substitute decision maker to facilitate their preference to receive MAiD at end-of-life.

Some members also highlighted the challenges of virtual assessments, potentially being an ineffective method of facilitating communication and assessment in circumstances where cognitive capabilities, capacity, and informed consent are difficult to ascertain.

Voluntariness

A few members identified that a family member was engaged throughout the MAiD assessment process, providing perspectives and clarifications, posing a risk for undue influence.

Independence of Secondary Assessment

A few members opined that the eligibility assessments were likely not completed independently. These members advised that the secondary assessor should have completed their assessment without the MAiD provider present. The MAiD provider also provided a summary of the requestor's medical history of illness trajectory with members presenting concerns of influencing the opinion of the second assessor.

Palliative Care Approach

Some members were concerned about the lack of consideration of the established end-of-life care plan and lack of collaboration with the treating palliative care team. A few members also questioned whether there were barriers to communication or collaboration with the MAiD practitioners that prevented the palliative care team from advocating for Mr. C's established end-of-life plan of care (i.e., transfer to hospice).

PRACTICE CONSIDERATIONS

- Engagement and collaboration between care teams (i.e., MAiD and palliative care teams) is an expected part of healthcare practice. All practitioners should consider existing and evolving end-of-life care plans and wishes in their approach to MAiD care.
- Existing care team should be engaged to offer assessment and perspectives for complex capacity determinations (e.g., to facilitate highest cognitive function via holding/timing of sedating medications as possible, offering perspectives of a fluctuating, or worsening cognitive status, considering the value of additional opinion(s) of cognitive capabilities/capacity to provide informed consent).
- Consider ensuring effective cognitive participation in MAiD eligibility assessments by holding sedation for a timeline that considers the medication half-life and physiological processes influencing medication clearance.
- MAiD practitioners should consider their approach to maintaining the independence of the secondary assessment (i.e., separate assessments, avoidance of participation of the primary assessor during or prior to the assessment).

SUMMARY

MAiD practitioners may facilitate the provision of MAiD over a short period of time when feasible and aligned with a person's request, and after all legislative eligibility criteria and safeguards have been met. Many MDRC members interpreted the current MAiD practice trends favorably. Same day or next day MAiD provisions occur relatively uncommonly, most often for persons with cancer diagnoses, with access to palliative care, and when clinical circumstances necessitate an urgent provision. Moreover, many members were reassured that the majority of same day or next day MAiD provisions were completed in hospital, possibly indicating access to an interprofessional care team with the resources to support the provision of comprehensive quality care. Most MDRC members with MAiD practice experience believed the practice of same day or next day provisions are not inherently problematic; urgent MAiD provisions may be facilitated when indicated with attention to care.

Most MDRC members opined that the specific cases presented for review were exceptions to typical MAiD practice. Most members believed that MAiD practitioners should have the knowledge and skill to identify when there are complex circumstances that require additional case management. Most members agreed that a person's request for an urgent MAiD provision should not be prioritized over maintaining MAiD practices that are thorough, complete, representative of quality care, and meeting legislative requirements of eligibility and safeguards. Furthermore, MAiD practitioners are responsible for ensuring their clinical decisions to provide MAiD are in alignment with professional practice standards.

This MDRC review identified areas of MAiD legislative criteria and safeguards that practitioners should attend to when navigating an urgent provision. In particular, most MDRC members identified that navigating complex diagnoses within a brief timeframe presented challenges. As discussed in a previous report (MDRC Report 2024.2), most MDRC members opined that a well-formulated and reviewable approach to diagnostic evaluations is required, particularly when confirming that a complex condition meets the criteria for a grievous and irremediable condition. In such clinical circumstances, a quality approach to diagnostic evaluations may include communicating with the existing specialists and care team, extensively reviewing records, and navigating additional investigations and treatments. Many MDRC members with clinical expertise opined that there were missed opportunities to ensure Mr. A received a comprehensive approach to care (e.g., additional psychiatric treatment and care; geriatric medicine consultation; and diagnostic evaluation of reported, and not previously established, cardiac condition). Moreover, some MDRC members discussed that a comprehensive diagnostic evaluation may be required to present alternate means to alleviate suffering. These members discussed that options to alleviate suffering presented to the requestor for consideration may be limited when the grievous and irremediable condition is not fully understood. Overall, most MDRC members agreed that navigating complex diagnoses likely required on-going follow-up and care over a period of time.

An additional consideration when confirming eligibility for a same day or next day provision is to carefully consider that the request was voluntary, and informed consent was provided. The MAiD practitioner should consider that in circumstances where external influence may be a concern, follow-up to establish that the request for MAiD is self-directed and aligned with personal values may be beneficial. Similarly, obtaining informed consent for MAiD may only be possible after alternate care options are considered (e.g., long-term care admission, and options to address caregiver burden).

When navigating the MAiD assessment process, MAiD practitioners are required to ensure safeguards are met – independence of the assessors must be maintained, and methods to ensure this independence in the event that sequential eligibility assessments are needed to facilitate timeliness should be a consideration. Moreover, a

quality approach to MAiD assessments should be maintained: consideration for time to review medical records, facilitating assessors' availability for in-person assessments when indicated, and allowing for additional consultation or reflection when there are divergent opinions of eligibility may require additional time.

All MDRC members agree that MAiD practitioners, when appropriate and possible, should actively engage family and caregivers when they are identified as part of a person's identified support system. Many members discussed that engagement of family often occurs over multiple interactions. Their involvement should be prioritized to participate in end-of-life discussions, facilitate understanding of healthcare decisions, and directly discuss possible areas of influence and address potential concerns. Many MDRC members believed that, where possible, addressing family needs should not be ignored in order to provide MAiD more urgently, particularly if assessment identifies that there is no clinical urgency. Moreover, some MDRC members cautioned that family members should not be directing the urgency of the request.

Healthcare System Challenges

MDRC members discussed the complexities of navigating MAiD within our current healthcare system. Many MDRC members shared their views that in some of these cases, MAiD was coordinated and accessible more quickly than other, and possibly preferred, end-of-life care options. Some MDRC members discussed that a separate coordination system for MAiD from end-of-life care poses potential risks for equitable access and navigation of end-of-life needs. Many members offered that when the MAiD system is coordinated separately from end-of-life care, there may be challenges facilitating the following:

- comprehensive assessment of the requestor's end-of-life care needs, options, and trajectory as discussions are often primarily more focused on MAiD,
- availability of information for all end-of-life care,
- opportunity to facilitate timely coordination of care and services, and
- ability to promote integration of care (coordinated management of complex diagnoses, facilitate communication and information sharing between involved practitioners).

MDRC members observed this occurrence in Mr. C's care. When MAiD practitioners and palliative care teams do not work collaboratively, facilitating MAiD may not be integrated into the person's end-of-life care plan, potentially causing unnecessary transitions of care and interruptions to palliative pain and symptom management.

Many MDRC members encouraged MAiD practitioners to reflect on their approaches, and duty to provide care that employs their expertise, advocacy, and knowledge of the health care system. Every person's end-of-life choice should be well informed and

aligned with their preferences for care and values within the context of their individual circumstances.

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 Ontario MAiD practitioners, government and regulatory bodies, and professional organizations identified in the recommendations to inform potential improvements to MAiD practice.

MDRC guidance issued in this report will inform approaches to MAiD oversight in Ontario. The OCC, based on feedback from the MDRC, is reviewing and will revise, if indicated, the oversight response to legislative and practice concerns that arise during the review of MAiD deaths to continue to support the mandate for public safety and protection. Some MDRC members discussed that all same day/next day provisions should be subjected to in-depth reviews given the potential challenges with ensuring that all legislative criteria and safeguards are met, and quality care is provided, in a short period of time.

The OCC has identified recipients and recommendations to inform potential improvements to the MAiD system in Ontario. These recommendations were informed by MDRC submissions and discussions specific to this topic and this review; however, some recommendations would benefit from consideration and implementation across all MAiD practices, and for all persons needing and/or seeking end-of-life care. Moreover, these recommendations should be situated within broad health and social system improvements, considered with a summative understanding of this report, and understanding the limitations of this report.

1. To Health Canada:

1.1 Health Canada (HC) to consider providing or supporting the development of guidance on approaches to MAiD assessment and provision when navigating complexities associated with providing MAiD within short timelines (i.e., an urgent request).

1.2 HC, in collaboration with the Department of Justice, to consider the issues and circumstances identified in this report to inform the national conversation for advance requests, and considerations for the involvement of substitute decision makers in the MAiD process.

2. To Ontario Ministry of Health:

2.1 The Ontario Ministry of Health (MOH) to evaluate and consider supporting the development of guidance, including regulatory requirements, for the utilization of virtual assessment in complex end-of-life circumstances.

3. To Ministry of Health, Ontario Health, and Ontario Hospital Association:

3.1 The MOH, Ontario Health (OH), and Ontario Hospital Association to consider an approach to the coordination and management of care within Ontario's public hospital system when hospitals with religious affiliations have institutional policies that limit MAiD practitioners' ability to facilitate MAiD eligibility assessments or care within the MAiD process (e.g., collaboration with care team), and require transfers for the provision of MAiD.

4. To Ontario Health (Palliative Care Service Delivery):

4.1 To potentially inform health system improvements for the delivery of end-of-life care, OH (Palliative Care Service Delivery) to consider evaluating (e.g., mapping of patient journeys) whether health system factors (e.g., regional variations in access to palliative care) influence patients' end-of-life options and decision-making, particularly their choice to access MAiD compared to palliative care/alternate care options (e.g., hospice).

4.2 OH to consider reviewing quality standards and approaches, particularly for the inclusion of psychosocial considerations (e.g., caregiver burnout), for hospice admission criteria.

5. To the Canadian Society of Palliative Medicine (CSPM) and the Canadian Hospice Palliative Care Association (CHPCA):

5.1 The CPSM and the CHPCA to consider employing this MDRC Report to consider collaborating with health system partners to facilitate the integration of MAiD care processes within the broader scope of palliative and end-of-life care.

6. To Ontario Ministry of Health and Ontario Health:

6.1 The MOH and OH to consider how MAiD care is integrated into a quality approach to end-of-life care coordination (see recommendation for provincial care coordination in MDRC Reports 2024 – 2 & 3). Care coordination may be required when end-of-life care needs are identified (e.g., MAiD request or life-

limiting diagnoses): triage and assess need for end-of-life care; promote understanding of locally available end-of-life care services, including MAiD and alternate care options; navigate and organize preferred end-of-life care; and integration of MAiD with healthcare services (e.g., existing palliative care team).

7. To the Provincial MAiD Coordination Service (MOH):

7.1 The Provincial MAiD Care Coordination Service (CCS) to consider the issues and discussions presented in this report to evaluate their current approaches to MAiD coordination in response to an urgent request/referral, including triage, referral process, and assessment and integration of end-of-life care needs.

7.2 The Provincial CCS to consider developing an enhanced referral intake process to:

- identify key determinations of the request for MAiD during intake (e.g., source of referral [voluntariness], approach to communicating with the requestor), and consider reviewing processes to ensure referrals for MAiD are requestor-led; and
- identify and differentiate formal requests for MAiD from requests for information of MAiD processes and care to facilitate effective referrals to MAiD practitioners.

8. To Toronto Academic Health Sciences Network (TAHSN):

8.1 The Toronto Academic Health Sciences Network (TAHSN), as part of their ongoing work developing a community of practice, to consider areas of MAiD practice identified within this report to inform opportunities for areas of support for MAiD practitioners (see also MDRC Report 2024 – 2 & 3):

- MAiD practitioners may benefit from access to – and involvement of – additional consultants (e.g., when there are divergent evaluations of MAiD eligibility, when additional expertise is valuable to MAiD assessment); and
- MAiD practitioners may benefit from access to interprofessional expertise (e.g., social worker, occupational therapist, ethicist) to assist in assessing and navigating concerns of external coercion, undue influence, or relational issues that require further evaluation.

9. To Canadian Association of MAiD Providers and Assessors (CAMAP):

9.1 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 guidance resources.

9.2 CAMAP to consider developing a practice guidance resource to support MAiD practitioners with approaches to engaging family and/or persons close to the requestor in the MAiD process (i.e., maintaining voluntariness when obtaining informed consent, considerations for family involvement during MAiD assessments).

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

10.1 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 the development of practice guidelines for navigating urgency within MAiD processes and care.

10.2 CPSO and CNO to consider employing this MDRC report to facilitate information sharing and education with healthcare professionals providing diagnosis and prognosis for life-limiting conditions and end-of-life care, regarding the necessity of timely and effective referrals of requests for MAiD (i.e., at the time of an informal or formal request for MAiD).

10.3 CPSO and CNO to consider supporting their members with guidance on completing medico-legal documentation, specifically documenting their evaluation of legislative eligibility and safeguards.

11. To the Canadian Medical Protection Association & Canadian Nurses Protective Society:

11.1 The Canadian Medical Protection Association (CMPA) and Canadian Nurses Protective Society (CNPS) to consider employing this MDRC report to inform medico-legal information, resources, and advice provided to MAiD practitioners.

11.2 CMPA and CNPS to consider developing and sharing learning materials with MAiD practitioners on completing medico-legal documentation (i.e., documenting their evaluation and confirmation of legislative eligibility and safeguards).

RESOURCES

Consider the following resources to inform MAiD practice:

Health Canada: Implementing the Framework

MAiD Reports: Please contact occ.deathreviewcommittees@ontario.ca to request additional MDRC reports.

APPENDIX

Table A1. Nature of Functional Decline and Suffering Among Track 1 Provisions in Ontario by Time Between Request and Provision, 2023

		Same day/next day provision (N=219)		2+ days to provision (N=4,309)	
		Number	Percent	Number	Percent
Decline	Unable to do most activities of daily living	202	92.2%	3,967	92.1%
	Reduced or minimal oral intake or difficulty swallowing	168	76.7%	2,474	57.4%
	Dependent on life sustaining treatments	65	29.7%	1,221	28.3%
	Significant dependence on aid(s) for interaction/or mobility	124	56.6%	2,635	61.2%
	Severe shortness of breath	80	36.5%	1,468	34.1%
	Persistent extreme fatigue/weakness	189	86.3%	3,625	84.1%
	Cachexia	110	50.2%	1,935	44.9%
	Persistent, significant, and escalating chronic pain	128	58.5%	2,304	53.5%
Suffering	Inability to engage in activities	207	94.5%	4,145	96.2%
	Loss of ability to perform ADLs	201	91.8%	3,849	89.3%
	Inadequate pain control	122	55.7%	2,191	50.9%
	Loss of dignity	141	64.4%	2,860	66.4%
	Inadequate control of other symptoms	114	52.1%	2,129	49.4%
	Perceived burden on family, friends, or caregivers	72	32.9%	1,884	43.7%
	Loss of control of bodily functions	79	36.1%	1,335	31.0%
	Isolation or loneliness	22	10.1%	693	16.1%
	Emotional distress/anxiety/ fear/existential suffering	133	60.7%	2,513	58.3%
	Loss of independence	182	83.1%	3,735	86.7%

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