2025

MAiD Death Review Committee (MDRC) Report: 2025 – 1

Evaluating Incurability, Advanced State of Irreversible Decline in Capability, and Reasonably Foreseeable Natural Death

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, 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 practice. While the circumstances of the deaths reviewed are not representative of the majority of 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 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 inform such improvements.

These reviews 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 opinions, 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.

CONTENTS

INTRODUCTION

As part of the legislative criteria for accessing Medical Assistance in Dying (MAiD), assessors must determine that the individual has a grievous and irremediable medical condition. This includes confirming that the person has:

1. A **serious and incurable illness, disease, or disability** (termed *incurability* throughout the report),
2. An **advanced state of irreversible decline in capability** (termed *advanced state* or *irreversible decline* throughout the report), and
3. **Enduring and intolerable suffering** that cannot be relieved in a manner acceptable to the individual (note: this third criterion is not the focus of this report).

Health Canada has provided guidance[i] to MAiD practitioners on how to evaluate both incurability and irreversible decline. According to this guidance, the determination of incurability is a shared decision between the practitioner and the individual, based on the absence of reasonable and effective treatment options that align with the person's values and goals of care.

When assessing irreversible decline, Health Canada notes that a reduction in function may occur across one or more domains, such as physical, cognitive, social, or occupational, and may be gradual, sudden, ongoing, or stabilized. For a condition to meet the threshold of an advanced state of decline, the reduction in function should be considered "severe." Decline is deemed irreversible when no reasonable interventions remain that are consistent with the person's health status, values, and care goals. Health Canada states that individuals cannot refuse all or most interventions in order to render themselves eligible for MAiD.

With the introduction of Bill C-7, the requirement for a reasonably foreseeable natural death (RFND) is no longer a condition of eligibility. Instead, the determination of RFND now serves to distinguish between two safeguard pathways, following the determination of eligibility:

- **Track 1**: For individuals whose natural death is reasonably foreseeable (RFND)
- **Track 2**: For individuals whose natural death is not reasonably foreseeable (NRFND)

Health Canada clarifies that RFND should be assessed in relation to the person's overall medical circumstances and anticipated death, rather than based solely on a certain type of medical condition (e.g., terminal cancer) or prognosis. The guidance

states that RFND “does require the person to be approaching the end of their life in the near term.”

This MDRC report presents three MAiD deaths involving complex presentations of grievous and irremediable conditions. While the primary focus is on the interpretation and application of eligibility criteria, discussions among MAiD Review Committee (MDRC) members also considered safeguard determinations, particularly where interpretations of illness and functional decline trajectories intersected. This review of MAiD deaths offers insight into how current practice guidance is being applied in nuanced and evolving clinical contexts.

TOPIC OVERVIEW

Between January 2023 and December 2024 there were a total of 9,602 MAiD deaths in Ontario, with similar proportions of Track 1 and Track 2 MAiD deaths observed in each year (Table 1). The serious and incurable illness and the nature of decline were examined for these MAiD deaths. Findings are presented below, with supplemental information and detailed data available in the appendix.

Table 1. Distribution of MAiD Deaths in Ontario by Track in 2023 and 2024

	2023		2024		2023-2024	
	Number of MAiD deaths	**Percent of MAiD deaths**	**Number of MAiD deaths**	**Percent of MAiD deaths**	**Number of MAiD deaths**	**Percent of MAiD deaths**
Track 1	4,528	97.5%	4,837	97.6%	9,365	97.5%
Track 2	116	2.5%	121	2.4%	237	2.5%
Total	**4,644**	**100.0%**	**4,958**	**100.0%**	**9,602**	**100.0%**

Serious and Incurable Illnesses

Among persons who accessed MAiD with Track 1 safeguards (RFND), the majority had cancer reported as the primary cause of death on their medical certificate of death (MCOD). Track 2 MAiD deaths (NRFND) had a more diverse range of underlying conditions, most commonly complex chronic illnesses, neurodegenerative disorders, and deaths categorized as ‘other’.

Table 2. Distribution of Cause of Death on the Medical Certificate of Death among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Cause of Death on Medical Certificate of Death	Track 1 (N=9,365)		Track 2 (N=237)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Autoimmune	32	0.3%	9	3.8%
Cancer-related	5,429	58.0%	5	2.1%
Cardiovascular	1,027	11.0%	26	11.0%
Complex chronic condition	281	3.0%	45	19.0%
Gastrointestinal disorder	177	1.9%	5	2.1%
Musculoskeletal disorder	139	1.5%	38	16.0%
Neurodegenerative	814	8.7%	45	19.0%
Respiratory	894	9.6%	10	4.2%
Other	572	6.1%	54	22.8%

When the specific serious and incurable illnesses reported by MAiD recipients were examined further, those with NRFNDs frequently reported Parkinson's disease, multiple sclerosis, vasculopathy, and diabetes. Persons with RFNDs reported lung cancer, COPD, and congestive heart failure most often (Table 3).

Table 3. Distribution of Serious and Incurable Illnesses among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Serious and Incurable Illnesses		Track 1 (N=9,365)		Track 2 (N=237)	
		Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Cancer	Lung	1,297	13.9%	2	0.8%
	Colorectal	667	7.1%	3	1.3%
	Pancreatic	498	5.3%	0	0.0%
	Prostate	448	4.8%	1	0.4%
	Hematologic	407	4.4%	3	1.3%
	Breast	366	3.9%	0	0.0%
	Esophageal	241	2.6%	0	0.0%
	Bladder	211	2.3%	0	0.0%
	Brain	208	2.2%	0	0.0%
	Ovarian	167	1.8%	0	0.0%
Neurological	Parkinson's	252	2.7%	17	7.2%
	Amyotrophic lateral sclerosis	246	2.6%	0	0.0%

	Dementia	142	1.5%	4	1.7%
	Multiple Sclerosis	72	0.8%	15	6.3%
Respiratory	COPD	944	10.1%	12	5.1%
	Pulmonary fibrosis	335	3.6%	5	2.1%
Cardiovascular	Congestive heart failure	963	10.3%	5	2.1%
	Atrial fibrillation	546	5.8%	3	1.3%
	Vasculopathy	525	5.6%	17	7.2%
Organ failure	Kidney failure	449	4.8%	4	1.7%
	Liver failure	207	2.2%	3	1.3%
Other	Diabetes	400	4.3%	22	9.3%

The length of time persons were living with a serious and incurable illness in Track 1 and Track 2 MAiD recipients has been provided (Figure 1). The number of conditions persons reported was also presented (Figure 2).

Track 2 MAiD recipients reported longer periods of time with their illness, with 60% reporting the condition for 5 years or longer. Track 2 MAiD recipients reported higher numbers with multiple comorbid conditions than those in Track 1, with 20% more Track 1 recipients reporting only a single condition compared to Track 2.

Figure 1. Length of Time with a Serious and Incurable Illness among MAiD Recipients in Ontario by Track, January 2023 to December 2024

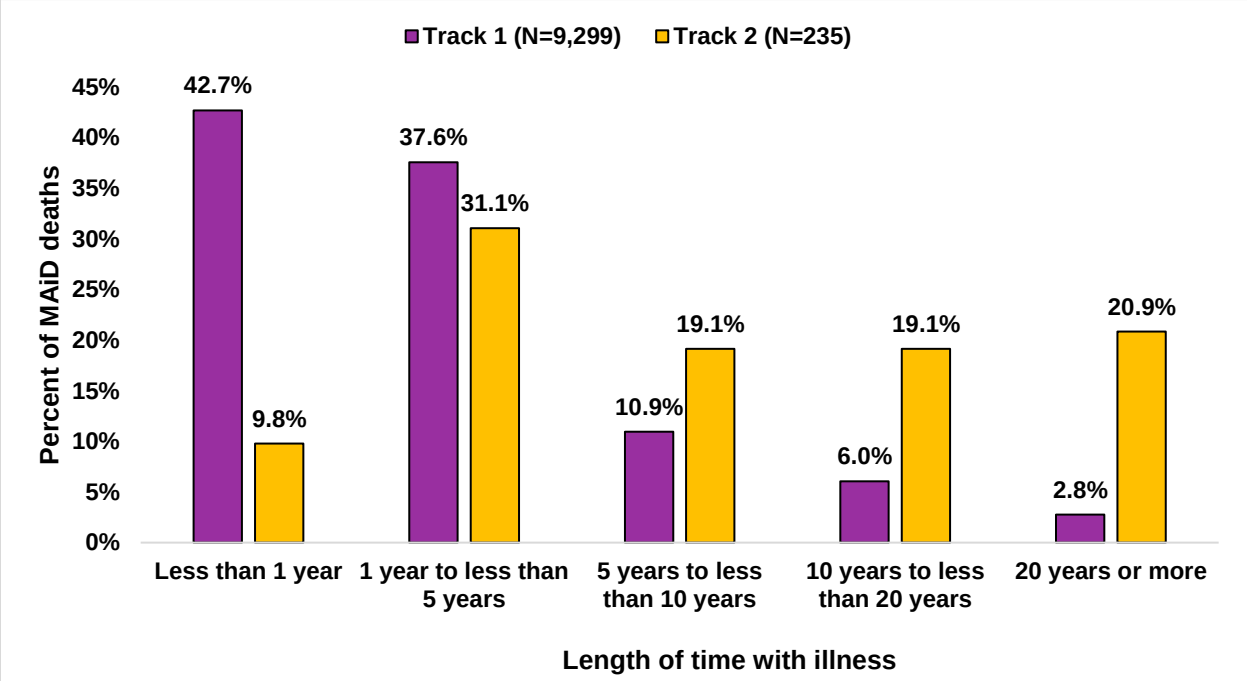


Figure 2. Number of Comorbid Serious and Incurable Illnesses Reported by MAiD Recipients in Ontario by Track, January 2023 to December 2024

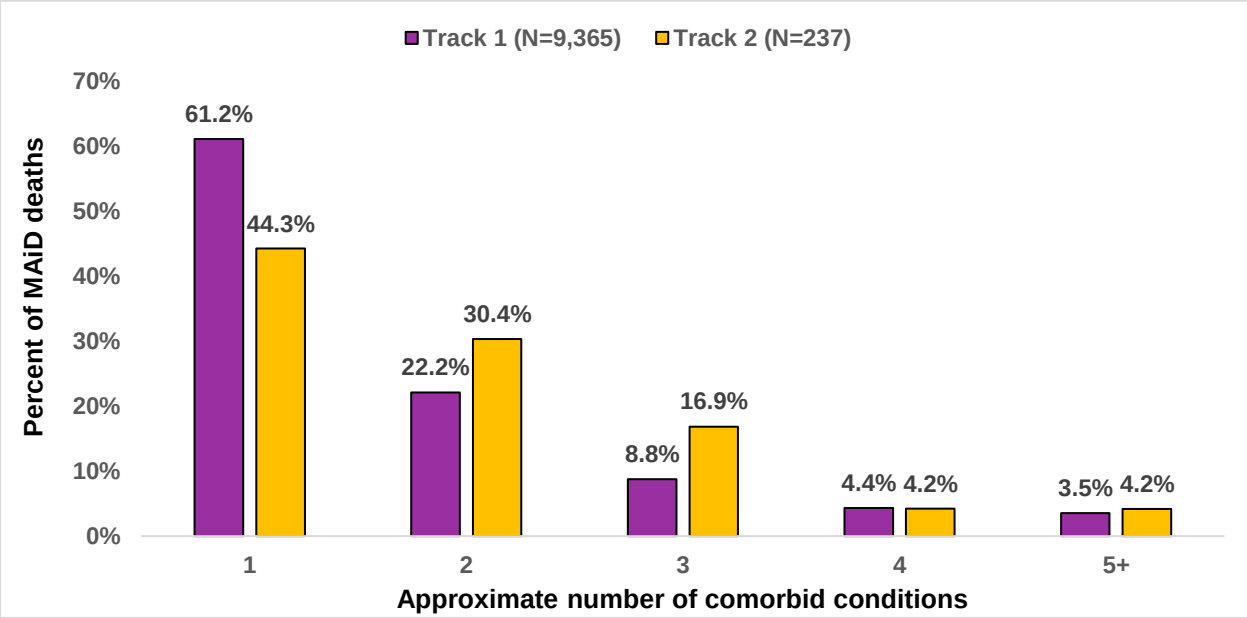


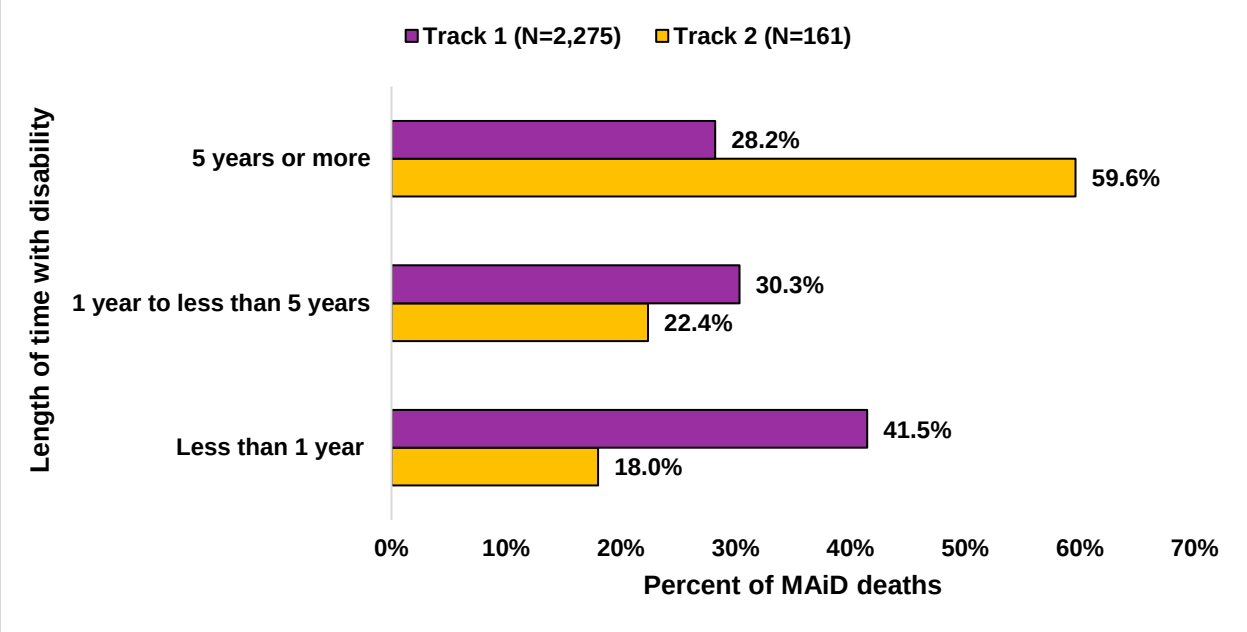
Table 3 illustrates the proportions of persons living with self-reported disability. Nearly three times as many Track 2 recipients reported having a disability compared to those in Track 1.

Table 3. Types of Self-Reported Disability among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Self-Reported Disability	Track 1 (N=9,365)		Track 2 (N=237)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Any disability	2,275	24.3%	161	67.9%
Mobility	1,918	20.5%	129	54.4%
Pain	1,059	11.3%	93	39.2%
Dexterity	516	5.5%	44	18.6%
Flexibility	508	5.4%	32	13.5%
Seeing	266	2.8%	26	11.0%
Hearing	262	2.8%	12	5.1%
Memory	103	1.1%	12	5.1%
Mental health	33	0.4%	5	2.1%
Learning	18	0.2%	1	0.4%
Developmental	4	0.0%	0	0.0%

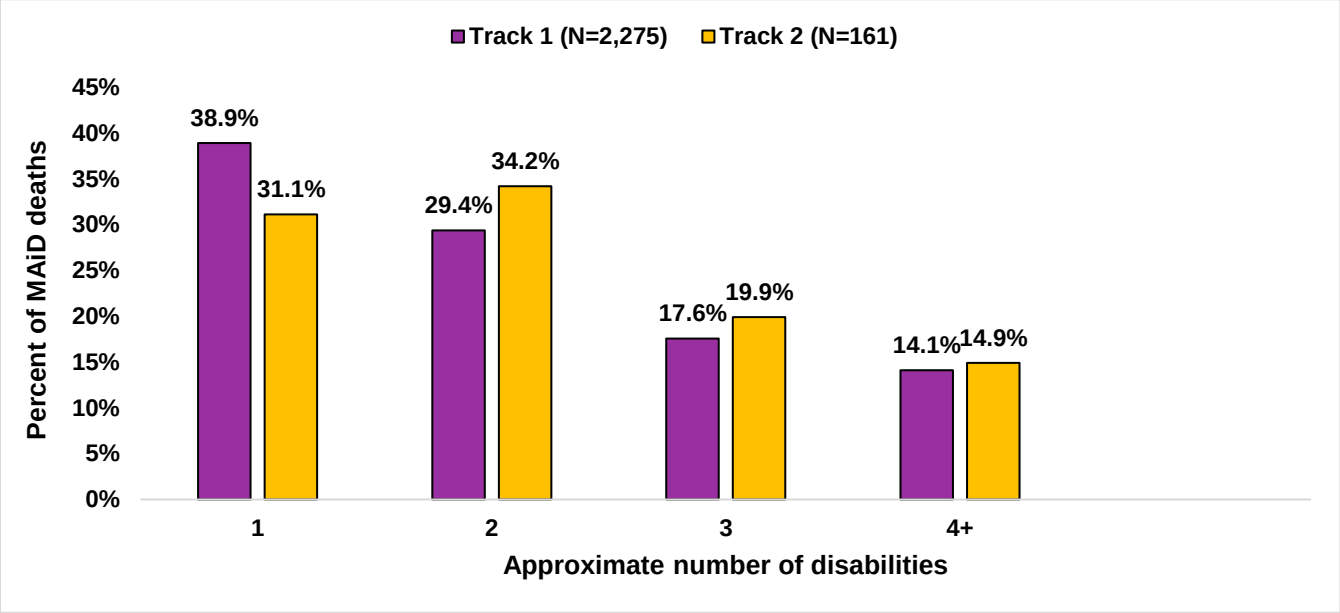
A higher proportion of Track 2 recipients self-reported living with a disability. These persons also reported living with the disability for a longer period of time (Figure 3).

Figure 3. Length of Time Living with a Self-Reported Disability among MAiD Recipients in Ontario by Track, January 2023 to December 2024



Approximately two-thirds (69.0%) of Track 2 recipients with a disability reported two or more disabilities, compared to 61% of Track 1 recipients (Figure 4).

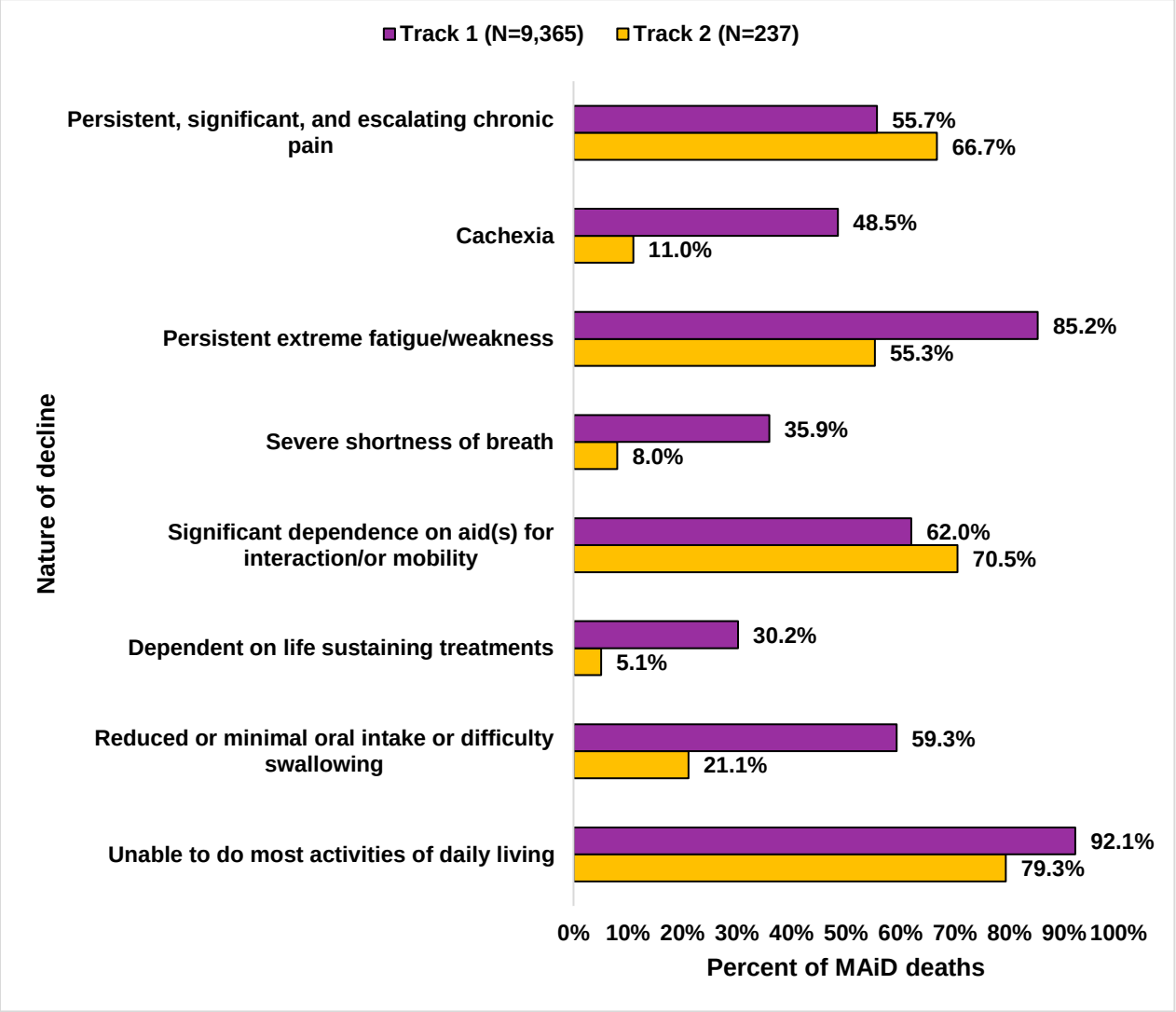
Figure 4. Number of Self-Reported Disabilities among MAiD Recipients in Ontario by Track, January 2023 to December 2024



Irreversible Decline in Capabilities

Across both safeguard tracks, the most frequently reported irreversible decline in capability was the inability to do most activities of daily living. Track 2 recipients reported higher levels of dependence on mobility aids and chronic pain than Track 1 recipients (Figure 5).

Figure 5. Nature of Decline among MAiD Recipients in Ontario by Track, January 2023 to December 2024



Palliative care was received by 81.6% of Track 1 recipients, whose deaths were reasonably foreseeable. Nearly all persons (97.4%) who received palliative care required it for pain/symptom management, and nearly 64% of persons received palliative care services for one month or longer. Approximately one-fifth of Track 1 recipients received palliative care for more than six months (Table 4).

Table 4. Receipt of Palliative Care among Track 1 MAiD Recipients in Ontario, January 2023 to December 2024

Palliative care metrics		Track 1 (N=9,365)	
		Number of Track 1 deaths	Percent of Track 1 deaths
Palliative care access	Palliative care required	7,774	83.0%
	Palliative care received	7,641	81.6%
Length of palliative care	Less than 2 weeks	1,263	17.6%
	2 weeks to less 1 month	1,338	18.7%
	1 to 6 months	3,090	43.1%
	More than 6 months	1,483	20.7%
Type of palliative care	Pain/Symptom Management	7,444	97.4%
	Personal Support Services	3,967	51.9%
	Psychosocial Care/Counselling	1,619	21.2%
	Palliative Chemotherapy	1,353	17.7%
	Palliative Radiation Therapy	1,173	15.4%
	Occupational Therapy	867	11.3%
	Spiritual Care/Counselling	820	10.7%
	Physiotherapy	708	9.3%
	Volunteer Supports	321	4.2%
Location of palliative care	Home-Based	4,989	65.3%
	Hospital-Based (in patient)	3,206	42.0%
	Hospital-Based Outpatient	1,206	15.8%
	Hospice Care	604	7.9%
	Hospital-Based (palliative care unit)	567	7.4%
	Long Term Care Facility	101	1.3%

Disability services were provided more frequently to Track 2 MAiD recipients than Track 1 recipients. Approximately two-thirds of Track 2 recipients had been receiving these services for two years or longer. Across both tracks, persons most frequently reported receiving a disability service to support their mobility needs (Table 5).

Table 5. Receipt of Disability Services among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Disability metrics		Track 1 (N=9,365)		Track 2 (N=237)	
		Number of Track 1 deaths	Percent of Track 1 deaths	Number of Track 2 deaths	Percent of Track 2 deaths
Access	Disability services required	4,507	48.1%	175	73.8%
	Disability services received	4,275	45.7%	168	70.9%
Length	Less than 6 months	1,680	47.7%	9	6.6%
	6 months to less 1 year	560	15.9%	19	13.9%
	1 year to less 2 years	405	11.5%	19	13.9%
	2 years or more	874	24.8%	90	65.7%
Type	Aids to support mobility	3,600	84.2%	148	88.1%
	Physical support	3,181	74.4%	101	60.1%
	Aids to support ADLs/transfers	2,479	58.0%	94	56.0%
	Physiotherapy	573	13.4%	39	23.2%
	Aids to support communication	512	12.0%	18	10.7%
	Mental health/ social support	388	9.1%	41	24.4%
	Disability income support	282	6.6%	35	20.8%

COMMITTEE REVIEW

CASE 5A

CASE OVERVIEW

Mrs. A was a female in her 60s living with chronic illnesses, specifically obesity, and associated chronic conditions (e.g., hypertension, dyslipidemia, type II diabetes mellitus, obstructive sleep apnea, and chronic pain due to fibromyalgia and osteoarthritis). Mrs. A also had a history of depression, pharmacologically managed.

Mrs. A experienced functional decline over a period of three to four years. Despite health service provider attempts to support her health needs (i.e., primary care and diabetes clinic), Mrs. A chose not to access healthcare during this timeframe. Mrs. A reported difficulty leaving her home due to physical and functional decline. She also experienced multi-factorial suffering that contributed to feelings of disengagement. Mrs. A chose to discontinue her medications, due to her “no longer having a will to live”. She reportedly made the decision to stop her medications understanding the impact to her health.

Mrs. A requested MAiD primarily due to her physical and functional decline. Over the course of years, she was mainly housebound. Mrs. A spent most of her time sitting, unable to mobilize due to severe dyspnea, deconditioning, and pain. She experienced functional incontinence. She reported severe chronic pain. Mrs. A reported profound psychological and existential suffering. She recognized that she had high care needs, and she did not want to access long-term care due to observing persons close to her experience similar care trajectories, particularly persons living with obesity.

Approach to MAiD Assessment and Eligibility Determination

The MAiD assessors documented that Mrs. A’s obesity and multiple chronic conditions / comorbidities would potentially improve with medical management (e.g., medical and/or pharmacologic interventions for weight loss and associated health conditions). Furthermore, her physical and functional decline could potentially be reversed and/or supported with rehabilitation, psychological care, and an enhanced level of care (e.g., in-home personal support services, assisted living and/or long-term care). Both the primary and secondary assessors offered Mrs. A extensive medical and care options.

Mrs. A declined medical management of her conditions, additional therapies, and alternate care options (e.g., palliative care and long-term care). The MAiD assessors determined that Mrs. A had a grievous and irremediable condition. Her condition, namely obesity with multiple comorbidities, was determined to be incurable without medical management. Additionally, Mrs. A’s decline in functional capabilities was determined to be advanced and irreversible due to her decision to not access care (e.g., rehabilitation or other therapies). The MAiD assessors determined her death to be reasonably foreseeable due to Mrs. A’s decision to not pursue additional treatment, including in response to an acute event, her state / trajectory of frailty and functional decline, and their determinations of predictable negative health outcomes associated with her multiple comorbid illnesses.

Both assessors also documented that Mrs. A did not present with depressive symptoms, nor suicidal ideations that could impair her decisional capabilities.

One of the MAiD assessors was Mrs. A's family medicine practitioner. The MAiD assessors did not document seeking additional expertise to inform their determinations of eligibility.

DISCUSSION

Request for MAiD

Some MDRC members expressed concern regarding the circumstances under which Mrs. A re-engaged with the healthcare system, specifically, that her re-entry appeared to be primarily for the purpose of accessing MAiD, following a prolonged period without chronic disease management or routine health services. These members emphasized that, from a quality and safety perspective, access to MAiD should be integrated within a broader continuum of care that aligns with a person's overall health needs.

These members advocated for a care-first approach, wherein the healthcare practitioner prioritizes re-establishing chronic disease management, facilitating access to primary and supportive care services, and offering referrals to psychological and psychosocial supports. In their view, MAiD assessments and discussions should not proceed until a consistent and supportive healthcare relationship has been re-established. This approach is intended to ensure that persons are making informed decisions within the context of comprehensive care, rather than as a result of unmet medical or social needs.

From a pragmatic standpoint, several MDRC members with clinical expertise highlighted the complexities of coordinating care for individuals, such as Mrs. A, who have made a personal decision to disengage from healthcare and support services. These members emphasized that the responsibility for navigating and coordinating care should not rest solely with MAiD practitioners. Instead, they advocated for a system-level response that includes early access to care coordinators to assess and address a person's health and support needs in response to their suffering and/or initial request for MAiD. This approach ensures that MAiD is considered within the context of a comprehensive care plan, rather than in isolation from the broader healthcare system.

Grievous and Irremediable Eligibility Determinations

Serious and Incurable Condition

Some MDRC members referenced guidance[ii] from the Canadian Association of MAiD Assessors and Providers (CAMAP), which states that the determination of incurability is a shared decision between the practitioner and the requestor. These members expressed concern that when an individual refuses all forms of care, thereby contributing to the incurability of their condition, the opportunity for meaningful shared

decision-making may be significantly constrained. In such circumstances, MAiD practitioners are encouraged to consider how their clinical perspectives are communicated and integrated into the assessment process, and to clearly document how these perspectives informed determination of a grievous and irremediable condition.

In Mrs. A's case, the MAiD provider presented a range of options to alleviate suffering associated with obesity, including weight loss surgery, pharmacological treatments, and disability supports. The provider also documented Mrs. A's responses, including her belief that pursuing these options would not alter her health trajectory. Some MDRC members viewed this exchange as an appropriate demonstration of shared decision-making, wherein the practitioner offered clinical guidance and the requestor's informed response to decline all care was respected. Other MDRC members contended that the documentation primarily reflected autonomous decision-making, with limited evidence that clinical engagement meaningfully informed legislative determinations. These members emphasized that MAiD legislation requires more than a respect for autonomy, it also mandates the application of clinical expertise to ensure that reasonable care options are considered. In their view, this requirement was not sufficiently demonstrated in the assessment process.

For some MDRC members, a more robust approach to shared decision-making would have involved re-establishing a form of regular healthcare engagement acceptable to Mrs. A, such as routine visits with a family physician, prior to or alongside MAiD assessments. This would allow for an ongoing dialogue about suffering and care options, with MAiD remaining a potential outcome as health responses were collaboratively monitored over time. However, a few MDRC members disagreed with this approach. They noted that both Health Canada and CAMAP recognize that a requestor's decision to decline treatment is a personal choice, shaped by individual values and lived experience. From this perspective, the MAiD provider's approach was consistent with respecting the requestor's autonomy and aligned with current guidance on eligibility assessments.

Advanced State of Irreversible Decline

Some MDRC members expressed concern that the MAiD practitioners' assessment of whether Mrs. A was in an advanced state of irreversible decline did not align with Health Canada's guidance, which states that individuals cannot refuse all reasonable treatment solely to meet eligibility criteria for MAiD. These members noted that Mrs. A's decision to decline chronic disease management and personal support services diverged from typical patient responses to standard care interventions.

A few members suggested that MAiD practitioners should more explicitly explore and document the rationale behind such refusals through structured clinical dialogue. For example, they proposed prompts such as: *"Patients with obesity often accept these interventions (e.g., medications, support services). Help me understand why these options are not a good choice for you?"* This approach would support a more thorough understanding of the requestor's decision-making process.

For some MDRC members, the refusal of routine care raised concerns about potential underlying psychological factors that may have influenced Mrs. A's choices. They emphasized that such factors should be carefully assessed and addressed before determining eligibility for MAiD, to ensure that the decision is informed, voluntary, and not driven by untreated mental health conditions.

Psychiatric Consultation and Psychosocial Care

Many MDRC members inferred from documentation that Mrs. A appeared to experience significant psychological distress. She potentially exhibited negative cognitive patterns, including catastrophic thinking, social withdrawal, and other symptoms consistent with depression. These members emphasized that a psychiatric assessment should have been coordinated as part of the MAiD eligibility process, particularly to evaluate whether psychiatric factors such as suicidality or distorted cognitive perceptions may have influenced her request or impaired her decisional capacity.

There was broad agreement among MDRC members that individuals seeking MAiD for complex conditions often experience psychological and psychosocial challenges. Most members stressed the importance of integrating psychological support and psychosocial care as a routine component of MAiD care. Some members expressed concern that Mrs. A was able to access MAiD without receiving such care or having her response to care monitored. They suggested that psychological intervention might have helped address her negative health perceptions, potentially supporting decision-making more aligned with health-promoting goals and altering the trajectory of her care decisions.

While multiple MDRC members acknowledged the difficulty of facilitating psychological care when a person refuses all health interventions, some emphasized the need to distinguish between psychiatric consultation for the purpose of informing MAiD eligibility and psychiatric care intended to provide direct support and care. While Mrs. A had the right to decline therapeutic psychiatric care, these MDRC members contended that a psychiatric consultation was necessary to assess her eligibility for MAiD. If she declined this assessment, the MAiD practitioner may have been obligated to inform her that eligibility could not be determined. These members underscored that MAiD practitioners

have a legal and ethical responsibility to ensure that all appropriate assessments are completed to inform their eligibility determinations.

Safeguard Determination

Many MDRC members with MAiD practice expertise discussed that the broadly accepted approach to evaluating whether a natural death is reasonably foreseeable (RFND) involves assessing whether the individual's death is reasonably predictable[iii] based on their clinical presentation. In Mrs. A's circumstance, a majority of members agreed with the MAiD practitioners' determination of RFND, citing known medical complications associated with her functional decline, such as increased risk of falls with fractures, pressure ulcers, and infections, factors that contribute to increased risk of mortality. Some members suggested that the inclusion of additional clinical tools, such as frailty indices, end-of-life trajectory models, or mortality risk projections (e.g., likelihood of cardiac events), could have further supported and substantiated the RFND determination. These members, particularly those with direct MAiD practice experience, emphasized that Mrs. A's documented clinical presentation would likely be recognized as meeting the RFND criterion within the broader MAiD community of practice.

In contrast, a few MDRC members disagreed with the RFND determination. They opined that RFND, and the associated Track 1 safeguards, should be reserved for persons with a terminal prognosis, typically characterized by a life expectancy of weeks to months. These members expressed concern that persons, especially those experiencing psychosocial vulnerabilities, may refuse all treatment and care to access MAiD without necessary safeguards, particularly the requirement to consult additional expertise and for an extended assessment (e.g., 90-day assessment period in Track 2 safeguards).

PRACTICE CONSIDERATIONS

- MAiD practitioners should consider that when a requestor refuses all reasonable healthcare options this may limit their ability to determine whether the legislative criteria for incurability or irreversible decline have been met. In such circumstances, MAiD practitioners should consider if they may be ethically and legally required to conclude that eligibility cannot be determined.
- MAiD practitioners should coordinate relevant consultations, such as psychiatric assessments for complex conditions or capacity evaluations, to inform MAiD eligibility determinations. If a requestor declines a consultation deemed necessary, practitioners must carefully consider whether eligibility can be ethically and legally determined.
- The determination of incurability is a shared decision between the requestor and the MAiD assessor, and as such, practitioners should ensure that their clinical expertise informs the assessment. Documenting patient choice alone, such as

the refusal of all care, may not fulfill a MAiD practitioner's legal obligation to apply clinical judgement and expertise to eligibility determinations. Comprehensive documentation should reflect how clinical perspectives were integrated in the eligibility determination.

- MAiD practitioners should thoroughly document all care options presented to the requestor to treat illness, manage functional decline, or alleviate suffering. When a requestor declines all interventions, practitioners should include detailed documentation of the rationale provided by the requestor. If concerns arise regarding how care options are evaluated or understood by the requestor, there would be benefit in consultation with a relevant expert.

CASE 5B

CASE OVERVIEW

Mr. B was a male in his 60s living with cerebral palsy. Due to advanced care needs, he was a resident of long-term care (LTC) for many years. Due to profound suffering, approximately six-to-eight weeks prior to his first MAiD assessment, Mr. B elected to voluntarily stop eating and drinking (VSED). His intake during this period was limited to one-or-two glasses of a caloric beverage per day. A referral for MAiD was initiated by Mr. B's physician in long-term care (MRP).

At his functional baseline, Mr. B was dependent on a wheelchair; however, he could independently propel his wheelchair, transfer, and toilet.

Mr. B expressed profound psychosocial suffering and loneliness due to limited social relationships and isolation from community – a lifelong experience. His transition to long-term care further contributed to feelings of a lack of belonginess. Mr. B valued his functional independence. Mr. B observed that as he aged, he was experiencing physical decline. He expressed anticipatory fear of further dependence.

Approach to MAiD Assessment and Eligibility Determination

Mr. B was assessed by the MAiD provider on multiple occasions over the course of three weeks. The MAiD provider involved Mr. B's MRP to provide clinical perspectives to inform the MAiD eligibility assessment. During his first assessment, Mr. B's weight was decreased, he was visibly fatigued, and LTC clinicians had observed that he required assistance with mobility on occasion (i.e., pushing his wheelchair). The MAiD provider expressed during this visit that Mr. B likely had an eligible grievous and irremediable condition, namely his cerebral palsy, an incurable condition, and considered his physical and functional decline as resulting from VSED. His suffering was mainly psychosocial and existentially oriented. The MAiD provider explored his mood and offered the option of trialing pharmacological interventions. The MAiD

provider documented that there was no historical or clinical evidence of depression. The MAiD provider communicated to Mr. B that further assessments were required, and he may be found eligible via track two safeguards for a non-reasonably foreseeable natural death. Following this first assessment, the MAiD provider counselled Mr. B on the role of oral intake to maintain decisional capacity. The MAiD provider documented that they did not counsel Mr. B on Track 1 vs Track 2 determinations to avoid influencing or coaching his personal care decisions (e.g., VSED).

The MAiD provider collaborated with Mr. B's LTC physician to monitor changes in his condition, and to facilitate MAiD follow-up. The MAiD provider coordinated an additional consultation with another MAiD practitioner with experience navigating VSED to also help inform their eligibility determinations.

Over the course of multiple follow-ups and consultations, the MAiD provider determined that Mr. B was eligible for MAiD via Track 1 safeguards. He had an incurable condition, mainly cerebral palsy. He was in an advanced state of decline due to outcomes associated with his decision to voluntarily stop eating and drinking: he had lost significant weight, he had severe weakness, he had become bedbound, and he was dependent for personal care. His death was determined to be reasonably foreseeable due to clinical signs of renal failure and his terminal trajectory of physical decline, both resulting from inanition and dehydration.

Following their determination of eligibility, the MAiD provider arranged for a secondary assessment. This secondary MAiD practitioner conducted a MAiD assessment and confirmed eligibility for MAiD, and all track one safeguards were determined to have been met.

DISCUSSION

Approach to MAiD Assessment

Most MDRC members acknowledged and appreciated the comprehensive approach documented by the MAiD provider when assessing Mr. B's eligibility and navigating the associated safeguards. Members highlighted several strengths in the practitioner's approach, including collaboration with Mr. B's MRP in the long-term care setting, consultation with a MAiD assessor experienced in similar complex circumstances, and the use of longitudinal clinical monitoring and assessment.

While a few MDRC members suggested that a more in-depth secondary assessment may have added perspective to MAiD eligibility, others felt that additional follow-up assessments would not have significantly enhanced the quality or outcome of the MAiD process in this case.

Some MDRC members raised concerns that Mr. B's voluntary stopping of eating and drinking (VSED) could be indicative of suicidal ideation. These members recommended that a psychiatric consultation should have been facilitated to assess whether underlying mental health concerns were influencing Mr. B's decision-making. Additionally, several members noted that psychiatric expertise could have helped explore whether a specific trigger, such as a recent event or change in circumstances, prompted Mr. B's decision to request MAiD (as many members asked, *"Why now?"*), and whether those experiences could have been addressed or supported through alternate interventions.

Grievous and Irremediable Eligibility Criteria

Advanced State of Irreversible Decline

A few MDRC members presented concerns regarding the interpretation of Mr. B's dependency, specifically, his need for long-term care, as meeting the legislative criterion of an advanced state of irreversible decline. These members cautioned that individuals with lifelong disabilities, such as cerebral palsy, often have baseline dependencies on others to support their basic care needs. Framing such dependency as evidence of an irreversible decline in capability potentially risks introducing an ableist perspective, wherein inherent disability-related needs are mischaracterized as functional decline that is aligned with an irreversible trajectory, rather than a person's basic care needs.

Additionally, some MDRC members opined that an advanced state of decline should be linked to a deterioration related to the requestor's underlying medical condition. In Mr. B's circumstance, while his functional decline, manifested through severe weight loss, fatigue, weakness, and becoming bedbound, was evident, it was largely the result of his severely limited intake. These members expressed concern that determining eligibility based on a self-facilitated decline, rather than condition-related progression, could undermine the legislative intent of MAiD safeguards and create pathways for circumventing eligibility criteria.

Conversely, other MDRC members highlighted the importance of respecting capable persons' rights to guide their own health decisions. They noted that persons are permitted to make autonomous health choices, including the refusal of nutrition and hydration, in other healthcare contexts without requiring provider intervention or limiting their healthcare options. From this perspective, the health and functional outcomes associated with Mr. B's decision to voluntarily stop eating and drinking should be assessed without further interpretation. For these members, Mr. B's VSED presentation was also interpreted as a serious and deliberate expression of his desire to access MAiD.

Safeguard Determination

Some MDRC members agreed that the VSED decision had clinical implications for determining safeguard assignment. These members agreed with the MAiD provider's approach of closely monitoring Mr. B's health status over multiple visits to inform their assessment. Based on the sustained trajectory of decline and the predictable progression toward organ failure, these members agreed that Mr. B's natural death was reasonably foreseeable, justifying the determination of Track 1 safeguards.

In contrast, other MDRC members expressed concern that Mr. B was assessed as having a RFND. They offered perspective that safeguard classification should be primarily informed by the person's underlying medical condition, rather than by the consequences of a person-led decision, such as VSED. These members discussed their perspectives that MAiD safeguards are designed to ensure a safe and thorough assessment process for persons accessing MAiD with complex non-terminal conditions. In their view, Mr. B's presentation was more closely aligned with same, and he would have benefited from the extended assessment period required under Track 2, which may have included additional consultations, particularly a psychiatric evaluation, to further explore the context and motivations behind his request and navigate options to alleviate his suffering.

MAiD Model-of-Care

For some MDRC members, the key considerations for quality MAiD practice and care in Mr. B's case were systemic in nature. These members identified missed opportunities to initiate psychiatric and/or psychosocial support at the early stages of suffering, specifically, at the onset of voluntary stopping of eating and drinking. Most MDRC members emphasized that high-quality MAiD care for persons experiencing profound suffering, particularly those with complex conditions, is best delivered within an integrated model of care that includes access to psychiatric and psychosocial services.

While many MDRC members expressed compassion for the depth of Mr. B's psychosocial suffering, some members acknowledged that access to psychiatric care may not have altered his decision to pursue MAiD. Nonetheless, several members maintained that persons experiencing profound suffering should be supported in navigating their MAiD requests alongside access to appropriate health and social care, such as psychiatric and psychosocial interventions tailored to their needs. Additionally, these members advocated for the integration of MAiD care with professionals who bring relevant expertise, such as rehabilitation specialists. This approach would help ensure that MAiD assessments are informed by disability-inclusive frameworks and anti-ableist principles.

Moreover, multiple MDRC members noted that the initiation of palliative care at the time Mr. B began restricting food and fluid intake could have provided a more coordinated,

goal-directed approach to end-of-life care. These members questioned whether earlier involvement of palliative care services might have addressed his suffering more effectively and potentially mitigated the need for VSED.

PRACTICE CONSIDERATIONS

- MAiD practitioners should clearly document their medicolegal decision-making, including the rationale supporting eligibility determinations and the approach taken in complex cases. This may include referencing applicable guidance documents, consultations accessed, and perspectives gathered from relevant communities of practice.
- MAiD practitioners should consider whether a person's grievous and irremediable condition is based on their current clinical presentation. Eligibility should carefully be determined when a person's functional decline is derived from person-led health decisions, such as VSED.
- In circumstances involving severe disability, chronic conditions, or psychosocial complexities, MAiD practitioners should collaborate with professionals such as rehabilitation specialists, psychologists, and social workers to inform MAiD assessments. This interdisciplinary approach may help to ensure that MAiD assessments are informed by experts, employing disability-inclusive frameworks.

CASE 5C

CASE OVERVIEW

Mr. C was a male in his 70s diagnosed with an essential tremor. He had been previously followed by a neurologist. He received pharmacologic management for his condition. Mr. C requested MAiD due to a complex multi-factorial experience of suffering associated with his essential tremor.

Mr. C expressed profound psychosocial and emotional suffering. His condition prevented him from engaging fully with life. His spouse had died in recent years. His tremoring impacted his self-esteem and self-confidence. He did not perceive that he had much to offer in a new relationship due to the functional limitations associated with his tremor. In turn, Mr. C expressed that he experienced profound hopelessness and loneliness – he had not been able to create a new life path with meaningful relationships, sense of purpose, and socio-emotional fulfillment. He requested to access MAiD due to same.

Mr. C also experienced a decline in hand-eye coordination and fine motor skills, difficulty eating with weight loss, and gait/mobility disturbances.

Approach to MAiD Assessment and Eligibility Determination

Mr. C was first assessed by the MAiD provider over two appointments over the course of a month. He was assessed a month later by the secondary assessor.

The MAiD provider documented that Mr. C's request for MAiD was mainly driven by emotional suffering and bereavement. Both MAiD assessors determined that Mr. C's request was resulting from an incurable condition, namely his essential tremor. The MAiD assessors documented functional decline, mainly attributed to his inability to engage in activities (i.e., meaningful hobbies / occupations). Mr. C was also experiencing difficulties with maintaining his day-to-day independence; however, he was completing his activities of daily living with various personal adaptations (e.g., requiring two-hands for fine motor tasks). The MAiD assessors also documented hand-eye coordination and gait changes.

The MAiD assessors determined that Mr. C's natural death was not reasonably foreseeable. As such, Track 2 safeguards were followed. Consultation expertise was sought from a neurologist. A neurologist confirmed that his condition was incurable. Multiple additional treatments (e.g., pharmacological and neuromuscular agents, neuromodulation, ultrasound therapy) were offered. Mr. C considered his options, and presented rationales (i.e., invasive, non-curable, additional risks, continued disease progression) for not wanting to pursue these options.

Given his psychosocial suffering and acknowledging a past-history of depression and psychological trauma, the secondary MAiD assessor offered Mr. C a referral to psychiatry and counselling services. Mr. C declined these alternate care options.

Mr. C was found eligible for MAiD by two assessors, and all safeguards were determined to have been met.

DISCUSSION

Grievous and Irremediable Eligibility Criteria

Serious and Incurable Condition

Many MDRC members with clinical expertise expressed concern that Mr. C's request for MAiD, based on a diagnosis of an essential tremor, did not align with typical clinical or legislative interpretations of eligibility. While acknowledging that an essential tremor is an incurable condition, several MDRC members questioned whether it met the legislative threshold of being "serious" in nature. Drawing from clinical experience, a few members noted that an essential tremor rarely progresses to cause severe disability or functional incapacity.

Additionally, some MDRC members highlighted that essential tremor symptoms can be exacerbated by psychological stress. They suggested that the assessment of the

seriousness of the condition may have been influenced by situational factors, such as grief, hopelessness, or social disengagement, rather than by the underlying neurological condition itself. These observations raised concerns for some members about whether the eligibility determination adequately distinguished between enduring suffering and potentially reversible psychological distress.

Psychosocial Suffering

Some MDRC members expressed concern that Mr. C's request for MAiD appeared to be primarily motivated by social withdrawal, grief, and hopelessness. These members noted that his suffering was largely situated within the social and psychological domains of functional decline. MAiD legislation prohibits access solely on the basis of a mental illness, as such, members acknowledged that Mr. C's eligibility was determined due to the presence of an underlying physical condition—essential tremor. Nonetheless, these members raised concerns that when psychosocial suffering is the primary motivation for a MAiD request, current approaches to implementing legislation and safeguards may be insufficient to ensure quality and safe practice.

Many MDRC members emphasized the urgent need to integrate psychosocial care, such as psychiatric, psychological, and social work support, into the MAiD model of care. Some members further opined that a psychiatric assessment should have been required to confirm eligibility in Mr. C's case. Such an assessment could have included collateral history-taking to provide a more comprehensive understanding of Mr. C's motivations and the nature of his suffering.

In contrast, a few MDRC members believed that the MAiD practitioner's role is to offer psychological support to alleviate suffering, and if declined by the requestor, eligibility can still be confirmed. Additionally, some members made the distinction that social burdens, such as isolation or grief, should not be conflated with psychiatric illness when evaluating whether a person meets the criteria for a grievous and irremediable condition or possesses decision-making capabilities.

Advanced State of Irreversible Decline in Capability

Many MDRC members observed that Mr. C had independently adapted to managing his day-to-day personal care needs while living with a disability. Thereby, these members discussed that his functional changes did not reflect a physical decline requiring assistance with basic activities of daily living (ADLs), which they considered as necessary to meet the legislative criteria for an advanced state of irreversible decline. For these members, the absence of significant physical decline prompted their consideration of other contributing factors of functional losses, particularly grief, psychological distress, and psychosocial despair, which they believed may have been situational and potentially reversible. As such, these members questioned whether a

comprehensive assessment of “advanced state” and “irreversible decline” had been completed, and whether the legislative criteria for a grievous and irremediable condition were fully met.

Conversely, other MDRC members emphasized that for individuals living alone, like Mr. C, challenges with instrumental ADLs may have a more pronounced impact on quality of life, as there is no shared responsibility or support for daily functioning. These members also pointed out that Mr. C’s decline was not limited to social factors - he experienced difficulty eating, resulting in weight loss, changes in upper extremity motor function, and gait disturbances. They stressed the importance of assessing how social isolation and living circumstances affect functional capabilities and recommended that MAiD practitioners explicitly consider and document the role of social supports in their assessments.

Additionally, a few members suggested that involving rehabilitation professionals, such as occupational therapists, could have helped identify alternate strategies and supports for managing daily life with a disability. This interdisciplinary input may have offered Mr. C additional care options and informed a more holistic understanding of his condition and needs.

PRACTICE CONSIDERATIONS

- When psychosocial factors appear to be primary motivators for a MAiD request, practitioners should explore whether these experiences are situational and potentially reversible. MAiD practitioners to consider psychiatric or psychological expert consultation in such circumstances to assess the nature and impact of psychosocial suffering on decision-making capabilities and eligibility.
- Interprofessional consultation, such as engagement with rehabilitation specialists (e.g., occupational therapists), should be considered to inform eligibility determinations, possible adaptive strategies, and alternate care options for persons with disabilities or functional limitations.
- When basic activities of daily living (ADLs) are not significantly impacted, MAiD practitioners should provide comprehensive documentation outlining the clinical rationale for determining that the individual meets the eligibility criteria for an “advanced state of irreversible decline in capability.” Many MDRC members recommend interprofessional expertise to inform a comprehensive understanding of the person’s condition, capabilities, and potential supports.
- MAiD practitioners should consider that persons living alone may experience greater functional burdens due to absence of shared support for activities of daily living. Practitioners should carefully assess and document these circumstances and the availability, absence, or decline of support services as part of the MAiD eligibility assessment.

SUMMARY

The review of three MAiD deaths prompted significant discussion among MDRC members regarding whether current MAiD practices and legislative interpretations remain sufficient in light of evolving clinical and social complexities. Many MDRC members with MAiD practice expertise drew on established legislative decisions, broadly accepted practice guidelines, and their own clinical experience to interpret the circumstances presented in the reviewed deaths.

While some MDRC members felt that existing interpretations and practices were appropriately applied, a few others emphasized that the evolving legislative landscape, particularly following the introduction of Bill C-7, requires consideration for a changed approach to eligibility determinations. These members noted that as practice culture shifts and more complex health and social contexts emerge, historical interpretations may no longer fully address the current state of MAiD requests. They advocated for a re-evaluation of current practices to ensure they remain aligned with the intent of the legislation and the principles of safe and person-centered MAiD care.

The following areas of interpretation prompted significant discussion and potential consideration for further guidance and clarification:

1. **Clarifying the Determination of Irreversible Decline**
   Benefit may be recognized from further consideration as to whether an advanced state of irreversible decline should be supported by a predictable clinical trajectory directly resulting from the person's incurable condition, rather than being facilitated through personal health decisions (e.g., voluntary stopping of eating and drinking [VSED] or refusal of routine care).

2. **Disability-Informed Assessment Approaches**
   Additional guidance would be valuable on how to assess irreversible decline in individuals with chronic illnesses (e.g., obesity) or long-standing disabilities (e.g., cerebral palsy) that involve baseline care-dependence. Engagement with disability communities is necessary to ensure assessments consider a disability-inclusive framework.

3. **Revisiting RFND Normative Practice in a Post–Bill C-7 Context**
   Consideration should be given to whether practice norms, based on previous court rulings, for the determination of a reasonably foreseeable natural death, may benefit from review in a legislative environment that now permits MAiD access for persons without RFND.

Integrated Model-of-Care for MAiD

An emerging MDRC discussion has highlighted an important distinction between accessing Medical Assistance in Dying (MAiD) *within* a model-of-care that includes palliative, disability, and/or psychosocial care, from accessing care to fulfill legislative safeguard requirements. Some MDRC members expressed concern that when care is accessed primarily to meet safeguards, persons may be less likely to accept potential care opportunities. In contrast, when MAiD is integrated within a broader model-of-care, care may be more easily realized *throughout* a person's MAiD journey.

The MDRC continues to emphasize the important need to integrate the MAiD system within a comprehensive and coordinated health and social care framework. Most members advocate for system-level reforms, particularly those that support persons accessing MAiD through regional and interprofessional models-of-care, to enhance both the quality and safety of MAiD services in Ontario.

Many members have underscored the specific role of MAiD practitioners within this model: to provide medico-legal expertise in applying legislative criteria and navigating safeguards. Many members caution against overextending the role of MAiD practitioners by assigning them responsibility for coordinating broader health and social care services aimed at alleviating suffering. Rather, MAiD practitioners should serve as expert consultants within interdisciplinary teams, collaborating with regional care providers to support individuals who, after receiving high-quality care, choose to pursue MAiD.

Psychosocial Care

Many MDRC members continue to emphasize the critical role of psychiatric and psychosocial expertise in informing MAiD practice and supporting individuals with complex health and social needs who are suffering and requesting MAiD. They noted that many MAiD requests, particularly among individuals with chronic illnesses or disabilities, are rooted in psychosocial suffering. As such, members strongly advocated for the integration of psychiatric and psychosocial care (e.g., psychiatrists, psychologists, and social workers) into MAiD assessment and care.

Considerations for Integrating Disability Perspectives

A few MDRC members raised concerns regarding the assessment of eligibility for MAiD from a disability care perspective. These members questioned whether determinations of a person's grievous and irremediable condition may be influenced by ableist assumptions about what constitutes an acceptable quality of life. Specifically, they expressed concern that a person's baseline disability status, such as requiring assistance with activities of daily living (ADLs), could unduly influence eligibility decisions, based on the presumption that such a life is inherently of lower quality. These members emphasized the importance of MAiD practitioners understanding the personal

and social meanings assigned to living with a disability. Such understanding is essential for exploring alternative approaches to alleviating suffering that do not rely on assumptions rooted in ableism.

Furthermore, these MDRC members suggested that criteria such as “an advanced state of irreversible decline in capability” should be interpreted with a nuanced understanding of functional decline. This interpretation should distinguish between progressive deterioration and long-standing disabilities that necessitate ongoing support but do not, in themselves, indicate a change in health status that may be informing a request for MAiD. To address these concerns, these members advocated for meaningful engagement with the disability community. They called for collaborative efforts to ensure that MAiD assessments and care practices are informed by lived experience and are designed to recognize and mitigate ableist biases.

Medico-Legal Documentation

Many MDRC members with MAiD practice experience reflected on the complexity of medico-legal decision-making in MAiD assessments. These members acknowledged that most MAiD practitioners have developed significant clinical and legal expertise that informs their eligibility determinations. However, they also noted that in the reviewed documentation this decision-making and medicolegal expertise is not frequently represented. Many practitioners have not established, or are unable to implement due to feasibility constraints, a consistent documentation practice that captures the full range of evidence and reasoning employed to inform each MAiD assessment.

Many MDRC members emphasized that MAiD assessments, particularly in complex cases, rarely rely on a single source of authority, such as legal precedent. Instead, practitioners often draw from a combination of their own clinical judgment, the shared experiences of other MAiD providers (as illustrated in Case B), and insights from professional communities of practice, such as the Canadian Association of MAiD Assessors and Providers (CAMAP).

Given this multifaceted approach, most MDRC members strongly encouraged the development and adoption of comprehensive documentation practices. These practices should reflect the diverse sources of knowledge and reasoning that inform medico-legal decisions, especially in complex or atypical cases. Doing so would enhance transparency, support accountability, and contribute to the ongoing evolution of safe and consistent MAiD practice.

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

The OCC has identified recipients to inform potential improvements to the MAiD system in Ontario. We recommend that these stakeholders, who remain committed to ongoing improvements to Ontario's MAiD system, reflect on this report to continue to inform practice guidance for their members, and/or provide additional clarity on legislative interpretations and applications, and/or improve the MAiD system of care where applicable.

1. **To Health Canada:**

1.1 To strengthen consistency, quality, and oversight of the provision of MAiD, Health Canada to facilitate interjurisdictional knowledge exchange through their Federal-Provincial-Territorial Assistant Deputy Minister Committee on MAiD for the following key areas of MAiD practice:

- Share approaches to application of Track 1 and Track 2 safeguards, particularly involving persons accessing MAiD with complex conditions.
- Share approaches to eligibility determinations and application of safeguards for persons who refuse standard treatment or voluntary stoppage of eating and drinking.
- Clarify how legislative eligibility and safeguards are being approached for persons accessing MAiD with complex psychological and psychosocial needs.

1.2 HC to consider funding person-centered research to evaluate whether current MAiD legislation and models-of-care uphold safety and quality care for priority populations, including:

- Persons with disabilities to assess whether safeguards align with disability inclusive social care frameworks.

- Persons experiencing complex psychosocial circumstances to examine how existing MAiD frameworks address their unique needs and vulnerabilities.

This research should inform future policy and clinical guidance to enhance the safety and quality of MAiD practices across diverse care contexts.

2. To Ontario Ministry of Health, the Provincial MAiD Care Coordination Service, and Ontario Health:

2.1 The Ontario Ministry of Health, the Provincial MAiD Care Coordination Service, and Ontario Health to consider the findings in this report to guide the continued development of a coordinated, system-wide approach to MAiD. This includes:

- Establishing early access to multidisciplinary[2] team-based assessments for persons who are suffering with complex health and psychosocial circumstances and requesting MAiD.
- Enhancing care coordination and system navigation, ensuring that requestors have access to comprehensive care while accessing MAiD.

3. To Canadian Psychiatric Association and Ontario College of Social Workers and Social Service Workers:

3.1 The Canadian Psychiatric Association and Ontario College of Social Workers and Social Service Workers to consider developing a guidance framework to support the integration of psychiatric and psychosocial expertise and supports into a MAiD model-of-care.

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

4.1 The Toronto Academic Health Sciences Network (TAHSN), as part of their ongoing work developing a community of practice, to consider integrating psychiatric and psychosocial expertise into their review of complex MAiD requests.

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

5.1 The Canadian Association of MAiD Assessors and Providers (CAMAP) to consider incorporating guidance into its MAiD education model that addresses

[2] A MDRC member with knowledge of interprovincial MAiD programs suggested engaging with Manitoba to consider their approach to provincial MAiD coordination and assessment.

the added complexities of assessing individuals who are socially vulnerable and/or living alone. CAMAP may consider including guidance that considers that social vulnerability may impact functional capabilities, psychosocial well-being, and the challenges posed by limited collateral information during assessments.

5.2 CAMAP to also consider developing practice guidance for their members of the critical role of psychiatry, psychological, and psychosocial expertise to inform MAiD assessment and care.

6. To the Ontario Medical Association and Ontario Nurse Practitioners Association:

6.1 The Ontario Medical Association and Ontario Nurse Practitioners Association to use the learnings shared within the MDRC reports to determine an avenue to inform and potentially enhance MAiD practice through member guidance and education.

7. To College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, Canadian Medical Protection Association, and Canadian Nurses Protective Society:

7.1 The College of Physicians and Surgeons of Ontario (CPSO), College of Nurses of Ontario (CNO), Canadian Medical Protective Association (CMPA), and Canadian Nurses Protective Society (CNPS) should consider the findings of this report when updating or sharing guidance for members.

RESOURCES

Consider the following resources to inform MAiD practice:

CAMAP: Interpretation and Role of Reasonably Foreseeable

Health Canada: Advice to the Profession

Health Canada: Implementing the Framework

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

For additional interpretations on incurability:

Gupta, M. & Downie, J. (2025). Interpretating and Operationalizing the Incurability Requirement in Canada's Assisted Dying Legislation. Retrieved from: Interpreting and operationalizing the incurability requirement in Canada's assisted dying legislation - PMC

APPENDIX

Table A1. Length of time with a Serious and Incurable Illness Among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Length of Time with a Serious and Incurable Illness	Track 1 (N=9,299)		Track 2 (N=235)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Less than 1 year	3,969	42.7%	23	9.8%
1 year to less than 5 years	3,494	37.6%	73	31.1%
5 years to less than 10 years	1,018	10.9%	45	19.1%
10 years to less than 20 years	562	6.0%	45	19.1%
20 years or more	256	2.8%	49	20.9%

Table A2. Number of Comorbid Serious and Incurable Illnesses Reported by MAiD Recipients in Ontario by Track, January 2023 to December 2024

Number with Multiple Serious and Incurable Illnesses	Track 1 (N=9,365)		Track 2 (N=237)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
1	5,731	61.2%	105	44.3%
2	2,074	22.2%	72	30.4%
3	821	8.8%	40	16.9%
4	407	4.4%	10	4.2%
5+	332	3.5%	10	4.2%

Table A3. Length of Time with a Self-Reported Disability among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Length of Time with a Self-Reported Disability	Track 1 (N=2,275)		Track 2 (N=161)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Less than 1 year	943	41.5%	29	18.0%
1 year to less than 5 years	690	30.3%	36	22.4%
5 years or more	642	28.2%	96	59.6%

Table A4. Number of Self-Reported Disabilities among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Number of Self-Reported Disabilities	Track 1 (N=9,365)		Track 2 (N=237)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
0	7,222	77.1%	80	33.8%
1	754	8.1%	46	19.4%
2	668	7.1%	55	23.2%
3	400	4.3%	32	13.5%
4+	321	3.4%	24	10.1%

Table A5. Nature of Decline among MAiD Recipients in Ontario by Track, January 2023 to December 2024

Nature of Decline in Capabilities	Track 1 (N=9,365)		Track 2 (N=237)	
	Number of Track 1 Deaths	Percent of Track 1 Deaths	Number of Track 2 Deaths	Percent of Track 2 Deaths
Unable to do most activities of daily living	8,622	92.1%	1,188	79.3%
Persistent extreme fatigue/weakness	7,978	85.2%	131	55.3%
Significant dependence on aid(s) for interaction/or mobility	5,804	62.0%	167	70.5%
Reduced or minimal oral intake or difficulty swallowing	5,550	59.3%	50	21.1%
Persistent, significant, and escalating chronic pain	5,215	55.7%	158	66.7%
Cachexia	4,543	48.5%	26	11.0%
Severe shortness of breath	3,363	35.9%	19	8.0%
Dependent on life sustaining treatments	2,826	30.2%	12	5.1%

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