Ministry of the Solicitor General

Monitoring and Oversight of Medical Assistance in Dying in Ontario

September 30, 2020

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Office of the Chief Coroner for Ontario

Ontario

Monitoring and Oversight- The Need

The Office of the Chief Coroner (OCC) was tasked with providing legislative oversight for MAiD to the province following Bill C-14 royal assent in 2016.

Compliance focused review:

1. Legislation/Safeguards
   - Clinicians followed the legislation/regulatory body practices
2. Documentation
   - Medical record documentation is thorough and complete
3. Medical
   - Medical approach does not significantly vary from best practice within a medical review framework
     - Grievous and irremediable criteria
     - Assessment of capacity

Ontario Approach

- MAiD deaths carry implications that required a unique and different approach from standard investigative procedures for coroner cases
- Goal: Provide the least intrusive approach by balancing the requirement for reporting, monitoring and oversight while respecting the needs of the patient, family and clinicians during the MAiD process
- Outcome: MAiD Team = small, centralized group of staff (coroner investigators) distinct from investigation team to ensure a consistent approach and to develop expertise in this area
  - Section 16.1 (1) of the *Coroners Act: "The Chief Coroner may appoint any person, in accordance with the regulations, to exercise the investigative powers and duties of a coroner"*

Federal Reporting: Hybrid Reporting in Ontario (November 2018-present)

For all cases ending in a MAiD death, the Office of the Chief Coroner acts as a designated recipient for attending clinicians and reports to Health Canada on their behalf.

- Diminish administrative burden for clinicians by minimizing duplicate reporting requirements.

Other scenarios for which clinicians are required to report directly to Health Canada:

- MAiD requests that are referred to another clinician
- MAiD requests that are withdrawn
- MAiD requests and assessments where a patient is found ineligible
- MAiD requests whereby a patient dies from a cause other than MAiD
- MAiD prescriptions that do not end in a MAiD death
- Pharmacists- any cases where MAiD drugs are dispensed

Monitoring & Oversight – Review Process

- MAiD provider contacts Provincial Dispatch — connect with MAiD Review Team
  - Speak with the reporting clinician
  - Speak with the family
  - Review ALL documentation/records related to MAiD
  - Determine need for investigation
    - Flowing from concerns re: MAiD
    - Reason for MAiD = other section 10 criteria (non-natural)
    - Potential for examination of body and completion of death certificate
  - Release the body
  - Follow up with family and/or clinician(s) (if indicated)
  - Complete documentation (report, data collection form)

Examples of concerns identified

Documentation and compliance with legislation

- Poor/no completion of accompanying assessment notes outlining how clinician came to the conclusion that eligibility for MAiD was met
- Counting of 10 clear days of reflection
- Timing of submission of documents for review; missing documents with submission
- Partial completion/no completion of federal reporting requirements by clinicians

Examples of concerns identified

Capacity concerns during MAiD review

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

Outcome - Clinician Feedback – Issues with Compliance with Legislation

(for cases from November 1, 2018 to September 15, 2020)

Level 1: Informal Conversation/Email : **16**

Level 2: Educational Email: **51**

Level 3: Notice Email: **9**

Level 4: Report to Applicable Regulatory Body: **0** *(*prior to Nov 2018=3)*

Level 5: Report to Police (and report to Applicable Regulatory Body): **0**

Oversight: Opportunities for Influencing Change

- Establishing clarity and strengthened oversight frameworks through data sharing and expert consultation with Ministry of Health and regulatory college partners
    - e.g. Self-Administration of MAiD
    - e.g. Independence of Assessors when in supervisory roles
    - e.g. Virtual witnesses during pandemic
- Informing care coordination through institution-level feedback
    - e.g. quality of care review resulted after concerns related to gaps in access were raised to hospital chief of staff and regional local health integration network (LHIN)
- Informing practice through clinician-level feedback
    - Repeated issues with compliance from the same provider are rare following verbal and written feedback.
- Informing practice at a systems level through lessons learned opportunities
- Enhancing quality and timeliness of data sharing with federal and provincial partners, researchers, and external stakeholders

Ontario

Appendix

Ontario

Statistics as of August 31, 2020:

- **Total number of cases completed in Ontario: 5835**
- **Number of Cases – August 2020: 202**
- **Number of Cases- Year to Date (2020): 1517**

- **Type:**
  - **Clinician-administered: 5833**
  - **Patient-administered: 2**

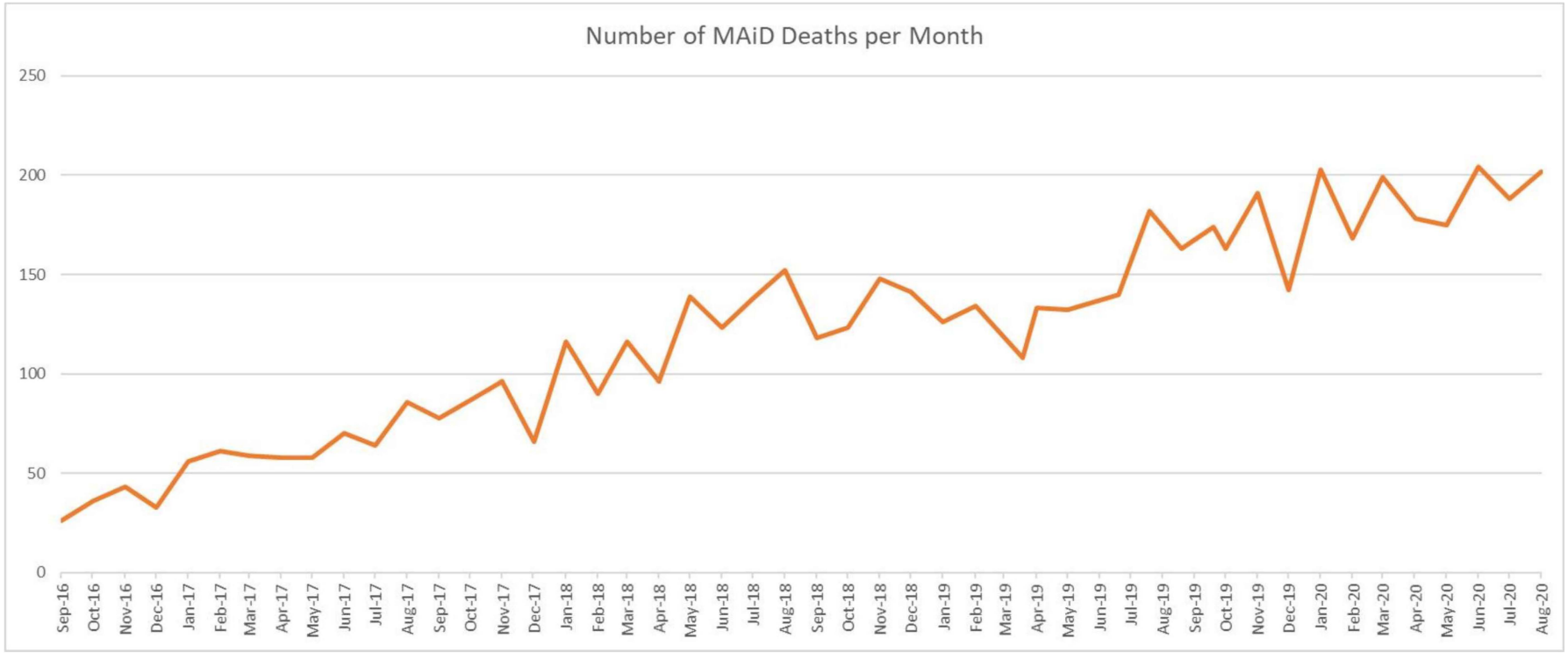
- **Age:**
  - **Average Age: 75**
  - **Youngest: 20**
  - **Oldest: 106**

- **Sex:**
  - **Female: 50%**
  - **Male: 50%**

- **Total number of cases with organ donation: 45**

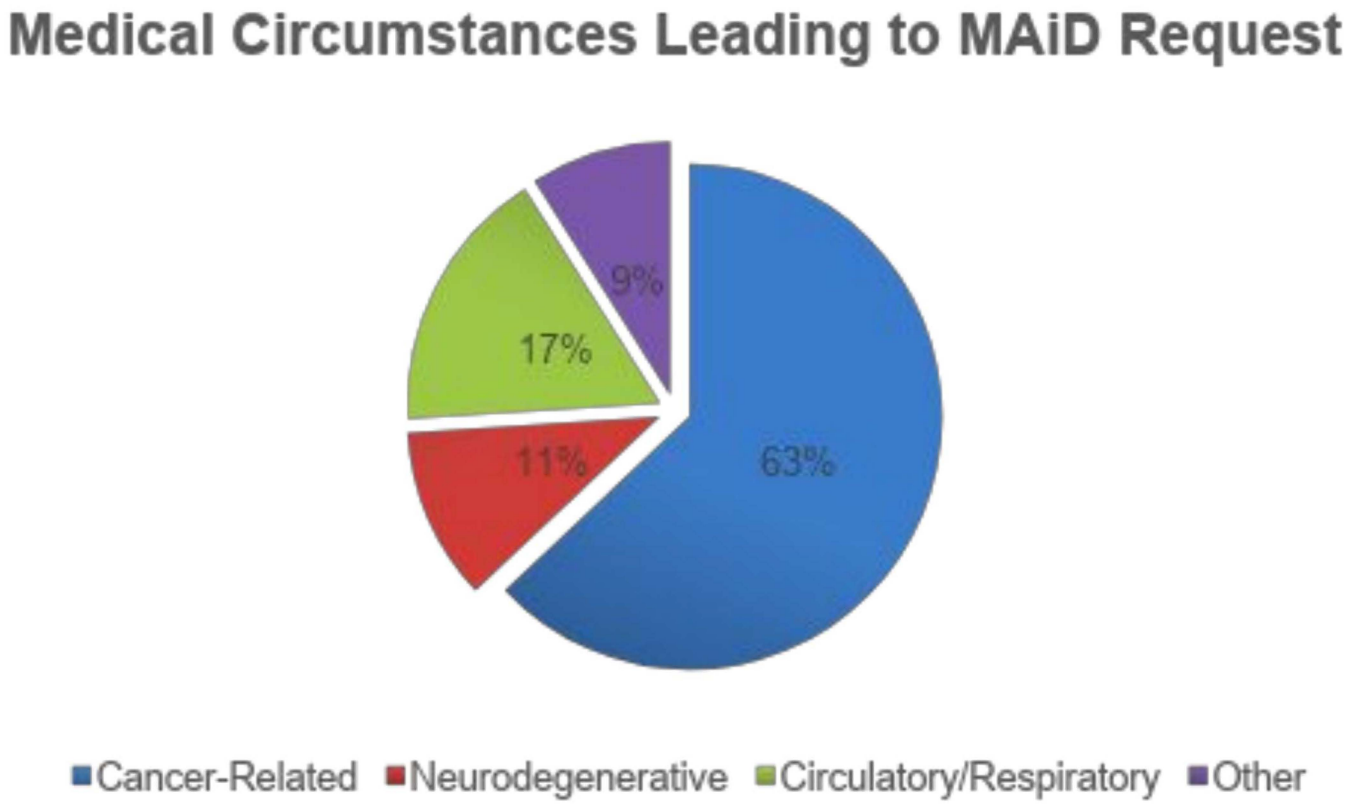
Ontario

MAiD Statistics – Ontario



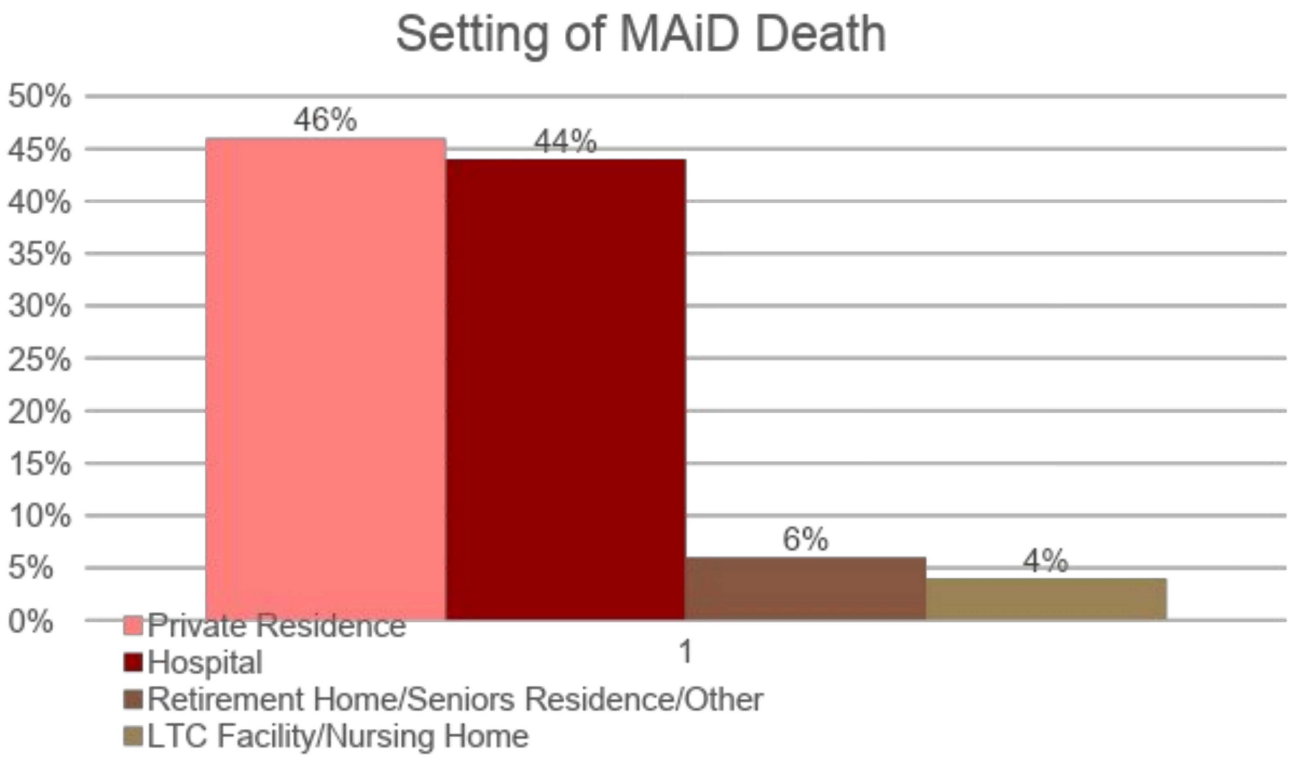
Ontario

MAiD Statistics – Ontario



Ontario

MAiD Statistics – Ontario



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