Second Annual Report on

MEDICAL ASSISTANCE IN DYING IN CANADA 2020

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Highlights

This is the Second Annual Report on Medical Assistance in Dying, using data collected under the Regulations for the Monitoring of Medical Assistance in Dying, adopted in 2018. This report builds upon the First Annual Report on Medical Assistance in Dying, released on July 24, 2020, and provides, for the first time, a look at year over year trends in who requests and receives MAID and the circumstances under which it is provided.

The data is based on reports from practitioners and pharmacists on written requests for and cases of MAID across Canada for the 2020 calendar year. This report follows a similar format to the first Annual Report, with additional data analysis in some sections, providing greater insights into the delivery of MAID in Canada in 2020. Significant collaboration between federal, provincial and territorial levels of government, as well as practitioners and pharmacists has permitted the collection, verification and accuracy of the data contained in this report.

The number of medically assisted deaths continues to increase in 2020

- In 2020, there were 7,595 cases of MAID reported in Canada, accounting for 2.5% of all deaths in Canada.
- The number of cases of MAID in 2020 represents a growth rate of 34.2% over 2019. All provinces experienced a steady year over year growth during 2020.
- When all data sources are considered, the total number of medically assisted deaths reported in Canada since the enactment of federal legislation in mid-2016 is 21,589.

Profile of MAID recipients

- In 2020, across Canada, a greater proportion of men (51.9%) than women (48.1%) received MAID. This gender differential is slightly greater than in 2019, although the percentage of men receiving MAID in 2019 was still slightly higher (50.9% vs 49.1%).
- The average age at time of MAID being provided in 2020 was 75.3 years. This is similar for both men (75.0) and women (75.5) at a national level. Across jurisdictions, the average age ranged from 72.1 in Prince Edward Island to 76.8 in British Columbia.
- Cancer (69.1%) was the most commonly cited underlying medical condition in the majority of MAID cases during 2020. This is followed by cardiovascular conditions (13.8%), chronic respiratory conditions (11.3%) and neurological conditions (10.2%). These trends are similar to those seen in 2019.

The majority of MAID recipients received palliative care and disability support services

- During 2020, the majority of MAID recipients (82.8%) received palliative care. Of the MAID patients who did not receive palliative care during 2020, 88.5% were reported to have had access to these services had they wished to avail themselves of palliative care
- In 2020, 43.6% of MAID recipients were reported as requiring disability support services. Of those, the overwhelming majority, 90.0%, were reported as having received these services.
- These results are consistent with findings reported in 2019.

Primary care physicians remain as the principal MAID providers, but the administration of MAID has shifted to home-based settings

- Overall, 1,345 unique practitioners administered MAID in Canada in 2020. 94.7% of providers were physicians and 5.3% of providers were nurse practitioners. 68.1% of cases of MAID were administered by a family physician.
- In 2020, the primary settings for the administration of MAID in Canada were private residences (47.6%) and hospitals (28.0%). Palliative care facilities accounted for 17.2% while the number of MAID procedures was slightly lower in residential care facilities such as long-term care facilities (5.7%) and other locations (1.5%). This is a significant change from 2019, which showed delivery in-hospital and in private residences nearly equal at 36.4% and 35.1% respectively at the national level.
- The percentage of MAID cases within an urban setting ranged from a low of 47.2% in Prince Edward Island to a high of 83.6% in British Columbia. Overall, the Atlantic provinces, including Newfoundland and Labrador, Prince Edward Island, Nova Scotia and New Brunswick had the higher overall percentage of MAID cases within rural areas (ranging from 30.4% to 52.8%). Ontario, Alberta and British Columbia had a higher percentage of MAID cases within urban areas (ranging from 81.0% to 83.6%).

Nature of suffering among MAID recipients

- The most commonly cited intolerable physical or psychological suffering reported by patients was the loss of ability to engage in meaningful activities (84.9%), followed closely by the loss of ability to perform activities of daily living (81.7%).
- These results are consistent with findings reported in 2019.

Other requests not resulting in a MAID death

- There were 9,375 written requests for MAID received in 2020, as reported through the MAID monitoring system. This represents an increase of 23.5% over the number of **written** requests received in 2019. 78.8% of these requests resulted in MAID being provided.
- Of the remaining requests, 21.2% did not result in a MAID death for one of the following reasons: (1) the patient died before receiving MAID (1,193 patients or 12.7% of requests), (2) the patient was deemed ineligible (566 patients or 6.0% of requests), or (3) the request was withdrawn (232 patients or 2.5% of requests).
- The main reasons for the withdrawal of a MAID request was that the patient changed their mind (66.4% of cases) or that palliative measures were sufficient (47.8% of cases).
- 22.0% of withdrawals (51 patients) occurred immediately before the MAID procedure when the patient was asked to provide final consent to receive MAID.
- The most common reason for an assessment of ineligibility was the judgement by a practitioner that the individual was not being capable of making decisions with respect to their health (37.1%). This was followed closely by practitioner assessment that the applicant's natural death was not reasonably foreseeable (27.7%) or that the person was not able to provide informed consent (17.3%).
- Of the patients who died from another cause prior to receiving MAID, 76.8% were reported to have cancer as the main underlying condition. On average, these patients died 8 days after submitting their written request for MAID.

Minister's Message

As Minister of Health, I am proud to present Health Canada's Second Annual Report on Medical Assistance in Dying (2020). This second report, using data collected under Canada's monitoring and reporting system, represents the collaborative efforts of federal, provincial and territorial governments and healthcare professionals to provide a comprehensive picture of the administration of medical assistance in dying (MAID) across the country.

The year 2020 was an eventful one for MAID policy development, due to the introduction of Bill C-7: An Act to amend the Criminal Code (medical assistance in dying) and associated dialogue and debate. Bill C-7 responded to the Superior Court of Québec's September 2019 ruling in Truchon and Gladu v. Canada (Attorney General) and Québec (Attorney General)[1], which struck down the MAID eligibility requirement that a person's natural death must be reasonably foreseeable. It also amended other aspects of the procedural safeguards included in the law, and enhanced data collection authority for monitoring purposes. Over the course of several months, Bill C-7 was subject to many hours of intense and heartfelt debate in Parliament, which speaks to the importance and emotional nature of the topic. Bill C-7 received Royal Assent on March 17, 2021.

Canadians have varied opinions on MAID depending on their personal circumstances, beliefs and experiences. During the debates on Bill C-7, we heard concerns from some that there may be insufficient protections in the legislation for those who may be susceptible to coercion or abuse, or who may request MAID out of a sense of hopelessness associated with their personal situation. We also heard concerns that the legislation could be too restrictive, in particular for those living with mental illness who are seeking this option to end their intolerable suffering. The new legislation on MAID supports individual autonomy to choose how one wishes to address intolerable pain and suffering, while ensuring the decision is made freely and not the result of external pressures or a temporary period of despair.

Apart from the introduction of new legislation, the onset of the COVID-19 pandemic in 2020 and associated public health measures have had important impacts on all aspects of health care, including MAID assessment and delivery. Despite challenges, practitioners have continued to do MAID assessments and procedures by adjusting their approaches to respect physical distancing and to ensure their safety and that of their patients. This reflects the adaptability and resilience of these professionals who provide this service with the utmost care, sensitivity and compassion.

As the new legislation governing MAID passed in March 2021, the data presented in this 2020 report reflect written requests made under the original 2016 MAID legislation (Bill C-14). The information contained in this and last year's annual report provides us with an initial sense of year-to-year trends in MAID data. I trust that these, and subsequent annual reports, will contribute to a rich and informed dialogue as Canada's MAID regime continues to evolve.

The Honourable Patty Hajdu,
Minister of Health

1 Truchon c. Procureur général du Canada, 2019 QCCS 3792

Introduction

Canada's federal MAID legislation, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying) was enacted on June 17, 2016. The related Regulations for the Monitoring of Medical Assistance in Dying came into force on November 1, 2018.

Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law. The need for the consistent collection of information and public reporting also reflects the seriousness of MAID as an exception to the Criminal Code prohibitions against the intentional termination of a person's life and aiding a person to end their own life.

This is the Second Annual Report on Medical Assistance in Dying, using data collected under the 2018 regulations. It builds upon the First Annual Report on Medical Assistance in Dying, released on July 24, 2020, which provided the first full year of data for 2019. Having a second full year of data allows for a continuing understanding of MAID requests, recipients and related circumstances. It also provides, for the first time, a sense of year over year patterns and trends. The data is based on reports from practitioners and pharmacists on written requests for and cases of MAID across Canada for the 2020 calendar year.

This report follows a format similar to the first Annual Report, with additional data analysis in some sections, providing greater insight on the administration of MAID in Canada in 2020.

1.0 The Evolution of Federal MAID Legislation

1.1 Bill C-14 and Bill C-7

In June 2017, two residents of Québec, Jean Truchon and Nicole Gladu, challenged both Québec's and Canada's existing MAID legislation on the basis that the federal requirement that an individual's natural death be "reasonably foreseeable" and the Québec requirement that a person be at the "end of life" were in violation of their Charter rights. On September 11, 2019, the Superior Court of Québec found these requirements to be unconstitutional. Neither the federal nor the Québec government chose to appeal the decision.

In February 2020, the federal government tabled Bill C-7 in Parliament to respond to the Superior Court of Québec's September 2019 ruling in *Truchon* by removing the eligibility requirement that natural death must be reasonably foreseeable, and included legislative changes on several other issues which emerged since the adoption of Canada's MAID framework in 2016. These changes will be discussed in greater detail in Section 8.0. The Bill received Royal Assent on March 17, 2021.

While Bill C-7 was being developed and considered by parliamentarians, the Québec Superior court suspended its judgement. During the period of suspension, Québec residents meeting all eligibility requirements (other than reasonably foreseeable natural death (RFND)) were able to make an application to a court for an individual exemption to have their request for MAID considered. A total of 19 Québec residents applied for and received exemptions during this period (in addition to the two plaintiffs Jean Truchon and Nicole Gladu). Fifteen Québec residents received MAID through an individual exemption in 2020, including Jean Truchon.[2]

Table 1.1: Bill C-14 Eligibility Criteria and Safeguards

Eligibility	Safeguards
• Request MAID voluntarily (self-request only) • 18 years of age or older • Capacity to make health care decisions • Provide informed consent • Eligible for publicly funded health care services in Canada • Diagnosed with a "grievous and irremediable medical condition," where a person must meet all of the following criteria: – **serious and incurable illness**, disease or disability – **advanced state of irreversible decline** in capability, – **intolerable** physical or psychological suffering, – natural death has become **reasonably foreseeable**	• Request must be in writing after the person is informed of grievous and irremediable condition • Written request must be witnessed and signed by 2 independent witnesses • 2 independent practitioners must confirm eligibility criteria are met • Patient must be made aware of all treatment options available, including palliative care, before they provide informed consent • Practitioner must confirm request has been made freely, without undue influence • 10 clear day reflection period unless death or loss of capacity is imminent • Final confirmation and consent at time of administration or provision of the medication or prescription for self-administration

While there is now new legislation in place governing MAID, any requests for and cases of MAID during the 2020 calendar year would have been carried out in accordance with the eligibility criteria and safeguards set out in the original 2016 legislation,[3] presented in Table 1.1

2 This was reported by multiple media sources in April 2020.

3 With the exception of the 15 Québec residents who received MAID through a court exemption.

1.2 Implementation of MAID across Canada

While the *Criminal Code*, which applies across Canada, establishes the eligibility criteria that must be met and safeguards that must be applied before MAID can lawfully be provided, the provinces and territories are responsible for the delivery of health care services and the implementation and enforcement of the Criminal Code. As such, each jurisdiction has taken its own approach to the organization and delivery of MAID services that best meets their unique population needs and existing health care delivery system.

For example, in Newfoundland and Labrador, Nova Scotia, New Brunswick, Québec and British Columbia, regional health authorities play a central role in the coordination of MAID, including supporting patients and providers who need assistance in navigating access to MAID services. Meanwhile, some other provinces, such as Ontario, Manitoba, Saskatchewan, and Alberta have set up province-wide MAID coordination systems to triage the intake of MAID requests, support patient information/access, help connect clinicians and streamline reporting (variations exist among jurisdictions). Smaller jurisdictions (e.g., Northwest Territories) typically have less formal systems set up primarily to support patients in connecting with a willing MAID provider.

In 2020, in response to the onset of the COVID-19 pandemic, some provincial governments and regulatory bodies adapted their policies and guidelines on MAID to promote physical distancing where possible. For example, Manitoba, Saskatchewan, Alberta and British Columbia permit virtual witnessing and in Nova Scotia, the Nova Scotia Health Authority (NSHA) allows people who work for the NSHA to act as a witness for the person requesting MAID, so long as that person isn't directly involved in the MAID applicant's care, related to them or included in the patient's will. These jurisdictions also permit virtual assessments for MAID.

With respect to oversight and ensuring compliance with the law, some jurisdictions, such as Saskatchewan, Alberta, and British Columbia have implemented review committees to ensure MAID is being provided in accordance with federal and provincial rules. In Ontario, all MAID deaths are reported to the Chief Coroner's Office, which is also responsible for oversight. In Québec, which has its own legislation in place governing MAID, the Commission on End-of-Life Care (la Commission sur les soins de fin de vie) examines all matters relating to end-of-life care and oversees the application of specific requirements pertaining to assisted dying. The regulatory bodies for medicine, nursing and pharmacy in each province and territory are also responsible for promoting the lawful practice of MAID and ensuring that health professionals act in accordance with principles of professional conduct and established standards of care.

To support MAID practice, provincial/territorial regulatory bodies can develop standards and guidelines to provide direction for clinicians in their jurisdictions. At the pan-Canadian level, the Canadian Association of MAID Assessors and Providers (CAMAP) provides a forum for information sharing among health care professionals, health system administrators, policy makers and researchers. Since its creation in 2017, CAMAP has hosted annual conferences to discuss emerging issues related to the delivery of MAID and developed several guidance documents for health professionals to support existing tools that may have been developed by provincial/territorial regulatory bodies.

2.0 Methodology and Limitations

2.1 Data Collection Under Federal Regulations

Health Canada now has two full years of comprehensive data collected in accordance with Regulations for the Monitoring of Medical Assistance in Dying that came into force in 2018. Under these Regulations, physicians and nurse practitioners are required to report on all written requests for MAID, and pharmacists must report on the dispensing of drugs for the purpose of MAID. Data on the first year (2019) was presented in the First Annual Report on Medical Assistance in Dying. With the release of the current report for 2020, we are able to identify any year-over-year changes that occurred between the two years.

In addition, data for the 2016–2018 period was provided voluntarily by the provinces and territories, and in the case of Québec, MAID data has been publicly available since the inception of Québec's MAID regime. Taken together, this data was compiled and published through four federal Interim Reports which are available on the Health Canada website. During these initial years (i.e., prior to the implementation of the Regulations) data availability was limited to basic patient demographics, medical condition, practitioner type and outcome with some provincial breakdown available. Altogether, the data available through the interim and annual reports allows for presentation of a high level picture of the growth and evolution of MAID since the inception of the federal legislative framework five years ago.

Since the implementation of the Regulations in 2018, all practitioners and pharmacists report to Health Canada in one of two ways: to their designated provincial or territorial body, or directly to Health Canada. Practitioners and pharmacists in Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Ontario (MAID requests not resulting in a MAID death), Manitoba and Yukon all report directly to Health Canada via a secure data portal. Practitioners and pharmacists in Québec, Ontario (requests resulting in a MAID death), Saskatchewan, Alberta, British Columbia, Northwest Territories and Nunavut report directly to their provincial or territorial body, and this data is submitted to Health Canada on a quarterly basis. Any questions or follow-ups are directed to the reporting individual (for those who report directly to Health Canada) or to the province or territory. Beyond the data that is reported to Health Canada, jurisdictions have the authority to collect additional data elements for their own analysis and oversight purposes. However, this information, while it may be publicly available, is not reported to Health Canada.

As noted earlier, both practitioners and pharmacists are required to report on MAID: the practitioner when there is a written request received for MAID and the pharmacist when MAID drugs are dispensed. Between these two sets of corresponding reports, there are three data elements in common: the practitioner license, the patient's date of birth, and the patient's provincial health insurance number (HIN). A data verification program matches these elements. This program has currently achieved a 95% exact match. Non-matches may be due to data entry errors in the HIN, date of birth or practitioner license (common due to the volume of reports received), or reports that have not yet been received by Health Canada due to differences in the timing of reporting requirements. Health Canada conducts follow-ups with jurisdictions to ensure the completeness of the match in these cases.

All reports submitted to Health Canada, either through the jurisdiction, or via the on-line portal, undergo electronic verification for completeness. A robust data validation program is run on each data submission, which verifies accuracy and logic, as well as detecting incomplete, missing or erroneous entries. These records are returned to the jurisdiction or practitioner for follow up. This rigorous process is followed for each data element on each record, whether or not the application ended in a MAID death.

2.2 Methodological Notes

The presentation of the results for 2020 follows a similar format to the 2019 report, along with year over year changes where applicable. This report also contains minor revisions to the 2018 and 2019 data, where new information was received or updated. Deeper examination of the data has permitted the analysis and presentation of new data under main condition, pharmacist location, and geographic analysis of patient location.

Provinces and territories were consulted during the preparation of the report, in order to validate the overall MAID numbers and any new information presented, ensuring coherence with their own reporting. Where applicable, explanatory data notes are contained below the charts and tables to indicate further details. For all years, the number of MAID deaths is counted in the calendar year in which the death occurred. For all other requests resulting in MAID not being provided (ineligibility, withdrawal, or patient death prior to MAID), the request is counted in the calendar year in which the practitioner receives it.

The data contained in Section 3.0 includes data voluntary provided by provinces and territories, accounting for all MAID cases, including those for which formal reports have not yet been received through the federal monitoring system as well as cases with a date of request prior to November 1, 2018. Analysis for sections 4.0 through 7.0, as well as Appendix A are based on the actual reports received by Health Canada by January 31, 2021. Specific differences in totals are noted in the explanatory notes under the charts and tables.

2.3 Data Limitations

Under the Regulations for the Monitoring of Medical Assistance in Dying, federal monitoring is based solely on written requests for MAID. This has resulted in some data gaps. For example, this does not capture verbal requests, informal discussions, or preliminary assessments in the absence of a written request. Additionally, only written requests received by physicians and nurse practitioners need to be reported. This does not capture, for example, written requests initially received by a nurse working within a care coordination service, which were never forwarded to a physician or nurse practitioner. These gaps make the data related to the total number of requests, and referrals, an unreliable indicator of the overall interest in MAID.

3.0 Cases of MAID in Canada

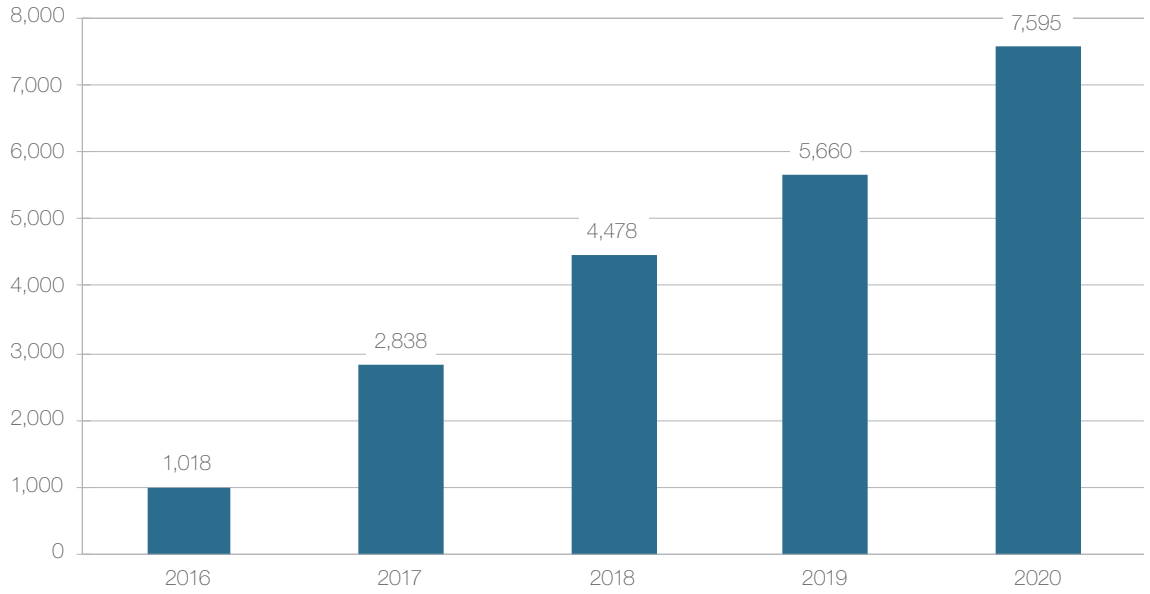
3.1 Number of Reported MAID Deaths in Canada (2016 to 2020)

2020 marks the fourth full year of access to MAID in Canada. In 2020, there were 7,595 cases of MAID reported in Canada, bringing the total number of medically assisted deaths reported in Canada since the enactment of legislation to 21,589. Annual growth in MAID cases has been steadily increasing each year and in particular rising 34.2% (2020 over 2019) from 26.4% (2019 over 2018). Increased awareness and greater acceptance by Canadians of MAID as an end-of-life option are likely contributing factors to this steady growth in MAID requests and cases.

In Québec, the end of life criterion was struck down on March 12, 2020. After this date, MAID was permitted for individuals in Québec where natural death was not reasonably foreseeable via a court exemption. These numbers are included in Québec's totals for 2020 MAID deaths (15 cases).

Self-administration of MAID is permitted in all jurisdictions except for Québec. There were fewer than seven reported cases of self-administered MAID in 2020 across Canada. This is consistent with previous years.

Chart 3.1: Total Reported MAID Deaths in Canada, 2016 to 2020



EXPLANATORY NOTES:

1. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request.
2. For 2016 - Québec data begins December 10, 2015 when its provincial Act respecting end-of-life care came into force. Data for the rest of Canada begins June 17, 2016.
3. Previous years' reporting has been revised to include corrections and additional reports.
4. This chart represents MAID deaths where a report was received by Health Canada by January 31, 2021 (7,384 deaths) as well as additional MAID deaths reported by the jurisdictions (211 deaths) where the report was not yet received by Health Canada, for a total of 7,595 MAID deaths in 2020.
5. Cases of self-administered MAID are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.

All provinces experienced a steady year over year growth rate with the highest percentage increases occurring in Newfoundland and Labrador, Prince Edward Island, Saskatchewan and Alberta. The greatest number of MAID deaths were recorded in Québec, Ontario and British Columbia with smaller overall numbers recorded in the Atlantic provinces and the Territories. Table 3.1 provides a breakdown of the number of MAID deaths by year and jurisdiction.

Table 3.1: Total Reported MAID Deaths in Canada by Jurisdiction, 2016 to 2020

MAID	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YT	NT	NU	Canada
2016	–	–	24	9	494	191	24	11	63	194	–	–	–	1,018
2017	–	–	62	49	853	839	63	57	205	677	–	–	–	2,838
2018	23	8	126	92	1,236	1,500	138	85	307	951	10	–	–	4,478
2019	17	20	147	141	1,602	1,788	177	97	377	1,280	13	–	–	5,660
2020	49	36	188	160	2,268	2,378	214	157	555	1,572	13	–	–	7,595
TOTAL 2016–2020	109	70	547	451	6,453	6,696	616	407	1,507	4,674	50	–	–	21,589

EXPLANATORY NOTES:

1. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request.
2. For 2016 - Québec data begins December 10, 2015 when its provincial Act respecting end-of-life care came into force. Data for the rest of Canada begins June 17, 2016.
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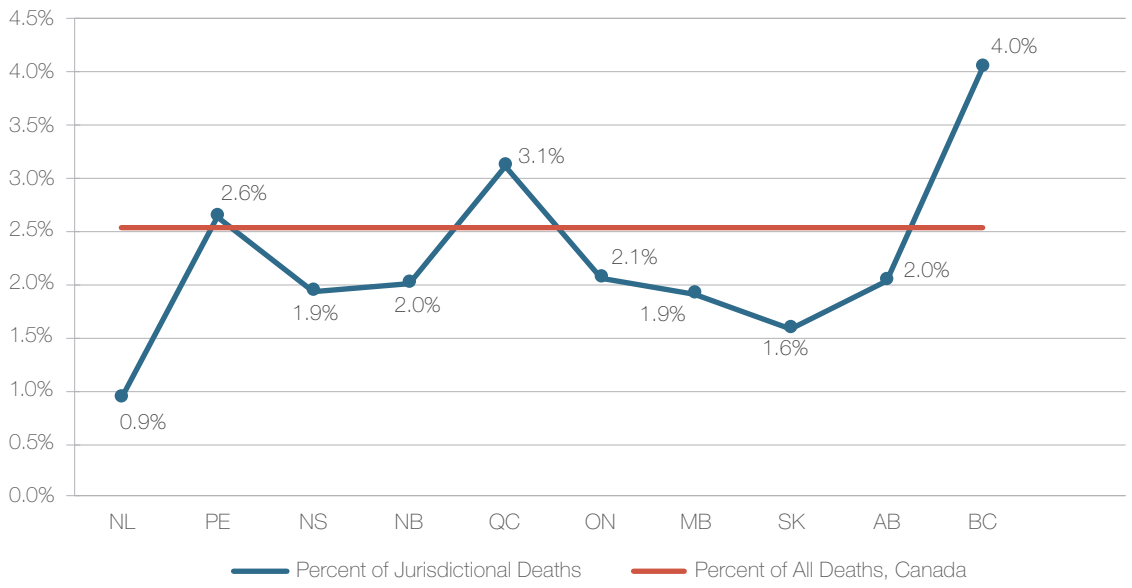
5. Cases of self-administered MAID are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.
6. Due to small numbers, some data have been suppressed to protect confidentiality (represented by dashes).

3.2 MAID Deaths as a Proportion of Overall Deaths in Canada

MAID deaths accounted for 2.5% of all deaths in Canada in 2020 compared to 2.0% of all deaths in 2019. Without exception, when comparing 2020 to 2019, each province experienced growth in the number of cases of MAID as a percentage of total deaths. As in 2019, the percentage of total deaths attributed to MAID varied significantly across the country. Likewise, similar to 2019, the highest rates were observed in Québec and British Columbia, at 3.1% and 4.0% respectively, which may be reflective of the greater acceptance of MAID among residents of these jurisdictions. The strongest growth was experienced by Newfoundland and Labrador (from 0.3% in 2019 to 0.9% in 2020) and Prince Edward Island (from 1.2% in 2019 to 2.6% in 2020). Their overall numbers are small and are therefore sensitive to small increases in case numbers. This may also be reflective of a gradual shift in attitudes towards MAID in these jurisdictions.

Chart 3.2: Percentage of Total Deaths Attributed to MAID by Jurisdiction, 2020



EXPLANATORY NOTES:

1. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request.
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3. Cases of self-administered MAID are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.
4. Given the small population size (and, hence, the small denominator), Yukon's percentage is sensitive to small increases in case numbers, and is therefore not included in this chart.
5. Source: Statistics Canada. Table 17-10-0006-01 Estimates of deaths, by age and sex, annual (2019/20)

4.0 Profile of Persons Receiving MAID

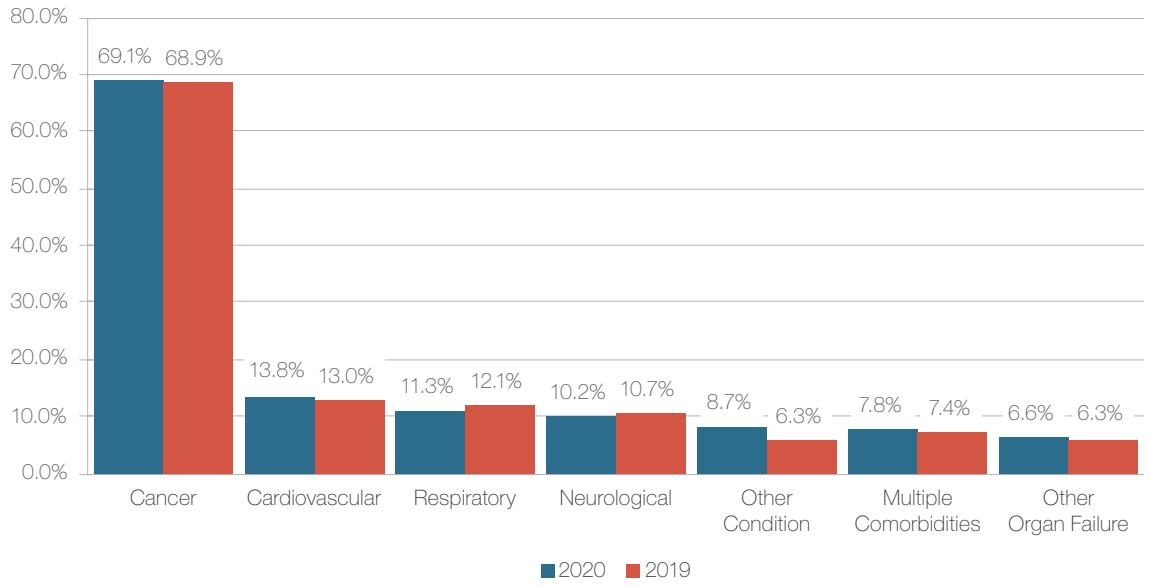
As indicated in Section 3.0, there was a total of 7,595 MAID deaths in Canada in 2020. The information presented in Section 3.0 provides aggregate data on total MAID deaths in 2020 based on formal reports completed by practitioners and received by Health Canada (7,384 cases) and supplemented by additional numbers on MAID deaths (211 cases) that were provided by provinces and territories for cases where a formal report was not yet received by Health Canada.

Sections 4.0 through 7.0, as well as Appendix A, provide an analysis on the detailed information that is included in the 7,384 formal reports on MAID deaths for 2020 received by Health Canada. These sections do not include the 211 additional MAID deaths reported by the provinces and territories and included in Section 3.0, since details on these MAID cases have not yet been received by Health Canada.

4.1 Underlying Medical Conditions of Those Receiving MAID

The majority of persons receiving MAID during 2020 were reported as having cancer as their main underlying medical condition (69.1%). This is followed by cardiovascular conditions (13.8%), chronic respiratory conditions (11.3%) and neurological conditions (10.2%). These trends are similar to those seen in 2019 and are consistent with the leading causes of death in Canada, which list cancer and diseases of the heart as the number 1 and 2 causes of death respectively.[4] Chart 4.1A shows a breakdown of the reported conditions for 2019 and 2020. There were no significant differences between men and women in the reported main condition.

Chart 4.1A: MAID by Main Condition, 2019–2020



EXPLANATORY NOTES:

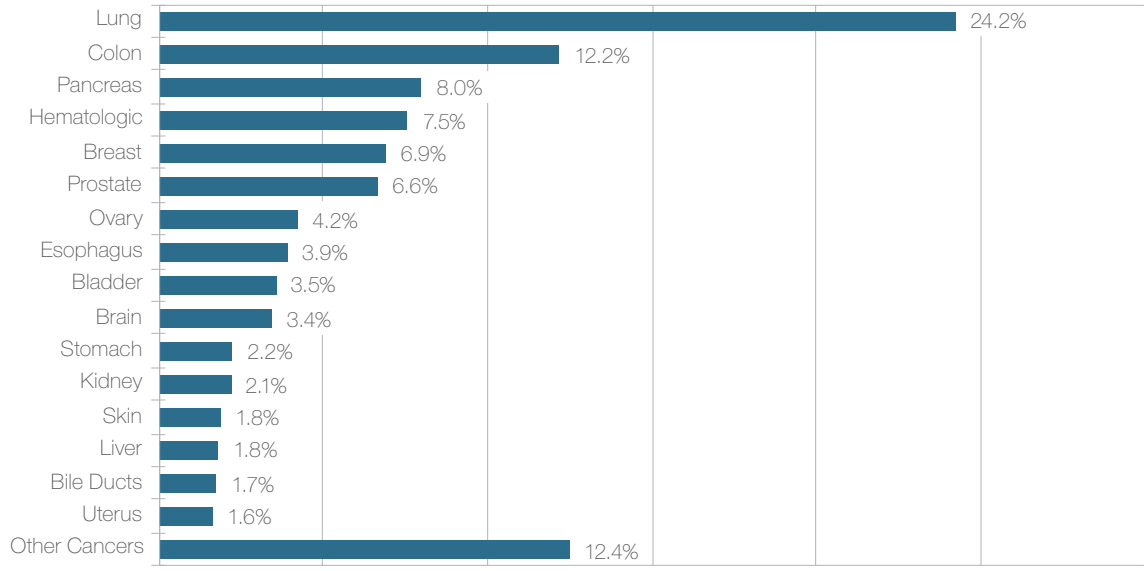
1. This chart represents MAID deaths where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Providers were able to select more than one medical condition when reporting; therefore, the total exceeds 100%.
3. Data adjustments has resulted in the revision of 2019 results, which are presented here for comparison purposes with 2020 data.

4 Statistics Canada, Table 13-10-0394-01

Chart 4.1B outlines the list of cancers most frequently reported (the selection of more than one is possible). Lung cancer was the type of cancer reported most frequently (24.2%) followed by colon cancer (12.2%), pancreatic cancer (8.0%), hematologic cancer (7.5%), breast cancer (6.9%) and prostate cancer (6.6%). This finding is consistent with lung cancer as the leading cause of death by cancer in Canada[5].

Cardiovascular conditions were the second most frequently cited main condition for persons receiving MAID. Congestive heart failure was the most frequently cited heart condition in this category (42.2%). Under respiratory conditions, chronic obstructive pulmonary disease (COPD) was the most frequently listed condition.

Chart 4.1B: MAID by Cancer Type 2020



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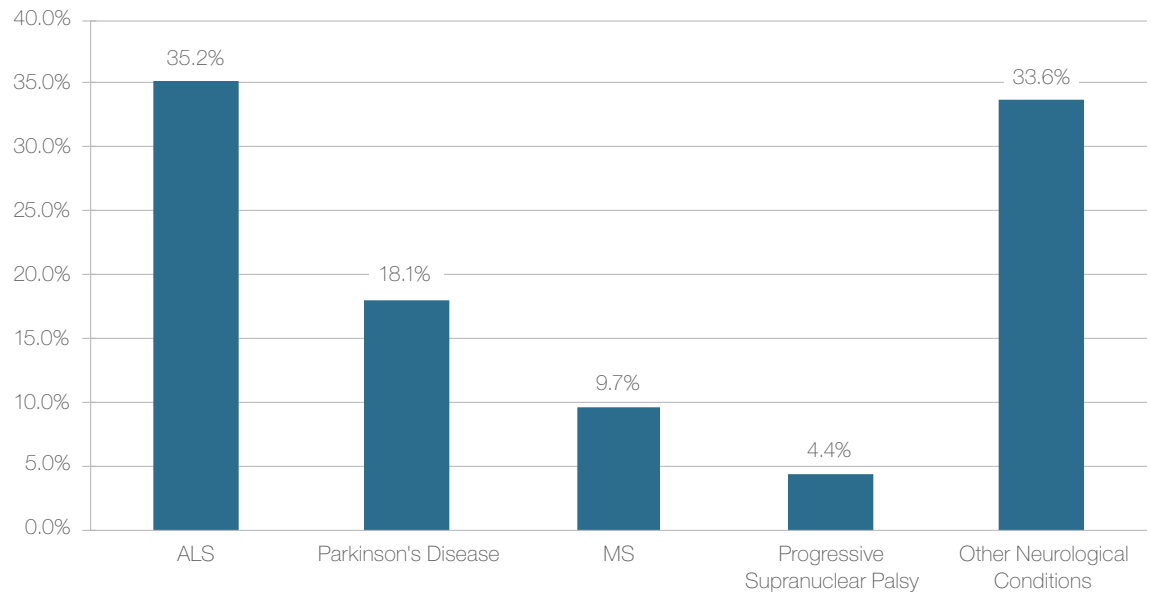
1. This chart represents MAID deaths where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Providers were able to select more than one medical condition when reporting; therefore, the total exceeds 100%.

Amyotrophic lateral sclerosis (ALS), also commonly known as Lou Gehrig's disease, was the leading neurological condition reported for persons receiving MAID (35.2%), followed by Parkinson's disease (18.1%) multiple sclerosis (MS) (9.7%), and progressive supranuclear palsy (4.4%). The remaining neurological conditions (33.6%) spanned a range of conditions including multiple system atrophy, neuropathy and Huntington's disease. In a small number of neurological cases, Alzheimer's disease or dementia was cited as one of the underlying main conditions (approximately 4.0% of neurological conditions or less than 0.5% of all MAID cases). In these cases, the patient was always able to provide informed consent.

> Patient was a brave woman who lived with a progressive neurological condition for the past 12 years. She was end-stage, severely frail and had lost the ability to care for herself. She was determined to die with dignity, as she did not wish to depend on others. She spoke with her children and others over the phone and said her goodbyes. She died through MAID accompanied by two hospice caregivers at home.
>
> *Practitioner report*

5 Statistics Canada, Table 13-10-0142-01

Chart 4.1C: MAID by Neurological Condition, 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Providers were able to select more than one medical condition when reporting; therefore, the total exceeds 100%.

Under organ failure, kidney disease (renal failure) was the most commonly reported condition (41.7%). Other organ failure conditions included liver failure or cirrhosis (13.8%) and bowel obstruction (9.3%). Multiple comorbidities and other conditions combined encompassed a wide range of conditions including diabetes, osteoporosis, osteoarthritis and fractures. Frailty was also commonly cited (nearly 3.0% of all MAID cases).

4.2 Gender, Average Age and Age Range of Patients Who Received MAID

In 2020, across Canada, a greater proportion of men (51.9%) than women (48.1%) received MAID. This gender differential is slightly greater than in 2019 (50.9% men vs 49.1% women). This finding is consistent across jurisdictions, with the exception of Manitoba, where the proportion of women receiving MAID was slightly higher.

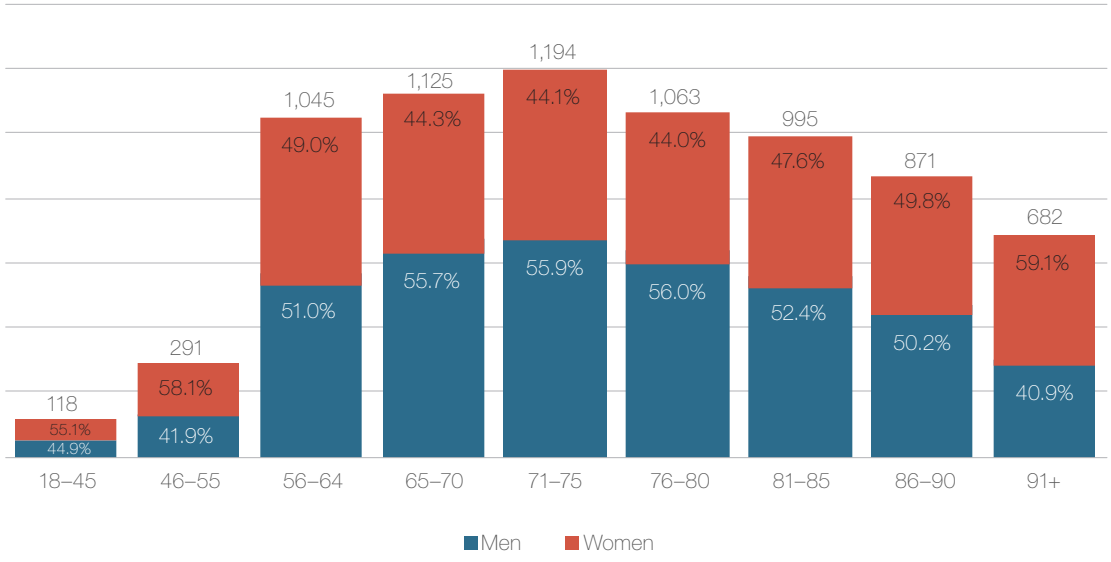
The average age at the time of MAID being provided was 75.3 years, virtually the same as in 2019 when the average age was 75.2 years. This is similar for both men (75.0) and women (75.5) at a national level. Across jurisdictions, the average age ranged from 72.1 in Prince Edward Island to 76.8 in British Columbia. Among the three largest jurisdictions with the greatest number of cases of MAID, Québec had the lowest average age at 73.9, while Ontario and British Columbia had a higher average age at 76.3 and 76.8 respectively.

The greatest proportion of persons receiving MAID in 2020 fell in the 71–75 age group (16.2%) followed closely by the 65–70 age category (15.2%) and the 76–80 age category (14.4%). Overall, 94.5% of MAID cases occurred at age 56 and older with 80.3% at age 65 and older. The fewest number of MAID cases occurred in the youngest age range (18–55) and oldest age range (age 91+) at 5.5% and 9.2% respectively.

Overall, the greatest number of MAID deaths occurs in the age range of 56 to 90. Within this age range, the proportion of men (50.2% to 56.0%) receiving MAID is slightly higher then women (44.0% to 49.8%). Outside this age range, the overall numbers of MAID provision are smaller and are therefore sensitive to small variations in case numbers. Interpretation of these results is therefore less reliable from a gender perspective. The greater number of women accessing MAID at age 90+ is consistent with the greater proportion of women than men living into their 10th decade.

These trends are consistent with 2019 observations. In keeping with the federal eligibility requirement under the federal legislation on MAID, there were no cases of MAID reported for persons under the age of 18.

Chart 4.2: MAID by Age Category, 2020

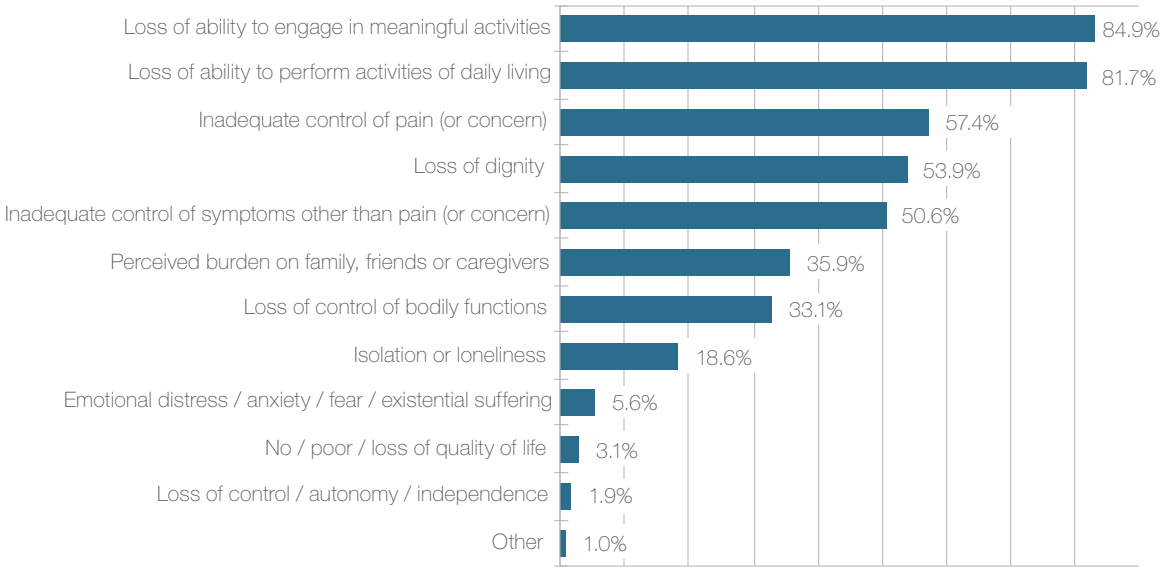


EXPLANATORY NOTE:
1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.

4.3 Nature of Suffering of Those Who Received MAID

In order to be eligible for MAID, patients must experience intolerable physical or psychological suffering that is caused by their medical condition or their state of decline and that cannot be relieved in a manner that the patient finds to be acceptable. Practitioners are required to report on how the person requesting MAID describes their suffering. The most commonly cited reason was the loss of ability to engage in meaningful activities (84.9%), followed closely by the loss of ability to perform activities of daily living (81.7%). These results are consistent with 2019 trends. A more detailed list of the nature of suffering is outlined in Chart 4.3.

Chart 4.3: Nature of Suffering of Those Who Received MAID, 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Providers were able to select more than one reason when reporting; therefore, the total exceeds 100%.

4.4 Palliative Care and Disability Support Services

Palliative care is an important component of the continuum of care at the end of life, offering essential supports to persons with life limiting illness. During 2020, the majority of MAID recipients (82.8%) received palliative care. Of those who received palliative care, the majority (54.8%) received those services for one month or more, 19.0% received palliative care services for a duration of two weeks to less than a month, and 18.1% received services for less than 2 weeks (with duration unknown in 8.1% of cases).

The receipt of palliative care did not vary significantly by jurisdiction, with nearly 70.0% or more patients in each jurisdiction reported as having received palliative care. The receipt of palliative care varied slightly by main condition with a higher percentage of cancer patients receiving palliative care (88.7%), compared to the receipt of palliative care for the following conditions: respiratory (74.0%), organ failure (73.3%), cardiovascular (72.1%), and neurological (62.4%).

Table 4.4: MAID Recipients Who Received Palliative Care and Disability Support Services, 2020

Palliative Care Services			Disability Support Services		
	Number	Percentage		Number	Percentage
Persons who received palliative care services	6,115	82.8%	**Persons who required disability support services**	3,219	43.6%
Persons who did not receive palliative care services	1,099	14.9%	**Persons who did not require disability support services**	2,783	37.7%
Unknown	170	2.3%	**Unknown**	1,382	18.7%
			Persons who received disability support services	2,897	90.0%
Palliative care was accessible if needed	973	88.5%	**Persons who required but did not receive disability support services**	123	3.8%
			Disability support services were accessible if needed	90	73.2%
Palliative Care - Duration			**Disability Support - Duration**		
Less than 2 weeks	1,104	18.1%	**Less than 6 months**	1,226	42.3%
2 weeks to under 1 month	1,163	19.0%	**6 months or longer**	1,012	34.9%
1 month or more	3,350	54.8%	**Unknown**	659	22.7%
Unknown	498	8.1%			

EXPLANATORY NOTES:
1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.

Of the MAID patients who did not receive palliative care (14.9%), 88.5% had access to these services, according to the reporting practitioner. These results are consistent with results reported in 2019, where 82.1% of MAID patients received palliative care, for similar durations, and with a similar rate of reported accessibility (89.6%). This is a significant finding given the overall importance of palliative care at the end-of-life and the shift to a greater percentage of cases where MAID is provided in home-based settings. These findings suggest that the COVID-19 pandemic did not affect the availability of palliative care for MAID patients in 2020.

In 2020, 43.6% of MAID recipients reported requiring disability support services. Of those MAID recipients who required disability support services, the majority, 90.0%, reported receiving these services in 2020. 42.3% received these services for less than six months, while 34.9% received services for 6 months or longer. 3.8% of MAID recipients reported needing disability support services but did not receive them. These results did not vary significantly by jurisdiction and are consistent with 2019 findings.

> The patient received palliative care for the last two years via family physician. The patient required disability supports, and services were available to him, but his wife wanted to provide all the care. In addition, patient had slurred speech and no other communication issues thus the only accommodation that was required was additional time.
>
> *Practitioner report*

A greater percentage of patients reporting a neurological condition (10.2%) were reported as requiring disability support services (64.0%). Cancer patients, who make up the majority of MAID cases (69.1%), reported the lowest requirement for disability support services (37.9%). Disability support services can encompass a wide range of supports, including assistive technologies, adaptive equipment, rehabilitation services, personal care services and disability based income supplements. This data does not speak to specific services provided, nor the adequacy of these services.

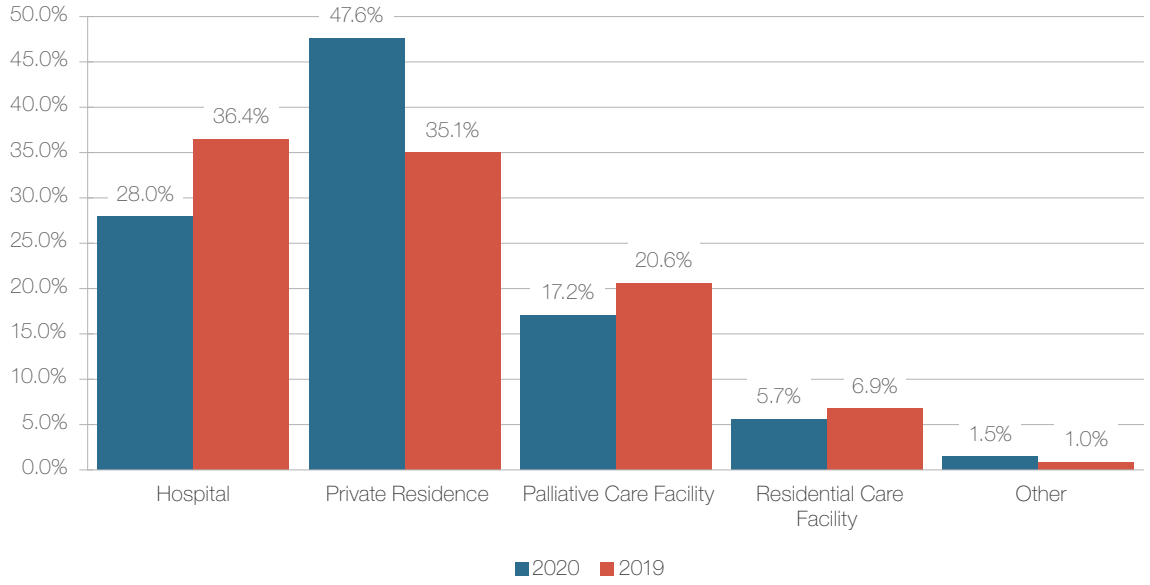
5.0 Delivery of MAID

5.1 Reported MAID Deaths by Setting

In 2020, the primary settings for the administration of MAID in Canada were private residences (47.6%) and hospitals (28.0%). This represents a significant change from 2019 where findings indicated that MAID was provided in hospitals and in private residences with nearly equal frequency (36.4% and 35.1% respectively). MAID was provided in palliative care facilities 17.2% of the time while the proportion of MAID cases taking place in residential care facilities such as long-term care facilities (5.7%) and other locations (1.5%) was lower.

MAID was more likely to be provided in private residences in Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. Hospital based delivery of MAID was more frequent only in Prince Edward Island and Québec. Notably, the percentage of provisions in hospital based settings in Québec decreased to 36.6% of cases in 2020 from 48.7% in 2019.

Chart 5.1: MAID Deaths by Setting, 2019 and 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Hospital excludes palliative care bed/unit; palliative care facility includes hospital-based palliative care bed/unit or hospice; residential care facility includes long term care facility; private residence includes retirement homes; other includes ambulatory setting or medical office / clinic.
3. 2019 data is presented here for comparison purposes with 2020 data.

The emergence of COVID-19 in early 2020 has influenced the delivery of health care nation-wide, with many health care services, including MAID assessments, in some jurisdictions, moving to online platforms. It is difficult to say conclusively if the shift in MAID delivery from an institutional setting to a home-based setting in 2020 correlates with the need for greater safety precautions associated with COVID-19 or to other factors. For example, there may also be a shift in patient preference away from long-term care homes and other similar facilities, in favour of remaining in their own homes[6], particularly in light of concerns around the transmission of COVID-19 among vulnerable populations. It may also be a reflection of the increased provincial/territorial emphasis on the delivery of health care in home and community-based settings.

> Jan died peacefully through MAID beside her husband at her home, overlooking the ocean. Registered Nurse and husband witnessed verbal consent. MAID was done with COVID-19 precautions.
>
> *Practitioner report*

5.2 Geographic Location of MAID: Urban vs. Rural Settings

Canadians living in urban areas generally have greater access to health care services than their rural counterparts.[7, 8] Although rural and remote location in itself may not necessarily lead to poor health, it may influence other socioeconomic, environmental and occupational health determinants.[9] Despite heterogeneity within and between Canadian rural communities, generally residents in these communities have worse health outcomes than those living in urban settings. Given this, it is worth exploring the data regarding geographic location of persons requesting and receiving MAID.

To better understand this dynamic in the context of assisted dying, work was done to link patient HINs to their associated postal codes in order to obtain the geographic classification of patients receiving MAID. In this analysis, the concept of a "population centre" is used to differentiate urban settings from rural areas. **A population centre is defined by Statistics Canada as having a** population of at least 1,000 and a population density of 400 persons or more per square kilometre, based on population counts from the current census.[10, 11, 12] **All areas outside population centres are classified as rural areas.**

Results show that the distribution of MAID patients in urban versus rural settings is roughly representative of their jurisdiction's general pattern of population distribution. Overall, the Atlantic provinces had the highest overall percentage of MAID cases in rural areas, ranging from 30.4% in Newfoundland and Labrador to 52.8% in Prince Edward Island. This is consistent with the fact that although the overall percentage of Canadians living in rural areas is 18.9%, the rural share of the population is higher in the Atlantic provinces. Ontario (81.4%), Alberta (81.0%) and British Columbia (83.6%) had the highest percentage of cases of MAID reported in urban areas. Similarly, this correlates with an urban population in excess of 80%.[13] Further study in this area may help to clarify any differences between access to and receipt of MAID based on geographic location.

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6 www.cbc.ca/news/canada/british-columbia/dr-ronald-bayne-geriatrician-seniors-advocate-medically-assisted-death-1.5931451

7 www.ncbi.nlm.nih.gov/pmc/articles/PMC7012120/

8 www.cihi.ca/sites/default/files/document/defining-stratifiers-measuring-health-inequalities-2018-en-web.pdf

9 www150.statcan.gc.ca/n1/pub/82-003-x/2019005/article/00001-eng.htm

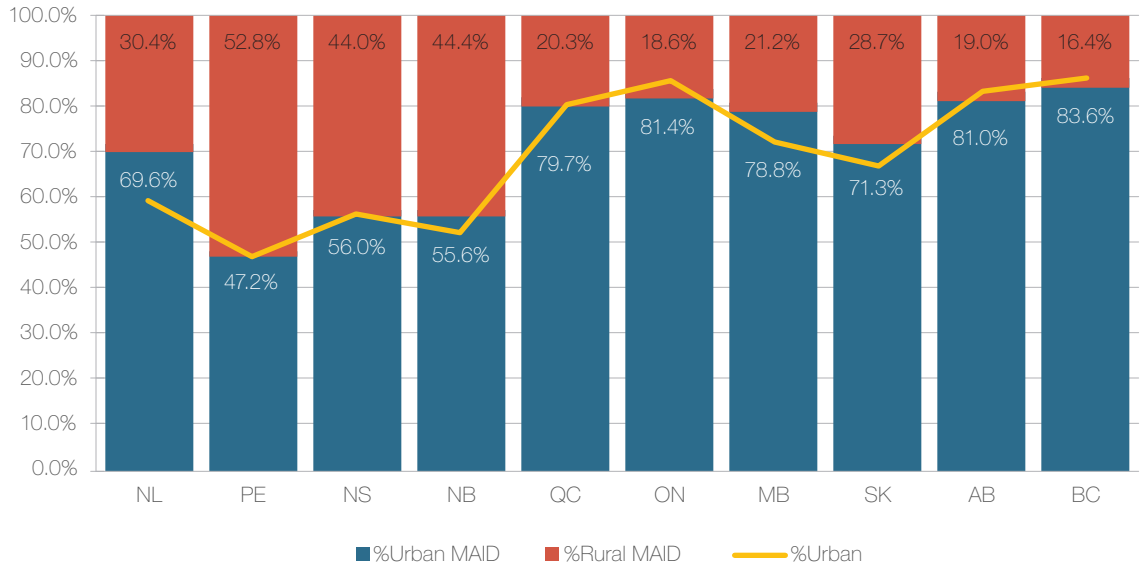
10 Statistics Canada, *Population Centre and Rural Area Classification 2016*. Ottawa, 2016. Available at: www.statcan.gc.ca/eng/subjects/standard/pcrac/2016/introduction.

11 What is defined as an "urban" setting encompasses small, medium and large population centres ranging in size from 1,000 to over 100,000 persons.

12 2016 Census

13 www150.statcan.gc.ca/n1/pub/91-003-x/2014001/section04/60-eng.htm

Chart 5.2: MAID Deaths: Urban vs Rural, 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Setting is derived via postal code analysis using the postal code associated with the patient's Health Insurance Number (HIN).
3. Statistics Canada. *Postal Code OM Conversion File Plus (PCCF+) Version 7C, Reference Guide*. February 2020.
4. % Urban: www150.statcan.gc.ca/n1/pub/91-003-x/2014001/section04/60-eng.htm

5.3 Number of Unique MAID Practitioners and Frequency of Provision

During 2020, physicians (representing 94.7% of MAID providers) provided 92.8% of medically assisted deaths, while nurse practitioners (representing 5.3% of MAID providers) provided 7.2%. In Canada, MAID can be provided by physicians in all provinces. Nurse practitioners practice in all jurisdictions but can provide MAID only in Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia and Nunavut. Within these provinces, nurse practitioners play a greater role in MAID, delivering 5.6% (Prince Edward Island) to 36.9% (Saskatchewan) of MAID procedures within their respective jurisdictions.

Overall, 1,345 unique practitioners provided MAID in Canada in 2020, representing an increase of 17.7% over the previous year. 1,274 (94.7%) were physicians and 71 (5.3%) were nurse practitioners. The number of unique nurse practitioners increased from 55 in 2019 to 71 in 2020 and their overall proportion in terms of the total number of providers increased slightly over 2019 (+0.5%).

In 2020, 40.2% of practitioners completed one MAID procedure, 44.9% completed 2–9 MAID procedures, and 14.9% completed 10 or more procedures. Notably, the percentage of practitioners completing 10 MAID procedures or more has increased by 2.5% in 2020 over 2019.

Despite the increase in the number of unique practitioners providing MAID during 2020, the percentage increase in cases of MAID in 2020 (34.2% over 2019), means that the MAID practitioners involved in multiple MAID procedures increased significantly in 2020.

Table 5.3: Unique MAID Practitioners in Canada and Frequency of Provision, 2019–2020

		2020		2019	
Number of Unique Practitioners	Physician	1,274	94.7%	1,088	95.2%
	Nurse Practitioner	71	5.3%	55	4.8%
	Total	1,345		1,143	
Practitioner Frequency	1 Procedure	541	40.2%	488	42.7%
	2–9 Procedures	604	44.9%	513	44.9%
	10+ Procedures	200	14.9%	142	12.4%
	Total	1,345		1,143	

EXPLANATORY NOTES:

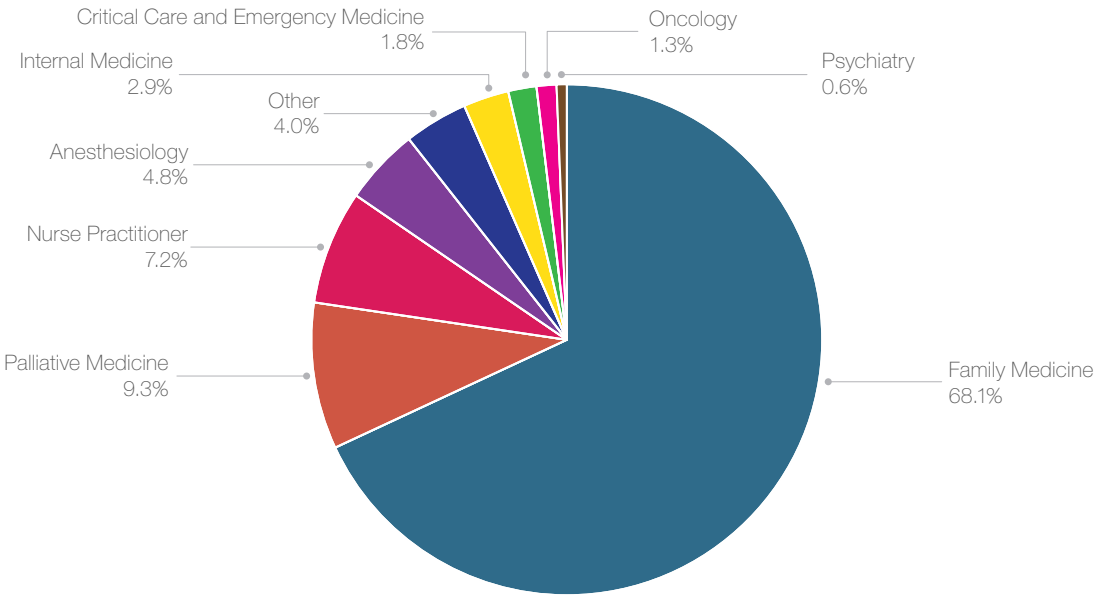
1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Data adjustments has resulted in the revision of 2019 results, which are presented here for comparison purposes with 2020 data.

5.4 Speciality of Practitioners Delivering MAID

The majority of practitioners providing MAID work within the specialities of family medicine (68.1% of procedures), palliative medicine (9.3% of procedures), nurse practitioners (7.2% of procedures) and anesthesiology (4.8% of procedures). The remaining 10.6% of procedures were delivered by practitioners working in a variety of medical specialities including internal medicine (2.9%), critical care and emergency medicine (1.8%), oncology (1.3%) and other (4.0%). These other specialists include surgeons, rehabilitation medicine specialists, MAID assessors/providers[14] and psychiatrists, found primarily in Québec, Ontario, Manitoba and Saskatchewan. Appendix A provides the breakdown of speciality of the MAID practitioner by jurisdiction.

14 While this speciality is not officially recognized by medical certifying bodies in Canada, it may be considered a functional speciality by some providers when MAID is the primary focus of their practice.

Chart 5.4: Speciality of MAID Practitioner, 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Specialty of MAID provider:
   Palliative Medicine includes: Palliative Medicine and Family and Palliative Medicine
   Internal Medicine includes: General Internal Medicine, Palliative care and Urology, Hospital Medicine, Gastroenterology and Endocrinology
   Critical Care and Emergency medicine includes: Emergency Medicine, Critical Care, Critical Care and Emergency Medicine
   Psychiatry includes: Psychiatry, Geriatric Psychiatry
   Other includes: MAID, Neurology, Respiratory Medicine, Surgeon, Rehabilitation Medicine, Nephrology, Cardiology, Geriatric Medicine, Obstetrician, Otolaryngology

5.5 Type of Practitioner Providing the Written Second Opinion (Assessment), 2020

For each case where MAID is provided, a second practitioner must provide a written second opinion confirming that the patient meets all of the eligibility criteria. In 2020, physicians provided 92.0% of second opinions, with 8.0% provided by nurse practitioners. This result is similar to 2019 data and again mirrors the proportion of practitioners providing MAID. No additional information is collected regarding the speciality of the practitioner providing the second opinion.

6.0 Safeguards and Supplementary Data

As discussed in Section 1.1, in order to receive MAID, all eligibility requirements as well as safeguards must be met (Table 1.1). All reports that are submitted to Health Canada, through the provincial/territorial designated recipients, or via the on-line portal, receive electronic verification for completeness. These include the verification of the patient's age as 18 years or older, that the person is eligible for publicly funded health care services in Canada, has been diagnosed with a grievous and irremediable medical condition, that the request is made voluntarily and that the patient is capable of making health care decisions and has provided informed consent. Under safeguards, the practitioner must confirm that the request has been made in writing and has been signed and dated by two independent witnesses, that eligibility has been confirmed by two independent practitioners and that the patient has been made aware of all treatment options available. This section discusses some other details surrounding eligibility and safeguards that are reported as part of the assessment and administration of MAID.

6.1 Source of the Written Request for MAID

When reporting MAID deaths, practitioners are required to identify from whom they received the individual's written request for MAID. Consistent with 2019 findings, in 2020 almost half of all written requests were received by practitioners through provincial or regional health authority MAID coordination services (46.4%). This was followed by requests that originated from the patient directly (30.1%) while other practitioners (physicians and nurse practitioners) were the source of 21.1% of requests. Finally, the remaining 2.4% of requests came from other sources such as hospitals, long term care facilities, or other care services, local/regional health authorities, nurses, social workers, or the request was a part of the patient's file.

These results vary substantially by jurisdiction. In Newfoundland and Labrador, Nova Scotia, Manitoba, Alberta and British Columbia, 60% or more of MAID requests were received through their provincial or regional health authority MAID coordination services. In Prince Edward Island, New Brunswick and Saskatchewan, over 50% of MAID requests were received from the patient directly. In Québec and Ontario, the jurisdictions with the highest overall number of cases of MAID, a significant number of requests were received from all three sources: MAID coordination services, the patient and other practitioners. A breakdown by jurisdiction is found in Appendix A.

6.2 Determination of the Patient's Request as Voluntary

A request for MAID must be made voluntarily, and not as a result of any external pressure. As part of the assessment of this eligibility criterion, practitioners are required to specify how they formed the opinion that the patient's request was voluntary. In nearly all cases where MAID was provided, the practitioner reported they had consulted directly with the patient to determine the voluntariness of the request for MAID.

As listed in Table 6.2, this determination was also made through consultation with family and friends, a review of medical records, and consultation with other health or social service professionals. In 14.1% of cases, the practitioner had knowledge of the patient from a prior consultation.

Table 6.2: Determination of the Patient's Request as Voluntary, 2020

Did the patient make a voluntary request for MAID that was not made of a result of external pressure? If yes, indicate why you are of this opinion.	
Consultation with the patient	99.2%
Consultation with family members or friends	59.8%
Review of medical records	46.3%
Consultation with other health or social service professionals	41.4%
Knowledge of patient from prior consultation (other than MAID)	14.1%
Other	0.4%

EXPLANATORY NOTES:
1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. Practitioners were able to identify more than one method they used to arrive at this conclusion, therefore totals exceed 100%.

6.3 Consultation With Other Health Care Professionals

In addition to the mandatory second opinion (assessment) required as part of the MAID legislation, practitioners also consulted with other health care professionals in 44.9% of cases. To inform their MAID assessment, practitioners may consult with other health care professionals who may be more familiar with the individual requesting MAID (e.g., the individual's primary care provider or a health care professional within the nursing home in which the individual lives) or who may have unique knowledge in the condition causing the individual's suffering. Nurses were the most commonly consulted health care professionals (44.1%) followed by primary care providers (35.9%), palliative care specialists (25.6%) and social workers (24.5%). A list of health care professionals that were consulted as part of MAID assessments is provided in Table 6.3. These results are consistent with findings from 2019.

> Prior to delivery of MAID the patient was interviewed alone, not under pressure to proceed with MAID, it was her choice, and she confirms her suffering. The patient is able to tell me what the procedure for MAID is and the outcome. She is competent to make the decision and proceed with MAID.
>
> *Practitioner report*

Table 6.3: Consultation With Other Health Care Professionals, 2020

Did you consult with other health care professionals to inform your assessment? Select all that apply.	
Nurse	44.1%
Primary Care Provider	35.9%
Palliative Care Specialist	25.6%
Social Worker	24.5%
Oncologist	12.0%
Other Physician	12.0%
Other - Record Review	5.1%
Other Consultation	5.1%
Psychiatrist	5.0%

EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.
2. "Other physician" included consultations with a wide range of over 20 medical specialties, the most common being neurologists, hospitalists, and respirologists/ pulmonologists.
3. Examples of entries in "other consultation" included psychologist, speech pathologist, spiritual care, and bio/medical ethicists.

6.4 The 10 Clear Day Reflection Period

Bill C-14 stipulates that there must be 10 clear days[15] between the day on which the patient signs the formal written request for MAID and the day on which MAID is provided. This is often referred to as the reflection period. In the majority of cases, the request is signed after the practitioner receives it. However, in a small minority of cases, the request is signed prior to it being submitted it to the practitioner.

The law permits this safeguard to be waived if both MAID assessors agree that the patient's death is imminent or that the patient is at risk of losing capacity to provide final consent prior to satisfying the 10-day reflection requirement.

In 65.7% of deaths, MAID was provided after completion of the 10-day reflection period, while in 34.3% of cases, this period was shortened. The most common reason cited for shortening the reflection period was the imminent loss of the patient's capacity to consent (87.4%) with imminent death cited in 50.1% of these cases.[16] These results are consistent with findings from 2019.

> Louie was a lovely man, diagnosed with stage IV lung cancer. I was involved in his care through palliative care. It was clear to him that he wanted to die through MAID. His decline was so fast that both assessors agreed to accelerate the date for MAID. Patient died peacefully beside his wife.
>
> *Practitioner report*

15 In calculating the 10 clear days, the day on which is request was signed and the day on which MAID was provided, are not included.

16 In some scenarios, both circumstances applied, explaining why the total exceeds 100%.

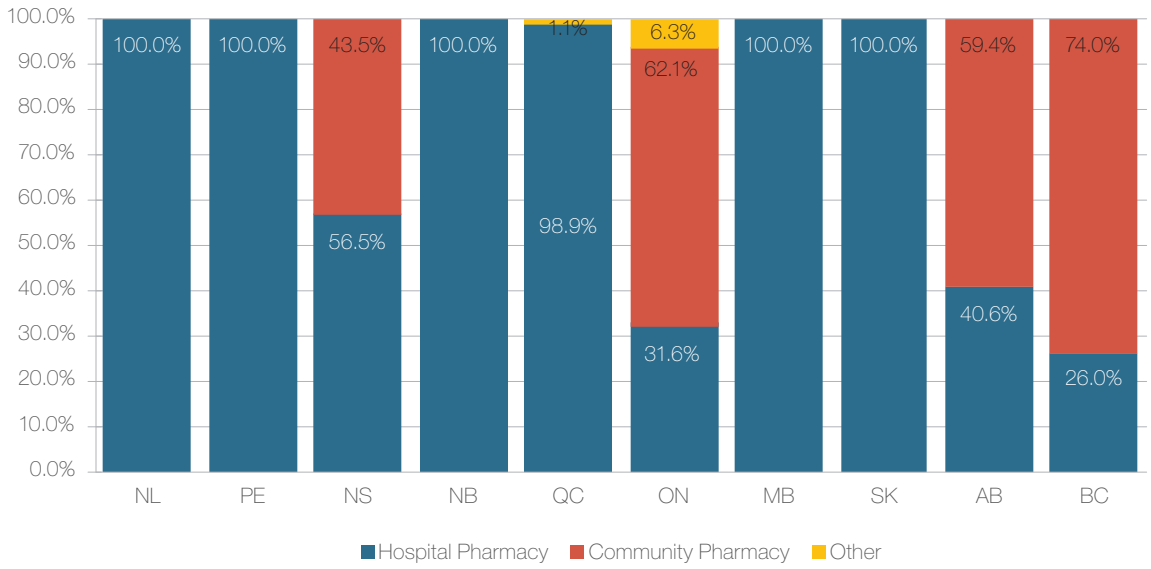
6.5 Information Received from Pharmacists

Pharmacists are required to report when a substance is dispensed for MAID. While the majority of pharmacist reports received are for drugs that have been used in the administration of MAID, in some instances, a pharmacist report may be received when a substance has been dispensed but the patient has died or withdrawn their request prior to MAID being administered. In the cases where MAID has been provided, pharmacist reports are matched to the corresponding practitioner report, as described under Section 2.1, in order to ensure completeness of MAID reporting.

Pharmacist reports also provide information about the type of pharmacy that dispensed the MAID drugs. Each jurisdiction has different guidelines regarding the dispensing of these types of drugs. In Newfoundland and Labrador, Prince Edward Island, New Brunswick, Manitoba and Saskatchewan, MAID drugs are dispensed exclusively by hospital pharmacies. In Québec, the majority of drugs (98.9%) are dispensed by hospital pharmacies; with the remainder (1.1%) being dispensed by pharmacies located within long-term care residences.

Nova Scotia, Ontario, Alberta and British Columbia allow dispensing of MAID drugs by both community and hospital pharmacies. In addition, Ontario also sources drugs from a small percentage of speciality pharmacies (IV, compounding). The use of community pharmacies correlates with a greater percentage of provisions in the home versus hospital settings.

Chart 6.5: Dispensing of MAID Drugs by Pharmacy Type, 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths.

7.0 Requests That Do Not Result in a MAID Death

7.1 Number of Requests and Outcomes

As outlined in Table 7.1, there were 9,375 written requests for MAID reported in 2020. This represents an increase of 23.5% over the number of written requests reported in 2019. As discussed in Section 2.3, federal monitoring is based solely on written requests for MAID. As such, the total number of requests reported does not fully reflect the interest in MAID. In particular, verbal requests are not captured in the number of total requests and associated outcomes, even when a formal assessment for MAID may have been undertaken. Similarly, total requests in the following analysis does not capture situations when a patient's initial request is received by a nurse or other health care professional and never forwarded to a physician or nurse practitioner.

The majority of written requests (7,384 or 78.8%) in 2020 resulted in MAID being administered. The remaining 1,991 (21.2%) resulted in an outcome other than MAID: 232 patients withdrew their request (2.5% of requests), 566 patients were deemed ineligible (6.0% of requests), and 1,193 patients died prior to receiving MAID (12.7% of requests). These results are similar to 2019, where 5,430 requests (71.5%) resulted in a MAID death, and 2,164 (28.5%) having one of the other outcomes: patient withdrew their request (3.8% of requests), patient was deemed ineligible (7.9% of requests), and patient died prior to receiving MAID (16.8% of requests).

Table 7.1: MAID Requests and Outcomes by Jurisdiction, 2020

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YT	NT	NU	Canada
Maid Requests	58	39	203	181	2,853	2,899	315	173	675	1,958	–	–	–	9,375
Requests that have been declined (ineligible)	–	–	–	–	256 (9.0%)	123 (4.2%)	–	–	47 (7.0%)	116 (5.9%)	–	–	–	566 (6.0%)
Requests that have been withdrawn	–	–	–	–	143 (5.0%)	43 (1.5%)	–	–	10 (1.5%)	24 (1.2%)	–	–	–	232 (2.5%)
Requests where the individual died prior to MAID	9 (15.5%)	–	16 (7.9%)	31 (17.7%)	334 (11.7%)	362 (12.5%)	93 (29.5%)	–	66 (9.8%)	265 (13.5%)	–	–	–	1,193 (12.7%)
Requests that resulted in a medically-assisted death	46 (79.3%)	36 (92.3%)	175 (86.2%)	144 (79.6%)	2,120 (74.3%)	2,371 (81.8%)	212 (67.3%)	157 (90.8%)	552 (81.8%)	1,553 (79.3%)	13 (–)	–	–	7,384 (78.8%)

EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths and an overall total of 9,375 written requests.
2. It is acknowledged that jurisdictions may report different numbers of total requests and outcomes for the various scenarios (ineligible, withdrawal, or patient died) based on their own methodology for receiving and counting requests.
3. Refer to Data Limitations (Section 2.3) for an explanation of why referrals are not included in this table.
4. Due to small numbers, some data have been suppressed to protect confidentiality (represented by dashes).
5. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request. All other requests are counted in the year in which they are received.
6. Cases of self-administered MAID are included in this table. They are not identified by jurisdiction in order to protect confidentiality.

7.2 Ineligibility

In 2020, 566 patients were deemed ineligible for MAID, representing 6.0% of the total written requests received. In 2019, this number was 602 (7.7% of written requests). In addition to those assessments reported through the federal monitoring regime, assessments of ineligibility may have been made via verbal assessment and without receipt of a formal written request, and not reported to Health Canada, therefore, not counted in the official numbers.

All eligibility criteria must be met in order to receive MAID (see Table 1.1). The most common reason for an assessment of ineligibility was due to the individual not being capable of making decisions with respect to their health (37.1%). This was followed closely by natural death not being reasonably foreseeable (27.7%) and not providing informed consent (17.3%). A summary of the reasons for ineligibility during 2020 is listed in Table 7.2. These findings are similar to 2019 trends.

> Unfortunately, between the times the patient completed Clinician A and Clinician C forms her condition deteriorated. She was no longer mentally capable of making an informed decision at the time I was asked to do the Clinician B assessment. Therefore, MAID was not pursued and the patient died peacefully of natural causes a few days later.
>
> *Practitioner report*

Slightly more females (53.5%) than males (46.5%) were deemed ineligible for MAID. The average age was 76.1 and 93.8% were age 56 and older. 55.6% of ineligible patients had cancer listed as their main condition.

Table 7.2: Reasons for Ineligibility for MAID, 2020

What were the reasons for the patient's ineligibility? Select all that apply.	
Not capable of making decisions with respect to health	37.1%
Natural death not reasonably foreseeable	27.7%
Could not provide informed consent	17.3%
Not in an advanced state of irreversible decline in capability	16.3%
Not experiencing suffering that is intolerable to them	15.2%
Did not have a serious and incurable illness, disease or disability	11.1%
Request was not voluntary	2.8%

EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 9,375 written MAID requests including 566 individuals deemed ineligible for MAID.
2. Since practitioners could determine that an individual did not meet more than one of these criteria, the total responses exceed 100%.

7.3 Patient Withdraws Their Request for MAID

In 2020, 232 patients withdrew their request for MAID, representing 2.5% of all written requests. A similar proportion of requests were withdrawn in 2019 (3.8%, or 289). 57.8% of the requests for MAID that were withdrawn were from men, while 42.2% were from women. This differs slightly from 2019 (54.4% of withdrawals were from women and 45.6% were from men). The average age was 75.8 and 93.5% were over the age of 56. Cancer was listed as a main condition in 57.3% of these cases.

> Upon admission to the palliative care unit for assessment by the first physician for a request for PAD, the patient was quickly relieved and taken care of in terms of care that was exhausting him at home (living alone). Adequate pain relief and appropriate care quickly led the patient to spontaneously conclude that he did not wish to die immediately, but to receive comfort care appropriate to his condition. The patient chose to cancel his PAD application spontaneously and voluntarily within hours of admission. His decision remained unchanged during the week.
>
> *Practitioner report*

When reporting, practitioners are asked to select from a list of reasons why a request for MAID was withdrawn. Practitioners could select more than one reason if applicable. The main reasons for the withdrawal of a MAID request were that the patient changed their mind (66.4% of cases) and/or that palliative measures were sufficient (47.8% of cases). These results differ slightly from 2019, where 54% of patients changed their mind, and 26.2% of patients decided that palliative measures were sufficient.

Given the small number of patients in this category relative to the overall MAID population, it is not possible to draw any definitive conclusions based on the annual differences in these results.

Of the 232 individuals that withdrew their request for MAID, 22.0% (51 patients) did so immediately before the MAID procedure.

Table 7.3: Reason for Withdrawal of MAID Request, 2020

What were the patient's reasons for withdrawing the request? Select all that apply.	
Changed their mind	66.4%
Palliative measures are sufficient	47.8%
Other	12.1%
Family members do not support MAID	7.8%
Unknown reason	1.3%
Withdrawal immediately before MAID	22.0%

EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 9,375 written MAID requests including 232 cases where the individual withdrew their MAID request.
2. Providers were able to select more than one reason for withdrawal; therefore, the total exceeds 100%.

7.4 Patient Died of a Cause Other Than MAID

In 2020, practitioners reported that 1,193 patients died of another cause prior to receiving MAID. This represents 12.7% of the total written requests received. This finding is slightly lower than in 2019, where 16.8% of written requests (1,273) resulted in a death prior to MAID. This scenario includes patients who died less than 10 days after submitting their written request, or prior to their scheduled date for MAID. Practitioners are required to report cases not resulting in MAID if the outcome occurs within 90 days of the receipt of the written request, where the outcome is known.

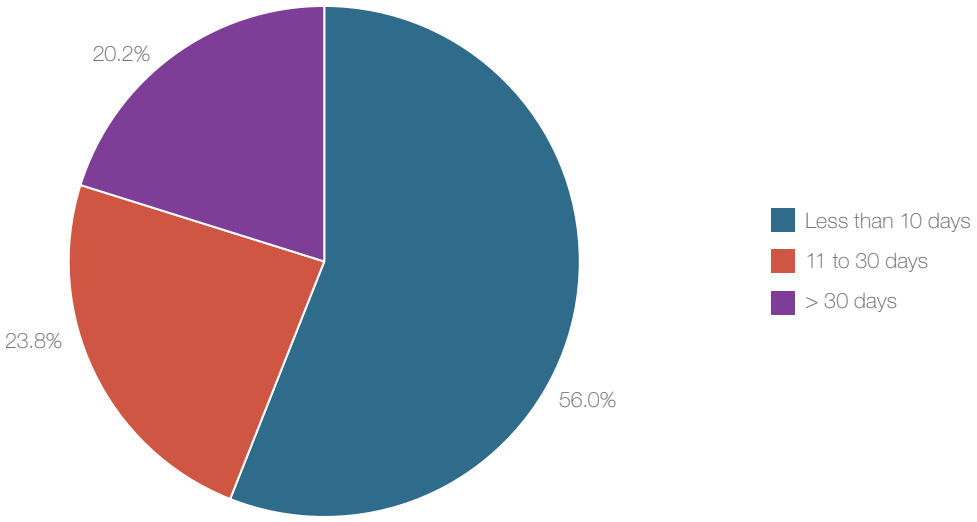
53.4% of patients who died prior to receiving MAID were men and 46.6% were women, which is similar to the sex distribution of patients who received MAID. The average age was 73.0. 87.5% received palliative care and, for those that did not, 95.5% had palliative care accessible to them if required.

Of the 1,193 patients who died prior to receiving MAID, 76.8% were reported as having cancer as the main underlying condition, followed by 9.8% with respiratory conditions, 8.6% with cardiovascular conditions and 4.3% with neurological conditions (more than one condition can be selected).

> The patient was seen by myself as First Physician to assess eligibility for MAID in the palliative care ward. She had not yet tried palliative sedation or other measures even though these were offered to her. She declined palliative medications because she was afraid of losing capacity to qualify for MAID. It was clear she needed immediate relief and I told her I expected she would die before the procedure, and that other measures were immediately available to her to give her relief. She consented to palliative sedation by the palliative care team and died very quickly and peacefully.
>
> *Practitioner report*

Where the date of death was reported (in 91.5% of cases), 611 (56.0%) of patients died within 10 days of submitting their request, while 260 (23.8%) died between 11–30 days after their request was submitted, and 220 (20.2%) died over 30 days following the submission of their request. It has been reported that some patients receive a therapeutic benefit just by being approved for MAID, even if they do not go through with receiving MAID. These trends are similar to 2019 results and do not suggest any timing differences due to COVID-19. On average, these patients died 8 days after submitting their written request for MAID.

Chart 7.4: Timing of Death Following Submission of the Written Request (Patient Died of Another Cause), 2020



EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 9,375 written MAID requests including 1,193 deaths prior to MAID.

8.0 Conclusion

The Québec Superior Court's ruling in Truchon and Gladu v. Canada (Attorney General) and Québec (Attorney General)[17] in September 2019, and the subsequent introduction of the Government's response through Bill C-7 in 2020, have re-ignited public discussions and debate on the topic of access to MAID for a broader group of Canadians.

At the beginning of 2020, the Government of Canada held online consultations and hosted in-person roundtables with experts and stakeholders to inform the Government's response to the court ruling. Following its introduction and prior to the prorogation of Parliament due to the pandemic, Bill C-7 was subject to intense scrutiny and debate in the House of Commons and the Senate. After the Parliamentary session resumed in the Fall of 2020, the House and Senate Committees tasked with reviewing Bill C-7 heard from over 120 expert witnesses from many fields, including law, medicine, ethics, health professional training and regulation, disability rights, mental health and Indigenous health. The final Bill, which passed and received Royal Assent on March 17, 2021, was informed by a broad range of expertise and opinion, and ensures support for the exercise of individual autonomy, while providing significant protections so individuals are not induced to pursue MAID when circumstances do not warrant serious consideration of a medically assisted death. The new law includes changes to eligibility – particularly in respect of applicants who are suffering grievously but whose death is not reasonably foreseeable – a two stream approach to procedural safeguards, and expansion of the framework for the federal government's data collection and reporting regime. A full list of the changes and information about Canada's current MAID framework can be found on the websites of the Department of Justice and Health Canada.

> Joe was my patient in the community for eight years. I knew him well and we had many conversations about MAID over the past two years. He was always clear that it was his intent to proceed, and when the time came, he requested MAID. I was able to attend to his home with our MAID team and administer medications after deeming him competent to make said medical decision and determining that he was free of external pressure. He had a very peaceful death. His family was very happy to be with him and have him lucid just before he passed.
>
> *Practitioner report*

As essential follow-up to Bill C-7, Health Canada will be amending the federal Regulations for the Monitoring of Medical Assistance in Dying to align with the revised eligibility criteria and safeguards as well as other data collection requirements spelled out in the new legislation.

As discussed in Section 2.3, collecting data based solely on written requests (as required by the former legislation and corresponding Regulations) has resulted in some data gaps. Bill C-7 addresses these gaps by allowing the collection of information on all assessments for MAID, including preliminary assessments undertaken by other health care professionals. To address concerns regarding the potential for some vulnerable groups to be over-represented in MAID cases, or possibly denied access, Bill C-7 requires that data be collected with respect to race, Indigenous identity and disability. Expanding the MAID monitoring regime in this way will help to determine the presence of any inequalities or disadvantages in Canada's MAID regime based on these or other characteristics.

17 Truchon c. Procureur général du Canada, 2019 QCCS 3792

In amending the MAID monitoring regulations, the Government will consult with a broad range of stakeholders, including groups representing persons experiencing inequalities, to ensure that appropriate information is collected and in a way that is respectful and inclusive. While the new regulations are being developed, to further strengthen data collection and reporting, Health Canada is exploring opportunities with Statistics Canada to securely link MAID data with other data holdings. These data linkages, along with the changes to the monitoring regime, will help us gain a fuller understanding of MAID in Canada.

Beyond requiring enhanced data collection, Bill C-7 sets out two other commitments for parliamentarians and the Government. First, it requires that "a comprehensive review of the provisions of the *Criminal Code* relating to medical assistance in dying and their application, including but not limited to issues relating to mature minors, advance requests, mental illness, the state of palliative care in Canada and the protection of Canadians with disabilities must be undertaken by a Joint Committee of both Houses of Parliament." Second, it requires the Ministers of Justice and Health to initiate an independent review "respecting recommended protocols, guidance and safeguards to apply to requests for MAID made by persons who have a mental illness." To address this requirement, Health Canada and the Department of Justice are launching an independent Expert Panel tasked with providing a final report of its conclusions and recommendations to Ministers by March 17, 2022 (within one year of Bill C-7 receiving Royal Assent), as per the legislation. This work will help ensure that practitioners are equipped to assess these requests in a safe and compassionate way based on rigorous clinical standards that are applied consistently across the country.

The expansion of the MAID regime to persons whose death is not reasonably foreseeable presents new challenges for provincial and territorial governments and practitioners as they work to ensure safe, sensitive and consistent application of the law in health systems across the country. Health Canada will continue to work closely with provincial and territorial governments, medical experts and other stakeholders over the next year and beyond to support the implementation of Bill C-7 and any future legislative changes that may occur.

Appendix A: Profile of Medical Assistance in Dying by Jurisdiction January 1 to December 31, 2020

Jurisdiction		NL		PE		NS		NB		QC		ON		MB		SK		AB		BC		YT		NT		NU	
Population		522,103		159,625		979,351		781,476		8,574,571		14,734,014		1,379,623		1,178,681		4,421,876		5,147,712		42,052		45,161		39,353	
Total number of medically assisted deaths		46		36		175		144		2,120		2,371		212		157		552		1,553		13		–		–	
Number of medically assisted deaths by setting	**Hospital**	14	30.4%	19	52.8%	77	44.0%	47	32.6%	775	36.6%	464	19.6%	71	33.5%	66	42.0%	181	32.8%	345	22.2%	–	–	–	–	–	–
	Private Residence	26	56.5%	10	27.8%	78	44.6%	57	39.6%	733	34.6%	1,382	58.3%	96	45.3%	72	45.9%	237	42.9%	820	52.8%	–	–	–	–	–	–
	Palliative Care Facility	–	–	–	–	13	7.4%	33	22.9%	515	24.3%	356	15.0%	28	13.2%	9	5.7%	62	11.2%	245	15.8%	–	–	–	–	–	–
	Residential Care Facility / Other	–	–	–	–	7	4.0%	7	4.9%	97	4.6%	169	7.2%	17	8.0%	10	6.4%	72	13.0%	143	9.2%	–	–	–	–	–	–
Average age of person who received MAID		72.7		72.1		73.6		72.6		73.9		76.3		75.8		73.4		73.3		76.8		75.3		–		–	
Age range of person receiving MAID	**18–45**	–	–	–	–	–	–	–	–	27	1.3%	38	1.6%	–	–	–	–	20	3.6%	19	1.2%	–	–	–	–	–	–
	46–55	–	–	–	–	14	8.0%	7	4.9%	88	4.2%	87	3.7%	–	–	–	–	30	5.4%	42	2.7%	–	–	–	–	–	–
	56–64	–	–	–	–	30	17.1%	29	20.1%	328	15.5%	305	12.9%	37	17.5%	21	13.4%	91	16.5%	185	11.9%	–	–	–	–	–	–
	65–70	–	–	–	–	25	14.3%	32	22.2%	386	18.2%	306	12.9%	32	15.1%	32	20.4%	84	15.2%	217	14.0%	–	–	–	–	–	–
	71–75	–	–	–	–	27	15.4%	26	18.1%	370	17.5%	364	15.4%	28	13.2%	24	15.3%	78	14.1%	260	16.7%	–	–	–	–	–	–
	76–80	–	–	–	–	20	11.4%	12	8.3%	314	14.8%	361	15.2%	29	13.7%	18	11.5%	82	14.9%	211	13.6%	–	–	–	–	–	–
	81–85	–	–	–	–	23	13.1%	20	13.9%	271	12.8%	341	14.4%	20	9.4%	15	9.6%	60	10.9%	228	14.7%	–	–	–	–	–	–
	86–90	–	–	–	–	21	12.0%	12	8.3%	221	10.4%	287	12.1%	24	11.3%	20	12.7%	65	11.8%	214	13.8%	–	–	–	–	–	–
	91+	–	–	–	–	–	–	–	–	115	5.4%	282	11.9%	32	15.1%	13	8.3%	42	7.6%	177	11.4%	–	–	–	–	–	–
Number of men / women receiving MAID	**Men**	31	67.4%	23	63.9%	102	58.3%	83	57.6%	1,097	51.7%	1,201	50.7%	104	49.1%	89	56.7%	300	54.3%	795	51.2%	–	–	–	–	–	–
	Women	15	32.6%	13	36.1%	73	41.7%	61	42.4%	1,023	48.3%	1,170	49.3%	108	50.9%	68	43.3%	252	45.7%	758	48.8%	–	–	–	–	–	–
Most common reported underlying medical condition of patients who obtain a medically assisted death	**Cancer-Related**	32	69.6%	24	66.7%	132	75.4%	107	74.3%	1,572	74.2%	1,598	67.4%	143	67.5%	116	73.9%	373	67.6%	990	63.7%	–	–	–	–	–	–
	Neurological Condition	–	–	–	–	18	10.3%	10	6.9%	211	10.0%	242	10.2%	20	9.4%	15	9.6%	72	13.0%	155	10.0%	–	–	–	–	–	–
	Chronic Respiratory Disease	–	–	–	–	18	10.3%	16	11.1%	216	10.2%	266	11.2%	20	9.4%	18	11.5%	72	13.0%	200	12.9%	–	–	–	–	–	–
	Cardiovascular	–	–	–	–	13	7.4%	14	9.7%	237	11.2%	363	15.3%	34	16.0%	23	14.6%	66	12.0%	265	17.1%	–	–	–	–	–	–
	Other Organ Failure	–	–	–	–	9	5.1%	–	–	125	5.9%	154	6.5%	13	6.1%	10	6.4%	39	7.1%	122	7.9%	–	–	–	–	–	–
	Multiple Comorbidities	–	–	–	–	–	–	8	5.6%	94	4.4%	220	9.3%	21	9.9%	14	8.9%	45	8.2%	160	10.3%	–	–	–	–	–	–
	Other Condition	–	–	–	–	–	–	–	–	96	4.5%	174	7.3%	13	6.1%	10	6.4%	54	9.8%	275	17.7%	–	–	–	–	–	–
Location	**Urban**	32	69.6%	17	47.2%	98	56.0%	80	55.6%	1,689	79.7%	1,931	81.4%	167	78.8%	112	71.3%	447	81.0%	1,299	83.6%	–	–	–	–	–	–
	Rural	14	30.4%	19	52.8%	77	44.0%	64	44.4%	431	20.3%	440	18.6%	45	21.2%	45	28.7%	105	19.0%	254	16.4%	–	–	–	–	–	–

Jurisdiction		NL		PE		NS		NB		QC		ON		MB		SK		AB		BC		YT		NT		NU	
Speciality of MAID provider	**Family Medicine**	31	67.4%	27	75.0%	90	51.4%	102	70.8%	1,696	80.0%	1,226	51.7%	123	58.0%	34	21.7%	407	73.7%	1,283	82.6%	–	–	–	–	–	–
	Palliative Medicine	–	–	–	–	16	9.1%	42	29.2%	166	7.8%	421	17.8%	0	0.0%	–	–	7	1.3%	18	1.2%	–	–	–	–	–	–
	Anesthesiology	–	–	–	–	16	9.1%	0	0.0%	27	1.3%	255	10.8%	0	0.0%	13	8.3%	–	–	42	2.7%	–	–	–	–	–	–
	Internal Medicine	–	–	–	–	–	–	0	0.0%	100	4.7%	60	2.5%	0	0.0%	0	0.0%	–	–	35	2.3%	–	–	–	–	–	–
	Critical Care / Emergency Medicine	–	–	–	–	15	8.6%	0	0.0%	19	0.9%	92	3.9%	0	0.0%	0	0.0%	–	–	0	0.0%	–	–	–	–	–	–
	Oncology	–	–	–	–	–	–	0	0.0%	31	1.5%	26	1.1%	0	0.0%	0	0.0%	26	4.7%	0	0.0%	–	–	–	–	–	–
	Psychiatry	–	–	–	–	–	–	0	0.0%	0	0.0%	0	0.0%	0	0.0%	42	26.8%	–	–	–	–	–	–	–	–	–	–
	Other	–	–	–	–	13	7.4%	0	0.0%	81	3.8%	94	4.0%	89	42.0%	–	–	–	–	–	–	–	–	–	–	–	–
	Nurse Practitioner	0	0.0%	–	–	21	12.0%	0	0.0%	0	0.0%	197	8.3%	0	0.0%	58	36.9%	90	16.3%	165	10.6%	–	–	–	–	–	–
Source of the written request	**Patient Directly**	10	21.7%	27	75.0%	28	16.0%	75	52.1%	678	32.0%	879	37.1%	54	25.5%	108	68.8%	49	8.9%	303	19.5%	–	–	–	–	–	–
	Another Practitioner	6	13.0%	9	25.0%	40	22.9%	61	42.4%	592	27.9%	485	20.5%	0	0.0%	22	14.0%	30	5.4%	307	19.8%	–	–	–	–	–	–
	Care Coordination Service	30	65.2%	0	0.0%	107	61.1%	7	5.6%	760	35.8%	945	39.9%	158	74.5%	27	17.2%	473	85.7%	924	59.5%	–	–	–	–	–	–
	Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	90	4.2%	32	2.6%	0	0.0%	0	0.0%	0	0.0%	19	1.2%	–	–	–	–	–	–

EXPLANATORY NOTES:

1. This chart represents MAID data where the report was received by Health Canada by January 31, 2021. For 2020, this represents 7,384 MAID deaths and an overall total of 9,375 written requests.
2. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request.
3. Due to small numbers, some data have been suppressed to protect confidentiality (represented by dashes).
4. Cases of self-administered MAID are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.
5. Statistics Canada. Table 17-10-0005-01 Population estimates on July 1st, by age and sex
6. Specialty of MAID provider:
   - Palliative Medicine includes: Palliative Medicine and Family and Palliative Medicine
   - Internal Medicine includes: General Internal Medicine, Palliative care and Urology, Hospital Medicine, Gastroenterology and Endocrinology
   - Critical Care and Emergency medicine includes: Emergency Medicine, Critical Care, Critical Care and Emergency Medicine
   - Psychiatry includes: Psychiatry, Geriatric Psychiatry
   - Other includes: MAID, Neurology, Respiratory Medicine, Surgeon, Rehabilitation Medicine, Nephrology, Cardiology, Geriatric Medicine, Obstetrician, Otolaryngology
7. Underlying Medical Condition: Providers were able to select more than one medical condition when reporting; therefore, the total exceeds 100%.
8. MAID By Setting: Hospital excludes palliative care bed/unit; palliative care facility includes hospital-based palliative care bed/unit or hospice; residential care facility includes long term care facility; private residence includes retirement homes ; other includes ambulatory setting or medical office / clinic.