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2nd Interim Report on

MEDICAL ASSISTANCE IN DYING IN CANADA

Canada

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INTRODUCTION

June 17, 2017 marked the one-year anniversary of the passage of legislation permitting medical assistance in dying in Canada. Since that time, most provinces and territories and their associated health provider regulatory bodies, have introduced guidelines and policies to support the oversight and delivery of medical assistance in dying in their respective jurisdictions.

In countries that permit some form of assisted dying, public reporting is considered to be a critical component in fostering transparency and public trust. The federal legislation that permits medical assistance in dying in Canada authorizes the federal Minister of Health to make regulations to collect and publicly report on information relating to requests for, and the provision of, medical assistance in dying in Canada. Health Canada is currently developing regulations to establish the federal monitoring system, which will come into force in 2018 following a period of public consultation.

All governments in Canada recognize the importance of timely public reporting on medical assistance in dying in ensuring transparency and public trust. To this end, federal, provincial, and territorial governments are working collaboratively to produce interim updates using available data while regulations to establish a permanent monitoring system are being put in place. The first of these federal updates was released on April 26, 2017, and covered the first six months of the implementation of the federal legislation on assisted dying (June 17 to December 31, 2016). This second update will build upon the first report, providing additional information on requests for medical assistance in dying between January 1 and June 30, 2017, and include an analysis of trends where comparable data permits.

IMPLEMENTATION OF MEDICAL ASSISTANCE IN DYING

While federal legislation establishes the eligibility criteria and safeguards related to the lawful provision of medical assistance in dying in Canada, it is provincial and territorial governments that are primarily responsible for the delivery of health care services and for law enforcement across the country. Over the past year, jurisdictions have worked to implement legislation or policies related to the oversight and delivery of medical assistance in dying in their jurisdictions.

For example, in May 2017, the Medical Assistance in Dying Statute Law Amendment Act, came into force in Ontario to provide greater clarity and legal protections for health service providers, including institutions, clinicians, and patients. This legislation ensures that insurance benefits that would otherwise be paid out to individuals are not denied because of a medically assisted death, provides protections to physicians and nurse practitioners from civil liability when lawfully providing medical assistance in dying, and requires health providers to notify the Chief Coroner of Ontario of all medically assisted deaths.

Some jurisdictions have also introduced additional measures that all health practitioners providing medical assistance in dying in the province must follow. The province of British Columbia requires the prescribing physician or nurse practitioner to be present with the patient during self-administered or administration of medical assistance in dying until death is confirmed, and to report all cases of assisted dying to the BC Coroner's Service.

The province of Quebec, whose legislation on *medical aid in dying* predated the federal legislation on medical assistance in dying, does not allow for self-administered assisted deaths in Quebec. With respect to monitoring and compliance, all cases of assisted death are reported to the *commission sur les soins de fin de vie* (Commission on End-of-Life-Care) which is responsible for the oversight of end-of-life care services, including medical aid in dying in the province.

Alberta and Manitoba have implemented centralized care coordination services or teams, which act as a single point of contact for patients, families and health care providers interested in medical assistance in dying. In Alberta, all medical assistance in dying events must be reported to the Office of the Medical Examiner and to the Medical Assistance in Dying Regulatory Review Committee. In Manitoba, the medical assistance in dying service team monitors and evaluates requests for, and cases of, assisted dying in the province. Nova Scotia and Newfoundland and Labrador are also considering central intake processes for patients and providers.

As can be seen from the brief description above, while the federal legislation on medical assistance in dying provides a consistent framework across Canada, the specific policies and processes related to the implementation and reporting of medical assistance in dying varies considerably across jurisdictions. Given the relative newness of the implementation of the legislation on medical assistance in dying, it is expected that how services are organized, delivered and monitored will continue to evolve as data becomes more available, and jurisdictions are able to evaluate existing policies and service delivery models. More information on end-of-life care, including medical assistance in dying, across Canada may be found in Annex A of this report, and on Health Canada's End-of-life care webpages.

METHODOLOGY AND PARAMETERS

As was the case in the first interim update, all data and information on medical assistance in dying have been provided by provincial and territorial governments, where collected and available. The territories (Yukon, Northwest Territories and Nunavut) were not able to share data for this reporting cycle due to privacy concerns.

In addition, under Québec's Loi concernant les soins de fin de vie, physicians and institutions are required to report the number of requests for medical assistance in dying received, declined, or provided. The data from Québec used in this report have been compiled from public reports posted on the websites of individual health and social service institutions in Québec and the Collège des médecins du Québec.[1] While these public reports do not represent an official record of the Government of Québec,[2] they do provide a reliable source of data. As such, the numbers presented here should not be considered a final accounting of all assisted deaths in Quebec over the past six months (from January 1 to June 30, 2017).

1 At the time of writing, five institutions had not yet released their report for the period between January 1 and June 30, 2017). As such, this does not represent a complete accounting for this timeframe, and numbers are likely to increase upon release of the information.

2 Official reports on medical aid in dying in Quebec are issued by *La Commission sur les soins de fin de vie*. Further information on medical aid in dying in Quebec, including a statistical profile and reasons for the non-provision of assisted dying between December 10, 2015, and June 9 or 10, 2016 (as per the parameters of the Commission's report), may be found in the first annual report of the *Commission des soins de fin de vie* (www.ledevoir.com/documents/pdf/rapport_csfv2016.pdf).

Table 1, *Total Number of Publicly-Reported Medically Assisted Deaths in Canada* presents a breakdown of the total number of medically assisted deaths in Canada when all of these sources are considered.

Table 1. Total Number of Medically Assisted Deaths in Canada[i]	
Number of medically assisted deaths in Canada between **June 17 and December 31, 2016**	803
Number of medically assisted deaths in Canada between **January 1 and June 30, 2017**[ii]	1,179
Total number of medically assisted deaths in Canada between **December 10, 2015 and June 30, 2017**	2,149*

i Due to privacy concerns, data from the Yukon, Northwest Territories, and Nunavut are not available.

ii Data was compiled from publicly available reports posted on the websites of Quebec's health and social services institutions and the *Collège des médecins du Québec*, but does not represent an official report from the Government of Quebec.

* Total includes 167 medically assisted deaths administered in the province of Quebec, prior to the federal legislation on medical assistance in dying receiving Royal Assent on June 17, 2016.

Most provincial and territorial governments were also able to provide basic demographic information on persons receiving medical assistance in dying, the settings in which medically assisted deaths occurred, and the most common underlying medical condition of those receiving medical assistance in dying for the reporting period in question (January 1 to June 30, 2017). *Table 2, Profile of Medically Assisted Deaths in Participating Jurisdictions*, presents nationally-aggregated data on these elements. In instances where there are fewer than 7 cases, the data has been supressed to protect the privacy and confidentiality of the patients and providers involved.

Table 2. Profile of Medically Assisted Deaths in Participating Jurisdictions (Excludes QC, NU, YT, NWT)

<table>
<tr><th></th><th>June 17 to December 31, 2016</th><th colspan="2">January 1 to June 30, 2017</th></tr>
<tr><td>Total number of medically assisted deaths</td><td>507</td><td colspan="2">875</td></tr>
<tr><td>Number of clinician-administered deaths (voluntary euthanasia)</td><td>503[i]</td><td colspan="2">874</td></tr>
<tr><td>Number of self-administered deaths (assisted suicide)</td><td>4[i]</td><td colspan="2">1</td></tr>
<tr><td>Number of medically assisted deaths by provider</td><td>N/A[†]</td><td colspan="2">837 (95.7%) Physician
38 (4.3%) Nurse Practitioner</td></tr>
<tr><td>Settings in which assistance in dying occurred:
In hospital
Home
LTC facility or Nursing home
Other[iii]</td><td>
249 (50%)
182 (37%)
30 (6%)
37 (7%)</td><td colspan="2">
368 (42%)
350 (40%)
78 (9.0%)
79 (9.0%)</td></tr>
<tr><td>Average age[iv] of persons receiving assisted death</td><td>72.27 years of age</td><td colspan="2">73 years of age</td></tr>
<tr><td rowspan="2">Age range of persons receiving medical assistance in dying</td><td rowspan="2">N/A±</td><th># of Cases</th><th>Age range</th></tr>
<tr><td>18
39
150
144
124
119
102
88
68
23</td><td>18–45
46–55
56–64
65–70
71–75
76–80
81–85
86–90
91+
Unknown[‡]</td></tr>
<tr><td>Proportion of men/women receiving assisted death[‡]</td><td>49% Men
51% Women</td><td colspan="2">463 (53%) Men
412 (47%) Women</td></tr>
<tr><td>Proportion of individuals receiving assisted death in large urban centres vs. smaller population centres[v‡]</td><td>65.8% Large urban centres
34.2 % Smaller population centres</td><td colspan="2">500 (57.1%) Large urban centres
375 (42.9%) Smaller population centres</td></tr>
<tr><td>Most common underlying medical circumstances of patients who obtain assistance in dying[€]</td><td>56.8% Cancer-related
23.2% Neuro-degenerative
10.5% Circulatory/respiratory system
9.5% Other causes</td><td colspan="2">63% Cancer-related
13% Neuro-degenerative
17% Circulatory/respiratory system
7% Other causes</td></tr>
</table>

i In the last interim report, 3 self-administered deaths were reported. This has been updated based on a further review of the data.

† Not able to report due to low numbers of nurse practitioners involved in medically assisted deaths

iii Other includes: palliative care hospice; clinician office; facility; undisclosed.

iv Several jurisdictions in Atlantic Canada were not able to provide information on the average age of persons receiving a medically assisted death due to privacy concerns. This figure is a mean of provincial and territorial averages, and not a calculation based on individual data; as such, it is not weighted to reflect an actual national average.

± These data were not collected during first reporting cycle.

‡ Unknown includes data that was suppressed by PTs due to privacy concerns.

€ This figure is not definitive as cases where the underlying medical condition was not reported, approximately 8% of all cases, have not been included in this calculation

In addition to these core data elements, a number of jurisdictions including Alberta, Saskatchewan, Manitoba, and several provinces in Atlantic Canada were able to provide information about the number of inquiries about medical assistance in dying and whether these requests were declined, withdrawn or unfulfilled. As part of its legislation on the end of life, the province of Quebec also requires physicians and institutions to report on the total number of requests for medical assistance in dying, the number of assisted deaths administered, and the number of those not administered, and the reasons for which they were not. Table 3, *Profile of Requests for Medical Assistance in Dying in Select Jurisdictions,* provides an overview of findings of comparable measures from these jurisdictions. How data on the number of requests declined or withdrawn were collected and categorized varied significantly across participating jurisdictions. While these results are not presented numerically here, they are discussed further in the summary of findings. A breakdown of available data, by province or region, can be found in Annex B.

Table 3. Profile of Requests for Medically Assisted Deaths in Select Jurisdictions (Excludes YK, NU, NWT, ON, BC)

	June 10 to December 31, 2016	January 1 to June 30, 2017
Total number of requests for medical assistance in dying	746	832
Most frequently cited reasons for why requests for medical assistance in dying have been declined±	N/A	Loss of competency Death not reasonably foreseeable Other
Number of cases where the individual died prior to the completion of the assessment process	N/A	202

± The province of Alberta includes requests where the individual dies as a result of their illness as being declined; while the province of Quebec does list reasons why medical aid in dying was not provided in their reports, these are closely aligned with Quebec legislation and not easily categorized according to criteria outlined in the federal legislation on medical assistance in dying. The data have not been presented numerically given these limitations.

SUMMARY OF FINDINGS

Across the country, there were 1,179 medically assisted deaths between January 1, 2017 and June 30, 2017, accounting for approximately 0.9% of all deaths in Canada during that time frame.[3] While this represents a 46.8% increase from the first six months that the legislation was in place, it remains consistent with international experience; between 0.3% to 4.6% of all deaths are reported as euthanasia or physician-assisted suicide in jurisdictions where they are legal.

Cancer was the most frequently cited underlying medical condition associated with an assisted death, representing approximately 63% of all assisted dying cases among reporting jurisdictions.[i] In international jurisdictions that allow some form of assisted dying, cancer is the most frequently cited underlying medical condition among those receiving an assisted death (72% in Oregon,[4] 69% in Belgium, and 71% in the Netherlands).[5]

The average age of individuals for whom medical assistance in dying was provided was approximately 73. Although the age of persons receiving medical assistance in dying spanned every age category (18 to 91+), the vast majority of Canadians were between the ages of 56 and 85. This is consistent with the data identifying cancer as the most frequently cited underlying medical condition, as over 96% of cancer-related deaths occur among those aged 50 and older,[6] whereas neurodegenerative disorders such as multiple sclerosis and amyotrophic lateral sclerosis, while more prevalent as individuals age, may have an earlier onset.[7]

This reporting cycle saw a slight increase in the number of medically assisted deaths administered outside of a hospital setting. Between January 1 and June 30, 2017 approximately 42% of all cases of assisted dying took place in hospital, as compared to 50% in the first six months that the legislation was implemented. Jurisdictions with the most marked increase in the number of medically assisted deaths taking place in the patient's home include British Columbia (from 43.6% to 51%) and Atlantic Canada (from 18% to approximately 35%). It is still too early to determine whether this is the beginning of a longer-term shift attributable to improved system integration and policies designed to facilitate home-based assisted death, which international research suggests many individuals prefer,[8] or may be due to other factors such as barriers to providing medical assistance in dying in hospitals in some jurisdictions or lack of infrastructure for providing this service in institutions in some smaller communities.

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3 This calculation is based on an estimate of 269,012 deaths in Canada between July 1 2015 and June 30, 2016, the most recent projection of death rates available. See: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo07a-eng.htm. The 49% figure is the proportion of deaths which occurred in the latter half of the year in 2013 (the last year for which monthly data is available. See: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo07a-eng.htm)

4 Source : http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

5 Source: www.dyingforchoice.com/docs/AssistedDyingPracticeInBeneluxWhitepaper1b2016.pdf

6 www.canada.ca/en/public-health/services/chronic-diseases/cancer/canadian-cancer-statistics-2016.html

7 www.phac-aspc.gc.ca/publicat/cd-mc/mc-ec/assets/pdf/mc-ec-eng.pdf

8 http://onlinelibrary.wiley.com/doi/10.1111/scs.12265/pdf

Canada is the only jurisdiction that legally allows for nurse practitioners (NPs) to take part in the direct provision of medical assistance in dying. While the number of NPs providing assisted dying remains relatively low, there has been a marked increase since the last reporting period (fewer than 7 cases between June 17 and December 31, 2016, to 38 or 4.3% of all cases between January 1 and June 30, 2017). Part of this increase may be the result of policy changes at the provincial level. For example, in April 2017, Ontario passed regulations enabling NPs to prescribe controlled substances, effectively removing a barrier to NPs administering medical assistance in dying in that jurisdiction. The comparatively small proportion of NPs administering assisted dying is also likely due to the fact that the number of NPs practicing in Canada, while increasing, remains a relatively small proportion of providers legally permitted to administer assisted dying (4,500 NPs in 2016[9] as compared to 82,198 physicians in 2015).[10]

As was the case in the first reporting cycle, the number of cases of self-administered assisted death reported during this data collection cycle was very small (N=1). There are a number of factors which may have contributed to this outcome. Prior research[11] has suggested that providers are less comfortable with self-administration due to concerns around the ability of the patient to effectively self-administer the series of medications, and the complications that may ensue. As such, some health institutions within jurisdictions have developed their own assisted dying policies that do not encourage self-administration. Of note, Quebec's legislation on end-of-life care only permits provider-administered assisted dying. Finally, although pharmacists can compound drugs for use in a self-administered assisted death, no drug commonly used for self-administration in international jurisdictions has been submitted for market approval in Canada, making access to these medications challenging in some communities. Health Canada will continue to work with the provincial and territorial governments on solutions for access to effective and appropriate drugs for self-administration.

Among jurisdictions that were able to provide supplementary information related to requests for medical assistance in dying (using comparable measures), findings indicate that approximately 1/3 of applicants who requested medical assistance in dying were declined. These findings should be interpreted with caution, however, as they represent a comparatively small number of all cases. The most commonly cited reasons were loss of competency (51%) and that death was not reasonably foreseeable (26%). Again, given data limitations[12] these findings may not present a complete or wholly accurate picture of why individuals may not be eligible for a medically assisted death. Approximately 24% of persons requesting medical assistance in dying in reporting jurisdictions died prior to the completion of the assessment process. This likely reflects, in part, the severity of illness experienced by most persons requesting an assisted death.

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9 www.cihi.ca/en/regulated-nurses-2016

10 https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC3267&lang=en

11 Much of the literature on this subject is based in the Netherlands. www.tandfonline.com/doi/full/10.3109/13814788.2013.813014

12 The province of Quebec does list reasons why someone has been declined for medical aid in dying in their public reports. Wherever possible, this information was included in these calculations. However, the categories listing why assisted dying was not provided are closely aligned with that of the province's legislation and not easily categorized according to criteria outlined in the federal legislation on medical assistance in dying. Furthermore, in March 2017 Quebec's Minister of Health entrusted the Commission on End-of-Life Care with a new mandate to examine all cases where requests for medical aid in dying were declined, since the coming into force of the Act Respecting End-of-Life Care.

ONGOING REPORTING

Federal officials are working closely with provinces, territories and key stakeholders on the parameters of the federal monitoring system, which will be put in place through federal regulations.[13] Given the complexity of the issue and the consequences for health care professionals, the Government is taking the time needed to get the regulations right. Draft regulations will be published in late fall or early winter for a period of public consultation, with final regulations coming into force in 2018.[14]

The data collected under the federal monitoring system will provide a more complete picture of who is requesting and receiving medical assistance in dying. This is essential to support transparency and public trust in the law, and will enable Canada to meet the standard of public reporting in other jurisdictions where medically-assisted dying is available. In addition, collecting more robust, nationally comparable data will create a base of evidence that will inform future discussions about medical assistance in dying in Canada.

Data under the federal monitoring system will also be made available to qualified researchers upon request, which will help to enrich the body of scholarly work on end-of-life care in Canada.

The federal government, in collaboration with participating provincial and territorial governments, will continue to provide additional updates on a six month basis until such time as regular reporting under the permanent monitoring system commences.

13 The regulations will outline the information that implicated health care providers will be required to report.

14 The regulations will be accompanied by guidance documents to assist health care professions in meeting their reporting obligations.

ANNEX A

REFERRAL SERVICES AVAILABLE FOR CLINICIANS AND PATIENTS

To facilitate care coordination, a number of provinces and territories have introduced mechanisms to support access and referrals for medical assistance in dying and end-of-life care. This includes helping to connect patients with a physician or nurse practitioner willing to provide medical assistance in dying, while protecting the privacy of all parties. With support from provincial and territorial health officials, a federal webpage was launched in June 2016 to support access and care coordination. Information is also available via 1-800-O-Canada. This content is being maintained and updated regularly. A brief description of these referral systems, as available, is provided below.

BRITISH COLUMBIA

Each health authority in British Columbia has implemented a care coordination service to ensure reasonable, safe access to medical assistance in dying. The care coordination service provides an additional point of contact for patients who require assistance in navigating access to medical assistance in dying. The service also serves to support health care providers and organizations to identify appropriate patient pathways, facilitate transfers, and connect patients with willing providers.

ALBERTA

Alberta Health Services has developed a Medical Assistance in Dying Care Coordination Service (CCS) which provides information to patients, families and practitioners on assisted dying. The CCS will help individuals find a practitioner to assess them and provide the service as well as arrange transfers if needed.

SASKATCHEWAN

Each regional health authority has a delegate who has agreed to be the primary contact point for information requests on medical assistance in dying. A number of Saskatchewan's 12 regional health authorities have established a page on their website for medical assistance in dying. Practitioners and patients can directly contact the regional delegate for assistance with all aspects of requests for assisted dying through information provided on Saskatchewan's medical assistance in dying website. The Ministry of Health has access to contact information for these delegates and can also contact or refer individuals to them if required. Note: Saskatchewan is moving to a single provincial health authority in Fall 2017.

MANITOBA

Manitoba has introduced an inter-disciplinary MAID team which serves as the central consultative and practical resource for health professionals, patients and families in Manitoba. The team is housed out of the Winnipeg Regional Health Authority.

ONTARIO

On May 31, 2017, Ontario launched a provincial care coordination service to assist patients, and their family members or caregivers, who are seeking access to additional information and services related to medical assistance in dying and other end-of-life options. Patients and caregivers looking for more information or support with medical assistance in dying can also call the care coordination service to request to be connected to a physician or nurse practitioner who can provide medical assistance in dying services, such as eligibility assessments. Physicians or nurse practitioners who are unable or unwilling to provide medical assistance in dying can also contact the care coordination service to refer their patients to physicians or nurse practitioners who can provide these services.

QUEBEC

Quebec has provided information on its Act Respecting End-of-Life Care as well as various documents developed to support its application. These include: guidelines for requests for medical aid in dying; terms of reference of an Interdisciplinary Support Group for medical aid in dying; and, a companion document for institutions in developing an end-of-life care policy.

NORTHWEST TERRITORIES

The Northwest Territories has established a Central Coordinating Service (toll-free phone number) that facilitates access to willing practitioners (to provide more information, assess, or provide a secondary assessment).

NEWFOUNDLAND AND LABRADOR

Newfoundland and Labrador has formed a provincial working group on medical assistance in dying and is working on establishing a care coordination service in the province.

PRINCE EDWARD ISLAND

PEI has established a process to help facilitate coordination for the provision of medical assistance in dying services. Physicians and nurse practitioners may contact their Health PEI Medical Director and Health PEI's Medical Affairs office to help facilitate the assessment process, and the provision of medical assistance in dying for eligible cases. For those patients without a primary care provider, patients are encouraged to call 811 for more information.

NOVA SCOTIA

A central intake process is coordinated through the Nova Scotia Health Authority's Vice President of Medicine's office. The Nova Scotia Health Authority is developing a policy on medical assistance in dying which is currently under review. The final policy document should be available in the coming months.

NEW BRUNSWICK

Patients can be connected to family physicians or nurse practitioners to obtain information about medical assistance in dying in the following ways: the website of one of the two Regional Health Authorities (Vitalité Health Network and Horizon Health Network); using the 811 Provincial Tele-care line; by contacting Patient Representatives Services or the Regional Ethics Office (as applicable); or through speaking with one's family physician or nurse practitioner directly. New Brunswick has also produced an information brochure on medical assistance in dying for patients.

ANNEX B

PROVINCIAL PROFILES

In instances where there are fewer than seven cases reported in a province or territory on any one data element, the data has been supressed in jurisdictional reports to protect the privacy and confidentiality of both patients and providers involved in medical assistance in dying. These numbers have been included in the national roll-up, wherever possible.

Table 4. Profile of Medical Assistance in Dying by Jurisdiction/Region January 1 to June 30, 2017

	British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Atlantic (NB, NS, NL, PEI)
Number of contacts or inquiries about medical assistance in dying	N/A	490[‡]	58	153	N/A	96
Total number of requests for medical assistance in dying	N/A	135	38	66	N/A	102
Number of requests for medical assistance in dying that have been declined	N/A	33	Less than 7	32	N/A	8
Number of cases where the individual died prior to the completion of the assessment	N/A	N/A	11	23	N/A	18
Total number of medically assisted deaths	312	102	18	30	362	51
Number of medically assisted deaths by provider type	287 (92%) Physician 25 (8%) Nurse Practitioner	95 (93%) Physician 7 (7%) Nurse Practitioner	18 (100%) Physician	30 (100%) Physician	356 (98%) Physician 6 (2%) Nurse Practitioner	51 (100%) Physician
Number of medically assisted deaths by setting	88 (28%) In hospital 160 (51%) Patient's home 26 (8%) LTC**/nursing home 38 (9%) Other[i]	38 (37.3%) In hospital 25 (24.5%) Patient's home 32 (31.3%) LTC**/nursing home	9 (50%) In hospital (Less than 7) Patient's home (Less than 7) Other[i]	18 (60%) In hospital 12 (40%) Patient's home/ Other[i]	192 (53%) In hospital 134 (37%) Patient's home 18 (5%) LTC**/nursing home 18 (5%) Other[i]	23 (45%) In hospital 18 (35.3%) Patient's home/ Other[i] 10 (19%) Unknown*
Average age of persons receiving assisted death	74.6	70.7	N/A	75	73.3	N/A

	British Columbia		Alberta		Saskatchewan		Manitoba		Ontario		Atlantic (NB, NS, NL, PEI)	
	# of Cases	Age range	# of Cases	Age range	# of Cases	Age range	# of Cases	Age range	# of Cases	Age range	# of Cases	Age range
Age range of persons receiving medical assistance in dying	10 14 41 55 47 42 36 33 34 0	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*	0 0 25 19 19 7 10 7 Less than 7 10	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*	0 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*	0 Less than 7 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 0	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*	8 20 60 56 51 58 44 39 26 0	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*	0 Less than 7 15 10 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7 Less than 7	18–45 46–55 56–64 65–70 71–75 76–80 81–85 86–90 91+ Unknown*
Number of men/women receiving an assisted death	167 (53.5%) Male 145 (46.5%) Female		50 (49.9%) Male 52 (50.1%) Female		11 (61.0%) Male 7 (39.0%) Female		10 (33.3%) Male 20 (66.7%) Female		198 (55%) Male 164 (45%) Female		27 (52.9%) Male 24 (47.1%) Female	
Number of individuals receiving medical assistance in dying in large urban centres vs. smaller population centres†	150 (48.1%) Large urban centres 162 (51.9%) Smaller population centres		59 (57.8%) Large urban centres 43 (42.2%) Smaller population centres		(More than 7) Large urban centres (Less than 7) Smaller population centres		24 (80%) Large urban centres 6 (20%) Smaller population Centres		237 (65.5%) Large urban centres 125 (34.5%) Smaller population centres		15 (29.4%) Large urban centres 36 (70.6%) Smaller population centres	
Most common reported underlying medical condition of patients who obtain a medical assisted death	200 (64%) Cancer-related 40 (12.8%) Neuro-degenerative 52 (16.7%) Circulatory/respiratory 20 (6.4%) Other causes		50 (49%) Cancer-related 13 (12.7%) Neuro-degenerative 11 (10.8%) Circulatory/respiratory 28 (27.5%) Other causes		11 (61%) Cancer-related 7 (39.0%) Other causes		21 (70%) Cancer-related 9 (30%) Other causes		236 (65.2%) Cancer-related 49 (13.5%) Neuro-degenerative 43 (11.9%) Circulatory/respiratory 34 (9.4%) Other causes		36 (70.5%) Cancer-related 11 (21.5%) Other causes 4 (8%) Unknown*	

i Other includes: palliative care hospice; clinician office; facility; undisclosed. In Ontario, "Other" includes hospices, retirement homes, seniors' residences, and assisted living facilities.

* Unknown includes cases that were not reported to Health Canada due to privacy concerns stemming from a small number of cases in a jurisdiction.

** LTC/Nursing homes includes long-term care facilities and nursing homes.

‡ There is no legal requirement to report requests for medical assistance in dying to the Care Coordination Service at Alberta Health Services. Therefore there may have been more individuals who contacted or made inquiries to a practitioner, or requested medical assistance in dying from a practitioner, who are not captured in these figures.

† A large urban centre consists of a population of 100,000 or more (Statistics Canada).