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chapter S-32.0001

ACT RESPECTING END-OF-LIFE CARE

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TITLE I

PURPOSE OF ACT

1. The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care, including medical aid in dying, so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.

In addition, this Act allows the exercise of some of those rights by patients who are not at the end of life so that they receive end-of-life care in cases where their condition requires it.

Lastly, this Act recognizes the primacy of freely and clearly expressed wishes with respect to care, in particular by establishing an advance medical directives regime.

2014, c. 2, s. 1; 2023, c. 15, s. 1.

TITLE II

END-OF-LIFE CARE

CHAPTER I

GENERAL PROVISIONS

2. The provision of end-of-life care is to be guided by the following principles:

(1) respect for patients and recognition of their rights and freedoms must inspire every act performed in their regard;

(2) patients must be treated, at all times, with understanding, compassion, courtesy and fairness, and with respect for their dignity, autonomy, needs and safety; and

(3) the healthcare team providing care to patients must establish and maintain open and transparent communication with them.

2014, c. 2, s. 2; 2023, c. 15, s. 2.

3. For the purposes of this Act,

(1) “institution” means any institution governed by the Act respecting health services and social services (chapter S-4.2) that operates a local community service centre, a hospital centre or a residential and long-term care centre, as well as the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons (chapter S-5);

(2) “palliative care hospice” means a community organization that holds an accreditation granted by the Minister under the second paragraph of section 457 of the Act respecting health services and social services and has entered into an agreement with an institution under section 108.3 of that Act in order to secure all or some of the care required by its users;

(3) “end-of-life care” means palliative care provided to end-of-life patients and medical aid in dying;

(4) “palliative care” means the total and active care delivered by an interdisciplinary team to patients suffering from a disease with reserved prognosis, in order to relieve their suffering, without delaying or hastening death, maintain the best quality of life possible and provide them and their close relations the support they need;

(5) "continuous palliative sedation" means care that is offered as part of palliative care and consists in administering medications or substances to an end-of-life patient to relieve their suffering by rendering them unconscious without interruption until death ensues; and

(6) "medical aid in dying" means care consisting in the administration by a competent professional of medications or substances to a patient, at the patient's request, in order to relieve their suffering by hastening death.

2014, c. 2, s. 3; 2023, c. 15, s. 3.

3.1. For the purposes of this Act, "competent professional" means a physician or a specialized nurse practitioner

2023, c. 15, ss. 4 and 58.

CHAPTER II

RIGHTS WITH RESPECT TO END-OF-LIFE CARE

4. Every person whose condition requires it has the right to receive end-of-life care, subject to the specific requirements established by this Act.

Such care is provided to the person in a facility maintained by an institution, in a palliative care hospice or at home. Medical aid in dying may be administered in another place so as to ensure respect for the person's dignity and autonomy as well as the importance of such care, provided the place is authorized beforehand by the director of professional services or the director of nursing care of the local authority referred to in section 99.4 of the Act respecting health services and social services (chapter S-4.2) that serves the territory in which the place is situated.

This section applies within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of institutions and the policy directions, policies and approaches of palliative care hospices and within the limits of the human, material and financial resources at their disposal. It complements the provisions of the Act respecting health services and social services and of the Act respecting health services and social services for Cree Native persons (chapter S-5) that relate to the rights of users and beneficiaries, including the right to receive the services required by their condition.

2014, c. 2, s. 4; 2023, c. 15, ss. 5 and 58.

5. Except as otherwise provided by law, a person of full age who is capable of giving consent to care may, at any time, refuse to receive life-sustaining care or withdraw consent to such care.

To the extent provided by the Civil Code, a minor of 14 years of age or over, and in the case of a minor or a person of full age who is incapable of giving consent, the person who may give consent to care on their behalf may also make such a decision.

The refusal of care or withdrawal of consent to care may be expressed by any means.

The competent professional must make sure that such a decision is made freely and provide the person with all information needed to make an informed decision, in particular information about other therapeutic possibilities, including palliative care.

2014, c. 2, s. 5; 2023, c. 15, s. 6.

6. A person may not be denied end-of-life care for previously having refused to receive certain care or having withdrawn consent to certain care.

2014, c. 2, s. 6.

CHAPTER III

ORGANIZATION OF END-OF-LIFE CARE

DIVISION I

SPECIAL RULES APPLICABLE TO PROVIDERS OF END-OF-LIFE CARE

§ 1. — *Institutions*

7. Every institution must offer end-of-life care and ensure that it is provided to the persons requiring it in continuity and complementarity with any other care that is or has been provided to them.

For this purpose, an institution must, among other things, establish measures to promote a multiple-discipline approach by health and social services professionals and the collaboration of the various other resources concerned who provide services to its users.

If the institution is a public institution, it must establish an interdisciplinary group composed of experts whose functions are to support and accompany, on request, the health or social services professionals or the other resources concerned who take part in the end-of-life care provided. Such a group supports and accompanies, on request, any professional or other resource concerned practising or exercising their functions in a centre operated by a private institution or in a palliative care hospice.

2014, c. 2, s. 7; 2023, c. 15, s. 7.

8. Every institution must adopt a policy with respect to end-of-life care. The policy must be consistent with ministerial policy directions and be made known to the personnel of the institution and to the health or social services professionals who practise in the institution. It must also be made known to patients whose condition could require end-of-life care and to their close relations.

The executive director of the institution must report annually to the board of directors on the carrying out of the policy. The report must include the number of end-of-life patients who received palliative care, the number of times continuous palliative sedation was administered, the number of requests for medical aid in dying, the number of times such aid was administered as well as the number of times medical aid in dying was not administered, including the reasons it was not administered.

The report must also state, where applicable, the number of times continuous palliative sedation and medical aid in dying were administered at the patient's home or in the premises of a palliative care hospice by a competent professional as a physician or a specialized nurse practitioner practising in a centre operated by the institution.

The report must list the information set out in the second and third paragraphs according to the type of competent professional concerned.

The report is to be published on the website of the institution and sent, not later than 30 June each year, to the Commission sur les soins de fin de vie established under section 38. The institution must include a summary of the report in a separate section of its annual management report.

2014, c. 2, s. 8; 2023, c. 15, ss. 8 and 58.

9. Every institution must include a clinical program for end-of-life care in its organization plan. In the case of an institution that operates a local community service centre, the plan must also include the provision of end-of-life care at the patient's home.

The organization plan must be consistent with ministerial policy directions.

The clinical program for end-of-life care is to be sent to the Commission sur les soins de fin de vie.

2014, c. 2, s. 9.

10. The code of ethics adopted by an institution under section 233 of the Act respecting health services and social services (chapter S-4.2) must have due respect for the rights of patients with respect to end-of-life care.

2014, c. 2, s. 10; 2023, c. 15, s. 9.

11. When an end-of-life patient requests in-home palliative care from an institution, but the person's condition or environment is such that proper care could not be provided at home, the institution must offer to admit the person to its facilities or direct them to another institution or to a palliative care hospice that can meet their needs.

2014, c. 2, s. 11.

12. An institution must offer every patient receiving end-of-life care a private room for the final few days preceding the patient's death.

2014, c. 2, s. 12.

§ 2. — *Palliative care hospices*

13. Palliative care hospices determine the end-of-life care provided in their premises. However, no palliative care hospice may exclude medical aid in dying from the care it offers.

Every palliative care hospice must inform persons of the end-of-life care it offers before admitting them. No palliative care hospice may refuse to admit a person for the sole reason that they have made a request for medical aid in dying.

2014, c. 2, s. 13; 2023, c. 15, s. 10.

14. A palliative care hospice and an institution must specify in their agreement under section 108.3 of the Act respecting health services and social services (chapter S-4.2) the nature of the services the institution is to provide in the premises of the hospice and the monitoring mechanisms that will allow the institution, or one of its boards, councils or committees determined in the agreement, to ensure that quality care is provided in the hospice.

On the request of the institution, the palliative care hospice must communicate any information required for the carrying out of the agreement. The manner in which such information is to be communicated is specified in the agreement.

2014, c. 2, s. 14.

15. Every palliative care hospice must adopt a code of ethics with respect to the rights of patients with respect to end-of-life care and adopt a policy with respect to end-of-life care.

These documents must be made known to the personnel of the palliative care hospice, to the health and social services professionals who practise in the hospice, and to patients whose condition could require end-of-life care and their close relations.

2014, c. 2, s. 15; 2023, c. 15, s. 11.

§ 3. — *Private health facilities*

16. End-of-life care may be provided at the patient's home by physicians practising in a private health facility within the meaning of section 95 of the Act respecting health services and social services (chapter S-4.2) and, within their scope of practice, by nurses practising in such a facility.

2014, c. 2, s. 16.

DIVISION II

SPECIAL FUNCTIONS OF HEALTH AND SOCIAL SERVICES AGENCIES

17. Every health and social services agency must, after consultation with the institutions and palliative care hospices in its territory, determine the general rules governing access to the end-of-life care provided by those institutions and hospices.

2014, c. 2, s. 17.

18. Every agency must inform the population living in its territory of the end-of-life care services available and the manner of accessing them, as well as the rights and options of patients with respect to such care.

This information must be available on the websites of the agencies.

2014, c. 2, s. 18; 2023, c. 15, s. 12.

DIVISION III

SPECIAL FUNCTIONS AND POWERS OF THE MINISTER

19. The Minister determines the policy directions that are to guide institutions and agencies when organizing end-of-life care, including those which institutions must take into account when formulating their end-of-life care policy.

2014, c. 2, s. 19.

20. The Minister may require of institutions, palliative care hospices and agencies that they supply, in the manner and within the time specified, statements, statistical data, reports and other information required for the performance of the functions vested in the Minister under this Act, provided it is not possible to link that information to any specific patient having received end-of-life care or to any specific health or social services professional having provided the care.

2014, c. 2, s. 20.

21. In order to ascertain compliance with this Title, a person authorized in writing by the Minister to carry out an inspection may, at any reasonable time, with due respect for the specific character of the premises and the needs of the persons receiving end-of-life care, enter any premises operated by an institution or a palliative care hospice.

Such a person may also, at any reasonable time, enter any premises where they have cause to believe that medical aid in dying is associated with a good or service supplied in the course of a commercial activity or that an amount related to obtaining such aid has been charged, to verify compliance with section 50.2.

The person may, during an inspection,

(1) examine and make a copy of any document relating to the end-of-life care offered in premises referred to in the first paragraph or any document relating to the promotion or advertising of a good or service referred to in section 50.2 or relating to an amount referred to in that section; and

(2) demand any information relating to the carrying out of this Title as well as the production of any related document.

Any person having custody, possession or control of such documents must make them available on request to the person conducting the inspection.

A person conducting an inspection must, if so required, produce a certificate of capacity.

Any person who hinders a person in the conduct of an inspection, refuses to provide any information or document the latter is entitled to require or examine, or conceals or destroys any document or other object relevant to an inspection is liable to a fine of $2,500 to $25,000 in the case of a natural person and to a fine of $7,500 to $75,000 in any other case.

2014, c. 2, s. 21; 2023, c. 15, s. 13.

22. The Minister may delegate the powers provided for in section 21 to a health and social services agency.

The agency informs the Minister of the designation of an inspector and of the results of the inspection.

2014, c. 2, s. 22.

23. A person authorized in writing by the Minister or, where applicable, by an agency to carry out an inspection may not be prosecuted for an omission or an act done in good faith in the performance of their duties.

2014, c. 2, s. 23.

CHAPTER IV

SPECIAL REQUIREMENTS FOR CERTAIN END-OF-LIFE CARE

DIVISION I

CONTINUOUS PALLIATIVE SEDATION

24. Before giving consent to continuous palliative sedation, an end-of-life patient or, where applicable, the person who may give consent to care on behalf of the patient must among other things be informed of the prognosis for the illness, the irreversible nature of the sedation and the anticipated duration of the sedation.

In addition, the competent professional must make sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure.

Consent to continuous palliative sedation must be given in writing on the form prescribed by the Minister and be filed in the patient's record.

2014, c. 2, s. 24; 2023, c. 15, s. 14.

25. If the patient giving consent to continuous palliative sedation cannot date and sign the form referred to in section 24 because the patient cannot write or is physically incapable of doing so, a third person may do so in the patient's presence. The third person may not be a member of the team responsible for caring for the patient, a minor or a person of full age incapable of giving consent.

2014, c. 2, s. 25.

DIVISION II

MEDICAL AID IN DYING

Not in force

§ 1. — *Request for medical aid in dying*

2023, c. 15, s. 15.

Not in force

25.1. A request for medical aid in dying must be made before such aid can be obtained.

Such a request is called a "contemporaneous request for medical aid in dying" or "contemporaneous request" where it is made with a view to an administration of such aid that is contemporaneous to the request. It is called an "advance request for medical aid in dying" or "advance request" where it is made in anticipation of a person becoming incapable of giving consent to care, with a view to an administration of such aid after the onset of that incapacity.

2023, c. 15, s. 15.

Not in force

§ 2. — *Special provisions applicable to contemporaneous requests for medical aid in dying*

2023, c. 15, s. 15.

26. In order to obtain medical aid in dying, a patient must, in addition to making a request that complies with this section and, where applicable, section 27, meet the following criteria:

(1) be of full age and capable of giving consent to care, subject to the exception provided for in the third paragraph of section 29 with regard to the patient's capacity;

(2) be an insured person within the meaning of the Health Insurance Act (chapter A-29);

(3) be in one of the following situations:

(a) suffer from a serious and incurable illness and be in a medical state of advanced, irreversible decline in capability; or

(b) have a serious physical impairment causing significant and enduring disabilities; and

(4) experience enduring and unbearable physical or psychological suffering that cannot be relieved under conditions the patient considers tolerable.

For the purposes of subparagraph 2 of the first paragraph, a person with respect to whom the cost of the insured health services they receive or may receive is assumed otherwise than under the Health Insurance Act due to their detention in Québec or due to the fact that they are resident in Québec and in active service in the Canadian Armed Forces is considered an insured person within the meaning of that Act.

For the purposes of subparagraph *a* of subparagraph 3 of the first paragraph, a mental disorder other than a neurocognitive disorder cannot be an illness for which a person may make a request.

The patient must request medical aid in dying themselves, in a free and informed manner, by means of the form prescribed by the Minister. The form must be dated and signed by the patient.

The form must be signed in the presence of and countersigned by a health or social services professional; the professional who is not the competent professional treating the patient must forward the signed form to the competent professional.

2014, c. 2, s. 26; 2023, c. 15, ss. 16 and 58.

27. If the patient requesting medical aid in dying cannot date and sign the form referred to in section 26 because the patient cannot write or is physically incapable of doing so, a third person may do so in the patient's presence. The third person may not be a member of the team responsible for caring for the patient, a minor or a person of full age incapable of giving consent.

2014, c. 2, s. 27.

28. A patient may, at any time and by any means, withdraw their request for medical aid in dying.

A patient may also, at any time and by any means, request that the administration of medical aid in dying be put off.

2014, c. 2, s. 28.

29. Before administering medical aid in dying, the competent professional must

(1) be of the opinion that the patient meets all the criteria of section 26, after, among other things,

(a) making sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure;

(b) making sure that the request is an informed one, in particular by informing the patient of the prognosis for the illness or of the anticipated clinical course of the physical impairment considering the patient's condition, of the therapeutic possibilities and their consequences or of the appropriate measures for compensating for the patient's disabilities;

(c) verifying the persistence of suffering and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition;

(d) discussing the patient's request with any members of the care team who are in regular contact with the patient; and

(e) if the patient so wishes, discussing the request with the patient's close relations or with any other person the patient identifies;

(2) make sure that the patient has had the opportunity to discuss the request with the persons they wished to contact;

(2.1) if the patient has a physical impairment, make sure that the patient has evaluated the possibility of obtaining support, advisory or assistance services from, among others, the Office des personnes handicapées du Québec, a community organization or a peer assistant, such as assistance to initiate a service plan process for them; and

(3) obtain the opinion of a second competent professional confirming that the criteria set out in section 26 have been met.

The professional consulted must be independent of both the patient requesting medical aid in dying and the professional seeking the opinion. The professional consulted must consult the patient's record, examine the patient and provide the opinion in writing.

If an end-of-life patient has become incapable of giving consent to care after making the request, the competent professional may nonetheless administer medical aid in dying to the patient, provided that, at the time the patient was at the end of life and before they became incapable of giving consent to care,

(1) all the conditions prescribed in the first paragraph had been met; and

(2) the patient had given consent, in writing by means of the form prescribed by the Minister and in the presence of a competent professional, and within 90 days before the date of administration of the medical aid in dying, to receiving the aid even if they were to become incapable of giving consent to care before the administration of the aid.

Any refusal to receive medical aid in dying expressed by a patient referred to in the preceding paragraph must be respected and it is prohibited to disregard it in any manner.

2014, c. 2, s. 29; 2021, c. 23, s. 9; 2023, c. 15, ss. 19 and 58; 2023, c. 15, s. 19.

Not in force

§ 3. — *Special provisions applicable to advance requests for medical aid in dying*

2023, c. 15, s. 20.

Not in force

I. — *Criteria for obtaining medical aid in dying*

2023, c. 15, s. 20.

Not in force

29.1. In order to obtain medical aid in dying following an advance request, a patient must, in addition to making a request that complies with sections 29.2, 29.3 and 29.7 to 29.10, meet the following criteria:

(1) at the time the patient makes the request:

(a) be of full age and capable of giving consent to care;

(b) be an insured person within the meaning of the Health Insurance Act (chapter A-29); and

(c) suffer from a serious and incurable illness leading to incapacity to give consent to care; and

(2) at the time medical aid in dying is to be administered:

(a) be incapable of giving consent to care due to their illness;

(b) still meet the criteria set out in subparagraphs *b* and *c* of subparagraph 1;

(c) be exhibiting, on a recurring basis, the clinical manifestations related to their illness that they described in the request; and

(d) be in a medical state

i. of advanced, irreversible decline in capability, and

ii. that gives a competent professional cause to believe, based on the information at their disposal and according to their clinical judgment, that the patient is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable.

For the purposes of subparagraph *b* of subparagraph 1 of the first paragraph, a person with respect to whom the cost of the insured health services they receive or may receive is assumed otherwise than under the Health Insurance Act due to their detention in Québec or due to the fact that they are resident in Québec and in active service in the Canadian Armed Forces is considered an insured person within the meaning of that Act.

For the purposes of subparagraph *c* of subparagraph 1 of the first paragraph, a mental disorder other than a neurocognitive disorder cannot be an illness for which a person may make a request.

2023, c. 15, s. 20.

Not in force

II. — *Criteria and other provisions relating to making an advance request*

2023, c. 15, s. 20.

Not in force

29.2. The patient must make the advance request for themselves, in a free and informed manner, and record it on the form prescribed by the Minister. The form must be dated and signed by the patient.

If the patient making the request cannot record it on that form or date and sign the form because they cannot write or are physically incapable of doing so, a third person may do so in the patient's presence.

The third person may not be a member of the care team responsible for the patient and may not be a minor or a person of full age incapable of giving consent.

2023, c. 15, s. 20.

Not in force

29.3. A patient making an advance request must be assisted by a competent professional.

With the assistance of the professional, the patient must describe in detail in the request the clinical manifestations related to their illness that, when the patient has become incapable of giving consent to care and a competent professional finds that they are exhibiting those manifestations, must be considered to be the expression of their consent to medical aid in dying being administered to them once all the criteria set out in this Act have been met.

The professional must ensure that the clinical manifestations described in the request meet the following criteria:

(1) be medically recognized as being clinical manifestations that can be related to the illness from which the patient suffers; and

(2) be observable by a competent professional who would have to observe those manifestations before administering medical aid in dying.

2023, c. 15, s. 20.

Not in force

29.4. The competent professional providing assistance to the patient must

(1) be of the opinion that the patient meets the criteria set out in subparagraph 1 of the first paragraph of section 29.1 and that the request is being made in accordance with section 29.2, after, among other things,

(a) making sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure;

(b) making sure that the request is an informed one, in particular by ascertaining that the patient has clearly understood the nature of the diagnosis and by informing the patient of the anticipated course of and the prognosis for the illness and of the therapeutic possibilities and their consequences;

(c) discussing the patient's request with any members of the care team who are in regular contact with the patient; and

(d) if the patient so wishes, discussing the request with the patient's close relations or with any other person the patient identifies; and

(2) make sure that the patient has had the opportunity to discuss the request with the persons the patient wished to contact.

2023, c. 15, s. 20.

Not in force

29.5. The competent professional providing assistance to the patient must notify them that the advance request, made in compliance with this Act, will not automatically lead to the administration of medical aid in dying. For that purpose, the competent professional must, in particular, inform the patient of the following:

(1) an eventual finding that they are exhibiting, on a recurring basis, the clinical manifestations related to their illness that are described in the request will not by itself suffice to allow medical aid in dying to be administered;

(2) the aid may be administered to them only if two competent professionals are of the opinion that both of the following criteria have been met:

(a) the patient's medical state gives those professionals cause to believe, based on the information at their disposal and according to their clinical judgment, that the patient is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable; and

(b) the patient meets all the other criteria set out in subparagraph 2 of the first paragraph of section 29.1; and

(3) the possibility of withdrawing or modifying the advance request and the applicable terms and conditions for the withdrawal or modification.

The competent professional must be sure to provide the information required under subparagraphs 1 to 3 of the first paragraph in a manner that is clear and accessible to the patient.

2023, c. 15, s. 20.

Not in force

29.6. The patient may designate in the advance request a trusted third person to whom they entrust the following responsibilities:

(1) notify a health or social services professional who provides care to the patient due to their illness where the trusted third person believes

(a) the patient is exhibiting the clinical manifestations related to their illness that are described in the request; or

(b) the patient is experiencing enduring and unbearable physical or psychological suffering; and

(2) when the patient has become incapable of giving consent to care, notify any health or social services professional who provides care to the patient due to their illness of the existence of the request, or remind such a professional of its existence.

The patient may also designate in the request a second trusted third person who, if the first trusted third person is deceased or is prevented from acting, in particular due to their incapacity, or refuses or neglects to do so, replaces that third person.

A trusted third person may not be a minor or a person of full age incapable of giving consent.

2023, c. 15, s. 20.

Not in force

29.7. After the form has been signed by the person making the advance request or, where applicable, by the third person referred to in the second paragraph of section 29.2, the competent professional providing assistance to the patient dates and countersigns the form to attest compliance with sections 29.3 to 29.5.

A trusted third person who consents to being designated affixes their signature on the form and dates it.

2023, c. 15, s. 20.

Not in force

29.8. The advance request must be made by notarial act *en minute* or in the presence of witnesses by means of the form referred to in section 29.2.

If the request is made by notarial act *en minute*, the duly completed form must be annexed to the notarial act.

If the advance request is made in the presence of witnesses, the patient declares, in the presence of two witnesses, that the form contains the patient's advance request, without having to disclose the contents.

The witnesses date and countersign the form.

No such witness may be a minor or a person of full age incapable of giving consent. Nor may they be designated as a trusted third person in the request or act as a competent professional for the purpose of administering medical aid in dying to the patient.

2023, c. 15, s. 20.

Not in force

29.9. All signatories of the advance request form must be in each other's presence when they affix their signature. A signatory may, however, be present remotely where the technological means used for that purpose allows all signatories to be identified, heard and seen in real time.

2023, c. 15, s. 20.

Not in force

29.10. Every advance request must, to be applicable, be recorded by the competent professional who provides assistance to the patient making the request or, where applicable, by the officiating notary in the register kept by the Minister in accordance with subparagraph 5 of the second paragraph of section 521 of the Act respecting health services and social services (chapter S-4.2).

2023, c. 15, s. 20.

Not in force

III. — *Withdrawal and modification of an advance request*

2023, c. 15, s. 20.

Not in force

29.11. A patient who is capable of giving consent to care may, at any time, withdraw their advance request by means of the form prescribed by the Minister. The second and third paragraphs of section 29.2 apply, with the necessary modifications, to the withdrawal form for such a request.

A patient who wishes to withdraw their request must be assisted by a competent professional. After the form has been signed, the competent professional dates and countersigns the form to attest that the patient is capable of giving consent to care. The professional must make sure that the request is removed, as soon as possible, from the register referred to in section 29.10.

A patient may modify an advance request only by making a new advance request by one of the methods specified in section 29.8. The new advance request replaces the previous one as soon as it is recorded in the register in accordance with section 29.10.

2023, c. 15, s. 20.

Not in force

IV. — *Processing of an advance request*

2023, c. 15, s. 20.

Not in force

29.12. A health or social services professional who provides care to a patient having obtained a diagnosis for a serious and incurable illness leading to incapacity to give consent to care must, when the professional becomes aware of that incapacity, consult the register referred to in section 29.10.

If the register contains an advance request made by the patient, the professional consults the request and files it in the patient's record, unless the request is already in the record. Furthermore, the professional must ensure that every trusted third person designated in the request has been notified of the onset of the patient's incapacity.

The professional also informs the health or social services professionals who are members of the care team responsible for the patient of the existence of the request.

2023, c. 15, s. 20.

Not in force

29.13. A patient having made an advance request must undergo an examination by a competent professional when the trusted third person notifies a health or social services professional that they believe, as applicable,

(1) that the patient is exhibiting the clinical manifestations related to their illness that are described in the request; or

(2) that the patient is experiencing enduring and unbearable physical or psychological suffering.

The health or social services professional must inform a competent professional of the reception of a notice from the trusted third person.

The purpose of the examination carried out by the competent professional is to determine whether the patient is exhibiting, on a recurring basis, the clinical manifestations referred to in subparagraph 1 of the first paragraph and whether the patient's medical state gives cause to believe, based on the information at the professional's disposal and according to their clinical judgment, that the patient is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable.

2023, c. 15, s. 20.

Not in force

29.14. If every trusted third person designated in an advance request is deceased or is prevented from acting or refuses or neglects to do so, the patient having made the request must undergo the examination prescribed in the third paragraph of section 29.13 where a competent professional, as applicable,

(1) finds, at first glance,

(a) that the patient is exhibiting some of the clinical manifestations related to their illness that are described in the request; or

(b) that the patient's medical state gives cause to believe that the patient is experiencing enduring and unbearable physical or psychological suffering; or

(2) is notified by a person that they believe the patient is exhibiting the clinical manifestations referred to in subparagraph *a* of subparagraph 1 or that the patient is experiencing enduring and unbearable physical or psychological suffering.

A competent professional must, before carrying out the examination, take reasonable measures to notify every trusted third person designated in the request of the situation.

2023, c. 15, s. 20.

Not in force

29.15. The first paragraph of section 29.14 applies, with the necessary modifications, to a patient who did not designate a trusted third person in the advance request.

2023, c. 15, s. 20.

Not in force

29.16. If every trusted third person designated in an advance request is deceased or prevented from acting or refuses or neglects to do so, or if no trusted third person was designated in such a request, a health or social services professional who is a member of the care team responsible for the patient having made an advance request must notify a competent professional if the health or social services professional believes that the

patient is exhibiting the clinical manifestations related to their illness that are described in the request or that the patient is experiencing enduring and unbearable physical or psychological suffering.

2023, c. 15, s. 20.

Not in force

29.17. The competent professional must, as part of an examination required by section 29.13, 29.14 or 29.15, have a discussion, where applicable, with the trusted third person and with the members of the care team responsible for the patient.

The professional records in writing the clinical manifestations related to the patient's illness that the professional has observed, the other relevant information in connection with the patient's medical state and the conclusions of the examination.

2023, c. 15, s. 20.

Not in force

29.18. After carrying out the examination required by section 29.13, 29.14 or 29.15, the competent professional must inform the patient who made the advance request, the members of the care team responsible for the patient and, where applicable, every trusted third person designated in the request of the professional's conclusions.

The professional must ensure that the process for administering medical aid in dying continues only where the professional concludes that the patient is exhibiting, on a recurring basis, the clinical manifestations related to their illness that they described in the request, and that the patient's medical state gives cause to believe, based on the information at the professional's disposal and according to their clinical judgment, that the patient is experiencing enduring and unbearable physical or psychological suffering that cannot be relieved under conditions considered tolerable.

2023, c. 15, s. 20.

Not in force

29.19. Before administering medical aid in dying following an advance request, the competent professional must

(1) be of the opinion that the patient meets all the criteria set out in subparagraph 2 of the first paragraph of section 29.1 and the first paragraph of section 29.2; and

(2) obtain the opinion of a second competent professional confirming that the criteria that must be the subject of an opinion under subparagraph 1 have been met.

The second paragraph of section 29 applies to the professional consulted.

Any refusal to receive medical aid in dying expressed by the patient must be respected and it is prohibited to disregard it in any manner.

If the patient is exhibiting behavioural symptoms resulting from their medical state, such as resistance to care, the competent professional must, based on the information at their disposal and according to their clinical judgment, rule out the possibility that the patient is refusing to receive medical aid in dying. The professional must record in writing the symptoms that the professional has observed and the conclusions of the assessment.

2023, c. 15, s. 20.

§ 4. — *Administration of medical aid in dying*

2023, c. 15, s. 20.

30. If a competent professional concludes, subsequent to the application of section 29, that medical aid in dying may be administered to a patient requesting it, the professional must personally administer it to the patient and take care of and stay with the patient until death ensues.

If the professional concludes however, subsequent to the application of that section, that medical aid in dying cannot be administered, the professional must inform the patient requesting it of the reasons for that conclusion and of the other services that can be offered to the patient to relieve their suffering.

Not in force

In the case of an advance request, the professional must also inform any trusted third person designated in the request and any health or social services professional who is a member of the care team responsible for the patient of the conclusion. Where the professional concludes that medical aid in dying may be administered, the professional must inform them before proceeding to administer such aid.

2014, c. 2, s. 30; 2023, c. 15, ss. 21 and 58.

Not in force

30.1. An advance request does not lapse because a competent professional has concluded that medical aid in dying cannot be administered, unless that conclusion results from the refusal expressed by the patient to receive such aid.

2023, c. 15, s. 21.

Not in force

30.2. Where a competent professional concludes that medical aid in dying cannot be administered to a patient having made an advance request due to the refusal expressed by the patient to receive such aid, the professional must make sure that the request is removed, as soon as possible, from the register referred to in section 29.10.

2023, c. 15, s. 21.

§ 5. — *Management of certain refusals and of information or documents related to a request for medical aid in dying*

2023, c. 15, s. 21.

31. Any competent professional practising in a centre operated by an institution must notify the executive director of the institution, or any other person designated by the executive director, and, where applicable, send the executive director or the designated person the medical aid in dying request form in the following cases:

(1) the professional refuses a request for a reason not based on section 29;

Not in force

(2) the professional refuses to provide assistance to a patient in making an advance request under section 29.3 or in withdrawing such a request under section 29.11; or

Not in force

(3) the professional refuses to carry out the examination required by section 29.13, 29.14 or 29.15.

The executive director of the institution, or the person designated by the executive director, must then take the necessary steps to find, as soon as possible, a competent professional willing to remedy the situation.

A competent professional practising in a private health facility must instead forward the notice of refusal to the executive director of the local authority referred to in section 99.4 of the Act respecting health services and social services (chapter S-4.2) that serves the territory in which the patient making the request resides, or notify the person designated by the executive director. The professional forwards the medical aid in dying request form received, if that is the case, to the executive director or designated person. The steps mentioned in the second paragraph must then be taken.

If no local authority serves the territory in which the patient resides, the notice referred to in the third paragraph is forwarded to the executive director of the institution operating a local community service centre in the territory or the person designated by the executive director.

2014, c. 2, s. 31; 2023, c. 15, ss. 22 and 58.

32. All information and documents in connection with a request for medical aid in dying, regardless of whether the competent professional administers it or not, including the form used to request such aid, the reasons for the competent professional's decision and, where applicable, the opinion of the competent professional consulted, must be recorded or filed in the patient's record.

A decision to withdraw a request for medical aid in dying or to put off the administration of such aid must also be recorded in the patient's record.

2014, c. 2, s. 32; 2023, c. 15, s. 23.

DIVISION III

SPECIAL FUNCTIONS OF THE COUNCIL OF PHYSICIANS, DENTISTS AND PHARMACISTS AND OF THE DIRECTOR OF NURSING CARE

2014, c. 2, Div. III; 2023, c. 15, s. 24.

33. The council of physicians, dentists and pharmacists established for an institution must, in collaboration with the director of nursing care of the institution, adopt clinical protocols for continuous palliative sedation and medical aid in dying. The protocols must comply with the clinical standards developed by the professional orders concerned.

2014, c. 2, s. 33; 2023, c. 15, s. 25.

34. A competent professional who provides continuous palliative sedation or medical aid in dying as a physician or a specialized nurse practitioner practising in a centre operated by an institution must, within 10 days following its administration, inform the council of physicians, dentists and pharmacists of which the competent professional is a member or, as applicable, the director of nursing care, whether the sedation or aid is administered in the facilities of an institution, in the premises of a palliative care hospice or at the patient's home.

The council of physicians, dentists and pharmacists, its competent committee or the director of nursing care assesses the quality of the care provided, particularly with regard to applicable clinical protocols.

2014, c. 2, s. 34; 2023, c. 15, s. 26.

35. If no council of physicians, dentists and pharmacists has been established for the institution, the head of medical services or, as applicable, the physician responsible for medical care in the institution assumes the functions assigned to the council by this division.

If no director of nursing care has been appointed by the institution, the nurse in charge of nursing within the institution assumes the functions assigned to the director by this division.

The competent professional must then inform the head of medical services or the physician responsible referred to in the first paragraph or, as applicable, the nurse in charge referred to in the second paragraph in accordance with the first paragraph of section 34.

2014, c. 2, s. 35; 2023, c. 15, s. 27.

DIVISION IV

SPECIAL FUNCTIONS OF THE COLLÈGE DES MÉDECINS DU QUÉBEC AND OF THE ORDRE DES INFIRMIÈRES ET INFIRMIERS DU QUÉBEC

2014, c. 2, Div. IV; 2023, c. 15, s. 28.

36. Competent professionals practising in a private health facility that provides continuous palliative sedation or medical aid in dying at the patient's home or in the premises of a palliative care hospice must, within 10 days following its administration, inform the Collège des médecins du Québec or, as applicable, the Ordre des infirmières et infirmiers du Québec and send it the information it determines, under the conditions and in the manner it prescribes.

The Collège or the Ordre, or their respective committee, assesses the quality of the care provided, particularly with regard to applicable clinical standards.

2014, c. 2, s. 36; 2023, c. 15, s. 29.

37. The Collège des médecins du Québec and the Ordre des infirmières et infirmiers du Québec must respectively prepare a yearly report on the end-of-life care provided by physicians and specialized nurse practitioners practising in private health facilities.

The report must state the number of times continuous palliative sedation and medical aid in dying were administered by such physicians and specialized nurse practitioners, and whether they were administered at the patient's home or in the premises of a palliative care hospice. The information must be grouped by local health and social services network territory and health and social services agency territory.

The reports are to be published respectively on the website of the Collège and of the Ordre and sent, not later than 30 June each year, to the Commission sur les soins de fin de vie.

2014, c. 2, s. 37; 2023, c. 15, s. 30.

CHAPTER V

COMMISSION SUR LES SOINS DE FIN DE VIE

DIVISION I

ESTABLISHMENT AND FUNCTIONING OF THE COMMISSION

38. A commission on end-of-life care ("the Commission") is established under the name "Commission sur les soins de fin de vie".

2014, c. 2, s. 38.

39. The Commission is composed of 13 members, appointed by the Government as follows:

(1) seven members are to be health or social services professionals, including

(a) three members appointed after consultation with the Collège des médecins du Québec;

(b) two members appointed after consultation with the Ordre des infirmières et infirmiers du Québec;

(c) one member appointed after consultation with the Ordre des pharmaciens du Québec; and

(d) one member appointed after consultation with the Ordre professionnel des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec;

(2) two members are to be jurists, appointed after consultation with the Barreau du Québec and the Chambre des notaires du Québec;

(3) two members are to be users of institutions, appointed after consultation with bodies representing the users' committees of institutions;

(4) one member is to be from the ethics community, appointed after consultation with university-level educational institutions; and

(5) one member is to be appointed after consultation with bodies representing institutions.

The Government must ensure that at least one member appointed under subparagraph 1 of the first paragraph is from the palliative care community.

The members of the Commission are appointed for a term of not more than five years. Their terms of office may be renewed consecutively only once. At the expiry of their terms, members remain in office until they are replaced or reappointed.

The Government designates, from among the members of the Commission, a chair and vice-chair; the vice-chair shall chair the Commission when the chair is absent or unable to act.

The Government fixes the allowances and indemnities of the members of the Commission.

2014, c. 2, s. 39; 2023, c. 15, s. 31.

40. The Commission may make by-laws concerning its internal management.

2014, c. 2, s. 40.

41. The quorum at meetings of the Commission is nine members, including the chair or the vice-chair.

Subject to the second paragraph of section 47, the decisions of the Commission are made by a majority vote of the members present. In the case of a tie vote, the person presiding at the meeting has a casting vote.

2014, c. 2, s. 41; 2023, c. 15, s. 32.

DIVISION II

MANDATE OF THE COMMISSION

42. The mandate of the Commission is to examine any matter relating to end-of-life care. For this purpose, it must, among other things,

(1) advise the Minister on any matter put before it by the Minister;

(2) evaluate the implementation of legislation with regard to end-of-life care;

(3) refer to the Minister any matter relating to end-of-life care that needs the attention of or action by the Government, and submit its recommendations to the Minister;

(4) submit a report to the Minister, every five years, on the status of end-of-life care in Québec; and

(5) conduct required analyses and produce required statistical information in order, in particular, to follow the evolution of end-of-life care, identify end-of-life care needs and determine what may constitute a limit to access to such care.

The Commission carries out any other end-of-life care-related mandate given to it by the Minister.

The Commission also has the mandate of overseeing the application of the specific requirements relating to medical aid in dying in compliance with this division.

The Commission is to submit an annual activity report, not later than 30 September each year, to the Minister.

2014, c. 2, s. 42; 2023, c. 15, s. 33.

43. The Minister tables the reports produced by the Commission in the National Assembly within 30 days of receiving them or, if the Assembly is not sitting, within 30 days of resumption. The competent committee of the National Assembly examines the reports.

2014, c. 2, s. 43.

44. In exercising its functions under the first paragraph of section 42, the Commission may take such measures as

(1) soliciting the opinion of individuals or groups on any end-of-life care issue;

(2) conducting or commissioning studies and research it deems necessary; and

(3) calling on outside experts to report to it on one or more specific points.

The Commission may also exercise the powers set out in subparagraphs 1 to 3 of the first paragraph for the purpose of carrying out a mandate given to it by the Minister under the second paragraph of section 42.

2014, c. 2, s. 44; 2023, c. 15, s. 34.

45. The Commission may require of institutions, palliative care hospices, competent professionals practising in a private health facility and agencies that they supply, in the manner and within the time

specified, the statements, statistical data, reports and other information it needs for the performance of its functions under the first paragraph of section 42 or to carry out a mandate given to it by the Minister under the second paragraph of that section, provided it is not possible to link that information to any specific patient having received end-of-life care or to any specific health or social services professional having provided the care.

2014, c. 2, s. 45; 2023, c. 15, s. 35.

46. A competent professional who administers medical aid in dying must give notice to the Commission within the next 10 days and send the Commission, in the manner determined by government regulation, the information prescribed by regulation. This information is confidential and may not be disclosed to any other person, except to the extent that is necessary for the purposes of this section and section 47.

Any person who finds that a competent professional has contravened this section must report the failure to the Collège des médecins du Québec or, as applicable, the Ordre des infirmières et infirmiers du Québec so that it can take appropriate measures.

2014, c. 2, s. 46; 2023, c. 15, ss. 36 and 58.

47. On receiving the notice from the competent professional, the Commission assesses compliance with section 29 in accordance with the procedure prescribed by government regulation.

On completion of the assessment, if two-thirds or more of the members present are of the opinion that section 29 was not complied with, the Commission sends a summary of its conclusions to the Collège des médecins du Québec or, as applicable, the Ordre des infirmières et infirmiers du Québec so that it can take appropriate measures. If a competent professional provided the medical aid in dying as a physician or a specialized nurse practitioner practising in a centre operated by an institution, the Commission sends the summary to the institution for the same purposes.

2014, c. 2, s. 47; 2023, c. 15, ss. 37 and 58.

47.1. A competent professional having received a request for medical aid in dying who does not administer such aid to the patient having made the request must notify the Commission within 30 days after any of the following events occurs:

(1) the professional finds that the patient does not meet the criteria set out in section 29;

(2) the professional finds or is informed that the patient has withdrawn their request;

(3) the professional finds or is informed that the patient has refused to receive medical aid in dying;

(4) the professional has forwarded a notice of refusal under section 31; or

(5) the professional finds or is informed that the patient has died before the administration of medical aid in dying.

When notifying the Commission, the competent professional must also send it, in the manner determined by government regulation, the information prescribed by that regulation and, where applicable, the information concerning any other service they provided to the patient to relieve their suffering. Such information is confidential and may not be disclosed to any other person, except to the extent that the information is necessary for the purposes of this section.

2023, c. 15, ss. 38 and 58.

47.2. A pharmacist who provides a medication or a substance to a competent professional for the purpose of the administration of medical aid in dying must notify the Commission within 30 days and send it, in the manner determined by government regulation, the information prescribed by that regulation. This information

is confidential and may not be disclosed to any other person, except to the extent that the information is necessary for the purposes of this section.

2023, c. 15, ss. 38 and 58.

47.3. In exercising its functions under the first paragraph of section 42, the Commission may use any information sent to it under sections 46, 47.1 and 47.2, provided it is not possible to link that information to any specific patient who made a request for medical aid in dying, to a patient to whom such aid was administered or to a health or social services professional, including a pharmacist referred to in section 47.2.

The Commission may also, on the same conditions, use such information for the purpose of carrying out a mandate given to it by the Minister under the second paragraph of section 42.

2023, c. 15, s. 38.

CHAPTER VI

MISCELLANEOUS PROVISIONS

48. Complaints regarding end-of-life care made by any person to a local or regional service quality complaints commissioner, in accordance with the rules prescribed in Divisions I to III of Chapter III of Title II of Part I of the Act respecting health services and social services (chapter S-4.2), must be given priority treatment. The same applies to complaints regarding end-of-life care made to the syndic of the Collège des médecins du Québec or to the syndic of the Ordre des infirmières et infirmiers du Québec.

2014, c. 2, s. 48; 2023, c. 15, s. 39.

49. The decision of a patient or, where applicable, of the person who may give consent to care on the patient's behalf to refuse certain life-sustaining care or withdraw consent to such care or to request continuous palliative sedation or medical aid in dying may not be invoked as a reason to refuse to pay a benefit or any other sum due under a contract.

2014, c. 2, s. 49.

50. A competent professional may refuse to administer medical aid in dying because of personal convictions, and a health professional may refuse to take part in administering it for the same reason.

Such professionals must nevertheless ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes.

In addition, the competent professional must comply with the procedure established in section 31.

2014, c. 2, s. 50; 2023, c. 15, s. 40.

50.1. The Minister may, by regulation, determine the form and content of any notices required under this Act as well as the conditions relating to their sending.

2023, c. 15, s. 41.

50.2. No one may promote or advertise a good or service supplied in the course of a commercial activity by associating it directly or indirectly with medical aid in dying or charge any amount related directly or indirectly to obtaining such aid.

The first paragraph does not have the effect of limiting the supply of health services or social services to a person having made a request for medical aid in dying.

Anyone who contravenes the first paragraph is liable to a fine of $5,000 to $50,000 in the case of a natural person or to a fine of $15,000 to $150,000 in any other case. The amounts of the fines are doubled for a subsequent offence.

2023, c. 15, s. 41.

TITLE III

ADVANCE MEDICAL DIRECTIVES

CHAPTER I

GENERAL PROVISIONS

51. A person of full age who is capable of giving consent to care may, by means of advance medical directives, specify whether or not they consent to care that may be required by their state of health, in the event they become incapable of giving consent. However, in such directives the person may not request medical aid in dying.

2014, c. 2, s. 51.

52. Advance medical directives are given by notarial act *en minute* or in the presence of witnesses on the form prescribed by the Minister.

At the request of their author, advance medical directives are to be recorded in the advance medical directives register established under section 63.

2014, c. 2, s. 52.

53. When advance medical directives are given in the presence of witnesses, the form must be completed by the person concerned.

The person then declares, in the presence of two witnesses, that the form contains the person's advance medical directives, without having to disclose the contents. The person dates and signs the form or, if this is already done, recognizes the signature as their own. The form is then signed by the witnesses in the person's presence.

If the person cannot complete the form because the person cannot write or is physically incapable of doing so, it may be completed by a third person in accordance with the person's instructions. The third person signs and dates the form in the person's presence.

Persons of full age incapable of giving consent and minors cannot act as a third person or a witness for the purposes of this section.

2014, c. 2, s. 53.

54. Advance medical directives may be revoked at any time by the person concerned by means of the form prescribed by the Minister.

Such directives may only be changed by writing new ones by one of the methods specified in the first paragraph of section 52. The new directives replace any previous ones.

Despite the first and second paragraphs, in emergency cases, if a person capable of giving consent to care verbally expresses wishes different from those in their advance medical directives, this entails the revocation of the directives.

2014, c. 2, s. 54.

55. When advance medical directives are given to a health professional, that professional files them in the record of the person concerned if this has not yet been done. If the directives are given to the health professional by the person concerned and the person is capable of giving consent to care, the health professional must first inquire whether they still correspond to the person's wishes.

2014, c. 2, s. 55.

56. A physician who notes a significant change in the state of health of a person capable of giving consent to care must, if advance medical directives have been filed in the person's record, inquire whether the directives still correspond to the person's wishes.

2014, c. 2, s. 56.

57. A physician who notes that a person is incapable of giving consent to care consults the register referred to in the second paragraph of section 52. If the register contains advance medical directives for the person, the physician files them in the person's record.

2014, c. 2, s. 57; 2023, c. 15, s. 44.

58. When a person is incapable of giving consent to care, wishes relating to care that are clearly expressed in advance medical directives recorded in the register referred to in the second paragraph of section 52 or filed in the person's record carry, for all health professionals having access to the register or record, the same weight as wishes expressed by a person capable of giving consent to care.

2014, c. 2, s. 58; 2023, c. 15, s. 45.

59. The author of advance medical directives is presumed to have been in the possession of the information needed to make an informed decision at the time of signing the directives.

2014, c. 2, s. 59.

60. If a person incapable of giving consent to care categorically refuses care which they had previously consented to in advance medical directives, article 16 of the Civil Code, requiring the authorization of the court, applies.

2014, c. 2, s. 60.

61. The court may, on the application of the mandatary, tutor of or any person showing a special interest in the author of advance medical directives, order that the instructions relating to care expressed in those directives be carried out.

The court may also, on the application of such a person, a physician or an institution, invalidate advance medical directives, in full or in part, if it has reasonable grounds to believe that the author of the directives was not capable of consenting to the care at the time of signing the directives or that the directives do not correspond to the author's wishes in the present situation.

The court may, in addition, make any other order it considers appropriate in the circumstances.

2014, c. 2, s. 61; 2020, c. 11, s. 254.

62. Instructions relating to care expressed in a protection mandate do not constitute advance medical directives within the meaning of this Act and remain subject to articles 2166 and following of the Civil Code.

In case of inconsistency between those instructions for care and the instructions contained in advance medical directives, the latter prevail.

2014, c. 2, s. 62; I.N. 2016-01-01 (NCCP).

CHAPTER II

ADVANCE MEDICAL DIRECTIVES REGISTER

63. The Minister establishes and maintains an advance medical directives register.

The Minister may manage the register or entrust its management to a body that is subject to the Act respecting Access to documents held by public bodies and the Protection of personal information (chapter A-2.1). In the latter case, the Minister enters into a written agreement with the manager.

2014, c. 2, s. 63.

64. The Minister prescribes, by regulation, how the register is to be accessed and operated, including who may record advance medical directives in the register and who may consult it.

2014, c. 2, s. 64.

TITLE IV

AMENDING, TRANSITIONAL AND FINAL PROVISIONS

CHAPTER I

AMENDING PROVISIONS

CIVIL CODE OF QUÉBEC

65. *(Amendment integrated into the Civil Code, a. 11).*

2014, c. 2, s. 65.

66. *(Amendment integrated into the Civil Code, a. 12).*

2014, c. 2, s. 66.

67. *(Amendment integrated into the Civil Code, a. 15).*

2014, c. 2, s. 67.

CODE OF CIVIL PROCEDURE

68. *(Amendment integrated into c. C-25, a. 776).*

2014, c. 2, s. 68.

MEDICAL ACT

69. *(Amendment integrated into c. M-9, s. 31).*

2014, c. 2, s. 69.

PHARMACY ACT

70. *(Amendment integrated into c. P-10, s. 17).*

2014, c. 2, s. 70.

71. *(Amendment integrated into c. S-4.2, s. 19).*

2014, c. 2, s. 71.

CHAPTER II

TRANSITIONAL AND FINAL PROVISIONS

72. *(Repealed).*

2014, c. 2, s. 72; 2023, c. 15, s. 46.

73. Until 10 December 2017, executive directors of institutions must report every six months to their board of directors as described in the second paragraph of section 8. The institutions are to forward the report to the Commission sur les soins de fin de vie as soon as possible and publish it on their website.

Until that date, the Collège des médecins du Québec is also to send the Commission the report required under section 37 every six months.

2014, c. 2, s. 73.

74. Institutions and palliative care hospices have until 10 December 2016 to amend the agreement they have entered into under section 108.3 of the Act respecting health services and social services (chapter S-4.2) in order to bring it into conformity with section 14.

2014, c. 2, s. 74.

75. Despite subparagraph 4 of the first paragraph of section 42, the Commission sur les soins de fin de vie must send its first report on the status of end-of-life care not later than 10 December 2018.

2014, c. 2, s. 75.

76. The Minister must, not later than 10 December 2019, report to the Government on the implementation of this Act, and subsequently every five years, report to the Government on the carrying out of this Act.

Such report is tabled by the Minister in the National Assembly within the next 30 days or, if the Assembly is not sitting, within 30 days of resumption. The report is examined by the competent committee of the National Assembly.

2014, c. 2, s. 76.

77. The Minister of Health and Social Services is responsible for the administration of this Act.

2014, c. 2, s. 77.

78. *(Omitted).*

2014, c. 2, s. 78.