2015

Draft Provincial/Territorial Legislation to Implement a Regulatory Framework for Medically-Assisted Dying Consistent with Carter v. Canada (Attorney General) 2015 SCC 5 and the Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying

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An Act Respecting End-of-Life Care for [province/territory]

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Drafted to be consistent with the SCC decision in *Carter v. Canada,* the Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, and a comparative review of legislation in all permissive regimes and analysis of available academic and grey literature

Purposes

The purposes of this bill are: to promote access to palliative care; to recognize the primacy of wishes of capable persons expressed freely and clearly with respect to end-of-life care; to provide for access to end-of life-care; to reconcile freedom of conscience of healthcare providers and patients and the right to life, liberty, and security of patients in [province/territory]; and to ensure that the vulnerable are well-protected and the system of medically-assisted death in [province/territory] is well-monitored.

Definitions

In this Act,

"assistance" means the provision of a prescription for a lethal dose of medication or a lethal injection for the purpose of medically-assisted death;

“assisting healthcare provider” means the physician, other healthcare provider acting under the direction of a physician, or nurse practitioner who is asked to provide assistance with death to a person seeking medically-assisted death;

“capable” means able to understand the subject-matter in respect of which a decision must be made and able to appreciate the consequences of that decision or lack of a decision, and “capacity” has a similar meaning as the context requires;

“consulting healthcare provider” means a healthcare provider who is qualified by specialty or experience to form a professional opinion about the matter on which

he has been consulted and who is not the assessing or reviewing healthcare provider;

“Commission” means the Commission on End of Life Care;

“direct transfer of care” means a transfer of care made in good faith directly to a non-objecting, available, and accessible healthcare provider willing and able to accept the person as a patient, to assess whether the criteria for access to medically-assisted death have been met, and provide medically-assisted death where the criteria for access are met;

“end-of-life care” means withholding or withdrawal of potentially life-sustaining care, palliative sedation, medically-assisted death, and palliative care;

"euthanasia" means the intentional ending of the life of a person, by another person, in order to relieve the first person's suffering;

“grievous” means very severe or serious;

“health authority” means a health authority as defined under the [provincial/territorial health authorities legislation]*;*

“healthcare provider” means a regulated health professional;

“indirect transfer of care” means a transfer of care using the health authority system set up to ensure the timely, safe, and effective transfer of care to a non-objecting, available, and accessible healthcare provider willing and able to accept the person as a patient, to assess whether the criteria for access to medically-assisted death have been met, and provide medically-assisted death where the criteria for access are met. Using the health authority system includes providing all relevant documentation including the patient’s medical record.

“institution” means any institution that is governed by the [name of all relevant Acts], and operates a health authority, hospital, a long-term care facility, a hospice, or continuing care services;

“irremediable” means cannot be alleviated by means acceptable to the patient;

“mature minor” means a patient under the age of majority who has capacity to make an informed decision about medically-assisted death and sufficient independence to make a voluntary decision;

"medically-assisted death" means medically-assisted suicide and voluntary euthanasia that is performed by a physician, other healthcare provider acting under the direction of a physician, or nurse practitioner;

“medically-assisted suicide” means the act of intentionally ending one’s life with the assistance of a physician, healthcare provider acting under the direction of a

physician, or nurse practitioner;

“Minister” means the Minister of Health and Wellness;

“palliative care” means care provided to people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life. The care is aimed at alleviating suffering – physical, emotional, psychological, or spiritual – rather than curing. It aims neither to hasten nor to postpone death, but affirms life and regards dying as a normal process. It recognizes the special needs of patients and families at the end of life, and offers a support system to help them cope;

“palliative sedation” means the intentional administration of deep and continuous sedation combined with the withholding or withdrawal of artificial hydration and nutrition where the purpose is to alleviate suffering where this will not, or may but is not certain to, shorten the life of the person;

“patient” means an individual under the care of a healthcare provider;

“patient information form” means the form prescribed by the Commission to gather demographic data and reasons for seeking medically-assisted death;

“personal directive” means directions given by a capable individual concerning what and/or how and/or by whom decisions should be made in the event that, at some time in the future, the individual becomes incapable of making health care decisions;

“physician” means a medical practitioner as defined in the [relevant province/territory legislation];

“potentially life-shortening symptom relief” means the administration of drugs designed for symptom relief in dosages which the healthcare provider knows may but are not certain to hasten death where the healthcare provider’s intention is to ease suffering;

“potentially life-sustaining care” means care that has the potential to sustain the life of a person including but not limited to, health care and oral and artificial hydration and nutrition;

“request” means something asked for by a person orally or in writing;

“Review Committee” means a committee established by this Act to retrospectively review all cases of medically-assisted death to determine compliance with this Act;

“reviewing healthcare provider” means the healthcare provider who is asked to provide a second opinion as to whether the person seeking medically-assisted death has met the criteria for access to medically-assisted death;

"voluntary euthanasia" means euthanasia performed in accordance with the wishes of a capable individual where those wishes have been made known through a valid declaration;

“withdrawal of potentially life-sustaining care” means intentionally ceasing care that has the potential to sustain a persons’ life;

“withholding of potentially life-sustaining care” means intentionally refraining from commencing care that has the potential to sustain a person’s life.

Palliative care

Every patient whose condition requires palliative care has the right to receive it. 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 institutions and within the limits of the human, material and financial resources at their disposal. It complements the provisions of the [province/territory health services and insurance legislation].

Palliative sedation

With a valid consent from the patient (if capable or through a valid personal directive if incapable) or the patient’s substitute decision-maker appointed under the [provincial/territorial advance directives and health care consent legislation] *(*if incapable), palliative sedation is legally permissible.

The healthcare provider shall make sure that a decision with respect to palliative sedation is made freely and provide the patient or substitute decision-maker with all information needed to make an informed decision, in particular information about the diagnosis, prognosis for the illness, the consequences of accepting or rejecting palliative sedation, the feasible alternative approaches including, but not limited to, comfort care, palliative or hospice care, symptom control, and medically-assisted death.

Withholding and withdrawal of potentially life-sustaining care

Except as otherwise provided by law, a capable patient may, at any time, refuse consent to potentially life-sustaining care or withdraw consent to such care. In the case of an incapable patient, the substitute decision-maker appointed under the [provincial/territorial advance directives or health care consent legislation] may also refuse to authorize potentially life-sustaining care or withdraw authorization of such care. A free and informed refusal of consent or authorization made by an individual with legal decision-making authority must be respected.

The healthcare provider shall make sure that a decision to refuse the initiation or continuation of potentially life-sustaining care is made freely and provide the

patient or substitute decision-maker with all information needed to make an informed decision, in particular information about the diagnosis, prognosis for the illness, the consequences of the refusal being respected, the feasible alternative approaches including, but not limited to, comfort care, palliative or hospice care, symptom control, palliative sedation, and medically-assisted death.

A patient may not be denied end-of-life care for previously having refused to receive certain care or having withdrawn consent to certain care or having had authorization of care withheld or withdrawn by a substitute decision-maker.

Potentially life-shortening symptom relief

With a valid consent from the patient (if capable or through a valid personal directive if incapable) or the patient's delegate or substitute decision-maker appointed under the [provincial/territorial advance directives or health care consent legislation] (if incapable) potentially life-shortening symptom relief is legally permissible where the healthcare provider's intention is to ease the patient's suffering.

The healthcare provider shall make sure that a decision with respect to potentially life-shortening symptom relief is made freely and provide the patient or substitute decision-maker with all information needed to make an informed decision, in particular information about the diagnosis, prognosis for the illness, the consequences of accepting or rejecting potentially life-shortening symptom relief, the feasible alternative approaches including, but not limited to, comfort care, palliative or hospice care, palliative sedation, and medically-assisted death.

Medically-assisted death

Criteria for access

Only a patient who meets all of the following criteria may access medically-assisted death under this Act:

a) is lawfully entitled to receive publicly-funded health services without charge in [province/territory];
b) has a grievous and irremediable medical condition (including an illness, disease or disability) that is causing enduring suffering that is intolerable to the individual based on their assessment of their personal circumstances; and
c) has personally given a clear and valid consent to medically-assisted death.

A clear consent under this section is one made through a valid declaration of the request for medically-assisted death that is in force.

a) In order to be valid, a declaration shall be on a Form prescribed by the Commission, in writing, dated and signed by the patient and in the presence of a witness who shall also sign or, where the patient is physically unable to sign, by a person who is not a relative of the patient on behalf of the patient at the patient's direction and in the patient's presence, and in the presence of a witness who shall also sign.

b) A valid declaration may be made prior to the onset of the enduring intolerable suffering.

c) If completed before the onset of enduring intolerable suffering, the declaration must clearly stipulate the conditions or symptoms which the patient considers constitute enduring intolerable suffering.

d) The declaration shall come into force after being signed by the assisting healthcare provider, the patient making the declaration, and the witness.

e) The declaration shall cease to be in force if it has been revoked. The following conditions apply to revocations:

    (i) only the patient who made the declaration can revoke it;
    (ii) a patient may revoke a declaration at any time;
    (iii) a written, oral, or other indication or withdrawal of consent is sufficient to revoke the declaration; and
    (iv) in the event of a declaration being revoked, the assisting healthcare provider shall ensure that a note recording its revocation is made clearly on the declaration that is in the patient's medical record.

A valid consent under this section is:

a) free from coercion and undue influence;
b) informed, in particular with respect to the diagnosis, prognosis for the illness, the consequences of the request being respected, the feasible alternative treatments including, but not limited to, comfort care, palliative or hospice care, symptom relief, and palliative sedation and the right to revoke the request at any time; and
c) made by an individual capable at the time of giving the consent.

Processes to ensure eligibility criteria have been met

Required assessments

Before providing medically-assisted death, the assisting healthcare provider shall:

(a) have reviewed the patient's record and examined the patient;

(b) be of the opinion (based on their own assessment of the patient or their own assessment of the patient in combination with the opinion of a consulting healthcare provider) that the patient has met all the criteria of section [number]
(c) have discussed the patient's request with anyone the patient has nominated for such a discussion;
(d) have concluded that the patient has had the opportunity to discuss the request with the persons they wished to contact;
(e) have obtained the second opinion of a reviewing healthcare provider confirming that the criteria set out in section [number] have been met; and
(f) have requested that the patient complete, or provide the information necessary for completion of, a Patient Information Form.

The assisting healthcare provider may base his or her opinion on an examination of and communication with the patient conducted remotely.

Second opinions

The reviewing healthcare provider shall review the patient's record, examine the patient, and provide the second opinion in writing. Before providing the second opinion, the reviewing healthcare provider shall be of the opinion (based on their own assessment of the patient or their own assessment of the patient in combination with the opinion of a consulting healthcare provider) that the patient has met all the criteria of section [number].

The reviewing healthcare provider may base his or her opinion on an examination of and communication with the patient conducted remotely.

Failure to meet the criteria

If the assisting healthcare provider determines that the conditions set out in *[*section*]* have not been met, the assisting healthcare provider shall inform the patient of the reasons for that determination. The patient is not precluded from seeking another assisting healthcare provider.

If the reviewing healthcare provider determines that the conditions set out in [section] have not been met, the reviewing healthcare provider shall inform the patient and assisting healthcare provider of the reasons for that determination. The assisting healthcare provider is not precluded from seeking another reviewing healthcare provider.

The patient retains the right to appeal against findings of incapacity using existing mechanisms available for challenging findings of incapacity in relation to other health care decisions.

Processes to reconcile access and conscience

Non-faith-based institutions

Every non-faith-based institution that offers any end-of-life care has a duty to provide medically-assisted death within the institution.

Non-faith-based institutions are permitted to offer a patient transfer to another institution for assessment and, if the criteria are met, provision of medically-assisted death, as long as the receiving institution can and will provide a healthcare provider who is willing and able to accept the person as a patient, to assess whether the criteria for access to medically-assisted death have been met, and where the criteria for access are met, to provide medically-assisted death. If the patient declines the offer, then the institution must make arrangements for the safe and timely provision of medically-assisted death within its walls.

No non-faith-based institution may make a commitment not to seek medically-assisted death a condition of admission.

No non-faith-based institution may make a commitment not to provide medically-assisted death a condition of employment or privileges.

Faith-based institutions

Every faith-based institution has a duty to either:

a) provide medically-assisted death to a patient who requests it and meets the criteria for access within the institution; or

b) complete a direct transfer of care of such a patient directly to another institution that is willing and able to accept the person as a patient, assess whether the patient meets the criteria for medically-assisted death and, where the person meets the criteria for access, provide medically-assisted death; or

c) complete an indirect transfer of care.

No faith-based institution may make a commitment not to seek medically-assisted death a condition of admission.

No faith-based institution may make a commitment not to provide medically-assisted death a condition of employment or privileges.

Healthcare providers

Healthcare providers have a duty to provide information about all end-of-life care options that may be available for a patient from them or others within the health care system to meet the patient's clinical needs, desires, or requests. Healthcare

providers must not withhold or delay the provision of information about the existence of any end-of-life care because of conflict with their conscience or religious beliefs.

Where healthcare providers are unwilling or unable to provide or participate in medically-assisted death for reasons other than having reached the conclusion that the criteria for access had not been met, they have a duty to either:

a) refer the patient to another healthcare provider for assessment where the healthcare provider is willing and able to accept the person as a patient, to assess whether the criteria for access to medically-assisted death have been met, and where the person meets the criteria for access, provide medically-assisted death; or

b) directly transfer care of such a patient directly to another healthcare provider who is willing and able to accept the person as a patient, assess whether the patient meets the criteria for medically-assisted death and, where the person meets the criteria for access, provide medically-assisted death; or

c) complete an indirect transfer care.

A transfer of care shall to the extent possible be provided within 72 hours or in any event not to exceed five days of the patient's first request for medically-assisted death.

Healthcare providers must not impede access to medically-assisted death for their existing patients, or those seeking to become their patients.

Healthcare providers who are unwilling or unable to provide or participate in medically-assisted death for reasons other than having reached the conclusion that the criteria for access had not been met also have a duty to proactively maintain an effective referral or transfer of care plan for medically-assisted death. They have a duty to inform their patients of the fact and implications of their conscientious objection.

No healthcare provider may make a commitment not to seek medically-assisted death a condition of acceptance or retention as a patient.

Processes to enable case review and system oversight

Patient's medical record

The assisting healthcare provider shall ensure that the following are filed in the patient's medical record:

a) the declaration required under section [number];
b) the patient information form;

c) where the assessment is completed, a note signed by the assisting healthcare provider and reviewing healthcare provider stating that they examined the patient and determined that the patient met the conditions set out in section [number] or that the patient did not meet the conditions set out in section [number] and the reasons for the determination;
d) where the assessment is not completed, a note signed by the assisting healthcare provider explaining why it was not completed;
e) where the patient was transferred to another healthcare provider or institution; a note explaining the reason(s) for the transfer;
f) where assistance was provided,
    i) a note signed by the assisting healthcare provider and patient stating that immediately prior to providing assistance (if the patient was still capable), the healthcare provider offered the patient the opportunity to revoke the declaration; and
    ii) a note signed by the assisting healthcare provider stating that they were satisfied that, at the date and time of their having provided assistance, all requirements under this Act had been met and indicating the steps taken to carry out the request.

Required reporting

The assisting healthcare provider shall ensure that:

a) within 14 days following the provision of means for a medically-assisted suicide or the provision of voluntary euthanasia, the patient information form (or a note confirming that the patient was asked but declined to complete or provide the information for the Form) and a report on the provision of medically-assisted death is submitted to the [province/territory] Review Committee, under the conditions and in the manner prescribed by the [province/territory] Review Committee;
b) any further information prescribed by the [province/territory] Review Committee is submitted in the manner, form, and timing as required by the [province/territory] Review Committee.

If not the assisting healthcare provider, the healthcare provider completing the medical certificate of death shall ensure that:

a) within 14 days following the completion of the medical certificate of death in which medically-assisted death was indicated as the manner of death, the medical certificate of death is submitted to the [province/territory] Review Committee, under the conditions and in the manner prescribed by the [province/territory] Review Committee; and
b) any further information prescribed by the [province/territory] Review Committee is submitted in the manner, form, and timing as required by the [province/territory] Review Committee.

Oversight

[Province/Territory] Commission on End-of-Life Care

[NOTE: this should be established as a pan-Canadian Commission but the text is included here in case a pan-Canadian approach is not taken - it can easily be adapted to establish a pan-Canadian Commission if that approach is taken]

The [province/territory] Commission on End-of-Life Care is hereby established as a body corporate that may exercise powers and perform duties only as an agent of Her Majesty in right of [province/territory].

The Objects of the Commission are:

a) setting policies and standards on the provision of and access to medically-assisted death;
b) supporting the development and delivery of education on moral, legal, and clinical aspects of medically-assisted death to healthcare providers, legal professionals, and the public;
c) overseeing the [province/territory] Medically-Assisted Death Review Committees;
d) reporting to the public on medically-assisted death in [province/territory] by generating and making available to the public an annual report on:
    (i) activities of the Commission; and
    (ii) information submitted to the Commission by the [province/territory] Review Committees;
e) supporting the development and maintenance of the Support, Consultation, and Education Network for healthcare providers around end-of-life care;
f) commissioning a retrospective study of the incidence of end-of-life practices with a possible or certain life-shortening effect and characteristics of patients, healthcare providers, and decision-making processes in all end-of-life decision-making every five years';
g) conducting or commissioning such other research it deems necessary in accordance with relevant federal and provincial law and policy;
h) soliciting the opinion of individuals or groups on any end-of-life care issue;
i) calling on outside experts to consult on any end-of-life care issue; and
j) making recommendations to the Minister about potential law and policy reform with respect to end-of-life care in [province/territory].
k) carrying out any other mandate given to it by the Minister.

The Commission consists of a Chair and ten other Commissioners to be appointed by the Minister with at least the following distribution:

a) Two members are to be physicians (one of which shall be from the palliative care community);

b) Two members are to be persons with a law degree and expertise in health law;
c) Two members are to be lay members of the public;
d) One member is to be a nurse;
e) One member is to be a pharmacist;
f) One member is to be healthcare ethics expert;
g) One member is to be a health administrator.

The Chair is the Chief Executive Officer of the Commission and presides at meetings of the Commission.

The Chair is to be appointed by the Minister.

The Commissioners shall elect one of themselves as Vice-Chair of the Commission.

If the Chair is absent or unable to act, or if the office of Chair is vacant, the Vice-Chair has all the powers, duties and functions of the Chair.

The Chair is to be paid the remuneration that is fixed by the Minister.

The Commissioners, other than the Chair, are to be paid the fees that are fixed by the Minister.

A Commissioner is entitled to be paid reasonable travel and living expenses incurred by the Commissioner while absent from the Commissioner's ordinary place of residence in the course of performing duties under this Act.

The Commissioners may make by-laws respecting generally the conduct and management of the work of the Commission.

The Chair and Commissioners are responsible for the overall management of the Commission and may, with the approval of the Minister make by-laws for the regulation of its proceedings and generally for the conduct of its activities.

[Province/Territory] Medically-Assisted Death Review Committees

The [province/territory] Review Committee system is hereby established. As many Committees as are required given the number of medically-assisted deaths each year shall be appointed by the Commission.

The mandate of the Committee(s) is to review all cases of medically-assisted death to determine compliance with this Act.

A Committee shall consist of four members, including one person with a law degree and expertise in health law who also chairs the Committee, one physician, one expert on ethical or moral issues, and one public representative.

A Committee shall also comprise alternate members from each of the categories mentioned in the first sentence.

The Chair, the members, and the alternate members shall be appointed by the Commission for a period of three years. They may be reappointed once for a period of three years.

The Chair, the members and the alternate members may tender their resignation to the Commission at any time.

The Chair, the members and the alternate members may be dismissed by the Commission on the grounds of unsuitability, incompetence, or other compelling reasons.

The Chair, the members and the alternate members shall be paid an attendance fee and a travel and subsistence allowance in accordance with current government regulations, insofar as these expenses are not covered in any other way from the public purse.

The members and alternate members of the Committee are obliged to maintain confidentiality with regard to all the information that comes to their attention in the course of their duties, unless they are required by a statute or regulation to disclose the information in question or unless the need to disclose the information in question is a logical consequence of their responsibilities.

A member of the Committee sitting to review a particular case shall disqualify her/himself if there are any facts or circumstances which could jeopardise the impartiality of his/her judgment. Any disqualified member shall be replaced by an alternate member.

The Committee shall adopt its findings by a simple majority of votes.

The Committee may adopt findings only if all its members who reviewed the case have taken part in the vote.

The Committee may meet by videoconference.

The Chairs of the [province/territory] Review Committees shall meet at least twice a year in order to discuss the methods and operation of the committees. A representative of the Director of Public Prosecutions, the [province/territory] College of Physicians and Surgeons, College of Nurses, and College of Pharmacists and the [province/territory] Health Authorities shall be invited to attend these meetings. The Review Committees may invite representatives of any other organizations to attend these meetings.

The [province/territory] Review Committee shall review the documentation submitted by healthcare providers under ss. [number] to ensure compliance with this Act. The Committee may request the assisting healthcare provider to supplement his report either orally or in writing, if this is necessary for a proper assessment of the case. The Committee may obtain information from any person or institution with relevant information if this is necessary for a proper assessment of each case.

Where the Committee determines that the healthcare provider acted in compliance with this Act, the healthcare provider shall be informed and the file shall be closed. Where a healthcare provider is thought to have potentially violated the Act or the *Criminal Code* or the professional standards for medically-assisted death, the [province/territory] Review Committee shall report this to the relevant College(s) of regulated healthcare providers for investigation and response under its professional self-regulatory powers. Any subsequent reporting by a College to the police shall follow the College's normal processes with respect to reporting suspected violations of provincial or federal legislation.

The Committee shall notify the assisting healthcare provider of its findings within six weeks of receiving the report referred to in section [number], giving reasons. This time limit may be extended once for a maximum of six weeks. The Committee shall notify the assisting healthcare provider accordingly in writing.

Where the Committee determines that any other person or institution or private facility did not comply with the Act, it shall direct a report to the relevant authority.

The [province/territory] Review Committee shall conduct a yearly review of medical certificates of death in [province/territory] on which the manner of death was noted to be medically-assisted death. For any case not already reviewed under s. [number], the [province/territory] Review Committee shall report the case to the relevant College(s) of regulated healthcare providers, or police as appropriate so that they can take steps within their respective jurisdictions to respond to the failure to submit the required documentation and investigate whether the Act was violated in any other ways and whether professional standards or the *Criminal Code* were violated.

The [province/territory] Review Committee shall prepare a yearly report on the medically-assisted death provided in [province/territory]. The report shall state the number of times each category of medically-assisted death was provided in [province/territory]. It shall provide summaries of the information gathered through the Patient Information Form required under s. [number]. The report shall be sent, not later than 30 June each year, to the [province/territory] Commission on End of Life Care and is to be included in an Annual Report on Medically-Assisted Death in [province/territory] published by the Commission not later than 30 August each year.

Powers of Commission

Provision of information

The Commission may require of healthcare providers, institutions, privately-funded facilities, agencies, and the [province/territory] Health Authorities that they supply, in the manner and within the time specified, medical records, statements, statistical data, reports and other information to the Commission and the [province/territory] Review Committees required for the performance of the functions vested in the Committees under this Act.

Inspection Powers

In order to ascertain compliance with this Act, 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 patients receiving end-of-life care, enter any premises operated by an institution.

The person may, during an inspection,

a) examine and make a copy of any document relating to the end-of-life care offered in those premises; and

b) demand any information relating to the carrying out of this Act as well as the production of any related document.

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

A person conducting an inspection shall, 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 guilty of an offence and is liable to a fine of [amount] in the case of a natural person and to a fine of [amount] in any other case.

A person authorized in writing by the Minister 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.

Inquiries

The Commissioners shall have all the powers, privileges, and immunities of Commissioners under the [province/territory public inquiries legislation].

Miscellaneous

Witnesses

The following persons cannot act as a witness for the purposes of this Act:

a) a person who is a relative (by blood, marriage, or adoption);
b) an employee (who is also a healthcare provider), owner, or operator of the institution or privately-funded facility in which the patient making the request is receiving treatment, or a patient or resident;
c) a healthcare provider who has been involved in the care of the patient; and
d) someone at the time of acting as a witness entitled to any portion of the estate upon death under any will or by operation of law.

Time

Healthcare providers and institutions performing functions under sections [insert numbers for preceding process sections] have a duty to perform these functions in a timely manner.

Liability insurance

The sale, procurement, or issue of any healthcare provider protective association membership fees or any healthcare provider malpractice insurance policy or the rate charged for the membership or policy shall not be conditioned upon or affected by whether the healthcare provider is willing or unwilling to participate in the provisions of this Act.

Immunity in civil proceedings

A person is immune from liability in civil proceedings for acts or omissions in good faith and without negligence in providing or intending to provide medically-assisted death.

Offences and penalties

A person who violates this Act or the regulations is guilty of an offence, and the Summary Proceedings Act applies in addition to any penalty otherwise provided for in this Act or the regulations.

Regulations

The Governor in Council may:

a) define any word or expression used but not defined in this Act;

b) further define or re-define any word or expression defined in this Act;

c) make regulations respecting any matter necessary or advisable to effectively carry out the intent and purpose of this Act.

The exercise by the Governor in Council of the authority contained in [section number] shall be regulations within the meaning of the *Regulations Act*.

Consequential, transitional, and final provisions

Amendment to [province/territory health authorities legislation]

All health authorities have a duty to develop and maintain an effective publicly-funded care coordination system to ensure access to medically-assisted death, in particular, but not limited to, removing barriers to access resulting from geography, healthcare provider supply, or healthcare provider or institutional objection through facilitating indirect transfers of care and direct access by patients.

Amendment to regulations under the [province/territory vital statistics legislation]

As per the [province/territory vital statistics legislation], the following is added to the [province/territory] prescribed form for the medical certificate of death:

a) In Box 19, Part II, definitions and checkbox for each of the following:

“medically-assisted suicide”; and
“voluntary euthanasia”

The name of the physician on the medical certificate of death in cases in which medically-assisted death is noted on the medical certificate of death is protected pursuant to s. [number] of the *Freedom of Information and Protection of Privacy Act.*

Amendments to [province/territory insurance legislation]

Insert definitions: "medically-assisted death" means “medically-assisted suicide, and voluntary euthanasia that is performed by a physician, a regulated health professional acting under the direction of a physician, or a nurse practitioner”; “medically-assisted suicide” means the act of intentionally ending one’s life with the assistance of a physician, healthcare provider acting under the direction of a physician, or nurse practitioner; "voluntary euthanasia" means euthanasia performed in accordance with the wishes of a capable individual where those wishes have been made known through a valid declaration;

Insert text: “In relation to any life insurance contract signed before the [date of coming into force of this Act], “suicide” includes “medically-assisted death”.”

Insert “medically-assisted death” into the [province/territory insurance legislation] in order to permit coverage in the context of medically-assisted death.

> (1) Where a contract contains an undertaking, express or implied, that insurance money will be paid if a person whose life is insured commits suicide or dies as a result of medically-assisted death, the undertaking is lawful and enforceable.