Gazette officielle du Québec

Part 2

No. 33
13 August 2014

Laws and Regulations

Volume 146

Summary

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Legal deposit – 1st Quarter 1968
Bibliothèque nationale du Québec

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Contents

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(1) Acts assented to, before their publication in the annual collection of statutes;

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Partie 1 "Avis juridiques":	$480
Partie 2 "Lois et règlements":	$656
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PROVINCE OF QUÉBEC

1ST SESSION

41ST LEGISLATURE

QUÉBEC, 10 JUNE 2014

OFFICE OF THE LIEUTENANT-GOVERNOR

Québec, 10 June 2014

This day, at fourteen minutes past four o'clock in the afternoon, His Excellency the Lieutenant-Governor was pleased to sanction the following bill:

52 An Act respecting end-of-life care

To this bill the Royal assent was affixed by His Excellency the Lieutenant-Governor.

NATIONAL ASSEMBLY

FIRST SESSION FORTY-FIRST LEGISLATURE

Bill 52
(2014, chapter 2)

An Act respecting end-of-life care

Introduced 22 May 2014
Passed in principle 22 May 2014
Passed 5 June 2014
Assented to 10 June 2014

Québec Official Publisher
2014

EXPLANATORY NOTES

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 and to recognize the primacy of wishes expressed freely and clearly with respect to end-of-life care.

The Act specifies rights with respect to end-of-life care, in particular by affirming the right of everyone to end-of-life care that is appropriate to their needs.

It sets out special rules applicable to the providers of end-of-life care, that is, institutions, palliative care hospices and private health facilities, in order to provide a framework for the organization and regulation of end-of-life care. In this respect, it specifies the special functions and powers of health and social services agencies and of the Minister of Health and Social Services.

It also establishes specific requirements for certain types of end-of-life care, namely, continuous palliative sedation and medical aid in dying. It prescribes the criteria that must be met for a person to obtain medical aid in dying and the requirements to be complied with before a physician may administer it. It further prescribes the special functions of the council of physicians, dentists and pharmacists of institutions and of the Collège des médecins du Québec with respect to end-of-life care.

A commission on end-of-life care is established under the name "Commission sur les soins de fin de vie", as well as rules with respect to its composition and operations. The mandate of the Commission is to examine all matters relating to end-of-life care and to oversee the application of specific requirements relating to medical aid in dying.

The Act establishes an advance medical directives regime and specifies the conditions that must be met in order for such directives to have binding force.

Lastly, it contains the necessary amending, transitional and final provisions.

LEGISLATION AMENDED BY THIS ACT:

– Civil Code of Québec;

– Code of Civil Procedure (chapter C-25);

– Medical Act (chapter M-9);

– Pharmacy Act (chapter P-10);

– Act respecting health services and social services (chapter S-4.2).

Bill 52

AN ACT RESPECTING END-OF-LIFE CARE

THE PARLIAMENT OF QUÉBEC ENACTS AS FOLLOWS:

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

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 end-of-life patients and recognition of their rights and freedoms must inspire every act performed in their regard;

(2) end-of-life 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 end-of-life patients must establish and maintain open and transparent communication with them.

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 physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death.

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.

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 that relate to the rights of users and beneficiaries.

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 physician 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.

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.

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.

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, to the health and social services professionals who practise in the institution, and to end-of-life patients and 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 physician as a physician practising in a centre operated by the institution.

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.

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.

10. The code of ethics adopted by an institution under section 233 of the Act respecting health services and social services must have due respect for the rights of end-of-life patients.

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.

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.

§2. — *Palliative care hospices*

13. Palliative care hospices determine the end-of-life care provided in their premises.

Every palliative care hospice must inform persons of the end-of-life care it offers before admitting them.

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 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.

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

§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 and, within their scope of practice, by nurses practising in such a facility.

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.

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 end-of-life patients.

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

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.

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.

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.

The person may, during an inspection,

(1) examine and make a copy of any document relating to the end-of-life care offered in those premises; 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 guilty of an offence and 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.

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.

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.

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 physician 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.

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.

DIVISION II

MEDICAL AID IN DYING

26. Only a patient who meets all of the following criteria may obtain medical aid in dying:

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

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

(3) be at the end of life;

(4) suffer from a serious and incurable illness;

(5) be in an advanced state of irreversible decline in capability; and

(6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

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; if the professional is not the attending physician, the signed form is to be given by the professional to the attending physician.

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.

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.

29. Before administering medical aid in dying, the physician 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 and of other therapeutic possibilities and their consequences;

(*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*) discussing the patient's request with the patient's close relations, if the patient so wishes;

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

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

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

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

If the physician determines that medical aid in dying cannot be administered, the physician must inform the patient of the reasons for that decision.

31. A physician practising in a centre operated by an institution who refuses a request for medical aid in dying for a reason not based on section 29 must, as soon as possible, notify the executive director of the institution or any other person designated by the executive director and forward the request form given to the physician, if that is the case, to the executive director or designated person. The executive director of the institution or designated person must then take the necessary steps to find, as soon as possible, another physician willing to deal with the request in accordance with section 29.

If the physician who receives the request practises in a private health facility and does not provide medical aid in dying, the physician must, as soon as possible, notify the executive director of the local authority referred to in section 99.4 of the Act respecting health services and social services that serves the territory in which the patient making the request resides, or notify the person designated by the executive director. The physician forwards the request form received, if that is the case, to the executive director or designated person and the steps mentioned in the first paragraph must be taken.

If no local authority serves the territory in which the patient resides, the notice referred to in the second 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.

32. All information and documents in connection with a request for medical aid in dying, regardless of whether the physician administers it or not, including the form used to request such aid, the reasons for the physician's decision and, where applicable, the opinion of the physician 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.

DIVISION III

SPECIAL FUNCTIONS OF THE COUNCIL OF PHYSICIANS, DENTISTS AND PHARMACISTS

33. The council of physicians, dentists and pharmacists established for an institution must, in collaboration with the council of nurses 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.

34. A physician who provides continuous palliative sedation or medical aid in dying as a physician 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 physician is a member, whether it 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 or its competent committee assesses the quality of the care provided, particularly with regard to applicable clinical protocols.

35. If no council of physicians, dentists and pharmacists is established for the institution, the head of medical services or the physician responsible for medical care in the institution, as applicable, assumes the functions assigned to the council under this division, and the physician informs that person in accordance with the first paragraph of section 34.

DIVISION IV

SPECIAL FUNCTIONS OF THE COLLÈGE DES MÉDECINS DU QUÉBEC

36. Physicians 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 and send to it, under the conditions and in the manner prescribed by the Collège, the information it determines.

The Collège or its competent committee assesses the quality of the care provided, particularly with regard to applicable clinical standards.

37. The Collège des médecins du Québec must prepare a yearly report on the end-of-life care provided by physicians 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 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 report is to be published on the website of the Collège and sent, not later than 30 June each year, to the Commission sur les soins de fin de vie.

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".

39. The Commission is composed of 11 members, appointed by the Government as follows:

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

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

(*b*) one member 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.

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

41. The quorum at meetings of the Commission is seven 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.

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) carry out any other 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.

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.

44. In exercising its functions under the first paragraph of section 42, the Commission may, as an exception, 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.

45. The Commission may require of institutions, palliative care hospices, physicians 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, 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.

46. A physician 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 notes that a physician has contravened this section must bring the breach to the attention of the Collège des médecins du Québec so that it can take appropriate measures.

47. On receiving the notice from the physician, 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 and, when the physician provided the medical aid in dying as a physician practising in a centre operated by an institution, to the institution concerned so that they can take appropriate measures.

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 the Act respecting health services and social services, 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.

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.

50. A physician 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.

In such a case, the physician or health professional 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 physician must comply with the procedure established in section 31.

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.

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.

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.

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 preceding 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.

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.

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.

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

58. When a person is incapable of giving consent to care, clearly expressed instructions relating to care that are recorded in the advance medical directives register 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.

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.

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.

61. The court may, on the application of the mandatary, tutor, curator 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.

62. Instructions relating to care expressed in a mandate given in anticipation of a person's incapacity 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.

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.

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.

TITLE IV

AMENDING, TRANSITIONAL AND FINAL PROVISIONS

CHAPTER I

AMENDING PROVISIONS

CIVIL CODE OF QUÉBEC

65. Article 11 of the Civil Code of Québec is amended

(1) by adding the following sentence at the end of the first paragraph: "Except as otherwise provided by law, the consent is subject to no other formal requirement and may be withdrawn at any time, even verbally.";

(2) by inserting "and has not drawn up advance medical directives under the Act respecting end-of-life care (2014, chapter 2) by which he expresses such consent or refusal" after "care" in the second paragraph.

66. Article 12 of the Code is amended by replacing "taking into account, as far as possible, any" in the first paragraph by "complying, as far as possible, with any".

67. Article 15 of the Code is amended by inserting "and in the absence of advance medical directives" after "state of health".

CODE OF CIVIL PROCEDURE

68. Article 776 of the Code of Civil Procedure (chapter C-25) is amended by adding the following sentence at the end of the first paragraph: "The same applies to any application under section 61 of the Act respecting end-of-life care (2014, chapter 2) concerning the carrying out of advance medical directives."

MEDICAL ACT

69. Section 31 of the Medical Act (chapter M-9) is amended

(1) by replacing the first paragraph by the following paragraph:

"**31.** The practice of medicine consists in assessing and diagnosing any health deficiency in a person in interaction with their environment, in preventing and treating illness to maintain or restore health or to provide appropriate symptom relief.";

(2) by adding the following subparagraph at the end of the second paragraph:

"(12) administering the drug or substance allowing an end-of-life patient to obtain medical aid in dying under the Act respecting end-of-life car (2014, chapter 2)."

PHARMACY ACT

70. Section 17 of the Pharmacy Act (chapter P-10), amended by section 2 of chapter 37 of the statutes of 2011, is again amended by replacing "in order to maintain or restore health" in the first paragraph by "in order to maintain or restore health or to provide appropriate symptom relief".

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES

71. Section 19 of the Act respecting health services and social services (chapter S-4.2) is amended by adding the following subparagraph after subparagraph 13:

"(14) for the purposes of the Act respecting end-of-life care (2014, chapter 2)."

CHAPTER II

TRANSITIONAL AND FINAL PROVISIONS

72. Despite section 7, an institution which, on (*insert the date of coming into force of section 7*), operates a general and specialized hospital centre and, within the range of care that may be offered pursuant to the mission of such a centre, only offers palliative care may continue to offer that care exclusively.

Such an institution must inform persons of the end-of-life care it offers before admitting them.

73. Until (*insert the date occurring two years after the date of coming into force of section 8*), 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.

74. Institutions and palliative care hospices have until (*insert the date occurring one year after the date of coming into force of section 14*) 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.

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 (*insert the date occurring three years after the date of coming into force of section 42*).

76. The Minister must, not later than (*insert the date occurring four years after the date of coming into force of this section*), 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.

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

78. Except for the second paragraph of section 52, section 57, section 58 to the extent that it concerns the advance medical directives register and sections 63 and 64, which come into force on the date or dates to be set by the Government, the provisions of this Act come into force on 10 December 2015, or any earlier date set by the Government.

Regulations and other Acts

M.O., 2014

Order 2014-10 of the Minister of Transport dated 30 July 2014

Highway Safety Code
(chapter C-24.2)

Transport Act
(chapter T-12)

Regulation respecting the addition and use of strobe lights on road vehicles used for the transportation of school children

THE MINISTER OF TRANSPORT,

CONSIDERING section 633.2 of the Highway Safety Code (chapter C-24.2), which provides that the Minister of Transport may, after consultation with the Société de l'assurance automobile du Québec, suspend the application of a provision of the Code, if the Minister considers that it is in the interest of the public and is not likely to compromise highway safety;

CONSIDERING the first paragraph of section 4.2 of the Transport Act (chapter T-12), which provides that the Minister may, by order, authorize a carrier to add safety equipment not regulated under paragraph *a* of section 5 of the Act to a road vehicle used for the transportation of school children;

CONSIDERING the second paragraph of that section, which provides that the order indicates the period and conditions of use of the safety equipment and that the order takes effect from the date of its publication in the *Gazette officielle du Québec*;

CONSIDERING that it is expedient to authorize, on certain conditions, the addition of a strobe light to a road vehicle referred to in the Regulation respecting road vehicles used for the transportation of school children (chapter T-12, r. 17);

CONSIDERING that, in accordance with sections 10 and 11 of the Regulations Act (chapter R-18.1), a draft Regulation respecting the addition and use of strobe lights on road vehicles used for the transportation of school children was published in Part 2 of the *Gazette officielle du Québec* of 11 June 2014 with a notice that it could be made by the Minister of Transport on the expiry of 45 days following that publication and that any interested person could make comments before the expiry of the 45-day period;

WHEREAS it is expedient to make the Regulation without amendment;

ORDERS AS FOLLOWS:

The Regulation respecting the addition and use of strobe lights on road vehicles used for the transportation of school children, attached to this Order, is hereby made.

ROBERT POËTI,
Minister of Transport

Regulation respecting the addition and use of strobe lights on road vehicles used for the transportation of school children

Highway Safety Code
(chapter C-24.2, s. 633.2)

Transport Act
(chapter T-12, s. 4.2)

1. A white strobe light having a range of 360° may be added on a road vehicle covered by the Regulation respecting road vehicles used for the transportation of school children (chapter T-12, r. 17).

The light is installed in the last third of the roof and centered on its width.

2. The strobe light may only be used when the vehicle is in the territory of the regional county municipalities of La Côte-de-Beaupré and Charlevoix and for the transportation of any person under 18 years of age.

3. The application of the provisions of section 239 of the Highway Safety Code (chapter C-24.2) is suspended when it prohibits a road vehicle from having a strobe light in accordance with section 1.

4. This Regulation comes into force on *(enter the date of publication in the Gazette officielle du Québec)* and ceases to have effect on 22 June 2016.

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Abbreviations: **A**: Abrogated, **N**: New, **M**: Modified

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