DAVID BAKER, LL.B., LL.M., L.S.M.
(416) 533 – 0040 x 222 | dbaker@bakerlaw.ca

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VIA E-MAIL to PDAM@parl.gc.ca

Special Joint Committee on Physician-Assisted Dying/
Comité mixte spécial sur l'aide médicale à mourir
1 Wellington St.
Ottawa, ON
K1A 0A6

Attention: Co-Chairs – The Honourable Kelvin Kenneth Ogilvie and the Honourable Robert Oliphant

RE: RESPONSE TO QUESTIONS POSED BY THE HONOURABLE SERGE JOYAL

I am indebted to Senator Joyal for his thoughtful questions and to the Committee for affording me the opportunity to respond.

Let me preface my remarks by saying that there are fewer differences on the key issue of statutory safeguards separating Professor Downie and myself than might have first appeared based upon the Committee proceedings on January 28th. Areas of agreement as well as the two key areas of difference became quickly apparent in an interview chaired by Rosalie Barton of the CBC's Power and Politics broadcast Monday February 1st (link to video).

In the event the Committee decides my re-attendance together with Professor Downie would be of assistance, it would be my honour to participate.

1. "Adult" – The Court clearly only granted a remedy to persons who have reached the age of majority. The Provincial-Territorial Committee, led by Professor Downie, suggests Parliament may wish to extend the Court's judgment to include children with the capacity to consent to physician-assisted dying. The Court's decision is consistent with American and most Benelux experience in evidence before the Trial Judge. The subsequent "criterion creep" in the Benelux countries has been highly controversial and can be anticipated to provoke a legislative response in the near future. The Committee may wish to compare the evidence before Smith J., (link to Judgment, see to para. 628-630) with a subsequent expansion into the area of mental health in the Benelux countries (link). Professor Trudo Lemmens is the Canadian expert on post-trial experience in these countries and has provided you with his opinion.

2. "Euthanasia" – Our intention had been to include both physician-assisted suicide and voluntary euthanasia under the definition of "assisted suicide". Professor Downie's definition of "assistance" as meaning "the provision of a prescription for a lethal dose of medication or a lethal injection for the purpose of medically-assisted death" is both more specific and acceptable to us. I would note that it was our intention to allow provinces jurisdiction to restrict assistance to either provision of a prescription or administration of a lethal dose as is done in Bill 52 s. 30, since we regard this as a medical issue.

3. "Grievous" – The Supreme Court addressed "physician assistance in dying". It expressly limited its decision at para. 127 to responding to "the factual circumstances in this case" (link). Contrary to what Professor Downie stated on Power and Politics, the factual circumstance of the applicants in *Carter* all involved persons with terminal conditions (link). Justice Smith went to great pains to assure people with non-terminal illnesses and disabilities that her intention was to exclude them from consideration when considering whether it was possible to establish effective safeguards (link, see para. 628-630). Persons with non-terminal conditions such as developmental disability, mental disorder, autism, blindness, or deafness had no reason to believe Parliament would be receiving submissions from advocates such as Professor Downie and Jean-Pierre Menard to establish criteria beyond those established in s. 26 of Bill 52. The relationship between the terms of the Courts declaration and s. 26 of Bill 52 was discussed with the Court on January 11th. Counsel for both the Attorney General of Canada and Quebec asserted the two were consistent. While no ruling was issued by the Court on point, a majority of the Court refused to extend the suspensions of the Court's declaration in the province of Quebec, thereby allowing Bill 52 to come into full force and effect (link to SCC Jan 15/16 Order). Senator Joyal raises a serious issue, with enormous ramifications for large numbers of persons with disabilities in Canada. As stated above, the Committee may wish to receive further evidence on point. Failing that, I would urge the Committee to accept the legal opinion offered to it by the Department of Justice.

4. "Quality of Life" – The only evidence before the Courts of why people, who subsequently were assisted to die, made this choice is to be found at para 400 (link) of Justice Smith's decision. These factors are listed in the definition of "quality of life care" in our Bill (link to draft legislation). These are quality of life not treatment issues, and are addressed with hospitalized patients by nurses, social workers, case managers and pursuant to applicable suicide prevention protocols. These are the health care providers who would have "informed" Mr. Fletcher about the support available to him and the real life choices he must consider when he was in hospital, actively contemplating suicide, following his accident. Professor Downie acknowledges that it is "best practice" that these health care providers be involved in informing patients about these choices, and is basically saying it would happen anyway. To this I respond: 1) PAS/VE will occur in the community, as well as in hospital, so it must be expressly required; 2) it does not happen in the Benelux countries, upon whose practices Professor Downie's proposal is based; 3) we do not require such counseling for persons such as Dr.

Donald Low whose death was imminent (link to draft legislation, see s. 241.1(4)(d) and 4) when dealing with an issue such as causing a person's death what could possibly be wrong with requiring adherence to best practices? Unlike the Benelux countries, Canada does not guarantee quality palliative care, home care and, according to Michael Ferguson, Canada's Auditor General in yesterday's Report, timely access to "disability pension benefits". Canada's shortcomings in these respects do not mean access to PAS/VE should be denied, but persons must be informed about entitlement to such supports so that they can make an informed choice about dying (link to Shakespeare).

5. "Suffering" – I am confused by the suggestion our draft Bill does not reflect the Court's decision. Our definition of "grievous" confirms that a causal link must exist between the illness or disability and the "constant and unbearable physical or psychological suffering which cannot be relieved in a manner that the patient deems tolerable" (link to draft legislation). The simple fact that a person with a disability is suffering would not meet the Court's criteria if the cause of the suffering were the breakdown of one's marriage, loss of one's job or any one of a myriad of other sources of suffering experienced by all Canadians, regardless of whether or not they have a grievous and irremediable condition. It would be discriminatory to suggest otherwise. While the suffering must be personal, the Court's criteria requires that a causal connect exist which is discernible by whoever is responsible for their application.

6. "Review Board" – Whether the criteria are applied by physicians alone or by a review board or court, based on evidence from health care providers, a statutory power of decision is being exercised which would each be subject to judicial review. A decision by a physician or physicians will additionally give rise to potential criminal and civil liability for the physicians. In the event a physician determines a patient does not meet the criteria, Dying with Dignity has asserted that a review process be established to hear such appeals. Unless patients are to be free to shop until he or she finds a "permissive" physician or physicians, as occurs in the Benelux countries, and as is contemplated by Professor Downie's proposal, it would appear some form of review would be required. I already indicated to the Committee the reasons why we recommend the name, composition and mandate of the Review Board established pursuant to s.672.38 be adapted to decide PAS/VE applications. Professor Downie and some Committee members appeared confuse the minimum number of members to be appointed to the Board (9) with the number of members appointed by the Chair to decide an application (3). My office is already assisting persons with applications to the Superior Court of Justice for constitutional exemptions. The largest obstacle we are encountering is physician unwillingness to participate. As I have advised my clients, I hope to be able to overcome this resistance by demonstrating that they are simply being asked to submit reports, not to make the legal decision. If I am unsuccessful my clients will encounter significant cost and delay attempting to secure the services of other physicians who are willing to participate. In our Bill the responsible physician is required, upon patient request, to submit a report. This enhances, rather than inhibits, patient access. It is also

entirely consistent with the CPSO mandatory reporting obligations with respect to 18 other comparable matters (link to CPSO mandatory reports). If patient choice, access and control, along with transparent and consistent application of all the criterion and assessment of vulnerability are to be achieved, a review board process is essential. Discreditable action by some physicians in the Benelux countries, which their *ex post de facto* review processes appear powerless to correct it, is bringing the entire process into disrepute, as indicated by Professor Lemmens. Prior review would obviate the need for a duplicative *ex post de facto* review process. Data collection and analysis could be performed on the written reasons of the review boards, with access to evidence filed on the application as required.

7. "Complex" – The draft Bill appears complex because it does not leave important issues to professional bodies to regulate. As Professor Downie recognizes, and I agree, Colleges of Physicians and Surgeons across Canada are issuing widely divergent guidelines. To avoid a patchwork of procedures and to ensure that every application is decided on a timely basis, without involvement of lawyers except in rare cases where vulnerability is suspected, our process is simple and straight forward for patients. I have reached out to Professor Downie in an effort to achieve consensus. We would willingly alter our s. 245.1(10) to maintain the expedited process, require written decisions within 10 days where no oral hearing is required and, where an oral hearing is required to shorten the period from application to decision from 45 days to 30 days or less.

All of which is respectfully submitted.

Yours truly,
BAKERLAW

David Baker

<u>Draft Federal Legislation to Amend the Criminal Code to be Consistent with</u> <u>*Carter v. Canada (Attorney General)* 2015 SCC 5</u>

David Baker and Gilbert Sharpe*

REVISED JANUARY 22, 2016

An Act to amend the Criminal Code as it relates to Physician-Assisted Suicide and the Review Board provisions

Her Majesty, by and with the advice and Consent of the Senate and House of Commons of Canada, enacts as follows:

(a) The following be added to s.14:

"except as provided in s.241.1."

(b) Section 21 unchanged being "aiding and abetting."

(c) Section 22 unchanged being "counselling."

(d) The following be added to s. 241(b):

"except as provided in s. 241.1."

(e) The heading preceding s.241.1 shall be:

"Physician-Assisted Suicide."

(f) The following new section be added following s.241:

241.1(1) Interpretation

"Adult" means a person of the age of majority in the province or territory in which he or she resides;

"Application" means a formal Request that includes a Patient's medical records, Witness attestations and Reports submitted to the Review Board for consideration of Physician-Assisted Suicide;

"Assistance" means the provision of knowledge, means or both;

"Assisted Suicide" means the act of intentionally killing oneself with the Assistance of an Assisting Physician who provides the means;

"Assisting Physician" means the Physician involved directly in Physician-Assisted Suicide;

* Assisted by Rebeka Lauks.

"Responsible Physician" means the Physician who has primary responsibility for the care of the Patient and treatment of the Patient's Irremediable condition and has a sufficient Patient relationship to allow him or her to provide relevant information concerning the requirements of Physician-Assisted Suicide;

"Competent" means the capacity to understand the subject-matter in respect of which a decision must be made and able to appreciate the reasonably foreseeable consequences of that decision or lack of decision;

"Consulting Physician" means a Physician who is qualified by specialty or experience to form a professional opinion about the matter on which he or she has been consulted;

"Counselling" means one or more consultations as necessary between a Patient and a person, whether or not a member of a regulated health profession, who, through training or experience, is in the opinion of the Responsible or Consulting Physician able to address with the Patient the causes of the Patient's potential Vulnerability;

"End-of-life care" means proportionate palliative care to end-of-life Patients and medical Physician-assisted suicide;

"Free Request" means a Request made voluntarily (i.e., without coercion or undue influence) to the Review Board;

"Grievous" means a condition or disease experienced by a Patient who is at the end of life and in an advanced state of irreversible decline in capability, which notwithstanding the availability of insured services and quality of life care, is capable of causing constant and unbearable physical or psychological suffering which cannot be relieved in a manner that the Patient deems tolerable;

"Informed Consent" means an express choice made after the Patient has been provided with sufficient information to evaluate the risks and benefits of Physician-Assisted Suicide and other alternative courses of action, including, but not limited to, insured services and quality of life care, that a reasonable Patient in the same circumstances would require in order to make a decision about the course of action; and the Patient received responses to his or her Requests for additional information about those matters;

"Irremediable" means a terminal disease that is incurable and has been medically confirmed by a Physician, and will by evidence-based medicine and using reasonable judgment, produce death;

"Insured services" means physician and hospital services to which the patient is entitled pursuant to s. 9 of the Canada Health Act R.S.C., 1985, c. C-6;

"Medically Necessary" means treatment, including palliative care, that is fully funded by the respective provincial or territorial government and is delivered based on the Patient's need, not their ability to pay;

"Patient" means a resident as that term is defined in the *Canada Health Act* under the care of a Physician;

"Personal Representative" means a neutral individual assisting the Patient file an Application with the Review Board or if the Patient does not have a Personal Representative, an Advisor appointed on Request by the Review Board;

"Physician" means a doctor of medicine licensed to practice medicine under the laws of the province or territory in which he or she practices and in good standing with the applicable provincial or territorial college;

"Prognosis" means predicting the likely outcome of Patient's current standing including an estimate of when the disease or illness will cause death;

"Proportionate Palliative Care" means palliative care appropriate to the needs of the Patient whether or not such care is available to the Patient;

"Quality of life care" means care related to the quality of life concerns expressed by the Patient, apart from "insured services"; and, without limiting the generality of the foregoing, includes services whether publicly or privately funded or provided by family members that address:

a) Loss of autonomy;

b) Ability to engage in activities to make life enjoyable;

c) Loss of dignity;

d) Loss of control of bodily functions;

e) Perceptions that care requirements represent a burden for family, friends or caregivers;

f) Pain control, including access to proportionate palliative care and/or hospice care; and

g) Concerns about the financial implications of care that is not an "insured service".

"Request" means a wish to proceed with Physician-Assisted Suicide asked for by a Patient in writing;

"Reports" means documents drafted by the Consulting Physician, Responsible Physician, and Counsellor sent to the Review Board as part of the Application for Physician-Assisted Suicide;

"Review Board" has the meaning set out in s.672.38;

"Vulnerable" means a Patient making a Request who in the opinion of the Patient's Responsible or Consulting Physician may be experiencing some or all of the following, any one of which could induce a person to commit suicide:

(a) Lack of access to insured services under the *Canada Health Act,* R.S.C. , 1985, c. C-6;

(b) Lack of access to Quality of life care;

(c) Lack of the opportunity to come to terms with the Patient's prognosis;

(d) Temporarily diminished competency due to a psychiatric or psychological disorder or depression capable of causing impaired judgment;

"Witness" means an individual of the age of majority under applicable provincial or territorial laws who is not a relative (by blood, marriage, or adoption), an owner, operator or employee of the health care facility in which the person making the Request is receiving treatment, or a resident, a Physician involved in the care of the Patient, or 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.

s.241.1(2) Initiating a written Request for an Application by a Patient for Physician Assistance to commit Suicide

(a) An Adult Patient who is Competent, free from coercion and undue influence may make a written Application to a Review Board set out in subsection 672.38 (1) to be permitted to commit Suicide with Physician Assistance.

(b) A copy of the complete Application shall be simultaneously transmitted to the Public Guardian and Trustee of the province or territory.

(c) An Application to the Review Board shall include a Report from the Patient's Responsible Physician, a Report from at least one Consulting Physician, a Report from the Counsellor, if such a referral has been made by the Responsible Physician or Consulting Physician, Witness attestations, and the Patient's medical

record containing at a minimum, a record of all Requests made by the Patient for Physician Assistance to commit Suicide, and all revocations of any such Request.

(d) No Patient shall qualify under the provisions of Physician-Assisted Suicide solely because of age or disability.

(e) Any person who pursuant to ss. (14) receives a verbal or written revocation of the Patient's Request for Physician-Assisted Suicide shall advise the Patient's Responsible Physician and notify the Review Board as soon as reasonably possible, and the revocation shall terminate the Request for all purposes.

s.241.1(3) Form of the written Request

(a) A valid Request for Physician-Assisted Suicide shall be signed and dated by the Patient in the presence of the Responsible Physician and witnessed by at least two individuals who, in the presence of the Patient, attest that to the best of their knowledge and belief the Patient is Competent, acting voluntarily, and is not being coerced to sign the Request.

(b) The Request shall include a statement by the Patient that he or she has not been induced or coerced to seek Physician-Assisted Suicide, and shall be accompanied by reasons, stated in the Patient's own words, why the suffering he or she is experiencing is resulting from his or her medical illness or condition and is considered to be intolerable and likely to be enduring.

(c) Before the Application is forwarded to the Review Board and the Public Guardian and Trustee, both the Patient and the Responsible Physician shall confirm in writing that it is complete to the best of their knowledge.

(d) The Witnesses shall be persons who are not:

1. A relative of the Patient by blood, marriage or adoption;
2. An owner, operator or employee of a health care facility where the Patient is receiving medical treatment or is a resident, except as stated in subsection 4; or
3. A person acting as a Witness would be entitled to any portion of the estate of the qualified Patient upon death under any will or by operation of law.

(e) The Patient's Responsible Physician at the time the Request is signed shall not be a Witness but shall record his or her presence at the signing in the Patient's medical record.

(f) If the Patient is a Patient in a long term care facility at the time the written Request is made, one of the Witnesses shall be an individual designated by the facility and having the qualifications specified by the Ministry of Health of the applicable provincial jurisdiction.

s.241.1(4) Responsible Physician responsibilities

The Responsible Physician shall:

(a) Make the initial determination of whether the requesting Patient appears Competent to provide Informed Consent and to be acting voluntarily, and confirm whether or not there appears to be a causal connection between the Patient's condition or disease and the suffering he or she has identified as being intolerable;

(b) Ensure that the Patient is making an Informed decision, such that he or she informs the Patient of:

1. His or her medical diagnosis, including a determination of whether or not the Patient suffers from a disease or condition that is Grievous and Irremediable and an identification of any Medically Necessary treatment, including Proportionate Palliative Care, that could alleviate some or all of the suffering experienced by the Patient;

2. the reasons why the treatment identified as Medically Necessary is not available to the Patient and the circumstances under which it could be made available;

3. His or her Prognosis based on receiving or refusing the Medically Necessary treatment identified, including a statement indicating whether the Patient's death is imminent;

4. The probable result of taking the medication to be administered, in the event the Patient's Request is granted by the Board;

5. The alternative courses of action that could alleviate the Patient's suffering, whether or not readily available, including, but not limited to medically necessary insured physician and hospital services, and Quality of life care; and

6. The right to revoke the Request at any time, whether verbally or in writing.

(c) Refer the Patient to at least one Consulting Physician with expertise related to the source of the suffering identified by the Patient for clinical advice;

(d) Refer the Patient for Counselling if death is not imminent and the Patient may be Vulnerable or where the concerns expressed by the Patient may be addressed, in whole or in part, by quality of life care;

(e) Advise the Patient that next-of-kin may be contacted or assign this responsibility to the Counsellor;

(f) Draft a Report to accompany the Application for the Review Board detailing: (i) the basis for perceiving the Patient is Competent; (ii) the information that was provided to the Patient and a confirmation that in the opinion of the Physician it was sufficient for the Patient to make an informed decision; (iii) the basis for concluding the condition or disease is Grievous and Irremediable, including a Prognosis regarding death is expected to occur within 12 months; (iv) Medically Necessary Treatment or alternative services that were recommended; (v) the basis for a referral to Counselling, if applicable, and (vi) the independence of the Patient's request and the role of the next-of-kin in accessing alternatives;

(g) Where the Responsible Physician contacts the next-of-kin with the consent of the Patient or in order to determine the availability of family provided quality of life care, he or she shall attempt to determine what if any impact family members had on the voluntariness of the Patient's Request and establish whether the family was willing and able to support the Patient in accessing Medically Necessary Insured services and Quality of life care. This information shall form part of the Responsible Physician's Report to the Review Board;

(h) Inform the Patient upon receipt of a Request that he or she has an opportunity to rescind the Request at any time and in any manner, and offer the Patient an opportunity to rescind the Request immediately prior to submission of the Application to the Review Board;

(i) Ensure that all appropriate steps are carried out in accordance with subsections 241.1(2)(2) and (9) prior to the Patient making an Application to the Review Board; and

(j) Confirm that all responsibilities under this Section have been performed.

s.241.1 (5) Consulting Physician confirmation

After the Patient informs the Responsible Physician that he or she wishes to commit Suicide with Physician Assistance, at least one Consulting Physician shall:

(a) Examine the Patient and his or her relevant medical records and develop an independent position, in writing, as to whether or not the Patient is suffering from a Grievous and Irremediable medical disease or condition;

(b) Examine the Patient and his or her relevant medical records and determine if Medically Necessary treatment exists that in their opinion could alleviate or help alleviate the suffering described by the Patient;

(c) Refer the Patient for Counselling if, in his or her independent opinion, the Patient's death is not imminent and the Patient may be Vulnerable or expresses concerns that may be addressed, in whole or in part, by Quality of life care, and the Responsible physician has not already done so;

(d) Draft a Report to accompany the Application for the Review Board detailing, in the Consulting Physician's independent opinion: (i) whether or not the Patient is Competent, and the basis for this conclusion; (ii) the information that was provided to the Patient and a confirmation that it was sufficient for the Patient to make an informed decision; (iii) the basis for concluding the condition or disease is Grievous and Irremediable, including a Prognosis regarding whether death is expected within 12 months; (iv) the Medically Necessary Treatment or alternative services that were recommended; and (v) the basis for a referral to Counselling, if applicable; and

(e) Confirm that all responsibilities under this Section have been performed.

s.241.1 (6) Counselling referral

(a) Counselling, whether publicly or privately funded, shall be made available if:

1. The Patient makes an oral or written Request; or
2. In the independent opinion of the Responsible Physician or the Consulting Physician, a Patient may be Vulnerable or expresses concerns that may be addressed, in whole or in part, by quality of life care.

(b) The Counsellor shall draft a Report to accompany the Application for the Review Board detailing: (i) whether the Patient attended and completed the recommended course of Counselling; (ii) the sources of Vulnerability addressed with the Patient; (iii) the impact the Counselling had on the suffering experienced by the Patient; and (iv) whether the Patient accessed the recommended Medically Necessary insured physician and hospital treatments and available Quality of life care that could alleviate his or her suffering.

(c) Where the Responsible Physician assigns responsibility to the Counsellor for informing the Patient's next-of-kin of the Request for Physician-Assisted Suicide with the Patient's consent or where members of the family must be contacted in

order to determine the availability of Quality of life care, the Counsellor shall attempt to determine what impact family members had on the Patient's Request and establish whether the family was willing and able to support the Patient in accessing Medically Necessary treatments and alternative services.

(d) The Counsellor shall confirm in writing that all responsibilities under this Section have been performed.

s.241.1(7) Next-of-kin Notification

The Responsible Physician shall advise the Patient that the next-of-kin can be informed of his or her Request for Physician-Assisted Suicide with his or her consent and that family members may be contacted to determine the availability of Quality of life care and further that they may be asked to provide information concerning the Patient, and that this information shall form part of the Application.

s.241.1(8) Public Guardian and Trustee

(a) Upon receipt of an Application, the Public Guardian and Trustee shall exercise the powers of the office to conduct such investigation as is deemed necessary, including contacting the Patient's next-of-kin, and based on the Application and the results of the investigation, advise the Review Board of whether an oral hearing is warranted.

(b) When there is an oral hearing, the Review Board shall notify the Public Guardian and Trustee to participate as a full party in the proceeding, with power *inter alia* to summon persons to give oral testimony, introduce documentary evidence, examine persons giving oral testimony and make submissions.

s. 241.1(9)Medical Record Documentation requirements for the Application

The Responsible Physician shall ensure that the following be documented and filed in the Patient's medical record that shall be provided together with the Request and the Reports to the Board by the Patient or Personal Representative:

(a) Any oral Requests by a Patient for Physician-Assisted Suicide, including any previous Requests;

(b) All written Requests by a Patient for Physician-Assisted Suicide;

(c) The Responsible Physician's diagnosis and Prognosis, including a determination of whether the person is suffering from a Grievous and Irremediable condition;

(d) The Responsible Physician's determination as to whether or not the Patient is Competent to make the Request;

(e) The Responsible Physician's opinion on whether the Patient is acting voluntarily and has made an Informed decision, and where a referral has been made to a Counsellor, the Counsellor is of the opinion that the Patient has been informed of the availability of quality life care;

(f) A record of all Medically Necessary treatment, including palliative care capable of alleviating some or all of the suffering experienced by the Patient, including an indication of whether the treatment was accepted or refused by the Patient and if accepted, whether or not the treatment was available and administered, and the observed consequence of receiving treatment on the Patient's suffering;

(g) One or more of the Consulting Physician's diagnosis and Prognosis, and verification that the Patient is Competent and has made an Informed decision;

(h) The date, names and contact information of the Witnesses who attested to the Patient's Request for Physician-Assisted Suicide;

(i) Any recommendations for the Patient to inform their next-of-kin, and whether or not to the knowledge of the person making the recommendation, the next-of-kin was informed;

(j) A Report of the outcome and determinations made during Counselling, if performed;

(k) The Responsible Physician's offer to the Patient to rescind his or her Request at the time of the Patient's initial Request, second Request and immediately before applying to the Review Board for a determination on Assisted Suicide;

(l) A record of any verbal or written revocation statements to the Request made by the Patient; and

(m) A note by the Responsible Physician indicating that all requirements under subsections 241.1(2)(2) and (9) have been met.

s.241.1(10) Application to Review Board

(a) A Patient or Personal Representative shall make a written Application to the Review Board that includes the requirements set out in subsection241.1(2)(2), including the Reports and the Witness attestations.

(b) Subject to the provision of an expedited process, the Review Board shall hear the completed Application and issue a decision within forty five (45) days of its receipt.

(c) An Application does not require an oral hearing unless:

1. The Patient chooses a hearing;
2. The Public Guardian and Trustee or the Board makes a determination that a hearing is required; or
3. A third-party makes an objection to the Review Board concerning the Patient's eligibility to undergo Physician-Assisted Suicide.

(d) The Board may follow an expedited process where the Responsible or Consulting Physician provides information indicating that the Patient is experiencing intense suffering caused by a sudden and unforeseeable deterioration in the Patient's condition or illness.

(e) The Board shall determine that an oral hearing is required where any of the following is apparent based on the Application, Request, the Witness attestations and the Reports submitted where:

1. The Patient has refused consent to either a treatment identified by a Physician as being Medically Necessary, or to attend and complete Counselling with a Counsellor to whom the Responsible Physician or Consulting Physician has made a referral;

2. A Physician expresses in their Report that the Patient's condition is not Grievous or Irremediable;

3. A Request has been initiated and withdrawn or has been previously rejected by the Board; or

4. The Patient's disease or condition is identified as being Irremediable, however a Physician is of the opinion that the disease or condition is unlikely to cause death within a twelve month period from the date of the Request.

s.241.1(11) Order from the Review Board

(a) The Board, having reviewed the record filed with the Request, and based on the evidence received at the oral hearing, if any, shall make one or more of the following orders:

1. Grant the Request following a determination that the Patient is Competent and is suffering from a Grievous and Irremediable condition or illness that is the cause of suffering considered to be intolerable by the Patient;

2. Deny the Request;

3. Adjourn the Request and direct that members of the Patient's next-of-kin be notified of the Request and the proceeding before the Review Board, with a Request for their participation;

4. Adjourn the Request with a direction that the Application or course of Counselling is incomplete and needs to be completed before an amended Application is re-submitted;

5. Adjourn the Request with a direction that a Physician or Counsellor appear and give testimony before the Board; or

6. Adjourn the Request with a direction that further evidence is required by the Board before it is prepared to make an order.

(b) A Patient having received an order to proceed with Physician-Assisted Suicide may select an Assisting Physician from a regional roster, maintained by the province or territory in which the Patient resides, of physicians willing to administer the dose of medication causing death.

(c) The Board shall report the Request, the nature of the suffering identified by the Patient, whether the Patient was unable or unwilling to access Medically Necessary treatment or alternative services, its order, together with forwarding the Report of the Assisting Physician, if any, to the Canadian Centre for Justice Statistics of Statistics Canada, which shall compile this information and present an Annual Report to Parliament.

s.241.1 (12) Informed decision

No Assisting Physician shall directly administer the medication causing death to a Patient unless he or she has confirms that the Patient made a voluntary and Informed decision. Immediately prior to administering the dose triggering death, the Assisting Physician shall verify that the Patient is making an Informed decision.

s.241.1 (13) Assisting Physician Responsibilities

The Assisting Physician shall:

(a) Offer the Patient an opportunity to rescind his or her Request for Physician-Assisted Suicide;

(b) Administer the medication causing death; and

(c) Report the Physician-Assisted Suicide, or rescission of the Request, to the Review Board.

s.241.1 (14) Right to rescind Request

A Patient may rescind his or her Request at any time and in any manner (oral or written) without regard to his or her mental state. Physician Assistance may not be provided to aid a Patient to commit Suicide without the Responsible Physician, Consulting Physician, Counsellor, if any and Assisting Physician offering the Patient an opportunity to rescind the Request.

s.241.1 (15) Insurance or annuity policies [NOTE: This is likely a matter within provincial jurisdiction.]

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a Request, by a person, to end his or her life by Physician-Assisted Suicide. Neither shall a Patient's act of ingesting medication to end his or her life in by Physician-Assisted Suicide have an effect upon a life, health, or accident insurance or annuity policy.

s.241.1 (17) Offences and penalties

(a) A person commits an offence if he willfully falsifies or forges a declaration made under this Act with the intent or effect of causing the person's death. A person guilty of an offence under this subsection shall be liable, on conviction, to imprisonment for a term not exceeding twenty-five years.

(b) A person commits an offence if he encourages, coerces or unduly influences a Patient to choose Physician-Assisted Suicide. A person guilty of an offence under this subsection shall be liable, on conviction, to imprisonment for a term not exceeding twenty-five years.

(c) A Witness commits an offence if he willfully puts his name to a statement he knows to be false. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(d) A person commits an offence if he willfully conceals or destroys a declaration or revocation made under this Act. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(e) A Physician or Counsellor with responsibilities in relation to an Application or an order of the Board commits an offence if he or she willfully fails to submit the information required under subsections (4), (5) and (6). A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(f) An Assisting, Responsible or Consulting Physician involved in the care of a Patient commits an offence if he takes any part whatsoever in assisting a Patient to die or in giving an opinion in respect of such a Patient, or acts as a Witness if he has grounds for believing that he will benefit financially or in any other way as the result of the death of the Patient. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

s.241.1 (18) Inconsistencies

(a) Where there is any inconsistency or conflict between this section and any other provision of this Act or any other federal legislation, this section prevails to the extent of the inconsistency or conflict.

The following revisions to be made to s.672.38:

(a) A Review Board shall be established or designated for each province to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is

rendered, and by a differently constituted panel address matters related to Physician-Assisted Suicide pursuant to s.241.1 herein, provided always that every panel shall be chaired by a justice or retired justice of the Superior Court of the province, and shall consist of not fewer than nine members appointed by the lieutenant governor in council of the province.