their lives, and that must be resisted too. No one should feel pressured to die for convenience.

The present bill hopes to add section 217.1 to the Criminal Code. This new paragraph states:

> Nothing in sections 14, 45, 216 and 217 of the Criminal Code shall be interpreted as (a) requiring qualified medical practitioners to commence or continue to administer surgical or medical treatment to a person who clearly requests that such treatment not be commenced or continued.

This paragraph alone could lead to complacency, I must point out, in patient care. An elderly woman may be languishing in her hospital bed, with a "no resuscitation" order on her chart, when she is struck by cardiac arrest. The nursing staff stand by, obeying the order, but making the woman as comfortable as possible, knowing this moment was imminent.

They call a doctor but not the crash emergency cart. The heart monitor begins to flatline and she is gone. Quickly dispatched, as were her wishes. Then an autopsy report reveals the woman's cardiac arrest was caused by a clogged respiration pipe, or a piece of food lodged in her throat. Is this the way she wanted to die? Does it make a difference? To medical ethicists, to caring staff, patients and family, the difference in manner of death would be viewed as wrong.

How would the Criminal Code deal with incidents like these? Could the hospital be charged with negligence and malpractice? Should it be? It is a situation like this I greatly fear. Every "no resuscitation" order I write on a chart is followed by lengthy details, qualifying this order after consultation with patient, nursing staff, other doctors and the patient's family. Life is precious when there is little left to live.

• (1810)

[*Translation*]

The Acting Speaker (Mr. DeBlois): I am sorry to interrupt the hon. member who has the floor but I must request the collaboration of all hon. members because the Chair and the people watching us can hardly hear. Thank you for your collaboration.

[*English*]

Mr. Pagtakhan: Thank you, Mr. Speaker. I repeat: life is precious when there is little left to live. To be taken prematurely, to be taken at all, is tragic.

I would like to think that this type of bill would never need to be introduced, but this is not an ideal world. Technology has advanced at a dizzying pace. We have machines that breathe, feed, clean the blood, start the heart and pump blood. But, ironically, over a dozen people in the past five years have died in hospitals because they were secured with restraining straps and left unattended. No, this is not an ideal world. All the technology in the world are only as good as the caring staff that administers it.

Faith in the medical system is key. Patients and doctors must consult, communicate and understand the wishes of each other. There should be no case where a person is made to suffer because of heroic treatments which may, in the end, serve no purpose. There would not be a case where a patient gives up when there is hope, and sometimes there is still hope when people choose to die. This is a fear of doctors and nurses who have been trained to save, comfort and ease pain. They also cannot complacently accept death. But they know they have to allow death to happen, but must insist not to will death to happen.

Maybe it would be easier not to care as much, to hasten death, to dispense pain killers and watch the light gradually fade from a patient's eyes instead of desperately trying to save.

To the best of my knowledge, doctors do not, as noted in paragraph 217.1(b) "commence or continue to administer surgical or medical treatment to a person where such treatment is medically useless and not in the best interests of the person".

To do so, against an advance directive of the patient, would be an assault. It is a statement like that which throws suspicion on the medical community, and to suggest a medical team would treat someone in that manner is misleading and unfair.

Already there are guidelines instructing doctors how to proceed in such cases. The Canadian Medical Association believes "the right to accept or reject any treatment or procedure ultimately resides with the patient or a duly empowered proxy. The Association also believes that this includes the right to accept or refuse resuscitative as well as life saving and/or life sustaining measures in general, would they become medically indicated."

Mr. Speaker, doctors are there to help the ill. Palliative care is meant to make the dying as comfortable as possible. The health care system, under-funded as it may be, is still filled with people who place the patient first. So, the patient must also give consideration to the doctor. My fear is that the relationship between patient and doctor may dissolve into one based on legalities. The