Legislative Assembly of Alberta

Title: **Tuesday, May 19, 1992 2:30 p.m.**
Date: 92/05/19

[Mr. Speaker in the Chair]

head: Prayers

MR. SPEAKER: Let us pray.

We, Thine unworthy servants here gathered together in Thy name, do humbly beseech Thee to send down Thy heavenly wisdom from above to direct and guide us in all our considerations.

Amen.

head: Introduction of Visitors

MR. ADAIR: Mr. Speaker, it's my pleasure today to introduce two fine gentlemen from Kiev, Ukraine: the copilot and the navigator of the Ukrainian Antonov 225 Cossack that will weigh 600 metric tonnes when loaded. They are accompanied by a gentleman from Edmonton, and I'd like to introduce them. Nikolai Bogoulia is the copilot on that aircraft, and Leonid Vouk is the navigator. They are accompanied by Bill Bayda, who is their host from Edmonton. I would also like to mention that they were here for the air show on the weekend, plus they will be going home tomorrow with the humanitarian airlift that is mainly medical supplies for the hospitals in Ukraine and for the children of the Chernobyl disaster. I'd like them to rise and receive the warm welcome of this Assembly.

head: Tabling Returns and Reports

MR. GETTY: Mr. Speaker, I'd like to table today four copies of the communiqués from the Western Premiers' Conference which concluded on Friday. It was held in 108 Mile Ranch and Vancouver in the province of British Columbia on Wednesday, Thursday, and Friday.

head: Introduction of Special Guests

MR. ELZINGA: Mr. Speaker, it's my pleasure, sir, to also introduce to you and to Members of the Legislative Assembly visitors that we have from Ukraine. Earlier we had discussions as to how we could create closer ties. Let me begin by introducing two Members of Parliament, the hon. Bohdan Horyn and the hon. Valeri Izmalkov, and they are joined by Mr. Borys Bazilewsky, chief councillor, the department of international relations. Accompanying them is the hon. Alex Kindy, Member of Parliament for Calgary Northeast, and his assistant Lynn Pitt. I would ask that they rise and receive the warm welcome of the Legislative Assembly.

MS BETKOWSKI: Mr. Speaker, Alberta is fortunate indeed to have some of the finest health administrators in Canada. Today seated in the members' gallery is one such administrator, Dr. Jean-Michel Turc. Dr. Turc is here with his parents, Paul and Jacqueline Turc, who are visiting us from Miers, France. I would like to ask Mr. and Mrs. Turc and their son Jean-Michel to rise and receive a very warm welcome from this Assembly.

MR. MAIN: The Legislative Assembly is replete with visitors this afternoon, including 27 from the constituency of Edmonton-Parkallen, specifically Lendrum school. They are in both the members' and public galleries. There are 22 students and five adults including three teachers, Mrs. Anderson, Mrs. Scott, and Mrs. Fraser, and a couple of parents, Mrs. Bulat and Mrs. Cotter. I would ask them to rise in both galleries and receive the traditional warm welcome of the House.

MR. SPEAKER: The Minister of Public Works, Supply and Services, followed by Edmonton-Jasper Place.

MR. KOWALSKI: Thank you, Mr. Speaker. In the members' gallery today are 41 visitors from Cherhill school. The young students are accompanied by two teachers, Miss G. Michalchuk and Mrs. A. Pollock, as well as a number of parents, Mrs. Cindy Dickinson, Mrs. Terri Cole, Mr. L. Zsoldos, Mrs. M. Quinlan, and Mrs. D. Proud. I'd ask our visitors to kindly stand and receive the warm welcome of my colleagues in the Assembly.

MR. McINNIS: Mr. Speaker, it's my pleasure to introduce two classes from Holy Cross school in the constituency of Edmonton-Jasper Place. They are unique in that they include the eldest daughter of the MLA. Their teachers are Mrs. Manuela Ferrante and Miss Marilena Tucci. They're in both galleries. I wonder if they would rise and please receive the welcome of the Assembly.

head: Oral Question Period

Electoral Boundaries

MR. MARTIN: Mr. Speaker, we know the boundaries commission final report came down on Friday, but because of this government's partisan interference in the drafting of the legislation it made the commission's task . . . [interjections] Well, they may go "oh" or not. That's what they say in it. It made the commission's task impossible, and we said that when we debated it here. Even the Conservative members on the commission couldn't come up with a solution within this government's rules. As a result, we have an absolute mess, a hung boundary commission with five different reports. That's the reality. My question to the Attorney General is simply this: what is the government going to do about boundary redistribution now that the process it created has fallen apart?

MR. GETTY: Mr. Speaker, first is to the hon. Leader of the Opposition, I certainly can't agree with him on his allegations regarding the legislation. We do have a problem, and it's obvious by the reports that have been filed with the Legislative Assembly. Shortly I will ask the Government House Leader to contact the House leaders of the other parties to see about a select committee which might deal with this report and make recommendations to us this year. We have that option, or we can go into the election with the existing boundaries. I think that if we work together as parties here in this Legislature – and I'm pleased that we have *Hansard* reports of the hearings – perhaps we can put together a recommendation to the House that we could deal with before the end of the year.

MR. MARTIN: Mr. Speaker, we've dithered away three years and almost $2 million in taxpayers' money. The problem was the enabling legislation and the rules that were set out. That's why we're having the problem.

To the Premier, then, if he's answering on this. It seems to me, Mr. Speaker, that the only fair thing now to do is to introduce legislation that will allow the Electoral Boundaries Commission to do its work properly. My question: is the government now prepared to take this simple measure?

2:40

MR. GETTY: Mr. Speaker, I question the hon. member's words with regards to the legislation. If you recall, the legislation was referred to Alberta's highest court, and in their answer they said that, yes, this legislation was correct and fair.

What I would say to the hon. Leader of the Opposition is that rather than immediately changing the legislation, it would seem to me to be wise if we would have a select committee take the report, make recommendations to us, which may involve changing the legislation, or they may in fact suggest to us that we continue on with the existing boundaries. I think it would be helpful if all parties participated in dealing with the matter.

MR. MARTIN: This is purely and simply a delaying tactic to get us through the next election which this government wanted on the old boundaries all the time, Mr. Speaker. That's why we have this problem that we have. It was a simple thing.

The 1991 census is now out, up-to-date census figures. My question to the Premier is simply this. Rather than delay any further, let's do the correct and proper thing. Will the government now use the 1991 census figures and establish a new commission to draw the boundaries as quickly and as fairly as possible and do that right now instead of delaying?

MR. GETTY: The hon. Leader of the Opposition couldn't have been listening to my answer, Mr. Speaker. I suggested that we immediately put together a select committee and that they recommend to us changes which we would deal with before the end of the year. I don't see any delaying tactics in that. As a matter of fact, I think the select committee could in fact look at the 1991 census figures, and if they are out, they perhaps will have that information to help us as well.

MR. SPEAKER: Second main question, Leader of the Opposition.

NovAtel Communications Ltd.

MR. MARTIN: Mr. Speaker, my second question goes to the Minister of Technology, Research and Telecommunications. As the minister's well aware, stories continue to swirl around about the future of NovAtel, that great bargain that we have for the taxpayers. The latest report suggests that NovAtel will be split between Northern Telecom and a Hong Kong based company. Meanwhile, the government refuses to give us public knowledge here, continues to plot the future of NovAtel behind closed doors without any information for the taxpayers, who have funded this fiasco. My question to the minister is simply this: will the minister finally let this Legislature and the people of Alberta know what is going on? Has a deal been struck to sell NovAtel?

MR. STEWART: Well, Mr. Speaker, going back a year or so ago when the government of Alberta had made a very important decision to take back NovAtel in order to preserve the integrity of the Telus share offering, the Premier said publicly at that point in time that the management committee that was put in place would re-examine that company, refocus it, restructure it in such a way as to either make it go in the business world in accordance with proper business practices and objectives, or alternatively it would be either sold or shut down.

Since that time the management committee has been working diligently, has been pursuing the matter of opportunities that may exist in order to preserve the technology and preserve the jobs in order for NovAtel to continue as part of Alberta. Those negotiations have led to widespread speculation, as the hon. leader indicates. I don't think that speculation is healthy for the employees and their families and the customers and the suppliers. Nevertheless, that speculation does exist. At such time as an announcement with respect to NovAtel is to take place, we will make that announcement.

MR. MARTIN: Mr. Speaker, it's taxpayers' money. Sure, integrity for the Telus shareholders but at the expense of all taxpayers. That's what's happening. Surely the taxpayers have a right to know.

Let's just look at it. The accounts show NovAtel had an accumulated deficit of $278 million at the end of 1990, far more than this government has ever let on. We still have not received a financial report from last year, Mr. Speaker. Instead of hiding, will the minister now tell us how many millions of dollars the taxpayers have lost with this white elephant?

MR. STEWART: Mr. Speaker, nobody is hiding. The information with respect to the 1990-91 operations was made public. The hon. leader knows that. He knows all the facts with respect to those losses that occurred in that year and the once only write-offs and so on. The information for the past fiscal year is being audited by the Auditor General. At such time as we receive those, then they'll be tabled in the House in the usual fashion.

MR. MARTIN: Mr. Speaker, we're almost into June, and we haven't got last year's report. In due course is when it's less embarrassing for the government. That's what they mean by that.

My last question is simply this: will the minister now tell us, because there are obviously negotiations going on, whether NovAtel's debt will be sold with the company, or once again will the taxpayers be left holding the bag?

MR. STEWART: Mr. Speaker, as I've indicated, discussions and negotiations have been going on for some time, and at such time as there is an announcement to be made, then we'll make that announcement.

Electoral Boundaries
(continued)

MR. DECORE: Mr. Speaker, opposition members made numerous attempts through amendments and much debate to change the government's position, its Bill, on electoral boundary change but to no avail. Because the government wouldn't change and because the government bullied through its position, we're suffering the consequences, total chaos. I like the Premier's suggestion, and that is to bring House leaders together. I wonder if the Premier would go a step further and agree to a very quick meeting of the Leader of the Opposition, myself, the Chief Electoral Officer, and the chairman of the commission to determine exactly what the legislative timetable should be and a commission timetable should be.

MR. GETTY: Mr. Speaker, I'll consider the hon. member's request, but my suggestion is that the House leaders meet to look at the feasibility of putting together a select committee of this Assembly and to then deal with this report. Now, they could meet with the people that they would want to meet with, but my position would be that we get them meeting as soon as possible so that we can deal with this matter before the end of the year. It presumably would mean a fall session this year, but that's something that is always a potential for this Assembly. If we had

the parties come together and work together, I think they could solve the problem.

MR. DECORE: Mr. Speaker, it didn't work. The previous position taken by the select committee and the government members of that select committee was to bully through a position. I think we've got to get over that and through that and accept a position that allows for depoliticizing of the issue and for making it work quickly.

I assume that the Premier has talked to the chairman of the commission. I wonder if the Premier can advise this Assembly whether the Premier has learned in that and through those discussions that that same commission is able to carry on and thus save some money and expedite things in terms of time.

MR. GETTY: Mr. Speaker, I'll ask the Attorney General to talk with the chairman of the commission. I have not had contact with the chairman. It may be that the Attorney General could add to my comments right now.

MR. ROSTAD: Mr. Speaker, all I can do is advise the House that the chairman has gone on holidays and will be away for a period of two or three weeks. When he's back, I'll definitely contact him.

MR. DECORE: Mr. Speaker, just so the hon. minister is aware, the chairman of that commission was in his office today, because one of our caucus members spoke to the chairman. This is indicative of the way the government is treating this matter. It's serious. Time is of the essence, and the government doesn't seem to be concerned with this.

Mr. Premier, my last question is this. I would like some sense of a timetable from the Premier when this select committee is going to be finished, when this matter is going to be concluded in terms of legislative work and in terms of commission work. Will the Premier give us that timetable?

2:50

MR. GETTY: First of all, Mr. Speaker, I'd just say to the hon. members that the government has treated this matter very seriously. We had a select committee that talked to the people of Alberta. We had legislation debated through this Assembly. We then had an Electoral Boundaries Commission come up with an interim report, then hold hearings, and then a final report. So certainly we've been dealing with the matter seriously.

I would like to see a select committee get together and start working immediately so that this matter would be concluded before the end of this calendar year.

MR. SPEAKER: The Member for Calgary-Fish Creek, followed by Edmonton-Avonmore.

Western Premiers' Conference

MR. PAYNE: Thank you, Mr. Speaker. With all of the western provinces struggling to match revenues with ongoing demands for capital and operating expenditures, it would appear that the western Premiers don't have much manoeuvring room to deal separately or jointly with our economic problems. My question this afternoon is to the Premier, and it has to do with the recently concluded Western Premiers' Conference. In view of these fiscal constraints, were the western Premiers able to develop any meaningful initiatives to deal with our current economic challenges?

MR. GETTY: Well, Mr. Speaker, the meeting was a very good meeting. It was made up of the four Premiers of the western provinces as well as the leaders from the territorial governments; that is, Yukon and the Northwest Territories. I was pleased that we were able to work together and issue some nine communiqués. One was of particular interest to Alberta. We tabled a document involving improving fiscal and financial management, a document that balances responsibilities as a government between ourselves and the federal government with financial capabilities. That document was endorsed unanimously by the participants at the Western Premiers' Conference and referred now to our treasurers or finance ministers, depending on the province, to work on that document in order that we may remove duplication and overlap between ourselves and the federal government and provide better government and more efficient government for the people of Alberta and Canada.

MR. PAYNE: Mr. Speaker, constitutional stability is of course an important component in any plan to achieve regional or provincial economic priorities, especially where investment is concerned. Can the Premier advise the Assembly if the western Premiers made any headway in reaching a consensus on any of the major constitutional issues now before us?

MR. GETTY: We had a very good discussion on the Constitution, Mr. Speaker. It wasn't officially on the agenda, but several of us felt that it is of sufficient importance – and of course it overhangs all economic decisions that can be made in our country right now – that we should talk about it, and we did for some period of time.

What I was pleased with was that we were able to gather together the leaders behind Alberta's position that western priorities in this Canada round of constitutional reform be treated on an equal basis with the priorities of Ontario and Quebec. I was pleased that the Premiers together unanimously issued a very strong statement regarding raising western priorities, western needs for future constitutional reform to the level of the very real concerns of the province of Quebec. Nevertheless, this is not a Quebec round; this is a Canada round. We want to make sure that the views of western Canada are taken as seriously as those of the province of Quebec.

So that very strong statement I believe will give direction to the federal ministers and to all of the ministers who are participating in the constitutional discussions this week. They will know that six leaders in Canada unanimously requested this raising of the level of attention to western priorities.

MR. SPEAKER: Edmonton-Avonmore, followed by Edmonton-Gold Bar.

Violence Against Women and Children

MS M. LAING: Thank you, Mr. Speaker. My questions are to the minister responsible for Family and Social Services. In stating his department's policy to pursue maintenance enforcement payments from fathers, the minister has failed to place priority on the safety of women and children. I spoke to a woman who is terrified that she will have to demand maintenance from a husband who has threatened to kill her and himself and who will, in the face of paying maintenance, demand access to the children. The risk and terror experienced by this woman are unacceptable. Will the minister now commit that no woman who fears for the safety of herself and her children will be required to ask for or give details of maintenance orders?

MR. OLDRING: Mr. Speaker, it's always difficult to respond to a specific case when the member hasn't brought forward the specific case to my attention as it relates to this individual. If she has a woman in that situation, obviously I would share her concern, and I would want to look into it.

Having said that, Mr. Speaker, I want to make it very clear that, no, we will not allow any of our policies to compromise a situation that a mother might find herself in. I want to make it very clear that if there are fathers that are out there and are responsible for children and child support, we want to be able to pursue every avenue available to us. We're going to continue to do that, and we'll do it without putting mothers at risk.

MS M. LAING: Mr. Speaker, it's such a serious issue that the Advisory Council on Women's Issues raised it in their most recent report. Every week we hear reports of battered women being murdered. Battered women in shelters or hiding out from abusive husbands know that society, including the judicial system and the police, has failed to guarantee the safety of themselves and their children. Social services fails them further by threatening to cut off or reduce their benefits if they fail to comply with their policies. I want a commitment from this minister as to what steps he will take to ensure the safety and well-being of battered women and their children as a top priority not to be compromised.

MR. OLDRING: Mr. Speaker, I fully agree with the member opposite. We do everything that we can to protect mothers that find themselves in that very vulnerable position. The member knows full well that we, perhaps better than any other province, have done a good job of providing shelters and other services to women that find themselves in that particular situation. We're going to continue to do that. As I say, we will not allow our policies to compromise a mother's concern in that respect. But again we do need to have the appropriate information, and we will treat it appropriately.

MR. SPEAKER: Edmonton-Gold Bar.

Sex Offenders Program

MRS. HEWES: Thank you, Mr. Speaker. The cuts to the Phoenix program, one of the few counseling programs available for sex offenders, continue to have serious ramifications. Now we learn that young people convicted of a sexual offence can no longer get treatment under the program. My questions are to the Solicitor General. Why has the minister declined or refused funding for the Phoenix program, especially when this particular treatment is ordered by the court?

DR. WEST: Mr. Speaker, I accept the question. In the Solicitor General's department we deal with counseling and direction to offenders that have been committed to our correctional facilities or are in the care of the Solicitor General. There are other avenues in our society. Once they go out of the supervision of the Solicitor General's department, they must then access the programs that are available through many other departments in this government. So I would ask that the hon. member do some research on this individual program and the direction for these and come up with better specifics.

MRS. HEWES: Mr. Speaker, one of the problems is that the courts are still listing Phoenix as a condition of treatment or probation. Will the Solicitor General at least be in touch with the courts to let them know that this program is no longer offered for young people and whatever programs he has that are available for young people convicted of a sexual offence?

DR. WEST: Mr. Speaker, I sure will.

MR. SPEAKER: The Member for Lloydminster, followed by Edmonton-Calder.

Heavy Oil Upgrader

MR. CHERRY: Thank you, Mr. Speaker. In September of 1988 when the agreement of understanding was signed for the construction of the biprovincial upgrader, all partners agreed that the financial investment would be shared according to the equity in the project. Now we find that Saskatchewan has said no to further dollars. My question is to the Minister of Energy. Have you been in contact with Saskatchewan regarding this most important matter?

3:00

MR. ORMAN: Mr. Speaker, I do respect the hon. member's interest in this project. It has a substantial economic and social impact in his community. I would be underestimating my concern if I said simply that I was disappointed with Saskatchewan's unwillingness to live up to their moral responsibility to continue the funding of the biprovincial upgrader. This project is in Saskatchewan. A lot of the economic benefit inures to the residents of Saskatchewan, as do corporate taxes and other benefits that do accrue from economic development in a certain jurisdiction.

Mr. Speaker, as the hon. member pointed out, there was an agreement, and the other three parties to the agreement will be covering the cost overruns for an interim period; that is, Husky, the federal government, and the province of Alberta. At this particular time the interim funding amounts to $37 million. We will be covering Saskatchewan's delinquent amount. In the meantime, there are ongoing discussions, as we speak for that matter, where there are officials trying to determine a way to deal with this.

Mr. Speaker, first and foremost, this project should be completed; it's about 90 percent complete. That's the key: to get some cash flow from this plant so that there is some real value both in cash and economic and social value in the communities it affects.

MR. CHERRY: A supplementary, Mr. Speaker. Well, in the event that an agreement cannot be found with Saskatchewan, the original understanding of agreement says that feedstock will be 50 percent from Saskatchewan, 50 percent from Alberta. I was wondering if the fairest way to go, in view of no more dollars from Saskatchewan, would be 25 percent from Saskatchewan, 75 percent from Alberta. [interjections]

MR. ORMAN: Mr. Speaker, I notice that the New Democrats are siding with the province of Saskatchewan, and I notice that the Member for Calgary-Mountain View is suggesting that all we're doing is spending, spending, spending. There was an agreement in place, as the Member for Lloydminster points out. There was a deal. We expect governments, whether they change in terms of which party is in power, to live up to those agreements.

Mr. Speaker, I think that the hon. member brings forward a point that is worthy of consideration. I should say that there are a number of options. First and foremost at this particular time is that with cost overruns the last dollars in are the first ones out.

Whether or not there is a prime plus a certain interest penalty associated with those dollars assessed against the interest of Saskatchewan, whether or not there's a new class of funding to deal with this particular shortfall, all of those issues are being examined. As a matter of fact, I expect this afternoon after question period to have a briefing from my officials who have been in contact with the federal government.

As I said, Mr. Speaker, the first priority is to get the economic benefit. This is why the project was agreed to: to create jobs and economic stimulus. That should be the priority.

Social Assistance Policy

MS MJOLSNESS: Mr. Speaker, my questions are to the Minister of Family and Social Services. Presently families with children on social assistance are allowed to keep their family allowance and child tax credit from the federal government to which they are entitled. On April 7 this minister was asked in this Assembly to make a commitment that such benefits would not be deducted from people on social assistance, and he said that they would not. Given that a few weeks later this minister is saying now that he's evaluating whether or not to pass on these child benefits, I'd like to ask the minister: how can Albertans trust him when he flip-flops on an issue that is so important to so many families?

MR. OLDRING: Mr. Speaker, our position hasn't changed on the current child tax credit and the family allowance. It was committed that we would pass it through, and we're doing just that.

MS MJOLSNESS: Mr. Speaker, I'm really pleased to hear that, but the public is a bit confused. I would ask the minister: if he is stating unequivocally that those child benefits will be passed on to those families, will he indicate it in writing to the clients and to workers so that there's no misunderstanding in terms of that benefit?

MR. OLDRING: Mr. Speaker, now the member is talking about child tax benefits, and I assume she is referring to the proposed changes that the federal government has announced that will be implemented at the beginning of January. I can say that it was an item of discussion with all of my counterparts from across Canada at a recent ministerial meeting, and not one minister has determined at this point what they will be doing with that. We're working together to see what would be most appropriate. I'll continue to dialogue with our own Provincial Treasurer and the Federal and Intergovernmental Affairs minister, and sometime between now and January we will make the appropriate decision and the appropriate announcement.

MR. SPEAKER: Calgary-North West.

Western Heritage Centre

MR. BRUSEKER: Thank you, Mr. Speaker. The western heritage centre site in Cochrane is fenced off, and there are neither workers nor construction materials at the site. The understanding I've obtained is that the project has been halted due to lack of funds despite the minister's optimistic claims to the contrary. My first question to the minister is simply this: why would you allow the project even to begin when it's now abundantly clear that they don't have the money to finish the job?

MR. MAIN: Mr. Speaker, the western heritage centre is a private initiative brought forward to government a number of years ago on the basis that, "If we raise some money, will you match it?" The answer to that question was yes, and the number is $5 million. The western heritage centre proponents have raised through pledges and committed dollars $5 million, and we have agreed to match that. It's lottery money, I should point out. The money is flowing from government on an invoiced 50 cents for each dollar spent basis. We've advanced sums of money, something less than half of our commitment so far. The Western Heritage Centre proponents are continuing to raise funds and to gather in the obligations and the pledges that have been met. They have money in the bank, but being prudent businesspeople, they're not going to spend money they don't have. The project is moving along. There has been work done. When I last visited the site several weeks ago, between then and today there's been a tremendous amount of work done. I expect that when the Western Heritage Centre people have their next load of money in place and they can let the next contract, they will do so.

MR. BRUSEKER: Well, Mr. Speaker, since in fact the project is halted and not moving along, I'm wondering what the minister plans to do with this 3 and a half million dollar basement that's sitting in the middle of a provincial park. Is it going to be the next bunker for Conservative cabinet ministers in the next election campaign?

MR. MAIN: I resist the urge, Mr. Speaker, to call that a stupid question. Let me say this. The proponents of the Western Heritage Centre brought their idea to government. The government examined it, agreed to meet them on a 50-50 basis. We've agreed to do that; our obligation is there. The proponents of the Western Heritage Centre want a Western Heritage Centre on the site of the Cochrane Ranche. They're continuing to fund-raise. They have a plan. They have contracts let. They have significant funds in the bank, and when the next load of money comes in and they can do the next stage of work, they will do that. It makes no sense to go ahead and spend money they don't have. The project may take longer than was originally envisaged because of the downturn in the economy. It may take a little longer to raise the funds because some of the donors are experiencing financial difficulty due to problems in the oil patch. The hon. Member for Calgary-North West knows full well that there's been a slight dip in activity in Calgary, and for that reason it may take a little longer than we all expected.

My impression and my conviction and my expectation remain the same today as they did when the project was first announced. There will be a Western Heritage Centre on the site of the Cochrane Ranche, but the timing may not coincide with that first envisaged.

MR. SPEAKER: Lesser Slave Lake, followed by Edmonton-Jasper Place. [interjections] Order please. Let's have some other questions than yours.

Ambulance Service

MS CALAHASEN: Thank you, Mr. Speaker. My question is to the Minister of Health. There has been some discussion about air ambulance services in the province and contractual agreements under which it is provided. These ambulance services are so important to my constituents, particularly in remote northern communities where many lives have been saved by these services. Naturally, my constituents are very concerned about the possibilities of contracts being fiddled with. Could the minister please advise the House whether she is contemplating renegotiating the

contracts currently in place with STARS ambulance service out of Edmonton and Calgary?

MS BETKOWSKI: Mr. Speaker, I have no intention of renegotiating contracts that we've negotiated with the Shock Trauma Air Rescue Society of Alberta. Last year we issued requests for proposals and publicly tendered and awarded contracts for service, including that to STARS. The STARS group has notified us they have some concerns with the existing contract. We are committed in Alberta Health to the terms and conditions of the present contract. Should the terms change or should changes be considered necessary – and certainly I would discuss that with the Provincial Advisory Committee on Trauma Services – then I would make the choice of retendering the contract. That's simply the way that we do business in Alberta Health.

3:10

MS CALAHASEN: Mr. Speaker, could the minister please advise the House: in the event that STARS withdraws from providing air ambulance service under the terms of their contracts, will this put air ambulance services out of Edmonton and Calgary in jeopardy, and how will that affect the other areas?

MS BETKOWSKI: Mr. Speaker, I can assure the hon. member that because of the concern that has been expressed by STARS, we have a contingency plan in place which would ensure that there was utilization of the carriers already approved by the contract and certainly would not allow health service access to be jeopardized because of the delay and the possible retendering of the contract.

MR. SPEAKER: Edmonton Jasper-Place, followed by Edmonton-Highlands.

Sunpine Forest Products Ltd.

MR. McINNIS: Thank you, Mr. Speaker. In response to the Dancik report on forest management in Alberta the minister tabled a document which said:

> In future, meaningful opportunities will be provided to the public to have input into all major policies and major allocation decisions that affect Alberta's forests.

My question is about a major allocation decision affecting Sunpine Forest Products Ltd. in an area in the Brazeau timber development area west of Rocky Mountain House. The opportunities for public input have been so slim that a group of local people assisted by other Albertans have gone so far as to initiate their own studies into wildlife issues, tourism, and the like. I wonder if the Minister of Forestry, Lands and Wildlife will tell us whether he will bridge the gap between his rhetoric and reality by referring this important allocation decision to the Natural Resources Conservation Board for a full public review.

MR. FJORDBOTTEN: First of all, Mr. Speaker, the negotiations and approvals for the Sunpine project have been long and difficult. There have been necessary changes made by the proponents with respect to the project because of environmental concerns that were raised. At this point there has certainly been a lot of public involvement and consultation.

MR. McINNIS: Mr. Speaker, it may have been long and difficult, but it's been in secret, and that's the whole point. Sunpine has scaled back their proposals to the point where many people in Rocky Mountain House now suspect that the real agenda is that Sunpine wants the timber from the FMA to feed its mill at Caroline; in other words, Rocky Mountain House is expendable. This is what they went through before with Weyerhaeuser, up to Drayton Valley. The local timber goes up there. That's what's happening to Peers as well. Will he state in this Assembly today that never again will he agree to take Rocky Mountain House timber to feed another project in another part of the province?

MR. FJORDBOTTEN: Mr. Speaker, to coin a word, a fresh word, I suppose, that was used in the Assembly a couple of years ago, it's the word `insinuendo'. The basis on which the hon. member bases his questions is full of insinuation and innuendo and based on no fact, just rumour. The Sunpine proposal is coming along just fine and will be reported in due course.

Edmonton Single Men's Hostel

MS BARRETT: Mr. Speaker, last week the residents of the inner city learned that the George Spady Centre is going to be cutting for two months its daytime detoxification program. When I raised the matter, the response I got from the government was, "Well, you know, it's better that they shut down for two months in the summer and let these people wander the streets than shut for two months in the winter and let them freeze." There's another agency in my riding that's also facing some troublesome times right now, and that's the Single Men's Hostel. A couple of months ago the government said that it was going to let the infirmary shut down. I questioned them. They said, "Okay, we'll change our mind; we'll keep the infirmary going." Now the provincially employed staff are being told that they're going to be placed in other jobs. My question to the Minister of Health or the minister of social services is this: why won't those ministers involve the staff at the hostel in the decision-making process so they can know whether or not the infirmary is going to survive?

MS BETKOWSKI: Mr. Speaker, I gave the hon. member the assurance last month, and I'll repeat it today, that the nursing services provided at this Single Men's Hostel will continue in some form. What form that will take, I can't give her exactly at this point. We are working towards the July 1 deadline. Certainly we recognize the importance of the health services provided in the hostel, and we are working to ensure that those continue.

MS BARRETT: Well, Mr. Speaker, the people with the not-for-profit organization that are going to be running the hostel, the Hope Mission, haven't been contacted about this, yet the nursing staff are being told that they're going to be forced to go into jobs elsewhere. When will the minister commit (a) to getting hold of the Hope Mission to consult with them and plan with them and (b) to provide the funding for the nursing care that the infirmary will need?

MS BETKOWSKI: Mr. Speaker, I'm not sure who's informing the people that are informing the Member for Edmonton-Highlands, but I will certainly look into the matter and provide her with the most current update that I can, recognizing that the deadline we've all set for ourselves is July 1.

MR. SPEAKER: Edmonton-Whitemud.

Vehicle Inspections

MR. WICKMAN: Thank you, Mr. Speaker. The department of transportation is now engaging in the practice of hiring students with a two-week crash course to carry out safety and mechanical inspections on tractor trailers. To the minister responsible for

transportation: will the minister explain how he can condone this training to be sufficient to inspect these vehicles?

MR. ADAIR: Mr. Speaker, two things that I might point out: it's Transportation and Utilities, not transportation, and also the fact that . . . [interjections] You were the guy that said that it was not going to get the Yellowhead opened in 1991. [interjection] That's exactly right.

Mr. Speaker, two things. Going back to the inspection of vehicles, we announced in January 1, 1992, that we were going into commercial vehicle inspection. I would have to check to make sure that the statement that you made relative to hiring students to do specifically that is occurring. What generally occurs is that the private inspection place, the garage in Manning, and the heavy-duty mechanic in that garage can get licensed to do the job, not the government. We will license that person in the private sector to do the job. We'll do that in Edmonton, and we'll do it Rimbey and Lloydminster and every area that applies for the right to have a heavy-duty mechanic do that inspection, because that is basically the way the rules are.

MR. WICKMAN: Mr. Speaker, my supplementary is again to the minister. Assuming that my information is correct – and it normally is correct – would the minister advise this House as to whom he would intend to hold liable if one of these vehicles were passed for inspection, certified improperly, and involved in a repeat of the situation such as we saw in Kamloops?

MR. ADAIR: Well, Mr. Speaker, two things. The only thing that he's usually had right is "Mr. Speaker," just that term itself.

Secondarily, what I said in my answer in the first place to the hon. member was: number one, the heavy-duty mechanics are out of the private sector. We do the classroom instruction with those heavy-duty mechanics, and they then are licensed by us to, in fact, provide that service of inspections of both buses and trucks.

MR. SPEAKER: West Yellowhead.

Coal Mine Safety

MR. DOYLE: Thank you, Mr. Speaker. The coal mine disaster in Nova Scotia has shown that coal mines remain to this day a very dangerous workplace. Hazards are not limited to explosions or cave-ins, however. Respiratory diseases, such as pneumoconiosis, pose a longer term and more insidious risk to the health of coal miners. As Alberta is now in the process of reviewing our mine safety regulations, the government has an excellent opportunity to reduce the health risks associated with coal mining. Will the minister of Occupational Health and Safety tell the Assembly whether the province's 6,000 mine workers can expect a new, preventative, environmental standard for the monitoring of dust levels at the worksite to replace Alberta's current medical standard, which discovers respiratory problems only after it's too late to do anything about them?

3:20

MR. TRYNCHY: Mr. Speaker, just a few days ago I answered a question similar to that in *Hansard*. Yes, as soon as the mine workers and the employers get their regulation proposals to me, we'll work as quickly as we can on them.

MR. DOYLE: Mr. Speaker, in 1981 a government study entitled Respiratory Disorders Associated with Coal Mining: Implications for Occupational Health Practices in Alberta recommended the adoption of an environmental standard for dust levels in coal mines. It is now 11 years later, and we still have no changes. If the refusal to implement an environmental standard is not simply due to the government's callous disregard for the lives of these Albertans, will the minister at least implement rules requiring mandatory retirement of coal miners with a full pension after 15 years, as is done in Europe, so their long-term exposure to coal and rock dust and therefore the risk of associated diseases may be limited?

MR. TRYNCHY: Mr. Speaker, the comments from the hon. member suggesting that we're not prepared to work is just garbage, if I can put it that way. It's been some three years since I asked the mine workers and employers to put the regulations together and get them to me. They haven't done it yet, and I'm waiting for them. If he can help us get those moved on quicker, then we will move quicker by bringing them into legislation.

MR. SPEAKER: Westlock-Sturgeon.

RCMP Contract

MR. TAYLOR: Thank you, Mr. Speaker. Today I'd like to direct my question to the Solicitor General. The Solicitor General's office has negotiated a number of contracts with the federal government on policing in Alberta, but there's one clause in the contract that says that if the RCMP are not happy with the contract, they can give a three-year notice and go ahead then and build accommodations and facilities and charge the MD. It appears to be a loophole in the contract. My question is: what is the Solicitor General going to do to close this loophole; for instance, in the case of Drumheller, who could be faced with $2 million costs to the municipality?

DR. WEST: Mr. Speaker, I am not aware of any problem with the RCMP contract. We just signed a 20-year contract for 61 municipalities. I haven't had any representation to date from any municipality in the province, but if the hon. member could bring forward specifics or have those communities get in touch with me, I would certainly be willing to communicate with the federal government and with the other departments involved in this.

MR. SPEAKER: Supplementary.

MR. TAYLOR: Thank you, Mr. Speaker. It would be most appreciated, because when they go to the federal Solicitor General, they tell them to see the provincial Solicitor General, and then I've been informed that when they went to your office, they've been told to see the federal; in other words, the old Tory ring-around-a-rosy. Now that I have the minister's promise that he will look into the thing, that's good enough for me.

Thank you.

head: Orders of the Day

head: Written Questions

MR. ANDERSON: Mr. Speaker, I move that written questions appearing on the Order Paper stand and retain their places.

[Motion carried]

head: Motions for Returns

MR. ANDERSON: Mr. Speaker, I further move that motions for returns appearing on the Order Paper stand and retain their places.

[Motion carried]

MR. SPEAKER: Might we revert to Introduction of Special Guests?

HON. MEMBERS: Agreed.

MR. SPEAKER: Opposed? Carried.

head: Introduction of Special Guests
(reversion)

MR. SPEAKER: First, Cardston; second, Edmonton-Avonmore.

MR. ADY: Thank you, Mr. Speaker. It's my pleasure to introduce to you and to the Assembly 41 members of the Raymond high school show choir from the Cardston constituency. This is their second year since they were organized by Mrs. Bronwyn Freeze, and they've performed extensively in southern Alberta and today performed in the fountain area of the Legislature Building for 45 minutes. They are accompanied by their chaperons and supervisors Mrs. Bronwyn Freeze, Mrs. Carol Dahl, Mrs. Lori Garner, Mrs. Karen Holt, and Kim Walburger. They are seated in the members' gallery, and I'd ask them to rise and receive the warm welcome of the Assembly.

MR. SPEAKER: Edmonton-Avonmore.

MS M. LAING: Thank you, Mr. Speaker. I'd like to introduce to you and through you to members of this Assembly 26 students from Notre Dame school in North Battleford, Saskatchewan. They are visiting with the students at J.H. Picard school, which is in Edmonton-Avonmore. I think they were seated in the public gallery but have probably left.

Thank you.

head: Motions Other than Government Motions

Right-to-die Legislation

213. Moved by Mr. Payne:
Be it resolved that the Legislative Assembly urge the government to establish an advisory committee to examine the policy implications of enacting right-to-die legislation.

MR. PAYNE: Mr. Speaker, I'm encouraged by the good attendance in the Assembly this afternoon on both sides of the House, and certainly I look forward to the comments that members might make with respect to Motion 213.

I think it goes without saying, Mr. Speaker, that this motion addresses a highly controversial and obviously emotional issue, the issue of death. More specifically, it addresses a fundamental question: do people have a legal and moral right to determine when and how they die? This question appears simple enough, and oftentimes it gets an immediate, unthinking, and unqualified yes or no. But if one is to take a few moments and reflect on the issue, it becomes obvious that this is not a simple matter indeed. Rather, it's a highly sophisticated question which challenges our views about morality, about the law, about humanity, and even about God.

Motion 213 asks the members of the Assembly and our constituents to think about death. It asks us to ask the question about the right of self-determination with respect to medical treatment. Furthermore, Motion 213 asks us to establish an advisory committee to examine the policy implications of enacting this type of legislation. Throughout their examination this committee would meet with health and legal professionals, stakeholder groups, and members of the general public, and the result of this examination would be expected to be an advisory report which would be submitted finally to the Legislative Assembly.

Right-to-die is one of those phrases that sounds simple and with repetition becomes perhaps even more simple, yet I'd like to suggest that it is a very complex phrase inferring a very complex thought. In essence, people who argue in favour of the right to die argue that the individual has the ultimate authority over what kind of medical treatment is received. Called self-determination, they believe that competent individuals have the right to determine what is done to their bodies, including what medical treatment will be administered or not administered or withheld.

In one study completed by the Manitoba Law Reform institute in November of '91, just really a few months ago, one set of authors state:

> There is a broad ethical, legal and medical consensus that competent adult patients have the right to determine the course of their medical care. In particular, patients have a fundamental ethical and legal right to refuse all proposed treatments including life-sustaining medical treatments. In ethics, this right is based on the principle of individual autonomy. In law, it is based on the common-law right to be free from unconsented bodily invasion.

Mr. Speaker, the legal means by which one may refuse medical treatment is through an advance health care directive called a living will. This document, the living will, expresses the writer's preferences and instructions with respect to future medical treatment. An individual may also authorize someone, usually a lawyer or a family member, to make decisions about the use of life-sustaining treatment for them in the event that they are unable to make such decisions for themselves. This is called a durable power of attorney or health care proxy.

3:30

Mr. Speaker, if a terminally ill individual decides to forgo medical treatment and his or her wishes are granted, this process is called euthanasia. Euthanasia has been defined as an act or practice of putting persons to death painlessly who are suffering from incurable or malignant diseases as an act of mercy. I would like to double underline the concluding phrase of that: an act of mercy.

Some in the House might feel the need to ask the very question: why do we need to examine right-to-die legislation? Before I continue any further this afternoon, Mr. Speaker, I believe it's useful and important that we ask ourselves another question: why do we need to examine the issues and implications of enacting right-to-die legislation? Well, quite simply the answer to this query is threefold. First, the spread of horrible debilitating diseases such as AIDS and Alzheimer's has increased public awareness of the realities of a lingering death by disease. Secondly, the remarkable advances in medical technology have determined that for the first time in our history we now are armed with the ability to prolong life artificially. We have all heard cases where, in essence, the individual appears to be dead. The vegetative state in which they exist is maintained only through machines which control vital organs. Thirdly, the costs associated with prolonged stays in hospital while accessing medical technologies are such that families and governments are now seriously re-examining all the options.

Mr. Speaker, my attention was drawn to this newspaper clipping recently. It appeared in the April 25, 1992, edition of the *Calgary Herald*. What caught my eye was the headline, "Doctor says costs of dying too high." In anticipation of this debate this afternoon

I read the clipping. It was based on a very controversial speech made by the president of the Foothills hospital, Dr. Clarence Guenter, who was speaking to a large conference of health care professionals. In the course of his remarks to that group Dr. Guenter said that

> 10 per cent of all [of our] health [care] dollars in Alberta . . .

I presume that means of the order of $400 million.

> . . . are spent treating people in the last month of life and that a full 25 percent [of our health care budget] . . .

In other words, something approximating a billion dollars.

> . . . is spent treating people in the last year of life.

Dr. Guenter went on to observe that

> this expenditure doesn't increase life expectancy.

Then he asks this challenging question:

> Is it not time that we address the resources allocated to futility?

Elsewhere in the article Dr. Bob McMurtry, a Canadian leader in medical cost cutting, agrees with the position advocated that day by Dr. Guenter but then went on to say that he felt "terminally ill patients could still receive better care." In making this latter point Dr. McMurtry said that he had talked to one dying patient for an hour and a half instead of simply prescribing some more drugs. "The man [simply] no longer needed the drugs in his last 36 hours," he said.

Then could I conclude this excerpt with this quote, Mr. Speaker. Again this is Dr. McMurtry.

> We should be talking a lot more about high touch in the last days and less high tech. It is easier to pump up the dose of morphine than dealing with the fact that you are going to die.

Mr. Speaker, since Sir Alexander Fleming's breakthrough discovery of the curative properties of penicillin in 1928 the advances in modern medicine have been truly amazing, and that almost sounds like an understatement. Now medicine can ensure that people are able to live longer and even when very ill or incapacitated can stave off death. Just last week I caught part of a television documentary in which the statistic was presented that in this century in Canada average life span has doubled: within this century. Yet the supremacy of modern medicine has given birth to a new fear, and it may be a fear that's shared by some of the members in this Assembly – one or two have confided that fear to me – and that's the fear of a hopeless lingering before an unavoidable death in a sterile, impersonal hospital or nursing home.

The reality, Mr. Speaker, is that doctors, machines, technology, and medicines are now able to prolong life far beyond natural expectancies. The cost, some would argue, for all this medical know-how has been the sacrifice of quality of life to quantity of life. Some people simply do not consider it to be living if living means a life in a coma or a life filled with pain-controlling drugs or a life hooked up to machines with little hope of recovery.

Mr. Speaker, it is the supremacy of medical technology in combination with the advent of the debilitating diseases that I referred to earlier which has resulted in the birth of the death-with-dignity movement. Several highly publicized cases – for example, the case of Karen Ann Quinlan in the States – and the release of books such as Derek Humphry's Final Exit have fueled on this movement and indeed brought it directly under the public spotlight and in part have triggered this afternoon's debate in this Assembly.

I'm sure many of the members here are familiar with case studies in recent times that have dramatized the questions that I have raised today. One of the most famous right-to-die cases, of course, involved a landmark decision of the New Jersey Supreme Court in the case of Karen Quinlan in 1976. It was this case, Mr. Speaker, that first brought the debate over qualitative versus quantitative life to the fore in ethical, medical, and legal circles throughout North America. In that case, you may remember that Karen Quinlan's parents sought and obtained a court order to have Karen, who had been diagnosed as being in a persistent vegetative state with no hope of recovery, removed from a respirator. The court found that Karen had the right to refuse medical treatment, and because she could not exercise this right because of her incompetence, her family could exercise it for her.

Much more recently here in our own country is the case of Nancy B. In November of 1991 Nancy B. attracted national attention when her lawyer petitioned the Quebec superior court to have Nancy's life-support system turned off so that she could die. She asked to have Nancy removed from life support because while the mind of this 25-year-old woman was still very much alive, Nancy remained imprisoned in a body that was all but dead. The result of a rare neurological condition, Guillain-Barre syndrome, Nancy B. was a quadriplegic who could not breathe without the help of a respirator. After a bedside hearing with Superior Court Justice Jacques Dufour, Nancy B. was granted her request and the machinery which had kept her alive was turned off. She died seven minutes later on the morning of February 13, 1992.

Mr. Speaker, while not all cases have received such national attention as the two I have just mentioned, the fact remains that while legislators are debating about changing the Criminal Code of Canada, Canadians are now taking matters into their own hands; for example, the recent case of Charles and Margaret LeMoir. Charles, a former Vancouver fire fighter, was 87 and suffering from cancer, heart problems, failing eyesight, and chronic painful headaches. His wife, 80, suffered from advanced osteoporosis, a painful and crippling deterioration of the bones. Their solution to a life lived too long and with too much pain was to strap themselves together with a belt and jump from their 14th-storey apartment.

3:40

It's a matter of public and journalistic record, Mr. Speaker, that doctors in Canada and in our own province are divided about this issue, as I suspect the members of own Assembly are divided on the issue. A Gallup poll released just last November asked Canadians the following question.

> When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law to end the patient's life through mercy killing, if the patient has made a formal request in writing?

Mr. Speaker, fully 75 percent of the Canadian public maintain that doctors should legally be allowed to end the life of an incurable patient through mercy killing if that patient has made a formal request in writing.

Mr. Speaker, Gallup the pollster saw fit to point out that these figures have changed little in recent years. In 1990, 78 percent of Canadians favoured legalized euthanasia, while two years ago this statistic registered 77 percent. It would appear to me that support for euthanasia is based not on the highly publicized cases like Nancy B. but rather is indicative of widespread public support for the practice. Despite this widespread public sentiment – should I say public consensus? – doctors in Alberta and in the nation remain divided on the subject of right-to-die legislation. In November of 1991, the *Calgary Herald* published a series of columns on the right to die. The majority of Alberta doctors believe that assisting in suicide should remain a crime while just 18 percent believe it should be decriminalized. Moreover, two-thirds of the doctors don't want a decision on patient euthanasia left in their hands.

In addition to the moral and medical aspects of euthanasia, Mr. Speaker, part of the struggle that doctors have in dealing with

right-to-die legislation is based on the legalities involved with this practice. I'm encouraged that our own Attorney General is in the House this afternoon, and I look forward at some point, if not today subsequent to our discussion, to his comment on these legalities.

Unfortunately, the reality is that Canadian law is outdated and uncertain in regard to the many decisions to administer or withhold medical treatment from patients such as those I have described today. Now, I realize, Mr. Speaker, that both the Charter of Rights and Freedoms and the Criminal Code are federal statutes, but they are germane to the provincial aspects of the issues that we are discussing today, and I'd like to explain the linkage. One of the problems surrounding enacting right-to-die legislation is that a number of provisions in the Criminal Code appear to indicate that medical treatment must be provided and must continue to be provided to a patient no matter what the circumstances. In addition, section 14 of the Criminal Code states that

> no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Thus it would appear that so-called mercy killing is clearly prohibited under the Criminal Code. Yet on the other hand, treatment by force against the wishes of the patient constitutes assault, an offence under sections 244 and 245 of the Criminal Code.

Mr. Speaker, it's not difficult to see how conflicting sections within the code have made our law incomplete, unclear, and outdated in dealing with mercy killing. However, this situation becomes even more unclear when combined with the enactment of the Canadian Charter of Rights and Freedoms, for several sections of the code appear to be in conflict with the Charter. The result appears to be that various sections under the code could have no force or effect.

Mr. Speaker, a landmark decision in Canada further complicated the legalities regarding mercy killing. The case of Malette versus Shulman, decided in the Ontario Court of Appeal in 1990, ruled that living wills are legally binding. In that case, Dr. Shulman administered a life-saving blood transfusion to an unconscious adult patient after a near-fatal car accident. An unsigned and undated card had been discovered in the patient's purse which identified her as a Jehovah's Witness and expressly forbade any form of blood transfusion. Miss Malette, the patient, survived because of the transfusion, but nonetheless she brought an action against Dr. Shulman. The court ruled in favour of Miss Malette and awarded her $20,000 in damages. It held that the undated card was legally binding and that Dr. Shulman had unlawfully administered the transfusion.

By way of a conclusion in my comments today, Mr. Speaker, let me say that as we are all aware, any ultimate changes to the status quo with respect to right-to-die legislation will have to take place at the federal level. In light of a recent private member's Bill, C-203, An Act to Amend the Criminal Code of Canada (Terminally Ill Persons), I'm hopeful that the discrepancies in Canada's laws will soon be redressed. Nonetheless, I believe that Alberta, too, must examine all the relevant issues pertaining to living wills, durable powers of attorney, and euthanasia.

Mr. Speaker, I think it goes without saying it is important that we act now on this issue, because as concern for the right-to-die-with-dignity movement becomes more widespread and as a greater proportion of our population reaches old age, more Albertans will be looking to advance directives to have their medical wishes fulfilled. This is likely to pose serious problems for the medical profession, which could face criminal and civil liability if they act or do not act upon the express written wishes of their patients.

In essence, Mr. Speaker, the private member's resolution before the Assembly this afternoon proposes that we strike an advisory committee – not an advisory committee of MLAs but an advisory committee of professionals and academics who bring particular legal or judicial or medical or ethical expertise to bear on the complex issues associated with right-to-die legislation. With great respect, I would suggest to you and to the members of the Assembly and particularly the members of the government party that these issues are coming at us like a high-speed freight train. How much better equipped we will be to develop policies, to develop legislation, to develop initiatives with respect to these issues if we have the prior advice that is contemplated by the advisory committee which is the subject of this motion.

I look forward to the comments of the members here today. I certainly would encourage their support of this timely and, I submit, very worthwhile private member's motion.

MR. SPEAKER: Edmonton-Centre.

REV. ROBERTS: Thanks very much, Mr. Speaker. I want to address a few remarks to this very complex and very important and urgent motion which the Member for Calgary-Fish Creek has rightfully brought forth to this Legislative Assembly. I agree with him almost in his entirety in terms of his analysis of the issue and the urgency and the need for action. I wanted just to spin out at the end of my remarks perhaps a broader approach to how to deal with this and many other similar issues dealing with bioethics and health care ethics, which, as the member says, are hitting us like perhaps a stealth bomber that's coming forward: we don't see them all, but they're coming at us from all directions. I think it's going to become even more difficult as legislators to try to keep ahead of the issues as they're developing out there and yet have so little guidance, as the member has pointed out, in terms of a legal or any kind of a sanctioned approach to dealing with them for the physicians, for the hospital administrators, people out there in the field. So it's urgent; it's important that we get on with this.

3:50

I do agree with the member. For some time I've been aware, as Clarence Guenter and others have pointed out, that we've come to a point in health care where – I, in fact, have heard that fully a quarter of all health care spending is on last-stage, often unproductive, unfruitful life-sustaining interventions and treatments, which would have lots of bearing in terms of extending life but basically just prolonging life and – now, what was the other expression? – that sort of prolong life but extend death. I think we need to look very carefully at where we've come as a technologically-driven society in terms of the ability just to keep people living and breathing but not making decisions or not having those decisions sanctioned and not having the quality life around them. In fact, we spend more money on more and more technology with plugs into every limb of every patient and the machines which keep us going in a way that I think really bears a lot of questioning.

[Mr. Deputy Speaker in the Chair]

In fact, I remember a beautiful poem by Duncan Campbell Scott called The Forsaken. It was a wonderful contrast to our technologically driven society: a native community where in fact a woman gets in a canoe and the canoe is sent off down the river. Then the native elder woman peacefully and naturally comes to

rest on this island where the frost covers her as a shroud, and she very naturally, very peacefully dies in a very dignified way. The way in which Duncan Campbell Scott depicts this in this poem, The Forsaken, stands in stark contrast to thousands and millions of people in North America particularly who are in beds with buzzers, and family might not even be able to visit sometimes except to just see how long the bills are going to run up for keeping them alive: as the member said, the high cost of dying.

The other thing: it's not, obviously, just the cost question but the quality of life and the quality of death question. To die with dignity a natural death is, as the member pointed out, what gives us as human beings dignity and stability to make decisions and to have those decisions upheld. If you take away our decision-making process, if you take away our ability to cognitively think and decide for ourselves and for our lives, there is very little left.

Now, I know that members in this Assembly say, "You know, that's why we don't even like government, because government gets in the way of people making their own individual decisions for themselves." Well, here is perhaps a very conservative issue of saying to government, "Let people decide how they want to live out their lives and to live out their natural death with the full dignity accorded to them as being able to be individuals deciding for themselves."

Again the member touched on what we get into, though, is that so much of what has developed is – I don't want to say "physician-generated care" but certainly a strong element in our society, particularly as seen in physicians who are trained day in, day out, for hour upon hour to preserve life and to develop cures. As one even said, "When in doubt, do something." Physicians are there to bring the full range of medical science and technology and all of the healing arts and skills that they possibly can to continue life. They just have a very difficult time in saying: "No. It's over. There is nothing more we can do." For a physician to say there's nothing more we can do, for many of them it admits to failure. "Well, there's got to be something. If we keep them alive this long, if we transplant this heart or this artificial heart in them long enough, there might just be a cure so that we can resolve it." And sure enough, there have been cases where in fact that has happened, that life has been prolonged just long enough in order that some cure or some treatment has enabled the person to walk away and back to a decision-making life-style that they had before the medical intervention.

So in some ways what we're dealing with here are competing rights: the rights of physicians and others to do everything possible to save, to cure, to enhance life and its quality and quantity and the rights of individuals to say: "No, I don't want any more, thank you very much. It's desperate enough. It's painful enough. I don't want to go through this misery. I can't stand any more, and I want you to pull the plug." So those competing rights are what is at the nub of this issue that I think we as people who represent the public will need to think very clearly and carefully about.

In fact, it's interesting that in the U.S., where there is more and more discussion of the right to die, or physician-assisted death or suicide, they have in that society people talking about that right without even having acknowledged that in fact people have a right to health care in the first place. The right to care, the right to access is often denied. So it's no wonder that, for instance, in the state of Washington, where they put a plebiscite on the ballot for people to decide should there be physician-assisted death, what those who looked into it discovered was that physician-assisted death was fine mostly for people on medicare and medicaid; they were getting awfully costly as it was. People who had full insurance for every kind of treatment, that was fine, but it would be nice to have physician-assisted death for those who were miserable enough anyway, who were costing the taxpayer a lot of extra money. "Let's give them the option of directing their physician to pull the plug because in fact it would save taxpayers money." They don't have a right to health care, but they were wanting to establish the right to physician-assisted death.

The question, as the member pointed out, what it comes down to, is the right for a reasonably competent person to consent to treatment or to refuse treatment. Again, as we have in our society with the right to health care, is the assumption on the part of the state that if there is an emergency – if somebody is in an accident or they are mentally incompetent or can't make the decision – it's temporarily in abeyance, that the state, the doctors, the hospitals will do anything and everything assuming that that person wants to live. The assumption is on the right to care and the right to intervene on behalf of the person even without consent. This is, I think, where the member was talking about, where a lot of our federal laws have come from. We want to err on the side of treatment and intervention on behalf of that person, because in some ways that person might be in an emergency or might be temporarily depressed or might just not want to go through with this pain and suffering today but will be very thankful a week or a month down the line that in fact such intervention was taken, that the treatment was given. So you have to take the longer view. For someone just to say: "Oh, well, why didn't you believe me? I didn't want to go through that misery," is to err on the side of giving up too soon.

In fact, I remember I used to have a crest on my wall in Latin, Mr. Speaker. I don't know how your Latin is today. The expression "Dum spiro, spero" means "While I live, I hope." There are those, particularly in this Legislature, who need to know that while we live, we hope – or in this country – because it can get awfully desperate and awfully depressing a lot of the time, but that life itself is not just a matter of decision-making; it's the matter of having hope and having hope spring eternal.

As the member has raised, cases of how to determine mental competency of adults who want to refuse treatment or want to give consent to treatment is a lot of the issue. It's further compounded by: guess who it is that often determines the mental incompetency of a patient? The doctor. Guess who it is who's often the one to say, "Oh, you're really not in your right mind to say you want to die"? It's the doctor who makes that kind of determination around mental competency. At least it has been in the case with mental illness or those who want to refuse to go into an institution for mental health. It's up to the doctors to decide if the person is mentally competent or incompetent. At least it has been. So what if a doctor's saying, "Well, we know you don't want this today, but even though you competently don't want treatment to proceed, I think maybe you should think this through," or the doctor doesn't grant the incompetency or says that the person isn't in their right mind?

4:00

Then the second issue. It's up to the courts to decide if the rights have been violated, and as the member points out, the courts are saying: "Well, we don't have enough legal guidance to know what is the proper thing to do, whether there is, in fact, a right to die or a right to live. We don't want to handle this hot question." So they now throw it back to us as the legislators, saying, "Give us more guidance on this issue how to determine competency or if the adult is competent enough to make that decision that they want to terminate their life." So it becomes, as someone said, "Well, we'll have a living will" or that advance directive to say the person will put in writing what their consent would be if they

were competent enough to make the decision at the time, and they do it by virtue of a living will.

My research shows that the state of California was one of the first that brought that in in the U.S. There were many others. I think over 30 states currently have right-to-die legislation, including advanced directives, but what they've found out is that even with living wills, the vast majority of people don't even want to sign up to that. I just don't have the figure here. You know it's hard enough to get people to have their own will anyway, let alone a living will. Although the legislation is there and there is a provision for people to use, many people get themselves into circumstances – I think 85 percent of the time, a figure in the state of Oregon – where they don't have a living will either. Again it's thrown back to the doctors or the hospitals or the courts or finally to the legislators.

As I said, in terms of developing a criteria around how competency is understood or how to determine competency in individuals, I remember that in this Assembly it took us four or five years to get the Mental Health Act. I'd like to go back and see if in fact the criteria around for developing competency or incompetency and the right to refuse treatment in the Mental Health Act might in fact help us on this issue.

There are two other issues I'd just like to just point out and then make my final point. Even with the living will or other ways of approaching this, as the member said, they often deal with prolonging imminent death. If you just pull the plug, the person will die almost immediately, within 24 hours. The question becomes: what if there is enough technology to keep that person living over a longer period in the case where death is not imminent? The living will expires after five years in these states. What about the issue of keeping someone alive just long enough so that some other intervention or treatment might be developed? That's another issue. It's not artificially to prolong the moment of death where death is imminent. That was the case of Karen Ann Quinlan. There was just nothing that could be done because even an advance directive would not be a provision that could have been used in her situation of a hopelessly vegetative state where death was not imminent.

Then the issue of physician-assisted death and suicide and euthanasia and the right to die. I myself feel it's very difficult to give someone the right to ask someone else to either hurry or enhance their moment of death. I think it's unfair and dangerous to implicate someone else in that decision-making process. So it's not just the case of an imminent death but of hurrying the death along in the point of euthanasia, mercy killing, or physician-assisted death as it's referred to in the U.S.

Again, as I pointed out, it's unethical, particularly in the U.S. where those on medicare and medicaid get second-rate care anyway and the right to die or to physician-assisted death is there even without the right to health care. I agree with the member – he's done a fine a job in terms of looking at how contradictory our laws are, particularly under the Charter – that we have some real problems here with the right for an individual to make their decision, but the number of other individuals that it's implicating or what their rights are vis-à-vis the person making the decision.

So I raise these as general issues just to spell out a few more of the complexities of this issue, but I agree with the member that as complex as they are, they are never too challenging for us as legislators to be able to deal with them.

My point, though, in conclusion is that this issue, as topical and relevant and headline-grabbing as it is, is only one of a number of other growing issues in the area of health care and biomedical research and other related issues. As the member might know, hospital ethics committees themselves in many hospitals and many centres are already meeting daily, weekly – at regular intervals – to determine what would be the best course of action not only for the individual but to protect the physician against any liability. These hospital ethics committees do a great service to spell out the full parameters of the issue, to look at the legal side of it, the personal side, the family side, and all of the different areas of concern.

I think the time is right not just to set up, as the member might suggest, a special advisory committee just to look at this issue. What I have advocated – and I know the Hyndman report supported me in it, and the Minister of Health has yet to do anything about it – is to establish a provincial health ethics committee. We have the Institute of Law Research and Reform which advises us on a number of legal matters. I think it would behoove us to have such a health ethics committee with the kinds of professionals and others from a cross section of resources which we have fully in this province in both the cities and throughout the province, people who look at these questions regularly and other related ones, to bring a group of six or seven of them together, to give them 50-50 cost-shared funding to be able to research and provide full discussion of a number of these kinds of issues which affect health care providers and health care recipients – and not just health care but others in the area of biomedical care: questions of life and death.

I think that would be a broader, more comprehensive approach to the issue because, as I said, there are a number of other issues. Has the member, for instance, heard of those who advocate that there needs to be the right not to be born? There was an interesting case where parents had a child who was Down's syndrome and discovered that it was because she was put on medication during her pregnancy. She found that out only while she was pregnant with her second child. She was still on that medication, so every indication was that this second child was going to be born with Down's syndrome, and for that child they wanted to argue in court the right not to be born. It needed to go to the courts. It spun out endlessly in the courts, and the decision was no, the parents had to have the child, or at least there was no right not to be born.

The other issue is around genetics. My goodness, you know, they now can find through examination of the gene pool incredible genetic predisposition to certain disease and conditions. What do we do with those who know that? For instance, member, if you have a genetic predisposition to a certain illness, should that person say, "Well, I don't want to live out that kind of condition," or insurers have access to that kind of information? There's a whole host of issues about that kind of information and what it's going to do. Should individuals be told what they're genetically disposed to and not disposed to? On and on it goes. They say these are just related issues that health, law, and ethics and others in health ethics committees deal with.

I would want to support in an interim fashion the member's call for an advisory committee to look at this very urgent and complex issue, one that I would support him in on the basic principle that individuals need to be able to have their own decision-making processes fully upheld and sanctioned, given that they are competently able to make those decisions. Nonetheless, it spawns a whole range of other questions and whole other issues where I think we'd be well served in this province to be the first in Canada – you know how this province likes to be the first in Canada – to have a provincial health ethics committee which would provide precisely the same kind of function as the member is asking for in an advisory committee on this issue but also provide a resource for us as legislators on a whole host and range of other pressing issues which are concerning our constituents both now and in the future.

Thank you.

4:10

MR. DEPUTY SPEAKER: The hon. Member for Calgary-Foothills, followed by Edmonton-Gold Bar.

MRS. BLACK: Thank you, Mr. Speaker. I'm pleased to participate today in Motion 213, a motion advocating the establishment of an advisory committee to examine the policy implications of right-to-die legislation.

Mr. Speaker, my colleague from Calgary-Fish Creek has asked us today to confront a highly contentious issue head on. He's asked that we debate an issue which some of us may believe is better dealt with by philosophers, theologians, and scholars. Yet there comes a time when we all must be prepared to deal with the fact that we are mortal creatures and sooner or later we will die.

The reality is that many of us will not simply pass away peacefully in our sleep. It appears that with the perks of life in an industrial city have come many dangers and even dire health conditions. Our fast-paced world has seen the advent of death in car accidents, plane crashes, and vicious killings. But what happens if one does not die quickly? What happens while one is lingering in a hospital hooked up to a machine? The frightening reality is that death does not always take us swiftly. Perhaps a dreadful car accident has left you in a vegetative state and you have no conscious connections with your physical world. As frightening as this may be, imagine the despair experienced by your family as they witness this near-death state day after day, year after year.

[Mr. Jonson in the Chair]

Mr. Speaker, these realities a certain Hippocrates never had to face when he came up with his famous oath. Yet from Hippocrates our medical community and indeed our society have obtained and promoted a belief in the sanctity of life which must be preserved at all costs. This belief in the sanctity of life is a noble ideal, which in normal circumstances must be adhered to. Unfortunately, as I've pointed out, some medical circumstances are very far from normal. We've come a long way from Hippocrates. He never had to deal with defibrillators, respirators, and heart machines. He never had to deal with the fact that we are now able to maintain human life artificially.

Canada is one of the few jurisdictions which has no official policy with respect to euthanasia and living wills. Moreover, we have no provisions which formally recognize legitimacy of living wills or durable powers of attorney. In Holland, for example, euthanasia is practised without criminal or civil prosecution. In 1984 provision for the validity of living wills was formalized in a Supreme Court decision that stated: mercy killing is not punishable if it is carried out in the context of an emergency situation and results from the physician's careful consideration of his conflicting duties and responsibilities.

In the United States individual states have specific legislation dealing with living wills, durable powers of attorney, and of course euthanasia. Many individual states support the right to refuse medical treatment in the form of living wills. However, with respect to durable powers of attorney some individual states will limit the decisions an attorney can made regarding medical treatment decisions after the principal becomes incompetent.

As I pointed out, Canada does not have an official policy regarding euthanasia. However, we have conducted several significant studies regarding the legal, moral, and ethical questions associated with legalizing euthanasia. In 1983 a major study undertaken by the Law Reform Commission of Canada entitled Euthanasia, Aiding Suicide and Cessation of Treatment endeavoured to answer three questions pertaining to euthanasia: one, should active euthanasia be legalized, or at least decriminalized; two, should aiding suicide be decriminalized by the repeal of section 241 of the Criminal Code; and three, should various sections of the code be revised to define the legal parameters regarding the refusal and cessation of medical treatment. The commission, Mr. Speaker, concluded that neither active euthanasia nor aiding suicide should be legalized and recommended that the present law with respect to these two areas be retained.

Regarding the cessation of treatment and palliative care, the commission recommended, first, that amendments be made to the Criminal Code to ensure that criminal liability would not ensue from administering palliative care which resulted in the shortening of life. Second, they recommended that the code be amended to ensure that it could not be interpreted to require a physician to continue to administer or to undertake medical care against the express wishes of a patient; also when the treatment would be therapeutically useless and not in the best interests of the patient. Finally, Mr. Speaker, they recommended that there be clear and formal legislative recognition of the competent patient's right to refuse medical treatment or to demand its cessation.

The findings of the commission are significant for a number of reasons. First, this was the first federal study which suggested significant changes to the Criminal Code, the result being that in certain circumstances doctors could legally turn off life-sustaining machines or withhold treatment. Secondly, it is significant because it did not favour legalization of active euthanasia or aiding suicide. The commission felt that there were too many risks associated with this, particularly when they considered the potentiality of incorrect diagnosis, the likelihood of a discovery of a cure, and the possibility of abuse.

In Alberta an initiative spearheaded by the Alberta Law Reform Institute in November of 1991 called Advance Directives and Substitute Decision-Making in Personal Health Care dealt specifically but not exclusively with living wills. They recommended that legislation be introduced to enable individuals to execute a health care directive in which they could appoint someone as their health care agent who would have the authority to make health care decisions on their behalf in the event that they become incapable of making these decisions personally, that they could identify anyone whom they did not wish as their health proxy, and they could provide instructions and information concerning future health care decisions.

4:20

Mr. Speaker, in my opening comments I mentioned that my colleague from Calgary-Fish Creek has confronted us with a highly contentious issue. I feel that he has, but I feel that he's been very responsible, because in fact this is an issue that is coming at us from all directions. It's an issue that we are going to have to deal with sometime.

The comments made by the Member for Edmonton-Centre: I agreed with most of his comments. We're dealing with an issue that draws upon our faith, our moral values, our principles, and it is very difficult to come to conclusions as laymen.

When I think back on my own personal upbringing, I was raised to believe that where there was life, there was hope. That was a fundamental in our belief. But I will say that in the last year and a half we in our family have gone through the death of three family members, all of whom had very strong religious, moral backgrounds. Two of those family members had terminal diseases. One of them was cancer, one was Alzheimer's disease,

and the other member developed an emergency situation that became life threatening.

[Mr. Deputy Speaker in the Chair]

When we were dealing with our grieving and our losses in our family and the emotional trauma and with the people who had the illnesses within the family, it became very difficult for all members – the patient and family members – to make decisions. The member who had been diagnosed with terminal cancer had made a decision she did not want to be put on life-support machines, and that was her choice. With the member who had Alzheimer's, his decision wasn't there for him because of a competency level. If anyone has ever gone to try and prove competency or incompetency within our courts when you're dealing with a family member, I can guarantee you will never want to go through that process, because it is the most demoralizing, humiliating experience that anyone should have to be put through. We elected not to make that choice because there was such a thing that we felt was important: that he should have dignity and that he should have dignity until the end.

The last situation in our family started off to be a simple cold and through a lot of unforeseen complications, some errors developed into a situation very quickly that involved respirators, heart machines, et cetera. The patient, because it happened so quickly, didn't have the opportunity to say: "I don't want to be put on a life-support machine. Don't put me on a respirator; that is not what I want."

Living wills would have provided that direction. When you're standing there and you're watching a family member and you have a machine that's going bleep, bleep, bleep and missing a few, and you're asked a question, "How long do you want this machine to continue on?" you know that if you were in a different emotional state and you were talking around a table, that person would have said, "Don't ever do that to me," but you're drawn in. You can't make that decision. You go back to your faith that says that where there's life, there's hope, and you believe in that, and then you get into the contradiction. A living will, if people had that, would have had their desire, their belief, and their wishes carried out. In essence what happens is then the family is drawn in, and the family isn't sure, and it goes on and on.

I will say that in the end, when our patient, our family member died, it made me realize how artificially we sustain life, because we were there, and when he died – actually from heart failure, which was different from what he was being monitored for; his heart gave out – it was hard to believe he was dead because the respirator was still pumping his lungs as if he was alive. He was artificially, visibly looking like he was alive, but he was in fact dead. In fact, he had died three months prior, and he was artificially maintained.

I know, when we went through our grieving portion in our family and we still are, he never would have wanted that. He would have liked to have just died, but we could not make that decision. I think if he'd had that opportunity in a living will, Mr. Speaker, he would have made the decision. I know he would not have believed in artificial life because he enjoyed life to the fullest when he was out and about.

So, Mr. Speaker, I support this motion by the Member for Calgary-Fish Creek I guess probably because we've experienced this this last year and a half. But I think it is very important that we look at right-to-die legislation and we strike a committee of people who have the theological background, the scholarly background, and the medical background who are capable of reviewing this and bringing something forward, because with the advent of the high technology in the medical profession, I don't think people are really prepared for the artificial interference in sustaining life. I guess this is something where we're going to have to draw upon ourselves and all our faith to believe that as we believe that God is a God of love, he would never want anyone to suffer. That's my personal religious background. Other people have their own. That's what got us through the trauma of the suffering and the mourning that we went through as a family.

I would ask all members to support Motion 213 to establish an advisory committee to examine the policy implications of right-to-die legislation.

Thank you, Mr. Speaker.

MR. DEPUTY SPEAKER: The hon. Member for Edmonton-Gold Bar.

MRS. HEWES: Thank you, Mr. Speaker. Just a few comments on this motion. I first of all want to thank the Member for Calgary-Fish Creek for bringing it forward, and I do intend to support it.

Mr. Speaker, this is a very complex contemporary subject. Thirty, 40 years ago we didn't need to talk about some of these things, but today it is imminent. It's an urgent subject, and I think the member in bringing forward the motion has suggested a means to us to begin to deal with the very complex medical/ethical problems that other members have spoken about. While I sympathize with the Member for Edmonton-Centre's idea that we should have a more comprehensive bioethical committee, I think that perhaps the Member for Calgary-Fish Creek, in putting this forward – this is a way we can begin perhaps with one part of this very complicated contemporary subject.

Mr. Speaker, other members have spoken about the rapid advances in medical technology. To be sure, we are very grateful for the immense advances that have been made – some to prolong life, to ease suffering, to effect remarkable cures – but the technology, as has been pointed out, can also rob us of the capacity to die with dignity. That, I think, is illustrated when we see people such as the Karen Quinlan case that became so famous some years ago or in the more recent one in Quebec of Nancy B., where the quality of their lives had ceased to have meaning. In Nancy B.'s case she was in a position to make that decision herself, and in essence she said her own living will. She communicated that.

4:30

Mr. Speaker, I'm grateful, too, for the tremendous developments in palliative care that aids people and their families through the process of the last months or weeks or days of life, but it comes right down to who makes the decisions. Who's going to make the decision? I think the work that was done by the Alberta Law Reform Institute is very carefully leading us in the right direction. I like their title better than the idea of living will, which I think has some implications of a will as a piece of legislation that only comes into effect when you are in fact dead. That's our understanding of it. In the case of the Law Reform Institute, they describe advance directives and substitute decision-making in personal health care, and I think that puts it in a rather more positive light. But the question is: who will make the decisions? Not every spouse, not every mate or dear friend or family member wants to be the proxy decision-maker or is able to. I think, therefore, we need methodology that allows the individual to maintain the control and, along with others in the family, to either name an individual to be responsible for the decision-making or to leave directives or both. The Law Reform Institute's paper covers

that very well. The idea is to leave the decisions about who and how in the hands of the individual.

Now, we know that right-to-die legislation is nothing new. It's present in a variety of U.S. states and enforced or adhered to with law, but not so in Canada. We don't have that legislation here, and I feel that it's high time that we should look at it.

Mr. Speaker, there is, of course, an assumption that if we have an advisory committee examining the policy and they come to us with recommendations, there will be some compelling reason to act. I think we have to accept that responsibility, and I believe that's what the member intended, that this will move us towards some legislation, some regulations, some means to act that will give force to the capacity of people to leave directives regarding their health care. I've had a number of excellent pieces of material to read in this regard, and I'm sure other members have availed themselves of them as well. I have a few quotes from them.

Mr. Speaker, in 1977, before my time in this House, Dr. Walter Buck set a precedent. He introduced Bill 242, an Act Respecting the Withholding or Withdrawal of Treatment Where Death is Inevitable. The Bill gave patients a right to reject medication or help needed to prolong their life when that was not desired. Of course, the Bill was not passed, but in 1977, those many years ago, Dr. Walter Buck was speaking about the issue.

Mr. Speaker, our province, of course, has no defined or legislated living will arrangement. There are two pieces of legislation that deal with the issue of authorizing a person to make medical decisions regarding another individual. One is the Dependent Adults Act. It recognizes the power of guardians and would allow the guardian to make decisions with respect to medical treatment if the patient is medically incapable of doing so. I had that experience with my own mother, who died almost four years ago and who was not capable of making decisions, and it was up to me to determine with the doctor whether any heroic measures were to be taken. I had a great deal of help from family members and advice in that regard, and my mother died peacefully, without all of the gadgetry that would, I'm sure, have terrified her. In Alberta psychiatric patients, of course, are exempt from that Act. They're covered under the Mental Health Act. Bill 10 of last year establishes the power of attorney which can be used for medical conditions affecting the patient directly. Unfortunately, these two Bills leave an obvious gap. Individuals who require or want serious medical decisions to be made on their behalf would have to have had protection under those two pieces of legislation. They'd have to have them both in place. With living will legislation, individuals could be assured of having their wishes with respect to medical treatment recognized.

Mr. Speaker, the definitions that I have found in my reading of living wills differ slightly. The issue here is to write a document that takes control and keeps control in the hands of the individual. One definition is that a living will is a document which indicates that the person who signs it will refuse a particular treatment, or several particular treatments, or any treatment at all where a decision has to be made regarding whether or not to continue to treat the patient and where the patient himself is no longer capable of expressing his wishes. That's a legal definition. The other one that I prefer comes from an excellent paper that I'd be glad to share with other members, if they haven't already seen it, from the Provincial Senior Citizens Advisory Council, 1985. It's a background paper on living wills, and their definition is as follows:

> A Living Will may be defined as a document wherein a competent adult with no reasonable expectation of recovery from a disability expresses a desire that they be allowed to die rather than kept alive by artificial or heroic means. In general terms a Living Will sanctions the concept of passive euthanasia.
>
> However a Living Will need not merely refuse treatment. This document allows a person to express their desires regarding the course of treatment and the situations wherein that treatment is not desired. Therefore such a document could indicate that that person wishes all means including extraordinary means to be utilized should they become terminally ill.

So it provides for positive as well as negative actions.

> The term "Living Will" is really a misnomer in that the term "Will" is a document which takes effect at the time of death . . . In contrast, the Living Will take effect during the lifetime of the person drawing up the will.

This is an excellent paper, Mr. Speaker, and I do commend it to members.

Mr. Speaker, the motion put before us today responds to, I believe, the demonstrated public demand for inquiry into examining the policy implications of enacting right-to-die legislation. The seniors' paper also described, I thought in good detail, what the issues are. The issues are the right to die; the right to refuse treatment, which results in death; the rights of the mentally incompetent adult patient; the criteria for the determination of death; euthanasia and assisted suicide; and the civil and criminal liability of health care professionals, the last one being an important issue that we have not had mentioned. I don't believe the Member for Calgary-Fish Creek included that in his comments, and I'd be grateful for his thoughts on that final point.

Further, Mr. Speaker, I have an excellent paper titled Advanced Treatment Directives and the Living Will, by Dr. John B. Dossetor, who is a highly respected ethics professor at the University of Alberta. This paper I think contains some very helpful and useful comments. It was given May 7 of this year. Dr. Dossetor in his paper deals with euthanasia, that some people see the subject of advance directives as ultimately leading to indirect euthanasia. He goes on to say:

> Personally, I strongly hold to the opposite view: that knowledge of advance directives will take some of the fear out of dying, and this will reassure people that they will be cared for as they would wish and only treated to the extent that had been previously decided. Patients will gain confidence, through advance directives, that their suffering will be relieved, that burdensome treatments which they do not want will not be forced upon them, and they will not demand to be killed once they know they will be in control.

I think Dr. Dossetor's paper describes the very essence of what the Member for Calgary-Fish Creek is trying to get us to put our minds to in the motion that he's put forward: that we need to study it, we need to have an advisory group to look at it carefully, to consult with people in Alberta, and to bring us some recommendations. The Law Reform Institute has 26 excellent recommendations in their document, and I understand that there's to be a further one coming from them. I'd be grateful, too, for any comments from the Attorney General in regard to that document.

4:40

Mr. Speaker, there are, of course, some concerns that one must consider. The wording of future legislation must be very direct and straightforward in order to avoid the chance of any vague interpretation by officials, doctors, attorneys, family members, even clergymen. Possible areas of contention regarding interpretations are that decisions could be based on financial or administrative reasons rather than on the moral and ethical question. Financial implications could sway in certain circumstances an interpretation of right-to-die legislation pertaining to a specific individual. Another is: how far would medical consent or rejection be adhered to and recognized in respect to treatment, life-support systems, artificial feeding, or accommodations, for

instance, in a nursing home? Then there is fear that right-to-die legislation could lead to euthanasia or assisted suicide. In general terms, a living will could possibly sanction the concept of passive euthanasia.

Mr. Speaker, the motion, however, urges on all members the establishment of an advisory committee. If the committee were to be established, it could begin by studying these 26 recommendations from the Law Reform Institute's paper. I understand that a final report from the institute will come out this fall.

Mr. Speaker, the general problems that I see are that the notion of living wills may in fact be in conflict with the Charter, so we may have to resolve some things around that incompatibility. Right-to-die legislation is an ethical and moral question, in my view. There are strong advocates on both sides of this question, so of course we would want the committee to have wide consultation with the public and with the care givers and the experts on the subject. If implemented, the medical field could feel that they may be defeated in their Hippocratic oath, their purpose to prolong life. If not brought in, the patient's desires and requests could be continually denied. Due to complications, right-to-die legislation is both hard to legalize and, on the other hand, hard to drop from any mandate.

The possible advantages that some other members have spoken to are: it could bring much less physical and mental suffering to the patient, the family, the friends; it could lower the costs of health care, with less money spent on this highly sophisticated technology to prolong life when it's futile; more spaces in our hospitals and nursing homes; possible promotion of organ transplants; peoples' wishes could be honoured. The member has mentioned the Jehovah's Witness incident.

Disadvantages would be that in situations of heart attacks and car crashes, a person's life may be stopped when they still have a chance to survive. Patients may die against their family's and friends' wishes. In certain cases, if a person's wish changes and they are considered mentally incompetent to make their own decisions, they would be subject to their trustee's decision.

Mr. Speaker, the Premier's Commission on Future Health Care for Albertans, the Hyndman commission, also addressed this issue. Their recommendation called for legislation to be introduced two years ago. Our caucus supported this recommendation with some qualifiers, some amendments, recognizing the importance of empowering individuals to make decisions regarding their health care as well as personal and financial matters. We did stress, however, that the concept of living wills should be given thorough public consultation before any legislation is drafted. The government's response to Hyndman evades any proper answer, in my view. They make a slight reference to Bill 10, claim they are presently addressing the problem further, refer to the study by the Alberta Law Reform Institute, and suggest they're waiting for it.

Well, Mr. Speaker, I think the time for waiting is over. I agree with the Member for Calgary-Fish Creek and other members who have spoken that it's important, the subject is urgent, the subject is upon us every day, and there is no need to wait any longer. I think this is a responsible motion to put together a committee to examine policy implications for this Legislature and for the people of Alberta.

Thank you, Mr. Speaker.

MR. DEPUTY SPEAKER: The hon. Member for Drayton Valley.

MR. THURBER: Thank you, Mr. Speaker. I'd like to stand in support of this motion. I've long been an advocate of right-to-die or living will legislation of one sort or another because I think as all of us go through life, we've experienced circumstances that bring this home to bear on you, where you see an elderly person who's in a coma and totally incapable of doing anything for themselves. They lie in a hospital bed for sometimes years; their mate comes to see them every day and wishes there was something they could do one way or the other, and it's impossible to do it.

With the advancement of technology certainly people live a lot longer, and this is certainly a tribute to research and the implementation and development of that research. In actual fact, people can conceivably be kept alive indefinitely and in some cases are, but the word "alive" in my view must have some meaning and some quality to it. In some cases, where a cure is imminent or appears possible, this may be justified. In some cases it does work, if you're able to keep them alive long enough to have a cure developed and maybe help them in the long term in that way, but in other cases people have begged to be let die. For a variety of reasons, relatives or doctors have made a decision to keep that person alive, without their permission and with a very loose translation of the word "alive," a very different one than that person may wish.

A friend of mine some years back became very ill. This man had been very active all his life on a small ranch. "Alive" after his illness in his case meant being tied to various paraphernalia, tubes and wires, and in his view this was not life at all. He was not able to talk or move or visit or, a lot of times, recognize his friends and relatives. This interpretation was not what he wanted and not what he wished. For this man there was no dignity for him to be, in somebody else's view, alive. In one of his more lucid moments, after about six weeks or a little better, he successfully disconnected the tubes and wires and thus enforced his wish to die rather than to accept this so-called life. He should not have had to go through this agony. As I said before, it was a case where his mate came to see him every day and wished that she could do something. The doctors wouldn't unhook him. They didn't have the right to. They didn't have the ability to or the legal wherefore to. If legislation were in place to allow a person to make this decision while in good health, that person would have been able, at a certain time according to his instructions, to die with dignity.

4:50

Mr. Speaker, this should not be left in the hands of judges or some outsider to decide; I think we should all have that right. Living wills and right-to-die legislation should be in place. I don't believe anyone should be forced by law to have a living will. I think the opportunity should be there to have a living will or a right-to-die statement of some sort, and it may be done when they get hurt or become ill or it may be done at some point earlier in their life. We can draw up a will leaving our property to somebody else. We can do that at any point in time in our life, and the latest will that we draw up becomes valid upon our death. Why can't we have a living will? You may make it out when you're only 20 years old, and if it's not changed, then you'll have to deal with it at that point in time. There are a lot of people who feel that it may be misinterpreted and that things may happen other than what they wish in a living will, but for people who feel strongly about this opportunity, the opportunity should be there. As I said before, I'm a great advocate of it and have been for many years.

I realize, Mr. Speaker, that in order to facilitate this, the Criminal Code of Canada has to be changed. It would appear to me that the Criminal Code and the Charter of Rights are sending mixed signals to us. No person is entitled to consent to have death inflicted on him, yet if somebody is not treated by a doctor,

it's illegal for him to not treat, and when he starts treatment, it's illegal for him to stop. I think these are some things that have to be dealt with, because that's where the problem lies, in the Criminal Code.

I know, Mr. Speaker, there are other people that wish to comment on this, but I would hope that this debate will be recorded and will send a message to the people that are dealing with the Criminal Code, to the federal Justice people, that we in Alberta would wish to have something done on this and as soon as possible, because the issue is becoming more complicated and more urgent all the time with the advent of the newer technology and the whole problem within the health care system of keeping people alive longer than they wish.

MR. DEPUTY SPEAKER: The hon. Member for Calgary-Glenmore.

MRS. MIROSH: Thank you, Mr. Speaker. I, too, would like to offer my comments and compliments to the Member for Calgary-Fish Creek on Motion 213, advocating the establishment of an advisory committee to examine the policy implications of right-to-die legislation.

Mr. Speaker, I find it very ironic that in 1992 I'm standing here discussing in the Legislative Assembly building the right to die. In 1962 my first assignment as a student nurse was this very subject. It was a subject that had been debated prior to that time as well: the right to die, the definition of euthanasia, the dignity in death, and so on. Many nurses and medical people have debated this issue year after year after year. Following my essay on the right to die, I then had to practise what I wrote.

It's easy for people to stand here and talk about the right to die and deal with death and the issues. When you're a medical person, it's a split-second decision. There's no time to debate. There's no time to ask people whether they have a will, what their rights are. You do what is right. As has been stated many times, the right of the dying is that a patient should always be presumed to want to live. That's always been an unwritten code of ethics in the medical profession. Normally, these decisions are made in a hospital or in a situation whereby you make a split-second decision, whether it's a car accident, someone entering into emergency or into the intensive care unit.

Mr. Speaker, I remember as a student nurse, when I was in intensive care, dealing with a young man who was in a terrible accident where an elevator shaft had come onto his head at one of our local wheat elevators. I remember interns coming around to this patient's bedside and saying: "Why are you nurses working so hard on this young boy? He's going to die. Let him die with dignity." Those were the days when a lot of technology was just beginning, and it just seemed right that we should give this young boy every chance and every right to die but also, most importantly, to live. Mr. Speaker, we saved that young boy, and he became a normal human being in society. What right is it of us to decide whether that young man should have died or continued to live? That moment we decided, as medical people, to let everyone live that had the chance, was still breathing, and it is still an unwritten code of ethics that in the medical profession you give everybody a chance and the right to live.

Later on, during the years after I had graduated in nursing, I realized that there were so many life and death situations and times where we did save people who did become vegetables and probably should have been left to die. Those are difficult decisions. I also remember making decisions in car accidents with regards to young people who were of the Jehovah's Witness faith and we didn't know at the time. Had the parents been there and not given the written consent, those young people would have been left to die and had no right to die. They were normal human beings. All they needed was a blood transfusion, and they were then saved and continued to live a normal life.

As years went by, I became a board member of a long-term care hospital. I then had the chance to move around the hospitals and realized the number of elderly people who are institutionalized who really want to die, who really feel that there is no quality in life left. Now we are at the stage in 1992 of who makes that decision on that right to die. Who really does make that decision? When you're looking after people with cancer, you give them a lot of analgesics to take away the pain, and you increase it and you increase it. You take away all the life-support systems, and really, I think, the right to die is usually made by nature.

Sometimes people would like euthanasia, the act of mercy. Many times medical people would certainly like to have that right. Families would like to have that right. But when it comes right down to making that decision and who does give that act of mercy or euthanasia, no one really wants to do it; nobody, no medical person. This is why doctors are split on this decision, this is why the commission has come up with a report that has no answers, because what is legal and what is ethical and what is moral and what is religious?

So we come here now, in 1992, still debating the same issue of the right to die, the dignity in death, and euthanasia. There are many, many examples of people you've already alluded to who've been written up in newspaper issues, but there are many people who haven't, who have been saved and have continued to live on and live a very normal life. Especially with children, who makes that decision whether this person should go and that person should live? I sure wouldn't want to be the person to make that decision.

Mr. Speaker, with this advisory committee to examine policy, I think we have to go deeper into what the actual law is. When I was a student nurse, we were told that as long as the person is brain-dead, that was death. At times we were told that when the heart stopped, that was death. Who makes that decision? Is it an advisory committee? Is it a group of doctors? Is it a group of lawyers, judges? I don't know if we'll ever come up with an answer on euthanasia and the act of mercy and the right to die.

Thank you for giving me this opportunity to speak on this topic – it's a difficult one – and thank you to the Member for Calgary-Fish Creek for bringing it to this House.

MR. DEPUTY SPEAKER: The Member for Edmonton-Highlands.

MS BARRETT: Thank you, Mr. Speaker. I'm really pleased that the Member for Calgary-Fish Creek is sponsoring this motion. I'm quite impressed, actually. It's got to be the most progressive motion sponsored by a Conservative MLA that I've seen in the 10 years that I've been here, and it's timely. [interjection] That's true; I was a researcher before I got elected, so I'm celebrating my 10th year of working in this building. Anyway, I'm really pleased that I'm able to make a couple of comments, especially having heard just the last few minutes of the Member for Calgary-Glenmore's observations. I had to be out of the House for a while, but I kept the speaker on downstairs and heard some of the debate.

My sister is a nurse, and I recognize that what the Member for Calgary-Glenmore is saying is absolutely true. As individuals the question of right to die is not one that individuals want to answer. However, I think we can work towards a very flexible policy, which I think is really what the Member for Calgary-Fish Creek was getting at. Let's not just set up an advisory council. I mean, you know, let's find out if there are guidelines that can be

flexible, that can allow family input, that can allow the concept of living wills to play a legal role. Why not? We are in a day and age where this kind of question is going to come up and hit us in the face whether we like it or not, so as elected representatives we might as well deal with it. It's certainly true that we will have to do work at the federal level as well in order to get legal sanction for any policy that would be a change from the current laws.

5:00

Now, it seems to me, Mr. Speaker, that one of the ways we could do this is maybe send it to the centre for medical ethics. Such a thing exists on paper; it doesn't have any funding by the provincial budget right now. I believe it should have some funding. I think that this is precisely the kind of thing that a whole bunch of health care providers – and let's talk specifics: philosophers with a concentration, a specialty, in ethics, lawyers, people who between them can have a real glimpse of the complexities that go with right-to-die rules.

I don't know if you ever talk about right-to-die legislation, although it does exist in other countries. I think what we have to talk about is a framework for right-to-die options, and it's not an easy thing for anybody to work out. Ordinarily, when I see a motion calling for another commission, I think, "I've had enough of the Trudeau years; I don't want any more commissions." But in this case I think that we do need an organization filled with people whose areas of expertise can dovetail to concentrate on what amounts to an issue of ethics and how we can handle it. I would hope that this motion would pass, and if it does, I hope that the Health minister, perhaps with the Member for Calgary-Fish Creek and others, would contemplate even a small amount of funding to get the centre for medical ethics up and operating so that they can start to take a look at this issue.

I can tell you from experience – now, this is bad experience, unfortunately – like the Electoral Boundaries Committee struck by the Legislature. That just took forever to get through, and then we had to get the commission, and that took a long time to get through. If I think that took a long time, that's nothing compared to how long it would take a group of people to come up with a framework. Let's not kid ourselves; it's a couple of years' project at the very least.

On the other hand, I can tell you that I can't cite locations or individuals, but being the health care spokesperson for this caucus for the last eight months, I have been exposed to an immense amount of information, including dilemmas that happen right on the ward, when the parents say, "Please declare such and such dead" for the purposes of removing the plug, or they're asking the health care professionals to participate in a decision that they are not legally entitled to make. I cannot say I know of such instances actually having occurred, but I have heard of such instances having occurred. I personally believe that they have occurred, although as I say, I can't cite you chapter and verse individuals or hospital locations.

The pressures are already there, and some are going to succumb to the pressure whether the law allows that person to do so or not. In some instances, it will be the direct relative of the person who is either very near death or has expressed wishing to die under certain circumstances, such as losing their ability to communicate, et cetera. We know about the case in Quebec a few months ago. It was heart-wrenching, but the conclusion was that the court said, "Yes, if you still want to be basically unplugged from the life-support system after Christmas, you shall be given the right to do so." We shouldn't have to have an environment in which every case like this goes to court. The poor woman knew what she wanted. Now, having been given the option, I don't know if she's exercised the option. Does anybody know about the Quebec woman who was paralyzed from the neck down? Did she exercise the option?

AN HON. MEMBER: Yes, she did.

MS BARRETT: Well, that's a brave soul, but the fact is that she had to go to court to do that. I don't think that individuals should have to go to court every time. I think if we provide a framework for the options to be exercised, that's all anybody can ask of us as legislators. Remember, passing this motion is just step one. Even when we get the recommendations from our committee or the centre for medical ethics, it's got to go all the way up the ladder to the federal government.

Anyway, I'd like to do my part in making sure that this motion passes. As I said to the Member for Calgary-Fish Creek at the conclusion of his opening comments, I have never heard that member speak for so many minutes consecutively. I can tell the issue is one of deep concern to him. I like the way he's approaching it. I think it's a very sensitive approach to this subject, and I for one don't want to be on my feet at 5:25; I want this motion to pass.

MR. DEPUTY SPEAKER: The hon. Member for Bow Valley.

MR. MUSGROVE: Thank you very much, Mr. Speaker. I, too, would like to congratulate the Member for Calgary-Fish Creek on this very important motion. In this province we have all kinds of programs so that people can live with dignity, but we've yet to have a program where people can die with dignity. I believe that living wills are something that are very important. However, I have to also say that it would be a very, very complex piece of legislation, so I also would have to agree that we need a committee to review the options on living wills.

As the chairman of the Seniors Advisory Council for Alberta I get quite involved in gerontology conferences, and of course bioethics and living wills are always a very high priority in those discussions. Now, I've also heard a lot of comments from my own medical doctor and from others saying that they are keeping people alive in some of our extended care institutions that for whose own good it would be better if they withdrew their life supports.

There is another concern, and we hear it from the people that already have done some work on living wills, and that is that it has to be worded so that it is well understood who will be involved in the withdrawal of life supports. I am reminded of an accident that a person working in a logging camp had at one time. As a matter of fact, that particular person happened to be my brother-in-law, and he was brought to the hospital in Edmonton and was termed terminally injured. He lived on life supports completely for one and a half months. That was over 20 years ago, and although still somewhat maimed by the accident, he has lived a normal life since that time and has even worked for quite a number of years after he had recovered from the injuries. So you have to be concerned that the words "terminally ill" are not interpreted by someone as something that is different than the intent was.

We do know now that living wills are practised in some cases. Although no one knows or seems to be able to tell us whether it is actually legal for them to practise living wills, it's still done and hasn't been challenged in court at this time. But the interpretation of whether or not it's time to take away the life supports has got to be very strongly indicated when the legislation is written. We have all kinds of examples at the present time of what we could

be using in these cases, but we are always cautioned on the writing of the legislation so that it cannot be interpreted any differently from what the meaning of it is. Mr. Speaker, I really think the same as all other members that have spoken to this motion, that it is very, very important that we do pass some legislation for living wills, but I also agree that it has to be very carefully done.

I would recommend that we support this motion, Mr. Speaker.

5:10

MR. DEPUTY SPEAKER: The hon. Member for Highwood.

MR. TANNAS: Thank you, Mr. Speaker. I'd like to make a few comments; first of all, to compliment the hon. Member for Calgary-Fish Creek. I appreciated the comments of my colleague for Calgary-Glenmore when she got into the issue of what is death, and I'd like to move a little along from that in the sense of what is quality of life.

During the Second World War a number of naval officers and men as well as air crew and army individuals suffered severe burns, usually related to gasoline explosions and that kind of thing, particularly air crew. When these burn victims had recovered to a certain extent and were able to view themselves in the mirror, they were horrified to see the burns that they had sustained to their heads and faces. Many people reacted – I guess it's a normal reaction under those circumstances – with depression and, in many instances, wished to die. There's a wonderful story there of the medical service and how they restructured people's faces and got people to come to grips with a quality of life that they could have that wasn't related to the cosmetics of their faces. Some active people who, through accidents or illness, suddenly become quadriplegic or paraplegic have felt that they have lost the quality of life that sustains their desire to continue to live. So I think we need to take into account what is the quality of life. What are we going to set up as the right to die? Is it when the heart stops and the brain goes dead, when the quality of life, whatever that might be, no longer makes it meaningful?

I remember in grade school hearing a wonderful poem about an Eskimo lady, now called Inuit, who had lived many winters, seen many snows fly. This was a particularly hard winter, and they broke camp this day and on went the family, but she did not go. She stayed. She was no longer useful to her family. She was now a drag on her family, and she decided that she would stay, and the poem spoke about this kind of reality. One can only think about the situation that may occur in accident scenes or battlefields, that kind of thing.

The right to die, for me, is an issue of nonextraordinary treatment. I think of a constituent of mine who recently died of a very painful type of cancer. In her last days there was no heroic intervention; what was there was a comfort support. I can think of another senior, 89 years of age – failure of circulation to the lower parts of her legs requiring, because gangrene had set in, amputation. They could go into marvelous life-support things in these instances. It seems to me in those kinds of instances there should be some choice by rational people as to the ending of these extraordinary treatments and that the support be not a life support but a comfort support. We have in some medical institutions a no-code rule, and as the hon. Member for Edmonton-Gold Bar alluded to, sometimes family members instruct the hospital in cases of their loved ones, "Please, do not use extraordinary intervention," in case of a sudden deterioration in their heart condition or whatever.

I think this is a motion that brings to many of us situations in our family life that cause us to reflect and feel that we need right-to-die legislation. Mr. Speaker, I wish to support this motion.

MR. DEPUTY SPEAKER: The hon. Member for Wainwright.

MR. FISCHER: Thank you, Mr. Speaker. I, too, would like to speak for a few moments on Motion 213. Certainly when I read this motion, I would like to be able to support this motion because dying with dignity is certainly one of my objectives as well. I think it should be something that is common sense that should prevail within our society today.

[Mr. Jonson in the Chair]

I just have a little bit of reservation about putting in some more legislation when we talk about another right, a right to die that was already a natural right that somehow or other we should have had all the way through, and possibly a committee to study it would show us the many things that took that right away. I'm sure that God made us to begin with. He put us on this Earth. He gave us food and water. He gave us everything there is in this great land that we have to feed us, to nourish us, to provide entertainment for us, and to give us a livelihood. When He put us here, possibly He should be the only one, then, that should take us away. I really believe that man should not be continually interfering with that.

When we talk about the right of dying and a living will, we are talking about liabilities, responsibilities. Whose is it? Soon we have the lawyers coming in, and there are lawsuits in our health care system now. Certainly within the union movement there's a certain amount of fear put into the health care givers. They're afraid to death. The union will say, "We're going to protect you; you pay us a little bit more." I wonder, if you had the right to die, what impact that would have on all our health care givers, because it would put more liability, responsibility on to them.

There's one thing that I have to say: when I go, I surely don't want to have lawyers and government making the decision of whether or not I have that right. I really believe that that is a right, if I'm not capable of doing it – and certainly with the number of drugs that we have and the medicine that's given in today's world, we don't always have our senses about us and we wouldn't be able to make the decision at that time. So I would have to say that I want my family and I want my doctor to help me make that decision. I would like to have a written will or maybe an unwritten will, if you like, or at least some kind of a policy that the rest of my friends or my family understood so that we could do that and do it together. I think a family goes through an awful lot of things in a lifetime together, and that's one of the things that we have to be prepared for, and we have to have some people who can make those very careful personal decisions. I just have a lot of reservations about that.

5:20

[Mr. Speaker in the Chair]

I can recall a number of people who have maybe fooled the system a little bit, and they have gotten a lot out of life after they would have been written off. It just seems to me that if there's something left in a human being and he has an opportunity to enjoy life, then I would hate to have somebody look at a living will that said, "I have the right to die." Somebody might interpret that will just a little bit differently than the next person, especially if you did get better again and you had another year or two.

I had a friend of mine that the nurses and everybody had given up on. They thought that he was dead, and the next morning he was going again. He lived for about a year and a half afterwards and got a lot out of life as well. He was a cancer victim, and

everyone had thought he was going to go. In that particular case, had there been a living will, I guess they would have unhooked him and let him go. I don't know; I guess we can all have some pretty mixed feelings about that. I can recall another man that broke his spinal cord that had nothing – they had tried for a year and a half. In a lot of pain, he went everywhere possible to try and get rid of the pain and get some kind of improvement. There was none, and he lived in pain for another couple of years and begged to die. Every time you went to visit him, he wanted to die. He didn't mind telling you that there was no hope left and he would like to end his life. In that case, I think it would have been humane to have let it happen. As it turned out, he eventually got pneumonia and it happened shortly after anyway, but it is very difficult for people to be making those decisions, and circumstances are entirely different.

Mr. Speaker, I would like to say about this motion that I can agree that we could study it, but I sure would have my reservations about putting in the actual right-to-die legislation.

Mr. Speaker, in view of the hour I move that we adjourn debate.

MR. SPEAKER: Having heard the motion, those in favour, please say aye.

SOME HON. MEMBERS: Aye.

MR. SPEAKER: Opposed, please say no.

SOME HON. MEMBERS: No.

MR. SPEAKER: The motion carries.
Deputy Government House Leader.

MR. ANDERSON: Mr. Speaker, I move that this evening the Assembly resolve itself into Committee of Supply in order to deal with the Department of Public Works, Supply and Services in estimates and that we therefore now adjourn until the committee rises and reports.

MR. SPEAKER: Having heard the motion, those in favour, please say aye.

HON. MEMBERS: Aye

MR. SPEAKER: Opposed, please say no. The motion carries.

[The Assembly adjourned at 5:25 p.m.]