FUTILE OR FRUITFUL: THE CHARTER AND THE DECISION TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENT

Glen Rutland*

1. Introduction

Whether from a tragic accident, or a long and protracted illness, there can come a point where health care practitioners, spouses, parents or other family members must decide whether potentially life-sustaining treatment should be withheld or withdrawn from a patient no longer competent or capable to consent. Often a consensus is reached based on knowledge of the wishes of the patient through an advanced directive or some other previous expression of their wishes. Other times, a consensus is reached through recognition that further treatment is of no benefit to the patient. All involved agree it is in best interests of the patient to withhold or withdraw life-sustaining treatment.

In Canada, it has been acknowledged that physicians “pull the plug” on incompetent patients daily without any interference from the law.¹ In the United Kingdom, the Intensive Care Society estimates 15,000 people die annually in intensive care wards and that most result from the withdrawal or limiting of treatment.² The question one is left with is what happens when the recommendation of the health care practitioner conflicts with

---

* Glen Rutland, Law Clerk Saskatchewan Court of Appeal, Regina, Saskatchewan. The author thanks Dr. Barbara von Tigerstrom for her comments and guidance on earlier drafts of this paper. This paper was written while the author was on education leave from the Government of the Northwest Territories. The views expressed in this paper are his own.


the expressed wish or advanced directive of an incompetent patient, or that patient’s substitute decision-maker? Although provinces and territories in Canada have enacted statutes governing issues of consent, advanced directives, and/or substitute decision-making for incompetent patients, the question of who has the final authority when a demand for life-sustaining treatment is made has not been answered by statute.  

When substitute decision-makers or family members disagree with the recommendation of a health care practitioner, aside from an informal dispute resolution system that may exist under hospital policy, the only recourse appears to be the courts. Although case law suggests this decision is to be made by the doctor, it remains unresolved as to whether there could be a rights-based argument in favour of life-sustaining treatment. In the English case of *Burke*, a rights-based argument succeeded at trial but was later overturned on appeal. In Canada, although *Charter* implications of end-of-life decisions have been raised on interlocutory applications, a full *Charter* argument has not been made. This paper examines whether a *Charter* argument would be futile or fruitful in challenging a decision to withhold or withdraw life-sustaining treatment. The author considers other *Charter* cases, the *Burke* and *Burke CA* decisions, and case law from Canada and Australia.

This paper focuses on challenging a decision to withhold or withdraw life-sustaining treatment from an incompetent or incapable patient. It is generally accepted a competent or capable patient can refuse life-saving or life-sustaining treatment. The issues related to whether a competent

---

3 Ontario, British Columbia, Prince Edward Island and the Yukon have comprehensive consent legislation, while Alberta, Manitoba, Newfoundland and Labrador, the Northwest Territories, Nunavut and Saskatchewan have legislation providing for advanced directives and substitute decision-making. See Patricia Peppin, “Informed Consent” in Timothy Caulfield, Jocelyn Downie & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 3d ed. (Markham: Lexis Nexis, 2007) 189 at 213.

4 *R (Burke) v. The General Medical Council*, [2004] EWHC 1879 (Admin) [*Burke*].

5 *R (Burke) v. The General Medical Council*, [2005] EWCA Civ 1003 [*Burke CA*].


7 These cases, including *Sawatzky, Jin* and *Golubchuk* are discussed in detail later in this paper.


patient can refuse to consent to the withdrawal of treatment requires separate exploration.

2. The State Of The Common Law

(a) Canada
In Canada, the starting point for the authority to withhold or withdraw treatment of an incompetent patient is the case of *R.L.* In this case a child, apprehended because of alleged abuse, was in a persistent vegetative state (PVS). Child and Family Services, based on their governing statute, obtained an order allowing them to provide consent for the doctors to impose a do not resuscitate (DNR) order on the child. The parents appealed the order. The Manitoba Court of Appeal held that “neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction, where in his or her judgment, the patient is in an irreversible vegetative state.” As for the wishes of the parents, or the child’s Guardian, their wishes should be taken into account, but their consent or approval is not required.

A slightly different conclusion was reached in *London Health Sciences.* In this case, the patient was an 80-year-old man on life support. The family initially opposed a DNR order, but had consented to discontinuing life support by the time the matter went to court. Justice McDermid noted that as the family now consented, he was “no longer required to decide whether the existing artificial life support systems may be withdrawn.” However, he was not prepared to state that a physician has a legal right in these circumstances to withdraw life support. Instead, because of the moral, ethical, legal and religious issues involved, he believed this was a question best dealt with by Parliament rather than the courts.

---

In Sawatzky\textsuperscript{16}, a Manitoba Queen’s Bench decision, the certainty of R.L. was questioned. This case involved a successful application for an interlocutory injunction by Mr. Sawatzky’s wife to prohibit the hospital from imposing a DNR order until a decision on the merits could be made at trial. In her judgment, Beard J. noted Canadians would be “surprised to learn that a doctor can make a ‘do not resuscitate’ order without the consent of a patient or his or her family, yet that appears to be the current state of the law in Canada.”\textsuperscript{17} She went on to suggest when there is a disagreement over the decision to provide, withdraw or refuse treatment “there is a role for the courts to play in making factual determinations and advising of the legality or illegality of disputed decisions before the patient is dead.”\textsuperscript{18}

Justice Beard noted that the effect of Charter rights or the Manitoba Human Rights Code was not considered in R.L.\textsuperscript{19} She granted intervenor status to the Manitoba League of Persons with Disabilities (MLPD) because “the nature of this case, being one raising significant Charter issues, would support the granting of intervenor status.”\textsuperscript{20} The MLPD believed the DNR order violated the right to life and security of person under s. 7; that it deprived Mr. Sawatzky of the right to equal protection under law as per s. 15; and questioned whether the action of withholding treatment subjected Mr. Sawatzky to cruel and unusual treatment contrary to s. 12.\textsuperscript{21} As Sawatzky never proceeded to trial, argument on the merits of the Charter issues never took place.

In Holland\textsuperscript{22} at issue was the refusal of substitute decision-makers to consent to the withholding or withdrawal of treatment, as their Catholic mother, the incompetent patient, believed that “where there’s life there’s hope”.\textsuperscript{23} The doctor, believing the substitute decision-makers were not acting in the best interests of the patient, challenged their decision through an application to the Ontario Consent and Capacity Board. The Board agreed with the doctor and directed consent be given, but this was overturned on

\textsuperscript{17} Ibid. at para. 5.
\textsuperscript{18} Ibid. at para. 38.
\textsuperscript{19} Supra note 10 at para. 26.
\textsuperscript{21} Ibid. at para. 27.
\textsuperscript{22} Holland v. Holland et. al., 2004 CanLII 34326 (ON Sup. Ct.).
\textsuperscript{23} Ibid. at para. 85.
appeal. Although Charter issues were raised on appeal, they were not determined as the decision was overturned on the grounds that the Board erred in its interpretation of the statute. Justice Cullity stated that the Charter issues should “be left to be determined in subsequent cases in which the Board has properly interpreted the statute and applied its provisions to the facts before it in accordance with section 21.”

In 2006 an application for an injunction against a DNR order was made in Nova Scotia in Yeung. Mr. Yeung’s wife sought to have a DNR order on his chart removed to provide time to see whether a traditional Chinese remedy would work to address his cancer. Mr. Yeung went into cardiac arrest and died before the application was decided.

In Jin at issue was whether a DNR order should be continued. The family of Mr. Jin sought an interim injunction preventing the hospital from imposing a DNR order. When considering whether to grant interlocutory relief, the judge found the case involved a serious issue. It was noted, “[t]here is no statute in Alberta which addresses this issue, the common law is not clear and the question has constitutional underpinnings and implications.” Although not directly referencing the Charter, it is reasonable to assume Martin J. was referring to the Charter implications of the decision to withhold or withdraw treatment as there are no identifiable issues or legislation that could be considered ultra vires of the jurisdiction of the province.

The Charter implications of withholding or withdrawing treatment were raised in the 2008 Manitoba case of Golubchuk. At issue was the decision to disconnect a ventilator sustaining Mr. Golubchuk’s life. As the matter was an application for interlocutory relief, the issue for determination was not the merits of the decision, but whether an interim injunction preventing health care providers from removing life-support systems should be continued before trial. The application was successful.

24 Ibid. at para. 104.
25 As Mr. Yeung died before a decision was made, the application was withdrawn and the case never decided or reported. See Jocelyn Downie, “Assisted Death at the Supreme Court of Canada” in Jocelyn Downie & Elaine Gibson, eds., Health Law at the Supreme Court of Canada (Toronto: Irwin Law, 2007) 219 at 239-40.
28 Ibid. at para. 1.
In applying the test for interlocutory relief, Schulman J. considered whether there were serious or material issues of law in question and found that “it is not settled law that, in the event of disagreement between a physician and his patient as to withdrawal of life supports, the physician has the final say.” Justice Schulman considered the questions of whether the plaintiff had a right to continuation of life-sustaining treatment under the Charter, or at common law, were questions still left open to be resolved. Finally, Schulman J. noted that in Sawatzky, it was “held that there was an untested triable issue relating to the applicability of the Charter to the actions of doctors or the Hospital.”

One issue raised in Golubchuk that was not up for determination at this stage but was expected to be argued had the matter gone to trial was the issue of the Charter protected right to freedom of religion. Mr. Golubchuk was an orthodox Jew and the plaintiffs argued that their refusal to consent to the withholding or withdrawal of treatment was based on his genuinely held religious belief. Charles Weijer, in an article on whether cardiopulmonary resuscitation for patients in a PVS is futile or acceptable medical treatment notes, “[i]n the Orthodox Jewish faith, there is a religious obligation to seek out and accept life-prolonging treatment.” The refusal to consent to withholding or withdrawing treatment is consistent with this religious obligation.

Only one week after the decision in Golubchuk, an application for an order that life-sustaining treatment be reinstated was unsuccessful in British Columbia. In Rotaru, the issue of the application of the Charter was not discussed. It is possible this issue was not raised because the applicant was self-represented and not familiar with the legal arguments available under the Charter.

29 Ibid. at para. 25.
30 Ibid.
31 Ibid.
32 Supra note 6 at s. 2(a).
33 Supra note 27 at para. 10.
Justice Burnyeat distinguished Rotaru from Golubchuk as there was no conflicting medical evidence as to the condition of the patient\(^{36}\), and further, it was not an application to prohibit health care providers from withdrawing treatment, but to order that treatment be reinstated.\(^{37}\) The relevant question was whether the courts could order health care practitioners to reinstate treatment that “is in their \textit{bona fide} clinical judgment...contra-indicated.”\(^{38}\) In answer to this question, Burnyeat J. held that it would be an abuse of the power of the court “to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient.”\(^{39}\)

Although Charter issues were raised in several interlocutory applications, no final determinations were made as the patients died before the matter went to trial. As these cases show, time is a significant challenge when opposing a health care practitioner’s decision to withhold or withdraw treatment. They do however indicate that courts do not yet feel this issue has been resolved and have recognized that there is, at minimum, a serious possibility that the Charter would apply to this decision.

(b) United Kingdom

The call by Beard J. in Sawatzky for a role for the courts is closer to the state of the common law in the United Kingdom. In \textit{Bland}\(^{40}\), the House of Lords held that the withdrawal of life support, specifically artificial nutrition and hydration (ANH), was not illegal without a court order, however for at least some time, an application should be made to court for approval before any decision to do so. It was believed that court review would protect patients and doctors, and reassure patients’ families and the public.\(^{41}\)

The England and Wales High Court in \textit{MB}\(^{42}\) took the view that the consent of family members is irrelevant to the final decision. This was the case of an infant hospitalized almost since birth. The doctors brought an application to withdraw life-sustaining treatment. The Court stated that although it must be mindful to the views of the parents, those views are “wholly irrelevant

---

\(^{36}\) \textit{Ibid.} at para. 19.
\(^{37}\) \textit{Ibid.} at para. 15.
\(^{38}\) \textit{Ibid.}
\(^{39}\) \textit{Ibid.} at para. 16.
\(^{40}\) \textit{Airedale NHS Trust v. Bland (acting by his Guardian ad Litem), [1992] UKHL 5, [1993] 1 All ER 821.}
\(^{41}\) \textit{Ibid.} at 19.
\(^{42}\) \textit{An NHS Trust v. MB, [2006] EWHC 507 (Fam) [MB].}
to consideration of the objective best interests of the child.”\textsuperscript{43} It has been suggested that the position of the court in \textit{M.B.} was that determining the child’s objective best interests remains solely the court’s responsibility.\textsuperscript{44}

In \textit{Burke} the applicant, Oliver Leslie Burke, was competent at the time of the application. He suffered from cerebellar ataxia, a degenerative neurological condition, and knew in the future he would require ANH in order to survive.\textsuperscript{45} Medical evidence at trial indicated that he would likely “retain full cognitive faculties even during the end stage of this disease” and would be aware of the “pain, discomfort and extreme distress that would result from malnutrition and dehydration.”\textsuperscript{46}

In his application, he sought clarification as to the circumstances in which doctors may withdraw ANH, and challenged the lawfulness of the Guidance issued on this subject by the General Medical Council (GMC).\textsuperscript{47} Burke believed\textsuperscript{48} the Guidance was unlawful in certain respects as it violated his rights under Articles 2 (right to life), 3 (right to protection from inhuman or degrading treatment), 6 (right to a fair hearing), 8 (right to respect private life) and 14 (prohibition of discrimination) of the European \textit{Convention for the Protection of Human Rights and Fundamental Freedoms}.\textsuperscript{49}

In what can be described as a comprehensive and exhaustive 225-paragraph judgment, Munby J.\textsuperscript{50} reviewed the case law in this area and, controversially in the opinion of some commentators, placed considerable emphasis “on the ‘absolute nature’ of the right to respect for autonomy and self-determination.”\textsuperscript{51}

\begin{itemize}
\item \textsuperscript{43} \textit{Ibid.} at 16.
\item \textsuperscript{44} Joan Gilmour, “Death, Dying and Decision-making about End of Life Care” in Timothy Caulfield, Jocelyn Downie and Colleen M. Flood, eds. \textit{Canadian Health Law and Policy}, 3d ed. (Markham: LexisNexis, 2007) 437 at 458.
\item \textsuperscript{45} \textit{Burke}, supra note 4 at para. 1.
\item \textsuperscript{46} \textit{Ibid.} at para. 5.
\item \textsuperscript{47} \textit{Ibid.} at para. 1.
\item \textsuperscript{48} \textit{Ibid.}
\item \textsuperscript{49} Council of Europe, \textit{Convention For the Protection of Human Rights and Fundamental Freedoms}, P.A., ETS no. 005 [\textit{Convention}].
\item \textsuperscript{50} Munby J., prior to his appointment to the Court was the Barrister on behalf of the Official Solicitor in the \textit{Bland} case, supra note 18 at para. 7.
\item \textsuperscript{51} J.K. Mason and G.T. Laurie, “Personal Autonomy and the Right to Treatment: A Note on R (on application of Burke) v. General Medical Council” (2005) 9 Ed. L. Rev. 123 at 127.
\end{itemize}
Justice Munby concluded health authorities and the National Health Service Trusts were public authorities for the purposes of the *Human Rights Act* and as such, were required to act in a manner consistent with the rights of a patient under the *Convention*. He then found that “the dignity interests protected by the Convention include, under Article 8, the preservation of mental stability and, under Article 3, the right to die with dignity and the right to be protected from treatment, or from a lack of treatment.”

Based on these conclusions, he held that in the presence of a clearly expressed wish to the opposite in a valid advanced directive, a decision to withdraw ANH at any stage before Burke finally lapsed into a coma would in principle involve clear breaches of Articles 3 and 8. He did note that it would not be a breach of these rights where, in the case of a patient who is being treated with dignity, ANH is “withdrawn in circumstances where it is serving absolutely no purpose other than the very short prolongation of life of a dying patient who has slipped into his final coma and lacks all awareness of what is happening.”

With the England and Wales Court of Appeal’s damning dismissal of *Burke*, one wonders whether a rights-based argument could again be successfully advanced. However, a review of the decision reveals the potential remains. Also, the argument advanced in *Burke* can be informative as to the content and likely success of a similar rights-based argument made in Canada.

One challenging aspect of applying *Burke* is the unique situation where the applicant was still competent. Translating this decision to the position of an incompetent or incapable patient is questionable. It was for this reason the Court of Appeal dismissed the action, finding that the relief claimed extended beyond what was necessary to adequately allay any concerns Mr. Burke had. The Court was of the view that the decision to withdraw treat-

---

52 (U.K.), 1998, c. 42.
53 *Supra*, note 4 at para. 117.
57 *Burke CA*, supra note 5. See also, Foster, *supra* note 2 at 1 where he describes the Court’s resounding criticism for Burke’s lawyers and the Court’s finding that Burke’s concerns were legally groundless.
58 *Burke CA*, supra note 5 at para. 16.
ment such as ANH cannot lawfully be made against the express wishes of a competent patient to stay alive.\textsuperscript{59}

However, the Court went on to deal with many of the issues raised in the trial judgment, noting that the common law duty of a doctor to continue to treat a patient once they have taken them into their care is not absolute. There is no duty to keep a patient alive by ANH where a competent patient refuses treatment, or where a patient is not competent and it is not considered in their best interest to continue treatment.\textsuperscript{60}

The Court of Appeal also dealt with the principles of autonomy and self-determination heavily relied upon by Munby J. The Court found that these principles do not entitle a patient to insist on receiving a specific medical treatment regardless of the nature of the treatment.\textsuperscript{61} The Court found there was no positive right to demand health care treatment that is adverse to a patient’s clinical needs.\textsuperscript{62}

Finally, in what could be considered a small but significant step away from \textit{Bland}, the Court stated there was no legal duty to obtain court approval for the withdrawal of ANH in the circumstances identified by Munby J. in the trial judgment.\textsuperscript{63} The Court notes there are times when it would be advisable for a doctor to seek approval of the decision from the Courts,\textsuperscript{64} but the court does not “authorize” treatment that would be unlawful, it simply makes declarations that the proposed treatment or withdrawal of treatment is lawful.\textsuperscript{65}

In dealing with the appeal, the Court conceded that much of the body of the judgment was uncontroversial and a correct statement of the law, but advised counsel against selectively using or parsing the judgment.\textsuperscript{66} What this leaves then is the potential for further exploration of the rights-based argument. It is unclear whether Munby J. was wrong in his analysis or simply that he went too far in setting out binding propositions of law.\textsuperscript{67}

\begin{tabular}{l}
\textsuperscript{59} \textit{Ibid.} at para. 53. \\
\textsuperscript{60} \textit{Ibid.} at para. 33. \\
\textsuperscript{61} \textit{Ibid.} at para. 31. \\
\textsuperscript{62} \textit{Ibid.} at para. 55. \\
\textsuperscript{63} \textit{Ibid.} at para. 70. \\
\textsuperscript{64} \textit{Ibid.} at para. 71. \\
\textsuperscript{65} \textit{Ibid.} at para. 80. \\
\textsuperscript{66} \textit{Ibid.} at para. 24. \\
\textsuperscript{67} \textit{Ibid.} at para. 22. \\
\end{tabular}
a different fact scenario, the possibility for a rights-based argument remains to be made.

Burke CA also addressed the question of what weight should be given to a valid advanced directive requesting all life-sustaining treatment be provided. The Court noted that while in Bland it was held that “an advance directive that the patient should not be kept alive in a PVS should be respected, we do not read that decision as requiring such a patient to be kept alive simply because he has made an advance directive to that effect”.68

(c) Australia

In Australia, ANH is generally considered a medical procedure that sustains life, and not solely palliative care. As a result, it is treated like other medical treatments. In the case of an incompetent patient without an advanced directive or a substitute decision-maker, a physician, in consultation with the family, may withdraw treatment.69

However, some limits on this power were established in Northridge.70 In this case, Annette Northridge succeeded in obtaining both interlocutory and ongoing relief against the doctors, hospital and health authority to ensure the provision of life-sustaining treatment to her brother, John Thompson. In this case the hospital had stopped ANH, placed Mr. Thompson under a DNR order and was withholding antibiotics.

Justice O’Keefe relied on the court’s parens patriae jurisdiction to order that Thompson be provided the necessary and appropriate medical treatment directed towards preserving his life and the promoting of his good health and welfare. He concluded the court had jurisdiction “to act to protect the right of an unconscious person to receive ordinary reasonable and appropriate (as opposed to extra-ordinary, excessively burdensome, intrusive or futile) medical treatment, sustenance and support.”71

Further, O’Keefe J. stated that the “court also has jurisdiction to prevent the withdrawal of such treatment, support and sustenance where the withdrawal may put in jeopardy the life, good health or welfare of such uncon-

68 Supra note 5 at para. 57.
71 Ibid. at para. 24.
Justice O’Keefe held that in the cases of disputes, there was a role for the court to play. He conceded the final decision was a medical one, but “where there is doubt or serious dispute...the court has the power to act to protect the life and welfare of the unconscious person.”

In the Messiha decision, a family unsuccessfully sought an order against a doctor’s decision to remove Mr. Messiha from intensive care, withdraw life-sustaining treatment and place him on palliative care. Justice Howie distinguished Northridge noting that in this case there was an absence of any medically substantiated evidence suggesting Mr. Messiha was not in a deep coma state.

Justice Howie considered the role and power of the court in end of life decision-making. He noted that courts are not bound to give effect to the medical opinion, even where, as here, it is unanimous. However, it seems to me that it would be an unusual case where the Court would act against what is unanimously held by medical experts as an appropriate treatment regime for the patient in order to preserve the life of a terminally ill patient in a deep coma where there is no real prospect of recovery to any significant degree.

In considering his final decision, Howie J. seemed to indicate a presumption in favour of the medical opinion noting the court “is in no better position to make a determination of future treatment than are those who are principally under a duty to make such a decision.”

(d) Conclusion

In Australia and the United Kingdom, the courts will generally act as a final arbiter of the best interests of a patient, particularly when the decision to withhold or withdraw life-sustaining treatment is in dispute. In the United Kingdom, even in cases such as Bland, where there is agreement between

---

72 Ibid.
73 Ibid.
74 Isaac Messiha (by his tutor Magdy Messiha) v. South East Health, 2004 NSWSC 1061.
75 Ibid. at para. 26.
76 Ibid. at para. 25.
77 Ibid. at para. 8.
the family and the health care providers, it appears the courts remain willing and able to play a role in confirming the decision.

In Canada, the identity of the decision-maker is unclear when one considers R.L. against the more recent cases reviewed above. In all jurisdictions, there exists a reliance on medical opinion, and it appears courts may be less likely to intervene where there is unanimous medical opinion supporting the withholding or withdrawal of life-sustaining treatment.

Although this is the prevailing common law position in these jurisdictions, the Burke decision in England, Sawatzky and the recent Canadian decisions of Jin and Golubchuk seem to highlight a potential rights or Charter-based argument that substitute decision-makers or families could mount to challenge the decision of a health care practitioner to withhold or withdraw treatment. Although the post-Golubchuk decision of Rotaru did not address the issue of a rights-based argument that may have been the result of a self-represented applicant. Also, this situation in Rotaru was distinguished from Golubchuk, likely not closing the door that has been opened to a potential rights- or Charter-based argument.

The discussion of whether another rights-based argument against the withholding or withdrawal of life-sustaining treatment could be successfully made in England will be left for another to review. However, using the experience of Burke, other Charter cases and the door that has been opened in Sawatzky, Jin and Golubchuk, the potential for a successful Charter- or rights-based argument in Canada is explored in the remainder of this paper.

3. Futile Or Fruitful: A Charter-based Challenge In Canada

Although the question of whether Charter rights are at stake in decisions to withhold or withdraw life-sustaining treatment was first raised in 1998\(^78\), there has yet to be a reported judicial determination of this question. The Supreme Court of Canada was faced with, and ruled against a Charter challenge to the criminal prohibition on assisted suicide\(^79\); however no case has been found involving the question of withholding or withdrawing life-sustaining treatment.\(^80\)

\(^78\) Sawatzky, supra note 16.


Returning to the scenario where there is an incompetent or incapable patient who has expressed the wish for treatment either through a valid advanced directive or through a substitute decision-maker, but the health care practitioners responsible wish to withhold or withdraw life-sustaining treatment, how would a family member or substitute-decision-maker challenge this decision?

(a) Informal Dispute Resolution
The first avenue is informal dispute resolution through the hospital. The Canadian Medical Association Joint Statement on Resuscitative Interventions recommends health care facilities develop a conflict-resolution mechanism for decisions on resuscitative interventions, ensuring sensitivity to cultural and religious differences.\(^8\) A similar recommendation is included in the Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care.\(^8\)

If the dispute cannot be resolved informally, then it will likely end up in the courts, as was done in *Sawatzky, Jin, Golubchuk* and *Rotaru* and other cases for resolution. An initial application for a court order will need to be made. Generally the authority to do so can be found in statute, or as was done in Australia, through the inherent *parens patriae* jurisdiction of the courts.\(^8\)

(b) Interlocutory Relief
As was the case in *Sawatzky, Yeung, Jin* and *Golubchuk*, if health care providers are either prepared to, or have already made the decision to withhold or withdraw life-sustaining treatment despite opposition, interlocutory relief

---


83 Supra note 70.
must be sought. As noted above, it is often difficult to achieve a resolution through the courts before a patient has succumbed to their illness. Time is also critical in the obtaining of interlocutory relief. A family must act quickly to prevent the withdrawal of treatment, or to ensure treatment is restarted or no longer withheld before a serious health event, such as respiratory or cardiac arrest occurs.

To obtain an interim injunction preventing the withdrawal or withholding of life-sustaining treatment, the standard test for interlocutory applications applies. There are three elements to this test: is there a serious legal issue in dispute, would there be irreparable harm done if the relief is not granted, and does the balance of convenience favour granting of the remedy.\(^84\)

The first element, is there a serious legal dispute, seems to be easily met by the door that has been opened in *Sawatzky*, *Jin* and *Golubchuk* and by the general uncertainty around the common law. In all three cases, it was noted that a serious legal issue existed, specifically identifying *Charter*, human rights or constitutional issues as potentially being in question. Also, all the judges believed there was uncertainty in the common law as to whether doctors had the ultimate decision-making authority as initially found in *R.L.*\(^85\)

The second element of the test, whether grave irreparable harm will occur if the relief sought is not granted, is also easily met. Judges have recognized there is a risk of death if the interim injunction or order is not granted, and that damages would not be an adequate remedy, as no relief would adequately compensate should the plaintiff be successful at trial, but the patient dies in the interim.\(^86\)

The third and final element, whether the balance of convenience test favours the granting of the relief, is the only element that may serve as a hurdle to a successful application. It appears that success on this element is very fact driven, however interlocutory applications in *Sawatzky*, *Jin* and *Golubchuk* were successful on this ground.

In *Sawatzky*, a DNR order had not previously been in place, and the court felt on a balance of convenience it was acceptable to maintain the


\(^85\) See above for how the Courts in these three cases dealt with the issue of whether there was a serious issue in dispute.

\(^86\) *Supra* note 16 at para. 18.
status quo that had been in place for five months. In Jin, simply changing Mr. Jin’s status from a Level Two to a Level One on the hospital’s existing classification system would ensure he would receive life-saving treatment without requiring elaborate or special instructions. In Golubchuk, interlocutory relief would maintain the status quo, and this would not raise serious ethical issues for the doctors and therefore favoured granting relief.

The other common thread in these cases was disagreement in medical opinion about the status of the patient and this seemed to support interlocutory relief. Had Rotaru been considered as an interlocutory matter, it is unlikely to have achieved success as there was a clear consensus of medical opinion that further treatment was futile. Also the balance of convenience would have been a greater hurdle as the application sought reinstatement of care rather than maintenance of the status quo or reinstatement of an order about care. In Australia, the degree of consensus in medical opinion of the patient seems to be the key difference in the results in Northridge and Messiha. It was even noted in Messiha that it is unlikely a court will overrule unanimous medical opinion on the benefit a patient will or will not receive from life-sustaining treatment.

If successful in obtaining interlocutory relief and treatment continues to be provided or offered, the family or substitute-decision-maker must prepare to make their substantial rights-based argument. To do so, they must first show the Charter applies to this situation.

(c) Application of the Charter

Section 32 of the Charter limits its application to Parliament, legislatures, governments and government actors who have been delegated authority. In many ways, this may be the greatest barrier to advancing a rights-based challenge. If a claimant is unable to convince a court the Charter applies to the decision to withhold or withdraw life-sustaining treatment, they will be unable to make a rights-based argument. The only remaining option would be to craft a discrimination argument under the relevant provincial human rights code.

87 Supra, note 16 at para. 30.
88 Supra, note 26 at para. 42.
89 Supra, note 27 at para. 28.
90 Supra, note 74 at para. 25.
91 Although the constitutionally protected rights in the Charter apply only to
There are four options for arguing that the decision to withhold or withdraw life-sustaining treatment falls within the *Charter*: arguing that hospitals are government actors or are implementing government policy; challenging the guidelines established by state-authorized regulatory bodies as was done in *Burke*; arguing that the common law authority to withhold or withdraw treatment is unconstitutional; and by asking the court to exercise its *parens patriae* jurisdiction in a manner consistent with the *Charter*.

The first option is to argue that the common law in Canada has now recognized that even if there is not a right to health care, the *Charter* applies to the delivery of health care. Although, the Supreme Court of Canada first held that the *Charter* does not apply to the day-to-day operations of a hospital in *Eldridge*, the court held that hospitals “act as agents for the government in providing the specific medical services set out in the Act.” Although Peter Hogg says the Court erred in characterizing the delivery of medical services as an exercise of statutory authority, Martha Jackman argues this was a significant shift from earlier jurisprudence and that combined with *Chaoulli*, it is now clear access to health care and government decision-making relating to access to health care falls within the *Charter*. Adèle Kent points to *Eldridge* to support the conclusion there is now “no doubt about the application of the Charter to the provision of medical services”.

Governments, provincial human rights legislation does apply to private operations within the province. Due to space limitations, the form and likelihood of success of a challenge under provincial human rights legislation is not examined in this paper.

If the provision of specific medical services does bring hospitals within the *Charter*, how does this apply to doctors as independent contractors and not employees of the hospital? An argument could be made that doctors in providing treatment and making decisions about the allocation of health care resources act as government agents in the same manner and therefore a doctor making a decision about the withholding or withdrawal of treatment could fall under the *Charter*. Jackman agrees, writing, “Justice LaForest’s analysis in Eldridge would appear to be equally applicable to individuals as to institutional care givers.” 99 In cases where the dispute between the family and the doctor results in the involvement of the hospital or health authority, an argument for the application of the *Charter* becomes stronger.

The second option for the application of the *Charter* is to challenge the guidelines established by the regulatory bodies of health care practitioners. This was the approach taken in *Burke*. This approach, although with some basis in law, would likely not be successful. It could be argued that provincial governments have, through statute, delegated their power to regulate the medical profession to the relevant provincial bodies. As an exercise of delegated government authority, this power must be exercised in a manner consistent with the *Charter*.

Where this argument struggles is in how this authority has been exercised. Only one provincial body, Manitoba’s, has created binding rules for end-of-life decision-making. 100 The majority of bodies, unlike the GMC Guidance in *Burke* 101, have not issued firm statements on who has authority to make the final decision on withholding or withdrawing treatment when there is not consensus on the best interests of the patient. In Ontario, the College of Physicians and Surgeons has issued a Policy Statement 102 which offers suggestions and directions but refers serious disputes to the legisla-

---


101 Supra, note 4 at paras. 9-17.

tive scheme for consent and substitute decision-making or to the courts. The Canadian Medical Association’s Code of Ethics frames this as an ethical rather than legal issue.\textsuperscript{103} Manitoba’s policy statement creates a process for physicians to follow when the withholding or withdrawing of life-sustaining treatment is being considered. As a statement is a formal position of the College with which members must comply,\textsuperscript{104} an argument could be made for judicial review of the policy’s compliance with the \textit{Charter}.

If it is accepted that there is, as per \textit{R.L.}, a common law authority for doctors to withhold or withdraw life-sustaining treatment then the best route may be to argue that this common law authority is inconsistent with the \textit{Charter}. This approach was discussed in both \textit{Sawatzky}\textsuperscript{105} and \textit{Golubchuk}\textsuperscript{106} where the judges stated they must develop the common law in a manner consistent with \textit{Charter} values. The Supreme Court in \textit{Dolphin Delivery}\textsuperscript{107} stated there is no doubt the \textit{Charter} does apply to the common law\textsuperscript{108} when there is some form of government intervention. However, even in situations of disputes between private litigants the Court must apply and develop the common law in a manner consistent with the \textit{Charter}.\textsuperscript{109}

In \textit{Northridge}, the authority for granting an order requiring the provision of treatment was made under its’ \textit{parens patriae} jurisdiction, a prerogative jurisdiction of the Crown delegated to the courts.\textsuperscript{110} In Canada, the \textit{Charter} would apply to how the courts exercised this jurisdiction, for example whether the Court’s decision on whether to withhold or withdraw treatment is consistent with the \textit{Charter}.\textsuperscript{111}

In conclusion, of the four possible methods for determining whether the \textit{Charter} applies, there are three arguments with a reasonable chance of meeting the threshold of government activity and engaging the \textit{Charter}. The

\begin{itemize}
\item \textsuperscript{103} \textit{Canadian Medical Association, Code of Ethics}, (Ottawa, Canadian Medical Association: 2004), online: Canadian Medical Association <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.
\item \textsuperscript{104} \textit{Supra} note 100 at 15S-115.
\item \textsuperscript{105} \textit{Supra}, note 16 at para. 29.
\item \textsuperscript{106} \textit{Supra}, note 27 at para. 25.
\item \textsuperscript{107} \textit{RWDSU v. Dolphin Delivery Ltd.} [1986] 2 S.C.R. 573, 33 D.L.R. (4\textsuperscript{th}) 174.
\item \textsuperscript{108} \textit{Ibid.} at para. 25.
\item \textsuperscript{109} \textit{Ibid.}, at para. 39.
\item \textsuperscript{110} \textit{Supra}, note 70 at para. 15.
\item \textsuperscript{111} See Hogg, \textit{supra} note 94 at pp 93-95 for a discussion of the application of the \textit{Charter} to courts and court orders.
\end{itemize}
first is through reliance on *Eldridge* and similar case law, the second by challenging a College’s policy, or third, challenging the common law authority to withhold or withdraw treatment.

Once the *Charter* is engaged, a number of hurdles must still be met; first, choosing which right to rely upon; second, meeting the test for a breach of that right; and third, showing the breach is not saved by s. 1 of the *Charter*. In the next section, four *Charter* rights are reviewed for their potential in challenging a decision to withhold or withdraw treatment.

**(d) Freedom of Religion**

The potential for a right-based argument on freedom of religion was raised in *Golubchuk* and *Holland*. Section 2(a) of the *Charter* guarantees everyone the freedom of religion; however, this can be limited by s. 1. Although it is common for religions to respect and value the sanctity of life, several religions have a particularly deep belief in the sanctity of life, and their beliefs oppose the aiding of death or the withdrawal of treatment. These include Orthodox Judaism, fundamental Protestants and conservative Catholics.112

In England, *S.A.*113 considered the question of religious beliefs where a family opposed the decision to withhold and withdraw treatment. The family members, including their father, the incompetent patient, were practicing Muslims and had received advice from an Imam that discontinuing treatment was contrary to the Islamic religious faith and belief system.114 This argument received little attention and support. The Court gave the religious beliefs less weight when assessing the best interests of the patient. The reason offered for this lower value was at one point the family, under the belief their father would die within minutes of removing treatment, did consent to the withdrawal of treatment.115 In Canada, such an argument would likely receive greater consideration and be given more weight when framed in the context of a *Charter* challenge and on different facts.

Hogg notes that in the absence of a compelling government interest to the contrary, s. 2(a) of the *Charter* requires the law to accommodate minority religion practices.116 He points to the Court’s decision in *Amselem*117 where

---

112 *Supra* note 34 at 492.
116 *Supra* note 94 at 255.
the majority noted its jurisprudence supports the view that freedom of religion includes not only the right to hold the beliefs but to undertake practices associated with those beliefs.\(^{118}\)

The freedoms and practices included within s. 2(a) are quite broad. The courts have gone as far as finding this includes the right to refuse life-saving blood transfusions for children based on the parent’s religious beliefs.\(^{119}\) However these freedoms can and have been limited, as it was in that case,\(^{120}\) by a valid state objective under s. 1.

For a claim under s. 2(a) a family must show that the incompetent or incapable patient held religious beliefs inconsistent with the withholding or withdrawal of treatment. In determining the religious beliefs of an incompetent patient, the test for these beliefs should not be onerous and in fact, should be a subjective one. In \textit{Amselem}, the Court found it is the spiritual element of an action, not its obligatory nature that is important. A claimant must sincerely believe in the significance of the practice in question and the inquiry into the sincerity of this belief should be as limited as possible.\(^{121}\)

The issue of religious freedom and the right to demand continued life-sustaining treatment was raised but not resolved in \textit{Holland}. The substitute decision-makers refused to consent to the withholding or withdrawal of treatment as their Catholic mother, the incompetent patient, believed “where there’s life there’s hope”.\(^{122}\) The doctor, believing the substitute decision-makers were not acting in the best interests of the patient, challenged their decision before the Ontario Consent and Capacity Board. The Board agreed with the doctor and directed consent be given, but was overturned on appeal.

One ground of appeal was that the \textit{Act},\(^{123}\) as applied by the Board violated s. 2(a) of the \textit{Charter}. The Board had found the religious beliefs of the patient not relevant, as the Catholic Church “had no fixed guidelines regarding treatment at all costs for the purpose of prolonging life when there was no prospect but death sooner or later.”\(^{124}\) On appeal, it was noted, “it is the fact

\(^{118}\) \textit{Ibid.} at para. 46.
\(^{120}\) \textit{Ibid.}
\(^{121}\) \textit{Supra} note 117 at paras. 47-51.
\(^{122}\) \textit{Supra} note 22 at para. 85.
\(^{124}\) \textit{Supra} note 22 at para. 78.
and not the correctness, of the belief to which weight and significance are to be attributed for the purposes of section 21(2).”\(^{125}\) The Court appeared to indicate that at a minimum these views should be considered, and the focus should be on the sincerity of the belief itself.

In addition to the challenge based on s. 2(a), the Board’s decision was also challenged under ss. 7 and 15 of the \textit{Charter}. However, no decisions were made on any of these arguments. The decision was overturned because the Board erred in law in its interpretation of the statute. Justice Cullity felt the \textit{Charter} issues should “be left to be determined in subsequent cases in which the Board has properly interpreted the statute and applied its provisions to the facts before it in accordance with section 21.”\(^{126}\)

As to whether a rights-based argument could be successful in this context, the majority decision in \textit{R.B.} is informative. In that case, the court held that the right of a parent to refuse a life-saving blood transfusion for their child based on religious beliefs is protected within s. 2(a). However, a majority of the Court believed the statutory scheme allowing the state to assume guardianship and authorize a transfusion was saved by s. 1 as the state interest in protecting the lives of children at risk is a pressing and substantial objective.\(^{127}\)

The argument for protecting children at risk, their vulnerability and inability to make their own decisions, can translate to the position of incompetent patients. Incompetent patients are vulnerable and unable to make their own decisions. Why should the state not protect, respect and accommodate their religious beliefs when it comes to a decision on whether to withhold or withdraw life-sustaining treatment?

This issue may be resolved through an analysis of the best interests of the patient; although the \textit{Charter} requires this concept of best interests be influenced by the religious beliefs of the patient. At some point, even the most strongly held religious beliefs may have to be compromised if the treatment provided is so harmful that it hastens death or violates the sanctity of life. Short of this, and in the absence of a compelling government objective, a sincerely-held religious belief in not withdrawing or withholding treatment should be respected. Given the small number of cases that end up in the courts for resolution, there is little argument that could be made under s. 1

\(^{125}\) \textit{Ibid.} at para. 85.
\(^{126}\) \textit{Ibid.} at para. 104.
\(^{127}\) \textit{Supra} note 119.
to limit this right. Beyond the allocation of resources, there is no compelling state interest in the death of a patient.

In *Golubchuk*, the ethical considerations of requiring health care practitioners to provide services they do not believe are required or appropriate was discussed. It is questionable whether this is a state interest; however it raises the question of balancing a doctor’s freedom of conscience against the patient’s freedom of religion. In discussing the right to manifest their freedom of religion, Dickson J. (as he then was) wrote it must “not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own.”\(^\text{128}\) Allowing a doctor to refuse to provide life-sustaining treatment because as a matter of conscience they believe it would be of no use, would mean the manifestation of this belief would injure his or her neighbour, the patient. In this scenario the greater harm is to the patient, as it would most likely result in their death, where the harm to the doctor is a limit on their freedom of conscience. As a result, in this fact scenario it is likely the right of the patient would be given precedence over the right of the doctor.

\textbf{(e) Right to Life, Liberty and Security of the Person}

Section 7 of the *Charter* protects the rights of everyone to life, liberty and security of the person. However, s. 7 includes an inherent limitation; these rights are not to be deprived except “in accordance with the principles of fundamental justice”.\(^\text{129}\) There is the potential for a *Charter* challenge on both the right to life and the right to security of the person, however a challenge on the basis of liberty may not be successful in the situation of an incompetent patient. In *R.B.*\(^\text{130}\) the Supreme Court noted liberty means an individual must be left room for personal autonomy to live his or her own life and to make decisions of fundamental personal importance. When a patient is incompetent because of a life-threatening illness and unable to make their own decisions, issues of autonomy are not as prevalent.\(^\text{131}\)

\(^{129}\) Supra note 6 at s. 7.
\(^{130}\) Supra note 119.
\(^{131}\) It is unclear whether the right to liberty would be engaged in a situation where an incompetent patient has left a clear advanced directive requesting life-sustaining treatment.
Assuming the Charter applies, the first step would be to show that the decision to withhold or withdraw life-sustaining treatment would breach the right to life or security of the person. The decision in Chaoulli, which involved a challenge under s. 7 of the prohibition in Quebec on private health insurance for provincially insured services, can be enlightening for how the court may view this argument. In Chaoulli, the court held that excessive wait times for health care treatment increased the risk of death and as a result were a violation of the right to life. They further found that wait times caused unnecessary pain and stress to those seeking treatment and were a violation of the right to security of the person.\textsuperscript{132} In Rodriguez, the court confirmed that the right to security of the person included control over one’s body.\textsuperscript{133}

If delays in receiving treatment and the increased risk of death are serious enough to engage both the right to life and to security of person, then the potential withholding or withdrawal of treatment that will hasten death must also, as a minimum, engage these rights.

Once engaged, the second stage is to determine whether these rights are being deprived in a manner consistent with the principles of fundamental justice. There is no clear definition of the principles of fundamental justice, but the Supreme Court has tried to enunciate what they embody. In Rodriguez, which dealt with the right to non-interference in assisted suicide, both the majority and minority in the 5-4 split decision gave interpretations of the principles of fundamental justice.

Justice Sopinka for the majority wrote that the principles of fundamental justice are those “principles which are ‘fundamental’ in the sense that they would have general acceptance among reasonable people.”\textsuperscript{134} In Sawatzky, Beard J. noted many Canadians would be surprised to learn a doctor can make a DNR order without the consent of his or her patient or family.\textsuperscript{135} A 2004 survey conducted by the Dalhousie Health Law Institute found that 46\% of respondents thought that it was illegal for a physician to stop providing potentially life-sustaining treatment when the patient wants treatment.\textsuperscript{136} The survey also showed that 42\% of respondents thought a

\textsuperscript{132} Supra note 96.
\textsuperscript{133} Supra note 79.
\textsuperscript{134} Ibid. at para. 173.
\textsuperscript{135} Supra note 16 at para. 5.
\textsuperscript{136} Dalhousie Health Law Institute, Survey Results of Public, Health Care Provider and Media Awareness Concerning End-of-Life Law and Policy in Canada (Final Report)
physician was required by law to provide all potentially life-sustaining treatment. Considering public reaction, it is possible the common law authority granting this power may not have general acceptance among reasonable people and therefore a doctor’s unilateral decision to withhold or withdraw life-sustaining treatment may be a violation of the s. 7 right to life and security of person.

The same result may also be available through the minority’s definition. They believed an arbitrary or unfair law would violate the principles of fundamental justice. The common law authority allowing a doctor to withhold or withdraw life-sustaining treatment is arbitrary. The decision is made by one person, without the consent of the person whose life and security of the person is being deprived, nor the consent of their substitute decision-maker or family.

The arbitrariness of the common law as interpreted in R.L. is reinforced by the fact that different religious and personal beliefs can be ignored or accepted depending upon the individual doctor treating the patient. In the absence of a formal, binding review or dispute resolution process a court could conclude the current law violates the principles of fundamental justice.

In the Ontario Court of Appeal decision Flora, at issue was whether the decision not to fund potentially life-saving treatment violated the right to security of the person. In this case, Mr. Flora went overseas for treatment not generally medically accepted in Ontario. Although the Court found Mr. Flora’s s. 7 rights were engaged, they were not being deprived by the state. The Court based this decision on the fact the state did not have a prohibition against, or create an impediment to an individual securing out-of-country treatment.

The decision in Flora can be distinguished in a challenge relating to the decision to withhold or withdraw treatment as the condition of the patient would restrict them from leaving the country to secure treatment. The state’s prohibition against private health care would act as a barrier to securing

---

137 Supra note 79 at para. 203.
139 Ibid. at para. 158.
140 Ibid. at para. 168.
treatment within Canada and a s. 7 challenge could have the potential for success.

If a family member or substitute-decision-maker successfully advances a s. 7 claim, it is unlikely a s. 1 limitation will be found. In essence, if a law is so arbitrary, unfair or unreasonable that it is not generally accepted, it is unlikely there will be a pressing or substantial objective, or that the law minimally impairs rights to the point where it could be saved under s. 1. The courts have indicated it is unlikely a violation of s. 7 can be saved by s. 1, and in Chaoulli, the Supreme Court stated “we question whether an arbitrary provision…will ever meet the rational connection test.”

Even if a court found that the common law authority to withhold or withdraw life-sustaining treatment without consent was a violation of s. 7 of the Charter, as I believe it could, it remains likely to be a hollow victory. If the arbitrariness of the law is what is at issue, a formal review process to review the doctor’s decision or a formal process to resolve disputes would likely be enough to accord with the principles of fundamental justice. A fair and meaningful opportunity for the family to express and discuss their wishes would be an improvement over the current state of the law, but would not address challenges under other Charter rights.

(f) Protection Against Cruel and Unusual Treatment

Section 12 of the Charter protects against “cruel and unusual treatment or punishment.” The trial decision in Burke was founded upon a similar provision in the Convention. In Burke, it was held that a “failure to provide life-prolonging treatment in circumstances exposing the patient to ‘inhuman or degrading treatment’ will in principle involve a breach of Article 3.” Although overturned on appeal, this was because the law as it currently stood addressed Mr. Burke’s concern. It does not completely rule out a similar argument being made. The question asked in this paper is whether a similar argument could be made in Canada, and what likelihood of success exists for such an argument.

141 Supra note 94 at 155-6.
142 Supra note 96 at para. 155.
143 Supra note 49 at Art. 3, which states “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”
144 Supra note 4 at para. 137.
145 Burke CA, supra note 5 at para. 23.
In *Rodríguez*, it was argued that the prohibition against assisted suicide was cruel and unusual treatment. Although that specific question was not decided, Sopinka J. for the majority declared a mere prohibition did not constitute treatment; only where there was an active state process involving an exercise of state control over an individual could a positive action, inaction or prohibition be considered treatment under s. 12.\(^{146}\)

The decision in *R.L.* also serves as a barrier. The Manitoba Court of Appeal decided “treatment” in the context of consenting to or authorizing medical treatment “is used only in a positive sense” and “[t]here is no need for a consent from anyone for a doctor to refrain from intervening.”\(^{147}\) Under this reasoning, withholding or withdrawing life-sustaining treatment is not “treatment” and as a result, the refusal to provide treatment would not violate s. 12. However, Gilmour disagrees, saying that the court’s position is not tenable when considered against the convention that consent is presumed for CPR, even when inappropriate, unless it has been specifically refused.\(^{148}\)

In Ontario, the Act defines “treatment” to include a “plan of treatment”, which is also defined in the Act.\(^{149}\) In *Holland*, the Court noted it is by this “definition that a decision to withdraw, or withhold, treatment would be a ‘treatment’ for the purpose of section 10 and would require a consent.”\(^{150}\) A final decision was left to be decided in another case more focused on this question, but Cullity J. indicated that it is likely the Board would not have “jurisdiction where the issue of consent relates to that question.”\(^{151}\)

Although whether consent is required remains to be decided, the decision in *Holland* may provide the opportunity to argue that the withholding or withdrawal of life-sustaining treatment is treatment for the purpose of s. 12. Given the weight of other decisions, even with this small opening it is unlikely a successful challenge could be made in Canada even if withholding or withdrawing treatment is considered “treatment” under s. 12.

\(^{146}\) *Supra* note 79 at para. 182.
\(^{147}\) *Supra* note 10 at para. 13.
\(^{148}\) *Supra* note 44 at 460.
\(^{149}\) *Supra* note 123 at s. 1(1).
\(^{150}\) *Supra* note 22 at paras. 20-21.
\(^{151}\) *Ibid.* at para. 44.
(g) Equality and Protection Against Discrimination

Section 15 provides for equal protection and benefit of the law. It also provides guarantees against “discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” 152 Three Supreme Court of Canada cases have raised, with mixed results, the subject of s. 15 and health care; Eldridge, Auton 153 and Rodriguez. In both Eldridge and Auton, the provision of health care services was challenged, arguing that the relevant laws discriminated on the ground of disability. In Eldridge, the court found the decision not to fund sign language interpretation for deaf people accessing medical services violated s. 15. This was viewed as a significant departure from the Court’s prior approach to health care and equality. 154

In Auton, where families challenged the decision not to fund new autism treatments, the court appeared to step back. 155 The claim failed as the comparator group was not other people receiving services, but those receiving novel services. In the absence of a disadvantage in relation to another comparator group, the claimants could not show unequal treatment. Neither could they meet the threshold of a benefit provided by law.

In Rodriguez, the prohibition against assisted suicide was challenged on the ground it discriminated on the basis of physical disability. Chief Justice Lamer and Cory J. accepted this argument finding the prohibition a violation of s. 15, however the majority, finding that any violation would be saved under s. 1, refused to decide this issue. 156

In the context of the decision to withdraw or withhold life-sustaining treatment, there are three possible arguments under s. 15. The first is discrimination on the grounds of disability. The patient is disabled because of their illness, i.e. being incompetent or incapable, and the law treats them differently on this basis. If this issue does not fit within disability, the same argument could be made on the basis of an analogous ground, that being of competency.

The second approach is to argue that the decision to withdraw or withhold life-sustaining treatment discriminates on the basis of religion. Although

152 Supra note 6 at s. 15.
154 Supra note 95 at 92.
155 Ibid. at 94.
156 Supra note 79 at para. 185.
a challenge based on religion can be advanced under s. 2(a) there is also the possibility the law as it stands discriminates against those whose religious beliefs place a high value on the sanctity of life or creates an obligation to actively seek out treatment to prolong life. In cases like Golubchuk, this provides several opportunities to demonstrate rights have been violated.

The third approach is discrimination on the basis of ethnic origin. The Yeung case is an example for the application of this ground. The applicant sought to have a DNR order lifted so there would be an opportunity for a traditional Chinese medicine practitioner to provide treatment. Although courts may not accept a direct correlation between ethnic origin and community practices within that ethnicity, if a applicant can show that link, an argument may exist.

The analysis under s. 15 focuses on two general areas; first, the challenged law must directly or indirectly impose a disadvantage on the claimant in comparison to other comparable persons; and second, the disadvantage is based on or is analogous to a listed ground in s. 15.157 In the s. 15 analysis, consideration should be given to whether the disadvantage constitutes an impairment of the human dignity of the claimant, however this is not an absolute requirement.158

For a claim based on disability, a claimant must establish that in most situations it is unlawful to withhold or withdraw life-sustaining treatment without consent from a competent patient, but it is lawful in the case of an incompetent patient.159 This imposes a disadvantage on an incompetent patient; a competent patient benefits from the protection of the law in a manner an incompetent patient does not. The discriminatory effect is magnified by the fact an incompetent patient can, under legislation, draft


158 Kapp, ibid. at para. 22.

159 See Burke CA, supra note 5. Note that in some cases it is allowed to withhold treatment without the consent of a competent patient, such as when decisions are made as to who will receive organ transplants or in the situation where a health care provider withholds antibiotics from a competent patient with a viral infection.
an advanced directive or appoint someone to consent on their behalf, but these actions are ignored when the decision is made to withhold or withdraw life-sustaining treatment, as no consent is required from an incompetent patient.

In a claim based on religion and/or ethnic origin, it will be harder to show the discriminatory effect of the law. A claimant must show they are discriminated against based on their religion or ethnic origin. The comparator group is not as clear as it is in the case of competent versus incompetent people. The key would be to show that the law has a discriminatory effect on them based on religion or ethnic origin, but not to others of a specific religion or ethnic origin.

The most significant hurdle for a claimant at this stage is to show the treatment is life-sustaining. As in Golubchuk, Jin, Yeung and other cases, health care practitioners may advance the position that treatment is not life-sustaining and therefore of no benefit or possibly harmful to the patient. If treatment would be of no effect, then there would be no discriminatory effect if treatment is withheld or withdrawn. For the second part of the test, disability or competency is a personal characteristic that is immutable or unchangeable by the patient, as is religion and ethnic origin.

In Rodriguez, McLachlin J. (as she then was) noted it was important to protect “the dignity and privacy of individuals with respect to decisions concerning their own body.” Individuals do not lose their dignity when they lose their competence and the law should not make such a distinction. For competent patients this standard is very high, even to the point of being able to refuse life-saving treatment. Allowing doctors to make the decision to withhold or withdraw life-sustaining treatment from an incompetent patient without their consent, or the consent of their substitute-decision-maker does not show the respect for decisions concerning one’s body or for the dignity associated with religious or ethnic identity. Although the individual may no longer be aware, dignity in their relationship with the family, who have may have similar religious or ethnic beliefs, should be maintained.

160 Supra note 3.
161 Supra note 10.
162 Supra note 79 at para. 200. Justice McLachlin was writing for the minority in Rodriguez.
163 Supra note 8.
The remaining hurdle to a successful s. 15 challenge on the basis of disability, or on the analogous ground of competency, is accommodation. Hogg argues, “unlike other grounds of discrimination, mental or physical disability is an impairment in ability; and some legal restrictions may properly be predicated on mental or physical disability.” However, an incompetent person can be accommodated through respect for an advanced directive or the decision of a substitute decision-maker, so there is a potential for a change to the law even if the issue of accommodation is raised.

Similar to a challenge under s. 7, if a family or substitute-decision-maker successfully argues s. 15, it is unlikely to fail on s. 1. Although the limitation of rights allowed in s. 1 applies to s. 15 of the Charter, it is worth noting that since the third element of an impairment of human dignity was added, only one law found to be discriminatory has been saved by s. 1.

(h) Application of Section 1 of the Charter

Section 1 of the Charter is considered separately as it applies equally to any rights argument found above. There are two likely s. 1 arguments: first, the need to allocate limited health care resources is a pressing and substantial objective in support of limiting the right to life-sustaining treatment, and second, the rights of physicians must be balanced against those of their patients.

The issue of s.1 and the allocation of limited health care resources has been hinted at, but often dismissed as not being relevant to end-of-life decision-making. As Ries notes, “[t]he Supreme Court of Canada has generally not been receptive to financial constraint arguments, and it has repeatedly warned against courts being too deferential in reviewing government action that violates Charter rights.” Ries points to the Court’s decision in NFLD (Treasury Board) where the Court stated:

…courts will continue to look with strong skepticism at attempts to justify infringements of Charter rights on the basis of budgetary

164 Supra note 94 at 673.
165 Ibid. at 652.
167 Supra note 13 at para. 9.
168 Ibid. at 557.
constraints. To do otherwise would devalue the Charter because there are always budgetary constraints and there are always other pressing government priorities.\textsuperscript{169}

In Eldridge, while declining to answer the question directly, the Court dismissed concerns about cost during their s. 1 analysis. The court found the right to equality was infringed by not providing medical interpretation services for the deaf and the estimated cost of providing the service, approximately 0.0025 percent of the provincial health care budget did not constitute a minimal impairment under s. 1.\textsuperscript{170}

Given Eldridge and NFLD (Treasury Board), in the limited number of situations\textsuperscript{171} that a demand for life-sustaining treatment would actually end up in court, the finding of a right to life-sustaining treatment would likely have a minimal effect on health care resources and not be limited on these grounds by s. 1 of the Charter.

The other s. 1 argument relates to the balancing of rights between patients and the health care practitioners who treat them. This was discussed above in the context of balancing a patient’s freedom of religion and a doctor’s freedom of conscience; two conflicting positions within the same right. In Sawatzky, it was noted that the decision of whether to withhold treatment, such as placing a DNR order, does not “raise the same ethical problems for the doctor that could be associated with controversial procedures like abortions.”\textsuperscript{172} In Golubchuk it was noted that physicians were already administering life-sustaining treatment and had done so in accordance with their ethical obligations, therefore maintaining it would not be a significant ethical burden even if facts had changed.\textsuperscript{173} As the patient faces the most harm from such a decision, it is likely the rights of the patient will outweigh those of the health care practitioner.

\textsuperscript{169} Newfoundland (Treasury Board) v. N.A.P.E., 2004 SCC 66, 3 S.C.R. 381 at para. 72.

\textsuperscript{170} Supra note 93 at para. 87.

\textsuperscript{171} Since R.L. in 1997, the author found only five reported cases in superior courts seeking an order to prevent the withdrawal of treatment. The assumption from these numbers is that most decisions to withhold or withdraw life-sustaining treatment are made by consent or resolved through informal dispute resolution mechanisms.

\textsuperscript{172} Supra note 16 at para. 31.

\textsuperscript{173} Supra note 27 at para. 28.
5. Conclusion

Whether a Charter-based challenge to the decision to withhold or withdraw life-sustaining treatment proves fruitful will depend greatly upon the facts involved. As a result, a definitive prediction on the success of such a challenge is impossible to make. However, from the review of applicable case law, and the door that has been opened by judges in Canada, there is considerable merit in advancing a Charter challenge. In the majority of cases, there are two possible options for a successful argument, a challenge under s. 7 and one under s. 15. In both cases, there is the potential for a successful argument. In a case such as Golubchuk, there is also a potential for a successful argument under s. 2(a) of the Charter. One scenario that may be successful is a patient with a strong religious belief who is in a persistent vegetative state where the doctors wish to withdraw or withhold ANH. In that situation, the treatment is still of benefit and there are possible arguments available under s. 2(a), 7 and s. 15.

Even with these avenues for argument, there remain considerable barriers to the actual success of a Charter challenge. Time and cost are just two of these challenges. One reason these Charter arguments were not explored in Sawatzky, Jin and Golubchuk is that the patient died before trial. It is difficult to conceive of a way of advancing this argument that would not face this challenge. The cost of mounting a challenge through three levels of courts could also serve as a barrier to litigating these issues.174

The most significant barrier is the message from the courts that there is no constitutionally protected right to health care or treatment. The concern is that in finding there is a right to demand the continuation or provision of life-sustaining treatment, it will be interpreted as a right to all health treatment. This concern was acknowledged in the Burke CA decision.175 A well-crafted Charter argument challenging the law allowing doctors to withdraw

174 In Morgentaler v. New Brunswick, 2009 NBCA 26, 306 D.L.R. (4th) 679, the Morgentaler Clinic received public interest standing to challenge the constitutionality of the provision prescribing which abortion services were to be paid by the province. Advancing a Charter challenge on the issue of withholding or withdrawing treatment through public interest standing is less likely to be successful. In that case, the challenge was clear and not as fact dependent as such a challenge would have to be on this topic. As with the MLPD in Golubchuk, it is more likely a group may receive intervenor status on an application and be able to bear the costs and burden of advancing the Charter arguments.

175 Supra note 5 at para. 20.
or withhold life-sustaining treatment without consent may be narrow enough to be successful without opening the door to broader claims based on a right to medical treatment.