IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Bentley v. Maplewood Seniors Care Society,* 2014 BCSC 165

Date: 20140203
Docket: S135854
Registry: Vancouver

Between:

Margaret Anne Bentley,
by her Litigation Guardian Katherine Hammond,
John Bentley and Katherine Hammod

Petitioners

And

Maplewood Seniors Care Society,
Fraser Health Authority and
Her Majesty the Queen in Right of the Province of British Columbia

Respondents

Before: The Honourable Mr. Justice Greyell

Reasons for Judgment

Counsel for the Petitioners:	K.A.G. Bridge
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Counsel for the Respondent, Fraser Health Authority:	P.A. Washington E.J. Allan
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Place and Date of Trial/Hearing:	Vancouver, B.C. December 17 - 19, 2013
Place and Date of Judgment:	Vancouver, B.C. February 3, 2014

Introduction

[1] This petition is brought by Margaret “Margot” Bentley through her litigation guardian, Katherine Hammond, by Mrs. Bentley’s husband, John Bentley, and by Mrs. Bentley’s daughter, Katherine Hammond. The petitioners apply for several orders, but primarily seek a declaration that Mrs. Bentley, who has advanced Alzheimer’s disease, not be given nourishment or liquids. They assert that Mrs. Bentley expressed strong wishes while she was mentally capable that she did not want to be given nourishment or liquids in her current condition.

[2] The Maplewood Seniors Care Society (“Maplewood”), the Fraser Health Authority (“FHA”), the Province of British Columbia (the “Province”), and the intervenor, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition - BC, oppose the petition. They argue that to stop giving Mrs. Bentley nourishment or liquids would cause her discomfort and bring about her death through dehydration and starvation. They take the position that such an act would constitute neglect within the meaning of the *Adult Guardianship Act*, R.S.B.C. 1996, c. 6 and may violate several criminal laws, including the prohibition against assisted suicide.

[3] This petition raises three critical questions. First, is Mrs. Bentley currently capable of making the decision to accept nourishment and liquids? Second, if Mrs. Bentley is not considered capable to make the decision to receive nourishment and liquids, who has the legal authority to make this decision on her behalf? Third, does the law allow her decision maker to refuse consent for nourishment and liquids on her behalf?

Background

[4] Mrs. Bentley was born on May 28, 1931. By all accounts, Mrs. Bentley has had a full and vibrant life. She worked as a registered nurse and as a real estate agent and she enjoyed travelling, gardening, painting, fishing, golfing and swimming. She had four children with her first husband, Katherine, Danielle, Stephen and Cameron, and married Mr. Bentley in 1981. Danielle submitted an affidavit in these proceedings indicating her support of the petition, Cameron died in 1978, and

although Stephen is on a solo sailing trip and cannot be contacted at this time, Ms. Hammond says he supports these proceedings.

[5] On November 24, 1991, Mrs. Bentley signed a statement of wishes in the presence of two friends who witnessed the document ("1991 Statement of Wishes"). There is no dispute that Mrs. Bentley was mentally capable at the time she signed this document. I set out the entire text of that document here. The bold portions reflect the handwritten portions of the text:

> *I, **Margaret A. Bentley** of **Mission, B.C**. hereby declare that if the time comes when I can no longer take part in decisions for my future, I wish this statement to stand as an expression of my wishes.*
>
> *If at such a time the situation should arise that there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by artificial means or "heroic measures".*
>
> *I do ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.*
>
> *I make this statement after careful consideration and is in accordance with my convictions and beliefs.*
>
> *I hereby absolve all who follow these instructions to be free of any legal liability. In particular, I would request the following instructions to be carried out:*
>
> *A. No electrical or mechanical resuscitation of my heart when it has stopped beating,*
>
> *B. No nourishment or liquids,*
>
> *C. No mechanical respiration when I am no longer able to sustain my own breathing,*
>
> *D. No surgery.*
>
> *E. Other. **In the event that mental deterioration is such that I am unable to recognize the members of my family, I ask that I be euthanized.***
>
> *I hereby designate **my husband John L. Bentley** of **Mission, B.C., Canada** to serve as my proxy for the purpose of making medical decisions on my behalf in the event that I become incompetent and unable to make such decisions for myself.*
>
> *Should **John Bentley** be unable to carry out my wishes, I hereby appoint **Kathy Littler** of **Mission, B.C**. as an alternate proxy.*
>
> [Emphasis added.]

[6] Mr. Bentley also signed a statement of wishes at the same time Mrs. Bentley signed hers. The text is identical except that Mr. Bentley's statement does not contain the handwritten request to be euthanized and he names Mrs. Bentley and another woman as his "proxies".

[7] Mrs. Bentley was diagnosed with Alzheimer's disease in December 1999. Mr. Bentley, Ms. Hammond and Danielle all state in their affidavits that following her diagnosis, Mrs. Bentley often verbally expressed to them that she did not want to live in a state of mental incapacity suffering from the symptoms of Alzheimer's disease. Mr. Bentley states in his affidavit at paras. 16-17:

> 16. Margot received her Diagnosis in December 1999. After that, she frequently referred to the fact that when she worked as a nurse, she often saw patients who are suffering from Alzheimer's disease and other forms of dementia, and she described their symptoms. She frequently said, "Don't let it happen to me" and other expressions to the same effect. I told Margot not to worry because she has made her living will and everything will be taken care of. Margot's typical response was, "I hope so, I hope so."
>
> 17. Margot and I had conversations like the one described in the preceding paragraph very frequently after she received her Diagnosis, often every day or several times each week.

[8] Mrs. Bentley entered a long term residential care facility, Ebenezer Home, in 2005. When Ebenezer Home closed in 2009, Mrs. Bentley entered the Maplewood care facility. Maplewood was provided with a copy of the 1991 Statement of Wishes at the time that she moved into the facility. Her family asserts that her condition has remained the same since she moved into Maplewood.

[9] In October 2011, Mr. Bentley found a two-page document in a desk drawer at his home ("Second Statement of Wishes"). This document is typewritten in its entirety and reads as follows:

Full Name:	*Margaret Anne Bentley*
Full Address:	*#10-30703 Blueridge Drive Abbotsford,B.C.*
Date of Birth:	*May 28th. 1931*
Doctor's Name:	*Pankratz. or Dr. C.A. Finch of Mission, B.C.*
Doctor's Address:	*Abbotsford, B.C.*
Doctor's Telephone No:	*604-854-6441.*

> *I have made this declaration at a time when I am of sound mind and after careful consideration. I understand that my life may be shortened by the refusals of treatment in this form. I accept the risk that I may not be able to change my mind in the future when I am no longer able to speak for myself, and I accept the risk that improving medical technology may offer increased hope, but I personally consider the risk of unwanted treatment to be a greater risk. I want it to be known that I fear degradation and indignity far more than death. I ask my medical attendants to bear this in mind when considering what my intentions would be in any uncertain situation.*
>
> *If the time comes when I can no longer communicate, this declaration shall be taken as a testament to my wishes regarding medical care. If it is the opinion of two independent doctors that there is no reasonable prospect of my recovery from severe physical illness, or from impairment expected to cause me severe distress or render me incapable of rational existence, then I direct that I be allowed to die and not be kept alive by artificial means such as life support systems, tube feeding, antibiotics, resuscitation or blood transfusions: any treatment which has no benefit other than a mere prolongation of my existence should be withheld or withdrawn, even if it means my life is shortened.*
>
> *I accept basic care however and I request aggressive palliative care, drugs, or any other measures to keep me free of pain or distress, even if they shorten my life.*
>
> *I do not, under any circumstances, wish to be a burden on any member or part of my family*
>
> *I wish the following person to be consulted in the event of uncertainty about my wishes:*
>
> | | |
> |---|---|
> | *Name:* | *My daughter Katherine Anne Littler* |
> | *Address:* | *10596 Shaw St., Mission, B.C..* |
> | *Telephone No:* | *604-826-0141* |
>
> [Emphasis added.]

[10] There is a signature which reads “Margot Bentley” at the bottom of the first page of the document, directly under the phone number of Katherine Littler (Ms. Hammond’s previous surname). No witnesses have signed the document. The second page of the document, which contains lines for the signature of “Margaret Anne Bentley” and the name and signature of a witness, has not been completed.

[11] There is no date on the Second Statement of Wishes. However, it is clear from the evidence that this document was made subsequent to the 1991 Statement of Wishes and prior to Mrs. Bentley moving into Ebenezer Home in 2005. A referral form on record with FHA, which was completed September 2, 2004, lists Mrs.

Bentley's general physician as "Dr. Pankratz/Dr. Finch before" and her address as #10 - 30703 Blueridge Drive, Abbotsford.

[12] Mr. Bentley deposes that he had never seen this document before he found it in October 2011. He further states that when he found the document there was no signature anywhere on the document. Ms. Hammond gave the Second Statement of Wishes to the Director of Maplewood in November 2011.

[13] Both Mr. Bentley and Ms. Hammond state in their affidavits that Mrs. Bentley never mentioned this Second Statement of Wishes to them. They also state that they are familiar with Mrs. Bentley's signature and that the signature on the Second Statement of Wishes is not hers. They assert that the signature is a forgery, but offer no explanation for who may have forged the signature or why.

[14] The respondents submit that if Mrs. Bentley's previous written expressions of wishes are to be consulted at all, then the Second Statement of Wishes is a more current expression of her wishes and should be given priority over the 1991 Statement of Wishes. They argue that there is no evidence that the signature was forged and that it is possible that Mrs. Bentley's signature changed as she aged.

[15] It seems more likely than not, given the nature of the Second Statement of Wishes and where it was found, that Mrs. Bentley authored this document or directed someone to draft it for her. Neither Maplewood nor FHA could have had any involvement in its drafting. The evidence does not support the petitioners' claim that the signature is a forgery. Despite the uncertainty about when precisely it was executed, I find as a matter of fact that the Second Statement of Wishes is an expression of Mrs. Bentley's wishes, which brings into question whether the 1991 Statement of Wishes expresses Mrs. Bentley's most recent wishes.

[16] FHA contends that Mr. Bentley has at times provided consent to Mrs. Bentley being provided oral nutrition and hydration. FHA refers to two documents in Mrs. Bentley's file entitled "Degree of Intervention Order" which Mr. Bentley signed on August 26, 2009 and June 3, 2011. These two documents indicate that if Mrs.

Bentley becomes ill and her family cannot be contacted in a timely manner, only supportive measures, such as symptom control and oxygen, should be administered, rather than therapeutic interventions. There is no mention of nourishment or hydration in these documents. In addition, FHA states that Mr. Bentley gave his verbal consent to the continued feeding of Mrs. Bentley on January 25, 2012. However, the evidence demonstrates that the majority of communication from Mr. Bentley and Ms. Hammond over the years that she has lived in Maplewood, both verbal and written, has clearly instructed that Mrs. Bentley not be provided with nourishment or liquids in any way.

[17] Although the petitioners originally sought a declaration to clarify that they are entitled to remove Mrs. Bentley from Maplewood, it was my understanding that the parties resolved this issue during the hearing. If I am wrong, the parties are at liberty to apply to make further submissions on that portion of the application.

Mrs. Bentley's Current Condition

[18] Mrs. Bentley has advanced Alzheimer's disease. It was clear from the petitioners' and respondents' evidence that Mrs. Bentley makes very few physical movements. She occasionally rubs the back of her hand, arm, or face. She is routinely transferred from her bed to a wheelchair. Her eyes are closed much of the time. She has not spoken since 2010. She does not indicate through her behaviour that she recognizes her family members or any other person.

[19] Mrs. Bentley can no longer eat independently. The staff at Maplewood have been assisting her with eating and drinking by placing a spoon or glass on her lower lip. When she opens her mouth to accept nourishment or liquid, the care attendant places the nourishment or liquid in her mouth and Mrs. Bentley swallows it. When she keeps her mouth closed despite being prompted, the care attendant will try again. If she keeps her mouth closed despite a couple of attempts, the care attendant makes no attempt to force her to accept nourishment or liquid. I will refer to this practice as assistance with feeding or the provision of oral nutrition and hydration.

[20] It was clear from a log entry presented from Mrs. Bentley's file that she accepts different types and amounts of nourishment and liquids on different days.

[21] Dr. Andrew Edelson has known Mrs. Bentley socially for about 30 years and has been her general physician since late 2011. Dr. Edelson was qualified to give an expert opinion in this petition as Mrs. Bentley's general physician, but he does not have any expertise in Alzheimer's disease or in incapacity assessment.

[22] Dr. Edelson believes that Mrs. Bentley is in a condition of extreme mental disability and that there is no reasonable expectation of her recovery. He is of the opinion that any response Mrs. Bentley has when she is prompted with a spoon or glass is "a reflex and is not indicative of any conscious decision about whether to eat or not." He opines that Mrs. Bentley "is in a vegetative state. She does not function mentally in any discernible way."

[23] Dr. Edelson assesses that Mrs. Bentley is in stage seven of the seven stages of Alzheimer's disease according to the Global Deterioration Scale for Assessment of Primary Degenerative Dementia. Stage seven - "Very severe cognitive decline" - can last for three years or more and is described as follows:

> All verbal abilities are lost over the course of this stage. Frequently there is no speech at all - only unintelligible utterances and rare emergence of seemingly forgotten words and phrases. Incontinent of urine, requires assistance toileting and feeding. Basic psychomotor skills, e.g., ability to walk, are lost with the progression of this stage. The brain appears to no longer be able to tell the body what to do. Generalized rigidity and developmental neurological reflexes are frequently present.

[24] Dr. Neil Hilliard is a hospice palliative care physician who assessed whether Mrs. Bentley was an appropriate candidate for a transfer to hospice on June 5, 2012. Patients can be transferred to a hospice for palliative care when there is a prognosis that they will live for less than four months and their symptoms cannot be managed in their current environment. Dr. Hilliard's report was appended to an affidavit submitted by FHA. He concluded that "[a]lthough Mrs. Bentley is not able to verbally express her wishes, she is able to nonverbally express her wishes by taking food when it is offered and declining food when she has had enough…Currently Mrs.

Bentley clearly chooses to eat." He concluded that Mrs. Bentley did not meet all of the criteria for admission to hospice because she was not actively dying, her prognosis was that she may live for more than four months, and her needs were being met in her current environment at Maplewood.

[25] Dr. Deborah O'Connor is a professor in the School of Social Work at the University of British Columbia and an Incapacity Assessor with the Office of the Public Guardian and Trustee. She was qualified to provide expert opinion evidence in this petition.

[26] On March 5, 2013 Dr. O'Connor conducted an independent assessment of incapability of Mrs. Bentley pursuant to s. 53 of the *Adult Guardianship Act* at the request of FHA. Mr. Bentley and Ms. Hammond were present during this assessment.

[27] Dr. O'Connor observed in her report that Mrs. Bentley grasps the hands of people who speak to her, but she does not make eye contact or appear to respond in other ways when people try to interact with her. The staff reported to Dr. O'Connor that Mrs. Bentley conveys when she is in pain by moaning and tightening her facial muscles. She is being given a small amount of hydromorphine regularly to address any pain she may be in.

[28] Dr. O'Connor is similarly of the view that Mrs. Bentley is in stage seven of Alzheimer's disease.

[29] During her assessment, Dr. O'Connor observed that after eating about a quarter of her main course of pureed potatoes, chicken and gravy, Mrs. Bentley stopped opening her mouth to prompting. The care attendant prompted her six times and then discontinued. The care attendant then told Mrs. Bentley that she was switching to dessert. Mrs. Bentley opened her mouth for dessert on the first attempt by the care attendant.

[30] Dr. O'Connor concluded as follows:

> Observing her, I was able to determine what food Mrs. Bentley preferred - suggesting that she does have some means for communicating. I was also able to determine when she was clear that she did not want more food. However, there was a grey space where it was unclear how much she was responding reflexively to continued prompting and hence, unable to exert a choice. Erring on the side that she does retain some capacity here, my suggestion would be that fewer attempts be made to convince her to continue eating.

[31] FHA also tendered into evidence a report from July 2013 that Mrs. Bentley would not open her mouth when prompted by the dental hygienist to have her teeth cleaned.

[32] On April 15, 2013 Mr. Bentley and Ms. Hammond met with Maplewood and FHA staff to discuss Dr. O'Connor's assessment. At this meeting, a care plan was established in which care attendants would continue to assist Mrs. Bentley to eat, but that she was only to be prompted with a spoon or glass a couple of times with each food item. It was FHA's understanding that Mr. Bentley and Ms. Hammond consented to this plan and FHA therefore did not pursue an application to court under s. 54 of the *Adult Guardianship Act* for a support and assistance order. Both Mr. Bentley and Ms. Hammond deny that they consented and state that since it was clear to them that FHA and Maplewood were not willing to cease giving Mrs. Bentley nourishment they believed the best option available to them to advocate for Mrs. Bentley's wishes was to ask that less prompting be given.

[33] Despite her cognitive and physical disabilities, Mrs. Bentley is not dying. If the petitioners' application for an order that Mrs. Bentley stop being offered nourishment and liquid is granted she will die from starvation or dehydration, rather than from any effect of Alzheimer's disease.

Issues

[34] The issues are as follows:

1) Is Mrs. Bentley currently capable of making the decision to accept nourishment and assistance with feeding?

2) Does assistance with feeding fall within the definition of health care or personal care?

3) If Mrs. Bentley is not currently capable of making the decision to accept nourishment, who has authority to make the decision?

4) Would failure to provide assistance with feeding constitute neglect within the meaning of the *Adult Guardianship Act*?

5) Would failure to provide assistance with feeding contravene a criminal prohibition?

Adult Guardianship Legislation

[35] There are a number of relevant statutes that govern the area of health care and personal care for adults who need assistance making decisions. These statutes often intersect and work in tandem with one another; it would be challenging to isolate any of the issues raised in this petition as falling within the confines of any one particular statute.

[36] Moreover, it is clear that the legislature intended these statues to work together as a package. In 1993 the legislature unanimously passed four pieces of legislation to reform the area of adult guardianship: the *Representation Agreement Act*, R.S.B.C. 1996, c. 405, the *Adult Guardianship Act*, the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 (the "*HCCCFA Act*") and the *Public Guardian and Trustee Act*, R.S.B.C. 1996, c. 383. These reforms were brought about by the initiatives of a broad based community coalition that provided extensive input into the legislation (British Columbia, *Official Report of Debates of the Legislative Assembly (Hansard)*, 36th Parl., 3rd Sess., Vol. 16, No. 15, (29 June 1999) at 14069). Most of this legislative package was proclaimed in force on February 28, 2000 following further public consultation (British Columbia, *Official Report of Debates of the Legislative Assembly (Hansard)*, 36th Parl., 3rd Sess., Vol. 16, No. 22, (12 July 1999) at 14259). I will therefore consider relevant portions of all of these statutes and others throughout these reasons.

[37] Counsel for the petitioners focused much of his argument on case law that defines the common law right to refuse medical treatment, including *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.) at 328 and *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.) at 312. While these cases confirm a common law right to refuse health care treatment, if I conclude that assistance with feeding by prompting with a spoon or glass is not health care, these authorities are not particularly instructive in determining the issues before me.

[38] In addition, the statutory scheme enacted by the British Columbia legislature is broad and comprehensive. I must first consider statutory definitions, rights, relationships, and obligations before turning to the legal authorities from the case law that may help in interpreting and applying these statutes.

[39] The relationships of the parties to this petition are largely governed by legislation. FHA is a regional health authority funded by the Province. Mrs. Bentley is a client of FHA, as she lives in the FHA service delivery area and is in need of residential care services.

[40] FHA contracts with Maplewood as a service provider to provide residential care services to adults, including Mrs. Bentley. FHA licenses Maplewood under the *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75 and holds a funding contract with Maplewood to provide long term residential care services to FHA clients residing at the Maplewood care facility.

[41] The *Community Care and Assisted Living Act* and its regulations, the *Residential Care Regulation*, B.C. Reg. 96/2009 and the *Community Care and Assisted Living Regulation*, B.C. Reg. 217/2004, also address the requirement to provide minimum standards for necessaries of life, which includes providing nutrition. All facilities, including Maplewood, must meet these minimum requirements as a condition of receiving a licence.

[42] In addition, FHA is a designated agency under the *Adult Guardianship Act* and has statutory obligations to investigate concerns regarding adults who need

support and assistance in situations of abuse or neglect. The *Adult Guardianship Act* and FHA's obligations under it will be further discussed below.

Is Mrs. Bentley Currently Capable of Making the Decision to Accept Nourishment and Assistance with Feeding?

[43] It is important to acknowledge from the outset that the relevant British Columbia legislation does not treat an adult's mental capability as an all or nothing concept. The package of legislation enacted in 1993 to reform adult guardianship law clearly sets out a more nuanced approach to assessing capability. As counsel for FHA points out, Mrs. Bentley could very well be incapable of making a complex decision, such as whether to undergo a risky surgery, but capable of making a basic decision, such as whether she wants to eat or not.

[44] This is not an application pursuant to the *Patients Property Act*, R.S.B.C. 1996, c. 349 to declare Mrs. Bentley "incapable of managing herself" (s. 3(1)) and the Court is not called on to make a global finding of Mrs. Bentley's mental capability. Instead, the question in issue is whether Mrs. Bentley is currently capable of making the decision to accept or refuse consent to receive nourishment and liquids and assistance with feeding in the form of bringing a spoon or glass to her lips in order to receive such nourishment and liquids. This is a factual determination which I must make based on the evidence before me.

[45] It is clear from s. 5 of the *HCCCFA Act* that health care may not be provided without obtaining consent. The elements of informed consent to health care are set out in s. 6 of that Act:

> **6** An adult consents to health care if
>
> (a) the consent relates to the proposed health care,
>
> (b) the consent is given voluntarily,
>
> (c) the consent is not obtained by fraud or misrepresentation,
>
> (d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,
>
> (e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

> (i) the condition for which the health care is proposed,
>
> (ii) the nature of the proposed health care,
>
> (iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and
>
> (iv) alternative courses of health care, and
>
> (f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

[46] I am not aware of any statute in British Columbia that sets out a legislated standard for informed consent for personal care or basic care. However, there is common law authority for the proposition that it is necessary to obtain consent before providing personal care or basic care. Indeed, intentional non-consensual touching can amount to the tort of battery (*Malette* at 327; *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at 246). Although most cases relating to consent rights have been decided in the context of a right to consent or refuse consent for health care treatment, the principles on which that right is based is the general right to personal autonomy and bodily integrity.

[47] For instance, in *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at 135 Cory J. said for the Court: “Everyone has the right to decide what is to be done to one's own body.” Similarly, in *Fleming* at 312 Robins J.A. observed that “[t]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection.” These statements recognizing the common law right to be free from non-consensual touching or care of one’s body must encompass the right to consent or refuse consent to personal care or basic care. For consent to personal care to be meaningful, the decision must be made by someone who is capable of understanding the proposed care and who is free from undue influence or coercion.

[48] The petitioners argue that Mrs. Bentley opening her mouth in response to prompting from a spoon or glass is reflexive, and not indicative of capable consent. They introduced a video of Mrs. Bentley opening her mouth to prompting from a spoon with no food on it. Her general physician, Dr. Edelson, is of the opinion that

when Mrs. Bentley opens her mouth it is a reflex and that she is not capable of making the decision to accept or refuse nourishment.

[49] FHA and Maplewood argue that Mrs. Bentley is indicating her consent by accepting or refusing food or liquids. They point to several facts in support of their position. First, Mrs. Bentley accepts more food or liquid on some occasions than others. When she refuses food or liquid by not opening her mouth, the Maplewood staff accept her refusal and do not force her to ingest food or liquid. Second, Mrs. Bentley stops opening her mouth to accept food after she has been eating for a while, which may indicate that she feels full. Third, Mrs. Bentley has communicated a preference for certain flavours by accepting more sweet foods than other foods. Fourth, Mrs. Bentley would not open her mouth for the dental hygienist when prompted. They argue that these behaviours are inconsistent with a reflex.

[50] Dr. O'Connor and Dr. Hilliard, both of whom have specialized knowledge and experience with Alzheimer's disease and end of life care, were of the opinion that Mrs. Bentley is capable of consenting to receive nourishment and liquids and is indicating her consent or refusal by accepting or refusing to open her mouth and swallow.

[51] FHA submitted an affidavit from Gina Gaspard, a Clinical Nurse Specialist in Gerontology, along with FHA's Protocol for the Actively Dying, which explains that when someone is actively dying the body begins to shut down and the brain no longer comprehends feelings of hunger or thirst. At this stage consuming food or liquid does not provide comfort or social interaction, but in fact may cause discomfort. FHA takes the position that if and when Mrs. Bentley permanently stops opening her mouth to accept food, they will not propose any further interventions, such as forcing her to accept nourishment and liquids or inserting a feeding tube.

[52] If Mrs. Bentley is currently capable of making the decision to accept or refuse nourishment there is no need to seek substitute consent either from another decision maker or by consulting her previously expressed wishes. If Mrs. Bentley is incapable

of making the decision then consent must be obtained from a substitute decision maker or in reference to her previously expressed wishes.

[53] Much of the applicable legislation sets out that adults are entitled to the presumption that they are capable of making decisions. Section 3(1)(b) of the *Representation Agreement Act*, s. 3(1) of the *HCCCFA Act*, and s. 3(1) of the *Adult Guardianship Act* state that "[u]ntil the contrary is demonstrated, every adult is presumed to be capable of making decisions" about personal care and health care. In addition, s. 3(2) of the *Representation Agreement Act*, s. 3(2) of the *HCCCFA Act*, and s. 3(2) of the *Adult Guardianship Act* state that an adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions. Section 9 of the *HCCCFA Act* sets out that consent to health care may be inferred by conduct.

[54] It is entirely possible that the decisions Mrs. Bentley predicted she would make for herself in the future through her "proxies" and as set out in her statements of wishes are different than the decisions she is currently making. All adults are entitled to change their mind subsequent to creating written instructions, which is one of the risks associated with written instructions for the future. This Court must consider the possibility that Mrs. Bentley's previously expressed wishes are not valid in the face of her current consent.

[55] It is clear from the provisions referred to above that the legislature expressly considered and precluded the possibility that a challenge to an adult's capability could be premised on her method of communicating. The fact that Mrs. Bentley could be communicating her decisions and preferences through non-verbal means, such as choosing when to accept and when to refuse food, does not mean that she is mentally incapable of making this decision.

[56] The petitioners state in their affidavits that they no longer see in Mrs. Bentley the active and creative person that they knew as their wife and mother. I appreciate that Alzheimer's disease has brought about many changes in Mrs. Bentley, including serious cognitive and physical disabilities. However, I agree with counsel for FHA

who asserts that it is of fundamental importance to respect and care for the person that Mrs. Bentley is now. The evidence presented of Mrs. Bentley's limitations, for instance, that she no longer recognizes her family members, does not speak, and has very limited physical movements, helps inform me of her current condition. However, these limitations do not necessarily mean that she is incapable of making the decision to accept or refuse to eat and drink.

[57] The petitioners' characterization of Mrs. Bentley as "vegetative" is neither useful nor accurate. Mrs. Bentley is not unconscious: she grasps the hands of her carers, she opens and closes her eyes, she rubs her hands and face, and she actively swallows food. I reject Dr. Edelson's opinion that Mrs. Bentley "does not function mentally in any discernible way". Mrs. Bentley would not be able to engage in any of the behaviour just described if she had no mental function.

[58] The video introduced by the petitioners of Mrs. Bentley opening her mouth to prompting from an empty spoon is not determinative of the issue. The video clip was approximately 30 seconds long; I have no way of knowing whether Mrs. Bentley would have continued or stopped opening her mouth to the prompting. There was no context provided, for instance, I do not know what time of day it was and whether it was close to a time when Mrs. Bentley regularly eats. The clip shows Mrs. Bentley during one brief point in time and is not as useful in conveying Mrs. Bentley's overall condition and behaviours as the evidence presented by experts who assessed her and by the Maplewood staff who observe her every day.

[59] Based on the evidence before me, I am of the view that the petitioners have not met their onus of rebutting the legislative presumption that Mrs. Bentley is capable of making the decision to accept or refuse to eat and drink. The preponderance of the evidence demonstrates that she has the capacity to make this decision. In coming to this finding, I have carefully considered and weighed the medical evidence as well as the descriptions of Mrs. Bentley's behaviour. I prefer the evidence of Dr. O'Connor, who has expertise in incapacity assessments, to that of Dr. Edelson, who is a general physician. I find it significant that Mrs. Bentley

indicates preferences for certain flavours and eats different amounts at different times. The petitioner has not established that Mrs. Bentley's behaviour is a mere reflex and not communication through behaviour, which is the only means through which Mrs. Bentley can communicate.

[60] The finding that Mrs. Bentley is currently capable of making the decision to eat and drink and is communicating her consent through her behaviour means that those providing her with care must continue to offer her assistance with feeding in the form of prompting her with a spoon or glass.

[61] However, even if I had found Mrs. Bentley incapable of making this decision that would not change the outcome of this petition. I will explain this in the reasons that follow as I address the petitioners' requests for declarations.

Does Assistance with Feeding fall within the Definition of Health Care or Personal Care?

[62] The petitioners seek a declaration that the provision of oral nutrition or hydration constitutes health care within the meaning of the *HCCCFA Act*. Whether such care is health care or a form of personal or basic care would determine how substitute consent would be sought if Mrs. Bentley was found incapable of consenting or refusing consent to oral nutrition or hydration.

[63] The definition of health care in the *HCCCFA Act*, s. 1 is as follows:

> **"health care"** means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes
>
> (a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,
>
> (b) a plan for minor health care that
>
> (i) is developed by one or more health care providers,
>
> (ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
>
> (iii) expires no later than 12 months from the date consent for the plan was given, and

> (c) participation in a medical research program approved by an ethics committee designated by regulation;

[64] The *Representation Agreement Act* and the *Adult Guardianship Act* adopt the definition of health care set out in the *HCCCFA Act*.

[65] Although there is no definition of personal care in the *HCCCFA Act*, such a definition is found in the *Representation Agreement Act*, s. 1:

> **"personal care"** includes matters respecting
>
> (a) the shelter, employment, diet and dress of an adult,
>
> (b) participation by an adult in social, educational, vocational and other activities,
>
> (c) contact or association by an adult with other persons, and
>
> (d) licences, permits, approvals or other authorizations of an adult to do something;
>
> [Emphasis added.]

[66] The petitioners take the position that the provision of oral nutrition and hydration falls within the *HCCCFA Act* meaning of health care. They argue that the definition of health care is broad and on its face includes the provision of nourishment or liquids. They refer to *Cuthbertson v. Rasouli*, 2013 SCC 53 at para. 47, in which the majority of the Court observed that the definition of "treatment" in the Ontario *Health Care Consent Act*, S.O. 1996, c. 2, s. 2 was "very broad". That definition includes similar wording to the definition of health care found in the *HCCCFA Act*: ""treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan…". The petitioners further argue *Ng v. Ng*, 2013 BCSC 97 is an authority which establishes that health care includes the provision of nourishment and liquids in British Columbia.

[67] The petitioners submit that if the British Columbia legislature had intended to exclude the provision of oral nutrition and hydration from the definition of health care that it would have done so explicitly. They point out that the Ontario *Health Care*

Consent Act expressly excludes assistance with eating or drinking from the definition of treatment. They say that if the Ontario legislature saw the need to exclude assistance with eating or drinking from the definition of treatment then that definition must, by implication, include assistance with feeding.

[68] The respondents and the intervenor argue that the provision of oral nutrition and hydration by prompting with a spoon or glass is not health care, but is instead a form of personal care or basic care. The respondents admit that providing nourishment through artificial means, such as a feeding tube, would constitute health care, however they distinguish between providing nourishment with a feeding tube and providing assistance to someone who is actively eating.

[69] In a Clinical Ethics Consult dated December 5, 2012, which was commissioned by FHA in response to Mr. Bentley and Ms. Hammond's requests that oral nutrition and hydration be withdrawn, Katherine Duthie, the leader of the FHA Clinical Ethics Consultation department, states:

> …The challenge was around the statement about nourishment or liquids. Traditionally, this kind of statement refers to the receipt of artificial nutrition and is meant to encompass situations in which a patient, or their substitute decision-maker, either refuses artificial nutrition (provided through a PEG, NG tube or some other invasive means) or requests that it be discontinued. There is consensus in the health care setting that in the absence of these conditions, receiving nutrition falls within basic care and not heroic and/or extraordinary measures.

[70] FHA points out that the regulation of daily living for a person who is in care is addressed in the *Residential Care Regulation* and the *Community Care and Assisted Living Regulation*. As mentioned, care facilities like Maplewood must abide by these requirements in order to receive their license. These regulations expressly govern nutrition, assistance with eating, and meal plans for adults who live in assisted living and care settings. For instance, ss. 66-67 of the *Residential Care Regulation* set out:

> **66** (1) A licensee must ensure that each person in care receives adequate food to meet their personal nutritional needs, based on Canada's Food Guide and the person in care's nutrition plan.

> (2) A licensee must ensure that fluids are provided to persons in care in sufficient quantity and variation to meet the needs and preferences of the persons in care.
>
> **67** (1) A licensee must provide each person in care with
>
> …
>
> (c) eating aids, personal assistance or supervision, if required by
>
> (i) a person in care who has difficulty eating, or
>
> (ii) the nutrition plan of a person in care.

FHA submits that these regulations demonstrate that the British Columbia legislature regards the provision of oral nutrition and hydration as distinct from health care governed by the scope of the *HCCCFA Act*.

[71] The Province argues that the common law doctrine of informed consent for medical treatment arose in response to the imbalance of knowledge inherent in a doctor-patient relationship. In *Hollis v. Dow Corning Corp.*, [1995] 4 S.C.R. 634 at para. 25 La Forest J. said for the majority that “[t]he doctrine of "informed consent" was developed as a judicial attempt to redress the inequality of information that characterizes a doctor-patient relationship.” Legislation has codified and expanded on this common law right to consent. The Province points out that unlike health care treatment decisions in which health care providers have expertise and specialized knowledge a patient does not have, there is no particular knowledge imbalance involved in the decision of whether to accept food and liquids.

[72] The Province further submits that the *HCCCFA Act* only applies to health care providers, a term defined by s. 1 as “a person, or a person in a prescribed class of persons, who, under a prescribed Act, is licensed, certified or registered to provide health care”. The relevant regulations identify and govern prescribed classes of health care providers, such as acupuncturists, licensed practical nurses, optometrists, and physical therapists, as licensed professionals who provide a specialized health care service for which they need informed consent (*Health Care Consent Regulation*, B.C. Reg. 20/2000, s. 3; *Health Professions Designation Regulation*, B.C. Reg. 270/2008). The Province says that people who provide

nourishment and assistance with eating do not typically fall within the definition of health care providers.

[73] The Province argues that reference to the Ontario *Health Care Consent Act* is misleading and unhelpful. It contends, among other things, that the Ontario legislation defines “treatment”, not “health care”; that the Ontario legislation has an entire part that governs how decisions regarding assistance with eating should be made, whereas the British Columbia legislation does not; and that the British Columbia legislation was enacted in 1993, before the 1996 Ontario legislation was enacted, and therefore the British Columbia legislature was not in a position to consider it.

[74] The Province also points out that there is a wide variety of definitions for health care and personal care across Canadian jurisdictions. For instance, the Nova Scotia *Personal Directives Act*, S.N.S. 2008, c. 8, s. 2 defines “personal care” as including nutrition and hydration. Newfoundland and Labrador’s comparable legislation, the *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1, s. 2(b), defines health care decisions as:

> (b) "health care decision" means a consent, refusal to consent, or withdrawal of consent of any care, treatment, service, medication, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health or personal care and includes…the administration of nutrition and hydration…

The Province says that the Newfoundland and Labrador legislature saw it as necessary to expressly include the administration of nutrition and hydration within the definition of health care because on its face the term did not include such care.

[75] The Province argues that there is no reason to prefer the legislation of any other particular Canadian jurisdiction in interpreting the *HCCCFA Act* and, instead, this Court should consider the *HCCCFA Act* in the context of other related legislation enacted in British Columbia. The *Representation Agreement Act*, which was enacted at the same time as the *HCCCFA Act* and which uses the same definition of health care as the *HCCCFA Act*, defines personal care as including the diet of an adult.

The Province says that for these Acts to work together coherently, an adult's nourishment must fall within the meaning of personal care and outside the scope of the *HCCCFA Act*.

[76] Finally, the Province submits that a number of absurd results would flow from a finding that the provision of oral nutrition and hydration is health care. For instance, when nourishment is provided by someone who is not a health care provider, their responsibilities would differ from a health care provider carrying out the same service. In addition, following the consent scheme outlined in the *HCCCFA Act* would require that health care providers seek and document consent or substitute consent each time an adult was provided with oral nutrition and hydration. Such a result, the Province contends, would be contrary to the legislature's intention to streamline consent processes, reduce administrative burdens for health care providers, and reduce the caregiving burdens on those who provide substitute consent (see British Columbia, *Official Report of Debates of the Legislative Assembly (Hansard)*, 37th Parl., 3rd Sess., Vol. 7, No. 9, (9 May 2002) at 3331).

Analysis

[77] For the reasons that follow, I conclude that providing oral nutrition and hydration by prompting with a spoon or glass is not health care within the meaning of the *HCCCFA Act* and instead is a form of personal care or basic care.

[78] In *Manoir de la Pointe bleue (1978) inc. c. Corbeil*, 1992 CarswellQue 1623 (C.S.) a care facility brought an application for a declaration that it was required to respect the wishes of a resident who was refusing consent for all medical treatment and who wanted to begin fasting. The resident, Mr. Corbeil, was a 35 year old man who was paralyzed below his shoulders following an all-terrain vehicle accident. He was found to be mentally capable of making treatment and care decisions. Although it is unclear precisely how he was assisted with feeding, the judgment notes that he was not attached to devices of any kind and that he was being fed naturally with help from care facility employees.

[79] While Rouleau J. considered whether assistance with feeding is medical treatment or a form of care, he ultimately decided that this finding did not have to be made because what was then art. 19.1 of the *Civil Code of Lower Canada* stated that an individual cannot receive either care or treatment without consent. His conclusion that the court had to respect Mr. Corbeil's wish to stop eating, just as it would have to respect an individual's wish to refuse chemotherapy, radiation therapy, or dialysis, is grounded in the wording of the *Civil Code of Lower Canada* (para. 94). I do not read this statement to mean that Rouleau J. considered assistance with feeding to be in the same category as those health care treatments. Indeed, he observed in *obiter* that providing food assures an elementary, base level of care to a patient and it is a non-therapeutic intervention (para. 94).

[80] The petitioners' reliance on *Ng* is misplaced for several reasons. The issue in that case was whether Mr. Ng's court appointed personal guardian was acting in Mr. Ng's best interest when she withdrew consent for Mr. Ng's feeding and fluid tubes. Whether feeding and fluid tubes were health care or personal care was irrelevant because Mr. Ng's personal guardian had authority to make decisions for both health care and personal care. Further, the respondents admit that feeding and fluid tubes fall within the definition of health care. *Ng* does not address the question of whether oral nutrition and hydration for an adult who is actively swallowing is health care.

[81] While it is true that the majority in *Rasouli* found that the definition of treatment within the Ontario *Health Care Consent Act* was broad - a definition which has similarities to the definition of health care found in the British Columbia legislation - I find that to be of little assistance in interpreting the *HCCCFA Act*. I accept that the meaning of health care in the *HCCCFA Act* is broad; that does not mean that the definition includes assistance with oral nutrition and hydration.

[82] I agree with the Province's submission that this Court should look to other relevant British Columbia statutes, rather than the legislation of other Canadian jurisdictions, in interpreting the *HCCCFA Act*. It is clear that jurisdictions in Canada have taken different, in fact sometimes contradictory, approaches to the definition of

health care. There is no evidence in this case that in passing the *HCCCFA Act* in 1993 the British Columbia legislature considered other jurisdiction's definitions of health care and turned its mind to whether the definition should include or exclude assistance with oral nutrition and hydration. As discussed above, the British Columbia statutes governing adults who need assistance with decision making has a unique foundation and were intended to work together.

[83] It is clear from the *Representation Agreement Act*, the primary method for appointing a substitute decision maker in British Columbia, that health care and personal care are distinct and that personal care includes decisions relating to an adult's diet. The legislature has chosen to make a clear distinction between the two by allowing an adult to authorize a representative to make personal care decisions or health care decisions (*Representation Agreement Act*, ss. 7, 9). Furthermore, the *Residential Care Regulation* and the *Community Care and Assisted Living Regulation* address nutrition, assistance with eating, and meal planning as an aspect of daily living outside of the scope of the *HCCCFA Act*.

[84] I find that providing oral nutrition and hydration by prompting with a spoon or glass is a form of personal care, not a form of health care within the meaning of the *HCCCFA Act*. It follows from this that the consent scheme laid out in that Act is not applicable in this scenario. This does not mean that service providers may provide oral nutrition and hydration without consent: adults have a common law right to consent or refuse consent to personal care services. When an adult is incapable of consenting, he is entitled to a substitute decision maker who will give or refuse consent, which will be discussed below.

Substitute Consent if Assistance with Feeding is Health Care

[85] Although much of the petitioners' argument turns on a finding that assistance with oral nutrition and hydration is health care, such a finding would not alter the outcome of this petition. In this section I will consider the application of the health care substitute consent system for Mrs. Bentley in order to demonstrate that even if

Mrs. Bentley was found incapable and oral nutrition and hydration was considered health care, this Court would not grant the declarations that the petitioners seek.

[86] If the provision of oral nutrition and hydration by prompting with a spoon or glass is a form of health care, then the system for obtaining consent for health care as set out in the *HCCCFA Act* must be followed. According to s. 5 of that *Act*, a health care provider must not provide any health care to an adult without the adult's consent except in certain exceptional circumstances outlined in ss. 11-15.

[87] One of the circumstances in which a health care provider may provide health care without consent is when there is an emergency within the meaning of s. 12 such that there is insufficient time to obtain substitute consent. Prompting Mrs. Bentley to eat with a spoon or glass has occurred several times a day for several years and is clearly not emergency treatment in which there is no time to seek substitute consent. Therefore s. 12.1, which states that a "health care provider must not provide health care under section 12 if the health care provider has reasonable grounds to believe that the person, while capable and after attaining 19 years of age, expressed an instruction or wish applicable to the circumstances to refuse consent to the health care" does not apply.

[88] If a health care provider believes an adult is not capable of giving, refusing, or revoking consent to proposed health care, and no exceptional circumstance applies, then substitute consent must be obtained (*HCCCFA Act*, s. 7). Substitute consent must be sought as follows: first, from a court appointed personal guardian; second, from a representative named in a representation agreement; third, from an advance directive; and fourth, from a temporary substitute decision maker. I will discuss each of these in turn.

1. Personal Guardian

[89] Consent for health care treatment must first be sought from a personal guardian appointed by a court under the *Patients Property Act*. Mrs. Bentley does not have a personal guardian and no application has been brought under the *Patients Property Act* to appoint a personal guardian.

2. Representative

[90] If there is no personal guardian, consent must be sought from a representative named in a representation agreement.

[91] Counsel for the petitioner is incorrect to assert that it is only necessary to look for the existence of a representation agreement if this Court finds that Mrs. Bentley's written wishes "cannot be directly enforced" (para. 138 of petitioner's written argument). It is clear on the face of the *HCCCFA Act* that a health care provider must seek consent from a representative before searching for written instructions.

[92] Section 11 of that Act states that a health care provider may provide the proposed health care if the adult's personal guardian or representative consents to it. Section 19.7(1) directs that a health care provider may only obtain consent from written wishes in the form of an advance directive if the health care provider "does not know of any personal guardian or representative who has authority to make decisions for the adult in respect of the proposed health care".

[93] Counsel for the petitioners argues that the 1991 Statement of Wishes should be considered a representation agreement within the meaning of the *Representation Agreement Act* and an advance directive within the meaning of the *HCCCFA Act*. However, this document cannot be both a representation agreement and an advance directive.

[94] An advance directive cannot appoint a decision maker who can give or refuse consent to health care for an adult upon future incapacity. The scope of an advance directive is to create written instructions that a health care provider may rely on, not to appoint a decision maker that a health care provider may seek consent from (*HCCCFA Act*, s. 19.2). A representation agreement is the only way adults in British Columbia can appoint someone to make health care decisions for them if they become incapable (*Representation Agreement Act*, ss. 7, 9).

[95] Although the *Representation Agreement Act* came into force in 2000 and the Statement of Wishes was completed in 1991, s. 39 of that *Act* provides that

> **39** An agreement that
>
> (a) was made before this Act authorized the making of a representation agreement, and
>
> (b) would have been a valid representation agreement if, at the time the agreement was made, this Act had authorized the making of a representation agreement,
>
> is valid and is deemed for all purposes to have been made under this Act.

[96] Further, pursuant to s. 32(4), this Court "may order that a representation agreement is not invalid solely because of a defect in the execution of the agreement." The petitioners deny that there is any defect in the execution of the representation agreement, but submit that if there is, this Court should exercise its power under this provision to "cure" it.

[97] The respondents, particularly FHA, argue that the 1991 Statement of Wishes is not a representation agreement. Counsel for FHA points out that the document does not comply with the requirements for execution, in that the required certificates have not been completed and attached and that the purported representatives did not sign the document until 2013.

[98] While there may be defects in the execution details that are not significant in deciding whether the document is valid, in my view the greater problem relates to the absence of clarity regarding the purported representatives' authority.

[99] Pursuant to s. 7 of the *Representation Agreement Act* an adult may authorize her representative to help her make decisions, or to make decisions on her behalf, regarding personal care, as defined in the *Representation Agreement Act*, and major health care and minor health care, as defined in the *HCCCFA Act*. These authorities are referred to as "standard".

[100] Under s. 9 of *Representation Agreement Act* an adult may authorize her representative to "do anything that the representative considers necessary in relation to the personal care or health care of the adult", including giving or refusing consent to "health care necessary to preserve life." This provision gives the representative a broader scope of decision making authority.

[101] Although it would appear from the words purporting to appoint her husband, and alternately, her daughter, "to serve as my proxy for the purpose of making medical decision on my behalf in the event that I become incompetent and unable to make such decisions for myself" that Mrs. Bentley intended her "representatives" to have authority to make health care decisions, it is not clear whether she intended them to have authority to make personal care decisions. Additionally, it is not clear whether Mrs. Bentley intended her "representatives" to have standard or broader powers, and therefore not clear whether they have the authority to refuse consent to health care necessary to preserve life.

[102] This uncertainty makes it inappropriate for the Court to exercise its power to hold that this document is a valid representation agreement despite its defects. The 1991 Statement of Wishes did not make Mr. Bentley or Ms. Hammond Mrs. Bentley's legal representatives within the meaning of the *Representation Agreement Act*.

3. Advance Directive

[103] If there is no personal guardian and no representative, a health care provider who proposes health care for an adult who is currently incapable of consenting may look to an adult's advance directive for consent (*HCCCFA Act*, s. 19.7). As previously noted, an advance directive may include an instruction to give or refuse consent to specific kinds of health care in future described circumstances.

[104] Although legislation introducing advance directives was not proclaimed in British Columbia until 2011, "written instructions made by a capable adult as described in that section are deemed to be advance directives if made and executed in accordance with sections 19.4 and 19.5 of the *Act*, as if those sections had been in force at the time the written instructions were made" (*HCCCFA Regulations*, s. 15).

[105] Section 19.4 sets out the required form of an advance directive as follows:

> **19.4** An adult who makes an advance directive must
> (a) include or address in the advance directive any prescribed matter, and

> (b) indicate in the advance directive that the adult knows that
>
> (i) a health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive, and
>
> (ii) a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consent in the advance directive.

[106] Section 19.5 outlines the execution requirements, such as the requirement that the form be signed by the adult making the advance directive in the presence of two witnesses.

[107] The petitioners argue that the 1991 Statement of Wishes is an advance directive that conforms with the requirements of the *HCCCFA Act* and instructs that Mrs. Bentley refuses consent for nourishment and liquids in these circumstances. FHA and Maplewood argue that the 1991 Statement of Wishes does not comply with the requirements of the *HCCCFA Act*.

[108] I agree with counsel for FHA that Mrs. Bentley did not indicate in the 1991 Statement of Wishes that she knew that a person may not be chosen to make decisions for her. In fact, she attempted to name two “proxies” to make medical decisions on her behalf, something that indicates that she may have believed that her health care providers would consult her “proxies”. Without even considering the execution requirements, the 1991 Statement of Wishes does not conform with s. 19.4 of the *HCCCFA Act* and therefore is not a valid advance directive.

[109] In addition, s. 19.8 of the *HCCCFA Act* sets out several circumstances in which a health care provider may not obtain consent from an advance directive and instead must turn to a substitute decision maker. One of these circumstances is s. 19.8(1)(b): “in relation to a health care decision, the instructions in an adult's advance directive are so unclear that it cannot be determined whether the adult has given or refused consent to the health care”.

[110] Although the petitioner argues that Mrs. Bentley’s refusal of consent is clear in the words “No nourishment or liquids”, when the 1991 Statement of Wishes is taken as a whole, the instructions become much less clear. The document states

that when “there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by artificial means or “heroic measures”.” It is not clear what relationship the items listed in A-E have with this preceding instruction. It is possible that the items listed are examples of what Mrs. Bentley considered “artificial” or “heroic”, but it is also possible or that she did not want “artificial” or “heroic” methods of providing the listed items. It is quite unlikely that the listed items were meant to stand alone with no relationship to this preceding instruction because the preceding instruction outlines the triggering event.

[111] The most likely interpretation appears to be that Mrs. Bentley did not want artificial delivery of nourishment or liquids through measures like a feeding tube. I do not believe many people would consider eating with a spoon or drinking from a glass, even when done with assistance, “artificial”. While “heroic measures” may be a commonly used expression, it does not communicate with any degree of clarity what a particular adult considers “heroic”. As Ms. Duthie’s Clinical Ethics Consult report states, there is consensus in the medical community that assistance with oral nutrition and hydration is neither artificial nor heroic.

[112] I find that the instruction “No nourishment or liquids”, when read in the context of the 1991 Statement of Wishes, is so unclear that even if this document could be considered a valid advance directive, this instruction could not be taken as consent by operation of s. 19.8(1)(b).

[113] I note briefly that, although it was not argued by the petitioner, the Second Statement of Wishes also cannot be an advance directive within the meaning of the *HCCCFA Act*. If Mrs. Bentley signed it, her signature was not witnessed, it does not adhere to the form requirements of s. 19.4, and it suffers from the same or even greater lack of clarity as her 1991 Statement of Wishes.

4. Temporary Substitute Decision Maker

[114] If there is no personal guardian, no representative, and no adequate instruction from an advance directive, then a health care provider must choose a

temporary substitute decision maker to give or refuse consent to health care (*HCCCFA Act*, s. 16). Section 16 of the *HCCCFA Act* sets out the list from which a health care provider must choose the first available and qualified decision maker; the first is a spouse and the second is an adult child.

[115] Accordingly, since Mrs. Bentley has no personal guardian, no representative, and no adequate instruction in an advance directive, if oral nutrition and hydration is considered health care, a health care provider must choose Mr. Bentley to consent or refuse consent. If he is not able or willing to act as a temporary substitute decision maker then the health provider must choose one of Mrs. Bentley's children to give or refuse consent.

[116] However, the authority of a temporary substitute decision maker is restricted by s. 18(2) of the *HCCCFA Act*:

> **18** (2) A person chosen under section 16 has authority to refuse substitute consent to health care necessary to preserve life, but only if there is substantial agreement among the health care providers caring for the adult that
>
> (a) the decision to refuse substitute consent is medically appropriate, and
>
> (b) the person has made the decision in accordance with section 19 (1) and (2).

[117] Section 19(1) and (2) set out the duties of a temporary substitute decision maker:

> **19** (1) A person chosen under section 16 to give or refuse substitute consent to health care for an adult must
>
> (a) before giving or refusing substitute consent, consult, to the greatest extent possible,
>
> (i) with the adult, and
>
> (ii) if the person chosen under section 16 is a person authorized by the Public Guardian and Trustee, with any near relative or close friend of the adult who asks to assist, and
>
> (b) comply with any instructions or wishes the adult expressed while he or she was capable.

> (2) If the adult's instructions or wishes are not known, the person chosen under section 16 must decide to give or refuse consent in the adult's best interests.

[118] If Mr. Bentley or Ms. Hammond is selected as a temporary substitute decision maker they would have to give or refuse consent based on Mrs. Bentley's previously expressed wishes: both those that she wrote down in her statements of wishes and those that she expressed verbally to them.

[119] However, in this case it is clear that the majority of the health care providers involved in Mrs. Bentley's care do not agree that it is medically appropriate to discontinue offering her assistance with eating by prompting with a spoon or glass. With the exception of Dr. Edelson, Mrs. Bentley's health care providers have indicated that it would be medically and ethically inappropriate to withdraw this care. It is equally clear that this care is preserving Mrs. Bentley's life as she would die from inadequate nutrition and hydration without it.

[120] Therefore even if assistance with oral nutrition and hydration was considered health care, Mrs. Bentley's temporary substitute decision maker would not have the legal authority to refuse consent since it would be health care necessary to preserve life and there is no substantial agreement among the health care providers caring for Mrs. Bentley that the decision to refuse substitute consent is medically appropriate. Mrs. Bentley's health care providers have an obligation to consult with her temporary substitute decision maker, which they have done. However, Mrs. Bentley's temporary substitute decision maker does not have the legal authority to make a binding decision when her health care providers believe it is medically inappropriate.

Substitute Consent if Assistance with Feeding is Personal Care

[121] As set out above, I have found that assistance with feeding is a form of personal care in British Columbia. Although I am aware of no statutory authority that outlines personal care consent rights, I have found that adults have a common law right to consent or refuse consent to personal care services. I am further persuaded in this conclusion by the fact that the British Columbia legislature has provided

methods for appointing a substitute decision maker to make personal care decisions in both the *Patients Property Act* and the *Representation Agreement Act*. The provision of substitute consent mechanisms must mean that personal care services cannot be provided without consent.

[122] If an adult is incapable of consenting or refusing consent to personal care services, substitute consent must first be sought by a court appointed personal guardian and if there is none, then from a representative named in a representation agreement. As discussed, Mrs. Bentley has no personal guardian. I have found that the 1991 Statement of Wishes is not a valid representation agreement within the meaning of the *Representation Agreement Act*. In addition, there is no indication that Mrs. Bentley intended to grant authority to make personal care decisions to her purported representatives with that document.

[123] If an adult has neither a personal guardian nor a representative who has authority to make personal care decisions, it is unclear who consent must be obtained from. An advance directive may not contain instructions relating to personal care; the scope of an advance directive is limited to health care (*HCCCFA Act*, s. 19.2(1)). There is no statutorily outlined substitute consent system for personal care like the temporary substitute decision maker system in the *HCCCFA Act* for health care.

[124] I am of the view that when an adult is incapable of making a personal care decision and has no personal guardian and no representative, the common law principles of personal autonomy and bodily integrity require that at minimum a service provider should consult with friends and family of the adult, who are best placed to know what the adult would have wanted, and with any written wishes the adult documented.

[125] In this situation, Maplewood and FHA have engaged in extensive consultations with Mrs. Bentley's family and considered her written statements of wishes. Mrs. Bentley's family is adamant that she would have refused consent for the assistance with eating that she is receiving. Mr. Bentley deposes in his affidavit

that “[i]n these circumstances, I have no doubt that Margot's wish is that she is not to be fed nourishment or liquids, and that she wants to be allowed to die.” Mrs. Bentley’s daughter, Danielle, states “[t]here is no doubt in my mind that Margot does not want to live in her present state.”

[126] The respondents believe they are compelled to continue providing Mrs. Bentley oral nutrition and hydration for two reasons. First, they interpret Mrs. Bentley’s written statements of wishes as indicating that she would refuse consent to the provision of nourishment or liquids through an invasive method like a feeding tube, not to assistance with feeding. They point out that her Second Statement of Wishes specifically states she does not want to be “kept alive by artificial means such as…tube feeding” but that she will accept basic care that will keep her free from pain and distress. They argue that assistance with oral nutrition and hydration is a form of basic care that prevents the pain and distress that would accompany death by dehydration. Secondly, the respondents submit that to stop providing Mrs. Bentley such assistance would constitute neglect within the meaning of the *Adult Guardianship Act* and may contravene criminal prohibitions.

[127] As already discussed, I find the instructions in both written statements of wishes to be unclear. This is particularly true in light of the specific reference to her wish not to be kept alive through artificial means such as tube feeding in her most recent written statement of wishes. Accordingly, I am not prepared to make the declaration sought by the petitioners that the 1991 Statement of Wishes expresses a clear instruction to withdraw the assistance with feeding that Mrs. Bentley is currently receiving.

[128] However, I have no doubt that Mrs. Bentley’s family has brought this petition genuinely believing her to be currently incapable of making a decision to continue eating and with the best of intentions to carry out Mrs. Bentley’s wishes. They firmly believe that she would have refused consent to the oral nutrition and hydration that she is receiving. Therefore, I will consider whether withdrawing assistance with

feeding in the form of prompting with a spoon or glass for someone who is not currently capable of making the decision herself is permitted by law.

Would Failure to Provide Assistance with Feeding Constitute Neglect within the Meaning of the *Adult Guardianship Act*?

[129] FHA has obligations as a designated agency appointed under s. 3 of the *Designated Agencies Regulation*, B.C. Reg. 19/2002 pursuant to s. 61 of the *Adult Guardianship Act*. As a designated agency, FHA has a duty to determine whether an adult who needs support and assistance is at risk for abuse or neglect and to respond accordingly. An adult who needs support and assistance is someone who is unable to seek support and assistance because of a physical restraint, a physical handicap that limits their ability to seek help, or an illness, disease, injury or other condition that affects her ability to make decisions about the abuse or neglect (*Adult Guardianship Act*, s. 44).

[130] I have no hesitation in finding that Mrs. Bentley's advanced Alzheimer's disease makes her an adult who needs support and assistance. Mrs. Bentley is unable to feed herself because she is physically incapable of lifting a spoon or glass to her mouth. Her disability requires that she be assisted with prompting in order to receive adequate nutrition and hydration.

[131] An adult who needs support and assistance and who may be in a situation of neglect is in need of protection under the *Adult Guardianship Act*. Neglect is defined in s. 1 of that Act as any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult in question serious physical, mental or emotional harm or substantial damage or loss in respect of the adult's financial affairs, and includes self neglect. FHA submits, and Maplewood and the Province agree, that to withdraw the assistance Mrs. Bentley is receiving with eating would constitute neglect within the meaning of the *Adult Guardianship Act*.

[132] As a resident of Maplewood and a client of FHA, Mrs. Bentley is entitled to rights set out in the *Residents' Bill of Rights*, a Schedule to the *Community Care and Assisted Living Act*:

> 2. An adult person in care has the right to the protection and promotion of his or her health, safety and dignity, including a right to all of the following:
>
> (a) to be treated in a manner, and to live in an environment, that promotes his or her health, safety and dignity;
>
> (b) to be protected from abuse and neglect;
>
> (c) to have his or her lifestyle and choices respected and supported, and to pursue social, cultural, religious, spiritual and other interests;

[133] FHA and Maplewood argue that failure to provide adequate nourishment and assistance with eating would be contravene this provision. Counsel for FHA states at para. 49 of their written submissions:

> Spoon feeding a resident who is incapable of bringing a spoon to her own mouth not only provides the resident with some nutrition and relief from the symptoms of hunger and thirst, but is an act of care promoting the person's dignity and protecting him or her from neglect, which is in fulfilment of his or her rights.

[134] Maplewood also refers to ss. 66 and 67 of the *Residential Care Regulation*, set out in full above, which state that care facility licensees must provide persons in care with adequate food and liquids to meet their needs and with personal assistance with eating for those in care who have difficulty eating.

[135] The Province asserts that the questions raised by this petition involves a "delicate balancing of a number of competing public policy objectives", such as the right to autonomy and the protection of adults who may be vulnerable to abuse and neglect. The Province refers to comments made in the Legislative Assembly when the 1993 package of statutes to reform adult guardianship law was passed:

> The worth of any society is measured in how we treat our most vulnerable members. Indeed, this package of adult guardianship legislation will ensure that we here in British Columbia have some of the best, most progressive legislation, to balance the responsibilities of individuals and their autonomy and society's responsibility to look out for those who need some help in looking out for themselves.

> [British Columbia, *Official Report of Debates of the Legislative Assembly (Hansard)*, 35th Parl., 2nd Sess., Vol. 11, No. 24, (7 July 1993) at 8324].

The Province argues that this balancing is a matter for the legislature to undertake, not the courts, and that the *Adult Guardianship Act* and *Criminal Code*, R.S.C. 1985, c. C-46 provisions discussed below evince a legislative intent to prevent the enforcement of the kind of decision Mrs. Bentley's family is advocating for.

[136] The petitioners argue that withdrawing nourishment or liquids and assistance with eating cannot be abuse or neglect within the meaning of the *Adult Guardianship Act* because Mrs. Bentley has consented to this withdrawal in her statements of wishes. They assert that if FHA believed that not providing nourishment and assistance with eating constituted neglect that FHA should have made an application for a support and assistance order in compliance with s. 54 of the *Adult Guardianship Act* and therefore the respondents must not provide Mrs. Bentley nourishment or liquids without a court order. They state that according to s. 53(2) of the *Adult Guardianship* Act any support and assistance plan created must comply with the consent requirements of the *HCCCFA Act*.

[137] Counsel for FHA responds that although FHA had begun creating a support and assistance plan, they abandoned it before making an application to court because they understood that Mr. Bentley and Ms. Hammond consented to the continued provision of nourishment and assistance for Mrs. Bentley in the April 15, 2013 meeting. FHA saw no need to proceed with the application for the support and assistance order once they believed Mr. Bentley and Ms. Hammond had provided this consent.

[138] FHA also responds that even if there was a clear indication from Mrs. Bentley's statement of wishes that she would refuse consent to the assistance with eating that she is receiving now, which they maintain there is not, the law would not permit this wish to be enforced. FHA claims that neither the *Adult Guardianship Act* nor the *Criminal Code*, which will be discussed below, permit an adult to consent to being killed or subjected to bodily harm.

[139] The petitioners' arguments with respect to the *Adult Guardianship Act* are premised on the finding that assistance with feeding constitutes health care within the meaning of the *HCCCFA Act*. Since I have found that it is not a form of health care, much of their argument is inapplicable. In addition, I have found that Mrs. Bentley's statement of wishes do not constitute clear refusal to consent to providing nourishment by prompting with a spoon or glass. Therefore her statement of wishes cannot be taken as determinative indications of her wishes for personal care either. However, Mrs. Bentley's family asserts that she would refuse consent to the nourishment and assistance she is currently receiving.

[140] Canadian courts have found that an adult may refuse to eat or drink and die by dehydration and starvation if he is mentally capable of making the decision. In the case *Manoir de la Pointe bleue* discussed earlier, Rouleau J. held that the staff at the care facility had no obligation and no right to provide food and liquids to Mr. Corbeil while he expressly refused consent for assisted feeding. *British Columbia (Attorney General) v. Astaforoff*, 1983 CanLII 510 (S.C.) aff'd 1983 CanLII 718 (C.A.) held that a woman in prison who was engaged in a hunger strike could not be force fed while she was conscious, competent, and refusing food and liquids in all forms.

[141] Similarly, in the Australian case *H. Inc. v. J. & Anor* [2010] SASC 176 the court found that a 74 year old woman who suffered from post polio syndrome and Type 1 diabetes was entitled to direct the staff at the care facility in which she lived to stop providing her with food and liquids so that she could die by dehydration. However, the court noted at para. 62 that the relevant legislation expressly excluded from a substitute decision maker's authority the right to refuse the natural administration of food and hydration on behalf of an adult who was mentally incapable of making that decision.

[142] In all three of these cases, the person expressing the wish to stop eating and drinking was found mentally capable of making that decision. It is clearly not settled law that a substitute decision maker has authority to refuse the provision of oral nutrition and hydration, such as prompting with a spoon or a glass, on behalf of an

adult who is incapable of making that decision. There are more risks associated with accepting such a direction from a substitute decision maker than from an adult himself.

[143] These risks were discussed by Thaddeus Mason Pope and Lindsey E. Anderson in "Voluntary Stopping Eating and Drinking: A Legal Treatment Option at the End of Life" (2011) 17 Widener L. Rev. 363. Although the authors argue that voluntarily stopping eating and drinking is a dignified and legal option for competent adults in many common law jurisdictions, they acknowledge that the right to refuse oral nutrition and hydration on behalf of an adult who is incapable of making that decision is not widely recognized at this time. They point to several substantive and procedural problems with such a decision being made on an adult's behalf, including the risk that she has changed her mind since expressing her wishes. They state at 426:

> Advance directives and surrogate appointments can be revoked by the patient. Revocation is typically straightforward when dealing with a patient with capacity. But what exactly constitutes revocation from an incapacitated patient? A severely demented patient might appear to request or desire food and water. Does a gesture such as pointing to one's mouth constitute a revocation of the patient's earlier (capacitated) instruction to not assist feeding under those circumstances?

[144] I am not satisfied that the British Columbia legislature contemplated that reference to previously expressed wishes or substitute decision makers could be relied on to refuse consent to personal care services on behalf of an adult that would lead to her death. The *HCCCFA Act* sets out that health care necessary to preserve life may be refused on behalf of an adult by a representative or, in some circumstances, a temporary substitute decision maker or an adult's previously expressed wish. Section 9(3) of the *Representation Agreement Act* expressly provides that a "representative may give or refuse consent to health care necessary to preserve life", however, there is no equivalent statement that a representative could refuse consent to personal care necessary to preserve life.

[145] In the circumstances of this case, I am of the view that if Mrs. Bentley was found incapable of deciding whether to accept or refuse oral nutrition or hydration that to withdraw the assistance she is receiving would amount to neglect within the meaning of the *Adult Guardianship Act*. As a designated agency, FHA would be obligated to respond appropriately to any concern that Mrs. Bentley may be placed in a situation of such neglect.

Would Failure to Provide Assistance with Feeding Contravene a Criminal Prohibition?

[146] The respondents and the intervenor take the position that to withdraw the assistance with feeding Mrs. Bentley is receiving may constitute a violation of several provisions of the *Criminal Code*. The respondents argue that if Maplewood staff adhere to Mrs. Bentley's family's decision to withdraw this care, the staff may expose themselves to criminal liability.

[147] The Province contends that by operation of s. 14 of the *Criminal Code* no one is entitled to consent to have death inflicted upon any person and accordingly it would be unlawful to act on such consent as it would per se be unlawful:

> **14.** 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.

[148] The respondents argue that s. 215 of the *Criminal Code* places a legal duty on Maplewood and FHA to provide Mrs. Bentley with the necessaries of life:

> **215.** (1) Every one is under a legal duty
>
> …
>
> (*c*) to provide necessaries of life to a person under his charge if that person
>
> (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
>
> (ii) is unable to provide himself with necessaries of life.
>
> (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if
>
> …

> (*b*) with respect to a duty imposed by paragraph (1)(*c*), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

[149] Finally, the respondents submit that even if they had clear direction from Mrs. Bentley's previously expressed wishes or from her family to withdraw nourishment and assistance with feeding, to enforce such a direction would be contrary to the *Criminal Code* prohibitions against assisted suicide and culpable homicide:

> **241.** Every one who
>
> …
>
> (*b*) aids or abets a person to commit suicide,
>
> whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.
>
> **222.** (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
>
> …
>
> (5) A person commits culpable homicide when he causes the death of a human being,
>
> (*a*) by means of an unlawful act;
>
> **229.** Culpable homicide is murder
>
> (*a*) where the person who causes the death of a human being
>
> (i) means to cause his death …

[150] In their petition, the petitioners seek a declaration that adherence to Mrs. Bentley's wishes constitutes a "lawful excuse" within the meaning of s. 215(2) of the *Criminal Code* for any person who might otherwise be obligated to provide the necessaries of life to her. They argue that the solution to Maplewood staff's unwillingness to withdraw nourishment and Maplewood staff's fear of criminal prosecution is to allow Mr. Bentley and Ms. Hammond to take Mrs. Bentley to their home or to another setting where nourishment and liquid will be withheld. During the hearing the parties reached an agreement that any further discussion regarding Mrs. Bentley's discharge from Maplewood would be held in abeyance pending the release of this decision.

[151] The Province argues that no declaration made by this Court can immunize Mrs. Bentley's care providers from criminal liability. In *London Health Sciences Centre v. K. (R.) (Litigation Guardian of)* (1997), 152 D.L.R. (4th) 724 (Ont. C.J.) a hospital and physician sought declarations permitting discontinuation of life-sustaining treatment for a patient and releasing them of all civil, criminal, professional and other legal liability. Jusice McDermid observed at paras. 14, 16:

> [14] It seems to me that the principles that militate against judicial review of prosecutorial discretion that has already been exercised are of even greater force when applied to a prospective limiting of that discretion. Immunity or protection from prosecution is not offered by judges. It is offered by prosecutors.
>
> …
>
> [16] In my opinion, the declaration sought either confers immunity upon the applicants, in which case it improperly interferes with the exercise of prosecutorial discretion, or, if the Attorney-General is free to disregard it, then it is merely an unenforceable judicial opinion, in which case it ought not to be given.

[152] I agree with the reasoning expressed by McDermid J. in this passage. As a civil court hearing this petition this Court has no ability to grant a declaration that could bind prosecutorial discretion. This Court cannot declare that those providing care to Mrs. Bentley would be immune from criminal liability for withdrawing nourishment and liquids by prompting with a spoon or glass. Nor can this Court declare that those providing care to Mrs. Bentley would be criminally liable for doing so. Since neither interpretation would be binding on the exercise of prosecutorial discretion any declaration would be an unenforceable judicial opinion, which ought not to be given.

Conclusion

[153] To summarize, I have found:

1. Mrs. Bentley is capable of making the decision to accept oral nutrition and hydration and is providing her consent through her behavior when she accepts nourishment and liquids;

2. The assistance with feeding that she is currently receiving must continue;

3. The provision of oral nutrition and hydration by prompting with a glass or spoon is a form of personal care, not health care within the meaning of the *HCCCFA Act*;

4. Neither the 1991 Statement of Wishes nor the Second Statement of Wishes constitute a valid representation agreement or advance directive;

5. Even if Mrs. Bentley was found incapable of making the decision to accept oral nutrition and hydration, I am not satisfied that the British Columbia legislature intended to allow reference to previously expressed wishes or substitute decision makers to be relied on to refuse basic personal care that is necessary to preserve life.

6. Withdrawing oral nutrition and hydration for an adult that is not capable of making that decision would constitute neglect within the meaning of the *Adult Guardianship Act*.

[154] The parties are at liberty to speak to the issue of costs.

"Greyell J."