

CANADA / JUDGMENT

Downey v. St. Paul's Hospital et al

2007 BCSC 478

COURT

Supreme Court of British Columbia

DECIDED

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2007 BCSC 478 Downey v. St. Paul's Hospital et al

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Downey v. St. Paul's Hospital et al,

2007 BCSC 478

Date: 20070405

Docket: S033871

Registry: Vancouver

Between:

Derek Edward Downey

Plaintiff

And

St. Paul's Hospital, Providence Health Care,

Peter Phillips, Barb Doe, ABC Co. Ltd. and

John and Jane Does No. 1 - 20

Defendants

And

Dr. Robert P. Reynolds and Dr. Gregory J. McKenna

Third Parties

Before: The Honourable Mr. Justice R. Goepel

Reasons for Judgment

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S. Grubb

Date and Place of Trial:

August 21-25; August 28-September 1; September 8; December 18-19, 2006

Vancouver, B.C.

INTRODUCTION

- [1] On July 18, 2001, M.L. was a patient at St. Paul's Hospital. His friend, Derek Downey, came to visit. Unbeknownst to anyone, M.L. had active tuberculosis ("TB"). Shortly thereafter, Mr. Downey learned he had contracted TB. Mr. Downey brings this action in damages against St. Paul's Hospital and Providence Health Care (collectively the "Hospital") pursuant to the provisions of the Occupiers Liability Act, R.S.B.C. 1996, c. 337 (the "Act"). He claims that the Hospital failed to take appropriate care to ensure that he was reasonably safe when visiting a patient. He makes no allegations against the individual doctors who treated M.L.
- [2] The Hospital submits that the question of whether M.L. ought to have been in respiratory isolation at the time of Mr. Downey's visit is a complex medical decision requiring a consideration of presenting symptoms, medical history and the patient's known risk factors. It submits that a medical decision to isolate a patient falls outside the ambit of the Act and that Mr. Downey's recourse is a common-law action in negligence, a claim Mr. Downey specifically abandoned prior to trial. Alternatively, the Hospital submits that, if the Act applies, it met the mandated duty of care set out in the Act.

BACKGROUND

A. Treatment of M.L.

- [3] In 2001, M.L., who is now deceased, was a 37-year old male on disability. He had been HIV positive since at least 1991. Prior to June 2001 he was diagnosed with AIDS.

- [4] M.L. was well known to the Hospital. As of June 16, 2001, he had received treatments on at least twenty-five previous occasions. This was not unusual for an HIV patient.
- [5] M.L. was admitted to the Hospital from June 16 to June 21, 2001, June 25 to July 7, 2001 and July 16 to July 25, 2001. On June 16, 2001, he presented with complaints of intermittent fevers, cough, aches and shortness of breath. He was admitted to the HIV Service on Ward 10C. Ward 10C is dedicated to HIV/AIDS patients. The admitting doctor decided that respiratory isolation was not required. Chest x-rays were performed on June 16 and June 17, 2001. These were normal.
- [6] On June 16, 2001, there was an order for an acid fast bacteria ("AFB") sputum sample. AFB tests are used to determine the presence of micro bacteria, including TB and micro bacterial avian complex ("MAC"). The sputum sample was not obtained.
- [7] The working diagnosis for M.L. at the time of the June 16, 2001 admission was community-acquired pneumonia ("CAP") exacerbated by asthma. He was treated with antibiotics. His condition gradually improved and his shortness of breath resolved. He was discharged from the Hospital on June 21, 2001. His discharge diagnosis was that of acute upper and lower respiratory tract infection and bronchitis.
- [8] On June 25, 2001, M.L. saw Dr. Philips. M.L. was now febrile with a cough and shortness of breath despite being on oral antibiotics. He had pain in his right hip. His chest x-ray now demonstrated a right middle lung zone infiltrate. He was admitted to the HIV Service with a diagnosis of pneumonia and started on antibiotics. A number of tests were ordered on admission, including sputum for AFB. Sputum was not produced during the admission and the test was not completed during the hospital stay.
- [9] During the course of M.L.'s second admission, investigations were carried out in relation to complaints of hip pain, leg numbness, right arm weakness and the loss of sensation. Investigations included an MRI of the brain and spine.
- [10] During the course of this admission, M.L.'s symptoms gradually improved. On July 5, 2001 his chest x-ray showed moderate clearing of the focal pneumonia in the superior segment of the right lower lobe. On July 6, 2001, he was discharged from the Hospital with instructions to continue with oral antibiotics. The working diagnosis upon discharge was community-acquired bronchopneumonia.
- [11] On July 16, 2001, M.L. again attended at the Hospital. An emergency physician assessment was carried out by Dr. Marsden, who noted shortness of breath, non-productive cough and chest crackles. His working diagnosis was pneumonia and AIDS.
- [12] Dr. Marsden referred M.L. to Dr. McKenna, a clinical associate with the HIV Service. Dr. McKenna took a medical history, did an examination, made admission notes and comprehensive admitting orders. Dr. McKenna was aware of M.L.'s recent admission for pneumonia and knew that three days after M.L. was discharged he had developed a fever. M.L. presented with progressive shortness of breath, a non-productive cough, fever,

weakness, sweats and recent weight loss. Dr. McKenna noted dyspnoea on exertion and again noted no sputum, no chest pain and ongoing weakness.

- [13] Dr. McKenna suspected CAP. He prescribed a broad spectrum antibiotic to cover a wide range of possible bacterial infections. He ordered an AFB sputum sample and blood cultures. He admitted M.L. to the HIV Service. Dr. McKenna determined that restrictive isolation was not required.
- [14] On July 17, 2001, Dr. Reynolds became responsible for M.L.'s care. Dr. Reynolds did not believe that M.L. had pneumonia. He discontinued the antibiotics. Dr. Reynolds thought M.L.'s painful right hip was the possible source of the ongoing fever and he ordered an MRI of the right hip.
- [15] On July 20, 2001, lab results established that the sputum was positive for AFB. Further tests confirmed that M.L. had active TB. The Hospital immediately put M.L. into an isolation room and began treatment for active TB.

B. Mr. Downey's Infection

- [16] Mr. Downey and M.L. had been friends for several years. On July 18, 2001, Mr. Downey visited M.L. in the Hospital. A nurse directed him to M.L.'s room. Mr. Downey says M.L. was cold, trembling and coughing uncontrollably. Mr. Downey was hit in the eye and mouth by phlegm when M.L. coughed. He asked the nurse if M.L. was contagious and she told him that, if he was, the Hospital would not allow Mr. Downey to visit.
- [17] There were no warning signs on the door or in the ward concerning infectious diseases. Mr. Downey testified that if the Hospital had warned him he would have worn a mask or not visited at all.
- [18] On July 20, 2001, M.L. told Mr. Downey that there was a problem and anyone who had visited him had to be tested. Mr. Downey contacted his personal physician, Dr. Philip Sestak. Dr. Sestak made enquires at the Hospital and learned that Mr. Downey may have been exposed to active TB.
- [19] On July 24, 2001, Mr. Downey was given a tuberculosis skin (PPD) test. The test was negative. A second PPD test performed on August 28, 2001 was positive. Mr. Downey was diagnosed as having TB on August 31, 2001. It takes about six weeks of incubation, after exposure, for a TB test to turn positive. Thus, the initial negative followed by a positive, is consistent with Mr. Downey contracting TB from M.L. on July 18, 2001.
- [20] Mr. Downey is HIV positive. To date his TB has not become active. Although it is possible that it never will, there is no guarantee that it will not. Should Mr. Downey's TB become active, it could exacerbate his HIV condition.

- [21] To protect against his TB becoming active, Mr. Downey took a 9-month course of treatment with INH, a drug with numerous side effects. He suffered from peripheral neuropathy while taking INH. Mr. Downey says that INH caused him to suffer nausea and weight loss.
- [22] As a result of his exposure to and contracting TB, Mr. Downey says that he has suffered and continues to suffer from anxiety. His evidence is that he thinks about TB daily and he has to be vigilant every time he coughs to ensure that if his TB activates that it is diagnosed immediately. Mr. Downey says he fears the medical system and thinks, like M.L., he will die. He has physical checkups every six months.
- [23] Mr. Downey's evidence is that he cannot work because of his psychological condition. Further, his social interactions and recreational activities have been severely curtailed. He is anxious about social contact, fearing that if his TB becomes active he might infect other people. He suffers panic attacks, the onset of which he attributes to the TB diagnosis.
- [24] Mr. Downey's evidence is that, prior to being diagnosed with TB, he was working and looking forward to establishing himself as a building manager. He has not worked since shortly after being diagnosed with TB on August 31, 2001. Mr. Downey's evidence is that his enjoyment of life has been dramatically reduced. He rarely goes out and he does not pursue social or recreational activities as he once did.
- [25] Mr. Downey seeks significant awards for non-pecuniary damages, past wage loss and loss of earning capacity.

C. Hospital Procedures

- [26] TB is a "communicable disease" as defined in the Health Act Communicable Disease Regulation, BC Reg. 4/83. Section 13 of the Regulation provides:

Where a medical health officer or physician knows or suspects that a person or animal is suffering from a disease listed in Schedule D, he shall ensure that the isolation procedures, quarantine and special measures set out in that schedule for the disease are included in the treatment of the infected person or animal and in the control measures taken or respecting the disease.

- [27] Section 16 of Schedule D reads as follows:

Tuberculosis/Isolation procedures:

(1). Respiratory isolation procedures shall apply to a person with pulmonary tuberculosis in an infectious form.

- [28] The Hospital established its HIV Service in February 1997. Dr. Philips is its medical director. He testified that approximately one-third of all patients admitted to the HIV Service suffer from respiratory problems. Only two per cent of those patients will have TB. TB is an uncommon diagnosis.

- [29] The Hospital's Infection Control Manual contained a written protocol (the "Policy") to deal with suspected TB cases. The purpose of the Policy was to minimize the exposure to TB. The Policy identified individuals who were at increased risk for TB. Those identified included persons infected with HIV, intravenous drug users, those who had been in contact with an individual with active TB, and First Nations members. The Policy called for the implementation of restrictive isolation after consultation with a doctor to confirm that the patient was at risk for TB.
- [30] A decision as to whether a patient needs to be isolated is made at the time the patient is admitted to the HIV Service. The admission form for patients to the HIV Service included a section that the admitting doctor must complete concerning whether or not a patient should be placed in isolation. The decision whether to isolate is constantly re-evaluated as more information becomes available. Less than five per cent of the patients placed in isolation for TB turn out to have the disease.
- [31] In a memo to clinical associates and attending staff dated October 8, 1998, Dr. Philips wrote:
- Certainly, patients with suspected tuberculosis who are coughing require respiratory isolation until the results of three SAT concentrated sputum specimens have been reported negative on smear for acid fast bacilli. Patients admitted with cough and pulmonary infiltrates, particularly injection drug users or First Nations patients, should all undergo respiratory isolation pending the results of three concentrated sputum specimens for AFB.
- [32] The Hospital has four isolation rooms on Ward 10C and more isolation beds are available, if necessary, in other wards of the Hospital. Respiratory isolation procedures are implemented if a doctor deems isolation appropriate. Dr. Philips testified that the decision on whether to isolate is a judgment call made by the attending doctor. The decision involves an assessment of all information before the doctor, including a review of the patient's history, signs, symptoms, appearance of chest x-rays, clinical progress, and an estimation of likelihood of whether a patient has TB. Dr. Philips testified that HIV positive patients, who possibly had TB, were not isolated unless those patients were at high risk of having TB.
- [33] The Hospital posts warnings for patients who are placed in isolation. No warnings are given concerning patients who are not placed in isolation. Dr. Philips testified that posting warnings for patients not in isolation would create confusion and likely dilute the effectiveness of warnings for patients who required them.

EVIDENCE OF TREATING PHYSICIANS

A. Dr. McKenna

- [34] In 2001, Dr. McKenna was employed as a clinical associate on the HIV Service at the Hospital. Clinical associates were responsible for the day-to-day care of patients on the HIV Service. He was familiar with the signs and symptoms of TB.

- [35] Dr. McKenna had minimal involvement with M.L. during his first two admissions. On July 16, 2001, M.L. was initially seen by an emergency room physician who requested an HIV Service consult. Dr. McKenna then attended the emergency room where he examined M.L. Dr. McKenna took a medical history from M.L. and examined him. Dr. McKenna knew M.L. had recently been treated at the Hospital for pneumonia and that he had a fever which had started three days after going home.
- [36] M.L. presented with a non-productive cough, fever, chills, weakness and diaphoresis. He was also suffering from weight loss and shortness of breath. Dr. McKenna ordered M.L. admitted to Ward 10C. His working diagnosis was a recurrence of CAP and he ordered treatment by way of antibiotics. He determined that M.L. need not be placed in isolation.
- [37] TB was on Dr. McKenna's differential diagnosis. A differential diagnosis includes all possible causes for a patient's symptoms, however remote. Dr. McKenna did not suspect that M.L. had TB. M.L. had no major risk factors for that disease. In Dr. McKenna's view, the pneumonia that M.L. was suffering from at the time of his earlier admissions had resolved and recurred.
- [38] Dr. McKenna ordered an AFB sputum test, as was his usual practice with patients that presented with respiratory symptoms. His practice was to order these tests early on in a patient's care because it allows physicians to explore other possibilities on the differential diagnosis, in a timely fashion, if the original diagnosis turns out to be incorrect.
- [39] Dr. McKenna agreed with the October 1998 memo, that all patients with suspected TB should be isolated. Dr. McKenna does not consider HIV in and of itself an increased risk factor for TB. In this case, he did not isolate because he did not suspect TB. Dr. McKenna believed that M.L. did not present with TB symptoms nor was he in a high-risk group for TB. Cough and fever symptoms are a common presentation. Of the many patients seen with respiratory infections, few turn out to have TB. Dr. McKenna was aware that HIV positive patients have atypical TB presentations. He considered this in making his diagnosis.

B. Dr. Reynolds

- [40] Dr. Reynolds was an attending physician on the HIV Service. He was in charge of supervising the clinical associates. He would attend daily rounds with the clinical team and the team would determine treatment plans for individual patients in Ward 10C. Since 1996 he has treated HIV patients almost daily. He treats about one or two TB patients per month.
- [41] Dr. Reynolds saw M.L. on June 17, 2001 during the course of his first admission. He diagnosed CAP. M.L. did not have any risk factors for TB and Dr. Reynolds did not suspect it, albeit TB was on his differential diagnosis. On June 18, 2001, Dr. Reynolds transferred care of M.L. to another physician.
- [42] Dr. Reynolds had no involvement with the second admission.

- [43] Dr. Reynolds was the attending physician during M.L.'s third admission. On July 17, 2001, he became responsible for M.L.'s treatment. On July 17, 2001, he examined M.L. in the course of rounds. He did not observe any significant evidence of pneumonia. Dr. Reynolds thought that asthma exacerbation was causing M.L.'s recurring respiratory symptoms. Dr. Reynolds discontinued the antibiotics ordered by Dr. McKenna.
- [44] While TB remained on his differential diagnosis, Dr. Reynolds did not suspect that M.L. had TB. It was important to Dr. Reynolds that M.L. was not a member of a group at high-risk for TB and that M.L. had been admitted twice within the past month and, on his prior two admissions, his condition had improved within twenty-four hours of commencing antibiotics. Dr. Reynolds testified that a positive response to antibiotics is not consistent with a diagnosis of TB. Dr. Reynolds agreed with Dr. McKenna's decision not to place M.L. in respiratory isolation.
- [45] Dr. Reynolds was aware of the isolation requirements of the Hospital and the October 1998 memo. Dr. Reynolds understood that whether a patient would be isolated depended on the patient's clinical presentation. A patient would only be isolated if the clinical presentation suggested that the patient was at high risk for TB. HIV patients are not placed in isolation when TB is low on the differential diagnosis. In this case, based on M.L.'s clinical presentation, Dr. Reynolds did not place him in isolation.
- [46] Dr. Reynolds does not agree with the Policy to the extent that it suggests that people with HIV are at a greater risk of having TB. He says that HIV in itself does not put one at an increased risk of catching TB and that HIV and non-HIV patients have equal chances of acquiring the disease.

EXPERT WITNESSES

A. Dr. McGowan

- [47] Dr. McGowan gave evidence in regards to the care provided by Dr. Reynolds and Dr. McKenna. He has practiced as an emergency physician for twenty-two years. He was the chair of the Medical Quality Committee and Burnaby Hospital's Infection Control Committee. He was qualified as an expert in diagnosis, treatment and infection control procedures as they relate to respiratory tract infections.
- [48] Dr. McGowan notes in his report that respiratory symptoms are the single most common reason a patient seeks medical attention and that respiratory problems are the most common reason for admission to most hospitals. He notes that very few patients with respiratory tract symptoms require isolation. He indicates that, in 2001, the general handling of patients with respiratory tract infections did not usually involve isolations except in cases considered at high risk of TB. He stated that a physician must take into account multiple factors before deciding whether respiratory isolation is required. He said it would be highly unusual to isolate a patient with pneumonia just because they were HIV positive, unless the clinical picture was strongly suggestive of TB.

[49] Dr. McGowan stated that M.L.'s clinical presentation was consistent with a viral or bacterial respiratory tract infection. He stated that M.L.'s response to antibiotic therapy, on the first two admissions, was powerful evidence to support the working diagnosis. In his opinion, the staff and physicians at the Hospital acted in a reasonable and cautious manner in treating M.L. Their treatment decisions, including not ordering restrictive isolation, were well thought out and reflected a reasonable standard of care, in 2001, for managing AIDS patients with respiratory symptoms.

B. Dr. Ghesquiere

[50] Dr. Ghesquiere testified with respect to the liability aspects of this matter. He is a Fellow of the Royal College of Physicians and Surgeons in both internal medicine and infectious diseases. He has been a consultant for infectious diseases and internal medicine for seventeen years with the Vancouver Island Health Authority.

[51] In his report, Dr. Ghesquiere concluded that both Dr. Reynolds and Dr. McKenna had followed the appropriate standard of care in the management of M.L. In particular, it was his opinion as an infectious disease consultant, that M.L.'s history, physical examination, laboratory and chest x-ray findings as of July 16 and 17, 2001 did not warrant respiratory isolation.

[52] In Dr. Ghesquiere's opinion, the treatment decisions of the medical staff and physicians at the Hospital, including Dr. Reynolds and Dr. McKenna, were appropriate and reasonable. The decision not to order restrictive respiratory isolation, immediately upon admission, was compatible with the standard of care of managing patients who are immunocompromised secondary to HIV with respiratory symptoms, in 2001.

[53] Dr. Ghesquiere stated that more aggressive measures were not warranted to rule out TB, as M.L. was improving on treatment appropriate for CAP and his fever had settled within twenty-four hours on the first two admissions. Dr. Ghesquiere stated that such a clinical presentation is incompatible with TB and, as such, further investigative steps were not warranted. Dr. Ghesquiere acknowledged in cross-examination that M.L.'s symptoms, including fever, night sweats, dry cough and chest x-ray infiltrate were consistent with TB. He stated, however, that the symptoms were also consistent with pneumonia and with a number of other diseases. In his opinion, TB would be much lower on the differential diagnosis. He testified that the fact that M.L.'s symptoms were recurring would not increase the suspicion that M.L. had TB over the course of the three admissions.

[54] Dr. Ghesquiere disagreed with the proposition that it was better to over-isolate than to under-isolate patients where TB is on the differential diagnosis. He stated that it was best to isolate appropriately and that, in M.L.'s case, considering the history and the clinical context, isolation was not appropriate.

C. Dr. Attwell

- [55] Dr. Attwell's evidence came in the form of a filed report. He was not required for cross-examination. He is a Fellow of the Royal College of Physicians and Surgeons in Canada in internal medicine. He was a clinical associate on the HIV Service at the Hospital from October 1998 to September 2003 and was qualified to comment on the care that Dr. McKenna provided to M.L.
- [56] In his report, Dr. Attwell noted that on Ward 10C all patients are HIV positive. The majority of admissions are for febrile illnesses and frequently patients present with cough, shortness of breath and possible pneumonia. In his view, it is neither possible, nor good clinical practice, to isolate every patient who is at any risk for TB. Physicians must use their clinical judgment and clinical practice guidelines to decide which patients should be placed in respiratory isolation.
- [57] Dr. Attwell notes that M.L. did not have any risk factors, other than his HIV disease, and had previously responded to therapy for CAP. His presentation was in keeping with a relapsed CAP, with asthma exacerbation. In Dr. Attwell's opinion, M.L. was not at high risk for TB, based on his demographic profile and clinical presentation, and it was reasonable for Dr. McKenna not to place M.L. in isolation on admission. In his opinion, Dr. McKenna met the standard of care of the day in deciding not to place M.L. in respiratory isolation on July 16, 2001.

D. Dr. Fitzgerald

- [58] Dr. Fitzgerald testified on the infection control measures taken with respect to M.L.'s care. Dr. Fitzgerald has practiced respiratory medicine since 1987. He is the head of the TB ward at Vancouver General Hospital and was the director of the B.C. Centre for Disease Control from 1989 to 2001. He was qualified as an expert in respiratory medicine with expertise in TB.
- [59] In his report, Dr. Fitzgerald states that appropriate infection control measures were taken. He notes there are multiple possible causes for his respiratory symptoms and fever, including asthma, as well as a possible mono arthritis in his hip. Dr. Fitzgerald testified that simply being HIV positive does not necessarily increase a patient's risk for TB.

OCCUPIERS LIABILITY ACT

- [60] Mr. Downey brings this claim under the Act. The relevant sections read as follows:

Application of Act

2. Subject to section 3 (4), and sections 4 and 9, this Act determines the care that an occupier is required to show toward persons entering on the premises in respect of dangers to them, or to their property on the premises, or to the property on the premises of persons who have not themselves entered on the premises, that are due to the state of the premises, or to anything done or omitted to be done on the premises, and for which the occupier is responsible by law.

Occupiers' duty of care

3. (1) An occupier of premises owes a duty to take that care that in all the circumstances of the case is reasonable to see that a person, and the person's property, on the premises, and property on the premises of a person, whether or not that person personally enters on the premises, will be reasonably safe in using the premises.
- (2) The duty of care referred to in subsection (1) applies in relation to the
 - (a) condition of the premises,
 - (b) activities on the premises, or
 - (c) conduct of third parties on the premises.

Independent contractors

5. (1) Despite section 3 (1), if damage is caused by the negligence of an independent contractor engaged by the occupier, the occupier is not on that account liable under this Act if, in all the circumstances,
 - (a) the occupier exercised reasonable care in the selection and supervision of the independent contractor, and
 - (b) it was reasonable that the work that the independent contractor was engaged to do should have been undertaken.

POSITION OF THE PARTIES

A. Mr. Downey

- [61] Mr. Downey submits that liability under the Act extends, by virtue of s. 3(2)(b), to "activities on the premises". He submits that caring for persons with communicable diseases is an activity on the Hospital's premises that must be undertaken with reasonable care to ensure that visitors are reasonably safe. He submits that where a hospital knows or ought to know, of a danger, it has a duty to either warn or take reasonable care. Where a hospital has a policy for protection of patients and visitors, it is incumbent upon the hospital to take reasonable steps to ensure that their policy is followed.

- [62] In the circumstances of this case, Mr. Downey submits that the Hospital was aware of the dangers of TB. It knew TB was a contagious disease of significant morbidity and mortality and that there had been a resurgence of TB in North America due, in part, to the HIV epidemic and, in part, to injection drug use. The Policy had recognized that persons who are HIV positive are at an increased risk of having TB. Mr. Downey submits that the Hospital had established the Policy to ameliorate the risk of visitors being exposed to TB. He submits that the Hospital's failure to follow the Policy is evidence of a breach of the duty of care the Hospital owed Mr. Downey.
- [63] Mr. Downey submits that, under the Act, the Hospital owed him a duty of care to ensure that he would not be exposed to persons such as M.L. who had, or were suspected of having, infectious diseases, including TB. He says that the Hospital should have ensured that patients with, or suspected of having, an infectious disease in the HIV/AIDS ward were placed in isolation. Mr. Downey submits that the Hospital breached its duty of care in failing to keep M.L. in isolation when the Hospital knew or suspected that M.L. had an infectious disease. Mr. Downey submits that the Hospital breached its obligations to him in allowing him to be exposed to M.L. when M.L. was known to, or suspected of having an infectious disease.
- [64] Mr. Downey submits that, at a minimum, the Hospital owed a duty to advise and warn him of the dangers or potential dangers in visiting M.L. He further submits the Hospital should have warned him to take precautions, including wearing a gown and protective mask, when he met M.L.

B. The Hospital

- [65] The Hospital denies that it breached any duty to Mr. Downey. It submits that the Act is inapplicable in the circumstances alleged in this action. In particular, it submits that the issue of identification and isolation of persons, who may pose a risk of infection to others, does not fall within s. 3(2) of the Act. It submits that identification of patients as being of sufficient risk to others, due to a potentially infectious disease, is a complex medical decision and not a matter that is covered by the Act.
- [66] The Hospital submits that s. 3(2) of the Act limits the duties set out in s. 3(1). It submits that the presence of M.L. in the Hospital does not meet any of the criteria set out in s. 3(2) of the Act. It relies on *Wiley v. Tymar Management Inc.* (1994), 1 B.C.L.R. (3d) 201 (S.C.), aff'd [1997] B.C.J. No. 770 (C.A.). In *Wiley*, the plaintiff sued a bingo hall operator after a wooden chair in the hall collapsed while she was sitting on it. Allan J. dismissed the claim concluding that the Act did not apply to chattels. Similar findings were made in *Howells v. Southland Canada Inc.*, [1995] B.C.J. No. 397 (S.C.), *Visser v. Loblaws Inc.*, 2001 BCSC 1781 and *Wray v. MacLeod*, [1992] B.C.J. No. 1231 (S.C.). The Hospital submits that M.L. is no more part of the "premises" than was the chair in *Wiley*.

- [67] The Hospital also submits that the plaintiff cannot establish that he was injured by virtue of an activity on the premises. It submits that M.L.'s lying on a hospital bed, breathing and coughing, can be considered no more an activity than a person sitting down on a chair in a bingo hall. In the Hospital's submission, this is a medical malpractice claim and it exceeds the bounds of the Act to attempt to apply it to matters involving complex medical decisions, such as whether a particular patient should be placed in restrictive isolation.
- [68] In the alternative, the Hospital submits that, if the Act does apply, it met the duty it owed to Mr. Downey under the Act. It submits that the Hospital had in place a reasonable system for assessing the need and appropriateness of respiratory isolation of its patients and that the system was properly implemented with respect to M.L.
- [69] In the further alternative, the Hospital submits that s. 5 of the Act provides a complete defence. The Hospital submits that the third party treating physicians were responsible for and made the decision not to place M.L. in respiratory isolation. The Hospital submits that the physicians are independent contractors and the Hospital cannot be liable for damage caused by their negligence.
- [70] The Hospital also raises a causation argument. It submits that Mr. Downey was exposed to other sources of TB in the six weeks prior to his visit with M.L., and that he has not proven that he contracted TB during his brief visit with M.L. on July 18, 2001.

C. The Third Parties

- [71] The third parties, Dr. McKenna and Dr. Reynolds, submit that the action against them must be dismissed. They submit that the decision as to whether M.L. should have been in isolation carries with it the necessity of judging matters requiring diagnostic or clinical expertise and, accordingly, it requires expert evidence. They submit there is no expert evidence critical of Dr. McKenna or Dr. Reynolds. They note that the plaintiff did not lead any expert evidence and that the expert evidence led by the Hospital is supportive of the third parties. They submit that the third parties exercised the degree of care and skill that could be reasonably expected of a normal, prudent practitioner of the same experience and standing.

FINDINGS OF FACT

- [72] Before turning to the questions arising under the Act, it is first necessary to make certain findings of fact.
- [73] The basis of the plaintiff's claim is that M.L. infected him with TB on July 18, 2001. On July 24, 2001, Mr. Downey's TB skin test was negative. On August 30, 2001, his test was positive. It takes about six weeks of incubation, after exposure, for a TB test to turn positive. Thus, the initial negative followed by a positive is consistent with a TB infection on July 18, 2001.

- [74] The Hospital submits that it is, however, also consistent with Mr. Downey being exposed to TB at some other time within six weeks of July 24, 2001. In such a case, his test would have been negative on July 24, 2001 and positive on August 30, 2001.
- [75] During that six-week window, prior to July 24, 2001, the plaintiff was living in an area where he was exposed to intravenous drug users. Mr. Downey was also a past user of cocaine. Evidence at the trial indicates that living in an area frequented by intravenous drug users and cocaine use carries with it significant risks of acquiring TB.
- [76] Mr. Downey's exposure to intravenous drug users and his own drug use was a constant in his life. While he may have contracted TB from other sources in the six weeks prior to July 18, 2001, such a conclusion is speculative at best. There is no evidence that he was exposed to TB other than in M.L.'s room on July 18, 2001. On a balance of probabilities, I find it is more likely than not that he contracted the disease during his visit with M.L.
- [77] The Policy suggests that HIV positive individuals are at an increased risk of TB. Several of the medical witnesses challenged that proposition. Based on the evidence led before me, I find that HIV positive individuals are not at a greater risk of contracting TB than non-HIV patients.
- [78] I find that the treatment of M.L., throughout his various visits, met the appropriate medical standards. On the evidence, I find that the decisions made by Dr. McKenna and Dr. Reynolds, not to isolate M.L. given his history and presentation, were consistent with the existing medical standards.

DISCUSSION

A. Applicability of the Act

- [79] The applicability of the Act in these circumstances appears to be a matter of first instance. No cases were cited to me in which the Act had been considered in the context of medical treatment. My own research was equally unsuccessful, but I did locate cases involving infections in hospitals which were determined on common-law negligence principles: *Vancouver General Hospital v. McDaniel et. al.*, [1934] 4 D.L.R. 593 (P.C.); and *Lindsey County Council v. Marshall*, [1937] A.C. 97 (H.L.).
- [80] Prior to the introduction of the Act, the common law of occupier's liability with its distinction between licensees, invitees and trespassers, was limited in application to dangers due to the state of the premises. In the circumstances where a danger arose from activities on premises, the duty of care was governed by the general rules of negligence: *Slater v. Clay Cross Co. Ltd.*, [1956] 2 Q.B. 264 (C.A.).
- [81] The Act did away with the distinction between occupancy duties and activity duties. The duty of care set out in s. 3 applies in relation to both the condition of the premises and activities on the premises.

- [82] I reject the Hospital's submission that the Act does not apply in these circumstances. Section 2 sets out that the Act determines the care that an occupier is required to show towards persons entering on premises in respect of dangers to them due to the state of the premises, or to anything done or omitted to be done on the premises. Pursuant to s. 3, the occupier owes a duty to take that care that in all of the circumstances of the case is reasonable, to see that a person entering on premises will be reasonably safe using the premises. The duty of care applies in relation to the conditions of the premises and the activities on the premises.
- [83] The Hospital occupies the premises. Mr. Downey is a person who has entered the premises. A major activity of the Hospital is the care of patients. The Hospital owes a duty to Mr. Downey to take such care, as is reasonable, to see that he is reasonably safe while he is on the premises. The fact that complex medical decisions may be involved in making the premises reasonably safe does not limit the existence of the duty. It is, however, a most important factor in determining whether the duty has been breached.
- [84] The cases relied on by the Hospital are distinguishable. They turn on whether chattels are part of the premises. This case is not concerned about the condition of the premises, but activities on the premises. The activity of the Hospital is to treat patients. Certain patients will be contagious and the Hospital owes a duty to take reasonable steps to ensure that such patients do not infect others. While liability in this case may turn on difficult medical decisions, other cases such as the failure of a hospital to isolate a known contagious patient, may not.

B. Breach of the Act

- [85] The fact that the Act applies does not necessarily lead to the conclusion that the Hospital has breached the Act.
- [86] Section 3(1) imposes a duty on the occupier and defines the standard of care necessary to fulfill that duty: *Weiss v. Young Men's Christian Association of Greater Vancouver* (1979), 11 B.C.L.R. 112 (C.A.). The standard expected of an occupier is one of reasonableness, not perfection. The standard was explained in *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.) aff'd 49 B.C.L.R. (2d) 99 (C.A.) by McLachlin J. (as she then was) at p. 58:

[T]he duty owed by an occupier of premises is to take reasonable care to see that persons using the premises will be reasonably safe. The Acts do not impose a duty to take reasonable care to insure that persons using the premises will be "absolutely safe". As stated in *Hagerman v. Niagara Falls* (1980), 29 O.R. (2d) 609, per Labrosse J. at p. 613, the occupier does not owe a duty to provide safety in all circumstances, but rather a duty to use reasonable care to prevent injury or damage from danger which is known or which ought to be known.

- [87] Mr. Downey submits that when a hospital knows, or ought to know, of the danger, it has a duty to either warn or take reasonable care. He submits that the Policy was intended to identify and isolate persons with suspected or confirmed TB and that it was incumbent upon the Hospital to take reasonable steps to ensure that the Policy was followed. He submits that the Policy was intended to reduce the risk of visitors being exposed to TB.
- [88] While a policy may be an important factor in determining the standard of care, it is not determinative, nor is it to be treated as if it were statute imposing civil obligations: *Roy v. British Columbia (Attorney General)* (2005), 38 B.C.L.R. (4th) 103 (C.A.). While policies and guidelines may assist a court in determining the standard of care, the court must give considerable weight to the evidence of experts who comment and interpret those policies and guidelines. That is particularly so in a case of this kind which involves questions of medical treatment that are beyond the ordinary experience and understanding of a judge or jury. The resolution of this case carries with it the necessity of judging matters that require diagnostic or clinical expertise.
- [89] Physicians have a duty to act in accordance with the conduct of a prudent and diligent doctor in the same circumstances. If a physician establishes that he or she followed a generally accepted standard of practice as that of his or her peers, it will normally result in the finding of no negligence: *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674.
- [90] The decision on whether to order respiratory isolation is complex, involving a consideration of a number of factors, not the least of which is a clinical assessment of the patient. For this reason, the attending physician is responsible for making the determination of whether to put a patient in respiratory isolation. In this case, there is no evidence that suggests that Dr. McKenna or Dr. Reynolds fell below the appropriate standard of care in determining that M.L. need not be isolated. All the medical evidence supports the decisions they made.
- [91] I do not accept that the Hospital failed to follow the Policy. The Policy left the decision, as to whether to enforce restrictive isolation, to the treating doctor. The Hospital was entitled to rely on the medical judgment of Dr. McKenna and Dr. Reynolds. In this case, the doctors concluded that there was no necessity to place M.L. in isolation. That decision was consistent with established standards and practice. The Hospital's duty is to isolate patients whom they suspect are contagious. The treating physicians did not suspect that M.L. was contagious. The Hospital did not fail to take the care that was reasonable in the circumstances of this case.
- [92] I do not accept Mr. Downey's submission that the Hospital breached its duty of care by failing to warn him that M.L. might possibly be contagious. The duty to warn cannot be divorced from the duty to isolate. The Hospital's duty is to take reasonable steps to ensure that patients do not infect others. Having decided that a patient did not require isolation, the Hospital is not required to warn visitors that the patient might possibly have TB. To do so would hold the Hospital to a higher standard than the Act requires.

- [93] The Act requires the Hospital to be reasonably safe for visitors. The Hospital is not an insurer of the health of visitors. Hospitals contain sick people. Sick people, for various reasons, can infect others. Visitors to hospitals know there are sick people present. Anyone with a respiratory illness could theoretically have TB. Few, in fact, do. Having properly determined that a respiratory patient does not require isolation, it is not reasonable or necessary to require hospitals to warn visitors that the patient could possibly have TB. Such warnings could dilute the effectiveness of warnings for patients who are in isolation. In the circumstances of this case, the Hospital, having determined that M.L. did not require isolation, was under no duty to warn all who may come into contact with him that he might possibly have TB.
- [94] In the result, I find that the Hospital did not breach the duty of care it owed to Mr. Downey. The action is dismissed.

COSTS

- [95] Unless there are matters of which I am presently unaware, my tentative conclusion is that the Hospital is entitled to its costs from Mr. Downey, while the third parties are entitled to their costs from the Hospital. The Hospital brought the third parties into this lawsuit. The plaintiff did not join or criticize the third parties. In the circumstances, the Hospital should pay the costs of the third parties and it will not be entitled to claim those costs from Mr. Downey.
- [96] If any party seeks a different cost order, they should file written submissions within twenty-one days from the date of these reasons. Any responsive submissions are to be filed within ten days thereafter.

"R.B.T. Goepel, J."

The Honourable Mr. Justice R.B.T. Goepel

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