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Mr. Jim Quail
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Dear Sir:

RE: **LEGAL OPINION**

OPINION

The following is my opinion concerning the potential liability of the Health Authorities and the Government if, as a consequence of contracting out housekeeping services in hospitals, the standard of cleanliness declines which results in the spread of infectious disease. Based on the assumptions outlined below, it is my opinion that the Health Authorities and Government, as well as the hospital itself, will be liable for the spread of infectious disease.

QUALIFICATIONS

I am a barrister and solicitor licensed to practice in the Province of British Columbia, and have been so for the last twenty three years. I graduated from the University of British Columbia Law School in 1978, clerked for the Chief Justice of the Supreme Court of British Columbia, and then articled and was an associate at Farris, Vaughan Wills & Murphy. For over twenty years I have been a partner in the law firm of Rosenberg & Rosenberg. My practice has been restricted to litigation and I have appeared at all levels of court in British Columbia and several times in the Supreme Court of Canada. I have conducted appeals in the Supreme Court of Canada on behalf of both appellants and respondents. For the last twelve years I have been an adjunct professor at the Law Faculty of the University of British Columbia.

BACKGROUND

The Fraser, Vancouver Coastal and Provincial Health Authorities have issued Request For Proposals to privately contract-out all housekeeping services in their acute and long-term care facilities. This includes 34 facilities and approximately 1850 housekeepers. The stated goal, from the Health

Authorities for contracting-out, is to reduce costs by lowering the wages and benefits paid to housekeepers by private contractors.
In the United Kingdom, where there is more than ten years of experience with contracting-out of housekeeping services, a number of problems with standards of cleanliness has arisen with respect to infection control issues and the relationship between infection control, cleanliness, and contracting-out.

The Hospital Employees Union has brought the relevant information concerning this matter to the attention of those making decisions about the contracting-out of housekeeping services at the Health Authority level. In addition, the Hospital Employees Union has made arrangements for Christine Perry, the Chair of the Infection Control Nurses Association in the United Kingdom to meet with managers and infection control professionals from the Health Authorities.

A number of concerned individuals including infection control professionals and doctors have advised the Health Authorities to move cautiously and develop a pilot that could be evaluated before contracting-out housekeeping services in acute and long-term care facilities.

ASSUMPTIONS

In rendering this opinion, I have taken into account the following provided assumptions:

(a) The Health Authorities and Provincial Government will contract-out housekeeping services in their acute and long-term care facilities in order to reduce costs.

(b) The Health Authorities and Provincial Government have been warned that in other jurisdictions where the contracting-out of housekeeping services has occurred, there have been problems with standards of cleanliness and the spread of infectious disease.

(c) The literature indicates that there is a direct relationship between contracting-out of housekeeping services and the risk of infection.

(d) A serious outbreak of an infectious disease, starting in the hospital, will occur, which will result in injury or loss to a number of patients and hospital employees.

(e) The outbreak will be a result of the poor cleaning done by the private firm and would likely not have occurred if the cleaning had not been contracted out.

ANALYSIS

A. Statutory Framework

The statutes we considered include:

1. Ministry Of Health Act R.S.B.C. 1996, Chap. 301
2. Health Authorities Act R.S.B.C. 1996, Chap. 180

3. Hospital Act R.S.B.C. 1996, Chap. 200
4. Hospital Insurance Act R.S.B.C. 1996, Chap.

Relevant excerpts from these statutes and regulations are attached as Schedule 1 to this opinion.

This legislative scheme establishes a system for delivery of institutional health care to those persons described as "beneficiaries" covered by the B. C. medicare plan. The minister of health, charged with all matters relating to health, public health and government operated health insurance programs under the Ministry of Health Act, provides the funding to, and appoints the boards of, five regional health authorities. Under the Health Authorities Act, each health authority controls the type of health services and facilities to be provided within its geographic area, including the location and size of hospitals, the amount of funding to be provided to each hospital, and the type of services each hospital is to provide. The health authority has the power to require the hospitals to contain costs by contracting out cleaning and housekeeping services. Established under the Hospital Act, the hospitals, which are managed by an independent board, are then charged with providing the services prescribed by the health authority within the budget allowed by the health authority. The Hospital Insurance Act requires the hospital to provide services to those insured by the provincial medicare plan. The provincial ministry does keep direct control over hospital operations under the Hospital Act. Notably the ministry appoints hospital inspectors under section 40 of that Act; each hospital must allow the provincial inspectors free access to review "the accounts, books, buildings, medical appliances, drugs and any other thing in or about the hospital".

As with the B. C. health legislation considered in the Eldridge case by the Supreme Court of Canada, this legislation "reveals that in providing medically necessary services, hospitals carry out a specific government objective" and "is not merely a mechanism to prevent hospitals from charging for their services. Rather, it provides for the delivery of a comprehensive social program."[1]

B. Common Law and Precedent

My opinion is that the hospital itself, the health authority, and the ministry would all be directly liable to a person who suffers injury or dies in an outbreak of an infectious disease, where that outbreak occurs as a result of the decision to contract out the cleaning and housekeeping functions at the hospital. The hospital's liability is based in negligence. However, the liability of the health authority and the ministry is not vicarious for the negligence of the contractor or the hospital. The liability is direct, based on a duty of care owed by each responsible authority. The duty is both a "non-delegable" duty, and a "fiduciary duty".

1. Non-delegable Duty – The legal concept of the "non-delegable duty" traces responsibility back through the entire chain of players in the delivery of institutional health care from the hospital to the health authority and the ministry. The seminal case in this area, Anns v. Merton[2], was followed by the Supreme Court of Canada in various contexts including Kamloops v. Nielsen[3] (liability of the municipality to private purchasers of new homes for negligent inspection during construction) and Just v. B. C.[4] (liability of the Ministry of Highways to users of the highway for inadequate highway maintenance), and Lewis v.

B. C.[5] (liability of the Ministry of Highways to users of the highway for inadequate highway maintenance performed by its contractor).
The extension of this concept throughout the common-law world leads to the inescapable conclusion that there exists a non-delegable duty on the part of the provincial ministry and the health authority to maintain a reasonable standard of care for patients admitted to the hospital.[6] This conclusion finds support in a number of cases from the Supreme Court of Canada. A non-delegable duty will be found to exist particularly where the user is vulnerable and is required to make use of the government service. Such a situation clearly exists, by analogy, for those ill or injured "beneficiaries" of the government health care plan who are admitted to a hospital providing insured services.

2. **Fiduciary Duty** - In addition to the concept of non-delegable duty, all three actors in the chain of responsibility potentially owe a duty to the beneficiaries of the medicare plan as fiduciaries. A fiduciary owes a duty of undivided loyalty to the beneficiary of the duty. Is the duty breached in lowering the hygiene standards in the publicly funded hospital to the point that the health of the patient is compromised? It has been argued that under Canadian law health care service providers are fiduciaries and that "a profit-driven cost-containment strategy which endangers patients is an odious breach of trust".[7] There are procedural benefits to basing an action on breach of fiduciary duty. However, as an action alleging the breach of a non-delegable duty would be more straightforward to prove, given that it does not require proof of an element of unconscionability. Nonetheless, a claim for breach of a fiduciary duty should be kept in mind in formulating an action arising out of an outbreak of infectious disease in a hospital.

C. Potential Liability

The potential for liability for each of the minister of health, the health authority, and the hospital involves somewhat different considerations. Consequently this opinion will deal with the legal responsibility, that is the duty of care and the standard of care, imposed on hospitals, health authority and ministers separately.

1. Hospitals – There is a long history of hospitals being directly responsible for injury to patients admitted to hospitals.[8] In 1947, the Court of King's Bench found the county council, as owners and managers of the hospital, liable for the death of a patient by reason of the hospital's systemic negligence in the administration of dangerous drugs.[9] The court made it quite clear that the hospital could not escape responsibility for a breach of the obligation it undertakes to a patient in the hospital merely because it has "employed another person whether a servant or an agent, to discharge it..."[10]

Of the duties a hospital owes to patients at common law, the duty to protect against infection has been specifically dealt with in Canadian caselaw[11]. That duty is breached when a patient becomes infected with disease while in the hospital (which may be from careless exposure to another patient who carries that infection but could also be from failure to clean sufficiently so as to contain the risk or spread of the infectious

agent).

In Bateman v. Doiron, the standard of care imposed on the hospital was to provide services which meet "standards reasonably expected by the community it serves".[12] If poor hygiene leads to an outbreak and spread of an infectious disease, then that would no doubt fail to meet that standard of care. "Community" standards dictate a clean environment kept sufficiently hygienic to discourage rather than encourage the growth of bacterial and viral infections. A system of cleaning that fails to do this would not meet the requisite standard of care and hence the hospital would be negligent.

2. Health Authorities –By application of the legal test in Anns v. Merton as described in by Justice Wilson in Kamloops v. Nielsen to establish the existence of a private law duty of care owed by the health authorities to the users of the hospitals[13], we can conclude that:

   (a) The establishment of the hospitals, the health services to be delivered at the hospitals, the programs to deliver those services, and the allocation of funding for those programs and services are decisions made by the health authority in the exercise of the powers given to it under the *Health Authority Act.*

   (b) There is a sufficiently close relationship between the health authority and the user of the hospital established by the health authority in the exercise of its statutory powers so that, in the reasonable contemplation of the health authority, carelessness on its part might cause damage to the user of the hospital.

   (c) There are no considerations which ought to negative or limit (a) the scope of the duty owed by the health authority, (b) the class of persons to whom it is owed or (c) the damages to which a breach of it may give rise.

We have considered the distinction made in Just v. British Columbia, by Mr. Justice Cory between policy decisions and operational decisions. A policy decisions is open to challenge only on the basis that it was not made in the *bona fide* exercise of discretion. On the other hand, the courts will apply the duty of care and attendant standard of care analysis to operational decisions that are "merely the product of administrative direction, expert or professional opinion, technical standards or general standards of reasonableness".[14] Applying the analysis from Just, once the decision to clean is made, choosing to contract out the cleaning of hospitals is such an operational decision reviewable by the courts, even if it done for financial reasons or as cost saving measure. In reviewing the scheme established to implement the statutory discretion or policy decision, the court will ensure that the scheme is "reasonable and has been reasonably carried out in light of all the circumstances, including the availability of funds, to determine whether the government agency has met the requisite standard of care".[15]

If the courts do find that the decision to contract out was a pure policy decision, then the decision would be properly reviewable if the decision was "not *bona fide* or was so irrational or unreasonable as to constitute

an improper exercise of governmental discretion." A decision taken to contract out the cleaning in hospitals in the face of the documented increase in risk to patient safety is one "in circumstances where its is so patently unreasonable as to exceed governmental discretion".[16]

In Lewis v. British Columbia[17] Mr. Justice Cory, in finding the provincial ministry of highways liable for the carelessness of the firm hired to maintain the highway on which Ms. Lewis was injured, stated at paragraph 24: "It is but fair that when a public authority exercises the statutory authority and power granted to it in circumstances which may have serious consequences for the public that it will be held liable for a breach of duty occasioned by the negligent acts of its contractor".

Chief Justice McLachlin agreed with Justice Cory's conclusion that "the wording of the statute, combined with policy considerations, imposes on the Crown, not only a duty to be careful in hiring or supervising independent contractors, but an additional non-delegable duty to ensure that the work of its contractors is done without negligence." (para 52)

The Chief Justice quotes at length from what she calls "the principled approach dependent on the circumstances of the case at hand" of Justice Mason in Kondis v. State Transport Authority: "In these situations the special duty arises because the person on whom it is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised."(para.54)

It is clear that the health authority, as the arm of government established by the Health Authorities Act to implement government policy regarding health services within its region, owes a duty of care to the hospital patient. The legal standard of care requires that it take "due" or fitting or appropriate care for the safety of the hospital user in making decisions, which directly affect the patient. The standard of care is what a reasonable person would do, or in the context of health care services as mentioned above in relation to hospitals, "standards reasonably expected by the community". Community standards would, we submit, dictate that those in charge of hospitals do not take a step that they are aware, from the beginning, could reasonably be expected to result in less clean, and less safe conditions for those already vulnerable, due to injury or illness, to the effects of an infectious outbreak. Of note will also be the standards in place in other not-for-profit schemes across Canada: if the other provinces are providing higher standards of cleanliness, then that is the measure of what will be expected in British Columbia.[18]

3. The Provincial Crown as represented by the Minister of Health – To review the statutory framework, as required by the Anns v. Merton test: the minister of health has authority to make decisions regarding all matters relating to health that are assigned to him and are not otherwise assigned. Further, the "ministry, under the minister's direction, has charge of all matters relating to public health and government operated health insurance programs". It is the minister who may designate the

health authority under the Health Authority Act and who sets the standards by which the health authority must abide in designing the health care plan for its region. Both the health authority and the hospital are under the direct control of the minister to whom the boards of both report. This control is further illustrated by the statutory scheme for hospital inspection by the Minister under section 40 of the *Hospital Act*, which empowers the Minister to appoint inspectors to whom the hospital reports directly.

This health care legislation from which the minister draws his authority imposes on the minister a non-delegable duty. In the Lewis case, Justice Cory described the duty, in reference to the minister of highways (para 24): "...It is the minister who is authorized and empowered by statute to maintain highways. The Minister may delegate the work involved in doing so, but he may not delegate the duty. That duty accompanies the power, and not the doing of the work".

In essence, the same argument that applies to the health authority as outlined above, will apply to the ministry. There is a chain of responsibility that runs from the minister to the hospital and the fact of delegation by the minister of some or part of the duty to an intermediary body does not break that chain.

As to the standard of care, the minister, like the health authority, would be expected to take reasonable or due care for the safety of the patient in the hospital under his control and is responsible for negligent care resulting from the operational decision to contract out cleaning, as are those below him in the chain of responsibility.

CONCLUSION

Based on the statutory authority vested in the Regional Health Boards and the Minister of Health regarding the planning, management, and delivery of health services, it is my opinion that liability cannot be avoided by contracting out the delivery of housekeeping and cleaning services in acute and long-term care facilities. It is reasonable to assume that members of the public who are admitted to hospitals expect that the Provincial Government is taking appropriate precautions to ensure that all of the services, including hygiene within the facilities, are being provided in a reasonable manner. If it turns out that the contracted services are sub-standard and cause the spread of infectious disease, then the Health Authorities and Provincial Government would be liable.

Yours sincerely,

ROSENBERG & ROSENBERG

Per:

David M. Rosenberg

DMR/rb

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[1] *Eldridge v. British Columbia (A.G.)* [1997] 3 S.C.R. 624
[2] *Anns v. Merton London Borough Council [1978] A.C. 728*
[3] *Kamloops v Nielsen[1984] 2 S.C.R. 2*
[4] *Just v. British Columbia [1989] 2 S.C.R. 1228*
[5] *Lewis (Guardian ad litem of) v. British Columbia[1997] 3. S.C.R. 1145*
[6] See "Non-delegable Duties Liability for the Negligence of Independent Contractors – Part I" in 4 Journal of Contract Law 183 and "Non-delegable Duties Liability for the Negligence of Independent Contractors – Part II" in 5 Journal of Contract Law 26, Swanton, J.P.
[7] "Fiduciary Law and For-Profit and Not-for-profit Health Care" by Moe M. Litman, in Health Reform & the Law in Canada: Meeting the Challenge, Caulfield, T.A. and von Tigerstrom, B. editors (University of Alberta, 2002) at page 115.
[8] See for example the discussion at pages 364 – 380 Chapter 11, Legal Liability of Doctors and Hospitals in Canada (3d Ed.), Picard, E.I. (Carswell, 1996)
[9] Collins v. Hertfordshire County Council, [1947] 1 K.B. 598
[10] *Ibid. at* p. 617
[11] *Supra,* endnote 8, at page 374.
[12] *Bateman* v. *Doiron*, (1991) 8 C.C.L.T. (2d) 284 (N.B.Q.B.) at 290, affd (1993) 18 C.C.L.T. (2d) 1 (C.A.) leave to appeal to S.C.C. refused (1994) 20 C.C.L.T. (2d) 320n.
[13] *Supra,* endnote 3, at paragraph 40.
[14] *Supra,* endnote 4, at page 1242, quoting *Sutherland Shire Council v. Heyman, Australia High Court.*
[15] *Supra,* endnote 4, at page 1243
[16] *Brown v British Columbia (Minister of Transportation & Highways)(1994), 328 D.L.R. (4th) 1 (S.C.C.) at pages 11-12* as quoted in *Gobin (Guardian ad Litem of) v. B.C. 2002 214 D.L.R. (4th) 328 (BCCA)* leave to Appeal to S.C.C. declined.
[17] *Supra,* endnote 3
[18] See for example *Walker Estate v. York-Finch General Hospital* [2001] 1 S.C.R. 647 in which the standard of care of the Canadian Red Cross Society, in a case of negligent blood donor screening, was set with reference to the procedure of the American blood collection agency. Failure by the C.R.C.S. to meet that standard was sufficient to impose liability on it for the death caused to the recipient of tainted blood.