WCAT Workers' Compensation Appeal Tribunal

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WCAT Decision Number: **WCAT-2013-00048**
WCAT Decision Date: **January 8, 2013**

Panel: Herb Morton, Vice Chair

WCAT Reference Number: 110389-A

Section 257 Determination
In the Supreme Court of British Columbia
Vancouver Registry No. VLC-S-S-098992
Gaganjit Gill v. Dr. Raphaelle Rodrigue-Vinet (Deceased), Dr. Christian Cheung, Dr. Stephen Pearce, Dr. David Revitt, Fraser Health Authority operating a public hospital under the name and style of Surrey Memorial Hospital and the said Surrey Memorial Hospital, Nurse Jane Doe, Dr. Wade Alexander Sabados and University of British Columbia

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Applicants: Fraser Health Authority operating a public hospital under the name and style of Surrey Memorial Hospital and the said Surrey Memorial Hospital ("defendants")

Respondents: Gaganjit Gill
("plaintiff")

Dr. Wade Alexander Sabados
("defendant")

Interested Person: Health Employers Association of B.C.

Representatives:

For Applicants:	Kristal Low GUILD YULE LLP
For Respondents:	
Gaganjit Gill	Morgyn R. Chandler HAMMERBERG ALTMAN BEATON & MAGLIO LLP
Dr. Wade Alexander Sabados	Michael G. Thomas HARPER GREY LLP
For Interested Person:	Alan D. Winter HARRIS & COMPANY LLP

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Introduction

[1] The plaintiff, Gaganjit Gill, worked as a carpet cleaner for Roaders Holding Co. Ltd. dba Sears Carpet & Upholstery Cleaning (Sears). On August 5, 2009, he sought medical attention at the emergency department of Surrey Memorial Hospital (the hospital), operated by the defendant Fraser Health Authority (FHA), for an allergic reaction. He was assessed by a medical resident, Dr. Raphaelle Rodrigue-Vinet (Dr. RV), who prescribed certain medications which were given to the plaintiff intravenously. The plaintiff developed tachycardia (involving an elevated heart rate), due to the epinephrine (adrenaline) being given intravenously rather than by injection (subcutaneously or intramuscularly). Dr. RV committed suicide the same day. The plaintiff learned of this from the defendant Dr. Wade Alexander Sabados when the plaintiff re-attended the hospital on or about August 11, 2009.

[2] The plaintiff is claiming damages for psychological injuries caused by the combination of the inadvertent administration of epinephrine intravenously on August 5, 2009, and for the negligent infliction of mental suffering based on Dr. Sabados' actions on August 11, 2009 in advising the plaintiff of Dr. RV's suicide.

[3] Pursuant to section 257 of the *Workers Compensation Act* (Act), the Workers' Compensation Appeal Tribunal (WCAT) may be asked by a party or the court to make determinations and certify to the court concerning actions based on a disability caused by occupational disease, a personal injury, or death. This application was initiated by counsel for the defendants FHA and Surrey Memorial Hospital on February 21, 2011. Transcripts have been provided of the examinations for discovery of the plaintiff on June 30, 2010, and of Dr. Christian Cheung on August 31, 2010.

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[4] The legal action has been dismissed or discontinued against the following defendants: Dr. Stephen Pearce, Dr. David Revitt, Dr. Christian Cheung, and the University of British Columbia (UBC). Sears is not participating in this application, although invited to do so.

[5] Written submissions have been provided by the parties to the legal action, and by the Health Employers Association of British Columbia (HEABC) as an interested person. The background facts are not in dispute, and this application does not involve any significant issue of credibility. I find that this application can be properly considered on the basis of the written evidence and submissions, without an oral hearing.

Issue(s)

[6] Determinations are requested concerning the status of the plaintiff (Gaganjit Gill), the defendant FHA operating a public hospital under the name and style of Surrey Memorial Hospital, and the defendant Dr. Wade Alexander Sabados, at the time the cause of action arose on or about August 5 and 11, 2009.

Jurisdiction

[7] Part 4 of the Act applies to proceedings under section 257, except that no time frame applies to the making of the WCAT decision (section 257(3)). WCAT is not bound by legal precedent (section 250(1)). WCAT must make its decision based on the merits and justice of the case, but in so doing must apply a published policy of the board of directors of the Workers' Compensation Board, operating as WorkSafeBC (WCB or Board), that is applicable (section 250(2)). Section 254(c) provides that WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law, and discretion arising or required to be determined under Part 4 of the Act, including all matters that WCAT is requested to determine under section 257. The WCAT decision is final and conclusive and is not open to question or review in any court (section 255(1)). The court determines the effect of the certificate on the legal action: *Clapp v. Macro Industries Inc.*, 2007 BCSC 840.

Status of the plaintiff, Gaganjit Gill

(a) Workers' compensation claim

[8] The plaintiff submitted an application for workers' compensation benefits dated September 19, 2009 in relation to his allergic reaction on August 5, 2009. He advised that he was employed by Sears as a labourer on a full-time basis. He indicated that his injury(ies) or exposure were related to a specific incident. He advised that this incident

occurred while he was performing his normal work duties, during his normal shift. He stated:

> Was doing an in-house call and exposed to something in the household that caused me to have a severe allergic reaction.
> [all quotations are reproduced as written, except as noted]

[9] The plaintiff further advised:

> My body broke out in hives, tongue swelled up, started to wheeze, and trouble breathing.

[10] The plaintiff noted that this occurred "[a]t a customer[']s residence somewhere in Vancouver." He described his regular work schedule as being five days a week, excluding Sunday and Tuesday.

[11] An employer's report of injury was provided by Sears. Sears provided the address of the customer in Burnaby where the plaintiff had been working on August 5, 2009. Sears advised that the plaintiff was employed on a full-time basis but was still in his probationary period. He started working for Sears on May 30, 2009. The incident happened during the plaintiff's normal shift. Sears advised that the plaintiff worked five days a week, eight hours a day, but the hours varied. In an attached letter dated August 12, 2009, Mark Fernandes, operations manager, Sears, advised:

> [The plaintiff] was exposed to some unknown substance which created an allergic reaction. He reported his symptoms to me after his first call of the day on August 5th. He was experiencing itchy eyes and skin, sinus congestion. He returned to the office shortly after. He has no known history of being allergic to anything specific. After a brief discussion, [the plaintiff] went home and took some Benadryl to ease the reaction. [The plaintiff] informed me the Benadryl calmed the reaction but did not have a great impact in reducing it. His family took him to the hospital. The details from here are best described by [the plaintiff] himself. It would appear there was an error in medication, or how medication was administered to him by the hospital. This apparently caused severe medical problems, which have prevented [the plaintiff] from returning to work.

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[12] In a memorandum dated September 13, 2009, a Board case manager, Long Term Disability and Occupational Disease Services, noted that the plaintiff had filed two prior claims with the Board for respiratory symptoms which were both disallowed. She noted:

> Claim 04…18 was disallowed for respiratory symptoms in this then 20-year-old sawmill laborer. Medical reports described chronic rhinosinusitis, in a highly atopic individual who underwent allergy shots in 2004. Allergies were demonstrated to a variety of items such as trees, grasses, weeds, and cats.
>
> Claim 04…74. The claimant again demonstrated from 2004 a history of allergies with multiple triggers. The claim was denied under section 55 of the *Workers Compensation Act* (the "*Act*"), and the merits of the claim were not considered.
>
> Medical testing was not positive for asthma.
>
> Both claims remained disallowed at the Review Division and WCAT levels.

[13] In a further memorandum on September 13, 2009, the case manager noted:

> This 25-year-old carpet cleaner with Sears was contacted on his cell phone September 8, 2009.
>
> The claimant remains off work following an incident August 5, 2009.
>
> …
>
> The claimant stated that he was working in an apartment on the first job, August 5, 2009 and the job was scheduled for two hours between 8 and 10 a.m. While he is not sure of the time he completed the job, he stated that it was approximately 45 minutes of work. When he completed the job he noted he had sneezing and irritation of the eyes with nasal congestion and shortness of breath. He stated the customer was an elderly Asian woman who did not speak much English but evidently was aware he was having some difficulties. The worker paged his employer, Mark Fernandes, Operations Manager. He explained he was having these symptoms and his manager advised him to drive to the office. He told me it was approximately a 20 to 25 minute drive to the office and by then he had stopped sneezing, but had hives on his body. His manager advised him to take benadryl and go home for the day. The claimant drove to a drugstore and took two benadryl while he was sitting in his car, waiting for

20 to 25 minutes. While the hives decreased, he continued to have wheezing. He drove home, approximately a 15-minute drive, and his sister stated he should go to the hospital as he had an acute onset of welts, shortness of breath and felt his tongue swelling. His sister drove him to Surrey Memorial Hospital where he ultimately spent two days. In the emergency department he was evidently inadvertently administered a dose of adrenalin intravenously, causing chest pain and rapid pulse. He had some type of cardiac injury, and the treating cardiologist, Dr. Stephen Pearce has advised him he will likely fully recover, although testing is ongoing.

The claimant was told by the cardiologist that the treating medical resident who administered the medication left the hospital and sadly committed suicide the same day.

The worker explained that he has been provided documents from the hospital from the treating cardiologist, who explained the method of delivery of the medication w encouraged to receive supportive treatment if required.

The claimant stated he currently feels well, although he does have shortness of breath with exertion. He recently underwent a treadmill test.

I asked the worker about his pre-existing allergies, and he stated there were a few problems in this regard. When I indicated his previous claims, he acknowledged he had some allergies and had in the past taken allergy shots. He moved to the Lower Mainland approximately 18 months ago. He stated he is on no medications, and that he does not have a family physician. However, he has been seen on a number of occasions at the King's Cross Medical Clinic in Surrey.

Reports from Surrey Memorial Hospital describe the worker was at a friend's house when he developed an acute onset of shortness of breath, wheezing and hives within 10 to 15 minutes. There is no indication on any of the hospital reports of a work related situation. Also, the hospital report indicates that after he developed the symptoms, someone consulted the Fraser Health Nurse Line and was advised to take Benadryl orally. Also indicated was that he was exposed at the friend's house to cat dander.

When asked for clarification, the worker stated that his sister provided most of the history to the hospital staff and there must have been some confusion about where he was when the symptoms occurred. He denied that anyone had consulted the Fraser Health Nurse Line. In terms of the cat dander, I asked whether the customer had cats. He stated this was not

the case, or at least he did not see any animals in the apartment. He then recalled that the portable cleaning machine had been used the day before by another Sears worker, and it was covered with some type of hair which he brushed off before he entered the customer's apartment.

I spoke with Mark Fernandes, Operations Manager. He confirmed the worker called him from the lobby after the first customer call, and indicated he had some allergy symptoms. When he arrived at work he did not appear in any respiratory distress, but was *"stuffed up"*. As the worker indicated, he was advised to go home for the day, and he suggested benadryl. The worker drove home on his own and other than nasal congestion, did not appear to be in any distress.

The employer stated there has been no change in any of the products or procedures with respect to the job done by the worker. The employer did speak with the customer's son, and evidently the customer did not notice the worker to be in any distress. The employer is under the impression that the customer did not have cats or other animals in the apartment. The employer stated that the worker told him he had no allergies at all when he was initially hired.

[14] The case manager requested that a Board field officer obtain statements from several persons to clarify the background events. The field investigator met with the plaintiff, interviewed the daughter of the customer (Mrs. Rae), and took a taped statement from Mark Fernandes on November 23, 2009. The plaintiff advised it was his intention to pursue a legal action rather than to claim compensation.

[15] A report dated December 7, 2009 was provided by the Board field investigator, Ralph Short. Fay Rae, the daughter of the customer(s) whose carpets were cleaned by the plaintiff on August 5, 2009, advised that her parents had moved into the suite in August 2007. They had 700 square feet of carpet to be cleaned, and the plaintiff performed this work on the morning of August 5, 2009. Upon completing the work, he offered to provide an extra "Scotchguard" treatment, which Mrs. Rae agreed to at an extra cost. Her parents had not owned or kept any pets in the apartment, they did not smoke, they had not done any renovations, and did not have air conditioning. They used a small tray of charcoal as an air freshener.

[16] Fay Rae further advised, after speaking with her mother, that the plaintiff was there for about 1 to 1.5 hours during the morning of August 5, 2009. Once he finished applying this, her mother recalled him sneezing at least four times by her front door. He used his cell phone to call his boss.

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[17] The field investigator attended the plaintiff's residence on November 3, 2009. The plaintiff advised that he had taken a portable Sears carpet cleaning unit to the customer's place on the morning of August 5, 2009. He noted cat hair on the machine when he picked it up from Sears earlier that morning. He tried to clean it off as best he could, before attending the customer's residence. When he arrived at the customer's residence, he again noted cat hair on the baseboards. He was covered in hives by the time he arrived home from work on August 5, 2009. The customer had offered him a Kleenex as he was sneezing.

[18] Fernandes advised that while the plaintiff was working for Sears from May 30, 2009 until August 5, 2009, he only missed one day of work due to illness. The plaintiff had telephoned him from the customer's residence on August 5, 2009 and complained of an allergic reaction. Fernandes instructed the plaintiff to return to the office. The plaintiff did so, and when Fernandes saw him at the office about 45 minutes later, he told him to go home.

[19] The field officer spoke with Carol Barron, acting supervisor, Health Records, at the hospital. She advised that Dr. RV appeared to be the first physician that saw the plaintiff after his admission to the hospital. Her notes indicated that the plaintiff stated he had had a previous similar reaction a few years ago in a sawmill. He was inside the house of a friend when he had a sudden rash and shortness of breath and wheezing. The field officer spoke with the plaintiff who advised that the reference to a friend's place was a misunderstanding, as this concerned his visit to the customer's house to perform carpet cleaning.

[20] By letter dated December 29, 2009, the case manager advised the plaintiff that his claim was suspended (as he wished to pursue a legal action). Accordingly, the plaintiff's claim for compensation was suspended without adjudication on the merits. In any event, item #18.1 of WCAT's *Manual of Rules of Practice and Procedure* (MRPP) provides that in a section 257 application, WCAT will consider all of the evidence and argument afresh regardless of a prior decision by a Board officer.

(b) Status as a worker

[21] There is no dispute regarding the plaintiff's status as a worker of Sears. I find that the plaintiff was a worker within the meaning of Part 1 of the Act.

[22] At issue is whether his allergic reaction on August 5, 2009 involved a personal injury which arose out of and in the course of his employment, or a disablement by occupational disease which was due to the nature of his employment.

(c) Examination for discovery of the plaintiff

[23] The plaintiff gave evidence at an examination for discovery on June 30, 2010, conducted by Mr. Sayn-Wittgenstein, counsel for the FHA. On a typical work day, he would arrive at the Sears Burnaby depot where he would be assigned a van (Q 377 to 378). The van came equipped with cleaning equipment and supplies (Q 379). He would be assigned work orders for the day (Q 380 to 381). On August 5, 2009, his shift started around 9:00 a.m., or perhaps 8:00 a.m. (Q 383).

[24] The plaintiff advised that on August 5, 2009, he had to take a portable machine to a customer's house (Q 382, 394). When he was pulling the machine off the truck, he noticed it had hair on it (Q 394). The hair was all over the machine, the hose, and the nozzle (Q 395). He advised (Q 397):

> …I took the equipment into the building, went up to the apartment and the lady opened the door and basically just told me – showed me what had to be done and I put the equipment together and I started to clean, and somewhere closer to the end I started feeling tightness in my chest and I started sneezing and my eyes started going I think red and she came in to help me, told me I could use the washroom and gave me Kleenex and stuff. I finished the job and I put my equipment – took my equipment apart and put it in the hallway and went downstairs and paged my supervisor and told him I was having a reaction where I was, and he just told me basically to come back to base.

[25] The plaintiff was unsure as to whether the hair on the equipment was cat hair (Q 399). He stated it looked like cat hair to him (Q 400). He previously had a reaction to cat hair when he had allergy testing (Q 401). He did not see any pets in the apartment he was cleaning (Q 402). The apartment was not unusually dirty; the plaintiff described its condition as "fair" (Q 406). His symptoms developed gradually over half an hour while he was cleaning in the apartment (Q 407). He developed hives while he was still in the apartment (Q 409). He also developed shortness of breath, watering eyes, and sneezing (Q 411 to 413). He had previously experienced similar symptoms of shortness of breath while working at the mill (maybe once) and also a few times when he had a reaction to getting an allergy shot (Q 415 to 416).

[26] After returning to the office, Mark Fernandes told him to wait 15 minutes (Q 423). Fernandes told the plaintiff to get an antihistamine from a store and go home (Q 423). The plaintiff was scratching himself as the hives were getting worse (Q 426 to 427). He drove directly home and his sister gave him two Benadryls (Q 432). The Benadryl stopped his condition from getting worse but it was not getting better (Q 433). His sister

drove him to the hospital (Q 440). The emergency record indicated that he arrived at 12:04 p.m. (Q 442). He was seen by a nurse, and then by a doctor at 12:13 p.m. (Q 444). He received an intravenous injection, and the plaintiff felt his heart start to race and he vomited (Q 497).

[27] The plaintiff re-attended the hospital on August 11, 2009, when he was seen by Dr. Sabados. Dr. Sabados advised him that the physician (Dr. RV) who had treated him on August 5, 2009 felt really bad about what had happened and committed suicide (Q 712, 720).

[28] The plaintiff also gave evidence at an examination for discovery on June 30, 2010, when he was examined by Mr. Thomas, counsel for Drs. Cheung, Pearce, and Revitt. He advised that his symptoms on August 5, 2009 could possibly have been due to his job duties on that date (Q 108), or could have been due to allergies in the environment (Q 109). His symptoms became serious while he was cleaning the apartment (Q 111). He stated: "I think what caused my allergic reaction is when I was in that apartment…." (Q 119).

(d) Medical records – allergic reaction and treatment

[29] The plaintiff was admitted to the hospital emergency department at 12:04 p.m. on August 5, 2009. The following history was noted:

> Had previous reaction few years ago similar when in sawmill. Was inside house of friend when sudden rash and ↑ SOB [increased shortness of breath] & wheezing. Benadryl helped.

[30] An allergic reaction was diagnosed. The admission assessment / patient profile information noted allergies to cats, dust, pollen, and sawdust. The plaintiff had shortness of breath, wheezing, and hives over his body.

[31] In a consultation report dated August 6, 2009, Dr. Christian Cheung, family medicine, noted:

> This patient was initially assessed and treated by a 2nd year family practice resident, Dr. Raphaelle Rodrigue-Vinet.
> …
> Approximately 12[:]30 p.m. I was called to the bedside to see the patient who had developed tachycardia and was profusely nauseous and vomiting and diaphoretic complaining of palpitations and chest pain. He

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> was in normal sinus rhythm with tachycardia between 150 and 160…. The duration of tachycardia was less than 5 minutes after which the palpitation and chest pain disappeared; however, he continued to be nauseous and was vomiting.
>
> …
>
> The patient and family was notified of the epinephrine being inadvertently given intravenously as opposed to subcutaneously or intramuscularly…. His hives has completely resolved.

[32] By report dated August 5, 2009, Dr. Stephen A. Pearce, cardiologist, advised:

> Mr. Gill is a 25-year-old man who is in good health, with no cardiac history. He does, however, have a history of ALLERGIES, PARTICULARLY TO WOOD PRODUCTS, and in fact had seen an allergies and had allergy shots done while in Kamloops several years ago. Today, he was at a friend's house and was exposed to cat dander, with resultant hives, wheezing, shortness of breath, and throat tightness. He took Benadryl but, because of ongoing symptoms, presented to the ER [emergency room].
>
> He was given Epinephrine 0.5 mg of a 1:10,000 concentration, but this was given intravenously, which was inadvertently done. Shortly after this injection, he developed increasing heart rate, associated with palpitations, chest pain lasting up to 5 minutes, and emesis. His symptoms gradually resolved and he is now pain free, although on deep breathing notes some mild throat discomfort. He otherwise is feeling well. His initial troponin after several hours, however, was elevated at 0.25.

[33] Dr. Pearce recorded the following impression:

> Mr. Gill is a 25-year-old man who has presented with an allergic reaction, likely precipitated by exposure to cat dander.

[34] In a discharge report on August 6, 2009, Dr. Pearce noted that the plaintiff had been asked not to perform any strenuous exertion until he was re-assessed. The plaintiff re-attended the hospital on August 17, 2009, reporting chest pain on and off for the past two weeks.

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[35] By report dated February 18, 2010, Dr. Saul Isserow, cardiologist, noted that the plaintiff was previously fit and enjoyed playing soccer and hockey. The plaintiff was reluctant to participate in these sports because of fear he would damage his heart if his heart rate went too fast. Dr. Isserow advised:

> Mr. Gill was inadvertently and inappropriately administered intravenous adrenaline. This caused the expected effect of this agent in that it caused a sudden increase in his heart rate and blood pressure with eventual reduction in blood pressure and probably some electrolyte shifts. As a consequence of the above, perhaps coupled with some spasm of his coronary arteries, he had a minimal amount of cardiac damage as manifested on elevation of his cardiac biomarker, troponin. The amount of heart muscle damaged, however, was so small that he had not been left with any residual left ventricular dysfunction, both clinically and on previous echocardiogram.
>
> From a purely cardiac point of view, he had completely recovered from this inadvertent administration of intravenous adrenaline. There is no significant heart muscle damage and certainly nothing which will adversely affect the quality of his life. He has not been left with a significant cardiac scar from which an arrhythmia could occur and he has normal left ventricular systolic function. He has no evidence of any residual lack of blood supply to the heart (ischemia) nor any evidence of any significant arrhythmias.

[36] Dr. Isserow concluded that the plaintiff was limited functionally by fear and anxiety rather than by any pure cardiorespiratory function limitations. Dr. Isserow advised that, from a cardiac point of view, the plaintiff could return to his previous employment. Dr. Isserow advised that it was imperative that the plaintiff return to the sporting endeavours which previously gave him pleasure.

[37] On March 9, 2010 and June 26, 2010, the plaintiff sought medical attention at the Peace Arch Hospital Emergency for allergic reactions involving wheezing, itching, and shortness of breath. The plaintiff submits that the evidence linking the plaintiff's allergic reaction on August 5, 2009 to his employment is speculative.

(e) Prior WCB claims / medical history

[38] The plaintiff's two prior WCB claims were both the subject of appeals to WCAT. *WCAT-2007-02822* dated September 19, 2007 concerned the plaintiff's claim for respiratory problems which first disabled him on February 25, 2004. The plaintiff

completed an application for compensation on October 26, 2005 (more than one year later). The WCAT panel found that there were no special circumstances which precluded the plaintiff from claiming compensation within one year of the date of his disablement. Accordingly, his claim for disablement in February 2004 was denied under section 55 of the Act, without being adjudicated on the merits.

[39] *WCAT-2007-01371* dated April 30, 2007 concerned whether the plaintiff's respiratory symptoms were causally related to his employment in a sawmill. The plaintiff began working as a sawmill labourer on January 21, 2004, at age 20 years. The WCAT panel summarized some of the medical reports concerning the plaintiff as follows (selected excerpts):

> On February 25, 2004, the worker was taken to hospital by ambulance. He reported that he had had bronchitis for two weeks and was short of breath. He complained of night sweats and weight loss. He denied any previous asthma. The emergency doctor noted poor air entry with wheezes and crackles in the worker's lungs. A chest x-ray demonstrated patchy air space disease. Because the worker's grandmother had recently died of tuberculosis, and had been living in the same house, the doctor wanted to rule out tuberculosis. [at page 2]
>
> …
>
> On January 18, 2005, the worker attended at the hospital emergency room with tightness in his chest, stating that he had been working in the sawmill without a dust mask. The diagnosis was extrinsic asthma. [at page 2]
>
> …
>
> On May 16, 2005, the worker saw an allergy specialist. He gave a 15-month history of upper airway congestion, rhinorrhea and sinus congestion. It was worst when he was exposed to fresh sawdust.
>
> The allergist noted that worker's upper airways were inflamed, but his chest was clear. Spirometry testing was normal. **Allergy tests showed widespread reactivity to pollens, animals, and house dust.** There was marked reactivity to trees, grasses and weeds (although these did not correlate with his history).
>
> The allergist stated that the worker was atopic by personal/family history and positive tests, and was presenting with chronic rhinosinusitis. He stated that, with the worker's degree of sensitivity, he could expect to have

increasing symptoms the longer he was exposed. It was important to keep the worker out of fresh sawdust. [at page 3]

…

The worker now began seeing a new family doctor, beginning on August 4, 2005. **He saw the doctor 23 times between August 4 and November 7, 2005, mostly for allergy shots. On October 11, 2005, the worker described an allergic reaction when he had ended up in the emergency room for an adrenalin shot**. On October 20, 2005, they discussed the worker's asthmatic airways, and his desire to put in a claim to the Board for protection in the future. [at page 3]

On September 22, 2005, the worker again saw the allergist. He had been doing well, until he had been exposed to dust a few days earlier. He stated that, if he was in the sawmill part of the operation, he got symptoms in just a few hours and could not function adequately. It took him several weeks to recover. That day, the worker's spirometry was normal. The allergist stated that the worker had atopy with a number of reactions, both to specific grasses and also to non-specific exposure. He thought that the worker should not be in the dust at the sawmill operation. [at page 4]

…

On December 14, 2005, a Board occupational physician reviewed the file. She noted that the worker's respiratory problems, in February and March 2004, had started with a lower respiratory infection, followed by symptoms consistent with hyper-reactive airways (diagnosed as viral trachiobronchitis). She noted that the worker had not undergone a methacholine challenge, so a diagnosis of asthma had not been confirmed. She noted that the worker was highly atopic, and had reacted strongly on skin testing to a variety of common environmental allergens. She acknowledged that exposure to high levels of dust made the worker's symptoms worse. However, she stated that there was no evidence to date that the worker's condition had been altered or worsened by his work. She agreed that the worker should avoid working in dusty conditions or should wear suitable protection. [at pages 4 to 5]

On December 15, 2005, the worker saw the allergist, with ongoing difficulty. He reported that he was much better off work on weekends, but developed symptoms within a few hours of returning to work. [at page 5]

…

On February 2, 2006, the worker again saw the allergist. His upper airways were congested and inflamed, but his chest was clear without wheezes or crackles, and the spirometry was normal. The allergist stated that the worker definitely had an atopic predisposition, with hay fever and other symptoms, and this made the worker more susceptible to irritants at work. He objected to the opinion by the Board occupational physician. He stated that the worker's symptoms and his days off work were related to his exposure at the mill. He acknowledged that it was accurate that the worker did not have objective evidence of disease. However, he stated that the worker's symptoms continued even though this was not reflected in the spirometry. He thought it important to separate out the worker's hay fever, not related to job exposure, from his symptoms at work which were aggravated by the dust irritation at the job. [at page 5]

…

On April 7, 2006, the worker again saw the allergist. The allergist's report, dated April 20, 2006, discussed the worker's symptoms in February 2004 (more than a year before he first saw the worker). The allergist stated that the worker's symptoms had completely subsided after he had been off work for four days. He reported that the worker's symptoms had returned, the day following his return to work after holidays. The allergist was under the impression (mistaken) that there was exposure to cedar dust in the mill. [at page 5]

The allergist reported that the spirometry testing of the worker's lung function, in May, June and September 2005 and February 2006, had all been normal. However, he stated that those tests had been done when the worker was not exposed. He stated that he had made a mistake earlier, stating that the worker was atopic by personal/family history and positive skin tests.

…

On July 11, 2006, the allergist [Dr. William W. Arkinstall] wrote a response to the review officer's decision…. The allergist stated that individuals with an atopic nature often have airway hyper-reactivity which makes them more susceptible to a respiratory reaction with exposure to high levels of dust and other irritations. He proposed that this was the worker's situation. It was not that the worker's allergies had been made worse, but that his allergies and associated airway reactivity had predisposed him to a reaction from dust. When the worker had started work in early 2004, his chest was normal and he had no pre-existing or respiratory symptoms. The exposure at the workplace had precipitated the symptoms. The

allergist admitted that the worker might have been more susceptible because of his atopic nature, but thought that it was the exposure to dust in the workplace that had activated the chest, causing his symptoms of cough, wheeze, discomfort and inability to effectively function in the dust exposure at work. He stated that atopy was not a disease, but, rather, an enhanced sensitivity to a variety of both allergenic and non-specific exposures. He thought that the worker had symptomatic asthma, precipitated by his workplace exposure to dust. He thought that the symptoms would not have occurred if he had not been in the workplace dust exposure. [at pages 6 to 7]

…

On July 13, 2006, the worker's family doctor [Dr. Christiaan Brink], wrote a letter "To Whom It May Concern." He stated that the worker had severe environmental allergies mostly related to his work. In August 2005, the worker had presented to the doctor with very clear history of allergy symptoms that resulted mostly when he started working at the sawmill. He had had multiple episodes of severe allergic reactions, requiring very urgent medical treatment. The doctor did not believe that it was a pre-existing condition. [at page 7]

There is a second copy of that letter, which appears to have been faxed on July 26, 2006, in which the word "mostly" is replaced by the word "entirely". That is, the severe environmental allergies are now entirely related to the work, and the symptoms resulted entirely when he started working at the sawmill. [at page 7]

On September 18, 2006, the worker's family doctor wrote a note "To Whom It May Concern". He again stated that the worker's asthma and other allergy problems began purely at the time when he started working in the sawmill. He stated that, after the worker's hospitalization in February 2004, he continued to have progressively worsening symptoms of allergies and asthmatic symptoms. He attributed those conditions to the work at the sawmill. [at page 7]

On May 1, 2006, the allergist wrote a letter to the employer. He stated that the worker's testing, on May 16, 2005, had shown a marked reaction to grasses, and a lesser reaction to other inhalants. He thought it significant that the worker showed a reaction to sawdust, a reaction which was virtually never seen in the population not exposed on a regular basis to wood dusts. He stated that the worker was known to be atopic and did have a history of seasonal hay fever in the months of May and June. This was easily treatable with immuno-therapy, which was begun then. From

the history obtained from the worker, he thought that there was no history of symptoms from wood dust until the worker began working at the sawmill. [at page 7]

The allergist noted his error in referring to cedar dust. However, he thought that wood dust in general was a specific irritant. Individuals with an allergic predisposition were more sensitive to any irritant, both specific and non-specific. They could develop reactivity to allergens, but could also react, in a greater degree than non-atopic individuals, to other irritants. [at pages 7 to 8]

…

On October 13 and November 20, 2006, the worker saw a new specialist in respiratory medicine. The specialist was aware of the initial diagnosis of bronchitis. He noted that the worker had not worked in the sawmill since April 4, 2006. He stated that the worker had not had breathing problems since then, and had not used inhalers since then. He noted that there had been no history of asthma in the family, but the worker's sister had had hay fever that cleared up as she became an adult. [at page 8]

Testing revealed strong reactions to grass and tree pollens, and positive reactions to other allergens. Spirometry tests on both dates were normal, and the methacholine inhalation challenge showed normal reactivity.

The specialist stated that the worker was atopic by skin testing, but did not have a history of nasal or bronchial symptoms until February 2004. Although the respiratory illness in February 2004 was presumed to be infective, he thought that one should consider that it might be due to irritation from the ash contaminating the wood dust. He noted that symptoms had recurred in the summer of 2005 and had cleared after the worker stopped work on April 4, 2006. The worker did not have active asthma at the time of examination.

The specialist considered that the worker's respiratory symptoms were caused by exposure to wood dust at work, persisted with continued exposure at work, and cleared after he was no longer exposed to wood dust at work.

At the oral hearing, the worker stated that he had never had respiratory problems until he started working in the sawmill in January 2004. By October 2005, his problems had increased to the point that he did not know what to do, so he applied to the Board for compensation. He kept working until the spring of 2006. By then, the employer did not feel safe placing him in a dusty environment. They provided two or three weeks of office work for him, and then there was no more work. His last day worked

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> was April 4, 2006. He stated that it took him about two weeks to become symptom-free. He stated that he no longer has seasonal allergies.
>
> [emphasis added]

[40] The WCAT panel concluded that the worker's respiratory problems were not compensable as an occupational disease due to the nature of his employment. The WCAT panel reasoned, in part:

> Much has been made of the statement that the worker had no breathing difficulties before he began working in the sawmill. This has been used to imply that the worker did not have a pre-existing condition**. However, it is undisputed that the worker was atopic, that is, that he had underlying allergic sensitivity and a predisposition to react to irritating or allergenic substances. Although he might have not been aware of that underlying sensitivity, it existed and was not caused by his employment at the sawmill.** It may be that the attack of viral bronchitis [in February 2004] was a factor in making his condition symptomatic. **However, I cannot conclude that the underlying condition was significantly aggravated, activated or accelerated by occupational exposure to sawdust. The evidence indicates that the symptoms were temporary, and resolved quite quickly when the worker was no longer exposed.** This was the case at the beginning of his employment at the sawmill, as well as at the end. The evidence does not suggest that his respiratory condition was worse at the end than at the beginning. Although his symptoms may have been temporarily aggravated by exposure, the evidence does not suggest that the underlying condition was aggravated.
>
> If the worker's condition was correctly diagnosed as asthma, which is a questionable conclusion in itself, then I find that the asthma was not caused, aggravated, activated or accelerated by occupational exposure. It does not constitute an occupational disease which was due to the nature of the worker's employment.
>
> [emphasis added]

[41] By letter dated July 13, 2006, Dr. Christiaan Brink, the plaintiff's general practitioner, advised:

> He has had multiple episodes of severe allergic reactions for which he required very urgent medical treatment. He had an episode where he had to be hospitalized for a period of nine days. His hospitalization was a result of allergies and resulted in very severe asthmatic airways.

> **He currently receives allergy injections which were prescribed by Dr. Arkinstall of Kelowna. He had a few episodes where he had an acute anaphylactic response to the allergens and as a result, had to receive epinephrine.**
>
> [emphasis added]

[42] A Kelowna Allergy Laboratory report concerning testing performed on the plaintiff on May 16, 2005 showed that the plaintiff was allergic to trees (alder, birch, cottonwood, mountain cedar, and pine), several grasses and weeds, sawdust, cat hair, and house dust. The plaintiff was not allergic to dog hair/dander, feathers, cattle hair, horse hair, or hamster hair.

[43] In a report dated December 8, 2006, Dr. Raja T. Abboud, respirologist, noted that on allergy skin testing the plaintiff showed strong reactions to grass and tree pollens, mixed nuts, and cat dander. He also had positive reactions to cockroaches, the dust mite D. pteronyssimus, weed pollen, and egg white. Dr. Abboud concluded:

> …Mr. Gill is atopic by skin testing, but he did not have a history of asthma or any respiratory symptoms prior to his exposure to wood dust. His symptoms started at work after exposure to wood dust, and cleared completely after he left work. At present, he has normal spirometry and normal bronchial reactivity. Thus I consider that his respiratory symptoms were caused by exposure to wood dust at work, persisted with continued exposure at work, and cleared after he was no longer exposed to wood dust at work.

(f) Law and policy

[44] Section 5 of the Act provides, in part:

> **5** (1) Where, in an industry within the scope of this Part, personal injury or death arising out of and in the course of the employment is caused to a worker, compensation as provided by this Part must be paid by the Board out of the accident fund.
>
> (2) Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable under this Part from the first working day following the day of the injury; but a health care benefit only is payable under this Part in respect of the day of the injury.

---

[45] Section 6 of the Act provides, in part:

> **6** (1) Where
>
> (a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed or the death of a worker is caused by an occupational disease; and
>
> (b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments,
>
> compensation is payable under this Part as if the disease were a personal injury arising out of and in the course of that employment. A health care benefit may be paid although the worker is not disabled from earning full wages at the work at which he or she was employed.
>
> (2) The date of disablement must be treated as the occurrence of the injury.

[46] Section 257 of the Act provides, in part:

> **257** (1) Where an action is commenced based on
>
> (a) a disability caused by occupational disease,
>
> (b) a personal injury, or
>
> (c) death,
>
> the court or a party to the action may request the appeal tribunal to make a determination under subsection (2) and to certify that determination to the court.
>
> (2) For the purposes of subsection (1), the appeal tribunal may determine any matter that is relevant to the action and within the Board's jurisdiction under this Act, including determining whether
>
> (a) a person was, at the time the cause of action arose, a worker,
>
> (b) the injury, disability or death of a worker arose out of, and in the course of, the worker's employment,

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[47] In August 2009, the policies in Chapter 3 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) included the following (selected excerpts):[1]

> **#13.00 PERSONAL INJURY**
>
> "Personal injury" is defined as any physiological change arising from some cause, for example, a limitation in movement of the back or restriction in the use of a limb. It is not confined to injuries which are readily and objectively verifiable by their outward signs, e.g. breaks in the skin, swelling, discolouration, deformity, etc. It includes, for example, strains and sprains.
>
> **#13.10 Distinction Between an Injury and Disease**
>
> A common difficulty is to distinguish between an injury and a disease. This distinction is one that can be illustrated more easily than defined.
>
> The following are examples of disorders classified as INJURIES:
>
> …
>
> 5. Sprains and strains, whether caused by a specific incident or by activity over time.
>
> …
>
> The following are examples of disorders classified as DISEASES:
>
> …
>
> 7. Allergic reactions.
>
> Only diseases which are occupational diseases are compensable. The compensation payable in respect of occupational disease is discussed in Chapter 4.
>
> **#13.40 Infectious Agent or Disease Exposures**
>
> No compensation is payable to a worker who withdraws from work or changes employment because of concern that exposure to the conditions at work may cause an injury or disease which does not yet exist.
>
> Wage loss benefits are not payable to a worker who remains off work or who changes employment to prevent a reoccurrence of a personal injury or occupational disease that has resolved, or to prevent an aggravation,

[1] In this decision, I have applied the policies in effect in August 2009. While the board of directors of the Board has approved a revision to the policies in Chapter 3 of the RSCM II, those new policies only apply to injuries or accidents that occur on or after July 1, 2010.

activation, or acceleration of a personal injury or occupational disease which has stabilized or plateaued. However, vocational rehabilitation assistance may be provided to a worker in this situation. Where the worker is left with a permanent impairment, the worker may be entitled to a permanent disability award.

#26.22 Non-Scheduled Recognition and Onus of Proof

In some cases a worker may suffer an occupational disease not listed in Schedule B. In other cases a worker may suffer from an occupational disease listed in Schedule B but was not employed in the process or industry described opposite to it in the Schedule. In some cases a worker may suffer a disease not previously designated or recognized by the Board as an occupational disease.

Here, the decision on whether the disease is due to the nature of any employment in which the worker was employed, is determined on the merits and justice of the claim without the benefit of any presumption. The same is true if for any other reason the requirements of section 6(3) are not met.

…

Therefore if the weight of the evidence suggesting the disease was caused by the employment is roughly equally balanced with evidence suggesting non-employment causes, the issue of causation will be resolved in favour of the worker. This provision does not come into play where the evidence is not evenly weighted on an issue. If the Board has no or insufficient positive evidence before it that tends to establish that the disease is due to the nature of the worker's employment, the Board's only possible decision is to deny the claim.

#26.55 Aggravation of a Disease

Where a worker has a pre-existing disease which is aggravated by work activities to the point where the worker is thereby disabled, and where such pre-existing disease would not have been disabling in the absence of that work activity, the Board will accept that it was the work activity that rendered the disease disabling and pay compensation. Evidence that the pre-existing disease has been significantly accelerated, activated, or advanced more quickly than would have occurred in the absence of the work activity, is confirmation that a compensable aggravation has resulted from the work.

This must be distinguished from the situation where work activities have the effect of drawing to the attention of the worker the existence of the pre-existing disease without significantly affecting the course of such disease. For example, a worker who experiences hand or arm pain due to an arthritis condition affecting that limb will not be entitled to compensation simply because they experience pain in that limb from performing employment activities. Similarly, a worker with a history of intermittent pain and numbness in a hand/wrist due to a pre-existing median nerve entrapment (carpal tunnel syndrome) will not be entitled to compensation just because their work activities also produce the same symptoms. **To be compensable as a work-related aggravation of a disease, the evidence must establish that the employment activated or accelerated the preexisting disease to the point of disability in circumstances where such disability would not have occurred but for the employment.**

Where the pre-existing disease was compensable, the Board must decide if the aggravation should be treated as a new claim or as a reopening of an earlier claim.

An aggravation of a pre-existing disease which is attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury and will be adjudicated in accordance with the policies set out in Chapter 3. For example, a worker who injures his or her back while performing a series of awkward lifts at work may suffer an aggravation to an underlying degenerative disc disease, or a worker with subacromial bursitis may strain the shoulder while completing a particular lift.

An aggravation of a pre-existing disease which is not attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a disease. For example, a worker with a prior history of carpal tunnel syndrome may aggravate such condition to the point of requiring surgery as a result of several weeks of exposure to vibrating equipment.

#29.20 Asthma

2. Pre-existing Asthma Condition

A pre-existing asthma condition is not compensable unless such underlying condition has been significantly aggravated, activated, or accelerated by an occupational exposure. **A worker is not entitled to compensation where his or her pre-existing asthma condition is**

> **triggered or aggravated by substances which are present in both occupational and non-occupational settings unless the workplace exposure can be shown to have been a significant cause of an aggravation of the condition. A speculative possibility that a workplace exposure to such a substance has caused an aggravation of the pre-existing asthma is insufficient for the acceptance of a claim.**
>
> **3. Temporary Disability**
>
> In the case of a compensable asthma or a respiratory tract reaction to a substance with irritating or inflammatory properties, temporary disability benefits are payable until the worker's acute symptoms resolve or stabilize or the worker reaches retirement age as determined by the Board.
>
> **#32.10 Psychological/Emotional Conditions**
>
> The Board does accept claims for personal injury where the injury consists of a psychological condition or where the psychological condition is a consequence of a compensable personal injury or occupational disease. (14) However, the Board has not recognized any psychological or emotional conditions as occupational diseases related to employment.
>
> [emphasis added]

(g) Submissions – allergic reaction

[48] No medical opinion has been provided which expressly concerns the cause of the plaintiff's allergic reaction on August 5, 2009, apart from the medical records provided in 2009 concerning the plaintiff's diagnosis and treatment.

[49] The plaintiff notes that despite his belief that there was cat hair on the carpet-cleaning machine, there is no evidence as to whether the machine actually had cat hair on it or whether this was sufficient to cause his allergic reaction. The plaintiff stated in his examination for discovery that he generally experienced hay fever symptoms around that time of the year. The plaintiff was an atopic individual who suffered severe allergic reactions on a number of occasions prior to his employment with Sears, and on occasions afterwards with no specific known trigger (such as on June 26, 2010 when he sought medical attention at the Peace Arch Hospital Emergency), but sensitivities to a wide range of common allergens. He had no previously accepted compensable conditions.

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[50] The plaintiff had worked as a carpet cleaner (since May 30, 2009) with no previous incidents of allergic reaction. The mere fact that he was present at a client's residence when his symptoms progressed is insufficient to establish that the symptoms were due to the nature of his employment. His symptoms got progressively worse after he left the client's residence. The only factor linking his allergic reaction with the nature of his employment is the temporal relationship between his work and the arrival of his symptoms, and this is insufficient to establish that his employment activated his symptoms to the point of disability where such disability would not have occurred but for the employment. The evidence linking the plaintiff's allergic reaction to his employment is speculative, particularly in light of his history of allergic reactions to various substances (some so severe they required hospitalization). The plaintiff submits that his allergy symptoms did not arise due to his employment, not did the nature of his employment aggravate an underlying allergic condition.

[51] The FHA submits that the plaintiff had a history of allergies to cat dander, nuts, wood products, and dust. There is no evidence he was exposed to any irritants prior to arriving at the client's residence on August 5, 2009. His first appointment on August 5, 2009 was at the client's house where he suffered the allergic reaction. The plaintiff's evidence was that he found cat hair on the machine. There is a strong temporal link between the plaintiff's workplace exposure to the cat hair and his allergic reaction.

(h) WCAT decisions – allergic reactions

[52] Several WCAT decisions have been cited by counsel. Some of the cited decisions concerned whether the employment was of causative significance to the development of the allergic condition (such as *WCAT-2009-01780*, concerning a claim for multiple chemical sensitivity). Other cited decisions concerned claims for an allergic reaction in a work environment, where the worker had a pre-existing non-compensable allergic condition. For the purposes of my decision, I consider the latter group of decisions to have relevance to the circumstances of this case in which there is clear evidence of the plaintiff's pre-existing allergic condition or disease.

[53] *WCAT-2009-03347* reasoned at paragraphs 46 and 47:

> Turning again to the two April 9, 2001 decisions, I conclude that while the worker did not suffer from acute respiratory irritation, **he nevertheless did suffer an aggravation of allergic vasomotor rhinitis of a sufficient degree as to warrant medical attention. I further conclude that this aggravation was not particularly significant, given no disability arose and treatment was essentially limited to advising against future exposure on a preventative basis.**

> **As such, I confirm the claims adjudicator's decision to limit the worker's entitlement to the provision of health care expenses only.** The decision to do so was consistent with section 6(1) of the Act, which provides for the payment of health care benefits in the circumstance where an occupational disease does not result in disablement from earning full wages at the work at which the worker was employed. I conclude that the worker was not disabled from earning full wages at the work at which he was employed. My conclusion in that regard is consistent with the facts, as well as item #26.30 of the RSCM I [*Rehabilitation Services and Claims Manual, Volume I*], which describes that an absence from work in order to prevent an onset of disability does not amount to a "disability" under the Act.
>
> [emphasis added]

[54] *WCAT-2010-01808* cited the policies at RSCM II item #29.20 and reasoned, in relation to a claim by a hospital worker who suffered an anaphylactic reaction as a result of being exposed to orange slices used as part of a meal service:

> [35] Therefore, and at least in terms of the adjudication of claims involving an aggravation of pre-existing asthma**, the relevant consideration when there can be exposures both in non-occupational and occupational settings is whether it was a workplace exposure that was a significant cause of an aggravation.**
>
> [36] I conclude that the same adjudicative principle ought to apply to the worker's claim, as it also involves consideration of an occupational disease claim from the perspective of whether there was a work-caused aggravation. The issue, therefore, is not resolved by evaluating relative risk between potential occupational and non-occupational exposures. In short, in the worker's case, the aggravation she experienced was clearly caused by a workplace exposure. That alone is sufficient reason to establish her claim.
>
> [emphasis added]

[55] The WCAT panel concluded that the worker sustained an occupational disease that arose due to the nature of her March 29, 2009 employment, being an aggravation of her pre-existing citrus allergy.

[56] The policy at RSCM II item #29.20, concerning a pre-existing asthma condition, provides that where a pre-existing asthma condition is triggered or aggravated by substances which are present in both occupational and non-occupational settings, it is

necessary to show that the workplace exposure was a significant cause of an aggravation of the condition in order for it to be compensable. In addressing the meaning of the term "significant cause," I am guided by the reasoning of the British Columbia Supreme Court in *Schulmeister v. BC (WCAT)*, 2007 BCSC 1580:

> [117] The panel stated that it could not conclude that Mr. Schulmeister's compensable injuries were a significant cause of the accident that led to his death. To explain its reasoning, the panel engaged in a comparative or relative analysis with other factors.
>
> …
>
> [119] The failure of the panel to restrict its analysis to the question of whether or not Mr. Schulmeister's compensable injuries were a significant cause of his death is, in my view, a failure to properly take board policy item #22.00 into account.
>
> [120] While the policy requires a finding of significant causation before an injury or death can be considered a compensable consequence of an event, it does not require that the event be the most significant cause of the injury or death, or that other factors cannot play a greater role than the compensable injuries.
>
> [121] Had the Board intended to require that sort of weighting of causes, it would have clearly stated that a relative analysis was needed. Instead, it stated only that a cause must be "a significant cause" of a later injury before it could be the basis for the reopening of a claim.

(i) Analysis – allergic reaction

[57] There were occasions prior to August 5, 2009 on which the plaintiff had to seek medical attention for a severe allergic reaction due to exposure to wood dust, or to allergens involving his course of treatment involving allergy injections. However, the plaintiff's evidence was that the prior similar episodes occurred after he received an allergy shot, and once at the mill (where he was exposed to wood dust). The evidence does not point to the plaintiff having suffered a prior severe allergic reaction in the absence of exposure to an identified allergen. While he had hay fever or seasonal allergies, these do not appear to have been severe in nature so as to produce a severe allergic reaction requiring medical treatment at a hospital prior to August 5, 2009.

[58] The plaintiff had a documented allergy to both cat hair and house dust. However, on August 5, 2009, he had been working as a carpet cleaning technician for over two months (since May 30, 2009).

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[59] The temporal relationship between the plaintiff's carpet cleaning activities at the customer's apartment on the morning of August 5, 2009 and the development of his allergic reaction is clear. This was his first appointment of the day, and by the time he left the apartment his symptoms had developed to the point where he called his supervisor regarding his symptoms and was told to return to the office. After returning to the office he was advised to take Benadryl and to go home.

[60] On the morning of August 5, 2009, the plaintiff found that the carpet cleaning machine had hair all over it. A likely inference is that this was pet hair from carpet cleaning performed the previous day. It could have been cat hair, to which the plaintiff was known to be allergic, or dog hair, to which the plaintiff was not allergic. It was the plaintiff's belief that this was cat hair.

[61] Absent the plaintiff's opinion, and in the absence of other evidence regarding the cleaning schedule for the previous day and particulars as to whether those residences had dogs or cats, it appears likely that the hair was due to the presence of a pet in a household where cleaning had been performed. Cats and dogs are common household pets.

[62] Section 250(4) of the Act provides:

> If the appeal tribunal is hearing an appeal respecting the compensation of a worker and the evidence supporting different findings on an issue is evenly weighted in that case, the appeal tribunal must resolve that issue in a manner that favours the worker.

[63] Section 250(4) of the Act applies to this application by virtue of section 257(3), which provides:

> This Part [Part 4 of the Act], except section 253 (4), applies to proceedings under this section as if the proceedings were an appeal under this Part.

[64] I interpret section 250(4) as meaning that where evidence is evenly balanced on an issue, the issue must be resolved in a fashion which supports the provision of workers' compensation coverage (rather than according to the worker's or plaintiff's preference in the particular case).

[65] In any event, the fact that the plaintiff identified the hair on the machine as cat hair, based on his observations, is some evidence which tends to tilt the weight of the evidence towards a conclusion that the hair was cat hair. As the plaintiff's evidence is the only evidence available regarding the type of hair on the machine, I consider that it warrants some consideration, while recognizing that the actual nature of the hair was never determined. Accordingly, I consider it more likely than not that the plaintiff was exposed to cat hair due to his work activities on the morning of August 5, 2009.

[66] The plaintiff received a list of different appointments each morning from Sears. His work required him to travel to multiple work locations each day to perform cleaning services. As such, he was a travelling employee within the meaning of the policy at RSCM II item #18.40, with workers' compensation coverage for his travels throughout the day after leaving the employer's depot (except in the event of a distinct departure on a personal errand, as set out in RSCM II item #18.41).

[67] I find that the plaintiff was working from the time he arrived at the Sears Burnaby depot. He was assigned a van at that location, which contained the carpet cleaning machine which had hair on it. Any exposure to cat hair or any other allergen which might have occurred inside the van, while driving in the Sears van from the Burnaby depot to the client's apartment in Burnaby, would also have been work related. Accordingly, if the plaintiff's exposure occurred in the van, or while he was removing the carpet cleaning equipment from the van and cleaning the hair from it, or during the course of his cleaning activities in the apartment, it was work related.

[68] The evidence as to the temporal connection between the plaintiff's cleaning activities on the morning of August 5, 2009 is strong. His symptoms developed while he was at the client's apartment to the point he called his supervisor and returned to the office. While his symptoms continued to progress after leaving the apartment, I consider that the timing of the onset of his symptoms was significant in terms of showing when the plaintiff suffered the exposure which gave rise to his allergic reaction.

[69] Upon consideration of the foregoing, I consider it more likely than not that the plaintiff's diagnosed severe allergic reaction on August 5, 2009 occurred as a result of a work-related exposure, rather than as a result of an exposure at his home or during his commute from his home to the Sears Burnaby depot that morning.

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[70] The evidence is clear concerning the fact that the plaintiff was suffering from a pre-existing allergic condition or disease. This pre-existed any exposure the plaintiff may have suffered at work on August 5, 2009. However, I consider that the weight of the evidence supports a conclusion that the plaintiff suffered a temporary aggravation of his allergic condition due to a work-related exposure on August 5, 2009. I consider that his need to seek medical attention at the hospital emergency on August 5, 2009, and related disablement from continuing to work after his first appointment on August 5, 2009, were due to this work-related exposure.

[71] Policy at RSCM II item #13.10 provides that allergic reactions are classified as diseases. However, policy at RSCM II item #25.55 provides that an aggravation of a pre-existing disease which is attributed to a specific event or trauma, or to a series of specific events or traumas, will be treated as a personal injury. I consider that there is an ambiguity as to whether the policy at RSCM II item #13.10 is intended to refer to the adjudication of the underlying allergic condition (i.e. such as in the case of red cedar asthma), or whether it is also intended to include specific incidents of work exposure in the presence of an underlying non-compensable allergic condition. While I am inclined to view the latter as being more akin to a claim for personal injury, I will apply the policy at RSCM II item #13.10 and address the plaintiff's allergic reaction as a claim for an occupational disease under section 6 of the Act.

[72] Under section 6 of the Act, where the disease is due to the nature of the employment, compensation is payable. A health care benefit may be paid although the worker is not disabled from earning full wages at the work at which he or she was employed. Accordingly, a claim is acceptable on an occupational disease basis even if it only involves a need for health care.

[73] I agree with the reasoning cited above from *WCAT-2010-01808* and would apply similar reasoning to the circumstances of this case. I accept that the factual and medical evidence establishes that the plaintiff suffered a work-related aggravation of his pre-existing allergic condition on August 5, 2009. It is possible that the plaintiff's allergic reaction was to some other cause. However, the weight of the evidence supports a conclusion that the allergic reaction was work related (including the fact that he was exposed to hair on the cleaning machine, his evidence that this appeared to be cat hair, to which he had a documented allergy, and the fact that his allergic reaction commenced while he was in the client's apartment).

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[74] Policy at RSCM II item #26.30 provided:

> Health care benefits may be paid to a worker who suffers from an occupational disease even though the worker is not thereby disabled from earning full wages at the work at which he or she was employed.
>
> There is no definition of "disability" in the Act. The phrase "disabled from earning full wages at the work at which the worker was employed" refers to the work at which the worker was regularly employed on the date he or she was disabled by the occupational disease. **This means that there must be some loss of earnings from such regular employment as a result of the disabling affects of the disease, and not just an impairment of function.** For example, disablement for the purposes of section 6(1) may result from:
>
> - an absence from work in order to recover from the disabling affects of the disease;
> - an inability to work full hours at such regular employment due to the disabling affects of the disease;
> - an absence from work due to a decision of the employer to exclude the worker in order to prevent the infection of others by the disease;
> - the need to change jobs due to the disabling affects of the employment.
>
> A worker who must take time off from his or her usual employment to attend medical appointments is not considered disabled by virtue of that fact alone. However, income loss payments may be made to such a worker (see policy item #83.13).
>
> [emphasis added]

[75] In this case, the plaintiff did not leave work for the purpose of seeking medical attention. Rather, he was sent home by his supervisor due to his allergic reaction, and subsequently sought medical attention at the hospital.

[76] In his examination for discovery, the plaintiff stated that his remuneration as a Sears carpet cleaner was primarily commission based. While there was a minimum hourly rate, he never made less than that amount so his payments were always based on the commissions (Q 367 to 373). Accordingly, in being sent home due to his symptoms on August 5, 2009, and not being able to attend to the other cleaning

assignments on that date, the plaintiff would have suffered some loss of earnings. I accept that this constituted a disablement from earning full wages.

[77] Section 5(2) of the Act provides:

> Where an injury disables a worker from earning full wages at the work at which the worker was employed, compensation is payable under this Part from the first working day following the day of the injury; but a health care benefit only is payable under this Part in respect of the day of the injury.

[78] I do not consider the fact that compensation other than health care benefits would not be payable by the Board for the plaintiff's disablement on August 5, 2009 detracts from a conclusion that he was disabled from earning full wages at the work at which he was employed on August 5, 2009.

[79] Accordingly, I find that the plaintiff suffered a temporary aggravation of his pre-existing allergic condition due to his employment on August 5, 2009, and that he was disabled from earning full wages on August 5, 2009 as a result of this temporary aggravation.

[80] In summary, I find that the plaintiff was a worker within the meaning of Part 1 of the Act. I further find that the plaintiff's disablement by an occupational disease on August 5, 2009 (involving a temporary aggravation of a pre-existing condition or disease) was due to the nature of his employment. Pursuant to section 257(2)(b) of the Act, I find that the plaintiff's disability caused by occupational disease, in respect of his allergic reaction on August 5, 2009, arose out of and in the course of his employment.

(j) Plaintiff's status while receiving medical treatment on August 5, 2009

[81] A further question concerns the plaintiff's status while receiving medical treatment for his allergic reaction on August 5, 2009.

[82] Policy at RSCM II items #22.00 and #22.10 provided:

> #22.00 COMPENSABLE CONSEQUENCES OF WORK INJURIES
>
> Once it is established that an injury arose out of and in the course of employment, the question arises as to what consequences of that injury are compensable. The minimum requirement before one event can be considered as the consequence of another is that it would not have happened but for the other.

> Not all consequences of work injuries are compensable. A claim will not be reopened merely because a later injury would not have occurred but for the original injury. Looking at the matter broadly and from a "common sense" point of view, it should be considered whether the work injury was a significant cause of the later injury. **If the work injury was a significant cause of the further injury, then the further injury is sufficiently connected to the work injury so that it forms an inseparable part of the work injury. The further injury is therefore considered to arise out of and in the course of employment and is compensable.**
>
> #22.10 Further Injury or Increased Disablement Resulting from Treatment
>
> **Where a further injury or increased disablement arises as a direct consequence of treatment for a compensable injury, it is sufficiently connected to the original work injury as to form part of that injury. The further injury is therefore considered to arise out of and in the course of employment and is compensable.**
>
> Where a worker is undergoing treatment for a compensable injury, the place of treatment is analogous to a place of employment. A further injury arising out of the place of treatment is compensable provided it is consistent with the worker being at the place of treatment for the purpose of treatment and does not result from activities of a personal nature. The further injury in these cases is compensable because it is sufficiently connected to the original work injury so that it forms part of that injury and is therefore considered to arise out of and in the course of employment. For example, if a worker is undergoing treatment at a hospital for a compensable injury and sustains a further injury by stumbling down the stairs in the hospital while en route to a treatment appointment, the further injury is also compensable.
>
> [emphasis added]

[83] These policies were approved by the board of directors in 2004 (Resolution of the board of directors 2004/01/20-01, "Re: The Status of Treatment Injuries," January 20, 2004). *Appeal Division Decision #93-1399*, 10 WCR 603, which applied a similar analysis, was found to be not patently unreasonable in *Kovach v. BC (WCB)*, 2000 SCC 3. The 2004 policy amendments had the effect of adopting the approach applied in the *Kovach* decision. Accordingly, where a worker suffers a further injury or increased disablement as a result of medical treatment for a work injury, the further injury or increased disablement is accepted as arising out of and in the course of the worker's employment.

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[84] The plaintiff points out that the policies at RSCM II items #22.00 and #22.10 are contained in Chapter 3 dealing with personal injuries. There is no comparable policy in Chapter 4 concerning occupational diseases. There is, therefore, no policy concerning the compensable consequences of an occupational disease, as to whether a further injury or increased disablement resulting from an occupational disease should be accepted as arising out of and in the course of the worker's employment.

[85] The plaintiff submits that in the absence of a clear policy directive in Chapter 4 regarding the compensable consequences of an occupational disease, it is open to WCAT to adopt a different approach than was applied in *Kovach*. The plaintiff cites the reasoning in *Appeal Division Decision #2002-3030*, *Downs v. Dr. Andrew Lee*, at paragraphs 91 and 93:

> (91) On the other hand, it is difficult to arrive at a conclusion that an alleged injury caused by surgery is an injury arising in the course of employment on the basis of any rational analysis that is consistent with principles of compensation law. There is a good deal of similarity between Mr. Justice Tysoe's definition of the phrase "arising out of and in the course of employment" and that of Professor Larson. Both indicate that the fundamental relationship which must be established is one of work causation (to paraphrase Justice Tysoe) or work connection, in the words of Professor Larson. When used as the threshold test for determining entitlement to compensation it is necessary to establish both aspects of the test to some minimal degree. It is conceivable that this phrase could support an alternative interpretation for the purposes of section 10 of the Act. But, in the absence of any foundation for an alternate interpretation in compensation law, the Act itself, **or the policies**, such an approach would fly in the face of the most basic rules of statutory interpretation.
>
> …
>
> (93) **If it is the intent of the legislature and/or the Board that these injuries have the status of injuries arising out of and in the course of employment, clear policy direction, or more likely, statutory amendment may be necessary.** In the absence of such direction, I find that the alleged injury arose out of the employment in that there remained a sufficient work connection to establish this aspect of the test; I find, however, that it did not arise in the course of employment.

> (94) In summary, I find that the plaintiff was a worker under Part 1 of the Act at the time of surgery but any alleged injuries caused by the surgery did not arise out of and in the course of employment.
>
> [emphasis added]

[86] As noted above, the board of directors approved the amended policies at RSCM II items #22.00 and #22.10, subsequent to the 2002 Appeal Division decision. The policy amendments provided clear policy direction approving the approach which had previously been applied in *Kovach*.

[87] I appreciate the basis for the plaintiff's submission. The absence of clear policy direction expressly dealing with the compensable consequences of occupational diseases leaves it open to WCAT to consider whether a different approach should be applied. It might even be argued that the provision of such policy guidance concerning personal injuries, coupled with a lack of corresponding policy guidance concerning occupational diseases, supports a conclusion that the policy amendments were not intended to apply to occupational diseases.

[88] I am, however, unable to discern any logical basis for distinguishing between personal injuries and occupational diseases, in terms of considering whether a further injury or increased disablement resulting from compensable treatment should be accepted as compensable. If a worker is undergoing compensable medical treatment, and experiences a further injury or increased disablement as a result of negligence in that treatment, why should it matter whether the need for the treatment was as a result of a personal injury or an occupational disease? Similarly, if the worker stumbles and falls while walking down the corridor in the hospital, why should it matter whether the need for the worker's hospital admission was as a result of a personal injury or an occupational disease? In the lack of any compelling reason to draw such a distinction, I consider it appropriate to take guidance from the policies at RSCM II items #22.00 and #22.10 even if they are not binding in this context.

[89] I note, in any event, that section 6(1) provides that compensation is payable for an occupational disease "as if the disease were a personal injury arising out of and in the course of that employment." Section 6(2) further provides that:

> The date of disablement must be treated as the occurrence of the injury.

[90] Accordingly, for the purposes of applying other provisions of the Act or policy, the date of disablement by an occupational disease is treated as the occurrence of the injury. On this basis, the policies at RSCM II item #20.00 and #20.10 may be considered binding. I would reach the same conclusion, under either analysis.

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[91] Accordingly, I find that the plaintiff's disability caused by occupational disease, including any injury or increased disablement resulting from his medical treatment on August 5, 2009, arose out of and in the course of his employment. This would include both the physical and psychological consequences of receiving epinephrine intravenously (and experiencing tachycardia, vomiting, and related symptoms).

(k) Psychological condition

[92] The plaintiff is claiming damages for psychological injuries caused by the combination of the inadvertent administration of epinephrine intravenously on August 5, 2009, and for the negligent infliction of mental suffering based on Dr. Sabados' actions on August 11, 2009 in advising the plaintiff of Dr. RV's suicide.

[93] The *Workers Compensation Amendment Act, 2011,* S.B.C. 2012, c. 23 (Bill 14, 2011) received royal assent on May 31, 2012. The amendments to section 5.1 (the mental stress provision) came into force on July 1, 2012.

[94] Section 5.1 of the Act was repealed and amended. The new provision applies to every decision made by the Board or WCAT on or after July 1, 2012 in respect of a claim made but not finally adjudicated before July 1, 2012. Section 5.1 provides:

> 5.1 (1) Subject to subsection (2), a worker is entitled to compensation for a mental disorder that does not result from an injury for which the worker is otherwise entitled to compensation, only if the mental disorder
>
> (a) either
>
> (i) is a reaction to one or more traumatic events arising out of and in the course of the worker's employment, or
>
> (ii) is predominantly caused by a significant work-related stressor, including bullying or harassment, or a cumulative series of significant work-related stressors, arising out of and in the course of the worker's employment,
>
> (b) is diagnosed by a psychiatrist or psychologist as a mental or physical condition that is described in the most recent American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the diagnosis, and
>
> (c) is not caused by a decision of the worker's employer relating to the worker's employment, including a decision to change the

work to be performed or the working conditions, to discipline the worker or to terminate the worker's employment.

(2) The Board may require that a psychiatrist or psychologist appointed by the Board review a diagnosis made for the purposes of subsection (1) (b) and may consider that review in determining whether a worker is entitled to compensation for a mental disorder.

(3) Section 56 (1) applies to a psychiatrist or psychologist who makes a diagnosis referred to in this section.

(4) In this section:

"psychiatrist" means a physician who is recognized by the College of Physicians and Surgeons of British Columbia, or another accredited body recognized by the Board, as being a specialist in psychiatry;

"psychologist" means a person who is registered as a member of the College of Psychologists of British Columbia established under section 15 (1) of the *Health Professions Act* or a person who is entitled to practise as a psychologist under the laws of another province.

[95] A medical-legal report dated December 2, 2009 has been provided by Dr. William J. Koch, registered psychologist, based on an assessment of the plaintiff. With respect to the occurrence of the medication error, Dr. Koch commented on page 7:

> By Mr. Gill's report, he felt that his life was in danger during his time in the emergency room and that he was very frightened. From his description, this event could potentially qualify as a Criterion A Traumatic Stressor by DSM [*Diagnostic and Statistical Manual of Mental Disorders*] rules.

[96] In footnote 28 on page 7, Dr. Koch explained:

> According to DSM rules, for an event to qualify as a traumatic stressor, "both of the following (must be) present: 1. the person experienced, or witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; 2. the persons response involved intense fear, helplessness, or horror." American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, Text Revision*. Washington, DC: Author.

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[97] Dr. Koch concluded that the plaintiff suffered from (in descending order of severity):

> Panic Disorder with Agoraphobia, Major Depressive Disorder, and Generalized Anxiety Disorder [GAD]. Although he meets the symptomatic criteria for PTSD [posttraumatic stress disorder] by interview, a careful review of his avoidance and hypervigilance symptoms suggests that these are better considered part of his Panic Disorder, Depression, or GAD.

[98] Dr. Koch noted that at the time of his report, it was only four months since the subject event in August 2009, and the plaintiff was in the acute stages of his Panic Disorder. With appropriate treatment, he had a reasonable chance of recovery from his Panic Disorder.

[99] Dr. Koch expressed an opinion that the "hospital event" did not contribute substantially to the plaintiff's worry proneness and Generalized Anxiety Disorder. He concluded, however:

> I believe that the most parsimonious explanation for his current Panic Disorder is that (a) he had some pre-existing vulnerability through his history of respiratory problems, (b) that this was aggravated by his anaphylactic reaction to cat hair, and then (c) that the combination of these two preceding factors and his tachycardia in hospital and uncertainty about outcome precipitated his subsequent Panic Disorder. Thus, I believe that the hospital event was likely the most substantial cause of his subsequent Panic Disorder, but not the sole cause.

[100] Dr. Koch further advised that while the plaintiff was likely at some risk to develop a depression in the future, given his excessive worry and relatively substantial psychosocial pressures pre-dating the hospital incident, his Major Depression was primarily a consequence of his Panic Disorder and the hospital incident.

[101] Dr. Koch's report noted on page 7 that by the plaintiff's report, sometime later than the August 5, 2009 hospital incident he heard that the medical resident who initially treated him had committed suicide on that day. Dr. Koch's report did not provide any additional analysis expressly concerning the plaintiff's response to this.

[102] In an addendum on December 9, 2009, following consideration of a report by the plaintiff's sister, Dr. Koch revised his opinion based on this third party evidence that the plaintiff's worry proneness had arisen primarily following the subject event. Accordingly, he found that the subject event was the primary precipitant of the plaintiff's excessive worry and Generalized Anxiety Disorder.

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[103] A medical-legal report dated May 21, 2010 was provided by Dr. Shaohua Lu, psychiatrist, based on an examination of the plaintiff on May 18, 2010. Dr. Lu noted that the medication error could not be viewed in isolation from the plaintiff's subsequent knowledge that the physician who ordered the medication committed suicide almost immediately following the administration of the medication. These events were linked in the plaintiff's mind, and he experienced the whole sequence of events as a trauma. Dr. Lu found that the plaintiff met the DSM-IV-TR [*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*] diagnostic criteria for posttraumatic stress disorder (PTSD) relating to the sequence of events in August 2009. His PTSD had a duration of more than three months and was considered chronic. Based on his current PTSD severity, the plaintiff was at increased risk of developing major depression.

[104] A report dated March 25, 2011 was provided by Dr. Stephen D. Anderson, psychiatrist, who saw the plaintiff on March 21, 2011 for an independent psychiatric assessment. Dr. Anderson concluded:

> In summary, Mr. Gill was emotionally traumatized by incidents which occurred in August 2009. The most significant traumatic event was likely the medication error which occurred on August 5th, 2009. Learning of the death of the physician on August 11th, 2009 would have likely contributed to Mr. Gill's emotional difficulties but would not have caused him to develop panic attacks. Of note, Mr. Gill likely had one panic attack between August 5th, 2009 and August 11th, 2009. My preferred diagnosis for Mr. Gill would therefore be panic disorder with mild agoraphobic symptoms, presently in remission. His panic disorder remitted approximately six months prior to the assessment. Mr. Gill does not presently have a psychiatric disorder.

[105] Dr. Anderson found that most of the plaintiff's present anxiety and depressive symptoms were likely due to premorbid factors.

[106] Policy at C3-13.00 provides:

> For the purposes of this policy, **a "traumatic" event is an emotionally shocking event, which is generally unusual and distinct from the duties and interpersonal relations of a worker's employment.** However, this does not preclude a worker who, due to the nature of his or her occupation, is exposed to traumatic events as part of their work (e.g., emergency workers).

> **In most cases, the worker must have suffered or witnessed the traumatic event first hand.** The reaction to the traumatic event or events is typically immediate and identifiable. In some situations, however, the reaction may be delayed. A work-related stressor is considered "significant" when it is excessive in intensity and/or duration from what is experienced in the normal pressures or tensions of a worker's employment.
>
> [emphasis added]

[107] The plaintiff heard about Dr. RV's suicide on August 11, 2009, six days after it occurred on August 5, 2009. However, he experienced the effects of the medication error first hand. Dr. Lu's opinion was that the medication error and the plaintiff's subsequent knowledge that the physician who ordered the medication committed suicide almost immediately following the administration of the medication, were linked in the plaintiff's mind and that he experienced the whole sequence of events as a trauma. I find that the medication error, and subsequent suicide of the treating physician, was emotionally shocking to the plaintiff and involved a traumatic event or events.

[108] The expert opinions of Drs. Koch, Lu, and Anderson all identify the event(s) at the hospital as a significant cause of a disabling psychological condition. I find that the plaintiff's mental disorder involved a reaction to the August 2009 event(s) at the hospital.

[109] Policy at C3-13.00 further provides:

> It [section 5.1] requires that a worker's mental disorder be diagnosed by a psychiatrist or a psychologist as a condition that is described in the most recent DSM, at the time of diagnosis.
>
> As set out in the DSM, a DSM diagnosis generally involves a comprehensive, multi-axial and systematic clinical assessment of the worker. A multi-axial diagnosis involves consideration of the following:
>
> - Axis I: Clinical disorders
> - Axis II: Personality disorders
> - Axis III: General medical conditions
> - Axis IV: Psychosocial and environmental problems
> - Axis V: Global assessment of functioning

> The Board is responsible for the decision-making process, and for reaching the conclusions on the claim. Under section 5.1(2) of the Act, the Board may obtain expert advice to review the diagnosis and where required, may obtain additional diagnostic assessment.
>
> In reviewing the diagnosis, the Board also considers all of the relevant medical evidence, including prior medical history, attending physician reports and expert medical opinion. The findings of this additional information are considered in determining whether there is a DSM diagnosed mental disorder.

[110] The opinions by Drs. Koch, Lu, and Anderson all provided diagnoses of a condition described in the most recent DSM, at the time of diagnosis. Drs. Koch and Lu made express reference to the DSM-IV-TR, and Dr. Anderson's report implicitly addressed these criteria in providing diagnoses of a condition described in the DSM-IV-TR.

[111] I find that the requirements of section 5.1 of the Act are met. I find that the plaintiff's mental disorder was a reaction to one or more traumatic events arising out of and in the course of this employment. These events involved experiencing the effects of the medication error, and learning the physician who ordered the medication committed suicide almost immediately following the administration of the medication. For the purposes of my decision on this point, I consider that the plaintiff's reaction related both to the physical effects of the epinephrine being given intravenously, and to his awareness that this involved a medication error.

[112] While not necessary to my decision, I note the recent British Columbia Court of Appeal (BCCA) decision in *Downs Construction Ltd. v. WCAT*, 2012 BCCA 392. The BCCA concluded that if the factual events giving rise to the claim for a mental disorder arose out of and in the course of the employment, then a legal action is barred irrespective of whether the requirements of section 5.1 of the Act are met. The requirements of section 5.1 are not relevant in determining whether a claim for a psychological injury/mental disorder is one arising out of and in the course of a plaintiff's employment. Accordingly, my certification would be the same even if I had found that the requirements of section 5.1 were not applicable or were not met. The factual events giving rise to the legal action arose out of and in the course of the plaintiff's employment (including the medical treatment provided as a consequence of his employment-related allergic reaction).

[113] Accordingly, I find that the plaintiff's disability caused by occupational disease, including any psychological injury resulting from the medication error on August 5, 2009, and his

being informed by Dr. Sabados on August 11, 2009 of Dr. RV's suicide, arose out of and in the course of his employment.

Status of the defendants, Fraser Health Authority operating a public hospital under the name and style of Surrey Memorial Hospital and the said Surrey Memorial Hospital

[114] The FHA submits that at all material times, it was an employer and engaged in an industry within the meaning of Part 1 of the Act. The plaintiff's submissions do not address this issue.

[115] By memorandum dated March 3, 2011, a research and evaluation analyst, Audit and Assessment Department of the Board (the analyst), advised that FHA operating Surrey Memorial Hospital, account number 687502, registered with the Board effective January 1, 2003 and remained registered in August 2009.

[116] I find that the defendant, FHA, operating a public hospital under the name and style of Surrey Memorial Hospital, was an employer engaged in an industry within the meaning of Part 1 of the Act.

[117] It does not appear that the Surrey Memorial Hospital had a separate legal identity. Accordingly, I have not provided any separate certification regarding its status.

Status of the defendant, Dr. Wade Alexander Sabados

[118] Dr. Sabados requests a determination of his status. The plaintiff and the FHA have not provided submissions concerning the status of Dr. Sabados.

[119] By memorandum dated July 13, 2011, the analyst advised that there was no record of a registration with the Board in the name of Dr. Wade Alexander Sabados.

[120] An affidavit was provided by Dr. Sabados dated July 19, 2012. Dr. Sabados advised that in August 2009, he was working in two different capacities at the Surrey Memorial Hospital. He worked as an emergency physician providing acute care to patients who attended at the hospital. When he provided services as an emergency physician, he would bill the Medical Services Plan and receive compensation directly from the Plan. He was also the chief of the Emergency Department at the hospital and received a salary in exchange for the administrative and departmental roles that he provided to the hospital.

---

[121] A preliminary question concerns whether Dr. Sabados saw the plaintiff on August 11, 2009 in his role as an emergency physician at the hospital, or in his role as the Chief of the Emergency Department. Dr. Sabados states that he did not have a formal work schedule as Chief of the Emergency Department, but generally made himself available to the hospital 24 hours a day, 7 days a week, with exceptions for holidays. He worked approximately 15 hours a week in his position of Chief of the Emergency Department, in addition to working approximately 35 hours per week as an Emergency Room physician at the hospital. Dr. Sabados advised in paragraphs 14 and 15 of his affidavit:

> The Chief of the Emergency Department has a specific mandate for services to be provided to the Fraser Health Authority. These duties are listed in the contract and in the Fraser Health Authority Bylaws and Rules. The essence of my activities involved communicating with various workers at the Hospital, supervising their activities, implementing programs and addressing problems and concerns that arose in the Emergency Department on behalf of the Fraser Health Authority.
>
> This was hands-on work that generally required me to be in the Hospital or accessible by phone. Although there was some set times for me to work, such as on scheduled committee meetings, the majority of my time was spent dealing with immediate issues on an on call basis. It was very common for me to set aside my role as an Emergency Room physician during a scheduled shift and perform duties as Chief of the Emergency Room.

[122] In paragraphs 18 and 19, Dr. Sabados further advised:

> As the Chief of the Emergency Department, one of my responsibilities was to personally review and/or meet with patients and/or their families about complaints he or she or they may have about care provided at the Emergency Department.
>
> There is a formal complaint procedure that can be initiated by a patient and/or his or her family. A formal complaint would involve myself, the patient advocate at the Hospital, who at the time was Ms. Eileen Schmeltze, and, depending on the circumstances, Ms. Christine Predy, the nursing manager.

[123] Dr. Sabados furnished a copy of a contract between him and the FHA dated October 7, 2008. This was entitled “Agreement to Perform Professional Services as Interim Chief of Emergency, Surrey Memorial Hospital.” The initial term of the Agreement was from April 21, 2008 to March 31, 2009, subject to renewal. Schedule B to the Agreement

provided that the FHA would pay Dr. Sabados $7,500.00 per month for administrative services. The Agreement provided that Dr. Sabados would not bill-for-service for the Services covered by the Agreement. The Agreement further provided that the fees payable under the Agreement did not represent payment for any services provided by Dr. Sabados which were able to be billed to the Medical Services Commission for British Columbia.

[124] Dr. Sabados advised that he became aware of Dr. RV's suicide a day or two after the event. At the time of the plaintiff's attendance at the hospital on August 11, 2009, Dr. Sabados was waiting to hear what investigation UBC was going to do into her death. He was concerned that Dr. RV's suicide would be taken up by the media (causing a significant invasion of privacy for her family).

[125] Although he did not recall the details, Dr. Sabados believed that a triage nurse advised him when the plaintiff returned to the hospital on August 11, 2009, and advised that he was the patient that had been treated by Dr. RV immediately prior to her suicide.

[126] There were eight Emergency Room physicians providing acute medical care to patient that day over a 24-hour period. Accordingly, at the time of the plaintiff's August 11, 2009 visit there were likely three or four Emergency Room physicians working the department. Dr. Sabados advised in paragraph 34:

> I directed the nursing staff not to send him to the busy Rapid Assessment Zone where he would be typically treated for his condition and arranged to see him and assess him directly in a private area. I believe that he was taken to the interview room next to the trauma rooms. Had I not intervened he would have been seen by a different Emergency Medicine physician in the department.

[127] Dr. Sabados ordered a CT scan of the plaintiff's head, reviewed his electrocardiogram, and asked that the electrocardiogram be repeated. He subsequently met with the plaintiff. Dr. Sabados notes in paragraphs 38 to 40:

> Mr. Gill was upset about what had happened to him during his August 5, 2009 hospital visit and was asking questions about who was involved. At this time I remained uncertain as to whether he had learned of Dr. Rodrigue-Vinet's suicide and was somewhat relieved that he did not bring it up.
>
> I advised Mr. Gill that I was Chief of the Emergency Department and that if necessary I would formally review what happened. The tenor and

> nature of our meeting changed rapidly. Although initially I was trying to reassure Mr. Gill about his chest pains and headache, our encounter was focused on who was involved with his prior visit and what I think may have happened to him.
>
> As Chief of the Emergency Department it was my role to answer his questions.

[128] In paragraphs 42 to 43, Dr. Sabados further advised that he ultimately informed the plaintiff of Dr. RV's suicide:

> Although I was initially relieved that Mr. Gill did not know about Dr. Rodrigue-Vinet's suicide, during the conversation I became certain that he was going to come to know of her death sooner or later through the investigation process. I felt the responsibility of disclosing this terrible incident fell on my shoulders as Chief of the Emergency Department.
>
> I do recall advising Mr. Gill that this was difficult to talk about I believe that I said, "We think that the resident thought that she had harmed you and that she left the ER after the incident. She was found a short time later after committing suicide."

[129] Dr. Sabados further advised Mr. Gill that Dr. RV could have been pushed to do this for any number of reasons and that he must not in any way blame himself for her death.

[130] In paragraph 47, Dr. Sabados advised that he did not bill the Medical Services Plan for this encounter with the plaintiff, as the primary nature of the encounter was a discussion of the events that occurred on August 11, 2009 which fell within his duties as Chief of the Emergency Department.

[131] I accept Dr. Sabados' evidence as to the basis on which he saw the plaintiff on August 11, 2009. Although Dr. Sabados was working an Emergency Room physician shift at the hospital on that date, I do not consider that it was merely by chance that the plaintiff came under his care on that date. I accept that Dr. Sabados was alerted to the plaintiff's attendance based on Dr. Sabados' role as Chief of the Emergency Department, given the sensitivities which attached to the medical error in the plaintiff's treatment on August 5, 2009 and Dr. RV's subsequent suicide. I further accept that the resulting discussion with the plaintiff by Dr. Sabados, which included disclosure of the fact that Dr. RV had committed suicide following her treatment of the plaintiff, was conducted pursuant to his role as Chief of the Emergency Department rather than as part of his scheduled shift as an Emergency Room physician. I accept Dr. Sabados' evidence that if an issue arose requiring him to perform duties as Chief of the

Emergency Department, he would perform those duties and return to working as an Emergency Room physician when possible.

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[132] Accordingly, I find that when Dr. Sabados saw the plaintiff on August 11, 2009, he did so in his role as the Chief of the Emergency Department rather than as an emergency physician. It is then necessary to consider Dr. Sabados' status while carrying out his duties as the Chief of the Emergency Department.

[133] Clauses 2.3 and 2.4 of the Agreement stated:

> While providing the Services under the Agreement, the Physician will not bill for clinical services.
>
> The Physician may, however, bill fee-for-service or directly for any and all services delivered outside the scope of this Agreement.

[134] Clause 2.6 of the Agreement further provided:

> The Physician must pay any and all payments and/or deductions required to be paid by him/her, including those required for income tax, Employment Insurance premiums, Workers Compensations premiums, Canada Pension Plan premiums or contributions, and any other statutory payments or assessments of any nature or kind whatsoever that he/she is required to pay to any government (whether federal, provincial or municipal) or to any body, agency, or authority of any government in respect of any money paid to the Physician pursuant to this Agreement. The Physician shall provide the Agency with proof of any required WCB coverage at the Agency's request.

[135] Notwithstanding clause 2.6, Dr. Sabados did not attempt to register with the Board, and the hospital did not request proof if his having obtained WCB coverage.

[136] The Agreement provided in clause 4.1:

> Nothing contained within this Agreement shall constitute the parties as joint venturers, fiduciaries, partners, employer or employee of each other, or create an agency relationship between them and it is understood that the physician is an independent contractor and not the servant, employee, or agent of the FHA. No employment relationship is created by the Agreement, or by the provision of the Services to the FHA by the Physician.

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[137] At paragraph 13 of his affidavit, Dr. Sabados advised:

> When I performed services pursuant to my position as Chief of the Emergency Department, I would not bill the Medical Services Plan but received compensation pursuant to my salary from the Fraser Health Authority. I was provided T4 income tax forms from the Fraser Health Authority.

[138] Dr. Sabados cites the decision of the Supreme Court of Canada in *Martel v. Hotel-Dieu St-Vallier* (1969), 14 D.L.R. (3d) 445, [1969] S.C.R. 745. That decision stated (in translation):

> In the case at bar, the anaesthetist was the salaried employee of the hospital. In addition to the salary that he received as a resident anaesthetist, he received a monthly amount predicated upon the fees collected by the hospital and charged to the patients as costs of anaesthesia. The plaintiff had nothing to do with the choice of his anaesthetist. The latter was assigned by the head anaesthetist of the hospital…. Certain witnesses alleged that the patient was by right entitled to choose his own anaesthetist. But, taking into account all the evidence on this point, the only possible conclusion is that there could have been exceptions to the general rule, according to which the anaesthetic was performed by an anaesthetist designated by the head anaesthetist.
>
> …
>
> Since the damage suffered by the plaintiff was therefore caused by a presumed fault on the part of the anaesthetist, during the course of the execution of the functions for which he was engaged by the hospital, the hospital must also be held liable.

[139] In August 2009, policy at AP1-1-3 of the *Assessment Manual* provided:

> The Board, for the purposes of the *Act*, has the exclusive power under section 96(1) to determine status. **The Board's jurisdiction cannot be excluded by private agreement between two parties, whether the agreement does this expressly, or indirectly by labelling the parties as independent operators (who would therefore be independent firms).** The Board makes its own judgment of their status, having regard

> to the terms of the contract and the operational routines of the relationship. However, decisions made by the Board are for workers' compensation purposes only and have no binding authority under other statutes.
>
> [emphasis added]

[140] The reasoning in this policy would similarly apply in respect of a WCAT status determination under section 257 of the Act. Accordingly, the statement in the contract that Dr. Sabados was an independent contractor is not determinative. Indeed, the FHA's issuance of a T4 to Dr. Sabados in relation to his earnings under the contract as the Chief of the Department of Emergency Medicine appears inconsistent with clause 4.1 of the Agreement which provided that he was an independent contractor and not an employee.

[141] Under the heading "General principles," policy at item AP1-1-3 of the *Assessment Manual* provided a list of factors to be considered in distinguishing an employment relationship from one between independent firms. The policy states that there is no single test that can be consistently applied. The major test, which largely encompasses these factors, is whether the individual doing the work exists as a business enterprise independently of the person or entity for whom the work is done. I have considered the list of factors set out in policy as follows:

- *whether the services to be performed are essentially services of labour*

[142] Dr. Sabados did not provide materials. He was paid a specified salary on a monthly basis. His services were essentially services of labour. This factor supports a finding of employment.

- *the degree of control exercised over the individual doing the work by the person or entity for whom the work is done*

[143] Schedule A to the Agreement set out a detailed list of Dr. Sabados' responsibilities as the Interim Chief of Emergency, under the headings Clinical Service, Departmental Structure, Recruitment and Retention of Department Members, Communication, Policy and Process Development, and Reporting Relationship and Accountability. He was provided with a Blackberry, and one of his job requirements was that he be available to deal with issues as they arose.

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[144] In *Joey's Delivery Service v. New Brunswick (Workplace Health, Safety and Compensation Commission)* (2001), 201 D.L.R. (4th) 450, (C.A.) leave to appeal denied, [2001] S.C.C.A. No. 425 (*Joey's*), the New Brunswick Court of Appeal addressed this issue in paragraph 76 as follows:

> **76** In classical terms, "control" is defined by reference to four aspects: (1) power to direct the thing to be done; (2) the means by which it will be done; (3) the way it will be done; and (4) directing the time and place it shall be done: see Ready Mixed Concrete (South East) Ltd. v. Min. of Pensions and National Insurance, supra. The modern law, however, eliminates the third aspect and instead emphasizes control in the sense of directing the residual "when and where" of the work, as opposed to the manner of its completion. **The elimination of the third criterion is necessitated by the fact that today professional employees and other highly skilled workers exercise a great deal of discretion in deciding how tasks are to be performed. The employer is more concerned with assigning tasks and their date of completion than with the way in which results are achieved**: see Wiebe Door Services Ltd. v. Minister of National Revenue, supra, at paras. 6 & 7.
>
> [emphasis added]

[145] As Chief of Emergency, it appears that Dr. Sabados had a considerable degree of autonomy in determining how to carry out the various responsibilities assigned to him. Under the contract, a detailed list of responsibilities were assigned to him. He was on call by means of the Blackberry to respond to issues as they arose. While the evidence on this point is mixed, on balance I consider that it favours a finding of employment.

- *whether the individual doing the work might make a profit or loss*

[146] Dr. Sabados received an annual salary for his duties as the Chief of Emergency. There was no opportunity for profit or loss.

- *whether the individual doing the work or the person or entity for whom the work is done provides the major equipment*

[147] Dr. Sabados advised that the hospital provided him with all necessary equipment and tools with the exception of a stethoscope. He provided his own stethoscope. Accordingly, the hospital provided all the major equipment. This factor supports a finding of employment.

- *if the business enterprise is subject to regulatory licensing, who is the licensee*

[148] This factor is largely neutral. Dr. Sabados was required to be a registered member in good standing of the College of Physicians of British Columbia, and a member of the medical staff of the FHA. The FHA and the hospital are listed at as being accredited health services organizations (Accredited Health Services Organizations, Accreditation Canada, at pages 14 and 15).[2]

- *whether the terms of the contract are normal or expected for a contract between independent contractors*

[149] The terms of the contract are in keeping with a contract between independent contractors. This factor supports a finding of independence.

- *who is best able to fulfill the prevention and other obligations of an employer under the Act*

[150] The hospital, as a large employer, would be best able to fulfill the prevention and other obligations of an employer under the Act. This factor supports a finding of employment.

- *whether the individual doing the work engages continually and indefinitely for one person or works intermittently and for different persons*

[151] Dr. Sabados was not able to bill for his services as an emergency physician when engaged in his duties as Chief of the Emergency Department (subject to clause 2.2 of the Agreement).

[152] While part time in nature, Dr. Sabados' role as Chief of the Emergency Department related exclusively to the performance of his duties in that role at the hospital for a set term, subject to extension. This involved a different role than his provision of services as an emergency physician, for which he billed the Medical Services Plan. I consider that this factor supports a finding of employment, in relation to his role as Chief of Emergency.

[2] http://www.accreditation.ca/uploadedFiles/Final%202012%20Accredited%20List.pdf

- *whether the individual doing the work is able or required to hire other persons*

[153] Clause 11.1 of the Agreement provided:

> With the exception of delegating authority to those persons authorized under the Medical Staff Bylaws such as assistant, associate or deputy head, etc., the Physician may not assign his or her rights and responsibilities under this Agreement without prior written consent of the FHA, which consent will be given at the sole discretion of the FHA.

[154] Dr. Sabados submits that he did not, and almost certainly could not have, hired anyone to help him provide his duties as Chief of the Emergency Department.

[155] As well, Schedule A to the Agreement listed Dr. Sabados' responsibilities as including the "management of physician resources including recruitment of innovative clinicians." He was also required to "appoint physicians to department positions such as assistant, associate or deputy head, education coordinator etc as appropriate and required," and to "Work with the appropriate Medical Director and designated Corporate Medical Leader to ensure sufficient medical staff is recruited into the discipline to meet identified service needs of the community, department, and affiliated institutions." To the extent Dr. Sabados was engaged in carrying out these functions, he would have been doing so on behalf of the hospital.

[156] I find that his factor supports a finding of employment.

[157] Dr. Sabados cites the British Columbia Supreme Court decision in *Watford v. BC (WCB)*, [1999] B.C.J. No. 128 in which the court cited with approval the following definition of a contract of service (at paragraphs 18 and 19):

> **18** **…** He did not define a contract of service, however a definition is provided in Employment Law in Canada, 2nd Edition. At page 13 there is a quote from Stevenson Jordan and Harrison Ltd. v. MacDonald Evans, [1952] 1 TLR 101, where Lord Denning stated;
>
> > It is often easy to recognize a contract of service when you see it, but difficult to say wherein the difference lies. A ship's master, a chauffeur and a reporter on the staff of a newspaper are all employed under a contract of service; but a ship's pilot, a taxi man and newspaper contributor are employed under a contract for services. One feature which seems to run through the instances is that, **under a**

> **contract of service, a man is employed as part of the business, and his work is done as an integral part of the business; whereas under a contract for services, his work, although done for the business is not integrated into it, but is only accessory to it**.
>
> **19** It would appear that the Commissioner concluded that B.C. Hydro's contracting out the clearing of brush and trees from the power lines was the contracting out of work done for the business, but not integrated into it and that it was work that was an accessory to the business of B.C. Hydro.
> [emphasis added]

[158] However, the business integration test was critiqued in *Joey's* at paragraphs 46 and 47 as follows:

> **46** In short, the business integration test views a contract of service as one in which the employee's work is an integral part of the business, whereas in a contract for service situation the work being performed is only accessory to it. However, in Wiebe Door Services Ltd. v. Minister of National Revenue, [1986] 3 F.C. 553, the late Justice MacGuigan, writing for the Federal Court of Appeal, effectively rejected this test for the reason that it inevitably leads to the conclusion that all workers are employees. At paragraph 14 of his reasons, Justice MacGuigan writes persuasively:
>
> > Lord Denning's test may be more difficult to apply, as witness the way in which it has been misused as a magic formula by the Tax Court here and in several other cases cited by the respondent[2], in all of which the effect has been to dictate the answer through the very form of the question, by showing that without the work of the "employees" the "employer" would be out of business ("Without the installers, the Appellant would be out of business"). As thus applied, this can never be a fair test, because in a factual relationship of mutual dependency it must always result in an affirmative answer. If the businesses of both parties are so structured as to operate through each other, they could not survive independently without being restructured. But that is a consequence of their surface arrangement and not necessarily expressive of their intrinsic relationship.

> **47** Justice MacGuigan was not the only one to appreciate the one-sidedness of the business integration test. Commentators and courts alike have expressed similar reservations over its appropriateness: see Wiebe Door Services Ltd., supra, at para. 12. I agree and, therefore, respectively decline to adopt the business organization test….

[159] While the business integration test would support a finding of employment, I have not relied on this test for the purposes of my decision.

[160] Policy at item AP1-1-3 further states:

> No business organization is completely independent of all others. It is a question of degree whether a party to a contract has a sufficient amount of independence to warrant registration as an employer. Many small parties may only contract with one or two large firms over a period of time. Yet they are often independent of the person with whom they are contracting in significant respects. For example, they must seek out and bid for their own contracts, keep their own books and records, make income tax, unemployment insurance and Canada Pension Plan deductions. They also retain the right to hire and fire their own workers and exercise control over the work performed by their workers. These factors must be considered.
>
> Some regard must also be paid to the structure and customs of the particular industry involved. Where an industry makes much use of the contracting out of work, this should be recognized as a factor in considering applications for registration as employers by parties to contracts in those industries.

[161] In his role as Chief of Emergency, Dr. Sabados was issued a T4 and did not make his own income tax deductions, or bid on contracts. To the extent he was involved in the recruitment of personnel or assignment of functions or responsibilities, it would have been on behalf of the hospital.

[162] Policy at item AP1-1-3 states that the major test is whether the individual doing the work exists as a business enterprise independently of the person or entity for whom the work is done. I do not consider that in fulfilling the role of the Chief of the Emergency Department, Dr. Sabados could be viewed as existing as a business enterprise independently from the hospital. His responsibilities as interim Chief of the Emergency Department would appear to have placed certain managerial responsibilities on him on

as a representative of the hospital. Having regard to the range of factors listed above, I consider that the weight of the evidence supports a conclusion that Dr. Sabados was an employee of the hospital in carrying out his role as the Chief of the Emergency Department.

[163] Practice Directive 1-1-3(B), "Status – Specific occupations," came into effect on May 1, 2010. If did not exist at the time of the events in question in August 2009, and is not applicable. Nevertheless, the reasoning in the practice directive is of interest. It provides the following guidance regarding the status of physicians:

> ***V PHYSICIANS***
>
> 15. A physician is an individual engaged in a profession – a specialized occupation or vocation characterized by each of a regime of formal education and training leading to a professional degree, and licensure by a regulatory body (e.g., the College of Physicians and Surgeons of British Columbia under the *Health Professions Act*).
>
> 16. With respect to physicians, each of structure – generally, medical services are a component of British Columbia's greater societal framework and are funded by the Government of British Columbia, which is responsible for each of the capital costs and the operating costs for such services, and custom – the common-law's recognition that a physician is not in a master-servant relationship suggests that the principles, test, and analysis that flow from a master-servant relationship cannot apply in its entirety in determining the status of a physician for the purposes of the *Act*.
>
> 17. A physician is presumed to be engaged under a contract of service and therefore a worker under the *Act*, if the physician
>
> - provides services to a **health authority** or any other **agency** under a **salary agreement**, or
> - receives a *T4 Statement of Remuneration Paid* or a *T4A Statement of Pension, Retirement, Annuity and Other Income*.
>
> The **agency** or the party which issued the *T4* or *T4A* would be an employer of the physician.
>
> This presumption may be disproved through evidence that the physician is not in a contract of service with the **agency** or party. The person seeking to disprove the presumption must present the

evidence necessary to establish that the physician is not engaged under a contract of service.

18. A physician operating within an industry in *Subsector 7660 – Health Care and Social Assistance* will be presumed to be an independent operator if the physician meets either of the following criteria:

a) the physician is a proprietor of or a partner in a private practice serving the general public, directly or by referral; or

b) the physician's income is derived solely or essentially through one or more of:

- a **service contract** (under which a physician provides services as an independent contractor to an agency),
- a **sessional contract** (under which a physician provides services on a time or sessional basis, in which a session equals 3.5 hours of the physician's professional services),
- **fee-for-service** payments from **Medical Services Plan**, and Workers' Compensation Board and Insurance Corporation of British Columbia services submitted through and paid by **Medical Services Plan**, or
- earnings related to private practice (third party, medico-legal and private billings).

[footnote deleted]

[164] While not necessary to my decision, I note that the hospital's provision of a T4 to Dr. Sabados in respect of his salary as Chief of Emergency, in combination with the other evidence cited above, would also support the conclusion set out above.

[165] Upon consideration of the foregoing, I find that at the time the cause of action arose on August 11, 2009, Dr. Sabados was a worker within the meaning of Part 1 of the Act. As set out above, I find that Dr. Sabados' interactions with the plaintiff on August 11, 2009 were carried out in his role as Chief of Emergency. I find that his action or conduct which caused the alleged breach of duty of care, arose out of and in the course of his employment.

Status of the defendant, Dr. Raphaelle Rodrigue-Vinet (Deceased)

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[166] The estate of Dr. RV (Deceased) has not been served. The HEABC was invited to participate as an interested person, and provided relevant evidence relating to the status of the deceased defendant.

[167] By memorandum dated March 3, 2011, the analyst advised that there was no record of a registration with the Board in the name of Dr. RV.

[168] By letter dated August 8, 2011, Roslyn Goldner, counsel for UBC, advised that although Dr. RV was a resident in a UBC postgraduate training program, there was no employment relationship. She stated that residents are employed pursuant to a collective agreement to which the Health Authorities were signatories. She provided relevant excerpts from the current collective agreement (2006 to 2010) between the HEABC and the Professional Association of Residents of British Columbia (PAR-BC). This indicated that in making the agreement, the HEABC was representing and acting on behalf of:

> Fraser Health Authority (Royal Columbian Hospital, Eagle Ridge Hospital and Health Care Centre, and Chilliwack General Hospital)

[169] By memorandum of April 16, 2012, I requested clarification as to whether the collective agreement applied to residents at the Surrey Memorial Hospital on August 5, 2009.

[170] By letter of May 18, 2012, Matt Prescott, manager, Heath Authority Services, advised that the collective agreement between the HEABC and PAR-BC applied to residents assigned to rotations at the Surrey Memorial Hospital on August 5, 2009. Copies were enclosed of two arbitration awards to explain the relationship between the teaching hospitals, operated by the health authorities, and residents.

[171] The HEABC also provided a copy of the Master Affiliation Agreement between FHA and UBC, dated November 15, 2002. Appendix A to this agreement listed the categories of UBC students in attendance at the FHA, which included medical residents. Medical residents were again listed in updated schedules of students in March 2005 and August 2009.

[172] Clause 3.2 of the Master Affiliation Agreement provided:

> The University and the Health Authority shall ensure that their respective personnel are eligible for workers' compensation benefits in the event of an injury received while working in or about the University or in or about the Health Authority premises.

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[173] In *St. Paul's Hospital (Hospital), and Professional Association of Residents and Interns*, [1976] B.C.L.R.B.D. No. 43, No. 43/76, the Labour Relations Board certified the Professional Association of Residents and Interns as the bargaining agent for the employees in this unit. The panel noted, in part:

> Where does the resident and intern fall within this spectrum, ranging from the apprentice tradesman to the student practical nurse? The Hospital appoints its house staff, schedules and directs their work, evaluates their performance, and may discipline or even dismiss them. The Hospital pays the residents on a regular two-week basis, subject to standard payroll deductions, provides certain welfare benefits, and allows paid statutory holidays and annual vacations. In return, the house staff provides extensive medical care to the patients in the Hospital**,** which would have to be obtained from other sources if the house staff were not available to the Hospital**.** All of the normal indicia of employee status are satisfied in the case of the residents and interns in the Hospital**.**
>
> However, it is also true that each of these "employee" features is subtly changed by the underlying educational theme in the residency programs. The initial selection of house staff by the Hospital is mediated by either the Canadian Matching Service or the University Medical Faculty; termination of the appointment ordinarily occurs when the prescribed program is completed, rather than because of any specific decision to dismiss a resident**;** scheduling of house staff work is shaped by the standards set by the Medical Colleges about the educational experiences which must be obtained; a high proportion of the medical care performed by the house staff on "teaching patients" is instructional in character; house staff are paid a yearly stipend, which increases each year they are in the program, but is not dependent on the varying number of hours of work which different specialties require; the funds for paying these stipends and benefits come from the provincial government as part of the "educational account" in the Hospital budget.
>
> **But notwithstanding these variations from the norm, I am persuaded that the status of house staff at the** Hospital **fits comfortably within the legal scope permitted to the concept of "employee"**. The agreement between PARI and the Hospital explicitly recognizes that "residents and interns are in fiscal and administrative affairs subject to control and direction of the Hospital". In practice, this means that the Hospital exercises the type of authority over its house staff which establishes a truly employment relationship, although the flavour of that

> relationship is also significantly influenced by the fact that residents and interns have come to the Hospital to pursue their clinical education.
>
> That judgment is thoroughly confirmed when the employee status is considered from within the prism of a collective bargaining statute….
>
> [emphasis added]

[174] An arbitration award dated December 6, 2010 between the HEA and the PAR-BC, involving a Dr. Baird, [2010] B.C.C.A.A.A. No. 184, noted that the teaching hospitals were not involved in the selection process and assignments for medical residents. That decision reasoned:

> Nevertheless, ever since the decision of the Labour Relations Board in St. Paul's Hospital [1976] B.C.L.R.B. No. 43, it has been accepted that an employment relationship exists between the Resident and the participating hospital(s) to which the Resident is from time to time assigned by the Program, for the period of such assignment. And there is a master collective agreement covering Residents between the Health Employers Association of B.C. (representing health sector employers, including VCHA [Vancouver Coastal Health Authority]) and the Professional Association of Residents of B.C. (PAR-BC), which is the trade union certified to represent the Residents in collective bargaining.

[175] That decision noted on page 30 that under the *Health Authorities Act*, a bargaining unit comprised of "residents" is one of the statutorily-recognized bargaining units for purposes of collective bargaining between the HEA and the union representing residents (PAR-BC). The arbitrator concluded at paragraph 93:

> **93** In sum, upon a proper interpretation and application of Article 6 of the collective agreement, considered in the light of the circumstances in which the collective agreement was intended to operate, my conclusion, as stated above, is that Dr. Baird's dismissal from the Psychiatry Residency Program, as upheld by the Appeals Committee on October 10, 2007, resulted as well in the termination of Dr. Baird's employment relationships with VCHA.

[176] In *Health Employers' Assn. of British Columbia v. Professional Assn. of Residents of British Columbia (Kelly Grievance)*, [2009] B.C.C.A.A.A. No. 179, the arbitrator cited the following evidence:

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12 Further particulars, generally agreed to by the parties, concerning the UBC Residency Program and its relationship with Residents and the hospitals**,** were set out in a September 8, 2008 letter from counsel for UBC (Roslyn Goldner and Donald J. Jordan, Q.C.):

UBC Residency Program

…

*During their residency training, Residents are employed by the various health authorities that operate the teaching hospitals that are affiliated with UBC. The terms and conditions under which Residents are employed are set out in the collective agreement between PAR-BC and HEABC. The collective agreement governs matters such as leaves, benefits, facilities for residents**,** uniforms, pagers and on-call areas, professional liability, scheduling, including on-call assignments, allowances and remuneration. Provision of these employment benefits is the responsibility of the employer/hospital**.***

*Funding for Residents' salaries is provided by the Ministry of Health. The BC Interns and Residents Paying Agency ("Paying Agency") was created in 1979-80 by the teaching hospitals in the lower mainland to administer payroll for the Residents employed by the hospitals**.** Vancouver Coastal Health Authority acts as paymaster for all the hospitals bound by the collective agreement which governs the terms and conditions of the Residents' employment with the hospitals**.** The Health Authorities are represented by HEABC which together with PARBC is signatory to the collective agreement. UBC is neither a signatory to, nor bound by, the collective agreement between PAR-BC and HEABC. UBC has no legal relationship with PAR-BC. UBC's relationship with the members of HEABC is governed by its affiliation agreements.*

[177] In the *Kelly* case, the employer was St. Paul's Hospital. The arbitrator concluded:

74 In conclusion, for the foregoing reasons, I find the Employer's position that it terminated the Grievor's employment as a Resident because he was no longer enrolled in the Residency Program, rather than because of discriminatory reasons, is not a matter of semantics or a

convenient fiction. Rather, it reflects the fundamental reality that the Employer can only employ persons as Residents those who UBC has assigned to it in the course of the Residency Program. I find the Employer terminated the Grievor's employment as a Resident because he was no longer assigned to it by UBC via the Residency Program, rather than because of his disability.

[178] Under Part 3 of the *Health Authorities Act*, [RSBC 1996] ch. 180, section 19.1 provides the following definition:

> In this Part:
>
> **"resident"** means a person who is taking post graduate training in medicine and is registered with the College of Physicians and Surgeons of British Columbia on the register or the temporary register.

[179] Section 19.4 provides:

> (1) Subject to section 19.5, the following are the appropriate bargaining units in the health sector:
>
> (a) residents;…

[180] In response to my inquiries for information regarding Dr. RV and the evidence provided by the HEABC, the FHA noted that whether Dr. RV was an employee, servant or agent of the FHA, does not alter the status of the FHA as an employer. The FHA commented that if Dr. RV was an employee, servant or agent of the FHA, then it is clearly apparent that her actions in providing treatment to the plaintiff while he was a patient at FHA would have been carried out in the course of her employment. The FHA further commented that at the time of the incident, Dr. RV was likely an employee of the FHA.

[181] It does not appear that any party has requested a determination of the status of Dr. RV. Accordingly, the foregoing is set out as background information without a determination of her status on August 5, 2009.

Status of the defendants, Dr. Christian Cheung, Dr. Stephen Pearce, Dr. David Revitt, and University of British Columbia

[182] The legal action has been discontinued or dismissed against these defendants, and determinations of their status are not requested.

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[183] In the event that any further determination is required, a request may be made for a supplemental certificate.

Conclusion

[184] I find that at the time the cause of action arose, on or about August 5 and 11, 2009:

(a) the plaintiff, Gaganjit Gill, was a worker within the meaning of Part 1 of the Act;

(b) the plaintiff's disability caused by occupational disease (including his allergic reaction on August 5, 2009 and any physical or psychological injury resulting from the medication error on August 5, 2009, and any psychological injury due to his being informed by the Defendant Dr. Wade Alexander Sabados on August 11, 2009 of Dr. Raphaelle Rodrigue-Vinet's suicide) was due to the nature of his employment and arose out of and in the course of his employment within the scope of Part 1 of the Act;

(c) the defendant, Fraser Health Authority operating a public hospital under the name and style of Surrey Memorial Hospital, was an employer engaged in an industry within the meaning of Part 1 of the Act;

(d) the defendant, Dr. Wade Alexander Sabados, was a worker within the meaning of Part 1 of the Act; and,

(e) any action or conduct of the defendant, Dr. Wade Alexander Sabados, which caused the alleged breach of duty of care, arose out of and in the course of his employment within the scope of Part 1 of the Act.

Herb Morton
Vice Chair

HM:gw

NO. VLC-S-S-098992
VANCOUVER REGISTRY

IN THE SUPREME COURT OF BRITISH COLUMBIA

IN THE MATTER OF THE WORKERS COMPENSATION ACT
REVISED STATUTES OF BRITISH COLUMBIA 1996, CHAPTER 492, AS AMENDED

BETWEEN:

GAGANJIT GILL

PLAINTIFF

AND:

DR. RAPHAELLE RODRIGUE-VINET (DECEASED), DR. CHRISTIAN CHEUNG, DR. STEPHEN PEARCE, DR. DAVID REVITT, FRASER HEALTH AUTHORITY operating a public hospital under the name and style of SURREY MEMORIAL HOSPITAL and the said SURREY MEMORIAL HOSPITAL, NURSE JANE DOE, DR. WADE ALEXANDER SABADOS and UNIVERSITY OF BRITISH COLUMBIA

DEFENDANTS

C E R T I F I C A T E

UPON APPLICATION of the Defendants, FRASER HEALTH AUTHORITY operating a public hospital under the name and style of SURREY MEMORIAL HOSPITAL and the said SURREY MEMORIAL HOSPITAL, in this action for a determination pursuant to section 257 of the *Workers Compensation Act*;

AND UPON NOTICE having been given to the parties to this action and other interested persons of the matters relevant to this action and within the jurisdiction of the Workers' Compensation Appeal Tribunal;

AND AFTER an opportunity having been provided to all parties and other interested persons to submit evidence and argument;

AND UPON READING the pleadings in this action, and the submissions and material filed by the parties;

AND HAVING CONSIDERED the evidence and submissions;

THE WORKERS' COMPENSATION APPEAL TRIBUNAL DETERMINES THAT at the time the cause of action arose, August 5 and 11, 2009:

1. The Plaintiff, GAGANJIT GILL, was a worker within the meaning of Part 1 of the *Workers Compensation Act*.

2. The disability of the Plaintiff, GAGANJIT GILL, caused by occupational disease (including his allergic reaction on August 5, 2009 and any physical or psychological injury resulting from the medication error on August 5, 2009, and any psychological injury due to his being informed by the Defendant Dr. Wade Alexander Sabados on August 11, 2009 of the Defendant Dr. Raphaelle Rodrigue-Vinet's suicide) was due to the nature of his employment and arose out of and in the course of his employment within the scope of Part 1 of the *Workers Compensation Act*.

3. The Defendant, FRASER HEALTH AUTHORITY operating a public hospital under the name and style of SURREY MEMORIAL HOSPITAL, was an employer engaged in an industry within the meaning of Part 1 of the *Workers Compensation Act*.

4. The Defendant, Dr. Wade Alexander Sabados, was a worker within the meaning of Part 1 of the *Workers Compensation Act*.

5. Any action or conduct of the Defendant, Dr. Wade Alexander Sabados, which caused the alleged breach of duty of care, arose out of and in the course of his employment within the scope of Part 1 of the *Workers Compensation Act.*

CERTIFIED this day of January, 2013.

_____

Herb Morton
Vice Chair

NO. VLC-S-S-098992
VANCOUVER REGISTRY

IN THE SUPREME COURT OF BRITISH COLUMBIA

IN THE MATTER OF THE WORKERS COMPENSATION ACT
REVISED STATUTES OF BRITISH COLUMBIA 1996, CHAPTER 492, AS AMENDED

BETWEEN:

GAGANJIT GILL

PLAINTIFF

AND:

DR. RAPHAELLE RODRIGUE-VINET (DECEASED), DR. CHRISTIAN CHEUNG, DR. STEPHEN PEARCE, DR. DAVID REVITT, FRASER HEALTH AUTHORITY operating a public hospital under the name and style of SURREY MEMORIAL HOSPITAL and the said SURREY MEMORIAL HOSPITAL, NURSE JANE DOE, DR. WADE ALEXANDER SABADOS and UNIVERSITY OF BRITISH COLUMBIA

DEFENDANTS

SECTION 257 CERTIFICATE

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