No. S-090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO, WALID KHALFALLAH by his litigation guardian DEBBIE WAITKUS, and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANT

AND:

DR. DUNCAN ETCHES, DR. ROBERT WOOLLARD, GLYN TOWNSON, THOMAS MCGREGOR, BRITISH COLUMBIA FRIENDS OF MEDICARE SOCIETY, CANADIAN DOCTORS FOR MEDICARE, MARIËL SCHOOFF, DAPHNE LANG, JOYCE HAMER, MYRNA ALLISON, and the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY

INTERVENORS

AND:

THE ATTORNEY GENERAL OF CANADA

PURSUANT TO THE *CONSTITUTIONAL QUESTION ACT*

PLAINTIFFS' FINAL ARGUMENT

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I. OVERVIEW

A. Background

1. Physical and mental health lie at the core of personal well-being. Maintaining one's health is a necessary precondition to living a happy, active and fulfilling life.

2. When an individual has suffered an injury or illness, the ability to obtain timely, high quality health care is of critical importance. Timely health care ends pain and suffering, restores function, and prevents an individual's health from further permanent deterioration.

3. That is why British Columbia has long been committed to the principle that no one should be denied necessary health care treatment because they are unable to pay for it. It has established a public health care insurance system in an attempt to fulfil that commitment.

4. The public health care system provides enormous benefits to British Columbians, and all of the parties agree that the British Columbia government should continue to maintain and improve this system to meet the health care needs of all residents.

5. If no one suffered unnecessary or avoidable harm due to a lack of timely access to treatment in the public system, there would be no need or demand for services outside of the public system. But, that is not true now, it has not been true for at least 30 years, and there is no prospect of it changing in the foreseeable future.

6. Instead, while the public health care system provides a reasonable level of care to many British Columbians, especially to those requiring emergency care, it fails many others. It does so by rationing medical services within the public system, which imposes unacceptably long wait times on thousands who are in need of medically necessary diagnosis and treatment by specialists for a wide range of conditions.

7. Since the Government has failed to satisfy the critical objective of providing timely medical care to <u>all</u> of its residents for at least the last three decades, it cannot lawfully cause British Columbians additional harm by preventing them from caring for their own health and wellbeing outside of the public health care system.

8. Preventing people from getting the health care treatment they need is inconsistent with the underlying rationale of the medicare system, which is to safeguard people's health and ensure that no one is denied access to medically necessary treatment.

9. The Government acknowledges the central importance of a person's health to their well-being. But the fundamental principle of Canada's public health care system - that no one should be denied treatment based on ability to pay - has been turned on its head by the BC Government.

10. It is being used, not to justify additional health care, but to justify deliberately preventing people who are not being well served by the public system from obtaining the health care treatment they need outside of that system.

11. This position is not pursued out of malice. Instead, the Government has laboured under a profound misconception; a misconception that it has been unwilling to seriously question or assess. For decades it has proceeded on the false assumption that preventing people from accessing private medical care is necessary to protect access to and the viability of the public system. Although this assumption is false, the Government has been unwilling to subject it to serious scrutiny. The Government has also proceeded on the basis of a legally and morally indefensible principle that it is better for all to suffer equally, than to allow individuals to take charge of their own health care, leaving some better off.

12. Specifically, the Defendant asserts that even though it cannot, and does not, provide timely health care to everyone, it is necessary that British Columbians accept the resulting harms to their health in order to preserve the public health care system. Some British Columbians must suffer grievously for the betterment of the rest.

13. But this is not so. Allowing British Columbians to obtain private medically necessary services would not result in any harm to either the accessibility or viability of the public health care system, as demonstrated by the experience over the past 20 years in British Columbia, when the prohibitions on access to diagnostic and surgical services were not enforced.

14. Further, the Government cannot justify imposing severe mental and physical harm on some residents on the basis of an ideological commitment to perfect equality in access to treatment, which is neither created by the legislation in question nor obtained in practice.

15. As Professor Bliss eloquently stated in his expert report in response to the Defendant's argument in support of now enforcing these prohibitions:

> Modern Canada is a dynamic, constantly expanding society, continually creating new wealth, continually increasing its spending on the goods and services Canadians want and need. It is not a lifeboat, whose first mate, pistol at the ready, grimly doles out the ration of hard tack and fresh water. A country that as a matter of public policy bars treatment to the sick in the hour of their need and pain has lost its moorings and drifted into the unnecessary acceptance of a bizarre form of social cruelty.

16. Fortunately, for British Columbians, the *Charter* prevents governments from needlessly inflicting physical and mental harm on individuals. It does so in two ways.

17. First, it guarantees the fundamentally important rights to life, liberty and security of the person, and prohibits governments from interfering with those rights unless doing so is rationally connected to and necessary to achieve an overriding and compelling justification.

18. Second, it guarantees equality rights, which ensure that the Government cannot prioritize the health care treatment of some by giving them access to more timely private treatment, while depriving others of that same opportunity.

19. Through these two constitutional guarantees, the *Charter* recognizes that every individual's life and physical and mental health is of equal and inherent value, and ensures that these fundamental rights cannot be sacrificed on the basis of either hypothetical or speculative concerns, or purely symbolic commitments that bear no connection to reality.

B. The Current Situation

20. It has been conclusively proven in British Columbia that the public health care system does not provide timely diagnostic and surgical services to everyone.

21. Lengthy wait times for diagnosis and treatment by specialists have been a persistent problem for at least 30 years in British Columbia. This began after global health care budgets were introduced, resulting in the rationing of diagnostic and surgical services in the public system.

22. Under a system of global budgeting, the Government provides a fixed budget to be spent under the Medical Services Plan and individual health authorities for medically necessary services covered by the public system.[1]

23. The fixed amount is not based on a calculation of how much is needed to provide timely services to the population, but rather on the basis of how much the province wants to devote to health care in light of its other spending priorities.[2]

24. Individual physicians in British Columbia are paid under the public plan in a number of different ways.[3]

25. Some physicians are paid directly by the MSP on a fee-for-service basis.[4] However, other surgeons are employees of a hospital or health authority, who are paid entirely on a salaried basis.[5] Other physicians enter into contracts with the health authorities to provide publicly funded services on a contract or sessional basis, rather than on a fee for service basis.[6]

26. Regardless of how they are paid, surgeons are given limited operating time in the public system, which has resulted in lengthy wait times.

27. Despite decades of pronouncements, initiatives and studies by the Provincial Government, assisted by the Federal Government, to solve the wait time problem, including significant increases in the funding of the public system, no real progress has been made in reducing these wait times.

28. The result is that thousands of British Columbians every year face entirely avoidable medical harms, ranging from prolonged pain and suffering, to permanent physical damage, and even a greater risk of a premature death.

29. The Defendant is not constitutionally required to provide medical care, let alone timely medical care. However, when the Government fails to provide timely access to necessary medical

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[1] **Exhibit 346A**, pp. 37 to 41, paras. 195 to 218 **[Plaintiffs' Condensed Book of Exhibits ("CBE"), Tab 83]**; **Transcript Day 63**, Testimony of Dr. Patrick McGeer, dated February 8, 2017, p. 5, lines 31 to 39, p. 6, line 39 to, p. 8, line 20, and p. 9, lines 1 to 27.
[2] **Exhibit 346A**, pp. 37 to 41, paras. 195 to 218 **[CBE, Tab 83]**; **Transcript Day 63**, p. 5, lines 31 to 39, p. 6, line 39 to, p. 8, line 20, and p. 9, lines 1 to 27.
[3] **Exhibit 2A**, p. 105, para 253 **[CBE, Tab 1]**.
[4] **Exhibit 3A**, p. 12, para 4(e) **[CBE, Tab 4(A)]**.
[5] **Exhibit 3A**, p. 11, para 4(a) **[CBE, Tab 4(A)]**; **Exhibit 2A**, p. 106 **[CBE, Tab 1]**.
[6] **Exhibit 3A**, p. 11, para 4(a) **[CBE, Tab 4(A)]**.; **Exhibit 2A**, p. 106 **[CBE, Tab 1]**.

care to every individual, it cannot then lawfully prevent individuals from obtaining private medical services to alleviate their suffering and protect their health.

30. But that is exactly what the BC Government is doing, by enforcing, for the first time, the prohibitions in the *Medicare Protection Act* ("***MPA***") which have the practical effect of preventing British Columbians from obtaining private diagnosis and treatment from specialists.

31. The Government has taken this step despite the fact that patients in British Columbia have had access to private surgeries performed by enrolled doctors for over 20 years, with no evidence of any harm to the public system, let alone any harm sufficient to justify the infringement of fundamental rights.

32. The consistent failure of the public system to provide timely private diagnosis and treatment by specialists to all residents means that it is essential to the health, and hence the life, liberty and security of the person, of British Columbians to have the opportunity to obtain private surgeries within the province to alleviate their suffering and avoid permanent harm.

33. As a result of the Government's decision to enforce these prohibitions, British Columbians now face the worst of both worlds: the Government fails to provide timely diagnosis and medical treatment to its residents under the universal public system, and then compounds the suffering by preventing its residents from protecting their own health through other means.

34. By its actions, the Government is imposing the very types of unnecessary and unjustified harms on individuals that the *Charter* is designed to prevent.

C. The Legal Analysis

35. The Plaintiffs submit that the prohibitions preventing British Columbians from obtaining timely treatment outside of the public system breach their ss. 7 and 15 *Charter* rights.

36. It has been clearly established that the health of patients can be harmed by waiting for surgeries, not only by suffering from pain and disability on an ongoing and progressive basis while waiting, but also from the risks of a poorer surgical outcome or progression of their disease, which includes the risk of permanent harm, disability or even death.

37. As the Government's own records show, many patients in all surgical categories and all priority groupings are unable to obtain surgeries within the maximum acceptable wait times beyond which

there is the potential for adverse consequences. And that does not take into account the harm being suffered from waiting even if a surgery is obtained within these maximum wait times.

38. Nevertheless, the Government still seeks to enforce the impugned provisions to prevent patients from avoiding their pain, suffering, disability, and risk of more serious harm that comes with delayed access to medically necessary diagnosis and treatment.

39. Preventing patients from obtaining the timely health care treatment they need, which is the effect of the impugned provisions of the *MPA*, deprives them of their right to life, liberty and security of the person under section 7.

40. The Government seeks to justify the provisions preventing people from protecting their own health in a number of ways.

41. First, it says that if the prohibitions on dual practice and private insurance are eliminated, this would harm access to diagnosis and surgery within the public system in British Columbia.

42. There is no evidence to support this contention, and it is belied by the experience over the past 20 years in British Columbia and other countries.

43. In making this argument, the Government asks the Court to consider what Professor Marmor, a government expert witness, describes as "prudent lessons" from other countries that have universal public health care systems and also permit, or even encourage, parallel private health care systems.

44. But what are the lessons? The countries with mixed public/private health care systems generally rate higher than Canada in terms of the performance of their health care systems, including access to health care and equitable treatment. The only exception is the U.S, which does not have a universal public health care system.

45. The poor ranking of Canada among countries with a universal public health care system was acknowledged by the former Federal Minister of Health, the Honourable Jane Philpott, who admitted that the public health care system in Canada has not been providing high quality care. In a 2016 speech to the Canadian Medical Association, she stated that "it's a myth that Canada has the best health care system in the world."[7]

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[7] **Exhibit 425**, Tab 1(B), AG Canada's Response to Plaintiffs' Note to Admit dated September 14, 2016, p. 4 **[CBE, Tab 99]**.

46. Minister Philpott then elaborated as follows:

> But flash forward to the reality of today. We spend more per capita on health care than many other countries. What's worse is that, while we do this, we get poorer outcomes for our patients. You all know the reports of the Commonwealth Fund, including the one that ranked us second from the last in a study that compared Canada to places like Australia, the UK, France, and Germany. The OECD also ranks us poorly on a number of specific areas that will be critical to our future health as a nation.[8]

47. Far from demonstrating the rationality or necessity of maintaining blanket restrictions on access to private treatment options, these international comparators demonstrate the opposite. They demonstrate, as Professor Marmor also testified, that permitting access to private health care is not incompatible with a universal public health care system.

48. Moreover, the experience in British Columbia over the past 20 years, and in other countries, conclusively proves that the prohibitions on dual practice and private insurance are not necessary to protect access to diagnosis and surgery in the public system.

49. This evidence proves that these prohibitions are arbitrary as they are not rationally connected to, and in fact directly undermine, the overall purpose of the *Act,* by imposing unnecessary medical harms on the population.

50. Further, by enacting what amounts to a blanket prohibition on access to health care outside of the public system, the impugned provisions are overbroad, because they go further than is necessary to adequately protect the public system.

51. As other jurisdictions have shown, any demonstrated need to protect the public system can be addressed by more targeted measures that do not have the effect of preventing people from caring for their own health when the public system fails to do so.

52. Moreover, the evidence in this case demonstrates that many physicians have excess surgical capacity, as a result of rationing in the public system. Prohibiting them from providing private treatment, in addition to fulfilling their public system time, does nothing to advance the goal of an accessible and viable public system.

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[8] **Exhibit 425**, Tab 1(B), p. 5 **[CBE, Tab 99]**.

53. In fact, the prohibitions directly undermine this objective, by unnecessarily forcing all of the need for medically necessary diagnostics and surgeries into the public system, which already cannot meet the needs of patients.

54. The evidence in this case shows that the prohibitions on access to private treatment do not actually achieve anything in terms of promoting the viability and accessibility of the public health care system.

55. To the extent that there are any viable concerns, based on evidence and not speculation, those can be addressed by measures directly targeted to those concerns, rather than through unnecessarily harmful blanket prohibitions on accessing private treatment.

56. Given the very severe harms caused, and the evidence that the impugned provisions do not protect the viability or accessibility of the public system in any meaningful way, the provisions are also grossly disproportionate to their objective.

57. The Government seeks to avoid this conclusion, by saying that it is necessary to prohibit people from caring for their own health outside of the public system in order to ensure equality between patients.

58. But this argument is inconsistent with the actual design and operation of the public health care system as a whole, which expressly and deliberately treats patients unequally.

59. The current health care system draws several distinctions between different classes of British Columbians, including:

a. the truly wealthy, who can obtain timely private treatment outside of British Columbia;

b. those injured at work or otherwise subject to exemptions in the *MPA*, who are entitled to obtain more timely private treatment in British Columbia;

c. those who are injured in automobile accidents who are entitled to expedited consultations; and

d. patients from other provinces who can obtain private diagnostic and surgical services from specialists enrolled in the public system in British Columbia.

60. Further, the current health care system treats British Columbians unequally based on ability to pay, by excluding essential health care services from the public health care system, such as dentistry, prescription medication and eyewear, prosthesis, many mental health services, ambulance services and physiotherapy. These services are covered by most other countries with a universal health care system and their exclusion in British Columbia's public system is a profound and acknowledged source of inequality.

61. Further compounding the inequality is that, among those ordinary British Columbians who are not wealthy and do not benefit from exemptions, the *Act* does not ensure that all patients are treated equally, since some receive treatment within medically acceptable wait times, and some do not.

62. Thus, it is obvious that neither the purpose nor the effect of the law is to achieve the formal equality between patients that the Government asserts. There are significant, deliberate and entrenched inequalities. Allowing more patients to obtain private treatment would in fact *improve* the equity of the system, by allowing more people to access timely treatment which is currently only accessible to a favoured few.

63. However, to the extent that the purpose of the impugned provisions is found to be the achievement of formal equality between patients, the prohibitions are grossly disproportionate to the substantial physical and mental harm that is caused to individuals who are forced to suffer on wait lists and face the risk of permanent medical harms as a result.

64. A professed commitment to a vague, symbolic, and unattainable objective, inconsistent with the actual operation of the *MPA*, cannot justify concrete, tangible, and severe harms to the psychological and bodily integrity of thousands of British Columbians every year.

65. In short, the impugned prohibitions are arbitrary, overly broad and grossly disproportionate, and hence contrary to the principles of fundamental justice under s.7 of the *Charter*.

66. Additionally, as a result of the WCB and other employment exemptions, these prohibitions also breach s.15 of the *Charter*, in that they discriminate against patients on the basis of age and disability.

67. That is because the effect of the prohibitions on accessing timely care outside of the public system is disproportionately suffered by individuals with genetic disabilities, or who are unable to work due to their age or disability. Such individuals can never obtain the benefit of the WCB exceptions

allowing individuals injured at work to obtain expedited treatment, and are therefore disproportionately impacted by the impugned provisions.

68. Finally, the prohibitions cannot be justified under s.1 of the *Charter*, because they are not rationally connected to their objective and do not minimally impair section 7 or 15 rights, and the benefits of the impugned provisions are vastly outweighed by the harms they cause.

69. In striking down these prohibitions, the Court should allow the Government sufficient time to take steps to amend the *MPA*, while at the same time ensuring that non-exempt British Columbians will continue to be able to obtain private diagnostic and surgical services while the Government is considering the necessary amendments to the *MPA*.

70. This will enable the Government to take targeted steps to address any valid concerns supported by the evidence, without adopting a blanket prohibition which causes unnecessary or avoidable harm.

D. Conclusion

71. While the issues of how the Government can best provide universal health care to the population, or whether it can ever improve wait times in the future, are complex, those issues are not before the Court.

72. The only questions for the Court are whether individuals are currently being harmed by delays in obtaining timely service in the public system, and whether the Government has a compelling reason, justified by the evidence, demonstrating the necessity of a blanket prohibition preventing people from alleviating that harm through access to medical care outside of the public system.

73. Answering these questions is the fundamental role of the Courts under the *Charter*. As Justice Deschamps stated in *Chaoulli*:

> [89] The courts have a duty to rise above political debate. They leave it to the legislatures to develop social policy. But when such social policies infringe rights that are protected by the charters, the courts cannot shy away from considering them.[9]

74. Indeed, the essence of this case is very simple. It was explained by Patrick Monahan, now Justice Monahan, as follows, in reference to the *Chaoulli* decision:

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[9] ***Chaoulli v. Quebec (Attorney General)***, [2005] 1 SCR 791, 2005 SCC 35 [***Chaoulli***] at para 89.

> Largely overlooked in this academic debate was whether anyone had an answer to the fundamental question of principle that had moved the Court to intervene in the first place. This question was simply whether it was legally and morally justifiable for the state, on the one hand, to require individuals to access healthcare services only through a universal, single-payer system and then, on the other, to deny them access to needed service when they were sick or dying. In such circumstances, which the Court found to prevail in Canada today, was it legitimate for the state to prohibit individuals from using their own resources to access the care they needed? Could the sick be legally compelled to wait indefinitely for care without legal consequences of any kind, even if it resulted in a serious deterioration of their health or even their death? ...
>
> Given the importance of this issue to the argument that follows, it bears explaining briefly why it cannot be legitimate in a free and democratic society to prevent individuals from utilizing their own resources to protect their health, in circumstances where the publicly funded system does not provide medical care in a timely manner. In these circumstances, the state is essentially forcing individuals to endure pain and even death in aid of the efficient operation of a social program. This offends the basic liberal principle that all persons should be treated "as equals"; that is, as entitled to equal concern and respect. No one citizen may be treated as a mere instrument to improve the welfare of another. Government fails to observe this bedrock moral principle when it imposes a "sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning his sense of his equal worth" (Dworkin 1985, 204).[10]

75. The Plaintiffs say that the answer to this question is equally straightforward in this case: no, the Government cannot legally force individuals to endure pain and suffering, an increased risk of permanent physical damage, or an increased risk of premature death, by prohibiting them from obtaining private diagnostic and surgical services within the province.

76. Until recently, it was not necessary for this claim to be brought, or for the Court to answer this question, because the prohibitions on non-exempt British Columbians being able to obtain private diagnostic and surgical services to alleviate their suffering and protect their health were not being enforced.

77. However, because the BC Government will no longer allow British Columbians to obtain these services privately within the province to deal with their own health care needs, it falls to the courts to uphold the constitutional rights of the residents of British Columbia.

78. As Justice Winteringham held in the *Injunction Decision*:

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[10] Patrick Monahan, "Chaoulli v. Quebec and the Future of Canadian Healthcare: Patient Accountability as the 'Sixth Principle' of the Canada Health Act", C.D. Howe Institute Lecture (November 29, 2006), pp. 9-10 (emphasis added).

> [185] I am satisfied that the Plaintiffs have demonstrated, for the purpose of the Injunction Application, a sufficient nexus between the prohibitions to private health care and being required to wait for treatment with no autonomous right to access private health care services. I am satisfied that there is evidence before me that at least some patients are at an increased risk of suffering physical and psychological harm by having to wait for public health care service. It is this waiting with no option to pursue an alternative that engages security of the person rights [...].[11]

II. THE PLAINTIFFS' CONSTITUTIONAL CLAIM

A. Introduction

79. The Plaintiffs brought this constitutional challenge to the prohibitions in the *MPA* against private health care to ensure that British Columbians may continue to obtain private diagnostic and surgical services, as they have for more than 20 years.

80. This past experience has proven that private treatment is an essential component of the health care system, because it allows patients to alleviate their suffering and protect their health in the face of the lengthy wait times in the public system.

81. Prior to 2008, it was not necessary to challenge the prohibitions in the *MPA,* because the Government had not taken any steps to enforce these prohibitions.

82. This changed when the Intervenor, Ms. Schooff, initiated legal proceedings in 2008 to compel the government to enforce the prohibitions and bring to an end private diagnosis and treatment by specialists in BC.

83. In response to these legal proceedings, it became necessary to challenge the constitutionality of the provisions of the *MPA* that prohibit private health care.

84. Ironically, Ms. Schooff's own experience and evidence demonstrates why the prohibitions on access to private diagnostic and surgical services cause unjustifiable harm to patients and are unconstitutional.

85. Ms. Schooff suffered greatly from a sinus condition, for which she was unable to obtain a timely surgery in the public system. She testified that her sinus condition caused excruciating pain, debilitating migraine headaches, loss of energy, difficulty breathing, and severe vision problems.

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[11] ***Cambie Surgeries Corp. v. British Columbia (Attorney General)***, 2018 BCSC 2084 [***Injunction Decision***] at para 185 (emphasis added).

86. These symptoms had a severe impact on Ms. Schooff's quality of life. She testified that they sometimes prevent her from caring for her children, regularly attending work, and even performing mundane day to day tasks. Two previous medical interventions had been unsuccessful in alleviating these severe symptoms.[12]

87. Ms. Schooff agreed in her evidence that it was necessary for her to obtain a private surgery from Dr. Amin Javer, an enrolled doctor to alleviate her suffering.[13]

88. She also agreed that private surgery greatly benefited her health and quality of life. She was suffering terribly from her disease, and would have waited many months or indeed years longer for treatment in the public system due to the limitations on operating room time for Dr. Javer.

89. Ms. Schooff was very grateful for the opportunity to have her surgery done privately so that she could relieve her suffering. However, she believed that the public system should have paid for her surgery.

90. Ms. Schooff's complaint is that the public system is failing to provide timely diagnostic and surgical services for her and many other patients – and therefore, that the Government should be forced to do whatever is necessary to correct this situation, so she and others do not have to pay for private diagnostic and surgical services.

91. Her position, apparently, is that the Government has a positive obligation to provide timely health care to all British Columbians, regardless of the cost or feasibility of fulfilling that obligation. That, of course, would be a very different and much more sweeping constitutional challenge than the Plaintiffs' current claim.[14]

92. The Plaintiffs' claim would not have been brought if the Government covered the cost of private diagnostic and surgical services for all British Columbians who are not receiving these services in a timely manner in the public system, as Ms. Schooff wants.

93. But the Government does not pay for private treatment when the public system does not provide timely surgeries to all patients, as shown by its refusal to reimburse Ms. Schooff.

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[12] **Transcript Day 157**, Testimony of Ms. Schooff, dated May 16, 2019, p. 17, lines 18 to, p. 19, line 17.
[13] **Transcript Day 157**, p. 30, line 11 to, p. 31, line 4.
[14] **Transcript Day 157**, p. 35, line 19 to, p. 36, line 29.

94. Ms. Schooff's situation occurred in 2003. Since then, patients continue to suffer harm every day in BC by unacceptably long wait times for medically necessary procedures.

95. The Government says in its evidence and submissions that it can fix and is "fixing", the public system. But, it is clear that despite their considerable efforts over the past 15 years, the public system cannot provide timely diagnostic and surgical services within the time frame each patient needs to alleviate their suffering and protect their health or indeed within even remotely reasonable time frames.

96. However, even if this might be possible, it is not a defence to a constitutional challenge to say that rights violation may end sometime in the future. The Constitution guarantees fundamental rights in the present. If rights have been violated, it is the obligation of the Court to address that wrong. An illegal search or seizure or an unlawful confinement is not vitiated by an assurance that it will not happen to anyone else in some distant future. Equally the harm to patients from the current law cannot be defended on the basis that there is a plan to harm fewer patients in the future.

97. In any event, it is clear that the Government cannot correct the situation so that no British Columbian will be harmed by waiting for diagnostic and surgical services in the future. The two Defendant witnesses, Ms. Copes and Dr. Hamilton, who have been spearheading the Government's efforts to reduce diagnostic and surgical wait times, confirmed that the Government has been unable to meet even its own very modest goals of reducing wait times for hip and knee replacements and not increasing wait times for all other surgeries.[15]

98. Thus, this case has to be adjudicated based on the situation in BC as it exists today (and for the last 30 years or so), in which thousands of patients are unable to obtain the timely diagnostic and surgical services they need in the public system to deal with their individual health care needs in the public system. Therefore, they cannot be constitutionally prohibited from obtaining these services privately in the province to alleviate their suffering and protect their health.

B. The prohibitions on access to private diagnostic and surgical services breach the s. 7 and s. 15 *Charter Rights of British Columbians*

99. The Plaintiffs claim that s. 14, 17, 18 and 45 of the *MPA* breach the s. 7 and s. 15 *Charter* rights of British Columbians by preventing B.C patients from obtaining private diagnostic and surgical services within the province to address their health care needs.

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[15] See **Section VI(F)**, below.

100. It also breaches the equality rights of British Columbians under s. 15 of the *Charter*, because the prohibitions disproportionately harm individuals who, because of their age or type of disability, are unable to obtain more timely private treatment afforded to workers whose condition arises from workplace illnesses or injuries.

101. Sections 14, 17, and 18 of the *MPA* prohibit doctors who are enrolled in the public system from providing medically necessary services, defined as benefits under the *Medicare Protection Act*, outside of the public system (the prohibition on dual practice).

102. In addition, s. 45 of the *MPA* prevents patients from paying for private medically necessary services obtained within the province through private insurance.

103. As a result, these prohibitions are designed and intended to make it very difficult, if not impossible, for British Columbians to obtain private diagnostic and surgical services inside the province if they do not come within an exemption in the *MPA*.

104. While it is theoretically possible for BC residents to obtain private diagnostic and surgical services in private clinics from unenrolled specialists who are paid by the patients out of their own pockets, this has not happened, and will not happen, for at least two reasons.

105. First, the evidence confirms that there are very few, if any, specialists who would give up the treatment of patients in the public system to work exclusively in the private sector. The surgical services that can be provided in private clinics are limited by College guidelines and regulation to short stay procedures and healthier patients, and most specialists do not want to limit their practice in this way.

106. And, second, the prohibition on private insurance makes it financially difficult for patients to purchase private medical services.

107. Thus, the practical effect of these prohibitions is to prevent BC physicians and private clinics from providing medically necessary services to non-exempt British Columbians on a private pay basis, with the result that non-exempt British Columbians cannot obtain private diagnostic and surgical services to alleviate their suffering and protect their health.

108. The Defendant does not dispute that the intended purpose and effect of the prohibitions on dual practice and private insurance is to prevent physicians and private clinics from being able to offer medically necessary services to patients outside of the public system.

109. Indeed, that is the basis of the Defendant's defence of these provisions. The Defendant claims that they are needed to prevent access to private health care in BC. Without dual practice there would be no specialists working in the private system and without private insurance there would be very few patients able to purchase private health care, even if it were available.

110. This was recognized as the intent and purpose of the prohibition on private insurance by both the majority and minority judges in *Chaoulli.*[16]

111. Based on the experience in British Columbia, the constitutional challenge in this case is to both the prohibitions on dual practice and the prohibitions on private insurance, as they apply to specialist services. Both prohibitions have to be struck down to enable all British Columbians to be able to obtain private diagnostic and surgical services within the province.

112. Over the past 20 years, the non-enforcement of the prohibition on dual practice has allowed some British Columbians to obtain private diagnostic and surgical services to protect their health in the face of lengthy wait times for the services in the public system.

113. This access has been assisted when some patients, such as the witness Barb Collin, were able to pay for their private surgeries through disability insurance provided by their employers. Other patients have been able to use their automobile insurance. But most patients have not been able to utilize their private insurance for this purpose as such use is not legally permissible. This has limited the access to private medical services in BC.

114. Both prohibitions must be eliminated to provide British Columbians with full access to private diagnostic and surgical services where they deem it necessary to alleviate their suffering and protect their health. Therefore, these prohibitions should be considered collectively for constitutional purposes just as they were enacted collectively to achieve the purpose of preventing the provision of private diagnostic and surgical services in BC.

115. The constitutional challenge is therefore focussed on the statutory prohibitions that prevent British Columbians from obtaining private diagnostic and surgical services within the province.

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[16] ***Chaoulli***, *supra* at para 56, per Deschamps J.; para 152, McLachlin C.J. & Major J.; para 181, Binnie & LeBel JJ.

116. The Plaintiffs are not saying that British Columbians have a positive constitutional right to have the government provide them with timely diagnostic and surgical services, or any medical service, to protect their health to protect their health.

117. The Plaintiffs accept that the government is entitled to decide whether to provide publicly funded health care services, and to what extent and in what manner or time frame.

118. Rather, the Plaintiffs say that if the Government fails to provide timely medical care, the Government cannot prevent British Columbians from protecting their health by obtaining those medical services privately within the province.

119. It has been conclusively proven over a long period of time that the public health care system does not provide timely diagnostic and surgical services to all British Columbians.

120. Hence, the prohibitions on access to private diagnostic and surgical services harm the health of British Columbians by preventing them from obtaining diagnostic and surgical services to protect their health outside of the public system.

121. The elimination of the prohibitions on access to private diagnostic and surgical services may not reduce wait times for these services in the public system, due to the pent-up and increasing demand for those services. But that is irrelevant to the Plaintiffs' claim.

122. The Plaintiffs are also not claiming that the Government is legally obliged to reduce the wait times for diagnostic and surgical services in the public system so that everyone receives these services in a time frame that protects their health.

123. The Plaintiffs say only that given the proven failure of the public system to provide timely diagnostic and surgical services, the Government's actions in preventing British Columbians from obtaining those medical services privately in BC is a breach of their *Charter* rights.

124. This is the same claim that was accepted by the Supreme Court in *Chaoulli* with respect to the prohibition on private insurance (there was no challenge in that case to the prohibition on dual practice).[17]

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[17] ***Chaoulli***, *supra* at paras 2, 4, 100, Deschamps J; paras 103-104, 158, McLachlin C.J. & Major J.

125. While disagreeing with the majority's analysis at the justification stage, the dissenting judges in *Chaoulli* agreed that preventing citizens from obtaining private health care could breach their *Charter* rights:

> 203 Reference has already been made to the question raised by our colleague Deschamps J. at para. 4 of her reasons
>
> > In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state.
>
> While we do not accept that there is a constitutional right "to spend money", which would be a property right, we agree that if the public system fails to deliver life-saving care and an individual is simultaneously prevented from seeking insurance to cover the cost of that care in a private facility, then the individual is potentially caught in a situation that may signal a deprivation of his or her security of the person.

126. The challenges in the *Bedford, PHS Community Services*, and *Carter* cases[18] were likewise to Government action that did not directly cause individuals physical or psychological harms, but, as here, prevented people from avoiding or alleviating these harms.

127. In *Bedford*, the government did not directly cause harm to sex workers; the harm was caused by exploitive pimps, violent customers, and other predators, and the claimants did not argue that the third parties causing harm violated their *Charter* rights, or that the Government had a positive obligation to prevent this harm from occurring.

128. Rather, the constitutional challenge in *Bedford* was to the criminal laws that prevented individuals from taking steps to protect themselves from harm when working as prostitutes.

129. Specifically, the applicants challenged provisions making it a crime to keep a bawdy-house, to live on the avails of prostitute or to communicate in public with respect to a proposed act of prostitution. The Applicants alleged that these provisions breached s. 7 of the *Charter* "...by preventing prostitutes from implementing certain safety measures – such as hiring security guards or "screening" potential clients – that could protect them from violent clients..." [19]

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[18] ***Canada (Attorney General) v. Bedford***, 2013 SCC 72 [***Bedford***]; ***Canada (Attorney General) v. PHS Community Services Society***, 2011 SCC 44 [***PHS Community Services***]; ***Carter v. Canada (Attorney General)***, 2015 SCC 5 [***Carter***].

[19] ***Bedford***, *supra* at paras 2, 6.

130. Thus, like the present claim, the constitutional challenge in *Bedford* was to a law that prevented persons from taking steps to protect their health and safety in the face of harms that were not directly caused by the laws being impugned.

131. The situation in *Carter* is also analogous. The direct harm in *Carter* was the suffering caused by living with a debilitating and painful condition. The impugned law prevented people from ending their suffering by ending their lives through physician assisted suicide. Denying people enduring great suffering from availing themselves of this option was found to be a breach of s. 7 of the *Charter*.

132. Similarly, in *PHS Community Services*, the harm was directly caused by drug use (which can lead to overdoses and death) and the social circumstances surrounding drug use and addiction. The Government did not require anyone to use drugs and thus the impugned law did not directly cause the harm in that sense. And, indeed, the Government used the criminal law to prevent people from having access to harmful drugs.

133. However, the impugned law prevented individuals from using drugs in a manner that would reduce the risk of serious harm or death. By prohibiting facilities in which the use of drugs could be monitored by trained staff and nurses, the government denied drug users an alternative that would have reduced the risk that drug use would cause death or other harms. It was the denial of this potentially beneficial alternative that was the breach of section 7.

134. All of these cases have a direct parallel with the current case. The direct or immediate harm in this case is caused by the patient's medical condition and the significant wait times. That is the background set of circumstances against which the impugned prohibitions on private health care must be assessed.

135. The breach of *Charter* rights is not, however, that the government is causing the detrimental medical condition or that the government has failed to provide timely access to necessary medical service.

136. Rather, the breach in this case, as in the cases just reviewed, is that the law is preventing people from taking steps to address their own health needs and avoid additional harm.

137. The prohibitions in the *MPA* are thus akin to laws that prevent drug users from taking steps to use drugs in as safe a manner as possible, laws that prevent sex workers from protecting themselves

from harms caused by third parties, and laws that prevent individuals with debilitating conditions from alleviating their suffering through physician assisted suicide.

138. In all of these cases, the harm is directly caused by a set of background circumstances, and the question is whether the Government has breached the *Charter* by preventing individuals from accessing services that would alleviate or end the harm or risk to their health.

139. Relying on these earlier decisions, the legal analysis leading to the conclusion that the prohibitions on access to private care are unconstitutional can be briefly stated.

140. Section 7 protects the rights to life, liberty or security of the person, which cannot be deprived except in accordance with the principles of fundamental justice.

141. All three rights under section 7 are infringed on the evidence in this case. In particular, the impugned provisions abridge:

a. the liberty interest, by preventing individuals from making the fundamentally personal decision to obtain medical treatment;

b. the security of the person interest, by preventing patients from obtaining the treatment they need to avoid prolonged and severe pain, immobility, psychological harm, physical deterioration, and permanent damage; and

c. the life interest, by increasing the risk that patients with life threatening conditions will suffer a premature death due to a lack of timely diagnosis or treatment.

142. In light of the true purpose of the impugned provisions - to protect the accessibility and viability of the public health care system - the infringements just described violate the principles of fundamental justice. In particular, the impugned provisions are:

a. Arbitrary, because they are neither necessary nor directly connected on the facts to their purpose; in fact, they undermine that purpose;

b. Overbroad, because they go further than necessary to achieve their purpose, and capture conduct that is entirely unconnected to their purpose;

c. Grossly disproportionate, because they cause severe and sometimes catastrophic harms for no compelling benefit, based on the evidence.

143. The purpose of the impugned provisions is not, as the Defendant says, to ensure equal health care treatment for all. This alleged purpose is not consistent with the provisions themselves, nor with how the system operates in practice, in which access to timely treatment differs based on wealth, location, type of condition, and the source of injury.

144. However, even if the purpose of the provision were to ensure equal treatment for all, the impugned provisions violate the principles of fundamental justice. They are arbitrary, because they prevent people from accessing the same timely treatment others are able to obtain. And they are grossly disproportionate, because the concrete and severe harms caused are out of all proportion to the pursuit of a vague, unattainable, and purely symbolic principle like 'equal care for all'.

145. The impugned provisions also violate section 15, because they have a disproportionate impact on the protected grounds of age, disability, and type of disability, in light of the exemption for individuals injured at work.

146. Individuals who cannot work because of their age or disability, or whose type of condition cannot be caused by a workplace injury or illness, are disproportionately harmed by the impugned provisions, resulting in substantive discrimination.

147. The prohibitions are also substantively discriminatory because they distribute a fundamentally important interest – access to medically necessary treatment – in an unequal manner, and without regard to medical need. This deprives non-exempt patients of the equal concern and respect that section 15 is designed to ensure.

148. Finally, the impugned provisions cannot be justified under section 1. The Plaintiffs acknowledge that, unlike the pursuit of a vague, unattainable, and purely symbolic objective, the purpose of protecting the viability and accessibility of the public system is a pressing and substantial objective that, in theory, can justify some limitation on *Charter* rights.

149. However, the impugned provisions are not rationally connected or necessary to achieve this purpose, nor do the provisions minimally impair the *Charter* rights infringed, in light of the fact that any valid concerns can be fully addressed in far less harmful ways. The impugned provisions also achieve no real benefit, while the deleterious effects are severe and widespread.

150. Therefore, the impugned provisions violate sections 7 and 15 of the *Charter*, cannot be justified under section 1, and must be struck down.

C. The standing of the Plaintiffs to bring this Constitutional Claim

151. This claim is brought by the Plaintiffs on behalf of all British Columbians. That is made clear in the Notice of Civil Claim.[20]

152. Justice Steeves has ruled that the Plaintiffs have both private and public interest standing.[21]

153. Notwithstanding this, and the extensive evidence tendered which goes well beyond the circumstances of the Plaintiffs, the Defendant has continued to raise the issue of standing. For instance, the Defendant argued in the injunction application that because the claim was limited to the circumstances of the individual Plaintiffs, the Court could not consider any evidence of harm that was not directly tied to the Patient Plaintiffs.

154. Justice Winteringham, and Justice Newbury on the appeal, both rejected this argument and confirmed the decision of Justice Steeves on the standing issue.[22]

155. Likewise, in *Chaoulli*, the Supreme Court of Canada held that the Plaintiffs had public interest standing to bring their constitutional challenge on behalf of all Quebeckers.[23]

156. Thus, there can be no doubt that the Patient Plaintiffs, Cambie and SRC, have public interest standing in this case.

157. As repeatedly confirmed by the Supreme Court of Canada, this means the Plaintiffs can rely on the breach of the *Charter* rights of other persons to support their constitutional claim.[24]

158. Therefore, pursuant to their public interest standing, the Corporate Plaintiffs, Cambie and SRC, are entitled to raise a systemic challenge to the prohibitions on dual practice and private insurance

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[20] Fifth Amended Notice of Civil Claim, paras 10-11.
[21] ***Cambie Surgeries Corp. v. British Columbia (Medical Services Commission)***, 2016 BCSC 1292, paras 58-59; ***Cambie Surgeries Corp. v. British Columbia (Attorney General)***, 2018 BCSC 1141, para 60.
[22] ***Injunction Decision***, *supra* at para 168; ***Cambie Surgeries Corp. v. British Columbia (Attorney General)***, 2019 BCCA 29, paras 52, 57(ii).
[23] ***Chaoulli***, *supra* at para 34, Deschamps J., paras 186-189, Binnie & LeBel JJ.
[24] See ***R. v. Nur***, 2015 SCC 15 at paras 49-52; ***Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society***, 2012 SCC 45 at paras 31, 33; ***R. v. Appulonappa***, 2015 SCC 59 at para 28.

to advance the *Charter* rights of all British Columbians to be able to obtain private diagnostic and surgical services to protect their health.

159. Also, although not strictly necessary given Cambie and SRC's public interest standing to bring this systemic claim on behalf of all British Columbians, Cambie and SRC also have standing to challenge the prohibitions on dual practice and private insurance because they are subject to a counterclaim by the Government based on their breach of the prohibitions.

160. This is akin to the *Morgentaler* case, where Dr. Morgentaler was accused of breaching the Nova Scotia *Medical Services Act* prohibitions regarding the performance of abortions outside of a hospital. Dr. Morgentaler's argued in his defence, and the Supreme Court of Canada agreed, that the prohibitions in question were *ultra vires* the province of Nova Scotia on the ground that they were in pith and substance criminal law.[25]

161. Similarly here, the defence of Cambie and SRC to the Government's counterclaim declaring Cambie to be in breach of ss. 17(1)(a), 17(1)(b) and (18(3) of the *MPA*, is that these prohibitions are unconstitutional because they breach the *Charter* rights of British Columbians to have access to private diagnostic and surgical services.

162. In addition, although, again not necessary from the perspective of standing, the law violated the rights of the Individual Plaintiffs specifically, the *Charter* rights of the individual Plaintiffs were breached by the impugned prohibitions. This is so even though the prohibitions were not being enforced during the period of time these patients were seeking and obtained diagnostic and surgical services.

163. Three of the Plaintiff patients were able to obtain private diagnostic and/or surgical services in BC to address their health care needs in the face of excessive wait times in the public health care system: Mandy Martens (consultation and colonoscopy), Chris Chiavatti (consultation and knee surgery) and Krystiana Corrado (knee surgery), because the prohibitions on access to such private services were not being enforced at that time.

164. However, neither these patients, nor their physicians, nor the private clinics which provided the facilities, staff, equipment and supplies for their treatment, should have had to act illegally in order

[25] ***R. v. Morgentaler***, [1993] 3 S.C.R. 463.

to provide these patients access to the medical services they needed and could not obtain in the public system in a timely way.

165. The fact that they were legally prohibited from alleviating their suffering and protecting their health through private treatment constitutes an infringement of their *Charter* rights. For the purposes of the Constitution, it is irrelevant that the law was not being enforced.

166. In the case of Plaintiff Walid Khalfallah, while he ultimately obtained his surgery outside of BC, which is not prohibited, his *Charter* rights were also violated by the prohibitions. This is so despite that there are no existing private facilities in BC that could provide this complicated spinal surgery.

167. Again, the Plaintiffs are not saying that Mr. Khalfallah was constitutionally entitled to obtain this surgery in the public system. And, the Plaintiffs acknowledge that this type of complex surgery is not presently performed in private clinics in British Columbia.

168. However, the Plaintiffs say that the prohibitions on dual practice and private insurance have the effect of preventing this type of surgery from being provided outside of the public system in BC, and thus have negated an alternative that may have existed for Mr. Khalfallah if the law were not in effect. Therefore, the prohibitions on dual practice and private insurance breached the constitutional rights of Mr. Khalfallah.

169. It can never be known what private surgical services may have been available if the prohibitions had not been enacted. It is thus no answer to say that private complex surgical services would not likely have been available even if the *MPA* prohibitions did not exist.

170. And, regardless of whether Walid's surgery could have been performed in a private clinic, if there were no prohibitions on dual practice and private insurance, then less complex surgical cases could have been lawfully performed at private surgical clinics on a private pay basis. This would have freed up more operating time in the public system for the more complex surgeries, such as the surgery required by Walid.

171. For all of these reasons, it is clear that the issue of whether the prohibitions on dual practice and private insurance in the *MPA* breach the *Charter* of rights of all British Columbians is squarely before the court in this case.

D. The harms to health from waiting for diagnostic and surgical services

172. The evidence in this case from the patient witnesses, physician witnesses, and expert witnesses confirms the findings of all of the SCC judges in *Chaoulli*: the life and security of the person of patients are harmed by waiting for diagnostic and surgical services.

173. The majority held that the following harms from delayed access to surgical procedures infringe the rights to life, liberty and security of the person[26]:

a. Delays that result in pain, discomfort;

b. Delays that result in limited mobility and quality of life while waiting for treatment, such as having a limited ability to walk or get around, or being confined to wheelchairs or house bound;

c. Delays that increase the "risk that their injuries will become irreparable";

d. Delays that cause "adverse psychological impact[s]", which "can have a serious and profound effect on a person's psychological integrity", such as "significant anxiety and depression", or "worry, anxiety or stress"; and

e. Delays that cause an increased risk of premature death, even marginally, given that over time, it becomes inevitable that at least "some patients will die if they have to wait for an operation."

174. The majority of the Court found that these types of harms engage section 7 of the *Charter*.[27]

175. Although the dissenting opinion of Binnie and Lebel JJ disagreed with the majority's analysis of the principles of fundamental justice, they did not dispute that delays in providing health care treatment can engage the rights in section 7 of the *Charter*.[28]

176. The evidence in this case demonstrates that all of the types of harms to the health of patients caused by waiting for diagnosis and treatment identified by the Judges in the *Chaoulli* case are suffered by British Columbians waiting for treatment. The evidence with respect to these harms will be

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[26] ***Chaoulli***, *supra* at para 40, 42, Deschamps J; paras 112, 114, McLachlin CJ & Major J.
[27] ***Chaoulli***, *supra* at paras 119, 121-124, McLachlin CJ & Major J.
[28] ***Chaoulli***, *supra* at paras 191, 200, Binnie & LeBel JJ.

outlined in detail in Section VII of this Submission – Harms of Waiting for Diagnosis and Treatment by Specialists.

177. Further, in addition to the direct physical and psychological harms suffered by patients, delays in obtaining treatment diminish the quality of patients' lives by depriving them of the ability to participate in everyday life, including work and educational activities, family responsibilities and relationships, and social activities.

178. It can also cause financial harm to patients and their families, due to inability to work and the cost of medications and non-medical therapies to reduce or address symptoms while waiting for diagnosis and/or treatment.

179. Many patients waiting for diagnosis and treatment suffer at least some of the above harms. Most of these harms are cumulative, such that the greater the delay, the greater the harm.

180. The prolonged pain and suffering, lack of mobility and independence, increased risk of irreversible and permanent harms or negative post-surgical outcomes, and psychological harm and suffering, all contribute to an overall loss of quality of life and financial loss that can never be recouped.

181. These harms have all been proven through direct evidence from patients, from their physicians, and from experts who explain the medical consequences of waiting.

182. They have also been confirmed by the wealth of systemic data that has been led in this case.

183. While the dissenting judges in *Chaoulli* found it difficult to determine what constituted "reasonable access to health care" or whether that was being met because there was a lack of guidelines for timely medical treatment and no good available data about wait times, that is not the case here.

184. In this case, there are officially accepted maximum acceptable wait times established by expert panels of physicians for almost all surgical services, based on the patient's diagnosis and condition, as well as for a number of diagnostic procedures.[29] As described in the Government's documents, the maximum acceptable wait time target associated with each priority level is the "time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences"[30].

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[29] **Exhibit 432**, "Paediatric Canadian Access Targets for Surgery (P-CATS)", pp. 1286-1302, 1303-1305 **[CBE, Tab 103]**.
[30] **Exhibit 243**, p. 7 **[CBE, Tab 46]**.

185. We also have comprehensive data from the Government's Surgical Patient Registry ("**SPR**") which shows that many (and for some conditions most) patients are waiting well beyond the maximum acceptable wait time for their condition.

186. That is not to say that patients only suffer harm after the maximum acceptable wait time for their condition has expired. Rather these maximum acceptable wait times are the outer limit of what is acceptable on a systemic basis for most patients.

187. Many patients will suffer harm within these wait time periods for surgical treatment, and indeed will have suffered harm while waiting for a diagnosis or a decision for surgery or other treatment, before the Wait Two time frame even starts.

188. And, there is individual variability among patients. Physicians and science cannot predict which patients will suffer a progression of their illness, including deterioration or progression to a point that cannot be recoverable with surgery or other treatment, or when.

189. Contrary to the Government's position, the reason that patients do not receive their diagnosis or surgical treatment in a timely fashion is not because their physician(s) decided they can safely wait longer or have failed to act in their patient's best interests.

190. Rather, the delays in treatment and the resulting harms to patients are due to specialists and surgeons in BC not being allocated sufficient operating room time or other facilities in the public system to permit them to treat all (or even most) of their patients in a timely way.

191. Ms. Schooff is a good example. She was suffering greatly while waiting for her surgery. Dr. Javer was not able to provide her with a surgery in any timely fashion because he had many other patients in the same situation and his allotted operating room time in the public system did not allow him to provide all or even most of them with timely surgery.

192. Tens of thousands of BC patients each year wait well beyond the maximum acceptable wait time for their surgical or diagnostic procedure in the public system, and also wait excessively long for a consultation with a specialist, with resulting harm to these patients.

193. The long wait times are not caused by specialists improperly triaging or prioritizing their patients, or selfishly declining to refer them to other specialists with short wait times; rather, it is because specialists and surgeons generally do not have access to sufficient operating room or other

equipment and facilities within the public system to provide timely diagnostic and surgical services to each or indeed many of their patients.

194. At all stages of the waiting process many patients are suffering harms that seriously impair their rights to life and security of the person.

195. This in itself proves that the life and security of the person of British Columbians are seriously affected by the prohibitions on obtaining private diagnostic and surgical services, because they are rendered unable to avoid the harms from waiting too long for treatment in the public system.

196. And, these harms are particularly egregious when it is seen that some preferred patients in BC – those in jail, or those who are injured or become ill in the workplace, do not have to endure these same lengthy waits for diagnosis and treatment. Instead, these preferred patients benefit from the financial incentives provided to physicians and private clinics to diagnose and treat these patients in a highly expedited time frame ahead of all other BC patients with the same condition who are prohibited from using their own resources or their insurance to obtain similar expedited treatment for themselves.

197. This not only demonstrates the arbitrariness of the prohibitions on private diagnostic and surgical services in the MPA, but also constitutes a breach of patients' s. 15 equality rights.

III. THE BACKGROUND, HISTORY, AND PURPOSE OF THE LEGISLATION

A. 1948 – 1984 - The Background

(i) Overview

198. The widespread adoption of public health insurance across Canada was rooted in a highly laudable objective: to ensure that everyone is able to obtain the timely medical treatment they need, without financial or other barriers. The fundamental purpose was to improve and protect peoples' health.

199. However, the BC Government is not only failing to adequately meet the medical needs of BC residents under the public health care plan, but it is actively prohibiting BC residents from responding to that failure by accessing adequate treatment elsewhere.

200. We have gone from a focus on ensuring that everyone has timely access to health care services without barriers, to deliberately erecting barriers in an effort to prevent people from obtaining timely access to health care services.

201. It is worth taking some time to describe how we arrived at such a profound reversal of priorities, before reviewing the impugned provisions in detail.

(ii) The Origins of Medicare

202. As a starting point, it is important to emphasize that the regulation of health care in Canada is primarily a provincial responsibility, falling within the provinces jurisdiction over the establishment, maintenance and management of hospitals, as well as property and civil rights, and matters of a local or private nature.[31]

203. However, beginning in the 1950s, the federal government intervened in the provincial health care field by using its so-called "spending power", which is a power inferred from sections 91(1A), 91(3) and 106 of the *Constitution Act, 1867*.[32]

204. The use of this spending power allowed the federal government to both contribute to the funding of health care services delivered by the provinces, and to require certain commitments from the provinces in exchange for that funding.

205. The history of medicare in Canada began in 1947, when Saskatchewan became the first province in Canada to establish public hospital insurance, followed soon thereafter by other provinces.[33]

206. In order to encourage and support the provision of hospital insurance by the provinces, the Federal Government enacted the *Hospital Insurance and Diagnostic Services Act* ("***HIDSA***") in 1957, which covered some of the costs of hospital and diagnostic services in provincial public insurance programs, but not physician services generally.[34] By 1961, all of the provinces were participating in the Federal Government's hospital insurance program and had insurance plans that provided access to hospital services.[35]

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[31] *Constitution Act, 1867,* ss. 92(7), 92(13), 92(16). ***Schneider v. The Queen***, [1982] 2 SCR 112 at 136-137; ***Eldridge v. British Columbia (Attorney General)***, [1997] 3 SCR 624 at para 24.

[32] ***YMHA Jewish Community Centre of Winnipeg Inc. v. Brown***, [1989] 1 SCR 1532 at ; ***Eldridge v. British Columbia (Attorney General)***, [1997] 3 SCR 624 at para 25; ***Chaoulli v. Quebec (Attorney General)***, 2005 SCC 35 at para 16, per Deschamps J. See also **Exhibit 433A**, pp. 1655-1657, Kirby Report, Vol I, at 5-7 **[CBE, Tab 104]**.

[33] **Exhibit 435A**, Affidavit #1 of Gigi Mandy, p. 8, para 27 **[CBE, Tab 108]**; **Exhibit 486**, Expert Report of Professor Marchildon, pp. 5-7 **[CBE, Tab 128]**.

[34] *Hospital Insurance and Diagnostic Services Act*, S.C. 1957, c. 28 ("***HIDSA***"). **Exhibit 435A**, Mandy Affidavit #1, p. 9, para 31 **[CBE, Tab 108]**.

[35] **Exhibit 486**, Marchildon 2014, p. 11 **[CBE, Tab 128]**.

207. In 1961, the federal government established a commission chaired by Justice Emmett Hall (the "**Hall Commission**"), with a mandate "to inquire into and report upon the existing faculties and the future need for health services for the people of Canada, the resources required to provide such services, and to recommend such measures... as the Commissioners believe will ensure that the best possible health care is available to all Canadians."[36]

208. The Hall Commission issued its report in 1964. It recommended the creation of public health insurance programs that would ensure that all Canadians had access to medically necessary care, including both hospital services and physician services, as well as prescription drugs, eye glasses, dental services, and long term/home care.[37]

209. While the Hall Commission recommended that extra-billing under the public insurance plans should not be permitted, the report did not recommend that patients be prevented from obtaining the treatment they needed outside of the public system, either generally or in response to a failure of the public plan to provide timely treatment. To the contrary, the report stated as follows:

> In recommending the programme we have proposed, we have steered clear of the views of those on the extreme right or extreme left. We are opposed to state medicine, a system in which all providers of health services are functionaries under the control of the state. We recommend a course of action based upon social principles and the co-operation and participation of society as a whole in order to achieve the best possible health care for all Canadians, an aim that Canadians by their individual efforts cannot attain.
>
> Such action, we insist, is based upon freedom of choice on the part of the citizen, and on services provided by free and self-governing professions. By safeguarding these elements, so vital to a free society, we believe we have avoided the difficulties inherent in a programme which attempts to nationalize the services which one group provides for others.[38]

210. In 1966, federal Parliament enacted the *Medical Care Act* ("***MCA***"),[39] which provided for annual financial assistance to each province in respect of the cost of insured physician services pursuant to a provincial medical care insurance plan.[40] The federal government offered to cover roughly 50% of the

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[36] **Exhibit 435A,** Mandy #1, Exhibit E, p. 46 Hall Report 1964, at xix **[CBE, Tab 108]**.
[37] **Exhibit 435A**, Mandy #1, Exhibit E, p. 64-143 Hall Report, at 17-92 **[CBE, Tab 108]**; **Exhibit 6**, Expert Report of Michael Bliss, as amended July 31, 2014, Appendix B, p. 4 [Michael Bliss, "Critical Condition: A Historian's Prognosis on Canada's Aging Healthcare System" *C.D. Howe Institute Benefactors Lecture* (2010) at 4] **[CBE, Tab 6]**.
[38] **Exhibit 435A**, Mandy #1, Vol 1, Exhibit E, p. 61 [Hall Report 1964, 13 (emphasis added)] **[CBE, Tab 128]**.
[39] *Medical Care Act*, S.C. 1966-67, c. 64 ("***MCA***").
[40] **Exhibit 435A**, Mandy #1, p 9-10, paras 31-33 **[CBE, Tab 108]**.

costs of any provincial health insurance program that met the criteria of universality, comprehensiveness, portability, and public administration.[41]

211. However, there was again no intention to prevent physicians from providing or patients from accessing services privately. The objective was to ensure that all Canadians had access to coverage if and when they needed it. As Professor Marchildon explained in his expert report, with regard to the purposes behind the *MCA*:

> [With respect to universality], Pearson was in effect rejecting any provincial plan that would differentiate among beneficiaries on the basis of health, age or income. As Pearson explained, "[s]ince the basic reason of a Federal contribution is to make Medicare possible for all Canadians, it would hardly be logical to bring a Federal contribution into play for plans not aimed at universal coverage.
>
> Those provincial premiers who preferred to increase coverage by subsidizing private health insurance, including W.A.C. Bennett of British Columbia, accused the federal government of trying to ram a compulsory model of Medicare down their throats. Pearson rejected at least part of the charge. While the taxes for the provincial schemes would be compulsory, he argued that there was "no compulsion on people to use the services, nor any compulsion on the individual doctor to join the plan if the demand for his services is such that he can practice successfully outside it. In other words, the federal government had no intention of setting conditions that would prevent physicians from opting out of provincial Medicare plans.[42]

212. By 1971 or 1972, all provinces had public health insurance systems that qualified for funding under the *MCA*.[43]

(iii) The BC Medical Services Act, 1967

213. In response to the passage of the federal *MCA*, the BC legislature enacted the first comprehensive medical insurance plan in the province, the *Medical Services Act* (the "***MSA***"),[44] in 1967, which allowed the province to receive federal fiscal transfers for a publicly funded health insurance scheme.[45]

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[41] **Exhibit 486**, Marchildon 2014, p. 35-36 **[CBE, Tab 128]**; see also **Exhibit 433A**, p. 1658 [Kirby Report, Vol I, at 8] **[CBE, Tab 104]**.; **Exhibit 6**, Bliss 2014, Appendix B, p. 4-5 **[CBE, Tab 6]**.
[42] **Exhibit 486**, Marchildon 2014, p. 36 (emphasis added) **[CBE, Tab 128]**.
[43] **Exhibit 486** - Marchildon 2014, p. 37 **[CBE, Tab 128]**; **Exhibit 433A**, p. 1658 [Kirby Report, Vol I, at 8] **[CBE, Tab 104]**; **Exhibit 6**, Bliss 2014, Appendix B, p. 1 **[CBE, Tab 6]**.
[44] *Medical Services Act*, S.B.C. 1967, c. 24 (the "***MSA***").
[45] *MSA*, s. 10.

214. The *MSA* and subsequent regulations created the Medical Services Commission (the "**Commission**") (s. 3(1)), and provided for the creation of a "voluntary medical care insurance plan for the residents of the Province" (ss. 8(1), 10). The regulations to the *MSA* created the Medical Services Plan ("**MSP**").

215. Under the regulatory supervision of the Commission, universal access to health insurance was provided by both a public plan, the BC Medical Services Plan, as well as through licensed private, not-for-profit insurance providers.[46] Both the public and private carriers covered individuals upon the payment of a premium under the plans.[47]

216. The clear purpose of the *MSA* was to ensure that all BC residents had access to health insurance, and to qualify BC for federal funding under the *MCA* cost sharing regime.[48]

217. Given this objective, the *MSA* contained no express restrictions on accessing health care privately. The need for private insurance and dual practice did not appear to be contemplated at the time, as generally patients were content with the timeliness and quality of treatment supplied through the MSP, prior to cost-containment and rationing that began to appear in the 1980s and 1990s.[49]

218. In terms of billing practices, regulations to the *MSA* [50] provided that enrolled physicians would charge the plan for "insured services", i.e. services "covered by the Plan" (s.5.01), and could charge patients an additional fee if consent was given by the patient (s. 5.11(2)). Physicians could also elect to receive payments directly from patients (s. 5.04), who would be entitled to reimbursement up to the plan amounts, if the patient was given notice and consented to the additional charge in advance (s. 5.10/11).

219. There were no express restrictions in the *MSA Regulations* on the ability of physicians to operate outside of the public plan entirely,[51] no restrictions on those physicians' billing practices, nor

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[46] **Exhibit 486**, Marchildon 2014, pp. 52-54 **[CBE, Tab 128]**.
[47] See *Medical Services Act Regulations,* B.C, Reg. 144/68 ("***MSA Regulations***"), s. 4.02. See also e.g. *Medical Services Amendment Act*, 1975, SBC c. 40, s. 2.
[48] See also **Exhibit 486**, Marchildon 2014, p. 53 **[CBE, Tab 128]**.
[49] See **Exhibit 6**, Bliss 2014, Appendix B, p. 5-6 **[CBE, Tab 6]**. See also **Exhibit 433A**, at pp. 1550-1552 **[CBE, Tab 104]**.
[50] *MSA Regulations, supra.*
[51] The ability of physicians to opt out of the public plan entirely was not addressed expressly by previous regulations, but was explicitly confirmed by *B.C. Reg. 213/86.*

any restrictions on the ability of patients to obtain private insurance outside of the public plan for medically necessary services.

220. The *MSA Regulations* therefore placed no express restrictions on the provision of medically necessary services outside of the public plan. And other than the requirement for notice and consent, the *MSA Regulations* placed no restrictions on extra-billing of patients on top of the amounts collected under the plan by opted-in physicians, nor any restrictions on the amounts that could be charged by physicians who elected to be paid directly by beneficiaries.

221. This was consistent with the fact that, under the medicare system as originally conceived and implemented, there was no intention to prohibit access to private health care options. Rather, the purpose was to ensure that everyone could access health care treatment without financial or other barriers. As explained in the Kirby Report:

> Tom Kent, a former federal deputy minister and senior policy advisor to Lester B. Pearson, explained that the underlying objective of federal health care policy was essentially to ensure timely access to necessary health services without undue financial impediment:
>
> > The number of Canadians who knew life before Medicare will very soon be, if it is not already, a minority. Of course, how life was before was the essential reason Medicare developed. As you all know, before that, treatment could be a financial disaster even for well-to-do people, and many poorer people just did not get care when it was needed. The aim of public policy was quite clearly and simply to change that situation to make sure that people could get care when it was needed without regard to other considerations.[52]

222. Given that the purpose of medicare was to ensure that everyone had access to health care insurance, there was no intention to prevent people from obtaining health care through other means. As explained by Professor Michael Bliss:

> Individual reliance on Canadian medicare was not compulsory. Citizens would have to pay a share of the costs of health insurance either in taxes or, in provinces that levied them, healthcare premiums, or both. But they could opt not to take any benefits and arrange to get their healthcare privately, just as they could educate their children privately while also paying school taxes or decline to cash baby bonus or old age pension cheques. Similarly, physicians, whose associations had lobbied strenuously to maintain professional independence from government and who had fought the government of Saskatchewan to a draw in a bitter doctors' strike, could choose to

[52] **Exhibit 433A**, p. 1657 [Kirby Report, Vol I, at 7 (emphasis added)] **[CBE, Tab 104]**.

> practice outside the system, billing patients at whatever rates they thought the market would bear…[53]

223. This was confirmed in the Hall Commission report, which stated that "a health program requires only payment of taxes; *there is no compulsion on anyone to accept or obtain services*... it is almost impossible to discover any element of compulsion with the hospital services in any form whatever."[54]

(iv) Cost Cutting and Extra-Billing

224. However, as more and more medical services were insured publicly, with little or no cost to individuals, the public health care system began to have a serious impact on government spending.[55] As Professor Bliss has explained:

> Very quickly after medicare's introduction, all Canadian governments began to be concerned about the affordability of the commitments they had made. As usage and public costs soared (see Figure 2), and critics began to wring their hands about the unlimited propensity to consume a free service, alarmist projections issued about the capacity of healthcare to take over practically the whole tent of government spending (Gray 1991). If the central problem before medicare had been to make modern healthcare accessible to all Canadians, the central problem after the introduction of medicare was how to pay for it. It has continued, into the present, to be a central problem.[56]

225. Faced with these cost pressures, Canadian governments sought ways to limit health care spending under the public plans, beginning in the late 1970s.

226. In 1977, the Federal Government replaced its open-ended 50% cost sharing commitment, which tied federal transfers to provincial expenditures, with what is called block funding.[57]

227. Under the Federal Government's new funding program, about half of the former cost-sharing, which had been fully in cash, was replaced by the permanent transfer of federal "tax points" (i.e. the federal government reduced taxes permitting provincial governments to increase them by an

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[53] **Exhibit 6**, Bliss 2014, Appendix B, p. 5 **[CBE, Tab 6]**.
[54] **Exhibit 435B**, Mandy #1, Exhibit E, p. 776 [Hall Report 1964, at 740] **[CBE, Tab 109]**.
[55] **Exhibit 6**, Bliss 2014, Appendix B, p. 8 **[CBE, Tab 6]**; **Exhibit 433A**, pp. 1659-1660 [Kirby Report, Vol I, at 9-10] **[CBE, Tab 104]**; **Exhibit 435G**, Mandy #1, Exhibit V, pp. 3005-3014 **[CBE, Tab 112]**.
[56] **Exhibit 6**, Bliss 2014, Appendix B, p. 8 **[CBE, Tab 6]**.See also **Exhibit 433A**, p. 1659-1660 [Kirby Report, Vol I, at 9-10] **[CBE, Tab 104]**; **Exhibit 435G**, Mandy #1, Exhibit V, pp. 3005-3014 **[CBE, Tab 112]**.
[57] **Exhibit 435A**, Mandy #1, p. 11, at para 35 **[CBE, Tab 108]**; **Exhibit 433A**, pp. 1657-1658 [Kirby Report, Vol I, at 7-8] **[CBE, Tab 104]**; **Exhibit 6**, Bliss 2014, Appendix B, p. 10-11 **[CBE, Tab 6]**.

equivalent amount). The remaining cash portion was no longer based on actual health spending, but rather on population plus an inflation adjustment.[58]

228. At least one purpose of this shift in funding model was to ensure cost-containment in relation to public health care expenditures. As Justice Hall explained in a 1980 report:

> It was anticipated, indeed, it was intended under EPF, that the Provinces, now solely responsible for the rate of increase in the costs of the medical and hospital care programs, would begin (or, in case of most, reinforce) their efforts to restrain the costs of the two established programs, the rates of increase of which, had exceeded by so much the rates of increase in the Consumer Price Index.[59]

229. In association with reduced federal funding,[60] the provinces began to tighten their controls on fees paid to doctors and grants to hospitals. Some provinces froze or reduced reimbursement rates to doctors, while others, including British Columbia, imposed direct costs on users, such as user charges at public hospitals.[61]

230. In response, some doctors engaged in "extra-billing," that is, charging patients an additional fee on top of what was paid to them by the government for their services to patients.[62] Some others opted out of the public plan entirely.[63]

231. This led to concerns, at both the provincial and federal level, that user charges and extra billing were making the public health care system inaccessible to some members of the public.

232. This concern was understandable. User charges at public hospitals require individuals to pay in order to obtain hospital services under the public health insurance plan, which can both deter patients from obtaining necessary care in the public system, and can impose a disproportionate impact on low income patients.

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[58] **Exhibit 433A**, pp. 1658-1662 [Kirby Report, Vol I, at 8-12] **[CBE, Tab 104]**.
[59] **Exhibit 435D**, Mandy #1, Exhibit L, p. 1696 [Hall Report 1980, at 10] **[CBE, Tab 110]**. See also **Exhibit 435G**, Mandy #1, Exhibit V, pp. 3010-3011 **[CBE, Tab 112]**.
[60] **Exhibit 433A**, pp. 1661-1674 [Kirby Report, Vol I, at 11-24] **[CBE, Tab 104]**.
[61] **Exhibit 6**, Bliss 2014, Appendix B, p. 10 **[CBE, Tab 6]**; **Exhibit 435D**, Mandy #1, Exhibit L, p. 1728 [Hall Report 1980, at 42] **[CBE, Tab 6]**.
[62] **Exhibit 486**, Marchildon 2014, pp. 40-42 **[CBE, Tab 128]**; **Exhibit 435A**, Mandy #1, p. 11, para 36 **[CBE, Tab 108]**; **Exhibit 433A**, Vol 1, pp. 1681-1682 [Kirby Report, Vol I, at 31-32] **[CBE, Tab 104]**; **Exhibit 6**, Bliss 2014, Appendix B, p. 10 **[CBE, Tab 128]**.
[63] **Exhibit 6**, Bliss 2014, pp. 10, 12-13, para 20 **[CBE, Tab 6]**.

233. In the same way, extra-billing – in the sense of adding an additional charge to patients on top of the amount paid to a physician by the public plan– also imposes financial barriers to the accessibility and use of the public insurance system.[64]

234. The federal and provincial responses to this concern did not involve an attempt to prohibit patients from accessing care outside of the public system. Rather, the goal was simply to ensure that everyone had access to health care insurance through the public system, and that they could access that system without financial impediments.

(v) The BC Medical Services Plan Act, 1981

235. The first statutory restrictions on extra-billing in BC arose in 1981, in the context of contentious negotiations between the BC Government and the BC Medical Association for a new physician master agreement to govern the uniform rates that would be paid under the public plan to participating physicians.[65]

236. The existing agreement included a provision that allowed physicians to extra-bill patients for services paid for under the public plan in the event of an impasse regarding overall fee rates.[66]

237. The Government decided to put an end to both the bargaining impasse and the entitlement to extra-bill, which it did by passing the *Medical Services Plan Act* ("***MSPA***") in 1981.[67]

238. In particular, section 3(2) of the *MSPA* provided that a physician "participating in the plan" could not charge a patient "for an insured service rendered in respect of an insured person", by seeking or obtaining "other than a payment under the agreement and plan".

239. The purpose of the extra-billing provisions of the Act was described in an explanatory note:

> The purpose of this Act is to ensure that after March 31, 1981 medical practitioners delivering services under the medical plan of the Province to persons eligible to receive

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[64] As Justice Hall commented in a 1980 report, the problem with extra-billing is that it "den[ies] access" to the public health care system and "taxes sick persons" who are already paying for the public system through their taxes. See **Exhibit 435A**, Mandy #1, p. 12, para 37 **[CBE, Tab 108]**.

[65] **Exhibit 486**, Marchildon 2014, pp. 56-57 **[CBE, Tab 128]**.

[66] **Exhibit 486**, Marchildon 2014, pp. 55-56 **[CBE, Tab 128]**.

[67] *Medical Service Plan Act, 1981*, 1981 (B.C.), c. 18 ("***MSPA***"). Section 3(2) of the *MPSA* provided: "(2) No medical practitioner participating in the plan shall, for an insured service rendered in respect of an insured person, seek compensation by means of balance billing, extra billing or extra charging, or demand or receive any payment other than a payment under the agreement and plan at the rate applicable for that service on March 15, 1981."

> insured services will do so without requiring patients to pay extra fees or charges in excess of those provided under the medical plan.[68]

240. As can be seen, the purpose of the *MSPA* in relation to the restrictions on extra-billing was to ensure that beneficiaries could receive services under the public plan without being forced to pay additional fees to the physicians. As with previous provincial legislation, the *MSPA* did not prohibit private insurance covering medically necessary services, nor did it expressly prohibit physicians from opting out of the plan.[69]

241. Rather, it merely prohibited physicians who were providing services to beneficiaries under the public plan from imposing an additional charge on top of the amounts received under the public plan, in order to ensure beneficiaries had unrestricted access to publicly funded services.

B. 1984 - The Canada Health Act

242. In 1984, federal Parliament enacted the *Canada Health Act* ("***CHA***"),[70] in an attempt to address the concern about user fees and extra-billing, and to add "accessibility" to the principles that provincial health care plans must adhere to as a condition of federal funding.

243. Given the financial pressures in the provision of health care through the public plan, ensuring eligibility for federal transfer payments under the *CHA* has played a significant role in the development of the provincial legislation at issue in these proceedings. As such, it is important to set out the purposes and principles of the *CHA* in some detail.

244. The overall policy objective of the *CHA* is to facilitate reasonable access to health services without financial or other barriers. As stated in the preamble and section 3 of the *CHA*:

> **Preamble**
> Whereas the Parliament of Canada recognizes:
> [...]
> - that the continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.
> [...]
> **Primary objective of Canadian Health Care Policy**
> 3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada

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[68] Bill 16 – *Medical Services Plan Act,* 3rd Sess, 32nd Parl, 29-30 Elizabeth II, 1980-81, Explanatory Note.
[69] In addition, s. 5 of the *MSPA* specifically contemplated billing in excess of the plan amounts by a practitioner who had opted-out of the plan.
[70] *Canada Health Act*, R.S.C., 1985, c. C-6 ("***CHA***").

and to facilitate reasonable access to health services without financial or other barriers.

245. As can be seen, the general purpose of the *CHA* is not to prohibit private access to treatment outside of the public plan, nor is it to ensure that there is *only* a single payer for medically necessary health services in the provinces. As Deschamps J. observed in the *Chaoulli* case, the *CHA* "does not prohibit private health care", but rather provides "only a general framework that leaves considerable latitude to the provinces".[71]

246. Thus, at least as it was initially conceived and understood, the purpose of the *CHA* was to ensure that everyone had "reasonable access" to health care treatment through the public plan without any financial impediment, such as additional user fees or extra-billing that were imposed on services that were already paid for under the public plan.[72]

247. Consistent with this objective, the *CHA* was not based on the premise that access to treatment outside of the public plan should be prohibited; rather, it was based on the principle that "every single Canadian is entitled to whatever hospital and medical care he needs, regardless of his ability to pay", and therefore "no one need worry about any financial burden resulting from an unforeseen illness".[73]

248. In particular, under the *CHA,* there are five general principles that provincial health care plans must meet in order to be eligible for federal transfer payments, and two specific provisions dealing with mandatory deductions from the federal contribution to the provinces.

249. The five principles in the *CHA* can be summarized as follows:

(i) *Public administration* (s. 8) – the health care insurance plan of a province must be administered on a non-profit basis by a public authority responsible to the provincial government.

(ii) *Comprehensiveness* (s. 9) – the health care insurance plan of a province must insure all hospital services, medically required services rendered by physicians, and surgical-dental services.

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[71] ***Chaoulli v. Quebec (Attorney General)***, 2005 SCC 35 [***Chaoulli***] at paras 16-17.
[72] **Exhibit 435A**, Mandy #1, pp. 11-17, paras 36-51 **[CBE, Tab 108]**. See also **Transcript Day 145,** Testimony of Gigi Mandy, dated April 17, 2019, p. 16, lines 4 to 23; p. 17, lines 13 to 19; p. 18, lines 13-15, 24-25; p. 19, lines 44-47 and p. 20, line 1; p. 21, lines 4-10, 30-34; p. 22, lines 1-6, 20-28; p. 23, lines 31-37; p. 24, lines 24-26; p. 24, lines 45-57, and p. 25, lines 1-3; p. 26, lines 43-47, p. 27, lines 1-6; p. 27, lines 21-26.
[73] **Exhibit 435A**, Mandy #1, p. 17, para 51 **[CBE, Tab 108]**.

(iii) *Universality* (s. 10) – all residents of a province must have access to the health care insurance plan and insured services on uniform terms and conditions.

(iv) *Portability* (s. 11) – this criterion requires the provinces to cover insured health services provided to their residents while they are temporarily absent from their province or from Canada.

(v) *Accessibility* (s. 12) – insured persons must have reasonable and uniform access to services under the provincial health insurance plan, free of financial or other barriers.

250. These five criteria contemplate a universal public health care system, in the sense of a publicly administered and publicly funded system that is available to all persons, without financial or other barriers. But they do not require or contemplate the elimination of a private health care option outside of that public system.

251. In particular, the principle of "accessibility", as defined in the *CHA,* does not purport to provide uniform access to health care treatment generally, but rather uniform access to "the health care insurance plan of a province".

252. The accessibility principle is, however, offended by charges that are imposed on top of services paid for by the public health care system, because those fees create financial barriers to accessing those publicly funded services.

253. Similarly, the principle of "universality", as defined in the *CHA,* means that everyone had to be covered by the public plan, not that the public plan had to be the only means by which patients could obtain treatment. It states as follows:

> In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

254. As can be seen, this language does not expressly or implicitly prohibit individuals from also being covered under other forms of health insurance, including with respect to insured services, nor does it prohibit access to medically necessary services outside of the public plan.

255. In short, the original purpose of the *CHA* was to ensure "that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be".[74] Minister Epp confirmed the point in his 1985 letter to the provinces, as follows:

> The intent of the Canada Health Act is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.[75]

256. Therefore, as written and initially understood, these five criteria do not preclude the provinces from allowing a supplementary private health care system covering medically necessary health care services to co-exist with a universal public health care system.

257. Indeed, if that outcome were intended, such a principle could be easily envisioned. For instance, the *CHA* could have included the principle of "exclusivity", i.e., that in order to be eligible for federal funding, the provincial health insurance plan must be the only lawful means of funding medically necessary services in the province. The *CHA* contains no such principle.

258. In furtherance of the principle of "accessibility", sections 18 and 19 of the *MPA* provide for mandatory deductions from transfers to provinces with respect to extra-billing and user fees imposed on top of the fees paid for by the public plan. Those sections read as follows:

> **18.** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the provinces for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.
>
> **19.** **(1)** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province. [emphasis added]

259. User charges and extra billing are defined in the *Canada Health Act* as follows:

> User charge means any charge for an insured health service that is authorized or permitted by a provincial health care plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra billing.

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[74] **Exhibit 435D**, Mandy #1, Exhibit L, p. 1730 [Hall Report 1980, at 44] **[CBE, Tab 110]**.
[75] **Exhibit 435H**, Mandy #1, Exhibit DD, p. 3825 [Letter to the Provinces from Minister Epp, dated June 18, 1985 at 4] **[CBE, Tab 113]**.

> Extra billing means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an accident in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.

260. Under s. 18, a province will not qualify for a full transfer of monies if, in respect of insured health services, there has been extra billing by medical practitioners – that is, charges to the patient in addition to what is paid by the public plan for the medical service in question.

261. Under s. 19, a province will not qualify for the full transfer of health care money if user fees are charged to a patient for services provided under the public plan – that is, charges in addition to what is paid for by the public plan for the service in question.[76]

262. The result of these two sections is that if there is a payment under the provincial health care plan for a portion of a medically necessary service, any further charge by a physician or a private clinic for the same service may constitute extra billing or a user charge under the *CHA*.

263. Again, the logic of this is simple: if fees are charged on top of services funded by the public plan, those additional fees would erect barriers to the use of the public health care system. This would undermine the accessibility principle, and the underlying purpose of the *CHA*: to facilitate "reasonable access to health services without financial or other barriers".

264. By contrast, private insurance and private payment for health care services outside of the public system do not erect financial or other barriers to the use of the public health care system.

265. As such, they are not prohibited directly by the *CHA*, nor are they inconsistent with its overarching principles, as written and understood in light of the concerns leading to the enactment of the *CHA*: financial barriers to accessing services paid for by the public plan.

266. The fact that the *CHA* does not require the prohibition of either private insurance or dual practice, but rather seeks to eliminate financial barriers to accessing the public plan, is confirmed by the variety of approaches taken by the provinces, a number of which do not prohibit private insurance or dual practice.

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[76] While the definition of "user charges" in the *CHA* may be ambiguous, this interpretation is confirmed by the language of s. 19 itself, which provides "user charges must not be permitted by the province for that fiscal year under the health care insurance plan" (emphasis added).

267. The variety of approaches adopted by the provinces were helpfully summarized by Deschamps J. in *Chaoulli* as follows:

> [70] The approach to the role of the private sector taken by the other nine provinces of Canada is by no means uniform. In addition to Quebec, six other provinces have adopted measures to discourage people from turning to the private sector. The other three, in practice, give their residents free access to the private sector.
>
> [71] Ontario (*Health Care Accessibility Act*, R.S.O. 1990, c. H.3, s. 2), Nova Scotia (*Health Services and Insurance Act*, R.S.N.S. 1989, c. 197, s. 29(2)) and Manitoba (*Health Services Insurance Act*, R.S.M. 1987, c. H35, s. 95(1)) prohibit non-participating physicians from charging their patients more than what physicians receive from the public plan. In practice, there is no financial incentive to opt for the private sector. It is worth noting that Nova Scotia does not prohibit insurance contracts to cover health care obtained in the private sector. Ontario and Manitoba prohibit insurance contracts but refund amounts paid by patients to non-participating physicians.
>
> [72] Alberta (*Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20, s. 9(1)), British Columbia (*Medicare Protection Act*, R.S.B.C. 1996, c. 286, s. 18(2)) and Prince Edward Island (*Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2, ss. 10, 10.1 and 14.1) have adopted a very different approach. In those provinces, non-participating physicians are free to set the amount of their fees, but the cost of the services is not refunded and contracts for insurance to cover services offered by the public plan are prohibited. This is the same policy as has been adopted by Quebec.
>
> [73] Saskatchewan (*Saskatchewan Medical Care Insurance Act*, R.S.S. 1978, c. S-29, s. 18(1.1)), New Brunswick (*Medical Services Payment Act*, R.S.N.B. 1973, c. M-7, s. 2.01(*a*), and *General Regulation — Medical Services Payment Act*, N.B. Reg. 84-20, Sch. 2, para. (*n.1*)), and Newfoundland and Labrador (*Medical Care Insurance Act, 1999*, S.N.L. 1999, c. M-5.1, s. 10(5), and *Medical Care Insurance Insured Services Regulations*, C.N.L.R. 21/96, s. 3) are open to the private sector. New Brunswick allows physicians to set their own fees. In Saskatchewan, this right is limited to non-participating physicians. The cost is not refunded by the public plan, but patients may purchase insurance to cover those costs. Newfoundland and Labrador agrees to reimburse patients, up to the amount covered by the public plan, for fees paid to non-participating physicians. In Newfoundland and Labrador, patients may subscribe to private insurance to cover the difference.
>
> [74] Even if it were assumed that the prohibition on private insurance could contribute to preserving the integrity of the system, the variety of measures implemented by different provinces shows that prohibiting insurance contracts is by no means the only measure a state can adopt to protect the system's integrity. In fact, because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved. The example illustrated by a number

> of other Canadian provinces casts doubt on the argument that the integrity of the public plan depends on the prohibition against private insurance. Obviously, since Quebec's public plan is in a quasi-monopoly position, its predominance is assured. Also, the regimes of the provinces where a private system is authorized demonstrate that public health services are not threatened by private insurance. It can therefore be concluded that the prohibition is not necessary to guarantee the integrity of the public plan.[77]

268. As the experience of other provinces have shown, neither the *CHA* nor its underlying principles, requires the prohibition of private health care insurance to cover treatments that are also ensured publicly, nor the prohibition of dual practice. Rather, to qualify for federal funding, the provinces simply have to ensure that the *public health care plan* is accessible to everyone without the payment of extra charges.

269. This understanding is consistent with the concerns that originally served as the catalyst for the enactment, as described above, as well as the interpretation of these provisions by previous federal governments.

270. In 1995, the then federal Minister of Health, the Honourable Diane Marleau, advised her provincial counterparts that the federal government considered the charging of facility fees by private clinics to patients constituted a "user charge" in circumstances where the province paid for part of the private service, such as the surgeon's fee.

271. This is discussed as follows in a 1995 letter sent by Minister Marleau to the provincial health ministers:

> While there is no definition of facility fee in federal or most provincial legislation, the term, generally speaking refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act [*Canada Health Act*].
>
> Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. The subsidization of two-tier health care is unacceptable...
>
> As a matter of both policy and legal interpretation, therefore, where a provincial plan

[77] ***Chaoulli,*** *supra* at paras 70-74 (emphasis added).

> pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.[78]

272. As can be seen, the federal government was specifically objecting to charging patients a facility fee on top of payments made by public plans. Such fees, as the Minister pointed out, can "impede access to medically necessary services" under the public plan.

273. This is consistent with the concerns that originally animated to adoption of the *CHA*: ensuring universal access to the public plan without financial or other barriers, and in particular, without user fees and extra-billing on top of payments made by the public insurance plans.

274. However, as can be seen in the above quote, Minister Marlowe's letter also refers to a second justification for prohibiting extra-billing and user fees on top of services paid for under the public plan, which was not articulated in the *CHA*: the need to avoid 'subsidizing' or encouraging the delivery of services paid for outside of the public plan.

275. At around this time, the federal government also became concerned that permitting physicians to practice outside of the public system in any capacity "provides economic incentives for certain practitioners to abandon their work within the public system", and that "movement of limited specialized health care professionals to a private system can have adverse effects on the availability of some skills in the public sector".[79]

276. Or, as suggested by Ms. Mandy in her affidavit, there was a concern that permitting private treatment options would undermine the viability of the public system, such as through decreased public support for medicare, or "the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system".[80]

277. Thus, as described by Ms. Mandy, Minister Marleau's letter suggests that the *CHA* had come to reflect a dual purpose: "ensuring reasonable access to medically necessary services" and "supporting the viability of the publicly funded and administered system in the future".[81]

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[78] **Exhibit 435H**, Mandy #1, Exhibit II, pp. 3867-3868 [Marleau Letter 1995 at 2-3 (emphasis added)] **[CBE, Tab 113]**.
[79] **Exhibit 435H**, Mandy #1, Exhibit EE, p. 3833 [Health Canada Information Sheet on Private Clinics and Facility Fees , dated October 1995, at 1] **[CBE, Tab 113]**.
[80] **Exhibit 435A**, Mandy #1, Vol 1, p. 26, at para 73. Other justifications for the alleged need to discourage private treatment options in order to protect the public system were subsequently identified by federal politicians years after the enactment of the *CHA*, such as the alleged need to curb conflicts of interests or unethical practices by physicians operating in the public system. See **Exhibit 435A**, Mandy #1, p. 25-28, paras 72-76 **[CBE, Tab 108]**.
[81] **Exhibit 435A**, Mandy #1, Vol 1, p. 25, para 72 **[CBE, Tab 108]**.

278. As Ms. Mandy testified, Health Canada has reinterpreted the CHA over the years to extend its range beyond the operation of the public health care system.[82]

279. It has gone from an initial focus on preserving access to publicly funded health care without financial barriers by prohibiting extra billing and user fees within the public system, to a focus on discouraging private care options generally. This is based on the assumption that this is necessary to preserve the viability of the public system by preventing the loss of physicians in the public system.

280. This shift in focus was implicitly observed in the Kirby Report, one passage of which states:

> As such, the [*Canada Health Act*] does not prevent private, or for-profit, health care providers and institutions from delivering and being reimbursed for provincially insured health services, so long as extra-billing and user charges are not involved. The *Act* does not prevent the provinces from allowing private health care providers, whether individual or institutional, to operate completely outside the publicly funded health care system. Health care providers and facilities may opt out of the provincial plan and bill patients directly for the full cost of services provided, without any penalty being imposed on the province under the *Canada Health Act*...

281. This passage is consistent with the initial purpose of the *CHA*, which was not to prohibit or even discourage access to private care outside of the public plan, but to ensure reasonable access to publicly funded care without financial or other barriers.

282. However, the Kirby Report goes on to discuss another objective, which arose later:

> The *Canada Health Act* is intended to discourage the cross-subsidization of health care providers and facilities that provide medically necessary services funded partially by public health care insurance and partially by the patient. According to the federal government, this discourages the growth of a second tier of health care, which, it claims, could pose a significant threat to Canada's publicly funded health care system. (It should be noted, however, that parallel public and private health care systems exist in most other industrialized countries.)[83]

283. This evolution is not surprising in light of the history of public health care provision in Canada, and the concerns that predominated at any point in time.

284. As described above, the primary concern when medicare was originally adopted was to ensure that everyone had access to medical insurance, so that they would be able to get necessary medical treatment without facing serious financial consequences. This objective was achieved through federal

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[82] **Exhibit 435A**, Mandy #1, p. 22-28, paras 64-76 **[CBE, Tab 108]**. See also **Transcript Day 145**, p. 9, lines 13-16; p. 33, lines 4-15; p. 39, lines 19-35.
[83] **Exhibit 433A**, p. 2084 [Kirby Report, Vol 4, at 39].

funding assistance (such as through the *MCA*), and provincial provision of health insurance to all residents (such as through the *MSA*).

285. The overwhelming concern around the time that the *CHA* was enacted was not to prohibit access to private treatment options, but to ensure that the public plan was accessible to all, without the prospect of having to pay additional costs with respect to services paid for in part by the public plan. In other words, the purpose was to ensure the accessibility of the public system. This was effectively ensured through the *CHA* and subsequent provincial legislation.

286. However, that was the treatment of a symptom, not the disease. It did nothing to solve the underlying problem that began in the late 1970s, became worse in the 80s and 90s, and that continues to this day: the continuous growth in the overall cost of providing health care services, leading to the rationing of services provided through the public system and long and harmful wait lists.[84]

287. As such, the focus in the early- and mid-1990s shifted to addressing the inevitable consequences of long and harmful wait lists in the public system: a need and demand for services outside of the public system, which had become necessary to protect patients' health.

288. Again, Canadian governments turned to addressing a symptom – the provision of medically necessary treatments outside of the public system to protect patients' health – and not the cause, being the need for access to private treatment options as a result of a lack of reasonable and timely access to health care services within the public system.

289. Thus, the objective had expanded from ensuring access to treatment in the public system, to also supporting the viability of the system, on the assumption that access to private care would undermine the ability of the public system to provide necessary care to patients.

290. This project began in earnest in the years following the enactment of the *CHA*, when various provinces – including British Columbia – began taking further steps to restrict access to private care, on the assumption that discouraging access to private care was necessary to protect the viability of the public health care system.

C. 1984-1996 - The *Medicare Protection Act* – Prohibitions on Private Care

[84] **Exhibit 6**, Appendix B, p. 7-14 **[CBE, Tab 6]**. See also **Exhibit 37**, Expert Report of Dr. McGurran, pp. 10-15, 23 **[CBE, Tab 19]**; **Exhibit 433A**, pp. 1550-1552 **[CBE, Tab 104]**; **Exhibit 433C**, p. 3249 **[CBE, Tab 105]**. And see **Section VI**, below.

291. By the early 1990s, rationing of services in the public sector led to significant concerns about the unavailability of timely services in the public health care system, and inevitably, a greater demand for alternative options to protect patients' health.

292. On the assumption that permitting patients to receive this treatment would harm the public system, the BC Government gradually introduced express statutory prohibitions on both private insurance and on so-called dual or blended practice (i.e., physicians enrolled under the public plan providing private medical services) in order to discourage access to privately funded services.

293. This process began in 1992 with the introduction of the *Medical and Health Care Services Act* (the "***MHCSA***")[85]. The *MHCSA* first introduced express statutory restrictions on direct (rather than merely extra) billing by practitioners that were both enrolled and opted-into the public plan. In particular, section 16 provided:

> 16. (1) A practitioner or other person on a practitioner's behalf must not charge a beneficiary
>
> (a) for rendering a benefit, or
>
> (b) for any other matter that relates to the rendering of a benefit except as provided for in the regulations or by the commission under this Act.[86]

294. However, under the *MHCSA*, physicians could continue to charge patients outside of the public plan, including in amounts greater than the MSP rate for services. Physicians could do so by either not enrolling in the public plan, or by opting out of enrollment for a period of time (s. 16(2)(b)).

295. Along with the prohibition on direct billing, the *MHCSA* introduced restrictions prohibiting BC residents from using private insurance to cover the cost of services that were benefits under the public plan. In particular, section 39 of the *MHCSA* provided:

> **39.** (1) A person must not provide, offer or enter into a contract of insurance with a resident for the payment, reimbursement or indemnification of all or part of the cost of services that would be benefits if performed by a practitioner.

296. This is the restriction on private insurance which, in modified form, currently exists in s. 45 of the *MPA*. It prevents ordinary British Columbians from being able to afford medically necessary

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[85] *Medical and Health Care Services Act*, S.B.C. 1992, c. 76 (the "***MHCSA***").

[86] "Benefits" were defined in s. 1 of the *MSHCA* as "medically required services rendered by a medical practitioner who is enrolled under section 12, unless the services are determined under section 4 by the commission not to be benefits".

services provided outside the public system, on the assumption that this was necessary to protect the viability of the public plan by discouraging physicians from 'opting-out' of the public system.

297. Subsequent amendments were made under the *Medical and Health Care Services Amendment Act* ("***MHCSAA***"), which renamed the legislation as the *Medicare Protection Act.* This statute included amendments to the billing provisions designed to further protect the accessibility and viability of the public system.[87]

298. In particular, it amended the *MHCSA* to provide that physicians who were enrolled in the public plan, but opted to be paid directly by patients, could no longer charge patients amounts in excess of the amounts provided under the plan (s. 17.2(3)), and that unenrolled physicians could not charge patients in amounts in excess of the amounts provided under the plan if those services were provided in a hospital or other public facility (s. 17.2(1), (2)).

299. In 1996, the legislature repealed the previous legislation, and replaced it with the *Medicare Protection Act* ("***MPA***"),[88] which (in amended form) is currently the legislation in place governing the provision of medical services by physicians in the public system.

300. The combined effect of the billing provisions established through these pieces of legislation was clear: physicians could either be enrolled in the public plan, and be entitled only to direct or indirect payments under that plan, or they could not enroll in the plan at all, in which case they could only provide services paid for privately and only in private facilities.

301. This is the restriction on "dual practice", which, in modified form, currently exists in ss. 14, 17-18 of the *MPA*.

302. The combined effect of the restrictions on dual practice, and the restrictions on private insurance, is that if they are enforced, it would make it effectively impossible for physicians to provide medically necessary services to patients on a private pay basis. As the title of the legislation suggests, the purpose of doing so was the assumption that this was necessary to "protect" the public system.

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[87] *Medical and Health Care Services Amendment Act,* 1995, SBC 1995, C 52 ("***MHCSAA***").
[88] *Medicare Protection Act*, R.S.B.C. 1996, c. 286 (the "***Act***" or the "***MPA***").

303. This objective was expressly set out in section 2,[89] which provides that the purpose of the *MPA* is to preserve a public health care system that meets the health care needs of British Columbia residents regardless of their ability to pay:

> **Purpose**
> **2.** The purpose of this *Act* is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay.

304. Since 1996, there have been various amendments made to the *MPA*, including to both the dual practice provisions and the private insurance provisions. However, the overall objective of the legislation, and the prohibition on private insurance and dual practice, remain the same.

305. The primary changes in the legislation since 1996 have been to gradually increase the scope of the prohibition on dual practice, to make it increasingly difficult for physicians to either charge patients for services that are paid for in part by the public system, or to practice entirely outside of the public system.

306. In addition, while the prohibitions on private insurance and dual practice have generally applied to all physician services, including surgical services, they did not previously apply to diagnostic imaging services.

307. That was as a result of a Medical Service Commission minute, which deemed such diagnostic services to not be "benefits" if performed outside of a hospital,[90] with the result that such services were not captured by the prohibitions on dual practice or private insurance.

308. That continued to be the case until 2018, when the BC Government brought into force long-dormant provisions, initially enacted in 2003 by the *Medicare Protection Amendment Act* ("***2003 Amendment Act***"),[91] which amended the dual practice provisions to ensure that they captured diagnostic services as well.[92]

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[89] This was initially enacted, in identical terms, through the *MHCSAA, supra*, s. 3 (adding s. 1.1, now s.2).
[90] **Exhibit 2B**, Tab 5, Exhibit 5, MSC Minute #97-068, s. 3(1) **[CBE, Tab 2]**. See also MSC Minute #89-921, dated October 17, 1989, referenced at **Exhibit 4**, p. 42, footnote 9 **[CBE, Tab 5]**.
[91] *Medicare Protection Amendment Act*, 2003, SBC 2003, C 95 ("***2003 Amendment Act***").
[92] *2003 Amendment Act, supra* s. 5 (adding s. 18.1), which was initially brought into force effective October 1, 2018 by *BC Reg 160/2018*, dated April 1, 2018, but the effective date has since been delayed twice by the Government. See *BC Reg 468/2018,* dated September 7, 2018 (effective date April 1, 2019), and *BC Reg 106/2019*, dated March 8, 2019 (effective date March 31, 2020).

309. The enforcement provisions of the legislation have also been gradually strengthened since 1996, including by expanding the role and powers of auditors (see ss. 36-40 of the current *MPA*), as well as including new enforcement provisions allowing the Commission to seek injunctions and fine physicians, who commit an offence by billing in contravention of the *MPA* (see ss. 45.1, 46(5.1), (5.2) of the current *MPA*).

310. While the offence and fine provisions were enacted in the *2003 Amendment Act*, they were also not brought into force until 2018, in the middle of this trial. This required the Plaintiffs to seek and obtain an injunction based on the irreparable harm to patients that enforcing the impugned provisions would cause.[93]

311. The other major change to the legislation came in 2008, when the *MPA* was amended to include a sixth fundamental principle: "sustainability".[94] This was done in light of the widespread concern about the ever-expanding costs of funding the public health care system, and the crowding out of other important spending priorities. As the Minister of Health stated at the second reading of the bill:

> If we look back about 20 years, the percentage of the overall provincial budget occupied by health care was about 28 percent. Back in 1995, just over a decade ago, the NDP Health Minister of the day Penny Priddy, in advising that the share of the provincial budget had grown to 35 percent of the overall provincial budget, said: "Surely 35 percent is enough."
>
> Well, it hasn't been, and the budget continues to grow. As I say, it's now about 45 percent in the current budget year. We expect that by 2013, we will see the percentage of the provincial budget occupied by health care to be probably just over 50 percent.[95]

312. With that historical background, it is possible to discuss in more detail what exactly the impugned provisions do, so that their effect and impact can be understood.

D. The Impugned Provisions

(i) The Prohibition on Private Insurance

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[93] *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2018 BCSC 2084, leave to appeal denied in *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2019 BCCA 29.

[94] *Medicare Protection Amendment Act*, SBC 2008, c. 37, s. 1-2 (adding language to the preamble relating to sustainability and s. 5.7 in the existing *MPA*).

[95] **Exhibit 584B**, p. 11634 [British Columbia, *Official Report of Debates of the Legislative Assembly (Hansard)*, 38th Parl, 4th Sess, Vol 31, No 5 (28 April 2008) at 11634 (Hon G Abbott)] **[CBE, Tab 155]**.

313. As noted above, the prohibition on private insurance was initially introduced in 1992 through the *MHCSA*, but the legislative record is thin with respect to the purpose behind this prohibition. Indeed, it does not appear to have been mentioned at all during the introduction and debates surrounding the bill.

314. However, the federal government had previously expressed concern that private insurance could be used to cover the costs of extra-billing or user fees, and hence would encourage the charging of additional fees on top of services paid for by the public system.[96]

315. In addition, as noted above, there was a general concern among some policy makers that by making private options affordable for and hence accessible to patients, this could lead physicians to opt-out of the public system entirely, which would in turn make them unavailable to treat patients in the public system due to the prohibitions on dual practice.

316. Thus, the prohibition of private insurance was tied to ensuring accessibility of the public health care system (by deterring extra billing on top of payments under the public plan), as well as its viability, on the assumption that this was necessary to retain physicians in the public system.

317. This was the purpose identified by the majority in *Chaoulli* with respect to the similar prohibition on private insurance in Quebec's legislation: "preserving the public plan" (Deschamps J, at para 56); or "to preserve the public health system" (McLachlin CJ & Major J, at para 156).

318. The prohibition on private insurance is currently found in section 45(1) of the *Act*, which prohibits the provision of private insurance for medically required services:

> **Private Insurers**
>
> **45(1)** A person must not provide, offer or enter into a contract of insurance with a resident for the payment, reimbursement or indemnification of all or part of the cost of services that would be benefits if performed by a practitioner.

319. This prohibition on private insurance does not apply to insurance for private health care services provided outside of Canada, which is specifically excluded from the prohibition, by s. 45(2)(b) of the *Act*. This exemption enables those with the financial means to travel for health care to obtain private insurance and private treatment for health care in another country.

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[96] **Exhibit 486**, Marchildon 2014, p. 39 **[CBE, Tab 128]**.

320. But those who cannot afford to do so are unable to practically access private insurance, because they are prohibited from obtaining private insurance for health care coverage delivered in BC or elsewhere in Canada.

321. This prevents, for example, insurance companies currently providing disability insurance to employees under employer plans from paying for private surgeries in BC to enable workers to return to work more quickly, as WorkSafeBC does.

(ii) The Prohibition of Dual Practice

322. As described above, the prohibitions on dual practice contained in the *MPA* were first enacted in the *MHCSA*, and have since been gradually expanded in the *MHCSAA,* the *MPA 1996*, as well as by the *2003 Amendment Act* amendments brought into force in 2018.

323. As indicated above, the *MPA* provisions respecting dual practice are based on different rules with respect to three different categories of physicians:

i. physicians who are enrolled in the public plan and must charge the public plan directly ("**Opted-In Physicians**");

ii. physicians who are enrolled in the public plan but have opted-out, such that they can charge patients directly, but those patients are reimbursed by the public plan ("**Opted-Out Physicians**"); and

iii. physicians who are not enrolled in the public plan, who are therefore prohibited from billing the public plan ("**Unenrolled Physicians**").

324. The *MPA* effectively prohibits doctors enrolled in the public plan, both Opted-In Physicians and Opted-Out Physicians (together, "**Enrolled Physicians**"), from providing medically necessary services in a private clinic. This is a result of the prohibitions currently set out in ss. 17 and 18 of the *Act*, respectively.

325. Section 17(1) provides:

> **17** (1) Except as specified in this Act or the regulations or by the commission under this Act, a person must not charge another person
>
> (a) for or in relation to a benefit, or

> (b) for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit.

326. This section prohibits Opted-In Physicians from charging anyone directly for any services that have been deemed to be a benefit by the Commission, and hence for any service that is covered by the public plan. It prohibits any kind of direct billing, whether for the entire service, a portion of the service, or any other fee on top of the amount payable under the public plan.

327. Section 17(2)(c) of the *MPA* provides that Opted-Out Physicians are not subject to the prohibition on direct billing set out in section 17(1). Opted-Out Physicians can charge patients directly, which patients are then reimbursed by the public plan (s. 14(7)).

328. However, Opted-Out Physicians cannot charge their patients more than the prescribed fee paid by the MSP for the service. This is set out in s. 18(3):

> 3) If a medical practitioner described in section 17 (2) (c) [an Opted-Out Physician] renders a benefit to a beneficiary, a person must not charge another person for, or in relation to, the benefit, or for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of the benefit, an amount that, in total, is greater than
>
> (a) the amount that would be payable under this Act, by the commission, for the benefit, or
>
> (b) if a payment schedule or regulation permits or requires an additional charge, the total of the amount referred to in paragraph (a) and the additional charge.

329. The combined effect of sections 17(1) and 18(3) of the *Act* is that Opted-In Physicians cannot charge their patients any fees for medically required services, and Opted Out Physicians cannot charge their patients fees that are higher than the prescribed MSP fee for the doctor's services.

330. These sections therefore prohibit the provision in a private clinic of any services insured by the public plan (a "benefit") by any Enrolled Physician, because no one can be charged by anyone for a medically required service or any facility fees related to that service provided by an Opted-In Physician, and no one can be charged more than the MSP fee for medically required services provided by an Opted-Out Physician.

331. This means that the physicians and the private facility, which provides the operating room, nursing and other staff, equipment and medical supplies, can collectively charge only the fee that the

doctor alone would be paid for providing the service in a public hospital, where the costs of the facilities and staff are covered by the health authorities.

332. The facility cannot charge an extra fee for the use of the surgical facility, nurses, staff, equipment and/or medical supplies, which would be in contravention of ss. 17(1) and 18(3), which has the intended effect of preventing Enrolled Physicians from charging fees that could cover the costs of providing medical services in a private clinic.

333. These restrictions in the *MPA* make it economically impossible for an Enrolled Physician to perform any medically required services in a private facility, and also economically impossible for a private clinic to allow the doctor to do so.

334. So, while the *MPA* technically permits enrolled but opted-out physicians to perform private surgeries for the fee paid under MSP, it prohibits the private facility from charging the patient any additional amount for all of the services it provides. Therefore, under the *Act*, it is not financially feasible or practicable for a private clinic to operate using Enrolled Physicians.

335. Unenrolled Physicians are not subject to restrictions with respect to the amounts they could charge patients outside of the public system. They are exempt from the restrictions on direct billing in section 17 that applies to Opted-In Physicians (see s. 17(2)(d)), and are not subject to the general prohibition on extra-billing that applies to Opted-Out Physicians (see s. 18(3)).

336. Rather, they are simply prohibited from obtaining payment through the MSP – and hence prohibited from providing care to patients using the public plan – and are subject to other restrictions on their billing practices when providing services in certain facilities.

337. Prior to the *2003 Amendment Act* provisions brought into force in 2018, Unenrolled Physicians could charge patients amounts in excess of the MSP amounts paid to Enrolled Physicians, as long as the medical services are provided in a private clinic, and not in a hospital or a community care facility.

338. The *2003 Amendment Act* went further to also prohibit Unenrolled Physicians from charging above the MSP amounts for services provided in a private medical or diagnostic clinic if a regional board or health authority "has contracted to have the service rendered" (s. 18(2)(d)).

339. To the extent this can be interpreted as applying to any services provided at a private clinic that contracts with public health authorities, it is a further restriction on the ability of physicians to maintain a practice outside of the public system.

340. In short, Unenrolled Physicians can only provide private diagnostic or surgical services by remaining entirely outside of the public system. Such physicians are unable to provide services to the vast majority of patients in the province, unable to obtain hospital privileges, unable to participate in the educational and mentorship opportunities at public hospitals, and unable to provide more complex surgeries that cannot be provided in private clinics.

341. Thus, Unenrolled Physicians are effectively marginalized from the profession, which is why few if any physicians are willing or able to choose this option, given the strong commitment of physicians to providing services in the public system.[97]

342. This is in addition to the fact that Unenrolled Physicians can only provide private treatments in private clinics, and even then, only in private clinics that are exclusively funded privately. When coupled with the prohibition on private insurance, which makes private care options unavailable to all but the very wealthy, it is effectively impossible for an Unenrolled Physician to maintain a practice.

343. The end result of the dual practice provisions in the *MPA* is that physicians must either be paid exclusively by the public plan, at rates that effectively prohibit the creation or maintenance of private clinics, or must choose to have no medical career at all in British Columbia.

344. That means that the excess available surgical time that many specialists have, beyond what they are able to utilize in the public system, cannot be used to provide medically necessary services to BC residents, even though this would not result in any loss of their services to the public system or any harm to the public system.

IV. SCOPE OF THE PUBLIC HEALTH CARE SYSTEM

345. When considering the plaintiffs' claim, it is important to keep in mind that the public health care system covers only a portion of the medically necessary services patients require to maintain and protect their health.

346. Numerous reports by the OECD and the Commonwealth Fund report that the portion of health care expenditures that are publicly funded in Canada (i.e. through Government using tax payer dollars) is and has been for many years about 70%.[98]

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[97] See **Section X**, below.

[98] **Exhibit 433E**, p. 4280 **[CBE, Tab 107]**; See also **Transcript Day 146**, Testimony of Michael Law, p. 41, lines 33 to 42 and p. 42, lines 2 to 13.

347. This is a significantly lower percentage of overall health care expenditures than in many other OECD countries.[99]

348. The other 30% of health care expenditures in Canada are privately funded by the individual patient, either using his/her personal resources or through private insurance.[100]

349. This public/private division of health care services is reflected in the Report entitled "British Columbia Provincial Health Workforce Strategy 2018/19 – 2020/21", referred to in the testimony of Defendant witness Joanne Maclaren.[101]

350. Approximately 30% (some 73,500 service providers) of the health care workforce in British Columbia is employed in the private health care sector. This number does not include the approximately 11,500 physicians in the province.[102]

351. As set out in Exhibit 565, the Government "recognizes that the provincial health services labour market is a shared resource influenced by both [the public and private] sectors."[103]

352. Public health care is devoted to the medically necessary services of physicians and services provided in public hospitals. For most British Columbians, the vast majority of other health care services provided outside an acute care hospital are primarily, if not exclusively, privately funded, including but not limited to the following[104]:

i. Psychological assessment, therapy or counselling by psychologists, therapists or social workers[105];

ii. Dental care, including orthodontics, prosthodontics and dental surgery;[106]

iii. Prescription medications; [107]

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[99] **Exhibit 433E,** pp. 4304-4305 **[CBE, Tab 107]**; See also **Transcript Day 146**, p. 46, line 43 to p. 47, line 18.
[100] **Exhibit 433E**, p. 4305 **[CBE, Tab 107]**; See also **Transcript Day 146,** p. 43, line 43 to p. 44, line 19.
[101] **Exhibit 565**, pp. 254-0316 **[CBE, Tab 152]**.
[102] **Exhibit 565**, p. 266 **[CBE, Tab 152]**.
[103] **Exhibit 565,** p. 267 **[CBE, Tab 152]**.
[104] See for e.g. **Exhibit 2A,** Tab 1, Exhibit 1, pp. 104-106 **[CBE, Tab 1]**; **Exhibit 432,** p. 146 **[CBE, Tab 103]**; See also discussion in **Transcript Day 146**, Testimony of Michael Law, p. 47, line 45 to p. 49 line 36.
[105] See discussion in **Section VIII(C)(xiv), Psychological Harms**, below. See for e.g. **Exhibit 391,** Affidavit #2 of Dr. Smith at paras 28, 30 **[CBE, Tab 91]**.
[106] See discussion in **Section VIII(C)(x), Dental Surgery**, below.
[107] See discussion in **Section VIII(C)(xiv), Psychological Harms**, below. See also **Transcript Day 146**, Testimony of Michael Law, p. 18, line 38 to p. 19, line 1 and p. 46 line 34 to p. 47, line 1; See also **Transcript Day 28**, Testimony of Jack Taunton, October 21, 2016, p. 61, line 13 to p. 62, line 17.

iv. Prosthetics, wheelchairs, crutches, braces, slings, orthotics, and other mechanical aids or equipment aids to assist patients to function in the face of injury and/or disability;[108]

v. Vision care provided by an optometrist, including assessment and treatment, and corrective lenses;[109]

vi. Physiotherapy;[110]

vii. Occupational therapy;[111]

viii. Chiropractic services;

ix. Podiatry;[112]

x. Speech Therapy;

xi. Massage Therapy;

xii. Acupuncture;

xiii. Naturopathy;

xiv. Osteopathy;

xv. Nutrition Counselling;

xvi. Hearing aids;

xvii. Family therapy;

xviii. MRI and CT scans provided outside a public hospital and ultrasounds provided in "non-approved" facilities;[113]

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[108] **Transcript, Day 30**, Testimony of Stefan Fletcher, November 1, 2016, p. 12, line 30 to p. 13, line 40; See also, **Transcript Day 28**, Testimony of Dr. Jack Taunton, p. 59 line 41, to p. 60, line 12; See also discussion in **Sections VIII(C)(vii)(a)**Arthroscopic Knee Surgery and **(d)** Foot and Ankle, below.
[109] **Transcript, Day 35**, Testimony of Dr. Kevin Wade, November 14, 2016, p. 47, line 33 to p. 48, line 6.
[110] See discussion in **Sections VIII(C)(vii)(a)** Arthroscopic Knee Surgery and **(d)**, Foot and Ankle; **Transcript Day 30**, p. 4, line 37 to p. 5, line 47; **Transcript Day 28**, p. 60, lines 13 to 18.
[111] **Exhibit 565**, p. 286 **[CBE, Tab 152]**.
[112] See discussion in **Section VIII(C)(vii)(d),** Foot and Ankle, below.
[113] See discussion in **Section VIII(C)(xiii)**, Diagnostic Imaging, below.

xix. Over the counter drugs and therapeutic supplies, including diabetic therapy aids such as blood-glucose monitoring machines, vitamins, pain killers, first aid ointments and other first aid supplies;

xx. External breast prosthesis;

xxi. Ambulance transportation;

xxii. Cost of travel within BC or Canada to obtain medical or hospital care (other than as reimbursed under the Travel Assistance Program);

xxiii. Emergency medical and/or hospital care provided to a BC resident outside of Canada, over and above the physician rates set out in the MSP fee schedule and $75.00 per day for inpatient hospital care; and

xxiv. Non-emergency medical or hospital care provided to a BC resident outside of Canada, other than where prior approval has been granted for complex care not available in Canada.[114]

353. In addition, many health care services are publicly funded only in part, which prevents some British Columbians from accessing those services while other British Columbians pay for the same services privately in whole or in part.[115] These include:

i. Addiction recovery services, including residential rehabilitative treatment;

ii. Eating disorders treatment;

iii. Assisted living and/or long term care for seniors with functional limitations, chronic illness or disability;

iv. Home nursing care;

v. Community mental health services.

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[114] **Transcript Day 156**, Testimony of M. Hallihan, dated May 15, 2019, p. 26, line 45 to p. 28, line 10, p. 29, lines 32-41; See also, **Exhibit 2B**, Tab 6, MSC Out of Province and Out of Country Medical Care Guidelines **[CBE, Tab 2]**.
[115] See for e.g. **Exhibit 2A,** Tab 1, Exhibit 1, p. 106 **[CBE, Tab 1]**; See also **Transcript Day 146**, Testimony of Michael Law, p. 47, line 45 to p. 49 line 36.

354. The public health care system also does not provide coverage for medical services that are deemed not to be medically necessary, as determined by the Medical Services Commission. These include, among others[116]:

i. Cosmetic Plastic Surgery or Cosmetic Dermatology;[117]

ii. Robotic surgery;[118]

iii. Advanced lenses and measurements for cataract surgery;[119]

iv. Fertility testing and assistance, including in vitro fertilization; and

v. Various types of preventative health testing or assessment.

355. There is no suggestion in any of the Defendant's documents or evidence that the Defendant intends to expand the scope of the public health care system to cover more of the medically necessary services that are necessary to the health and well-being of British Columbians and which are currently available to British Columbians only on a private pay basis.

V. PRIVATE HEALTH CARE INSURANCE IN CANADA

356. The publicly funded health care system covers most hospital and physician costs for patients. Public funding makes up about 70 percent of health care expenditures in Canada.[120]

357. The other 30 percent is privately funded.[121]

358. About 66% of Canadians (around 24 million) are covered by extended health care insurance plans for health care services not covered by the public plan, such as prescription drugs, dental care, vision care, physiotherapy and prosthetics.[122]

359. About 90% of these extended health care benefits are provided by employers.[123]

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[116] See for e.g. **Exhibit 2A,** Tab 1, Exhibit 1, p. 106 **[CBE, Tab 1]**.
[117] **Transcript, Day 40**, Testimony of Dr. Van Laeken, November 28, 2016, p. 5, line 42 to p. 6, line 21.
[118] See for e.g. **Transcript Day 35,** Testimony of Dr. Wade, p. 20, lines 18 to 37 and p. 24 lines 27 to 30.
[119] See discussion in **Section VIII(C)(v)**, Cataract Surgery, below; **Transcript Day 120**, Testimony of Dr. Parkinson, p. 64, lines 7 to 16; **Transcript Day 35**, Testimony of Dr. Wade, p. 67, line 21 to p. 68, line 11.
[120] **Exhibit 435],** Mandy Affidavit #1, Exhibit LLL, Swedish User Fees, p. 4 **[CBE, Tab 114]**; **Exhibit 433E,** p. 4280, 4304-4305 **[CBE, Tab 107]**: **Transcript Day 146,** p. 41, lines 33 to 42, p. 42, lines 2 to 13 and p. 43, line 43 to p. 44, line 19.
[121] **Exhibit 433E,** p. 4280, 4304-4305 **[CBE, Tab 107]**; Transcript Day 146, p. 41, l. 33 to 42, p. 42, lines 2 to 13 and p. 43, l. 43 to p. 44, l. 19.
[122] **Transcript Day 146,** Testimony of Michael Law, p. 50, lines 31 to 33.
[123] **Exhibit 432,** p. 1462-1463 **[CBE, Tab 103]**.

360. About 666,000 Canadians have group critical illness insurance coverage and 1.1 million have individual critical illness insurance coverage, with some overlap.[124]

361. About 11 million Canadians have employer provided disability benefits/insurance for injuries and illnesses that are not related to the workplace.[125]

362. The impugned provisions of the *MPA* prohibit using this disability insurance to pay for private diagnostic and surgical services covered by the public plan, but because these provisions have not been enforced for 20 years in BC, disability benefits have been used to expedite a return to work for injured employees who are not already covered by WCB.[126]

363. Private insurance companies use disability benefits to expedite care for the same reason that expedited diagnostic and surgical services are provided to injured workers through Workers Compensation insurance; it is better for employees, their employers and the insurance companies.

364. For employees, it alleviates their suffering more quickly and best ensures that they will not be permanently impaired and unable to return to work.

365. For employers, it returns valuable employees to work sooner and reduces the cost of providing disability benefits/insurance:

366. Mr. Walters testified that:

> Further disability premiums (and thus the affordability of disability coverage for employers and employees) are affected by the total claim payments which are driven by both the number of people going on to claim and how long they stay on claim. Insurers will spend money during the initial 4 to 6 months to help those with disability to make a speedy recovery and be able to return to productive employment; making investments equal to a number of months of benefit for the ability to return to work earlier by a greater number of months (not one for one as there are some costs to manage this and some uncertainty as to the result).
>
> Premiums cover both claims and claims management costs which are thus paid for by employers in general; a reduction in claim payments in excess of the cost of achieving that reduction would help to mitigate LTD premium increases or even lead to premium reductions.[127]

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[124] **Exhibit 449,** Michael Law's Working File, p. 60 **[CBE, Tab 117]**.
[125] **Exhibit 449**, p. 60 **[CBE, Tab 117]**.
[126] See **Section VII(C)(vii)(a)(vi)** Marshal Van de Kamp, below.
[127] **Exhibit 268**, Expert Report of Gary Walters, p. 7 of report **[CBE, Tab 52]**.

367. Mr. Walters also testified that there are similar incentives for automobile insurance to pay for expedited diagnostic and surgical services:

> Similar incentives apply to Automobile insurers, within limits prescribed by legislation, to get those disabled back to being productive. Success in reducing the time people are collecting benefits because they are able to return to work earlier will reduce one pressure on auto insurance rates.[128]

368. As can be seen, private health insurance already plays a significant role in the provision of health care to Canadians.

369. The question is why the provision of public health care to all Canadians should preclude them from also having private insurance to protect their health when the health care services are covered by the public plan.

370. The public system covers health care procedures that are medically necessary precisely because these services are so important to the health and wellbeing of individuals. But if these health services are crucial to each individual, allowing patients to obtain private health care when the public system fails them, becomes even more compelling.

371. And the evidence has clearly established that the public system has been consistently unable to provide timely diagnostic and surgical services to all patients.

372. The only possible justification is that this prohibition is necessary for the protection of access to health care in the public system, regardless of the fact that the health of patients is being harmed from waiting too long for diagnostic and surgical services in the public system.

373. In other words, for such a prohibition to be justified, it must be necessary to sacrifice the health of some patients to protect the health of other patients.

374. But that was not considered necessary at the time the *Canada Health Act* was passed.

375. The Act was concerned only with providing universal access, without any financial barriers, to all Canadians within the public health care system.[129]

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[128] **Exhibit 268**, p. 7 of report **[CBE, Tab 52]**.
[129] **Exhibit 435F**, Mandy #1, Exhibit U, pp. 2873-2874 **[CBE, Tab 111]**.

376. There was no suggestion at that time that this required the provinces to prohibit private insurance and dual practice.[130]

377. And indeed, some provinces don't prohibit private insurance or dual practice, and one province, Newfoundland, doesn't prohibit either.[131]

378. But without any supporting evidence or studies, the Defendant and Canada have come to believe that it is now necessary for patients to be prohibited from obtaining private diagnostic and surgical services to preserve the public system.[132]

379. Obviously, it should take more than mere speculation or hypothetical concerns to support this position. Depriving patients of their life, liberty and security of the person requires some hard evidence of significant harms to the public system to be in accordance with the principles of fundamental justice, and to be justified under s. 1 of the *Charter*.

VI. WAIT TIMES FOR DIAGNOSIS AND TREATMENT BY SPECIALISTS IN BC

A. Overview of the Wait Time Problem

380. There are very long wait times for medically necessary care in British Columbia, including for diagnostic testing, consultation with specialists, and for surgical treatment and/or procedures.

381. These wait times cause harms (pain, suffering, disability, and potential risks to life and long-term health) to the patients who are waiting for care.

382. The delay in treatment is not just a matter of inconvenience or impatience. Waiting for medically necessary treatment causes emotional and psychological distress; prolongs physical suffering, dependence and immobility; leads to risks of permanent physical degeneration; and increases the risk of death in the case of life threatening conditions.

383. The pre-eminent Vancouver orthopaedic surgeon Dr. Bassam Masri testified for the Plaintiffs as a lay witness and an expert. He is the Surgeon in Chief for Vancouver Coastal Health Authority, in charge of all surgical specialities, Head of Orthopaedics at Vancouver General Hospital and UBC Hospital, and was qualified in this litigation as an expert in the effects of waiting for surgery on surgical

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[130] **Exhibit 435F**, pp. 2873-2874 **[CBE, Tab 111]**.
[131] **Exhibit 449**, p. 69 **[CBE, Tab 117]**.
[132] See **Section X**, below.

outcomes after joint replacement, and in the management, allocation, and utilization of surgical resources in the BC public health care system.

384. Dr. Masri testified that "...nobody argues that patients shouldn't be waiting longer because they're being...harmed for a variety of reasons by waiting. The health authority agrees with that. The ministry agrees with that."[133]

385. As set out below, the BC Government (the Ministry of Health and Health Authorities) has established various target surgery volumes that are to be completed each year within wait time benchmarks to try to address this serious wait time problem.

386. However, as the Defendant's own witnesses testified, and as the BC Government's wait time data clearly shows (see below), BC has failed, and continues to fail, to provide medically necessary care within these targets.

387. These failures continue in the face of a 20-year government effort (across different federal and provincial governments) to address the serious issue of patients waiting too long for medical care in the public health care system.

388. As set out below, there have been attempts by the Federal Government to address the wait time problems, including (a) identifying the magnitude of the problem across the entire patient experience, (b) establishing "maximum acceptable wait times" for certain procedures; (c) measuring and publicly reporting the wait times faced by patients; and (d) encouraging the establishment of patient wait time guarantees to provide patients with recourse.

389. The BC Government has participated in some of these efforts, and has established its own method to measure wait times and to compare them against maximum acceptable wait times.

390. The Federal and Provincial Governments have invested billions of dollars on these efforts.

391. However, there has not been any lasting improvement in wait times.

B. Government's Unsuccessful Attempts to Address Wait Times – a 20 Year Effort

(i) Early 2000s - Government Admits there are Unacceptable Wait Times

[133] **Transcript Day 71**, Evidence of Dr. Masri, p. 53, line 17-22.

392. As described in the Standing Senate Committee on Social Affairs, Science and Technology's Report, "Time for Transformative Change; A Review of the 2004 Health Accord" ("**Senate Report**"):

> "Beginning in 2000, Canadians became increasingly concerned with the quality of health care they were receiving, including the long wait times they were experiencing for hospital and medical services, resulting from fiscal constraint associated with the recession of the 1990s.... In response to these concerns, [Federal, Provincial and Territorial] Governments began a dialogue examining ways in which they could collaborate to improve the quality of health-care systems across the country, and the overall sustainability of Canada's medicare system. This resulted in a series of agreements and financial commitments, and culminated in the *2004 10-Year Plan to Strengthen Health Care*".[134]

393. The pre-2004 Accord efforts included the 2000 Communique on Health, in which the First Ministers agreed to a number of health-care related initiatives, including to "improve access to quality care", and to "coordinate efforts to increase the supply of health professionals". The Federal Government agreed to invest "in health equipment and infrastructure that allow for timely access to appropriate preventative, diagnostic, and treatment services."[135]

394. In support of the various objectives, the Federal Government "increased federal cash transfers by $23 billion over five years". After this, the Federal Government undertook two major studies regarding the public health care system:[136]

i. The Federal Government established the Royal Commission on the Future of Health Care, chaired by Roy Romanow, former premier of Saskatchewan, to dialogue with Canadians "on the future of Canada's public health-care system, and to recommend policies and measures...required to ensure long-term sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians, and strikes an appropriate balance between investments in prevention and health maintenance, and those directed to care and treatment," and;

ii. The Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Kirby, examined the public health care system (specifically, the "federal role in the public health-care system and the pressures and constraints facing that system").

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[134] **Exhibit 451**, Affidavit #1 of L. VanAmburg, made August 9, 2016, Exhibit B, p. 36 **[CBE, Tab 118]**.
[135] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 37 **[CBE, Tab 118]**.
[136] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 37 **[CBE, Tab 118]**.

395. Both reports were issued in 2002 and called for increased federal funding, greater accountability by all governments and strategic reforms to health services in order to improve access to, and the quality of, health care.[137]

396. The recommendations from these two reports formed the basis of the 2003 First Ministers' Accord on Health-Care Renewal. Among other things, the 2003 Accord prioritized increasing the availability of publicly funded diagnostic care and treatment services to improve quality of care and reduce wait times. In support of this, the Federal Government established a 3-year, $1.5 billion diagnostic/medical equipment Fund.[138]

397. The 2003 Accord also established the Health Council of Canada to monitor and make annual public reports on the implementation of the 2003 Accord. It was to report publicly through the Federal and Provincial Ministers of Health and include representatives of government, experts, and the public.[139]

398. The Health Council of Canada described the significance of the wait times issue as follows:

> Canadians began to name health care as the single most important problem facing the country, overtaking concerns about the economy, which dominated public opinion surveys throughout the 1990s.[140]

(ii) The 2004 Accord and the Development of Benchmarks in 5 Priority Areas

399. In response to the public's concern and pressure about wait times, a further First Ministers' Meeting was held in 2004 (the "**2004 Accord**").

400. The purpose of the 2004 Accord was set out in the report "A 10-year plan to strengthen health care"[141](the "**10-Year Plan**") and included a commitment to improve access to care and reduce wait times where they were longer than medically acceptable, as well as to provide accountability and reporting to citizens.[142]

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[137] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 37 and 38 **[CBE, Tab 118]**.
[138] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 38 **[CBE, Tab 118]**.
[139] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 38 **[CBE, Tab 118]**.
[140] **Exhibit 346A**, Day Affidavit #9, para 241, referring to Exhibit "ZZ" **[CBE, Tabs 83 and 84]**.
[141] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 39 **[CBE, Tab 118]**.
[142] **Exhibit 451**, VanAmburg Affidavit, at p. 3, paras 6-8; Exhibit C, p. 128-130 **[CBE, Tab 118]**.

401. Specifically, the Federal and Provincial Governments agreed to develop indicators of access, evidence-based benchmarks for medically acceptable wait times, along with multi-year targets, across 5 priority areas.[143]

402. As stated by the Canadian Institute of Health Information ("**CIHI**") :"In 2004 Canada's First Ministers agreed to reduce wait times in five priority areas: cancer treatment, cardiac care, diagnostic imaging, joint replacement, and sight restoration. They also agreed to work towards meeting evidence-based benchmarks for medically acceptable waits, which were established in late 2005 for some priority procedures. CIHI was mandated to collect and annually report on wait time information and monitor provincial progress in meeting benchmarks." [144]

403. Benchmarks were established for the five priority areas ("**Pan-Canadian Benchmarks**"), and 8 provinces also established targets for meeting the benchmarks. The targets were performance goals set by provinces and territories over time (collectively, the "**Pan-Canadian Targets**").

404. The Canadian Institute of Health Research ("**CIHR**") funded and supported research teams across Canada that would form the basis of the development of the first set of benchmarks.

405. As noted in the review undertaken for the *Health Care Guarantees in Europe and Australasia: Lessons for Canada* project, the true nature and extent of the problem of barriers to access cannot be well understood in the absence of valid real-time information describing the urgency/priority of patients waiting and the length of their wait.[145]

406. As explained by the Health Council of Canada in the "Background Note on Benchmarks for Wait Times November 2005": evidence-based benchmarks of medically acceptable wait times were to be established. Benchmark refers to a recommended maximum wait time, and target refers to the expected percentage of patients who are treated or served in that period of time.[146]

407. These medically acceptable evidence-based benchmarks were thus maximum wait times. After the work of the Federal and Provincial Governments that included large CIHR funded research projects, the evidence-based benchmarks were established in the 5 Priority Areas. The evidence-based

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[143] **Exhibit 451**, VanAmburg Affidavit, at p. 4, para 9; Exhibit C, p. 130 **[CBE, Tab 118]**.
[144] **Exhibit 433E**, p. 4415 **[CBE, Tab 107]**.
[145] **Exhibit 451**, VanAmburg Affidavit, Exhibit E, p. 157**[CBE, Tab 118]**.
[146] **Exhibit 433C**, p. 3018 **[CBE, Tab 105]**.

Pan-Canadian Benchmarks were unanimously accepted by the Federal and Provincial Ministers and announced on December 12, 2005.[147]

408. As part of the $41.3 billion provided in support of the 10-Year Plan's objectives, the Federal Government committed to investing $5.5 billion over 10 years specifically to address wait times through a $4.24 billion Wait-Times Reduction Trust and an annual Wait-times Reduction Transfer of $250 million beginning in 2009/10, and $500 million for medical equipment.[148]

409. As set out in the BC Ministry of Health Fact Sheet, as a result of the efforts following the 2004 Accord, BC developed "Access Targets" based on the "evidence-based" wait time benchmarks[149] (**Appendix, Part A, Section VI(B)(ii), Table 1**).

(iii) Expansion of Benchmarks Beyond 5 Priority Areas

410. The 2004 Accord prompted various initiatives to create evidence-based wait time benchmarks.

411. In 2005, Dr. Brian Postl was appointed the Federal Advisor on Wait Times. He was mandated to review the factors contributing to long wait times and to consult with governments, health care providers, and organizations to achieve more timely access to health care services.[150] Specifically, he was asked to "advance further action to achieve meaningful reductions in wait times" and to "identify and continue to develop consensus on establishing comparable indicators and evidence-based benchmarks".[151]

412. In 2005, the Federal Government announced an additional federal initiative, the National Wait Times Initiative, to help advance the 2004 Accord commitments. Its aims included "improving access to care and reducing wait times" and "to support demonstrable progress on benchmarks and indicator commitments".[152]

413. As set out in the Synthesis of Results of the National Wait Times Initiative – Final Report, prepared for Health Canada in 2009, the Federal Government noted Dr. Postl's recommendation that "the first set of benchmarks which serve as the foundation for evidence-based research in wait times

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[147] **Exhibit 451,** VanAmburg Affidavit, Exhibit D, pp. 140-144 **[CBE, Tab 118]**.
[148] **Exhibit 451**, VanAmburg Affidavit, Exhibit B, p. 39 **[CBE, Tab 118]**.
[149] **Exhibit 12A**, p. 289 **[CBE, Tab 7]**.
[150] **Exhibit 451**, VanAmburg Affidavit, Exhibit E, p. 283 **[CBE, Tab 118]**.
[151] **Exhibit 575B**, pp. 1276-1277 **[CBE, Tab 153(B)]**.
[152] **Exhibit 451**, VanAmburg Affidavit, Exhibit E, p. 150 **[CBE, Tab 118]**.

must continue and extend to inform the development of additional benchmarks and system improvement in managing access."[153]

414. The Federal Government invested additional funds ($13 million over 3 years, beginning in 2006-2007) into the National Wait Times Initiative to help advance the 2004 Accord commitments.[154]

415. In 2005, groups such as the Western Canada Waiting List Project ("**WCWLP**") and the Wait Time Alliance (made up of medical specialist groups and the Canadian Medical Association), proposed clinically-relevant and evidence-based wait time benchmarks for medically acceptable wait times, beyond the five Pan-Canadian Benchmarks.[155]

(iv) Ongoing Wait Times and BC's Failure to Establish Patient Wait Time Guarantees

416. One reason that wait times did not meaningfully improve during and after this time was because the 2004 Accord Pan-Canadian Benchmarks were only benchmarks – there were no corollary remedies for patients that waited longer than the established target. Patients had no recourse.

417. At that time, the Federal Government clearly understood the importance of providing alternatives to care if medically necessary services could not be provided in a timely fashion, as well as the importance of certainty of access to care when patients need it.

418. That is why, in 2007, the Federal Government committed over $1 billion in funding (over three years) to support provincial governments in establishing "Patient Wait Time Guarantees" in at least one of the five priority areas identified in the 2004 Accord.[156]

419. The Patient Wait Times Guarantees consisted of two key components: (a) a defined timeframe and (b) access to alternate options of care (recourse) should that timeframe be exceeded (for example, patients would be given the opportunity to receive timely care at another health care institution within the province or within another province).[157]

420. In March 2007, BC signed an agreement with the Federal Government to establish a Patient Wait Time Guarantee for radiation therapy by March 31, 2010. The guarantee consisted of (a) an 8 week guarantee of timely access, and (b) timely access at an alternative BC Cancer Agency regional

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[153] **Exhibit 451**, VanAmburg Affidavit, Exhibit E, p. 285 **[CBE, Tab 118]**.
[154] **Exhibit 451**, VanAmburg Affidavit, pp. 5-6 at para 13 **[CBE, Tab 118]**.
[155] **Exhibit 263**, Expert Report of Dr. Masri, Exhibit C, including pp. 131, 135, 152, 155-162 **[CBE, Tab 49]**.
[156] **Exhibit 451**, VanAmburg Affidavit, p. 6, paras 14-15 **[CBE, Tab 118]**.
[157] **Exhibit 451**, VanAmburg Affidavit, p. 6, para 14 and Exhibit "F", pp. 341-343 **[CBE, Tab 118]**.

treatment centre for patients who wait longer than 8 weeks.[158] BC selected an 8 week target for the Patient Wait Time Guarantee even though the Pan-Canadian Benchmark was 4 weeks.[159]

421. At the time of entering into the agreement, BC was already meeting this benchmark - 90% of patients received radiotherapy under 3.5 weeks. Thus, BC was not committing to making any new commitments to patient care.[160]

422. As part of its efforts to encourage the provinces to provide certainty of access to care when needed, the Federal Government made funding available to assist the provinces to meet the guarantees (for example, to purchase new equipment or hire more health professionals) and to support pilot projects. BC did not submit any proposals for pilot project funding, while other provinces submitted more than one proposal.[161]

423. BC refused to establish Patient Wait Time Guarantees for treatments and procedures other than radiation therapy. In a BC Government Information Briefing Document on the Patient Wait Time Guarantees to the Deputy Minister, one of the reasons given for not implementing patient wait time guarantees more broadly was that "The funding required to support wait time guarantees for special services will mean that there is less government funding for other health care needs (e.g. public health and prevention) as well as social services and other government priorities."[162]

424. The BC Government further noted "A guarantee with recourse significantly raises the level of risk to the province compared to an access target of less than 100 percent. This is because the cost of the recourse options for care is likely to be much higher than the cost of the non-recourse options; as well the legal risk is much higher with a care guarantee."

425. Notably, as set out in the affidavit of Canada's key witness, Ms. VanAmburg, the *International Review of Citizen Litigation under Wait Time Guarantee Systems* concluded that there was no dramatic increase in patient litigation arising from waiting times guarantees in any of the countries it reviewed. The review presented a number of potential reasons for this:[163]

i. Good recourse mechanisms;

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[158] **Exhibit 451**, VanAmburg Affidavit, p. 8, para 17 and Exhibit H, pp. 350-352 **[CBE, Tab 118]**.
[159] **Exhibit 12A**, p. 289 **[CBE, Tab 7]**, and See **Appendix,** Part A, Section VI, Table 1.
[160] **Exhibit 458A,** Affidavit #6 of Roland Orfaly, Exhibit 4, p. 9 **[CBE, Tab 119]**.
[161] **Exhibit 451**, VanAmburg Affidavit, para 15, and Exhibit J, p. 382 **[CBE, Tab 118]**.
[162] **Exhibit 12A**, pp. 269-274 **[CBE, Tab 7]**.
[163] **Exhibit 451**, VanAmburg Affidavit, Exhibit E, pp. 184 and 189 **[CBE, Tab 118]**.

ii. Duplicate private insurance systems: those who may otherwise be motivated to litigate can likely afford the option of private insurance as an alternative route to health care;

iii. Citizens of EU countries have a right to access health care in any other EU country in instances where the patient's home country is not providing care without undue delay;

iv. Most reviewed countries have a patients complaints mechanism, if not a formal tribunal; and

v. Public malpractice compensation plans: the Scandinavian countries provide no-fault insurance coverage for patients injured in the medical care process, including through long wait times.

426. BC residents were not provided Patient Wait Time Guarantees, nor did they have access to any of the safety valves identified above (other than a patients' complaints mechanism, pursuant to which a patient may receive a carefully worded response from a Ministry of Health representative with "standard messaging", stating that the patient's surgeon is in control of their wait list).[164]

C. BC's Establishment of the Maximum Acceptable Wait Times for Surgery

(i) Overview

427. The Pan-Canadian Benchmarks were an important first step in addressing wait times, but insufficient for a number of reasons.

428. First, they only covered the five priority areas, and CIHI has only been able to collect data from some provinces on these areas. For example, while BC has collected wait time data on MRIs for years[165], it has only provided this data to CIHI for 2018; other provinces, such as Alberta and Ontario, have reported MRI data to CIHI going back to 2008.[166]

429. Second, within the priority areas, the Pan-Canadian Benchmarks are overall maximum wait time targets, and as such, do not account for the urgency of patients within those general categories.

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[164] **Transcript Day 68**, p. 30-38; in particular, see p. 36.
[165] **Exhibit 4**, p. 29, para 80 **[CBE, Tab 5]**.
[166] **Exhibit 433E**, pp. 4531-4533 **[CBE, Tab 107]**.

430. For example the Pan-Canadian Benchmark for hip replacement surgery is 26 weeks. However, many patients in need of hip replacement surgery require the surgery within a shorter timeframe, to avoid continuation or worsening of unacceptable pain, disability and suffering, or irreversible harm.

431. Third, the Pan-Canadian Benchmarks did not address the entirety of the wait times experienced by the patient (i.e. the full patient journey).

432. There are three general categories of waits that patients are subjected to in the BC public health care system:

i. **Wait One**: time from GP referral to specialist consultation;[167]

ii. **Wait Two**: time from decision to have surgery to the time the surgery is done;[168] and

iii. **Wait Three**: time from patient being recommended a diagnostic testing and obtaining it (may be before or after a specialist consultation, or part of preventative screening).[169]

433. Each of these wait times affect the time it takes a patient to obtain a surgery or treatment.

434. Although there are significant wait times for both Wait One and Wait Three[170], historically the focus of the Federal and BC Government has been on Wait Two.

435. In terms of Wait Two, over the past ten years, the BC Government, working together with dozens of surgeon experts, established comprehensive maximum acceptable wait times for surgical procedures, based on patient need, diagnosis, and symptoms (the "**maximum acceptable wait times**"), along with corollary Priority Levels and Priority Codes, for a **Patient Prioritization System**.

(ii) <u>BC Government Establishes Patient Prioritization System</u>

a) Adult Wait Times

436. In 2010, the Ministry of Health and BC's health authorities developed and implemented the Patient Prioritization System for scheduled surgery. As the Defendant's *Prima Facie* Facts document sets out:[171]

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[167] **Exhibit 2C,** Tab 14, p. 22 **[CBE, Tab 3]**.
[168] **Exhibit 431**, p.138 **[CBE, Tab 102]**.
[169] **Exhibit 2C,** Tab 14, p. 22 **[CBE, Tab 3]**.
[170] See **Appendix A, Section VI(B)(ii) Tables 2, 3 4 and 4** for Wait One times, and **Section VII(D)** for explanation of Wait Three.
[171] **Exhibit 2**, p. 145, paras 362-365 **[CBE, Tab 1]**.

> 362. The Provincial Surgical Advisory Council ("PSAC") was established in 2009 to provide clinical and strategic advice and leadership in acute care and surgical access in the Province. It was initially established by PHSA following a surgical services conference in January 2009 (entitled "Access to Surgery in British Columbia – The Cutting Edge"), and included Medical Practitioners, Health Authority surgical services representatives, and Ministry representatives.
>
> 363. PSAC led the development and implementation of the Patient Prioritization Initiative... in 2010. [It] was a Province-wide project that introduced a standardized approach to prioritizing adult patients waiting for Scheduled Surgeries in the Province. Surgeons use their assessment of the patient to select a diagnosis/clinical condition from a standardized list. Each diagnosis/clinical condition is assigned one of five priority levels and a corresponding maximum recommended wait time in weeks. (...)
>
> 364. In the event that, in the surgeon's opinion, the diagnosis/clinical condition code does not appropriately prioritize the specific patient's surgery, the surgeon may assign a code to the patient that ascribes a different (more appropriate) priority level.
>
> 365. Surgeons are required to assign a patient prioritization code when booking a patient for surgery. The patient prioritization code is recorded in the Surgical Patient Registry. Surgeries are then expected to be completed, in part, on the basis of their priority and within the wait time benchmarks associated with the priority level.

437. The purpose of the Priority Codes is to "provide a clear and consistent picture of clinically acceptable benchmarks for patients using a standard methodology, to enable comparisons with how long patients are actually waiting, and therefore, to better understand capacity needs across the province."[172]

438. The Priority Codes, initially adopted and implemented by the BC Government in 2010, underwent a comprehensive review and update in 2015 through the "BC Patient Prioritization Codes Review Project", which was aimed at producing "clinically acceptable benchmarks".[173]

439. The 2015 Review involved over 14 BC Government and Health Authority representatives and over 60 surgeon representatives from across BC, representing 11 surgical specialty groups.[174]

440. As part of the 2015 Review, the BC Government confirmed that the maximum acceptable wait times establish "the time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences".[175]

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[172] **Transcript Day 87**, April 13, 2018, p. 6, line 4 to p. 35, line 17 and **Exhibit 243**.
[173] **Exhibit 243,** p. 9 **[CBE, Tab 46]**.
[174] **Exhibit 243**, pp. 4, 8-10 **[CBE, Tab 46]**.
[175] **Exhibit 243**, p. 7 **[CBE, Tab 46]**.

441. As described in "Patient Prioritization Codes: Overview"[176]:

> "...when the patient prioritization codes were implemented in 2010, they were accompanied by a commitment for a review once the use of the codes had stabilized. Completion of this comprehensive review – to ensure that the existing descriptions of diagnosis/clinical conditions used in the adult patient prioritization codes are correct, comprehensive, and have an appropriate wait time target – is a top priority of the Provincial Surgical Executive Committee (PSEC)...
>
> PSEC provides strategic oversight for the planning of surgical services across the continuum of care in order to meet the needs of the BC population. Using a patient centered approach, the committee provides advice and recommendations to, and receives strategic direction from, the Ministry of Health with the goal of improving surgical care in accordance with the dimensions of quality. Membership includes surgeons, anaesthetists, health authority administrators, the Ministry of Health, patient representatives, and representatives from various key health organizations.
>
> Phase 1 and 2 of the review were completed by the summer of 2014 during which input was collected from individual surgeons and Health Authority surgeon groups on suggested changes to the codes.
>
> Phase 3 and 4 were completed by March 2015 during which the codes were reviewed by provincial groups representing each clinical specialty, such as "General Surgery' or 'Ophthalmology'....
>
> As part of the final phase - Phase 5 - a 'Wise Council' was established in April 2015 to conduct a cross-specialty review of all the specialties' proposed changes to all the codes' structure, descriptions and priority levels as well as address any outstanding issues. Membership included PSEC surgeons and anaesthetists;
>
> administrators from the Health Authorities and the Ministry of Health; and patient and family physician representatives.
>
> This multi-phase code review has now concluded and the updated codes/wait time targets and implementation plan were signed-off on by PSEC on June 26th, 2015. "

442. The general descriptors for each of the five priority levels, excluding those that apply to orthopaedic and dental surgeries, are as follows:[177]

i. **Priority 1** requires treatment within **2 weeks**, and is applied to codes that involve severe pain or acute conditions, risk of permanent functional impairment, tumour/carcinoma/cancer/high risk of malignancy, or time sensitivity;

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[176] **Exhibit 431**, p. 193 **[CBE, Tab 102]**.
[177] **Exhibit 243**, p. 12 **[CBE, Tab 46]**; **Exhibit 2**, p. 146-147, at para 363 **[CBE, Tab 1]**.

ii. **Priority 2** requires treatment within **4 weeks**, and the condition involves severe pain or severe/progressive condition, tumour/carcinoma/cancer/suspected malignancy, or 'moderate symptoms';

iii. **Priority 3** requires treatment within **6 weeks**, and is for conditions with moderate pain or benign condition, functional compromise, and cancers that are slow growing/malignancy not suspected, or 'stable symptoms';

iv. **Priority 4** requires treatment within **12 weeks**, and is for conditions with moderate pain or moderate/benign/stable conditions, and where malignancy/cancer is ruled out;

v. **Priority 5** requires treatment within **26 weeks**, is for conditions with mild pain or mild/stable condition, a 'moderate' impact on lifestyle, non-time sensitive conditions, and benign tumour/masses.

443. As Dr. Masri testified, the maximum acceptable wait times are patient-centric; and are based on clinical judgement: an objective assessment of a patient's diagnosis and current condition. In other words, doctors specify the maximum acceptable wait time depending on the needs and circumstances of patients.

444. The Clinical Diagnosis Descriptions for many conditions incorporate clinical judgment and assessment. The Defendant's expert Dr. Guyatt opined that physicians can and should use clinical judgment, not benchmarks, to assign a priority to individual patients. However, he was not familiar with BC's Prioritization Initiative, which incorporates clinical judgement of the physicians into the benchmarks. In the end the prioritization system he described and endorsed is exactly how the system works in BC.[178]

445. The Ministry of Health and the Health Authorities have produced a list of conditions and diagnoses, with their corresponding priority levels and maximum acceptable wait times (in weeks), dated July 23, 2015 ("Adult Priority Codes – List").[179]

446. BC's Prioritization Codes now cover over 600 diagnoses (plus additional orthopaedic codes) in the areas of dental surgery, general surgery, neurosurgery, obstetrics & gynecology, ophthalmology, oral, orthopaedics, otolaryngology, plastic surgery, spinal surgery, thoracic surgery, urology, and vascular surgery. Cardiac surgery also has diagnosis codes, but these are collected separately and use a different format.

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[178] **Transcript Day 178**, Evidence of Dr. Guyatt, p. 14, line 4 to, p. 16, line 19; p. 17, line 32 to line 36.
[179] **Exhibit 431**, p. 141-160 **[CBE, Tab 102]**.

b) Meaning of the Maximum Acceptable Wait Times

447. As noted, the BC Government defined the maximum acceptable wait times arising from the BC Patient Prioritization Code Project as "**the time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences**". The purpose of establishing diagnosis codes was described by the Ministry of Health as to "... [p]rovide a clear and consistent picture of clinically acceptable benchmarks for patients using a standard methodology..."[180]

448. Similarly, the March 2018 "Our Health Care Report Card", prepared by Vancouver Coastal Health Authority and Providence Health Authority, describes the purpose of the patient prioritization codes, and measuring the health authority's performance against them as: "We monitor the percentage of elective (non-emergency) surgeries we complete within the [Patient Prioritization Code Project] benchmark wait time assigned by a patient's surgeon.... We want to ensure patients have timely access to surgery and do not wait beyond the maximum medically acceptable wait times."[181]

449. Despite this, in the trial, Defendant's counsel sought to undermine the BC Government's own comprehensive effort to establish the maximum acceptable wait times.

450. In cross-examination, Defendant's counsel suggested to the Plaintiffs' physician witnesses that "there really isn't a universally accepted method of establishing waitlist benchmarks".[182]

451. While it is true that any time frame can be called a "benchmark", it must be understood that the maximum acceptable wait times (developed, established, and reviewed, and retained by the BC Government), are based on the best clinical or scientific evidence available, as well as what a maximum acceptable wait time ought to be from the patients' perspective.[183]

452. Several of the Plaintiffs' and Defendant's expert witnesses (Dr. Masri, Dr. Bohm, and Mr. McGurran) were directly involved in the CIHR-funded research that lead to the establishment of the Pan-Canadian Benchmarks and Targets. Similarly, many of the parties' witnesses were involved in the development of BC's maximum acceptable wait times (Dr. Sahjpaul, Dr. Penner, Dr. Masri and Dr. Hamilton).

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[180] **Exhibit 243**, p. 7 **[CBE, Tab 46]**.
[181] **Exhibit 430**, p. 990 **[CBE, Tab 101]**.
[182] **Transcript Day 87**, April 13, 2018, p. 94, lines 45-47.
[183] **Transcript Day 87**, April 13, 2018, p. 103, lines 34-44.

453. Dr. Ramesh Sahjpaul, a prominent Vancouver neurosurgeon, served as a surgeon representative to the BC Government in the project to establish the maximum acceptable wait times,[184] and testified on behalf of the Plaintiffs.

454. He stated that the various benchmarks that the Ministry or Health Authority use, such as completing a certain number of surgeries within 52 weeks or 40 weeks, are *not* based on evidence or medical rationale; rather, they are simply arbitrary numbers picked by administrators to assist in tracking performance (i.e. a "nice round number").[185]

455. However, the maximum acceptable wait times are based on the "the opinions of the working groups that were established [by the BC Government]...physicians and surgeons got together and determined on medical grounds the maximum allowable wait time"[186] and "if ... we code a patient as having a benchmark wait time of four weeks what I'm saying is that as a surgeon that patient should have their surgery done by four weeks at the latest. That doesn't preclude that they potentially should have their surgery done earlier, but four weeks is the longest that they should wait."[187]

456. Dr. Sahjpaul testified that "...we are expected to get the patients in for surgery within the maximal allowable wait time target".[188] Despite this expectation, Dr. Sahjpaul noted that "I know...from my role as the head of the surgery program and looking at wait time issues...we are doing better in patients waiting longer than 52 weeks, and we know that as a health authority that there are fewer and fewer patients waiting longer than 52 weeks, but we are not doing well in terms of meeting the diagnosis-based benchmarks. So patients are still not getting in to have their surgery within the time frame that the surgeon decided, but yes, fewer patients are waiting 52 weeks, which is a fairly long time, in my opinion."[189]

457. Dr. Sahjpaul explained the Patient Prioritization System is used to try to manage risk of harm to a patient:

> Because these are maximum allowable wait times, so in our world we see a lot of patients with spinal pathology such as spinal cord compression and they've got weakness in their arms and legs, and I know that the longer that person is waiting the less is the chance that they're going to have a good outcome. So if I code them as four

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[184] **Exhibit 243**, p. 8 **[CBE, Tab 46]**.
[185] **Transcript Day 22**, October 13, 2016, p. 37, lines 2.
[186] **Transcript Day 22**, October 13, 2016, p. 36, lines 40-47; p. 37, lines 1-13.
[187] **Transcript Day 26**, October 19, 2016, p. 86, lines 26-33.
[188] **Transcript Day 22**, October 13, 2016, p. 42, lines 4-7.
[189] **Transcript Day 26**, October 19, 2016, p. 87, lines 3-21.

> weeks, say, I know I'm not going to get them in in four weeks, and during the time frame that they're waiting for the surgery there is a chance that they could deteriorate. And so that's a risk that I assume as a clinician that they're going to deteriorate while on my waiting list, and that's a stress to me, to my office, not to mention to the patients. But we do the best we can based on what's in front of us with the patient. We try our best to get them in as quickly as possible...
>
> ...Something untoward or unexpected could happen within a week, but I think if that were the situation that would be a patient in which I would do, you know, on my OR time this week and bump somebody else. So if I felt there was a clinical -- real risk of the patient deteriorating within a week or even two weeks I would do whatever it took to get that patient done quickly. **It's the middle group of patients that are always challenging, and there is a cumulative risk when we deal with neurological issues in that the increased amount of time that the nervous system is under, you know, pressure -- spinal cord or nerves are under pressure, that does result in chronic changes that become ultimately irreversible.** That's why we do our best to get the surgery done as quickly as possible, understanding that we're not going to be able to do the surgery as quickly as I would like or as the patient would like...
>
> ...So those patients -- the six-month patients would be the ones who perhaps have a stable neurological picture, but pain, basically, and that's why the patients with chronic pain end up getting pushed to the end of our list because we're constantly dealing with the urgent neurological issues.[190]

458. In determining how the wait times may increase the risks to the patient, Dr. Masri noted that the best evidence available was evidence-based medicine in the published literature, professional experience, and end-patient opinion, and that this evidence is what the maximum acceptable wait times were based on.[191]

459. As part of his work as a surgeon representative in the development of the Patient Prioritization System, Dr. Masri described the BC Government's instructions to him as follows:

> ...I was in the working group that set those prioritization codes for orthopedics. At that time we were instructed to come up with prioritization codes for....diagnoses for all of surgery....
>
> The instructions were that -- that was based on work that was done -- at least in orthopedics that was based on work that was done by the Western Canada Waitlist Project in the past, and the benchmark to our mind was the maximum acceptable wait time for those patients. In other words, patients should not wait beyond X, and that was the benchmark. And it was done for a variety of services.

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[190] **Transcript Day 26**, October 19, 2016, p. 90, lines 29-46, p. 91, lines 10-29 and 36-42.
[191] **Transcript Day 87**, April 13, 2018, p. 95, lines 1-17.

460. Dr. Masri confirmed that the maximum acceptable wait time was accepted as "the time beyond which patients are potentially harmed, physically, psychologically, medically..."

461. In cross-examining Dr. Masri, Defendant's counsel tried to suggest that benchmarks in and of themselves are not determinative of whether a patient experiences a successful outcome. In other words, that it was the outcome of the treatment that was important, and not whether a particular benchmark was met.[192]

462. However, Dr. Masri confirmed that the maximum acceptable wait times were "approaching something beyond which it's unacceptable"[193] and that based on the best evidence and clinical assessments possible, it was clear "the longer [patients] wait, the higher the probability that they're not going to achieve an above-expected outcome."

463. In addition, in relation to Dr. Masri testifying that that the "higher severity patients get prioritized ahead of the lower severity patients", Defendant's counsel suggested that "...in that sense the benchmarks aren't really an important part of the consideration; it's the individuals patient's characteristics?" Dr. Masri corrected that the benchmarks were important, stating: "So what happens with those, we put them in the more urgent bucket, in the less than 12 weeks, so the priority 4 as opposed to priority 5".[194]

464. Notably, Dr. Masri noted the maximum acceptable wait times were not ideal wait times: "the benchmarks are invisible to the patients. The patients care about when they get done because they're in pain; they want to get it over with. That's really what the patient cares about."[195]

465. Although the Patient Prioritization System is useful to understand when patients experience an unacceptable risk of suffering adverse health consequences as a result of waiting, the time frames are defined as the *maximum* acceptable wait times because individual patients may suffer harmful consequences even *within* these time frames.

466. By necessity, the maximum acceptable wait times cannot account for each individual patients' unique circumstances, nor does it address the amount of time patients have already been waiting prior

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[192] **Transcript Day 87**, April 13, 2018, p. 102, lines 29-34.
[193] **Transcript Day 87**, April 13, 2018, p. 98, line 6-11.
[194] **Transcript Day 87**, April 13, 2018, p. 101, lines 13-22
[195] **Transcript Day 87**, April 13, 2018, p. 102, lines 40-46

to (a) seeing a surgeon; (b) obtaining necessary diagnostic tests; and (c) making the decision that a surgery is required.

467. Moreover, even if no permanent adverse consequences arise from a patient's wait for medical treatment; while they are waiting, patients suffer ongoing pain, may need narcotics (with the risk of addiction), and may suffer other significant limitations on their daily lives. This suffering is compounded by the length of delay.

c) Paediatric Wait Times Benchmarks

468. Due to their unique development and physiology, there are separate maximum acceptable wait times for children.

469. This issue was addressed in the Final Report of the Federal Advisor on Wait Times "Addressing wait times for children's clinical and surgical interventions is therefore a moral responsibility - a trust responsibility - that needs to be shared by society at large[196]...There is however a significant difference for children in that their growth and development is rapid. For some conditions the opportunity to intervene clinically or surgically is brief - the window opens and closes quickly. To miss that opportunity is to miss getting the most from the procedure over time. Related to this are of course the social, educational and psychological effects associated with illness, hospitalization and the inability of the child to participate in the real work of growing up. The failure to progress with their cohort can affect a child's life for a long time."[197]

470. Wait time benchmarks for children were not specifically included in the mandate of the Federal Advisor on Wait Times. However, as Dr. Postl commented in his Final Report, meeting clear and evidence-based benchmarks are particularly important for children: "Yet the timing of interventions may be particularly critical for children for two reasons. First, there may exist in the normal development of a child a limited window of opportunity in which an intervention can have the most beneficial effect. Second, the delay of an intervention can cause normal growth and development to be impeded. We need to ensure that wait times for children are given due consideration."[198]

471. As such, Dr. Postl recommended as follows: "The provincial and territorial governments give consideration to the access targets developed by the National Youth and Child Health Coalition and

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[196] **Exhibit 577B**, Defendant's Expert Report of Dr. Guyatt – References, p. 55 **[CBE, Tab 155]**.
[197] **Exhibit 577B**, p. 56 **[CBE, Tab 155]**.
[198] **Exhibit 577B**, p. 13 **[CBE, Tab 155]**.

consult as required with clinical leaders in children's health care, in order to consider their implementation. Further, that the conditions affecting children be included alongside adult-related conditions at the outset of future benchmarking processes to ensure that children receive equitable attention to their time-sensitive needs."[199]

472. To this end, the Canadian Paediatric Surgical Wait Times Project ("**CPSWTP**") was announced in January 2007 by the Federal Government (Prime Minister Harper) to ensure more children requiring surgery would receive timely access to care. It was funded by Health Canada as part of the National Wait Time Initiative.[200]

473. The CPSWTP was a multi-stage project. In June 2008, the CPSWT Project Stage II was announced by the Government of Canada and then Minister of Health Tony Clement to build on the national pilot project. The CPSWTP Stage II was a 21-month, $9.8 million project.[201]

474. The initial goal of the CPSWT Project was to determine the duration of waits for surgery for children and youth across Canada using clinically-derived and nationally-accepted standardized access targets.[202]

475. This initiative led to the creation of the Pediatric Canadian Access Targets for Surgery ("**P-CATS**"), which sets out priority codes for children in need of surgeries, similar to the BC Prioritization System discussed above. The P-CATS cover over 850 diagnoses/conditions across 11 surgical subspecialties and were developed by over 100 expert Canadian pediatric surgeons.[203] It is currently governed by the Pediatric Surgical Chiefs of Canada with input from National Expert Panels.

476. The P-CATS were developed and implemented by the CPSWT Project as the standard for measuring wait times for surgery based on clinical need. The targets were defined as "acceptable time frame waiting for consultation and surgery".

477. The CPSWT Project prepared a document titled "Paediatric Canadian Access Targets for Surgery (P-CATS)" which set out the P-CATS Priority Levels I through VI (Priority I being the highest

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[199] **Exhibit 577B**, p. 63 **[CBE, Tab 155]**.
[200] **Exhibit 432**, p. 1193-1200 **[CBE, Tab 103]**.
[201] **Exhibit 432**, p. 1193-1200 **[CBE, Tab 103]**.
[202] **Exhibit 432**, p. 1193-1200 **[CBE, Tab 103]**.
[203] **Exhibit 432**, p. 1273-75 showing 11 surgical specialties **[CBE, Tab 103]**.

urgency (requiring treatment within 24 hours) and Priority VI being the lowest urgency (requiring treatment within 12 months)). This was updated in 2016.[204]

478. Therefore, like the adult patient prioritization codes in BC, the P-CATS codes are linked to a maximum acceptable wait time. However, unlike the maximum acceptable wait times for adults, the P-CATS identify a specific wait time for both Wait One (time from referral to a specialist to the initial specialist consultation) and Wait Two (time between the date on which a decision is made to proceed with surgery and the surgery date).[205]

479. As set out in the P-CATs, these are "the maximum acceptable waiting periods for the completion of specific types of surgery."[206]

480. The Canadian Medical Association Journal article dated June 14, 2011, entitled "Waiting for children's surgery in Canada: the Canadian Pediatric Surgical Wait Times project" ("**CMAJ June 2011 Article**) also discusses the Canadian Paediatric Surgical Wait Times Project as follows:

> The Canadian Paediatric Surgical Wait Times project developed a pan-Canadian standardized approach to evaluating pediatric surgical wait times within all pediatric surgical subspecialties. The pediatric access targets have now been adopted as a provincial standard by British Columbia and Alberta, which means that two provinces now use a uniform and standard approach to measuring wait times for surgery based on clinical need.[207]

481. The CMAJ June 2011 Article reported that the treatment for children regularly exceeded acceptable wait times for surgery and procedures, and that delay has real and detrimental effects on surgical outcomes.[208]

482. In December 2009, the BC Children's Hospital in Vancouver adopted P-CATS as the provincial BC standard. In a letter dated May 1, 2012, Dr. John Chritchley of the Provincial Health Services Quality Review Board, confirms the adoption of the P-CATS targets by the BC Children's Hospital.[209]

483. BC adopted P-CATs for all pediatric patients in BC during the implementation of the diagnosis prioritization methodology for adult patients, as confirmed in the SPR Backgrounder (2015), which

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[204] **Exhibit 432**, p.1174 and p. 1310-1328 for 2016 update **[CBE, Tab 103]**.
[205] **Exhibit 432**, p. 1174 **[CBE, Tab 103]**.
[206] **Exhibit 433E**, p. 4588 **[CBE, Tab 107]**.
[207] **Exhibit 433E**, p. 4588-93 **[CBE, Tab 107]**.
[208] **Exhibit 433E**, p. 4588 **[CBE, Tab 107]**.
[209] **Exhibit 26**, Tab J, p. 3 **[CBE, Tab 16]**.

was developed by the PHSA SPR Central Office staff in consultation with health authority and Ministry of Health SPR representatives. The 2015 SPR Communications Backgrounder stated "paediatric wait time is calculated from the decision date (Decision Date) to the date of surgery performed".[210]

484. The P-CATs Wait Two is defined specifically to be calculated from "the time between the date on which a decision is made to proceed with surgery and the surgery date".[211]

485. The CPSWTP prepared a report entitled "Paediatric Canadian Access Targets for Surgery (P-CATS) Update Project", dated April 1, 2016.[212]

486. In March of 2016, Ministry of Health and the Health Authorities released updated Pediatric Canadian Access Targets for Surgery (P-CATS) list of patient condition and diagnosis description.[213] Surgeons in British Columbia were informed about the newly completed national updated paediatric codes in March of 2016.[214]

D. Collection and Publication of Surgical Wait Time Data in BC

(i) Description of the British Columbia Surgical Patient Registry and Data Collected

487. Wait times data for "scheduled" surgeries and some treatments in British Columbia are collected in a central Government computer database, called the Surgical Patient Registry ("**SPR**"). The Defendant described the SPR as follows in its *Prima Facie* Facts – Ministry of Health:[215]

> 322. Also in 2007, the Ministry started collecting the data for the Surgical Wait Times website and the Surgical Patient Registry ("SPR") in an effort to provide a Province-wide reliable and consistent approach for prioritizing patients' access to surgery....
>
> 324. The SPR is a Province-wide system that tracks patients (adult and pediatric) waiting for Scheduled Surgery in BC. Patient information and data gathered from Health Authorities' operating room booking systems are entered into the registry by way of a nightly batch upload and used to evaluate and monitor surgical wait times across Health Authorities and specific physicians.
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> 325. The purpose of the SPR is to provide clinically relevant, accurate, and

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[210] **Exhibit 413**, Affidavit #1 of S. Wannamaker made February 6, 2019, Exhibit A, p. 9, 10, 11 **[CBE, Tab 96]**.
[211] **Exhibit 432**, p. 1174 **[CBE, Tab 103]**.
[212] **Exhibit 413**, Wannamaker Affidavit, p.5, para 12, Exhibit K, p. 177 **[CBE, Tab 96]**.
[213] **Exhibit 432**, p. 1310 **[CBE, Tab 103]**.
[214] **Exhibit 430**, p. 1131 **[CBE, Tab 101]**.
[215] **Exhibit 2,** p.135, paras 322-326 **[CBE, Tab 1]**.

> comprehensive information on patients waiting for surgery identified by surgeon, by diagnosis/clinical condition, by procedure, by priority level, by hospital, and by Health Authority. Wait time data is also collected for performed surgical cases.
>
> 326. The SPR captures adult and pediatric surgical procedures that are typically completed in an operating room or another room that requires similar equipment and human resources and are scheduled in the hospital's operating room booking system.

488. 100% of all hospitals which perform surgery in BC submit data to the SPR.[216]

489. Defendant's witness Dr. Hamilton, confirmed the accuracy of the SPR for Completed Cases.[217]

490. The Health Authorities enter this information directly into the SPR on a daily basis.[218]

491. The data itself comes from the Operating Room booking form ("**OR Booking Form**") that surgeons (or surgeons' offices) fill out for every patient in BC that ultimately receives scheduled surgery.[219]

492. The OR Booking Form records the following information for the surgeons' patients: (a) **Diagnosis Code** of the patients, based on their diagnosis and Priority Level arising from the maximum acceptable wait time; (b) **Referral Date**: Date the patient was referred to the surgeon from the general practitioner; (c) **First Consult Date**; (d) **Surgery Decision Date** ("**Decision Date**"),: Date the decision to have surgery was made (which is a mandatory field); (e) **OR Date;** and (e) **Booking Form Received Date** ("**BFRD**"): date entered by OR booking staff after the OR Booking Form is submitted by the surgeons' office; as noted on the form, it is for "Hospital Use Only".[220]

493. These pieces of information, along with other data, are entered into the SPR for Scheduled Surgery patients. From this information, various analyses can be done, including measuring components of the wait times that patients experience, such as:

i. **Wait One:** the time between the date a specialist's office receives a patient referral from a GP and the date on which the patient attends the initial consultation with the specialist.

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[216] **Exhibit 413**, Wannamaker Affidavit, Exhibit A, p. 7 **[CBE, Tab 96]**.
[217] **Transcript Day 173**, p. 26; lines 4-15.
[218] **Exhibit 2**, p.136, paras 327 **[CBE, Tab 1]**.
[219] **Exhibit 2**, p.136, paras 327 **[CBE, Tab 1]**.
[220] **Exhibit 69**, Regional OR Booking Form; p. 1-2 **[CBE, Tab 27]**.

ii. **Wait Two from Surgery Decision Date ("Wait Two from Decision Date"):** the time between the decision to have surgery and the surgery date.

iii. **Wait Two from Booking Form Received Date ("Wait Two from BFRD"):** the time between the date a surgical facility receives the operating room booking package (including the OR Booking Form) and the date on which the surgery is performed.

494. For completed surgical cases, there is therefore information on the length of Wait One, Wait Two from BFRD, and Wait Two from Decision Date for a specific surgeon, hospital, health authority, or for the entire province.

495. Although the Defendant's witnesses could not identify any established problems with the reliability of Wait One, or Wait Two from Decision Date, the Province repeatedly claimed that it is not reliable. It has not, however, done anything to test or correct the anecdotal claims of unreliability.[221]

496. By claiming that the information is unreliable, the Government can justify not reporting or using the information.[222] Obviously, these numbers would show even longer wait times.

497. Regardless, the Wait Two data that is collected can be used to determine how the BC public health care system is performing generally. For example, the BC Government measures percentile wait times, such as the 50th percentile (median), on the basis that these are a more accurate measure than average wait times because averages can be affected by just a few cases that are waiting a very long time, while percentiles (such as the median) are not.[223] Specifically, the BC Government reports on:

i. **50th percentile Wait Two from BFRD**: the median wait time, or the time at which 50% of all patients who require and receive surgery have still not received it.

For example, in 2017, the 50th percentile wait time for Wait Two from BFRD for orthopaedic surgery across all priorities was 13.1 weeks.[224] This represents the median wait time, and therefore means 50% of these patients waited less than 13.1 weeks for surgery and 50% of patients waited longer than 13.1 weeks.

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[221] **Transcript Day 114**, p. 27, lines 41-47, p. 28 lines 1-47; p. 29, lines 1-14, p. 45-48
[222] **Transcript Day 114**, p. 27, lines 41-47, p. 28 lines 1-47; p. 29, lines 1-14, p. 45-48
[223] **Exhibit 458A,** Affidavit #6 of Roland Orfaly, Exhibit 2, p. 2 **[CBE, Tab 119]**.
[224] **Exhibit 317**, Tab B8, p. 5 of 8 **[CBE, Tab 71(C)]**.

ii. **90th percentile wait time:** the time at which 10% of patients who require and receive surgery have still not received it.

For example, in 2017, the 90th percentile Wait Two from BFRD for orthopaedic surgery across all priorities was 44.9 weeks.[225] This means 10% of patients who received this class of surgery waited longer than 44.9 weeks.

iii. The 50th and 90th percentile wait time information can also be used to determine the wait time that 40% of patients (the patient population between the 50th and 90th percentiles) faced. For the 2017 Orthopaedic Surgery wait times, 40% of patients waited between 13.1 weeks and 44.9 weeks.

498. In this litigation, the Plaintiffs also demanded the disclosure of the 99th percentile wait times (which the Defendant does not report on). The 99th percentile wait time is the time at which 1% of all patients who require and receive surgery have still not received it. This measure is important because it provides a better estimate of the wait time experienced by those treated last. This number is typically *significantly* higher than the 90th percentile wait time. For example, in 2016, the 90th percentile Wait Two from BFRD for Orthopaedic Surgery in Interior Health Authority (IHA) was 47.6 weeks, while the 99th percentile wait time was 80.5 weeks.[226]

499. This means that for patients who required and received surgery, 10% of patients waited over 47.6 weeks, and their waits ranged between 47.6 weeks and at least 80.5 weeks. Notably, the longest maximum acceptable wait time for orthopaedic surgery is 26 weeks.

500. Indeed, comparing the percentile wait times against the maximum acceptable wait times to determine the proportion of patients waiting beyond the established maximum acceptable wait times (or other time frames of interest to the BC Government, such as 40 or 52 weeks) provides important information about system performance. In the example above, it is clear that IHA is not dealing with a situation where a few patients wait too long for care; rather, this is a systemic issue where IHA and the BC Government are simply not able to provide timely care to the majority of its patient population.

501. The Wait Two data can be tracked over time, to understand performance trends such as whether wait times and number of surgeries are increasing or decreasing.

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[225] **Exhibit 317**, Tab B8, p. 7 of 8 8 **[CBE, Tab 71(C)]**.
[226] **Exhibit 321,** Tab 2, p. 4 and 6 of 7 8 **[CBE, Tab 75]**.

502. In addition to the analyses that can be done on Cases Completed, the SPR can provide a snapshot of "Cases Waiting" at any given time.

503. While the wait time data collected in the SPR can provide information about the performance of the BC public health care system, it is important to understand that this data only measures a small portion of the actual wait time faced by BC patients.

(ii) SPR Data Is Gross Under-Estimate of True Wait Times Experienced by BC Patients

504. Although it demonstrates that many patients wait far too long for care, the BC Government's wait time data provides a significant under-estimate of the wait time actually experienced by BC patients.

505. First, the BC Government does not publicly report on Wait One (wait time to see a specialist) or Wait Three (wait time for diagnostic testing); and the wait times for each of these can be many months long. For example, the 90th percentile wait time for MRIs in 2015 was 245 days (four times longer than the maximum acceptable wait time for the lowest urgency MRIs).[227]

506. Therefore, while the Wait Two times are significant in and of themselves, the true patient experience must be understood as also including Wait One and Wait Three, which add additional weeks and months to the patient experience when trying to access medically necessary care.

507. Second, the BC Government's main performance measure of Wait Two from BFRD only represents part of the actual Wait Two time experienced by BC patients as it is based simply an administrative date (BFRD) that does not reflect anything of clinical significance.

508. To properly account for a patient's experience of Wait Two, it must be measured from the time of the decision to have surgery to the surgery date (Wait Two from Decision Date). Despite this, the BC Government only reports the Wait Two from BFRD, which always results in shorter Wait Two wait times.

509. As Dr. Hamilton testified, there is a delay between the time the patient decides to have surgery, and the time the OR booking form is received by the OR booking facility, and this delay can be in the

[227] **Exhibit 4**, p. 29, para 81 **[CBE, Tab 5]**.

order of weeks. As stated in the Wait Two Measurements Report, in 26% of adult procedures and 15% of paediatric cases, the time between the two dates (BFRD and Date) is longer than 4 weeks.[228]

510. Therefore, when the BC Government reports on the percent of patients who receive surgery within the maximum acceptable wait times based on Wait Two from BRFD (vs. Wait Two from Decision Date), it is over-estimating the number or percentage of surgeries completed within this time frame (i.e. claiming to do better than the reality). For example, the 50th percentile Wait Two from BFRD for all Priority 2 cases (maximum acceptable wait time of 4 weeks) in 2017 was 3.4 weeks.[229] Based on the Wait Two from BFRD data, the BC Government would report that 50% of patients received their surgery within the maximum acceptable wait time.

511. However, the 50th percentile Wait Two from Decision Date is 4.9 weeks.[230] Based on this data, the BC Government would be required to report that even the median wait time for patients in this relatively urgent priority exceeds the maximum acceptable wait time.

512. In addition to the delay caused by the administrative process, many surgeons' offices hold onto the booking forms until they are able to submit them for an actual surgery date.[231] These situations lead to an even larger gap between Wait Two from BFRD and Decision Date, and a further shortening of the Wait Two times (and therefore, again over-estimation of the percentage of surgeries completed within the maximum acceptable wait times). This is why Decision Date is a preferred start for the measure of Wait Two.

513. Other factors result in under-estimation of the wait times actually faced by BC patients. For example, the BC Government primarily reports wait time data for Cases Completed; however, this wait time is significantly shorter than the wait time for Cases Waiting. Dr. Hamilton gave evidence regarding a policy change recommendation he made to the Deputy Minister of Health, Mr. Stephen Brown; namely to change from measuring the wait times for cases *completed* to cases *waiting*. In a 2016 email to Mr. Brown, Dr. Hamilton stated:

> "In BC, we report largely on the wait for procedure performed. All the data on the public website is for procedures performed. This does not accurately address the information that patients need to make an informed choice....what we see, across the province, is that the median wait time for performed (cases) is much shorter than that

[228] **Exhibit 341**, p. 1-3 **[CBE, Tab 81]**.
[229] See **Table 4** in Appendix, Part A, Section VI(B)(ii).
[230] See **Table 4** in Appendix, Part A, Section VI(B)(ii).
[231] **Transcript Day 66**, p. 18, lines 31 to 47.

> for patients still waiting... As you can seen (sic), for all of BC, only 1.9% of patients who had their procedure completed had waited greater than 52 weeks. But in fact, 13% of patients still waiting had waited greater than 52 weeks....we can't ignore any patients on a wait list if we look at this performance measure and use it for accountability."[232]

514. In cross-examination, Dr. Hamilton stated that cases waiting was the appropriate performance measure to reflect as closely as possible the actual patient experience.[233]

515. Wait Two data for cases waiting is always longer than for cases completed, and often much longer. For example, at the end of 2017, the 50th and 90th percentile Wait Two from BFRD for all priorities for Cases Waiting in British Columbia was 12.3 weeks[234] and 41.7 weeks[235] respectively, while the 2017 50th and 90th percentile wait time for Wait Two from BFRD for all priorities for Cases Completed in British Columbia was 7.3 weeks[236] and 33.0 weeks, respectively.[237]

516. In addition, wait time data is regularly removed from the SPR which results in unaccounted wait time data. Some examples of this are set out below.

517. **Patient receives surgery on emergency basis**: While patients wait for Scheduled Surgery, their condition may deteriorate to the point of requiring Emergency Surgery (performed more urgently than the Priority 1 timeframe of 2 weeks). In such circumstances, the time the patient waited for their scheduled surgery is not accounted for.. Therefore, the wait times for surgery, and the overall performance of the BC health care system, appears to be better than it actually is.

518. **Removal of Patient through Wait List Audit:** Health authorities conduct audits on surgical wait lists, to remove patients from the wait list.[238] Per the BC Government's "Surgical Waitlist Management Policy", cases that must be permanently removed from health authority wait lists include patients whose "clinical condition has deteriorated to the point where surgery is no longer possible"; and "[health authority] and provincial records show the patient as deceased".[239]

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[232] **Exhibit 562**, Email chain between Stephen Brown and Dr. Hamilton **[CBE, Tab 150]**.
[233] **Transcript Day 174**, p. 38, lines 16.
[234] **Exhibit 322**, Tab 1, p. 85 of 105 **[CBE, Tab 76(A)]**.
[235] **Exhibit 322**, Tab 1, p. 95 of 105 **[CBE, Tab 76(A)]**.
[236] **Exhibit 317,** Tab B1, p. 5 of 8 **[CBE, Tab 71(B)]**.
[237] **Exhibit 317,** Tab B1, p. 7 of 8 **[CBE, Tab 71(B)]**.
[238] **Exhibit 2C,** Tab 9, at p. 2 **[CBE, Tab 3]**.
[239] **Exhibit 3D**, Health Authorities PFF, Exhibit 67 **[CBE, Tab 4(B)]**.

519. Cases that are flagged for temporary/permanent removal from health authority wait lists include patients who have "waited longer than one year" (i.e. "long waiters"); and patients who have waited longer than the national and provincial benchmarks.[240]

520. Dr. Hamilton testified that 41% of patients were removed from the IHA wait lists following an initial audit in 2013, and that subsequent audits (multiple times per year since the initial audit) typically result in the removal of 5-7% of patients.[241] He confirmed that some patients were removed because they had passed away while waiting for surgery.[242]

521. Notably, despite these regular audits to clean up the data, the SPR data *still* shows that thousands of BC surgical patients wait beyond the maximum acceptable wait times.

522. The impact of cases that are temporarily or permanently removed from the wait list on the SPR data (and ultimately, on the BC Government's performance measures) must be understood. Specifically, at *no point* do removed cases affect the Wait Two times for Cases Completed (the Ministry's standard performance measure). That is because patients removed through the audit process have not received surgery (i.e. they were still waiting for care at the time of removal).

523. To be clear, removed cases cannot affect the wait times for Cases Completed reported by the BC Government. Indeed, cases that are not completed, for any reason (even if they are not removed from the wait list), are not measured at all in the Wait Two Cases Completed performance measure. Therefore, BC's dismal Wait Two times for Cases Completed cannot be blamed on data that ought to have been removed.

524. Removing patients who do not receive Scheduled Surgery within the BC public health care system (whether it be because they are deceased, too ill for surgery, or obtain surgery elsewhere), results in their wait times not being accounted for in the SPR at all.

525. For example, Plaintiff Walid Khalfallah waited over a year for spinal surgery at BC Children's Hospital. His condition deteriorated while he waited, and the lengthy wait time he faced was acknowledged to be a serious concern by his doctor, and Ministry representatives.

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[240] **Exhibit 3D**, Prima Facie Facts - Health Authorities, Exhibit 67 **[CBE, Tab 4(B)]**.
[241] **Transcript Day 174,** p. 39, line 39.
[242] **Transcript Day 173,** p. 29, lines 10-18.

526. However, because his case was not ultimately performed in the BC public health care system, Walid's case would have been permanently removed from the wait list per the BC Government's Surgical Waitlist Management Policy. This means that it would not be included in either the Cases Completed or Cases Waiting data. This would make the BC Children's Hospital Wait Two times appear shorter than they actually are.

527. There was also evidence that patients who were removed from the surgical wait list through wait list "clean-up" were subsequently added back to surgical wait lists; however, the clock was reset (the previous wait times was not captured).[243] Such actions would make it appear as though patients experienced a shorter wait time than they actually experienced.

528. **Systemic Issues with Data Collection and Entry:** Some BC hospitals are not entering accurate data into the SPR, resulting in problems with the Wait Two from Decision Date data.

529. For example, according to the "Wait Two Measurements Report", the BC Government stated that Decision Date is not being used in 57% of paediatric cases, which artificially makes the wait times appear better (i.e. shorter) than the Decision Date method.[244] This is particularly problematic, as the P-CATS are required to be measured from Decision Date.

530. As discovered by the Plaintiffs in the course of this litigation, after 2014, when the wait times were extremely long for paediatric surgery and BC Children's Hospital was mandated to reduce its wait times, BC Children's Hospital stopped entering the Decision Date data into the SPR and began to use the BFRD for *both* the BFRD and Decision Date fields in the SPR data.

531. As the President of BC Children's and Women's Health and Vice President of the Provincial Health Services Authority ("**PHSA**") set out in her affidavit, "BC Children's does not currently enter the Decision Date into their OR Booking System (and thus into the SPR). BC Children's Hospital enters the Booking Form Received Date as the Surgery Decision Date."[245]

(iii) <u>BC Doctors' Assessment of their own Wait Times is Accurate</u>

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[243] **Exhibit 563 [CBE, Tab 151]**; **Transcript Day 174,** Testimony of Dr. Hamilton, p. 44, line 29 to p. 46, line 2
[244] **Exhibit 341**, p. 1-3 **[CBE, Tab 81]**.
[245] **Exhibit 413**, Wannamaker Affidavit, p. 5, para 10 **[CBE, Tab 102]**.

532. Despite the various known issues with the BC Government's own SPR data that always results in the wait times looking much shorter than they actually are, the Defendant repeatedly claimed that the Plaintiffs' surgeons exaggerated their wait times.

533. The Defendant spent much time trying to undermine the Plaintiffs' physician witnesses' evidence regarding their own wait times, because they were often longer than the Cases Completed Wait Two from BFRD data.

534. Given that the Defendant had in its possession both the Wait Two from Decision Date data for Cases Completed *and* Cases Waiting (which would have most closely coincided with the physician's assessment of their wait times; i.e. patient's waiting for surgery), it was very misleading to not put the correct information to the surgeon witnesses in cross-examination.

535. Prior to the commencement of the trial, the Defendant produced various wait time documents ("**Defendant's Initial Wait Time Reports**").

536. Many of these reports, which contained some Wait One data and some Wait Two from BFRD data, were generated by specific request of Defendants' counsel. Defendant's counsel provided the Defendant instructions for what information to include and *not* to include in these reports.

537. Defendant's counsel repeatedly asserted that Wait Two from BFRD was the only Wait Two data in its possession.

538. The Plaintiffs relied on these representations and used the Defendant's Initial Wait Time Reports at trial, including putting them to their physician witnesses.

539. The physician witnesses testified that their actual Wait Two times were longer than represented in the Defendant's Initial Wait Time Reports. In cross-examination, Defendant's counsel disputed this evidence.

540. For example, Dr. Arno Smit, an orthopaedic surgeon practicing in White Rock, BC, who provided care to Ms. Erma Krahn (a former plaintiff in this litigation; now deceased), had advised that the expected wait time for her surgery was "well over one year" (as confirmed in his written response to questions from the Defendant provided prior to the start of the trial).[246]

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[246] **Exhibit 30**, p. 2 **[CBE, Tab 18]**.

541. On cross-examination, the Defendant asserted that, based on the information in Defendant's Initial Wait Time Reports, Dr. Smit had overstated his surgery wait times (to Ms. Krahn and Defendant's counsel).[247] Defendant's counsel further disputed Dr. Smit's assertion that his estimates to Ms. Krahn were accurate when taken from the Decision Date.[248]

542. Dr. Smit testified that the Wait Two from BFRD in the Defendant's Initial Wait Time Reports did not fully represent the wait times that he knew his patients faced, and that the data the Defendant was presenting him in Court was missing the source data, thereby creating erroneous results.

543. However, the Defendant was not interested in the correct data. Defendant's counsel asserted in Court that "the surgical patient registry records the date on which the booking form is received by the hospital and the hospital records the date on which the surgery is performed. Those are the only two points of data that are measured".[249] As explained below, this was not correct.

544. Dr. Smit stated "If you wanted to have this data you could have contacted me. I would have provided you with the consent signing date and the date of surgery....then the steps that create error would have been omitted from the process."[250]

545. Dr. Smit testified that reports based on Wait Two from BFRD did not show the full wait time, and that the Wait Two from Decision Date (based on the source data, from the booking form and available in his office) was more accurate than the Defendant's Initial Wait Time Reports.[251]

546. The surgeons' understanding of their own wait times are informed generally by their ongoing review of patient charts for those who have had surgery (including the patient's referral date, consultation date, decision to have surgery date, and ultimately, surgery date), along with their OR time, and the number of people currently waiting for surgery.

547. What the surgeons generally do not have is the date that the booking form is received by the OR booking facility; as explained above, this is an administrative date that occurs *after* the booking form leaves the surgeons' office, and is for hospital use only. As this date has no clinical relevance, surgeons do not use it to estimate patient wait times.

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[247] **Transcript Day 19**, p. 69, line 5-40.
[248] **Transcript Day 19**, p. 68, line 4 to p. 76, line 26.
[249] **Transcript Day 19**, p. 70, lines 14-18.
[250] **Transcript Day 19**, p. 70, line 5 to 13.
[251] **Transcript Day 19**, p. 69, line 27-35, p. 70, lines 2 to 32.

548. Dr. Smit identified other issues with the Defendant's Wait Two from BFRD data. For example, he testified that certain patients described as having a Wait Two of just five weeks (per the Defendant's Initial Wait Time Reports) had actually waited much longer for surgery. He testified that because these cases had been transferred from one hospital to another (along with their booking cards), their wait time had been "reset".[252] The Defendant's own evidence, subsequently demanded by the Plaintiffs, ultimately confirmed this.[253]

549. Likewise, Dr. Lauzon, a general surgeon who provided care to Plaintiff Mandy Martens, was adamant in his evidence that the Defendant's Initial Wait Time Reports[254] significantly understated his actual wait times for surgery.[255] He testified that the Wait Two from Decision Date would be a much more accurate depiction of the patient's actual wait time. He also provided evidence of situations where the Wait Two from BFRD measurement would cause Wait Two times to be artificially low, such as situations in which he had received an additional surgical date at another hospital and this made the Wait Two from BFRD appear to be very short[256] (similar to Dr. Smit).

550. In cross-examination, Defendant's counsel suggested, first, that Dr. Lauzon was merely speculating about how long his patients waited from Decision Date. Defendant's counsel again asserted in Court that the Wait Two from BFRD was the *only* Wait Two data being collected by the Ministry. Dr. Lauzon reiterated that Wait Two from Decision Date would be much more accurate.[257]

551. Dr. Regan, an orthopaedic surgeon, also testified that the Wait Two from BFRD data[258] did not show the "true" Wait Two time patients experienced.[259]

552. On cross-examination, Defendant's counsel challenged Dr. Regan's evidence on his wait times, by taking him to three examples of patients who had, apparently, waited less than 10 weeks for surgery[260] according to Exhibit 173 (a report of Dr. Regan's Wait Two from BFRD generated by the Defendant).

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[252] **Transcript Day 19**, p. 30, Line 21 to p. 32, line 5
[253] **Exhibit 320A**, Tab 5, pp. 25-26 **[CBE, Tab 73(D)]**.
[254] **Exhibits 110 and 116 [CBE, Tabs 32 and 33]**.
[255] **Transcript Day 37**, p. 28, line 3 to p. 35, line 9.
[256] **Transcript Day 37**, p. 28, line 3 to p. 35, line 9.
[257] **Transcript Day 37**, p. 32, lines 37-45; p. 70, line 38 to p. 75, line 32.
[258] **Exhibit 171 [CBE, Tab 38]**.
[259] **Transcript Day 49**, p.27, line 10 to p.29, line 11; p.42, lines 9-20; p. 52, lines 33-43; p.58, line 43 to p.59, line 11, p.62
[260] **Transcript Day 49**, p. 50, lines 26-36

553. Because the Defendant did not disclose Exhibit 173 prior to putting it to Dr. Regan in cross-examination, Dr. Regan was not able to comment on these three patients. Defendant's counsel suggested that this meant that Dr. Regan's testimony about his wait times was unreliable.[261]

554. Defendant's counsel further asserted that Dr. Regan's wait times were improving over time, based on Exhibit 181, which again showed Wait Two from BFRD.[262]

555. Dr. Regan disputed the accuracy of Exhibit 181 and reiterated that the Wait Two from BFRD did not reflect how long patients are truly waiting,[263] and his understanding of the wait times were based on the time patients actually waited.

556. Following his testimony, Dr. Regan reviewed his medical records and confirmed to Plaintiff's counsel that when taken from the surgical Decision Date, the three patients identified by the Defendant at trial had, in fact, waited *more than a year* for surgery.

557. The Plaintiffs sought the Defendant's agreement to enter Dr. Regan's Booking Forms (which showed Decision Dates for surgery) for these three patients, in order to provide accurate information to the Court. Defendant's counsel refused. The Plaintiffs intended to bring an application to have these records admitted; however, as explained below, the Plaintiffs ultimately demanded and received disclosure of SPR data that had the important information in Dr. Regan's booking forms (Wait Two from Decision Date).[264]

558. As part of its ongoing disclosure obligations, on January 12, 2017, the Defendant disclosed Document BC5160600 "Wait Two Definition Change Project Progress Report" which stated that the BC Government intended to change the start date for the calculation of Wait Two from the "Booking Form Received Date" to the "Decision Date" or "Ready to Treat Date". The document noted that reporting of the Decision Date by physicians had been *consistently above 99.97% since 2013/2014.*[265]

559. Upon reviewing this document it became apparent to the Plaintiffs that the Defendant *did* have substantial Wait Two from Decision Date data in its possession, contrary to what was being asserted by Defendant's counsel in Court.

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[261] **Transcript Day 49**, p. 50, line 37; p. 79, line 37-45.
[262] **Transcript Day 49**, p. 71, line 41 to p. 72, line 3
[263] **Transcript Day 49**, p. 71, lines 46 to p. 72, line 3.
[264] **Transcript Day 82,** Submissions for the plaintiffs by Mr. Grant re joint adjournment application, p. 3, lines 29 to 38
[265] **Exhibit 431,** p. 139 **[CBE, Tab 102]**.

560. In February 2017, the Plaintiffs demanded the production of wait time data that included Wait Two from Decision Date. The Defendant initially refused, but ultimately agreed and around August 2017 (almost a year after the trial commenced) produced various reports containing Wait Two from Decision Date for the first time.[266]

561. The Defendant did not agree to tender this data (or extracts of it) into the Common Book, and opposed the Plaintiffs' application to have this data admitted into evidence. The Plaintiffs ultimately tendered the newly disclosed Wait Two from Decision Date data through Ms. Sandra Feltham, a director in the Health Sector Information Analysis and Reporting Division" at the Ministry of Health,[267] whom the Plaintiffs called as an adverse witness.

562. Notably, the Wait Two from Decision Date data was entirely consistent with the testimony of the Plaintiffs' physician witnesses both generally (patients were waiting longer for surgery than depicted by the Defendant's Wait Two from BFRD data), and in relation to specific patients, which had been the subject of the physician's testimony.

563. Exhibit 320, showing Dr. Smit's surgeries and Wait Two times from BFRD and Decision Date shows that the five patients with a Wait Two from BFRD of 25 days (April 15, 2016 to May 20, 2016) all had actually waited at least 11.5 months or more before their surgery date (Decision Dates ranging from March 16, 2015 to June 8, 2015).[268]

564. Exhibit 320 further shows that there is a gap of weeks and sometimes months between the Decision Date and the Booking Form Received Date.

565. The data ultimately produced by the Defendant showed that Dr. Lauzon's testimony (that his Wait Two from Decision Date was significantly longer than the Wait Two from BFRD) was entirely accurate.[269]

566. Similarly, Document BC5199449[270] shows Dr. Regan's Wait Two from BFRD and Decision Date data. This document confirms Dr. Regan's testimony that:

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[266] **Day 137,** Submissions for the defendant by Ms. J. Hughes re admissibility of the affidavit of Dr. Firoz Miyanji, at p. 21, lines 42 to 46.
[267] **Transcript Day 109,** Testimony of Sandra Feltham, p. 2, lines 36 to 40
[268] **Exhibit 320B,** Tab 5, p. 1 **[CBE, Tab 74(A)]**.
[269] **Exhibit 320B,** Tab 19, p. 1 **[CBE, Tab 74(D)]**.
[270] **Exhibit 320A**, Tab 2, p. 4 **[CBE, Tab 73(B)]**.

i. his Wait Two from Decision Date was significantly longer than the Wait Two from BFRD reports suggested;

ii. his Wait from Decision Date for shoulder surgery is very long, with the majority of his patients waiting close to one year or more; and

iii. his wait times were not improving over time but were worsening.

567. Further, this document shows that the Wait Two from Decision Date for the three patients referred to by Defendant's counsel in Dr. Regan's cross-examination, who had, based on the BFRD data selected by the Defendants, waited less than 10 weeks for surgery, were: 81 weeks, 104.4 weeks, and 74.4 weeks, respectively.[271]

568. Thus, despite its assertions in Court, the Defendant was collecting and did have in its possession reliable data with respect to Wait Two from Decision Date dating back to at least 2013.

569. Despite this, the Defendant put inaccurate assertions and information to the Plaintiffs' physician witnesses and attacked their credibility based on data that the Defendant knew was incomplete, while having in its possession records that wholly supported their testimony.

570. The Wait Two from Decision Date data clearly demonstrate that the Defendant's attacks on the credibility of the physician witnesses were wholly unwarranted and that the physician's evidence of their wait times was both accurate and verifiable by the Defendant's data.

571. Dr. Nouri, a paediatric dentist, also testified that the wait times data produced by the Defendant, which suggested that his average Wait Two from BFRD was 4.4 weeks for all priorities at the 90th percentile, was inaccurate because his office waited until he was given an OR date to send in the booking forms for his patients, although they have been waiting six to nine months by that point.[272]

572. In cross-examination, Defendant's counsel asserted that the Defendant had no access to information by which it could test Dr. Nouri's evidence on this point. As is clear, this assertion was inaccurate, as the Defendant was in fact collecting Wait Two from Decision Date data from 2014 onwards. This fact was not discovered by the Plaintiffs until February 2018, well after Dr. Nouri's

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[271] **Exhibit 320A**, Tab 2, p. 16 **[CBE, Tab 73(B)]**.

[272] **Transcript Day 66**, p. 21, line 10 to p. 22, line 33. In any event, Dr. Nouri was cross-examined on this point, and confirmed that this (submitting the booking cards about one month prior to the surgery date) had been the practice of his office for 19 years he had worked at BCCH: **Transcript Day 66**, p. 36, line 8-25.

testimony. It was also later revealed that for the years 2014-2018, BCCH was entering the BFRD as the Decision Date in the SPR, with the result that the Wait Two from Decision Date was not correctly recorded in the SPR.[273] This is information that the Defendant ought, with reasonable diligence, to have known and disclosed several years ago.

E. BC Performance against Surgery Maximum Acceptable Wait Times

573. The BC Government has established a target of having all surgeries performed within the maximum acceptable wait times.[274]

574. However, the BC Government's own SPR data shows that thousands of patients are routinely waiting beyond the maximum acceptable wait times for their procedures, across all priority areas, every year.[275]

575. Notably, the overall number of scheduled surgeries has not increased, despite many BC Government initiatives and significant investments, particularly over the past 10 years.[276]

576. The data for all surgical specialties across all priorities shows that BC patients frequently wait many months for a consultation, and many months for surgery (**Appendix, Part A, Section VI(B)(ii), Table 2**).

577. While the Defendant tried to downplay the significance of these long wait times by referring to these surgeries as being "non-emergencies", it is clear that patients are waiting very long for urgent surgeries as well. For example, the median wait time for patients classified at Priority 1 (the most urgent priority level requiring treatment within 2 weeks or else be at increased risk of negative consequences), is 2.1 weeks, and the 90th percentile wait time has been at least 10 weeks since 2012 – five times longer than the maximum acceptable wait time (see Table 2 below).

578. The magnitude of the problem is illustrated by the BC Government's "Surgical Performance Indicators" document,[277] which shows the number and percent of cases waiting over the Maximum Acceptable Wait time for each quarter of each year.

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[273] **Exhibit 413,** Wannamaker Affidavit, p. 5, para 10 **[CBE, Tab 96]**.
[274] **Transcript Day 166**, Testimony of Ms. Copes, p. 63, line 13 to, p. 64, line 12.
[275] See Wait Times Tables at **Appendix,** Part A.
[276] **Exhibit 560**, p. 3 **[CBE, Tab 148]**.
[277] See **Exhibit 322,** Tab 1, p. 14 **[CBE, Tab 76(A)]**.

579. This document shows that across all specialities and priorities, in BC between 2011 and 2017, well over 30,000 patients (or over 40% of patients) were waiting beyond the target on the last day of the last quarter of each year.[278]

580. Most concerning is that, during that same time, each year, over 2250 patients (over 80% of patients) were waiting beyond the maximum acceptable wait time for Priority 1 treatment.[279]

581. This document also sets out the number of patients that are waiting beyond 26 weeks (i.e. longest maximum acceptable wait time); between 2011 and 2017 more than 16,000 patients (over 22%) were waiting in each year.

582. As can be seen from Tables 2, 3, 4, and 5 British Columbians suffering from a broad range of conditions are waiting longer than the maximum acceptable wait time for treatment, including for many surgeries needed to correct severe daily pain and suffering and to avoid irreversible physical deterioration[280] (**Appendix, Part A, Section VI(B)(ii), Tables, 2, 3, 4, and 5**).

583. The fact that many children continue to wait beyond the maximum acceptable wait times for surgeries is confirmed by the BC Government's wait time data.

584. For example, Strabismus is a condition that causes crossed or wandering eyes, for which early detection and treatment is crucial. As recognized by the Ministry of Health in its "Provincial Scorecard of the Innovation and Change Agenda: 2011/12 Year End and 2012/13 Q1 Progress Report," vision deficits such as strabismus are "common problems in the preschool and school age population" and "Early Detection and treatment of these deficits, particularly in children of vulnerable families, will lessen the possibility of any damaging long-term effects and may have a direct impact on each child's opportunity for academic success and learning potential."[281]

585. An article by Dr. James Wright, Rena Menaker, and the Canadian Paediatric Surgical Wait Times Group, "*Waiting for children's surgery in Canada: the Canadian Paediatric Surgical Wait Times project*," noted a wait of six months for "pediatric strabismus (wandering eye) at critical junctures could

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[278] See **Exhibit 322,** Tab 1, p. 14 **[CBE, Tab 76(A)]**.
[279] See **Exhibit 322,** Tab 1, p. 14 **[CBE, Tab 76(A)]**.
[280] **Exhibit 317** - ***Wait One*** at Tab A1, p. 4 **[CBE, Tab 71(A)]**; ***Wait Two # of Cases Completed*** at Tab B1, p. 4 **[CBE, Tab 76(B)]**.; ***50th and 90th percentile for Wait Two from BFRD*** at p. 5 & 7 respectively; ***50th and 90th percentile for Wait Two from Decision Date,*** p. 6 & 8 respectively.
[281] **Exhibit 431**, p. 871 **[CBE, Tab 102]**.

influence brain development."[282] The group included the head of surgery for BCCH, Dr. Geoffrey Blair.

586. In BC, the condition of "**Strabismus: < 2 years**" (Diagnosis Code 63CQAA), has a maximum acceptable wait time target of 6 weeks.[283] However, in 2017, only 35.9% of these surgeries were performed within the 6 week target, meaning approximately 64% of children in need of this vision-sparing treatment waited beyond the maximum acceptable wait time of 6 weeks.[284] In 2017, the 90th percentile for these paediatric patients was 21.9 weeks when measured from BFRD and 27.2 weeks when measured from DD.[285]

587. Children are also waiting for otologic surgeries, such as Diagnosis Code 61DKAB, "**Otitis Media with Effusion - documented moderate Hearing Loss & Speech Delay**," which has a maximum acceptable wait time of 6 weeks.[286] Only 46.5% of patients in 2017 received treatment within six week maximum target, and some waited significantly longer.[287] Instead of waiting 6 weeks, in 2017, the 90th percentile for these paediatric patients was 16.4 weeks when measured from BFRD, and 17.1 weeks when measured from DD.[288]

588. As with visual acuity issues, hearing loss and speech delay are undoubtedly crucial concerns for these patients, and must be addressed in a timely way to avoid developmental problems and ongoing issues.

589. The above conditions are just a small subset of the various other diagnoses and conditions for which BC patients are waiting well beyond the maximum acceptable surgical wait times in the public system, and suffering harm to their current and future health and well-being as a result.

590. Because the Booking Form Received Date is used for Wait Two Data in the Government's "Percentage of cases Performed within Target" spreadsheet, the actual wait times experienced by paediatric patients will often be longer than they appear in this Government data.

591. As noted above, this data underestimates the full wait time, because many of the Health Authorities continue to use Wait Two from BFRD instead of Wait Two from Decision Date for

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[282] **Exhibit 433E**, pp. 4588-4592 **[CBE, Tab 107]**.
[283] **Exhibit 432**, p. 1318 **[CBE, Tab 103]**.
[284] **Exhibit 315A**, Tab 4, p. 19 **[CBE, Tab 64, d]**.
[285] **Exhibit 316D**, Tab 11, p. 14 **[CBE, Tab 70(C)]**.
[286] **Exhibit 432**, p. 1323 **[CBE, Tab 103]**.
[287] **Exhibit 315C**, Tab 9, p. 33 **[CBE, Tab 66(A)]**.
[288] **Exhibit 316D**, Tab 11, p. 30 **[CBE, Tab 70(C)]**.

paediatric patients, and in fact, as explained above, BC Children's Hospital has been entering the BFRD data into *both* the BFRD and Decision Date fields, thereby eliminating the opportunity to properly measure the true wait times paediatric patients experience.[289]

592. Nevertheless, the recent BC government data show harmful waits for children in many specialties, especially orthopaedics, dental surgery, otolaryngology, and ophthalmology, which place children at risk for negative consequences.

(i) Wait Times for Diagnostic Testing in BC

593. As set out in Section VII(C)(ii) and(xiii), BC patients wait months and even years for critical diagnostic procedures such as colonoscopies and diagnostic tests such as MRIs and CT scans. The BC Government has established maximum acceptable wait times which the evidence shows that the province continues to fail to meet.

(ii) Recent CIHI Data Shows BC's Ongoing Poor Performance Even Within Priority Areas

594. In February of 2006, as mandated, CIHI started to report on the wait times of the priority areas against the Pan-Canadian Benchmarks. CIHI continues to report on these wait times, and as discussed below, the data shows that BC is failing to meet the targets.

595. The most recent CIHI Report is "*Wait Times for Priority Procedures in Canada*" provides pan-Canadian wait time data for 2018 (the "**2018 CIHI Report**"). It refers to "medically acceptable timeframes" for priority procedures.[290]

596. As the 2018 CIHI Report emphasizes, this data covers only Wait Two times for the Pan-Canadian Benchmarks, which represents "just one part of the wait experienced by patients."[291]

597. Provinces other than BC generally report Wait Two based on the "Decision Date", i.e., the date when a treatment has been recommended by a specialist and the patient is ready to be treated.[292]

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[289] See discussion at **Section VII(D)(ii)**, above.
[290] **Exhibit 433E**, p. 4521 **[CBE, Tab 107]**.
[291] **Exhibit 433E**, p. 4327 **[CBE, Tab 107]**.
[292] **Exhibit 431**, p. 138 **[CBE, Tab 102]**; **Exhibit 433E**, p. 4470 **[CBE, Tab 107]**.

598. However, BC reports Wait Two from BFRD, which is generally at least two to four weeks after the Wait Two from Decision Date (as described above). This artificially reduces the actual wait time that a patient experiences.

599. Nevertheless, the data reported to CIHI shows that BC is doing poorly with regard to the percent of patients receiving care within the priority procedure benchmarks (even when using the shorter Wait Two from BFRD).

600. In particular, the 2018 CIHI Report shows that many British Columbians are waiting past the Pan-Canadian Targets, as follows:[293]

i. 33% of BC patients in need of a hip replacement are not receiving treatment within the maximum acceptable benchmark of 26 weeks (90th percentile wait time is 46 weeks or 321 days);

ii. 41% of BC patients in need of a knee replacement are not receiving treatment within the maximum acceptable benchmark of 26 weeks (90th percentile wait time is 51 weeks or 358 days);

iii. 15% of BC patients in need of a hip fracture repair are not receiving treatment within the maximum acceptable benchmark of 48 hours (90th percentile wait time is 59 hours) and;

iv. 36% of BC patients in need of cataracts are not receiving treatment within the maximum acceptable benchmark of 16 weeks (90th percentile wait time is 36 weeks or 253 days); and

v. 7% of BC patients in need of radiation therapy for cancer do not receive it within the maximum acceptable benchmark of four weeks (90th percentile wait time is 27 days).

601. In addition, the 2018 CIHI Report for BC shows a significant increase in wait times for hip fracture repair since 2015, with a *decrease* in the number of surgeries done (from 2,206 surgeries in 2015 to 1,532 surgeries in 2018).[294]

602. Similarly, for radiation therapy, the wait times have been increasing since 2015, and there has been a *decrease* in the volume of radiation therapy treatments performed (from 7,029 treatments in 2015 to 6,170 treatments in 2018).[295]

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[293] **Exhibit 433E,** p. 4425-4235 **[CBE, Tab 107]**; See **Appendix, Part X, Section VI(B)(ii), Table 6** data for specific page references.
[294] **Exhibit 433E,** p. 4425-427 **[CBE, Tab 107]**; See **Appendix, Part X, Section VI(B)(ii), Table 6** data for specific page references.
[295] **Exhibit 433E,** p. 4431 **[CBE, Tab 107]**; See **Appendix, Part X, Section VI(B)(ii), Table 6** data for specific page references.

603. This counters the BC Government defensive suggestion that while wait times continue to be unacceptably long, the number of procedures performed is increasing (i.e.: more people are getting care). As the 2018 CIHI Report shows, even for serious procedures like hip fixations and cancer therapies, fewer patients are receiving treatment, and those who do are waiting longer. CIHI does not report on the wait times faced by people who are still waiting for care.

604. The 2018 CIHI Report also shows a significant reduction in the percentage of BC patients receiving treatment within the benchmark wait time for the other three priority procedures:[296]

i. hip replacements – from a high of 87% patients receiving treatment within the benchmark in 2010, to 67% in 2018;

ii. knee replacements – from a high of 80% patients receiving treatment within the benchmark in 2010, to 59% in 2018; and

iii. cataract surgery – from a high of 85% receiving treatment within the benchmark in 2012, to 64% in 2018.

605. CIHI also published wait time information for certain cancer surgeries (no benchmarks to compare to), as follows:[297]

i. Bladder Cancer surgery - from a 90th percentile wait time of 50 days in 2015 to an increased 90th percentile wait time of 60 days in 2018 (and a decrease from a high of 1,704 procedures provided in 2017 to 1,580 procedures provided in 2018).

ii. Breast Cancer surgery – from a 90th percentile wait time of 39 days in 2013 to an increased 90th percentile wait time of 42 days in 2018; and

iii. Prostate Cancer surgery - from a 90th percentile wait time of 73 days in 2014 to an increased 90th percentile wait time of 91 days in 2018.

606. For the first time in 2018, BC also provided its wait time data for MRI and CT.

607. This data is summarized in Table 4; as can be seen, BC has never achieved any of the Pan-Canadian Targets, except for radiation therapy, and once for hip fixation target[298] (**Appendix, Part A, Section VI(B)(ii), Table 6**).

608. Notably, BC actually set a target of 95% completed within 48 hours for hip fractures.[299]

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[296] **Exhibit 433E,** p. 4525-4526 (Hip and knee replacements) and p.4528-4529 (cataracts) **[CBE, Tab 107]**; See **Appendix, Part X, Section VI(B)(ii), Table 6** data for specific page references.
[297] **Exhibit 433E,** p. 4531-4533 (Radiation therapy) and p.4528-4529 (Cataracts) **[CBE, Tab 107]**; See **Appendix, Part X, Section VI(B)(ii), Table 6** data for specific page references.
[298] **Exhibit 433E,** p. 4531-4533 (Radiation therapy) and p.4525 (Hip fixation acute) **[CBE, Tab 107]**.
[299] **Exhibit 12A,** p. 289 **[CBE, Tab 7]**; and **Appendix, Part A, Section VI(B)(ii) Table 1.**

609. In considering BC's dismal performance, it should be emphasized that the Pan-Canadian Benchmarks for hip and knee replacements is a *26 week* benchmark target – equivalent to a Priority 5 under BC's patient prioritization system. (i.e. the longest wait time for the lowest priority)

610. As set out in Section VII(C)(vii)(c), a large number of BC patients are in higher priority levels based on them experiencing moderate to severe pain and functional disability.

611. Therefore, the fact that a patient was treated within the pan-Canadian benchmark time of 26 weeks does not mean that they were treated within the maximum acceptable wait time.

F. Significant and Ongoing Wait Times for Care Despite Government Initiatives

612. As the above discussion makes clear, the BC Government has recognized for many years that there are significant problems with access to surgical services – including both diagnosis and treatment – in British Columbia, with the primary difficulty being excessive wait times for these services.

613. Over the last decade, in particular, the Ministry of Health has undertaken various initiatives to try to improve access to surgical services and reduce wait times. Evidence about these efforts is contained in the Defendant's Ministry of Health PFF[300], and updated evidence to present was given by Ministry of Health representative Marilyn Copes and the Executive Medical Director for Surgery for Interior Health Authority, Dr. Andy Hamilton.

614. Dr. Hamilton was formerly the Co-Chair of the Provincial Surgical Advisory Council ("PSAC") from 2009 to 2014, and Dr. Hamilton and Ms. Copes have been the Co-Chairs of the Provincial Surgical Executive Committee ("PSEC"), which replaced PSAC in mid-2014.

615. Dr. Hamilton was the author of the Report "A Synopsis of Surgical Services in British Columbia", which he authored in 2013 ("Synopsis of Surgical Services")[301]. This Report went to the Deputy Minister and the Minister of Health.

616. In "Synopsis of Surgical Services", Dr. Hamilton acknowledges that wait times for elective surgery are longer than they should be, and that none of the Health Authorities are meeting the maximum acceptable wait times set out in the Prioritization Codes.[302] Dr. Hamilton also notes that it is important to collect and publicly report Wait One data, and that it is vital that information in the

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[300] **Exhibit 17E**, p. 7274 **[CBE, Tab 12]**.
[301] **Exhibit 17E**, p. 7269- 7275 **[CBE, Tab 12]**.
[302] **Exhibit 17E**, p. 7271 **[CBE, Tab 12]**.

SPR be shared with physician offices to allow for effective wait list management and scheduling of patients.

617. Dr. Hamilton further notes that PSAC members were frustrated by a lack of support and funding from the Ministry of Health for surgical projects.[303]

618. This report led to the establishment of PSEC, which had a different governance structure (including Ms. Copes as representative of the Ministry of Health as Co-Chair), and more authority. It also served as the foundation of the "Future Directions for Surgical Services for British Columbia" policy paper ("Future Directions") which was published in 2015.[304]

619. Dr. Hamilton and Ms. Copes both testified that in 2014-2015 there had been insufficient funding for surgical services initiatives, including for Ministry directives to Health Authorities to increase volumes, as a result of which there was little progress in these years.[305]

620. The Ministry of Health PFF sets out the Ministry's goals, strategies and action plans for surgical services as of April 2016.[306] At this time, as seen at page 169, the goal for surgery wait times was that no more than 5% of BC patients would wait more than 40 weeks (Wait Two from BFRD) for their surgery.

621. As set out in Exhibit 2A, and as elaborated upon by Ms. Copes, the Ministry's Surgical Services Plan contains a number of related initiatives and elements which have been implemented by the Ministry and the Health Authorities to varying degrees over the period 2013 to present. All of these initiatives have the ultimate goal of increasing the volume of surgical services performed and reducing wait times.[307]

622. As Ms. Copes testified, this surgical services action plan was refreshed in the spring of 2017, to create a new three-year plan for 2017/18 to 2019/20. The new plan carried forward all of the initiatives set out 2015-2017 action plans.

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[303] **Exhibit 17E**, p. 7273 **[CBE, Tab 12]**.
[304] **Exhibit 2C**, Vol 3, Tab 14 **[CBE, Tab 3]**.
[305] **Transcript, Day 166,** Testimony of Ms. Copes, June 17, 2019, p. 39 lines 3-16; **Transcript, Day 173**, Testimony of Dr. Hamilton, July 11, 2019, p. 40, lines 4 to 12.
[306] **Exhibit 2A**, Vol. 1, pp. 168-172 **[CBE, Tab 1]**.
[307] **Exhibit 2A**, pp. 168-172 **[CBE, Tab 1]**.

623. An increase of base funding for each of the three fiscal years of 2017/18, 2018/19 and 2019/20 was provided to aid in achievement of the surgical services plan, for a total of $225 million over the three years.

624. The evidence with respect to these various initiatives and their current status are briefly summarized below.

(i) Collection and Reporting of Wait One Data

625. The Ministry commenced collection of Wait One data in the SPR in April 2014, and by December 2014 had determined that the data was of sufficient quality to be publicly reported, this information has yet to be publicly reported. [308]

626. As Exhibit 340 shows, the decision of Ministry leadership to report this data on the BC Wait Times Website as of early 2015 was overturned by the Minister of Health. [309]

627. Despite the assertions of Ms. Copes and Dr. Hamilton about the importance to PSEC and to the Ministry, of addressing the patient's entire wait for treatment and recovery, there is no evidence that the 2015 decision to withhold the Wait One data from public reporting has ever been revisited. Nor has it been properly explained.

628. The Wait One data in the SPR reports the degree of compliance with the inclusion of the Wait One information in the surgical booking form provided by surgeons' offices to the hospital. The rate of compliance is very high.[310]

629. The Co-Chair of PSEC, Dr. Hamilton, was unable to explain what the "data reliability" problem was, and stated he had merely been informed that a reliability issue existed but it had not been explained to him.[311]

630. It must be concluded that the Ministry continues to withhold the Wait One data from public disclosure because it would clearly demonstrate to the public that overall wait times for diagnosis and surgical treatment in BC are not, in fact, going down.

(ii) Implementation of Hip and Knee Pooled Referral Programs

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[308] **Exhibit 2C**, Tab 14, p. 22 **[CBE, Tab 3]**.
[309] **Exhibit 340**, Ministry of Health Briefing Note, pp. 1-2 **[CBE, Tab 80]**.
[310] **Exhibit 340**, pp. 1-3 **[CBE, Tab 80]**.
[311] **Transcript Day 174**, p. 28, line 12 to p. 29, line 14.

631. Another component of the Three-year surgical services Action Plan was the introduction of a pooled referral program for hip and knee replacements. This has now been implemented in at least some sites in each Health Authority (other than PHSA) and is in the process of being expanded across all sites doing hip and knee replacements.

632. The Government envisions that this will reduce Wait One for patients waiting for referrals to a surgeon for consultation for a possible hip or knee replacement, similar to the ReBalanceMD program[312].

633. As is clear from the evidence of programs such as ReBalanceMD, and FAST, while pooled referral programs can reduce Wait One, the result is a corresponding increase in Wait Two.[313]

634. It should be noted that many of the initiatives are *not* new ideas. As the evidence of Ms. VanAmburg shows, recommendations of pooled referrals, increased OR efficiencies etc. were set out years ago based on projects funded by the National Wait Times Initiative.[314]

635. As noted above, Ministry of Health leadership engaged in a review of the Surgical Services Action plan in the spring of 2017, and created a new three-year plan for 2017-2018 to 2019-2020.

636. At this time, Dr. Hamilton advocated to the Deputy Minister and others within the Ministry of Health that the target should be for all surgeries, not for any targeted surgeries. He noted that past focus on certain types of surgeries resulted in other surgeries being compromised, and that despite the ongoing focus on hip and knee replacements, it remained an area with excessively long wait times.[315]

637. As Exhibit 523 shows, the target initially established by Ministry of Health leadership in the spring of 2017 for 2017/18 and 2018/19 was initially set at "no more than 5% of patients waiting more than 26 weeks" for surgery, and the target for 2019/20 was "surgeries completed within benchmark wait times".[316]

638. However, this was not the plan that was adopted by the Ministry of Health. Instead, in the fall of 2017, the Minister of Health, Adrian Dix, directed the adoption of a three-year plan for which

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[312] **Transcript, Day 166**, p. 19, lines 14 to 23.
[313] **Exhibit 2C**, Tab 14, p. 37 **[CBE, Tab 3]**; **Transcript, Day 64**, Testimony of Dr. M. Penner, p. 20, line 27 to p. 21, line 37.
[314] **Exhibit 451**, VanAmburg Affidavit, Exhibit "E", Synthesis of Results of the National Wait Times Initiative, for e.g. pp. 212-213, and 310 **[CBE, Tab 118]**.
[315] **Exhibit 559**, p. 1 **[CBE, Tab 147]**; **Transcript, Day 173**, p. 84, line 30 to p. 86, line 47.
[316] **Exhibit 523**, p. 1 **[CBE, Tab 135]**; **Transcript, Day 167**, Testimony of Ms. Copes, p. 61, line 44 to p. 63 line 21.

only hip replacements, knee replacements and dental surgery had a target of "no more than 5% of patients waiting more than 26 weeks". For all other surgical procedures, the target was simply to not have the wait times worsen as compared to 2016/2017 results.[317] Surgical volumes targets for each health authority were set in accordance with these targets.

639. It is notable that the actual surgical volumes achieved in 2016/2017 (the baseline year for the current three-year Surgical Services Plan) were less than the number of surgeries performed in the province in 2011.[318] Further, the wait times for surgical services had been worsening substantially over time since 2009 (90th percentile Wait Two from BFRD 24.4 weeks) to 2017 (33 weeks).

640. The surgical volumes planned to be performed in each of 2017/18 and 2018/19, as compared to 2016/2017 are set out in a February 2018 Briefing Note to Minister Dix.[319] It states that in 2017/2018, there would need to be a 3 percent increase in "all other surgeries" in 2017/18 over 2016/17 in order to "keep up" with current demand, for a total of 220,406 cases.[320] This plan was then reduced in March 2018 to a target of 217,545 for "all other surgery" cases. Even this lesser target was not achieved. Only 214,823 "all other surgeries" were performed in 2017/2018.[321]

641. As set out in the Briefing Note, in 2018/2019, a 5% increase in "all other surgeries" over 2016/2017 would be required, for a total of 225,226 cases being performed.[322] This plan was increased in May 2018 to anticipate 226,803 "all other surgeries" in 2018/2019.[323]

642. However, as can be seen in Exhibit 560, which provides the results for the final (13th) period of the 2018/19 fiscal year, this volume of "all other surgeries" was not achieved. Only 224,032 "all other surgeries" were performed. And, the percentage of patients waiting more than 26 weeks for "all other surgeries", in all priority levels, measured from BFRD, was 23.1%. [324]

643. The 2018/19 planned surgical volumes for the "target surgeries" of hip and knee replacements (19,687) and dental surgeries (7,472) were also not achieved by the end of fiscal 2018/2019. For hip

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[317] **Exhibit 524,** Appendix A, p. 1 **[CBE, Tab 136]**; **Transcript, Day 167**, p. 64, line 7 to p. 67, line 42; **Transcript Day 173**, p. 82, lines 33 to 35.
[318] **Exhibit 431,** p. 621 **[CBE, Tab 102]**; **Exhibit 317,** Tab B1, p. 4 **[CBE, Tab 71(B)]**; **Transcript, Day 167**, p. 60, line 16, to p. 61, line 39.
[319] **Exhibit 565,** pp. 123-126 **[CBE, Tab 152]**.
[320] **Exhibit 565**, p. 124 **[CBE, Tab 152]**.
[321] **Exhibit 431**, p. 621 **[CBE, Tab 102]**.
[322] **Exhibit 565**, p. 124 **[CBE, Tab 152]**.
[323] **Exhibit 431**, p. 621 **[CBE, Tab 102]**.
[324] **Exhibit 560,** p. 4 **[CBE, Tab 148]**.

and knee replacements, there was a shortfall of over 1000 surgeries (about 5% of planned volumes), and 26.5% of patients in all priority levels still waited more than 26 weeks for surgery (Wait Two from BFRD). The 90th percentile Wait Two time from BFRD for hip and knee replacements (all priorities) was 42.1 weeks[325].

644. For dental surgery, there was a shortfall of 365 surgeries (again about 5% of planned volumes), and 7.3% of patients still waited more than 26 weeks for surgery (Wait Two from BFRD for all priorities).

645. The results for colonoscopies and other GI endoscopies were similarly disappointing, with planned volumes for colonoscopies not being met, and over 42 % of patients waiting beyond the maximum acceptable wait time for a colonoscopy based on their symptoms, and a 90th percentile wait time for all priority levels ranging between 28 and 79 weeks. The only area in which volume targets were met was MRIs, but this still left 46% of BC patients waiting beyond the maximum acceptable wait time for their MRI, with a 90th percentile wait time for all priorities of 194 days. [326]

646. The Surgical Services Action Plan targets for 2018/2019 have been repeated for 2019/2020. The intended addition of a cancer target was removed by the Minister.[327] However, as noted in the IHA "Catch Up and Keep Up" Project Charter for IHA, achievement of these targets for 2019/2020 is at high risk due to anesthesiology resources issues, and likely insufficient funding.[328]

647. What is clear from this data is that, despite all of the initiatives undertaken by the federal government, the province, the Health Authorities and physicians since the Chaoulli decision in 2005, and in particular over the past several years in BC, there has been no meaningful progress in reducing wait times, even for the focus procedures such as hip and knee replacements, and colonoscopies.

648. It clear that the Government will never provide the timely diagnostic and/or surgical services that each and every patient needs to alleviate their suffering and protect their health.

649. We turn to the detailed evidence of harms being suffered by British Columbians as a result of waiting too long for diagnostic and surgical services in the public health care system.

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[325] **Exhibit 560**, p. 4 **[CBE, Tab 148]**.
[326] **Exhibit 560**, p. 4 **[CBE, Tab 148]**.
[327] **Exhibit 514,** pp. 1-4 **[CBE, Tab 134]**.
[328] **Exhibit 553**, pp. 7-9 **[CBE, Tab 144]**.; **Transcript, Day 174**, p. 50, line 17 to p. 52, line 14.

VII. HARMS OF WAITING FOR DIAGNOSIS AND TREATMENT BY SPECIALISTS

A. Introduction

650. In the following sections, the Plaintiffs will review the extensive evidence before the Court with respect to the harms to British Columbians which are being suffered as a result of patients waiting too long for medically necessary diagnosis and treatment in the BC public health care system.

651. The evidence shows that British Columbians are suffering all of the different types of harms identified by the judges in the *Chaoulli* case.

652. First, many patients endure severe and disabling pain which often worsens while waiting for diagnosis and surgical treatment.

653. Second, many patients are functionally disabled as a result of their condition, with limited use of their limbs or bodies while waiting for diagnosis and surgical treatments, which limits their ability to lead normal, fulfilling and independent lives.

654. Third, many patients suffer anxiety, depression, and other psychological harms while waiting for diagnosis and surgical treatments. These harms include development of reliance upon or addiction to opioid painkillers and/or drugs or alcohol taken to "self-medicate".

655. Fourth, many patients suffer from conditions where delays in treatment increase the risk of permanent, irreversible harm or reduce the chances of a successful surgical outcome.

656. Fifth, while waiting for medically necessary diagnosis and surgical treatment the patient's medical condition can deteriorate. This may result in patients experiencing increased pain, suffering and disability while waiting, with a consequential reduction in the quality of their lives over the waiting period. The condition may become so serious, even life-threatening, that it requires emergency surgery, with its attendant higher costs, increased anxiety and poorer patient outcomes.

657. Sixth, waiting for medically necessary diagnosis and surgical treatment often allows the underlying condition to progress, making the surgery or treatment riskier, more difficult, and less effective than it would have been if the diagnosis and treatment had been provided without unnecessary delay.

658. And, finally, waiting for medically necessary diagnosis and surgical treatment for conditions that are, or could become, life-threatening increases the risk of mortality for the patient and can, in

some cases, actually result in death which could have been avoided by earlier diagnosis and/or treatment.

659. In addition to these direct harms to the health of patients, delays in obtaining treatment will often diminish the quality of patients' lives. The delay in diagnosis and treatment unnecessarily prolongs the loss of ability to participate in everyday life, including work and educational activities, family responsibilities and relationships, and social activities.

660. It can and often does also cause financial harm to patients and their families, because the patient cannot work and must incur the costs of medications and non-medical therapies to reduce or address symptoms while waiting for diagnosis and/or treatment. Further, the evidence shows that patients whose conditions force them off work while waiting have a reduced likelihood of returning to work after surgery.

661. Many patients waiting for diagnosis and treatment suffer at least some, and sometimes all, of the above harms. Many of these harms are cumulative, such that the greater the delay, the greater the harm.

662. The prolonged pain and suffering, lack of mobility and independence, increased risk of irreversible and permanent harms or negative post-surgical outcomes, and psychological harm and suffering, all contribute to an overall loss of quality of life and financial loss that can never be recouped by the patient and their family, even if the treatment is ultimately successful in fully restoring the patient to health.

663. These harms have all been proven through direct evidence from patients, from the physician witnesses and from experts who explain the medical consequences of waiting.

664. In *Chaoulli*, the dissenting judges commented that there were no national standards for timely treatment. However, all seven judges found that the delays in Quebec's public health care system impaired the right to life, because they sometimes increase the risk of death, and also impaired the right to security of the person because they always prolonged pain and stress and sometimes resulted in less than fully successful treatment.

665. In this case, as discussed above, there are officially established and accepted maximum acceptable wait times in British Columbia for virtually all scheduled surgical treatments as well as a number of diagnostic procedures. As described by the BC Government in its own documents, the

maximum acceptable wait time associated with each priority level for each diagnosis or condition is accepted to be the "time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences".[329]

666. We also have extensive data that shows that many BC patients are not receiving their medically necessary diagnostic and/or surgical treatment within the maximum acceptable wait time for their condition.

667. That is not to say that patients only suffer harm after the maximum acceptable wait time for their condition has expired – rather the maximum acceptable wait times reflect the outer timeframe that clinicians and experts believe any patients should ever be required to wait.

668. Many patients will suffer harm within these wait time periods for surgical treatment, and indeed will have suffered harm while waiting for a diagnosis or a decision for surgery or other treatment, before the Wait Two time frame even starts.

669. The maximum acceptable wait times contained in the BC prioritization code system thus reflect the outer limit of what is acceptable on a systemic basis for most patients.

670. In the case of children, there are established and adopted maximum acceptable wait times for specialist consultations following referral from a GP (Wait One) as well as from the Decision Date for surgery to the surgery date (Wait Two). Again, the establishment of the PCATS targets do not mean or suggest that children waiting less than these time frames cannot suffer harm – again, they are the absolute outer limits of what may be clinically acceptable for most patients with the specified condition and symptoms, beyond which the risk of adverse effects is unreasonable.

671. There is also individual variability among patients. As the expert and physician evidence makes clear, physicians and science cannot predict which patients with similar symptoms and urgency status will suffer a progression of their illness, including deterioration or progression to a point that cannot be recoverable with surgery or other treatment, and which will not.

672. The increased risk of harm as well as the fact of harms being suffered by patients waiting for diagnosis and treatment in BC, is confirmed by the expert and lay evidence in this case.

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[329] **Exhibit 243**, Patient Prioritization Code Review Project, Phase 3 and 4 – Final Report, p. 7 **[CBE, Tab 46]**.

673. The BC Government's own "Diagnosis Descriptions" which form part of the Patient Prioritization Codes confirm the harm being suffered by patients as they wait for treatment. Many of the Diagnosis Descriptions refer to patients experiencing serious pain or functional disability and/or a serious risk of progression of the illness.

674. The evidence of the Patient Plaintiffs and Patient Witnesses (including some of the Patient Intervenors) makes clear that the harms that could be suffered by failure to provide timely diagnosis or treatment are real, and were in fact suffered by these individuals. Further, the evidence of the physician witnesses and experts, and the Government's own documents, establishes that these are not isolated cases.

675. And, contrary to the position of the Government, the excessive waits experienced by patients are not the fault of physicians allowing certain patients to "fall through the cracks" or selfishly keeping patients on long wait lists for the physicians' own financial or reputational gain. Nor can they be attributed to patients' failure to adequately explore other options for treatment within the public health care system.

676. The evidence overwhelmingly and uncontrovertibly establishes that the excessive wait times for diagnosis and/or treatment experienced by the patient witnesses in this case, and by British Columbians generally, and the resulting harms to them, are due to a fundamental, systemic and ongoing lack of sufficient capacity in the public health care system, primarily due to limitation in facilities and funding. The problem is province-wide, and across all health authorities.

677. In the section that follows, we summarize the evidence with respect to the harms suffered by British Columbians in relation to various conditions and/or procedures with respect to waiting for diagnosis and treatment. This is followed by a discussion of the expert evidence on harms and the relative weight which should be attributed by the Court to this evidence.

678. At the outset, however, we address the Defendant's position that any excessive wait times experienced, or resulting harms to patients, are attributable to the failure of physicians to act appropriately or of patients to engage in appropriate self-help.

B. The Defendant's Claim that Harms to Patients are the Fault of Physicians

679. The Defendant has pleaded that, to the extent that BC patients are suffering harm as a result of waiting too long for medically necessary diagnosis and/or treatment by specialists in BC's public

health care system, this is attributable to the physician's failure to provide appropriate treatment to their patients within the BC system.

680. The Plaintiffs understand the Defendant is making the following assertions in this regard:

(a) General Practitioners ("**GPs**") can and should be referring their patients to the surgeons who have the shortest wait time for a particular procedure, by using the BC Wait Times Website;

(b) Surgeons who see patients in consultation who require surgery, and who have a long wait time, should refer the patients to a different surgeon with a shorter wait time;

(c) Surgeons are imposing harm on patients by exaggerating the length of their wait lists – they should tell patients their average wait time or their median wait time, rather than a longer wait time which is closer to their 90th percentile;

(d) It is entirely up to surgeons to control their wait lists, and they could move any patient up the wait list to an earlier date if they were of the view that that patient was suffering harm by waiting; and

(e) In many cases, surgery is not the best treatment option for the condition at the time or at all.

681. We will address the evidence in relation to each of these assertions in turn.

(i) <u>General Practitioners can and should be referring their patients to the surgeons or specialists who have the shortest wait time for the procedure or assessment needed by their patient.</u>

682. The first, and primary, point in response to this assertion is that virtually all surgeons and specialists in British Columbia have lengthy wait times. While the Defendant attempted to portray that there are some surgeons and other specialists with much shorter wait times than others, this is not borne out on the Government's own wait time evidence.

683. With respect to surgeons, the vast majority of surgeons with similar specializations within a particular health authority have similar Wait Two times. Where one or two surgeons may have a shorter Wait Two time, this is often because they have a longer Wait One time.[330]

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[330] See **Transcript, Day 64,** Testimony of Dr. Penner, pp. 20-21; **Exhibit 299,** Javer Affidavit, pp. 12-13 **[CBE, Tab 58]**;

684. The second point in response to this assertion is that, despite that it is entirely within the purview of the Government to make accurate wait time data available to General Practitioners, the Government has chosen not to do so.

685. The Defendant often suggested that GPs and/or patients should utilize the BC Surgical Wait Times ("SWT") website to find the surgeons in their health authority with the shortest wait time for a particular procedure. However, the evidence is clear that the SWT website is of little, if any, meaningful information to physicians or patients.

686. First, the SWT website only provides information on Wait Two from BFRD for a small number of surgeries performed over a three month time frame. There is no information on Wait One. Looking at Wait Two without Wait One provides no useful or valid information about how long a patient would wait overall for consultation and treatment by a particular surgeon. Despite collecting Wait One data since April 2014, and determining that this data could and should be made publicly available as of early 2015[331], the Ministry has yet to publish this data.

687. Further, as is amply demonstrated in the evidence, the Wait Two from BFRD measurement is always shorter, sometimes dramatically so, than the Wait Two from Decision Date. Leaving aside Wait One, it is Wait Two from Decision Date which is the important Wait Two time frame from the perspective of the patient and the referring physician. Despite this, the BC Wait Times Website reports only Wait Two from BFRD.

688. In addition, the use of only the last three months of surgeries presents only a potentially unrepresentative sample of the surgeries done by a particular physician and the wait times.

689. The SWT Website also includes only Wait Two time (50th and 90th percentiles) for a surgeon across all priority levels. This includes the wait times for the most urgent priority levels, which may be relatively short compared to the wait times for the less urgent priorities, which is the group for whom the website is most likely to be used.

690. Further, as discussed by a number of physicians, the SWT Website does not distinguish between surgeons based on their particular experience and expertise.

Exhibit 311, Younger Affidavit #2, pp. 7-8, paras 66-74 **[CBE, Tab 61]**.
[331] **Exhibit 2C**, Tab 14, p. 22 **[CBE, Tab 3]**.

691. And finally, the SWT Website does not provide any information about how much OR time a given surgeon will have going forward or how long the patients currently on that surgeon's list can expect to wait.

692. As Dr. Hamilton testified, since the inception of the SPR over 10 years ago, it has been envisioned that all of the data in the SPR should be available to all physicians and hospital administrators within the public health care system, so that all participants can see real time valid and useful information.[332] However, this has not yet occurred, and it will clearly be many more years before this is achieved, assuming funding is ever approved.[333]

693. The specialist wait time information available to GPs is thus based on information they obtain from specialist's offices, who often tell them what their wait time is,[334] and from the experiences of their own patients.

694. In summary, GPs do not have access to the wait time or other data they would need in order to be able to determine which specialists in their region with the expertise they seek have the shortest wait times or if one specialist has a shorter wait time than another.

695. And, if they did have access to this data, it would show that virtually all surgical specialists in BC have similarly long wait times for diagnosis and surgical treatment as a result of limited public facilities, and thus there are no realistic options for General Practitioners to obtain more timely treatment by specialists for their patients in the public health care system.

(ii) Surgeons who see patients in consultation who require surgery, and who have a long surgical wait time, should refer the patients to a different surgeon with a shorter wait time.

696. This proposition was addressed by several of the surgeons at trial. While the surgeons generally testified that they tell their patients they can look into this option, they made clear that this was not generally a realistic or feasible proposition to shorten patients' wait times.[335]

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[332] **Transcript Day 173,** Testimony of Dr. Hamilton , p. 24, l. 33 to, p. 26, l. 35; **Exhibit 17E**, "Synopsis of Surgical Services", p. 7271 **[CBE, Tab 12]**; **Exhibit 561 [CBE, Tab 149]**.
[333] **Exhibit 557 [CBE, Tab 146]**; **Transcript Day 174,** pp. 11-13.
[334] **Transcript Day 174,** p. 21, lines 5-21
[335] **Transcript Day 64,** Testimony of Dr. Murray Penner, dated February 9, 2017, p. 100, line 37 to, p. 102, line 12; **Exhibit 301,** Outerbridge Affidavit, p. 4, para 36 **[CBE, Tab 59]**.

697. First, as various specialists testified, it is not for them to second-guess the decision of the referring GP. And, even within subspecialties, surgeons have different areas of interest, specific expertise and experience. For example, as Dr. Nacht described, Dr. Wing, Dr. Penner and Dr. Younger all have different areas of expertise and focus of their surgical practices despite all being foot and ankle surgeons at St. Paul's.[336]

698. Second, specialists cannot themselves simply direct the referral to another specialist. The patient would need to go back to the GP and obtain a new referral for a different specialist, and then wait again for a new consultation, thus doubling the patient's Wait One time.[337]

699. Third, a surgeon cannot simply direct patients to another surgeon to perform the surgery. As explained by Dr. Regan, professional standards require that surgeons must see patients in consultation and obtain informed consent for the particular surgical procedure they are going to perform. A surgeon cannot perform surgery on a patient he has not previously met or assessed.[338]

700. Fourth, as Dr. Lauzon and other physicians testified, it would generally be pointless and inaccurate to tell patients that they could find a surgeon with a shorter wait time. The surgeons generally know from discussions with their colleagues and involvement in departmental meetings that no one else has a significantly shorter wait time.[339]

(iii) Surgeons are imposing harm on patients by exaggerating the length of their wait lists – they should tell patients their average wait time or their median wait time, rather than a longer wait time which is closer to their 90th percentile

701. The Defendant claims that specialist who also provide services on a private pay basis tend to exaggerate their wait times in order to induce their patients to see them privately.

702. As the evidence clearly demonstrates, there is no factual basis whatever for this assertion. To the contrary, the evidence makes clear that the physicians' own descriptions of their wait times are entirely borne out by the SPR data, in particular when one examines Wait Two from Decision Date,

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[336] **Transcript Day 57**, Testimony of Dr. Nacht, p. 6, line 11 to, p. 7, line 15; p. 10, lines 7-35.
[337] **Transcript Day 49,** Testimony of Dr. Regan, p. 18, line 20 to, p. 19, line 7.
[338] **Transcript Day 49,** p. 19, lines 9 to 20
[339] **Transcript, Day 37**, Testimony of Dr. Lauzon, November 16, 2016, p. 57, lines 10 to 39. See also, **Transcript Day 49**, p. 18, line 20 to, p. 19, line 7; **Transcript Day 64**, Testimony of Dr. Murray Penner, February 9, 2017, p. 100, line 37 to, p. 102, line 12; **Exhibit 318**, Costa Affidavit, p. 9, paras 60, 62-65 **[CBE, Tab 72]**.

which is the Wait Two measure being considered by surgeons when they are advising patients about their surgical wait lists and wait times.

703. The Defendant also suggested to some physicians that they should communicate their median wait times to patients, rather than giving them a range closer to the 90th percentile. Defendant's counsel suggested this would be "kinder" to patients as it would make them feel they would get their surgery more quickly.

704. The physicians disagreed strongly with this proposition. They testified that their wait time estimates to patients were based on the wait times for their most recent surgeries performed on patients in a similar priority level to the patient joining the surgical wait list. As the surgeons testified, it would not be appropriate (or ethical) to give patients false hope of an earlier surgery date, particularly when the surgeon could not be sure that his/her current OR time allocation would be maintained going forward, or what other more urgent patients would be referred for surgery who would further bump the less urgent patients back.[340]

705. The psychological harm regularly suffered by BC patients thus stems not from physicians providing inaccurate or exaggerated information about their wait times, but rather from the lack of OR time and other public system facilities which cause the long wait times. It is no answer for the Government to suggest that physicians should act contrary to their professional ethics by lying to patients or providing them with what the physician believes is inaccurate information, or by withholding from their patients information about how long they will likely have to wait for their surgery based on the physician's experience.

(iv) It is entirely up to surgeons to control their wait lists, and they could move any patient up the wait list to an earlier date if they were of the view that that patient was suffering harm by waiting

706. This is the Defendant's primary position and its most popular refrain in this case. That is, that "surgeons control their own wait lists" and can move any patient forward in terms of priority if they feel the patient may suffer harm by continuing to wait.

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340 **Transcript Day 26**, Testimony of Dr. Sahjpaul, p. 82, line 27 to, p. 83, line 23.

707. It would be wonderful if this were factually true and that physicians could avoid the harms currently being suffered by thousands of BC patients every year from waiting too long for medically necessary diagnosis and treatment simply by moving patients around on their list.

708. If this proposition were true, and all patients could be diagnosed quickly and treated within the maximum acceptable wait time for their condition, or even earlier if their condition worsened while waiting, the Plaintiffs would not be before the Court in this case.

709. However, as the Court heard from all the physicians who testified, including the few physicians who testified for the Defendant, and as the documentary and wait time evidence presented to the Court makes clear, this proposition is without any foundation.[341]

710. Specialists can and do triage and prioritize their patients both for consultation and for surgery based on the nature and severity of their condition when they receive a referral and/or when they see a patient in consultation, with the intended and usual result that the most urgent patients generally receive their diagnosis and/or treatment more quickly than patients whose condition appears to be less urgent or severe.

711. However, the fact is that many patients with the most urgent conditions, who are prioritized in the most urgent categories, do not receive their diagnosis or treatment within the maximum acceptable wait time.

712. And, each time a more urgent patient is given priority access to diagnostic or surgical facilities over other patients, all these other patients necessarily wait longer. As Dr. Matheson opined, and the cardiac studies he relies upon show, the longer any patient waits, the greater the risk that the patient will experience serious negative health consequences from waiting.[342]

713. It is only if <u>all</u> surgeons had available to them adequate OR time and other necessary resources within the public system to able to treat <u>all</u> patients within their maximum acceptable wait time for their condition, including accommodating new patients who require urgent treatment or waitlisted patients who suddenly deteriorate and need to be treated more quickly than anticipated, could it be

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[341] **Transcript Day 19**, Testimony of Dr. Smit, p. 14, lines 9 to 46; **Exhibit 318**, Costa Affidavit, p. 8, para 58 **[CBE, Tab 72]**.

[342] Discussed below in Cardiac and Vascular Surgery section (**Section VII(C)(xi)**).

said that harms to patients from waiting could potentially be avoided by appropriate prioritization or triaging of patients by physicians or hospital staff.

714. But that is not the case in the BC public health care system. It has not been the case for at least 30 years and based on the available evidence, it is extremely unlikely that it will ever be the case. The public system will never have sufficient resources to enable physicians to treat all patients within the maximum acceptable wait time for their condition.

715. As Dr. Matheson opined, this creates an ethical conflict for physicians as they know that, regardless of how they try to prioritize patients based on urgency, this necessarily means that some patients will suffer more as result of waiting longer.[343]

716. Nor is it realistically possible that surgeons can minimize the particularly negative impacts that might be suffered by some individual patients on their wait list as a result of their particular circumstances. First, as many of the surgeons testified, when the majority of patients have the same urgency levels based on their clinical conditions and symptoms, it is ethically very problematic and potentially impossible to differentiate between patients so as to prioritize one above another.[344] And every patient is suffering significant stress, anxiety, disability and potential or likely progression of disease while waiting.

717. For a patient to even have a chance at being "moved up the queue" on a surgeon's wait list, they must return to their GP or other referring practitioner and seek a second consultation with the surgeon for re-evaluation. Aside from necessitating further expenditure of public resources for the second consultation, this does not mean the patient will in fact be moved up the queue – only a significant change in their condition could justify moving them ahead of other patients who have already been waiting even longer than them.

718. This was illustrated in the situations of patient witnesses Peggy Eburne and Denise Tessier. Both were justifiably very upset about their waits for surgery due to the disability and anxiety they were suffering. Ms. Eburne was very concerned about the progression of her cataracts and other ocular conditions, while she waited for her cataract surgery. Ms. Tessier was suffering extreme pain

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[343] **Exhibit 274,** Expert Report of Dr. Matheson, p. 10 **[CBE, Tab 53]**; **Transcript, Day 90**, p. 22, line 18 to, p. 23, line 8.

[344] See, for example, **Transcript Day 19**, Testimony of Dr. Smit, p. 14, lines 9 to 46; **Exhibit 318**, Costa Affidavit, p. 8, para 58 **[CBE, Tab 72]**.

and substantial functional impairment of her mobility and daily life. Both felt that they should have their surgery much more quickly than was possible based on public system facility constraints.

719. Their respective treating physicians, Dr. Parkinson and Dr. Costa, both testified that they sympathized with these patients' situations, but could not justify expediting these patients' surgery ahead of others on their wait list as all patients were in a similar situation.

720. The BC Government's recent adoption of the First In, First Out policy also reflects that it is not ethically or reasonably possible for physicians to try to differentiate between patients within the same urgency category in terms of the timing of their surgery.

721. Finally, as noted by Dr. Masri, when patients have an inherently progressive condition, such as osteoarthritis necessitating a hip or knee replacement, it is to be expected that many patients will deteriorate while waiting, particularly, if they are being displaced by new patients coming into the wait list with a more urgent clinical presentation.[345] By the time the "less urgent" patients (as categorized at their consultation) reach their turn for surgery, their condition has progressed such that they are now more urgent.[346]

722. For all of these reasons, it is clear that the harms suffered by the Patient Plaintiffs and patient witnesses in this case, and thousands of British Columbians on an ongoing basis, as a result of waiting for diagnosis and treatment, are <u>not</u> due to physicians failing to properly prioritize patients or "move up" patients who might suffer harm by continuing to wait.

(v) <u>In many cases, surgery is not the best treatment option for the condition at the time or at all.</u>

723. The Defendant seems, by this assertion, to be suggesting that BC surgeons (or at least those who also perform surgeries in private clinics on a private pay basis) regularly book patients for surgery who do not in fact require surgery.

724. It is not clear if the Defendant claims that as a result of this practice, surgical wait lists for some or all surgical specialists in BC are artificially long because they include patients who do not actually need the surgery, or if the Defendant claims that some physicians are doing this to exaggerate their wait lists so as to induce patients to see them on a private pay basis, or both.

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[345] **Transcript, Day 87,** Evidence of Dr. Masri, p. 55, line 34 to, p. 56, line 17, p. 121, line 40 to, p. 124, line 3.
[346] **Transcript, Day 87,** Evidence of Dr. Masri, p. 55, line 34 to, p. 56, line 17, p. 121, line 40 to, p. 124, line 3.

725. There is no evidence to support either of these propositions or that this is happening at all. Indeed, the evidence is wholly to the contrary.

726. First, there is no evidence that BC surgeons are placing patients on their surgical wait lists who do not require surgery, much less that they are doing so in order to exaggerate their wait lists.

727. None of the Defendant's witnesses adduced any evidence of this practice nor was it supported in the evidence of any of the many physician witnesses who testified for the Plaintiffs, many of whom held administrative or medical management positions such that they would have been aware of this practice had it been occurring.

728. Ms. Copes testified that the issue of appropriateness being reviewed by the Ministry had to do with "reducing unnecessary pre-operative testing and reducing the use of opioid analgesics beyond the immediate post-operative period."[347] There was no suggestion by any of the Defendant's witnesses, nor is there any other suggestion in the evidence, that there were large numbers of unnecessary surgeries being carried out.

729. Nor, in particular, was there any evidence that surgeons who work at Cambie or other private clinics were booking patients for surgery in the public system who did not require surgery in order to exaggerate their wait lists so as to induce patients to see them privately.

730. The only reference in the evidence of any potential issue with the appropriateness of surgical treatment in BC was with respect to a review of rates of surgery for meniscal tears in patients with advanced knee osteoarthritis. Dr. Masri testified about this review, and noted that surgery for meniscal tears in these patients was now viewed as contraindicated as likely providing little benefit, and surgeons who appeared to have high rates of this surgery were being reviewed to ensure that they were referring patients for surgery appropriately.[348] However, as Dr. Masri testified, the concerns appeared to be limited to one or two physicians and had been addressed, and there was no evidence that this was occurring on a widespread basis.[349]

731. However, as Dr. Masri and other physicians also testified, the lack of public system funding for medically necessary treatments, such as physiotherapy, which might postpone or avoid entirely the need for surgery for some patients, means that many of these patients cannot afford the non-surgical

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[347] **Transcript Day 166**, p. 67, lines 19-36.
[348] **Transcript Day 87**, Testimony of Dr. Masri, p. 112, line 7 to, p. 113, line 5.
[349] **Transcript Day 87**, Testimony of Dr. Masri, p. 111, lines 24 to 36.

treatment option.[350] As a result, they may not be able to derive as much or any benefit from the non-surgical treatment option, and thus may require surgery when otherwise this may not have been required.

(vi) Conclusion

732. It is clear from the SPR data that the specialist physicians cannot be blamed for the lengthy delays experienced by patients in obtaining diagnostic and surgical services in British Columbia. Rather, the reason for these delays, and the resulting harms to patients, is the limitation on physicians' access to public system resources and facilities, in particular OR rooms and procedure rooms, to treat patients.

733. Nor is there any evidence that physicians have been uncooperative with the initiatives undertaken by the Ministry of Health and the Health Authorities to try to make the public system more efficient. To the contrary, as the review of the physician evidence will show, physicians have often been at the forefront of these initiatives, and have had to fight for them in the face of administrative reluctance or blockage due to funding constraints.

734. There is thus no support whatsoever in the evidence for the Defendant's assertions that physicians are at fault for the harms suffered by BC patients due to waiting too long for medically necessary diagnosis and treatment in the public health care system.

C. Harms by Specialty

(i) Endoscopic Sinus Surgery

d) Introduction

735. We had evidence in this case from two patients with serious sinus conditions, Ms. Michelle Graham and Patient Intervenor Ms. Mariel Schooff, and from their doctor, Dr. Amin Javer.

736. Both Ms. Graham and Ms. Schooff had been suffering greatly for a long time from their sinus disease. Not only did they experience significant pain and discomfort, but their sinus conditions greatly harmed their quality of life.

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[350] **Transcript Day 87**, Testimony of Dr. Masri, p. 110 line 33 to, p. 112, line 11.

737. To alleviate their suffering and improve their quality of life, they chose to obtain private surgery from Dr. Javer at the False Creek Surgical Centre.

738. Dr. Javer's waiting list for surgeries in the public system is and has always been very long, because he has been given insufficient operating time in the public system to meet the need for endoscopic sinus surgery.

739. At the time of Ms. Schooff's surgery, Dr. Javer was the only surgeon in BC who could perform endoscopic sinus surgery. At the time of Ms. Graham's surgery there was only one other surgeon who performed this type of surgery.

740. Computer-assisted endoscopic sinus surgery significantly increases the chances of a successful result compared to other types of sinus surgery. As a result, there was and is a great demand from patients with serious sinus maladies to see Dr. Javer for this surgery.

741. Ms. Graham and Ms. Schooff were not wealthy people who could easily afford the cost of a private surgery. And, they were prohibited by the *MPA* from obtaining personal insurance or using employer-provided disability insurance to cover the costs of the surgery.

742. However, they made the decision to incur this cost personally, in order to alleviate their suffering and restore their health and quality of life. The private surgeries they obtained from Dr. Javer and False Creek were wholly successful.

743. The only reason this was possible was because the Government was not enforcing the provisions in the *MPA* prohibiting dual practice. This permitted False Creek to purchase endoscopic surgical equipment, and permitted Dr. Javer to perform surgeries on a private pay basis at False Creek, in addition to using all of his allotted OR time in the public system.

744. Allowing Ms. Graham and Ms. Schooff to alleviate their suffering in this way, and allowing Dr. Javer and False Creek to assist them in doing so, did not increase the wait times of the individuals waiting for endoscopic sinus surgery in the public system.

745. It simply allowed Ms. Graham, Ms. Schooff, and the many others that Dr. Javer has treated privately, to obtain the treatment they need to alleviate their suffering in timely way, while also taking them off the public wait list.

746. As will be discussed below, there are still many patients waiting far too long for sinus surgery in British Columbia. While there are now two more doctors who are performing endoscopic sinus surgery, the wait times for these surgeries far exceed the maximum acceptable wait times for this condition and, indeed, are excessively long by any standard.

747. Thus, there is still a need for sinus surgery patients in BC to be able to alleviate their suffering and protect their health by obtaining sinus surgery privately.

i. Evidence of Dr. Javer

748. Dr. Amin Javer treats patients with complex and advanced chronic sinus disease, as well as tumours. He works primarily at St. Paul's Hospital ("SPH") and also at False Creek Surgical Center ("False Creek").

749. In his affidavit, Dr. Javer described the typical medical condition of his patients as follows:[351]

> 83. Most of the patients I see, particularly with chronic rhinosinusitis, are in significant pain. They also suffer from fatigue, lack of energy, headaches, facial pressure and pain, and post-nasal discharge. Most already have substantially curtailed movement and life activities. Many, if not all, have attempted other forms of treatment without success, including in many cases surgeries which have failed. That is the reason they have been referred to me by their GP or other specialists.
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> ...
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> 86. By the time I see these patients for a surgical consultation, typically their condition has further advanced. These patients are often very disabled by their pain.

750. He testified that:

> ... But most patients are unwell and sick do not want to wait six months or a year or a year and a half or two years or three years. If you were sick and you couldn't function for six months that would be a big deal to anyone ...[352]

751. Endoscopic surgery is "a significant advancement on other sinus surgery".[353]

752. Dr. Javer introduced this surgery in the province in 2001, when he assisted in raising $500,000 from private donors to purchase endoscopic surgical equipment for SPH.[354]

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[351] **Exhibit 299**, Javer Affidavit, p. 10, para 83, p. 11, para 86 **[CBE, Tab 58]**.
[352] **Transcript Day 105,** Testimony of Dr. Javer, July 3, 2018, p. 44, lines 46-47, and p. 50, lines 1-5.
[353] **Exhibit 299**, p. 6, para. 45-46 **[CBE, Tab 58]**.
[354] **Exhibit 299**, p 7, paras 49-50, pp. 7-8, paras 56-59 **[CBE, Tab 58]**.

753. From 2000 to 2002, Dr. Javer had one day per month of operating time at SPH. This meant that he was only able to perform 24 surgeries per year in the public system, as each surgery takes two to three hours. He feared he would be unable to maintain his surgical skills and considered returning to the US to practice.[355]

754. At that time, he was the only surgeon in Vancouver trained to perform endoscopic sinus surgeries. By 2001, Dr. Javer had over 2000 patients waiting for surgery, and by 2005, his wait time for surgery was up to several years.[356]

755. As he did not want to leave Canada, he "decided to improve access to care at SPH", and arranged financing for the necessary equipment for endoscopy surgery, through private donations. Further efforts by Dr. Javer resulted in SPH obtaining additional equipment by donation in 2009, and again in 2013/14.[357]

756. Dr. Javer's operating time was increased for brief periods in 2008 and 2013 to two ORs per week. But this was still inadequate to allow him to reduce his wait list in any meaningful fashion. For this, he would need at least three OR days per week. [358]

757. At the time he swore his affidavit in February 2018, Dr. Javer had been informed that, starting in April 2018, he would be allocated an additional two OR days per month at Mount St. Joseph Hospital, which would give him a total of 1.5 days per week at SPH and MSJ. However, by the time he testified on July 3, 2018, the MSJ time had been reduced to about one day per month and he had been told it may not be stable going forward.[359]

758. Dr. Javer trained many doctors at the SPH Sinus Surgery Centre, but was unable to retain them in British Columbia, due to the lack of OR time to allocate to them. Finally, in 2017, another surgeon trained in endoscopic sinus surgery obtained hospital privileges at SPH, Dr. Andrew Thamboo[360]. Another surgeon trained by Dr. Javer has been unable to find a position in Canada due to lack of OR time.

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[355] **Exhibit 299**, p 7, paras 49- 54, p. 8, paras 60-61 **[CBE, Tab 58]**.
[356] **Exhibit 299,** p. 6, para 51, p. 8, para 60 **[CBE, Tab 58]**.
[357] **Exhibit 299**, p.7, paras 55-58, p. 8, 63-64 **[CBE, Tab 58]**.
[358] **Exhibit 299**, p. 8, para. 61-62 **[CBE, Tab 58]**.
[359] **Exhibit 299**, p. 8, para 68 **[CBE, Tab 58]**; **Transcript Day 105**, p. 20, lines. 1-5.
[360] **Exhibit 299**, para. 78 **[CBE, Tab 58]**.

759. Dr. Javer's wait list for surgeries became so long that in 2013 SPH told him that he could not accept any new sinus referrals other than those that are life threatening or tertiary in nature. The tertiary referrals are "from other sinus surgeons for cases that they are unable to treat themselves or where treatment has been unsuccessful." These restrictions on his practice continue. [361]

760. Even with his restricted practice, the wait times for surgery with him remain very long, because there is not sufficient operating time in the public system to meet the health care needs of sinus patients.

761. When Dr. Javer performed Ms. Graham's surgery in 2013, SPR data shows that his 50th percentile Wait 2 time (for all priority levels) from Decision Date was 107.6 weeks, and his 90th percentile Wait 2 time was 198 weeks.[362]

762. Due to his inability to obtain sufficient OR time in the public health care system to treat his patients in a timely fashion, and to utilize all of his available time, Dr. Javer began performing endoscopic sinus surgeries at False Creek Surgical Centre in 2000.[363]

763. To facilitate this, False Creek purchased a full set of endoscopic equipment, which it has maintained and replaced since that time.[364]

764. Since that time, Dr. Javer has informed his surgical patients of the wait time at SPH, as well as the option to have surgery performed privately. He believes it would be unethical not to tell his patients of the private option.[365]

765. Almost 50% of Dr. Javer's patients elect to have surgery privately at False Creek. About ten patients per week see him privately for consultation at False Creek, and several more choose to have private surgery at False Creek after learning of the public wait time.[366]

766. In the early 2000s, Dr. Javer billed MSP for the surgeries he performed privately at False Creek. The payment he received was the same as if he performed the surgery in SPH. This changed after Ms. Schooff complained about being charged for her surgery at False Creek, and thereafter Dr. Javer has been paid through False Creek for the private surgeries he performs there. He charges the Doctors

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[361] **Exhibit 299**, para. 101-102; 105 **[CBE, Tab 58]**.
[362] **Transcript Day 105**, p. 45, lines 21-26; **Exhibit 298**, p. 9 **[CBE, Tab 54]**.
[363] **Exhibit 299**, p. 13, para. 107 **[CBE, Tab 58]**.
[364] **Exhibit 299**, p. 13-14; para 107-110 , para. 107 **[CBE, Tab 58]**.
[365] **Exhibit 299**, p. 13-14, para. 107-114 **[CBE, Tab 58]**.
[366] **Exhibit 299**, p. 16, para. 131-132 **[CBE, Tab 58]**.

of BC recommended rate for private surgery, which is the same as he charges a non-MSP beneficiary who has surgery at SPH.[367]

767. From 2005/2006 until recently, VCHA has contracted out endoscopic sinus surgeries to False Creek. Dr. Javer provided surgeries under these contracts, and billed MSP.

768. The public patients are given priority over private patients at False Creek. However, due to College of Physicians restrictions, Dr. Javer cannot operate on patients classified as ASA 3 or higher at False Creek, and more than 50% of his patients are ASA 3 or higher. In addition, the VCHA contract with False Creek only allowed him to operate on public patients who had waited more than a year on his public surgical wait list. Nonetheless, this contract allowed him to significantly reduce his public wait list down to about 18 months in 2016-2017.[368]

769. However, he exhausted his wait list for ASA 1 and 2 patients who had waited more than one year, and had to wait for additional patients to reach the one year mark to treat them. As a result, he was only doing "one day of public outsourced patients every two weeks or so at False Creek", and his "surgical wait lists at SPH is approximately two years."[369]

770. False Creek's contract with VCHA to perform endoscopic sinus surgeries (as well as its contracts for other surgical services) was cancelled in August 2018, at the direction of the Ministry of Health.[370]

771. Dr. Javer's Wait Two list as of February 2018, was about 200 patients on the "hospital surgical wait list" (a booking card had been sent in) and about 194 patients on the "pre-surgical wait list" in his office. This "pre-surgical wait list" has been maintained by his office since 2016 to minimize the number of people on the hospital's surgical waitlist who are waiting over 52 weeks, so as to reduce negative repercussions for the hospital, Health Authority and patients of having official Wait Two of longer than 52 weeks. However, due to the size of the wait list, and emergent and urgent cases pushing back previously scheduled cases, patients often end up waiting 18 months on the hospital surgical wait list.[371]

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[367] **Exhibit 299,** p. 14-15, para. 116-119 **[CBE, Tab 58].**
[368] **Exhibit 299,** p. 15, para. 121-127, p. 150 **[CBE, Tab 58].**
[369] **Exhibit 299,** p. 16, para. 128-130; para, 149 **[CBE, Tab 58].**
[370] **Exhibit 400,** Affidavit #1 of Ian Tait, p. 4 **[CBE, Tab 94].**
[371] **Exhibit 299,** p. 19, paras 152-154 **[CBE, Tab 58].**

772. At all times, both Dr. Javer's wait time for endoscopic sinus surgery, and the wait time for sinus surgeries generally in BC, has far exceeded the maximum acceptable wait times for the applicable conditions for the majority of patients in BC.

773. This is made clear from Dr. Javer's surgical wait times from 2014 to 2016 for endoscopic sinus surgery for all priorities (**Appendix, Part A, Section VII(C)(i), Table 1**).[372]

774. The significant gap starting in 2016 between Dr. Javer's BFRD and DD wait times in Table 1 confirms his evidence of his office's "pre-surgical wait list", to minimize the number of people on the hospital's surgical waitlist who were waiting over 52 weeks.[373]

775. Even for Dr. Javer's patients with more urgent priorities (Priorities 1 to 3), his wait times from 2014 to 2016 for endoscopic sinus surgery were much longer than the maximum acceptable wait times, even when measured from the BFRD.[374]

776. In 2016, for instance, the 90th percentile wait time for his Priority 1 patients was 43 weeks from BFRD, which is 21 times longer than the two week maximum acceptable wait time.[375] For his Priority 2 patients the 90th percentile wait time was 50 weeks from BFRD, which is 12 times longer than the maximum wait time of four weeks.[376] And, for his Priority 3 patients the 90th percentile wait time was 51.7 weeks from BFRD, which is eight times the maximum wait time of six weeks.[377]

777. The Government's SPR data regarding the wait times for sinus surgeries generally in the province, also shows that a significant number of patients are waiting well beyond the maximum acceptable wait times for a variety of sinus-related conditions.

778. In 2017, patients in the most urgent priority (Priority 1) with a diagnosis of "Sinusitis Acute – Complicated" were waiting well beyond the established two week maximum acceptable wait time. The 50th percentile for these patients was 22.3 weeks from BFRD, and 32.8 weeks from Decision Date.[378]

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[372] **Exhibit 320B**, Tab 14, p. 4 **[CBE, Tab 74(B)]**.; **Appendix,** Part A, Section VII(C)(i), Table 1.
[373] **Appendix**, Part A, Section VII(C)(i), Table 1.
[374] **Exhibit 299**, Exhibit "D", p. 47 **[CBE, Tab 58]**; **Appendix,** Part A, Section VII(C)(i), Table 1.
[375] **Exhibit 299**, Exhibit "D", p. 47 **[CBE, Tab 58]**.
[376] **Exhibit 299**, Exhibit "D", p. 47 **[CBE, Tab 58]**.
[377] **Exhibit 299**, Exhibit "D", p. 47 **[CBE, Tab 58]**.
[378] **Exhibit 316C**, Tab 5, p. 126 **[CBE, Tab 69(A)]**.

The 90th percentile wait time was 50.2 weeks from BFRD, and 64.2 weeks from Decision Date. [379] Only 5% of patients received their surgeries in the maximum wait time of two weeks.[380]

779. In 2018 (as of March 31, 2018), the 50th percentile wait time for Priority 1 patients was 40.1 weeks from BFRD, and 45.4 weeks from DD.[381] The 90th percentile wait time was 54.4 weeks from BFRD, and 63.3 weeks from Decision Date.[382] Only 16.7% of patients in this group received their surgeries in the maximum wait time of two weeks.[383]

780. This is clearly not a case of a few patients waiting a few days beyond the maximum acceptable wait time. Rather, many patients in the most urgent priority are waiting 20 to 30 times longer than the clinically established maximum acceptable wait time.

781. The same issues apply with patients diagnosed with Priority 4 sinus disease. The SPR shows two Priority 4 diagnoses for sinus surgeries ("Chronic Sinusitis Polyposis" and "Benign Neoplasm Sinus"). Both groups of patients waited well past the maximum acceptable wait time of 12 weeks in 2017 and 2018 (as of March 31, 2018).

782. In 2017, the 50th percentile wait time for patients with "Chronic Sinusitis Polyposis" was 14.7 weeks from BFRD, and 20 weeks from Decision Date.[384] The 90th percentile wait time was 39.2 weeks from BFRD, and 46.4 weeks from Decision Date.[385] Only 42.9% of these patients were treated within the maximum acceptable wait time of 12 weeks.[386]

783. As of March 31, 2018, the 50th percentile wait time for patients in this category was 13.3 weeks from BFRD, and 17.6 weeks from DD. The 90th percentile wait time was 39.3 weeks from BFRD, and 46 weeks from DD.[387] Only 46.1% of these patients were treated within the maximum acceptable wait time of 12 weeks.[388]

784. Clearly, the public system is not meeting the health care needs of many patients with sinus disease. The experiences of Michelle Graham and Mariel Schooff are illustrative of the experiences of

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[379] **Exhibit 316C**, Tab 5, p. 126 **[CBE, Tab 69(A)]**.
[380] **Exhibit 315C**, Tab 9, p. 24 **[CBE, Tab 66(A)]**.
[381] **Exhibit 316C**, Tab 6, p. 87 **[CBE, Tab 69(B)]**.
[382] **Exhibit 316C**, Tab 6, p. 87 **[CBE, Tab 69(B)]**.
[383] **Exhibit 315C**, Tab 9, p. 24 **[CBE, Tab 66(A)]**.
[384] **Exhibit 316C**, Tab 5, p. 126 **[CBE, Tab 69(A)]**.
[385] **Exhibit 316C**, Tab 5, p. 126 **[CBE, Tab 69(A)]**.
[386] **Exhibit 315C**, Tab 9, p. 24**[CBE, Tab 66(A)]**.
[387] **Exhibit 316C**, Tab 6, p. 87 **[CBE, Tab 69(B)]**.
[388] **Exhibit 315C**, Tab 9, p. 24 **[CBE, Tab 66(A)]**.

patients needing endoscopic sinus surgery in BC, and the harm they suffer from waiting, and clearly demonstrate the need for a private option in order for patients to be able to alleviate these harms for themselves.

ii. Michelle Graham's experience

785. At the time of her affidavit (February 15, 2018), Ms. Graham was a 47-year old lawyer in Gibsons, British Columbia. She had previously lived in Ontario. Ms. Graham was not cross-examined on her Affidavit.

786. **Redacted due to evidence subject to a sealing order.**

787. **Redacted due to evidence subject to a sealing order.**

788. Ms. Graham paid for an expedited private consultation with Dr. Javer at False Creek. Even assuming that Ms. Graham could have been referred to Dr. Javer in the public system (given the limitations that had been imposed on his ability to accept referrals), there was a six month wait time to see Dr. Javer for a consultation in the public system.[391]

789. Dr. Javer recommended endoscopic sinus surgery for Ms. Graham.[392] At the time, his wait list in the public system was three to four years.[393]

790. **Redacted due to evidence subject to a sealing order.**

791. Dr. Javer performed her surgery privately at False Creek in October 2013.[395]

792. **Redacted due to evidence subject to a sealing order.**

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[389] **Redacted due to evidence subject to a sealing order.**
[390] **Redacted due to evidence subject to a sealing order.**
[391] **Transcript Day 105**, Testimony of Dr. Javer, p. 37, lines 28 to 36.
[392] **Exhibit 299,** p. 12, paras 172-173 **[CBE, Tab 58]**.
[393] **Exhibit 299,** p. 12, para 100, paras 172-173 **[CBE, Tab 58]**.
[394] **Redacted due to evidence subject to a sealing order.**
[395] **Exhibit 299,** p. 22, para 175 **[CBE, Tab 58]**.

793. **Redacted due to evidence subject to a sealing order.**

794. Dr. Javer testified that Ms. Graham would have had to wait for more than 2 years for a surgery in the public system. [398]

795. Ms. Graham was suffering greatly. If the prohibition on dual practice had been enforced, her suffering would have continued for many more months, and perhaps years.

iii. Mariel Schooff's experience

796. Ms. Schooff also had been suffering greatly for a long period of time before she obtained surgery privately from Dr. Javer in January 2003. [399]

797. Ms. Schooff was referred by her family physician to Dr. Miller, an ear, nose and throat specialist.[400] Dr. Miller told her that he no longer performed sinus surgery because of the danger associated with the procedure, including the risk of brain damage. Dr. Miller suggested that she see Dr. Javer.

798. Dr. Javer testified that when he saw Ms. Schooff for a consultation in 2003, she had typical symptoms of sinus disease and was suffering significantly from these symptoms. He testified that he advised her of the wait time and gave her the same option he gave all patients of waiting for surgery in the public system or seeing him privately. She chose to see him privately and he was able to do her surgery quickly at False Creek. [401]

799. In her direct evidence at trial, Ms. Schooff asserted for the first time that Dr. Javer told her that his wait time was "five years", as opposed to "up to five years" as stated in her Affidavit sworn in 2014.[402] Dr. Javer's evidence on this point was that he generally provided a range.[403] In any event,

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[396] **Redacted due to evidence subject to a sealing order.**
[397] **Redacted due to evidence subject to a sealing order.**
[398] **Exhibit 299**, p. 22, para 177 **[CBE, Tab 58]**.
[399] **Exhibit 478**, Schooff Affidavit, sworn June 23, 2014, p. 2, para 6 **[CBE, Tab 127]**.
[400] **Exhibit 478**, p. 2, para 7 **[CBE, Tab 127]**.
[401] **Exhibit 299,** Javer Affidavit, paras 161-165 **[CBE, Tab 58]**.
[402] See **Exhibit 478**, p. 3, para 11 **[CBE, Tab 127]**; **Transcript Day 157**, Testimony of Ms. Schooff, p. 5, lines 23-35.
[403] **Transcript Day 105**, Testimony of Dr. Javer, p. 76, lines 11-20.

the evidence is clear that Dr. Javer's wait time was several years at the time he saw Ms. Schooff in consultation, and that regardless of whether the wait had been two years or five years, it was too long for Ms. Schooff to wait.

800. Ms. Schooff was clear that she simply could not wait for surgery in the public system, because "she was in too much pain".[404]

801. Counsel for the Patient Intervenors sought to imply that Dr. Javer used public resources to facilitate Ms. Schooff's private surgery, and further that he could have simply moved her up his public surgical wait list based on her condition. Dr. Javer made clear that neither of these assertions was valid – the CT scan was required regardless of where Ms. Schooff had her surgery, and it did not reveal any complication that would have justified moving her up the wait list ahead of his other patients.[405]

802. Ms. Schooff testified that her surgery was a complete success. She had immediate relief of her symptoms and pain, and was able to breathe properly for the first time in years. It allowed her to get back to living her life as she wished, to return to work, to look after her children properly, and to significantly reduce her use of painkillers.[406]

803. Ms. Schooff chose to have her surgery privately, and while she was not happy about having to pay, and later sought (through the BCNU) to get her money back from the Government or from False Creek, she was deeply grateful that she was able to have private surgery.

804. If the prohibition on dual practice had been enforced, or if Dr. Javer and False Creek had not been prepared to breach the *MPA* in order to treat Ms. Schooff and others like her privately, Ms. Schooff would have been suffering for many more years.

(ii) Cancer Diagnosis And Surgery

a) The Harms of Waiting for Cancer Diagnosis and Surgery

805. There can be no dispute that waiting for cancer diagnosis and surgery can result in significant, and potentially irreversible, harms to a patient's health and life.

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[404] **Transcript Day 157**, Testimony of Ms. Schooff, p. 27, lines 33-43.
[405] **Transcript Day 105**, Testimony of Dr. Javer, p. 66, line 36 to, p. 67, line 47.
[406] **Transcript Day 157,** Testimony of Ms. Schooff, p. 8, lines 6-9.

806. This is because cancer is a progressive disease. And so waiting for cancer diagnosis, treatment and surgery, can result in worsening or spreading of the disease, which in turn may decrease a patient's chances of survival.[407]

807. The expert and lay evidence in this case clearly establishes that waiting for cancer diagnosis and/or surgery causes significant psychological stress and anxiety, and can result in deterioration and/or advancement of the disease such that the patient suffers adverse health consequences including a decreased chance of cure, and thus survival and/or degree of recovery.

808. Defendant expert, Dr. Guyatt, stated in his expert report that "[w]aiting for some medical and surgical procedures can cause irreparable morbidity and sometimes mortality, and for certain conditions a patient's health status is likely to deteriorate during prolonged waits."[408] In his testimony, he agreed that this was true of certain types of cancers.[409]

809. Dr. Guyatt also opined that "[if] the natural history of the condition is progression, sufficiently long waits will result in deterioration."[410] This is true of many types of cancer.

810. Further, Defendant expert Dr. Eric Bohm, who was on the taskforce on establishing national evidence-based maximum acceptable benchmarks for hip/knee replacements testified that "generally speaking waiting longer than [the] benchmark is not a good thing and that's why there's a benchmark, because presumably there's some evidence around the benchmark to say waiting longer than this may have some negative health or other effects."[411]

811. Dr. Bohm agreed that in the case of certain types of cancer with a risk of progression, delaying diagnosis and treatment could result in in serious health consequences for the patient.[412]

812. Dr. Bohm further testified that patients could die waiting for surgery for conditions that are serious and pose a risk of mortality. As he stated, "[...] if you're having surgery to change your mortality risk, then yes you could die while waiting for that surgery."[413]

813. With respect to bladder cancer, Plaintiff expert Dr. Matheson, opined that:

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[407] **Exhibit 274**, Tab 11, p. 155.
[408] **Exhibit 577A**, p. 4 **[CBE, Tab 154]**.
[409] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 10, line 28 to p. 11, line 5.
[410] **Exhibit 577A**, p. 14 **[CBE, Tab 154]**.
[411] **Transcript Day 153**, Testimony of Dr. Bohm, p. 27, lines 21-26.
[412] **Transcript Day 153**, Testimony of Dr. Bohm, p. 26, lines 19-22.
[413] **Transcript Day 153**, Testimony of Dr. Bohm, p. 34, lines 17-19.

> Patients waiting longer for radical cystectomy for bladder cancer have a lower survival rate and this is particularly true for patients with minimally invasive, potentially curable disease [11].[414]

814. In support, Dr. Matheson refers to the study by Kulkarni et al., entitled "Longer Wait Times Increase Overall Mortality in Patients With Bladder Cancer", which states as follows:

> We demonstrated that shorter wait times between TUR [transurethral resection] and cystectomy are significantly associated with improved overall survival in patients undergoing radical cystectomy for bladder cancer with the effect of waiting most pronounced for those with lower stage disease. Our data suggest that ideal maximum wait time for patients undergoing cystectomy is 40 days.[415]

815. Defendant expert witness Dr. Robert McMurtry, who was Chair of the Health Council of Canada's Wait Times Group funded by Health Canada, likewise testified that delaying treatment for cancer or heart disease can result in serious harm.[416] He testified that if left undiagnosed or untreated, there is a risk that "malignant cancers can spread, compromising control of the cancer and leading to higher rates of complications and mortality".[417]

816. The expert evidence is supported by the lay evidence of specialist general surgeon Dr. Lauzon.[418] Dr. Lauzon primarily practices at Peace Arch Hospital in White Rock,[419] and has privileges at Abbotsford Regional Hospital, Langley Memorial Hospital, Delta Hospital and Jim Pattison Surgical Outpatient Clinic.[420]

817. Dr. Lauzon was the head of the department of surgery at Peace Arch from 2009 to 2010. He was also the regional department head of surgery for FHA from August 2010 to October 2015.

818. Dr. Lauzon also works at Cambie and SRC performing surgeries for WCB patients and patients that obtain necessary diagnostic and surgical services privately. At Cambie, Dr. Lauzon performed a private colonoscopy for Patient Plaintiff, Ms. Martens.

819. Drawing on his extensive experience, Dr. Lauzon testified as follows about the need for timely cancer diagnosis and surgery:

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[414] **Exhibit 274**, p. 8 **[CBE, Tab 53]**.
[415] **Exhibit 274**, Tab 11 **[CBE, Tab 53]**.
[416] **Transcript Day 159**, Testimony of Dr. Robert McMurtry, May 29, 2019, p. 45 lines 44-47.
[417] **Transcript Day 159**, Testimony of Dr. McMurtry, p. 46 lines 1-9.
[418] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 5, lines 26-32, and p. 42, lines 12-13.
[419] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 1, lines 36-39
[420] **Transcript Day 37**, p. 4, lines 19-31.

(i) "with any cancer the goal is to remove the primary cancer as soon as possible to hopefully prevent it from spreading elsewhere, which can be very detrimental to the patient, so time is of the essence";[421]

(ii) "[a]ny time a cancer is diagnosed, the sooner we can treat it the better, because you never know at which point in time the tumour will go from a stage 1 to 2, or 3 or 4";[422]

(iii) "every tumour is different. Some very big tumors I've operated on have no spread to the lymph nodes; some small tumours I've operated on have multiple lesions in the liver. There's no way to predict.";[423] and

(iv) "[b]ut the urgent cases, if they're delayed too long as well there's a significant chance of the patient deteriorating. If it's cancer there's a chance of it spreading".[424]

820. When Government undertakes to provide cancer diagnosis and surgery to its residents, it is crucial that these services are made available within the established maximum acceptable wait times, because cancer is a life-threatening disease, and there are serious consequences to the patients in delayed treatment.

821. This was confirmed by Defendant witness Dr. Hamilton who testified that British Columbia's cancer strategy must require that "patients receive their treatment within the appropriate time frame" established for their particular cancer, and that it doesn't matter how many patients require cancer surgery, every patients who "comes through the door" needs to be treated within this time frame. As he stated, "cancer is cancer". [425]

822. As emphasized by Dr. Bohm, Dr. McMurtry, Dr. Lauzon, and Dr. Hamilton, "time is of the essence" for cancer diagnosis and surgery, due to the risk of cancer spread and patient death.

823. In the UK and New Zealand, the public system guarantees that cancer patients will receive their specialist consultations and surgeries within expedited time frames.[426]

824. In the UK, for instance, the NHS guarantees that patients with suspected cancer will be able to see a specialist in 2 weeks.[427] And, in the UK and New Zealand, as well as in the other OECD

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[421] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 49, lines 6-10.
[422] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 11, lines 6-10.
[423] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 11, lines 11-15.
[424] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 67, lines 23-39.
[425] **Transcript Day 174**, Testimony of Dr. Hamilton, July 11, 2019, p. 55, line 36 to, p. 46, line 5.
[426] **Transcript Day 162**, Testimony of Professor Cumming, p. 23, lines 12 to 30.
[427] **Exhibit 274**, Tab 8, p. 122 **[CBE, Tab 53]**.

countries, patients with suspected cancer have the ability to obtain private diagnostic and surgical services, rather than waiting in the public system for such services.

825. This is based on the recognition that in the case of cancer patients, the maximum acceptable wait times for diagnostic and surgical procedures represent the outer limit of time that any patient should wait, beyond which time a patient is much more likely to suffer irreparable damage to their health and life.[428]

826. The irreparable harm from delayed colon cancer diagnosis and treatment has been acknowledged by Former Health Minister Terry Lake in the Legislative Assembly, who stated that "we know that early detection and treatment will raise survival rates significantly, and with early detection and treatment, survival rate is close to 90 percent."[429]

827. It is also vital to appreciate that the established "maximum acceptable wait times" for cancer surgeries only apply to the surgery itself, after the cancer has been diagnosed and staged. Delays in diagnosis may also cause irreparable harm, even before surgery is contemplated (as illustrated by Mandy Martens' case), and with any wait for surgery, there is potential that any given patient's cancer may progress, worsen and/or metastasize, leading to serious adverse health outcomes for such patients. This is not predictable from patient to patient, but rather is a risk associated with life-threatening diseases like cancer which applies to all patients, with any duration of waiting for cancer diagnosis and surgery.

828. Further, there is no doubt that cancer patients waiting for diagnosis of suspected cancer and for surgery, regardless of the length of wait, experience significant mental distress, anxiety and fear over their health, which is prolonged and exacerbated by the length of the wait time.

b) Wait Times in British Columbia for Cancer Surgeries

829. Despite the efforts of the Governments of Canada and British Columbia, wait times for cancer diagnosis and surgeries in the public system in BC have been continuously rising.[430]

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[428] **Exhibit 431**, pp. 613-615 **[CBE, Tab 102]**; **Exhibit 412**, Gentile Affidavit **[CBE, Tab 95]**; **Exhibit 12C**, p. 2111 **[CBE, Tab 9]**; **Exhibit 426**, Tab 19, pp. 4968-4969, statements made by the Honourable Terry Lake in the Legislative Assembly **[CBE, Tab 100]**.
[429] **Exhibit 426**, Tab 19, p. 4968 **[CBE, Tab 100]**.
[430] **Transcript Day 173**, Testimony of Dr. Hamilton, p. 72, line 10 to, p. 75, line 17; **Exhibit KKKKK2**, "Cancer Surgery Wait Times Summary, Time period: FY2011/12 Q1 to FY 2018/19 Q2", p. 3 **[CBE, Tab 161]**.

830. While national maximum acceptable wait times have not been established for cancer surgeries in Canada, CIHI reports on wait times across Canada for surgery for bladder cancer, breast cancer, colorectal cancer, lung cancer, and prostate cancer across the provinces.[431]

831. British Columbia has established provincial maximum acceptable wait times for all cancer surgeries. Despite this, patients are waiting beyond the maximum wait times for life-saving surgeries, even when Wait Two is measured from the BFRD rather than from the Decision Date, which is the date from which the maximum acceptable wait times have been established. This is also true of diagnostic procedures necessary for cancer diagnosis, including MRIs, CT scans and colonoscopies.[432]

832. Most cancer conditions in BC are categorized as Priorities 1 and 2 (two weeks and four weeks). There are some rectal and prostate cancers categorized as Priority 3 (six weeks).

833. The CIHI data shows that BC is not meeting its maximum acceptable wait times for any of the cancer surgeries it reports on.[433] BC is not completing 90% of surgery cases within six weeks for any of the colorectal or prostate cancer surgeries.[434] British Columbia is also not completing 90% of cases within two to four weeks for bladder cancer, breast cancer, or lung cancer.[435]

834. It should be noted that the CIHI definition for cancer surgery wait time is: "The number of days a patient waited, between the date when the patient and the appropriate physician agreed to a cancer surgery and the patient was ready to receive it, and the date the patient received a planned cancer surgery."[436] Again, BC reports to CIHI based on Wait Two from BFRD, not from the Decision Date, which makes BC's performance appear better than it is.

835. British Columbia's SPR data also confirms that a significant number of patients are not getting their cancer surgeries within the maximum acceptable wait times, and many are waiting weeks beyond the maximum acceptable wait times. Not only does this contribute to the psychological suffering of patients, but these delays are life-threatening.

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[431] **Exhibit 433E**, pp. 4531, 4534 **[CBE, Tab 107]**.
[432] MRIs and CT scans are discussed in more detail in **Section VII(C)(xiii)**, below.
[433] **Exhibit 433E**, pp. 4531, 4534 **[CBE, Tab 107]**.
[434] **Exhibit 433E**, pp. 4531, 4534 **[CBE, Tab 107]**.
[435] **Exhibit 433E**, pp. 4531, 4534 **[CBE, Tab 107]**.
[436] **Exhibit 433E**, p. 4488 **[CBE, Tab 107]**.

836. The Government's SPR data shows the number of surgical cases completed, the percentage of cases completed within the maximum wait times, and the 50th and 90th percentile wait times for various cancer diagnoses in 2017 and 2018 (to March 31, 2018).

837. Table 1 (**Appendix, Part A, Section VII(C)(ii)**) shows that in every diagnosis category, many patients are not receiving their surgeries within the maximum acceptable wait times, even when measured from BFRD.[437]

838. An example from Table 1 is patients diagnosed with the most urgent category of bladder cancer, with "high risk of cancer progression".[438] In 2017, 2071 surgeries were performed for patients in this category, of whom only 28.4% received their surgeries within the maximum acceptable wait time of 2 weeks. As a result, 71.6% of these patients experienced a higher risk of progression of their cancer, and at least some will have had a worse prognosis, reduced life quality, and lower life expectancy due to spread of bladder cancer as a result of the wait.

839. As of March 31, 2018, 520 patients in this category had received surgery in 2018, of whom only 29.2% received their surgeries within 2 weeks.[439] For these patients, the 50th percentile wait was 3.1 weeks from BFRD and 4.4 weeks from Decision Date,[440] and the 90th percentile wait was 10.6 weeks from BFRD and 16.2 weeks from Decision Date.[441] All of these patients suffered mental distress, poor quality of life and lowered chances of survival while waiting.

840. Another example is patients diagnosed with prostate cancer, with "high risk of cancer progression".[442] In 2017, 603 patients in this category received surgery. Of these, only 41% received their surgeries within the maximum acceptable wait time of 4 weeks. Therefore, 59% of these patients were exposed to a higher risk of cancer progression and irreparable harm to their health, while others experienced significant mental distress, lowered quality of life, and a risk of lowered life expectancy while waiting.

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[437] **Appendix**, Part A, Section VII(C)(ii), Table 1.
[438] **Appendix**, Part A, Section VII(C)(ii), Table 1.
[439] **Appendix**, Part A, Section VII(C)(ii), Table 1.
[440] **Exhibit 316C**, Tab 6, p. 98, diagnosis code: 39PMCD **[CBE, Tab 69(B)]**.
[441] **Exhibit 316C**, Tab 6, p. 98, diagnosis code: 39PMCD **[CBE, Tab 69(B)]**.
[442] **Appendix**, Part A, Section VII(C)(ii), Table 1.

841. In 2018, 149 patients in this category received surgery as of March 31, 2018.[443] Of these, only 37.6% received their surgeries within the maximum acceptable wait time of 4 weeks.[444] For these patients, the 50th percentile wait time was 5 weeks from BFRD, and 6.6 weeks from Decision Date,[445] and the 90th percentile wait time was 10.6 weeks from BFRD, and 11.9 weeks from Decision Date.[446] Again, all of these patients would have experienced prolonged mental distress, lowered quality of life and the likelihood of worse prognosis.

842. PSEC and the BC Cancer Agency (now called BC Cancer) have recently raised concerns over the rising wait times for cancer surgery in the province.[447]

843. Dr. Carl Brown of the BC Cancer Agency, who is the provincial physician lead on cancer surgery, presented "The Cancer Surgery Plan" to PSEC on September 21, 2018, due to concerns that a significant number of patients do not obtain their cancer surgeries within the established maximum wait times.[448] As set out in the presentation:

> Wait times for cancer surgery have been continuously rising since 2012 with over 40 percent of procedures being performed later than the target time (figure 1 and 2) while all specific cancers examined have a significant number of patients missing target time for surgery the variation does exist between cancers. These range from 25 percent of patients waiting longer than target time for breast cancer procedures to approximately 60 percent of patients above target for bladder, lung and prostate cancer procedures.[449]

844. The presentation also included a discussion, which Dr. Hamilton recalled,[450] about how British Columbia was performing poorly in comparison to the other provinces in terms of wait times for cancer surgeries:

> Traditionally, BC is well known for high performance across many aspects of cancer. However, these data indicate that nationally BC is a moderate to poor performer for cancer surgery wait times (Figures 15-19).
>
> Cancer incidence is expected to increase over the next 15 years. Assuming the rate of increase in cancer surgical procedures is proportionate to the increase in cancer incidence, the demand for cancer surgery is expected to increase by 25-30% in the next

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[443] **Appendix**, Part A, Section VII(C)(ii), Table 1.
[444] **Exhibit 315C**, Tab 12, p. 21, diagnosis code: 39QTCA **[CBE, Tab 66(D)]**.
[445] **Exhibit 316C**, Tab 6, p. 100, diagnosis code: 39QTCA **[CBE, Tab 69(B)]**.
[446] **Exhibit 316C**, Tab 6, p. 100, diagnosis code: 39QTCA **[CBE, Tab 69(B)]**.
[447] **Transcript Day 173**, Testimony of Dr. Hamilton, p. 75, lines 13-17; **Exhibit 526**, p. 1 and 5 **[CBE, Tab 137]**.
[448] **Exhibit 526**, p. 5 **[CBE, Tab 137]**.
[449] **Exhibit KKKKK2**, p. 3 **[CBE, Tab 161]**; **Exhibit 526**, p. 1 and 5 **[CBE, Tab 137]**; **Transcript Day 173**, p. 74, line 27 to p. 75, line 17.
[450] **Transcript Day 173**, p. 72, lines 10 to 32.

decade (Figure 20).[451]

845. Dr. Hamilton testified that he recalled Figures 15-19 of the presentation, showing the 50th and 90th percentile wait times for bladder, breast, colorectal, lung and prostate cancer surgeries across Canada, and that BC was not performing compared to other provinces.[452]

846. At the September 2018 PSEC meeting, David Ball of Analysis Works and Dr. Dean Chittock, Vice President of Quality at VCHA, also presented information on the work of cancer surgery modeling at VCHA.[453] Ms. Copes testified that the goal of such work was to make an effort to deliver cancer surgeries within shorter wait times in the province.[454] This reflects an acknowledgment by Government officials that the wait times are too long.

847. As a result of these presentations, the PSEC members concluded that cancer surgery should be one of the "catch-up" priority groups for 2019/2020, in order to improve wait times for cancer surgeries.[455]

848. Health Authorities prepared their Project Charters for 2019/2020 on this basis.[456] As of March 29, 2019, IHA had included cancer surgeries as a catch-up priority in its Project Charter, for breast, colorectal, prostate, bladder, lung liver, bladder, lung, liver, pancreas, ovarian, uterine, gastroesophageal, esophageal and brain cancers.[457] As of March 29, 2019, the target was that "by the 31st of March 2020, no more than 10% of patients who have a wait time target of 28 days or less waiting longer than 28 days for their cancer surgery".[458]

849. Despite this clear need to reduce cancer surgery wait times, the Minister of Health directed that cancer surgeries not be a "catch-up" surgery for 2019/2020, and rather the focus would continue to be on hip and knee replacements and dental surgeries.[459] Thus, the current target for cancer surgery wait times is that, like all other surgeries, they should simply not get worse than last year.

850. This means that many British Columbians with a cancer diagnosis, including those needing urgent surgery to avoid progression or spread of the disease, will continue to wait well beyond the

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[451] **Exhibit KKKKK2**, p. 3 **[CBE, Tab 161]**.
[452] **Transcript Day 173**, Testimony of Dr. Hamilton, p. 74, lines 9-26; **Exhibit KKKKK2**, pp. 12-15.
[453] **Exhibit 526**, p. 7 **[CBE, Tab 137]**.
[454] **Transcript Day 168**, Testimony of Ms. Copes, June 19, 2019, p. 14, lines 11-31.
[455] **Transcript Day 168**, Testimony of Ms. Copes, p. 15, line 44 to, p. 16, line 6.
[456] **Exhibit 553 [CBE, Tab 144]**.
[457] **Exhibit 553, p. 5 [CBE, Tab 144]**.
[458] **Exhibit 553, p. 5 [CBE, Tab 144]**.
[459] **Transcript Day 168**, p. 15, lines 10 to 28.

maximum acceptable wait time for critical cancer surgeries, with resulting serious harm to their health, likelihood of survival, and mental health.

851. The inability to predict which patients waiting will have their cancers spread means, at the very least, that no patient with cancer should exceed the maximum acceptable wait times for that cancer diagnosis, and indeed should have their surgeries done on a timely basis within the maximum acceptable wait times.

c) The Harms of Waiting for a Colonoscopy

852. Colorectal cancer is the second most common cancer diagnosed in men, and the third most common cancer diagnosed in women[460] In 2016, 3,200 British Columbians were diagnosed with colorectal cancer and 1,280 individuals died from the disease.[461]

853. Colonoscopies are a critical step in the initial detection, diagnosis, assessment and management of colorectal cancer, as well as for inflammatory bowel disease. The survival rate for colorectal cancer is high if the cancer is diagnosed early. Otherwise, patients risk spread and progression of cancer while waiting for colonoscopy.[462] Colorectal cancer incidence and mortality in BC can be reduced "by finding and removing pre-cancerous polyps (adenomas) and by finding cancers early - before they have had a chance to spread".[463]

854. As a result, the BC Government has expended significant effort and resources to improve wait times for colonoscopies in the public system.[464]

855. Despite this, the wait times for colonoscopies, even urgent ones, in the public system continue to be much longer than the established maximum acceptable wait times.[465]

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[460] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 9, lines 24-31. **Exhibit 412**, Gentile Affidavit, Exhibit "A", p. 5.
[461] **Exhibit 412**, Gentile Affidavit, Exhibit "A", p. 5 **[CBE, Tab 95]**.
[462] **Exhibit 412**, Gentile Affidavit, Exhibit "A", p. 5 **[CBE, Tab 95]**.
[463] **Exhibit 412**, Gentile Affidavit, Exhibit "A", p. 5 **[CBE, Tab 95]**.
[464] **Exhibit 2A**, pp. 173-174, paras 411-414 **[CBE, Tab 1]**; **Exhibit 12B**, pp. 1532-1536 **[CBE, Tab 8]**; **Exhibit 12C**, pp. 2028-2079, 2107-2166 **[CBE, Tab 9]**; **Exhibit 426**, Tab 18, p. 8789, statements made by the Honourable Terry Lake in the Legislative Assembly **[CBE, Tab 100]**.
[465] **Exhibit 315A**, Tab 1, p. 18, diagnosis code: 30OZDA **[CBE, Tab 64(A)]**; **Exhibit 322**, Tab 6, pp. 4-9 **[CBE, Tab 76(D)]**; **Exhibit 433D**, p. 3671 **[CBE, Tab 106]**.

856. Dr. Lauzon explained that especially in the case of colon cancer, "the majority of patients have very little or no symptoms until it's fairly advanced and diagnosing somebody sooner improves the prognosis tremendously".[466]

857. In light of the unpredictability of colon cancer, and the importance of early detection, delays in obtaining diagnostic colonoscopy not only cause psychological suffering and preventable advancement of the disease, but can be life-threatening.

858. As shown by the experience of Patient Plaintiff Ms. Martens, waiting for diagnostic colonoscopy puts a patient's health at risk of irreparable harm. Ms. Martens, however, is only one example. There are a large number of patients who are waiting beyond the maximum acceptable wait times for colonoscopies in BC.

859. The long wait lists and potential harm caused by delays in medically necessary colonoscopies were discussed in the Legislative Assembly in 2015, by the now-Minister of Mental Health and Addictions, Judy Darcy, and then-Minister of Health, Terry Lake:

> **J. Darcy:** Last October in this House we raised the case of Michael Goldman from Qualicum Beach. He had surgery for colon cancer in January 2011. A colonoscopy in June of 2013 showed that Michael had a 40 percent chance of recurrence of his cancer. According to the government's own guidelines, Michael should have had a follow-up colonoscopy within six months. It has now been 20 months, and Michael Goldman has still not had the colonoscopy that he needs. And it's been four months since we raised this issue in this House. Can the minister explain to Michael Goldman, a high-risk patient at severe risk of recurrence of his cancer, why he's had to wait 20 long and very worrying months for his follow-up treatment?
>
> **Hon. T. Lake:** Thank you to the member for the question. I certainly have sympathy for anyone that's waiting for treatment, especially when there's a worrisome diagnosis involved. I know the ministry and the health authorities are very concerned about wait-lists. Colonoscopy has been a challenge since we instituted the new FIT procedure to screen people for colon cancer. It is the right thing to do in terms of detecting cancers early. But what we've done is we've created a burden on the system that we need to correct, and we are working hard with our health authorities to do that. I apologize for any patients that have had to wait longer than necessary. Having said that, all of the health authorities are working hard to reduce those wait-lists and make sure that people are seen in a timely fashion for their follow-up procedures. [467]

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[466] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 66, lines 2-7.
[467] **Exhibit 426**, Tab 10, p. 6095 **[CBE, Tab 100]**.

860. These lengthy delays in obtaining necessary diagnoses – like colonoscopies – not only delay treatment and necessary surgeries, with resulting pain, suffering, and risk of permanent damage, but can compromise a patient's ability to obtain lifesaving treatments in time.

861. Further, delays in providing colonoscopies in the public system not only result in harms to patients, but also in harms to the public health care system. Colonoscopies have been shown to reduce long term costs of treating colon cancer in the public system, by identifying and treating patients with cancer early on, before the disease progresses and spreads. As a result, colonoscopies prevent "downstream, expensive adverse events" that the public system would otherwise have to deal with. [468]

862. Whatever burdens the public system may experience in respect of delivery of colonoscopies, it is not acceptable to leave patients with no other choice but to wait too long. Certainly, patients with a potentially serious diagnosis such as colon cancer must have a choice to access an independent colonoscopy in the face of these long wait times.

863. At the time of Ms. Martens' experience with the public system in 2011, the Government had not established benchmarks for colonoscopies, nor did it track wait times.

864. The Government has since established maximum acceptable wait times for colonoscopies by priority.[469] These were based on the "acuity categories" established by the Canadian Association of Gastroenterologists ("CAG")'s Wait Time Consensus Group.[470]

865. The BC maximum acceptable wait time for a colonoscopy for patients with "high likelihood of cancer based on imaging or physical exam" (Priority 1) is two weeks. There are three Priority 3 diagnoses, which require colonoscopies to be performed within eight weeks: patients with "bright red rectal bleeding or chronic unexplained abdominal pain"; patients with a positive fecal occult blood ("**FIT**") test in the BC Cancer Agency Colon Screening Program ("**Screening Program**"); and patients with a positive FIT test outside of the Screening Program. The lowest priority group of patients are those being screened for personal or significant family history or gastrointestinal symptoms (Priority 5), who have a maximum wait acceptable wait time of 26 weeks for colonoscopy.[471]

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[468] **Exhibit 12C**, p. 2111 **[CBE, Tab 9]**.
[469] **Exhibit 322**, Tab 6, p. 3 **[CBE, Tab 76(D)]**.
[470] **Exhibit 431**, pp. 611-615 **[CBE, Tab 102]**.
[471] **Exhibit 322**, Tab 6, p. 3 **[CBE, Tab 76(D)]**.

866. Laura Gentile, who has been the Director of Screening Operations, Cervix and Colon Screening with the BCCA for the past 10 year, testified about the long wait times for participants in the Screening Program with a positive FIT test for colonoscopies.[472]

867. The Screening Program, which was introduced in 2013, is aimed at reducing colon cancer incidence and mortality in the province by screening at risk members of the population for early detection of cancer through FIT tests or colonoscopies.[473]

868. As explained in the Screening Program Report, there was a rapid increase in the number of individuals requiring colonoscopy following introduction of the Screening Program in 2013, which created a challenge in every Health Authority to meet a 60-day target for participants with a positive FIT test to receive their colonoscopies.[474]

869. In 2015, Ms. Copes was the Co-Chair of a Government working group which prepared a Report on Colonoscopy Services in BC.[475] This Report confirms that the Screening Program created a "bow wave" of demand for colonoscopies, with approximately 36,000 people waiting for colonoscopies at the end of June 2015, and the number of patients increasing at a rate of 800 to 1,000 per month.[476] This was found to have "exacerbated the existing, long wait times, wait lists and overall costs for colonoscopies" in the province.[477]

870. The Colonoscopy Services Report also indicates that no policies were adopted to eliminate the extensive wait times for colonoscopies that existed prior to the start of the Screening Program.[478]

871. This was confirmed by Dr. Lauzon. From his experience as Regional Head of Surgery at FHA, Dr. Lauzon testified that the public system has faced difficulties in providing timely colonoscopies to both asymptomatic patients in the BC Colon Screening Program and symptomatic patients who are not in the Screening Program, because there was no increase in hospital resources to accommodate the influx of patients requiring colonoscopy.[479]

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[472] **Exhibit 412**, Gentile Affidavit **[CBE, Tab 95]**.
[473] **Exhibit 412**, Gentile Affidavit, "A", p. 5 **[CBE, Tab 95]**.
[474] **Exhibit 412**, Gentile Affidavit, Exhibit "A", p. 18 **[CBE, Tab 95]**.
[475] **Exhibit 12C**, p. 2028 **[CBE, Tab 9]**.
[476] **Exhibit 12C**, p. 2045 **[CBE, Tab 9]**.
[477] **Exhibit 12C**, p. 2039 **[CBE, Tab 9]**.
[478] **Exhibit 12C**, p. 2071 **[CBE, Tab 9]**.
[479] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 16, lines 10-42.

872. While the Screening Program Report states that "[a]ppropriate case prioritization is important to minimize the negative impact on health outcomes, for all patients requiring colonoscopy" both within and outside of the Program,[480] this is only workable if there are sufficient public facilities available to perform the more urgent procedures. As Dr. Lauzon explained, this has not been the case.[481] Even when case prioritization is possible, it can only help to minimize the negative impact on health outcomes for patients waiting too long for colonoscopy but cannot eradicate these negative impacts.

873. Gastroenterologists have raised concerns about Screening Program patients "receiving colonoscopies sooner than symptomatic or other non-Colon Screening Program patients" regardless of patient priority.[482] Dr. Lauzon also testified to this problem.[483]

874. The Screening Program thus creates inequities in the public system, by allowing Screening Program patients to get access to reserved colonoscopy procedure time in place of symptomatic patients outside the Program, regardless of their relative urgency or likely risk level. However, until the colonoscopy is performed, it is unknown which patient has the more urgent condition.

875. Despite the reserved colonoscopy procedure time for patients in the Screening Program, the wait times for patients in the Screening Program still exceeds the 60-day target set by the Program, as well as the provincial maximum acceptable wait time of 8 weeks (56 days) for patients with a positive FIT test in the Screening Program. From April to September 2018, the 50th percentile wait time was 106 days for Screening Program patients to obtain their colonoscopy in BC overall, and 142 days at VCHA.[484] No health authorities met the 60 day maximum acceptable wait time. [485]

876. The Government data for colonoscopies done outside the Screening Program in 2017 and 2018 also shows that a significant number of patients in all priority groupings, with potentially life threatening colon cancer, are waiting beyond the maximum acceptable wait times to have their colonoscopies done in the public system.

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[480] **Exhibit 412**, Affidavit #1 of Laura Gentile, Exhibit "A", p. 18 **[CBE, Tab 95]**.
[481] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 16, lines 10-42.
[482] **Exhibit 12C**, p. 2112 **[CBE, Tab 9]**.
[483] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 16, lines 10-42.
[484] **Exhibit 412**, Affidavit #1 of Laura Gentile, Exhibit "B" **[CBE, Tab 95]**.
[485] **Exhibit 412**, Affidavit #1 of Laura Gentile, Exhibit "B" **[CBE, Tab 95]**.

877. In 2017, 50% of patients with "high likelihood of cancer" received their colonoscopies outside the maximum acceptable wait time of two weeks. For 2018, as of March 31, 2018, 25% of patients in this category waited longer than two weeks for their colonoscopies.[486]

878. In 2017 and 2018, approximately 40% of patients with "bright red rectal bleeding" or "chronic unexplained abdominal pain" waited beyond the maximum acceptable wait time of 8 weeks.[487]

879. In 2017, approximately 72% of patients with a positive FIT test outside of the BC Colon Screening Program waited beyond the maximum acceptable wait time of 8 weeks. In 2018, as of March 31, 2018, approximately 78% of patients in this category waited longer than 8 weeks for their colonoscopies.[488]

880. It is important to note that this data is for patients who did receive a colonoscopy in 2017 or the first three months of 2018. It does not include patients who were still waiting.

881. Dr. Lauzon testified that his wait time for colonoscopy after a positive FIT test averaged 12 to 16 weeks.[489]

882. This is not a matter of some patients waiting a day or two longer than the maximum acceptable wait time. Rather, half of BC patients with a positive FIT outside of the Screening Program test waited more than 15.4 weeks in 2017 (almost twice as long as the maximum acceptable wait time), and more than 27.3 weeks in 2018 (up to March 31, 2018) (more than three times longer than the maximum acceptable wait time).[490]

883. In 2017, the Government acknowledged in its "Magnetic Imaging and Colonoscopy Data" Report, that the Health Authorities were not meeting the maximum wait times for colonoscopies.[491] Ms. Copes confirmed that this was still the case in 2019.[492]

884. It is clear that the Government has simply given up on providing all British Columbians with access to colonoscopies within the maximum acceptable wait times. Instead, in 2017, it set a target of

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[486] **Exhibit 315A**, Tab 1, p. 18, diagnosis code: 30OZDA **[CBE, Tab 64(A)]**.
[487] **Exhibit 315A**, Tab 1, p. 19, diagnosis code: 30OZDD **[CBE, Tab 64(A)]**.
[488] **Exhibit 315A**, Tab 1, p. 11, diagnosis code: 30NMDD **[CBE, Tab 64(A)]**.
[489] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 17 lines 35-36.
[490] **Exhibit 316C**, Tab 5, p. 4; **Exhibit 316C**, Tab 6, p. 4 **[CBE, Tabs 69(A) and (B)]**.
[491] **Exhibit 431**, p. 619 **[CBE, Tab 102]**.
[492] **Transcript Day 167**, Testimony of Ms. Copes, pp. 88-91; **Exhibit 560**, p. 4 **[CBE, Tab 148]**; See also: **Exhibit 431**, p. 619-620 **[CBE, Tab 102]**.

having "no more than 15% of patients waiting beyond the maximum wait times by March 31, 2019".[493] This target "result[ed] from analysis of data currently available and is less onerous than the typical surgical target of no more than 5% waiting over benchmark."[494]

885. This means that the Government accepts that at least 15% of patients needing a colonoscopy for diagnosis of suspected cancer, or other serious disease, will wait beyond the established maximum acceptable wait time, which could result in irreparable, life-threatening harms to such patients.

886. Further, the Government did not even attempt to meet this less stringent target in 2018/19, as Health Authorities' planned volumes of colonoscopies were based on "keeping up" with demand and eliminating the "backlog" of waitlisted patients, and not with providing 85% of patients with colonoscopies within the maximum wait times.[495] And, even in relation to this insufficient target volume, there was a shortfall of 1,442 colonoscopies in 2018/19 in BC.[496]

887. The BC Government's data from March 31, 2019, confirms that none of the Health Authorities even came close to meeting the target of providing 85% of patients with their colonoscopies within the applicable maximum acceptable wait time:[497]

COLONOSCOPIES

HA	YTD Vol Comp	YTD Target		% Wait over Bnch	Ttl Cases Waiting	50th Pctl Wait Time	90th Pctl Wait Time
BC	138,959	140,401	◆	42.1% ↓	34,015		
IHA	31,363	31,634	◆	39.9% ↓	7,094	10.6 ↓	48.6 ↓
FHA	41,346	42,215	◆	37.1% ↑	9,052	9.3 ↑	52.7 ↓
VCHA	32,076	32,500	◆	51.6% ↓	8,022	15.6 ↓	78.8 ↑
VIHA	25,350	25,075	●	42.4% ↑	8,707	9.9 ↑	26.6 ↓
NHA	8,824	8,977	◆	28.0% ↔	1,140	5.0 ↓	28.9 ↑
PHSA		N/A					

Wait time not available for BC.

888. As seen above, as of March 31, 2019, 42.1% of patients were waiting beyond the maximum acceptable wait times for their colonoscopy for their priorities, (ranging from 28% to 51.6% by Health Authority). Only VIHA met its volume target for the year, but still had over 42% of patients waiting beyond their maximum acceptable wait times.

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[493] **Exhibit 431**, p. 619 **[CBE, Tab 102]**; **Exhibit 556**, p. 6 **[CBE, Tab 145]**.
[494] **Exhibit 431**, p. 619 **[CBE, Tab 102]**.
[495] **Exhibit 556**, p. 5. **[CBE, Tab 145]**.
[496] **Exhibit 560**, p. 4 **[CBE, Tab 148]**.
[497] **Exhibit 560**, p. 4 **[CBE, Tab 148]**.

889. The target of no more than 15% of patients waiting longer than their maximum acceptable wait time for a colonoscopy has been adopted again for 2019/20.[498]

890. The evidence thus demonstrates that there are thousands of patients each year whose chance of successful recovery from life threatening cancer is compromised as a result of excessive waits in the public system for the critical diagnostic procedure of colonoscopy, and this number is increasing every year.

d) The Safety Valve of Access to Private Cancer Diagnosis and Surgeries in BC

891. While doctors in the public system attempt to prioritize patients on the basis of medical need, Dr. Lauzon testified that "there are always going to be some patients that would have benefited from much earlier treatment".[499] This, however, is not possible in the public system due to the rationing of hospital resources, such as operating room time.

892. As a result, patients require an alternative form of access to necessary cancer diagnosis and surgery to alleviate their suffering and protect their health, in the face of the persistently long wait times in the public system.

893. This is the reason why Dr. Lauzon and other specialists perform necessary cancer diagnostic and surgical services not only in the public system, but also at private clinics.

894. Dr. Lauzon testified about his lack of operating room time in the public system. He stated that at Peace Arch Hospital he gets one OR day per week.[500] Further, at the other hospitals at which he has privileges, he only gets OR time if there is OR time that is not being used by other surgeons at those hospitals, which does not occur often.[501]

895. As a result, he works once a month at Cambie or SRC, providing diagnostic and surgical services to WCB patients, and procedures such as colonoscopies and gastroscopies to patients like Ms. Martens who feel they cannot wait for care in the public system.[502]

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[498] **Exhibit 556,** p. 6 **[CBE, Tab 145]**.
[499] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 65, lines 40-44.
[500] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 5, lines 8-21.
[501] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 4, line 34 to, p. 5, line 6.
[502] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 37, lines 31-37, p. 40, line 39 to, p. 41, line 37.

896. Currently, private clinics in the province are approved to provide a variety of diagnostic and surgical services relating to cancer. Many kinds of surgeries, including cancer surgeries, can be done as day or short stay procedures. Only patients in the high-risk anaesthesia category cannot be treated in private surgical clinics.

897. For example, Cambie is approved for cancer treatments and surgeries including breast cancer surgery, laparoscopic surgical treatment of ovarian cancer, skin cancer, uterine tumours, ear, nose and throat cancer surgery, biopsies or excision of certain tumours or cancers of bones, muscles, soft tissues, lymph nodes, and salivary gland tumors, as well as colonoscopies and their associated excisional biopsies and polypectomies.[503]

898. In addition, Dr. Brian Peterson testified that he initiated a private screening colonoscopy program at Okanagan Health Surgical Centre to provide patients with timely access to colonoscopies which could not be obtained in the public system.[504]

899. Due to the lack of operating room time in the public system, the Health Authorities have contracted with private clinics in the province to provide patients with timely access to publicly-funded cancer surgeries and colonoscopies. VIHA, for instance, has had such contracts with private clinics since 2004.[505] Norm Peters, Executive Director of Surgery, End of Life Care and Residential Care of VIHA, explained that through these contracts, "thousands of patients have benefited from timely, accessible, publicly-funded day surgery".[506] With respect to cancer surgeries and colonoscopies, he stated that "[b]y increasing the number of surgeries and colonoscopies we perform outside hospital, we can free up operating rooms for more complex cases and reduce wait times for both day and inpatient surgery".[507]

900. Although many patients have benefitted from these government contracts with private facilities, they are not sufficient to reduce the wait times, and patients still need to have the ability to protect themselves from harm by obtaining private diagnoses and cancer surgeries.

e) Ms. Martens' Experience Waiting for a Diagnostic Colonoscopy in the Public System

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[503] **Exhibit 346A**, Affidavit #9 of Dr. Day, Exhibit "GG" **[CBE, Tab 84]**.
[504] **Exhibit 376**, Peterson Affidavit, pp. 2, 5, and 7, paras 3, 46-47, and 76-79 **[CBE, Tab 86]**.
[505] **Exhibit 395**, Affidavit #1 of Norm Peters, Exhibit "B" **[CBE, Tab 93]**.
[506] **Exhibit 395**, Affidavit #1 of Norm Peters, Exhibit "B" **[CBE, Tab 93]**.
[507] **Exhibit 395**, Affidavit #1 of Norm Peters, Exhibit "B" **[CBE, Tab 93]**.

901. Patient Plaintiff Ms. Martens was diagnosed with Stage 4 colon cancer at age 35, after waiting too long in the public system for a diagnostic colonoscopy. [508] She obtained a colonoscopy privately at Cambie, which enabled her to have more timely cancer surgery to avoid potentially irreversible harm to her health and further pain and mental anguish.

902. Ms. Martens' experience with the public system began in May 2011, when she observed blood and mucus in her stool and attended her family doctor's office.[509]

903. Dr. de Vynck (who was substituting for her regular GP, Dr. Hansen) referred Ms. Martens to Dr. Scott Cowie, a general surgeon in the public system, for a consultation and possible diagnostic colonoscopy.[510] When Ms. Martens contacted Dr. Cowie's office, she was informed that the first available appointment was 7 months later, in November 2011.[511]

904. Because of Ms. Martens' symptoms, and her young age, her physicians did not suspect that she had cancer.[512] Ms. Martens, however, was very worried that she might have cancer.[513]

905. Even in June 2011, when she developed loose bowel movements and red blood in her stool, it was thought that she may have inflammatory bowel disease. Cancer was still not considered a likely possibility.[514]

906. Dr. Hansen testified that after her appointment in June, 2011, a five month wait for a diagnostic colonoscopy would be inappropriate, given Ms. Martens' rectal bleeding and loose stools with mucous. [515] He testified that Ms. Martens should have a diagnostic colonoscopy within six to eight weeks.[516]

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[508] **Exhibit 54,** Agreed Statement of Facts of Ms. Martens, p. 5, para 23 **[CBE, Tab 25]**.
[509] **Exhibit 54,** p. 2, para 3 **[CBE, Tab 25]**; **Transcript Day 24**, Testimony of Ms. Martens, p. 2, lines 10-24, p. 3, lines 8-16.
[510] **Exhibit 54**, p. 2, para 4 **[CBE, Tab 25]**.
[511] **Exhibit 54**, p. 3, para 7 **[CBE, Tab 25]**.
[512] See **Transcript Day 37**, Testimony of Dr. Lauzon, p. 50, lines 1-13, and p. 58, lines 34-47; **Transcript Day 39**, Testimony of Dr. Hansen, p. 8, lines 1-39, and p. 31, lines 5-18, and p. 42, lines 23-29; **Exhibit 54**, p. 3, para 12 **[CBE, Tab 25]**.
[513] **Transcript Day 24**, Testimony of Ms. Martens, p. 10, lines 38-44; **Transcript Day 37**, Testimony of Dr. Lauzon, p. 50, lines 1-13. **Exhibit 54**, p. 3, para 12.
[514] **Transcript Day 39**, Testimony of Dr. Hansen, p. 16, line 1 to, p. 18, line 12.
[515] **Transcript Day 39**, Testimony of Dr. Hansen, p. 19, lines 5-20.
[516] **Transcript Day 39**, Testimony of Dr. Hansen, p. 19, lines 26-35.

907. If Ms. Martens' had continued to wait for care in the public system, she would have likely waited several more months for her consultation with Dr. Scott Cowie, and her diagnostic colonoscopy would have taken place some time after that.[517]

908. As a result, she would have waited well beyond the clinically established two month target which would have applied to her circumstances (even based on her symptoms, which did not reflect the severity of her condition), and would have put her life at great risk.

909. While waiting in the public system for a colonoscopy, Ms. Martens experienced pain, gastrointestinal issues, emotional suffering and the unknown risk of irreparable harm to her health and life from the progression of her cancer.[518]

910. Additionally, during this time, Ms. Martens testified that she experienced fear and anxiety over her health and well-being, and a sense that something was "going wrong" with her body.[519] While Ms. Martens' doctors thought it unlikely that she had cancer, Ms. Martens was anxious that something was seriously wrong with her health.[520]

911. Dr. Lauzon testified that, for patients with colon cancer, such as Ms. Martens, there is always a potential for the cancer to progress and spread, which could result in death.[521] Thus, Ms. Martens' health and life was also put at risk of irreparable harm, even mortality, while waiting for a colonoscopy in the public system.

912. It is this inability to predict who will have cancer that elicits the need for patients to have timely access to colonoscopy in the public system, and access to private colonoscopies in the event that timely access in the public system is not possible. Moreover, any patient who believes that their life may be at risk from disease will suffer severe anxiety and stress while waiting for their diagnosis.

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[517] **Exhibit 54,** p. 2, para 4, p. 3, para 7 **[CBE, Tab 25]**; **Transcript Day 39**, Testimony of Dr. Hansen, p. 19, lines 16-20.
[518] **Transcript Day 24**, Testimony of Ms. Martens, p. 2, lines 10 to 13, p. 4 line 46 to, p. 5, line 6, p. 5, line 43 to, p. 6, line 5; See also **Transcript Day 37**, Testimony of Dr. Lauzon, p. 49, lines 32 to 43.
[519] **Transcript Day 24**, Testimony of Ms. Martens, p. 4, lines 36 to 47 , p. 5, lines 1-7, and p. 5, line 43 to, p. 6, line 33; **Exhibit 54,** p. 4, para 8-12.
[520] **Transcript Day 24**, Testimony of Ms. Martens, p. 10, lines 38-44; **Transcript Day 37**, Testimony of Dr. Lauzon, p. 50, lines 1-13. **Exhibit 54,** p. 3, para 12.
[521] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 48, lines 15 to 23.

913. It was for this reason, to protect her health from adverse consequences, that Ms. Martens arranged an expedited consultation and colonoscopy with Dr. Lauzon on June 20, 2011 at Cambie.[522]

914. Dr. Lauzon performed a colonoscopy followed by a biopsy that diagnosed Stage 4 colon cancer.[523] The cancer had metastasized to her liver.[524] With this diagnosis, Ms. Martens was subsequently able to book an emergency appointment with Dr. Paul Phang at St. Paul's Hospital, where she was admitted for a colon resection on June 28, 2011.[525]

915. Post-surgery and after a short recovery period, Ms. Martens commenced three rounds of chemotherapy at Abbotsford Cancer Agency in September 2011.[526] Ms. Martens was then admitted for liver surgery at Vancouver General Hospital with Dr. Steven Chang on October 14, 2011.[527] Ms. Martens' treatments and surgeries were successful.

916. Ms. Martens' colonoscopy and biopsy, diagnosis of Stage 4 cancer, subsequent surgeries, and three rounds of chemotherapy all occurred prior to November 2011, when Mandy had been scheduled to have her first diagnostic colonoscopy in the public health care system.

917. Ms. Martens paid for the medical services she received at Cambie, but was subsequently reimbursed by Cambie, after she sought reimbursement from the Government.[528] Ms. Martens explained that she sought reimbursement as she felt this very necessary procedure ought to have been provided in a timely way by the public system.[529]

918. The ability to obtain a private colonoscopy allowed Ms. Martens to protect her health, and have much more timely access to cancer diagnosis, treatment and surgery, than would have been possible in the public system. This may well have saved her life. Certainly, it prevented her cancer from further progressing as would otherwise have occurred.

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[522] **Exhibit 54**, p. 5, para 22 **[CBE, Tab 25]**.
[523] **Exhibit 54**, p. 5, para 23 **[CBE, Tab 25]**.
[524] **Exhibit 54**, p. 7, para 34 **[CBE, Tab 25]**.
[525] **Exhibit 54**, p. 5, para 24 **[CBE, Tab 25]**.
[526] **Transcript Day 24**, Testimony of Ms. Martens, p. 14, lines 6-13.
[527] **Exhibit 54**, p. 5, para 35(a) **[CBE, Tab 25]**.
[528] **Exhibit 54**, p. 6, para 28 **[CBE, Tab 25]**.
[529] **Transcript Day 24**, Testimony of Ms. Martens, p. 19, lines 29-34.

919. Ms. Martens testified that she chose to participate in this case as a Patient Plaintiff to protect the ability of other patients to access more timely services in the private system, when such access is not possible in the public system.[530]

920. Ms. Martens' situation illustrates why patients waiting for colonoscopy (even those asymptomatic with positive FIT tests) should never exceed the maximum wait times and should always have the ability to seek an expedited diagnosis privately. Regardless of the likelihood, if the diagnosis is cancer, an earlier diagnosis leads to a better prognosis.

921. Dr. Hansen supported Ms. Martens' decision to pursue private colonoscopy as part of his belief in patient-centered care. She was anxious and worried despite Dr. Hansen telling her that the likelihood was a non-ominous diagnosis.[531]

922. The key word here is "likelihood". Despite a diagnosis of colon cancer being unlikely for Ms. Martens, it could not be ruled out until she had a specialist consultation and colonoscopy. She was anxious and she could not wait any longer for a definitive diagnosis. "[T]he colonoscopy changed everything".[532]

923. Because access to private pay cancer diagnosis and surgeries has existed in the province for over 20 years, patients like Ms. Martens have been able to obtain more timely cancer diagnosis and surgery, when this is not possible in the public system. The result has been not only vitally important and beneficial for the life and health of these patients, but it has allowed them to obtain diagnosis and treatment earlier, when their cancer is at an earlier stage, and thus more treatable and less resource-intensive for the public health care system.

(iii) Gallbladder Surgery

924. Cholecystectomy, also known as gallbladder removal surgery, falls under the umbrella of general surgery. Patients diagnosed with "biliary colic" require gallbladder removal surgery.

925. We had evidence from Ms. Monica Forster, a patient who waited well beyond the maximum acceptable wait time for a cholecystectomy, gallbladder removal surgery, in the public system, with the result that her condition deteriorated to the point that she experienced life-threatening adverse

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[530] **Transcript Day 24**, Testimony of Ms. Martens, p. 30, lines 24-32.
[531] **Transcript Day 39**, Testimony of Dr. Hansen, p. 32, line 35 to, p. 33, line 6.
[532] **Transcript Day 39**, Comments by the Court, p. 42, lines 39-40.

consequences. Ms. Forster's testimony was given by way of affidavit. She was not cross-examined on her affidavit.

926. Dr. Jean Lauzon, a general surgeon, testified about the adverse health consequences a patient may suffer as a result of waiting for gallbladder surgery. He testified that patients can and do develop cholecystitis while waiting for their surgery, which is inflammation of the gallbladder which becomes an emergent condition.[533] He explained that while cholecystitis in unpredictable and can occur any time while patients are waiting for gallbladder surgery, "the longer they wait the higher the overall risk" of developing such infection.[534] Another complication of gallbladder disease that can and does occur while waiting for gallbladder surgery is that a gallstone could pass into their bile duct.[535] A third condition that can happen with gallstone disease is pancreatitis, which can be very serious.[536]

927. Plaintiff's expert Dr. Gordon Matheson testified that patients waiting for gallbladder surgery are at risk of emergency admission for the awaited procedure, due to the worsening of their condition over time, and the added risk of complications:

> Waiting for gall bladder surgery worsens the disease and increases the risk of complications requiring urgent medical attention [17].[537]

928. In support of this opinion, Dr. Matheson referred to a study by Sobolev entitled, "Risk of emergency admission while awaiting elective cholecystectomy", which found that the probability that a patient on a waiting list will be admitted for emergency cholecystectomy consistently increases with the duration of the wait, particularly after 20 weeks. Specifically, the rate of emergency surgery was 1.6 times higher after 20 weeks, as compared to the first four weeks on the wait list, two times higher after 28 weeks and seven times higher after 40 weeks.[538] The authors concluded that:

> When treatment is delayed, the condition of a patient on a surgical waiting list may deteriorate and require urgent medical attention. In this case, emergency admission for the awaited procedure may be regarded as an adverse effect of waiting. Also, routine operating room activity may be seriously disrupted by unexpected nonelective admissions of patients on waiting lists.
>
> In patients with biliary colic caused by cholelithiasis, extended treatment delays may increase the probability that the patient will be admitted for delayed cholecystectomy

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[533] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 46, line 35 to, p. 47, line 2.
[534] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 46, line 35 to, p. 47, line 2.
[535] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 46, line 35 to, p. 47, line 2.
[536] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 46, line 35 to, p. 47, line 2.
[537] **Exhibit 274**, Tab A, Expert Report of Dr. Matheson, p. 8 **[CBE, Tab 53]**.
[538] **Exhibit 274**, Tab 17, p. 196, Sobolev at p. 662 **[CBE, Tab 53]**.

> as an emergency case. Emergency admission may be associated with more frequent or more severe attacks of biliary colic or other biliary complications such as acute cholecystitis, obstructive jaundice, cholangitis or pancreatitis.

929. A Ministry of Health Briefing Note prepared for Sandra Feltham, a government witness who testified in this case, reviewed the Sobolev study, as well as other studies about the consequences of waiting for surgical procedures, and concluded that the generalizability of the Sobolev study results was good.[539]

930. An expert witness for the Defendant, Dr. Eric Bohm, agreed that when a patient on a waiting list is admitted to the hospital on an emergency basis for the procedure they are waiting for, and undertaking the intervention earlier would have prevented that from happening, this is an adverse consequence of waiting:[540]

931. Further, Dr. Bohm agreed that waiting for scheduled surgery for a serious condition can imperil a patient's health, and perhaps even their life:[541]

932. In situations such as Ms. Forster's, where patients are scheduled for surgery and require emergency admission because their conditions have deteriorated while waiting, there are not only harms to the specific patient, but also harms to other patients.

933. First, there are harms to other patients waiting in the public system for scheduled surgery whose surgeries have to be delayed and rescheduled, when hospital resources, such as operating room time and staff, are diverted to patients on waiting lists who are admitted on an emergency basis, due to deterioration of their condition. Defendant's expert Dr. Bohm confirmed that this was his experience in the public system:[542]

934. Second, as Ms. Forster's situation illustrates, when the condition of a patient on the wait list for scheduled surgery deteriorates to the point of emergency admission, the public system must expend additional resources to treat the patient's urgent needs, and any other complications that may have arisen during the wait (i.e. intensive care unit resources, prolonged hospital stay, additional treatments and surgery).

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[539] **Exhibit 431**, p. 124 **[CBE, Tab 102]**.
[540] **Transcript Day 153**, p. 30, lines 16 to 33.
[541] **Transcript Day 153**, Testimony of Dr. Lauzon, p. 31, line 42 to, p. 32, line 2.
[542] **Transcript Day 157**, Testimony of Dr. Bohm, p. 30, lines 34 to 40.

935. Dr. Andrew Hamilton confirmed that when surgery is done on a scheduled basis, as opposed to an emergency basis, it is less expensive for the system (at least in terms of the length of time in hospital) and gives rise to better outcome for the patient. Dr. Hamilton referred to gall bladder surgery specifically as an example of a situation in which emergency surgery generally results in a longer hospital stay than when done on a scheduled basis, which is generally day surgery[543].

936. Plaintiff's expert Dr. Leslie Vertesi also provided evidence on the added costs to the public health care system in such circumstances:[544]

> My second story concerns a woman I attended in Emergency who came in with an infected gall bladder. She had been previously completely investigated and proven to have a gall bladder packed with stones, and was booked for surgery about 3 months later. She hadn't lasted more than a week and had to be admitted, and stayed in hospital for several days for something that could have been managed as a simple outpatient procedure. Actually the story is not about her at all but about the added cost, the impact to our already overloaded hospital capacity, and the fact that this kind of event now happens repeatedly across all the specialties to the point where it is no longer even noticed as unusual.

937. Dr. Vertesi confirmed in cross-examination that waiting until the patient's gallbladder became infected increased the cost of caring for the patient.[545]

938. Dr. Vertesi also testified to the complications that can occur due to waiting for gallbladder surgery. He testified that patients, in particular those with frequent gallbladder attacks are at risk of infection. Once the gallbladder is infected, patients must be admitted to hospital, as they could die. As he opined, "you can get them [gallbladder surgeries] done as a daycare with no complications to the patient, no infections. Once they become infected, it's several days in the hospital. They can have recurrent problems with infections and adhesions".[546]

939. The Health Council of Canada's working group on wait times and access, of which Defendant Expert, Dr. McMurtry was Chair, discussed these harms to the public system in its report entitled "Wait Times and Access":[547]

> Waiting too long has implications for the health care system as well. Deterioration in health status while waiting for care can lead to greater care needs for patients in the

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[543] **Transcript Day 174**, Testimony of Dr. Hamilton, p. 43, lines 29 to, p. 43, line 16.
[544] **Exhibit 334**, Expert Report of Dr. Vertesi, p. 7 **[CBE, Tab 79]**.
[545] **Transcript Day 113**, Testimony of Dr. Vertesi, p. 67, lines 26 - 35.
[546] **Transcript, Day 113**, p. 72, lines 16-22.
[547] **Exhibit 489**, pp. 3 and 5 **[CBE, Tab 129]**.

> long run. This cannot be good news for a system straining to meet many competing demands. ... (p. 3)
>
> 3.1 Patients compete for hospital resources.
>
> In large hospitals, the majority of hospital services – beds, operating rooms, nursing care – are consumed by patients admitted on an emergency basis. This leaves little room for those who need beds for scheduled procedures.
>
> The interaction between scheduled and emergency surgeries is complex. Patients who have been on a waiting list for scheduled surgery sometimes get worse and come in through the emergency department. And conversely, it is common for patients assessed in emergency to be given a less urgent classification and be discharged, but placed into a scheduled or semi-urgent waiting pattern for a needed procedure. For example, an unstable wrist fracture in an adult can safely be put in a cast for a few days before surgery is done. A man presenting at the emergency department with a gall bladder attack may be diagnosed as definitely requiring surgery. But he may be placed on a waiting list with others who need the same surgery.
>
> When the collision between non-urgent and urgent patients becomes too frequent, physicians can be faced with a decision about who comes first, the patient in emergency or the patient who has been waiting and may already have been cancelled several times. (Vertesi 2004)(p. 5)

940. The priority levels and associated maximum acceptable wait times for patients requiring gallbladder removal surgery for biliary colic are: Priority 1 (2 weeks) for "Biliary Colic – Severe (Daily Pain); Priority 3 (6 weeks) for "Biliary Colic – Intermediate (Frequent Pain)"; and Priority 4 (12 weeks) for "Biliary Colic – Chronic (Infrequent Symptoms)".[548]

941. We do not have a booking form for Ms. Forster, but based on her symptoms she would likely have been categorized as Priority 4, for biliary colic, with a maximum wait time of 12 weeks.

942. In 2015, the same year that Ms. Forster required surgery, approximately 40% of patients with Priority 4 biliary colic did not receive their surgeries within 12 weeks (based on the BFRD).[549]

943. The 90th percentile wait time for Priority 4 biliary colic patients in 2015 was 33 weeks (7.5 months) from BFRD, and 39.1 weeks (9 months) from Decision Date.[550] Patients in all three of the priority levels for cholecystectomy surgery in BC are waiting well beyond their maximum acceptable

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[548] **Exhibit 315A**, Tab 1, p. 15, diagnosis codes 30ODAB, 30ODAC and 30ODAD **[CBE, Tab 64(A)]**.
[549] **Exhibit 315A**, Tab 1, p. 15, diagnosis code 30ODAD **[CBE, Tab 64(A)]**.
[550] **Exhibit 316B**, Tab 3, p. 5 **[CBE, Tab 68(A)]**.

wait times, as can be seen from the wait time information set out in **Appendix, Part A, Section VII(C)(iii), Table 1.**

944. The situation in BC has not improved since 2105 for patients requiring gallbladder surgery for biliary colic. The SPR data show that in 2017 and 2018, less than half of patients received their surgery within the maximum acceptable wait time for their condition, with the 90th percentile even from BFRD far exceeding maximum acceptable wait time. [551]

945. Patient Witness Monica Forster testified by Affidavit and was not cross-examined. Her experience epitomizes the harms to patients who wait too long for gall bladder surgery.

946. **Redacted due to evidence subject to a sealing order.**

947. **Redacted due to evidence subject to a sealing order.**

948. **Redacted due to evidence subject to a sealing order.**

949. **Redacted due to evidence subject to a sealing order.**

950. **Redacted due to evidence subject to a sealing order.**

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[551] **Exhibit 316C**, Tab 6, p. 5 **[CBE, Tab 69(B)]**.
[552] **Redacted due to evidence subject to a sealing order.**
[553] **Redacted due to evidence subject to a sealing order.**
[554] **Redacted due to evidence subject to a sealing order.**
[555] **Redacted due to evidence subject to a sealing order.**
[556] **Redacted due to evidence subject to a sealing order.**
[557] **Redacted due to evidence subject to a sealing order.**
[558] **Redacted due to evidence subject to a sealing order.**

951. As noted above, Ms. Forster was likely diagnosed with "Biliary Colic – Chronic (Infrequent Symptoms)", and thus should not have waited more than 12 weeks for her surgery.[559]

952. **Redacted due to evidence subject to a sealing order.**

953. **Redacted due to evidence subject to a sealing order.**

954. **Redacted due to evidence subject to a sealing order.**

955. **Redacted due to evidence subject to a sealing order.**

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[559] Exhibit 315A, Tab 1, p. 15, diagnosis code 30ODAD [CBE, Tab 64(A)].
[560] **Redacted due to evidence subject to a sealing order.**
[561] **Redacted due to evidence subject to a sealing order.**
[562] **Redacted due to evidence subject to a sealing order.**

956. **Redacted due to evidence subject to a sealing order.**

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[568] **Redacted due to evidence subject to a sealing order.**
[569] **Redacted due to evidence subject to a sealing order.**

960. **Redacted due to evidence subject to a sealing order.**

961. The delay in receiving scheduled surgery resulted in Ms. Forster's condition deteriorating to the point of septic shock and near fatal complications, which necessitated much more extensive and complex medical interventions and put Ms. Forster at risk of irreversible harm and death. All of these outcomes occurred as a result of Ms. Forster's excessive wait for medically necessary gallbladder surgery, and would have been avoided had she received her surgery in a timely way.

962. Some private clinics, such as Cambie, are approved to provide gallbladder surgeries.[571]

963. In the face of the persistently long waits in the public system, patients must continue to have the ability to access timely gallbladder surgery at private clinics in the province.

(iv) Plastic Surgery

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[570] **Redacted due to evidence subject to a sealing order.**
[571] **Exhibit 346A**, Affidavit #9 of Dr. Day, Exhibit "GG", p. 303 **[CBE, Tab 84]**.

964. Plastic surgery encompasses a wide variety of procedures pertaining to reconstructions of all areas of the body.[572] Procedures within this specialty can include management of chronic wounds and pressure sores in paraplegic patients, skin cancer procedures, breast and facial reconstruction, scar contracture, hand surgeries, treatment of carpal tunnel and nerve compression syndromes, and cosmetic surgery among others.[573]

965. The evidence in this case demonstrates that both urgent and non-urgent plastic surgeries are being delayed beyond their maximum acceptable wait times, resulting in harm to patients.

966. Dr. Nancy Van Laeken, a plastic surgeon, testified to the difficulties of providing timely care for plastic surgery patients. Dr. Van Laeken's practice focuses primarily on performing breast reconstruction surgeries for breast cancer patients, and to a lesser extent on facial reanimation, microsurgery, and other plastic surgeries.[574] She has privileges at several hospitals including Lions Gate, Mount Saint Joseph's, St. Paul's, Vancouver General, BC Women's, and BC Children's Hospital.[575]

967. Dr. Van Laeken also works at Cambie Surgery Centre, False Creek Surgical Centre, and the Ambulatory Surgical Centre, performing a variety of surgeries contracted out by the public system, as well as cosmetic surgeries, and WCB cases mostly involving hand traumas.[576]

968. Approximately two or three times per year, Dr. Van Laeken also travels overseas to perform charitable surgeries, primarily focusing on treating burn injuries in India and Bangladesh. Part of the reason she works privately is to fund her volunteer surgical trips to these countries.[577]

969. Dr. Van Laeken has held various administrative roles in the healthcare system, including serving as the division head, and later department head, of plastic surgery at St. Paul's Hospital, the department head in surgery and the surgeon in chief at Providence Health Care, the chairman of the medical advisory committee, as well as serving on the Regional Surgical Executive Council, and as a member of the provincial surgical advisory committee.[578]

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[572] **Transcript Day 40**, Testimony of Dr. Nancy Van Laeken, p. 4, lines 15 to 24.
[573] See for e.g. **Transcript Day 40**, p. 5, line 26 to p. 7, line 16.
[574] **Transcript Day 40,** p. 4, line 28, to p. 5, line 42.
[575] **Transcript Day 40**, p. 6, lines 22 to 35.
[576] **Transcript Day 40**, p. 6, lines 29 to 31, p. 26 line 45 to p. 27 line 23, and p. 32 lines 27 to 33.
[577] **Transcript Day 40**, p. 34, line 41 to p. 36, line 15.
[578] **Transcript Day 40**, p. 11, line 42 to p. 13, line 16.

970. As is the case for other surgical specialties, Dr. Van Laeken testified that non-urgent, "non-acute" plastic surgery procedures are often delayed to accommodate more urgent surgeries.[579] This has caused "non-acute" plastic surgery patients, in particular, to suffer unnecessary harm as a result of waiting for surgery.

971. We also had evidence from Patient Witness Ms. Barbara Collin, who waited well beyond the maximum acceptable wait time for the removal of her tissue expanders following a mastectomy and breast reconstruction surgery, and suffered psychological and physical harm, as well as a prolonged inability to work, as a result.

a) Harms from waiting for plastic surgery

972. "Non-acute" plastic surgery cases include less urgent patients who require nonetheless vital procedures such as breast reconstruction following a mastectomy, facial reconstruction after facial palsy, and prophylactic mastectomy for individuals diagnosed with a cancer gene and high likelihood of developing cancer but not yet showing symptoms.[580]

973. Dr. Van Laeken testified that these patients are often delayed and waiting, as they are lower priority than cancer patients and therefore considered not urgent.[581]

974. In the context of breast reconstruction surgery following a mastectomy, Dr. Laeken explained the process of tissue expander insertion: "tissue expanders are temporary implants that are placed at the time of mastectomy. They're put under the pectoral muscle to stretch the muscle to allow for placement of a permanent implant in the future."[582]

975. Depending on the size of the breast, the time between insertion of the tissue expanders to the time when the patient is ready to receive the permanent implant is typically three to six months, for patients who do not require any adjunctive therapy.[583]

976. Dr. Van Laeken testified to her observation of the experiences of patients during the waiting period for the reconstruction surgery: patients feel like "it's an unfinished piece of work or an unfinished aspect of them, that they can't move on with their life." They are often unable to return to

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[579] See for e.g. **Transcript Day 40**, p. 13, line 42 to p. 14, line 14.
[580] **Transcript Day 40**, p. 14, lines 15 to p. 15, line 20.
[581] **Transcript Day 40**, p. 14, line 15 to p. 15 line 20.
[582] **Transcript Day 40**, p. 42, lines 2 to 6.
[583] **Transcript Day 40**, p. 56, line 37 to p. 57 line 8.

work, with corresponding economic hardship, and experience psychological impacts including anxiety and depression.[584]

977. Dr. Van Laeken also testified that the "degree of emotional distress" experienced by the patient affects the physicians' decision about the priority to give to the patient, but that it's ultimately challenging to prioritize patients in this way, with a need to "look at the extent of disease and use the science with the emotion to make the final decision".[585]

978. With respect to prolonged wait times for removing the tissue expanders, Dr. Van Laeken testified that the tissue expanders are often quite uncomfortable at the end of the expansion, with the result that [...patients can have significant pain. It can cause them difficulty sleeping at night. And that pain is normally relieved when the bigger expander is removed and the smaller, permanent, softer implant is placed." [586]

979. Dr. Van Laeken further testified that the expander puts increasing tension on the pectoralis muscle, and "puts a tremendous amount of pressure on the ribcage." This pressure is so great that it causes rib fractures in some patients. She reiterated that the expanders "can be very painful," explaining, "It can be neurogenic pain, which is very hard to reverse. And it usually keeps them awake at night which is very fatiguing. And we are reluctant to have them on regular pain medication because it can be problematic. But I don't want to understate that in the very late stages of a tissue expander it's very uncomfortable."[587]

980. In terms of the effects of this pain on her patients, Dr. Van Laeken testified that the "[p]ain can restrict their ability to use their arm, the pectoral muscle in particular. They may not be able to do weight training or yoga. If they have a job that's a heavy labour job, lifting and carrying, it may be uncomfortable for them."

981. She also testified that near the end of the tissue expansion, the expanders will come up above where normal clothing would cover, causing "almost a tumour-looking appearance in the chest" which patients find difficult to cover.[588]

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[584] **Transcript Day 40**, p. 24, line 45 to p. 25, line 36.
[585] **Transcript Day 40**, p. 87, lines 32 to 42.
[586] **Transcript Day 40**, p. 42, line 39 to p. 43, line 2.
[587] **Transcript Day 40**, p. 57, lines 21 to 44.
[588] **Transcript Day 40**, p. 58, lines 25 to 35.

982. Dr. Van Laeken also testified that, in an attempt to obtain improved access to breast cancer reconstruction, she has worked on studies developing patient reported outcomes and quality of life outcomes, which "studies have confirmed that there is no question that patients' quality of life is lessened by a limited access to breast reconstruction."[589]

983. For patients waiting for facial reconstruction and reanimation surgery, such as individuals who have suffered trauma damaging their facial nerve, or who have had a tumor and removal of a nerve for brain surgery, or who have developed a Bell's Palsy that does not recover, Dr. Van Laeken explained that "the focus is to provide movement and stability of the facial area, which improves their ability to speak clearly, to eat properly, and it improves their breathing."[590] Timely access to these surgeries is crucial to facilitating patients' abilities to move on with their lives after experiencing nerve damage.

984. Dr. Van Laeken testified that she has observed the following in her facial palsy patients while waiting for surgery: "The most disturbing thing for them is the inability to smile. If you have seen a patient who's had a stroke or who has had a brain tumour removed, when their face is paralyzed it's completely placid, meaning the cheek is hanging and they can be drooling and they have difficulty breathing. Their eye is exposed, so they're tearing. So they are usually not working. They are usually distraught. Often they're a little bit depressed."[591]

985. She explained that the goals for that facial surgery "are to enhance function," and also "to make [the patients] appear to be more socially acceptable, in their own opinion."[592]

986. Dr. Van Laeken testified that for her breast reconstruction and facial palsy patients "their quality of life is hampered by their inability to have their surgery completed in a timely fashion. It's associated with anxiety, it can be associated with pain, if they don't return to work because of it it's associated with a socio-economic impact and it certainly takes a toll in their personal life."[593]

b) Provision of plastic surgery in BC

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[589] **Transcript Day 40**, p. 44 lines 10 to 34.
[590] **Transcript Day 40**, p. 4, lines 1 to 14.
[591] **Transcript Day 40,** p. 25, line 43, to p. 26, line 10.
[592] **Transcript Day 40,** p. 26, lines 12 to 18.
[593] **Transcript Day 40**, p. 44 lines 11 to 20.

987. Dr. Van Laeken testified to her surgical wait times and the impact of urgent surgeries on her ability to perform other non-acute surgeries such as facial and breast reconstruction.

988. Unlike her urgent cancer patients who are ideally seen within two to four weeks of diagnosis, Dr. Van Laeken described that for "non-urgent reconstructive procedures the target would be between three months and six months maximum wait time, including what we would call second stage or a delayed reconstruction."[594]

989. For scheduling the second stages of breast reconstruction surgery, Dr. Van Laeken explained her wait time for her patients to get to this second stage surgery is "approximately six months" but that it "can be longer if [she has] more cancer cases to book, and it will be longer if [she doesn't] get the extra time to do the outsource work that [she's] been getting."[595]

990. In BC, the maximum acceptable wait time for "Post-mastectomy defect - for breast reconstruction post radiation or chemo therapy (35YMCD) is six weeks.[596] The maximum acceptable wait time for "Mastectomy Defect for Delayed Reconstruction" (35YMAA) is 26 weeks.[597]

991. Dr. Van Laeken testified that she is typically allocated a total of four operating days per month, sometimes increasing up to six or eight days, depending on the time of year and allocation of OR days. She also works approximately four to six days per month in a private facility. [598]

992. She schedules her time working in the private system so as not to conflict with her allocated time in the public system.[599]

993. She testified that occasionally she may be given extra time by the public system to perform public surgeries that are outsourced to private facilities. For example, this occurred in 2015, which allowed her to do an additional 50 outsourced cases. She took on as much of this work as she could, but the funding for additional time was only temporary. [600]

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[594] **Transcript Day 40**, p. 13, lines 27 to 34.
[595] **Transcript Day 40**, p. 25, lines 39 to 42.
[596] **Exhibit 431**, p. 155.
[597] **Exhibit 316A**, Tab 2, p. 156 of 172.
[598] **Transcript Day 40**, p. 8, lines 21 to 34.
[599] **Transcript Day 40**, p. 32, lines 1 to 6.
[600] **Transcript Day 40**, p. 22, line 46 to p. 23, line 20.

994. Dr. Van Laeken has never turned down any additional days allotted to her for surgeries in the public system.[601]

995. She does not feel that she currently gets enough operating time in the public system to provide timely care to her patients.[602] She explained: "The patients who are left languishing, I would say, are those that are not acute, that don't have cancer, they're not trauma victims, they're not having chest pain. Those patients are subject to, I think, unnecessary wait times."[603]

996. Of her surgical group's wait times, Dr. Van Laeken testified that they "don't often meet the targets," in particular for non-cancer, non-acute cases.[604]

997. In particular for non-urgent, non-acute cases, she explained that "these are the patients that will get delayed or postponed or put on a waiting list until [the surgeons] have operative time available," and that her group is "often 2- to 300 percent over what's the recommended wait time for those specific cases."[605]

998. Even though her group is better at meeting the targets for cancer cases than non-cancer cases, she was recently involved in a regional assessment of the delivery of breast health care, which "identified that our wait times across all of the acuities is much longer than it should be."[606]

999. Breast cancer patients wait about two to four weeks for a consult with Dr. Van Laeken, and skin cancer patients will see her for a consult within four to six weeks. Non-cancer patients, such as those with facial palsy, wait about six to twelve months for a consult. [607]

1000. Dr. Van Laeken's surgical wait time varies, depending on the volume of breast cancer cases she gets, since "Everything gets put on hold so that the cancers have priority." Thus, she tells her non-cancer patients their surgical wait time will be anywhere between 6 to 18 months.[608]

1001. At the time of her testimony, the most recent prophylactic mastectomy she had performed had waited over 14 months.[609] These patients are all at "very, very high" risk of developing breast

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[601] **Transcript Day 40**, p. 23, lines 25 to 28.
[602] **Transcript Day 40**, p. 45, lines 34 to 37.
[603] **Transcript Day 40,** p. 44, lines 6 to 11.
[604] **Transcript Day 40**, p. 13, lines 40 to 46.
[605] **Transcript Day 40**, p. 14, lines 6 to 14.
[606] **Transcript Day 40**, p. 13, line 44 to p. 14, line 3.
[607] **Transcript Day 40**, p. 13, lines 22 to 34.
[608] **Transcript Day 40**, p. 17, lines 1 to 10.
[609] **Transcript Day 40**, p. 26, lines 35 to 44.

cancer due to their cancer gene. As. Dr Van Laeken testified, "So those patients, once they've had the diagnosis, obviously are aware that they are going to get cancer."

1002. In BC, the maximum acceptable wait time for patients with the diagnosis "Breast Cancer Risk Requiring Prophylactic Mastectomy" (35YMBA) is 12 weeks (Priority 4). [610] In 2017, the 90th percentile Wait Two time for this procedure was 43.8 weeks from BFRD and 57.5 weeks from Decision Date. Only 38.3% of cases were completed within 12 weeks. [611]

1003. For 2009/2010, 2010/2011, 2011/2012 and 2012/2013, Dr. Van Laeken had a very significant surgical wait time, with a 90th percentile wait of 168.4 weeks in 2009/2010 up to 244.7 weeks in 2011/2012. Dr. Van Laeken testified that it would have predominately been her breast reconstruction and reduction cases waiting that long.[612]

1004. Dr. Van Laeken testified that she will refer patients to other surgeons when she receives a referral for a consult and knows that her wait time for the consultation will be too long.[613]

1005. However, it is unlikely that patients' wait times are much reduced at a result. The government's data shows that breast reconstruction has been among the top 15 procedures with the longest Wait One times in BC from the time the government started measuring Wait One in 2014 until at least 2017.[614]

1006. According to the SPR data, the 90th percentile Wait One time for breast reconstruction in BC was 39.3 weeks in 2014/15, 39.7 weeks in 2015/16, and 39.6 weeks in 2016/17.[615]

1007. The Wait Two time for these procedures is also well beyond the maximum acceptable wait time. For example, in 2014, the 90th percentile wait time from BFRD for "Mastectomy Defect for Delayed Reconstruction" (Priority 5 --26 weeks), was 41.4 weeks and from Decision Date was 50.1 weeks.[616]

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[610] **Exhibit 316C**, Tab 5, p. 134 **[CBE, Tab 69(A)]**.
[611] **Exhibit 315C**, Tab 10, p. 32 **[CBE, Tab 66(B)]**.
[612] **Transcript Day 40**, p. 31, lines 4 to 21; See also **Exhibit 84**, p. 3 **[CBE, Tab 166]**.
[613] **Transcript Day 40**, p. 15, line 36 to p. 16, line 8.
[614] **Exhibit 431**, p. 236, and pp. 238-239 **[CBE, Tab 102]**.
[615] **Exhibit 431**, p. 238 **[CBE, Tab 102]**.
[616] **Exhibit 316A**, Tab 2, p. 156 of 172 **[CBE, Tab 67(A)]**.

1008. In 2014, the 90th percentile wait time from BFRD for "Post-Mastectomy Defect - For Breast Reconstruction Post Radiation Or Chemo Therapy" (4 weeks) was 29.1 weeks and from Decision Date was 39.7 weeks.[617]

1009. Patients waiting for urgent plastic surgery in other areas are also waiting beyond their maximum acceptable wait times. For example, the diagnosis "Hand Condition: Severe Pain – Patient Cannot Self-Care – Delay Will Lead to Serious Harm (E.G. Loss of Nerve Function" has a maximum acceptable wait time of two weeks, but the 90th percentile wait from Decision Date in 2015 was 7.6 weeks,[618] and by March 31, 2018 had increased to 11.4 weeks.[619]

c) Patient experience – Barbara Collin

1010. The Court heard evidence from Patient Witness Barbara Collin, who waited for a long period in the public system for breast reconstruction surgery following breast cancer and mastectomy.

1011. Ms. Collin suffered significant pain and discomfort, and was unable to work while waiting to have the tissue expanders in her chest removed for the final step in her breast reconstruction.

1012. The date of Ms. Collin's mastectomy and insertion of tissue expanders was July 7, 2009. Ms. Collin was ready to have her final surgery to remove the tissue expanders about six months later in December 2009,[620] but the earliest surgical date for her in the public system would have been June 2010 due to surgical backlogs.

1013. If Ms. Collin had waited for her surgery in the public system, Ms. Collin would have waited at least six months beyond the point at which she was ready to have her expanders removed. As she did not feel she could or should wait that long, she persuaded her long term disability to insurer to pay for her to have earlier surgery privately, so that she could return to work.

1014. Ms. Collin had a bilateral mastectomy at Mount St. Joseph's Hospital on July 7, 2009. Her breast tissue was removed and Dr. Van Laeken inserted tissue expanders.[621]

1015. When Ms. Collin met with Dr. Van Laeken in the fall of 2009, Dr. Van Laeken told her that she would be ready for her final surgery by December 2009 or January 2010. Dr. Van Laeken later

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[617] **Exhibit 316A**, Tab 2, p. 156 of 172 **[CBE, Tab 67(A)]**.
[618] **Exhibit 316B**, Tab 3, p. 165 of 183 **[CBE, Tab 68(A)]**.
[619] **Exhibit 316C**, Tab 6, p. 91 of 103 **[CBE, Tab 69(B)]**.
[620] **Transcript Day 54**, Testimony of Ms. Barbara Collin, p. 12, line 13 to p. 13, line 7.
[621] **Transcript Day 54**, p. 9, lines 34 to 39.

advised Ms. Collin that she would not have surgery until after February 2010 because of surgical backlogs.[622]

1016. This was a difficult time both physically and emotionally for Ms. Collin. She was aware of the physical abnormality of her chest and was embarrassed by the size and location of the tissue expanders. The tissue expanders made it "awkward and uncomfortable" to even do simple things like greet others with a hug as she had before and they were causing her constant chest pressure.[623] Ms. Collin testified: "it was really uncomfortable, and it was really consuming, this chronic pain."[624]

1017. Ms. Collin was eager to go back to work but understood that she wasn't cleared to do so and personally didn't think that she would have been in psychological state fit to do so:

> ... So I wanted to go back to work, but I -- psychologically no, I couldn't, because my focus wouldn't have been at work; it would have been I know I have to finish my -- you know, the whole process. I know I have to get these expanders out and implants in. So your mind is still in the process of doing everything you have to do to get well again and get back to normal.[625]

1018. Around late February or early March 2010, Ms. Collin contacted Dr. Van Laeken's office to ask when she would be scheduled for her final surgery. Dr. Van Laeken's office advised that she did not yet have a surgery date and to call back in another three months to find out when her surgery date might be.[626]

1019. Ms. Collin was distressed when she learned the earliest she could have her final surgery would be June 2010 and thought she "couldn't do this anymore".[627] She had been diagnosed with breast cancer in August 2008, and had been unable to work since then. Moreover, she had already been waiting since December 2009 for her final surgery.

1020. The physical pain from the chest expanders continued to restrict Ms. Collin's mobility. She felt angry and experienced anxiety and depression.[628] She could not do the activities she enjoyed and considered an essential aspect of her life, such as participating at her son's high school events.[629]

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[622] **Transcript Day 54**, p. 12, lines 13 to 23, and p. 13, lines 1 to 7.
[623] **Transcript Day 54**, p. 10, lines 4 to 23
[624] **Transcript Day 54**, p. 10, lines 11 to 13.
[625] **Transcript Day 54**, p. 10, line 26 to p. 11 line 30.
[626] **Transcript Day 54**, p. 12, line 25 to p. 13 line 19
[627] **Transcript Day 54**, p. 13, lines 11 to 19.
[628] **Transcript Day 54**, p. 35, lines 25 to 36.
[629] **Transcript Day 54**, p. 17, lines 30 to 37.

1021. Aside from her physical pain and discomfort during this time, being unable to work had a number of negative effects on her and her family. She was receiving benefits from the disability insurance offered through her employer, which were about 65% of her usual earnings. This caused financial hardship for her family as she was the "major breadwinner". Her husband had to cash in an RRSP during this period while she was waiting for surgery so her family could meet its financial commitments.[630]

1022. After having waited several months from the time she was ready for surgery, when she learned in March 2010 that the earliest surgery date would be June 2010, Ms. Collin looked for alternatives.[631]

1023. Dr. Van Laeken advised Ms. Collin that the surgery could be performed at Cambie as early as April 1, 2010 and would cost approximately $5,500. After obtaining these details from Dr. Van Laeken, Ms. Collin wrote to her employer-provided disability insurance carrier, and requested that the insurer pay for the surgery.[632]

1024. She explained to the insurer that she was in a lot of pain and was eager to get back to work, but still required a final surgery. She explained that it would be less expensive for the insurer to pay for the surgery to be done privately so she could get back to work sooner, rather than for them to continue to pay her disability benefits while she waited for surgery in the public system, and that the private surgery option was not only more cost effective for the disability insurance provider but also physically and emotionally better for her.

1025. The disability insurance provider agreed and paid for her to have her surgery privately.[633]

1026. **Redacted due to evidence subject to sealing order.**

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[630] **Transcript Day 54**, p. 13 line 40 to p. 14 line 8; and **Exhibit 205**, Statement of RRSP Income for D. Collin **[CBE, Tab 167]**.
[631] **Transcript Day 54**, p. 13, lines 11 to 23.
[632] **Transcript Day 54**, p. 14, lines 15 to 27.
[633] **Transcript Day 54**, p. 14, lines 11 to line 33; See also **Exhibit 206,** Emails between Barbara Collin and Great West Life dated March 10 and 11, 2010 **[CBE, Tab 168]**; **Exhibit 207**, Letter from Barbara Collin to Diane Bezdikian dated March 15, 2010**[CBE, Tab 169]**; and **Exhibit 208,** Correspondence between Barbara Collin and Terri Connelly at Great West Life dated April 1, 2010, and April 23, 2010 **[CBE, Tab 43]**.
[634] **Redacted due to evidence subject to sealing order; Transcript Day 54**, p. 43, lines 3 to 13.

1027. Once Ms. Collin's tissue expanders were removed, she no longer had chronic pain. She began a gradual return to work in May 2010 and shortly thereafter returned to work full time,[635] before she would even have had her surgery had she continued to wait in the public system.

1028. Following her surgery, Ms. Collin was once again able to participate fully in her family life and professional life.

1029. Getting back to work sooner meant that Ms. Collin was not only able to relieve her physical and emotional suffering, but also to relieve the financial troubles her family suffered while she was off work.[636]

1030. Without the option of having her surgery done privately, and without the assistance of her disability insurer in agreeing to fund it despite this being contrary to the *MPA*, Ms. Collin would have continued to suffer physical and emotional pain and discomfort even longer than she already had, and would have been forced to remain off work longer, unable to finally move on with her life after surviving cancer.

(v) Cataract Surgery

1031. Patients are enduring lengthy and harmful waits beyond the maximum acceptable wait times for cataract surgery in BC.

1032. This is despite the Federal and BC governments' continued efforts to prioritize cataract surgeries since 2005, due to the high volume and long wait times that have accumulated for these surgeries in the public system, and the resulting harms to patients.

1033. As outlined below, while cataracts are not usually a life-threatening condition, the evidence in this case has shown that long waits in the public system for cataract surgery lead to serious adverse consequences for patients, including the potential for life-threatening physical injury.

a) Expert Evidence

1034. There is no dispute in the expert evidence of the harms to patients from waiting for cataract surgery.

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[635] **Transcript Day 54**, p. 15, lines 4 to 10, and p. 15, line 43 to p. 16 line 10.
[636] **Transcript Day 54**, p. 13, line 40 to p. 14, line 8.

1035. Defendant's expert, Dr. Robert McMurtry, former Chair of the Wait Times Group for the Health Council of Canada, testified that "neither cataracts nor arthritis are usually life-threatening conditions," but also agreed regarding cataracts that, "Poor visual acuity can lead to accidents and injury which may be disabling or even life-threatening".[637]

1036. Plaintiffs' expert, Dr. Gordon Matheson, opined that "[p]atients waiting for cataract surgery experience decreases in vision and quality of life, and an increased frequency of falls, hip fractures and motor vehicle crashes."[638]

1037. Dr. Matheson cited two systematic reviews that informed this opinion,[639] which had found that "[p]atients who wait more than 6 months for cataract surgery may experience negative outcomes during the wait period, including vision loss, a reduced quality of life and an increased rate of falls,"[640] and that "individuals with cataracts are at an increased risk of falls, hip fractures, and motor vehicle crashes the absence of pre-existing eye disease, and better baseline visual acuity and visual function are associated with better outcomes, and average WTs of 6-12 months are associated with a decline in visual acuity in patients while waiting."[641]

1038. Dr. Matheson further opined in reliance upon a study by Boisjoly et al. that "[p]atients with cataracts who wait less time have fewer falls, burns, cuts, bruises and car accidents."[642]

1039. Plaintiffs' expert, Dr. Keith Chambers also opined that "those with visual deterioration secondary to cataracts that is severe enough to require cataract surgery will have loss in vision such that it impacts on quality of life and risk of falling" and "in the case of cataract surgery, delays in surgery result in harms to patients in the form of reduced quality of life related to reduced visual acuity and increased risk of serious falls. He relied for this opinion on the studies by Hodge et al. and Boisjoly et al."[643]

1040. The timing of serious life-threatening falls and resultant fractures due to decreased vision cannot be predicted, but the risk is greater for patients exceeding the maximum acceptable wait times

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[637] **Transcript Day 159**, Testimony of Dr. Robert McMurtry, p. 45, lines 4 to 30.
[638] **Exhibit 274,** Expert Report of Dr. Matheson, Vol. 1, Tab A, p. 8 **[CBE, Tab 53]**.
[639] **Exhibit 274, Tab 18** (Hodge); **Exhibit 274, Tab 19** (Connor-Spady) **[CBE, Tab 53]**.
[640] **Exhibit 274,** Tab 18, Hodge et al., p. 201 **[CBE, Tab 53]**.
[641] **Exhibit 274**, Tab 19, Conner-Spady et al., p. 208 **[CBE, Tab 53]**.
[642] **Exhibit 274**, Tab A, p. 8 **[CBE, Tab 53]**.
[643] **Exhibit 289A,** Expert Report of Chambers, Vol. 1, p. 7, para. 4 and Tab C, p. 15 **[CBE, Tab 54]**.

for cataract surgery. As Defendant's expert, Dr. Eric Bohm, noted, "all patients are at risk of mortality after a hip fracture."[644]

1041. Thus, cataract patients that fall and sustain fractures are at increased risk of mortality, which is increased further if they don't receive timely surgery.

1042. Dr. Bohm provided evidence of decreased mortality if operated on within 24 hours. He testified that "all patients are at risk of mortality after a hip fracture. And we have good evidence to show that the longer you wait for surgery, generally the higher your risk of mortality is," and went on to say that "delays to hip fracture surgeries remain common."[645]

1043. Further, when testifying about falls that lead to hip fractures, Plaintiffs' expert, Dr. Bassam Masri referenced the need to get cataract surgeries done to prevent patients from falling, stating: "There's a whole reason why patients fall. So elderly patients, you need to declutter, you need to make sure the rugs don't slip, you need to make sure you treat their vision, so that's why cataracts -- there's a push to getting cataracts done so that people don't fall."[646]

b) Physician Witnesses

1044. Dr. Kevin Wade and Dr. Kevin Parkinson, who are both ophthalmologists and cataract surgeons, provided evidence about their experience in treating patients with cataracts and other eye conditions.

1045. Dr. Wade treats patients with a variety of conditions involving the cornea, optic nerve, and retinal diseases.[647] In addition to his office in Kerrisdale[648] where he sees patients for consultation and ongoing treatment, he performs cataract surgery at the Eye Care Centre at Vancouver General Hospital.[649] He was previously the head of the resident ambulatory clinic, where he continues to teach residents.[650] He also performs private surgeries at Cambie.[651]

1046. **Redacted due to evidence subject to sealing order;**

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[644] **Transcript Day 153**, Testimony of Dr. Eric Bohm, p. 22, line 46 to p. 23, line 2.
[645] **Transcript Day 153**, Testimony of Dr. Eric Bohm, p. 22, line 43 to p. 23, line 6.
[646] **Transcript Day 87**, Testimony of Dr. Bassam Masri, p. 63, lines 5 to 11.
[647] **Transcript Day 35**, Testimony of Dr. Kevin Wade, p. 6, lines 26 to 32.
[648] **Transcript Day 35**, p. 4, line 42 to p. 5, line 2.
[649] **Transcript Day 35,** p. 12, lines 11 to 18.
[650] **Transcript Day 35,** p. 4, lines 25 to 29, and p. 15 lines 38 to 44.
[651] **Transcript Day 35**, p. 27, lines 3 to 9.

He currently works at Coquitlam Ophthalmology Associates, which was his private practice from 2000-2015, now only performing in-office procedures there. He has not performed any surgeries since 2015.[653]

1047. As Dr. Parkinson and Dr. Wade testified, for patients with cataracts, even while waiting within the maximum acceptable wait times, patients' vision loss and deterioration impairs their ability to carry on with tasks of daily life, and increases the risks of their surgery.

1048. Dr. Wade testified that the length of time a cataract has been allowed to progress can affect the prognosis for a patients' recovery, their ultimate health, as well as the length of the surgery. Dr. Wade explained that as patients wait for surgery, "[t]he cataract is getting worse, so when I do their surgery it's a more difficult surgery with more risk of complications for them," as opposed to if he had done the surgery earlier. He testified that while there is always a risk with cataract surgery, the risk multiplies the longer the patient waits.[654]

1049. Dr. Wade testified that the lens becomes denser the longer a cataract waits, and thus requires more energy, ultrasound power, and time to perform the surgery.[655]

1050. He explained, in turn, that the amount of ultrasound energy delivered in the eye can impact the patients' recovery speed and pressure after surgery. For example, if he uses more ultrasound energy on a dense cataract, patients are more likely to have corneal swelling for a week after surgery where their vision is still not good enough to drive or to see well.[656]

1051. Dr. Wade further testified that he cannot tell which patient is "going to suffer any of the adverse consequences while waiting,"[657] and in particular, "[O]f the people who do need surgery, I can't tell who's going to go home and fall and break their hip."[658]

1052. Dr. Wade testified that his patients waiting for cataract surgery "are more socially isolated, they have less interaction with their environment, they're at a higher risk of motor vehicle accidents."[659]

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[652] **Redacted due to evidence subject to sealing order;**
[653] **Transcript Day 120**, Testimony of Dr. Parkinson, p. 9, line 44 to, p. 10, line 24.
[654] **Transcript Day 35**, p. 40, lines 16 to 30.
[655] **Transcript Day 35**, p. 16, lines 22 to 41.
[656] **Transcript Day 35**, p. 16, line 42 to, p. 17, line 1.
[657] **Transcript Day 35**, p. 40, lines 10 to 12.
[658] **Transcript Day 35**, p. 40, lines 3 to 5.
[659] **Transcript Day 35**, p. 40, lines 10 to 15.

1053. **Redacted due to evidence subject to a sealing order.**

1054. **Redacted due to evidence subject to sealing order;**

1055. **Redacted due to evidence subject to a sealing order.**

1056. A Ministry of Health Briefing Note dated June 14, 2018 recognized that studies show patients are sensitive to waiting times if they wait beyond 26 weeks for surgery, with the consequences of waiting being increased risks of falls, hip fractures, car crashes and vision loss.[663] Nonetheless, because surgical outcomes are not likely to be significantly affected by wait times, in contrast to other types of surgery, the Briefing Note concluded that cataract surgery should be a "Low Priority" among the Ministry of Health's future surgical priorities.[664]

c) Wait Times

1057. A federally-mandated evidence-based benchmark for cataract surgery was implemented in Canada in 2005, following Canada's first ministers signing the 2004 *10-year Plan to Strengthen Health Care.* The federal benchmark for cataract surgery to provide the surgery within 112 days of a specialist determining the surgery was required. The 16 week evidence-based maximum benchmark was unanimously adopted by the Prime Minister and premiers of each of the provinces and territories.[665]

1058. Cataract surgery still has a federally mandated wait time target of 112 days (16 weeks),[666] however, shorter maximum acceptable wait times have been accepted by the BC Government and the

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[660] **Redacted due to evidence subject to a sealing order.**
[661] **Redacted due to evidence subject to sealing order;**
[662] **Redacted due to evidence subject to a sealing order.**
[663] **Exhibit 431**, p. 111 **[CBE, Tab 102]**.
[664] **Exhibit 431**, p. 108 **[CBE, Tab 102]**.
[665] **Exhibit 2A**, pp. 128 to 129, paras. 301 and 302(d), and footnote 59 **[CBE, Tab 1]**.
[666] **Exhibit 430**, p. 990 **[CBE, Tab 101]**.

medical profession and implemented for different degrees of cataract disease in BC as of 2010. These were renewed in 2015.

1059. **Redacted due to evidence subject to a sealing order.**

1060. Thus, in BC as of 2015, cataract surgeries have been priority levels 3 (6 weeks), 4 (12 weeks) and 5 (26 weeks).[670]

1061. However, BC patients have not been receiving cataract surgery within the BC maximum acceptable wait times, nor within the federal 16 week target. They have been waiting far longer than this.

1062. While the number of cataract surgeries increased in BC from 48,572 in 2012/2013 to 55,148 in 2015/2016, the percentage of patients being treated within the 16 week benchmark for those surgeries decreased from 81% to 59%.[671]

1063. A Ministry of Health Briefing Note dated March 20, 2017 stated: "With regard to joint replacement surgery (hip replacement, knee replacement) and cataract surgery, over the last five years BC shows a significant decrease in the proportion of people treated within benchmark, and is performing worse than most other provinces..."[672]

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[667] **Redacted due to evidence subject to a sealing order.**
[668] **Redacted due to evidence subject to a sealing order.**
[669] For e.g. BC has shorter wait times for "Cataract – unable to function without assistance" (62CLAC) – Priority Level 3, **6 weeks**, and "Cataract – work driving impairment or impairment in the ability to function in the workplace" (62CLAG) – Priority Level 4, **12 weeks**; See also **Exhibit 431**, p. 148, **Redacted due to evidence subject to a sealing order.**

[670] **Exhibit 431**, p. 148 **[CBE, Tab 102]**.
[671] **Exhibit 431,** p. 104 **[CBE, Tab 89]**.
[672] **Exhibit 431**, at p. 106 **[CBE, Tab 89]**.

1064. In 2016, only 34.5% of patients diagnosed with 62CLAC "Cataract – unable to function without assistance" received their surgery within the six week maximum acceptable wait time for this urgency level, and in 2017, only 40.2% did.[673] This is so even though this data is calculated based on Wait Two from BFRD, not from the Wait Two from Decision Date. In 2017, the 90th percentile Wait Two time from BFRD for this diagnosis was 22 weeks, and from Decision Date was 29.7 weeks.[674]

1065. In 2016, only 52.1% of patients diagnosed with 62CLAG "Cataract – work driving impairment or impairment in the ability to function in the workplace" received their surgery within the 12 week maximum acceptable wait time, and in 2017, only 51.0% did.[675] In 2017, the 90th percentile Wait Two time was 28.1 weeks from BFRD and 36.7 weeks from Decision Date.[676]

1066. A large percentage of British Columbians are still waiting past the maximum acceptable wait time in all cataract surgery diagnosis codes in recent years as shown in the SPR data for the years 2017 to March 31, 2018 (based on Wait Two from BFRD) (see **Appendix, Part A, Section VII(C)(v), Table 1**).[677]

1067. The most recent 2018 wait time data from CIHI shows that only 64% of British Columbians are receiving their cataract surgery within the federal maximum benchmark time of 112 days, with the 90th percentile wait time at 253 days.[678]

1068. **Redacted due to evidence subject to a sealing order.**

1069. **Redacted due to evidence subject to a sealing order.**

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[673] **Exhibit 315A**, Tab 4, Page 11 of 26 **[CBE, Tab 64, d]**.
[674] **Exhibit 316C,** Tab 5, Page 28 of 149 **[CBE, Tab 69(A)]**.
[675] **Exhibit 315A**, Tab 4, Page 11 of 26 **[CBE, Tab 64, d]**.
[676] **Exhibit 316C**, Tab 5, Page 29 of 149**[CBE, Tab 69(A)]**.
[677] **Exhibit 315A,** Tab 4, Page 11 of 26 **[CBE, Tab 64, d]**; **Appendix,** Part A, Section VII(C)(v), Table 1.
[678] **Exhibit 433E**, at p. 4528 **[CBE, Tab 107]**.
[679] **Redacted due to evidence subject to a sealing order.**
[680] **Redacted due to evidence subject to a sealing order.**
[681] **Redacted due to evidence subject to a sealing order.**

1070. During cross-examination, Dr. Parkinson was presented with Exhibit "C" to his affidavit, showing his 50th percentile wait times from 2011 to 2015 ranging from 8 months up to 11-12 months.[682] In response to questions from the Court, Dr. Parkinson explained that what may appear to be shorter Wait 2 times based on the SPR data from 2011 to 2015, was due to the surgery for the second eye being included in these overall wait times. Surgery for the second eye can only be booked after the first eye has been completed, and the second eye generally has a much shorter wait time. Thus, including the second eye surgeries with the first eye surgeries artificially shortened the wait times overall.[683]

1071. Likewise, Dr. Wade testified that there is a hidden wait time for all patients who require a second eye surgery (80% of cataract patients require cataract surgery in both eyes). This hidden wait occurs because the second eye is not counted as waiting until the first eye surgery is done. Dr. Wade testified that the second eye does not show up on public waiting lists until the surgery is actually booked, and the first day physicians are allowed to book the surgery is after the first eye is done.[684] Again, this makes the reported wait times for cataract surgery appear to be shorter than they are.

1072. Dr. Wade explained that prioritizing second eye surgeries inevitably lengthens the wait times for first eye surgeries of other patients: "...when I do try and get someone in for a second surgery sooner, the -- that does bump someone off the first eye list. Because if we're making more room for second eyes to come in to balance between the two eyes, that just extends the wait for the average person on the first list."[685]

1073. The average wait time for a consult with Dr. Wade is about two to three months for patients with a progressive deterioration, while patients who are referred to him for a routine screening may be waiting as long as two years for a consultation.[686]

1074. Dr. Wade's wait for cataract surgery, once it has been determined that a patient has cataracts and requires surgery (i.e. Wait Two), was about five months at the time of his testimony, but can vary up to 14 months for the first eye.[687]

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[682] **Transcript Day 120**, p. 19, line 38 to p. 20, line 20.
[683] **Transcript Day 120,** p. 70, lines 7 to 34.
[684] **Transcript Day 35**, p. 11, lines 15 to 44.
[685] **Transcript Day 35,** p. 75, lines 40 to 47.
[686] **Transcript Day 35,** p. 10, lines 30 to 37.
[687] **Transcript Day 35,** p. 11, lines 11 to 14.

1075. Dr. Wade testified that even his trauma patients regularly wait beyond the target hours.[688]

1076. Dr. Wade testified that he cannot simply assign people a shorter priority code in order to move them up the wait list. They all have similar conditions and symptoms, so it is difficult to move some ahead of others: "If people are all suffering, how can I make someone come sooner than someone else?"[689]

1077. Dr. Wade testified that patients have long been able to pay for upgraded lenses and measurements in both the public and private system. If they opt for a private lens in the public system, they pay the Health Authority, and if they do so for a private surgery, the transaction is done through Dr. Wade's office.[690] Patients in both the public and private system can and do opt to also pay for additional eye measurements not covered by MSP prior to their surgery, to ensure their surgical outcome is as ideal as possible. The physicians receive additional compensation over and above the MSP rate for these advanced measurements.[691]

1078. Dr. Wade provided the following example for a patient in the public system opting to pay for a multifocal lens that is not covered by MSP: "When patients select a multifocal lens, they will then buy that from the hospital at a charge of approximately $1,100, and then they would charge on top of that for the extra steps required to implant a multifocal lens, and that charge would usually be in the range of $800."[692]

1079. Dr. Wade provided another example of a patient paying for a Toric lens that is not covered by MSP: "To use a Toric lens I need more measurements and calculations and there are more surgical steps to marking the eye, positioning the lens at the correct angle to neutralize the astigmatism. So it is optional to patients. We tell them what's available to all of them, and that's why some will choose it and some won't. If they do choose a Toric lens they buy the lens for $502 from the -- from the hospital or the health authority and I charge them $400 for the extra measurements, extra formulas, calculations of the angle of the lens and the surgery steps to do that." This $400 is over and above what MSP would pay him for the surgery.[693]

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[688] **Transcript Day 35,** p. 42, lines 7 to 37.
[689] **Transcript Day 35,** p. 36, line 38 to p. 37 line 11.
[690] **Transcript Day 35**, p. 67, lines 25 to 40.
[691] **Transcript Day 35**, p. 67, line 40 to p. 68, line 43.
[692] **Transcript Day 35**, p. 19, lines 37 to 43.
[693] **Transcript Day 35**, p. 19, lines 11 to 23.

1080. He testified he knows the health authority makes a small profit in selling the Toric lens.[694]

1081. Dr. Parkinson also testified that patients have the option of paying for additional premium lenses and diagnostics for their cataract surgery, regardless of whether they choose to have their surgery done privately or in the public health care system.[695]

1082. Dr. Wade further testified that Cambie has purchased a femtosecond laser, which is not available anywhere in the public system. This equipment is "now thought to be the highest level of accuracy and the best outcomes for cataract surgery, it leads to more accurate visual targeting, a faster healing, earlier return to stable, good vision."[696]

d) Resource Issues / Private Clinics

1083. Both Dr. Wade and Dr. Parkinson testified to the lack of resources to provide timely care for cataract surgery patients in the public system and the role of private clinics in alleviating these long cataract wait times.

1084. Dr. Wade is only allotted about 10 surgery days in the public system per month. He testified that "it really is often an exercise in scarce resources" when his surgical group has to divide among themselves the time allocated to their group.[697]

1085. Dr. Wade testified that he is a strong believer in BC's public health care system and that he initially only reluctantly started working at Cambie when his public wait list became so long and his patients were begging him to do their surgeries in any way he could, "some of them crying in [his] exam chair because they couldn't work or couldn't drive, it had taken a long time to get in to see me, either through their delay initially or through their doctor's referral delay, and they were very upset that it was impacting their life...".[698]

1086. Dr. Wade testified that the time he spends working at Cambie does not detract from the time he spends in the public system, and has not increased his wait times in the public system, but has instead reduced them by approximately 20%. Since about 20% of his patients are choosing to have

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[694] **Transcript Day 35**, p. 19, line 46 to p. 20, line 6.
[695] **Transcript Day 120**, p. 64, lines 7 to 16.
[696] **Transcript Day 20**, p. 25, lines 25 to 41.
[697] **Transcript Day 35**, p. 12, lines 15 to 44.
[698] **Transcript Day 35**, p. 20, line 45 to p. 21, line 22.

their surgery done privately, this frees up more of his allotted time in the public system to do surgeries for the patients on his public wait list.[699]

1087. In Dr. Wade's experience, the patients who came to Cambie for private surgery were not the wealthiest, but "the patients with the worst cataracts that couldn't wait, that were begging to have the surgery done, sometimes lower socioeconomic status who were borrowing money to have the surgery, but they were so pleased to have the option of getting it sooner rather than waiting the length of the waiting time [he] had in the public system for both their first and then their second eye."[700]

1088. Dr. Parkinson testified that working at the private clinic, Coquitlam Cataract Surgery, over and above the time he was given in the public system, had allowed him to do a higher volume of surgeries for his patients than if he had only worked in the public system.[701]

1089. Dr. Parkinson billed MSP for the surgeries he was performing at the private clinic. He made less money for each surgery done privately than he would have made if he had done them in the public system.[702]

1090. The BC Government has outsourced many publicly funded cataract surgeries to private clinics in order to provide more timely care. All health authorities (other than PHSA) have contracted out cataract surgeries to private clinics for years.[703] Nonetheless, the wait times for cataract surgeries in the public system have not decreased, due to increasing demand.

e) Cataract Surgery Patients

1091. The experience of witness, Peggy Eburne, is illustrative of the harm experienced by a cataract patient while waiting for cataract surgery.

1092. **Redacted due to evidence subject to sealing order;**

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[699] **Transcript Day 35**, p. 27, lines 14 to 28.
[700] **Transcript Day 35**, p. 21, lines 27 to 37.
[701] **Transcript Day 120,** p. 25, lines 3 to 26.
[702] **Transcript Day 120**, p. 25, lines 7 to 14.
[703] See for e.g. **Exhibit 431**, pp. 738 to 739, which shows private facilities providing "Cataracts" procedures to Health Authorities as of February 2018, except PHSA; and **Exhibit 431**, pp. 805-809, which lists private facilities performing eye surgeries contracted out to them by the Health Authorities over the years 2014-2017**[CBE. Tab 1021.**
[704] **Redacted due to evidence subject to sealing order;**

1093. When she visited her optometrist, Dr. Chi, in May 2012, Ms. Eburne was concerned about having deteriorating eyesight, being unable to drive as a result, and worried about glaucoma.[705]

1094. Ms. Eburne was seeing a "halo around her eyes", with her eyesight functioning as if she was "looking through a coke bottle." Her eyesight was getting "darker" and she couldn't see "white" very well. Her vision had been getting worse and this was troubling to her.[706]

1095. **Redacted due to evidence subject to sealing order;**

1096. **Redacted due to evidence subject to sealing order;**

1097. **Redacted due to evidence subject to a sealing order.**

1098. **Redacted due to evidence subject to sealing order;**

1099. **Redacted due to evidence subject to a sealing order.**

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[705] **Transcript Day 143**, Testimony of Peggy Eburne, p. 12, lines 37 to 46.
[706] **Transcript Day 143**, p. 12, lines 37 to 46 and p. 20, lines 15 to 29.
[707] **Redacted due to evidence subject to sealing order;**
[708] **Redacted due to evidence subject to sealing order;**
[709] **Redacted due to evidence subject to a sealing order.**
[710] **Redacted due to evidence subject to a sealing order.**
[711] **Redacted due to evidence subject to a sealing order.**
[712] **Redacted due to evidence subject to sealing order;**
[713] **Redacted due to evidence subject to a sealing order.**
[714] **Redacted due to evidence subject to a sealing order.**
[715] **Redacted due to evidence subject to a sealing order.**

1100. **Redacted due to evidence subject to sealing order;**

She did not want to utilize private surgery as a matter of principle. This was, of course, her choice to make.

1101. Ms. Eburne's concern continued as she waited. Her eyesight wasn't getting any better, and she continued to be unable to drive, and had continual worry about her glaucoma and not being able to know when she would have surgery.[717]

1102. While waiting for surgery, Ms. Eburne's deteriorating eyesight also resulted in her being unable to read to the extent she had before. Ms. Eburne testified that she had previously been "a great reader," but this waiting period "took away a lot of [her] pleasure because [she] actually read a tremendous amount, and it wasn't pleasurable to read."[718]

1103. **Redacted due to evidence subject to sealing order;**

1104. **Redacted due to evidence subject to sealing order;**

1105. **Redacted due to evidence subject to sealing order;**

1106. **Redacted due to evidence subject to a sealing order.**

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[716] **Redacted due to evidence subject to sealing order;**
[717] **Transcript Day 143**, p. 27, lines 37 to 47.
[718] **Transcript Day 143**, p. 28, lines 4 to 13.
[719] **Redacted due to evidence subject to sealing order;**
[720] **Redacted due to evidence subject to sealing order;**
[721] **Redacted due to evidence subject to sealing order;**
[722] **Redacted due to evidence subject to a sealing order.**
[723] **Redacted due to evidence subject to a sealing order.**

1107. Ms. Eburne waited about 40 weeks from the date of her first consult with Dr. Parkinson in July 2012 to her first eye surgery with Dr. Parkinson in April 2013.

1108. Ms. Eburne endured months of discomfort and deterioration in her eyes, and resulting disruption in her daily life, being unable to read and drive as she had before.

1109. This harm to Ms. Eburne and similarly-situated patients on Dr. Parkinson's wait list was not caused by Dr. Parkinson failing to properly prioritize his patients, but rather insufficient OR time in the public system.

1110. Dr. Parkinson, like Dr. Wade, had many other similarly-situated patients, all of whom were experiencing very long waits for cataract surgery.

1111. Ms. Eburne agreed that she experienced a "great relief" and "improvement to her life" once she had her cataract surgeries done.[724]

1112. While Ms. Eburne's surgical outcome was successful, she suffered while waiting for the surgery, with increasing concern about the risk of further deterioration in her vision as her wait progressed. This harm was the direct result of the public system being unable to provide her cataract surgery in a timely manner.

1113. Ms. Eburne was more fortunate than some patients as the risk of falling and further injuring herself due to poor eyesight while waiting for cataract surgery was not realized.

1114. Dr. Jack Taunton was not so lucky. He fell and fractured his spine due to poor vision while waiting for his own cataract surgery:

> ...all of a sudden I lost vision in my left eye. And just very rapidly. Frightening. And so I was assessed, and they ultimately said well, I need, you know, cataract surgery. And so I'm continuing to walk, slowly losing vision on the other eye. This eye I'm almost -- you know, down to very little vision. And I fell. And I fell off the sidewalk, broke a pole, and I broke a quarter of the vertebrae at L3. That ensured that I had now no sensation in my quadriceps. I had no power in my quadriceps or my hip flexor, and I was bent over at 30 degrees. Now I'm in another emergency. And I had emergency surgery, you know that night.[725]

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[724] **Transcript Day 143**, p. 37, lines 37 to 45.
[725] **Transcript Day 28**, Testimony of Dr. Jack Taunton, p. 73, line 35 to p. 74, line 1.

1115. It is apparent from the wait time data above that many cataract patients are waiting well beyond the point at which they are at an increased risk of negative consequences.

1116. Cataract surgery is commonly done on a private pay basis at private clinics. If the option to pay privately for cataracts was no longer available, it is clear that these patients would be placed back on the public waitlists, further extending an already lengthy wait time for patients waiting for cataracts in the public system.

1117. The BC government has recognized that removing private clinics as a safety valve for cataract surgeries in particular would flood the public system with thousands more patients, for whom the government simply could not provide timely treatment.[726] As noted by Ms. Copes, "the patient experience will suffer as they wait longer for access to surgery."[727]

1118. The continued availability of private surgery for cataract patients in BC is clearly essential to ensure that cataract patients have access to timely care to restore their vision and to avoid unnecessary and irreparable harm.

(vi) Bariatric Surgery

a) Provision of Bariatric Surgery in British Columbia

1119. Obesity is a growing health care problem in Canada generally and in British Columbia, specifically. Bariatric surgery is an intervention of last resort for persons who are morbidly obese with a body mass index (BMI) of 40 or over (or with a BMI of 35 or over and with one or more co-morbid conditions), and who have not responded to standard care.[728]

1120. In 2011, PHSA did a review and report in conjunction with the Ministry of Health and surgeon representatives titled "Recommendations for a Provincial Bariatric Surgery Strategy in British Columbia". This report states that there are significant negative health effects from obesity, including:[729]

(a) A significant decrease in life expectancy of between three and eight years, depending on age of onset of obesity;

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[726] See for e.g., **Exhibit 527,** Email Chain at p. 1; **Exhibit 526**, PSEC Minutes at p. 8 **[CBE, Tab 137]**; **Exhibit 431,** at pp. 735-737 **[CBE, Tab 102]**.
[727] See for e.g., **Exhibit 527,** Email from M. Copes at p. 1 **[CBE, Tab 138]**.
[728] **Exhibit 431,** p. 437-8 **[CBE, Tab 102]**.
[729] **Exhibit 431,** p. 439-441 **[CBE, Tab 102]**.

(b) Standard care (enhanced physical activity, dietary modification, caloric restriction and use of medications) does not result in sustained weight loss for many patients suffering from obesity and morbid obesity;

(c) A variety of co-morbidities, which are caused and/or exacerbated by obesity, including diabetes, hypertension, hyperlipidemia, and sleep apnea. These co-morbidities are often a precursor to others such as stroke and cardiac and renal disease.

(d) The prevalence of diabetes within the bariatric surgery population is 15%.

1121. Bariatric surgery has been demonstrated by evidence to be the most effective treatment for morbid obesity – it is greatly needed as rates of obesity are growing.[730] As set out in the PHSA's Report "Recommendations for a Provincial Bariatric Surgery Strategy in British Columbia", from 2011, about 780 to 1560 persons in BC at any given time would be eligible and suitable for and willing to undergo bariatric surgery.[731]

1122. The benefits of the surgery to patients in terms of improved quality of life, including in relation to employment and physical activity and length of life, are substantial.[732] It is also cost-effective and provides significant cost avoidance to the health care system for diabetic patients.[733]

1123. The PHSA Report outlined the positive effects of bariatric surgery, including that it is proven to result in a sustained decrease in BMI for obese and morbidly obese patients, is cost-effective, and produces resolution or improvement in severity of several co-morbidities, including an 80% resolution rate for diabetes; 75% resolution rate for hypertension; 70% resolution rate for hyperlipidemia; and an 80% resolution rate for sleep apnea.[734]

1124. Pursuant to the BC patient prioritization system, the maximum acceptable wait time for patients who need bariatric surgery is 26 weeks for those who are morbidly obese and have no urgent medical needs, and six weeks for those who are morbidly obese, have multiple co-morbidities and are considered urgent from a health perspective.[735]

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[730] **Exhibit 12A,** p. 382 and 508 **[CBE, Tab 7]**.
[731] **Exhibit 431**, p. 438 **[CBE, Tab 102]**.
[732] **Exhibit 431,** p. 441 **[CBE, Tab 102]**.
[733] **Exhibit 431,** p. 459 **[CBE, Tab 102]**.
[734] **Exhibit 431,** p. 459 **[CBE, Tab 102]**.
[735] **Exhibit 431,** p. 460 **[CBE, Tab 102]**.

1125. In 2007, bariatric surgery was only available in two centers in BC: VIHA and a private clinic in Surrey. The private clinic was only able to perform the less complex (and less effective) lap-band surgery.[736] VIHA had requested at that time to develop a provincial centre of excellence (the Provincial Bariatric Surgery Tertiary Centre for bariatric services). This proposal was not accepted by the Ministry, and in 2009 the Ministry stated that it had no additional funds to increase bariatric surgery.[737]

1126. The number of public-funded bariatric surgery cases done in BC had declined from a high of 145 in 2002/03 to 80 to 2009/10.[738] Due to lack of available services in BC and elsewhere in Canada, many patients were sent to the US for surgery at significant cost. As of October 31, 2010, the waitlist in BC for bariatric surgery was 477 persons, with almost 90% having waited longer than 52 weeks.[739]

1127. A Health Operations Committee Briefing Document acknowledged that there is a significant service gap in BC for bariatric surgery.[740]

1128. A November 2012 Decision briefing note to Leadership Council states that in 2012, the PHSA submitted a business case to the Ministry for adult bariatric surgery and associated services.

1129. And in a 2012 Briefing Note on bariatric surgery, the Ministry of Health acknowledged that the business case outlined that delivery of bariatric services in BC is characterized by lack of coordination, variable care pathways and significant capacity constraints. Limited access to these services imposes travel and expense burdens on many patients.[741]

1130. The business case cited evidence for gastric bypass surgery as an effective treatment for morbid obesity, and economic analyses indicate bariatric surgery is cost-effective. As of September 2012, there were 363 people waiting for bariatric surgery. Of these 75% had waited for over one year, and some over 7 years.[742]

1131. In response the Ministry of Health stated that while the Ministry was funding 76 additional high-priority bariatric surgery cases to be performed in the 2012/13 year, this created a "cost pressure"

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[736] **Exhibit 13A,** p. 2761 **[CBE, Tab 10]**.
[737] **Exhibit 12A,** p. 382-383 **[CBE, Tab 7]**.
[738] **Exhibit 431,** p. 514 **[CBE, Tab 102]**.
[739] **Exhibit 431,** p. 438 **[CBE, Tab 102]**.
[740] **Exhibit 12A,** p. 382 **[CBE, Tab 7]**.
[741] **Exhibit 12C,** p. 1802 **[CBE, Tab 9]**.
[742] **Exhibit 12C,** p. 1885 **[CBE, Tab 9]**.

and that no funding exists within the health authorities' funding allocations or within the Ministry to expand the bariatric surgery program.[743]

1132. In April 2014, the Ministry directed that VIHA and VCHA should together perform 400 bariatric surgeries into the future, while acknowledging that this would result in increased wait times as this is insufficient capacity to meet provincial demand. The Ministry also directed that IHA and FHA implement bariatric services as a priority action, but noted that they may not consider it a priority "given other fiscal pressure". No additional funding was to be provided to the health authorities for these purposes.[744]

1133. In 2016, the Medical Directors for the Bariatric Surgery Programs at Victoria and Richmond emailed Colleen Hart (Vice President of the Provincial Population Health and Chronic & Specialized Populations at PHSA), identifying that BC is lagging behind the rest of the country in terms of delivery of bariatric surgery services, and that there were some 1400 persons on the wait list for bariatric surgery in BC. They discussed forming a steering committee composed of health care professionals, PHSA leadership and MOH representatives to improve this situation.[745] However, they received notice from the MOH that this work would be put on hold because the regional health authorities needed to concentrate on the Primary Care Homes initiative.[746]

1134. As of 2016, of completed bariatric surgery cases, the 90th percentile wait time for patients diagnosed with non-urgent morbid obesity was 65.1 weeks from BFRD and 84 weeks from Decision Date.[747]

1135. It is clear that the British Columbia health care system is unable to provide timely access to bariatric surgery to patients needing this surgery to overcome obesity and morbid obesity, with the result that patients are waiting excessive periods for this surgery (if they can get it at all). As evidenced, the result is a substantially increased incidence and experience of diabetes, sleep apnea, hypertension, poorer quality of life, and decreased life expectancy for these patients while they wait for this surgery, and increased risk of developing life-threatening complications of these co-morbidities while they wait.

b) Experience of Grant Pearson

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[743] **Exhibit 12C,** p. 1839 **[CBE, Tab 9]**.
[744] **Exhibit 12A,** p. 707-709 **[CBE, Tab 7]**.
[745] **Exhibit 431,** p. 431 to 434 **[CBE, Tab 102]**.
[746] **Exhibit 431,** p. 431 **[CBE, Tab 102]**.
[747] **Exhibit 316B,** Tab 4, p. 6 **[CBE, Tab 68(B)]**.

1136. The experience of Patient Witness, Grant Pearson, demonstrates the experience of patients waiting for bariatric surgery in BC, and the harms resulting to patients from the excessive wait times for this surgery.

1137. **Redacted due to evidence subject to sealing order;**

1138. Mr. Pearson has battled a weight issue his entire life.[749] He was a compulsive eater and has a long history of obesity.[750] He's seen his weight fluctuate up to 377 pounds and he felt pain in his knees when he weighed that much.[751]

1139. He had genetic issues in his family such as heart issues, diabetes, glaucoma, stroke, and Crohn's disease. Mr. Pearson developed some of these conditions – he was diagnosed with Crohn's when he was a teenager, developed the onset of Type 2 Diabetes as a young adult, and developed extreme sleep apnea as a result of the weight around his throat.[752]

1140. Regarding his sleep apnea, Mr. Pearson testified that for a long time he thought it was normal to need a nap at 1 o'clock in the afternoon, as he was used to being groggy.[753]

1141. Mr. Pearson traveled from the Yukon to Vancouver for a sleep study. He was given a sleep apnea machine which helped but did not cure the problem.[754]

1142. Mr. Pearson had four surgeries relating to his Crohn's disease. He had 9 inches of his intestinal tract removed and also had gout which was very painful.[755]

1143. Mr. Pearson was diagnosed with diabetes when he was in the hospital for Crohn's and his blood count was high, so they put him on maximum dosages of various medications. He tried several different types of medication, and then was put on insulin. Mr. Pearson was scared when he learned he had diabetes. He had to monitor his sugars, poke his finger every day, stab himself with a needle every day and basically cut out sugars. [756]

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[748] **Transcript Day 56,** Testimony of Grant Pearson, dated January 19, 2017, lines 11 to 18, p. 9, lines 2 to 3
[749] **Transcript Day 56,** p. 3, lines 31 to 32
[750] **Redacted due to evidence subject to sealing order;**
[751] **Transcript Day 56,** p. 3, lines 35-36
[752] **Transcript Day 56,** p. 3, line 47 to p. 4, line 9
[753] **Transcript Day 56,** p. 5, lines 3 to 13
[754] **Transcript Day 56,** p. 5, lines 3 to 19
[755] **Transcript Day 56,** p. 13, lines 7 to 13
[756] **Transcript Day 56,** p. 5, lines 24 to 39

1144. Because of his diabetes, Mr. Pearson had to notify the Motor Vehicle Branch and had to do a physical and mental test every year, as he had a second job on the weekends, driving a truck.[757]

1145. He had 'recurrent gallstone colic' in which he had to have his gall bladder removed.[758]

1146. Over the years, Mr. Pearson had attempted various different diets and weight loss regimes, but was never able to lose much weight or to keep it off.

1147. Around 2007, he started talking to his family doctor, Dr. Peter Methven, about the possibility of weight loss surgery. Dr. Methven explained that there was a doctor in Victoria (Dr. Bradley Amson) that was doing weight loss surgeries and that he was very vigorous about putting his patients through a gauntlet to make sure you were a good candidate.[759]

1148. Dr. Methven referred Mr. Pearson to Dr. Amson in Victoria for a consultation in June, 2008.[760] Mr. Pearson waited a year, to June 4, 2009, for his first appointment with Dr. Amson.[761]

1149. Mr. Pearson testified that that the wait for consultation was disheartening and depressing. He said he got himself emotionally prepared and then had to wait for a year after that decision.[762]

1150. **Redacted due to evidence subject to sealing order;** Dr. Amson told Mr. Pearson that he was a good candidate for a laparoscopic vertical sleeve gastrectomy surgery. He also told Mr. Pearson that it would be another six months to a year before he could do the surgery.[764]

1151. Mr. Pearson was required to have check-in appointments every six months before his surgery, to ensure that he was still a good candidate for the surgery and on-track in terms of preparation. He had his first follow-up appointment on December 1, 2009. Dr. Amson again told Mr. Pearson that he was hoping to have the surgery date within six months to a year.[765]

1152. These six month check-in appointments continued over the next four years, in which Mr. Pearson was repeatedly told that his surgery would be within another six months to a year.[766]

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[757] **Transcript Day 56,** p. 5, line 43 to p. 6, line 28
[758] **Transcript Day 56,** p. 12, lines 33 to 40
[759] **Transcript Day 56,** p. 8, line 38 to p. 9, line 13.
[760] **Transcript Day 56,** p. 9, lines 26 to 31, p. 11, lines 24 to 28.
[761] **Transcript Day 56,** p. 13, lines 27 to 31.
[762] **Transcript Day 56,** p. 13, line 40 to p. 14, line 6.
[763] **Redacted due to evidence subject to sealing order;**
[764] **Transcript Day 56,** p. 15, lines 23 to 27.
[765] **Transcript Day 56,** p. 16, line 17, p. 17, lines 12 to 14.
[766] **Transcript Day 56,** p. 18, lines 8 to 9.

1153. Each time he went to Victoria, it was an expense as he travelled from the mainland to the island. He had to take time off work and his work did not reimburse him.[767]

1154. During the wait for his surgery, Mr. Pearson experienced significant pain and psychological harm as his health issues were compounded by the fact that he had to wait so long for his surgery. The process of six month checkups over the course of five years while he waited for surgery was emotionally draining, and taxing on his family and job.[768]

1155. He was frustrated that there was a tool that could improve his condition, which was being held off because of the long wait times.[769]

1156. **Redacted due to evidence subject to sealing order.**

1157. **Redacted due to evidence subject to sealing order;**

The gastric bypass surgery would relieve his diabetes all together. Further, the medications which Mr. Pearson was required to take were costly; for example, each pen for insulin and Losec was $200 a pen.[772]

1158. In March of 2012 while he was working, he started to sweat and feel ill. He suffered chest pains and attended the hospital because he was scared he was having a heart attack. [773]

1159. He was unable to do everything he wanted with his kids because of his weight and this impacted him negatively.[774]

1160. With his family history, he believed that he was on a path to dying.[775]

1161. Mr. Pearson tried to mitigate his health issues during his wait for surgery, including trying to exercise (including martial arts),[776] he saw a respirologist,[777] he saw a dietitian,[778] he went to Overeaters

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[767] **Transcript Day 56,** p. 49, lines 45 to p. 50, line 6.
[768] **Transcript Day 56,** p. 19, lines 20 to 35.
[769] **Transcript Day 56,** p. 22, lines 21 to 25.
[770] **Transcript Day 56,** p. 4, lines 17 to 19; **Redacted due to evidence subject to sealing order;**
[771] **Redacted due to evidence subject to sealing order;**
[772] **Transcript Day 56,** p. 24, lines 39 to 46.
[773] **Transcript Day 56,** p. 19, lines 41 to 43, p. 21, lines 7 to 21.
[774] **Transcript Day 56,** p. 3, lines 38 to 42.
[775] **Transcript Day 56,** p. 25, lines25 to 26.
[776] **Transcript Day 56,** p. 3, lines 33 to 34.
[777] **Transcript Day 56,** p. 18, line 41.
[778] **Transcript Day 56,** p.15, line 33.

Anonymous meetings,[779] and he had an upper GI gastroscopy to make sure there wasn't any issues like ulcers or other problems which could impede the healing process.[780]

1162. He understood that his risk of complications from the surgery would increase as he got older.[781]

1163. Because of the long wait, Mr. Pearson looked into obtaining the surgery privately but ultimately decided that it was too expensive ($15,000), and that the gastric band surgery available privately was not suitable for him.[782]

1164. Mr. Pearson wrote an email to his MLA (Mary Polak) regarding his understanding of the "budget cutbacks and the lack of surgical time for surgery" that were affecting his wait time.[783] In his email to his MLA, he notes the information he has learned including VIHA's funding cuts to bypass bariatric surgery resulting in a more than 50% reduction from the surgeries performed in 2009; that VIHA is the only regional health authority in BC that performs bypass bariatric surgery; and that his obesity-related diseases will continue to worsen and contribute 10 times more to health care costs than the bariatric surgery would cost the province (ex. the medication he was on was expensive). He asked his MLA to "[H]elp get the funding back so we do not end up dead before we can get the surgery."[784]

1165. A Ministry of Health representative ultimately responded to Mr. Pearson's email, and stated that while the Ministry considers morbid obesity a serious health issue, if Mr. Pearson has concerns with the wait time, he should discuss them with his surgeon, as the surgeons are in charge of prioritizing their patients.[785] Mr. Pearson testified that he understood the Ministry of Health to be telling him to "get in line".[786]

1166. Dr. Amson repeatedly told Mr. Pearson that he was a prime candidate for bariatric surgery, and was waiting on Dr. Amson's wait list with all of his other patients.[787]

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[779] **Transcript Day 56,** p. 17, lines 27 to 33.
[780] **Transcript Day 56,** p. 20, lines 14 to 17.
[781] **Transcript Day 56,** p. 24, lines 44 to 45.
[782] **Transcript Day 56,** p. 22, lines 32 to 39
[783] **Transcript Day 56,** p. 23, lines 42 to 43
[784] **Exhibit 209,** Email from Mr. Pearson to MLA Mary Polak, and response letter **[CBE, Tab 44]**.
[785] **Exhibit 209,** p. 1 **[CBE, Tab 44]**.
[786] **Transcript Day 56**, p. 26, lines 1 to 2.
[787] **Transcript Day 56,** p. 26, lines 29 to 30.

1167. On July 22, 2013, Mr. Pearson finally had bariatric surgery.[788] His total Wait 2 time was 216 weeks (over four years) -- June 4, 2009 to July 22, 2013.

1168. Mr. Pearson's Wait Two time was consistent with the 90th percentile Wait Two time for most bariatric surgery patients at the time, which was 208.9 weeks from BFRD and 231.1 weeks from Decision Date.[789]

1169. Mr. Pearson's surgery was successful. After his surgery, he had a dramatic improvement in his health, both physically and mentally, and a dramatic improvement in his overall quality of life: he lost weight; he was able to go off of all his diabetic medication; his sleep apnea improved; his Crohn's disease went into remission; and he no longer had to do a yearly assessment with the eye doctor.

1170. In addition, from a social and relationship perspective, he is better able to do his job; he is a better husband and father; he can fit into cars, he has more stamina and can walk farther, and he feels "awesome" and his "overall life has improved". He testified that the surgery saved his life and got him more healthy and active with a better and more positive mindset.[790]

1171. Mr. Pearson ought to have been able to experience these benefits of bariatric surgery much earlier – within the 26 week maximum acceptable wait time for this treatment. Instead, he suffered with significant medical and health problems, and exacerbation of those health problems, as well as reduced life expectancy and quality of life for over four years – time which he can never regain.

(vii) Orthopaedic Surgery

a) Arthroscopic Knee Surgery

i. Introduction

1172. Patients in British Columbia are enduring excessive waits for diagnosis and treatment of problems in the knee joint such as cartilage tears and ligament injuries, virtually all of which can be treated through minimally invasive arthroscopic surgery,[791] in order to avoid unnecessary physical and psychological harms.

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[788] **Transcript Day 56,** p. 28, lines 1 to 3.
[789] **Exhibit 316A,** Tab 1, p. 6 **[CBE, Tab 67(A)]**.
[790] **Transcript Day 56,** p. 30, line 13 to p. 32, line 19.
[791] **Transcript Day 20,** Testimony of Dr. Fadi Tarazi, p. 44, lines 35 to 39, p. 18 lines 5 to 9.

1173. We had evidence from Mr. Chris Chiavatti and Ms. Krystiana Corrado, two paediatric Patient Plaintiffs, as well as from Ms. Erma Krahn, an elderly patient who has since passed away, all of whom suffered while waiting for arthroscopic knee surgery, for anterior cruciate ligament (ACL) repairs or meniscal repairs.

1174. We also had evidence from Marshal Van de Kamp, a young man who had surgery to repair a work-related ACL and meniscal tear injury, expedited by WorkSafeBC, in order to allow him to return to work as soon as possible. He later suffered a similar knee injury which was not work-related, and would have had to wait a very prolonged period for diagnosis and treatment in the public system with resulting significant pain, disability, and financial loss.

1175. Each of these witnesses was able to access private diagnostic imaging and/or surgery in order to expedite their treatment and recovery from these injuries, without which they would have suffered greater harm by waiting even longer in the public system.

1176. Several physicians also testified about the diagnosis and arthroscopic surgery for knee injuries in British Columbia, and the detrimental effects of delays in diagnosis and treatment on their patients' health and well-being.

1177. These physicians included Dr. Fadi Tarazi, an orthopaedic surgeon who specializes in knee and shoulder arthroscopies,[792] who was a treating physician of Ms. Corrado. Dr. Tarazi has privileges at Burnaby Hospital and False Creek Surgical Centre, where he performs both WCB and ICBC work. Dr. Tarazi testified to the lack of available OR time preventing the timely treatment of his patients and the resulting harms to them.

1178. Dr. Mary Weckworth, Ms. Corrado's family physician, testified to the harms Ms. Corrado experienced while waiting for her surgery.

1179. Dr. Arno (Bernardus) Smit, a general orthopaedic surgeon whose practice focuses on knees, shoulders, and hips, and a treating physician of Ms. Krahn, also testified to the wait times and harms experienced by his patients. Dr. Smit has privileges at UBC Hospital, Delta Hospital, as well as at Peace Arch Hospital, where he has served as the head of the department of surgery for several years.[793] Dr. Smit also previously worked at Cambie and False Creek, and currently is the owner of the White

[792] **Transcript Day 20,** p. 3, lines 1 to 3.
[793] **Transcript Day 19**, Testimony of Dr. Arno Smit, p. 2, lines 1 to 19.

Rock Orthopaedic Surgery Centre ("**WROSC**"), which he started as a means to address the insufficient OR capacity in his community, and where he performs WCB work, ICBC work and private pay work.[794]

1180. Dr. Day testified about his surgical treatment of Ms. Corrado (ACL knee surgery), Mr. Chiavatti (arthroscopic meniscectomy knee surgery) and Erma Krahn (two knee meniscal surgeries). He also performed both Mr. Van de Kamp's WorkSafeBC knee surgery and his private knee surgery.

1181. Dr. Day was instrumental in introducing arthroscopic joint surgery and other minimally invasive surgical techniques in Canada.[795] He has been a visiting professor, lecturer, and speaker worldwide, teaching arthroscopic techniques internationally, and is one of only three Canadians in its 38 year history to become President of the Arthroscopy Association of North America (the world's leading academic society in the field).[796]

1182. Dr. Day has worked in both the public and private systems, though his current practice involves performing private (including WCB) surgeries on shoulders and knees at Cambie.[797]

1183. As discussed below, despite arthroscopic knee surgery typically being a relatively non-invasive day surgery, it is technically complex, and is one of the areas of orthopedic surgery with some of the longest wait times for treatment, with the result that patients in BC have endured unnecessary pain, physical impairment inhibiting regular daily activities, including work, and psychological distress.

ii. Harms from waiting for knee arthroscopy diagnosis and surgery

1184. All of the physicians who testified on this topic described similar observations of their patients who are waiting for diagnosis of and/or surgery for knee injuries treatable through arthroscopic surgery. Their patients experience pain and disability, weakness and buckling in the knee, lack of conditioning and muscle atrophy, lack of ability to participate in activities of daily life, including athletics, school and physical work, as well as depression and anxiety while waiting for treatment. Further, patients who wait too long often experience deterioration in their condition.

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[794] **Transcript Day 19**, p. 38, line 20 to p. 39, line 2.
[795] **Exhibit 346A**, Affidavit #9 of Dr. Day, p. 4, para. 21 and Exhibit A, p. 1 **[CBE, Tabs 83 and 84]**.
[796] **Exhibit 346A,** p. 8, para. 36, to p. 9, para. 37 **[CBE, Tab 83]**.
[797] **Exhibit 346A**, p. 41, para. 220 **[CBE, Tab 83]**.

1185. Dr. Tarazi testified that while waiting for their knee surgeries some of his patients will aggravate their injuries or reinjure themselves by twisting their knee, their knee buckling, falling down, or having more pain and swelling, which will require a further visit with him.[798]

1186. Some patients cannot work and will ask Dr. Tarazi to fill out disability insurance forms.[799]

1187. Patients who still want to be active while waiting for surgery often need prescriptions from Dr. Tarazi for protective braces.[800]

1188. Some patients reinjure themselves while waiting for surgery and have to see Dr. Tarazi again. He testified that he will often prescribe further physiotherapy for them to recover from the recurrent injury.[801] As physiotherapy is no longer a benefit under the *MPA*, some patients may not be able to afford sufficient or any physiotherapy.[802]

1189. Some of Dr. Tarazi's patients are on pain killers for pain management while waiting. Dr. Tarazi testified that he has these patients' family physicians prescribe the painkillers, as his patients are typically waiting a period of six to 12 months for surgery and he does not "want to be involved in the care of narcotic treatments for a period of six months because of the risk of narcotic tolerance, narcotic abuse."[803]

1190. Dr. Smit testified that patients with a meniscal tear in particular will typically have symptoms of pain and "can cause mechanical symptoms, such as locking or catching."[804]

1191. Dr. Smit testified that some of his patients deteriorate to the point of collapse while waiting for surgery, in which case they need to be reassessed and reprioritized. For example, a patient may initially present to him with a painful knee, but for some patients the pain suddenly gets much worse, which can happen for many possible reasons such as the tear in their knee extending or a "disruption of the vascularity due to part of the bone called osteonecrosis."[805]

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[798] **Transcript Day 20,** p. 23, lines 19 to 25.
[799] **Transcript Day 20,** p. 23, lines 26 to 28.
[800] **Transcript Day 20,** p. 23, lines 28 to 31.
[801] **Transcript Day 20,** p. 24, lines 33 to 43.
[802] **Exhibit 346A,** Affidavit #9 of Dr. Day, p. 53, para. 281, p. 69, paras. 370-371, and p. 94, para. 507 **[CBE, Tab 83].**
[803] **Transcript Day 20,** p. 24, lines 9 to 32.
[804] **Transcript Day 19,** p. 4, lines 36 to 39.
[805] **Transcript Day 19,** p. 15, lines 33 to 44.

1192. Dr. Day testified that he has witnessed first-hand the significant medical, financial, and personal problems that patients suffer when their surgeries are cancelled or otherwise delayed, whether for knee arthroscopies or otherwise.[806]

1193. Dr. Day has personally observed his patients suffering mentally and physically while they waited for medically necessary surgeries at public hospitals.[807]

1194. He has observed patients waiting in pain or with reduced mobility.[808]

1195. Dr. Day's patients have often been on strong addictive narcotic pain killers and often needed surgery to reduce pain and give them the best chance of regaining their functioning without suffering further harm or permanent damage.[809]

1196. Some of his patients are unable to work due to their injury and while waiting for surgery. The longer they waited for surgery, the longer they were out of work and the greater their financial and other hardships, which caused them a great deal of stress and anguish.[810]

1197. Further, patients waiting in pain for over six months may also evolve into a different risk category if they are on narcotics and become drug dependent, which requires them to be reassessed and re-examined, and requires hospital bookings to be redone.[811]

1198. During Dr. Day's time in the public system, he observed the deterioration of his patients' conditions while they waited for treatment, and personally required some patients to get updated assessments as a result of these waits.[812]

1199. Dr. Day observed that these delays create difficulties for pre- and post-surgical rehabilitative care for patients. He also observed patients suffering significant impairment due to physiotherapy being delisted from MSP, and thereafter requiring payment by the patient. [813]

1200. He has observed patients suffering from pain that affects their daily lives, negative effects on their psychological state, an inability to return to work after being off work for a lengthy period, serious

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[806] **Exhibit 346A,** p. 43, para. 229 **[CBE, Tab 83]**.
[807] **Exhibit 346A**, p. 43, para. 230 **[CBE, Tab 83]**.
[808] **Exhibit 346A,** p. 43, para 231 **[CBE, Tab 83]**.
[809] **Exhibit 346A**, p. 43, para 232 **[CBE, Tab 83]**.
[810] **Exhibit 346A**, p. 43, para. 233 **[CBE, Tab 83]**.
[811] **Exhibit 346A,** p. 60, para. 323 **[CBE, Tab 83]**.
[812] **Exhibit 346A**, p. 60, para. 324 **[CBE, Tab 83]**.
[813] **Exhibit 346A**, p. 69, para. 371 **[CBE, Tab 83]**.

financial consequences for patients and their families, and long term negative effects on patients' physical well-being and their lives generally. [814]

1201. At Cambie, he frequently sees "patients who are off work, limping in pain, using a cane, unable to fully bend or straighten their knee, and in despair, having been told that they must wait up to 12 to 18 months for treatment in the public system."[815]

iii. Wait times for provision of knee arthroscopy for meniscal tears and ACL repairs in BC

1202. The SPR data confirm that patients in BC are waiting well beyond the maximum acceptable wait times for arthroscopic knee surgery.

1203. The Government has adopted surgical targets, called P-CATS, for children under 17, which set out the maximum acceptable wait times children should wait for surgery. The development of the P-CATS followed from the Final Report of the Federal Advisor on Wait Times, who stated as follow with respect to wait times for children:

> "Addressing wait times for children's clinical and surgical interventions is therefore a moral responsibility - a trust responsibility - that needs to be shared by society at large. [page 55]
>
> (...)
>
> There is however a significant difference for children in that their growth and development is rapid. For some conditions the opportunity to intervene clinically or surgically is brief - the window opens and closes quickly. To miss that opportunity is to miss getting the most from the procedure over time. Related to this are of course the social, educational and psychological effects associated with illness, hospitalization and the inability of the child to participate in the real work of growing up. The failure to progress with their cohort can affect a child's life for a long time. [page 56]"[816]

1204. The Government has also established maximum acceptable surgical wait times that adults should wait for surgery.

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[814] **Exhibit 346A**, p. 94, para. 508 **[CBE, Tab 83]**; and **Exhibit 346B,** Affidavit #9 of Dr. Day, Exhibit OOOO, p. 827 **[CBE, Tab 85]**.
[815] **Exhibit 346A**, p. 94, para. 509 **[CBE, Tab 83]**.
[816] **Exhibit 577B,** Defendant's Expert Report of Dr. Gordon Guyatt – References, Vol. 1 of 3, Tab 48, pp.55-56 **[CBE, Tab 155]**.

1205. The 90th percentile Wait Two time from BFRD for "Knee Arthroscopy" generally across BC was 61.3 weeks in 2009/10; 51.3 weeks in 2010/11; 48.6 weeks in 2011/12; 56.3 weeks in 2012/13; 41.4 weeks in 2013/14; and 42.2 weeks as of July 31, 2014.[817]

1206. The 90th percentile Wait Two time from BFRD for "Knee – ACL Repair" across BC was 60.9 weeks in 2009/10; 47.0 weeks in 2010/11; 51.7 weeks in 2011/12; 58.4 weeks in 2012/13; 41.7 weeks in 2013/14; and 42.6 weeks as of July 31, 2014.[818]

1207. The 90th percentile Wait Two time from BFRD for "Knee – Meniscectomy" across BC was 46.1 weeks in 2009/10; 28.9 weeks in 2010/11; 24.9 weeks in 2011/12; 25.7 weeks in 2012/13; and 36.3 weeks in 2013/14.[819]

1208. These lengthy Wait Two times have not meaningfully improved in recent years.

1209. In 2017, the 90th percentile Wait Two time across BC for Ms. Corrado's adult diagnosis, "Knee - Ligament Dysfunction-Severe Constant Pain Or Constant Functional Deficit, Imminent Threat To Role Or Independence" (34VGIM), (maximum acceptable wait time of six weeks), was 23.7 weeks from BFRD, and 29.1 weeks from Decision Date.[820] In 2016, the 90th percentile wait time for 34VGIM was 20.6 weeks from BFRD and 30 weeks from Decision Date.[821] In 2016 only 46.3% of patients with this diagnosis and urgency level received their surgeries within the six week target, even when measured from BFRD, and in 2017, only 46% did.[822]

1210. For the less severe diagnosis of "Knee - Ligament Dysfunction - Moderate To Severe Pain With Significant Or Severe Functional Limitation" (34VGIN), (maximum acceptable wait time of 12 weeks), the 90th percentile Wait Two time in 2017 was 35.3 weeks from BFRD and 40.2 weeks from Decision Date.[823] In 2016, the 90th percentile wait time for 34VGIN was 32 weeks from BFRD and

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[817] **Exhibit 2A,** MOH PFF, p. 16**[CBE, Tab 1]**.
[818] **Exhibit 2A,** MOH PFF, p. 16 **[CBE, Tab 1]**.
[819] **Exhibit 12B,** p. 970 **[CBE, Tab 8]**.. Note – the Defendant's MOH PFF (**Exhibit 2A**, p. 16, contains wait time data for knee Meniscectomy, but the data for 2012/13 is clearly in error and not in accordance with the SPR data) **[CBE, Tab 1]**.
[820] **Exhibit 316C**, Tab 5, p. 91 of 149 **[CBE, Tab 69(A)]**.
[821] **Exhibit 316B**, Tab 4, p. 98 of 160 **[CBE, Tab 68(B)]**.
[822] **Exhibit 315B**, Tab 7, p. 286 of 421 **[CBE, Tab 65]**.
[823] **Exhibit 316C**, Tab 5, p. 91 of 149 **[CBE, Tab 69(A)]**.

37.9 weeks from Decision Date.[824] In 2016 only 62% of patients with this diagnosis and urgency level received their surgeries within the 12 week target, and in 2017, only 56.9% did.[825]

1211. Even for the more severe knee ligament dysfunction diagnosis, patients wait well beyond their maximum acceptable wait time. In 2017, for "Knee - Ligament Dysfunction - Severe Pain And/Or Urgent Impairment/Disability, Immediate Threat To Role Or Independence - E.G. Collapsed Femoral Head, Avn," (34VGIL) (4 weeks), the 90th percentile Wait Two time was 16.2 from BFRD and 19.6 weeks from Decision Date.[826] In 2016, the 90th percentile Wait Two time was 13.4 weeks from BFRD and 15.2 weeks from Decision Date.[827] In 2016, only 50% of patients with this more severe diagnosis received their surgeries within the four week target, and in 2017, only 44% did.[828]

1212. Further, "Knee Arthroscopy" was among the top procedures with the longest Wait One times in BC for 2014/15 to 2016/17, with a 90th percentile Wait One time of 30.3 weeks in 2014/15, 31.4 weeks in 2015/16 and 32.3 weeks 2016/17.[829]

1213. Dr. Tarazi testified that there were seven orthopaedic operating rooms at Burnaby General, but at least three of these rooms were not being utilized at any given time due to a lack of funding. During certain times of the year, even fewer OR rooms are running.[830]

1214. Consistent with the testimony of other surgeons, Dr. Tarazi testified that the addition of a new surgeon to his department at Burnaby Hospital did allow the group to operate on more patients. Instead, the group had to divide the existing operating time among more surgeons.[831]

1215. Dr. Tarazi also testified that the wait times for orthopaedic surgery persist. "[T]here's lots of orthopedic surgeons in the community looking for work. Fully trained, fully qualified, but they do not have any positions in the hospitals, in Burnaby or in BC, to operate in. So they do not have active privileges. Any active privileges surgeon requires operating room time, and there's no time for

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[824] **Exhibit 316B**, Tab 4, p. 98 of 160 **[CBE, Tab 68(B)]**.
[825] **Exhibit 315B**, Tab 7, p. 286 of 421 **[CBE, Tab 65]**.
[826] **Exhibit 316C**, Tab 5, p. 90 of 149 **[CBE, Tab 69(A)]**.
[827] **Exhibit 316B**, Tab 4, p. 98 of 160 **[CBE, Tab 83]**.
[828] **Exhibit 315B**, Tab 7, p. 285 of 421 **[CBE, Tab 65]**.
[829] **Exhibit 431**, p. 239 **[CBE, Tab 102]**.
[830] **Transcript Day 20,** p. 22, lines 13 to 39, and p. 76, lines 34 to 46.
[831] **Transcript Day 20,** p. 3, lines 31 to 41, and p. 21, lines 43 to 47.

them."[832] He testified that "they can't get work because there's no resources at hospitals"[833] and "we can't hire somebody and expand our workforce because we don't have the resources to give them."[834]

1216. Dr. Tarazi testified that further complicating this wait time is the fact that emergency surgeries will bump scheduled surgeries, resulting in scheduled surgeries being cancelled. For example, when the government implemented a directive to have all hip fractures repaired within 48 hours, there was no increase in the amount of OR time to his group to perform the hip fracture surgeries more quickly; instead the OR time was taken from the existing time. Dr. Tarazi's group lost scheduled surgery time in favour of the trauma patients, and "ended up essentially operating on less elective patients."[835]

1217. Dr. Tarazi testified that (before recently slowing down his practice) the wait time for a consultation with him was about a year, and "very often more than a year."[836]

1218. Dr. Tarazi testified that when he refers patients to his colleague, Dr. Pate, for joint replacement, the wait time to see Dr. Pate is "several months".[837]

1219. Dr. Tarazi has performed surgeries at False Creek from 1999 to present. He started there because he had been referred some WorkSafeBC patients and False Creek was one of the private clinics with which WorkSafeBC had a contract to expedite these surgeries.[838]

1220. He testified that WorkSafeBC pays a premium to surgeons if they complete their patients' surgeries within 20 days of the consult with the worker.[839]

1221. Dr. Tarazi's work at False Creek has not detracted from the time he spends working in the public system. He explained: "My work at the hospital has not been affected. I work at the hospital. I cannot operate on any more patients; this is the time that's allotted to the orthopedic group. I use my time, and anything beyond that then I either do medicolegal work for personal injury claims or False Creek Surgical Centre. There's no point in seeing a thousand people, putting them on the list to add three years of surgical waitlist. It doesn't make sense. The same number of patients are going to be operated on at the end of the year at the hospital. So they might as well go -- be referred to somebody

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[832] **Transcript Day 20,** p. 21, lines 34 to 41.
[833] **Transcript Day 20**, p. 74, lines 44 to 46.
[834] **Transcript Day 20**, p. 74, line 47 to p. 75, line 2.
[835] **Transcript Day 20**, p. 19, line 6 to 25; and p. 20, line 39 to p. 21, line 2.
[836] **Transcript Day 20**, p. 16, lines 7 to 12.
[837] **Transcript Day 20**, p. 30, line 47 to p. 31, line 8.
[838] **Transcript Day 20**, p. 34 line 35 to p. 35, line 5.
[839] **Transcript Day 20,** p. 35, lines 34 to 46.

else. That's why at times over the last 15 years I've stopped taking patients just to get control of the waitlist, and then we reopen it. As the waitlist for consultation decreases, then I will open it up again."[840]

1222. Dr. Tarazi testified that his work in private clinics interacts with his public work in that it defuses the problem. He explained that instead of having a lot of patients booked on the surgeries waitlist at the hospital, some of these patients choose to pay for their surgery at the clinic, and thus never make it onto the hospital wait lists, "[s]o it opens up a spot for somebody else that cannot pay or is not willing to pay for it privately."[841]

1223. He testified that he works two days a week either doing medicolegal assessments or working at False Creek. This does not interfere with his work in the public system, because he would still have the same limited OR time in the public system even if he had been working in the public system on those days instead. He explained: "...as I said earlier, those two days, if I had seen more patients in consultation and booked more surgeries, how could I have done those surgeries in time -- in a timely fashion with the OR time that I was allocated? I was using the available OR trauma time, all my elective OR time within those 40 weeks."[842]

1224. Dr. Smit similarly testified about his lengthy wait times for surgery.

1225. Dr. Smit testified that he aims to see patients for a consultation "within eight weeks or so".[843]

1226. Dr. Smit testified that in February 2009, the time at which Ms. Krahn saw him for a consult and was put on his waitlist for surgery,[844] his patients waiting for arthroscopy were waiting "well over one year" for the surgery.[845]

1227. Dr. Smit testified that the OR time allocation at Peace Arch Hospital had not changed since 2009, with five surgeons still sharing the same amount of time allocated in 2009.[846]

1228. Dr. Smit testified that with the health authorities' recognition about 10 years ago of certain surgical priorities, including hip and knee replacement surgery, he was able to take patients to the UBC

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[840] **Transcript Day 20**, p. 38, lines 15 to 31.
[841] **Transcript Day 20**, p. 40, lines 30 to 39.
[842] **Transcript Day 20**, p. 59, lines 23 to 31.
[843] **Transcript Day 19**, p. 3, lines 14 to 18.
[844] **Transcript Day 19**, p. 8, lines 21 to 24.
[845] **Transcript Day 19,** p. 9, lines 1 to 13.
[846] **Transcript Day 19,** p. 18, lines 6 to 11.

hospital program dedicated to joint replacements. However, he was later asked to curtail his time at UBC, and no longer received any time at UBC as of 2016.[847] As a result, as of his testimony date in October 2016, Dr. Smit had a hundred or so hip and joint patients on his wait list.[848]

1229. Since the hip and knee replacement patients are still a priority, all of his Peace Arch hospital time was being used for those surgeries. Dr Smit could now only do arthroscopic surgery in his clinic at WROSC, with some limited time at Delta Hospital.[849] He had been told "we cannot expect many slates for the foreseeable future" at Delta Hospital.[850] The last OR slate assigned to him at Delta Hospital prior to his testimony was in August 2016, when he performed seven arthroscopies. Those patients had waited about a year since their consultation.[851]

1230. Dr. Smit completed 82 Knee Arthroscopies in 2014. Of these, his 50th percentile Wait Two time (all priorities) was 74.1 weeks from Decision Date and his 90th percentile Wait Two time was 139.3 weeks from Decision Date.[852]

1231. Like Dr. Tarazi, Dr. Smit testified that two new orthopaedic surgeons were hired at Peace Arch Hospital in Fall 2009, but there was no increase in the amount of OR time available to the orthopaedic surgery group and no decrease in Dr. Smit's wait lists.[853]

1232. Dr. Smit also testified that his involvement in and provision of orthopaedic services at WROSC does not in any way limit the amount of services he provides in the public system. He takes all the public operating room time that is offered to him and does a full complement of call; he is fully engaged in the provision of MSP work.[854]

1233. Dr. Smit testified that if a patient expressed interest in being referred to another orthopedic surgeon, he would pass this information on to their family physician, but explained that "[m]ost patients prefer to stay with the surgeon that they have initially been referred to".[855]

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[847] **Transcript Day 19**, p. 18, line 26 to p. 19, line 12.
[848] **Transcript, Day 19**, p. 20, lines 14 to 18.
[849] **Transcript Day 19**, p. 21, lines 4 to 32.
[850] **Transcript Day 19**, p. 21, line 46 to p. 22, line 1.
[851] **Transcript Day 19**, p. 22, lines 1 to 13.
[852] **Exhibit 320A**, Tab 5, p. 2-3 **[CBE, Tab 73(D)]**.
[853] **Transcript Day 19,** p. 12, line 39, to p. 13, line 16; and p. 17 line, to p. 18, line 11.
[854] **Transcript Day 19,** p. 50, lines 12 to 22
[855] **Transcript Day 19,** p. 54, line 38 to p. 55, line 10.

iv. Erma Krahn (Meniscal Tear)

1234. **Redacted due to evidence subject to a sealing order.**

1235. **Redacted due to evidence subject to a sealing order.**

1236. **Redacted due to evidence subject to a sealing order.**

1237. Ms. Krahn continued to have pain in her left knee and difficulty walking.

1238. **Redacted due to evidence subject to a sealing order.**

1239. **Redacted due to evidence subject to a sealing order.**

1240. **Redacted due to evidence subject to a sealing order.**

1241. Ms. Krahn advised Dr. Smit that she wanted to pursue the knee arthroscopy, and Dr. Smit put her on his public wait list as of Feb. 2, 2009. At that time Dr. Smit had approximately 300 patients

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[856] **Redacted due to evidence subject to a sealing order.**
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[858] **Redacted due to evidence subject to a sealing order.**
[859] **Redacted due to evidence subject to a sealing order.**
[860] **Redacted due to evidence subject to a sealing order.**
[861] **Redacted due to evidence subject to a sealing order.**
[862] **Redacted due to evidence subject to a sealing order.**

on his waitlist for a variety of procedures, and his patients waiting for arthroscopy were waiting over one year.[863]

1242. In his response to questions from the Defendant, Dr. Smit explained that:

> 11/ [Ms. Krahn] was explained that a significant wait list existed, with expected waiting time well over one year.
>
> As an illustration, two knee arthroscopies were performed on February 3. 2009, the day after the date of surgical decision making, one arthroscopy the subsequent operative day, February 10, 2009. The surgical wait times had been 15 months, 10 months and 12 months respectively.[864]

1243. **Redacted due to evidence subject to a sealing order.**

1244. **Redacted due to evidence subject to a sealing order.**

1245. Dr. Smit had thought that surgical resources might become available at Peace Arch Hospital to shorten the wait time by Fall 2009, but those resources did not materialize.[867]

1246. **Redacted due to evidence subject to a sealing order.**

1247. Dr. Smit testified that he considered prioritizing Ms. Krahn by moving her up the queue on his public wait list, but that Ms. Krahn had presented with the same knee condition as many of his other patients, and he could not further prioritize one patient over another. He explained: "once prioritized to a level of equal priority, then I think the fairest is to provide people with care basically based on the time when they were booked. It is my responsibility to be fair to everybody within the parameters that I have to work with."[869]

1248. He gave the following example: "...[H]ow do I -- take the 35-year-old man who is a truck driver who is sitting at home with his young family and who can't drive his truck, how do I judge that against

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[863] **Transcript Day 19**, p. 8, lines 25 to 39.
[864] **Exhibit 30,** Written Responses by Dr. Arno Smit, p. 2 **[CBE, Tab 18]**; **Transcript Day 19,** p. 9, lines 1 to 17.
[865] **Redacted due to evidence subject to a sealing order.**
[866] **Redacted due to evidence subject to a sealing order.**
[867] **Exhibit 30**, p. 2 **[CBE, Tab 18].**
[868] **Redacted due to evidence subject to a sealing order.**
[869] **Transcript Day 19,** p. 14, lines 3 to 46; and p. 16, line 42 to p. 17, line 2.

a 94-year-old woman who likes to travel a little bit more who is waiting for things, or in a situation like this? It's not really feasible. There is no methodology for that. And I think once the condition is similar at some point one cannot further prioritize."[870]

1249. Ms. Krahn did not want to endure another year wait in a painful and incapacitated state as this would have wholly undermined her ability to enjoy her life.

1250. **Redacted due to evidence subject to a sealing order.**

1251. **Redacted due to evidence subject to a sealing order.**

1252. **Redacted due to evidence subject to a sealing order.**

1253. As seen by the SPR wait time data for her condition, Ms. Krahn's long Wait Two time was a systemic problem across BC. In 2009/2010, as referenced above, the 90th Percentile Wait Two time from BFRD for knee arthroscopy, across BC, was 61.3 weeks.

1254. Ms. Krahn's likely priority code would have been 34VGRN ("Knee - Cartilage disorder - moderate to severe pain with significant or severe functional limitation"), for which the maximum acceptable wait time is 12 weeks.[874]

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[870] **Transcript Day 19,** p. 14, lines 37 to 46.
[871] **Redacted due to evidence subject to a sealing order.**
[872] **Redacted due to evidence subject to a sealing order.**
[873] **Redacted due to evidence subject to a sealing order.**
[874] See for e.g. **Exhibit 316B,** Tab 4, p. 102 of 160 **[CBE, Tab 16, b].**

1255. **Redacted due to evidence subject to a sealing order.**

1256. She met with Dr. Day at Cambie in October 2009, and had her knee operation at Cambie just over a week later.

1257. **Redacted due to evidence subject to a sealing order.**

1258. **Redacted due to evidence subject to a sealing order.**

1259. **Redacted due to evidence subject to a sealing order.**

1260. **Redacted due to evidence subject to a sealing order.**

1261. **Redacted due to evidence subject to a sealing order.**

1262. **Redacted due to evidence subject to a sealing order.**

1263. **Redacted due to evidence subject to a sealing order.**

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[875] **Redacted due to evidence subject to a sealing order.**
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[881] **Redacted due to evidence subject to a sealing order.**

1264. **Redacted due to evidence subject to a sealing order.**

1265. The treatment Ms. Krahn obtained in the private system permitted her to live the final years in her life doing what she wanted to do, instead of being laid up and in severe pain.

1266. If she did not have the option to obtain her surgery privately, she would have been forced to suffer in pain waiting for surgery in the public system for likely the remainder of her life.

1267. Ms. Krahn did not take away surgical time or resources from the public system by seeking private care, but rather freed up space for someone else, in a system lacking in resources to provide timely care.

v. Chris Chiavatti (Meniscal Tear)

1268. Mr. Chris Chiavatti is a pediatric Patient Plaintiff who gave evidence of the harms he experienced while waiting for knee surgery.

1269. On January 14, 2009, at age 14, Mr. Chiavatti hyperextended his knee during his physical education class at school. He was in pain, had difficulty walking, and his knee was locking.[884]

1270. **Redacted due to evidence subject to sealing order;**

1271. Mr. Chiavatti was unable to participate in physical activities, which was very upsetting to him. He testified that he took value in participating in his extracurriculars and doing well in class, and that he knew extracurriculars were a big part of what universities were looking for, which was very important to him. These activities were also things that he really liked to do, so missing them "was not a positive thing for [him] at all."[886]

1272. **Redacted due to evidence subject to sealing order;**

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[882] **Redacted due to evidence subject to a sealing order.**
[883] **Redacted due to evidence subject to a sealing order.**
[884] **Exhibit 53**, ASF of Chris Chiavatti, dated October 13, 2016, p. 2, paras. 4 and 5 **[CBE, Tab 53].**
[885] **Redacted due to evidence subject to sealing order;**
[886] **Transcript Day 23**, p. 10, lines 23 to 33.
[887] **Redacted due to evidence subject to sealing order;**

1273. Mr. Chiavatti tried using a knee brace, but it made his symptoms worse; he felt "uncomfortable," put pressure on the meniscal tear, and "made it more painful."[888]

1274. While Mr. Chiavatti waited in the public system, he experienced significant pain in his knee that interfered with his ability to walk, sleep, and participate in school and extracurricular activities. He testified regarding his experience as follows:

a. "...It was as painful and getting worse.... Burnaby North is a very large school...so there's a lot of walking around, and by the third period of the day it was really even hard to get to my next class because I was in a lot of pain from walking all day. And that's not normal for a ninth grader.....[889]

b. "...if I was in pain it was pretty hard to sleep. A lot of tossing and turning."[890]

c. "I really took a lot of value from...my extracurriculars and doing well in class...I'm a pretty highly motivated student, and...the extracurriculars were a very big part of... what universities are looking for these days, and it was very important for me. And they were also things that I really liked to do. So missing some of those was not a positive thing for me at all."[891]

d. "I had tried a brace at one point -- I can't remember exactly when -- but it actually made it worse, I think because it was a combination of being uncomfortable and, you know, probably made me walk a little different which increased I guess the pressure on the meniscal tear. But it made it more painful. Really the best solution for me was to not do anything, but that's not really much of a solution at all." [892]

1275. Mr. Chiavatti's lack of function and mobility also greatly affected him emotionally. Mr. Chiavatti testified "...the sum of these things really made me quite unhappy. I was kind of grouchy, frankly. I was in a lot of pain by the end of the day and not being able to do things that I like. I mean, January/February is peak ski season, which is one of my favourite activities, and, you know, I couldn't go with the school; I couldn't go with any of my friends. So yeah, I mean, it was a bit isolating as well."[893]

1276. The Government's Wait One target time under P-CATS (the time from referral to initial specialist consultation) for this diagnosis is Priority IIa – within one week.[894]

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[888] **Transcript Day 23,** p. 13, lines 3 to 11.
[889] **Transcript Day 23,** p. 10, lines 6 to 13.
[890] **Transcript Day 23**, p. 10, lines 34 to 36.
[891] **Transcript Day 23**, p. 10, lines 25 to 33.
[892] **Transcript Day 23**, p. 13, lines 3 to 11.
[893] **Transcript Day 23,** p. 10, line 45 to p. 11, line 7.
[894] **Exhibit 432**, p. 1286 and 1297 **[CBE, Tab 103]**; and **Exhibit 346A**, p. 89, para. 475 **[CBE, Tab 84]**.

1277. Mr. Chiavatti had an initial consultation with Dr. Reilly on February 18, 2009.[895] Mr. Chiavatti's Wait One time was 20 days (3 weeks; January 29, 2009 to February 18, 2009), which was shorter than Dr. Reilly's usual consultation wait time because Mr. Chiavatti was able to get a last-minute cancellation with Dr. Reilly.[896]

1278. Dr. Reilly testified that his consultation wait times in 2009 were over one year, so Mr. Chiavatti likely would have waited that long if this cancellation had not occurred.[897]

1279. Mr. Chiavatti did not receive a definitive diagnosis for his knee condition from Dr. Reilly at that time, because he needed an MRI, after which he needed another appointment with Dr. Reilly so that Dr. Reilly could review it and confirm the diagnosis.[898]

1280. Mr. Chiavatti had an MRI at BCCH on April 1, 2009. The radiologist advised Mr. Chiavatti that he would then need to follow up with Dr. Reilly's office to discuss the results.[899]

1281. Mr. Chiavatti's mother phoned Dr. Reilly's office a few weeks after the MRI, but the receptionist advised that Mr. Chiavatti would probably be waiting for a few or several months to see Dr. Reilly, and his office would be in touch to arrange an appointment."[900]

1282. Mr. Chiavatti's mother phoned Dr. Reilly's office again in May 2009, and learned Mr. Chiavatti still did not have an appointment. She phoned again in June or July 2009, but was advised that there were approximately 400 people ahead of Mr. Chiavatti, that emergencies from other patients could create further delays, and she should stop calling.[901]

1283. By September 23, 2009, when Mr. Chiavatti visited his physician, Dr. Gordon, he was still waiting for a consult with Dr. Reilly. Dr. Gordon advised that she was aware that other children were waiting a long time for treatment.[902]

1284. The P-CATS Wait Two target time for this diagnosis is Priority IIb – within three weeks.[903] There was clearly no chance that Mr. Chiavatti would get his surgery within this time frame.

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[895] **Exhibit 53**, p. 3, para. 14 **[CBE, Tab 24]**; **Redacted due to evidence subject to sealing order;**
[896] **Exhibit 53**, p. 2, paras. 8 and 9, p. 3, para. 14 **[CBE, Tab 24]**; and **Transcript Day 23**, p. 7, lines 23 to 26.
[897] **Transcript Day 18**, p. 37, line 9.
[898] **Exhibit 53**, p. 4, paras. 21 to 24 **[CBE, Tab 24]**.
[899] **Exhibit 53**, p. 4, paras. 19 to 20 **[CBE, Tab 24]**; **Redacted due to evidence subject to sealing order;**
[900] **Exhibit 53**, p. 4, para. 21 **[CBE, Tab 24]**.
[901] **Exhibit 53**, p. 4, paras. 22-23 **[CBE, Tab 24]**.
[902] **Exhibit 53**, p. 4, para. 24 **[CBE, Tab 24]**.
[903] **Exhibit 432**, p. 1286 and 1297 **[CBE, Tab 103]**.; **Exhibit 346A**, para. 475 **[CBE, Tab 84]**.

1285. Because the wait list to see Dr. Reilly even for a second consult was so long, Mr. Chiavatti's parents looked into the possibility of expediting his surgery. They made an appointment to see Dr. Day at the Specialist Referral Clinic on October 28, 2009.[904]

1286. As referenced above, the wait time problem was not specific to BCCH and Dr. Reilly. In 2009/2010, not only was Wait One a problem, but also Wait Two. The 90th Percentile Wait Two time from BFRD for all adult arthroscopies was 51.3 weeks.

1287. BCCH did not report to the SPR in 2009/2010. It did however, measure its wait times versus the P-CATS and shared the data with the Ministry of Health and the other Paediatric Hospitals across Canada.[905] In 2010/11, 45.26% of orthopaedic surgeries at BCCH were completed outside the maximum P-CATS for all orthopaedic conditions.[906]

1288. **Redacted due to evidence subject to a sealing order.**

1289. **Redacted due to evidence subject to a sealing order.**

1290. On November 19, 2009, Dr. Day performed a partial arthroscopic meniscectomy on Mr. Chiavatti to repair his right knee.[909]

1291. Dr. Day observed that Mr. Chiavatti's knee condition had deteriorated over time, as there was softening and damage of the tissue around his knee.[910]

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[904] **Exhibit 53**, p. 4, paras. 25 and 27 **[CBE, Tab 24]**.
[905] **Exhibit 433A**, p. 1264 **[CBE, Tab 104]**.
[906] **Exhibit 432**, p. 1306 **[CBE, Tab 103]**.
[907] **Redacted due to evidence subject to a sealing order.**
[908] **Redacted due to evidence subject to a sealing order.**
[909] **Exhibit 53**, p. 5, para 32, **Exhibit 346A**, p. 90, para. 482 **[CBE, Tab 24]**.
[910] **Exhibit 53**, p. 5, para. 33; **Transcript Day 23**, p. 14, lines 15 to 19 **[CBE, Tab 24]**.

1292. **Redacted due to evidence subject to sealing order;**

1293. Once he had his surgery, Mr. Chiavatti's recovery was very rapid. He was able to resume his regular activities quickly, even skiing within a month. He was relieved that he was able to get back to his normal life as he had missed doing many activities.[912]

1294. Thus, after waiting 9 months after the initial consultation (February 19, 2009 to November 2009) and 7 months after his MRI (April 1, 2009 to November 2009), Mr. Chiavatti had not received his follow-up consultation, nor was he scheduled for surgery at BC Children's Hospital by the time he had private surgery with Dr. Day.

1295. In January 2010, Dr. Reilly's office called to schedule a consultation (not surgery) for September 2010 -- 20 months after the initial consultation and 18 months after the MRI.

1296. Mr. Chiavatti's wait time in the public system would have been years had he continued to wait, essentially destroying his high school experience.

1297. Pursuant to the P-CATS, the maximum time Mr. Chiavatti should have waited (combined W1 and W2) was four weeks.

1298. Had Mr. Chiavatti been a teacher who injured his knee in the same class instead of a student, he would have been received expedited treatment in a private clinic funded through WCB insurance, as well as fully funded physiotherapy.[913]

vi. Marshal Van De Kamp (ACL Rupture and Meniscal Tear)

1299. Marshal Van de Kamp is a young man who had suffered an ACL rupture and meniscal tear in his right knee at work as a welder on September 13, 2014. This injury was covered by WorkSafeBC's insurance, who expedited his treatment privately, and provided physiotherapy and vocational rehabilitation to assist in his recovery.

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[911] **Redacted due to evidence subject to sealing order;**
[912] **Transcript Day 23**, p. 14, lines 28 to 40.
[913] **Exhibit 346A,** p. 90, para. 476 **[CBE, Tab 84]**.

1300. In the period leading up to his claim being accepted by WorkSafeBC, Mr. Van de Kamp continued working, "despite the severe pain in [his] knee" as no medical professional had told him that he should not be working at that time and he needed the income.[914]

1301. Working was difficult at this time, however. He affirmed, "My right knee would occasionally dislocate when I was walking, or even when I was sleeping, which caused severe and shooting pain" and "I experienced pain every day from my knee injury, which impacted almost every aspect of my life, and made it very difficult to work or do any other daily activities.[915]

1302. For almost two months, he took approximately two Tylenol and ibuprofen every 4-6 hours each day, which still did not fully relieve his pain. He later developed problems with his liver, which he understood was a result of his prolonged Tylenol use for knee pain.[916]

1303. WorkSafeBC ultimately accepted his work injury claim on October 28, 2014,[917] and referred him for an expedited MRI, which occurred on November 17, 2014.[918]

1304. WorkSafeBC expedited an orthopaedic surgery consultation with Dr. Day on January 21, 2015, who confirmed that Mr. Van de Kamp had an ACL rupture. Dr. Day was concerned that he had continued to work with that injury, and wrote him a note to remain off work.[919]

1305. WorkSafeBC then expedited and paid for Mr. Van de Kamp's ACL surgery, which was performed by Dr. Day on February 12, 2019.[920]

1306. WorkSafeBC funded physiotherapy for Mr. Van de Kamp pre- and post-surgery, which Mr. Van de Kamp found to be "very helpful in facilitating [his] recovery." [921]

1307. WorkSafeBC also provided vocational rehabilitation for Mr. Van de Kamp to train for alternate work as a heavy machine operator, as WorkSafeBC had determined that returning to his job as a welder was not appropriate, given his limitations with his knee injury.[922]

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[914] **Exhibit 295,** Affidavit #1 of Marshal van de Kamp, p. 3, para. 14 **[CBE, Tab 55]**.
[915] **Exhibit 295,** p. 3, paras. 15-16 **[CBE, Tab 55]**.
[916] **Exhibit 295**, paras. 19-21 **[CBE, Tab 55]**.
[917] **Exhibit 295**, p. 3, para. 22 **[CBE, Tab 55]**.
[918] **Transcript Day 104**, p. 5, lines 38 to 40.
[919] **Exhibit 295,** p. 4, paras. 30-32 **[CBE, Tab 55]**.
[920] **Exhibit 295,** p. 5, paras. 33-34, and Exhibits M and N **[CBE, Tab 55]**.
[921] **Exhibit 295**, p. 3, para. 26, p. 5, para. 35, and Exhibit I **[CBE, Tab 55]**.
[922] **Exhibit 295,** p. 5, paras. 37-39 **[CBE, Tab 55]**.

1308. WorkSafeBC paid for medications such as painkillers, and also provided wage loss benefits.[923]

1309. Mr. Van de Kamp explained, "As I went through my rehabilitation and re-training, I began to feel more optimistic. My pain subsided, and my knee function gradually improved. I looked forward to beginning my new career."[924]

1310. Even with the assistance from WorkSafeBC, recovering from his right knee injury was a lengthy process.

1311. Mr. Van de Kamp then suffered an ACL rupture and meniscal tear in his left knee while playing recreational football on August 6, 2016.[925]

1312. This left knee injury was not covered by WorkSafeBC, and in fact caused WorkSafeBC to end his vocational rehabilitation training and benefits for his right knee as of August 7, 2016.[926]

1313. On August 8, 2016 Mr. Van de Kamp attended Mission Hills Medical Clinic. He understood from this visit that there would be a six to eight month wait for a diagnostic MRI, which would prolong his surgical wait. Mr. Van de Kamp testified "This news was very upsetting to me. I knew there were significant wait times for surgeries, and had been prepared to pay for the privately [sic] surgery to access timely care. However, I had not known that there would also be a six to eight month wait just for the diagnostic MRI," and stated "I did not feel I could wait that long for an MRI. The longer I waited, the longer I would be in pain, and the longer it would take before I could get back to work. [927] Therefore he paid to have a private MRI on August 10, 2016.[928]

1314. Mr. Van de Kamp "was also concerned about having a projected surgery time of 18 to 24 months."[929]

1315. In 2016, the 90th percentile Wait Two time for Mr. Van de Kamp's diagnosis, 34VGIN, "Knee - Joint Internal Derangement...Moderate To Severe Pain With Significant Or Severe Functional Limitation," (maximum acceptable wait time of 12 weeks), was 26.4 weeks from BFRD and 32.3 weeks

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[923] **Exhibit 295, Exhibit "E",** p. 13, Exhibit "Q", p. 39 **[CBE, Tab 55]**.
[924] **Exhibit 295**, p. 6, para. 44 **[CBE, Tab 55]**.
[925] **Exhibit 295**, p. 6, para. 45 **[CBE, Tab 55]**.
[926] **Exhibit 295**, p. 8, para. 64 **[CBE, Tab 55]**.
[927] **Exhibit 295**, p. 7, paras. 56-58 **[CBE, Tab 55]**.
[928] **Exhibit 295**, p. 7, paras. 59-62 **[CBE, Tab 55]**.
[929] **Exhibit 295**, Exhibit "AA," p. 66 **[CBE, Tab 55]**.

from Decision Date. [930] Only 62% of patients had their surgery performed within the maximum acceptable wait time.[931]

1316. Further, had Mr. Van de Kamp had to wait for a public MRI, his wait would have been much longer. At the time, the wait time for a Priority 3 MRI (Acute Joint Symptoms i.e. ACL Meniscus) (maximum wait of 30 days), was 255 days for the 90th percentile.[932]

1317. Had Mr. Van de Kamp waited for a consultation with a surgeon in the public system, the 90th percentile Wait One time for knee arthroscopy was 32.3 weeks in 2016/17.[933]

1318. Due to Mr. Van de Kamp's experience with private surgery at Cambie through WorkSafeBC, his stress "about the prospect of having to wait a long time for surgery" in the public system, and not wanting his "life to be put on hold" while waiting, Mr. Van de Kamp chose to have private surgery at Cambie for his left knee as well.[934]

1319. On September 29, 2016, Dr. Day performed an arthroscopy and repair of ligaments on Mr. Van de Kamp's left knee at Cambie.[935]

1320. Mr. Van de Kamp affirmed that his experience recovering for his left knee surgery was much different than his right knee, without the support of WorkSafeBC. He explained, "I had WorkSafeBC support after my Right Knee Surgery, which assisted me in organizing my treatment and paying for my physiotherapy. In addition, I had income support during that period, which reduced the stress caused by being off-work due to my injury."[936]

1321. He explained that after his left knee surgery, he attended physiotherapy, but because he was unemployed and without benefits, he had to pay for it and could not afford to attend very often. He tried to do the exercises at home, but this was not as useful or productive as the supervised rehabilitation program provided through WorkSafeBC.[937]

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[930] **Exhibit 316B**, Tab 4, Page 99 **[CBE, Tab 68, b]**.
[931] **Exhibit 315B**, Tab 7, Page 286 **[CBE, Tab 65]**.
[932] **Exhibit 322**, Tab 5, Page 6 **[CBE, Tab 76, c]**.
[933] **Exhibit 431,** p. 239 **[CBE, Tab 102]**.
[934] **Exhibit 295**, p. 6, paras. 48 to 52 **[CBE, Tab 55]**.
[935] **Exhibit 295**, p. 8, para. 70 and Exhibit BB **[CBE, Tab 55]**.
[936] **Exhibit 295**, pp. 8 to 9, paras. 72 to 73 **[CBE, Tab 55]**.
[937] **Exhibit 295**, p. 9, paras. 74-75 **[CBE, Tab 55]**.

1322. Having the option to seek private care for his left knee allowed Mr. Van de Kamp to return to work faster than he could have, had he been forced to wait for his knee surgery in the public system, and to substantially reduce the length of time he suffered pain and disability.

1323. Mr. Van de Kamp would have been prevented from working for far longer than necessary, living on greatly reduced or no income, and potentially risking further harm to his left knee, if he did not have the option to seek private care for his left knee.[938]

vii. Krystiana Corrado (Acl Rupture and Meniscal Tear)

1324. Patient Plaintiff Krystiana Corrado testified about harm she experienced while waiting for arthroscopic knee surgery following an ACL tear.

1325. Ms. Corrado was an active athlete who played elite level soccer. She had expectations of achieving a soccer scholarship to a Canadian university.[939]

1326. On April 14, 2011, shortly after her 16th birthday, Ms. Corrado twisted her right knee in the course of a soccer game. She immediately felt intense pain in and around her right knee and was unable to walk or put weight on it.[940]

1327. As a result of this incident, she had a complete tear of her anterior cruciate ligament, P-CATS Code 44WZFA (Ligament Injury (ACL) – Acute). She later developed a meniscus tear that occurred during her wait for consultation/surgery.[941]

1328. Ms. Corrado's family physician, Dr. Mary Weckworth, testified that Ms. Corrado's knee was very swollen and "quite painful" at her first appointment,[942] and she was still in discomfort at her follow-up visit.

1329. After her second visit, Dr. Weckworth sought to expedite Ms. Corrado's MRI as she was aware that there was a very long wait time for obtaining an MRI.[943]

1330. On June 2, 2011, Ms. Corrado had an MRI, which showed a complete tear of her ACL.[944]

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[938] **Exhibit 295**, p. 6, paras. 48 to 52 **[CBE, Tab 55]**.
[939] **Exhibit 52,** ASF of Krystiana Corrado, p. 2, paras. 2 and 3 **[CBE, Tab 23]**.
[940] **Exhibit 52**, p. 2, para. 5 **[CBE, Tab 23]**.
[941] **Exhibit 52,** p. 4, para. 14; **Exhibit 346A**, p. 89, para. 472 **[CBE, Tab 84]**.
[942] **Transcript Day 15,** Testimony of Dr. Mary Weckworth, dated October 3, 2016, p. 49, lines 20 to 29.
[943] **Exhibit 52**, p. 3, para. 12 **[CBE, Tab 23]**.
[944] **Exhibit 52**, p. 4, para. 14 **[CBE, Tab 23]**.

1331. On June 22, 2011, Ms. Corrado went back to Dr. Weckworth to review the results and Dr. Weckworth advised her that she would likely require surgery to repair the ACL tear, and referred her to Dr. Christopher Reilly at the BC Children's Hospital.[945]

1332. Dr. Weckworth's referral to BCCH and Dr. Reilly was appropriate, as Ms. Corrado was only 16 years and 2 months old. With her PCATS Code, Ms. Corrado's maximum acceptable Wait One was 3 weeks and Wait Two was 12.86 weeks, for a combined maximum acceptable wait time for completion of surgery of 16 weeks.[946] At the latest, Ms. Corrado should have had her surgery by mid-October 2011, at which time she would still have been 16 years old.

1333. Ms. Corrado was not able to see Dr. Reilly until October 2011 due to his lengthy wait list. At that time, Dr. Reilly confirmed her right knee ACL tear and that she would require surgery. He told her that he would not be able to perform the surgery before she turned 17 in April 2012. Because she would be older than 16 at that point, he would require special permission from the Head of Surgery at the hospital in order to perform the surgery, and there was no guarantee that he would be given that permission.[947]

1334. **Redacted due to evidence subject to a sealing order.**

1335. Dr. Weckworth testified that after Dr. Reilly told Ms. Corrado he could not treat her, Ms. Corrado was crying from her stress and frustration and that her knee was in significant pain."[949]

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[945] **Exhibit 52,** p. 4, paras. 15 and 16 **[CBE, Tab 23]**.
[946] **Exhibit 432**, p. 1286 and 1297 **[CBE, Tab 103]**.
[947] **Exhibit 52**, p. 5, para. 21 **[CBE, Tab 23]**.
[948] **Redacted due to evidence subject to a sealing order.**
[949] **Transcript Day 15,** p. 54, lines 1 to 13.

1336. An appointment for Ms. Corrado was arranged with Dr. Fadi Tarazi for December 2, 2011.[950] Dr. Tarazi saw Ms. Corrado at the Cast Clinic, where he sees patients that he wants to see soon or for urgent referrals.[951]

1337. This need for a second consult with Dr. Tarazi meant that Mr. Corrado's Wait One time was extended to over 5 months, well beyond the P-CATS target of three weeks.

1338. Dr. Tarazi confirmed that Ms. Corrado needed surgery urgently. He diagnosed her as "Knee – Ligament dysfunction –Severe Constant Pain or Constant Functional Deficit, Imminent Threat to Role of Independence", Priority 3 (maximum acceptable wait time of six weeks).[952]

1339. However, at Ms. Corrado's consultation, Dr. Tarazi told her that, based on his wait list, it was unlikely that she would have surgery for another 7 months after her consultation.[953]

1340. Dr. Tarazi would normally tell his patients that the wait time was between six to 12 months, but wanted to try to perform Ms. Corrado's surgery faster. Ultimately, the conditions of others on his wait list and his allotted OR time did not permit him to move Ms. Corrado further up his wait list to complete the surgery within 6 weeks. Dr. Tarazi explained:

> ...I try to move patients if the condition allows it without endangering others. So I have to -- I cannot act in just for one patients; I have to look at everybody. So in her situation with the medical condition that she had, my goal was to do it within six weeks. Unfortunately, I was not able to do it within six weeks because there wasn't enough operating room time available to treat her within six weeks and to treat the others within their time -- the time parameters that I wanted to do the others as well. So that's why she ended up having to wait longer.[954]

1341. The SPR data for Dr. Tarazi's cases completed for ACL repairs in 2011 shows that his 50th percentile Wait Two time was 24.9 weeks and 90th percentile Wait Two time was 35.9 weeks, from BFRD.[955]

1342. The long wait encountered by Ms. Corrado was systemic across BC. As noted above, in 2011/2012, the 90th percentile Wait Two Time for Knee-ACL Repair was 51.7 weeks from BFRD.

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[950] **Exhibit 52,** p. 6, para. 27 **[CBE, Tab 23]**.
[951] **Transcript Day 20,** p. 78, lines 22 to 24.
[952] **Exhibit 316A,** Tab 1 p. 112 **[CBE, Tab 67, a]**.
[953] **Exhibit 52,** p. 6, paras. 26 and 28 **[CBE, Tab 23]**.
[954] **Transcript Day 20,** p. 13, lines 20 to 31.
[955] **Transcript Day 20,** p. 25, lines 31 to 36.

1343. Ms. Corrado experienced significant pain and psychological harm while waiting for care for her knee condition. She experienced constant pain (aching and sharp), and her mobility was severely restricted (with her knee frequently and unexpectedly giving out). Her restricted mobility impacted all aspects of her academic, athletic, and home life, and her life plans. Because she did not know the nature of her diagnosis, for the majority of her wait time, she was very concerned about worsening her condition. Ms. Corrado reported feeling anxious and depressed while waiting for care and struggled with the reality that her life, and potentially her future, had come to a standstill for no justifiable reason. She testified as follows:

a. "It was very difficult getting around places ... But it was hard to get to school. I was always late for class. I was late to get home. I would go home and I really couldn't do much, so I would sit and with my leg up not doing much because I was scared to -- because I didn't know what it was, I was scared to make it worse. So I didn't do my usual activities. I didn't go to sports. I tried to watch practices, but it was very difficult." [956]

b. Her knee was: "unstable, painful. It was still pretty big. It was...very uncomfortable. I couldn't put much pressure on it, and when I did it wasn't for very long. It was just not pleasant. I was very, very distraught about everything. Because it -- I guess it had a snowball effect. Because as soon as I wasn't able to move, essentially, I couldn't play sports; I couldn't do my student government roles; I couldn't do what I needed to do and what I usually did. It was very new. I'm used to playing sports four or five times a week, and it just suddenly stopped, and I couldn't really do much about it." [957]

c. "It was probably the darkest period of my life, honestly. I wasn't used to being so stationary and just not moving. I wasn't used to not being able to exercise. I did fall behind in school. I did my best to -- I was a straight A student. I did my best to keep up with that, but it was hard to focus because I felt **like there was no point** in getting good grades if I wasn't -- I was just very down on myself, so it was a very dark time. It was hard to move around. When my friends would go out I couldn't..."[958]

d. Her knee was in "constant pain that I was starting to get used to, which was sad, because it would just be an aching and a sharp pain. My knee would give out, but ... I became accustomed to it. So that was disappointing. I would constantly have to keep my leg elevated, ice it. I was still using the elevator key at my school. I couldn't obviously play sports." [959]

e. "From my opinion I was not someone you wanted to be around. From my parents' opinion I believe I was depressed, always, like, anxious. Very hard ... to talk to. Hard to reason with. It affected all of us, not just me. Everyone in the household was

[956] **Transcript Day 27**, p. 8, lines 5 to 19.
[957] **Transcript Day 27**, p. 8, lines 26 to 39
[958] **Transcript Day 27**, p. 10, lines 31 to 43
[959] **Transcript Day 27**, p. 11, lines 14 to 24

disappoint -- like, not disappointed but they were, like, saddened for me. So it was hard." [960]

f. Regarding the wait time between her consult from Dr. Reilly to the consult with Dr. Tarazi: "It was very demoralizing, honestly. I had gone into seeing Dr. Reilly thinking, okay, I'm going to get a date; I'm going to get surgery soon; I'll be able to play soccer soon; okay, great. But then finding out that I couldn't -- that I wasn't going to be able to get surgery with him and put on another waitlist, I was just praying, praying that something would happen, like, something so I could actually play in my grade 11 year, hopefully even in my grade 12 year.... "

...

"As I said, I'd been accustomed to the constant buckling of the knee, the pain, the random swelling. It wasn't pretty to look at.... It was hard to be in my household, like I said, with me. I was constantly upset. There was nothing that made me feel better. I couldn't do anything. I would sit. I would study and read. I couldn't do anything regarding physical activity, which when you do that and you identify that as your hobby, your life, and it's just gone, honestly I didn't know what to do with myself in those months." [961]

g. "I threw away my ideas of playing soccer in high school, threw away the whole idea of playing in university;" and the wait "meant I couldn't play soccer in high school or university. That meant, like, all the work I'd put in to get to where I was just went down the drain"[962]

1344. In early 2012, a friend suggested that Ms. Corrado's father consult with Dr. Day at Cambie to see if he could provide Ms. Corrado with surgery more quickly than in the public system.[963]

1345. On January 12, 2012, Ms. Corrado saw Dr. Day for a consultation. Dr. Day observed that Ms. Corrado had a very dysfunctional knee – it was unstable and painful when it shifted out of position. Ms. Corrado was distraught about not being able to participate in physical activities and about not being able to obtain a sports scholarship because of the surgical delay. She told him she was depressed, not sleeping well and having trouble concentrating on her school work because of her knee injury.[964]

1346. On January 19, 2012, Dr. Day performed ACL reconstruction surgery on Ms. Corrado's right knee at Cambie.[965]

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[960] **Transcript Day 27**, p. 11, lines 26 to 33
[961] **Transcript Day 27**, p. 13, lines 22 to 31 and p. 13, line 47, to p. 14 line 17.
[962] **Transcript Day 27**, p. 15, lines 5 to 7 and 19 to 22.
[963] **Exhibit 52,** p. 6, para. 30 **[CBE, Tab 23]**.
[964] **Exhibit 346A**, p. 89, para. 471 **[CBE, Tab 83]**.
[965] **Exhibit 52,** p. 7, para. 35 **[CBE, Tab 23]**.

1347. Dr. Brian Day found that she had a lateral meniscal tear and a complete tear of the anterior cruciate ligament. The lateral meniscus tear, which is a long-term concern in such a young person, had occurred during her wait for surgery, as it had not been present on the MRI performed on June 2, 2011.[966]

1348. Ms. Corrado's recovery from her surgery was successful, eventually allowing her to get back to playing soccer, however not at the same level or on the same elite team as before,[967] and she was ultimately unable to obtain a soccer scholarship to university.[968]

viii. Conclusion

1349. Both Mr. Chris Chiavatti (aged 14) and Ms. Krystiana Corrado (aged 16), were under the age of 17 at the time of their knee injuries. They waited well beyond the Government's established maximum acceptable wait times for their diagnoses, prior to obtaining private consultations and surgeries and moving on with their recovery. [969]

1350. Ms. Krahn also benefitted greatly from having the choice to expedite her surgery by seeking private care, and with the result that she had a much better quality of life for her remaining years than if she had waited for care in the public system.

1351. Mr. Van de Kamp's situation illustrates the stark difference in the expedited diagnosis, treatment, rehabilitation assistance, and financial assistance provided to patients who are injured in the workplace as compared to those who are injured outside of work.

1352. As reflected in the wait time evidence above, this is not a situation where these patients could have simply been referred elsewhere for treatment sooner. Extremely long waitlists for these types of surgery were, and continue to be, an issue across the province.

1353. Mr. Chiavatti, Ms. Corrado, Ms. Krahn, and Mr. Van de Kamp did not take away any resources from anyone who was waiting for surgery in the public system by choosing to seek private care. Instead, by accessing private care, they freed up space on the already inundated waitlists of surgeons in the public system that were unable to provide timely care. And, they were able to limit the harm

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[966] **Exhibit 346A**, para. 472 **[CBE, Tab 83]**.
[967] **Transcript Day 27,** p. 16, lines 27 to p. 17, line 17.
[968] **Transcript Day 27**, p. 17, line 28 to 39.
[969] **Exhibit 52,** p. 2, paras. 1 and 5 **[CBE, Tab 23]**; **Exhibit 53**, p. 2, paras. 1 and 4 **[CBE, Tab 24]**.

and damage to their own lives that they were experiencing due to the long waits in the public system, and what they would have further experienced had they been required to continue to wait.

b) Shoulder And Elbow Surgery

1354. Evidence about shoulder and elbow surgery was provided by Dr. William Regan. Dr. Regan is an orthopedic surgeon specializing in reconstruction of the shoulder and elbow – shoulder or elbow replacements due to end stage arthritis in these joints; rotator cuff repairs; and elbow or shoulder tendon and ligament repairs.[970] Dr. Regan often gets tertiary referrals – more complex cases in which the patient has had a prior unsuccessful surgery or where another orthopedic surgeon is not comfortable doing the case due to its complexity.[971]

1355. Dr. Regan testified that the patients he sees are generally suffering pain, and loss of function. They may be unable to feed themselves easily or to wash their hair. A significant problem is inability to sleep due to discomfort, which may render them unable to work and miserable.[972]

1356. Prior to surgery, these patients' quality of life is often poor. They may be taking narcotics for pain, often in large amounts. They may be unable to cope with normal situations, and become depressed. Following surgery and rehabilitation, they are often able to get off the painkillers, and their quality of life is much improved.[973]

1357. Dr. Regan testified that it generally takes up to two years or more to see him for a consultation, although particularly urgent patients will get in much more quickly. He will advise the referring physician, where it is apparent from the referral, that the patient will need an MRI or other imaging for the purposes of diagnosis, in order to try to reduce the "Wait Three" time and avoid the need for a second consultation.

1358. In many cases, as part of the diagnostic process, Dr. Regan refers his patients for nerve blocks, which are image-guided injections (which may be carried out by radiologists, anesthesiologists or physiatrists), to attempt to determine the source of pain experienced by the patient. The wait time for

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[970] **Transcript Day 49**, Testimony of Dr. William Regan, December 9, 2016, p. 11, lines 18 to 46
[971] **Transcript Day 49**, p. 14, lines 25 to 41
[972] **Transcript Day 49**, p. 12, lines 30 to 47
[973] **Transcript Day 49**, p. 13, lines 1 to 38

these injections was six months at the time of Dr. Regan's testimony.[974] Sometimes more than one block is required for the diagnosis and treatment plan.[975]

1359. Dr. Regan and his orthopedic surgical group (Dr. Gilbart and Dr. Chin) practice primarily in the Joint Preservation Centre at UBC Hospital ("UBCH"), and occasionally at VGH. Previously, Dr. Regan also had surgical privileges at Mount St. Joseph Hospital, St. Vincent Hospital and Shaughnessy Hospital, but the latter two hospitals were closed in 1998 and 1993, respectively.[976]

1360. In about 2005, UBCH ceased being a full-service hospital, with the result that the ER and ICU were closed and there is no longer anesthesia coverage overnight. Thus, surgeries can only be performed at UBCH during the day, and only ASA 1 and 2 patients can have surgery there. At the time of Dr. Regan's testimony, he had not been allocated any OR time at VGH since April 2015, and thus was unable to offer surgery to his ASA 3 or 4 patients.[977]

1361. Dr. Regan's patients are occasionally bumped to do urgent trauma cases because there is no longer OR time in the evenings at UBCH.[978]

1362. Dr. Regan testified that the focus on hip and knee replacements results in orthopedic OR time being allocated to do hip and knee replacements to the detriment of other forms of orthopedic surgery such as that performed by his group.[979]

1363. Dr. Regan is aware of over 100 fully trained orthopedic surgeons, many of whom have fellowship training, who are unable to find a position in a hospital.[980]

1364. The UBCH orthopedic group has sought to hire more orthopedic surgeons over the past several years, but has been unable to do so because there is no additional OR time to be allocated to their group. [981]

1365. Since the early 2000s, VCHA has contracted out many of the surgical procedures done by Dr. Regan's group at UBCH to private surgical facilities – first to Cambie, then Ambulatory Care Centre,

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[974] **Transcript Day 49**, p. 23, lines 6 to 35
[975] **Transcript Day 49,** p. 22, line 1 to p. 24, line 47
[976] **Transcript Day 49,** p. 3, lines 14 to 29, p. 7, lines 1 to 13, p. 44, lines 17 to 22
[977] **Transcript Day 49,** p. 29, lines 15 to 40
[978] **Transcript Day 49,** p. 63, line 11 to p. 65, line 7
[979] **Transcript Day 49**, p. 65, line 25 to p. 66, line 17; **Exhibit 172**, Affidavit #1 of Dr. William Regan, dated October 9, 2012, p. 5, para 27 **[CBE, Tab 39]**.
[980] **Transcript Day 49**, p. 38, lines 20-34.
[981] **Transcript Day 49**, p. 38, lines 1-19.

and then (at the time of Dr. Regan's testimony in 2016) to False Creek. Almost 50% of the surgeries done by the UBCH orthopedic surgical group are contracted out to private surgery centres.[982]

1366. Dr. Regan also performs surgery at Cambie. Most of this is WCB work, or for the RCMP, but he also performs surgery on a private pay basis. He also does private consultations at SRC. Most patients who are seen privately in consultation who require surgery, have the surgery privately at Cambie, but some are unable to do so as a result of their ASA level or their body mass index.[983]

1367. Dr. Regan is the team orthopedic surgeon for the Vancouver Canucks. Their surgeries are all done privately, if that is possible based on the nature of the surgery.[984]

1368. Approximately 40 to 45% of Dr. Regan's patients seen in consultation ultimately require surgery.[985]

1369. Dr. Regan testified that while he does distinguish Priority 1 and 2 patients, who require urgent surgery, assigning a Priority 3 is of little value in getting his patients' surgery done sooner. Thus he assigns most of his patients a Priority 4 (12 weeks).[986]

1370. There is often a significant gap in time between the Decision Date for surgery, and the Booking Form being submitted to a hospital because the anesthetic team needs to determine if the surgery can be done at UBC (only ASA 1 and 2 patients) or must be done at VGH or elsewhere due to the patients' anesthetic risk. In addition, due to the long surgical wait and the need for renewed tests after a certain wait, Dr. Regan's assistant does not submit her surgical booking forms until she has Dr. Regan's OR schedule for the upcoming three month period.[987] As a result, the Wait Two from BFRD data in the SPR substantially understates Dr. Regan's surgical wait times.

1371. Dr. Regan's most recent wait time data (2016) showed that he completed 67 shoulder surgeries. Of these cases, the 50th percentile from BFRD was 5.1 weeks and the 50th percentile from Decision Date was 60 weeks. The 90th percentile from BFRD was 11.6 weeks and the 90th percentile from Decision Date was 78.6 weeks.[988]

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[982] **Exhibit 172,** p. 6, para 30 **[CBE, Tab 39]**.
[983] **Transcript Day 49,** p. 35, line 1 to p. 37, line 47.
[984] **Transcript Day 49,** p. 38, line 35 to p. 39, line 16
[985] **Transcript Day 49,** p. 25, lines 7 to 8
[986] **Transcript Day 49,** p. 40, line 39 to p. 41, line 33
[987] **Transcript Day 49,** p. 26, line 10 line 25 to, p. 29, line 12
[988] **Exhibit 320A,** Tab 2, p. 4 **[CBE, Tab 73, b]**.

1372. The SPR data for shoulder surgery generally in BC reveals the alarming state of access to shoulder surgery, for patients in all urgency categories.

1373. For example, as can be seen from Table 2 (**Appendix, Part A, Section VII(C)(vii)(b)**), in 2017, for patients with the diagnosis of "Elbow–Arthritis/Joint Degeneration - moderate to severe pain with significant or severe functional limitation -- 34TMAN" (Priority 4) (12 weeks), only 37.9% of surgeries were completed within target.[989] The 50th percentile Wait Two time was 20.1 weeks from BFRD and 24.4 weeks from Decision Date. The 90th percentile Wait Two was 50.1 weeks from BFRD and 51 weeks from Decision Date.

1374. BC patients are also waiting longer than the maximum acceptable wait time for many shoulder conditions that cause severe pain and functional disability. For example, Code 34TAAM (Priority level 3) involves conditions where the diagnosis description reflects that they are in "severe constant pain" or a "constant functional deficit" with an "imminent threat to role or independence."

1375. Table 1 shows that in 2017, only 34.4% of these patients received surgery within the 6-week maximum acceptable wait time. The 50th percentile Wait Two was 14.4 weeks from BFRD and 21.6 weeks from Decision Date. The 90th percentile Wait Two was 49.8 weeks from BFRD and 50.7 weeks from Decision Date (Code 34TAAM).

1376. As this data at Table 1 shows, and Dr. Regan's testimony confirms, many British Columbians who have shoulder or elbow conditions that require surgery wait far too long for their surgery, and well past the maximum acceptable wait time for their condition. [990] They suffer significant pain and disability, and loss of function while waiting for treatment.

1377. This situation will worsen significantly if the private facilities are no longer available to perform contracted out surgeries and/or WCB surgeries. All of those procedures would need to be done in the public hospitals which simply do not have the capacity.

c) Hip and Knee Replacement Surgery

1378. Hip and knee replacement surgery (arthroplasty) has been one of the surgical focusses of federal and all provincial governments, including British Columbia since 2005.[991]

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[989] **Appendix**, Part A, Section VII(C)(vii)(b), Table 2.
[990] **Appendix**, Part A, Section VII(C)(vii)(b), Table 1.
[991] **Exhibit 2A,** Prima Facie Facts, MOH, p. 128-129, para 302

1379. This is due to the high prevalence of osteoarthritis, which leads to significant pain and disability, loss of mobility and quality of life. As the population ages, the percentage of the population developing osteoarthritis is also increasing. In addition, because hip and knee replacement surgery outcomes are generally very successful in relieving the pain and disability experienced by the patient, the demand for the surgery is high.

1380. Despite this ongoing focus, wait times for hip and knee replacement surgery in British Columbia remain excessively high.[992]

1381. Substantial expert and lay evidence about the impact of waiting for surgical consultation and treatment on patients with osteoarthritis requiring hip or knee replacement surgery was provided to the Court. Expert evidence was provided by Dr. Bassam Masri, Dr. Keith Chambers and Dr. Gordon Matheson, as well as lay physician evidence from Dr. Masri, Dr. Anthony Costa and patient witness Denise Tessier. Defendant experts Dr. Gordon Guyatt and Dr. Eric Bohm also testified with respect to the harmful effects of waiting for hip or knee replacements on patients.

1382. Dr. Bassam Masri is an internationally renowned orthopedic surgeon with a subspecialty in hip and knee joint replacement (arthroplasty).[993] He has privileges at VGH and UBC Hospital, as well as operating privileges at SPH. He also has privileges at Cambie but had not performed surgery at Cambie since 2011.[994]

1383. Dr. Masri has served in a variety of roles in surgical, hospital and health authority management, and at the time of his testimony was the Head of the Department of Orthopedics for Vancouver Acute (UBC Hospital and VGH) and also Surgeon-in-Chief for Vancouver Acute, and Co-Chair of the Regional Surgical Program for VCHA. He had previously served on a variety of provincial committees, including the Provincial Surgical Advisory Council ("PSAC"), the Provincial Musculoskeletal Council, and the BC Ministry of Health Expert Panel on wait times for joint replacement. He was also the Chair of the Manpower and Advocacy subcommittee of the Canadian Orthopedic Association from 2010 to 2011, and the President of the Canadian Orthopedic Association from 2014-2015.[995]

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[992] See **Appendix**, Part A, Section VII(C)(vii)(c).
[993] **Transcript Day 71,** Testimony of Dr. Masri, dated March 8, 2017, p. 3, lines 20 to 22.
[994] **Transcript Day 42,** Testimony of Dr. Masri, dated November 30, 2016, p. 44, lines 21 to 28.
[995] **Transcript Day 42**, p. 42-56, p. 62.

1384. Dr. Masri is a tenured professor in the UBC Faculty of Medicine, and the head of the department of orthopedics in the UBC Medical School. He has mentored and supervised dozens of fellows, interns and residents. Dr. Masri and his fellow joint replacement surgeons at UBC have also engaged in significant research into joint replacement and other surgical interventions, and have published widely.[996]

1385. Until 2011, Dr. Masri performed surgeries occasionally on a private pay basis or for WCB at Cambie, and has also provided private consultations at SRC as well as doing medico-legal work. He saw Erma Krahn for a surgical consultation at SRC in 2011 in which he determined that she did not require a knee replacement at that time, but was free to return to see him if her condition worsened.[997]

1386. Dr. Anthony Costa is an orthopedic surgeon specializing in advanced knee surgery, including knee replacements, and working in the Northern Health Region. Dr. Costa has privileges at University Hospital of Northern British Columbia in Prince George and also at two smaller regional hospitals.[998]

i. Harms from waiting for hip or knee replacement surgery

1387. Dr. Masri first testified as a lay witness and provided evidence of what his patients with osteoarthritis experience in his observation:

> ... [O]steoarthritis is a degenerative process. So it's progressive, and it starts out with a little bit of pain. The pain is -- usually it starts out with nothing; initially it's tolerable. Then it progresses, stays tolerable for a while; it might affect certain activities. And over time it gets worse and worse and worse to the point that patients end up having difficulty walking more than a few blocks, have difficulty sleeping at night because they wake up with pain. They have difficulty going up and down stairs. In the case of the hip they have difficulty tying their shoelaces, putting on socks because they can't bend far enough to get there. And it affects their ability to lead a normal life, not only just -- not only work if they're in a high demand job or athletics, but also day-to-day life.
>
> And because it's a spectrum you have – the trick to determining when they need surgery is when the degree of the pain is sufficient enough that it is interfering with their life a sufficient amount that they're willing to accept the risk of an operation, and that's how I phrase it to patients: is your pain bad enough that you're willing to risk the potential negative outcomes of an operation? Infection, dislocation, death, et cetera. And it becomes a personal decision, but if pain is bad enough people are generally willing to accept those possible consequences.[999]

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[996] **Transcript Day 42**, p. 46, line 6 to p. 49, line 8.
[997] **Transcript Day 87**, Testimony of Dr. Masri, 46, line 13 to 17.
[998] **Exhibit 318,** Affidavit #1 of Dr. Costa, p. 2-3, para 12 **[CBE, Tab 72]**.
[999] **Transcript Day 42,** p. 64, lines 2 to 32

1388. Dr. Masri further testified that when he sees patients for consultations, those who are booked for surgery have a lot of pain. Some can walk only a few blocks, others use a cane, crutches or a wheelchair. Many are taking heavy narcotic painkillers, which have significant side effects, including constipation, mental deterioration, inability to drive, and in some cases addiction.[1000]

1389. Dr. Costa, an orthopedic surgeon specializing in hip and knee replacements in the Northern Health Authority testified that most of the patients referred to him, in particular for knee replacements and other joint reconstruction, already have advanced arthritis. He observes and his patients report to him that they are in significant pain, and have substantially curtailed movement which limits their ability to participate in regular life activities. By the time he sees them in consultation, their condition has advanced, and their symptoms are often worse.[1001]

1390. Dr. Costa's clinical observations of his patients while they wait for treatment are that they are suffering from pain, disability, inability to work or care for dependents, lack of mobility, inability to participate in their activities of daily life, and sometimes depression and/or narcotic dependency. Many patients experience further deterioration of their condition.[1002]

1391. Dr. Masri also provided expert evidence about the impact of waiting for hip and knee replacements, and the development of maximum acceptable wait times for hip and knee replacement surgery. He was the primary director of the CIHR-sponsored review of the effects of waiting for hip and knee replacement surgery, which was part of the process for the establishment of the federal wait time benchmarks for hip and knee replacement surgery.[1003]

1392. As Dr. Masri testified, the "overall evidence showed that there are deleterious effects for patients when they wait a long time for specialist assessment and/or treatment, such as increased morbidity, physical decline, functional disability and negative psychological and social impacts, including prolonged sick leave or loss of employment, and altered social functioning and relationships".[1004]

[1000] **Transcript Day 42**, p. 89, line 17 to p. 90, line 15.
[1001] **Exhibit 318,** p. 7, para 50 **[CBE, Tab 72]**.
[1002] **Exhibit 318,** p. 8, para 58 **[CBE, Tab 72]**.
[1003] **Exhibit 263**, Expert Report of Dr. Masri, Tab 1, p. 5, para. 19-21 **[CBE, Tab 49]**.
[1004] **Exhibit 263**, p. 5-6, para. 22; Exhibit C, p. 183-185 **[CBE, Tab 49]**.

1393. The evidence also shows that waiting more than six months is associated with significant declines in surgical outcomes, as well as prolonged discomfort and disability for the patients.[1005]

1394. Dr. Masri's group performing this review concluded that the maximum acceptable wait times for major joint replacement are: one month for the most urgent cases, three months for the next most urgent, and five to six months for all other cases. As most joint replacement cases are quite urgent by the time they come to surgical consultation, a maximum wait time of three months would be appropriate for the typical joint replacement candidate.

1395. Dr. Masri also testified with respect to his own widely referenced study which assessed 201 patients with osteoarthritis who were on the waiting list for total hip arthroplasties, both pre-operatively and post-operatively. While all patients are expected to improve in terms of pain and functioning with hip replacement surgery, it is well known that patients who are in worse condition preoperatively will be in worse condition post-operatively as compared to patients who are in better condition pre-operatively. Dr. Masri's study compared patients' actual outcomes post-surgery with their individual "expected surgical outcome" based on their pre-surgical scores. The "expected surgical outcome" based on the medical literature is a 35% improvement in the post-operative score over the pre-operative score.[1006] The study found that waiting longer than six months for surgery from the decision date resulted in a 50% decrease in the odds of achieving a better than expected functional outcome, and this further decreased by 8% for each month on the waiting list after six months.[1007]

1396. In his expert report and in his oral evidence, Dr. Masri explained that this outcome is biologically plausible, because physical conditioning, muscle atrophy, and tissue contractures worsen, the longer patients wait for surgery, and this may not be regained after surgery, with the result that functional outcomes are not as good for patients who wait longer.[1008]

1397. Finally, Dr. Masri opined that the goal is to keep each person's musculoskeletal system as pain-free and functional as possible for as long as possible. A patient-centered approach requires that the focus be on the "ongoing pain, disability and reduced quality of life while on a waiting list, rather than the degree to which the situation worsens while waiting", that the research all confirmed that no matter the change while waiting, health-related quality of life at admission to the surgical wait list is

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[1005] **Exhibit 263**, Exhibit C, p. 184 **[CBE, Tab 49]**.
[1006] **Exhibit 263**, Exhibit B, p. 127 **[CBE, Tab 49]**.
[1007] **Exhibit 263**, p. 4, paras 14-17 and Exhibit B, p. 125-130 **[CBE, Tab 49]**.
[1008] **Transcript Day 87**, p. 55, line 34 to p. 56, line 21.

consistently worse than population controls, and further that the experience of waiting for surgery by itself contributes to lowered quality of life.[1009]

1398. In his oral evidence, Dr. Masri explained that patients who are waiting for surgery always suffer pain and disability and loss of quality of life as compared to the general population, and that the longer one has to wait with pain the more detrimental that is to the patient physically and psychologically. The pain itself is a negative health effect, which may also lead to further negative effects such as GI bleeds from anti-inflammatories or the need to take narcotics.[1010]

1399. Dr. Masri's evidence in this regard was concurred with by Plaintiff experts Dr. Matheson and Dr. Chambers, as well as by Defendant expert Dr. Eric Bohm.

1400. Dr. Matheson opined that the evidence showed reduced functional outcomes, reduced quality of life, increases in pain and disability, and worse outcomes for patients waiting beyond six months for hip replacement surgery, as well as disease progression for patients waiting for knee replacement surgery. He concluded that waiting time has a statistically significant, negative impact on health gains from hip and knee replacement surgery". [1011]

1401. Dr. Chambers testified in his expert report that "...it is my opinion that prolonged waiting for THR and TKR is harmful for some patients. In my opinion, prolonged waiting for THR and TKR causes patient harm in some cases in terms of suffering while on the wait list. The identified harms are in loss of function and increased pain for longer waits and a less chance of better than expected outcome for longer waits. The number of studies showing a negative impact of wait times support that this opinion with respect to THR and TKR is a valid one."[1012]

1402. Defendant's expert Dr. Eric Bohm agreed that patients on waiting lists for hip and knee surgeries suffer prolonged pain and loss of function, as well as impairment in their quality of life and possibly cessation of work. Patients who are forced off work due to their arthritis also suffer negative economic consequences, as will their employer and society as a whole.[1013]

1403. Dr. Bohm further testified that about 20 percent of patients in the workforce who are awaiting total hip arthroplasty are off work due to their hip condition while waiting. This was the conclusion

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[1009] **Exhibit 263,** Exhibit E, p. 312 **[CBE, Tab 49]**.
[1010] **Transcript Day 87,** p. 59, line 5 to p. 61, line 22.
[1011] **Exhibit 274,** Expert Report of Dr. Matheson, p. 7-8**[CBE, Tab 53]**.
[1012] **Exhibit 289A,** Expert Report of Dr. Chambers, p. 7, para 3 **[CBE, Tab 54, a]**.
[1013] **Transcript Day 153,** Testimony of Dr. Bohm, p. 32, line 38 to p. 35, line 17.

of the study done by Dr. Bohm and others entitled "Employment Status and Personal Characteristics in Patients Awaiting Hip Replacement Study". This study further found that cessation of work resulted in a median drop in income for these patients of $15,000 CDN, and foregone tax revenues for governments of $3800 per person.[1014]

1404. Dr. Bohm's follow-up paper titled "The Effect of Total Hip Arthroplasty on Employment" found positive effects of total hip arthroplasty for patients' ability to return to work and concluded that to help patients remain in the workforce, surgery should be undertaken before the patient's hip dysfunction deteriorates to the point that they have to stop working.[1015]

1405. Dr. Bohm also agreed that many studies have found that patients with osteoarthritis have deterioration in their condition over time, so that their function worsens with time. Some patients worsen more rapidly than others and for some patients the worsening during the wait time may affect the post-operative results, and a physician cannot predict which patients will have these effects. As Dr. Bohm put it in his report:

> There is reasonably good observational data that for degenerative conditions disease severity generally worsens with time, although not always, and that worse pre-operative status can be associated with worse post-operative status.[1016]

1406. Dr. Bohm further confirmed that as a result of this, he agrees with the setting of the maximum acceptable wait times.[1017]

1407. Finally, Dr. Bohm testified that while it may be difficult to objectively assess the degree of a patient's pain, physicians can assess the impact on the patient's quality of life and function.

1408. Dr. Bohm stated "Generally speaking with degenerative conditions your function and pain worsen with time, and we know that pre-operative function and pain is predictive of post-operative function and pain. So if you wait too long that will have an impact on the final outcome but the challenge and what is that for each patient and it's unique with the patient and surgeon together".[1018] He noted that the problem with shuffling patients on the wait list to always do the patients with the most severe conditions is that by the time the patients who were less severe to begin with are reached,

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[1014] **Transcript Day 153,** p. 36, lines 1 to 20.
[1015] **Exhibit VVVV,** The Effect of Total Hip Arthroplasty on Employment **[CBE, Tab 164] ;Transcript Day 152,** p. 37, l 5 to 25.
[1016] **Exhibit 470,** Expert Responsive Report, Dr. Bohm, p. 4 **[CBE, Tab 123].**
[1017] **Transcript Day 153,** p. 56, lines 13 to 26.
[1018] **Transcript Day 153,** p. 63, line 26 to 34.

they have deteriorated and thus will likely have a worse post-operative outcome than if they received their surgery sooner.[1019]

ii. Provision of hip and knee replacement surgery in BC.

1409. The outcome of the reviews performed by Dr. Masri, Dr. Bohm, and others in the early 2000s was the adoption of federal evidence based benchmarks for wait times for hip and knee replacement surgery of six months (26 weeks) from the date that a specialist determines that surgery is required. This is also the maximum acceptable wait time for the lowest urgency hip and knee replacement surgeries (Priority 5) under BC's patient prioritization system. As Dr. Masri testified, six months should be the "absolute cut-off".[1020]

1410. Speaking from the perspective of his role as the Surgeon in Chief for Vancouver Acute, Dr. Masri testified that the Health Authority and Ministry agreed that patients were being harmed by waiting longer than the maximum acceptable wait times for surgical care.[1021]

1411. The establishment of the federal benchmarks for hip and knee replacement surgery also came with additional federal funding to assist the provinces in reducing wait times for these surgeries. In BC, this federal funding helped to establish the Centre for Surgical Innovation at UBC Hospital, which became a focused centre for hip and knee replacements, initially for the province as a whole. However, after a number of years, the CSI program became available only to patients of Vancouver Acute, due to OR resource shortages at VGH in particular.[1022]

1412. As Dr. Masri and many other physicians testified, while this did allow for the provision of many additional hip and knee replacement surgeries in British Columbia, and initially reduced wait times, the focus on hip and knee replacement surgeries came at the cost of patients waiting for other forms of orthopedic surgery and surgery for non-orthopedic conditions.[1023]

1413. Despite the focus on hip and knee surgeries, which continues to this day, British Columbia has still never come close to meeting the federal benchmark for hip and knee replacement surgeries.

[1019] **Transcript Day 153,** p. 64, line 29 to p. 65, line 13.
[1020] **Transcript Day 87,** p. 18, line 44 to p. 19, line 7.
[1021] **Transcript Day 71,** p. 53, lines 15 to 24.
[1022] **Transcript Day 42,** p. 90, line 16 to p. 97, line 35.
[1023] **Transcript Day 173,** Testimony of Dr. Hamilton, p. 82, line 41 to p. 87, line 7; **Exhibit 559,** Email from Dr. Hamilton to Lynn Stevenson **[CBE, Tab 147]**.

Nor has BC (or any Health Authority) come close to meeting the maximum acceptable wait times for the more urgent patients needing hip and knee replacement surgeries.

1414. The most recent wait time data from the Canadian Institute for Health Information (CIHI) shows that in 2018 only 67% of patients requiring hip replacement and 59% of patients requiring knee replacement met the 26 week benchmark in BC.[1024] No BC regions performed 90% of cases within 26 weeks.

1415. The same CIHI report shows that the 90th percentile wait time for patients receiving hip replacement and knee replacement surgery in British Columbia in 2018 was 321 days (45.9 weeks)[1025] and 358 days (51.1 weeks), respectively.[1026]

1416. Dr. Masri was involved in the Patient Prioritization Initiative and the 2015 Patient Prioritization Code Review in British Columbia. Dr. Masri confirmed that the wait time targets associated with each priority level are the maximum acceptable wait time for patients with that condition. He testified that the definition of the target as the "time beyond which patients presenting with a particular diagnosis/condition could suffer negative consequences" was the maximum acceptable wait time beyond which there is potential harm, and that waiting longer than this time would be clinically inappropriate.[1027]

1417. The SPR data shows that a large percentage of patients are waiting past the maximum acceptable wait time for hip and knee replacements for all priority levels.

1418. As the SPR data show, the majority of British Columbians who had knee degeneration were diagnosed as Priority 4 due to their "moderate to severe pain" and "significant or severe functional limitation", with a maximum acceptable Wait Two time of 12 weeks.

1419. However, the SPR data shows that of Priority 4 patients, only 21.4% in 2017, and 25.2% in 2018 (as of March 31, 2018), received surgery within 12 weeks, and many patients in Priority 5 waited past 26 weeks – only 40.1% in 2017 and 47.8% in 2018 (as of March 31, 2018) were performed within the target.[1028] **Appendix, Part A, Section VII(C)(vii)(c), Wait Times Table 1.**[1029]

[1024] **Exhibit 433E,** p. 4570 to 4575 **[CBE, Tab 107].**
[1025] **Exhibit 433E,** p. 4570 **[CBE, Tab 107].**
[1026] **Exhibit 433E,** p. 4573 **[CBE, Tab 107].**
[1027] **Transcript Day 87,** p. 6, lines 12 to 21.
[1028] **Exhibit 315B,** Tab 7, p. 274-275 **[CBE, Tab 65].**
[1029] **Appendix,** Part A, Section VII(C)(vii)(c), Table 1.

1420. Most patients needing hip replacement surgery were likewise designated Priority 4 (12 weeks) on the basis of their condition. As Dr. Masri testified, this is the priority he most often assigned to his patients based on their condition, as Priority 5 was not applicable to his surgical patients as it entails "minimal pain."[1030]

1421. The SPR data shows that of Priority 4 patients, only 24.8% in 2017, and 27.5% in 2018 (as of March 31, 2018), received surgery within 12 weeks, and many patients in priority 5 waited past 26 weeks – only 49.8% in 2017 and 51.8% in 2018 (as of March 31, 2018) were performed within the target.[1031] **Appendix, Part A, Section VII(C)(vii)(c), Wait Times Table 2.** [1032]

1422. Dr. Masri testified that he would never prioritize patients based on the relative benefit he thought they would derive from the surgery, although he did occasionally take into account factors such as job loss or other significant financial harms that the patient was experiencing.[1033]

1423. Dr. Masri testified that he and other surgeons were directed in 2017 to allocate virtually all hip and knee replacement patients to the Priority 5 (26 weeks) rather than using Priority 4, so that the Health Authority would appear to be coming closer to meeting its benchmarks.[1034]

1424. Dr. Masri's own wait times for hip and knee arthroplasty are found at Exhibit 261. As Dr. Masri testified, Exhibit 261 shows that his 90th percentile Wait 1 time for the years 2014 to 2017 was about 35 weeks in 2014 and 2015, and rose to about 50 to 55 weeks in 2016 and 2017. [1035] This is similar to the Wait One for all orthopedic surgeries in VCHA in this period.[1036]

1425. Dr. Masri's 90th percentile Wait 2 times (for all priorities) varied from approximately 37 to 41 weeks from the BFRD in 2014-2017, and about three weeks longer (i.e. 40 to 44 weeks) when measured from the Decision Date.[1037] This difference in Wait Two from BFRD and Wait Two from Decision Date was even more significant when examined for all orthopedic surgeons in VCHA – the difference was 8 to 11 weeks.[1038]

[1030] **Transcript Day 87,** p. 4, line 44 to p. 5, line 6, page 12, lines 16-19
[1031] **Exhibit 315B,** Tab 7, p. 274-275 **[CBE, Tab 65]**.
[1032] **Appendix,** Part A, Section VII(C)(vii)(c), Wait Times Table 2.
[1033] **Transcript Day 87,** p. 20, line 45 to p. 21, line 43.
[1034] **Transcript Day 87,** p. 18, lines 20 to p. 19, line 14.
[1035] **Exhibit 261**, Dr. Masri's Wait One, p. 1 **[CBE, Tab 48]**.
[1036] **Exhibit 333,** Vancouver Coastal Wait One, p. 2 **[CBE, Tab 78]**.
[1037] **Exhibit 261**, p. 3 **[CBE, Tab 48]**.
[1038] **Exhibit 333**, p. 3 **[CBE, Tab 78]**; **Transcript Day 87**, p. 25, line 31 to p. 27, line 2.

1426. In cross-examination, Dr. Masri was asked about the new centralized intake process for hip and knee replacements which was being introduced, which was similar to the OASIS system already in place. Dr. Masri testified that while the centralized intake process may reduce Wait One for patients, it was likely to increase Wait Two.[1039]

1427. Dr. Masri explained that surgeons have to continually adjust their number of consultations so as to try to see patients in a timely way while also ensuring that they are not placing so many patients on their surgical wait list that their Wait 2 time lengthens considerably. Just prior to his April 13, 2018 testimony, Dr. Masri was told by the Health Authority that he should reduce his consultations because the surgical resources could not keep up.[1040]

1428. Dr. Bohm agreed that a balance was required between Wait I and Wait 2. He testified that his Wait 1 was 14 months and his Wait 2 was about 5 months.[1041]

1429. Exhibit 560 demonstrates the outcomes of the Ministry's new three-year surgical strategy for 2017-2020, as of March 31, 2019, which continues to focus on hip and knee replacement surgeries as a priority surgery in BC. It has a "catch up" target for hip and knee replacement surgeries of "no more than 5% of patients waiting more than 26 weeks". This is the maximum acceptable wait time for the least urgent patients needing hip or knee replacements.

1430. As Exhibit 560 shows, despite the additional funding which has been provided, the establishment of the centralized intake programs for hip and knee surgeries across the province, as well as the focus on improving operating room efficiency, neither BC as a whole nor any of the Health Authorities have met the target for hip and knee replacements. Volume targets for hip and knee replacements in the 2018/2019 fiscal year were not met, and there continue to be over 26.5 % of patients in BC waiting more than 26 weeks for hip or knee replacement surgery. The 90th percentile wait time for hip and knee replacement surgery in BC generally (for all priority levels) as of March 31, 2019, is 42.1 weeks[1042]

1431. Note that these measurements are based on Wait 2 from BFRD and performance would therefore be worse if measured from Decision Date. They also do not include Wait 1.

[1039] **Transcript Day 87,** p. 70, line 29 to p. 71, line 24.
[1040] **Transcript Day 87,** p. 24, line 36 to p. 25, line 29.
[1041] **Transcript Day 153**, p. 64, lines 1 to 19.
[1042] **Exhibit 560**, p. 4 **[CBE, Tab 148]**.

1432. Dr. Masri testified about the importance of the Health Authorities being able to contract out day surgeries to the private clinics. This frees up OR space at UBC and other hospitals at which those contracted out surgeries would otherwise have to be performed. This in turn allows lower anaesthetic risk hip/knee replacement surgeries to be moved from VGH to UBCH.[1043] Dr. Masri has no concerns about the quality of care at the private facilities used by VCHA. He expressed concern for wait times in the public system if the private facilities were to cease operation.[1044]

1433. It is not currently possible to perform total hip and knee replacements in private surgical clinics in British Columbia, due to it not being a permitted procedure at private clinics pursuant to government policies that determine College Guidelines. Dr. Masri testified that many joint replacements are done in the US at day surgery clinics, and that there is now a working group in BC to do outpatient joint replacement. Thus, it should soon be possible to perform hip replacements (at least) as day surgery in BC, and these could be done at private clinics if the BC government policies and College guidelines were adjusted.[1045]

1434. Further, in both Alberta and Quebec, hip and knee replacements are performed in private surgical clinics.[1046] The BC Government previously gave consideration in 2015 to expanding the nature and type of surgeries that could be performed in private surgical clinics up to those requiring three day stays, which would have allowed hip and knee replacements to be performed in at least some private clinics. This initiative was ultimately not pursued by the Government as it was determined that legislative change would be required.[1047]

1435. Dr. Masri saw Erma Krahn for a consultation at SRC in 2011. He concluded that her knee pain was not sufficient to recommend a knee replacement at that time, but advised her to return to see him if the pain worsened. At that time, Dr. Masri was doing private pay consultations at SRC, in addition to his public system work, usually about once a month for two hours or so.[1048] Dr. Masri ceased doing private consultations when he learned it was not permissible under the MPA. He now only does occasional medico-legal cases.[1049]

[1043] **Transcript Day 42**, p. 60, line 37 to p. 61, line 1.
[1044] **Transcript Day 87**, p. 45, line 5 to 8; p. 42, lines 2 to 12.
[1045] **Transcript Day 87,** p. 44, line 11 to p. 45, line 6.
[1046] **Exhibit 155,** Expert Report of Yanick Labrie, p. 26 **[CBE, Tab 36]**.
[1047] **Exhibit 2C,** Tab 14, p. 52-55 **[CBE, Tab 3]**; **Transcript, Day 167,** Testimony of Ms. Copes, dated June 18, 2019, p. 51, line 21 to p. 53, line 31.
[1048] **Transcript Day 87,** p. 45, line 9 to p. 47, line 14.
[1049] **Transcript Day 87,** p. 47, line 15 to 33.

1436. Dr. Anthony Costa testified about the provision of orthopedic care, and in particular knee replacement surgery, to patients in the Northern Health Authority. UHNBC is a full-service hospital, and is the tertiary hospital in Northern BC.[1050]

1437. There are seven full-time positions for orthopaedic surgeons at UHNBC and eight orthopedic surgeons in the UHNBC orthopaedic surgery group. Prior to 2013, there were only six full-time positions in the orthopaedic surgery group, which were filled by the orthopaedic surgeons already in the group (not including Dr. Costa or his wife who is also an orthopaedic surgeon). Each of the other six surgeons in the orthopaedic group received one designated elective OR day each week (based on 40 operating weeks in the year).[1051]

1438. In 2013, a seventh full time orthopaedic position was created with the understanding that there would be no new OR time made available to the orthopaedic group. Instead, the seventh position would rely on the redistribution of existing elective OR time within the orthopaedic group (i.e. when surgeons were on holidays or otherwise unable to use their elective time).[1052]

1439. Dr. Costa and his wife accepted this seventh position based on the understanding the redistribution of OR days within the orthopaedic group would likely amount to a substantial number of elective OR days throughout the year at UHNBC, but this did not materialize. Instead, OR time was often cancelled or given to other groups other than orthopaedics and sometimes it was used for emergency surgery.[1053]

1440. In 2015, Dr. Costa and his wife together received a combined total of 17 elective OR days at UHNBC. In 2016, they received a combined total of 15 elective OR days. In 2017, they received a combined total of 25 elective OR days.[1054]

1441. A program called the Joint Room Program was set up to help reduce the wait times for patients awaiting knee and hip arthroplasty. From this program, Dr. Costa and his wife together received a total of 12 Joint Room Days in 2016 and 10 Joint Room Days in 2017.[1055]

[1050] **Exhibit 318,** p.3, para 18 **[CBE, Tab 72]**.
[1051] **Exhibit 318,** p. 3, paras 20 and 21 **[CBE, Tab 72]**.
[1052] **Exhibit 318,** p. 4, para 22 **[CBE, Tab 72]**.
[1053] **Exhibit 318,** p. 4, para 23 and 24 **[CBE, Tab 72]**.
[1054] **Exhibit 318,** p. 4, para 25 **[CBE, Tab 72]**.
[1055] **Exhibit 318,** p. 4, para 27 **[CBE, Tab 72]**.

1442. Dr. Costa augments the OR time he receives at UHNBC with OR days at other hospitals (SJH and BVDH). He had nine OR days in 2016 and seven OR days in 2017 at SJH. He had three OR days in 2016 and four days in 2017 at BVDH.[1056]

1443. Dr. Costa feared that he may lose his skills with respect to more advanced knee reconstructive procedures as a result of the limitations on this OR time. As a result, he started to consider seeking employment elsewhere. He felt frustrated and demoralized to not be able to offer many of his patients timely and appropriate care.[1057]

1444. Dr. Costa's 90th percentile Wait 1 times for 2014 to 2016 were 41 weeks in 2014, 54.3 weeks in 2015 and 63.1 weeks in 2016. Some patients waited considerably longer than this.[1058]

1445. Some 30 to 40% of patients Dr. Costa sees in consultation require surgery. Other than for urgent or emergent surgeries, most of his patients wait far longer than their maximum acceptable wait times for their conditions.[1059] Dr. Costa's 90th percentile Wait 2 time from Decision Date for all priority levels was 60 weeks in 2015 and over 70 weeks in 2016.[1060]

1446. Dr. Costa testified that while it is often suggested that surgeons could simply move a patient up in terms of priority and thus do the patient's surgery more quickly, the reality is that virtually all of his patients are suffering considerably in terms of pain and/or disability. To move one patient up in terms of priority means that all other patients are pushed back and must wait longer. He viewed it as extremely difficult, and possibly unethical, to differentiate between patients based on their particular life circumstances.[1061]

1447. Dr. Costa also testified that one surgeon cannot simply re-refer a patient to another orthopaedic surgeon with a shorter wait time. First, all surgeons do not have the same expertise and experience. Second, a referral to a different surgeon means that the patient must be sent back to their GP and restart their wait for a consultation. Moreover, most hospitals give primacy to patients from their local catchment area or health authority, other than in relation to specialized province-wide programs. Finally, even if a surgeon would accept a referral for a patient from another health authority, many patients cannot travel easily due to their disability and do not want to be forced to commute

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[1056] **Exhibit 318,** p. 5, paras 30 to 33 **[CBE, Tab 72]**.
[1057] **Exhibit 318,** p. 5, paras 35-37 **[CBE, Tab 72]**.
[1058] **Exhibit 318,** p. 7, para 47 **[CBE, Tab 72]**.
[1059] **Exhibit 318,** p. 7, paras 48 and 49 **[CBE, Tab 72]**.
[1060] **Exhibit 318,** p. 7, para 52 **[CBE, Tab 72]**.
[1061] **Exhibit 318,** p. 8, para 59 **[CBE, Tab 72]**.

long distances for follow-up. It is the expected standard of care that surgeons will provide follow-up review and care to their own patients following surgery.[1062]

iii. The Experience of Denise Tessier

1448. Dr. Costa was also the treating physician for Patient Witness, Denise Tessier. Ms. Tessier testified by way of affidavit, and was not cross-examined by the Defendant.

1449. Ms. Tessier is an elderly patient who required a full knee replacement, yet was faced with a very long wait time for surgery in the public system, well beyond the BC maximum acceptable wait times for her condition, and well beyond the 26 week federal benchmark. After waiting 39 months in pain, mental anguish and with limited mobility, Ms. Tessier held a sit-in at the hospital in protest of the long wait, which led to her finally obtaining her surgery.

1450. **Redacted due to evidence subject to a sealing order.**

1451. **Redacted due to evidence subject to a sealing order.**

1452. **Redacted due to evidence subject to a sealing order.**

1453. **Redacted due to evidence subject to a sealing order.**

1454. **Redacted due to evidence subject to a sealing order.**

[1062] **Exhibit 318**, p. 9, paras 60-63 **[CBE, Tab 72]**.
[1063] **Redacted due to evidence subject to a sealing order.**
[1064] **Redacted due to evidence subject to a sealing order.**
[1065] **Redacted due to evidence subject to a sealing order.**
[1066] **Redacted due to evidence subject to a sealing order.**
[1067] **Redacted due to evidence subject to a sealing order.**

1455. **Redacted due to evidence subject to a sealing order.**

1456. **Redacted due to evidence subject to a sealing order.**

1457. Dr. Costa observed that she was in significant pain and already had advanced stiffness and restricted movement in her knee and that her right knee was also affected. They agreed that she would have a knee replacement of her left knee, followed by her right knee if required thereafter.[1074]

1458. Dr. Costa told her she would likely not get surgery for another 1.5 years. Ms. Tessier was very upset by this.[1075] At that time, Dr. Costa's Wait Two for surgeries that could only be performed at UHNBC was approximately 14-18 months.[1076]

1459. **Redacted due to evidence subject to a sealing order.**

[1068] **Redacted due to evidence subject to a sealing order.**
[1069] **Redacted due to evidence subject to a sealing order.**
[1070] **Redacted due to evidence subject to a sealing order.**
[1071] **Redacted due to evidence subject to a sealing order.**
[1072] **Redacted - evidence subject to sealing order.** **Exhibit 318,** p. 11, paras 78 and 79 **[CBE, Tab 63].**
[1073] **Exhibit 318,** p. 11, para 80 **[CBE, Tab 72].**
[1074] **Exhibit 318,** p. 12, para 83-84 **[CBE, Tab 72].**
[1075] **Exhibit 318,** p. 12, para 86 **[CBE, Tab 72].**
[1076] **Exhibit 318,** p. 11, para 81 **[CBE, Tab 72].**

1460. **Redacted due to evidence subject to a sealing order.**

1461. **Redacted due to evidence subject to a sealing order.**

1462. **Redacted due to evidence subject to a sealing order.**

1463. **Redacted due to evidence subject to a sealing order.**

1464. **Redacted due to evidence subject to a sealing order.**

[1077] **Redacted due to evidence subject to a sealing order.**
[1078] **Redacted due to evidence subject to a sealing order.**
[1079] **Redacted due to evidence subject to a sealing order.**
[1080] **Redacted due to evidence subject to a sealing order.**
[1081] **Redacted due to evidence subject to a sealing order.**
[1082] **Redacted due to evidence subject to a sealing order.**
[1083] **Redacted due to evidence subject to a sealing order.**

1465. **Redacted due to evidence subject to a sealing order.**

1466. **Redacted due to evidence subject to a sealing order.**

1467. **Redacted due to evidence subject to a sealing order.**

1468. **Redacted due to evidence subject to a sealing order.**

1469. **Redacted due to evidence subject to a sealing order.**

1470. While her surgical outcome has been good, the nearly three-year wait for assessment and treatment caused her to suffer prolonged pain, disability and stress, and significant loss of enjoyment of her life for those three years, which time will never be regained.

d) Foot And Ankle

[1084] **Redacted due to evidence subject to a sealing order.**
[1085] **Redacted due to evidence subject to a sealing order.**
[1086] **Redacted due to evidence subject to a sealing order.**
[1087] **Redacted due to evidence subject to a sealing order.**
[1088] **Redacted due to evidence subject to a sealing order.**
[1089] **Redacted due to evidence subject to a sealing order.**

1471. There have been and still are excessively long waits for foot and ankle diagnosis and surgery in British Columbia, which cause significant harm to patients requiring such surgery. Evidence about foot and ankle assessment and treatment was given by Drs. Murray Penner, Kevin Wing, Alastair Younger and Jeffrey Nacht.

1472. Dr. Murray Penner, Dr. Kevin Wing and Dr. Alastair Younger are orthopedic surgeons, all with subspecialty fellowship training and extensive expertise in foot and ankle orthopedics, working at St. Paul's Hospital ("SPH"). Each of these three physicians are also clinical professors at the medical school at UBC, and together created the fellowship program in foot and ankle surgery at UBC.

1473. Drs. Wing, Penner and Younger participate in a wide range of research and publication in the area of foot and ankle surgery. They contribute their own funds to keep the orthopedic research office running.[1090] They also run a foot and ankle symposium every other year to train surgeons in foot and ankle surgical techniques.[1091]

1474. Dr. Penner also has privileges at Cambie and False Creek, and in addition, provides specialist care a number of weeks each year in the Yukon.

1475. Dr. Penner has been the regional department head of the department of orthopedics for VCHA and PHC since 2013 and the head of the department of orthopedics for SPH since 2012.[1092] He is also Chairman of the Regional Orthopedic Executive Council, and on a variety of other medical and administrative committees for the Health Authority and SPH.[1093]

1476. Dr. Kevin Wing is the Past President of the BC Orthopedic Association. He is a tenured professor at the UBC Faculty of Medicine. In addition to performing foot and ankle surgery at SPH, he has privileges at the Ambulatory Surgical Centre ("ASC"), a private surgical facility across the street from SPH. Dr. Wing performs WCB-funded surgeries at the Ambulatory Surgical Centre and, for a short period in or around 2010, he performed publicly funded surgery at ASC under a contract between SPH and ASC. Dr. Wing also performs foot and ankle surgeries for the Yukon Health Authority.[1094] Dr. Wing provided both lay and expert evidence.

[1090] **Transcript Day 66,** Testimony of Dr. Penner, p. 48, lines 31-36.
[1091] **Transcript Day 64**, Testimony of Dr. Penner, p. 17, lines 1-11.
[1092] **Transcript Day 64,** p. 1, lines 33-41; p. 8, line 1 to p. 9, line 38.
[1093] **Transcript Day 64,** p. 11, line 28 to p. 14, line 30.
[1094] **Transcript Day 115,** Testimony of Dr. Wing, p. 20, line 24 to p. 22, line 47.

1477. Dr. Alastair Younger is the third orthopedic surgeon from the SPH foot and ankle group who testified. He also has fellowship training in joint arthroplasty, arthritis surgery and foot and ankle surgery. He was an Associate Professor at UBC Medical School since 2014, and has been a tenure track professor since then. In addition to SPH, he has privileges at Cambie and SRC. In 2018, he was President of the BC Orthopedic Association.[1095]

1478. All three of these surgeons utilize all of the OR time they are allocated in the public system, and have continuously requested additional OR and clinic (consultation) time and sought out and implemented methods to improve access to timely foot and ankle care for British Columbians. All of these surgeons testified that they are not provided with sufficient OR time in the public health care system to fully utilize their surgical skills and time.[1096]

1479. Dr. Jeffrey Nacht was the director of the Foot and Ankle Screening and Triage ("FAST") clinic at SPH at the time of his testimony (this transitioned to the Footbridge Clinic in 2018). Dr. Nacht specialized in orthopedic foot and ankle reconstruction in Tacoma, Washington for many years before retiring from his surgical practice in 2012 to assume a full-time role as the FAST clinic director. He is also the director of the year 3 clinical program in the UBC Faculty of Medicine Orthopedic program, and teaches residents and foot and ankle fellows in the FAST clinic. Dr. Nacht continues to do surgical assisting for other orthopedic surgeons.[1097]

i. Impacts on patients of waiting for foot and ankle diagnosis and treatment

1480. Foot and ankle orthopedics involves assessment and treatment of injury and/or arthritis-related conditions below the knee. The four main populations needing this care are:

(a) patients with rheumatoid arthritis or osteoarthritis who require joint realignment, fusion or an ankle replacement.[1098] These patients are suffering debilitating pain and disability as a result of the arthritis;

(b) patients with diabetes who have neuropathy and thus develop ulcers or infections in their feet as a result of loss of feeling;[1099]

[1095] **Exhibit 311,** Affidavit #2 of Dr. Younger, p. 2, paras 4 to 12 **[CBE, Tab 61]**.
[1096] **Transcript Day 115**, p. 19, lines 19 to 28; **Transcript Day 107,** p. 15, lines 14 to 22; Transcript Day
[1097] **Transcript Day 57,** Testimony of Dr. Nacht, p. 3, line 30 to 47.
[1098] **Transcript Day 66,** p. 72, line 44 to p. 73, line 33.
[1099] **Transcript Day 64,** Testimony of Dr. Nacht, p. 24, line 41 to p. 25, line 46.

(c) congenital disorders such as high arches, flat feet, bunions, club foot or other foot deformities which cause pain and significant disability for activities of daily living;[1100] and

(d) post-trauma, sports medicine and surgical failures, resulting in chronic ankle instability, acute fractures, and/or improperly healed fractures. [1101] Many of these patients have had very severe injuries such as a crushed heel bone or multiple foot fractures and are unable to walk and/or work.[1102] These patients often have chronic pain.[1103]

1481. Dr. Nacht testified that about 10% of the patients seen in the FAST clinic for their initial assessment are on chronic narcotic use due to pain, and need a narcotic elimination program before surgery or non-surgical care could be successful.[1104]

1482. Dr. Penner testified that when he sees patients in consultation, typically the patients are in a great deal of pain, they are limping and have a reduced capability to walk any distance, and as time goes on, their level of deformity will increase, which increases the complexity of their future surgery. They are also impacted in their demeanour and affect, and are quite despondent when they realize how long they are going to have to wait.[1105]

1483. Dr. Younger testified that his patients have pain preventing mobility, deformity preventing mobility and ability to wear shoes, and weakness and instability preventing mobility. He further testified that his patients experience anxiety and depression while waiting for surgery, and some of his patients have lost their jobs while waiting for treatment.[1106]

1484. Dr. Wing provided expert evidence of the impact of foot and ankle conditions on patients, and the impact of waiting on patients' health states, including level of pain and disability and depression/anxiety. He testified that the evidence shows that patients experience altered mental states while waiting for surgery, including depression and anxiety, and they experience significant, and some cases severe, pain and disability while waiting. Some patients deteriorate over time while they wait

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[1100] **Transcript Day 64**, p. 26, line 29 to p. 27, line 21.
[1101] **Transcript Day 64**, p. 27, lines 22 to 35; **Exhibit 237**, p. 5.
[1102] **Transcript Day 64,** p. 39, line 12 to p. 41 line 20
[1103] **Transcript Day 57**, p. 17, line 40- p. 18, l. 3.
[1104] **Transcript Day 57**, p. 17, line 40 p. 18, line 3
[1105] **Transcript Day 64,** p. 103, line 24 to p. 104, line 3
[1106] **Exhibit 311,** Affidavit #2 of Dr. Younger, p. 3, para 2 to p. 4, para 22, p. 5, para 35 **[CBE, Tab 61]**.

for assessment and surgical treatment, experience irreparable physical, mental and financial harm as a result of the excessively long wait times for foot and ankle surgery in British Columbia.[1107]

1485. Dr. Younger also provided expert evidence on the effects of foot and ankle conditions on patient's mental and physical health, and the effect of surgery on these conditions and the patients' mental and physical health. In his expert report, he opined that loss of mobility is a primary concern as it interferes with the patient's ability to work and function in society. It also interferes with their ability to exercise, leading to weight increase and risk of diabetes and heart disease. Patients can have difficulty maintaining independence. These patients are as disabled as those with hip arthritis and have worse mental health scores.[1108]

1486. Dr. Younger further opined that earlier assessment and surgical intervention results in overall better health and increases the likelihood of a successful outcome, as well as better maintaining their mental health and mobility. Delays in assessment and surgery, even if the surgery is successful in reducing pain and increasing mobility, may mean that the patient cannot get back into the work force and mental health does not improve. [1109]

ii. Provision of foot and ankle diagnosis and treatment in British Columbia.

1487. By 2006, Drs. Penner, Wing and Younger had a combined wait list for consultations of almost 4000 patients, which resulted in them each closing their practice to new referrals from GPs. The median wait time for a consultation was two years, and for patients requiring surgery, about 80% of patients were waiting longer than their target wait time.[1110]

1488. They developed the FAST clinic in 2007 in an effort to provide patients with more timely assessment of their foot and ankle conditions to determine whether surgery was likely necessary or some other treatment such as physiotherapy, braces, or orthotics. They brought in Dr. Jeffrey Nacht as Director, as well as a number of GPs with additional training in foot and ankle conditions, to assess patients to determine who required a surgical consult and who should be directed to other forms of non-surgical treatment.

[1107] **Exhibit 343**, Expert Report of Dr. Wing, p. 3-7 **[CBE, Tab 82]**.
[1108] **Exhibit 312A,** Expert Report of Dr. Younger, p. 7-8 **[CBE, Tab 62]**.
[1109] **Exhibit 312A,** p. 7-8 **[CBE, Tab 62]**.
[1110] **Transcript Day 64**, p. 29, line 3 to p. 31, line 13; **Exhibit 237,** p. 11-12 **[CBE, Tab 170]**.

1489. About 22-25% of patients are referred for a surgical consult, while the remainder are referred to non-surgical care, which may include physiotherapy, podiatry, orthotics, or home exercises. Some patients also receive pain injections, particularly for osteoathritis of the ankle. The services of podiatrists are not covered by MSP, so patients must pay for these services, as well as for orthotics or physiotherapy, or hyaluronic acid injections (about $400 per injection).[1111]

1490. Dr. Penner testified that they were able to reduce their wait list for consultation from about 4000 patients to several hundred patients over about 18 months, and also to limit the patients they were seeing for surgical consultations to those who were more likely to need surgery.[1112]

1491. The result of this for the surgeons was that the percentage of patients seen in consultation who needed surgery rose from about 15% to about 65%. As Dr. Penner noted, this meant that instead of adding three to five patients to his surgical wait list each week he was now adding about 16 patients per week. However, he still only had the same OR time, and could only operate on three or four cases per week, so his surgical wait list and his Wait Two time grew substantially.[1113]

1492. Dr. Wing testified that for patients referred directly to him, about 25 to 30% require surgery whereas of patients referred from the FAST clinic, about 65% require surgery.[1114]

1493. Dr. Wing testified that he has to limit the number of consultations he does so as to avoid his surgical wait list getting too long. He testified that he would have physical capacity to operate three days per week if he were given the OR time, including doing the necessary consultations to fill this time, and follow-up, but he is only allocated on average one day per week.[1115]

1494. Dr. Younger also testified that he has had to limit the referrals he accepts for consultations as a result of his limited OR time, and his lengthy wait list. SPH has directed him to limit the number of consultations he does and also to stop seeing patients in consultation at the FAST clinic. Dr. Younger has therefore restricted his practice by no longer accepting referrals from family doctors, and by closing his practice to new referrals from time to time.[1116]

[1111] **Transcript Day 57**, p. 18, line 18 to p. 19, line 19; p. 40, line 37 to p. 42, line 35.
[1112] **Transcript Day 64,** p. 19, lines 22 to 37.
[1113] **Transcript Day 64**, p. 20, line 27 to p. 22, line 3.
[1114] **Transcript Day 115,** p. 71, line 19 to 27.
[1115] **Transcript Day 115,** p. 73, lines 4 to 6.
[1116] **Exhibit 311,** p. 8, para 68 **[CBE, Tab 61]**.

1495. The initial funding for the FAST clinic, and associated OR improvements such as a swing room, only lasted two years.

1496. In 2013, SPH announced that the FAST clinic was going to be closed, as a result of budgetary issues, which meant that the hospital could no longer fund the clerical staff person for the clinic. After a short reprieve, this arose again in 2014, and the outcome was that the clerical staff is now funded by the four FAST clinic screening physicians.[1117]

1497. While the foot and ankle surgery group was able to bring in a fourth foot and ankle surgeon, Dr. Veljkovic, in 2016, this was only as a result of Dr. Penner giving up some of his OR time.[1118]

1498. Dr. Penner also testified that at times he has to cancel scheduled surgeries for patients who have waited a long time, because they have medically worsened while waiting or because their surgical condition has deteriorated while waiting such that a different, more complex surgery is now required.[1119]

1499. With respect to the possibility of referring patients to another foot and ankle surgeon, Dr. Penner testified that based on the data for VCHA, there was no reason to believe that any of them have a shorter wait list. And, even if a patient were referred to another surgeon, they would need to go through the referral and consultation process again and would likely end up further behind. Further, it is not possible from a professional perspective for one surgeon to operate on another surgeon's patient without seeing that patient in consultation.[1120]

1500. Dr. Penner further testified that the cost of non-operative treatments, such as physiotherapy or braces, can be an impediment to those patients pursuing those non-operative treatments, and causing them to opt to surgery. As Dr. Penner explains, this is a form of economic discrimination for some people who feel they cannot access certain parts of what would be their optimal care plan, and can also cause significant further delays in getting to surgery if the patient is unable to pay for necessary pre- and post-surgical physiotherapy.[1121]

1501. At the time of Dr. Nacht's testimony in January, 2017, the average wait time from GP referral to a first assessment at the FAST clinic was about seven months. The 50th percentile wait time was

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[1117] **Transcript Day 64,** p. 41, lines 24 to 28.
[1118] **Transcript Day 64,** p. 21, line 37 to p. 22, line 3.
[1119] **Transcript Day 64,** p. 77, lines 39 to 43.
[1120] **Transcript Day 64,** p. 100, line 37 to p. 102, line 12.
[1121] **Transcript Day 66,** p. 59, line 39 to p. 61, line 24.

eight months, and the 90th percentile wait time was 10 months.[1122] Dr. Nacht testified that they try to expedite patients with a condition that could progress substantially, but "if a patient is complaining that they're in terrible pain, that doesn't really warrant expediting, because everyone has that same complaint and we couldn't prioritize everyone".[1123]

1502. For patients referred by the FAST clinic for a surgical consult, the wait time from the referral by FAST to the surgical consult was 12 to 14 months as the "steady state" at the time of Dr. Nacht's testimony. [1124]

1503. The FAST clinic has now been disbanded and the Footbridge clinic has opened in its place. This clinic, which is offsite from St. Paul's now houses both the assessment and non-operative treatment component formerly performed by the FAST clinic, but also the offices of the four foot and ankle surgeons.[1125] As Dr. Penner testified, they were only able to develop and house this multi-disciplinary foot and ankle clinic as a result of funding from a private donor.[1126]

1504. Dr. Penner testified that his Wait 1 time varies from a very short time, for urgent cases such as an infection, to a year or two for other more standard referrals, such as those from the FAST clinic. For patients who require surgery, his Wait 2 will vary from a few weeks (for urgent cases) to nine to 12 months.[1127]

1505. Dr. Wing likewise testified that his Wait 1 time varied from a few weeks, for urgent cases referred directly to him by another orthopedic surgeon or specialist, to six to nine months for cases referred to him from the FAST clinic.[1128]

1506. Dr. Younger's wait time for consultation has been over one year for many patients for the last few years. In 2014-2016, it ranged between 49.3 weeks to 82 weeks for the 90th percentile for patients who went on to surgery.[1129]

1507. Dr. Penner testified about his involvement in the Patient Prioritization Code Review process in 2014. He confirmed it was his understanding that the benchmark wait times for each priority level

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[1122] **Transcript Day 57**, p. 25, line 2-27; p. 32, line 13-24
[1123] **Transcript Day 57**, p. 27, line 22-26.
[1124] **Transcript Day 57**, p. 32, line 27 to p. 35, line 30
[1125] **Transcript Day 115**, p. 29, line 22 to p. 26, line 33
[1126] **Transcript Day 64**, p. 9, line 46 to p. 10, line 36.
[1127] **Transcript Day 64**, p. 102, line 13 to p. 103, line 5.
[1128] **Exhibit 343,** Tab 1, p. 3 **[CBE, Tab 82]**.
[1129] **Exhibit 320B,** Tab 18, p. 5, 16 **[CBE, Tab 74, c]**.

were intended by the provincial government to reflect "the time beyond which patients presenting with this particular diagnosis/condition could suffer negative consequences", as set out in the materials sent by the Ministry of Health.[1130]

1508. Dr. Penner's average Wait Two time from BFRD for Priority 5 cases was 35.7 weeks for the 50th percentile and 51 weeks for the 90th percentile in 2015; and 28.8 weeks and 61 weeks respectively for 2016.[1131] As Dr. Penner noted in his testimony, this data did not include the time frame, which could be up to 10 weeks, between the Decision Date for surgery and the date the Booking Form was entered into hospital system.

1509. The most recent data (2016) shows that of the 28 foot/ankle surgeries Dr. Penner performed, the 50th percentile Wait Two time from BFRD was 46.5 weeks while the 50th percentile from Decision Date was 57.8 weeks. Similarly, the 90th percentile Wait Two time from BFRD was 53.7 weeks and the 90th percentile from Decision Date was 72.1 weeks.[1132]

1510. The SPR data for Dr. Wing shows that his Wait 1 time in the period 2014 to 2017 ranged from 22 to 53 weeks for the 50th percentile and 70 to 85 weeks for the 90th percentile. For Wait 2, his 90th percentile Wait 2 time from BFRD ranged from four weeks to 33 weeks in the years 2014 to 2017 and his 90th percentile Wait 2 time from Decision Date ranged from 24 weeks to 41 weeks. The significant difference in Wait 2 when measured from the BFRD or from the Decision Date was due to his MOA only submitting the OR booking packages to the hospital after Dr. Wing received his OR schedule from the hospital and scheduled in his patients, and was due to a desire to reduce duplication and confusion at the hospital and within his office.[1133]

1511. Dr Younger's Wait One and Wait Two times are Exhibits F, G and H to Exhibit 0311.[1134] As this data shows, his 90th percentile Wait Two from Decision Date for all priorities was 51.8 weeks. Again, the Wait Two from Decision Date is generally several weeks longer than the Wait Two measured from BFRD.

[1130] **Transcript Day 64,** p. 83, line 36 to p. 84, line 4.
[1131] **Exhibit 249,** p. 4 of 81 **[CBE, Tab 47]**.
[1132] **Exhibit 320A**, Tab 1, p. 4 **[CBE, Tab 73, a]**.
[1133] **Transcript Day 115,** p. 17, line 3 to p. 19, line 42; p. 67, line 29 to p. 70, line 13.
[1134] **Exhibit 311,** Exhibits F-H **[CBE, Tab 61]**.

1512. It is not just the Footbridge Clinic group at SPH who have very lengthy wait times for foot and ankle care. British Columbians across the province are waiting well past the maximum wait times for many foot and ankle surgeries.

1513. For example, with regard to ankle arthritis, the SPR shows that the majority of patients across BC diagnosed with "Ankle – Arthritis/Joint Degeneration - Moderate to Severe pain with significant or severe functional limitation" (34WAAN) are categorized as Priority 4 (12 weeks). Of the 124 cases completed in 2017, 37.1% were completed within the 12 week maximum acceptable wait time, with the 50th percentile Wait Two time at 19.1 weeks from BFRD and 25.1 weeks from Decision Date. The 90th percentile Wait Two time was 47.4 weeks from BFRD and 53.9 weeks from Decision Date.

1514. Patients with a similar diagnosis and priority level for foot arthritis also waited well past their maximum acceptable wait time of 12 weeks. Of the 227 cases completed in 2017, only 42.7% were completed within 12 weeks, with the 50th percentile Wait Time at 15.3 weeks from BFRD and 21 weeks from Decision Date. The 90th percentile Wait Two time for Priority 4 foot arthritis surgery was 45.8 weeks from BFRD and 51.6 weeks from Decision Date.

1515. A chart showing these wait times as well as those for other foot and ankle conditions is found at **Appendix, Part A, Section VII(C)(vii)(d), Wait Times Table 1.**[1135]

1516. As a result of the restrictions on their public system OR time, Dr. Younger and Dr. Penner both see private pay patients for consultations at SRC and perform private pay surgeries at Cambie. Dr. Younger testified that he has worked at Cambie since 1998 and does this in order to access more OR time, improve his surgical skills, and provide more surgeries to more patients and in a more timely way. Without this opportunity he would not have stayed in Canada. [1136]

1517. Dr. Younger typically does one OR day every other week at Cambie, which allows him to provide surgery to four additional patients per month and to keep these patients off his surgical wait list at SPH. He does not advise his public patients about the option to have surgery at Cambie unless they specifically ask about this option.[1137]

1518. Dr. Younger testified that he will always remain committed to working at SPH and within the public health care system. Not only does this enable him to teach and conduct research but he can

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[1135] **Appendix,** Part A, Section VII(C)(vii)(d), Table 1.
[1136] **Exhibit 311,** para. 144-145, 150 **[CBE, Tab 61]**.
[1137] **Exhibit 311,** para. 146-148, 151 **[CBE, Tab 61]**.

perform more complex surgeries and treat all types of patients, some of whom would not be eligible to be treated in a private clinic, based on the College guidelines. He prioritizes his work at SPH and does not book surgical time at Cambie until he has received his SPH OR schedule.[1138]

e) Orthopaedic Spinal Surgery

1519. There is substantial evidence from experts, physicians, and patients about the lengthy wait times for adult and paediatric spinal surgery in BC and the resulting harms to patients. The evidence shows that both adult and paediatric patients are waiting well beyond the maximum acceptable wait times for a variety of spinal surgeries, with ongoing pain and disability and, in some cases, substantial risk of permanent damage.

1520. With respect to adult spinal surgery, we have evidence from Plaintiffs' expert, Dr. Chambers, and from Dr. Marcel Dvorak.

1521. Dr. Marcel Dvorak is an orthopaedic spine surgeon specializing in adult spine trauma, arthritis, and deformity. Dr. Dvorak has practiced in a spine clinic group at Vancouver General Hospital (VGH) since 2001.[1139] He was the medical director of the combined surgical and orthopaedic spine program at VGH from 2001 to 2003,[1140] and now has an administrative role at VGH as associate senior medical director of Vancouver Acute.[1141] Dr. Dvorak is a tenured professor in the UBC Department of Orthopaedics and trains spine surgeons in a spine fellowship.[1142] Dr. Dvorak had privileges at Cambie from approximately 2000 to 2014.[1143]

1522. With respect to pediatric spinal surgery, Plaintiffs' expert, Dr. Matheson, opined on the risks that accompany prolonged wait times for paediatric scoliosis patients.

1523. Dr. Christopher Reilly and Dr. Thomas Warshawski, treating physicians of Plaintiff Patient Mr. Walid Khalfallah, both testified about Mr. Khalfallah's situation, and the harms from waiting for surgery for kyphosis.

[1138] **Exhibit 311**, para. 146-148, 151 **[CBE, Tab 61]**.
[1139] **Transcript Day 36**, Testimony of Dr. Dvorak, dated November 15, 2016, p. 7, lines 27 to 31.
[1140] **Transcript Day 36**, p. 8 line 46 to p. 9 line 4, and p. 10 lines, 45 to 47.
[1141] **Transcript Day 36**, p. 39, lines 18 to 24.
[1142] **Transcript Day 36**, p. 30, lines 1 to 25.
[1143] **Transcript Day 36**, p. 38, lines 2 to 27.

1524. Dr. Reilly is an orthopaedic surgeon and head of the paediatric orthopaedic department at BC Children's Hospital,[1144] where he practices in the paediatric orthopaedic surgery group, providing subspecialty care for paediatric knee and spine problems.[1145] He also teaches at UBC medical school's orthopaedic residency training program.[1146]

1525. Dr. T. Warshawski is a pediatrician practicing in Kelowna, BC. Previously, he was the president of the BC Paediatric Society and Society of Specialist Physicians and Surgeons of BC, as well as a negotiator for the BC Medical Association. He is currently the chair of the Childhood Obesity Foundation.[1147]

1526. Ms. Debbie Waitkus testified about the tragic experience of her son Walid, and her own experience as a parent attempting to obtain timely care for her son.

i. Adult Spinal Surgery - Harms from waiting

1527. With respect to adult spinal conditions requiring surgery, Plaintiffs' expert Dr. Chambers opined that those with longer wait times were more likely to experience higher pain intensity and less improvement in outcome post-surgery.[1148]

1528. Dr. Chambers relied for this opinion on a study by Quon et al. that showed "for those undergoing elective surgical lumbar discectomy (ESLD), patients with a wait time of more than 12 weeks (long-wait patients) were 70% more likely to experience higher pain intensity at 6 months post-surgery." He also relied on a study by Braybrooke et al. that showed "a wait of 12 weeks or more for surgery resulted in 'less improvement in outcome following surgery.'" Dr. Chambers found these studies to be valid and reliable.[1149]

1529. Dr. Dvorak testified that the two primary symptom types that his spinal patients experience relate to pain and neurology. All of these patients "have some degree of pain and a resulting disability from that so that they may not be able to walk, they may not be able to stand, they may not be able to hold objects, do up their buttons, feed themselves...Or they may have neurologic decline so that they

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[1144] **Transcript Day 18**, Testimony of Dr. Christopher Reilly, p. 12, lines 25 to 26.
[1145] **Transcript Day 18**, p. 20, lines 13 to 19.
[1146] **Transcript Day 18**, p. 21, line 31, to p. 22 line 17.
[1147] **Transcript Day 25**, Testimony of Dr. Warshawski, p. 1, line 44 to p. 2, line 12.
[1148] **Exhibit 289A**, Expert Report of Dr. Chambers, Vol. 1, p. 8, para. 5 **[CBE, Tab 54, a]**.
[1149] **Exhibit 289A**, p. 8, para. 5 **[CBE, Tab 54, a]**.

feel their legs are weak, their hands are weak, they drop objects, they have numbness in their legs, tingling pains down their arms or down their legs."[1150]

1530. He testified that he frequently receives letters from GPs seeking a second assessment because a patient waiting for a consult has now deteriorated. This leads to another assessment and that patient then becoming an urgent or emergent referral.[1151]

1531. Dr. Dvorak further testified that he "frequently get[s] calls from emergency departments" across the province advising that a patient referred to him is now in the emergency room with a worsening condition or intractable pain.[1152]

1532. Dr. Dvorak's patients often need to redo diagnostics like blood work and EKGs while waiting for spinal surgery, because the results of their initial tests expired while waiting.[1153] This is an additional strain on both patients and the already limited resources in the public system.

ii. Provision of Adult Spinal Care in BC

1533. Dr. Dvorak has worked in VGH's spine clinic group since 2003, The group currently consists of four orthopaedic surgeons and three neurosurgeons[1154] who perform surgery for urgent spine trauma and other spinal conditions such as spinal deformities, degenerative conditions, sciatica, cervical radiculopathy, and spinal metastasis.[1155]

1534. Dr. Dvorak testified that his consultation wait time is approximately one year or more. Some of his patients become urgent or emergent during the waiting period for a consultation.[1156]

1535. In 2015 Dr. Dvorak had just over 1.5 days of OR time per week in the public system for the 42 working weeks per year. This was about the same for each surgeon in the group.[1157] All of the surgeons in the spine group use all of their allocated OR time.[1158]

1536. Dr. Dvorak testified that operating room access for elective patients has "diminished dramatically over the last three years" in his experience, with about 30% of OR allocation being used

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[1150] **Transcript Day 36**, p. 27, lines 26 to 40.
[1151] **Transcript, Day 36**, p. 26, line 36 to p. 27, line 4.
[1152] **Transcript Day 36**, p. 27, lines 5 to 18.
[1153] **Transcript Day 36,** p. 46, line 47, to p. 47 line 6.
[1154] **Transcript Day 36**, p. 9, lines 24 to 27.
[1155] See **Exhibit 106 [CBE, Tab 31]**.
[1156] **Transcript Day 36**, p. 26 line 30 to p. 27 line 18.
[1157] **Transcript Day 36**, p. 13 lines 10 to 26 and p. 69 lines 2 to 7.
[1158] **Transcript Day 36**, p. 16, lines 24 to 29.

for emergency patients:[1159] Scheduled spinal surgeries are often bumped for unexpected urgent and emergent surgeries that arise. This causes patients significant emotional distress.[1160]

1537. He testified that his spine group sees the urgent/emergent patients first, but they have files for about 2,400 individuals with a valid surgical pathology who require and are waiting for a surgical consultation.[1161]

1538. The spine group at VGH was recently able to increase from six to seven, but there was no increase in OR time for the group; instead, the group had to divide OR time previously available for six surgeons among seven surgeons.[1162] Dr. Dvorak knows of many qualified graduates trained by their group who are unable to find work.[1163]

1539. The SPR data demonstrates that many adult patients in BC are waiting for spinal surgeries well-beyond their prescribed maximum acceptable wait times. For example, the maximum acceptable wait time for "Acute Persistent Lumbar or Cervical Radiculopathy with Severe Symptoms" (33SCBA), is two weeks, but in 2016, only 32.3% of patients received their surgeries within two weeks, and in 2017, only 42.6% did.[1164] The 90th percentile Wait Two time for these patients was 14.1 weeks from BFRD and 19.6 weeks from Decision Date.[1165]

1540. Patients with "Acute Persistent Lumbar Or Cervical Radiculopathy With Moderate Symptoms" (33SCBB) have a maximum acceptable wait time of four weeks. In 2016, only 34.4% of patients received surgery within four weeks, and in 2017, only 17.9% of patients did.[1166] In 2017 the 90th percentile Wait Two time was 38.9 weeks from BFRD and 50.8 weeks from Decision Date.[1167]

1541. Dr. Dvorak previously performed surgeries at Cambie from about 2000 to 2013/2014, primarily for WCB cases but also some privately.[1168] These were lumbar discectomies, single-level

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[1159] **Transcript Day 36**, p. 14, lines 42 to 47 to p. 15, lines 1 to 6.
[1160] **Transcript Day 36,** p. 77, lines 8 to 16.
[1161] **Transcript Day 36**, p. 20, lines 30 to 41.
[1162] **Transcript Day 36**, p. 33, lines 24 to 33.
[1163] **Transcript Day 36**, p. 34, line 5 to 43.
[1164] **Exhibit 315B**, Tab 7, Page 11 **[CBE, Tab 65]**.
[1165] **Exhibit 316C**, Tab 5, Page 36 **[CBE, Tab 69, a]**.
[1166] **Exhibit 315B**, Tab 7, Page 11 **[CBE, Tab 65]**.
[1167] **Exhibit 316C**, Tab 5, Page 36 **[CBE, Tab 69, a]**.
[1168] **Transcript Day 36**, p. 38, lines 2 to 27.

lumbar laminectomies and single-level anterior cervical fusions, as these can be performed at Cambie under BC College guidelines. More complex cases, such as fusions, must be done at VGH.[1169]

1542. Dr. Dvorak's private work did not interfere with his public work, his clinic, or teaching, as he would schedule his private and WCB surgeries for mornings or afternoons that were available in his existing schedule.[1170]

iii. Paediatric Spine Surgery - Harms from waiting

1543. Plaintiffs' expert, Dr. Matheson, testified to the risks of prolonged wait times for paediatric scoliosis patients, including a heightened risk of a need for repeat surgery because of the progression of the spinal curve while waiting. He opined that "Adolescents with idiopathic scoliosis waiting longer times for corrective surgery have a ten-fold greater need for repeat surgery because the spinal curvature worsened while waiting."

1544. Dr. Matheson relied for this opinion on a study by Ahn et al., "Empirically Derived Maximal Acceptable Wait Time for Surgery to Treat Adolescent Idiopathic Scoliosis" (CMAJ).[1171] The authors state that "Patients who wait too long for scoliosis surgery may require additional surgery such as anterior release to achieve satisfactory correction of the spinal curvature. These patients may also need longer surgeries and may be at increased risk of complications such as increased blood loss, neurologic deficits, or inadequate correction of the curvature.[1172]

1545. The study found that 14.8% of patients that waited longer than 6 months did require further surgery), with the associated risks inherent in surgery,[1173] including neurologic deficits. The study also found that patients waiting past 3 months have a poorer outcome (less correction of the curvature).[1174] The authors concluded that "[a] prolonged wait for surgery increased the risk of additional surgical procedures and other adverse events. An empirically derived access target of three months for surgery to treat adolescent idiopathic scoliosis could potentially eliminate the need for additional surgery by

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[1169] **Transcript Day 36**, p. 38, line 47 to p. 39, lines 1 to 9.
[1170] **Transcript Day 36**, p. 39, lines 10 to 15.
[1171] **Exhibit 274,** Expert Report of Dr. Matheson, p. 8. Tab 12, "Empirically Derived Maximal Acceptable Wait Time for Surgery to Treat Adolescent Idiopathic Scoliosis", CMAJ, June 14, 2011, 183(9), p. 162. This study was co-authored by Dr. James Wright, an orthopaedic surgeon specializing in scoliosis, who was the Lead of the Canadian Paediatric Surgical Wait Times Project **[CBE, Tab 53]**.
[1172] **Exhibit 274,** Tab 12, p. 163 **[CBE, Tab 53]**.
[1173] **Exhibit 274**, Tab 12, p. 163 **[CBE, Tab 53]**.
[1174] **Exhibit 274,** Tab 12, p. 167 **[CBE, Tab 53]**.

reducing progression of curvature. This is a shorter access target than the six months determined by expert consensus."[1175]

1546. Dr. Reilly testified to the effects of spinal deformities on paediatric patients, stating there is "a wide variety, depending on the patient. The deformity may cause pain that limits their function, their ability to sit in school, for example. In some cases the deformity might affect their athletic performance or their -- in severe cases of scoliosis their lung function."[1176]

1547. The progression and deterioration associated with scoliosis, and increased surgical risk has been acknowledged by the BC Government. A Briefing Note prepared for Minister of Health Services, Hon. Kevin Falcon, states "In severe cases of scoliosis, surgery is required to correct the curve in the spine or stop it from worsening. If left untreated, acute cases of scoliosis can cause severe pain, weakness, further deformities and potentially heart and lung problems," and that "certain children on the wait list are considered high priority as their condition often deteriorates during the wait time leading to more extensive and complicated surgery."[1177]

1548. These harms are also acknowledged by PHSA. A November 12, 2009 document prepared by PHSA, "Steps taken to increase capacity for scoliosis surgeries at BC Children's Hospital", states:

> "• Patients waiting for idiopathic scoliosis surgery are felt to be a priority in addressing the wait list as the curve typically deteriorates during the wait time.
> • Longer waits often allow curves to progress, with the potential leading to more extensive surgery, more extensive implants, ICU stays, a higher complication rate, and the possibility of permanent lung disease.
> • As well, when small idiopathic curves operated on, patients do not necessarily require the Pediatric Intensive Care Unit (PICU) for post-operative care." [Emphasis added.] [1178]

iv. Provision of Pediatric Scoliosis Surgery in BC

1549. In BC, all paediatric scoliosis surgeries are performed at BC Children's Hospital (BCCH) run by PHSA. BCCH has struggled for many years to provide these complex and vital surgeries in a timely way.

[1175] **Exhibit 274,** Tab 12, p. 163 **[CBE, Tab 53]**.
[1176] **Transcript Day 18,** p. 47, lines 26 to 31.
[1177] **Exhibit 431**, p. 518 **[CBE, Tab 102]**.
[1178] **Exhibit 431**, pp. 520-521 **[CBE, Tab 102]**.

1550. Extensive communications between the Ministry of Health, the PHSA, and BCCH, shows that the wait times for scoliosis surgery in BC put patients at unacceptable risk of serious harms. These waits are the result of inadequate OR time resulting from limited budgets.[1179]

1551. The possibility of sending patients out of province was considered, but all Canadian hospitals also had long wait lists. The possibility of sending patients to Seattle Children's Hospital was also considered but deemed to be too expensive. [1180]

1552. In early 2013 the Ministry approved BCCH offering long-waiting patients the option to go to Montreal Shriners on a temporary basis. In conjunction with this approval, the Ministry directed PHSA/BCCH to eliminate all the cases waiting more than 52 weeks by September 2013, and ensure that the 90th percentile wait time is 26 weeks or less by January 2014. [1181]

1553. Under P-CATS, the maximum acceptable Wait Two time for pediatric patients diagnosed with stable scoliosis (44SCHA) is 26 weeks. In 2013, the 50th percentile Wait Two was 18.7 weeks from BFRD and 32 weeks from Decision Date. The 90th percentile Wait Two time was 82.3 weeks from BFRD and 86.9 weeks from Decision Date.[1182]

1554. Despite neither the Ministry targets nor the P-CATS target being met, BCCH and the Ministry did not offer to send children to Shriners' hospitals unless their wait for surgery exceeded 12 months, well past the maximum acceptable wait time and the Ministry's 26 week target.[1183]

1555. The SPR data shows that paediatric patients needing scoliosis surgery still wait well beyond the maximum acceptable wait times as set out in the P-CATS. In 2017, only 45.8% of paediatric patients diagnosed with stable scoliosis (44SCHA) had their surgery within the maximum acceptable Wait Two time in P-CATS of 26 weeks.[1184] The 90th percentile Wait Time was 59.7 weeks.[1185]

v. Patient experience (Walid Khalfallah)

1556. At age 8, Mr. Khalfallah was diagnosed with kyphosis, a medical condition that involves an exaggerated forward-rounding of the back, beyond 50 degrees.[1186] The curvature in kyphosis is in a

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[1179] For e.g **Exhibit 431**, pp. 518-519; **Exhibit 431**, p. 517 **[CBE, Tab 102]**.
[1180] **Exhibit 477**, Ministry of Health Decision Briefing Note, p. 3 **[CBE, Tab 126]**.
[1181] **Exhibit 431**, p. 528 **[CBE, Tab 102]**.
[1182] **Exhibit 316D**, Tab 7, p. 20 **[CBE, Tab 70, b]**.
[1183] **Exhibit 431**, pp. 518-519 **[CBE, Tab 102]**.
[1184] **Exhibit 315B**, Tab 7, Page 401 **[CBE, Tab 65]**.
[1185] **Exhibit 316D**, Tab 11, Page 23 **[CBE, Tab 70, c]**.
[1186] **Exhibit 51**, ASF of Walid Khalfallah, p. 1, para. 8 **[CBE, Tab 22]**.

different place from that in scoliosis but the impacts on the patient of delays in treatment are very similar. In particular, increased curvatures in both conditions increase the complexity and risk of surgery.

1557. Due to complications that arose during his long-delayed spinal surgery, Mr. Khalfallah was left with complete paralysis below the navel.[1187]

1558. "Kyphosis – Unstable (likely to progress)" has a P-CATS Wait One target time (time from referral to a specialist to initial specialist consultation) of Priority III (within 6 weeks) and Wait 2 time of Priority IV (within 3 months).[1188]

1559. "Kyphosis – Stable (unlikely to progress), has a P-CATS Wait One target time of Priority IV (within 3 months) and Wait Two target time of Priority V (within 6 months). [1189]

1560. Ms. Waitkus took Mr. Khalfallah to see his pediatrician Dr. Warshawski in May 2009, when she had noticed a visible change in Mr. Khalfallah's back.[1190]

1561. Dr. Warshawski observed that Walid's kyphosis had substantially progressed. He put in an urgent referral to the orthopaedic department at BCCH.[1191]

1562. Over the next 13 months, Ms. Waitkus made repeated calls to Dr. Reilly's office, to ask about a consultation date. She returned to Dr. Warshawski in March 2010 to ask for his assistance in expediting the consultation. Dr. Warshawski undertook additional assessments and it was not until June 2012, that Ms. Waitkus was told that there was a consultation scheduled for August 3, 2010.[1192]

1563. In the meantime, Walid's condition was progressing significantly. On March 2, 2010, an X-ray revealed that Walid's kyphosis had progressed to about 100 degrees.

[1187] **Exhibit 51**, p. 9, para. 46 **[CBE, Tab 22]**.
[1188] **Exhibit 432,** diagnosis code 3487, p.1297, also see classification at p. 1286 **[CBE, Tab 103]**.
[1189] **Exhibit 432**, p. 1297, also see classification at p. 1286 **[CBE, Tab 103]**.
[1190] **Exhibit 51,** p. 3, para. 11 and **Transcript Day 16**, p. 19, lines 23 to 45 **[CBE, Tab 22]**.
[1191] **Exhibit 51,** pp. 3-4, paras. 3-13; **Transcript Day 16**, p. 22, lines 12 to 21 **[CBE, Tab 22]**.
[1192] **Exhibit 51**, p. 4, para. 18 **[CBE, Tab 22]**.

1564. At the consultation on August 3, 2010, Dr. Reilly told Ms. Waitkus that Mr. Khalfallah's prognosis would be very poor if he didn't have surgery,[1193] and that it was a high risk surgery,[1194] but the wait list would be 2 years[1195].

1565. In his consultation report to Dr. Warshawski, Dr. Reilly stated that: "Walid's kyphosis would progress severely and would ultimately lead to great compromise in quality of life" and that, without surgery, "Walid's prognosis was poor".[1196] He further stated that the "wait list was going to be a problem for this boy because his kyphosis will progress dramatically as we wait".[1197]

1566. At this appointment, Dr. Reilly also discussed the need for Mr. Khalfallah to have an MRI and CT scan "ASAP," and that there were waitlists for these as well.[1198] Dr. Reilly testified that an MRI was a pre-operative requirement[1199] and that the wait time for a sedated MRI at BCCH was over a year.[1200]

1567. Dr. Reilly put Mr. Khalfallah on his surgical waitlist and said he wanted to see Mr. Khalfallah again in 5 months.[1201]

1568. Ms. Waitkus called Dr. Reilly's office around October or November 2010, since she had not heard from them about the next appointment, but they said no appointment was yet scheduled. The appointment was ultimately scheduled for February 22, 2011.[1202]

1569. Ms. Waitkus was distressed by this wait. Dr. Warshawski testified that he understood her concern as he understood the risk of neurological compromise that comes with kyphosis progression,[1203] and the importance of operating before any neurological damage occurs, as operating afterward is simply too late.[1204]

[1193] **Transcript Day 16**, p. 27, lines 45-46.
[1194] **Transcript Day 16**, p. 28, lines 13 to 34.
[1195] **Transcript Day 16,** p. 29, lines 3 to 5.
[1196] **Exhibit 51**, p. 4, paras. 19 to 20 **[CBE, Tab 22]**.
[1197] **Exhibit 51**, p. 4, paras. 19-21 **[CBE, Tab 22]**; **Redacted due to evidence subject to sealing order;** See also **Transcript Day 18**, p. 54, lines 13-24.
[1198] **Transcript Day 16,** p. 34, line 45 to p. 25, line 13.
[1199] **Transcript Day 18**, p. 66, lines 4 to 13.
[1200] **Transcript Day 18**, p. 65, lines 43-44.
[1201] **Exhibit 51**, p. 5, para. 23 **[CBE, Tab 22]**; **Transcript Day 16**, p. 29, lines 36 to 37.
[1202] **Exhibit 51**, p. 5, para. p. 26 **[CBE, Tab 22]**; **Transcript Day 16**, p. 30, lines 1 to 12.
[1203] **Transcript Day 25**, Testimony of Dr. Warshawski, p. 40, lines 32 to 36.
[1204] **Transcript Day 25**, p. 43, lines 40 to 46.

1570. While waiting for the second consultation with Dr. Reilly, Ms. Waitkus observed Walid's condition worsening significantly:

> ... one of the things that surprised me the most is how things really started to progress now. It wasn't only his back that was being affected. Now it was this deformity of his chest. He developed a barrel chest. His ribs were kind of turning in on themselves... it was like Walid's head entered the room before the rest of his body because he was starting to stoop over so much
>
> [...]
>
> He had increased pain in his legs. When he was -- if we were out shopping -- and this – he would say, mom, my legs are really tired; they really hurt; can we go home? And that doesn't sound really too bizarre, but I'm talking about a child that had double hernias and never cried once about it. He has a super high tolerance of pain. [1205]

1571. At the February 22, 2011 appointment, Dr. Reilly told Ms. Waitkus that Mr. Khalfallah was now in urgent need of surgery. Thus, Mr. Khalfallah was taken off the main surgical wait list, and put on the urgent list.[1206]

1572. Dr. Reilly told Ms. Waitkus that "... at this stage of Walid's kyphosis you could even expect a spontaneous spinal cord injury."[1207] Dr. Reilly advised Ms. Waitkus of the additional risks from his condition such as "punctured lung" or "irreparable organ damage," and also said that "the correction of his back of course is now more limited." Ms. Waitkus understood this was because there is only so much correction you could get and "the longer you leave it the less of a correction you're going to get."[1208] Dr. Reilly confirmed these risks in his testimony.

1573. At this point, Ms. Waitkus was "very, very scared."[1209]

1574. **Redacted due to evidence subject to sealing order;**

[1205] **Transcript Day 16**, p. 32, lines 20 to 26.
[1206] **Exhibit 51**, p. 6, para. 30, Transcript Day 16, p. 33, lines 1 to 34 **[CBE, Tab 22]**.
[1207] **Transcript Day 16**, p. 33, lines 37 to 40.
[1208] **Transcript Day 16**, p. 34, lines 1 to 10.
[1209] **Transcript Day 16** p. 34, lines 37 to 41.
[1210] **Redacted due to evidence subject to sealing order;**

1575. As described by Dr. Reilly in his testimony, by this time, the surgical risk and difficulty associated with Walid's surgery had increased substantially:

> Dr. Reilly: Yeah. If you have a moderate curve I might do many of those little cuts, and it would loosen the spine up. And then the third stage would be I'd put some rods in to then correct the deformity where I was trying to get it. Walid's case was too severe for that. So the second thing I might do to correct the deformity, if he's got a curved spine that's curved forward, I might cut a wedge out of the spine, and then close it like that so it hinges on the front. That's called a pedicle subtraction osteotomy.
>
> THE COURT: This is in the thoracic spine?
>
> Dr. Reilly: THE WITNESS: Yes. He had a curve that was quite high. So it's way more powerful than the little cuts because I can take a wedge out, and then it gives me the ability to correct a lot of the kyphosis by hinging on the front of the spine. It has higher risks associated with it, though. If the deformity is even more severe than that and the surgeon doesn't think the pedicle subtraction osteotomy would be enough, when they have that curved block of bone they can actually cut a whole big piece out and then move it around wherever you want. And that's associated with even more risk to the spinal cord, and it makes the surgery riskier. That's called a vertebral column resection. So that's the -- when I met Walid that's the planning process that was going through my mind, and I didn't know which of the second two would be required. I knew that the first wouldn't be enough because of the location of his kyphosis, and that it was stiff, so I dictated that it would be -- require a complex spine surgery, and with that there's greater risk. [1211]

1576. Ms. Waitkus frequently called Dr. Reilly's office and eventually found out near the end of June 2011 that Walid was not on the surgery slate, which covered bookings up to September 2011.[1212]

1577. This was now almost a year after the Decision Date for surgery in August 2010, and Ms. Waitkus was now desperate to obtain treatment for Walid. She began to look for other options to have Walid's surgery done.

1578. She also researched online and learned about other families who had complained about similar experiences with their children having long surgical wait times at BCCH, and in the process found out about alternatives to BCCH including Shriners Hospitals in Montreal, Spokane and Seattle.[1213]

1579. Around this time, Ms. Waitkus filed a complaint with the Patient Care Quality Office.[1214]

[1211] **Transcript Day 18**, p. 57, lines 44 to 47, to p. 58 lines 1 to 19.
[1212] **Transcript Day 16,** p. 36, lines 24 to 35.
[1213] **Transcript Day 16**, p. 38, lines 14 to 31, and p. 39, lines 3 to 26.
[1214] **Transcript Day 16,** p. 38, lines 1 to 9.

1580. Ms. Waitkus received a response from the Patient Care Quality Office that Mr. Khalfallah's wait time at Children's Hospital was consistent with wait times across Canada for that surgery.[1215] Ms. Waitkus testified as to how she felt about this as follows:

> Well, I just -- I was actually just floored that they would give me a response like that and somehow that would make me feel better after I was on the -- I mean, it was a very emotional phone call. So now all of a sudden this just seemed so empty to me. Now I understand that children all across Canada are waiting and my wait is in line with everybody's else's wait. That horrified me. That -- I just -- I've said before I can't believe that any procedure of a child would include a waitlist because we all know children really can't wait; they're changing so rapidly. So I was -- yeah, I was horrified. And as a nurse as well I have to say that that influenced me too.[1216]

1581. Ms. Waitkus also received correspondence from Teri Collins, on behalf of the Michael de Jong, Minister of Health, which stated that "In order to complete life-saving emergency and urgent surgical cases, non-urgent cases may be delayed" and explaining the need to prioritize patients[1217]. Ms. Waitkus testified that she felt Ms. Collins' response showed "no indication that anything that happened to me was out of the ordinary" and felt like it was "not getting [her] anywhere because it's still being passed off as standard practice."[1218]

1582. On July 11, 2011, Shriners Hospital in the United States contacted Ms. Waitkus after seeing a news story about Walid, and after some consideration she decided to pursue surgery for Mr. Khalfallah at Shriners.[1219]

1583. In August 2011, Dr. Reilly called Ms. Waitkus, expressed gratitude for her advocating for her son's surgery, and said he was working on a plan to have a surgical date for Walid in November 2011 at BCCH. Ms. Waitkus told him that she intended to take Mr. Khalfallah to Shriners Spokane, but Dr. Reilly advised against it because of the significantly advanced stage of Mr. Khalfallah's kyphosis.[1220]

1584. Ms. Waitkus had still not heard about the booking of MRI scans at BCCH, and had lost confidence in the surgery ever being done there. Ms. Waitkus went to Shriners with Mr. Khalfallah for a consult in Sept. 2011.[1221]

[1215] **Transcript Day 16**, p. 57, lines 7 to 19, and **Exhibit 26**, Tab A.
[1216] **Transcript Day 16**, p. 57, lines 34 to 47.
[1217] **Transcript Day 16**, p. 62, lines 20 to 24; and **Exhibit 26**, Tab D, p. 2.
[1218] **Transcript Day 16**, p. 62, lines 40 to 42.
[1219] **Transcript Day 16,** p. 45 lines 3 to 47 to p. 46, lines 1 to 44.
[1220] **Transcript Day 16**, p. 45, line 41 to p. 46, line 17.
[1221] **Exhibit 51,** p. 7, para. 40 **[CBE, Tab 22]**.

1585. Around one week after Mr. Khalfallah's September 2011 consultation with Shriners, Mr. Khalfallah got MRI scans through Shriners in October 2011.[1222]

1586. After having Mr. Khalfallah's MRI completed at Shriners, Ms. Waitkus described her state of mind as follows:

> ...when I got back to Canada I went to Dr. Warshawski, because ... I heard over and over that my son had been left defenceless against a progressive disease that wasn't going to stop. It had its own agenda and it wasn't going to wait for surgery. The surgeon said ... how difficult the surgery was going to be now. They do their surgeries usually around 75 to 80 degrees. This was now, you know, 47 degrees higher than the normal time that they do surgery. They don't want to do it too early because you don't want to do it unless you have to do it. So 75/80 is the parameters that I've read over and over again. [1223]

1587. **Redacted due to evidence subject to a sealing order.**

1589. By October 2011, when Ms. Waitkus decided to proceed with Shriners, Walid had waited well over two years from the date of Dr. Warshawski's referral to BCCH in May 2009.

1590. By the time of his surgery, Walid was a at a significantly increased risk of an adverse outcome as a result of the progression of his kyphosis while he waited for assessment and treatment at BCCH.

1591. Due to complications in his surgery at Shriners Hospital, Walid was left with complete paralysis below the navel.

1592. Ms. Waitkus was devastated by this outcome. She testified:

> I mean, my health started to really decline too. I became very depressed, very anxious. Thankfully I was -- I've spent the last two years really healing from that too, and my family and friends have been enormous, but it just never seemed to end. Like, just, like ... You know how they say, you know, God only gives you as much as you can handle. I was, like, okay. It was -- yeah, it was difficult. It was definitely difficult. [1225]

[1222] **Exhibit 51**, p. 8, para. 43 **[CBE, Tab 22]**.
[1223] **Transcript Day 16**, p. 64, lines 34 to 47.
[1224] **Redacted due to evidence subject to a sealing order.**
[1225] **Transcript Day 16,** p. 54, lines 10 to 19.

1593. On April 16, 2012, the PCQRB had completed their review of Mr. Khalfallah's case and provided a report to PHSA with recommendations for action plans and steps.[1226]

1594. The Ministry of Health noted in an August 2012 Briefing Note following the review that "the Board found that the delay in treatment for Walid was unreasonable, allowed his condition to deteriorate unnecessarily, and increased the risk to his health. They commented that Mr. Khalfallah's case was 'an indication of system failure.'"[1227]

1595. BC's Patient Care Quality Review Board Report considered the Ahn study referenced by Dr. Matheson in finding that Mr. Khalfallah did not receive quality care, and the delay in treatment allowed his condition to "unnecessarily deteriorate and increased the risk" to his health.[1228]

1596. Ms. Waitkus ultimately received a report from the PCQRB dated May 1, 2012, which stated that "Walid did not receive quality care. The delay in treatment allowed Walid's condition to unnecessarily deteriorate and increase the risk to his health,"[1229] and that "that the health authority did not meet the Pediatric Canadian Access Targets For Surgery ... (P-CATS) and did not follow provincial and health authority policy."[1230] The PCQRB also found that there was "inadequate communication with the patient and family in regard to patient and family and other options".[1231]

1597. The PCQRB "recommended that the Minister of Health ensure that BCCH is managing its surgical waitlist in accordance with the accountabilities of the Ministry of Health in the Surgical Waitlist Management Policy."[1232]

1598. However, there is no evidence to show that any real steps were taken to comply with the recommendations. As set out in the Affidavit of Susan Wannamaker, President of BC Children's and Women's Health, and Vice President, Provincial Health Services Authority (PHSA):

> "PHSA has been unable to identify or locate any documents in its possession or control" involving
> "(a) All reports and action plans received by PHSA or created by PHSA in relation to the Ministry PCQRB recommendations to PHSA, as accepted by PHSA, per its letter to the PCQRB of June 12, 2012, including:

[1226] **Exhibit 413**, Affidavit #1 of Wannamaker, p. 5, paras. 3 to 4 **[CBE, Tab 96]**.
[1227] **Exhibit 431**, p. 178.
[1228] **Ex. 431** at pp. 178, 524 **[CBE, Tab 102]**.
[1229] **Transcript, Day 16**, p. 71, lines 31 to 35.
[1230] **Transcript, Day 16**, p. 72, lines 20 to 27.
[1231] **Transcript, Day 16,** p. 72, p. 35 to 41.
[1232] **Exhibit 26**, Tab J, Letter from PCQRB to Ms. Waitkus, May 1, 2012, p. 4 **[CBE, Tab 16]**.

i. The periodic waitlist reports and P-CATs Targets and documents that cross-reference those targets with paediatric wait lists, dating back to 2009;

ii.Detailed reports regarding the wait lists and patients who fall outside of the P-CATS targets arising from review with applicable Division heads; and

iii.Action plans for patients that fall outside of the P-CATs Targets." [1233]

1599. Walid Khalfallah's story demonstrates in stark and devastating terms the type of harm that can and is suffered by BC patients as a result of waiting too long for medically necessary assessment and surgical care in BC.

1600. No part of this delay was due to any failure by Dr. Reilly. Rather, it was due to a lack of sufficient surgical resources and funding for these resources, at BCCH and in the province generally.

1601. Walid is one of the patients for whom the worst happened. But, similar risks accrue to BC patients every day as a result of waiting too long for medically necessary diagnosis and treatment.

1602. As Ms. Waitkus testified, "we need to do something to look at other avenues, look at other ways of doing health care"[1234] for patients who are waiting too long for medically necessary care.

(viii) Neurosurgery

1603. The evidence in this case has also shown that patients in BC are waiting too long for diagnosis and treatment of neurological issues, and suffering harm while waiting.

1604. Dr. Ramesh Sahjpaul, a neurosurgeon, testified about the ongoing problem of the lack of resources to provide timely care for his neurosurgical patients in the public system, and the harms he has observed in his patients who are waiting for care.

1605. Dr. Sahjpaul's practice consists of general neurosurgery, including both cranial and spinal surgeries.[1235] About 70 percent of his practice is devoted to spinal disorders, largely because the volume of spine issues in the community far outnumbers brain issues.[1236]

1606. Dr. Sahjpaul provides a specific type of pain-related surgery called spinal cord stimulation, in the spine procedure program at St. Paul's Hospital, which is the main pain program of this kind for

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[1233] **Exhibit 413**, p. 3, para. 7 **[CBE, Tab 96]**.
[1234] **Transcript Day 17**, p. 3, lines 40 to 43.
[1235] **Exhibit 83,** Affidavit #1 of Dr. Sahjpaul, p. 3, para. 8 **[CBE, Tab 28]**.
[1236] **Transcript Day 22**, p. 6, lines 4 to 15.

BC.[1237] His patient population at St. Paul's Hospital is unique, consisting of patients with severe intractable pain and major chronic pain.[1238]

1607. At Lion's Gate Hospital, the large majority of his practice is devoted to spine patients.[1239] At Vancouver General Hospital, Dr. Sahjpaul treats patients suffering from epilepsy.[1240]

1608. Dr. Sahjpaul is the Chief of Surgery at Lions Gate Hospital and at the Coastal Community of Care. He is also the head of the Department of Surgery at Lions Gate Hospital. Since 2007, he has also been the Medical Director of the surgery program at Lions Gate Hospital, which includes allocation of operating room time between surgeons, divisions and departments, among other responsibilities.[1241]

1609. Additionally, Dr. Sahjpaul teaches students and surgical residents at the UBC medical school.[1242]

1610. Dr. Sahjpaul also works at Cambie and SRC, as well as at WCB's Visiting Specialist Clinic where he does WCB consultations.[1243]

a) Harms from Waiting for Neurosurgery

1611. Dr. Sahjpaul testified about the impact on his patients waiting for surgery, as a result of delayed treatments and excessive wait times, which includes cases deteriorating from non-urgent to emergent, patients suffering physical, emotional and psychological effects that could be avoided with earlier treatment, an inability to work, restricted mobility and neurological function, depression, anxiety, and dependence on pain killers.[1244]

1612. In his testimony, Dr. Sahjpaul explained that the pain patients experience with their wait times for neurosurgery can have effects in "physical, social and emotional spheres."[1245]

[1237] **Transcript Day 22**, p. 9, lines 2 to 29, and p. 25, lines 29 to 34.
[1238] **Transcript Day 22**, p. 16, lines 4 to 12.
[1239] **Transcript Day 22**, p. 15, lines 37 to 39.
[1240] **Transcript Day 22**, p. 14, lines 4 to 26.
[1241] **Transcript Day 22**, Testimony of Dr. Ramesh Sahjpaul, p. 8, lines 3 to 46.
[1242] **Transcript Day 22,** p. 16, lines 38 to 40.
[1243] **Transcript Day 22**, p. 44, lines 24 to 47.
[1244] **Exhibit 83,** p. 4, paras. 14 to 15 **[CBE, Tab 28]**; and **Transcript Day 22**, p. 39, line 35 to p. 40, line 16.
[1245] **Transcript Day 22**, p. 10, lines 16 to 22.

1613. Dr. Sahjpaul further testified that chronic pain is a large factor in the physical impacts on patients from waiting for care in his experience, as follows:

> So the physical effects of pain is patients who are in chronic pain, their mobility is reduced and they become overall deconditioned if they cannot function, if they can't exercise, if they can't work, for example. So physically they become deconditioned. The emotional effects are clear, at least in my experience, and the literature certainly supports there's a strong causal relationship between chronic pain and the development of depression. There's a relationship with drug addiction, opioid addiction, and there are other social consequences to somebody who has chronic pain, relationship problems and so forth.[1246]

1614. Dr. Sahjpaul testified that "patients need larger and larger doses to achieve the same pain relief effect," and "even if their pain is relieved by eventual surgery, they're addicted to the medication."[1247] This is a pressing issue, given that "almost every one of [his] patients is on some form of pain medication, typically narcotic medications like oxycodone or morphine or hydromorphone."[1248]

1615. Dr. Sahjpaul also testified to his observations of the various harmful effects from waiting for surgery on his spine patients at Lions Gate Hospital generally, which includes, "progression of their neurologic deficit while waiting for surgery," "worsening pain," and "worsening psychosocial situation because of the ongoing pain and deficits that they experience."[1249]

1616. Dr. Sahjpaul testified that his population of pain patients at St. Paul's Hospital is particularly vulnerable to waiting, as these patients have "severe intractable pain, major chronic pain issues;" he testified that the consequences on their lives "is very significant."[1250]

1617. Dr. Sahjpaul also testified that for a lot of spinal pathology patients, the longer the patient waits for surgery, the less the patient's chance of having a good surgical outcome, as follows:

> Because these are maximum allowable wait times, so in our world we see a lot of patients with spinal pathology such as spinal cord compression and they've got weakness in their arms and legs, and I know that the longer that person is waiting the less is the chance that they're going to have a good outcome. So if I code them as four weeks, say, I know I'm not going to get them in in four weeks, and during the time frame that they're waiting for the surgery there is a chance that they could deteriorate. And so that's a risk that I assume as a clinician that they're going to deteriorate while on my waiting list, and that's a stress to me, to my office, not to mention to the patients. But we do the best we can based on what's in front of us with the

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[1246] **Transcript Day 22,** p. 10, lines 24 to 36.
[1247] **Transcript Day 22,** p. 40, lines 34 to 42.
[1248] **Transcript Day 22,** p. 40, lines 17 to 22.
[1249] **Transcript Day 22,** p. 15, lines 35 to 44.
[1250] **Transcript Day 22,** p. 16, lines 6 to 12.

patient. We try our best to get them in as quickly as possible.[1251]

1618. Dr. Sahjpaul also testified about the harms faced by his epileptic patients waiting for surgery in particular, who usually continue to have multiple seizures daily, and whose risks can include dying from epilepsy while waiting for surgery.[1252]

1619. Dr. Sahjpaul also testified that his patients can deteriorate to the point of having intractable pain or worsening neurological deficit and function and cannot recover even if they are taken urgently to the operating room.[1253]

1620. Beyond physical harms, Dr. Sahjpaul has observed frustration and anger in his patients who are waiting for surgery. He also testified that there is "a lot of stress that waiting for surgery imparts on [his] patients and their families."[1254]

1621. Plaintiffs' expert, Dr. Keith Chambers, also opined that, for BC residents waiting for spinal surgery medical research shows evidence of harm to their health from waiting.[1255]

1622. Dr. Chambers referred in his report to a study by Quon et al. which showed that for those undergoing elective surgical lumbar discectomy (ESLD), patients with a wait time of more than 12 weeks (long-wait patients) were 70% more likely to experience higher pain intensity at 6 months post-surgery. Dr. Chambers also referenced a study by Braybrooke et al. which found that a wait of 12 weeks or more for posterior lumbar spinal surgery for degenerative spinal disorders resulted in "less improvement in outcome following surgery."[1256]

1623. Dr. Sahjpaul testified that some of his patients waiting for epilepsy surgery at VGH "are waiting [...] sometimes in excess of a year, year and a half on some occasions,"[1257] despite the serious risks of seizures and potentially death described above.

1624. When presented with the suggestion that he only had a handful of patients on his wait list waiting for epilepsy surgery at VGH as of September 30, 2016 according to the SPR data, Dr. Sahjpaul explained the data did not reflect the number of epilepsy patients waiting for surgery and their wait,

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[1251] **Transcript Day 26,** Testimony of Dr. Ramesh Sahjpaul, p. 90, lines 30 to 46.
[1252] **Transcript Day 22**, p. 16, lines 13 to 25.
[1253] **Transcript Day 22**, p. 39, line 35 to p. 40, lines 16.
[1254] **Transcript Day 22,** p. 41, lines 8 to 16.
[1255] **Exhibit 289A,** p. 8, para. 6 **[CBE, Tab 54, a]**.
[1256] **Exhibit 289A**, Expert Report of Dr. Chambers, p. 8, para. 5**[CBE, Tab 54, a]**; **Exhibit 298B**, Tab 29, p. 269 (Quon), **Exhibit 298B**, Tab 30, p. 283 (Braybrooke) **[CBE, Tab 57]**.
[1257] **Transcript Day 22**, p. 14, lines 31 to 35.

stating that the "data doesn't even begin to address the number of patients that are definitely candidates for surgery that have not even been investigated" and shows "only the patients that we've managed to get through our one monitored bed at VGH."[1258]

1625. This reflects the reality that patients are suffering while waiting for a diagnosis, before they even have the ability to go on a waitlist for surgery.

b) Provision of Neurosurgery in BC

1626. The SPR data shows that patients across BC waiting for epilepsy surgery are waiting well beyond their maximum acceptable wait times for epilepsy surgery.

1627. For example, in 2017, the 90th percentile Wait Two time for "Refractory Epilepsy" (32BZAF), with a maximum acceptable wait time of 12 weeks, was 13.7 weeks from BFRD and 22 weeks from Decision Date.[1259] In 2018 (to March 31, 2018), the 90th percentile surgical wait for this diagnosis was 16.6 weeks from BFRD and 22 weeks from Decision Date, well beyond the maximum acceptable wait time of 12 weeks.[1260]

1628. Dr. Sahjpaul testified that the wait for his spine patients from symptom onset to surgery can be up to 2.5 years.[1261]

1629. Further, Dr. Sahjpaul testified that, not accounting for any imaging delays, his Wait One time from referral to consult, for spine patients at Lion's Gate Hospital can be "anywhere between six to 12 months".[1262]

1630. For his pain patients at St. Paul's Hospital, Dr. Sahjpaul testified that the wait from the point of the referral through to the surgery is on average about a 12-month wait.[1263]

1631. As of 2016, Dr. Sahjpaul's 90th percentile Wait Two time for all priority levels for "Cranial Surgery" was 4.5 weeks from BFRD and 7.7 weeks from Decision Date; for "Spinal Back/Surgery" his 90th percentile Wait Two time was 32.7 weeks from BFRD and 34.6 weeks from Decision Date;

[1258] **Transcript Day 26**, p. 61, lines 6 to 29.
[1259] **Exhibit 316C**, Tab 5, p. 24 **[CBE, Tab 69, a]**.
[1260] **Exhibit 316C**, Tab 6, p. 17 **[CBE, Tab 69, b]**.
[1261] **Transcript Day 22**, p. 45, line 44 to p. 46, line 9.
[1262] **Transcript Day 22**, p. 19, lines 4 to 30.
[1263] **Transcript Day 22**, p. 11, lines 14 to 23.

and for "Nerve Surgery" his 90th percentile Wait Two time was 16.8 weeks from BFRD and 17.2 weeks from Decision Date.[1264]

1632. A review of Dr. Sahjpaul's case by case wait time data shows that in the vast majority of cases, his patients waited far longer for their surgery than the maximum acceptable wait time for their surgery based on their urgency level.[1265]

1633. Dr. Sahjpaul testified that he knows from speaking to his neurosurgical colleagues across BC that there are no neurosurgeons with short waitlists who can simply start to see the patients that his group cannot see in a timely way.[1266]

1634. Again, as reflected in the SPR data above, this issue of long surgical wait lists for patients in the public system is not a matter applicable to only a few surgeons that can be resolved by simply referring patients elsewhere. Dr. Sahjpaul testified that when he receives referrals, he does "try to provide some advice to the referring physician and say, you know, can you please try somebody else, but that's usually not effective" because he knows his other colleagues do not have short wait lists even if patients were to be referred to them instead.[1267]

1635. Indeed, the SPR data show that overall neurosurgery wait times are lengthy in BC. As shown in the SPR data for end of the year 2016, across all surgeons and all health authorities, for all priorities, the 90th percentile Wait One time in the specialty of neurosurgery was 30.4 weeks and the 99th percentile Wait One time was 113.1 weeks. By the end of 2017, across all surgeons and all health authorities, for all priorities, the 90th percentile Wait One time had increased to 38.1 weeks and 99th percentile wait time had increased to 139.1 weeks.[1268]

1636. The 90th percentile Wait Two time in 2016 for neurosurgery across BC and all priorities, was 31.2 weeks from BFRD and 40.1 weeks from Decision Date. In 2017, the 90th percentile Wait Two time was 27.3 weeks from BFRD and 38.1 weeks from Decision Date.[1269]

1637. The SPR data demonstrate that many patients in BC are not receiving surgeries within the maximum acceptable wait times even for neurological conditions recognized as "severe" and

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[1264] **Exhibit 320A**, Tab 4, p. 4 **[CBE, Tab 73, c]**.
[1265] See for e.g. **Exhibit 320A**, Tab 4, pp. 10-13 **[CBE, Tab 73, c]**.
[1266] **Transcript Day 22**, p. 28, lines 8 to 13; See also, **Transcript Day 26**, p. 76, lines 8 to 15.
[1267] **Transcript Day 22,** p. 28, lines 1 to 13.
[1268] **Exhibit 431,** p. 387 **[CBE, Tab 102]**.
[1269] **Exhibit 431**, p. 389 **[CBE, Tab 102]**.

"progressive," as illustrated by the examples set out in **Appendix, Part A, Section VII(C)(viii), Wait Times Summary 1.** [1270]

1638. The evidence further shows that patients in BC are waiting well beyond 12 weeks for treatment of their lumbar spine diagnoses. The 12 week point was identified in the studies cited by Dr. Chambers, and referred to above, as the point beyond which patients experienced higher pain intensity six months after surgery.

1639. For example, in BC in 2016, patient[s] with "Persistent Neurogenic Claudication Secondary To Lumbar Spinal Stenosis" (33SCAP), which has a maximum acceptable wait time of 12 weeks, experienced a 90th percentile wait time for surgery of 63.8 weeks when measured from BFRD and 64.1 weeks when measured from DD.[1271]

1640. For "Patient[s] With Persistent Neurogenic Claudication Secondary To Lumbar Spinal Stenosis-Significant Difficulties With All Activities Of Daily Living" (33SCAH), the maximum acceptable wait time is two weeks. However, in 2016, the 90th percentile wait time for surgery was 44.8 weeks when measured from BFRD and 46.3 weeks when measured from DD.[1272]

1641. The wait time data above are just a small subset of the evidence showing that many patients have waited and continue to wait well beyond the maximum acceptable wait times for neurosurgery with the attendant risk of serious harm, as well as ongoing pain and disability while waiting.

1642. In 2012, Dr. Sahjpaul was only allotted one day of OR time per week on average, and despite being capable of performing a greater number of procedures weekly if he were to be given more OR time. Budgetary constraints in the public system restricted the number of procedures he could do.[1273]

1643. These budgetary constraints and lack of OR time have persisted and continue to hinder Dr. Sahjpaul's ability to provide timely care to his patients as reflected in his testimony in 2017.

1644. In his role as director of the surgery program at Lions Gate Hospital, Dr. Sahjpaul is "charged with determining or trying to allocate OR time between the surgeons, between the divisions and between the departments".[1274] He testified that at Lions Gate Hospital, there is not enough operating

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[1270] **Appendix,** Part A, Section VII(C)(viii), Wait Times Summary 1.
[1271] **Exhibit 316B**, Tab 4, Page 29 of 160 **[CBE, Tab 68, b]**.
[1272] **Exhibit 316B**, Tab 4, Page 28 **[CBE, Tab 68, b]**.
[1273] **Exhibit 83**, p. 3, paras. 9 to 11 **[CBE, Tab 28]**.
[1274] **Transcript Day 22**, p. 8, lines 16 to 21.

room time to meet the diagnosis-based wait times, and that even if they hired another surgeon, this would not help to resolve the issue as there is still a limited amount of OR time available for allocation regardless of how many surgeons are hired.[1275]

1645. In 2017, Dr. Sahjpaul was still only receiving on average one day per week of OR time at Lions Gate Hospital on Fridays. He also testified that he ends up losing some of these Fridays due to closures by the hospital, which he understands is primarily due to budgetary issues.[1276] The four other neurosurgeons at Lions Gate Hospital are also given approximately one day per week of OR time each.[1277]

1646. Dr. Sahjpaul also testified that he only receives about four hours per week at St. Paul's Hospital to perform spinal cord stimulation procedures on Mondays. Again, some of these days are lost to planned hospital closures.[1278]

1647. Further, Dr. Sahjpaul receives approximately five to seven days per year to perform surgeries on epilepsy patients who are not responding to medications, at Vancouver General Hospital. This amounts to only about 20 epilepsy procedures performed per year during this operating time, and there are no other similar programs for epilepsy surgery anywhere else in BC.[1279]

1648. Dr. Sahjpaul testified that based on the data available, we should be doing approximately 150 or 160 of these surgeries for intractable epilepsy per year in BC in order to keep up with demand and service the patients who need this treatment.[1280]

c) Use of Private Clinics

1649. Dr, Sahjpaul spends approximately half to three-quarters of a day per week doing consultations at Specialist Referral Clinic,[1281] and approximately 3 days per month performing surgeries at Cambie.[1282]

[1275] **Transcript Day 22**, p. 41, lines 21 to 35.
[1276] **Transcript Day 22**, p. 6, lines 21 to 47.
[1277] **Transcript Day 22**, p. 7, lines 37 to 40.
[1278] **Transcript Day 22**, p. 12, line 42 to p. 13, line 12.
[1279] **Transcript Day 22**, p. 14, lines 4 to 25.
[1280] **Transcript Day 22**, p. 14, line 44 to p. 15, line 6.
[1281] **Transcript Day 22**, p. 26, lines 27 to 34.
[1282] **Transcript Day 22**, p. 42, lines 37 to 45.

1650. Dr. Sahjpaul explained that his provision of neurosurgeries privately to patients is helping to provide more timely care to all patients, by offsetting the number of surgeries waiting in the already overburdened public system.

1651. Dr. Sahjpaul gave evidence that, by providing services privately, he is able to increase the number of overall surgeries he performs per month, performing about 8 to 10 procedures more per month than he would be able to if he were only working in the public system.[1283]

1652. In 2012, Dr. Sahjpaul affirmed that his ability to perform private surgeries for patients in fact facilitates more timely care for patients in the public system, and does not reduce his work in public hospitals:

> 24. My work at SRC and CSC does not reduce my work in public hospitals. Rather, it enables me to fully utilize my surgical skills and time, which benefits the residents of British Columbia. Also, by operating at CSC, I am able to decongest my surgical wait list in the public system, especially for larger cases. In this way, my work at SRC and CSC facilitates more timely care in the public sector.[1284]

1653. Dr. Sahjpaul explained that if he only did consultations in the public system instead of also doing consultations at SRC, this would "add onto [his] current waiting list for surgery in the public system" and "overall patients would be waiting even longer" for their surgery.[1285]

1654. Dr. Sahjpaul explained that even if he did more consults overall to shorten the Wait One time patients have to wait from the time of referral to the time of consult, this would simply worsen the Wait Two time that his patients have to wait for their surgery.[1286]

1655. As Dr. Sahjpaul testified, in his experience, the relationship between the private and public health care sectors in BC is a complementary one, explaining, "I believe it's a complementary relationship in that the patients that I operate on at Cambie otherwise would end up having to see me in the public system, which would strain my current capacity to manage those patients."[1287]

d) Patient Experience – Carol Welch

[1283] **Exhibit 83**, p. 5, para. 20 **[CBE, Tab 28]**.
[1284] **Exhibit 83**, pp. 5 to 6, para. 24 **[CBE, Tab 28]**.
[1285] **Transcript Day 22**, p. 27, lines 22 to 27.
[1286] **Transcript Day 22**, p. 42, lines 16 to 23.
[1287] **Transcript Day 22**, p. 45, lines 33 to 43.

1656. The experience of patients waiting for spinal surgery in the public system, and the benefit to them of having access to earlier consultation and/or surgery in private clinics, is illustrated in the evidence provided by a Patient Intervenor Carol Welch, who has since passed away, and was not cross-examined by either party on her evidence.

1657. Ms. Welch learned from her physician around mid-November 2006 that she had nerve damage and a herniated disc in her back that would require a consultation with a surgeon. Her family physician's office told her the first available appointment in the public system with Dr. Richard Chan, a neurosurgeon, was July 4, 2007. Her family physician's office told her that there was no other surgeon to whom she could be referred sooner. [1288]

1658. Ms. Welch felt she could not wait until July for a consult, so she contacted False Creek Surgical Centre, and was able to see Dr. Chan for a private consult on December 20, 2006.[1289]

1659. Dr. Chan confirmed that Ms. Welch had a herniated disc and recommended surgery. Dr. Chan informed Ms. Welch that she could have her surgery done faster privately than in the public system, but Ms. Welch chose to wait to have her surgery in the public system.[1290]

1660. While Ms. Welch waited for surgery "she was in a great deal of pain," she "could only work half days at her job," and her condition required that she see her family physician approximately every 10 days to assess her condition and continue her pain medications.[1291]

1661. Ms. Welch ultimately had a bilateral L4-5 discectomy and L5 foraminotomy on May 3, 2007 in the public system, about 20 weeks after her consultation with Dr. Chan.[1292] This was two months sooner than her consult with Dr. Chan would have occurred in the public system.

1662. Had she not seen Dr. Chan for a consult privately, she would have still been waiting for a consult with him for another two months after that surgery date, and then waited several months more for surgery. She would have been in pain, unable to work full time, and on pain medications throughout this period.

[1288] **Exhibit 537**, ASF of Carol Welch, p. 2 to 3, paras. 5 to 6 **[CBE, Tab 141]**; and **Exhibit 538,** Affidavit #1 of Welch, p. 2, para. 6 **[CBE, Tab 142].**
[1289] **Exhibit 537,** p. 3, paras. 7 to 8 **[CBE, Tab 141].**
[1290] **Exhibit 537,** p. 3, paras. 9 and 10 **[CBE, Tab 141].**
[1291] **Exhibit 537,** p. 3, para. 10 **[CBE, Tab 141]**; and **Exhibit 538,** Affidavit #1 of C. Welch, p. 4, para. 14 **[CBE, Tab 142].**
[1292] **Exhibit 537**, p. 3, para. 11 and Tab 8 **[CBE, Tab 141]**.

1663. Her Wait Two time for her lumbar discectomy was still significantly longer than the 12-week period beyond which patients are shown to experience a higher pain intensity post-surgery in the studies referred to by Dr. Chambers.[1293]

1664. In light of the above, it is clear that prohibiting surgeons such as Dr. Sahjpaul from providing care to patients privately would only serve to lengthen the wait times for neurosurgery patients in BC's public system, which are already well beyond the maximum acceptable wait times for these conditions, with resulting additional harm to patients waiting for diagnosis and treatment for these conditions.

(ix) Pain Management Procedures

1665. Acute and chronic pain afflicts thousands of British Columbians on an ongoing basis. The Court heard evidence about the experience for patients of chronic pain, and the treatment of chronic pain through image-guided injections from Dr. Mark Adrian. He testified viva voce and by affidavit.[1294]

1666. Dr. Adrian is a physiatrist, with sub-specialty training in Spine, Musculoskeletal & Occupational Medicine. He specializes in interventional spinal medicine, which includes the treatment of disabling acute and painful conditions through use of image-guided injection treatments for lumbar disc herniations, stenosis and sciatica.[1295]

1667. A herniated disc can be an extremely painful, disabling condition. It puts pressure on the sciatic nerve, which cause severe pain down the leg and sometimes neurologic sequelae such as weakness and numbness. It can be disabling to the extent that patients cannot get out of bed, walk or do their activities of daily living or work. [1296]

1668. Stenosis is a degenerative narrowing of the spinal channel that often develops as a result of arthritis in the back. It can cause severe pain with standing and walking and nerve pain down the legs.[1297]

1669. Since 2001, Dr. Adrian has worked in the Spine Centre, Department of Orthopedics and Division of Physical Medicine at Vancouver General Hospital (VGH) and in Musculoskeletal

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[1293] **Exhibit 289A**, p. 8, para. 5 **[CBE, Tab 54, a].**
[1294] **Transcript Day 31**, Testimony of Dr. Adrian, dated November 2, 2016, p. 65-84; **Exhibit 392** Affidavit #2 of Dr. Adrian, dated February 2, 2018 **[CBE, Tab 92]**; **Transcript Day 122**, Testimony of Dr. Adrian, dated October 5, 2018
[1295] **Exhibit 392**, pp. 2-3, paras 14-15 **[CBE, Tab 92].**
[1296] **Transcript Day 31**, p. 68, lines 4 to 16
[1297] **Transcript Day 31**, p. 69, lines 36 to 47

Medicine and Interventional Spine Medicine at Burnaby Hospital (BH). He also provides injection treatments at Cambie and does consultations at SRC.[1298]

1670. Dr Adrian owns 20 shares in SRC, for which he receives dividends amounting to approximately $6700 per year.[1299]

1671. He is also a Rehabilitation Consultant to the WCB, and provides injection treatments at Cambie on a private pay basis and for the WCB.[1300]

1672. Dr. Adrian also engages in clinical and academic teaching of UBC residents and fellows in the area of musculoskeletal and spine medicine.[1301]

1673. Dr. Adrian testified that his patients are in substantial and debilitating pain when they are referred to him for consultation and treatment. Most are on painkillers while they wait for treatment, some requiring opioids. In addition, the pain often requires reduced activity and limits the patients' ability to work. Functional capacity is often severely impaired.[1302]

1674. With regard to chronic pain, Plaintiffs' expert witness, and emergency physician, Dr. Les Vertesi also explained that he had targeted BC Health Services Purchasing Organization funds towards procedures to alleviate pain, because he "realized how destructive this is to individuals and also families," but felt this area had been neglected as "no one was dying" or "bleeding to death" from these less urgent conditions.[1303] In describing his wife's own suffering from chronic nerve root pain syndrome requiring spinal epidural injections, Dr. Vertesi stated in his expert report, "we both experienced what it was like to live with debilitating pain that stopped all normal family activities including work."[1304]

1675. Dr. Vertesi also explained in his expert report, that during activity based funding by the BC government, injections to alleviate chronic nerve root pain were contracted out to a private facility due to capacity constraints at St. Paul's Hospital.[1305]

[1298] **Exhibit 392**, p. 2, paras 1, 10-11 **[CBE, Tab 92].**
[1299] **Transcript Day 122**, p. 13, line 4 to p. 14, line 13
[1300] **Exhibit 392,** Exhibit A, p. 2 **[CBE, Tab 92].**
[1301] **Exhibit 392,** Exhibit A, p. 7 **[CBE, Tab 92].**
[1302] **Exhibit 392**, p. 4, paras 27-31 **[CBE, Tab 92].**
[1303] **Transcript Day 113**, Testimony of Dr. Vertesi, p. 74, lines 13 to 23.
[1304] **Exhibit 334,** Expert Report of Dr. Vertesi, Tab 1, p. 6 **[CBE, Tab 79].**
[1305] **Exhibit 334**, Tab 1, p. 6 **[CBE, Tab 79].**

1676. Dr. Adrian provided evidence that he prioritizes his patients by providing treatments more quickly to patients who are in the most severe pain, but each time he does so means that other patients wait longer. Dr. Adrian's patients often have to wait longer than would be desirable and where there is no medical reason for waiting for treatment.[1306]

1677. Dr. Adrian is provided two half-day periods per week in the radiology suite at Burnaby Hospital, in which he can carry out four injection procedures per session. He also does consultations at both BH and at VGH for four or five half days per week. Dr. Adrian fulfills all of the time he is given in the public system for injections and consultations. He has attempted to obtain additional radiology suite time in public hospitals over the years in order to treat more public patients, but has been unsuccessful.[1307]

1678. On a patient count basis, approximately 85% of Dr. Adrian's work is MSP work (i.e. public patients). The other 15% is WCB, medico-legal, third party payor (such as insurers, ICBC, RCMP, military), and private pay patients.[1308]

1679. Approximately 90% of Dr. Adrian's income from non-MSP work comes from medical-legal assessments, for which he is paid substantially more per assessment than for any other type of work.[1309]

1680. The other 10% of Dr. Adrian's non-MSP income comes from consultations and treatment paid for by third party payors, such as ICBC, employers, private insurers, and private pay patients, the military and the RCMP. These consultations are done at SRC and the injection treatments are done at Cambie. Dr. Adrian schedules his Cambie procedures at the beginning of the day or at lunchtime.[1310]

1681. Dr. Adrian also does consultations at the WCB Visiting Specialist Clinic in Richmond, where he does one or two half-day sessions per week. He is paid between $2000 and $2500 per session.[1311]

1682. If WCB patients seen in consultation at VSC would benefit from an injection treatment, these will be performed at Cambie, leaving his limited time in the public system to treat patients on his public wait list. Dr. Adrian is paid $1100 by WCB for each injection procedure. When Dr. Adrian provides injection treatments in the public system, he bills MSP and is paid approximately $400 per

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[1306] **Exhibit 392**, p. 4, para 24 **[CBE, Tab 92].**
[1307] **Transcript Day 31**, p. 79, lines 11 to 23
[1308] **Transcript Day 122,** p. 22, lines 2 to 9
[1309] **Transcript, Day 122,** p. 23, lines 12-24
[1310] **Transcript Day 122**, p. 21, lines 27 to 33
[1311] **Transcript Day 122**, p. 11, lines 20 to 43

procedure. When he provides these same treatments at Cambie (whether paid by third party payors or by private pay patients) he is paid $500 per injection procedure.[1312]

1683. Occasionally, Dr. Adrian's MSP patients who wish to have their treatments done more quickly will ask if he performs injection treatments privately, and he will direct them to Cambie. In that case (which is rare), if they pursue this option, he will perform their injection treatment at Cambie.[1313]

1684. The Court did not permit Dr. Adrian to testify about his wait times based on his personal knowledge and experience. Instead, he was required to provide documentary evidence of his wait times.

1685. The Ministry of Health has elected not to track wait times for pain management injections, and does not require reporting of these wait times by physicians or Health Authorities. While the Defendant could access this information from MSP billing records, it advised the Court that this would be difficult and declined to do so.[1314]

1686. The Court refused to admit Dr. Adrian's medical records which contain all of the information from which wait times can be determined. The Court was only prepared to admit tables of wait times prepared personally by Dr. Adrian and set out in his affidavit based on his review of all of the medical records and his calculation of the wait times.[1315] The Court was advised that Dr. Adrian was unable to perform this work and therefore no affidavit could be tendered. As a result, there is no specific evidence before the court of the wait times for pain management consultations and treatments.

1687. Nevertheless, Dr. Adrian's evidence clearly established that patients waiting for an image-guided injection treatment suffer daily from debilitating pain and that there was no medical reason to delay their treatment. The only reason patients were waiting is that Dr. Adrian and others providing these treatments were not provided with sufficient time in the radiology suite to perform the minimally invasive procedure that would give patients almost immediate relief.

(x) Dental Surgery

1688. The provision of timely dental surgery has been an issue in British Columbia for some time.

[1312] **Transcript Day 122**, p. 22, line 36 to p. 23, line 11
[1313] **Transcript Day 122**, p. 10, lines 4 to 47
[1314] **Transcript Day 103**, p. 36, lines 5 to 8, p. 36, lines 18 to 32
[1315] **Transcript Day 103,** p. 48, lines 12 to 25

1689. While dental health is an important aspect of general health, especially for children, dental care is one of the areas which is excluded from coverage under the public health care system, other than in specific limited circumstances.

1690. As a result, the vast majority of dental care in the province (and across Canada) is provided on a private pay basis. While many British Columbians have the benefit of private dental insurance through their employment or purchased individually, which covers a significant portion of the cost of basic dental care, there is usually a co-pay requirement as well as limits on coverage. And, some British Columbians, who do not have private insurance, must pay for all dental care personally.

1691. There can be overlaps between the services provided by dentists (which the patient must pay for privately or have covered by private insurance) and those which are provided by physicians (which are covered by the public system and cannot be provided on a private pay basis).

1692. The situation of the Patient Intervenor, Myrna Allison, is an example of the overlap between treatment provided by dentists, which patients must pay for privately, and treatment provided by physicians which is covered by MSP and cannot be paid for privately.

1693. Redacted due to evidence subject to sealing order.

1694. **Redacted due to evidence subject to a sealing order.**

1695. Ms. Allison did not want to have to pay for this service, and so opted to have it performed by a physician, under the public health care plan. She had to wait longer for this than if she had had the biopsy performed by Dr. Naito.

1696. **Redacted due to evidence subject to sealing order;**

[1316] **Redacted due to evidence subject to sealing order;**
[1317] **Redacted due to evidence subject to a sealing order.**

1697. Ms. Allison thus had the option of choosing whether to pay privately for her medically necessary biopsy (and have it done more quickly) or to wait and have the biopsy, and the associated referrals and consultations, done in and paid for by the public system. She chose to wait for care in the public system rather than pay privately.

1698. Dr. Nouri, a pediatric dental surgeon, testified about the provision of dental surgery and treatment for children in British Columbia.

1699. There are a wide range of pediatric dental diseases and conditions that are health-threatening, and in some cases, life-threatening for children. The most common of these is dental caries, which as Dr. Nouri explained, is a contagious and progressive disease that, due to bacteria in the mouth, is breaking down the teeth in the child's mouth. The infection can cause the nerves in the tooth to die, and can also spread to the jaw, and ultimately to the face (cellulitis) and/or neck (Ludwig's angina).[1319]

1700. As described in a 2013 CIHI report:

> The consequences of ECC [early childhood caries] can be dire. Pain, difficulty eating and sleeping, speech difficulties and poor self-esteem may occur, affecting growth and the ability to concentrate and function. Quality of life can be seriously impaired.[1320]

1701. Dental caries is the leading cause of day surgery for children ages one to four years, and accounted for 31% of day surgeries in this age group in the period 2010-2012.[1321]

1702. In addition, there are other harmful conditions such as retained primary teeth, periodontitis (infection of the gum tissue around a tooth), other infections and dental abscesses, osteomyelitis

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[1318] **Redacted due to evidence subject to sealing order;**
[1319] **Transcript Day 66**, Testimony of Nouri, p. 7, line 34 to p. 9, line 14, p. 12, line 34 to p. 14, line 26; **Exhibit 26, Tab K** (P-CATS), p. 2-3 **[CBE, Tab 16].**
[1320] **Exhibit 433E,** p. 4190 **[CBE, Tab 107].**
[1321] **Exhibit 433E**, Vol 5, p. 4196 **[CBE, Tab 107].**

(infection of the bone), ankyloglossia (attachment of the tongue). There can also be cancerous lesions in the mouth.[1322]

1703. As explained by Dr. Nouri, the vast majority of treatment for these conditions, including surgical treatment, is provided on a private pay basis. This includes the dental surgery that was being previously provided by community pediatric dental surgeons at BCCH.[1323]

1704. It is only where the condition has progressed to the point that it involves other organs and is life threatening to the patient that it is covered by the public health care system.

1705. Pediatric dental treatment and surgery that can be done under local or no anesthetic is generally done in the dentist's office.

1706. However, in some cases, due to the nature of the condition and/or the mental, emotional or physical status of the patient, the assessment and/or surgical treatment can only be done under a general anesthetic. In that case, the treatment must be performed in a surgical facility, with an anesthesiologist present.[1324]

1707. In Dr. Nouri's case, he performs virtually all such pediatric dental surgeries at Cambie Surgery Centre. Cambie has pediatric anesthesiologists on its medical staff, and has fully equipped ORs for this purpose. While the anesthesiologists bill MSP for their work on these cases,[1325] the fees of the dental surgeon and the facility fee are paid privately by the patient or, if they are covered by private dental insurance, by the insurer.

1708. There are some patients whose families qualify for income assistance from the provincial government, and there is some public funding available for dental treatment and surgery for these patients.[1326] Further, as Dr. Nouri explained, the goal at Cambie is to look after patients, so when patients do not have insurance, the dentists and Cambie will work with the family to make it affordable through discounts or for free, as in the case of a Syrian refugee, the dental care was provided at no cost and Cambie waived its facility fee.[1327]

[1322] **Exhibit 432,** p. 1312 **[CBE, Tab 103].**
[1323] **Transcript Day 66**, p. 6, lines 5 to 23
[1324] **Transcript Day 66**, p. 6, lines 5 to 23
[1325] As explained by Ms. Wannamaker, this is arranged through contracts with PHSA. **Transcript, Day 135**, Testimony of Ms. Wannamaker, February 21, 2019, p. 7, line 35 to p. 8, line 25
[1326] **Transcript Day 66,** p. 17, lines 22 to 37
[1327] **Transcript, Day 66**, p. 42, lines 10 to 19

1709. Where a child is under two years old and/or is obese or has other medical problems, they are not eligible to be treated at a private surgical facility such as Cambie, based on College of Physicians and Surgeons guidelines, and must be treated in a full-service hospital.[1328] BCCH is the primary centre for pediatric dental surgery in the province. The vast majority of cases (95%) at BCCH are paid for privately by the patient (or their parents) or through private insurance.[1329]

1710. Prior to mid-2015, Dr. Nouri and other community pediatric dental surgeons were allocated some limited OR time at BCCH to provide dental surgeries for their patients who are not eligible for treatment at Cambie. However, due to pressures on OR time at BCCH and demand for dental surgeries for BCCH inpatients, the OR time at BCCH for community pediatric dental surgeons was repeatedly cut back and eliminated altogether in 2015.[1330]

1711. Dr. Nouri also testified that the wait times data from the SPR produced by the Defendant which suggested that his Wait 2 time from the decision for surgery to the surgery date were very short (an average of 4.4 weeks for all priorities at the 90th percentile), was inaccurate, because his office waited until he was given an OR date to send in the booking forms for his patients, although they have been waiting six to nine months by that point.[1331]

1712. Dr. Nouri's evidence is also entirely consistent with the data reported by the 2013 CIHI paper on Early Childhood Caries:

> Even while day surgery for ECC is considered an example of preventable health care use and costs, there are concerns that children suffering from ECC do not have timely access to care. A recognized lack of timely dental treatment for young children resulted in the identification of dental treatment under general anesthesia as one of six pediatric surgical areas included in the Canadian Pediatric Surgical Wait Times Project in 2007. To put this into context, there were approximately 2,490 ECC-related day surgery operations performed annually in BC from 2010-2011 to 2011-2012. As of June 30, 2013, there were 1,303 children awaiting pediatric dental surgery in BC. Some of these children had to wait six months or longer for their care. Half of the children on the waiting list received surgery within 6.3 weeks, and 90% received surgery within 27.6 weeks. While timely access to dental care for children is necessary, the use of hospital resources for ECC has contributed to prolonged wait times for other urgent pediatric care.[1332]

[1328] **Transcript Day 66,** p. 42, line 20 to p. 43, line 7
[1329] **Transcript Day 66,** p. 40, lines 12-37
[1330] **Transcript Day 66,** p. 18, lines 12 to 30
[1331] **Transcript Day 66**, p. 21, line 10 to p. 22, line 33; **Transcript, Day 66**, p. 36, line 8-25
[1332] **Exhibit 433E,** p. 4204 **[CBE, Tab 107].**

1713. Both adult and pediatric dental surgery (which does not include the surgeries provided by community dental surgeons on a private pay basis but only more complex surgeries), is also one of the three "target areas" that the Ministry of Health identified for its three-year Surgical Services Plan for 2017-2020 (along with hip and knee replacements), and for which additional targeted funding was provided to the Health Authorities over this three year period. This was because it was recognized that British Columbians were waiting too long for necessary dental surgeries.[1333]

1714. As part of the effort to improve wait times for dental surgeries, several of the Health Authorities have contracted with private clinics to provide these surgeries to patients on the public system wait list.[1334]

1715. As Exhibit 560 shows, BC as a whole did not meet the target of "no more than 5% of patients waiting longer than 26 weeks for dental surgery" for the 2018-19 fiscal year.[1335] PHSA was the only health authority to meet this target for 2018-2019, but it must be noted that this was based on measuring Wait Two from BFRD, as opposed to Wait Two from Decision Date, which is the intended Wait Two measurement under P-CATS.

1716. Further, it must be noted that 26 weeks (from Decision Date) is the longest maximum acceptable wait time for any form of dental surgery under PCATS. It is only appropriate for those conditions which are not progressive. As Dr. Nouri testified, and as the PCATS shows, there are very few pediatric dental conditions for which surgery can or should be delayed for 26 weeks. The vast majority of pediatric dental conditions requiring surgery have a Maximum Acceptable Wait Time of three months or less.[1336] Advanced dental caries (visible carious lesions and/or pain)", for example, has a maximum acceptable wait time of 12.86 weeks under PCATS.[1337]

1717. Thus, meeting a target of no more than 5% of patients waiting longer than 26 weeks for dental surgery (even if that target were being met, which is not the case) would still mean that the majority of pediatric patients in British Columbia are waiting far longer than the maximum acceptable wait time for surgery for their (likely progressive) dental condition.

[1333] **Exhibit 514,** p. 1 **[CBE, Tab 134].**
[1334] **Exhibit 431,** pp. 703-707, 731, 736, 776 **[CBE, Tab 102].**
[1335] **Exhibit 560,** p. 4 **[CBE, Tab 148]; Exhibit 514,** p. 1 **[CBE, Tab 134].**
[1336] **Exhibit 413,** Exhibit F **[CBE, Tab 96].**
[1337] **Exhibit 316D**, Tabs 7-12, p. 2 of all tabs **[CBE, Tab 70].**

1718. This is clearly demonstrated by the SPR wait time data. Exhibit 0316D contains the SPR reports showing the percentage of pediatric dental cases completed within their maximum acceptable wait time, based on PCATS, for the years 2013 to 2018. As can be seen from this data, not only do the vast majority of pediatric dental conditions have a maximum acceptable wait time for surgery of far less than 26 weeks, but many of the more common pediatric dental surgical procedures have less than 50% of patients typically receiving surgical treatment within the maximum acceptable wait time for their condition.[1338]

1719. Exhibit 315A also shows that many adult patients in BC are waiting longer than their maximum acceptable wait time for their dental surgeries, of which the majority, again, have a maximum acceptable wait time of less than 26 weeks.[1339]

1720. For example, for adult patients who have been diagnosed with "Dental Disease – Severe Pain/Infection with Severe Medical Risk", only 43.5% in 2017 and 40% in 2018 received their surgery within the maximum acceptable wait time of 2 weeks.[1340]

1721. For adult patients who have been diagnosed with "Erupted Teeth – Associated with Severe Dental Disease Requiring Extraction", only 31.3% in 2017 and only 37.5% in 2018 received their surgery within the maximum acceptable wait time of 4 weeks.[1341]

1722. Likewise, for adult patients who have been diagnosed with "Chronic Oral Infection", only 33.3% in 2017 and only 25% in 2018 received their surgery within the maximum acceptable wait time of 2 weeks.[1342]

1723. Thus, despite dental surgery having been a Canadian priority for children since 2007 and a BC priority for adults since 2017, many BC adults and children are still waiting far longer than the maximum acceptable wait times for surgery for their dental conditions in the public system, and far too long, generally. They are suffering harm in terms of pain, disfigurement, and progression of disease, as a result.

(xi) Cardiac And Vascular Surgery

[1338] **Exhibit 316D**, Tabs 7-12. See, for example, Supernumerary Tooth, with or without associated pathosis (Tab 12, p. 13); Periodontitis (Tab 12, p. 12); and dental caries, including advanced dental caries (Tab 12, p. 11) **[CBE, Tab 70].**
[1339] **Exhibit 315A**, Tab 5 **[CBE, Tab 64, e].**
[1340] **Exhibit 315A**, Tab 5, p. 19 **[CBE, Tab 64, e].**
[1341] **Exhibit 315A**, Tab 5, p. 9 **[CBE, Tab 64, e].**
[1342] **Exhibit 315A**, Tab 5, p. 18 **[CBE, Tab 64, e].**

1724. It is well-established that waiting for heart surgery creates an increased risk of death.

1725. In his expert report, Dr. Gordon Matheson referred to a number of studies which make this clear.

1726. First, patients waiting for aortic valve replacement are likely to deteriorate and have a significant risk of death while waiting. In one study referenced by Dr. Matheson which was carried out in Vancouver, it was found that 10.5% of patients with severe symptomatic aortic valve stenosis who were waiting for aortic valve replacement died while waiting; 60% with no warning. The mean waiting time for the procedure was 106.8 days.[1343]

1727. These studies show that waiting for aortic valve replacement carries a risk of mortality which increases the longer the patient waits, regardless of the patient's condition when placed on the wait list. Thus, any delay in aortic valve replacement surgery increases the risk of mortality for all patients.

1728. Likewise, it is well-established that patients waiting longer for coronary artery bypass grafting surgery are more likely to die post-operatively in hospital.

1729. Dr. Matheson referenced two studies which were carried out in British Columbia by Sobolev et al., which examined the relationship between length of wait for surgery and the risk of in-hospital mortality in the immediate post-operative period.

1730. The first study found that patients who received their surgery after the maximum acceptable wait time (six or 12 weeks, depending on urgency) were significantly more likely to die post-operatively (1.5 % vs. 1 % death rate) while in hospital than those who received their surgery within the recommended time frame. Further, the risk of dying increased the longer the patient waited for surgery -- there was a 5% increase in the odds of an in-hospital death for every additional month of delay before surgery.[1344]

1731. The second study compared in-hospital mortality rates for patients who received their coronary artery bypass graft ("CABG") surgery within shorter time frames recommended by the Canadian Cardiac Society (two weeks or six weeks, depending on urgency) (the "short wait"), the longer time frames used in British Columbia for the same urgency levels (six weeks or 12 weeks) (the

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[1343] **Exhibit 274**, Tab A, Expert Report of Dr. Matheson, p. 8, study cited at Footnote 13, Tab 13, p. 169-170 **[CBE, Tab 53].**

[1344] **Exhibit 274**, p. 8; study cited at Footnote 9, p. 136-143, specifically p. 137 **[CBE, Tab 53].**

"prolonged wait") and those who waited longer than the provincial targets (the "excessive wait"). The results were that patients in the excessive delay group had the highest percentage rate of death in the immediate post-operative period (1.3%), while those in the short wait group had the lowest percentage rate of death (0.6%). The prolonged wait group had a 1.1% death rate. This was despite the fact that those in the short and prolonged wait groups were sicker than those in the excessive wait group.[1345]

1732. With respect to the risk of death while waiting, a further study with respect to CABG surgery demonstrated that the risk of death while waiting for surgery increases 11% each month of waiting for CABG surgery. The impact of waiting on mortality was most pronounced for more urgent patients who were not operated on within their recommended maximum wait time. Overall, 6% of the patients on the wait list died before their procedure, with a mean wait time for 55 days.[1346]

1733. Patients waiting more than three months for CABG surgery also experience increased morbidity while waiting, as compared with patients waiting less than three months, even where there was no difference between the two groups when they were placed on the wait list. Both Dr. Chambers and Dr. Matheson cite the same study from Quebec which found that patients waiting more than three months for CABG had reduced physical functioning, vitality, social functioning and general health both immediately prior to and six months after the procedure, showing that they deteriorated more while waiting, and also had a poorer post-operative outcome. In addition, patients who waited longer than three months were significantly less likely to return to work and were at increased risk for stroke and myocardial infarction.[1347]

1734. The harm from waiting for cardiac bypass surgery is also addressed by Dr. Keith Chambers in his expert report.

1735. Dr. Chambers opines that: "... in the case of cardiac bypass surgery, waiting time for surgery causes an increased risk of in-hospital mortality, an increased risk of mortality while on the wait list relative to those with a shorter wait time and likely physical and mental hardship prior to and after surgery." [1348]

1736. In support of this opinion, Dr. Chambers relied upon the largest systematic review of risks of mortality for patients undergoing CABG versus medical therapy for ischemic heart disease, which

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[1345] **Exhibit 274**, p. 8; study cited at Footnote 10, p. 144-153, specifically p. 150 **[CBE, Tab 53].**
[1346] **Exhibit 274**, p. 8; study cited at Footnote 14, p. 171-177, specifically p. 172 **[CBE, Tab 53].**
[1347] **Exhibit 274**, p. 8, study cited at Footnote 15, p. 178-183, specifically p. 179 **[CBE, Tab 53].**
[1348] **Exhibit 289A**, Expert Report of Dr. Chambers, p. 7, References 1-10, p. 60-137 **[CBE, Tab 54, a].**

found a significant benefit for CABG over medical therapy. The risk of mortality from the disease increased from 15.8% at five years to 30.5% at ten years. As Dr. Chambers explained, this shows an increased risk of mortality the longer one is on a wait list for CABG.[1349]

1737. Dr. Chambers also reviewed and relied upon two of the Sobolev studies referenced by Dr. Matheson, as well as two additional studies published by the Sobolev group.

1738. A 2006 BC study found that despite having less serious heart disease, patients who were categorized as non-urgent had a risk of dying while waiting for surgery which was 1.66 times that of the "semi-urgent" group, due to the non-urgent group being on the wait list longer.[1350]

1739. A similar finding was reached by Sobolev et al in a 2013 BC study, which found that the death rate per patient week was similar in the semi-urgent and non-urgent groups of patients waiting for CABG surgery, but because the non-urgent patients were waiting longer, they had double the cumulative incidence of death while waiting for surgery.[1351]

1740. Dr. Matheson characterizes these latter two studies as demonstrating failure in prioritization, as the patients who were prioritized as less urgent in fact had higher death rates due to waiting longer for surgery.[1352]

1741. Whether or not this is characterized as a "failure" of prioritization, what these studies show is that all patients waiting for CABG carry a risk of mortality which increases the longer the patient waits, regardless of the patient's condition when placed on the wait list. Thus, any delay in CABG increases the risk of mortality for all patients.

1742. Nonetheless, BC continues to prioritize patients for CABG into urgency categories. In BC, there are 3 priority categories for CABG surgery; Priority 1 (2 weeks), Priority 2 (6 weeks), and Priority 3 (26 weeks)[1353]. Regardless of the urgency category, all patients waiting on the CABG wait list are at risk of death and the longer they wait, the greater the risk.

1743. Dr. Chambers and Matheson also opined on harms from waiting for carotid endarterectomy for carotid stenosis (i.e. vascular surgery to treat the narrowing of the artery).

[1349] **Exhibit 289A,** Appendix A, p. 9 **[CBE, Tab 54, a].**
[1350] **Exhibit 289A,** p. 10; study cited at Footnote 4, p. 82-89, specifically p. 83 **[CBE, Tab 54, a].**
[1351] **Exhibit 289A,** p. 7; study cited at Footnote 7, p. 108-122, specifically p. 109 **[CBE, Tab 54, a].**
[1352] **Exhibit 274,** p. 7, para 5 **[CBE, Tab 53].**
[1353] **Exhibit 322,** Tab 2, p. 4 **[CBE, Tab 76, b].**

1744. Dr. Matheson explained that carotid imaging assesses whether the carotid artery is normal size or whether it is blocked with cholesterol, plaque, thrombus or clot. If it is significantly blocked then surgery (endarterectomy) is needed to remove the obstruction. He also explained that a transient ischemic attack (TIA) is a reduction of oxygen to the brain for a limited period of time.[1354]

1745. Dr. Chambers opines there is an increased risk of otherwise preventable stroke prior to surgery:

> A study out of the U.K. on patients undergoing carotid endarterectomy for carotid stenosis shows that the median time to referral was 9 days, the median time to imaging was 33 days and the median time to surgery was 100 days. For those undergoing carotid endarterectomy, 6% had surgery within 2 weeks of onset of symptoms and less than half within 12 weeks (47%). The **risk of stroke prior to surgery was much higher** with a wait of 12 weeks (32%) as opposed to a shorter wait of 2 weeks or less (21%). The authors concluded that "Delays to carotid imaging and endarterectomy after TIA or stroke in the United Kingdom are similar to those reported in several other countries and are associated with **very high risks of otherwise preventable early recurrent stroke**.[1355]

1746. Dr. Matheson also referenced this same study and opined that delays in the provision of carotid imaging and endarterectomy following a transient ischemic attack or stroke cause a high risk of otherwise preventable recurrent stroke.[1356]

1747. In British Columbia, the wait time data for carotid stenosis in 2017 and 2018 (to March 31, 2018) makes clear that some symptomatic patients are waiting too long for this procedure, with resultant very serious risks to their health, including a significantly increased likelihood of a preventable recurrent stroke (see **Appendix, Part A, Section VII(C)(xi), Table 1**).[1357]

1748. As can be seen from Table 1, the 90th percentile wait from BFRD was more than twice the maximum acceptable wait times for carotid stenosis with symptoms.[1358]

1749. Patients are also waiting too long to receive stroke preventative surgery for carotid stenosis with narrowing of the artery showing greater than 70% occlusion. The risk of adverse consequences, in this case a stroke or transient ischemic attack, is present during the whole wait but increased after

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[1354] **Transcript Day 90**, p. 18, line 47 to p. 19, line 23.
[1355] **Exhibit 289A,** p. 8; citing Footnote 28 in **Exhibit 289B**, p. 262-267, specifically p. 263 **[CBE, Tab 54].**
[1356] **Exhibit 274,** p. 8; citing Footnote 22, p. 229-234, specifically p. 230 **[CBE, Tab 53].**
[1357] **Appendix**, Part A, Section VII(C)(xi), Table 1.
[1358] **Appendix**, Part A, Section VII(C)(xi), Table 1.

four weeks. As can be seen in the SPR data, even the 50th percentile wait time is longer than the accepted maximum wait time for this condition.

1750. Defendant's expert, Dr. Bohm, described the seriousness of an aortic aneurysm that ruptures, stating: "delaying surgical treatment of a rupture aortic aneurysm (the main vessel that carries blood from the heart) will almost certainly result in death (mortality) – this is therefore an emergent condition."[1359]

1751. When an enlarged aortic aneurysm is diagnosed (37KAAC), timely surgery is important to prevent the risk of rupture. As can be seen from Table 2 (**Appendix, Part A, Section VII(C)(xi)**), a large percentage of BC patients are waiting with a risk of aneurysm rupture.[1360]

1752. Table 2 shows that the 50th and 90th percentile Wait Two times from Decision Date for 37KAAC in 2017 were 3.6 and 10.2 weeks respectively,[1361] and for 2018 (to March 31, 2018), the 50th and 90th percentile Wait Two from Decision Date for 37KAAC was 2.6 and 7.6 weeks respectively.[1362]

(xii) Hernia Surgery

1753. There was also evidence before the Court about the harms suffered by patients while waiting for diagnosis and/or treatment of hernias.

1754. Hernias are a fairly common condition which can be suffered by both adults and children.

1755. As Plaintiff expert Dr. Matheson explained, an inguinal hernia occurs when the fascia in the abdominal wall has a breach or hole and the bowel comes through the breach.

1756. Incarceration means that the section of the bowel which has come through the abdominal wall becomes inflamed and swells, and then cannot go back into the abdomen. This section of bowel is now "incarcerated" outside the body, which causes the bowel to be obstructed, lose its blood supply and begin to die. This is very serious, and requires significant surgery, including in some cases removing portions of the bowel.[1363]

[1359] **Exhibit 469**, Defendant's Expert Report, Dr. Bohm, Tab 1, p. 5 **[CBE, Tab 122].**
[1360] **Appendix**, Part A, Section VII(C)(xi), Table 2.
[1361] **Exhibit 316C**, Tab 5, Page 148 of 149 **[CBE, Tab 69, a].**
[1362] **Exhibit 316C**, Tab 6, Page 102 of 103 **[CBE, Tab 69, b].**
[1363] **Transcript Day 90,** Testimony of Dr. Matheson, p. 19, line 24 to, p. 25, line 13.

1757. Inguinal hernias are common in infants. As set out in the study at footnote 25 of Dr. Matheson's report, of those infants who have an inguinal hernia, about 12% will experience incarceration (30% in the first year of life), and for those who suffer incarceration there is up to a 30% risk of testicular atrophy.[1364]

1758. Dr. Matheson testified about the harm caused to children when waiting for surgery for their inguinal hernia. As stated in his expert report:

> Infants and children under two years of age have a 12% incidence of incarceration and recurrent incarceration of their inguinal hernia while waiting for elective surgery.[1365]

1759. Dr. Matheson relied for this opinion on two Ontario-based studies by Zamakhshary et al., published in 2008 and 2009, respectively. In the first study, the authors found that infants and children under two years of age who were diagnosed with inguinal hernias had double the risk of incarceration of their hernia, requiring an emergency department visit, if they waited more than 14 days from diagnosis to surgery for hernia repair surgery.[1366] The authors noted that these results were similar to those found in prior studies.[1367] The authors also noted that other studies had found that parental stress and anxiety was high and was an important issue.[1368] The authors concluded that all inguinal hernias in infants and young children should be repaired within 14 days after surgical consultation.[1369]

1760. It is this 2008 study that led the CPSWT Study Group, that included Dr. Geoffrey Blair (Chief of Surgery at BCCH), to opine that the PCATS Target of 3 weeks (measured from decision-to-treat) is "probably too long."[1370]

1761. In a second study published in 2009, the same group compared Canadian and American pediatric patients waiting for inguinal hernia repair surgery.[1371] The Canadian patients had a significantly longer Wait Two for surgery from diagnosis (60 days on average) as compared to patients in the US (11 days on average). [1372] Nearly 20% of the Canadian patients suffered at least one

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[1364] **Exhibit 274**, Expert Report of Dr. Matheson; Study cited at footnote 25, p. 252 **[CBE, Tab 53].**
[1365] **Exhibit 274,** p. 8 **[CBE, Tab 53].**
[1366] **Exhibit 274**, pp. 245-249; study cited at footnote 24 **[CBE, Tab 53].**
[1367] **Exhibit 274**, pp. 245-249; study cited at footnote 24 **[CBE, Tab 53].**
[1368] **Exhibit 274**, p. 248; study cited at footnote 24 **[CBE, Tab 53].**
[1369] **Exhibit 274**, p. 245; study cited at footnote 24 **[CBE, Tab 53].**
[1370] See "Waiting for children's surgery in Canada: the Canadian Paediatric Surgical Wait Times project" (CMAJ, 2011 Jun 14; 183(9): E559-E564) at **Exhibit 346B,** Affidavit #9 of Dr. Day, Exhibit "QQQQ", p. 854 **[CBE, Tab 85]**; See also **Exhibit 433E**, pp. 4592-3 **[CBE, Tab 107].**
[1371] **Exhibit 274**, p. 251; study cited at footnote 25 **[CBE, Tab 53].**
[1372] **Exhibit 274**, p. 251; study cited at footnote 25 **[CBE, Tab 53].**

incarceration while waiting, while none of the US patients did.[1373] The authors concluded that there was an urgent need to reduce wait times for surgery in Canada for children with inguinal hernias. [1374]

1762. The maximum acceptable wait times in the PCATS for pediatric inguinal hernias are as follows: (a) Wait One of 24 hours and Wait Two of 24 hours for children diagnosed with "Inguinal hernia: Incarcerated, Non-Reducible";[1375]Wait One of one week and Wait Two of three weeks for children diagnosed with "Inguinal Hernia (Non-incarcerated): < 1 Year";[1376] and Wait One of 6 weeks and Wait Two of 12.86 weeks for children diagnosed with "Inguinal Hernia (Non-incarcerated): > 1 year".[1377]

1763. However, as the Government's SPR data shows, BC children are waiting much longer than this for surgery for their inguinal hernias. It is important to note that the Government's SPR data only provides the duration of Wait Two from BFRD and Decision Date for these hernia conditions.

1764. In BC, the majority of these children's surgeries are completed at BCCH. Due to the problem at BCCH with the BFRD date incorrectly being inserted for the Decision Date, the BFRD and Decision Date are the same or very similar. This leads to an underestimation of the wait times.

1765. In 2017, 56 surgeries were completed for children diagnosed with "Inguinal Hernia (Non-incarcerated): < 1 Year", which has a maximum Wait Two of 3 weeks. The 50th percentile Wait Two time for these children was 3.4 weeks from BFRD and 3.6 weeks from Decision Date. The 90th percentile Wait Two was 8.0 weeks from BFRD and 8.3 weeks from Decision Date. Thus, some children in this high priority waited almost three times longer than the maximum wait time of three weeks.[1378]

1766. More recently in 2018 (as of March 31, 2018), 19 surgeries were performed for children in this category.[1379] The 50th percentile Wait Two time was 3.9 weeks from BFRD and Decision Date.[1380] The 90th percentile Wait Two time was 14 weeks from BFRD, and 14.7 weeks from Decision Date.[1381] As a result, some children waited almost five times longer than the maximum wait time of 3 weeks.[1382]

[1373] **Exhibit 274**, p. 251; study cited at footnote 25 **[CBE, Tab 53].**
[1374] **Exhibit 274**, p. 251; study cited at footnote 25 **[CBE, Tab 53].**
[1375] **Exhibit 432**, p. 1289 **[CBE, Tab 103].**
[1376] **Exhibit 432**, p. 1289 **[CBE, Tab 103].**
[1377] **Exhibit 432**, p. 1289 **[CBE, Tab 103].**
[1378] **Exhibit 316D**, Tab 11, p. 7 **[CBE, Tab 70, c].**
[1379] **Exhibit 316D**, Tab 12, p. 9 **[CBE, Tab 70, d].**
[1380] **Exhibit 316D**, Tab 12, p. 9 **[CBE, Tab 70, d].**
[1381] **Exhibit 316D**, Tab 12, p. 9 **[CBE, Tab 70, d].**
[1382] **Exhibit 316D**, Tab 12, p. 9 **[CBE, Tab 70, d].**

1767. In 2017, 155 surgeries were completed for children diagnosed with "Inguinal hernia > 1 year non-incarcerated", which has a maximum Wait Two time of 3 months (12.86 weeks). The 50th percentile Wait Two time for these children was 7 weeks from BFRD, and 7.3 weeks from Decision Date. And, the 90th percentile Wait Two time was 26.1 weeks from BFRD, and 27.6 weeks from Decision Date. As a result, some children in this category waited twice as long as the maximum wait time of 12.86 weeks, with increased risk of incarceration.[1383]

1768. In the first three months of 2018, 43 surgeries were completed for children in this category. The 50th percentile Wait Two time was 11.9 weeks from BFRD and Decision Date. The 90th percentile Wait Two time was 20.4 weeks from BFRD, and 20.6 weeks from Decision Date. As in the year prior, some patients waited almost twice as long as the maximum wait time of 12.86 weeks.[1384]

1769. This creates a significant risk of harm to BC infants and children of incarceration, and related and resulting complications.

1770. Dr. Lauzon testified about the incidence and impacts of adult hernias, and the wait times to access diagnosis and repair of hernias for adults in BC.

1771. Dr. Lauzon is a general surgeon who performs a range of abdominal surgeries, including gall bladder surgery, intestinal surgery, and various cancer surgeries, including colon cancer, breast cancer and others.[1385] Dr. Lauzon also performs many hernia surgeries.[1386] He also performs a number of emergency surgeries, stemming from his on call practice, including for appendicitis and cholecystitis and perforated intestines or stomach.[1387]

1772. Dr. Lauzon has privileges at several public hospitals in the FHA,[1388] and has held various positions at FHA such as Regional Department Head for General Surgery and member of GI Council.[1389]

[1383] **Exhibit 316D**, Tab 11, p. 7 **[CBE, Tab 70, c].**
[1384] **Exhibit 316D**, Tab 12, p. 9 **[CBE, Tab 70, d].**
[1385] **Transcript Day 37**, Testimony of Dr. Lauzon, p. 2, line 47 to, p. 3, line 7.
[1386] **Transcript Day 37**, p. 2, line 47 to p. 3, line 7.
[1387] **Transcript Day 37**, p. 6, lines 12 to 26.
[1388] **Transcript, Day 37**, p. 4, lines 24 to 31.
[1389] **Transcript, Day 37,** p. 5, lines 26 to 35.

1773. Hernias which are asymptomatic may not require surgery.[1390] However, hernias that become symptomatic can cause pain, and can prevent patients from performing their regular employment.[1391] In addition, in some occupations, even a non-symptomatic hernia can prevent the ability to work. [1392] Pilots who have a hernia are not permitted to fly and divers cannot dive.[1393]

1774. In BC, the Health Authorities regularly contract out hernia repair surgeries to private clinics, which allows the Health Authority to then allocate OR space and time for more complex surgeries.[1394]

1775. However, even with this contracting out to private clinics, the Government's SPR data shows that adult patients waiting for hernia repair surgery wait far too long.

1776. In British Columbia, the wait time data for hernias in 2017 and 2018 (to March 31, 2018) makes it clear that patients are waiting too long for this procedure, resulting in very serious risks to their health **(see Appendix, Part A, Section VII(C)(xii), Table 1).**[1395]

1777. At the time of Dr. Lauzon's testimony, the Defendant had not produced Wait Two from Decision Date data (and claimed that this data did not exist in the SPR). Dr. Lauzon testified that the Wait Two data (from BFRD) produced by the Defendant in relation to his surgeries significantly understated his wait times for surgery, as it did not include the time between the Decision Date for surgery and the date the Booking Form information was entered into the hospital system by the hospital OR booking clerk.[1396]

1778. Dr. Lauzon also testified that in some cases, such as those where the wait time seemed very short, he had just been given a last minute additional OR day at another hospital and the Wait Two from BFRD time was restarted when the booking form was provided to that hospital.[1397] This happened most often for hernia surgeries.[1398] In addition, Dr. Lauzon testified that his MOA often waited to send booking packages to the hospital for hernia patients because it was expected they would have to wait a long time.[1399]

[1390] **Transcript, Day 37**, p. 7, line 1 to, p. 8, line 9.
[1391] **Transcript, Day 37**, p. 7, lines 21 to 25.
[1392] **Transcript, Day 37**, p. 7, line 1 to, p. 8, line 9.
[1393] **Transcript, Day 37**, p. 7, line 1 to, p. 8, line 9.
[1394] **Exhibit 431**, pp. 738, 778 **[CBE, Tab 102].**
[1395] **Appendix**, Part A, Section VII(C)(xi), Table 2.
[1396] **Transcript Day 37**, p. 33, line 9 to, p. 33, line 40.
[1397] **Transcript Day 37**, p. 31, lines 26-39.
[1398] **Transcript Day 37**, p. 31, lines 26-39 and p. 32, lines 25-34.
[1399] **Transcript Day 37**, p. 31, line 14 to, p. 32, line 32, p. 33, lines 41-46.

1779. Defendant's counsel challenged Dr. Lauzon on this evidence.[1400] However, Dr. Lauzon's SPR data shows that his Wait Two from Decision Date is much longer than Wait Two from BFRD. In 2016 (which is the latest data), Dr. Lauzon performed 90 abdominal hernia repairs. For these cases, the 50th percentile from BFRD was 13 weeks, while the 50th percentile from Decision Date was 20.3 weeks. Similarly, the 90th percentile from BFRD was 27.9 weeks, while the 90th percentile from Decision Date which was 31.3 weeks.[1401]

1780. Dr. Lauzon testified that in addition to his OR time and endoscopy suite time, and other administrative duties in the public health care system, he also performs consultations and surgeries at SRC and Cambie about one day per month.

1781. At Cambie he performs primarily hernia surgeries, including for WCB patients, as well as colonoscopies, and some gastroscopies. At SRC, he sees patients in consultations, third party medicals and for medicolegal assessments.[1402]

1782. Dr. Lauzon testified that all of the patients he operates on at Cambie are either WCB patients or have self-referred to him through the SRC.

1783. Dr. Lauzon testified that Air Canada and WestJet pay to have their pilots receive expedited surgery for hernias at Cambie.[1403]

1784. Private clinics in British Columbia have been performing hernia repair surgeries for many years.

1785. Dr. Lauzon testified that the work he does at Cambie and SRC does not detract in any way from the time he spends in the public health care system.

(xiii) Diagnostic Imaging

a) The Harms of Waiting for Diagnostic Imaging

1786. Magnetic Resonance Imaging ("MRI") involves taking a scan of a patient using magnetic forces and radio-frequency waves to make detailed pictures of organs, soft tissues, bone and other

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[1400] **Transcript Day 37**, p. 7, lines 21-25.
[1401] **Exhibit 320B**, Tab 19, p. 4 **[CBE, Tab 74, d].**
[1402] **Transcript Day 37**, pp. 38-41; **Exhibit 111.**
[1403] **Transcript Day 37**, p. 47, lines 9 to 24.

internal body structure. These images are three dimensional, which provides a great deal of detail to treating physicians.[1404]

1787. Computed Tomography ("CT") scans involve the use of a computer to put a series of special x-ray images together to create a detailed three-dimensional image of organs, tissues, bones and blood vessels in the body.[1405]

1788. Timely access to MRIs and CTs is vital to the diagnosis and determination of appropriate treatment for many conditions, from orthopedic conditions to diagnosis and treatment of neurological conditions and many cancers.[1406]

1789. Diagnostic imaging is accepted as an essential component of the surgical process. As the Defendant states in its Prima Facie Facts on MRI and CT Services:

> Diagnostic imaging is an essential part of the patient pathway for many conditions and presentations. Accurate diagnosis is required for medical practitioners to make appropriate clinical decisions about patient treatment. For example, approximately 30% of MRI scans result in either avoidance of surgery or a decision to operate.[1407]

1790. Diagnostic imaging is also one of the five priority areas that was identified by Canada's First Ministers in the 2004 Heath Accord as requiring meaningful reductions in wait times across the provinces.[1408]

1791. Since 1997, when the Medical Services Commission passed Minute 97-068 permitting private access to diagnostic services in facilities not approved by the Commission, patients have been able to obtain these diagnostic services privately in light of the lengthy wait for these services in the public system.[1409]

1792. The expert and lay evidence in this case establishes that waiting for diagnosis and/or surgery causes significant psychological stress and anxiety, and can result in deterioration of a patient's condition to the point that they suffer adverse health consequences.

[1404] **Exhibit 4**, p. 7, para 6 **[CBE, Tab 5].**
[1405] **Exhibit 4**, p. 8, para 8. **[CBE, Tab 5].**
[1406] **Exhibit 4,** p. 7, para. 5 **[CBE, Tab 5]**; **Exhibit 13A**, Current State of MRI Services in BC and Recommendations for Change, p. 2885 and 2903 **[CBE, Tab 10]**; **Exhibit 13A**, A 5-year Provincial Plan for PET/CT for British Columbians, p. 2864-2867 **[CBE, Tab 10].**
[1407] **Exhibit 4,** p. 7, para. 5 **[CBE, Tab 5].**
[1408] **Exhibit 2A**, p. 128, para 301 **[CBE, Tab 1].**
[1409] **Exhibit 4**, pp. 43-44, paras 119-123 **[CBE, Tab 5].**

1793. Many of the physicians who testified in the trial discussed the very lengthy wait times their patients experienced, in particular for MRIs, and the resulting harm to their patients in terms of waiting for diagnosis by a specialist and referral for appropriate care, with resulting pain, suffering, disability, stress and anxiety, and in some cases, financial harm from an inability to work, deterioration and risk to life and limb.

1794. Dr. Day, for example, testified that timely MRIs are necessary for the purpose of diagnosing patients' conditions, improving their health and facilitating their surgery and/or treatment.[1410] He testified that there was an increasing demand for MRIs in British Columbia, and that patients are experiencing significant delays for MRIs in the public system in the province.[1411]

1795. We also had evidence in this case from Ms. Erma Krahn, an elderly patient who in 2008 lawfully obtained a private MRI in BC to expedite the process of obtaining a diagnosis for her knee condition, and subsequent arthroscopic knee surgery. Ms. Krahn decided to do this rather than waiting for an MRI in the public system, which would have been many months. Had she waited for an MRI in the public system, she would have languished with mental distress, pain, restricted mobility, and low quality of life during the last years of her life, both while waiting for her MRI, as well as for her subsequent knee surgery.[1412]

1796. The Government has recognized in its Advanced Imaging Strategy that diagnostic imaging is an essential part of the patient pathway, and that diagnosis is required for physicians to make key clinical decisions about patient treatment. [1413] And, as a result, delays in diagnosis, treatment and resolution/amelioration of the patient's condition impact on patient outcomes.[1414]

1797. Until recently, the Government had never taken steps to prohibit private pay MRIs or CT scans, largely because the Government acknowledged the value to patients of having the private option, and because the Government could not keep up with demand for publicly funded MRIs and CTs even with many patients utilizing the private option.

1798. The newly proclaimed amendments to the *MPA* will mean that British Columbians will no longer have the option to access private MRI or CT Scans.

[1410] **Exhibit 346A**, pp. 70-71, paras 378-383 **[CBE, Tab 83].**
[1411] **Exhibit 346A**, pp. 70-71, paras 378-383 **[CBE, Tab 83].**
[1412] See **Section VII(C)(vii)(c)(xiii)**.
[1413] **Exhibit 12C**, p. 2182 **[CBE, Tab 9].**
[1414] **Exhibit 12C**, p. 2182 **[CBE, Tab 9].**

1799. The excessive and harmful wait times for diagnosis and surgery experienced by British Columbians have existed even with the availability of private MRI and CT scans. The removal of this option will only further exacerbate those wait times, and create greater harm for British Columbians by further prolonging their waits for diagnostic and surgical services.

1800. In progressive conditions such as cancer, this delay can be life-threatening and can diminish the chance of curative treatment, which could mean the difference between life and death.[1415]

1801. In other, non life-threatening situations such as many orthopedic cases, patients waiting for diagnostic imaging suffer ongoing pain, disability, stress and anxiety, and in many cases, financial harm from an inability to work, and deterioration of their condition.[1416] And, in many cases, this occurs while they are waiting for their initial consultation and/or diagnosis by a specialist, to determine the nature of their condition and the appropriate treatment.[1417]

1802. This fact has been recognized by the Government itself in its internal documents on the new amendments and their anticipated effect on the ability of British Columbians to access necessary diagnostic services in the provinces in a timely manner.[1418]

1803. The existence of these harms from waiting for necessary diagnostic imaging services was acknowledged and emphasized by then Opposition Critic on the Health Portfolio (and now Minister of Mental Health and Addictions, Judy Darcy) in 2015. As noted by Ms. Darcy "thousands of other patients are also waiting unacceptably long times to get absolutely necessary medical procedures", and "[t]he government's own clinical benchmark says that no patient should have to wait more than two months for an MRI, but Vancouver Coastal Health and Providence Health Care's figures reveal that they are only meeting this standard in 13 percent of the cases".[1419]

1804. In reply to Minister Terry Lake's assertion that when patients need an urgent MRI, their physicians can get it for them urgently, Ms. Darcy stated:

> **J. Darcy**: Well, once again the minister blames everybody else instead of taking responsibility himself. The minister claims that urgent or emergent cases do get the attention they need, and the minister knows that that's not the case. Vancouver Coastal and Providence Health Care's own figures show that patients who are classified as so urgent that they need an MRI within

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[1415] See **Section VII(C)(ii)**, above.
[1416] **Exhibit 13A**, p. 2903 **[CBE, Tab 10]**; **Exhibit 147**, p. 20 **[CBE, Tab 35]**; See **Section VII(c)(vii)(c)(iv)** above.
[1417] See **Section VII(c)(vii)(c)(iv)**, above.
[1418] See **Exhibit 431**, pp. 725-739 **[CBE, Tab 102]**.
[1419] **Exhibit 426**, Tab 20, p. 9961 **[CBE, Tab 100]**.

> seven days are waiting an average of 40 days, and some are waiting 117 days for an urgent MRI.
>
> According to the B.C. society of radiologists, we're talking about patients with tumours that could be benign or malignant, or patients who will require treatment for prostate cancer, among others. That is simply not acceptable. Surely we can do better than that in the province of British Columbia.[1420]
>
> [emphasis added]

1805. More recently in 2017, Ms. Darcy referred to the situation of a patient suffering from epilepsy who was faced with an excessive wait time for an MRI in the public system:[1421]

> **J. Darcy**: Imagine having to go to Calgary for brain surgery to treat your epilepsy because the waits are too long in B.C. Imagine going back to your doctor because you're suffering from terrible headaches, and the doctor, a neurosurgeon, orders an MRI. Then you get a notice in the mail telling you that your MRI is scheduled for 2019, 2½ years away. That's what Linda M----- from Surrey is dealing with, and the notice says: "Please note the year of appointment: August 14, 2019."
>
> Does the Health Minister think it's acceptable that Linda Mc---- has to wait 2½ years for an MRI?

1806. The situations of these patients are commonplace in British Columbia, as the majority of British Columbians who are waiting for MRIs or CT scans have been and still are waiting well beyond the maximum acceptable wait times for their diagnostic scan in the public system.

b) The Persistently Long Wait Times for Diagnostic Imaging in BC

1807. Wait times for diagnostic imaging in British Columbia, such as MRI and CT scans, are among the longest in Canada, and much longer than in other OECD countries.

1808. As with surgical interventions, and other critical diagnostic procedures such as colonoscopies, there are maximum acceptable wait times for MRIs and CT scans, which were developed initially by the Canadian Association of Radiologists.[1422]

1809. The BC Radiological Society then used the maximum wait times established by the Canadian Association of Radiologists and worked with radiologists in the Province to develop a consensus on how a variety of patient conditions should be assigned to urgency categories.[1423] This framework of

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[1420] **Exhibit 426**, Tab 20, p. 9961 **[CBE, Tab 100]**.
[1421] **Exhibit 426**, Tab 31, p. 14128 **[CBE, Tab 100]**.
[1422] **Exhibit 431**, p. 556 **[CBE, Tab 102]**.
[1423] **Exhibit 4**, p. 26, para 72 **[CBE, Tab 5]**.

maximum wait times was then endorsed by the BC Medical Imaging Advisory Committee and implemented by all Health Authorities.[1424]

1810. Table 3 (**Appendix, Part A, Section VII(C)(xii)**) shows British Columbia's maximum acceptable wait times for MRI and CT scans.[1425] As can be seen from Table 3, the Priority 1 wait time of 24 hours is "emergent" and applies where the examination is necessary to diagnose and/or treat disease or injury that is "immediately threatening to life or limb". Priority 2 is "urgent", and applies where "an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan that is not immediately threatening to life or limb".[1426] For patients in this priority, negative outcomes related to delay in treatment are not expected if the patient's examination is completed within the maximum wait time of 7 days.[1427] Priority 3 and 4 also expressly contemplate that harms may be suffered by patients in these categories if their MRI scan is not completed within the associated maximum wait times of 30 days and 60 days.[1428]

1811. As the Defendant's Prima Facie Facts on MRI and CT Services indicate, by adoption of these priority levels, including their definitions, the Defendant has acknowledged that patients who wait longer than the maximum wait time for their priority level may suffer adverse health outcomes in relation to delay of receiving such services.[1429]

1812. However, to date, the BC public health care system has been wholly unable to provide MRI and CT scans in a timely way, with the result that wait times for diagnosis and treatment by specialists are even further exacerbated.

1813. As of April 2015, the 90th percentile wait time for non-emergent MRIs in BC was 245 days (i.e. over four times the maximum acceptable wait time of 60 days). [1430]

1814. This is longer than the 90th percentile wait time in any other reporting province at that time: Alberta (214 days), Prince Edward Island (172 days), Manitoba (167 days), Nova Scotia (163 days), and Ontario (73 days).[1431]

[1424] **Exhibit 431**, p. 556 **[CBE, Tab 102].**
[1425] **Exhibit 4**, p. 28, para. 77; **Appendix**, Part A, Section VII(C)(xiii), Table 3.
[1426] **Exhibit 4**, p. 28, para. 77 **[CBE, Tab 5].**
[1427] **Exhibit 4**, p. 28, para. 77 **[CBE, Tab 5].**
[1428] **Exhibit 4**, p. 28, para. 77 **[CBE, Tab 5].**
[1429] **Exhibit 4**, p. 28, para. 77 **[CBE, Tab 5].**
[1430] **Exhibit 4**, p. 29, para 81 **[CBE, Tab 5].**
[1431] **Exhibit 4**, p. 30, para 83 **[CBE, Tab 5].**

1815. That is because, as the Prima Facie Facts explain, the BC public health care system has the lowest number of MRI machines per capita in Canada, which is well below the OECD average.[1432]

1816. As can be seen from the wait time data from Table 1 **(Appendix, Part A, Section VII(C)(xiii))** for MRIs from 2015 to 2017, the 90th percentile wait times for all four priority levels have continued to significantly exceed the maximum wait times that have been established in the province:[1433]

1817. As is made clear from the data at Table 12, the public system has consistently been unable to meet the maximum acceptable wait times for patients in all priorities.

1818. And, this is not a case of patients waiting a day or two beyond the maximum acceptable wait times, but rather is one where patients in some cases are waiting up to five times longer than the maximum wait times.

1819. While one of the goals of the Government's Advanced Imaging Strategy has been to improve patient outcomes by providing "all patients with services within the national wait time guidelines set by the Canadian Association of Radiologists (which has been endorsed by the BC Medical Imagining Advisory Committee)" since 2015, it is clear that in 2019 the Government is still far from accomplishing this goal.[1434]

1820. The previous Minister of Health, the Honourable Terry Lake, acknowledged on May 3, 2016 the Province's poor record in providing MRIs in the public health care system:

> **Hon. T. Lake**: The information, at this point, is that MRI wait times for all procedures in April 2015 — so when we looked at this a year ago — was 245 days. That's the 90th percentile, which means that nine out of ten patients received the service within 245 days.[1435]

1821. The most recent Government data we have from 2018/19 shows that the 90th percentile wait times for MRI scans by Health Authority still greatly exceed the established maximum acceptable wait times:[1436]

[1432] **Exhibit 4**, p. 13, paras 22-23 **[CBE, Tab 5].**
[1433] **Exhibit 322**, Tab 5, p. 6 **[CBE, Tab 76, d].**; **Appendix,** Part A, Section VII(C)(xiii), Table 1.
[1434] **Exhibit 12C**, p. 2184 **[CBE, Tab 9].**
[1435] **Exhibit 426**, Tab 25, p. 12642 **[CBE, Tab 100].**
[1436] **Exhibit 560**, p. 4 **[CBE, Tab 148].**

MRIs

HA	YTD Vol Comp	YTD Target		% Comp w/in Bnch	50th Pctl Wait Time	90th Pctl Wait Time
BC	233,369	227,988	●	46.0% ↑	39 ↓	194 ↓
IHA	27,219	26,052	●	35.0% ↑	42 ↔	222 ↓
FHA	65,302	64,330	●	31.0% ↔	66 ↓	268 ↓
VCHA	64,606	63,911	●	62.0% ↑	25 ↓	118 ↓
VIHA	49,346	48,000	●	51.0% ↔	43 ↔	134 ↓
NHA	14,084	13,500	●	52.0% ↑	28 ↔	163 ↓
PHSA	12,812	12,195	●	26.0% ↑	107 ↓	736 ↓

There is a discrepancy in wait times calculated by the Ministry and PHSA most likely related to data importing within MIWT. PHSA is supporting the Ministry with the data validation.

1822. As can be seen, in 2018/19, the 90th percentile wait times for MRI scans in every Health Authority are well beyond the maximum wait times for all priorities, by a significant amount of time. In some cases, patients that would be in the least urgent priority group are waiting as long as 12 times the maximum acceptable wait time of 60 days. Further, at all Health Authorities there are a large number of patients that are not receiving their MRI scans within the maximum acceptable wait times. This is extremely significant as it represents only one segment of patients' wait times, and diagnosis and treatment are often dependent on the information in the diagnostic imaging scan.

1823. Due to the long wait times for MRIs in the public system, the BC Government has acknowledged that "[a]ccess to MRI is the most urgent concern" and that "[i]ncreasing service volumes is a priority action."[1437]

1824. Because of these concerns, since as early as 2010, the Defendant has made significant investments in reducing wait times for MRIs in BC, [1438] and in 2014 made this a priority area of focus in its three-year surgical strategy.[1439]

1825. However, even with these investments and focus, the most recent wait times evidence produced by the Defendant from 2018/19 shows that the 90th percentile wait time for an MRI (for all priorities) is 194 days.[1440] And, only 46% of British Columbians are receiving their MRIs within the maximum acceptable wait times.[1441]

[1437] **Exhibit 12C,** p. 2182-2183 **[CBE, Tab 9].**
[1438] **Exhibit 2C**, pp. 149, 178-181, paras 372, 423-430 **[CBE, Tab 3].**; **Exhibit 4**, pp. 37-40, paras 102-112 **[CBE, Tab 5].**; **Exhibit 431**, pp. 577, 621, 623, 633 **[CBE, Tab 102]**; **Exhibit 12C**, p. 2195 **[CBE, Tab 9].**
[1439] **Exhibit 2C,** pp. 158-161, paras 401-404, priority #5 **[CBE, Tab 3].**
[1440] **Exhibit 560,** p. 4 **[CBE, Tab 148].**
[1441] **Exhibit 560,** p. 4 **[CBE, Tab 148].**

1826. The wait times for MRIs have become so bad, that the BC Government has indicated that "[t]here are barriers to appropriate orderings" of MRI scans in the province.[1442] Specifically, the Health Authorities have reported that physicians are ordering CT scans as a substitute for MRI scans because of the excessive wait times for MRIs in the public system, which unnecessarily exposes patients to radiation.[1443]

1827. This shows that without private diagnostic imaging facilities filling the gap, there will be tens of thousands of patients in need of MRIs who will go without necessary diagnostic imaging, or added to the long wait list in the public system.

1828. Similarly, BC also has among the longest wait times for CT scans in the country, and demand for this service continues to increase.

1829. For CT scans, the same priority levels and maximum wait times apply as with MRIs.

1830. The Defendant's Prima Facie Facts on MRI and CT Services report that as of April 2015, the 90th percentile wait times for CT scans were the second highest in BC as compared to other provinces that collected the data: approximately 64 days wait in BC, as compared with 46 in PEI, 44 in Alberta, 40 in Manitoba, and 30 in Alberta.[1444]

1831. The Government's SPR data also shows that the wait times for CT scans by priority. As can be seen from Table 2 **(Appendix, Part A, Section VII(C)(xiii))** from 2015 to 2017, patients in all priorities waited well beyond the maximum acceptable wait times for CT scans.[1445]

1832. Further, according to the CIHI data from 2018, BC's 50th and 90th percentile wait times for CT scans were 21 days and 93 days.[1446]

1833. The Health Authorities in British Columbia recognize that they are unable to provide all patients with MRI and CT scans within the established maximum acceptable waits. Indeed, they have simply given up on providing even a majority of their patients with their MRI and CT scans within the maximum wait times (much less than 90%). For instance, Vancouver Island Health Authority set a target in 2017/18 of accomplishing 45% of MRI scans and 42% of CT scans within the maximum

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[1442] **Exhibit 4**, p. 31, paras 85(c) **[CBE, Tab 5].**
[1443] **Exhibit 4**, p. 31, paras 85(c) **[CBE, Tab 5]**; See **Exhibit 146**, p. 25 **[CBE, Tab 34].**
[1444] **Exhibit 4**, p. 16, para 82 **[CBE, Tab 5].**
[1445] **Appendix, Part A, Section VII(C)(xiii),** Table 2.
[1446] **Exhibit 433E**, p. 4531 **[CBE, Tab 107].**

acceptable wait times.[1447] And, even with these modest targets, Vancouver Island Health still only provided 46% of MRI scans (1% above its target) and 32% of CT scans (10% below its target) within the maximum wait times.[1448]

1834. The Defendant has set out the following reasons for the long wait times for MRIs and CT scans in the public system in its Prima Facie Facts on MRI and CT Services:

> 85. The Ministry of Health has identified a number of underlying issues that lead to increasing MRI/CT Waitlists:
>
> (a) Governance and service models limit publicly funded services to hospital settings, and are not integrated with the broader service delivery system for diagnostics;
>
> (b) The current funding model has resulted in under-servicing (for example, Health Authorities must fund volume increases from existing funding envelopes. As such, there is no routine method for increasing capacity as demand increases);
>
> (c) There are barriers to appropriate orderings (for example, Health Authorities report that due to long wait times for MRIs, physicians are ordering CT scans as a substitute);
>
> (d) There are challenges to capital and service planning at the Health Authority level (for example, the process required for the replacement of aging equipment), and at the Provincial level (health authorities, other than the LMMIP group, are not mandated to coordinate capital planning or service planning for medical imaging with other Health Authorities); and
>
> (e) The information management and information technology infrastructure is not in place to support the Ministry in monitoring quality, planning and accountability.
>
> 86. The Health Authorities have not reported any difficulties in obtaining the necessary human resources for Advanced Imaging Services.[1449]

1835. These are all major problems that are highly unlikely to be resolved in any meaningful way in the near future in the public health care system. In the meantime demand will continue to rise.

c) Private clinics have provided a safety valve for access to timely diagnostic imaging in BC

[1447] **Exhibit 395**, Affidavit #1 of Norm Peters, Exhibit "D", pp. 17-18 **[CBE, Tab 93].**
[1448] **Exhibit 395**, Affidavit #1 of Norm Peters, Exhibit "D", pp. 17-18 **[CBE, Tab 93].**
[1449] **Exhibit 4**, p. 31, paras 85-86 **[CBE, Tab 5].**

1836. On all of the evidence in this case, despite the efforts and initiatives of the BC Government, it is clear that many patients in British Columbia are faced with persistently long wait times in the public system for necessary diagnostic imaging.

1837. As a result, British Columbians have availed themselves of private pay MRI or CT scans, which until very recently, were legally available in BC, in order to obtain more timely diagnosis and treatment of their medical conditions.[1450] As recognized by the Defendant, this alternative access also removed these patients from the public system wait lists for MRI and CT scans, allowing other public patients to receive their scans more quickly.[1451]

1838. As of 2016, there were some 17 private clinics providing MRIs and two providing CT scans in British Columbia. [1452]

1839. These clinics used the services of radiologists to arrange and interpret MRI and CT scans, most or all of whom also worked in the public system and thus were engaged in dual practice. Former Health Minister Lake stated in the Legislative Assembly in 2016 that there was not an issue of a shortage of radiologists in British Columbia. Rather, he stated, that additional spaces had been allocated to radiography technology diploma programs in the province.[1453]

1840. Up until recently, these private clinics have performed a crucial role in providing lawful expedited diagnostic services to BC patients in the province, when the public system has been unable to do so.

1841. As Andrew Montgomerie, the Director of Financial Services and Health Care Programs at WorkSafeBC, testified, WorkSafeBC also utilizes private clinics to expedite diagnostic imaging – such as MRI and CT scans – for WCB patients.[1454]

1842. Mr. Montgomerie testified that WorkSafeBC pays expedited fees for diagnostic imaging, at private clinics, and that "MRI facilities typically achieve the 15 day turnaround target on all referrals, so the expedited fee is paid more than 90% of the time" to private clinics.[1455] As Mr. Montgomerie explains, WorkSafeBC's rationale for expediting diagnosis, and any subsequent treatment and/or

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[1450] **Exhibit 431**, pp. 703-709, 725-739 **[CBE, Tab 102]**.
[1451] **Exhibit 431,** 725-733 **[CBE, Tab 102]**.
[1452] **Exhibit 4**, p. 40, para 113 **[CBE, Tab 5]**.
[1453] **Exhibit 426**, Tab 25, p. 12642 **[CBE, Tab 100]**.
[1454] **Exhibit 533**, p. 4, para 19; **Transcript Day 171**, p. 36, line 42 to, p. 37, line 11 **[CBE, Tab 140]**.
[1455] **Exhibit 533**, p. 4, para 19; **Transcript Day 171**, p. 39, lines 9-15 **[CBE, Tab 140]**.

surgery, is that it is beneficial for the worker, the employer, the insurer (WorkSafeBC), and the province to have injured or ill workers return to work as soon as possible.[1456]

1843. This rationale applies not only to workers injured on the job, but those injured off the job, as is made clear through the evidence of a Patient Witness, Marshal Van de Kamp.[1457]

1844. We also have evidence from Dr. Mark Godley, a certified anesthesiologist who is the founder of False Creek.[1458] Dr. Godley testified that after he completed his training in 1995, he was unable to obtain a staff position in the public hospitals in British Columbia, due to the limitations on available operating time in the public system.[1459]

1845. As a result, Dr. Godley provided locum services for anesthesiologists at various hospitals across British Columbia, and observed the lengthy wait times for medically necessary services in the public system.[1460] This led him to establish False Creek, which has been providing private diagnostic services, including MRI, CT and ultrasounds since 2012 to both WCB patients and patients who elect to obtain such services privately.[1461]

1846. Even with the existence of the private clinics, like False Creek, and the resulting removal of many patients from the public system, wait times for MRI and CT scans in British Columbia have been nothing short of abysmal, with consequential serious harms to patients.

1847. It is clear in these circumstances that allowing patients to lawfully access private MRI and CT scans in the province has been beneficial to both patients and the public health care system by removing demand for such services from an already constrained and overwhelmed public system. The Government has acknowledged this. And the experiences of patients such as Ms. Krahn and Mr. Van de Kamp who have benefitted from more timely access to private diagnostic services in the province confirms this to be the case.

(xiv) Psychological Harm While Waiting For Diagnosis And Treatment

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[1456] **Exhibit 532**, p. 11, para 46 **[CBE, Tab 139]**; **Transcript Day 171**, p. 39
[1457] See **Section VII(c)(vii)(c)(vi)**, above.
[1458] **Exhibit 385**, p. 2, paras 3 and 5 **[CBE, Tab 87]**.
[1459] **Exhibit 385**, p. 3, para 15 **[CBE, Tab 87]**.
[1460] **Exhibit 385**, p. 3, paras 16-17 **[CBE, Tab 87]**.
[1461] **Exhibit 385**, p. 3, paras 50-53 **[CBE, Tab 87]**.

1848. There can be no real dispute that many patients who are waiting for diagnosis and treatment of injuries and illnesses suffer psychological harm as a result of the wait, and that this harm increases with the length of the wait.

1849. Patients who are waiting for assessment and treatment for injuries or illness experience stress and anxiety as a result of the illness or injury, and as result of waiting for diagnosis and treatment and the uncertainty of when that will take place and what the results will be.

1850. Patients may also experience depression as result of chronic pain and/or due to the limitations on their activities of daily living and/or ability to work, as well as anxiety related to loss of income. Waiting for treatment may also lead to the development of other mental illnesses, including dependence or addiction on narcotics or alcohol or drugs which the patient may be using to self-medicate.

1851. Virtually all of the physicians who testified in this proceeding testified that their patients experience anxiety, mental stress and/or depression while waiting for diagnosis and treatment. In addition, many of the Defendant's own documents acknowledged the significant psychological harm, in terms of stress and anxiety, which is imposed on patients who are waiting for diagnosis and treatment of a medical condition.

1852. There was also expert evidence about psychological harms suffered by patients while waiting for care. Dr. Matheson, for example, opined in his expert report that patients who are waiting for care suffer from "anxiety, depression, angst, uncertainty, disruption of life, thwarted goals, and inconvenience" and that "there is no doubt these factors are an important cause of harm."[1462]

1853. Dr. Matheson notes that "many authors in the medical literature have called attention to waiting as a source of psychological harm."[1463] In his report, he referred in particular to a 2007 study by Oudhoff et al that found that patients waiting for surgical treatment for varicose veins, inguinal hernia and gallstones in 27 hospitals had prolonged periods of decreased health that negatively affected their psychological and social lives.[1464]

1854. Dr. Matheson also referenced a 2014 Ontario study by Harrington et al which examined the effects on patients of waiting for a specialist consultation for a new condition. The study found that

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[1462] **Exhibit 274,** Expert Report of Dr. Gordon Matheson, p. 9 **[CBE, Tab 53]**.
[1463] **Exhibit 274,** p. 7 **[CBE, Tab 53]**.
[1464] **Exhibit 274**, p. 9, Reference #26, p. 256-266 **[CBE, Tab 53]**.

20% of patients reported negative effects on their life while waiting for the specialist consultation. The longer the time spent waiting, the more likely the patient reported negative effects. Worry, stress and anxiety were the most frequently reported impacts (almost 70% of patients), followed by pain (42%), stress on family/friends (25%), reduction in daily living activities (24%), deterioration of health (22%). Loss of work, loss of income and increased use of over the counter medication was reported by over 10% of patients.[1465]

1855. While acknowledging that there has been little data collected on psychological harm, Dr. Matheson testified that "we all know...that psychological harm does exist in waiting. Anxiety, depression, fear, as well as the components of the person's life that have been disrupted that cause psychological effects".[1466]

1856. Dr. Matheson further testified that most patients experience these effects as a result of illness or injury. Thus, the longer they wait for diagnosis and treatment, the longer they will be experiencing these effects.[1467]

1857. Defendant's expert Dr. Guyatt also agreed that patients suffer from anxiety and psychological stress of knowing that they have a medical condition and waiting for the treatment for that condition.[1468]

1858. Likewise, Defendant's expert Dr. Bohm also confirmed that he was aware of evidence that chronic pain is associated with mental health challenges and that he would expect that being forced off work could be associated with mental health issues as well.[1469]

1859. Plaintiff's expert Dr. Derryck Smith is a psychiatrist who has practiced in the BC public health care system for over 30 years. His areas of specialization in psychiatry are attention deficit hyperactivity disorder and traumatic brain injury. Dr. Smith provided lay and expert evidence in this proceeding.

1860. Dr. Smith was a clinical professor for many years at UBC Faculty of Medicine, including 25 years as the head of Child and Adolescent Psychiatry at UBC. He is now Professor Emeritus. He has been president of the Medical-Legal Society of BC, he was on the board of the Canadian Medical

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[1465] **Exhibit 274**, p. 9, Reference #27, p. 275-278 **[CBE, Tab 53]**.
[1466] **Transcript Day 90**, Testimony of Dr. Matheson, p. 21, lines 32 to 38.
[1467] **Transcript Day 91,** Testimony of Dr. Matheson, p. 45, line 28 to p. 46, line 3.
[1468] **Transcript Day 178,** Testimony of Dr. Guyatt, p. 8, line 32 to p. 9, line 46.
[1469] **Transcript Day 153,** Testimony of Dr. Bohm, p. 34, lines 38 to 43.

Association for eight years, and on the board of the BCMA for 12 years and president for 2 years. He was a BCMA representative on the Medical Services Commission from 1998 to 2006, and on the editorial board of the Canadian Psychiatric Association for 20 years. He was the head of Psychiatry at BC Children's Hospital for 20 years.[1470]

1861. In his expert report, Dr. Smith opined that he agreed with Dr. Frank that individuals who are experiencing chronic stress can develop various psychological or psychiatric conditions as well as medical conditions such as Type II diabetes.[1471]

1862. Dr. Smith also opined that physical illnesses or injuries themselves lead to the development of mental stress and psychological or psychiatric conditions, and that this is especially so when patients must wait a long time for diagnosis and treatment and/or when the timing of diagnosis or treatment is uncertain. [1472]

1863. Dr. Smith further opined that patients in Canada who have more chronic problems such as depression or individuals in need of joint replacements are typically on waiting lists for months, if not years. The uncertainty and worry associated with waiting for necessary healthcare will often result in increased psychiatric illness, including mental stress, anxiety and depression.[1473]

1864. In addition, access to appropriate psychiatric care for patients who have mental health problems is limited in Canada, and in British Columbia.[1474]

1865. Dr. Smith referred to a study done by Dr. Elliot Goldner et al, which demonstrates that timely access to needed psychiatric care is difficult to achieve in Canada. This study showed that of 230 psychiatrists in Vancouver contacted about a typical referral of a male patient with major depressive disorder, 70% stated that they could not accept the referral. Of those who were prepared to accept the referral, 90% said that they could not provide an appointment date until provided with detailed referral information.[1475]

[1470] **Exhibit 391**, Affidavit #2 of Dr. Derryck Smith, dated February 1, 2018, p. 2-3, paras 1-15 **[CBE, Tab 91]**.
[1471] **Exhibit 0390,** Expert Report of Dr. Smith, p. 2, para 6 **[CBE, Tab 90]**.
[1472] **Exhibit 0390,** p. 2, para 6 **[CBE, Tab 90]**.
[1473] **Exhibit 0390,** p. 3, para 12 **[CBE, Tab 90]**.
[1474] **Exhibit 390**, p. 3, para 12 **[CBE, Tab 90]**.
[1475] **Exhibit 390,** Appendix B, p. 24-31 **[CBE, Tab 90]**.

1866. In his lay evidence, which was provided through affidavit and cross-examination, Dr. Smith testified that prior to 2012 (when he reduced his practice), he had about 2000 patient visits a year. He is now semi-retired and only sees patients three days per week.[1476]

1867. In addition to his work as a treating psychiatrist, Dr. Smith does a substantial number of independent medical examinations, which are privately billed and paid. For many years, he also provided assessment and treatment for WCB patients with brain injuries due to workplace injuries. This work was paid by the WCB at a higher rate than what he would bill the MSP for the same service. The WCB patients were given rapid, preferred access to specialty medical and health care, including psychiatric assessment and treatment, and were able to return to their work and life responsibilities more quickly than non-WCB patients. This reduced the personal harms suffered by the WCB patients.[1477]

1868. There is limited and insufficient access to psychiatric care in British Columbia, which is exacerbated when patients do not have a family doctor.[1478]

1869. In many cases, Dr. Smith will refer patients to psychologists for certain types of therapy, such as cognitive behaviour therapy, which can be critical to long-term management of the illness and/or recovery. Patients must pay privately for treatment by a psychologist.[1479]

1870. In addition, the vast majority of psychiatric patients require medication to treat and manage their condition, sometimes on an ongoing basis for years or their lifetime. Most patients must pay out of their own pocket for medications, unless they have prescription drug coverage through their employment insurance. As Dr. Smith testified, financial constraints with respect to the cost of prescription medications are often a significant concern for patients with mental health problems.[1480]

1871. Untreated or delayed treatment of psychiatric conditions can lead to many co-morbidities, including other mental illnesses or self-medicating through drugs or alcohol, which can lead to addiction. Treatment of addiction is also very difficult for patients to access in BC, and rehabilitation treatment can often only be accessed from private pay providers.[1481]

[1476] **Exhibit 391**, Affidavit #2 of Dr. Smith,, p. 3, para 12 **[CBE, Tab 91]**.
[1477] **Exhibit 391**, p. 3-4, para 14-16 **[CBE, Tab 91]**.
[1478] **Exhibit 391**, p. 4, para 21 **[CBE, Tab 91]**.
[1479] **Exhibit 391**, p. 5, para 27 **[CBE, Tab 91]**.
[1480] **Transcript Day 121**, Testimony of Dr. Smith, October 4, 2018, p. 37, lines 16-26.
[1481] **Exhibit 391,** p. 6, para 36 **[CBE, Tab 91]**.

1872. Dr. Smith further testified that untreated mental illness can lead to violence against others, or more often, self-harm, including suicide.[1482]

1873. Finally, chronic and/or severe pain is a significant problem for many patients, who can develop depression secondary to pain and/or addiction issues due to ongoing use of narcotics for pain.[1483]

1874. Prolonged waits, especially past maximum acceptable wait times, increase the probability of negative effects from pain medications, such as non-steroidal anti-inflammatory drugs (NSAIDs) which are used to treat pain and inflammation. As Dr. Masri noted, patients using these drugs are at risk for GI bleeds.[1484]

1875. In addition, for severe pain or when NSAIDs are no longer effective, patients require narcotic medications with resulting risk of dependence and addiction. Several of the physician witnesses testified to the prevalence of the development of dependence and addiction in many of their patients who endure long waits in pain, including Drs. Nacht, Masri, Sahjpaul, Day, Tarazi and Weckworth.[1485] As Dr. Nacht testified, patients on narcotics may require a narcotic elimination program before they can have surgery.[1486]

1876. The harm caused by severe pain and the resulting need for narcotics is expressly recognized in the Diagnosis Descriptions in the BC Patient Prioritization System, in relation to gynecological conditions. For example, the diagnosis "Endometriosis, severe, laparoscopically verified, debilitating, requiring narcotics" (50RMEC) has a maximum acceptable wait time of six weeks. [1487] In 2017, only 35.6% of these cases were completed within six weeks. The 90th percentile Wait Two time was 25.7 weeks from BFRD and 27.1 weeks from Decision Date.[1488]

1877. Similarly, patients diagnosed with "Pelvic Pain (Requiring Regular Use of Narcotics and/or Frequent Visits to ER and/or Frequent Hospital Admissions)"(50RZDF) should have their surgery within a maximum period of six weeks.[1489] However, in 2017, of the 221 cases completed in BC, only

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[1482] **Exhibit 391,** p. 6, para 38 **[CBE, Tab 91]**.
[1483] **Exhibit 391,** p. 6, para 37 **[CBE, Tab 91]**.
[1484] **Transcript Day 87**, p. 61, lines 8-12.
[1485] See **Transcript Day 57**, Testimony of Dr. Nacht, p. 40, lines 22-32; **Exhibit 346A**, Affidavit #9 of Dr. Day, p. 43, para 232 **[CBE, Tab 83]**; **Transcript Day 22**, Testimony of Dr. Sahjpaul, p. 10, lines 24-36.
[1486] **Transcript Day 57**, p. 39, line 45 to, p. 40, line 11.
[1487] **Exhibit 315A**, Tab 2, page 23 **[CBE, Tab 64]**.
[1488] **Exhibit 316C**, Tab 5, p. 20 **[CBE, Tab 69]**.
[1489] **Exhibit 315A**, Tab 2, page 28 **[CBE, Tab 64]**.

57.9% were completed within six weeks. The 90th percentile Wait Two time was far beyond this at 17.3 weeks from BFRD and 23.9 weeks from Decision Date.[1490]

1878. These patients are not only in "severe and debilitating pain" but are "requiring narcotics", which can lead to addiction as well as delayed recovery and impaired pain following surgery. It is vital that these patients receive timely surgery to relieve their pain and risk of addiction, however, this is not occurring in BC.

D. Expert Evidence On Harms

1879. The plaintiffs' tendered nine expert reports on the effect of delayed access to diagnostic and surgical services on the health and well-being of patients; Nadeem Esmail; Prof. Kessler, Prof. McGuire, John McGurran, Dr. Matheson, Dr. Chambers, Dr. Wing, Dr. Younger and Dr. Masri.[1491]

1880. All of these experts reached the same conclusion. Based on their own research and experience, and on the research of others, they concluded that patients suffer serious harm to their physical and mental health and overall well-being from waiting for diagnosis and treatment by specialists.[1492]

1881. These harms were of two types: (1) the suffering endured while waiting for treatment including severe pain, physical disabilities, the limited ability to work or enjoy life, and physiological stress; and (2) irreparable or permanent harms such as the deterioration of their medical condition and worse outcomes when the treatment was finally provided.[1493]

1882. The Court indicated that little weight would be given to expert opinions on the harms to patients from experts who were not medical doctors. The Plaintiffs therefore rely primarily on the

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[1490] **Exhibit 316C**, Tab 5, p. 22 **[CBE, Tab 69]**.

[1491] See: **Exhibit 18**, Expert Report of Nadeem Esmail **[CBE, Tab 13]**.; **Exhibit 183A**, Expert Report of Professor Kessler **[CBE, Tab 40]**; **Exhibit 215**, Expert Report of Professor McGuire **[CBE, Tab 45]**; **Exhibit 37**, Expert Report of John McGurran **[CBE, Tab 19]**; **Exhibit 274A**, Expert Report of Dr. Matheson **[CBE, Tab 53]**; **Exhibit 289A**, Expert Report of Dr. Chambers **[CBE, Tab 54a]**; **Exhibit 343**, Expert Report of Dr. Wing **[CBE, Tab 82]**; **Exhibit 312A**, Expert Report of Dr. Younger **[CBE, Tab 62]**; **Exhibit 263**, Expert Report of Dr. Masri, **[CBE, Tab 49]**.

[1492] See: **Exhibit 274A**, Expert Report of Dr. Matheson, p. 3 of Report, p. 6 of Exhibit **[CBE, Tab 53]**; **Exhibit 289A**, Expert Report of Dr. Chambers, pp. 7-8 **[CBE, Tab 54a]**; **Exhibit 263**, Expert Report of Dr. Masri, p. 4, para 1, and p. 6, para 24 **[CBE, Tab 49]**; **Exhibit 312A**, Expert Report of Dr. Younger, pp. 7-8 **[CBE, Tab 62]**; **Exhibit 343**, Expert Report of Dr. Wing, p. 7 **[CBE, Tab 82]**.

[1493] See: **Exhibit 274A**, Expert Report of Dr. Matheson, p. 3 of Report, p. 6 of Exhibit **[CBE, Tab 53]**; **Exhibit 289A**, Expert Report of Dr. Chambers, pp. 7-8 **[CBE, Tab 54a]**; **Exhibit 263**, Expert Report of Dr. Masri, p. 4, para 1, and p. 6, para 24 **[CBE, Tab 49]**; **Exhibit 312A**, Expert Report of Dr. Younger, pp. 7-8 **[CBE, Tab 62]**; **Exhibit 343**, Expert Report of Dr. Wing, p. 7 **[CBE, Tab 82]**.

expert opinions of Dr. Matheson, Dr. Chambers, Dr. Wing, Dr. Younger and Dr. Masri, all of whom are medical doctors.

1883. Dr. Matheson concluded that:

(a) Evidence published in peer-reviewed medical journals demonstrates consistently and irrefutably that waiting for medical or surgical treatment can increase morbidity and mortality, and reduce quality-of-life and functional outcomes following treatment or surgery.

(b) There is similar evidence that waiting for medical or surgical treatment causes worsening or progression of the patient's disease while waiting, and increases the frequency of complications of the disease prior to treatment or surgery.

(c) The strength of evidence in the medical literature underpinning these conclusions is strong.[1494]

(d) The worsening and progression of the disease while waiting for treatment is often accompanied by increased pain and disability[1495]

1884. Dr. Chambers concluded

> I have reviewed a number of studies looking at the "effect" or impact of waiting time for elective medical services, including for conditions involving high cost and high-frequency such as cardiac surgery, hip replacement surgery, knee replacement surgery and cataract surgery as well as other health conditions such as back surgery, bladder cancer surgery and carotid endarterectomy.
>
> ...
>
> In summary and with regards to the question of the consequences for the health of BC residents involved in waiting for health services, it is my opinion that, for several health conditions, published medical research supports that there is significant evidence of harm to the physical and mental health of BC residents waiting for health services.[1496]

1885. Dr. Masri concluded that:

> Waiting longer than six months for [hip replacement] surgery resulted in a 50% decrease in the odds of achieving a better-than-expected outcome. We concluded that prolonged waiting

[1494] **Exhibit 274A**, Expert Report of Dr. Matheson, p. 3 of Report, p. 6 of Exhibit. **[CBE, Tab 53]**.
[1495] **Exhibit 274A**, Expert Report of Dr. Matheson **[CBE, Tab 53]**; **Exhibit 289A**, Expert Report of Dr. Chambers, p. 8, footnotes 15 to 25 **[CBE, Tab 54, a]**.
[1496] **Exhibit 289A**, Expert Report of Dr. Chambers, pp. 7-8 **[CBE, Tab 54, a]**.

times may impair patient outcomes. This result makes sense from a medical and physiological perspective because the arthritic process in major joints may result in muscle atrophy, tissue contractures, and deterioration of the general medical condition that may not be recoverable after surgery in the event of surgical delays.[1497]

...

With respect to the impacts of waiting [For hip and knee replacement surgery] on patients generally, the overall evidence showed that there are deleterious effects for patients when they wait a long time for special assessment and/or treatment, such as increased morbidity, physical decline, functional disability and negative psychological and social impacts, including prolonged sick leave or loss of employment, and altered social functioning and relationships.

We then review the scientific evidence with respect to the consequences for waiting for hip and knee replacement procedures. While both procedures have the capability to provide very good short-term and long-term outcomes, the evidence shows that waiting more than six months are associated with significant declines in surgical outcomes, as well as prolonged discomfort and disability for patients.[1498]

1886. Dr. Younger concluded that:

The loss of mobility secondary to foot and ankle pain interferes with patients' ability to work and function in society. This is our primary concern. It interferes with their ability to exercise. This can cause increase in weight, and as a result increase their risk of diabetes and heart disease.

...

Patients with foot and ankle problems can have difficulty maintaining independence. This affects both the elderly and younger patients such as those with congenital diseases. Foot and ankle symptoms can make the difference between institutional living, wheelchair dependency, and independence.

...

If we are able to treat these patients with surgery early in their deterioration, we can better maintain their health and increase the likelihood of a successful outcome. We can prevent them from gaining weight and becoming depressed. If they are potentially dependent we can maintain their independence through this, we can maintain their mental health. We can maintain their employment and their independence.

...

If their consultation and surgery is delayed, even if we are able to reduce their pain and improve mobility and correct deformity with successful surgery, we may be unable to get patients back

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[1497] **Exhibit 263**, Expert Report of Dr. Masri, p. 4, para 15 **[CBE, Tab 49]**.
[1498] **Exhibit 263**, Expert Report of Dr. Masri, p. 6, para 24 **[CBE, Tab 49]**.

into the workforce and unable to improve their mental health.[1499]

1887. Dr. Wing concluded that:

> While there is variability from patient-to-patient, it is clear in the raw data that some patients are significantly disabled and have altered states consistent with severe pain and significant depression and/or anxiety. The data further indicates that some of the same patients deteriorate over time as they wait for assessment by both the FAST practitioners and by orthopedic surgeons. .... It is my opinion that some foot and ankle patients are denied the optimal improvement they may have experienced because of the delay in consultation and ultimately the delay in performing surgery"[1500]

1888. The Defendant tendered only one expert report on the harm to patients from waiting, the Report of Dr. Guyatt.[1501]

1889. Although the Defendant advised the Court of its intention to call Jason Sutherland to give evidence on the effect on health of waiting for health services, neither Dr. Sutherland nor any other experts were called on this issue.

1890. The defendant's expert witnesses, Drs. Bohm, and McMurtry did not file expert reports dealing specifically with the harm to patents from delayed treatment, but gave expert evidence on this issue in the course of their cross-examinations.

1891. Dr. Guyatt's report responded only to the reports of Dr. Matheson and Dr. Masri.

1892. Further, Dr. Guyatt was not asked to provide an expert opinion on Dr. Masri's expert evidence about the harm to patients caused by waiting. He was only asked to address Dr. Masri's evidence respecting benchmarks.[1502]

1893. Consequently, there is no expert evidence challenging the opinions or conclusions of Dr. Chambers, Dr. Wing, Dr. Younger or Dr. Masri on the harm to patients caused by waiting.

1894. Although Dr. Guyatt raised some technical objections to portions of the report of Dr. Matheson, he agreed with the general conclusions of all of the plaintiffs' experts that patients suffer

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[1499] **Exhibit 312A**, Expert Report of Dr. Younger, pp. 7-8 **[CBE, Tab 62]**.
[1500] **Exhibit 343**, Expert Report of Dr. Wing, p. 7 **[CBE, Tab 82]**.
[1501] See: **Exhibit 577A**, Expert Report of Dr. Guyatt **[CBE, Tab 154]**.
[1502] See: **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 2 for reference to instruction letter, and Tab 1(B) for instruction letter**[CBE, Tab 154]**.

serious harm to their physical and mental health and general well-being from waiting for diagnosis and treatment by specialists.

1895. Dr. Guyatt testified that patients suffer on a daily basis while they wait for surgery:

Q And you deal with that -- if you could turn to page 14 of your report. And there's a heading there "Progression While Waiting For Surgery." Do you see that?

A I do.

Q And if we go to the second sentence you write:

> There is no doubt patients who suffer on a daily basis from a condition requiring surgery continue to suffer while they wait for surgery.
>
> So that's -- there's no doubt based on your review of the literature and your understanding, more generally, that patients do suffer -- patients who are suffering continue to suffer while they're waiting.

A Yes. That's true.[1503]

. . .

Q At page 15 now.

[...]

Q -- under the heading "Conclusion" you write:
"In summary, there are situations in which undue waiting surely leads to suffering while waiting ..."
I'll just stop there. So that's consistent with what you said on the previous page?

A Yes, it is. [1504]

1896. Dr. Guyatt testified that patients suffer in several ways while they wait for surgery, including physical pain, incapacitation or disability, and psychological well-being:

Q So I want to identify at least two kinds of suffering. One is many patients waiting on lists are suffering from physical pain.

A Yes.

Q Right. And many patients waiting on surgical lists also suffer from some degree of

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[1503] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 8, lines 27-44.
[1504] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 9, lines 5-17.

incapacitation or disability or limited use of their limbs and limits in their ability to move. That's true too, isn't it?

A Yes.

Q And so that's, I take it, what you had in mind when you talked of suffering. It's at least of those two kinds of circumstances.

A That is indeed at least primarily what I had in mind.

Q And I -- and again, this is something you deal with a bit in your answer with respect to psychological well-being, that there's also another kind of suffering, which is just the anxiety, the psychological stress of knowing that you have a medical condition and waiting for the treatment for that condition; is that right?

A Yes, that is indeed another type of suffering that patients may experience.[1505]

1897. In his expert report, Dr Guyatt elaborated further on the importance of the psychological well-being of patients as follows:

> Intuitively, psychological status is likely to bear on health outcomes. Dr. Matheson cites one review bearing directly on the first statement. The limited evidence of which I am aware does provide modest support for the contention that psychological well-being is an important determinant of treatment and surgical outcomes"[1506]

1898. Dr. Guyatt also confirmed that waiting for treatment can lead to adverse long term outcomes.[1507]

1899. He stated that, "in summary, there are situations in which undue waiting surely leads to suffering while waiting, and to adverse long-term outcomes"[1508]

1900. Earlier in his report he stated that "waiting for some medical and surgical procedures can cause irreparable morbidity and sometimes mortality, and for certain conditions a patient's health status is likely to deteriorate during prolonged waits"[1509]

1901. He also concluded that "if the natural history of the condition is progression, sufficiently long waits will result in deterioration"[1510]

1902. All of the experts, including the Defendant's only expert who prepared a report on the harm to patients from delay, therefore agree that while patients wait for diagnosis and treatment they suffer

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[1505] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 9, lines 23-46.
[1506] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 15 **[CBE, Tab 154]**.
[1507] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 9, line 47 to, p. 10, line 15.
[1508] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 15 **[CBE, Tab 154]**.
[1509] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 4 **[CBE, Tab 154]**.
[1510] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 14 **[CBE, Tab 154]**.

a variety of often increasing harms to their health, including suffering from physical pain, incapacitation, disability, limited mobility, and psychological stress.

1903. In fact no one has ever disputed that many patients waiting for medically necessary treatments suffer these harms on a daily basis while they wait.

1904. All of the experts, including Dr Guyatt, also agreed that delay in receiving treatment can cause permanent harm in the form of further deterioration, adverse long-term outcomes, irreparable morbidity and sometimes mortality.

1905. The only point of disagreement between Dr. Guyatt and Dr. Matheson (or any of the other Plaintiffs' experts) on the issue of permanent harms from delayed treatment was the universality and prevalence of these harms. Delay in treating some conditions in some patients may be less likely to cause permanent harm than delay in treating other conditions in other patients.

1906. Dr. Guyatt described the point of difference in this way in his report:

> On the other hand, there are many conditions in which waiting does not cause irreparable morbidity or increased mortality… and there is no progressive worsening or deterioration (indeed, there may rather be an improvement while waiting). Thus, concern about wait times must be addressed on a condition by condition basis.[1511]

1907. In other words, Dr. Guyatt has simply added the qualification that the risk of permanent harm from waiting depends upon the patient, the nature of the condition, the severity of the condition and the length of the delay. He does not dispute that some patients with some conditions will suffer permanent harms as a result of waiting too long.

1908. The expert evidence therefore unequivocally establishes the Plaintiffs' claim that waiting for diagnostic and surgical services in the public system causes harm to patients, including a risk of permanent harm and even mortality.

1909. Although this is sufficient to establish the plaintiffs' claim on this point, there is some utility in exploring the character of the defendant's challenge to the expert evidence of harms from waiting, to make clear that it was of little or no significance.

1910. First, Dr. Guyatt in his evidence and the defendant, in its cross-examination, proceeded on the basis that the Plaintiffs were arguing that all patients with all conditions always suffer irreparable

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[1511] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 4 **[CBE, Tab 154]**.

harm from any delay in treatment. Identifying some counterexamples was therefore put forward as refuting the plaintiffs' claim.

1911. This, of course, has never been the plaintiffs' argument and is a classic example of setting out to refute a strawman. The Plaintiffs' claim does not depend in any way on establishing that every patient is permanently harmed by delay. The Plaintiffs' claim, and the Plaintiffs' expert evidence, is simply that some patients with some conditions risk permanent harm the longer they wait.

1912. Identifying some circumstances in which patients are not permanently harmed by delay is therefore irrelevant, as it has nothing to do with the Plaintiffs' actual claim.

1913. A particularly obvious example of this attack on a strawman is Dr. Guyatt's claim that Dr. Matheson was selective in his report by excluding specific conditions and treatments in which studies suggest that delay in providing the treatment was beneficial or in which the treatment seemed to offer no benefit at all.[1512]

1914. There was no reason for Dr. Matheson to include these studies in his report, since he was not claiming that every patient with every condition risks permanent harm from delay in receiving every type of treatment.

1915. Identifying a few specific examples in which patients are better off delaying a particular treatment or in which a treatment was shown not to be efficacious is simply no answer to the Plaintiffs' actual claim. This is not responsive to the many patients who are being harmed, or subjected to an increased risk of harm, by waiting for treatments which are known to be efficacious and for which there is no benefit in delay.

1916. Further, studies of conditions in which it has been shown that patients improve through a postponement in treatment, or in which the treatment is ineffective, have nothing to do with the medical conditions at issue in this case.[1513]

1917. The only conditions on which wait time data is collected are ones in which the specialist has determined, based on the current best available evidence, that the patient will likely benefit from the

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[1512] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 12, discussing studies cited at footnote 15 through 19 of the Report **[CBE, Tab 154]**.
[1513] **Exhibit 577A**, Expert Report of Dr. Guyatt, see the studies cited in footnotes 16, 18 **[CBE, Tab 154]**; **Transcript Day 178**, Testimony of Dr. Guyatt, p. 28 line 28 to, p. 29, line 13.

treatment as soon as it can be administered. If that were not so, the patient would not have been placed on the waiting list.

1918. So the types of conditions and treatments identified by Dr. Guyatt in his Report, in which waiting is beneficial, are simply not part of the wait time evidence before the Court.[1514]

1919. Equally studies of treatments such as post-operative physical therapy[1515]or early treatment of whiplash by physiotherapists, chiropractors and massage therapists[1516] have nothing to do with this case. The case is about the harm caused by waiting for diagnosis and treatment by specialists, not all health care professionals.

1920. Further, physiotherapists, chiropractors and massage therapists are not covered by the public system and therefore are not subject to any prohibitions on dual practice. Their patients are not prohibited from obtaining private insurance to cover their services. Studies about their services are therefore doubly irrelevant.

1921. So, Dr. Guyatt's opinions and the Defendant's cross-examination on these studies have nothing to do with the Plaintiffs' claim or the actual medical conditions at issue in the case. There was no reason for any of the Plaintiffs' experts to include these studies in their reports.

1922. Second, Dr. Guyatt in his Report and testimony accused Dr. Matheson of being selective in his choice of studies by not including <u>all</u> of the studies that pointed to a different conclusion on permanent harm from waiting.

1923. Dr. Guyatt was, however, even more selective in his choice of studies to be included in his Report.

1924. In his letter of instruction, he was asked whether or not he agreed with Dr. Matheson's opinions regarding the negative impact of waiting for treatment upon medical outcomes and disease progression.[1517]

[1514] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 30, lines 5-15.
[1515] **Exhibit 577A**, Expert Report of Dr. Guyatt, see study cited at footnote 17 **[CBE, Tab 154]**; **Transcript Day 178**, Testimony of Dr. Guyatt, p. 25, line 40 to, p. 26, line 12.
[1516] **Exhibit 577A**, Expert Report of Dr. Guyatt, see study cited at footnote 19 **[CBE, Tab 154]**.
[1517] See: **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 2 for reference to the instruction letter, and Tab 1(B) for instruction letter **[CBE, Tab 154]**.

1925. This was a neutral question calling upon Dr. Guyatt to conduct his own balanced review of the literature and offer his expert opinion on whether waiting for treatment adversely affected medical outcomes and disease progression for the medical conditions considered by Dr. Matheson.

1926. But Dr. Guyatt did not focus on the neutral question posed for him in this way.

1927. Instead of assisting the Court by providing his own expert opinion on whether waiting for treatment causes permanent harm for the conditions considered by Dr. Matheson, he refashioned his instructions as a request that he identify weaknesses in the expert report of Dr. Matheson.

1928. In short, rather than providing assistance to the court by providing a balanced review of the scientific evidence, he simply provided a selective collection of studies that he thought were inconsistent with the studies cited by Dr. Matheson in his report.

1929. Dr. Guyatt acknowledged this in cross-examination.

Q Now, in preparing your response report I take it you -- you're not claiming you did a systematic review of the literature in this area.

A I did not do a systematic review. That is correct.

Q And in particular, looking at the report it appears as though what you were looking for were studies that were inconsistent with the positions -- I'm thinking now of Dr. Matheson. That was your focus; is that right?

A My point was to point out that there had been selective citation and that the apparent impression that one might get from Dr. Matheson's report in particular was that all the studies showed a similar conclusion. The point I was making was that there are disparities in results across studies and that in particular the most trustworthy studies, two particular randomized trials, show results that are inconsistent with the observational studies on which Dr. Matheson relies.

Q Right. So if in your review, which was not a systematic review, you came across studies that supported Dr. Matheson's view, you weren't going to include those in your report. Isn't that right?

A I would be unlikely to have done so, although I don't remember having done -- having come across such studies.

Q Right. But the purpose wasn't to provide your balanced view of the area; it was to support your argument that Dr. Matheson had been selective, specifically omitting studies that you say were inconsistent; right?

A It was in fact to support my balanced view of the area, and my -- and in support of my

> balanced view of the area all that was, in my view, required was to demonstrate the fact that the results were inconsistent across studies.[1518] [emphasis added]

1930. This recasting of his instruction, as a selective presentation of studies thought to be inconsistent with Dr. Matheson's studies, was not consistent with the neutral question he was asked and it was also inconsistent with his obligation under Rule 11-2, to assist the Court and not be an advocate for a party.

1931. Dr. Guyatt's selective presentation of only the studies that he believed were inconsistent with the studies referenced by Dr. Matheson was an inevitable consequence of his clear, long-standing and deeply held opposition to parallel private practice and his strong desire to have the Plaintiffs' not succeed in this case.

1932. When Dr. Guyatt was asked very simple and direct questions about his membership in various advocacy groups and his views on parallel private pay surgeries, he was evasive and disingenuous.

1933. In the end, however, the basic facts are clear.

1934. Dr. Guyatt has personally advocated against private pay surgeries for his entire career[1519].

1935. He is on the Board of Directors of the Ontario Health Coalition, because he wants to support the organization[1520]. One of the missions of the Ontario Health Coalition is to protect the public healthcare system from threats of privatization.[1521]

1936. The Ontario Health Coalition is affiliated through a national coalition with the BC Health Coalition.[1522] The BC Health Coalition has intervened in this case, under the name "British Columbia Friends of Medicare Society", to oppose the Plaintiffs.[1523]

1937. The Ontario Health Coalition openly and vigorously advocates against private surgical clinics and against the Plaintiffs' claim in this case.[1524] Indeed, the Ontario Health Coalition is openly

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[1518] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 7 line 28 to, p. 8, line 19.
[1519] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 39, line 7 to, p. 50, line 10, and p. 54, line 32 to, p. 55 ln 1.
[1520] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 33, line 29 to, p. 34, line 24.
[1521] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 35, line 5.
[1522] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 47, line 47 to, p. 48 line 14.
[1523] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 37, line 22.
[1524] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 37, line 46 to, p. 38, line 16.

soliciting donations to support the BC Health Coalition's participation in court as intervenors to oppose the Plaintiffs' claim and Dr. Guyatt supports that activity.[1525]

1938. Dr. Guyatt is also a member of Canadian Doctors for Medicare, another group of interveners opposing the Plaintiffs' claim.[1526] Canadian Doctors for Medicare is a successor organization to a group called the Medical Reform Group that Dr. Guyatt founded with others in around 1979.[1527]

1939. He opposed Dr. Day's candidacy for president of the Canadian Medical Association because Dr. Day has been a proponent of more private pay surgery in Canada.[1528]

1940. Finally, Dr. Guyatt does not want the Plaintiffs to succeed in this case because of his strong opposition to those with more means getting speedier care through private diagnosis and treatment by specialists.[1529]

1941. Dr. Guyatt's support for and affiliation with interveners opposing the Plaintiffs' claim, his long-standing and deeply held opposition to private healthcare, and his personal interest in defeating the Plaintiffs' claim must all be considered in assessing his evidence.

1942. As Dr. Guyatt himself acknowledged, even if a bias is not intentional, unintended biases do affect the views and perceptions even of scientific researchers.[1530]

1943. At the very least, therefore, Dr. Guyatt prepared his report with a strong predisposition against the conclusions of the Plaintiffs' experts. He disregarded his instructions to provide his opinion on the harms identified by Dr. Matheson for various conditions and instead prepared a report designed solely to raise doubts about the strength of the studies referenced by Dr. Matheson. The result was a focussed assault, rather than an expert opinion on the issue.

1944. And the Defendant must have known about Dr. Guyatt's advocacy, deeply held views and affiliations, when they selected him as their only expert, rather than Jason Sutherland, whom they had previously identified as their expert, or a medical doctor who did not have a long history advocating against the Plaintiffs' very claim.

[1525] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 46, line 45 to, p. 47, line 26.
[1526] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 5, line 1.
[1527] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 33, line 3.
[1528] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 2, line 34 to, p. 4, line 26.
[1529] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 4, line 28 to, p. 5, line 41.
[1530] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 4, line 28.

1945. Although Dr. Guyatt generally agreed with the Plaintiffs' position that some patients suffered daily harms while waiting for treatment and that some patients will be permanently harmed by postponing treatment, it is worth examining some of the studies that the Dr. Guyatt identified as being inconsistent with the studies referenced by Dr. Matheson.

1946. It will be seen that Dr. Guyatt has exaggerated the significance of many of the studies he cited or mischaracterized their conclusions. He also levelled unfounded criticisms of the studies cited by Dr. Matheson.

1947. This was inevitable when an expert called by a Defendant has such a long and deep interest in defeating the Plaintiffs' claim.

1948. For example, he writes in his Report:

> Some studies did not carry out a satisfactory adjusted analysis. The failure to take into account obvious confounders such as differences in age or preoperative function increases the likelihood that imbalance in these confounders, rather than wait times, is responsible for differences in outcome in those with short and long wait times[1531].

1949. One of the studies identified in this passage is a study coauthored by Dr. Masri, which is cited in Dr. Masri's expert report, Dr. Chambers' expert report, Dr. Matheson's expert report and Prof. Kessler's expert report.

1950. When counsel began to cross-examine Dr. Guyatt about this statement he quickly admitted that his criticism of these studies was wrong. The studies had in fact adjusted for age, preoperative function, gender and comorbidity.

1951. After making this admission, however, Dr. Guyatt attempted to supplement his report by raising additional factors that he claimed the reports had not adjusted for. This answer was not in any way invited by the question asked and is inadmissible as an improper attempt to supplement his expert report, with the obvious prejudice that the Plaintiffs are not in a position to test his new theories and arguments on the fly when those arguments are raised for the first time in cross-examination.

1952. The complete exchange follows:

> Q And then you carry on, just so we have the complete context:
>
> The failure to take into account obvious confounders such as differences in age or pre-

[1531] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 12 **[CBE, Tab 154]**.

operative function increases the likelihood that imbalance in these confounders, rather than wait times, is responsible for differences in outcome in those with short and long wait times.

A Correct.

Q And I take that that -- what I just read out, all of that is in reference to the studies that are at footnotes 9 and 10.

A Not quite. The -- you're perhaps thinking of the study by Garbuz. I suspect that's where we're going. And Garbuz did take age and pre-operative function. And indeed most of the studies took into account age and pre-operative function, so that was perhaps on my part a poor choice. What I should have said, for instance, was socioeconomic status and patient expectations and what we call somatic preoccupation, which, to make it simple, is a patient who has aches and pains all over their body has a large level of somatic preoccupation. Those in the context of the studies number 9 and 10 would have been much superior variables that should have been adjusted for than the more obvious ones that I chose in that sentence.

Q Okay. But from reading your report there's no way anyone would know that that's the basis of your criticism of those reports, is there?

A Right. And you have just identified a deficiency in my report that I regret. As I say, were I doing it now, I would have said socioeconomic status and expectations such as – expectations and somatic preoccupation, which has been demonstrated to be associated with adverse outcomes.

Q Right. But you see, the difficulty with you not putting it in the report but now in your testimony today for the first time identifying some other concerns is that there's no way for the authors of this report to respond or to advise me of a proper response. It's just impossible to test something if you raise it for the first time in cross-examination, not having raised it in the report. You understand that?

A Yes, although I would say if the -- if they had read the full report, my full report, they would have identified that the prognostic factors, the confounders for which it would have been ideal to have adjusted, are mentioned in other parts of the report.

Q But it's not mentioned in reference to their study, is it?

A Yes. And that is a limitation of my report, which I now regret.

Q But you do agree that those studies did adjust for age, pre-operative function, as well as -- and I'm looking at the report you mentioned. It's at tab 9, the Garbuz report. They say they adjusted for age, gender and comorbidity as well as for the pre-operative condition, didn't they?

A Yes, they did, and as I say, I regret that I didn't point -- that I refer to the obvious variables that they did adjust for and not the also extremely important variables for which

they did not adjust.[1532]

1953. Dr. Guyatt therefore acknowledged that his only criticism of these published studies in his report was unfounded. There is therefore nothing in his report that would weaken the strength of the conclusions in these reports.

1954. Dr. Guyatt then criticizes Dr. Matheson for failing to consider two studies examining the effect on surgical outcomes of waiting for hip replacement and knee replacement surgery.

1955. Dr. Guyatt puts it this way in his report:

> The most problematical omission in Dr. Matheson's summary is, however, the highest-quality evidence regarding the impact of waits on long-term outcomes that comes from two clinical trials. In a randomized trial in patients with osteoarthritis schedule for hip replacement, 174 patients were allocated to a short wait time group and 221 to a non-fixed wait group. The mean waiting time was 74 days in the short wait group and 194 days in the non-fixed group. Generic health related quality of life and functional outcomes did not differ in the two groups at one year after surgery"[1533]

1956. But the two studies that Dr. Guyatt identifies in this passage as of higher quality than the studies cited by Dr. Matheson on waiting for hip and knee replacement are not actually inconsistent with the studies cited by Dr. Matheson.

1957. The studies cited by Dr. Matheson report that typically there are worse outcomes for hip and knee replacement surgery for patients that wait more than six months.[1534]

1958. The two studies identified by Dr. Guyatt compare patients in two randomized groups, those waiting less than 3 months and those waiting more than 3 months. The mean waiting time for the two groups was 74 days in the short wait group and 194 days in the long wait group. (194 days is just over 6 months).[1535]

1959. The randomized studies cited by Dr. Guyatt, therefore, are not strictly comparable to the studies cited by Dr. Matheson reporting statistically significant worse postsurgery outcomes for waits greater than six months, since the randomized studies deal mostly with waits of less than 6 months.

[1532] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 20, line 6 to, p. 41, line 29.
[1533] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 13 **[CBE, Tab 154]**.
[1534] **Exhibit 274A**, Expert Report of Dr. Matheson, pp. 7-8 **[CBE, Tab 53]**.
[1535] **Exhibit 577A**, Expert Report of Dr. Guyatt, see footnotes 24 and 25 **[CBE, Tab 154]**.

1960. This point is made in one of the recent studies cited by Dr. Matheson in which the authors comment on the randomized studies cited by Dr. Guyatt, as follows:

> The reasons for the conflicting evidence are unclear. The randomized controlled trials have focused on comparing routine wait times with faster access to treatment. In these studies, fast access ranged from 1 to 3 months [citations omitted], whilst routine wait times ranged from 3 to 8 months [citations omitted]. In contrast, the observational studies that find significant negative impacts on waiting time on outcomes arise from long waits, typically of 6 to 12 months or longer [citations omitted]. It is possible that the waiting time in the randomized control trials were not sufficiently long to influence the pretreatment health or post treatment outcomes.[1536]

1961. There are also problems with the randomized trials cited by Dr. Guyatt which do not permit them to be treated as the high quality evidence typically associated with randomized controlled studies.

1962. The main problem is that the crucial defining characteristic of the two groups compared in the study, those with surgery performed in less than three months and those with surgery performed in more than three months, was not actually achieved in the study.

1963. Instead, 49 patients constituting 35% of the short wait group actually had their surgeries after waiting more than three months, with some of them waiting substantially more than three months.[1537]

1964. This meant that they overlapped with patients in the long waiting group on the key characteristic, waiting time.

1965. Further, about 20% of the patients in the long wait group had their surgery in less than three months.[1538]

1966. This meant that they overlapped with patients in the short waiting group on the key characteristic, waiting time.

1967. As a result, there was a substantial overlap or crossover between the control and the treatment groups, contrary to the design requirements of every randomized controlled study.

1968. This crossover would necessarily affect both the outcome and the reliability of the study, making it a lower quality randomized controlled study.

[1536] **Exhibit 274A**, Expert Report of Dr. Matheson, see footnote 8 (Nikolova study), p. 123 **[CBE, Tab 53]**.
[1537] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 51, line 29.
[1538] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 52, line 5.

1969. This point was put to Dr. Guyatt repeatedly in cross-examination, but rather than answering the question, he repeatedly restated the obvious point, which was not in dispute, that for ethical and other reasons it is not always possible to maintain the integrity of the two randomized groups when treating human beings in the real world.[1539]

1970. For example, patients in the longer waiting group might have deteriorated, and therefore required earlier treatment for ethical reasons. Patients in the shorter waiting group could not be treated within the design time limit of three months because resources were not available to treat them within that period.

1971. The question, however, as Dr. Guyatt fully understood, was not whether there were good reasons for departing from the study design. The question was what was the effect on the outcome of the study and the reliability of the study of this departure from the design. Dr. Guyatt simply refused to answer this question[1540].

1972. The effect of overlap between the two groups is, however, easy to understand.

1973. If we took a group of 200 patients and randomly assigned them to two groups of 100 each in which the control group would receive a placebo and the treatment group would receive some new medication being tested, we can immediately see that there will be a problem with the outcome of the study and its reliability if some of the individuals in the control group actually receive the medication instead of the placebo and some of the patients in the treatment group do not receive the treatment, but instead received the placebo.

1974. In fact, if the crossover reached 50%, so that 50% of those in the control group received the medication and 50% of those in the treatment group did not receive the medication, the two groups would be statistically identical. In each group 50% of the patients would have received the medication and 50% of the patients would have received the placebo.

1975. If we compared the two groups there would be no measurable difference because the two groups are in fact identical.

[1539] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 50, line 42 to, p. 61, line 3.
[1540] **Transcript Day 178**, Testimony of Dr. Guyatt, p. 50, line 42 to, p. 61, line 3.

1976. This example is directly related to the study cited by Dr. Guyatt, in which the members of control group were to have surgery after 3 months, and the members of the treatment group were to have their surgery in less than 3 months.

1977. Imagine a study in which 35% of the patients in the treatment group (the short wait group) do not receive the treatment (surgery in less than 3 months) and 20% of those in the control group (longer wait group) group do receive the treatment (they have the surgery in less than 3 months).

1978. While the two groups will not be statistically identical, as they would be if the percentage reached as high as 50%, it is obvious that if 35% of those in the treatment group do not receive the treatment and 20% of those in the control group do receive the treatment, it will necessarily affect the outcome. In fact, it will necessarily diminish any difference between the two groups, because they are more alike.

1979. This crossover effect will be even more profound if there is some reason why some people in the control group were treated and some people in the treatment group were not treated, so that the cross-over is not random. In the two studies, it is very likely that there was a reason for the cross-over.

1980. It is very likely that those in the long wait group who received their hip surgery in less than three months did so because their condition worsened and it would be unethical to further delay their surgery. Performing their surgery more quickly than planned, however, would likely improve their outcomes, thereby reducing the difference between the short waiters and the long waiters.

1981. Equally, it is likely that those in the short wait group who waited more than three months would likely have worse outcomes, again diminishing the difference between the two groups.

1982. It is not possible to correct this problem by simply removing the 35% of patients in the short wait time group and the 20% of patients in the long wait time group from the study. This would undermine the crucial random selection of the patients. It is highly probable that those in the short wait group who waited longer than 3 months were different from those who did not, perhaps because their condition was deteriorating more slowly than others and that those in the long wait group who waited less than 3 months were different from those who did not receive the surgery in less than 3 months, because their condition was deteriorating more quickly than others and required immediate attention.

1983. This problem with overlap between the control and the treatment group in the two studies was described succinctly in one of the studies cited by Dr. Matheson in which the authors stated:

> The trials also exclude high proportions of eligible participants for refusing consent, limiting the generalizability of results. In addition, there was overlapping waiting times in faster access (intervention) and routine (control) groups, which may dilute any difference in outcome.[1541]

1984. When Dr. Masri was cross examined on these studies, he explained that whenever a result is not biologically plausible it could be an error in the study design or a crossover effect from one group to another. He explained that a study that doesn't fit with what you expect from empirical evidence must be taken with a grain of salt.[1542]

1985. He also noted that it was possible that the patients in the short waiting time group were worse to begin with because the cost of medications was higher in this group. He explained that this can happen due to the ceiling effect when the health related quality outcome tool is not sensitive enough to pick up these differences when the condition is already very serious.[1543] This suspicion was confirmed in the study itself, which states:

> Those in the [short wait time] group had a worse pain score at baseline, which reflected in an increased use of DSM during the waiting period.[1544]

1986. Dr. Masri explained that the results might have been different if there hadn't been a significant number of patients that crossed over between the two groups. [1545]

1987. With regard to high numbers of eligible participants refusing consent, Dr. Masri also explained that randomized controlled trials have quality issues in surgery. He stated "so just because they are randomized controlled trials doesn't mean they are the holy gospel". [1546]

1988. In surgery it is difficult to do randomized studies because patients who are "bad" will refuse to be randomized in case they are placed in the longer waiting group. Dr. Masri's experience with

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[1541] **Exhibit 274A**, Expert Report of Dr. Matheson, see footnote 8 (Nikolova study), Nikolova study can be found at exhibit p. 123 (p. 965 of the published Nikolova study) **[CBE, Tab 53]**.
[1542] **Transcript Day 87,** p. 56, lines 1 to 17; p. 81, lines 2 to 20.
[1543] **Transcript Day 87,** p. 81, lines 17 to 27.
[1544] **Transcript Day 87,** p. 120, lines 5 to 7.
[1545] **Transcript Day 87,** p. 119, lines 9 to 20.
[1546] **Transcript Day 87**, p. 19, lines 9-20.

randomized controlled trials in surgery is that his recruitment rate is about 5% of patients approached, but that doesn't get reported. [1547]

1989. The point of all this is not that the studies are worthless or of no value. The point is simply that Dr. Guyatt was misleading in his report when he claimed that the studies should be given the high evidentiary value typically associated with randomized controlled studies and admonishing Dr. Matheson for not including them. They simply do not provide the strong evidence against Dr. Matheson's views that Dr. Guyatt claimed.

1990. The one study that considers these randomized controlled studies does not treat them as definitive, or as having refuted the results of the earlier (or subsequent) studies. Indeed, these randomized studies are treated as unexplained anomalies[1548].

1991. Dr. Chambers referred to these studies in his expert report and commented on the cross contamination between the two groups and concluded: "In my opinion, these are failed clinical trials in terms of determining the impact of waiting time on outcome for those requiring THR or TKR."[1549] Dr. Guyatt was not asked to review Dr Chambers' report and therefore did not comment on Dr. Chambers' rationale for rejecting them because of the serious problem of cross-contamination.

1992. Finally, Dr. Guyatt, criticizes Dr. Matheson for not referring to a systematic review, authored by Prof. Hoogeboom and others, of 15 studies examining progression of pain and functional limitations while waiting for hip and knee replacement[1550].

1993. It is important to appreciate that this study is not about the relationship between waiting and worse outcomes after surgery. It is about deterioration in the patient's condition while waiting for the surgery.

1994. Dr. Matheson only cited two studies[1551] dealing with the deterioration of patients while waiting for hip and knee replacement surgery and one of the studies was published after the systematic review mentioned by Dr. Guyatt and therefore was not considered in that review.[1552]

[1547] **Transcript Day 87**, p. 82-83 lines 34-47, 1-10.
[1548] **Exhibit 274A**, Expert Report of Dr. Matheson, see footnote 8 (Nikolova study), Nikolova study can be found at exhibit p. 123 (p. 965 of the published Nikolova study) **[CBE, Tab 53]**.
[1549] **Exhibit 289A**, Expert report of Dr. Chambers, Appendix B, p. 12 **[CBE, Tab 54a]**.
[1550] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 14, footnote 27 **[CBE, Tab 154]**.
[1551] **Exhibit 274A**, Expert Report of Dr. Matheson, p. 8, see footnotes 16 and 23 **[CBE, Tab 53]**.
[1552] **Exhibit 274A**, Expert Report of Dr. Matheson, p. 8, see footnote 16 **[CBE, Tab 53]**.

1995. In any event, the conclusion of the systematic study was as follows:

> The results of this review indicate that whilst waiting a moderate time (< six months) for joint replacement there is strong evidence that pain (hip and knee OA) and self-reported functional status (hip OA) do not change. There is conflicting evidence for change in self rated functioning in patients with knee OA. Indefinite results are reported toward long waiting times (greater than or equal to six months), though pain might increase in people with hip OA with regard to predictors of future pain or functional status, female gender was found to be the only predictor of intensified pain"[1553]

1996. The study therefore doesn't reach any valid conclusions about deterioration when waiting more than six months.

1997. Significantly, the study cited by Dr. Matheson that was published after the systematic review concludes that patients waiting more than six months suffer significant deterioration.[1554] This conclusion is not in any way inconsistent with the conclusion in the systematic review and fully supports Dr. Matheson's opinion.

1998. There is also a serious inherent limitation to studies examining the deterioration of patients while waiting for hip and knee replacement. The questionnaires used to measure a patient's condition cover the spectrum from a healthy patient to a patient with a very serious condition, and questionnaires have been shown to provide a consistent and reliable quantitative measure of changes in a patient's condition along this spectrum.

1999. The measuring instrument, however, is much less sensitive if it is used to measure a narrow range of patient conditions from bad to very very bad. This is because the instrument has an upper bound or "ceiling" which is the highest score that can be given to every question in the survey. Consequently, patients who have deteriorated from bad to very very bad, may have little or no difference in point scores because they have already recorded the highest score in each category.

2000. Dr. Masri commented on this limitation in his evidence, as follows: [1555]

> The influence of the ceiling effect in this respect has not yet been discussed. Patients with a very high baseline score are less likely to deteriorate on questionnaire with a ceiling effect.

[1553] **Exhibit 577A**, Expert Report of Dr. Guyatt, p. 14, see footnote 27, at p. 1425 **[CBE, Tab 154]**.
[1554] **Exhibit 274A**, Expert Report of Dr. Matheson, p. 8, see footnote 16 **[CBE, Tab 53]**.
[1555] **Transcript Day 87**, p. 122, lines 34-38.

2001. Dr. Masri explained that if a patient's condition is really bad, it will be difficult to detect further deterioration due to the maximum scores used in the instrument. As he explained, if a patient has already checked "severe pain" there is nothing more than "severe" that the patient can check and therefore there will be no record of deterioration, even though the patient's condition is worse. This is an illustration of the "ceiling effect".

2002. The systematic study acknowledged this significant limitation:[1556]

> To summarize, it is possible that the group of patients at risk for deterioration during the waiting list period is more significant than the results of this systematic review imply.

2003. Although Dr. Guyatt identified additional studies dealing with some of the medical conditions considered by Dr. Matheson, he did not do so for all of the conditions. In particular, Dr. Guyatt did not identify any studies that cast doubt on the high level evidence on the harms of waiting for cataract surgery, including two large systematic reviews.

2004. In summary, despite the obvious purpose of Dr. Guyatt's critique of Dr. Matheson's expert report, the two are largely in agreement and where they differ, Dr. Guyatt's criticisms are not significant or compelling.

2005. In addition to the experts who specifically filed reports on the harm to patients from waiting for treatment, two of the defendant's experts, who were also medical doctors, agreed in cross-examination that waiting for treatment was harmful.

2006. In his cross-examination, Dr. Bohm gave the following evidence:

> Q And again, maybe you can't answer this because of the limits of your expertise, but wouldn't you agree, being a doctor, that there are many other conditions that are very serious and pose a risk of mortality which you could die from waiting for the surgery for that condition?
>
> A Yeah. If you're having surgery to change your mortality risk, then yes, you could die while waiting for that surgery.
>
> Q Okay. Now, and then again, within your -- and I want to just stay within your expertise of hips and knees. You will agree that patients on waiting lists for hip and knee surgeries can suffer prolonged pain; correct?
>
> A That's why they're having surgery. If they're appropriate, they're having surgery because they have pain and loss of function.

[1556] **Exhibit 266**, p. 1426 **[CBE, Tab 50]**.

Q Yes. They have limitations in their physical function?

A Yeah.

Q There's -- it's impairment of their quality of life; correct?

A Yes.

Q And possibly even cessation of work?

A That's a possibility, yep. Loss of function.[1557]

...

Q Now, you did an update report entitled "The Effect of Total Hip Arthroplasty on Employment." Correct?

A I did. It's sort of a second look at the same group of patients. This paper characterizes their status prior to surgery and the second paper looks at what impact the surgery had on their ability to return to work and perform their workplace duties.

Q And I'll take you, please, to the abstract, and for my purposes I'll just take you to the bottom four lines where you state:

> Total hip arthroplasty has positive effects on work capacity in patients who returned to work. To help patients remain in the workforce surgeries should be undertaken before a patient's hip dysfunction forces them off work. And that's your opinion

A It is my opinion.[1558]

...

Q So that's why I put it to you that it's not that there weren't any adverse health consequences. They found that there were some, didn't they?

A What they found, as many other authors have found, is that patients with osteoarthritis, their function worsens with time; it's a degenerative condition. If it wasn't degenerative, people wouldn't come to surgery. And this is -- has been found in many other studies, so they worsen with time. The challenge is really some patients worsen rapidly, some worsen very, very slowly and some almost not at all.[1559]

...

Q Thank you. Okay. Now, I want to take you back to your report on page 4. And in that same

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[1557] **Transcript Day 153**, Testimony of Dr. Bohm, p. 34, lines 11-35.
[1558] **Transcript Day 153**, Testimony of Dr. Bohm, p. 37, lines 5-25.
[1559] **Transcript Day 153**, Testimony of Dr. Bohm, p. 49, lines 8-19.

section, now the second paragraph under the heading "Effect of Waiting Times on the Health of Patients," you say:

> I would therefore underscore Dr. Frank's assertion that the length of wait for surgery is only one factor in the eventual outcome of surgery.

And you explained that response to questions from Mr. Penner.

> There is reasonably good observational data that for degenerative conditions disease severity generally worsens with time, although not always, and that worse pre-operative status can be associated with worse post-operative status.

And we've gone through that. But now you say:

> Therefore, choosing a maximum acceptable wait time -- while not always possible to support with the literature -- does appear to be reasonable.

So I take it from that you agree with the setting of these maximum acceptable wait times?

A Yes.

Q Yes. And you in fact were I think it's called a co-investigator in the two reports that led to the establishment of these maximum acceptable wait times?

A Correct.

Q And Mr. McGurran was a co-collaborator on those reports?

A Indeed he was.[1560]

2007. Another defendant expert, Dr. McMurtry, was the Chair of the Health Council of Canada's Wait Times Group. He made clear in his testimony that patients that wait beyond the priority benchmarks for the treatment of their conditions are at higher risk of harm.[1561]

2008. He stated that he continued to agree with the opinions reached by him and the other authors of the Health Council paper on wait times, as follows:[1562]

(a) They know that waiting too long for care may harm your health. But, left untreated, arthritis can affect the structure and function of joints and deterioration of the muscles that control them.

[1560] **Transcript Day 153**, Testimony of Dr. Bohm, p. 55, line 38 to, p. 56, line 29.
[1561] **Transcript Day 159**, Testimony of Dr. McMurtry, p. 44, lines 27-42.
[1562] **Transcript Day 159**, Testimony of Dr. McMurtry, pp. 43-47.

(b) Poor visual acuity can lead to accidents and injury which may be disabling or even life-threatening.

(c) Timely access to care can mean the difference between active participation in the workforce, home life or leisure activities and a spiral of increasing pain, injury and disability

(d) For cancer or heart disease, delaying treatment can be even more serious. Left unchecked, malignant cancers can spread, compromising control of the cancer and leading to higher rates of complications and mortality.

(e) Timely interventions can prevent premature disability and death

(f) In addition to physical risks, there is anxiety around the uncertainty associated with waiting for treatment.

(g) Waiting too long has implications for the health care system as well.

(h) Deterioration in health status while waiting for care can lead to greater care needs for patients in the long run.

2009. In summary, all of the experts reached the same conclusion. Based on their own research and experience, and on the research of others, they concluded that patients suffer serious harm to their physical and mental health and overall well-being from waiting for diagnosis and treatment by specialists.[1563]

2010. These harms were of two types: (1) the suffering endured while waiting for treatment including severe pain, physical disabilities, the limited ability to work or enjoy life, and physiological stress; and (2) irreparable or permanent harms such as the deterioration of their medical condition and worse outcomes when the treatment was finally provided or even risk of death.

2011. Not one expert offered the opinion that patients are not harmed daily while they wait for treatment in a state of physical pain, disability, incapacitation, diminished well-being and psychological

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[1563] See: **Exhibit 274A**, Expert Report of Dr. Matheson,, p. 6 **[CBE, Tab 53]**; **Exhibit 289A**, Expert Report of Dr. Chambers, pp. 7-8 **[CBE, Tab 54a]**; **Exhibit 263**, Expert Report of Dr. Masri, p. 4, para 1, and p. 6, para 24 **[CBE, Tab 49]**; **Exhibit 312A**, Expert Report of Dr. Younger, pp. 7-8 **[CBE, Tab 62]**; **Exhibit 343**, Expert Report of Dr. Wing, p. 7 **[CBE, Tab 82]**.

stress. And not one expert offered the opinion that patients are not at risk of permanent irreparable harm while waiting for treatment for many medical conditions.

2012. Consequently, the plaintiffs' claim that, at least some, patients are harmed while waiting for treatment has been decisively established by the expert evidence.

VIII. THE HISTORY OF PRIVATE SURGICAL CLINICS IN BC

A. Introduction

2013. Up until the mid-1980's, the Government funded all surgeries that were performed, without any restriction on operating time. This pay for performance method of funding meant there were effectively no wait times for surgeries.[1564]

2014. In the mid-1980's, the Government implemented global budgets for the provision of health care. The resulting budgetary limitations resulted in restrictions on operating time for surgeries, and the takeover of surgical services. This led to lengthy wait times for scheduled surgeries.[1565]

2015. It also led to the undermining of the quality of surgical services.[1566]

2016. The restrictions on operating time meant that surgeons had less operating time in the public system than was recommended by the Canadian Orthopaedic Association to maintain their competence and skills.[1567]

2017. The rationing of surgeries also led to reduced opportunities for surgeons to obtain operating time in the public system.[1568]

2018. Dr. Day testified that "additional doctors could not be added to the staffs at VGH and UBC unless the existing physicians relinquished some or all of their operating time."[1569]

2019. He gave as an example the situation of Dr. Regan: "When Dr. Regan was appointed at UBC Hospital in or around 1990, the existing surgeons [including himself] had to give up some of their

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[1564] **Exhibit 346A,** Affidavit #9 of Dr. Brian Day, pp. 34 to 37, paras. 175 to 194 **[CBE, Tab 83]**.
[1565] **Exhibit 346A**, pp. 37 to 41, paras. 195 to 218 **[CBE, Tab 83]**; **Transcript Day 63**, Testimony of Dr. Patrick McGeer, dated February 8, 2017, p. 5, lines 31 to 39, p. 6, line 39 to p. 8, line 20, and p. 9, lines 1 to 27.
[1566] **Exhibit 346A**, pp. 45 to 50, paras. 246 to 264 **[CBE, Tab 83]**.
[1567] **Exhibit 346A**, p. 41, para. 217 **[CBE, Tab 83]**.
[1568] **Exhibit 346A**, p. 40, paras. 211 and 212 **[CBE, Tab 83]**.
[1569] **Exhibit 346A**, p. 40, para. 212 **[CBE, Tab 83]**.

operating room time so that Dr. Regan could have scheduled operating room time at UBC Hospital."[1570]

2020. Dr. Day relinquished his operating time when he became President of the Canadian Medical Association, and his operating time was given to other surgeons.[1571]

2021. Similarly, when Dr. Peterson, the founder of the Okanagan Health Surgical Centre relinquished his operating time in the public system, this surgical time in the public system was given to another plastic surgeon.[1572]

2022. Dr. Day and Dr. Peterson are exceptions. As this case shows, enrolled doctors have not given up their operating time to provide surgeries outside of the public system. Rather, they have continued to fulfill their surgical obligations in the public system, and have used their excess surgical capacity to provide additional medically necessary surgeries through private surgical clinics.[1573]

2023. And, as the evidence in this case shows, there are a significant number of surgeons who are unable to obtain work, there is a sufficient supply of surgeons to replace any surgeons that do leave the public system. [1574]

2024. During the course of the trial, other enrolled doctors have testified about their excess surgical capacity, above their allocation of operating time in the public system.[1575]

2025. The problem for them has been they have the capacity to perform additional surgeries, but the public system has not provided them with additional operating time to perform these surgeries.

2026. To make use of this excess surgical capacity – to provide additional surgeries for BC patients – enrolled doctors had to perform surgeries outside of the public system.[1576]

[1570] **Exhibit 346A**, p. 40, para 213 **[CBE, Tab 83]**.
[1571] **Exhibit 346A**, pp. 10 to 11, paras. 49 and 50 **[CBE, Tab 83]**.
[1572] **Transcript Day 119**, Testimony of Dr. Brian Peterson, dated October 1, 2018, p. 22, lines 3 to 24.
[1573] See Section **VII(C)(iv) and (vii),** above.
[1574] **Transcript Day 152**, Testimony of Professor Marmor, p. 45, lines 28 to 40; **Exhibit 132C**, Expert Report of Dr. Hollinshead, Vol III, p. 18; **Transcript Day 41**, Testimony of Dr. Hollinshead, November 29, 2016, p. 39, lines 1 to 5; **Exhibit 471**, Expert Responsive Report of Dr. Cyril Frank, Tab 2, p. 9 **[CBE, Tab 124]**.
[1575] **Exhibit 299**, Affidavit #1 of Dr. Javer, p. 3, para. 16, p. 7, paras. 49 to 53, p. 8, paras. 61 to 62 **[CBE, Tab 61]**; **Exhibit 172**, Affidavit #1 of Dr. Regan, pp. 3 to 4, paras. 14 to 18 **[CBE, Tab 39]**; **Exhibit 311**, Affidavit #2 of Dr. Younger, p. 3, para. 15, p. 6, paras. 45 and 49 **[CBE, Tab 61]**; **Exhibit 83**, Affidavit #1 of Dr. Sahjpaul, p. 3, paras. 9 to 11 **[CBE, Tab 28]**.
[1576] **Exhibit 346A**, pp. 40-41, paras. 214-216 **[CBE, Tab 83]**.

2027. Canadians became frustrated in the 1990's about the long wait for surgeries in the public system.[1577]

2028. As will be explained later in this submission, patients experience pain and limited mobility and physical incapacity while waiting for surgeries, which results in psychological harm. As well there can be deterioration of a patient's condition that could result in permanent harm to a patient's health.

2029. The rationing of surgeries in the public system, that can result in harms to the health of patients, coupled with the fact that enrolled surgeons had unused surgical capacity as a result of this rationing, led to the establishment of private surgical clinics in BC, which rely on enrolled surgeons to provide surgeries outside of the public system.

2030. The use of enrolled doctors to provide private medically necessary surgeries outside of the public system has not decreased the numbers of surgeries performed in the public system. These are additional surgeries. There is no evidence that the provision of these additional private surgeries has taken doctors or nurses out of the public system and thereby prevented the public system from providing the number of surgeries it could have performed within the global budgets they were allocated. The global budgets were fully utilized by the Health Authorities.

B. Cambie Surgery Centre

2031. As a result of the rationing of surgeries and resulting lengthy wait times for surgeries, Dr. Day and others established the Cambie Surgery Centre[1578] to provide private surgeries performed by surgeons enrolled in the public system.

2032. A primary client for these private surgical services was at the outset, and still is, the Workers Compensation Board of BC (now called WorkSafe BC).

2033. In 1997, the Medical Services Commission passed Minute #97-068, which added injured workers covered by workers compensation insurance to the list of British Columbians exempted from the prohibitions on access to medically necessary surgeries under the *MPA*.[1579]

[1577] **Exhibit 346A**, p. 44, para 241, Exhibit "ZZ" p. 391 **[CBE, Tab 83]**.
[1578] **Transcript Day 116**, Testimony of Dr. Brian Day, dated September 17, 2018, p. 30, lines 1 to 2; **Exhibit 0346A**, paras 75, 77, 78, 81, 135, 317, 333, 337 **[CBE, Tab 83]**.
[1579] **Exhibit 2B,** Tab 5 **[CBE, Tab 2]**, Exhibit 5; **Exhibit 346A**, p. 58, para. 308 **[CBE, Tab 83]**.

2034. Workers compensation patients—those who become injured or ill as a result of their employment—are excluded from the definition of insured health services in the *Canada Health Act*.[1580]

2035. As explained by the Defendant's expert witness, Professor Jeremiah Hurley in his article "Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers" (Trial Exhibit MMMMM), because of the lengthy wait times for surgeries in the public system, in the 1990's Workers Compensation Boards began contracting with private surgical clinics to perform expedited private surgeries paid for by the Workers Compensation Boards for injured workers.[1581]

2036. Prof. Hurley testified that these initiatives were designed to get quicker surgeries for people.[1582]

2037. Dr. Day collaborated with the Workers Compensation Board of BC to establish the Visiting Specialist Clinics in 1997, to provide for expedited assessments and surgeries for injured workers covered by this exemption.[1583]

2038. Mr. Andrew Montgomerie, Director of Financial Services and Health Care Programs of WorkSafe BC, a witness for the Defendant, confirmed that "WorkSafe has determined that these expedited services would benefit injured workers and employers by expediting workers' access to required medical care necessary for their recovery and eventual return to work" and that "if recovery and return to work is improved by 6 months, the wage loss costs are reduced by an average of $13,000.00 per worker."[1584]

2039. Dr. Day testified that in addition to WCB patients, Cambie has always also performed surgeries for non-exempt British Columbians, using enrolled doctors. [1585]

2040. As well, for a period of time, from 2004 to around 2013, Cambie performed surgeries for MSP patients pursuant to contracts with the Health Authorities.[1586]

[1580] See *Canada Health Act*, s. 2: "***insured health services*** means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation; (services de santé assurés)."

[1581] **Transcript Day 169**, Testimony of Professor Hurley, p. 40, lines 30 to 44; p. 93, line 27 to p. 94, line 47 p. 95, l. 1 to p. 97 l.1.

[1582] **Transcript Day 169**, p. 92, lines 17 to 27.

[1583] **Exhibit 346A**, p. 58, paras 308 to 312 **[CBE, Tab 83]**; **Exhibit 532,** Affidavit #1 of Andrew Montgomerie, p. 7, para. 22 **[CBE, Tab 139]**.

[1584] **Exhibit 532**, p. 11, para 46 **[CBE, Tab 139]**.

[1585] **Exhibit 346A**, p. 22, para. 109 **[CBE, Tab 83]**.

[1586] **Exhibit 346A**, p. 24, paras. 119 to 122 **[CBE, Tab 83]**; **Transcript Day 118**, Testimony of Dr. Day, p. 60, lines 31

C. Specialist Referral Clinic

2041. The Specialist Referral Clinic ("**SRC**") was established in 2001 "...patterned after the Visiting Specialist Clinic at WorkSafe BC".[1587]

D. False Creek Surgical Centre

2042. Dr. Mark Godley is the founder of the False Creek private surgical clinic.

2043. He testified that False Creek started performing private hand surgeries for the Workers Compensation Board in 1997. In 1999, he opened the False Creek Surgical Centre, which performed other surgeries for WCB patients.

2044. At the same time – 1999 – the False Creek Surgical Centre began providing surgeries for non-exempt British Columbians, using enrolled surgeons.[1588]

2045. Both Dr. Day and Dr. Godley testified that their private surgeries for non-exempt BC residents have been paid for by ICBC on behalf of ICBC claimants and by employers, as well as by the patients.[1589]

2046. False Creek has also performed surgeries for MSP patients pursuant to contracts with the Vancouver Coastal Health Authority.[1590]

E. Kamloops Surgical Centre

2047. Dr. Ross Outerbridge established the Kamloops Surgical Centre in about 2003.[1591]

2048. The Kamloops Surgical Centre is owned by the 8 orthopaedic surgeons at Royal Inland Hospital, who each have 1 day of operating time per week in the public system.[1592]

2049. The Kamloops Surgical Centre provides "cosmetic surgery, orthopaedic surgery, neurosurgery, ophthalmology, dental surgery, general surgery, and pain management."[1593]

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to 38

[1587] **Exhibit 346A**, p. 59, paras. 317-318, and p. 61, para. 333 **[CBE, Tab 83]**.
[1588] **Exhibit 385**, Affidavit #1 of Dr. Godley, pp. 3 to 5, paras. 26 to 43 **[CBE, Tab 87]**.
[1589] **Exhibit 385**, p. 5, paras. 40-46 **[CBE, Tab 87]**; **Exhibit 346A**, pp. 22-23, paras. 107 & 110, and pp. 25-26, paras. 129-131 **[CBE, Tab 83]**; **Transcript Day 118**, p. 30, lines 2 to 15
[1590] **Exhibit 385**, p. 5, para. 46.
[1591] **Exhibit 301**, Affidavit #1 of Dr. Ross Outerbridge, p. 2, para. 4 **[CBE, Tab 59]**.
[1592] **Exhibit 301**, p. 2, paras. 14-15 **[CBE, Tab 59]**.
[1593] **Exhibit 301**, p. 2, para. 16 **[CBE, Tab 59]**.

2050. These medical services are provided by enrolled surgeons to both exempt (WCB) and non-exempt residents of British Columbia.[1594]

2051. The Kamloops Surgical Centre also has performed surgeries for MSP patients pursuant to a contract with the Interior Health Authority.[1595]

F. White Rock Orthopaedic Centre

2052. Dr. Arno Smit is the founder of the White Rock Orthopaedic Centre.

2053. Dr. Smit testified about establishing the White Rock Orthopaedic Centre, a private surgical clinic, in 2007.[1596]

2054. He is the owner of the White Rock Orthopedic Centre, and from time to time other surgeons work there as well.[1597]

2055. Dr. Smit explained his reasons for establishing his private surgical clinic was so he "could not see too much progress" in the public system with respect to increasing capacity, "[s]o I decided to build an operating room, in effect increasing the capacity in our community by a third, with the anticipation that I would find a way to collaborate with the health authority and just, you know, basically address the issue, or at least partly, of insufficient OR capability in our community."[1598]

2056. The White Rock Orthopaedic Centre has one operating room that cost Dr. Smit about $1,000,000 to build.[1599]

2057. Dr. Smit performs "a variety of orthopedic procedures that require no more than 24 hours of hospitalization. So I do knee arthroscopy, ACL reconstruction, a variety of shoulder procedures, arthroscopic primarily, including shoulder reconstruction. I do unicompartmental or partial knee replacements. I do some fractures. I do a smattering of other smaller procedures as they come along."[1600]

[1594] **Exhibit 301**, p. 2, paras 17 and 18 **[CBE, Tab 59]**.
[1595] **Exhibit 301,** p. 5, para. 40 **[CBE, Tab 59]**.; **Transcript Day 106**, Testimony of Dr. Outerbridge, July 4, 2018, p. 14, lines 35 to 43, p. 35, lines 10 to 15, p. 48, lines 15 to 23.
[1596] **Transcript Day 19**, Testimony of Dr. Smit, p. 38, lines 20 to 25, lines 32 to 38.
[1597] **Transcript Day 19**, p. 38, lines 26 to 28.
[1598] **Transcript Day 19**, p. 38, line 32 to, p. 39, line 2.
[1599] **Transcript Day 19**, p. 39, lines 3 to 8.
[1600] **Transcript Day 19**, p. 39, lines 3 to 17.

2058. He provides these surgical services to both exempt (WCB) and non-exempt BC patients.[1601]

2059. He also provides private surgical services to ICBC patients.[1602]

2060. The White Rock Orthopaedic Centre has also provided surgical services to MSP patients by way of contracts with the Health Authorities.[1603]

G. Okanagan Health Surgical Centre

2061. Dr. Brian Peterson testified that he established the Okanagan Health Surgical Centre in 2004.

2062. Beginning in 1992 he started performing medically necessary surgeries at Kelowna General Hospital ("KGH") such as hand surgeries, trauma, reconstructive breast surgery, cleft lip and palate surgery. He had one day per week of operating time.[1604]

2063. He also performed private cosmetic (non-medically necessary) surgeries at Kelowna General Hospital. The patients paid his surgeon's fee and the anesthesiologist fee directly to him, as well as a "day rate" fee, which Dr. Peterson remitted to Kelowna General Hospital.[1605]

2064. As the wait times for medically necessary surgeries became longer, Dr. Peterson was no longer able to use operating rooms at Kelowna General Hospital for his private cosmetic surgeries, so he established the Okanagan Plastic Surgery Centre in 1996 to provide these private surgical services. He continued to perform medically necessary surgeries at KGH.[1606]

2065. In the late 1990's, Dr. Peterson began providing expedited plastic surgery services for acutely injured workers at the Okanagan Plastic Surgery Centre. This was expanded around 2000 to include urgent and elective plastic surgeries, mainly hand surgeries.[1607]

2066. In 2000, WCB asked Dr. Peterson to also provide orthopaedic surgeries at his private surgical clinic.[1608]

[1601] **Transcript Day 19**, p. 48, line 4 to, p. 49, line 33.
[1602] **Transcript Day 19**, p. 44, line 13 to, p. 45, line 47, and p. 46, line 1 to, p. 48, line 48.
[1603] **Transcript Day 19**, p. 41, lines 7 to 41.
[1604] **Exhibit 376**, Affidavit #1 of Dr. Peterson, p. 3, paras. 20 & 22.
[1605] **Exhibit 376,** p. 3, paras. 25 to 27 **[CBE, Tab 86]**.
[1606] **Exhibit 376**, p. 3, paras. 23 to 32 **[CBE, Tab 86]**.
[1607] **Exhibit 376**, p. 4, paras. 33 to 36 **[CBE, Tab 86]**.
[1608] **Exhibit 376,** p. 4, para. 38 **[CBE, Tab 86]**.

2067. The six orthopaedic surgeons at KGH agreed to provide orthopaedic surgeries for WCB at the Okanagan Plastic Surgery Centre.[1609]

2068. Dr. Peterson and the other plastic surgeons at KGH also had one day of operating time every week or two at the Summerland Hospital.[1610]

2069. In 2004 the Summerland Hospital was closed, resulting in the loss of 4 to 6 operating room days per month for these plastic surgeons. There was no additional operating room time available at KGH.[1611]

2070. The plastic surgeons entered into an arrangement with KGH to perform the "Summerland" surgeries at the Okanagan Plastic Surgery Centre for the payment of a facility fee by KGH.[1612]

2071. Given the increased volume of surgeries at the Okanagan Plastic Surgery Centre, Dr. Peterson built a free standing surgical clinic with 3 operating rooms on the new property he purchased. The new private surgical clinic was named the Okanagan Health Surgical Centre.[1613]

2072. The new Okanagan Surgical Centre provides surgeries in a number of specialties, including plastics, orthopaedics, general surgery (mainly hernia), ENT, urology, and gynecology.[1614]

2073. The Okanagan Surgical Centre initially provided surgical services only to WCB patients and to MSP patients pursuant to a contract with KGH.[1615]

2074. The Okanagan Surgical Centre had contracts with KGH to provide surgical services to MSP patients from 2006 to 2014.[1616]

2075. In 2007, the Okanagan Surgical Centre began performing private surgeries for non-exempt British Columbians outside of the public system.[1617]

[1609] **Exhibit 376**, p. 4, para. 39 **[CBE, Tab 86]**.
[1610] **Exhibit 376,** p. 4, para. 41 **[CBE, Tab 86]**.
[1611] **Exhibit 376**, p. 4, para. 42 **[CBE, Tab 86]**.
[1612] **Exhibit 376**, p. 4, para. 43 **[CBE, Tab 86]**.
[1613] **Exhibit 376**, p. 5, paras. 45 & 46 **[CBE, Tab 86]**.
[1614] **Exhibit 376,** p. 5, para. 47 **[CBE, Tab 86]**.
[1615] **Exhibit 376**, p. 6, para. 65 **[CBE, Tab 86]**.
[1616] **Transcript Day 119**, p. 5, lines 33 to 41; **Exhibit 376**, p. 6, para. 64 **[CBE, Tab 86]**.
[1617] **Exhibit 376**, p, 6, para. 66 **[CBE, Tab 86]**.

2076. The non-exempt private surgeries are a small portion of the surgical procedures currently performed at OHSC. In 2015, OHSC did 47 private-pay surgeries, in 2010, it did 49 private-pay surgeries and in the first five months of 2017, it did 23 private-pay surgeries.[1618]

2077. Dr. Peterson ceased having regular operating time at KGH in or around 2006.[1619]

H. The number of Private Diagnostic/Surgical Clinics (Non-Hospital Facilities) in BC

2078. According to the Government's document entitled "Informational Bullets - Impact of Changes to *Medicare Protection Act* on Surgical Services" (undated), discussing the impact of Bill 92, which the Government proclaimed on April 4, 2018, there are 62 private surgical facilities in BC.[1620]

I. The Diagnostic and Surgical Services Presently Performed by Private Clinics

2079. The types of diagnostic and surgical services that can be provided by private clinics in British Columbia is regulated by the Government through the *Health Professions Act,* through the College of Physicians & Surgeons of British Columbia (the "**College**").

2080. First, a Non-Hospital Medical and Surgical Facilities Program ("**NHMSFP**"), and its Committee approves the list of all procedures that can be performed by the medical staff at private clinics. This list of approved procedures must be maintained on file at the private clinic. While exceptions can be made by the NHMSFP Committee, there are procedures that the College does not generally allow to be performed at private clinics.[1621]

2081. Second, while the College bylaws and accompanying standards do not expressly limit the amount of time that a patient may stay, the provincial government has not allowed the College to permit longer stays,[1622] and private clinics follow the College's policy position, published as a guideline, the non-hospital surgical facilities (private clinics) are accredited for daycare procedures only.[1623]

2082. The types of diagnostic and surgical services performed at Cambie include:[1624]

[1618] **Transcript Day 119**, p. 15, line 20 to p. 16, line 18.
[1619] **Transcript Day 119**, p. 19, lines 18 to 27, and p. 21, line 43 to, p. 22, line 47.
[1620] **Exhibit 431,** Plaintiffs' Supplemental Common Book, MoH, Vol. 1, p. 707 **[CBE, Tab 102]**.
[1621] **Exhibit 2A**, Prima Facie Facts - Ministry of Health, p. 355, Exhibit 2C, Tab 15, Exhibit 15, pp. 70 -77 **[CBE, Tab 1]**.
[1622] **Exhibit 346A**, p. 28, para. 143, and p. 305, Exhibit HH **[CBE, Tab 83]**.
[1623] **Exhibit 2C**, Prima Facie Facts – Ministry of Health, Tab 16, CPSBC Overnight Stay Guideline, at p. 2 **[CBE, Tab 1]**; **Exhibit 346A**, pp. 27 to 28, paras. 140 to 143 **[CBE, Tab 83]**.
[1624] **Redacted due to evidence subject to sealing order;**

Exhibit 346A, pp. 27-28,

i. **Pediatric Dental Surgery:** extractions and restorations

ii. **General Surgery:** Diagnostic colonoscopy (for cancer); procedural colonoscopy – polyp removal, excision of skin lesions/soft tissue lesions, lumps; gastroscopy – diagnostic; laparoscopic surgery such as cholecystectomy; hernia repair, breast surgery, including mastectomy for cancer.

iii. **Gynecological Surgery:** cystocoele and rectocele repair, laparoscopic procedures, - ovarian cystectomy (removal of cysts from ovaries)

iv. **Interventional Pain**: nerve blocks (for serious, debilitating pain)

v. **Neurosurgery:** lumbar discectomy, laminectomy, anterior cervical discectomy with fusion (spine surgery)

vi. **Ophthalmology:** Cataract extractions

vii. **Orthopedic surgeries:** Arthroscopy for hip, knee, shoulder, elbow, wrist, and finger; small joint replacement, rotator cuff repair; fracture and dislocation repair; tendon repair; excision of bone or soft tissue tumors; nerve transposition (to alleviate nerve and compression); ACL reconstructions, ankle joint replacement, hemiarthroplasty (partial knee replacement).

viii. **Plastic Surgery**: excision of lesions, including cancerous lesions, tendon grafting, amputation of finger

2083. The BC public health care system contracts with private clinics for a wide range of diagnostic and surgical services.[1625]

2084. The private clinics perform hundreds of cancer surgeries each year.[1626]

2085. The Government has been identifying "opportunities to utilize private facilities to help address surgical wait times".[1627] These opportunities include:

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paras 138-145 **[CBE, Tab 83]**.
[1625] **Exhibit 431,** pp. 797-804 **[CBE, Tab 102]**.
[1626] **Exhibit 431**, pp. 840-851 **[CBE, Tab 102]**.
[1627] **Exhibit 431,** p. 780 **[CBE, Tab 102]**.

i. General increase of volumes of all types of day surgeries already being performed in private clinics;

ii. Focused increase of volumes for particular types of day surgeries already being performed in private clinics;

iii. Encourage new types of day surgery in private facilities to help address issues such as significant backlog for specific types of surgeries such as Gastrointestinal-type surgeries and procedures.[1628]

2086. If the Plaintiffs succeed in this case, private clinics can lawfully provide all of the diagnostic and surgical services for which they already have approval (and those that the government may approve in the future).

2087. The Government will not be required as a result of the Court's decision to expand the range or types of diagnostic and surgical services that can be provided in private clinics.

2088. The Plaintiffs accept that the Government has the legal right, and obligation, to ensure that diagnostic and surgical services can be performed safely in a particular clinical setting.

2089. However, that determination must be made on the basis of considerations of quality and safety – and not on the false pretext that prohibiting access to private diagnostic and surgical services is necessary to protect the provision of these services in the public system.

2090. It is clear from the SPR data that the public system is failing to provide timely surgeries in all surgical categories, including life threatening procedures.

2091. Therefore, subject to safety and quality considerations, private clinics should be allowed to perform every type of surgery that can be safely performed in that setting.

2092. This doesn't mean that the Government cannot take the steps necessary to ensure that the public system has sufficient specialists to meet its needs.

2093. But, as explained in more detail below, that can easily be dealt with, if necessary, through a regulation requiring doctors to work in the public system to the extent they are required. As Justice

[1628] **Exhibit 431,** p. 776 **[CBE, Tab 102]**.

Deschamps noted in *Chaoulli*, Quebec has a provision in its public health care statute that allows the government to impose such a requirement.[1629]

2094. The only question therefore with respect to the provision of private diagnostic and surgical services is how the public system decides to provide its diagnostic and surgical services and what can be safely performed in private clinics, either as part of the public system or privately as a safety-valve to that system.

J. Payment of private surgeries for non-exempt British Columbians through private insurance and other third parties

2095. Dr. Day testified that private surgeries for non-exempt British Columbians have been paid by the patients and their families as well as by employers, either directly or through employer provided disability benefits and by ICBC pursuant to automobile insurance.[1630]

2096. Dr. Day also testified that Health Authorities and provincial crown corporations, such as BC Hydro, have paid for private surgeries at Cambie for their employees, as have Canada Post and trade unions, including the Nurses Union, the Plumbers Union, the Postal Workers Union, and the Boilermakers Union.[1631]

2097. He testified that Cambie has also provided private surgeries and services for Federal Judges and senators, paid for by the Federal Government.[1632]

2098. With respect to ICBC patients, Dr. Day testified that sometimes this was arranged through ICBC lawyers and sometimes through the lawyer for ICBC claimants.[1633]

2099. Dr. Smit also testified that he provided surgical services to ICBC patients, paid for by ICBC and not the MSP. [1634]

2100. Dr. Godley testified that False Creek has held contracts with various Health Authorities, and has provided exempt British Columbians with private, medically necessary diagnostic and surgical services. For example, False Creek has provided private diagnostic and surgical services to: RCMP

[1629] ***Chaoulli***, 2005 SCC 35, para 64.
[1630] **Exhibit 346A**, pp. 22-23, paras. 107 & 110, and pp. 25-26, paras. 129-131 **[CBE, Tab 83]**; **Transcript Day 118,** p. 30, lines 2 to 15
[1631] **Exhibit 346A**, p. 22, para. 110 **[CBE, Tab 83]**.
[1632] **Exhibit 346A**, pp. 21-22, para. 107(iv), and p. 26, para. 130.
[1633] **Transcript Day 118**, p. 30, lines 18 to 44.
[1634] **Transcript Day 19**, p. 44, lines 13 to 47, and p. 46, lines 1 to 47.

members paid for by Blue Cross, Federal prisoners paid for by the Federal Government, ICBC claimants paid for by their lawyers, and corporations paid for by their employers.[1635]

2101. Dr. Day testified that sometimes the private surgeries performed at Cambie were paid by employer private disability insurance.[1636]

2102. Barbara Collin, a patient witness, testified that she had her breast reconstruction surgery, following a mastectomy, paid for by her disability benefits provider, Great-West Life.[1637] i

K. Non-enforcement of the prohibitions on dual practice and private insurance

2103. Despite being aware from at least 2000 that private clinics were providing private surgeries to non-exempt British Columbians in contravention of the prohibition on dual practice, there was no attempt to enforce this exemption until legal proceedings were commenced in 2005.[1638]

2104. Up until then, the Government's policy was simply to respond to letters from patients seeking reimbursement of the fees they paid for private surgeries by asking the private clinics to reimburse the patients. There was no follow-up by the MSC if the patients weren't reimbursed by the private clinics.

2105. However, in 2008, the MSC commenced an audit of Cambie and SRC.[1639]

2106. The MSC also advised some other private surgical clinics in 2008 that it would be conducting audits of them. However, it did not proceed with any other audits until the summer of 2017.[1640]

2107. Though the Government has identified 11 surgical clinics that it says have been providing surgeries in breach of the prohibitions on dual practice, it had only audited 6 of them as of 2017.[1641]

2108. For example, Dr. Smit testified that he had received two letters from the Medical Services Commission about letters it had received from three patients of his White Rock Orthopaedic Centre seeking repayment of the fees they had paid to the clinic for private surgeries.[1642]

[1635] **Exhibit 385**, p. 5, para 46 **[CBE, Tab 385]**.
[1636] **Transcript Day 117**, Testimony of Dr. Brian Day, dated September 18, 2018, p. 23, lines 18 to 29.
[1637] **Transcript Day 54**, Testimony of Ms. Collin, dated January 17, 2017, p. 33, lines 37 to 42; **Exhibit 208**, Letter from Great-West Life to Ms. Collin, dated April 23, 2010 **[CBE, Tab 43]**.
[1638] **Exhibit 346A,** p. 63, paras. 339 to 341, p. 71, para. 385 **[CBE, Tab 83]**; and **Exhibit 346B**, at Exhibit "RRR" HEU Press Release, July 11, 2000, p. 548 **[CBE, Tab 84]**.
[1639] **Exhibit 346A**, p. 79, para 420 **[CBE, Tab 83]**.
[1640] **Exhibit 346A**, p. 81, para 432 **[CBE, Tab 83]**.
[1641] **Exhibit 442**, Canada Health Act – Financial Statement of Actual Amounts of Extra-Billing and User Charges for the Period April 1, 2016 to March 31, 2017, p. 2 **[CBE, Tab 116]**.
[1642] **Transcript Day 19**, p. 49 line 35 to, p. 50 line 10.

2109. The MSC did not pursue this matter further with Dr. Smit.[1643]

2110. The Court asked the Defendant after Dr. Smit's testimony to provide an explanation about why this was not pursued by the MSC.[1644]

2111. The Defendant never provided an explanation for not following up with the White Rock Orthopaedic Centre or pursuing audits of other private surgical clinics until it audited three of them in 2017.

2112. The result of the Government's non-enforcement of the prohibition on dual practice and private insurance is that the private provision of surgeries (considered benefits within the public system) to non-exempt British Columbians by enrolled doctors, which are sometimes paid for by employers, either directly or through employer provided disability benefits or by ICBC, has become an established (and as will be explained later, necessary) component of the health care system in British Columbia.

IX. LESSONS FROM OTHER JURISDICTIONS: THE COMPARATIVE EVIDENCE OF EXPERTS

A. Introduction

2113. Canada is the only developed country in the world that prohibits patients from paying for necessary health care services provided by specialists and private surgical clinics. Instead, it requires all medically necessary health care to be publicly controlled and funded.[1645]

2114. For more than 20 years, private diagnostic and surgical services were available in British Columbia, with the surgeries performed by specialists enrolled in the public system. The evidence from this experience demonstrates that the existence of this private system has not caused any harm or disadvantage to the public system.[1646]

2115. Remarkably, neither level of Government has undertaken any study to determine whether the private system provided a benefit to the health of British Columbians or the public health care system. And, despite having no evidence of harm, or any real evidence about the private system, British Columbia elected to introduce new enforcement measures to end private diagnostic and surgical

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[1643] **Transcript Day 19**, p. 50, lines 4 to 10.
[1644] **Transcript Day 19**, p. 93 lines 37 to 43.
[1645] **Transcript Day 33,** Testimony of Ake Blomqvist, November 4, 2016, p. 32, line 37 to, p. 33, line 11.
[1646] **Transcript Day 172,** Testimony of Jeffrey Turnbull, p. 65, lines 25 to 31.

services in the province. The only reason ever offered was financial coercion by the government of Canada, also taken without any evidence.

2116. Instead of evidence, the Government relies on speculation about problems that might be experienced in a mixed system and an ideological commitment to the existing system.

2117. The evidence from other jurisdictions refutes the Government's speculation about possible problems if the prohibitions are eliminated.

2118. Every other OECD country permits, or even encourages, privately funded health care and these countries generally provide better health care, more efficiently, and no less equitably, than Canada's provincial health plans.[1647]

2119. Although other countries are constantly seeking inspiration from others, no country in the world is considering modelling its health system on the Canadian example.[1648] No country, other than Canada, believes that prohibiting the private delivery of diagnostic services and treatments would solve any problem faced by the health care system, or improve the health care system. No country is considering prohibiting the private delivery of diagnostic services and treatments as part of its proposed health care reform.

2120. The reason is not that Canada's history, culture or health care needs are so unusual that it alone needs to prohibit private health care to preserve its universal public system. Canada is not very different from these other developed countries, especially other countries with a common legal, political and cultural tradition, like the U.K, Australia, New Zealand and Ireland. The reason for the difference is that Canada alone has doggedly pursued an ideological course, without subjecting its position to careful scrutiny or empirical verification.

2121. Several experts gave evidence about the health care systems in their own jurisdictions:

i. The UK – Professor McGuire and Professor Oliver;

ii. New Zealand – Professor Cumming and Dr. Ross Davidson;

iii. Ireland – Professor Normand;

[1647] **Exhibit 44,** CIHI Report, How Canada Compares, p. 35 **[CBE, Tab 20]**.
[1648] **Exhibit 93,** Ake Blomqvist Expert Affidavit, Exhibit "B", p. 21 **[CBE, Tab 30]**; **Transcript Day 33**, p. 32, lines 1 to 15.

iv. Australia – Professor Gillespie; and

v. Quebec – Professor Premont and Professor Yanick Labrie.

2122. The two most comparable health care systems to British Columbia are the United Kingdom and New Zealand.

2123. That is because both of these countries have a universal public health care system that is funded by tax revenues and neither country uses tax subsidies or other public payments to promote private health insurance or private health care, unlike Ireland and Australia.[1649]

2124. Both the UK and New Zealand have allowed dual practice and private insurance since the inception of their universal public health care systems.[1650]

2125. As the experts from those countries testified, allowing dual practice and private insurance in the UK and New Zealand has not harmed the public health care system or more specifically reduced access to health care services in the public system.[1651] Rather it has simply increased capacity and opportunities by enabling patients to opt for private medical services to deal with their individual health care needs when they believe that it was necessary to alleviate their suffering and protect their health.[1652] When patients opt for private care, they free up resources in the public system for the treatment of others. The public system has also been able to contract services from the private system as a safety valve.[1653] The private system has also created additional sources of income for highly trained specialists.[1654]

2126. In Australia and Ireland the expert evidence also confirmed that allowing dual practice and private insurance had not harmed the public system and in fact both countries actively subsidize and promote parallel private health care.[1655] The main issues of concern in these countries were not the existence of private healthcare, but user fees and charges in the public system, incomplete coverage

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[1649] **Exhibit 17D**, pp. 6704-6075, 6796-6797 **[CBE, Tab 11]**; **Exhibit 491**, Response Report of Professor Oliver, p. 1 **[CBE, Tab 131]**.
[1650] **Exhibit 17D**, pp. 6705, 6797 **[CBE, Tab 11]**.; **Exhibit 490**, Expert Report of Professor Oliver, p. 1 **[CBE, Tab 130]**; **Exhibit 200**, Expert Report of Dr. Davidson, p. 3 **[CBE, Tab 41]**.
[1651] **Exhibit 215**, Expert Report of Professor McGuire, p. 10 **[CBE, Tab 45]**; **Exhibit 200**, p. 5 **[CBE, Tab 41]**; **Exhibit 490**, pp. 5-6 **[CBE, Tab 130]**; **Exhibit 491**, p. 2 **[CBE, Tab 131]**.
[1652] **Exhibit 215**, p. 10 **[CBE, Tab 45]**; **Exhibit 200**, p. 5; Exhibit 490, p **[CBE, Tab 41]**.
[1653] **Transcript Day 162**, p. 14, lines 15-33.
[1654] **Exhibit 490**, pp. 5-6 **[CBE, Tab 130]**.
[1655] **Transcript Day 163**, Testimony of Professor Normand, p. 74, lines 16-19; **Transcript Day 164**, Testimony of Professor Gillespie, p. 30, lines 23-28.

of necessary medical services in the public system, and public hospitals providing preferential private care to private patients. None of these issues arise in this case, since the challenge does not in any way seek to have the government or the public healthcare system subsidize or promote private healthcare.

2127. In Quebec, reforms were introduced to implement the SCC's decision in *Chaoulli*, by allowing private insurance for the three surgeries which had the longest wait lists. The expert evidence did not indicate that these reforms had resulted in any harm to the public health care system.

B. The United Kingdom

(i) Introduction

2128. There were two expert witnesses on the UK health care system, Professor Alistair McGuire called by the Plaintiffs and Professor Oliver called by the Defendant.

2129. Both witnesses confirmed that in the UK, access to private care has added capacity to the health care system in the UK without harming the public health care system.[1656]

2130. Like British Columbia and New Zealand, the UK has a universal public health care system that is funded by tax revenues.[1657]

2131. Private insurance and dual practice have been permitted in the UK since the inception of its public health care system in 1948.[1658]

2132. Unlike Australia and Ireland, the UK has not promoted or financially supported private insurance in their health care system.

2133. The UK has simply allowed its residents to obtain and use private insurance to pay for private medical services if they wish. There is no restriction on the scope of private insurance coverage and it extends to treatments available in the public system.[1659] The cost of private insurance is not tax deductible.[1660]

[1656] **Exhibit 215**, p. 11 **[CBE, Tab 45]**; **Exhibit 491**, Expert Responsive Report of Professor Oliver, p. 2 **[CBE, Tab 131]**
[1657] **Exhibit 215**, Tab 1, p. 9 **[CBE, Tab 45]**.
[1658] **Transcript Day 58**, Testimony of Professor McGuire, January 24, 2017, p. 74, lines 26-31.
[1659] **Exhibit 215**, Tab 1, p. 9 **[CBE, Tab 45]**.
[1660] **Exhibit 215**, Tab 1, p. 9 **[CBE, Tab 45]**.

2134. About 10-15% of the population in the UK have private insurance.[1661]

2135. Demand for private insurance is correlated with the length of the waiting times in the public system.[1662] As would be expected, the longer the wait times, the greater the demand for private health care.

2136. Private insurance has been mainly provided through employers.[1663]

2137. There is no regulation of private health insurance products or their pricing.[1664]

2138. In the UK, most specialists in the public system have service contracts that pay them a salary for a certain number of hours a week of work in a public hospital.[1665]

2139. In response to questions from the Court, Professor McGuire explained that public hospitals work on a 24-hour basis with 18 week wait time guarantees for all procedures from the time of referral to the specialist. Most specialists are paid a salary, although a fee-for-service arrangement generally leads to higher procedure rates. The specialists must manage their patient lists based on the hospital time made available to them.[1666]

2140. Public hospitals in the UK have so-called "pay beds" for private patients who can be treated by doctors with service contracts in those hospitals.[1667]

2141. Professor McGuire confirmed that there is no empirical evidence of any harm to the timeliness or quality of treatment arising from this arrangement. Professor Oliver suggested that there had been anecdotal evidence that specialists were prioritizing "their privately covered patients in financially lucrative NHS pay beds".[1668]

2142. To deal with any risk of preferential treatment or perceived conflicts of interest, the Government sought to eliminate the private "pay beds" in the public hospitals, but this was met by strong opposition from doctors.[1669]

[1661] **Exhibit 215**, Tab 1, p. 9 **[CBE, Tab 45]**.
[1662] **Exhibit 215**, Tab 2, p. 52-53 **[CBE, Tab 45]**.
[1663] **Exhibit 215,** Tab 1, p. 9 **[CBE, Tab 45]**.
[1664] **Exhibit 215,** Tab 1, p. 9 **[CBE, Tab 45]**.
[1665] **Exhibit 215,** Tab 1, p. 19 **[CBE, Tab 45]**.
[1666] **Transcript Day 59**, Testimony of Professor McGuire, January 26, 2017, p. 65, line 27 to, p. 66, line 34.
[1667] **Transcript Day 160,** p. 53, lines 24 to 41
[1668] **Exhibit 490**, Expert Report of Professor Oliver, pp. 4-5, heading 4 **[CBE, Tab 130]**.
[1669] **Transcript Day 160,** p. 19, line 39 to p. 20, line 5.

2143. Instead, the Government introduced a new consultant contract in 2003 for doctors who worked in the public system, which required the doctors to commit to 10 four hour sessions per week (40 hours per week), plus four hours of overtime, to be able to also provide private medical services.[1670]

2144. This ensures that salaried specialists in the public sector fulfil their obligations to public patients. Indeed, a 2013 study showed that specialists are in fact working *more* than their required hours in the public system.[1671]

2145. Finally, the evidence shows that the UK has reduced the wait lists in the public system, [1672] through a variety of techniques, including wait time guarantees.

2146. There has been no suggestion that the government's ability to address wait times has been in any way affected by the fact that UK physicians can engage in dual practice, and that patients can use private insurance to obtain services privately.[1673]

2147. As such, the UK experience shows that permitting a private care option is perfectly compatible with a universal public health care plan.[1674]

2148. The fact that the UK has been able to maintain a viable and accessible public health care system, and to address long public sector wait times, without prohibiting private care demonstrates that there is no connection between the impugned provisions and protecting the public system.

(ii) Private Health Care has not harmed the NHS in the UK

d) Professor McGuire

2149. Professor McGuire testified that allowing patients to access private health care added to the total capacity of the health care system in the UK which benefitted the health of its residents, without any corresponding harm to the public system.

2150. As he put it in his Main Report:

> Therefore, it is my opinion that duplicate PHI can be used to underwrite private sector health care capacity, which can increase overall capacity and consequently relieve pressure on public health care capacity. The release of public sector capacity, through the existence of a viable

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[1670] **Exhibit 490,** p. 4, heading 4 **[CBE, Tab 130]**.
[1671] **Exhibit 215,** Tab 1, p. 8 **[CBE, Tab 45]**
[1672] **Exhibit 215,** Tab 1, p. 11 **[CBE, Tab 45]**.
[1673] **Exhibit 215,** Tab 1, p. 19 **[CBE, Tab 45]**.
[1674] **Exhibit 215,** Tab 1, p. 17 **[CBE, Tab 45]**.

> private health care sector as underwritten by duplicate PHI, necessarily allows greater servicing of demand.[1675]
>
> ...
>
> Of the potential negative impacts, manipulation of public waiting times to increase demand for privately provided services is the most commonly cited, but there is no empirical evidence to support this assertion. Neither is there empirical evidence to support the idea that the evolution of a private health care sector, supported by duplicate PHI, leads to supply shortages in the public sector. Indeed even if such a shortage were found to exist, this will only ever be a short--term phenomenon given appropriate operation of the labour market, and would be self--correcting in the long-run.[1676]

2151. In his direct evidence in the trial, Professor McGuire explained what he meant by self-correcting. Increased demand would always be met by an increase in the supply of doctors, as needed, although there would be some time lag. The government controlled the medical schools and therefore could always increase the supply.[1677]

2152. In his Reply Report Professor McGuire explains that if, contrary to the empirical evidence, public wait times increased because of a parallel private system, more patients would still be treated which would improve the health of more people.[1678]

2153. Professor McGuire elaborated upon the increase in capacity and new demand in his testimony in cross-examination at the trial. He explained that public wait times depend on the balance between supply and demand and an increase in supply may encourage more people in need to seek treatment resulting in an increase in demand. But it will always mean more patients are treated, which increases the overall welfare and health of the population.[1679]

2154. Professor McGuire explained that this was demand that had previously been suppressed by lengthy waits in the public system.

2155. In response to questions from the Court, Professor McGuire elaborated that a parallel private system would always free up time in the public system to treat more patients.[1680]

[1675] **Exhibit 215,** Tab 1, p. 18 **[CBE, Tab 45]**.
[1676] **Exhibit 215,** Tab 1, p. 17 **[CBE, Tab 45]**.
[1677] **Transcript Day 58**, p.43, lines 17 to 36
[1678] **Exhibit 215**, Tab 2, p. 52-53 **[CBE, Tab 45]**
[1679] **Transcript Day 58**, p. 20, lines 6-25.
[1680] **Transcript Day 59**, p. 69, lines 4-24.

2156. In his reply report, Professor McGuire testified that the argument that allowing access to private health care results in increased wait times in the public sector is not supported by the empirical research and ignores that the overall welfare is increased because more people are treated as a result of the increased capacity. Any concerns about how specialists divide their time between public and private patients can, and has been, addressed through the public contracts with the specialists.[1681]

e) Professor Oliver

2157. Professor Oliver testified that allowing patients to obtain private health care in the UK had not caused wait lists in the public system to increase.

2158. In particular, Professor Oliver's evidence discredited the speculation that allowing more people to access private treatment through private insurance would lead to an insufficient supply of physicians in the public system, and hence longer public system wait times.

2159. To the contrary, Professor Oliver found no connection whatsoever to the availability of private care options and increases in public sector wait times.[1682]

(iii) Comparison of Wait Times Between Canada and the UK

2160. Professor McGuire explained that the waiting time for surgeries in the UK is measured from the date of the GP referral to a specialist to the date of surgery. The maximum wait time is 18 weeks under the guarantee/penalty system in the UK[1683].

2161. In British Columbia, the maximum wait time limit is measured either from the date of the surgical decision or the date the surgical booking card is received by the hospital. This excludes the wait to see specialists ('Wait One') and the wait time for any diagnostic procedures prior to seeing a specialist, which are included in the measure of the maximum wait time in the UK.

2162. The maximum Wait Two time in British Columbia, excluding the wait one time or a delay in obtaining diagnostics, is six months, which is well beyond the 18 weeks maximum wait time in the UK which is measured from the time of referral to treatment.

[1681] **Exhibit 215,** Plaintiffs' Expert Prof. Alastair McGuire Reply Report, Tab 2, p. 51-57 **[CBE, Tab 215]**.
[1682] **Transcript Day 160**, p. 16, line 46 to, p. 17, line 21; **Exhibit 490,** Defendant's Expert Report, Dr. Adam Oliver, Tab 1, p. 1 **[CBE, Tab 130]**.
[1683] **Exhibit 459,** Affidavit #9 of Roland Orfaly, dated April 4, 2019, Exhibit 5, p. 104 **[CBE, Tab 120]**.

2163. In his main expert report, Professor McGuire compared the wait times for diagnostic and surgical services in Canada with the UK and other countries.

2164. He stated that:

> At the international level according to the Commonwealth Health Care Profile (2013), which compares specific health indicators across 11 different countries, Canada had the worst access to health care. In particular, Canada had amongst the lowest scores for individuals waiting more than 2 months to see a specialist (41% of those individuals surveyed waited more than 2 months for specialist care in the last 2 years), and for individuals waiting 4 months or more for elective surgery (25% of those surveyed waited more than 4 months for required elective surgery in the past 2 years).[1684]

2165. Indeed, Canada has consistently rated much lower than the UK and other countries in the Commonwealth Fund surveys since then, even though it spends far more on per capita health costs than the UK.

2166. As can be seen, the UK has done much better than British Columbia in providing high quality and timely health care to its residents, while permitting a parallel private system.

(iv) Equity Concerns

2167. The Commonwealth Fund surveys also show that Canada rates more poorly in terms of equitable access to health care than the UK and other countries that permit patients to obtain private health care.[1685]

2168. This shows that equitable access is not dependent upon a prohibition on access to private health care.

2169. Professor Oliver makes the point (which was echoed by Dr. John Frank, an expert witness called by Canada) that the way to reduce inequalities in access to diagnostic and surgical services is by reducing waiting times for these services in the public system, as occurred in the UK.[1686]

2170. This is supported by the studies that Professor McGuire refers to in his reply report:

> There is some empirical evidence on equity of access, which is relevant but not referred to. Cooper et al (2009), as noted above, shows that waiting times for elective surgery fell as patient choice and competition, including greater freedom to use private providers, was introduced in

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[1684] **Exhibit 215**, Tab 1 pp. 12-13 **[CBE, Tab 45]**.
[1685] **Exhibit 44,** p. 6 **[CBE, Tab 20]**.
[1686] **Exhibit 490 [CBE, Tab 130];** Defendant's Expert Report of Prof. Oliver, p. 1; **Exhibit 491 [CBE, Tab 131];** Expert Response Report of Professor Oliver, p. 2.

> the UK. This study also found that waiting times fell faster among the most deprived socio-economic groups during this set of reforms, consistent with equity of access improving for the worse off. Similarly Cookson et al (2012) found no evidence that the choice and competition reforms, which included the effects of increased access to private care, worsened socioeconomic equity in health care in the UK.[1687]

(v) Wait Time Guarantees

2171. As the OECD has advised, wait time guarantees, which were implemented in the UK, can be an important ingredient for the overall reduction of wait times for diagnostic and surgical services.

2172. As such, they can be an effective way of reducing the number of patients waiting too long for treatment, and hence the harm that many patients suffer, in general terms.

2173. But, as Professor McGuire explained, general wait time guarantees or maximum wait times don't necessarily prevent patients from suffering harm while waiting for treatment, because they cannot take into account individual medical needs. Some patients may suffer permanent harm even if they are treated within the guaranteed maximum wait time.[1688]

2174. Importantly, the UK and other jurisdictions such as New Zealand and Quebec that have implemented wait time guarantees recognize that it is necessary for the protection of the health of their residents that they be able to opt for private health care to alleviate their suffering and protect their health without waiting until the end of the guaranteed maximum waiting time in the public system.

(vi) Comparison of the UK Health Care System with British Columbia

2175. Professor McGuire and Professor Oliver disagree on whether the health care system in the UK has application to British Columbia.

a) Professor McGuire

2176. Professor McGuire testified as follows on this point:

> England has had success in countering excessive wait times (see Figure 1 below) and hospital quality issues generally, through a mixture of policy reforms, as advocated by the OECD.[7] These reforms have supplemented wait time guarantees with increased choice and competition for patients through increasing capacity, partly by explicitly allowing private owned clinics and private hospitals to provide substitute treatment options, which adds to health care capacity.

[1687] **Exhibit 215,** Tab 2, p. 58-59 **[CBE, Tab 45].**
[1688] **Exhibit 215,** Tab 1, p. 10; **Transcript Day 58,** p. 41, line 37 to p. 42, line 31 **[CBE, Tab 45].**

> The existence of this private care is only possible because of the complementary existence of PHI.
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> ...
>
> Moreover, increased choice for patients in health care systems, when coupled with competition appears to increase the quality of care generally.[8] To emphasize, the case for duplicate PHI support of a private sector does not rest on this argument. This benefit augments the fundamental case for increasing capacity through the private sector. Again England provides recent empirical evidence on this, incorporating the influence of a dual private market. A number of studies have documented the subsequent improvement in public sector (NHS) hospital quality.[9]
>
> There is strong evidence that the policy of promoting patient choice and increasing competition, partly through increased access to private facilities, increased overall public hospital quality and stimulated productivity within the public sector. Moreover capacity was freed within the NHS (public) sector such that coupled with waiting time targets, increased demand was serviced and waiting times were reduced.
>
> ...
>
> In BC increased private sector capacity would, in my opinion, supplement the existing waiting time initiatives. However for capacity to be enhanced through increased private sector provision, duplicate PHI would have to be introduced as in the UK to ensure the existence of a viable private health care sector would evolve.[1689]

2177. In cross-examination, Professor McGuire testified that, like in the U.K., if dual practice presented any real or perceived problems this could be addressed through regulation.[1690]

2178. Professor Oliver stated that "[t]he features of the UK health care system do not apply to Canada and thus the perhaps moderate threat to social justice presented by the parallel private tier in the UK context cannot be extrapolated to the Canadian situation."

2179. In support of this contention, he notes that the public system in Canada covers fewer medical services than in the UK, and that a high percentage of Canadians already have supplementary private health insurance for medical services not included in the public plan.

2180. He claimed that this "represents a far greater challenge to equity and social justice than when only a small minority of the population engage in the individual nature of private insurance, because the extension of private insurance to diagnostic and surgical services to the public system "may lead to a decline in middle class support for Canadian Medicare."

[1689] **Exhibit 215,** Tab 1, p. 11 **[CBE, Tab 45]**.
[1690] **Transcript Day 58,** p. 76, line 45 to p. 77, line 14.

2181. As discussed before, there is no evidence to support this speculative concern about a decline in public support for the public system.

2182. And, his speculation is also unfounded. It is not relevant that a significant percentage of British Columbians have supplemental insurance for medical services and products not covered in the public system. The current inequity of the public system is caused by its failure to provide the full range of necessary health care services, not the existence of the private system. When the public system fails entirely to provide a necessary medical service, those of lesser means will necessarily be disadvantaged. But the experience with services not covered is of no assistance in understanding possible inequities in services that are covered. And no one is suggesting that the extension of private coverage to the surgical services would be accompanied by the withdrawal of these services from the public system. The reference to inequities in existing coverage of the public system is therefore irrelevant.

2183. Further, like the UK, it is likely that private insurance would only cover a small percentage of medical services covered by the public plan.

2184. Professor Oliver's main point is that salaried doctors are less incentivised to perform to maximize revenue as those, such as Canadian doctors who work in fee-for-service systems and are considered to be arms-length independent contractors.[1691]

2185. With the greatest respect, this argument makes no sense. While there is some evidence that specialist paid on a fee-for-service basis will perform more procedures in the public system than salaried specialists, the fee structure does not create an incentive for specialists to seek to make more money in the private system. Whether or not specialists would have an incentive to supplement their incomes with private work would depend upon the total amount of compensation they receive in the public system, not the particular structure of the compensation.

2186. Indeed, a salaried compensation structure increases the risk of physicians curtailing their public work to pursue private income, since their income is not directly tied to the number of public procedures they perform. In contrast specialists in British Columbia paid on a fee-for-service basis, would lose income in the public system if they ever reduced the number of public procedures in order

[1691] **Transcript Day 160**, p. 15, line 23 to p. 16, line 1

to pursue more work in the private system. Consequently, they have a direct financial incentive to fully utilize the time made available to them in the public system.

2187. In any event, there is no evidence, only speculation, that allowing dual practice could harm the public system because specialists will devote more time to the private system.

2188. The speculation is also contradicted by the experience in British Columbia over the past 20 years, during which the commitment of surgeons to fully utilize the time made available to them in the public system has been confirmed, without exception. The defendant could not provide one example of a specialist in BC failing to fully utilize his or her time in the public system in order to pursue more private surgeries.

2189. Professor Oliver argues that it would be more difficult to require a certain amount of work in the public system, as a precondition to providing diagnostic and surgical services in the private system, than it is in the UK where specialists work under service contracts.

2190. This was again pure speculation on his part, as he did not know how the health care system in British Columbia operates, and specifically that many surgeons are paid salaries pursuant to service contracts in this province, and that all surgeons require hospital privileges to be able to provide services in the public system.

2191. In fact, the same type of hourly service commitments as in the UK could be required of those surgeons in British Columbia who have service contracts.[1692]

2192. Although it is unclear why the form of payment would make any difference, it confirms that the Health Authorities could require agreements with every specialist providing surgical services in the public system and could include in those agreements commitments to provide a certain number of procedures per month, devote a certain amount of time to the public system, or fully utilize their allotted operating room time and on call responsibilities.

2193. As Professor McGuire explained on cross-examination, regardless of whether the surgeons have service contracts or are paid on a fee for service basis in the public system, they can be contractually required to provide a certain amount of services in the public system to be able to be able to work in the private system.[1693]

[1692] **Transcript Day 36,** p. 10, line 10 to p. 15, line 6; **Transcript Day 18**, p. 17, line 34 to p. 20, line 12
[1693] **Transcript Day 59,** p. 35, lines 32 to 46

2194. Moreover, from the evidence in this case, it is clear that the features of the UK health care system that led Professor Oliver to opine that "it is difficult to conclude definitively that these conflicts of interest cause a significant problem in reality",[1694] also apply to British Columbia:

i. "the relatively small size of the private health insurance sector"

The percentage of the private health insurance sector in terms of the overall public health system will also be very small, as it will be mainly employer provided insurance (as in the UK) and automobile insurance that will be used to pay for private diagnostic and surgical services.

ii. "the likelihood that the majority of doctors are highly committed to the NHS"

That is also true in British Columbia.

iii. "the broadly held belief that the NHS offers a generally satisfactory and comprehensive standard of care"

That again is the case in British Columbia, despite the concerns about timeliness of diagnostic and surgical services.

iv. "the constraints imposed by the 2003 contract, and the lack of hard evidence on this issue"

If it ever became necessary, similar constraints could be imposed in British Columbia.

2195. As noted in the previous section regarding asserted justifications, there are obviously many other ways in which physician supply in the public sector could be guaranteed, if it ever became a problem.

(vii) Conclusion

2196. The important point from the UK experience is that it does not support the hypothetical concerns of the Defendant and Canada that the public system will be harmed by allowing patients to obtain private diagnostic and surgical services to alleviate their suffering and protect their health in the face of lengthy wait times in the public system.

[1694] **Exhibit 490,** Tab 1, p. 5 **[CBE, Tab 130]**.

2197. Rather, the UK experience proves that allowing access to private health care is, as Professor Marmor testified, completely compatible with a high quality public health care system, and that permitting dual practice or private insurance has not in any way harmed the viability or accessibility of the public health sector. [1695]

2198. To the contrary, as Professor McGuire testified, it has led to an overall increase in capacity, which has allowed more patients to obtain their medically necessary services in a timely manner.

2199. As the United Kingdom has realized, that should be the overall goal of health care provision, not to attempt to prevent people from getting the treatment they need, which is what the impugned provisions accomplish.

C. New Zealand

2200. Like British Columbia and the UK, New Zealand has a universal public health care system that is funded by tax revenues.

2201. Professor Cumming, the expert witness called by the Defendant regarding the New Zealand health care system, testified that, as in the UK, New Zealand has a parallel private system which provides private diagnostic and surgical services for less acute procedures.

2202. New Zealand allows both private insurance and dual practice.

2203. There is no regulation that specialists perform a certain amount of hours of service in the public system in order to provide private services:[1696]

2204. About 33% of New Zealanders have private insurance.[1697]

2205. And about 50% of surgeons provide services in both the public and private system. [1698]

2206. New Zealand has an Accident Compensation Commission (ACC) which provides private surgeries for people who suffer injuries from accidents, whether they occur inside or outside the workplace (there is no WCB system for occupational injuries). [1699]

[1695] **Transcript Day 152,** Testimony of Prof. Marmor, May 9, 2019, p. 24 to 30, p. 43, line 45 to p. 44, line 3.
[1696] **Transcript Day 162,** Testimony of Prof. Cumming, June 6, 2019, p. 13, lines 6-20.
[1697] **Transcript Day 162,** p. 12, lines 11 to 14.
[1698] **Transcript Day 162,** p. 13, lines 21 to 24.
[1699] **Transcript Day 14**, lines 21 to 33.

2207. Professor Cumming agreed that being able to obtain quicker private surgeries saves money for the ACC, and that this is also better for patients, their families, employers and society as a whole.[1700]

2208. This also applies to British Columbia. Patients, their families, employers, and society would benefit if patients were able to obtain quicker surgeries in the private system, regardless of where they suffer their injuries.

2209. The New Zealand experience with the ACC shows that while it makes sense to have a workers compensation scheme in BC, it is irrational and inequitable to *limit* the access to quicker surgeries in the private system to occupational injuries.

2210. While we don't have the equivalent of the ACC in British Columbia, and the Government cannot be required to provide such an insurance system for persons injured in accidents, the New Zealand experience also shows that it is not necessary for the preservation of the public system to prohibit non-exempt patients from using private insurance to pay for private diagnostic and surgical services for non-occupational as well as occupational injuries.

2211. Professor Cumming further testified that for surgeries that are not the result of an accident, patients have an option to obtain surgeries in either the public or private systems.

2212. The public system is designed to let patients know right at the outset whether they will be able to obtain a timely surgery in that system.

2213. Patients are guaranteed an assessment within 4 months, and if they are rated highly enough in terms of their need by the surgeon, they are guaranteed a surgery within 4 months in the public system.

2214. This is clearly a much shorter time frame than in BC, where the maximum wait time is six months after booking the surgery (for 90% of patients), and there is no guarantee that patients will receive their surgery within that maximum wait time.

2215. The most important point is that, as Cumming says in her report and confirms in her testimony, the New Zealand public system provides "certainty" to patients when the decision is first made which enables them to opt for a private surgery to take care of their health needs if they don't want to wait for surgery in the public system.[1701]

[1700] **Transcript Day 162**, p. 15, line 18 to p. 16, line 23.
[1701] **Transcript Day 162,** p. 21, line 5 to p. 39.

2216. Especially in light of the fact that there are no wait time guarantees in BC, patients need to have the option of obtaining faster access to surgery, rather than being forced to linger on the public waiting list without knowing when they will get their surgery, with the attendant anxiety, pain, immobility, deterioration of their condition, and loss of earnings.

2217. Otherwise, patients are left in the very situation that Professor Cumming described: "long waiting lists with many people on them, and those people would not know whether they would ever get their surgery in the public hospital and they could wait in some cases, in the worst cases 18 months, and not be sure whether they were going to get treated."[1702]

2218. Significantly, Professor Cumming did not refer to any equity concerns about the operation of the New Zealand system. She only mentioned an equity issue in how people are rated/prioritized in the public system.

2219. Thus, as can be seen, the experience in New Zealand does not support the Defendant's asserted justifications for prohibiting non-exempt patients from obtaining private diagnostic and surgical services.

2220. Rather, it confirms what Professor Marmor said, and what the majority in *Chaoulli* found: that allowing patients to obtain private health care services is compatible with a high quality public health care system[1703].

D. Ireland

2221. Ireland has a universal public healthcare system available to all residents, but with user fees.[1704] Ireland also permits private diagnostic and surgical services which duplicate the services available in the public system, funded out-of-pocket or through private insurance.

2222. The funding for the Irish healthcare system is 80% from general taxation, 8% from private medical insurance and 12% through out-of-pocket charges to patients. These proportions have remained very stable over the last 50 years.[1705]

[1702] **Transcript Day 162,** p. 21, lines 21 to 39.
[1703] **Transcript Day 152,** p. 21, lines 24 to 32.
[1704] **Transcript Day 163,** p. 24, line 17 to p. 29 line 33; p. 31, line 19.
[1705] **Exhibit 501**, Normand Report, Tab 1, p. 4 **[CBE, Tab 132]**.

2223. Oddly, most of the out-of-pocket payments are for general practitioner care, since the majority of the population is not covered for GP services and private insurance is not available for GP services[1706]. Patients must be referred by a GP before they can consult with a specialist.[1707]

2224. Private medical insurance is provided on a community rated, rather than risk rated, basis, so that within any given insurance package the premium is the same regardless of the age or health status of the insured.[1708]

2225. Currently around 46% of the population has supplementary private medical insurance.[1709]

2226. There is no private medical insurance for general practitioner services, community drugs or hospital outpatient services but it does cover the cost of private inpatient and day care services.[1710]

2227. Public hospitals treat public patients and private patients often in the same facilities.[1711]

2228. Doctors in public hospitals can be employed through a range of contracts, some allowing private practice anywhere, some allowing it only on the public hospital site and some not allowing it at all[1712]. They are typically paid a salary under these contracts for a certain time commitment[1713]. Generally specialists prefer contracts which commit them to more public work at a higher salary.[1714]

2229. Restrictions are imposed on public hospitals limiting the proportion of private patients they may accept to protect access for public patients[1715].

2230. User charges are imposed on most medical services, but those of limited means receive medical cards which excludes them from most user charges and GP charges.[1716]

2231. Patients with medical cards are the most frequent users of GP services because they are not discouraged by the fee. This is one of the inequities of the Irish public healthcare system.[1717]

[1706] **Exhibit 501,** p. 7 **[CBE, Tab 132]**; **Transcript Day 163,** p. 23, line 42 to 44; p. 24 line 37 to 41.
[1707] **Transcript Day 163,** p. 28, line 11 to 24.
[1708] **Exhibit 501,** p. 4 **[CBE, Tab 132]**.
[1709] **Exhibit 501,** p. 4 **[CBE, Tab 132]**.
[1710] **Exhibit 501,** p. 4 **[CBE, Tab 132]**.
[1711] **Exhibit 501,** , p. 5 **[CBE, Tab 132]**.
[1712] **Transcript Day 163,** p. 47, line 40 to p. 48, line 20.
[1713] **Transcript Day 163,** p. 48, line 21 to p. 49, line 2.
[1714] **Transcript Day 163,** p. 50 line 35 to p. 52, line 2.
[1715] **Transcript Day 163,** p. 41, line 11 to 44.
[1716] **Exhibit 501,** p. 5 **[CBE, Tab 132]**.
[1717] **Transcript Day 163,** p. 25 line 3 to 12.

2232. Those with medical cards also get drugs free of charge subject to a prescription charge of €1.5 per item.[1718]

2233. Community health services, which includes community nursing services, physiotherapy, occupational therapy, home help services and other community support is provided free to those with medical cards. These services are generally not available to others, even for a fee[1719]

2234. There are both for-profit and not-for-profit hospitals that are funded from fees and charges to patients and private insurers.[1720]

2235. Specialists in the public system will be paid an additional fee when treating a private patient in a public hospital[1721]. The public hospital will also charge the private insurer for the patient's stay in the public hospital, although the patient will often receive a private room, if available[1722].

2236. There are also private hospitals that receive no public funding. While these hospitals may accept private patients who pay out of pocket, this is very rare. Almost all private patients are funded by private medical insurance.[1723]

2237. The public hospitals may contract with private hospitals to provide facilities for public patients when the need is great[1724]

2238. In terms of equity, in general those with low incomes who do not have insurance receive significant subsidies from richer people, but among those with private medical insurance there are some subsidies from poor fitter people to richer sicker ones.[1725]

2239. Significantly, the only group using more medical services than their needs would predict are those who have both a medical card and private medical insurance, not those who have private medical insurance alone[1726].

2240. One of the arguments in favour of private medical insurance is that it provides additional capacity in the healthcare system with no additional cost to taxpayers. Prof. Normand sought to

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[1718] **Exhibit 501**, p. 5 **[CBE, Tab 132]**.
[1719] **Exhibit 501**, p. 5 **[CBE, Tab 132]**.
[1720] **Exhibit 501**, p. 5-6 **[CBE, Tab 132]**.
[1721] **Transcript Day 163,** p. 37, line 1 to 17.
[1722] **Transcript Day 163,** p. 37, line 36 to p. 38, line 10.
[1723] **Transcript Day 163,** p. 42 line 15 to p. 43, line 34, p. 44 line 11 to 29.
[1724] **Transcript Day 163,** p 45, line 9 to 31.
[1725] **Exhibit 501**, p. 6 **[CBE, Tab 132]**.
[1726] **Transcript Day 163,** p. 63 line 10 to 25, p. 69 line 31 to p. 70, line 15.

determine this additional contribution and concluded that "the parallel private insurance funding does add to the net resources available for the health system, and does provide some care that would otherwise be a charge on the public system".[1727]

2241. The complex mix of public and private care in Ireland, in which private care is provided in public hospitals, has raised concerns about salaried specialists failing to fulfil their commitments to the public system, while devoting excessive time to private patients. As a result, rules have been put in place to regulate the work of specialists in the public system who also provide private services. These regulations are complicated by the fact that the public specialists are paid a salary for their time, rather than a fee for their service and because their public and private patients are located in the same hospital making it difficult to determine how much time they have allocated to public patients versus private patients.

2242. This allocation would not be difficult to determine if physicians were paid on a fee-for-service basis in the public system or had to treat private patients in entirely separate and remote private facilities.

2243. Reforms have been proposed to reduce waiting, eliminate user charges and charges for GP services[1728], increase capacity in the public system, and to remove private care from public hospitals.[1729] There have been no proposals to eliminate parallel private healthcare.

2244. In short, the Irish system further demonstrates that there is no incompatibility between a parallel private healthcare system and a universal public healthcare system.

2245. The Irish system is, however, unnecessarily complex and has serious issues of inequity resulting from user fees in the public system. It is unlikely that governments in Canada would adopt an Irish model if access to private insurance and private diagnostic and surgical services were permitted.

2246. What it further demonstrates is the wide range of policy options open to governments in maintaining a universal public health care system while allowing patients the freedom to choose to opt for private care when they believe it is necessary.

[1727] **Exhibit 501**, p. 10 **[CBE, Tab 132]**.
[1728] **Transcript Day 163,** p. 70 line 26 to p. 71, line 20.
[1729] **Transcript Day 163,** p. 40, line 40 to p. 41, line 10.

E. Australia

2247. Like British Columbia, Australia has a universal public healthcare system financed through general taxes and levies.

2248. The Australian public healthcare system, however, provides a wider range of medical services.

2249. There is public coverage for the full range of physician services, family doctors, hospital care and specialist services ("Medicare") and a national Pharmaceutical Benefits Scheme (PBS) for drugs[1730].

2250. Unlike BC, however, a broad range of private medical services are available and private health insurance is not only permitted, it is significantly subsidized by the federal government.[1731]

2251. Medicare and PBS are intended to allow universal access to care, irrespective of ability to pay, by subsidizing access to physician and hospital services as well as drugs.

2252. Although there are user charges, the public plans reimburse patients for most of the cost of doctor visits as well as all in-hospital costs when a patient is treated as a public patient in a public hospital. General practitioners are permitted to extra bill, in the sense of charging patients fees in addition to the amount received from the public system.[1732]

2253. All residents are eligible for coverage under the public plan.

2254. There is also a large private health insurance market, which is heavily promoted by the government through a combination of subsidies and financial penalties[1733].

2255. Private insurance is purchased to help cover some of the charges that are not covered under the universal health and drug plans, but some private plans also enhance patients' care choices. Specifically, they may subsidize the cost of being treated in a private hospital, something not covered under the public plan.

2256. Legislation does, however, prohibit private health insurance covering services performed outside of a hospital that are eligible for Medicare payments. These services include extra billing by GPs or by specialists providing consultation in their private clinics rather than in hospitals. Private

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[1730] **Transcript Day 164,** p. 63 line 24 to p. 64, line 1.
[1731] **Transcript Day 164,** p. 69, lines 36 to 45.
[1732] **Transcript Day 164,** p. 35, line 44 to p. 45, line 6; p. 36 line 45 to p. 46, line 11.
[1733] **Exhibit 504**, Tab 1, p. 5 **[CBE, Tab 133]**; **Transcript Day 164,** p. 66 lines 20 to 31.

insurance is, however, permitted for all medical services offered in hospitals whether covered by Medicare or not.[1734]

2257. Public hospitals in Australia perform both public and private surgeries.[1735] For private patients in public hospitals, the hospital is paid by Medicare at 75% of the scheduled fee for that surgery. The remaining hospital fee is paid by the patient or the private insurer. Typically private patients pay a significant copayment out-of-pocket.[1736] The specialist performing the private surgery in the public hospital, paid by the private insurer according to a set fee, may demand an additional payment which would be made by the patient.[1737]

2258. Private hospitals also receive payment from Medicare equal to 75% of the fee schedule paid for the surgery. The private hospitals can, however, charge any additional amount that they choose to set. The private insurance companies will reimburse the patient for all or some of these additional hospital charges. The surgeon performing the surgery at the private hospital can set his or her own fee and the patient will be reimbursed from the private insurer for an amount determined by the insurance policy.[1738]

2259. One reason many people choose this option is that private patients can choose which specialist will treat them when hospitalized. Public patients are treated by whichever doctor is next available.

2260. Private insurance has been important to the establishment and maintenance of private hospitals and clinics.[1739]

2261. Individuals are eligible to receive a substantial government subsidy when they purchase private insurance.

2262. Like in the UK, Ireland, and New Zealand, Australian doctors can operate dual practices and provide services for patients covered by both public and private insurers' plans[1740]. Although specialists may work in both the public and private system, 40% of surgeons work only in the private sector with more than 30% of orthopedic, neuro- and plastic surgeons doing no public-sector

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[1734] **Transcript Day 164,** p. 41 line 32 to 38.
[1735] **Transcript Day 164,** p. 50 line 30 to 34.
[1736] **Transcript Day 164,** p. 52, line 9 to p. 53, line 7.
[1737] **Transcript Day 164,** p. 53 lines 9 to 26.
[1738] **Transcript Day 164,** p. 55 line 42 to p. 57, line 5.
[1739] **Transcript Day 164,** p. 69 line 13 to p. 70, line 43.
[1740] **Exhibit 504**, Tab 1, p. 9; **Transcript Day 164,** p. 46, line 9 **[CBE, Tab 133]**.

consulting. Cardiac and pediatric surgeons were the only specialists who did more work in the public than the private sector[1741]

2263. Specialists in the public system enter into standard contracts for services and are paid a salary.[1742] But each individual specialist may negotiate his or her hourly or monthly time commitment to the public system.[1743] There are no restrictions on specialists doing other work, including private surgeries.[1744]

2264. The public sector has entered into contracts with private hospitals to provide surgical facilities to cut waiting lists in the public sector.[1745]

2265. Australia and Ireland have the most extensive coverage of duplicate PHI. For Australia coverage is over 45% of the population.[1746] The actual expenditure accounted for by PHI is 8% to 10%.[1747]

2266. The relatively high levels of private health insurance in Australia is not primarily the result of free-market consumer demand. It is the result of a government policy to encourage private health insurance through strong financial incentives and penalties.[1748]

2267. There are often very high out-of-pocket payments made by patients covered by private health insurance creating an incentive for people with private health insurance to continue using the public system as public patients.[1749]

2268. There is an Australian study showing that longer wait times in the public system for certain procedures are correlated with a higher percentage of those same procedures being performed in the private system. This correlation does not mean, however, that private surgeries cause longer public wait times. Indeed the converse is much more plausible. When patients must wait longer for a procedure in the public system, they will be more inclined to have the procedure performed privately, even though they will have to make significant copayments beyond their insurance benefits to receive

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[1741] **Exhibit 504**, Tab 1, p. 9 **[CBE, Tab 133]**.
[1742] **Transcript Day 164,** p. 45 line 2 to p. 46, line 27.
[1743] **Transcript Day 164,** p. 46 line 28 to p. 47, line 26.
[1744] **Transcript Day 164,** p. 47 line 27 to p. 48, line 41.
[1745] **Exhibit 504**, Tab 1, p. 10 **[CBE, Tab 133]**.
[1746] **Exhibit 504**, Tab 1, p. 8 **[CBE, Tab 133]**.
[1747] **Exhibit 504**, Tab 1, p. 5 **[CBE, Tab 133]**.
[1748] **Exhibit 504**, Tab 1, p. 5 **[CBE, Tab 133]**; **Transcript Day 164,** p. 66 line 20 to p. 68, line 35.
[1749] **Exhibit 504**, Tab 1, p. 6 **[CBE, Tab 133]**.

the surgery. As Professor Gillespie testified, the claim that the correlation means that private surgeries cause longer wait times simply reflects the political predisposition of the authors of the study[1750].

2269. Wait times are also a poor measure of the benefits of having access to private surgery. Introducing private surgeries should increase the total number of procedures performed. However, it is well-known that when surgeries become more readily available, the demand for surgery increases because fewer people are discouraged by the very long wait times.[1751]

2270. Issues of access and equity have been identified in the Australian system, including extra billing by GPs.[1752] Australia also continues to have relatively long wait times in the public system for certain procedures. There are, however, no proposals to eliminate private surgeries as a way to reduce wait times in the public system, or address any other problems with the public system. At most, the issue is whether the government should continue to subsidize private insurance and private healthcare at the current levels.

2271. There is nothing in the Plaintiffs' case that would give rise to the principal concerns expressed about the Australian healthcare system. It would not, for instance, give rise to extra billing by physicians operating in the public healthcare system. It would not give rise to public hospitals competing to treat private patients for a fee. In the absence of significant financial incentives and penalties, private healthcare would also remain relatively small. As in the UK, there would be no need to regulate the insurance market and in particular to impose a community risk model, since everyone would continue to be covered in the public system.

2272. In short, the Australian system further demonstrates that there is no incompatibility between a parallel private healthcare system and a universal public healthcare system, but the Plaintiffs' success in this case would not in any way lead to a healthcare system modelled after Australia.

2273. What Australia further demonstrates is the wide range of policy options open to governments in maintaining a universal public health care system while allowing patients the freedom to choose to opt for private care when they believe it is necessary.

F. Quebec after Chaoulli

[1750] **Transcript Day 164,** p. 90 line 22 to page 91 line 13.
[1751] **Transcript Day 164,** p. 91 line 45 to p. 93, line 10.
[1752] **Transcript Day 164,** p. 107, lines 35 to 47.

2274. In Quebec, the constitutional challenge was only to the prohibition on private insurance, and not to the prohibition on dual practice.

2275. Thus, the Court's decision only focused on this prohibition, which the majority struck down.

2276. Quebec was given one year by the SCC to revise its legislation to implement the *Chaoulli* decision of the Court.

2277. Professor Prémont, the expert called by an intervenor, confirmed that the Quebec Government moved "cautiously" with its reforms after Chaoulli[1753].

2278. The Quebec reforms were preceded by public discussion, the publication of a White Paper, and a 19-day Parliamentary Commission hearing at which 108 individuals and organizations presented their reaction to the White Paper.[1754]

2279. The White Paper was entitled "Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality."

2280. Professor Prémont agreed in her testimony that the title of the White Paper reflects the Government's stated objective with the reforms.[1755]

2281. The initial reforms were implemented in Bill 33, which allowed private insurance for three types of surgeries: hip and knee replacements and cataracts; and provided for wait time guarantees in the pubic system for these surgeries.

2282. There is no evidence that these reforms have resulted in any harm to the public system in Quebec.

2283. Professor Prémont agreed that change in the health sector is inevitable:[1756]

2284. After the passage of Bill 33, the Quebec Government established a Commission chaired by Claude Castonguay to make recommendations regarding the financing of health care in Quebec.[1757]

[1753] **Transcript Day 154**, Testimony of Marie-Claude Premont, May 13, 2019, p. 14, line 38 to p. 16, line 31; **Exhibit 473**, Affidavit of Julian Thorsteinson, October 24th, 2018, p. 4 **[CBE, Tab 125]**.
[1754] **Transcript Day 154**, p. 38, line 3 to p. 38, line 7.
[1755] **Transcript Day 154,** p. 38, lines 26 to 39; p. 40, line 41 to p. 41, line 1.
[1756] **Transcript Day 154**, p. 61, line 9 to p. 62, line 16.
[1757] **Transcript Day 154**, p. 60, lines 1 to 10.

The Commission published its report in 2008, which was entitled "Getting our Money's Worth." One of the recommendations was the elimination of the prohibition of dual practice.[1758]

2285. The Plaintiffs constitutional challenge is to both the prohibition on private insurance and the prohibition on dual practice.

2286. As the experience in British Columbia over the past 20 years shows, both prohibitions need to be eliminated to provide non-exempt British Columbians with meaningful access to private diagnostic and surgical services to alleviate their suffering and protect their health.

2287. Professor Prémont testified that to her knowledge "there is no private insurance being offered in Quebec for the three designated surgeries."

2288. She explained that "the reason why private insurance cannot expand at this time in Quebec or anywhere else, in most provinces where it is prohibited, is that very few physicians could provide that service because they're all enrolled or non-participating. So you have to include and there we come with the hybrid or the mixed or the dual medical practice, which is the next step, you know, that Mr. Castonguay is asking, and he's not the only one asking for it. ... Dual medical practice is one of them; introducing private insurance is the other one".[1759]

2289. Professor Prémont did not know whether employer provided disability insurance is being used to pay for private knee, hip and cataract surgeries.

G. How Does BC Compare with other Jurisdictions?

2290. In British Columbia, non-exempt patients have been paying for private diagnostic and surgical services performed by enrolled specialists through employer provided disability insurance benefits and automobile insurance for over 20 years.

2291. So, we already have long experience in British Columbian with both private insurance and dual practice which shows that there would be no resulting harm to the public system if both of these prohibitions were eliminated.

[1758] **Transcript Day 154**, p. 65 to 70.
[1759] **Transcript Day 154**, p. 69, lines 26 to 46; **Exhibit BBBBB,** Castonguay – The Health Care System Towards Significant Changes **[CBE, Tab 159]**.

2292. We have seen that every other developed country with a universal public healthcare system permits parallel private healthcare and private insurance.

2293. This demonstrates, at the very least, that parallel private healthcare and private insurance are compatible with a universal public healthcare system.

2294. The evidence further demonstrates, however, that prohibiting parallel private healthcare does not result in a better, more efficient or more equitable public healthcare system.

2295. The most reliable and widely used comparison between the healthcare systems in Canada and other developed countries is the series of Commonwealth reports.[1760]

2296. The Commonwealth Fund International Health Policy Surveys provide important information about the performance of public health care systems in a number of developed countries.[1761]

2297. Canada and 10 other countries participate in the survey annually. The Health Council of Canada has co-sponsored this survey annually from 2007 to 2013.[1762]

2298. The Canadian Institute for Health Information (CIHI) oversees the Canadian portion of the Commonwealth Fund survey and funds an expanded Canadian sample for the survey.

2299. These reports consistently demonstrate that Canada, including British Columbia, is not amongst the top public healthcare systems in the world. Further, the comparison demonstrates that there is no correlation, whatsoever, between the quality, efficiency or equity of a public healthcare system and the existence of a parallel private healthcare system.

2300. The 2010 Commonwealth Fund International Health Policy Survey', which provides a broad measurement of waiting times for adult populations, shows that Canadians likely endure longer delays for access to emergency care, primary care, specialist consultations, and treatment than residents of 9 other developed nations that maintain universal access to health insurance (Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom)[1763].

2301. Canadians were among the least likely to report:

[1760] **Transcript Day 178,** p. 17, line 37 to p. 19, line 3.
[1761] **Exhibit 323B,** page 144 **[CBE, Tab 77].**
[1762] **Exhibit 433D,** Vol. 4, at p. 3660 **[CBE, Tab 106].**
[1763] **Exhibit 18,** Tab 1, p. 7 **[CBE, Tab 13].**

i. relatively short waits for specialist appointment (less than 1 month), 41% in Canada compared to 45% in Sweden to 83% in Germany; and

ii. relatively short waits for elective surgery (less than 1 month), 35% in Canada compared to 34% in Sweden to 78% in Germany.[1764]

2302. Looking at longer wait times, Canadians were among the most likely to report:

i. relatively long waits for specialist appointment (two months or more), 41% in Canada compared to 34% in Norway to 5% in Switzerland; and

ii. relatively long waits for elective surgery (four months or more), 25% in Canada compared to 22% in Sweden to 0% in Germany.[1765]

2303. In the overall ranking of the healthcare systems in 11 countries, Canada ranked 10th, behind Australia, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the UK. The United Kingdom was ranked first. Only the United States was ranked lower than Canada.[1766]

2304. On measures of equity, Canada placed ninth, just ahead of the United States. Significantly, Canada fell well below countries like the UK, which permit parallel private healthcare.[1767]

2305. The Commonwealth Fund, in their *2015 International Profiles of Health Care Systems*, provides a broad measurement of waiting times for adult populations in 2013. The data shows that Canadians report longer delays for access to primary care, specialist consultations, and elective surgery than residents of 8 other developed nations that maintain universal access to health insurance (Australia, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom)[1768].

2306. Since all the countries who do better than Canada, and British Columbia, in the overall ranking of their healthcare system and specifically in providing shorter wait times for specialist consultations and specialist treatments, also permit parallel private healthcare, the comparison with other countries clearly demonstrates that prohibiting private healthcare does not result in a better healthcare system,

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[1764] **Exhibit 18,** Tab 1, p. 6 **[CBE, Tab 13]**.
[1765] **Exhibit 18,** Tab 1, p. 7 **[CBE, Tab 13]**.
[1766] **Exhibit 18,** Tab 3 – Mirror Mirror on the Wall – How the Performance of the US Health Care System Compares Internationally, June 2014, p. 7 **[CBE, Tab 13]**.
[1767] **Exhibit 18,** Tab 3, page 25 **[CBE, Tab 13]**
[1768] **Exhibit 18,** Tab 2, p. 4 **[CBE, Tab 13]**.

a more equitable healthcare system or a healthcare system with speedier access to diagnostic and surgical services.

X. THE ASSERTED JUSTIFICATIONS FOR THE PROHIBITIONS ON DUAL PRACTICE AND PRIVATE INSURANCE

A. Introduction

2307. Every OECD country, other than the United States, seeks to provide universal health care coverage to its population, to ensure that no one is unable to afford the medical treatment they need.[1769]

2308. However, with the exception of Canada, no other OECD country prohibits their residents from obtaining private health insurance, and no other OECD country prohibits physicians from providing services in both the public and private systems.

2309. All of these OECD countries have managed to provide more comprehensive health care to their entire population – often at a higher quality, lower cost, and in a more accessible and equitable manner than Canada – without eliminating the ability of patients to obtain private health care.

2310. As discussed in the 2008 Quebec report entitled "Getting Our Money's Worth" (chaired by Claude Castonguay[1770] the "father" of Quebec's public health care system who also testified for the Quebec Government in the *Chaoulli* case), these other countries have been facing the same financial challenges as British Columbia in providing high quality, timely medical services to their residents.[1771]

2311. But unlike in these other countries, there has been no reform to the health care system in British Columbia to meet these modern challenges.[1772]

2312. As a result, British Columbia has fallen far behind in being able to provide timely, quality health care, as demonstrated by the lengthy wait times for diagnostic and surgical services in the Province that have persisted for over 30 years.[1773]

[1769] See **Section IX,** above.
[1770] His name is associated with the Quebec health insurance card, which is still nicknamed the "Castonguette". **Transcript Day 154**, Testimony of Professor Premont, May 13, 2019, p. 58, lines 3-15, and p. 59, lines 26-35.
[1771] **Exhibit 433C**, "Getting Our Money's Worth (Summary)", p. 3176 **[CBE, Tab 105]**; **Transcript Day 154**, p. 61, l. 1 to p. 63, l. 35.
[1772] See **Section VI(F)** and **IX.**
[1773] See **Section VI**, above.

2313. It is significant that in reforming their health care systems, none of the other OECD countries have even considered prohibiting access to private health care.[1774]

2314. The reason is that such a prohibition is not helpful, let alone necessary, to ensuring the provision of timely, quality health care in a universal public health care system. All other countries have recognized that patients have to be able to obtain private health care as a safety valve in case the primary health care system fails to provide reasonable or timely care to meet an individual patient's health care needs.[1775]

2315. British Columbia did send a delegation headed by the Premier to examine the health care systems in other countries, which came away favourably impressed.[1776]

2316. But this didn't lead to legislative reform. Unfortunately, as Professor Blomqvist explained, because of entrenched interests, reforms can be a slow process.[1777]

2317. The BC Government chose instead not to actively enforce the prohibitions on non-exempt British Columbians obtaining private diagnostic and surgical services to alleviate their suffering and protect their health in the face of the persistent inability of the public system to provide these services in a timely manner to all British Columbians.

2318. This provided a much needed health care safety valve for British Columbians.

2319. But now the Defendant, supported and encouraged by Canada, has announced that it is going to enforce these prohibitions, and has brought into force long dormant sections of the *MPA* designed to do so.

2320. The Defendant and Canada say that this is necessary to preserve the public health care system, despite the fact that the non-enforcement of these prohibitions in British Columbia over the past 23 or so years has not resulted in any harm to the public health care system and has only benefitted the health of British Columbians by providing additional diagnostic and surgical services.

2321. As will be discussed, the Defendant and Canada base their position in this case on hypothetical concerns which have not arisen in British Columbia over the past 23 years, and that, as shown in other

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[1774] See **Section IX**, above.
[1775] See **Section IX**, above.
[1776] **Exhibit 334**, p. 2 **[CBE, Tab 79]**;
[1777] **Transcript Day 33**, Testimony of Professor Blomqvist, dated November 4, 2016, p. 62, line 19.

countries, could, if they ever arose, be managed without a prohibition on access to health care outside of the public plan.

2322. It is clear on the evidence in this case that prohibiting British Columbians from obtaining private diagnostic and surgical services to alleviate their suffering and protect their health does not assist, or better enable, the public system to provide high quality health care services on a timely basis.[1778]

2323. However, given the position of the Defendant, it is necessary for British Columbians to rely on their *Charter* rights to ensure that they are not prohibited from being able to continue to obtain private diagnostic and surgical services to alleviate their suffering and protect their health, as they have been able to do for the last two decades.

2324. The Plaintiffs want to stress that they are not saying that it is the task of the Court under the Charter to reform the health care system. That is the role of the legislature.

2325. Rather, as in *Chaoulli*, the Plaintiffs are simply asking the Court to rule on whether it is constitutionally permissible for the Government to enact provisions that have the purpose and effect of preventing British Columbians from obtaining private diagnostic and surgical services, given the significant harms patients suffer as a result of the persistent failure of the Government to provide such services in a timely manner in the public system.

2326. If the Court agrees with the Plaintiffs that it is not constitutionally permissible, then the matter is turned over to the Government (the "baton is passed" to the legislature, pursuant to the constitutional dialogue between courts and the legislature) to revise the *Medicare Protection Act* to implement the Court's decision in a way which the Government decides best meets its objective of providing high quality, timely health care to British Columbians in the public system, while not denying access to private care.

2327. This will not result in the adoption of a "US style health care system" in which British Columbians will be unable to continue to have access to public health care based on their need and not their ability to pay. The US is the anomaly in the OECD. No country is striving to adopt a US health care system.

[1778] For example, see **Section IX**, above.

2328. If the Court determines that the prohibitions on British Columbians being able to obtain private diagnostic and surgical services within the province are unconstitutional, this will leave the Government with the necessary ability to meet the objectives of the public health care system in British Columbia.

2329. All that the Court's decision will do is constitutionally require the Government to add a much needed safety value to the public system, which has been unable to provide timely access to diagnostic and surgical services to tens of thousands of suffering patients. The Government will be able to take whatever steps it believes are necessary to provide high quality medical services in the public system based on medical need rather than an ability to pay without being impaired by this safety value.

2330. As the Defendant's own expert Professor Marmor explained, allowing access to private health care is entirely compatible with a high quality public system.[1779]

2331. This is proven by the experience in British Columbia over the past 20 years, as well as the experience elsewhere, which shows that providing a high quality system is not in any way impaired by allowing patients access to private health care to alleviate suffering and protect individual health care needs.[1780]

2332. In defending the prohibitions on access to private diagnostic and surgical services, the Defendant and Canada ignore the experience in British Columbia and elsewhere. Instead, they rely on speculation and "concerns" to argue that the enforcement of the impugned provisions, that have not been enforced for 23 years, is necessary in order to avoid:

(a) Insufficient health care personnel – most notably physicians – in the public system to meet its needs, and therefore longer wait times for diagnostic and surgical services in the public system (the "**Specialist Supply Justification**");

(b) Increases in the costs of providing medical services in the public system as a result of increased wages (the "**Labour Costs Justification**");

[1779] **Exhibit 467**, Expert Report of Professor Marmor, p. 5 **[CBE, Tab 121]**; **Transcript Day 152**, Testimony of Professor Marmor, line 21 to, p. 22, line 5, and p. 29, lines 11-45; **Exhibit SSSS**, "Evaluating the Landmark Chaoulli Decision", pp. 316-318; **[CBE, Tab 163]**; **Transcript Day 154**, pp. 65-66.

[1780] See **Section IX**, above.

(c) A decline in political support for the public health care system leading to the reduced quality of publicly funded health care (the "**Popular Support Justification**");

(d) Physicians abandoning their professional obligations *en masse*, and engaging in harmful and unethical practices in order to maximize profit (the "**Unethical Practices Justification**");

(e) An alleged harm to the public system of having all of the more complicated cases performed in the public system (the "**Cream Skimming Justification**");

(f) The inequity of permitting some BC patients to obtain more timely care through access to private treatment options (the "**Equity Justification**");

(g) Harm to patients as a result of a lesser quality of services provided in the private system as compared to the public health care system (the "**Reduced Quality Justification**");

(h) An increase in overall demand for diagnostic and surgical services, which will result in no improvement to, and perhaps even increases in, wait times in the public system (the "**Increased Demand Justification**"); and

(i) An overall increase in health care spending in the province (the "**Overall Costs Justification**"); and

(j) Disentitling British Columbia to Canada Health Transfers, or otherwise running afoul of the principles of the *Canada Health Act* (the "**Canada Health Act Justification**").

2333. The Plaintiffs submit that some of these justifications – such as maintaining political support and avoiding potential administrative costs – are not the purposes of the impugned provisions in this case, nor are they the type of justifications that could ever justify a breach of *Charter* rights, even if the evidence supported these concerns (which it does not).

2334. Nevertheless, the Plaintiffs will address all of the asserted justifications below.

2335. In order to do so, it is helpful to begin with the *Chaoulli* case, and the approaches of both the *Chaoulli* majority and dissenting judgments, in order to place the evidence of this case into context.

2336. As discussed below, the evidence in this case has confirmed the factual conclusions of the *Chaoulli* majority, while at the same time resolving the evidentiary concerns expressed by the *Chaoulli*

minority judgment – including uncertainty about the harmful impacts of restrictions on access to private treatment, and uncertainty about whether permitting private treatment will harm the public plan.

B. How the asserted justifications for prohibiting access to private diagnostic and surgical services were dealt with in *Chaoulli*

(i) The Majority Decisions in *Chaoulli*

2337. The majority in *Chaoulli* found that the arguments advanced in support of the prohibition on access to private surgical services did not justify the harms suffered by patients as a result of the prohibition.

2338. Many – if not all – of the justifications offered by Canada and the Defendant in this case were considered, and rejected, by the majority decisions in *Chaoulli.*

2339. Justice Deschamps divided these justifications into two general categories. First, Justice Deschamps listed those alleged justifications that dealt with "human reactions" as follows:

> [63] 1. Some witnesses asserted that the emergence of the private sector would lead to a reduction in popular support in the long term because the people who had private insurance would no longer see any utility for the public plan. Dr. Howard Bergman cited an article in his expert report. Dr. Theodore R. Marmor supported this argument but conceded that he had no way to verify it.
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> 2. Some witnesses were of the opinion that the quality of care in the public plan would decline because the most influential people would no longer have any incentive to bring pressure for improvements to the plan. Dr. Bergman cited a study by the World Bank in support of his expert report. Dr. Marmor relied on this argument but confirmed that there is no direct evidence to support this view.
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> 3. There would be a reduction in human resources in the public plan because many physicians and other health care professionals would leave the plan out of a motive for profit: Dr. Charles J. Wright, cited a study done in the United Kingdom, but admitted, that he had read only a summary and not the study itself. Although Dr. Marmor supported the assertion, he testified [page829] that there is really no way to confirm it empirically. In his opinion, it is simply a matter of common sense.
>
> 4. An increase in the use of private health care would contribute to an increase in the supply of care for profit and lead to a decline in the professionalism and ethics of physicians working in hospitals. No study was cited in support of this opinion that seems to be based only on the witnesses' common sense.[1781] [emphasis added]

[1781] *Chaoulli*, para 63.

2340. In explaining why these alleged justifications could not be accepted, Justice Deschamps set out the following:

> [64] It is apparent from this summary that for each threat mentioned, no study was produced or discussed in the Superior Court. While it is true that scientific or empirical evidence is not always necessary, witnesses in a case in which the arguments are supposedly based on logic or common sense should be able to cite specific facts in support of their conclusions. The human reactions described by the experts, many of whom came from outside Quebec, do not appear to me to be very convincing, particularly in the context of Quebec legislation. Participation in the public plan is mandatory and there is no risk that the Quebec public will abandon the public plan. The state's role is not being called into question. As well, the HEIA contains a clear provision authorizing the Minister of Health to ensure that the public plan is not jeopardized by having too many physicians opt for the private system (s. 30 HEIA). The evidence that the existence of the health care system would be jeopardized by human reactions to the emergence of a private system carries little weight.[1782]

2341. Second, Justice Deschamps discussed the alleged justifications based on the "Impact on the Public Plan", as follows:

> [65] 1. There would be an increase in overall health expenditures: the alleged increase would come primarily from the additional expenditures incurred by individuals who decide to take out private insurance; the rest of the increase in costs would be attributable to the cost of management of the private system by the state.
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> 2. Insurers would reject the most acute patients, leaving the most serious cases to be covered by the public plan.
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> 3. In a private system, physicians would tend to lengthen waiting times in the public sector in order to direct patients to the private sector from which they would derive a profit.[1783] [emphasis added]

2342. Justice Deschamps responded to these concerns as follows:

> [66] Once again, I am of the opinion that the reaction some witnesses described is highly unlikely in the Quebec context. First, if the increase in overall costs is primarily attributable to the individual cost of insurance, it would be difficult for the state to prevent individuals who wished to pay such costs from choosing how to manage their own finances. Furthermore, because the public plan already handles all the serious cases, I do not see how the situation could be exacerbated if that plan were relieved of the clientele with less serious health problems. Finally, because of s. 1(e), non-participating physicians may not practise as participants; they will not therefore be faced with the conflict of interest described by certain witnesses. As for physicians who have withdrawn (s. 1(d) HEIA), the state controls their conditions of practice by way of the agreements (s. 1(f) HEIA) they are required to sign. Thus,

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[1782] *Chaoulli*, para 64.
[1783] *Chaoulli*, para 65.

> the state can establish a framework of practice for physicians who offer private services.[1784] [emphasis added]

2343. The same alleged justifications were rejected by Chief Justice McLachlin and Major J. (Bastarache J. concurring).[1785]

2344. First, they addressed the alleged "common sense" argument that permitting a private care option would divert resources away from the public system, leaving it unable to provide timely access to medically necessary services:

> [135] The government argues that the interference with security of the person caused by denying people the right to purchase private health insurance is necessary to providing effective health care under the public health system. It argues that if people can purchase private health insurance, they will seek treatment from private doctors and hospitals, which are not banned under the Act. <u>According to the government's argument, this will divert resources from the public health system into private health facilities, ultimately reducing the quality of public care.</u>
>
> [136] In support of this contention, the government called experts in health administration and policy. Their conclusions were based on the "common sense" proposition that the improvement of health services depends on exclusivity (R.R., at p. 591). They did not profess expertise in waiting times for treatment. Nor did they present economic studies or rely on the experience of other countries. They simply assumed, as a matter of apparent logic, that insurance would make private health services more accessible and that this in turn would undermine the quality of services provided by the public health care system.
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> [137] The appellants, relying on other health experts, disagreed and offered their own conflicting [page854] "common sense" argument for the proposition that prohibiting private health insurance is neither necessary nor related to maintaining high quality in the public health care system. Quality public care, they argue, depends not on a monopoly, but on money and management. They testified that permitting people to buy private insurance would make alternative medical care more accessible and reduce the burden on the public system. The result, they assert, would be better care for all. The appellants reinforce this argument by pointing out that disallowing private insurance precludes the vast majority of Canadians (middle-income and low-income earners) from accessing additional care, while permitting it for the wealthy who can afford to travel abroad or pay for private care in Canada.
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> [138] To this point, we are confronted with competing but unproven "common sense" arguments, amounting to little more than assertions of belief. We are in the realm of theory. But as discussed above, a theoretically defensible limitation may be arbitrary if in fact the limit lacks a connection to the goal.[1786]

[1784] *Chaoulli*, para 66.
[1785] *Chaoulli*, paras 135-148
[1786] *Chaoulli*, paras 135-148.

2345. Given the lack of definitive guidance from the expert evidence, the Court turned to the international evidence, which demonstrated that "there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system":[1787]

> [139] This brings us to the evidence called by the appellants at trial on the experience of other developed countries with public health care systems which permit access to private health care. The experience of these countries suggests that there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system.
>
> [140] The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada. This demonstrates that a monopoly is not necessary or even related to the provision of quality public health care.
>
> (...)
>
> [149] In summary, the evidence on the experience of other western democracies refutes the government's theoretical contention that a prohibition on private insurance is linked to maintaining quality public health care. [emphasis added]

2346. The majority decision then went on to elaborate upon this point, in response to the concerns expressed by the dissenting judges, Binnie and Lebel JJ.:

> [150] Binnie and LeBel JJ. suggest that the experience of other countries is of little assistance. With respect, we cannot agree. This evidence was properly placed before the trial judge and, unless discredited, stands as the best guide with respect to the question of whether a ban on private insurance is necessary [page858] and relevant to the goal of providing quality public health care. The task of the courts, on s. 7 issues as on others, is to evaluate the issue in the light, not just of common sense or theory, but of the evidence. This is supported by our jurisprudence, according to which the experience of other western democracies may be relevant in assessing alleged arbitrariness. In *Rodriguez*, the majority of this Court relied on evidence from other western democracies, concluding that the fact that assisted suicide was heavily regulated in other countries suggested that Canada's prohibition was not arbitrary: pp. 601-5.[1788] [emphasis added]

2347. The majority then concluded as follows:

> [152] When we look to the evidence rather than to assumptions, the connection between prohibiting private insurance and maintaining quality public health care vanishes. The evidence before us establishes that where the public system fails to deliver adequate care, the denial of private insurance subjects people to long waiting lists and negatively affects their health and security of the person. The government contends that this is necessary in order [page859] to

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[1787] *Chaoulli*, paras 139-140, 149.
[1788] *Chaoulli*, para 150.

preserve the public health system. The evidence, however, belies that contention.

> [153] We conclude that on the evidence adduced in this case, the appellants have established that in the face of delays in treatment that cause psychological and physical suffering, the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice.[1789] [emphasis added]

2348. Thus, the majority's reasoning emphasized the importance of relying on the evidence rather than the assumptions or theoretical justifications offered. On that basis, they concluded that the alleged justifications offered, which mirror those in this case, were unsupportable.

2349. As discussed below, the very same analysis applies in this case. The Defendant has again raised purely theoretical and speculative concerns, which are not only inconsistent with the international experience, but more importantly, inconsistent with British Columbia's own 20 year experience with dual practice.

(ii) The Minority Decision in *Chaoulli*

2350. The minority in *Chaoulli* held that the asserted justifications for the prohibitions on access to private health care outweighed the harms to the health of patients.

2351. This was based, in large part, on what the minority considered to be an absence of compelling evidence that patients were actually harmed by being deprived access to a private care option, as well as a deferential posture to the government in terms of the alleged harms to the public health care system that the minority believed at least could occur.

2352. More specifically, the minority's reservations with the majority's factual conclusions were primarily based on the following conclusions:

(a) The impact on or harm to patients was unclear or uncertain, because

i. there were no consensus or agreed upon standards to determine whether individuals had reasonable access to timely treatment;[1790]

ii. There was no accurate data on the seriousness of the wait-list problem;[1791]

[1789] *Chaoulli*, paras 152-153.
[1790] *Chaoulli*, paras 212, 219-220, 223.
[1791] *Chaoulli*, paras 212, 217-220, 223.

iii. There was a lack of certainty over how many people were actually harmed by waiting in the public system, and how seriously they were harmed;[1792]

(b) It was not clear that eliminating the prohibition on access to private diagnostic and surgical services would solve the problem of delay and access in the public system;[1793] and

(c) There were concerns that the elimination of the prohibitions on access to diagnostic and surgical services "would have a harmful impact on the pubic system", notwithstanding the international evidence to the contrary.[1794]

2353. Whatever the merits of these concerns in the context of the issues and evidence in the *Chaoulli* case, they are all resolved on the issues and evidence in *this* case:

(a) There is now far greater certainty about the scale and gravity of the harm suffered by patients, because:

i. There is now agreed upon and consensus standards for the outer limits of medically acceptable wait times, based on the BC Patient Prioritization System;

ii. There is accurate data, collected by the Government through the SPR, which shows that these maximum acceptable wait times are not being met for a significant percentage of patients in all priority groupings for all surgical categories;

iii. There is comprehensive evidence led in this case, from patients, physicians, and experts, with respect to both the cause and degree of the physical and psychological harms suffered by patients waiting for treatment in the BC public health care system;

(b) As Justice Deschamps explained,[1795] the relevant constitutional issue is not whether the elimination of these prohibitions will solve the problem of delays and access in the

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[1792] *Chaoulli*, paras 219, 220, 223, 265.
[1793] *Chaoulli*, paras 215, 221-222.
[1794] *Chaoulli*, paras 240, 242-247
[1795] *Chaoulli*, paras 2, 68, 100: [2] ... The appellants do not claim to have a solution that will eliminate waiting lists. Rather, they submit that the delays resulting from waiting lists violate their rights under the Charter of Human Rights and Freedoms, R.S.Q., c. C 12 ("Quebec Charter"), and the Canadian Charter of Rights and Freedoms ("Canadian Charter ")... [68] ... Thus, the judge's finding that the appellants had failed to show that the scope of the prohibition was excessive and

public system, but rather whether, in light of the persistent existence of significant delays in the public system, prohibiting patients from obtaining private health care to alleviate their suffering and protect their health deprives them of their life and security of the person in violation of the principles of fundamental justice; and

(c) In addition to the international evidence relied on by the majority (and questioned by the minority), there has been:

i. over 23 years of direct experience in British Columbia of allowing patients to obtain private diagnostic and surgical services, and

ii. Almost 15 years of experience in Quebec following the *Chaoulli* decision, which resulted in none of the harms to the public system that the Government speculated would occur. This confirms the majority's conclusion that based on the experience in all other countries that provide universal public health care, while permitting access to private health care, that private care will not harm the public system.

iii. Evidence by experts in this trial that there are many international countries that allow private insurance and dual practice which provide more comprehensive, universal care in a more timely manner than is available in British Columbia.

iv. CIHI and Commonwealth Fund data that confirms most developed countries that allow private insurance and care significantly outperform Canada in terms of accessibility, wait lists and quality.

2354. In essence, the minority in *Chaoulli* was uncertain about the extent to which patients were actually being harmed by waiting for diagnostic and surgical services, and accepted the largely

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that the principles of fundamental justice had not been violated was based solely on the "fear" of an erosion of resources or a [TRANSLATION] "threat [to] the integrity" of the system (p. 827 (emphasis deleted)). But the appellants did not have the burden of disproving every fear or every threat. The onus was on the Attorney General of Quebec to justify the prohibition. ...

[100] The relief sought by the appellants does not necessarily provide a complete response to the complex problem of waiting lists. However, it was not up to the appellants to find a way to remedy a problem that has persisted for a number of years and for which the solution must come from the state itself. Their only burden was to prove that their right to life and to personal inviolability had been infringed. ...

speculative evidence that there would be a negative impact on the public system if patients were freely allowed to obtain private health care to deal with their health care needs.

2355. It is now clear on the evidence in this case that the health of many thousands of patients is being harmed in British Columbia by waiting for diagnostic and surgical services, both within the maximum acceptable wait times that have been established since *Chaoulli*, and outside these wait time standards.[1796]

2356. And the evidence of the experience in British Columbia over the past 23 years, and of the experience in Quebec after *Chaoulli*, confirms the international evidence accepted by the majority: that the absence of prohibitions on patients obtaining private diagnostic and surgical services to alleviate their suffering and protect their health will not result in harm to the public system.[1797]

2357. Put simply, as confirmed by the Defendant's own experts in this case, there is no inherent incompatibility between having a high quality and universal health care system and permitting patients to obtain care privately. [1798]

2358. More specifically, in terms of the minority's concerns in the *Chaoulli* case, it is now clear, some fifteen years after *Chaoulli*, that the elimination of the prohibitions on access to private care will not result in any of the harms that the Government alleges.[1799]

2359. The fact that the *Chaoulli* minority raised all of these concerns, that the Government now purports to rely on, does not mean that they are all relevant to the constitutional analysis.

2360. In particular, the only objectives relevant to the section 7 analysis are those that pertain to the actual animating purpose underlying the impugned provisions – namely, protecting the viability and accessibility of the public health care system – not every imaginable risk that the Government speculates may arise in the absence of the impugned provisions.

2361. Nevertheless, the evidence in this case proves that none of these concerns are anything more than speculative or hypothetical, and indeed, the evidence shows that these alleged harms simply will not occur.

[1796] See **Section VI and VII(a)**, above.
[1797] See **Section IX**, above.
[1798] **Transcript Day 152**, p. 27, line 47 to, p. 28, line 45.
[1799] See **Section IX**, above.

C. Permitting Private Care is Compatible with a High Quality Public Health Care System

2362. Many of the Defendant's alleged justifications are premised on the assumption that there is an inherent incompatibility between maintaining a high quality and universal public health care system, and permitting patients to obtain care outside of the public system when the public plan fails to provide adequate and timely care.

2363. In other words, the Defendant and Canada argue that if a private care option is permitted, this will necessarily harm the access to or the viability of the public health care system, in various ways.

2364. However, the evidence about the 23-year experience of non-enforcement of the impugned prohibitions, and expert opinions about the experience in other countries in this case, prove that access to private health care services is compatible with a high quality public health care system.

2365. This was confirmed by one of the key government witnesses on the impact of the private provision of medical services on a universal public system, Professor Theodore Marmor who was also a witness for the Defendant Quebec Government in the *Chaoulli* case.

2366. Professor Marmor said that there were lessons – he called them "prudent lessons" – from comparator jurisdictions that should be taken into account by Canadian Governments in reforming their health care system to allow patients to obtain private diagnostic and surgical services, but he testified that allowing patients to obtain private health care was not incompatible with a high quality public system.[1800]

2367. According to Professor Marmor, it was a serious mistake in *Chaoulli* for the Government to argue that permitting private care options was incompatible with a high quality universal public health care plan.[1801]

2368. Shortly after the *Chaoulli* decision was issued, Professor Marmor wrote an article in which he stated that "There was and is no reason to believe that parallel systems cannot maintain adequate quality, prevent runaway inflation, or survive in recognizable form."[1802]

2369. This was, in essence, the finding of the majority in the *Chaoulli* case: that based primarily on the experience in other jurisdictions that do not prohibit a private care option, there is no reason to

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[1800] **Transcript Day 152**, p. 29, line 37 to, p. 30, line 17; **Exhibit SSSS**, pp. 317-318 **[CBE, Tab 163]**.
[1801] **Exhibit 467**, p. 5 **[CBE, Tab 121]**; **Transcript Day 152**, Testimony of Professor Marmor, p. 19, line 21 to, p. 22, line 5, p. 26, lines 36-44, and p. 29, lines 11-45; **Exhibit SSSS**, pp. 316-318 **[CBE, Tab 163]**. **Transcript Day 152,** p. 24, l. 16 to p. 28, l. 11 to 22.
[1802] **Exhibit SSSS**, p. 318 **[CBE, Tab 163] Transcript Day 152,** p. 24, l. 16 to p. 26, l. 44. p. 26, l. 1 to 46.

believe a prohibition on access to private care is rationally connected to the objective of protecting a viable public health care system.

2370. In cross-examination in this case, Professor Marmor said that he still agrees with the opinion he expressed in this article that access to private health care is not incompatible with Canada's public health care system.[1803]

2371. And now, we have the 23 year experience in British Columbia which confirms that allowing access to private diagnostic and surgical services does not harm the public system.

2372. It was Professor Marmor's opinion that the real issue at stake in the *Chaoulli* case, and in the case at hand, is not whether access to a private care option is incompatible with a public health care system, which he said it obviously was not, but rather whether access to private health care would improve the public system.[1804] He opined that it would not, and, therefore, for this reason, the prohibitions on such access were justified.[1805]

2373. Professor Marmor was legally incorrect on this point,[1806] for the same reason that the minority in *Chaoulli* was incorrect to rely on this concern.

2374. The legal issue is not whether the problems with delays and access in the public system will be solved or alleviated by eliminating the prohibitions on access to private diagnostic and surgical services.

2375. Rather, the issue is whether the elimination of these prohibitions on the ability of patients to alleviate their suffering and protect their health can be justified on the basis that this is necessary to preserve the public system.

2376. And as Professor Marmor testified, and as will be expanded upon in the following sections addressing the specific alleged justifications of the Defendant and Canada, the answer is clearly no.[1807]

D. The Hypothetical Concerns of the Defendant

[1803] **Transcript Day 152**, p. 27, line 47 to, p. 28, line 45.
[1804] **Transcript Day 152**, p. 22, lines 16-37, and p. 24, line 45 to, p. 26, line 18.
[1805] **Transcript Day 152**, p. 24, line 16 to, p. 25, line 14.
[1806] In addition, there is in fact good reason to believe that permitting a private care option will advance, rather than detract from, the objective of protecting the viability of and access to public health care plan that provides reasonable treatment to all based on need.
[1807] **Exhibit 467**, p. 5 **[CBE, Tab 121]** ; **Transcript Day 152**, p. 19, line 21 to, p. 22, line 5, and p. 29, lines 11-45

2377. The same hypothetical concerns about the impact on the public system that were raised in the *Chaoulli* case have been advanced in support of the prohibitions on British Columbians being able to obtain private diagnostic and surgical services in this case.

2378. The evidence in support of these concerns has not become any stronger in the fifteen years since *Chaoulli;* rather, the new evidence demonstrates that the concerns are meritless.

2379. That is not only because we have this 23 year experience of there being no harmful impact on the public system of non-enforcement of these prohibitions, and the experience in Quebec after *Chaoulli* showing no negative effect on the public system.

2380. It is also because the expert evidence in this case about other jurisdictions, since *Chaoulli*, such as the UK and New Zealand (which are the closest comparators to the health care situation in BC over the past 23 years) clearly establishes, as Professor Marmor testified, that access to private health care is not incompatible with a high quality public health care system.

(i) The Specialist Supply Justification

2381. In paragraphs 59 to 64 of its Response to Amended Notice of Civil Claim, the Defendant sets out the following concerns, which it says will come to pass in the absence of the impugned provisions:

> 59. To the extent that enrolled physicians operate in private clinics like Cambie and SRC, they are not only unavailable to provide elective surgery in the public system, but also to provide diagnosis and triage of patients and, further, they are also unavailable to treat urgent and medical conditions.
>
> 60. This unavailability interferes with the ability of the public system to provide appropriate and timely medical care to beneficiaries.
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> 61. Private for-profit medical clinics, including Cambie and SRC, exist for the purpose of maximizing the income of their owners and of the physicians who practise there.
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> 62. Physicians are able to earn more money for the same, or less, effort in private clinics such as Cambie and SRC as compared with practising in public hospitals and otherwise in the public health care system.
>
> 63. Because such practice is more lucrative and less demanding, there is a tendency for physicians to prefer private practice over practice in the public health care system, with a corresponding reduction over time in both the quantity and quality of medical care available to British Columbia residents who are unable to afford the cost of care at private clinics.
>
> 64. The inevitable result of encouraging a truly parallel private health care system is to increase the wait times experienced by beneficiaries who cannot afford treatment in that

system.

(...)

70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:

(...)

(e) Wait times in the public health care system can increase, particularly when physicians are permitted to work in both the public and private systems;

2382. Similarly, Canada inaccurately alleges that only the wealthy will be able to obtain private insurance,[1808] and as a result, "the much larger part of the population which could not access private care would likely experience even longer wait times and lower quality care in the eroded public system".[1809]

2383. These claims all relate to the speculation that if the prohibitions on non-exempt patients being able to obtain private diagnostic and surgical services are eliminated, this will result in physicians fleeing the public system for more lucrative private practices and therefore an insufficient supply of specialists to perform services in the public system.

2384. The simple response is that these hypothetical concerns have not materialized in British Columbia over the past 23 years of non-enforcement of the impugned prohibitions, and can be easily managed by the Government if it ever became a possible problem.

2385. More specifically, both exempt and non-exempt patients have been able to obtain private diagnostic and surgical services from enrolled surgeons within the province for over 23 years – without resulting in any unavailability of surgeons to provide the amount of diagnostic and surgical services that the public service chooses to provide.

2386. On this point, Professor Kessler testified that there is no reason to expect that dual practice will reduce the effort of specialists in the public system. [1810]

2387. And, he provided empirical support that dual practice, in fact, has been found to increase overall specialist supply:

[1808] See **Equity Justifications (vi),** below.
[1809] Opening Statement of Canada, p. 21, para 74.
[1810] **Exhibit 183A**, Tab 1, Initial Expert Report of Professor Kessler, pp. 8-9 **[CBE, Tab 40]**.

> In fact, a 2011 review of the dual-practice literature in the peer-reviewed journal Health Policy concludes that dual practitioners increase overall labor supply.[1811]

2388. Professor Kessler also testified that there is empirical evidence that dual practice has not reduced the hours committed by specialists in the public health care system.[1812]

2389. The Defendant has provided no evidence, not even one anecdotal example, of specialists engaging in dual practice over the past 23 years in British Columbia failing to use all of the public OR time allocated to them in order to pursue more private surgeries.

2390. The Defendant nevertheless speculates that, despite the direct evidence to the contrary of specialists engaged in dual practice in British Columbia over the past 23 years, that this will occur if the impugned provisions are struck down.

2391. This speculation is based on a number of assumptions that are refuted by the evidence, namely:

(k) That any time spent performing scheduled surgeries in the private system prevents physicians from performing scheduled surgeries in the public system;

(l) That any time spent performing scheduled surgeries in the private system prevents physicians from treating urgent or emergent conditions in the public system.

(m) That any time spent performing scheduled surgeries in the private system prevents physicians from undertaking the necessary amount of consultations in the public system;

(n) That, if given an opportunity, a significant number of specialist physicians would abandon the public system; and

(o) that, if the supply of specialists in the public system ever did become a concern, there would be nothing that the Government could do to remedy that situation, short of an outright prohibition on physicians providing *any* services privately.

(ii) Scheduled Surgeries

[1811] **Exhibit 183A**, Tab 2, (Second Version), p. 6 **[CBE, Tab 40]**.
[1812] **Exhibit 183A**, Tab 3, Update Report, p. 3 **[CBE, Tab 40]**.

2392. The fundamental reason why providing services in the private system does not deprive the public system of the physician resources it requires is because the public system rations health care, and therefore does not use the full capacity of all specialist physicians in the public system.[1813]

2393. The evidence in this case conclusively establishes that enrolled specialists do not have sufficient operating room time in the public system for them to fully utilize their diagnostic and surgical skills.

2394. Indeed, the evidence is that some do not even have sufficient operating time in the public system to adequately maintain their surgical skills.[1814]

2395. Also, the evidence shows there is a large number of diagnostic and surgical specialists who are seeking hospital privileges in British Columbia, but cannot obtain them because of the lack of operating time.[1815]

2396. The services of such specialists are not only being underutilized in the public system, but if the prohibitions are enforced, they will not be able to provide additional diagnostic and surgical services to non-exempt British Columbians.

2397. It is beyond dispute on the evidence in this case that enrolled specialists – individually and as a group – have considerable excess diagnostic and surgical capacity that can be utilized to provide much needed additional diagnostic and surgical services to British Columbians.[1816]

2398. And, the evidence also conclusively proves that the private surgeries performed by enrolled specialists are in addition to the surgeries they are allowed to perform in the public system – and not in substitution of public surgeries.[1817]

[1813] **Transcript Day 63**, Testimony of Dr. Patrick McGeer, p. 6, line 23 to, p, 9, line 28, and p. 11, lines 2-42; **Exhibit 346A**, Affidavit #9 of Dr. Day, p. 32, para 168, and pp. 40-41, paras 214-215, 217 **[CBE, Tab 83]**; See Section

[1814] **Exhibit 346A**, pp. 40-41, paras 214-217 **[CBE, Tab 83]**; **Exhibit 299**, Affidavit of Dr. Javer, p. 3, para 16, p. 7, para 53 **[CBE, Tab 58]**; **Exhibit 311,** Affidavit #2 of Dr. Younger, p. 3, para 15, p. 6, paras 49, 53, p. 7, para 63, and p. 17, para 150 **[CBE, Tab 61]**; **Exhibit 376**, Affidavit of Dr. Peterson, p. 4, paras 40-42 **[CBE, Tab 86]**; **Exhibit 301**, Affidavit #1 of Outerbridge, p. 2, paras 11-14 **[CBE, Tab 59]**; **Exhibit 318**, Affidavit of Dr. Costa p. 5, para 35-36 **[CBE, Tab 72]**.

[1815] **Exhibit 299**, pp. 9-10, paras 75-80 **[CBE, Tab 58]**; **Transcript Day 29**, Testimony of Dr. Douglas, October 31, 2016, p. 19, line 37 to, p. 20, line 33, p. 23, lines 4-27, and p. 25, line 22 to, p. 26, line 25.

[1816] **Exhibit 346A**, pp. 40-41, paras 214-217 **[CBE, Tab 83]**; **Exhibit 299**, p. 3, para 16, p. 7, para 53 **[CBE, Tab 58]**; **Exhibit 311,** Younger Affidavit #2, p. 3, para 15, p. 6, paras 49, 53, p. 7, para 63, and p. 17, para 150 **[CBE, Tab 61]**; **Exhibit 376**, p. 4, paras 40-42 **[CBE, Tab 86]**; **Exhibit 301**, p. 2, paras 11-14 **[CBE, Tab 59]**; **Exhibit 318**, p. 5, para 35-36 **[CBE, Tab 72]**.

[1817] **Exhibit 299**, p. 14, para 112, p. 17, para 141 **[CBE, Tab 58]**; **Exhibit 311,** pp. 17-18, paras 145-147, 153-155 **[CBE, Tab 61]**; **Transcript Day 40**, Testimony of Dr. Van Laeken, November 28, 2016, p. 23, lines 24-28.

2399. Enrolled surgeons have been fulfilling their allotted quota of operating time in the public system, despite also performing private diagnostic and surgical – as well as other medical services over the past 23 years.

2400. The result is that the total number of surgeries performed in the province has been increased, with absolutely no reduction in the availability of public surgeries. This has only been to the benefit of the health of British Columbians.

2401. If the prohibitions on dual practice are enforced, this will prevent enrolled specialists from providing these additional diagnostic and surgical services to non-exempt British Columbians, which will only harm, not help, their health.

2402. And, there is no evidence of physicians diverting resources or attention to the private sector, leading to higher wait times in the public system. This is baseless speculation on the part of the Defendant, which was refuted by the evidence of specialists in British Columbia and the experts.

2403. As explained by one of the Defendant's expert witnesses, Dr. Bohm, physicians operating privately would only lead to increased wait times in the public system if the physician had "declined public system OR slates or decreased his/her clinics to the point that they result in fewer surgical bookings than their allocated public slates can accommodate".[1818]

2404. Because this has not occurred in British Columbia in BC over the past 23 years, nor any evidence or reason to believe it would occur in the future, there is no valid concern about a lack of physicians to provide all of the surgeries that the public system will support.

a) Emergent Cases

2405. Nor is there any reason to believe that permitting physicians to use their excess surgical time outside of the public system would deprive the public sector of necessary resources for urgent or emergent cases.

2406. Again, the Defendant has led no evidence of this occurring over the past 23 years in British Columbia, and no basis for thinking that it would start to become a problem in the future. It is purely speculation on the Government's part, which was refuted by its own experts.

[1818] **Exhibit 469**, Expert Report of Dr. Bohm, Tab 1, p. 6-7 **[CBE, Tab 122]**.

2407. Moreover, Dr. Bohm, explained why speculation about physicians failing to perform emergent treatment is not plausible:

> The treatment of urgent or emergent cases typically occurs when one is on call; it would be highly unusual for a surgeon to not arrange coverage for their on-call responsibilities in order to do private work. Doing so would be a breach of their duty to patients, and ultimately would likely result in loss of their OR time in the public system.[1819]

2408. In any event, if there were any actual evidence of this occurring, or if it became a problem in the future, it is an issue that can be easily dealt with without a blanket prohibition on providing private surgical treatment, as discussed below.

b) Consultations

2409. Without any supporting evidence, the Defendant also speculates that even if physicians are using all of their allotted surgical time in the public system and are meeting their on-call obligations, performing additional surgeries in the private system prevents them from performing as many public consultations in the public system as they should or could be doing.

2410. This suggestion is based on the incorrect assumption that surgeons should be performing as many consultations as possible in the public system, regardless of the limits on their operating room time.

2411. The assumption is fundamentally misguided. The evidence established that in every specialist practice, a predictable percentage of patients assessed in consultations will require treatment. Performing more consultations would therefore only increase the number of patients waiting for treatment, given the limited allocation of operating room time. More consultations would therefore not serve any conceivable healthcare purpose.

2412. The evidence in this case confirms that conducting more consultations in the public system does not result in reducing the total time it takes to obtain a surgery, and hence does not reduce the amount of harm that patients suffer while waiting.[1820]

[1819] **Exhibit 469**, Tab 1, p. 6 **[CBE, Tab 122]**.

[1820] **Exhibit 311**, pp. 7-8, paras 66-74 **[CBE, Tab 61]**; **Exhibit 299**, pp. 12-13, paras 100-106 **[CBE, Tab 58]**; **Transcript Day 30**, Testimony of Stefan Fletcher, November 1, 2016 p. 66, line 12 to, p. 67, line 7; **Exhibit 92,** Waitlist and Wait Time Trend Report September 30, 2016 **[CBE, Tab 29]**; **Transcript Day 174**, Testimony of Dr. Hamilton, July 12, 2019, p. 24, line 16 to, p. 25, line 44, and p. 27, lines 6-14; **Transcript Day 153**, Testimony of Dr. Bohm, May 10, 2019, p. 39, line 11 to, p. 40, line 11; **Exhibit 2C**, Prima Facie Facts Amendment Agreement - Ministry of Health , Tab 10, p. 37 **[CBE, Tab 3]**.

2413. It may result in a shorter wait for consultations, but at the cost of a longer wait for surgeries.[1821] For instance, instead of a patient waiting 6 months for a consultation and a year for their surgery, the patient might wait one month for a consultation and an additional year and a half for a surgery. No progress is made from shifting the patient from one line to another.

2414. To the contrary, performing more consultations in the public system, without corresponding additional operating room time to perform any required surgery, will actually waste resources and increase the overall pressure on the public system.

2415. That is because consultations (and associated tests and procedures) must be performed within a reasonable amount of time before any surgery is conducted. If they are performed before that time, those tests, procedures and consultations simply have to be done again closer to the time of the surgery.

2416. Thus, not only does using all excess time to perform additional consultations do nothing to improve patients care, or reduce wait times – it will only increase the wait time on the surgical side of the ledger, it will make things worse overall by requiring more consultations and diagnostic procedures than would otherwise be the case.

2417. Also, contrary to the Defendant's argument about consultations, the Government actually discourages physicians from providing too many consultations without corresponding operating room time.[1822]

2418. That is because it causes a problem from a public relations or optics standpoint for the Government, in that it leads to longer *surgical* wait times (i.e. Wait Two), which are the only wait times reported publicly.[1823]

2419. This was the testimony of many witnesses at trial.[1824]

2420. Dr. Javer's situation illustrates this point about how both access to consultations and surgeries are rationed – and hence need to be balanced in the public system. He was specifically told by hospital administrators that unless he had a referral from another specialist, he should not take additional

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[1821] **Transcript Day 30**, p. 66, line 12 to, p. 67, line 7; **Exhibit 92 [CBE, Tab 29]**; **Transcript Day 174**, p. 24, line 16 to, p. 25, line 44, and p. 27, lines 6-14; **Transcript Day 153**, p. 39, line 11 to, p. 40, line 11.
[1822] **Exhibit 311**, pp. 7-8, paras 66-74 **[CBE, Tab 61]**; **Exhibit 299**, pp. 12-13, paras 100-106 **[CBE, Tab 58]**.
[1823] **Transcript Day 174**, p. 26, line 12 to, p. 28, line 7; See **Section VI**, above.
[1824] **Transcript Day 87**, Testimony of Dr. Masri, April 13, 2018, p. 25, lines 12-24; **Exhibit 311**, p. 7-8, paras 66-74 **[CBE, Tab 61]**; **Exhibit 299**, pp. 12-13, paras 100-106 **[CBE, Tab 58]**; See Section **VII(B)**.

consultations, because that would only increase his surgical wait list, which the hospital wanted to avoid.[1825]

2421. Thus, it is clear on the evidence that the objective of specialist physicians is not – and should not be – to perform as many consultations as possible, within the shortest amount of time possible.

2422. Rather, the objective from a medical health standpoint is to perform as many consultations as can reasonably be accommodated, balancing the physician's operating room time and the number of consultations that generally results in a decision to proceed with surgery for that surgeon. [1826] Any surgeon who did not balance the number of consultations with the available OR time would necessarily see his or her wait time for surgery increase relentlessly year after year. Indeed this happened to Dr. Younger early in his practice and he had to severely restrict consultations to reduce his Wait Two time.[1827]

2423. For Dr. Javer, given the nature of his referrals, a very high percentage of the patients he sees need to have surgery to correct their sinus problem.[1828] For other surgeons, the percentage of consultations resulting in surgeries will be lower, around 30%.[1829]

2424. But in all cases, a balance must be struck between consultations and operating time, which as the evidence in this case shows, is what the surgeons do regardless of whether they are engaged in dual practice. This is what surgeons currently do, and should continue to do.

2425. Requiring surgeons to use all excess time to perform as many consultations as possible, as the Defendant's argument implies they should be doing, makes no sense, and would have no health care benefit to patients.

2426. In summary on this point, physicians must perform the number of consultations that are necessary to use the operating room time they have been given – providing more than that will not actually create any health care benefit to anyone, and will simply lead to a waste of resources.

[1825] **Exhibit 299**, pp. 12-13**[CBE, Tab 58]** ; **Exhibit 311**, pp. 7-8, paras 66-74 **[CBE, Tab 61]**.
[1826] **Transcript Day 153**, p. 39, line 11 to, p. 40, line 11.
[1827] **Exhibit 311**, pp. 7-8, paras 66-74 **[CBE, Tab 58]**.
[1828] **Exhibit 299**, p. 11, para 87 **[CBE, Tab 58]**.
[1829] **Transcript Day 20**, Testimony of Dr. Tarazi, October 11, 2016, p. 15, lines 31-34; **Transcript Day 30**, p. 18, lines 31-36; **Transcript Day 115**, Testimony of Dr. Wing, September 14, 2018, p. 71, lines 19-33.

2427. And the evidence shows that specialists have been performing sufficient consultations to fulfill their allotted operating time in the public system, since all allocated time is fully utilized.

2428. However, there is another overarching reason why the Defendant's speculative fears will not in fact come to pass: physicians are firmly committed to the public system, for both personal and moral reasons, as the evidence in this case shows.

c) Physician's commitment to the public system

2429. The Government seeks to shore up its lack of evidence by relying on speculation that physicians would abandon the public system.

2430. This seems to be based on the assumption that enrolled surgeons will be enticed by the greater pay for private surgeries to give up some or all of their operating time in the public system to spend more time performing private surgeries, with the result that there might not be sufficient specialists to meet the requirements of the public system, and thereby increasing wait times in the public system.

2431. Again, this is not supported by the evidence in this case; indeed, it is directly contradicted by that evidence.

2432. Beyond the fact that this has not occurred over the past 23 years, and there is no reason to believe it will start to occur, there is also very good reason to believe it will not occur: specifically, that all of the enrolled doctors who were witnesses in this case testified about their strong commitment to the public health care system.

2433. They testified that they would provide additional diagnostic and surgical services in the public system if they were allocated more operating room time to do so.[1830]

2434. For example, Dr. Javer has been providing private sinus surgeries since 2000, while at the same time utilizing all his operating time in, and contributing significantly in other ways to, the public system.[1831]

[1830] **Exhibit 299**, p. 3, para 16, p. 7, para 53 **[CBE, Tab 58]**; **Exhibit 311,** p. 3, para 15, p. 6, paras 49, 53, p. 7, para 63, and p. 17, para 150 **[CBE, Tab 61]**; **Exhibit 376**, p. 4, paras 40-42 **[CBE, Tab 86]**; **Exhibit 301**, p. 2, paras 11-14; **[CBE, Tab 59]**; **Exhibit 318**, p. 5, para 35-36 **[CBE, Tab 72]; Transcript Day 40**, p. 23, lines 24-28.
[1831] **Exhibit 299**, p. 2, paras 7-13, p. 6, para 48, 55-58, and pp. 16-17, paras 133-134, 136, 139 **[CBE, Tab 58]**.

2435. Up until September 4, 2018, Dr. Javer was performing additional less complex sinus surgeries in the public system at the False Creek Surgical Centre for patients who had been waiting for over a year for their surgeries.[1832]

2436. He testified that he always gave public surgeries at False Creek priority over his private surgeries.[1833]

2437. Moreover, the evidence in this case demonstrates that the physicians providing private treatments are firmly committed to the public system in other ways.

2438. For instance, it is clear from Dr. Javer's testimony that he has contributed significantly to the public system, beyond his foremost commitment to providing services to patients in the public system.[1834]

2439. He also testified that throughout his time at St. Paul's Hospital, he has worked with St. Paul's Hospital "to improve access to medically necessary care for sinus patients in British Columbia",[1835] and that he has "conducted patient-focused research, repeatedly sought out additional OR time in the public system, requested additional funding, worked on bringing in funding, recruited new surgeons, sought to re-organize how care is delivered to sinus patients to increase efficiencies and altered the management of his practice."[1836]

2440. Many other specialists in this case, including Dr. Van Laeken, Dr. Wade, Dr. Sahjpaul, Dr. Smit, Dr. Day, Dr. Lauzon, Dr. Dvorak, Dr. Reilly, Dr. Warshawski, Dr. Masri, and Dr. Nouri, testified about their contributions to the public health care system in British Columbia.[1837]

2441. As Professor Oliver testified about specialists in the UK, there is considerable prestige and status from working in the public system in British Columbia, which doctors do not want to give up.[1838]

2442. And, contrary to what the Defendant claims, the private surgical clinics were not established to maximize the incomes of the specialists.

[1832] **Exhibit 299**, p. 16, paras 127, 131-134 **[CBE, Tab 58]**.
[1833] **Exhibit 299**, p. 16, paras 133-134 **[CBE, Tab 58]**.
[1834] **Exhibit 299**, p. 2, paras 8-12, pp. 16-17, paras 134-136, 139 **[CBE, Tab 58]**.
[1835] **Exhibit 299**, p. 3, para 17 **[CBE, Tab 58]**.
[1836] **Exhibit 299**, p. 3, para 18 **[CBE, Tab 58]**.
[1837] See **Section VII,** above.
[1838] **Transcript Day 160**, Testimony of Professor Oliver, June 4, 2019, p. 39, lines 29-31.

2443. Yes, the doctors are supplementing their incomes by providing these additional diagnostic and surgical services to non-exempt patients in BC, just as they do by providing expedited diagnostic and surgical services to exempt WCB patients, by preparing medical legal reports for litigants in court proceedings, and by providing medical services that are considered not to be medically necessary under the public plan.[1839]

2444. However, it was clear from specialists who testified in this case that they are not providing private diagnostic and surgical services out of greed or profit maximization, but rather because these services are desperately needed in the province by non-exempt patients to alleviate their suffering and to protect their health given the persistent inability of the public system to meet the health care needs of everyone in a timely manner.[1840]

2445. And it is also undeniable that providing additional medically necessary services – private diagnostic and surgical services – is of more benefit to the health of British Columbians, than providing medico-legal services or other non-medically necessary services, which physicians are lawfully permitted to do as enrolled doctors.

2446. For example, it is clearly of more benefit to the Province's health care system that Dr. Van Laeken provide additional private medically necessary surgeries rather than more cosmetic surgeries. That is the irony, and indeed perversity of the prohibitions – they do not prevent doctors from providing medical services privately that are not considered medically necessary, only those medical services that are deemed to be medically necessary.

2447. However, regardless of how Dr. Van Laeken, or other specialists, use their excess capacity– whether it is on medical legal opinions, cosmetic surgeries, volunteering medical services in third world countries or providing private medically necessary surgeries, the key is that she is completely fulfilling all of the operating time she is allotted in the public system –there is no harm to the public system from how she is using her excess capacity.

2448. If she, or any other specialists, ever failed to fulfill the duties that the public system requires from them, regardless of the reason, whether it be because she is performing private non-medically

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[1839] **Transcript Day 122**, p. 21, line 18 to, p. 23, line 45.

[1840] **Exhibit 346A**, pp. 11-12, paras 58-59, 61-67 **[CBE, Tab 83]**; **Transcript Day 19**, Testimony of Dr. Smit, dated October 7, 2016, p. 52, lines 19-47; **Exhibit 385**, Affidavit #1 of Godley, p. 4, para 35 **[CBE, Tab 87]**; **Exhibit 376**, p. 6, para 62; **[CBE, Tab 86]; Exhibit 301 [CBE, Tab 146]**, p.3, para 21; **Transcript Day 40**, p. 34, line 41 to, p. 36, line 23.

necessary services either in the Province or elsewhere, the public hospitals can deal with that by cancelling their hospital privileges. Significantly, that has never been an issue with any of the specialists who have, in addition to providing other non-medically necessary services, been performing private diagnostic and surgical services in the extra time they have available to them because of their limited operating time in the public system.

2449. Indeed, if anything, providing these additional medically necessary diagnostic and surgical services privately has taken time away from the non-medically necessary services they can lawfully perform, which are more lucrative, and not from the medically necessary services they are providing in the public system.[1841]

d) No Harm to the Public System

2450. Thus, there is no plausible reason to believe that there would be any harm to the public system caused by permitting enrolled physicians to provide private diagnostic and surgical services, given that the public system can't utilize the full surgical capacity of the specialists that have hospital privileges and the commitment of the specialists to the public system.

2451. As two of the Defendant's experts, Dr. Bohm and Dr. Hurley testified, there would only be an increase in wait times in the public sector if physicians did not perform their full amount of operating room time (and other associated obligations) in the public system.[1842]

2452. And, the evidence shows that the physicians performing private diagnostic and surgical services over the past 23 years have fully satisfied their operating, clinical, and on-call commitments in the public system, and no reason to fear that it would change in the future.

2453. Professor Kessler testified that there is no empirical evidence that this has occurred elsewhere.[1843]

2454. In summary, the evidence establishes that allowing access to private health care in British Columbia will not harm the public system or increase wait times in the public system, as the Defendant and Canada allege.

[1841] **Transcript Day 122**, Testimony of Dr. Adrian, dated October 5, 2018, p. 21, line 18 to, p. 23, line 45.
[1842] **Transcript Day 169**, Testimony of Professor Hurley, dated June 20, 2019, p. 50, lines 21-41, p. 90, lines 28-46; **Exhibit 490**, Expert Report of Dr. Bohm, p. 6 in response to paragraph 60 **[CBE, Tab 130]**.
[1843] **Exhibit 183A**, Tab 1, p. 9 **[CBE, Tab 40]; Transcript Day 50**, Testimony of Professor Kessler, dated December 12, 2016, p. 61, line 37 to, p. 62, line 19.

e) Less intrusive safeguards are readily available

2455. Moreover, in the future if there were evidence – and not speculation - that allowing non-exempt British Columbians to obtain private diagnostic and surgical services was depriving the public system of the specialists it needed – which is very unlikely – this could be addressed by measures that are far less harmful than a blanket prohibition on physicians using their excess capacity to provide additional medically necessary diagnostic and surgical services to patients.

2456. Specifically, there are many ways that the supply of specialist surgeons in the public system could be ensured, including through regulations by the College, requirements at the hospital or health authority level, or laws or regulations enacted by the legislative assembly.

2457. As Justice Deschamps stated in *Chaoulli* (at paras 83, 97), the Government could impose a requirement on doctors to perform a certain amount of diagnostic and surgical services in the public system to be able to provide these services privately as has been successfully done in other jurisdictions like the UK.[1844]

2458. Thus, even if a lack of supply of specialist surgeons to provide services in the public system was a valid concern in BC, which the evidence shows it is not, it could be addressed by means that are directly tied to <u>that</u> problem, rather than through a blanket prohibition.

(iii) <u>Labour Costs Justification</u>

2459. The Government has also alleged that permitting a private care option will create competition for the supply of medical health professionals, as a result of the increased cost of training and paying health care professionals:

> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (...)
>
> (j) Because the private and public health care systems must compete for a finite supply of physicians, nurses, and technicians, the overall cost of those health human resources increases, and the cost to the public health care system of maintaining the same level of service is increased.

[1844] **Exhibit 469**, p. 7 noting "the National Health System in the United Kingdom, where consultants are typically required to provide 10 sessions (equivalent to 10 ½ days) per week in the public system before providing any care in the private system" **[CBE, Tab 122]**.

2460. In effect, the Defendant claims that it needs to prohibit patients from accessing the health care treatment they need, with all of the associated harms that result to those patients, in order to control the cost of training and paying physicians, nurses and technicians.

2461. To put this allegation into context, it is important to recognize that the wait time problem was exacerbated by the Government's policy decision in the 1980s and 1990's to control costs, as another means of rationing health care services, by reducing the number of doctors, nurses and technicians that were trained in the Province. [1845]

2462. Thus, to the extent there have been insufficient health care personnel to supply the public system, and to maintain it at a reasonable cost to the public system, this problem was deliberately created by the Government.

2463. Having said that, there is no shortage presently of specialists to work in the public system. There are many specialists who cannot obtain hospital privileges because of the rationing of surgeries in the public system.[1846]

2464. In terms of nurses and technicians, there is no evidence of any lack of these health care professionals in absolute terms.

2465. To the contrary, the evidence shows that the public system has had sufficient nurses and technicians over the past 23 years, despite some of them being employed in private clinics.[1847]

2466. There have been shortages of operating room nurses, which is in the process of being remedied, that have occasionally prevented surgeries from going ahead as scheduled, but there is no evidence that this shortage was exacerbated by nurses working – often on a part-time basis – in private clinics.[1848] Rather, these shortages were the result of poor human resource planning in the public

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[1845] **Exhibit 346A**, paras 90, 94, 250, 448 **[CBE, Tab 83]**; **Exhibit 575A**, pp. 723-724 **[CBE, Tab 153a]**; **Transcript Day 176**, Testimony of Joanne Maclaren, p. 37, lines 19-23; See also **Transcript Day 151**, Testimony of Professor Hsiao, dated May 8, 2019, p. 55, lines 18-43.

[1846] **Exhibit 299**, pp. 9-10, paras 75-80 **[CBE, Tab 58]**; **Transcript Day 29**, p. 19, line 37 to, p. 20, line 33, p. 23, lines 4-27, and p. 25, line 22 to, p. 26, line 25.

[1847] **Transcript Day 176**, p. 11, lines 15-42, p. 16, line 39 to, p. 17, line 30, p. 18, lines 3-39, and p. 22, lines 1-42; **Transcript Day 132**, p. Testimony of Janine Johns, p. 30, line 42 to, p. 31, line 8; **Transcript Day 126**, Testimony of Norman Peters, December 3, 2018, p. 33, lines 31-47.

[1848] **Exhibit 346A**, pp. 9-10, para 42, pp. 18-19, paras 94-102 **[CBE, Tab 83]**; **Exhibit 565**, Supplemental Common Book - Ministry of Health (Vol 1 of 1), pp. 292, 309 **[CBE, Tab 152]**; **Transcript Day 176**, p. 30, lines 12-40, p. 33, lines 11-25, and p. 35, line 44 to, p. 37, line 18; See **Section VI(F),** above.

system and the difficulty of attracting and retaining nurses in the most demanding OR departments without additional compensation or job benefits.[1849]

2467. As the history of British Columbia intentionally reducing the supply of physicians, nurses and other health care professional's shows, the supply of health professionals is not "finite" as the Defendant suggests.[1850] The supply of these health care professionals is entirely in the control of the Government.[1851]

2468. Thus, just as the number of health care professionals has been reduced by the Government's policies over the years, the number can be increased through policy decisions of the Government, such as ensuring competitive wages and benefits, and by training more members of these professions.

2469. For instance, the Defendant led evidence that it has introduced a training program for operating room nurses at Children's Hospital, and that the demand for this training was overwhelming.[1852] It also led evidence that it has increased the number of OR nurses being trained within the Health Authorities, and has adopted the AORN training program on a province-wide basis to promote consistency in training.[1853]

2470. Professor McGuire testified that allowing patients to obtain private care does not cause a shortage of health care professionals in the public system.[1854]

2471. The Defendant has not produced any evidence – from BC over the past 23 years, or from Quebec after the *Chaoulli* decision, or from international jurisdictions – to contradict Professor McGuire's opinion on this point. Nor have they explained why the supply of health professionals cannot be increased as necessary by increasing the numbers being trained.

2472. The evidence shows that allowing non-exempt British Columbians to obtain private diagnostic and surgical services has not increased costs for physician, nursing, or technician services in the public

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[1849] See **Section VI(F),** above; **Exhibit 346A**, p. 18, para 94 **[CBE, Tab 83]**.
[1850] **Transcript Day 176**, p. 37, lines 19-23.
[1851] **Transcript Day 176**, p. 11, lines 15-42, p. 16, line 39 to, p. 17, line 30, and p. 18, lines 3-39, p. 22, lines 1-42, p. 23, lines 6-43.
[1852] **Transcript Day 139**, Testimony of Susan Wannamaker, March 8, 2019, p. 15, line 8 to, p. 16, line 9.
[1853] **Transcript Day 176**, p. 8, line 28 to, p. 11, line 27, p. 19, line 3 to, p. 21, line 6; **Transcript Day 174**, p. 40, lines 36-44; **Transcript Day 167**, Testimony of Ms. Copes, June 18, 2019, p. 8, lines 18-39; **Transcript Day 116**, Testimony of Dr. Day, September 19 2019, p. 31, lines 8-16; **Transcript Day 126**, p. 18, lines 16-33.
[1854] **Exhibit 215**, Tab 1, Expert Report of Professor McGuire, p. 19 **[CBE, Tab 45]**; **Transcript Day 58**, Testimony of Professor McGuire, January 24, 2017, p. 43, lines 17-36.

sector, which disproves the Defendant's hypothetical allegation that permitting private care would somehow overburden the public health care system.

2473. Most important from a constitutional perspective is that the need to ration the supply of diagnostic and surgical services in the public system to save costs – by limiting operating time and the pay and supply of health professionals – is not a justification for prohibiting non-exempt British Columbians from obtaining private diagnostic and surgical services to alleviate their suffering and protect their health; rather, it is the very reason that constitutionally they can't be denied this ability.

2474. As the Plaintiffs will explain in more detail in the legal basis section of this submission, a policy decision to restrict the overall supply of medical services being provided to people who need them, in order to artificially restrict labour or other costs in the public system, is not a sufficient justification in law to impose significant and widespread pain and suffering, or a greater risk of loss of life, on the population.

2475. Indeed, it is precisely this policy choice that has led to the problem of excessive waiting times in the public system, and the harms to the life, liberty and security of the person of thousands of British Columbians every year, in the first place.

2476. That is not to say that the Government is constitutionally required to spend more, or even any, money in the public system to increase the level of medical services in the public system. The Government can freely decide – as it clearly has– to reduce costs in the public system by rationing medically necessary services.

2477. But the Government cannot legally make budgetary decisions which lead to considerable harms for patients in the public health care system, and then prohibit those same patients from protecting their health outside that system.

2478. For the same reason, while the Government may claim that it needs to artificially suppress the wages of physicians, nurses, and other health care professionals, this does not provide a constitutionally sound justification for imposing considerable bodily and psychological harm on the population.

2479. The policy decision to reduce the costs of providing medical services in the public system is legally open to the Government, but is not a justification, in accordance with the principles of fundamental justice, for prohibiting patients from obtaining private diagnostics and surgical services

to alleviate their suffering and protect their health in the face of lengthy wait times for these services in the public system.

2480. In summary:

(a) The evidence establishes that there has been no shortage of physicians, nurses, or technicians currently, or any resulting increases in labour costs in the public system, as a result of the existence of private treatment options for the past 23 years in British Columbia;

(b) The evidence shows that if, in the future, permitting a private treatment option leads to an increase in wages in the public system, this is the result of:

i. An increase in the overall number of patients being treated within a reasonable time, and hence a decrease in harm to the population;

ii. The government's failure to train sufficient health care professionals to meet the need for treatment; and

(c) Even if there was evidence that there would be a significant increase in the costs of ensuring sufficient health care human resources as a result of permitting private care option, which there is not, the objective of artificially depressing the wages of physicians and nurses is not a legally sound justification for causing widespread and severe bodily and psychological harm to the population.

(iv) Popular Support Justification

2481. The Defendant and Canada have both alleged that if a private care option is permitted, this will inevitably lead to decreased popular or political support for the public sector health care plan.

2482. For instance, Canada states that "the plaintiffs' model will ... lead to weakened public support for the public system" (at para 10).

2483. Similarly, the Defendant makes the following assertions in its pleadings:

> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (a) The demand for duplicate private health care insurance is associated with reduced quality of publicly funded health care;

(...)

73. If the two systems offer comparable levels of care, however, individuals will not purchase insurance. They will only purchase insurance if the quality of care offered in the private system is superior to the quality of care offered in the public system.

2484. And the Defendant stated in its Opening Statement (at para 56) that the impugned provisions are justified in order to ensure "continued public support for the funding and operation of the public health care system".

2485. The Defendant and Canada appear to be making two claims here, one that is essentially empirical, and one that is essentially normative or prescriptive:

(a) *Empirical claim*: That there is a ***correlation*** between the demand for private health care services and the failure of the public health care system to provide the same quality and timeliness of care as can be provided privately (Significantly there is no claim that increased private healthcare causes lower quality public healthcare);

(b) *Prescriptive claim*: That permitting individuals to care for their health care needs outside of the public system should be discouraged, because otherwise they will cease supporting the public system.

2486. As discussed below, the empirical claim is largely self-evident, however it supports the Plaintiffs' constitutional argument, not the Defendant's.

2487. The essentially normative claim is not supported by the evidence, and in any event is a wholly illegitimate, unprecedented, and ultimately disturbing justification for preventing people from accessing the medically necessary health care services they need.

a) The Correlation between Demand for Private Care and the Quality of Treatment in the Public System

2488. The evidence in this case shows that the demand for private health care is correlated with a lack of timely provision of medical services in the public system.[1855]

[1855] **Exhibit 490**, p. 1: "The ONS (2004) study referred to above also reported no significant relationship between national waiting times and individual private health care insurance purchase, but did find a significant positive relationship between regional waiting times and private coverage, where individuals living in areas with relatively high waits were more likely to purchase private insurance. It is this finding that they attributed to a declining demand for private coverage following the drop in waiting times in the early 2000s" **[CBE, Tab 130]**; **Exhibit 490**, pp. 5-6 **[CBE, Tab 130]**.

2489. In this sense, the Defendant is correct to note that there is a factual association between reduced quality of care in the public system (including timeliness) and the demand for private care and insurance.[1856]

2490. That is, and should be, obvious. If patients do not get the health care treatment they need in the public system, they will seek to have their health care needs met elsewhere. If they do get the treatment they need in a timely way in the public system, there would be no reason to seek out other options.

2491. And we should expect nothing else. Individuals suffering in pain and agony, with severely reduced mobility, with a risk of serious complications or permanent physical damage, or who may even fear for their survival, will have a very strong incentive to find ways to address those harms as soon as possible.[1857]

2492. If the public system fails to provide health care treatment in a timely manner due to rationing and long wait times for treatment, more individuals will naturally seek to get the treatment they need outside of the public system to protect their health and wellbeing.[1858]

2493. Conversely, if the public system were able and willing to provide timely health care services to the entire population, without any risk of prolonged pain, suffering, or permanent harm, the demand for private insurance and private care options would plummet.[1859]

2494. It follows therefore that if the public system in British Columbia is able to reduce its wait times, there will be less need, and hence demand, to obtain private diagnostic and surgical services.

2495. Thus, it is entirely within the Defendant's power to reduce the extent to which British Columbians need, and therefore seek to obtain, private diagnostic and surgical services, by providing these services on a more timely basis in the public system.

2496. But, it is clear from the experience in British Columbia and elsewhere that the Government will never provide timely access to diagnostic and surgical services so that nobody's health is harmed from waiting.

[1856] **Exhibit 490**, pp. 1, 5-6 **[CBE, Tab 130]**; **Transcript Day 151**, p. 52, lines 7-16.
[1857] See Section VII(C)(ii)(a), above; Section VII(C)(vii)(c), above.
[1858] **Exhibit 490**, p. 1; **Transcript Day 179**, Testimony of Dr. John Frank, dated July 19, 2019, p. 16, lines 26-38 **[CBE, Tab 130]**.
[1859] **Exhibit 490**, p. 1; **Transcript Day 179**, p. 16, lines 26-38 **[CBE, Tab 130]**.

2497. Therefore, the Government cannot fairly, justly, ethically, or legally tell patients that they cannot have their health care needs met outside of the public system, unless they are wealthy enough to go to another jurisdiction, or fortunate enough to have been injured at work.

2498. Therefore, the claim that poor quality public healthcare is directly correlated with increased demand for private care is of no assistance to the Government's efforts to justify the harms inflicted on thousands of patients every day in BC.

b) The Prescriptive Claim: The Government must prohibit non-exempt patients from obtaining the diagnostic and surgical services they need to alleviate their suffering and protect their health to maintain support for the public system

2499. The second aspect of this claim – that a prohibition on private care options is necessary to maintain public support for the public care system – is fundamentally misguided, both in fact and, even more importantly, in principle.

2500. In terms of the factual claim, there is no evidence that the elimination of the impugned provisions would have the effect of decreasing public support for public health care, to the point where an elected government would no longer prioritize the quality of services supplied in the public health care system.

2501. Specifically, there is no evidence that the non-enforcement of the prohibitions on access to private diagnostic and surgical over the past 23 years has "weakened public support for the public system" in British Columbia.

2502. And there is no empirical evidence that this has occurred elsewhere.

2503. This was confirmed by the Defendant's own expert witness, Professor Jeremiah Hurley, who testified that there is only very weak evidence that this has been a problem in other countries.[1860]

2504. Professor Kessler also testified that there is no persuasive empirical evidence that the availability of private health care changes voters' political preferences. [1861]

2505. Professor Bliss opined as follows on this point:

> (10) Given that mixed private and public health-care systems exist in most countries,

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[1860] **Transcript Day 169**, p. 100, lines 23 to 29.
[1861] **Exhibit 183A**, Tab 1, pp. 11-12 **[CBE, Tab 40]**.

> without apparent system breakdown, global experience seems prima facie to contradict these assumptions. Further, none of the authors' speculation about public-private competition in health-care refers to analogous areas in the provision of socially desirable services, such as pensions or public and secondary education. In education, most Canadian provinces allow public and private school systems to jostle for student and parent support. In most jurisdictions public and private schools appear to engage in healthy, stable, and potentially creative competition. Few Canadians would support the abolition of private schooling and the creation of a public education monopoly. Such measures would probably be litigated as a violation of Canadians' fundamental rights.[1862]

2506. Thus, Justice Deschamps comments on this point in *Chaoulli* are confirmed by the evidence in this case:

> While it is true that scientific or empirical evidence is not always necessary, witnesses in a case in which the arguments are supposedly based on logic or common sense should be able to cite specific facts in support of their conclusions. The human reactions described by the experts, many of whom came from outside Quebec, do not appear to me to be very convincing, particularly in the context of Quebec legislation. Participation in the public plan is mandatory and there is no risk that the Quebec public will abandon the public plan.[1863] [emphasis added]

2507. The prescriptive claim also ignores the fact that almost everyone will require emergency care at some time in the public system and therefore will remain deeply committed to its quality. Further it ignores that most people support social programs, like universal healthcare, not just out of self-interest, but because it leads to a more just society.

2508. More fundamentally from a constitutional perspective, the artificial maintenance of a certain degree of popular support for a particular Government policy in its current form can never be a justification for imposing significant bodily harm and sometimes death on members of the population.

2509. The claim that the Government must be able to prevent people from getting the health care treatment they need – that is, to knowingly cause harm to the population – in order to ensure that the population does not cease to support the Government's chosen policies, borders on authoritarianism.

2510. The argument presumes the absolute perfection of the system under scrutiny, and seeks to justify the harms it causes by the need to maintain public support for the very system causing the harm.

2511. It presumes that the Canadian public is a pliant and submissive entity, whose democratic preferences can and should be molded and manipulated by the Government through the infliction of

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[1862] **Exhibit 6**, Tab 1, Expert Report of Professor Bliss, p. 7, para 10 **[CBE, Tab 6]**.
[1863] *Chaoulli*, para 64.

pain, suffering and hardship, in order to ensure they demonstrate the appropriate degree of support for the Government's policies.

2512. Never before has the alleged need to "maintain public support" for a Government's preferred policy been used as a constitutionally relevant justification for violating fundamental rights and causing widespread harm to the public.

2513. This argument is fundamentally paternalistic and undemocratic. It is Orwellian. And it should be rejected in the most unequivocal terms.

(v) Harmful & Unethical Practices Justification

2514. In paragraphs 65 and 66 of its Response, the Defendant advances these further justifications for the impugned prohibitions:

> 65. There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems to encourage their patients to seek treatment from them privately by:
>
> (a) Maintaining long wait lists;
>
> (b) Failing to provide beneficiaries with accurate information regarding wait times for treatment in the public system; and
>
> (c) Withholding from beneficiaries information regarding options available to them in the public system.
>
> 66. There is also an incentive, and a tendency, for physicians who practise in both the public and private health care systems, and who have an ownership interest in a private clinic, to refer beneficiaries to the private clinic for care and treatment that is not appropriate.
>
> (...)
>
> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (...)
>
> (f) When physicians are permitted to work in both the private and public health care systems, higher remuneration in the private system provides them with an incentive to delay surgery in the public system so that patients are attracted or forced into the private system;
>
> (g) Ethical concerns may arise when physicians have ownership interests in the private clinics to which they refer privately insured patients;

2515. In effect, the Defendant is alleging that if physicians are permitted to provide private care, they will ignore their most fundamental professional obligation – to do no harm – to such an extent that they will deliberately harm their patients in the pursuit of additional profit.

2516. According to the Defendant, doctors will do so by:

(a) Artificially maintaining long wait lists in the public system in order to provide more business for their private practice (para 65(a), 70(f));

(b) Depriving their patients of the medical information they need to make informed decisions about their health care treatment (para 65(b), (c)); and

(c) Recommending to their patients treatments that they do not need – including invasive surgeries – in order to maximize their personal wealth (paras 66, 70(g)).

2517. Again, the most straightforward answer to this challenge to the integrity of the profession is that the evidence of the 23 years of experience in British Columbia demonstrates that none of this conduct actually occurred, and that providing private treatment has not resulted in any harm to British Columbia patients.

2518. In particular, there have been no ethical complaints raised with the College of Physicians and Surgeons of any of this conduct occurring, nor any complaints relating to enrolled surgeons advising patients of their option to obtain private diagnostic and surgical services.

2519. Further, the evidence from other countries demonstrates a private treatment option has not led to these problems.[1864]

2520. As Professor McGuire testified, there is simply "no empirical evidence to support" the assertion that physicians will manipulate public waiting times to increase demand for privately provided services.[1865]

2521. Again, the Defendant led no evidence, anecdotal or otherwise, that physicians in BC who had been working in both the public and private systems had engaged in any of this alleged conduct, or that they would be likely to do so in the future.

[1864] See **Section IX**, above.
[1865] **Exhibit 215**, Tab 1, p. 19 **[CBE, Tab 45]**.

2522. Thus, there is no evidence of a genuine risk based on alleged conflicts of interest, or of the associated claim that physicians would recommend unnecessary surgical treatment in order to maximize profits.

2523. And with respect to ownership of private clinics, it should be noted that Professor Premont, the Defendant's expert on Quebec's health care system, testified that physicians are required to own a majority of shares in private clinics in that province.[1866]

2524. While it is true that physicians operating in the public system have informed patients that there is a difference in the public and private sector waiting times, due to limited operating room time in the public system, and that they could obtain more timely private diagnostic and surgical services, there is nothing unethical about this.

2525. **Redacted due to evidence subject to a sealing order.**

2526. Consistent with the autonomy, independence, and rights of patients to decide the course of their own health care treatment, patients must have the opportunity to decide for themselves whether they want to obtain treatment privately, by incurring additional costs (if any) -- not the Government and not the physician. And their specialists are in the best position to advise patients of this option.

2527. Ms. Schooff's situation demonstrates that non-exempt patients have welcomed the opportunity to alleviate their suffering and protect their health by being able to obtain private diagnostic and surgical services.[1868] She had no complaint about Dr. Javer, and indeed was very appreciative of his services.[1869]

2528. Indeed, there is considerable evidence that many patients of all income levels have chosen to obtain private treatment over the past 23 years in BC, rather than continue to suffer in pain or fear of permanent physical harm. This is consistent with the Manitoba Cataract study and the Quebec study

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[1866] **Exhibit 158,** Expert Report of Professor Premont, pp. 16-17 **[CBE, Tab 37]**.
[1867] **Redacted due to evidence subject to a sealing order.**

[1868] **Section VII(C)(i)(a)(iii)**, above.
[1869] **Transcript Day 157**, Testimony of Ms. Schooff, p. 40, lines 7-17.

conducted by the Montreal Economic Institute, as explained by Professor Kessler in his expert report.[1870]

2529. Put simply, patients of all income levels are constitutionally entitled to have the ability, like Ms. Schooff, to obtain private diagnostic and surgical services to meet their individual health care needs, even if the Government might prefer to have them suffer in pain or risk their life and well-being waiting for treatment in the public system, so that they will be sufficiently motivated to "support" the public system.

2530. However, the problem with the Defendant's allegations goes deeper. The Defendant alleges that physicians would have a "tendency" to deliberately or knowingly cause harm to their patients in order to maximize their personal wealth.

2531. Such an attack on the integrity of an entire profession would seem to require the most compelling evidence. The Defendant has led none other than general speculation.

2532. Making this type of serious allegation without any evidence to support it not only demonstrates the grasping nature of the Defendant's allegations, but is inconsistent with the "well-deserved respect for the professionalism of all physicians in this province" that this Court has addressed already.[1871]

2533. All of the conduct that the Defendant alleges would occur in the absence of the impugned provisions – such as deliberately maintaining long wait lists, deliberately withholding information necessary to provide informed consent, and recommending unnecessary and invasive treatments – are among the most egregious violations of medical ethics.

2534. All of the evidence shows that this would not occur on a systemic or regular basis, nor that it has even occurred on an exceptional basis over the past 23 years in which physicians in British Columbia have provided medically necessary care privately. Specialists seeking to increase their incomes have many options, including medico-legal opinions. Even if earning more money were the overriding goal of specialists, contrary to the evidence, they would not have to harm or deceive patients to achieve it.

[1870] **Exhibit 183A**, Tab 1, pp. 14-15; footnotes 12 (Manitoba Centre for Health Policy and Evaluation) and 22 (Guenett) **[CBE, Tab 40]**; **Transcript Day 172**, Testimony of Dr. Turnbull, dated July 10, 2019, p. 54, line 33 to, p. 57, p. 14, **Exhibit OOOOO**, De Coster C Waiting Times for Surgery, pp. 21-22 **[CBE, Tab 162]**.
[1871] *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2017 BCSC 258 at para 44.

2535. But in any event, even if this were a valid concern supported by evidence, which it is not, these types of clear ethical breaches are already addressed by the College of Physicians and Surgeons, and are not a matter for the court to rule on in the context of this constitutional claim.[1872]

2536. The Defendant has provided no basis for questioning the College's ability to deal effectively with such cases as they arise, in the same way the College would address physicians who were recommending inappropriate treatment to maximize their MSP billings in the public system.

2537. In short, the Defendant's allegations to the effect that physicians will breach their most fundamental ethical obligations are unsupportable on the evidence of this case, and in any event, such egregious ethical breaches are regulated by the College.

2538. As such, it does not provide a valid reason for denying patients the ability to obtain private insurance and private diagnostic and surgical services to alleviate their suffering and protect their health in the face of the persistently long wait times for such services in the public system.

(vi) The Equity Justification

2539. The Defendant and Canada have also attempted to justify the restrictions on access to private treatment on the basis of "equity" concerns. There are generally two overarching claims made, one specific and one general:

(a) Specific Claim: That if private health insurance can be used for medically necessary services, such insurance will only be available to the wealthy, who will (as a result) have more timely access to health care services; and

(b) General Claim: That allowing some individuals to get more timely treatment than others is inequitable in terms of the overall distribution of health care treatment in the province.

2540. Both of these allegations are misguided and insufficient to justify inflicting serious harm on thousands of patients.

[1872] **Exhibit 2A**, Prima Facie Facts Amendment Agreement - Ministry of Health, p. 196, paras 477-479, p. 198, para 483 **[CBE, Tab 1]**.

2541. The evidence in this case shows that the availability of private health insurance is overwhelmingly tied to employer, union, and other group plans, rather than individual purchasers, and thus covers a wide spectrum of society.[1873]

2542. In terms of the general claim that this would lead to inequity in the overall distribution of health care services, this is refuted by the evidence showing that jurisdictions that do not prohibit private care are more equitable in the provision of health care than British Columbia.[1874]

2543. And while it may be the case that not everyone in BC will have ready access to private treatment, this is still a more equitable result than the current situation under the *MPA*, where certain privileged classes of persons - based on wealth, the cause of their injury, their employer, their region, their luck, or other medically-irrelevant factors - are able to get timely treatment, while others are not.

2544. And this must be viewed in the context of the rather arbitrary line that is drawn between medically necessary and non-medically necessary services for the purpose of inclusion in the public system and the fact that many important medical needs such as outpatient prescription drugs, ambulance services, dentistry, physiotherapy, artificial limbs, braces and certain eye care services are not covered by the public system.[1875]

2545. Some of these services, such as physiotherapy, were once designated as medically necessary, but were de-insured in 2002.[1876] There is no rational or valid medical explanation for delisting certain medical services under the public system – these decisions are made on the basis of cost.

2546. A public system that fails to cover the cost of drugs prescribed to treat a potential life or limb threatening infection, or the treatment of a tooth abscess that is capable of spreading into the brain, or an ambulance when urgent hospital care is required, is clearly inequitable. Thus, it rings hollow for the Government to claim to be concerned about the equity of allowing patients who are unable to obtain timely diagnostic and surgical services in the public system to obtain these services privately within the province – rather than requiring them to go outside the province to alleviate their suffering and protect their health.

[1873] **Transcript Day 169**, p. 74, lines 7-34.
[1874] **Exhibit 18**, Expert Nadeem Esmail, Tab 3, p. 7 **[CBE, Tab 13]**; **Exhibit 323B**, Addendum Expert Report of Nadeem Esmail, pp. 159-160 **[CBE, Tab 77]**; **Transcript Day 151**, p. 67, lines 41-47; See Section IX, above.
[1875] See Section IV, above.
[1876] **Transcript Day 30**, p. 4, line 37 to, p. 5, line 29; **Exhibit 346A**, p. 53, para 281 **[CBE, Tab 83]**.

2547. This is particularly so when, with respect to those services that are designated medically necessary, there are already many British Columbians who have access to more timely private care options, either within or outside of BC. Allowing more people to have the same entitlement as WorkSafeBC patients, federal prisoners, federal employees and other exempted groups is more, rather than less, equitable.

2548. As Professor Kessler testified, dual practice and access to private health care does not harm equity, and may in fact improve equity.[1877]

2549. He also testified that equity in terms of health outcomes is more important than equity in terms of access for the purposes of this case.[1878]

2550. Thus, even if permitting a private treatment option would create more inequity than exists currently– which the evidence shows is not the case – it still would not make anyone worse off than they are now in terms of their overall health outcomes, while at the same time making many others much better off.

2551. Ensuring that everyone suffers equally is not a morally or legally compelling justification for the impugned provisions, particularly when the timeliness and quality of care in the public system – and hence the health outcomes of those patients unable to access private treatment – is within the control of the Government.

a) The Availability of Private Health Insurance

2552. The Defendant makes the following claims in its pleadings in relation to private insurance:

> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (...)
>
> (b) Individuals with high income and education levels are more likely than others to purchase, and benefit from, duplicate private insurance;
>
> (c) Individuals who cannot afford duplicate private insurance have more limited access to care and coverage;

[1877] **Exhibit 183A**, Tab 1, pp. 13-14 **[CBE, Tab 40]**.
[1878] **Transcript Day 32**, Testimony of Professor Kessler, p. 79, lines 33-46; **Transcript Day 59**, Testimony of Professor McGuire, p. 48, January 26, lines 41-47, p. 47, lines 1-9.

(...)

74. In addition, insurance will only be affordable to, and purchased by, the more affluent. The inevitable result is that medical care will not be equally accessible on the basis of need, but will be preferentially accessible on the basis of ability to pay.

75. Further, in the absence of the kind of extensive regulation typically found in jurisdictions that feature parallel public and private health care systems, insurance will not be available to persons with pre-existing conditions and will be prohibitively expensive to persons with ongoing chronic conditions.

2553. These claims are inconsistent with the evidence, which shows that the vast majority of private health insurance in Canada is based on employment status, rather than wealth.

2554. This is the case for supplementary health insurance currently, which covers a wide range of services that are not covered by the public plan, including prescription drugs, physiotherapy, dentistry, eye care, mental health, ambulance care, artificial limbs, and orthodontics.[1879]

2555. Approximately 91% of supplementary health insurance in BC is provided through employers and unions, who employ or represent a wide range of individuals of various income classes, rather than wealthy individuals purchasing this insurance separately. [1880]

2556. For the past 23 years, non-exempt patients have been able to obtain private diagnostic and surgical services from enrolled doctors, and where applicable, to have these services paid for through employer provided disability benefits/insurance and ICBC automobile insurance.[1881]

2557. Employer provided disability benefits/insurance and automobile insurance cover a wide range of British Columbians in a wide range of income groups[1882]

2558. The evidence is that about 11 million Canadians are covered by employer provided disability benefits/insurance. This covers a wide range of workers of all income classes.[1883]

2559. In addition, automobile insurance covers patients who suffer injuries in automobile accidents. This applies to all British Columbians who are injured in motor vehicle accidents, and not just high income and highly educated individuals.

[1879] See **Section IV**, above.
[1880] **Transcript Day 169**, p. 74, lines 6-34.
[1881] **Exhibit 385**, p. 5, paras. 40-46 **[CBE, Tab 87]**; **Exhibit 346A**, pp. 22-23, paras. 107 & 110, and pp. 25-26, paras. 129-131 **[CBE, Tab 83]**; **Transcript Day 118**, p. 30, lines 2 to 15.
[1882] **Exhibit 268**, Expert Report of Gary Walters, p. 9 **[CBE, Tab 52]**.
[1883] **Exhibit 268**, p.8 **[CBE, Tab 52]**.

2560. With the elimination of the prohibition on private insurance, a significant number of British Columbians will immediately be able to have their private diagnostic and surgical services lawfully paid for through these existing forms of insurance.

2561. The wide availability of employer provided disability benefits/insurance and automobile insurance to pay for private diagnostic and surgical services makes these services more accessible to non-exempt patients facing lengthy wait times in the public system for these services, not less.

2562. And it is vastly more equitable than a system in which only the truly wealthy can obtain treatment privately – outside of the province – while everyone else is effectively prohibited from doing so.

2563. In addition, those British Columbians who do not have employer provided insurance or who aren't injured in a car accident or on the job will not have less access to care because of the elimination of the prohibitions on private insurance and dual practice.

2564. They will have the same access to care and coverage that they would have if the prohibitions were maintained and enforced.

2565. And, they will also have the same opportunity that British Columbians over the past 23 years - like Ms. Schooff – have had to pay for private diagnostic and surgical services to alleviate their suffering and protect their health when faced with lengthy wait times for these services in the public system.

2566. Finally, as stated before, the need, and hence demand, for private diagnostic and surgical services is associated with the length of the wait times for these services in the public system.

2567. The more that these services are rationed in the public system, the greater the need and demand for them to be provided privately.

2568. As it stands now, medical care is not equally accessible on the basis of need in the public system – as proven by the fact that many people in a priority category do not obtain surgeries within the maximum acceptable wait times – and thus allowing non-exempt patients to obtain private diagnostic and surgical services will make medical services more accessible based on need, not less.

2569. The Defendant has expressed a concern that it will be necessary to regulate private health insurance used for private diagnostic and surgical services.

2570. But, that is not so, just as it has not been for supplementary private health insurance.

2571. As shown in other jurisdictions such as the UK and New Zealand, where private health insurance is an adjunct to the public health care system, as here, and health care services are available to everyone in the public system, as here, there is no need for any additional regulation of private health insurance if the prohibitions on private insurance is eliminated for diagnostic and surgical services. [1884]

2572. This was confirmed by Professors Hurley and Gillespie, witnesses for the Defendant, as well as by Professor McGuire.[1885]

2573. And, as in the UK, the private health insurance will likely not cover catastrophic conditions, but, again, that poses no problem for the public system, which has to deal will all such cases now – and which benefits from having more time to handle the more acute cases if the less acute cases are dealt with privately.[1886]

2574. Thus, none of these outcomes are harmful to the public system or in any way negatively impact access to care in that system.

2575. In summary, the evidence shows that private insurance will be broadly available across the population, regardless of income status, through employer and union plans, and through automobile insurance, and in any event, individuals who do not have private insurance will at least have an increased opportunity to ensure their health care needs are met.

b) The Equity of Permitting Private Treatment Options

2576. In paragraph 67 of its Response, the Defendant attempts to justify the infliction of harms on non-exempt British Columbians by preventing them from obtaining private diagnostic and surgical services on the basis that it would generally be inequitable for them to do so:

> 67. The Impugned Provisions are intended to, and do, inhibit the development of such inequitable provision of medical care to British Columbian beneficiaries.

[1884] **Exhibit 17D**, Common Book of Documents, Volume 4 of 8, pp. 6704-6075, 6796-6797 **[CBE, Tab 11]**; **Exhibit 491**, Response Report of Professor Oliver, p. 1 **[CBE, Tab 131]**.
[1885] **Transcript Day 169**, p. 101, line 35 to, p. 102, line 25; **Transcript Day 58**, p. 72, line 20 to, p. 74, line 10; **Transcript Day 164**, Testimony of Professor Gillespie, June 11, 2019, p. 6, lines 22-36.
[1886] **Transcript Day 160**, p. 24, lines 26-38.

2577. The Defendant says that eliminating the prohibitions on non-exempt British Columbians being able to obtain private diagnostic and surgical services to alleviate their suffering and protect their health will create an inequity in access to such services.

2578. Similarly, Canada alleges that "The plaintiffs' model will make the health care system less equitable" (at para 10), by which they are presumably referring to the overall distribution of health care services in the province.

2579. Finally, Canada alleges:

> The evidence will show that the changes urged by the plaintiffs are highly likely to erode Canada's publicly financed and publicly administered health care insurance system and will increase socio-economic and health inequalities in Canadian society, thereby placing vulnerable individuals in an even more precarious position

2580. The simple and complete answer to this contention is that forcing some patients to suffer to supposedly maintain a more equal public system that is unable to provide timely diagnostic and surgical services to everyone is not a valid legal justification for depriving patients of their life and security of the person by preventing them from obtaining private diagnostic and surgical services to alleviate their suffering and protect their health. This will be further addressed in the legal basis.

2581. Also, although it is not necessary from a constitutional perspective to refute the factual basis for this general equity justification, it is proven on the evidence that eliminating the impugned prohibitions will make the overall distribution of health care services in BC more equitable, rather than less equitable.

2582. First, this conclusion is consistent with the fact that Canada consistently ranks among the lowest in terms of the overall equity of its health care system, notwithstanding (or perhaps because of) its prohibition on using insurance to cover private treatment, coupled with significant rationing in the public health sector.[1887]

2583. Second, the evidence in this case shows that permitting more individuals to access a private care option will in fact increase the equity in the health care system overall.

2584. Allowing non-exempt British Columbians to obtain private diagnostic and surgical services enables ordinary British Columbians to access timely private care within the Province that wealthy

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[1887] **Exhibit 18**, Tab 3, p. 7 **[CBE, Tab 13]**; **Exhibit 323B**, Addendum Expert Report of Nadeem Esmail, pp. 159-160 **[CBE, Tab 77]**; **Transcript Day 151**, p. 67, lines 41-47; See **Section IX**, above.

British Columbians have had access to outside of the Province. Permitting ordinary British Columbians the same opportunity as wealthy British Columbians will increase the overall equity of health care treatment in the province.

2585. As well, in British Columbia's health care system, certain patients that come within an exception in the *MPA* – such as the exemptions relating to the WCB system, or participation in a federal health care plan – are lawfully able to obtain expedited diagnostic and surgical services from private clinics in British Columbia outside of the public system.

2586. There may be valid reasons for establishing such exemptions, but it is undeniable that this creates an inequity in terms of access to timely diagnostic and surgical services in British Columbia's health care system. Allowing individuals who are not currently in a preferential group the same opportunity will improve equity in access to health care.

2587. Also within the public system, some people obtain timely diagnostic and surgical services to meet their individual health care needs, but others do not. This results in a further inequity in the health care system of British Columbia, that can be alleviated by allowing patients to obtain the timely treatment they need privately within the Province.

2588. The Defendant suggests that this is not necessarily the case, because even though they have not been able to do this in the past, surgeons are able to triage their wait lists to ensure that no patient's health is harmed by waiting too long for diagnostic and surgical services.

2589. Clearly, that is not possible and has not happened. Surgeons have limited operating time to provide diagnostic and surgical services and many patients in every priority grouping are waiting for these services.[1888]

2590. As a result, the surgeons are simply unable to triage their patients to enable all of them to receive timely diagnostic and surgical services to meet their individual health care needs.[1889]

2591. Thus, because of the limited operating time in the public system and the lengthy waiting lists in each priority category at any given time for diagnostic and surgical services, it is inevitable that some people in the same medical situation will receive more timely diagnostic and surgical surgeries than others. This can not be prevented by triaging patients.

[1888] **Transcript Day 19**, p. 14, lines 9 to 46; **Exhibit 318**, p. 8, para 58 **[CBE, Tab 72]**.
[1889] **Transcript Day 19**, p. 14, lines 9 to 46; **Exhibit 318**, p. 8, para 58 **[CBE, Tab 72]**.

2592. This is another inequity in the health care system in British Columbia that was conclusively established in this case.

2593. In short, allowing more people to access private treatment and avoid the harms caused by lengthy public sector wait times will not create perfect equality. But it will be more equitable than the current situation, because it will allow more people to access the same timely treatment currently available to the very wealthy, to WCB patients, to ICBC patients, to participants in a federal health care plan, to out of province patients, and those few with the good fortune to obtain their treatment in the public system without prolonged delay.

2594. This increases the overall equity of the system, rather than decreases it, as the Defendant and Canada allege.

c) The Defendant's Experts

2595. The Defendant called Professor Kluge as an expert on equitable access to health care.

2596. Professor Kluge claimed, based on a peculiar moral theory, that allowing some people to get faster treatment than others on the basis of having been injured at work, or based on their profession, or their financial contribution to society, does not actually create a morally significant 'inequity'.

2597. Specifically, he opined that it was equitable to provide some patients in the same priority category with more timely diagnostic and surgical services on the basis that they contributed more to society.[1890]

2598. For Professor Kluge, equitable access to diagnostic and surgical services, based on his system of prioritization, is an absolute goal of a public health care system, which trumps the need of patients who are given a low priority to obtain the health care they need outside of the public system.[1891]

2599. That may make some sense in the philosophical world of Professor Kluge. .

2600. However, in the real world, a patient, such as Erma Krahn or Chris Chiavatti, who waits longer for diagnostic and surgical services than others who have the same medical condition, because they are not working due to their age or other circumstances, are not being treated equitably, and their

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[1890] **Transcript Day 150**, Testimony of Professor Kluge, May 7, 2019 p. 68, line 47 to p. 69, line 37; p. 70, lines 18 to 42; p. 57 lines 17 to 21.
[1891] **Transcript Day 150**, p. 96, lines 2-26.

medical needs cannot be sacrificed to Professor Kluge's philosophical notions about equality with respect to the provision of health care services.

2601. Interestingly, Professor Kluge did not view it as inequitable for patients to spend their own money for medical services that are not covered by the public plan.[1892]

2602. Logically, it should follow from Professor Kluge's ethical perspective that unless it is proven to have a harmful effect on access to diagnostic and surgical services in the public system, it is not unethical or inequitable for patients to spend money on diagnostic and surgical services that are included in the public system. It should also be noted that at one point in his testimony, even Professor Kluge seemed to agree with this.[1893]

2603. The expert witness called by Canada on inequalities was Dr. John Frank. It became clear from Dr. Frank's testimony that he did not support a complete prohibition of private insurance and access to private health care, which is the fundamental question at issue in this proceeding.[1894]

2604. Professor Frank testified that when looking at socio-economic inequalities across various countries of the OECD, the availability of private health care – and hence the necessity of provisions designed to completely eliminate private health care - was not a determinant of whether countries were doing better or worse in comparison to others on measures of equity.[1895]

2605. He also testified that in order to reduce socio-economic inequalities that exist in Canada, changes were required in the public health care system to provide all Canadians, especially those at the lowest-socioeconomic groups, with universal health care, and timely access to diagnostic and surgical services.[1896]

2606. This point was also made by Professor Oliver, another expert witness for the Defendant. He said that the way to deal with inequities in access to health care is to reduce the waiting times and access issues in the public system.[1897]

[1892] **Transcript Day 150**, p. 57, line 42 to, p. 58, line 9, p. 58, lines 26 to 41.
[1893] **Transcript Day 150**, p. 63, lines 3 to 15.
[1894] **Transcript Day 179**, p. 28, lines 16-44.
[1895] **Transcript Day 179**, p. 36, line 16 to, p. 41, line 16; **Exhibit 587**, "In-It-Together-Highlights-Canada" **[CBE, Tab 158]**.
[1896] **Transcript Day 179**, p. 27, line 46 to, p. 28, line 15.
[1897] **Exhibit 490**, pp. 2-4 **[CBE, Tab 130]**.

2607. As such, the evidence in this case demonstrates conclusively that rather than creating or exacerbating inequities – either in the provision of private insurance specifically, or in the overall distribution of health care services more generally – eliminating the impugned provisions will have a beneficial impact on the equity of the system.

(vii) Cream Skimming Justification

2608. Both the Defendant and Canada contend that it is somehow problematic if private clinics perform less complex surgeries, while the public system performs more complex surgeries.

2609. In particular, the Defendant alleges:

> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (...)
>
> (h) Private clinics restrict their practices to less complicated cases, leaving public hospitals with a relatively more complex and expensive case mix

2610. There is a very good reason why private clinics in BC have historically performed less complex surgeries: they have been required to restrict the complexity of the surgeries they perform, by the BC College, as mandated by the BC Government.[1898] Private clinics would like to do a broader range of surgeries.

2611. But even if private surgical clinics focussed on less complicated cases, this would benefit, not disadvantage the public system.

2612. Put simply, the argument on "cream-skimming" does not apply in a health system in which the amount of funding made available to the public system is determined by the provincial budgeting process and not through insurance premiums paid to health authorities by participating beneficiaries, as is the case with ICBC or WCB.

2613. Under the financing system in BC, every procedure performed in a private clinic using private insurance is a case removed from the public system and represents a cost saving to the public system. The money saved can be spent treating other patients. So-called "cream skimming" simply frees up

[1898] **Exhibit 346A**, paras 145-146, Exhibit "HH" and "JJ" **[CBE, Tab 83]**.

money in the public system to treat more patients overall. There is a benefit, not a harm, to the public system every time a patient is diverted to the private system.

2614. As Justice Deschamps noted in *Chaoulli*, "because the public plan already handles all the serious cases, I do not see how the situation could be exacerbated if that plan were relieved of the clientele with less serious health problems" (at para 66).

2615. The cream-skimming argument is based on the idea that, in the absence of the impugned prohibitions, the public sector would be competing with the private sector for the premiums paid by patients, and that the private sector would somehow be successful in this competition by getting the 'easier', more lucrative, patients and their premiums.

2616. But, there is no competition for patient premiums between the public and private hospitals in British Columbia. Patients do not pay premiums or fees to the public system. Treating patients is not a source of revenue for the public system. All of the money comes from the provincial budget.

2617. If access to private diagnostic and surgical services is prohibited, the public hospitals would have to perform all complex and all less-complex diagnostic and surgical services covered by the public system within the budget allocated to them.

2618. Clearly it is beneficial to the public system for the private system to handle at least some of the lower complexity cases. Not only does it relieve the public system of the cost of providing some surgeries and increase overall capacity in the province to provide timely services, it also benefits the public system by enabling the public hospitals to better meet the demands for more acute cases.[1899]

2619. As Minister of Health Terry Lake stated in the Legislative Assembly on May 3, 2016:

> There are particular procedures that lend themselves very well to a private facility. And it could be a non-private facility, maybe operated by a non-profit. Cataract surgeries, for instance, don't have to be done in the big building downtown. They can be done in a smaller facility in a very safe way that is very efficient. There may be other procedures that lend themselves to that.[1900]

2620. Clearly, therefore, the "cream-skimming" concern has no application in British Columbia and is a complete red herring, as Professor Kessler testified.[1901]

[1899] **Transcript Day 87**, p. 42, lines 5-30.
[1900] **Exhibit 426**, Tab 25, p. 12637 **[CBE, Tab 100]**.
[1901] **Exhibit 183A**, Tab 5, Response Report, p. 138 **[CBE, Tab 40]**.

(viii) Overall Demand/ Costs Justification

2621. The Defendant alleges that:

> 70. The evidence from jurisdictions that permit parallel private health care systems and duplicate private health care coverage is that:
>
> (d) Wait times in the public health care system are not reduced by the existence of the parallel private system;
>
> (...)
>
> (i) The existence of private insurance does not simply shift demand from the public to the private system, but stimulates an overall increase in demand for health care

2622. First, as stated before, in determining whether the deprivation of these fundamental rights is in accordance with the principles of fundamental justice, it is not necessary for the Plaintiffs to establish that eliminating these prohibitions will reduce wait times in the public system.

2623. Second, while allowing non-exempt British Columbians to obtain private diagnostic and surgical services will take some patients out of the public system, this will not necessarily reduce waiting times for these services in that system because of pent-up or latent demand that is not satisfied and therefore not reflected in in the wait times statistics.

2624. **Redacted per J. Steeves' ruling dated September 5, 2018.**

2625. Monica Forster is a good example of the drop-off situation described by Dr. Vertesi. After waiting too long for her gallbladder surgery, without a surgery date, she removed herself from the wait list, only to have her gallbladder burst two weeks later, which required an emergency surgery, at higher cost to the public system and a risk of a worse outcome.[1903]

2626. If more diagnostic and surgical services become available in the public system – either because some patients opt to have these services performed privately or the public system increases the number of diagnostic and surgical services it performs – the patients who have not previously sought these services or who have "dropped-off" the public waiting lists may now decide to get the treatment

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[1902] Redacted per J. Steeves' ruling dated September 5, 2018.
[1903] See **Section VII(C)(iii),** above.

they need.[1904] That is the latent or pent-up demand. To the extent it is not currently satisfied in the public system is simply another example of its failure.

2627. Thus, taking some patients out of the public system queue by lawfully permitting them to obtain private diagnostic and surgical services may result in latent demand for such services coming forward in the public system, but this is beneficial from a health perspective, and not harmful as the Defendant suggests.

2628. In this respect, it is important to recognize that the so-called "demand" for surgeries is not like the demand for consumer goods. Patients do not get surgeries just because they want them. They get surgeries when they are recommended as an appropriate treatment option by their physicians.

2629. And as explained by Professor Oliver, "most health care is probably not a very pleasant thing to go through".[1905]

2630. Thus, to the extent that the Defendant is alleging that permitting a private health care option will not necessarily decrease wait times in the public system, the Defendant may be right. But that will depend on a wide range of factors, including whether or not the Defendant continues to ration services in the public system as a way to contain costs.

2631. However, permitting a private treatment option will result in an overall increase in access to health care treatment in the province, and an increase in capacity in the public system to provide that treatment, because some services that would otherwise be performed in the public system, and paid for by the public system, will be performed and paid for privately. Professor Kessler provided empirical evidence in support of this point.[1906]

2632. Also, Professor Hurley, the Defendant's expert on this point, explained, that any new demand would be reflected in the private system, not in the public system. In fact, he testified that there would be a net reduction in demand in the public system if patients are able to obtain private medical services.[1907]

[1904] **Transcript Day 30**, p. 67, line 29 to, p. 68, line 5.
[1905] **Transcript Day 160**, p. 78, line 30 to, p. 79, line 28.
[1906] **Exhibit 183A**, Tab 3, p. 5 **[CBE, Tab 40]**.
[1907] **Transcript Day 169**, p. 88, lines 1 to 22.

2633. While this will increase the overall cost of health care –because more British Columbians are able to get timely treatment to protect their health – this is not a problem, because it results in more patients obtaining the diagnostic and surgical services they need in a timely manner.

2634. And this extra cost is borne by the patients themselves, and not the public health care system. As Justice Deschamps noted, "if the increase in overall costs is primarily attributable to the individual cost of insurance, it would be difficult for the state to prevent individuals who wished to pay such costs from choosing how to manage their own finances" (at para 66).

2635. The claim that the Government must prevent people from spending their own money to address their health care concerns, because the Government knows how they should spend their money better than they do, is clearly not an argument that can justify the widespread harm caused by the impugned provisions.

2636. None of this is to suggest that if the Defendant had proven that permitting people to care for their health in a timely way would increase the cost to the public system, this would somehow justify the severe deprivation of their life, liberty and security of the person.

2637. The fact that health care expenditures might increase overall – because people may choose to spend more money to protect their health and well-being – is not a valid basis for prohibiting people from caring for their own health.

(ix) Reduced Quality Justification

2638. The Defendant asserts as follows in paragraph 78 of its Response:

> 78. Where health care is delivered by for-profit entities, such as the plaintiffs Cambie and SRC, the quality of care may be lower than where health care is delivered by public or private non-profit entities. The evidence shows that, in general, permitting health care to be delivered by for-profit entities results in higher mortality rates and lower quality outcomes.

2639. This alleged justification is directly contrary to the Defendant's assertion that removing the impugned provisions will be inequitable, because the timeliness and quality of care will be superior in private clinics.

2640. And it is inconsistent with the fact that the impugned provisions, and the *MPA* generally, do not ban private clinics, but rather prohibit private funding.

2641. In any event, there has been no issue about the quality of diagnostic and surgical services in private clinics since they started performing these services in or around 1996, for the WCB, and then for non-exempt patients both on a private basis and for the public system.

2642. The Defendant's allegation, without evidence, is also directly contradicted by the fact that the physicians supplying services in private clinics have been among the most competent and professional that BC has to offer.

2643. And it is directly contradicted by the fact that the evidence shows that private clinics in BC provide at least as high quality care as public hospitals.[1908]

2644. Professor Kessler provides empirical evidence that the services provided in private clinics would be of the same, or of better, quality than those provided in the public system. [1909]

2645. Finally, this allegation is also directly contradicted by the fact that the public health care system often contracts with private clinics. Unless the Defendant is taking the position that the public system routinely consigns patients to substandard care in private clinics, it cannot also allege that private clinics provide substandard care. To repeat, Minister Lake stated in the Legislative Assembly, particular procedures can be done at private clinics "in a very safe way that is very efficient."[1910]

2646. And, in any event, the quality of care in the private clinics is tightly regulated in British Columbia, and as such, this provides no justification for a blanket prohibition on access to private care options.

(x) Canada Health Transfer

2647. The Defendant asserts as follows in paragraph 15 of its Response:

> 15. If the Province permits access to medical care in British Columbia to be impeded or precluded by allowing beneficiaries to be charged, it will be denied part or all of the Canada Health Transfer by the Governor General in Council and/or the federal Minister of Health.

2648. With respect, there is no merit to this argument, either factually or legally.

[1908] **Exhibit 346A**, pp. 30-31, paras 152-155, 156 **[CBE, Tab 83]**
[1909] **Exhibit 183A**, Tab 1, p. 19, Tab 3, pp. 5-6 **[CBE, Tab 40]**.
[1910] **Exhibit 426**, Tab 25, p. 12637 **[CBE, Tab 100]**.

2649. First, as will be explained in the legal basis section, saving money is not a justification for a *Charter* violation, unless there is a fiscal emergency, which the Government has neither pleaded nor attempted to prove.

2650. Put simply, the availability or unavailability of federal funding under the *Canada Health Act* cannot be used to justify such a violation of fundamental rights.

2651. Second, the *Canada Health Act* is not violated when a province permits private diagnostic and surgical treatments in cases where there is no public sector financing.

2652. As described above,[1911] the purpose of the *CHA* was limited to eliminating extra charges and user fees imposed on patients *using the public system*, not charges wholly in the private system. This was confirmed by Canada's own witnesses.[1912]

2653. Finally, if the Plaintiffs succeed, it would be unconstitutional for the federal government to use its spending power to coerce a province into pursuing unconstitutional actions such as prohibiting private health care.

2654. Put another way, one level of government cannot lawfully attempt to bribe or coerce another level of government to breach the *Charter*, or withhold funds on the basis of a refusal to breach a Court order.

2655. It is also significant that although the Government of Canada has fully participated in these proceedings, it has not argued or tendered any evidence that it would withhold funds under the *Canada Health Act* if the Plaintiffs are successful.

XI. LEGAL BASIS – PROHIBITIONS ON PRIVATE CARE BREACH SECTIONS 7 AND 15

A. Overview of Section 7 Argument

(i) Guiding Principles

[1911] See **Section III**, above.

[1912] **Exhibit 436**, Affidavit #2 of Gigi Mandy, pp. 9-10, paras 32-35, and Exhibit "V", p. 569 **[CBE, Tab 115]**; **Exhibit 435J**, Affidavit #1 of Gigi Mandy, Exhibit "LLL" **[CBE, Tab 114]**; **Exhibit 346A**, p. 69, paras 373-374 **[CBE, Tab 83]**.

2656. The Plaintiffs submit that under section 7, the BC Government cannot both fail to provide timely medically necessary services to the population, and also prohibit patients from protecting their health by obtaining those services outside of the public system.

2657. That is ultimately because, in a free and democratic society, a government cannot impose severe harms to the most fundamental human interests – their life, liberty, and security of the person – where doing so is not directly connected to, unnecessary to achieve, and out of all proportion to, the objective the legislature is trying to achieve.

2658. The Defendant disagrees with the Plaintiffs' legal analysis and their conclusion.

2659. In resolving the dispute over the interpretation and application of section 7 in the case at hand, it is trite law that the *Charter* must be interpreted in both a purposive and contextual manner,[1913] rather than through a technical or abstract analysis.[1914]

2660. That means that the section 7 rights at issue must be understood and applied in light of the purposes of the *Charter* as a whole, the interests that were meant to be protected by the *Charter* provision at issue, as well as the interests actually at stake on the evidence in this case.[1915]

2661. First, any *Charter* analysis must be undertaken in light of the overall purposes of the *Charter,* which is grounded in "basic beliefs about human worth and dignity".[1916] The *Charter* recognizes the innate value, autonomy, and human dignity of every individual,[1917] and seeks to ensure "the unremitting protection of individual rights and liberties".[1918]

2662. At the same time, the *Charter* provides a "continuing framework for the legitimate exercise of governmental power";[1919] it allows for governments to pursue important common objectives,

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[1913] See e.g. ***R. v. Stillman***, 2019 SCC 40 at para 21; ***Greater Vancouver Transportation Authority v. Canadian Federation of Students — British Columbia Component***, 2009 SCC 31 at para 27; ***Siemens v. Manitoba (Attorney General)***, [2003] 1 SCR 6, 2003 SCC 3 at para 17; ***R. v. Jarvis***, 2002 SCC 73 [***Jarvis***] at paras 60-65.

[1914] ***Doucet-Boudreau v. Nova Scotia (Minister of Education)***, 2003 SCC 62 [***Doucet-Boudreau***] at para 23; ***R. v. Grant***, 2009 SCC 32 [***Grant***] at para 16.

[1915] See e.g. ***Edmonton Journal v. Alberta (Attorney General)***, [1989] 2 SCR 1326 at 1355-1356, per Wilson J ("the importance of the right or freedom must be assessed in context rather than in the abstract and [] its purpose must be ascertained in context").

[1916] ***Mounted Police Association of Ontario v. Canada (Attorney General)***, 2015 SCC 1 [***MPAO***] at para 50.

[1917] ***Vriend v. Alberta***, [1998] 1 SCR 493 [***Vriend***] at para 104; ***Prud'homme v. Prud'homme***, 2002 SCC 85 at para 44; ***R. v. Oakes***, [1986] 1 SCR 103 [***Oakes***] at para 64.

[1918] ***Hunter v. Southam Inc***, [1984] 2 SCR 145 [***Hunter***] at 155 (emphasis added).

[1919] ***Hunter,*** *supra* at 155.

including those necessary to protect and advance the public interest, in accordance with values central to a free and democratic society.

2663. In striking a balance between these underlying purposes of the *Charter*, the courts seek to ensure that the Government has considerable room to govern, while also ensuring that measures that undermine *Charter* rights are both rational and necessary, and employed in service of a sufficiently important purpose to justify the harm in question.

2664. If the Government imposes harms that are not necessary to reasonably achieve its objective, or if it imposes a degree of harm that significantly outweighs the importance of its objectives, it has violated these core precepts underlying the *Charter*.

2665. Second, under a purposive interpretation, it is critical to take into account the interests that were specifically meant to be protected by the *Charter* provision at issue.[1920] Section 7 of the *Charter* protects those rights that are truly basic and fundamental to the ability to live in a democratic society: the rights to life, liberty and security of person.

2666. These are among the most "fundamental human rights guaranteed by our Constitution";[1921] they are "basic to our conception of a free and democratic society".[1922] That is because without one's life, liberty, safety, and health, all other rights are illusory or insignificant by comparison.

2667. An individual who is deprived of their basic physical liberty, the ability to make fundamental life choices, or who is bedridden with illness or injury or suffering from constant and debilitating pain, cannot partake fully in a free and democratic society. An individual subjected to a premature death can exercise no *Charter* rights at all.

2668. Section 7 is therefore designed to ensure that any deprivation of these fundamentally important interests can only be justified by laws of exceptional importance and necessity.

2669. This was explained long ago in the very first section 7 case decided by the Supreme Court of Canada, the *BC Motor Vehicle Reference*. In that case, the Court stated:

> For the narrower the meaning given to "principles of fundamental justice" the greater will be the possibility that individuals may be deprived of these most basic rights. This latter result is

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[1920] ***Re B.C. Motor Vehicle Act***, [1985] 2 SCR 486 [***BC Motor Vehicle Reference***] at para 22.
[1921] ***Victoria (City) v. Adams***, 2009 BCCA 563 [***Adams***] at para 75.
[1922] ***Charkaoui v. Canada (Citizenship and Immigration)***, 2007 SCC 9 [***Charkaoui***] at para 66. See also ***Sahaluk v Alberta (Transportation Safety Board)***, 2017 ABCA 153 at para 175, per Paperny JA (dissenting but not on this point).

> to be avoided given that the rights involved are as fundamental as those which pertain to the life, liberty and security of the person, the deprivation of which "has the most severe consequences upon an individual" (*R. v. Cadeddu* (1982), 40 O.R. (2d) 128 (H.C.), at p. 139).[1923]

2670. As the Court recognized long ago, reading section 7 narrowly or technically would make the all-important and fundamental rights it protects subject to less protection than less fundamental constitutional interests.[1924]

2671. A narrow reading of section 7 would mean that the government could subject someone to life imprisonment more readily, and for a less compelling reason, than it could limit the freedom to engage in commercial advertising under section 2(b).

2672. It would mean that the Government could subject a detainee to physical or psychological torture more readily, and for a less compelling reason, than they could fail to inform a detainee promptly of the reasons for an arrest under section 11(a).

2673. And it would mean that the Government could sentence an individual to death more readily, and for a less compelling reason, than it could limit one's right to communicate with public officials in the official language of their choosing under section 20.

2674. Thus, the Court must interpret and apply section 7 purposively, in a manner that gives effect to the significant and fundamental importance of the constitutional interests at stake. It should avoid the absurdity of relegating the most fundamental interests of all to diminished protection compared with other *Charter* rights and freedoms.

2675. Third, a contextual analysis requires that the section 7 analysis be undertaken in light of the severity of the deprivation of rights at issue, in the particular context of the case.[1925]

2676. This is consistent with the "firmly established" principle that *Charter* rights must be understood and applied in a contextual manner, which means that the "scope of a particular Charter right or freedom may vary according to the circumstances".[1926]

2677. As reviewed in earlier sections, the evidence in this case demonstrates that many patients suffer prolonged pain, immobility and psychological distress while waiting for treatment. This suffering and

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[1923] ***BC Motor Vehicle Reference***, *supra* at para 25.
[1924] ***BC Motor Vehicle Reference***, *supra* at paras 26-27.
[1925] ***R. v. Lyons***, [1987] 2 SCR 309 at para 85 (the principles of fundamental justice "are not immutable; rather, they vary according to the context in which they are invoked"); see also ***Charkaoui***, *supra* at para 25.
[1926] ***Jarvis***, *supra* at para 63. ***R. v. Wholesale Travel Group Inc.***, [1991] 3 S.C.R. 154, at p. 226, Cory J.

agony can be entirely debilitating, depriving individuals of the capability to lead a normal functioning life. It can permeate their entire existence, day to day and hour to hour.

2678. The evidence also demonstrates that waiting for treatment causes a risk of deterioration, irreversible physical damage, a poorer surgical outcome, and other permanent harms. To use just one example, patients with kyphosis, like Mr. Khalfallah, face progressive spinal deformity and a greater risk of an adverse health consequences the longer they wait for surgery.

2679. In addition, the evidence demonstrates that, in certain contexts, waiting for treatment imposes a greater risk of a loss of life. There is simply no greater harm that can be imagined.

2680. For instance, if Ms. Martens did not get her colonoscopy privately, and instead waited in the public system, she might not be alive today. Short of when it is necessary to save the lives of others, government action causing death can never be justified, no matter how compelling the government's purported objectives.

2681. The longer such patients wait, the longer they suffer extreme pain, immobility, psychological harm, and the more likely they are to suffer permanent disabilities or a loss of life, as a result of being prevented from accessing timely treatment.

2682. Were the same degree of suffering or harm imposed by state agents directly, rather than indirectly by preventing people from obtaining medically necessary treatment, it would be classified as a form of torture. For patients waiting for or (unknowingly) in need of life saving treatment, the prohibition on accessing private care can operate like a death penalty.

2683. This extreme harm that individuals can suffer as a result of the impugned provisions must be kept in mind in understanding the place of section 7 within the overall constitutional order.

2684. Another important part of the factual context in this case is the sheer ubiquity of these harms. It is well established that the mere risk of serious and irreversible harm to the life or security of <u>one</u> person is sufficient to demonstrate that a law is unconstitutional under section 7. As the Court held in *Bedford*:

> [A] grossly disproportionate, overbroad, or arbitrary effect on *one* person is sufficient to establish a breach of s. 7..... If screening could have prevented one woman from jumping into Robert Pickton's car, the severity of the harmful effects is established.[1927]

[1927] ***Canada (Attorney General) v. Bedford***, 2013 SCC 72 [***Bedford***] at paras 123, 158.

2685. However, where this degree of harm is caused on an ongoing and systemic basis across the population, the Government's objective must be all the more important, and the means it chooses must be even more directly connected to the achievement of that purpose.

2686. In this case, while there is considerable evidence of the harmful impact of waiting for treatment on a number of individuals, this is just the tip of the iceberg, as the Government's data shows.[1928]

2687. Even leaving aside the harms that occur to patients within the maximum acceptable wait times, there are literally tens of thousands of patients every year, across every surgical category, who are waiting beyond maximum acceptable wait times, and predictably suffering harm as a result.[1929]

2688. In summary, the above analysis leads to the following principles which should guide the Court's approach to the section 7 analysis in this case:

i. Among the fundamental, organizing precepts of the *Charter* is that the Government cannot impose harms to *Charter* rights that are unnecessary to the achievement of sufficiently important government objectives;

ii. Section 7 protects among the most important and fundamental rights in the *Charter*, which are necessary preconditions to living a productive, healthy and happy life, or any life at all;

iii. The more severe the harms suffered by individuals, and the more widespread the harms across the population, the more judicial scrutiny must be applied to ensure that those harms are strictly necessary to the achievement of a sufficiently important government objective;

iv. In this case, the impugned laws can cause the most severe physical and psychological harms imaginable, including prolonged pain and suffering, irreversible physical harms such as the loss of eyesight or the use of limbs, and in extreme cases, a greater risk of a premature death;

v. While imposing these severe harms on a single individual can render a law arbitrary, overbroad, or grossly disproportionate, any government justification must be all the

[1928] See generally **Section VI,** "Wait Times for Diagnosis and Treatment by Specialists in BC", above.
[1929] See generally **Section VII,** "Harms of Waiting for Diagnosis and Treatment by Specialists", above.

more pressing in this case given that these harms are imposed on thousands of people across the entire population every year.

2689. It is within this legal and factual context that the Government's proposed justifications for the law must be addressed.

(ii) The Government's Justifications

2690. In this case, the Defendant and its experts raise a number of allegations in an attempt to justify the impugned provisions and the severe harms they would cause if they were enforced. [1930]

2691. To name a few, the Defendant has suggested that an absence of the impugned provisions would result in increased administrative costs, diminished popular support for public health insurance, or the creation of new ethical dilemmas for physicians.

2692. Leaving aside the absence of evidence that these types of concerns had anything to do with the enactment of the impugned provisions, or any evidence justifying these hypothetical and speculative concerns, those types of objectives simply cannot justify the imposition of such severe harms on the life, liberty and security of the person of patients across BC.

2693. No sensible interpretation of the *Charter* could result in the conclusion that the Government can impose prolonged pain and suffering, irreversible and drastic reductions in physical mobility or capacity, and even the risk of death, in an attempt to avoid administrative burdens, to manipulate the political priorities of the population, or to eliminate the mere existence of occasional ethical quandaries.

2694. The Defendant also raises other justifications that, if valid and supported by the evidence, may justify imposing some limitations on access to necessary health care outside of the public system, to the extent that there was no other means available to avoid the harms in question.

2695. However, the evidence in this case establishes that these concerns are either entirely hypothetical and contrary to the evidence in this case, or that any valid concerns raised by an entirely unregulated private health care sector can be addressed in ways that do not deprive British Columbians of a private care option when the public system causes them physical and psychological harm.

[1930] See generally **Section X,** "The Asserted Justifications", above.

2696. To use a few examples, there is no evidence in this case that permitting physicians to engage in dual practice would lead to an exodus of physicians from the public to the private system, or deprive the public system of the physicians it needs to provide all of the services that the Government is willing to supply.

2697. To the contrary, the evidence shows that physicians are fully committed to the public system, and that those who work in the private system do so only to the extent that they have excess capacity after fulfilling all of their obligations in the public system.

2698. However, if the Government could establish through evidence – rather than speculation – that the existence of access to private treatment options compromised the ability of the public health care system to provide care to patients, there are far less harmful ways that this can be avoided, short of an outright prohibition on access to private treatment.

2699. To use just one example, regulations could be put in place to impose quotas in the public system that must be met for physicians to be able to provide private services.

2700. This would allow the achievement of the Government's objective – i.e., the protection of the public health care system – to the very same extent, without imposing entirely unnecessary harms to the health of British Columbians by preventing such physicians from providing additional services privately after fulfilling their responsibilities in the public system.

2701. As another example, the Defendant claims that permitting dual practice would cause physicians to ignore their professional obligations and engage in grossly unethical conduct – such as manipulating wait lists, recommending unnecessary invasive treatments, and depriving patients of information they need to make informed medical decisions – in order to maximize their revenue.

2702. As noted previously, there is absolutely no concrete evidence of this occurring – either in BC over the past 20 years, or in other jurisdictions – nor any evidentiary basis for the assertion that physicians would completely abandon their ethical obligations in this manner. It is purely speculation on the Government's part, and is disproven by the actual evidence in this case.

2703. However, if there ever were evidence of such practices becoming a problem, this could obviously be regulated without prohibiting private care altogether, with all the harm that causes in circumstances where patients are unable to get timely treatment in the public system. Indeed, such conduct already is regulated through the College of Physicians and Surgeons. These purely speculative

concerns therefore provide no legal justification for a blanket prohibition on access to private care options.

2704. Similarly, the Defendant has alleged that private clinics provide a diminished quality of care to patients, which it says justifies the impugned provisions. The Defendant led no concrete evidence to support this allegation, nor is there evidence to support the allegation that this is a genuine concern in the BC context.

2705. To the contrary, the evidence shows that the services provided by private clinics meet or exceed the standards for safety and quality at public hospitals, and that the surgeons providing care at private clinics are among the most expert in the province.[1931]

2706. Indeed, the government itself routinely uses private clinics to deliver publicly funded services, which is wholly inconsistent with an allegation that patients are subjected to substandard care, and demonstrates the grasping nature of many of the Defendant's arguments.

2707. However, again, if there were clear evidence to support the Defendant's contention, the objective of ensuring high standards of practice at private clinics can be achieved through means far less drastic and harmful than a blanket prohibition on access to private care. The government can (and in fact, already does) [1932] ensure that private clinics provide at least as high a quality of treatment as public hospitals without prohibiting private care options altogether.

2708. In addition to showing the absence of any need to prohibit patients from receiving treatment outside of the public system, these examples demonstrate another critical point in this case: finding that the impugned prohibitions violate the *Charter* does not in any way limit the Government's ability to achieve any valid and important objectives it has.

2709. All of the Government's legitimate concerns, if demonstrated with evidence that the concerns actually exist and pose a risk of harm to the public system or the health of the population, can be addressed through direct and targeted means that do not impose the same degree of harm as blanket prohibitions on access to private treatment options.

[1931] **Exhibit 346A,** Affidavit #9 of Dr. Day, Exhibit MM **[CBE, Tab 84]**.
[1932] See **Section X(D)(ix),** "Reduced Quality Justification", above.

2710. As noted above, ensuring that the Government does not seek to fulfil valid objectives in a manner that imposes unnecessary harms is the essence of the analysis under section 7, and is fundamental to achieving the overall purpose of the *Charter*.

(iii) The Legal Framework

2711. With these principles in place, it is possible to see how it fits into the more technical legal analysis supplied by the courts. An inquiry under section 7 involves a two-step process:

i. first, it must be demonstrated that at least one section 7 interest – life, liberty or security of the person – is infringed by the law in question; and

ii. second, it must be determined whether such infringement is in accordance with the principles of fundamental justice.

2712. If a law infringing on these fundamental section 7 interests is arbitrary, overbroad, or grossly disproportionate, it will not be in accordance with the principles of fundamental justice. Such laws will violate section 7 and must be struck down, unless there are exceptional circumstances that justify a breach under section 1.[1933]

2713. At the first stage of the section 7 analysis, it is clear that the impugned *MPA* provisions in this case deprive persons of their right to life, liberty and security of the person.

2714. The right of everyone to protect and secure his or her own mental and physical health, well-being, and survival, are central to the values underlining section 7, including the personal integrity, autonomy and dignity of each individual.

2715. Legislation that prevents individuals from acting to protect and secure their life, health and wellbeing, clearly deprives individuals of these fundamental rights.

2716. As set out in more detail below, the courts have consistently found that the right to obtain medically necessary health care treatment, without obstruction from the state, is central to the interests protected by the section 7 guarantee.

[1933] ***Bedford***, *supra* at paras 124-129.

2717. To repeat, the Plaintiffs in this case are not seeking a "positive" right to a certain quality or timeliness of publicly-funded health care. They accept that the Government has the right to determine the level or extent of services it wants to provide in the public system.

2718. Rather, they say that the Government cannot legally prevent patients from making decisions about their bodily integrity, to take steps to alleviate their pain and suffering, and to ensure their health and survival, given the public system has failed to provide timely diagnostic and surgical services to all patients.

2719. These options are currently foreclosed by the prohibitions found in the *MPA,* thereby clearly depriving British Columbians of their life, liberty and security of the person.

2720. The Government seeks to justify depriving persons of the right to life, liberty, and security of person on the basis of the need to protect the viability and accessibility of the public health system, or on the basis of a purely symbolic commitment to equal care for all.

2721. However, as set out below, the deprivations of section 7 interests in this case are not in accordance with the principles of fundamental justice because:

i. The true purpose of the impugned provisions is to protect the viability and accessibility of the public health care system;

ii. The laws are arbitrary because, on the facts and evidence, they are not directly connected to, are unnecessary to achieve, and in fact undermine, the objective of protecting the viability and accessibility of the public health care system;

iii. The laws are overbroad because they go further than necessary to ensure the viability and accessibility of the public system, both in the sense that there are other ways to achieve this objective, and in that they capture certain conduct that has no connection to the achievement of the objective;

iv. The laws are grossly disproportionate because, on the facts and evidence of this case, the harms caused to the section 7 interests of patients is out of all proportion to the degree of protection it allegedly affords the public system.

2722. Moreover, even if the purpose of the law is found to be ensuring 'equal care for all' – which, as discussed below, is inconsistent with the evidence of the legislature's purpose and how the laws

actually operate – the laws are clearly both arbitrary and grossly disproportionate to the achievement of that objective.

2723. They are arbitrary because some British Columbians are able to access timely treatment, either within or outside the public system, and the impugned provisions deprive many other British Columbians of the same opportunity. This contradicts the alleged purpose of ensuring equal access of treatment for all, making the impugned provisions arbitrary.

2724. They are also grossly disproportionate to this purported objective, because the fundamental rights protected under section 7 cannot be sacrificed for the purpose of achieving vague, unattainable, or purely symbolic public objectives, particularly where the harms caused are concrete and severe, as in this case.

2725. These conclusions are consistent with the core purpose of section 7, and the *Charter* as a whole, which is to affirm the inherent value, autonomy, and human dignity of every individual.

2726. As Professor Hamish Stewart has explained in his treatise on section 7, a core purpose underlying section 7 is to ensure that individuals are "able to be, and to see themselves as, more than mere means or resources for the state to use in its pursuit of public objectives".[1934]

2727. This is exactly the principle that was upheld by the majority decisions in *Chaoulli*, which found that imposing significant physical and psychological harms on persons by preventing them from caring for their health was not required in order to protect the public health care system.

2728. Put simply, just as the Government could not seek to monopolize the food supply while it failed to feed the population, it cannot fail to provide medically necessary treatment in a timely manner while prohibiting patients from getting that treatment elsewhere.

2729. Thus, the true effect and result of *Chaoulli* was to uphold values central to our constitutional order, and central to section 7 in particular. As Patrick Monahan has explained:

> Largely overlooked in this academic debate was whether anyone had an answer to the fundamental question of principle that had moved the Court to intervene in the first place. This question was simply whether it was legally and morally justifiable for the state, on the one hand, to require individuals to access healthcare services only through a universal, single-payer system and then, on the other, to deny them access to needed service when they were sick or dying. In such circumstances, which the Court found to prevail in Canada today, was it

[1934] Hamish Stewart, *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms*, 2nd ed (Toronto: Irwin Law, 2012) [**Stewart, *Fundamental Justice***] at 373-374.

> legitimate for the state to prohibit individuals from using their own resources to access the care they needed? Could the sick be legally compelled to wait indefinitely for care without legal consequences of any kind, even if it resulted in a serious deterioration of their health or even their death? Yet critics of the decision largely ignored this fundamental question, preferring to focus attention on subsidiary questions, such as whether the Supreme Court had a proper appreciation of the complex operation of health insurance in other OECD countries, or whether the courts had any business interfering in a complex policy area such as medicare.
>
> Given the importance of this issue to the argument that follows, it bears explaining briefly why it cannot be legitimate in a free and democratic society to prevent individuals from utilizing their own resources to protect their health, in circumstances where the publicly funded system does not provide medical care in a timely manner. In these circumstances, the state is essentially forcing individuals to endure pain and even death in aid of the efficient operation of a social program. This offends the basic liberal principle that all persons should be treated "as equals"; that is, as entitled to equal concern and respect. No one citizen may be treated as a mere instrument to improve the welfare of another. Government fails to observe this bedrock moral principle when it imposes a "sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning his sense of his equal worth" (Dworkin 1985, 204). By way of illustration, as a democratic society we believe it would be wrong and immoral to put an innocent person to death, even if by so doing we might increase the health or welfare of others in society. The fundamental defect in such a proposal is that it treats the person to be sacrificed as a mere means to increase the welfare of others in society, rather than as an equal person entitled to the same concern and respect as those who stand to benefit from his or her death.
>
> Nor is this merely a moral principle. The Supreme Court of Canada has indicated that the "ultimate standard" for justifying limits on rights must be the values of a free and democratic society, which values include respect for the "inherent dignity of the human person" (*R. v Oakes*, 136). It is for this reason that any healthcare system which deliberately and systematically imposes pain or even death on innocent individuals in the name of improving healthcare provided to others cannot be justified either morally or legally, since it fails to treat all individuals as equally deserving of concern and respect. Nor could such a system be regarded as being in accordance with the "principles of fundamental justice" enshrined in section 7 of the Canadian *Charter*, since any legal regime which treated one person as a mere instrument for the satisfaction of the needs of another must be regarded as odious and fundamentally unjust. It is for this reason that the Supreme Court's conclusion in *Chaoulli* was correct, both legally and morally.[1935] [emphasis added]

2730. Then-Dean Monahan poses the fundamental question – legal and moral – before the court in this case: Can the state force individuals to risk their own health, well-being, and, in extreme circumstances, life, in order to preserve the state's monopoly on the provision of health care?

[1935] Patrick J. Monahan, "*Chaoulli v. Quebec* and the Future of Canadian Healthcare: Patient Accountability as the 'Sixth Principle' of the Canada Health Act" *C.D. Howe Institute, Benefactors Lecture, 2006* (Toronto, November 29, 2006) **[Monahan, "*Chaoulli v. Quebec*"]** at 4-5 (emphasis added).

2731. Is that, in and of itself, a sufficiently important objective to justify the extreme harms suffered by patients? And is a blanket prohibition on access to private treatment options a rational or necessary way to protect and maintain a high quality, universal public health care system?

2732. The Plaintiffs submit that the answer to these questions is clearly no.

2733. That is simply because the underlying purpose of the impugned provisions – namely, the protection of the accessibility and viability of the public system – can be achieved without imposing these harms.

2734. Therefore, for these reasons elaborated upon below, the prohibitions on access to private medical care in the *MPA* violate the rights to life, liberty and security of the person in a manner inconsistent with the principles of fundamental justice, and this deprivation cannot be justified under section 1.

B. The Impugned Provisions Jeopardize Life, Liberty and Security of the Person

2735. The impugned provisions in this case clearly impinge upon all three section 7 interests: life, liberty and security of the person, at the first stage of the section 7 analysis.

(i) The Right to Liberty is Infringed

2736. First, prohibiting persons from accessing timely medical treatment violates their right to liberty under section 7.

2737. The liberty interest under s. 7 is engaged where the state interferes with decisions that are "fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence".[1936]

2738. Deciding whether and how to access health care treatment are among the most fundamental life choices an individual can make.[1937]As the Court found in *Carter*, interference with "fundamentally important and personal medical decision-making" will implicate the section 7 liberty interest.[1938]

[1936] ***Godbout v. Longueuil (City)***, [1997] 3 SCR 844 [***Goudbout***] at para 66; ***Blencoe v. British Columbia (Human Rights Commission)***, 2000 SCC 44 [***Blencoe***] at paras 49-54.

[1937] ***Carter v. Canada (Attorney General)***, 2015 SCC 5 [***Carter***] at paras 66-68; ***A.C. v. Manitoba (Director of Child and Family Services)***, 2009 SCC 30 [***A.C.***] at paras 41-45.

[1938] ***Carter***, *supra* at para 65-66. See also ***R. v. Smith***, 2015 SCC 34 [***Smith***] at para 18 (the laws in question "limit liberty by foreclosing reasonable medical choices").

2739. As with other aspects of the section 7 analysis, such an approach must be contextual. For instance, in *Adams*, the BC Court of Appeal found that the decision to erect a shelter was, in the context of a person in need of shelter, a choice of fundamental personal importance.[1939]

2740. In this case, the effect of the impugned provisions is to tell patients that they are lawfully prohibited from obtaining the treatment they need for their medical condition, and must suffer in pain, or with the risk that their condition will deteriorate, or worsen, unless and until that treatment is provided by the public system.

2741. The effect of the impugned provisions is to impose a fundamental deprivation of the right to decide what to do with one's body. It prevents a person from being able to decide to take steps to alleviate their physical malady, whether it be a knee or hip condition, a deteriorating spine, or a tumorous growth.

2742. It is to tell people likeMs. Corrado that, because of her condition, she has to give up on her plans to get a university scholarship to play soccer, and instead must suffer in pain and immobility while she waits years for treatment.

2743. It is to tell people like Ms. Krahn that she is prohibited from making the decision to obtain private treatment, even if it means that she will suffer in debilitating pain and without mobility for the last few years of her life.

2744. And it is to tell people like Ms. Martens that she must take the risk that her condition may be life threatening, which it was, and cannot make the fundamental personal decision to obtain treatment by other means, even if it is necessary to save her life.

2745. This impact on the individual's liberty interest to decide whether to obtain more timely medical services interferes with the fundamental ability of individuals to choose how to live their lives. It deprives them of their fundamental autonomy over their own body, and is a profound interference with fundamental personal decision making.

2746. Normally, the government will attempt to interfere with such profound personal decision making only in circumstances where it will prevent a serious and immediate harm from occurring. For instance, the state has attempted to justify interference with the decision of whether or not to obtain

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[1939] ***Adams***, *supra* at para 109.

medical treatment where a patient's refusal to consent to a blood transfusion would cause their death.[1940]

2747. In this case, however, the BC Government seeks to prevent people from exercising their autonomy over their own body, knowing that it will actually alleviate the severe harms they are suffering. Indeed, the impugned provisions create the perverse result that patients are prohibited from obtaining private medical services when they are medically necessary, but not when they are considered to be medically unnecessary.

2748. Taken as a whole, these circumstances clearly infringe the liberty interest of section 7.

(ii) The Right to Security of Person is Infringed

2749. The phase "security of the person" refers to both the bodily and psychological integrity of an individual.[1941]

2750. An infringement of the security of person interest has been described by the Courts in a number of ways, including "state interference with bodily integrity" and "serious state-imposed psychological stress",[1942] "state interference when a person's life or health is in danger";[1943] "state action which has the likely effect of impairing a person's health",[1944] and "state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering".[1945]

2751. As described in some detail previously, B.C. residents face exactly these types of harm as a result of the prohibition on having their medical needs met outside of the public system, in light of the harms they face waiting for treatment within that system.

2752. By preventing people from accessing medically necessary treatment, the prohibitions on private health care in the *MPA* interfere with their physical and psychological integrity, and cause physical and psychological harm, which infringes the right to security of the person.

[1940] ***A.C.***, *supra*.
[1941] Stewart, *Fundamental Justice, supra* at 95.
[1942] ***R. v. Morgentaler***, [1988] 1 SCR 30 [***Morgentaler***] at 56, per Dickson C.J.
[1943] ***Morgentaler***, *supra* at 90, *per* Beetz J.
[1944] ***R. v. Monney***, [1999] 1 SCR 652 [***Monney***] at 685.
[1945] ***Carter***, *supra* at para 64.

2753. Significantly, all of the members of the Court in *Chaoulli* – both the majority and the dissent – found that the similar Quebec restrictions on access to private treatment infringed the right to security of person. The Court also decided unanimously that the deprivation was caused by the impugned provisions.[1946]

2754. However, as Peter Hogg has observed, *Chaoulli* was not the first case to decide that limiting accessibility to necessary medical procedures violated the *Charter*. The first case was *Morgentaler*, a case in which the state imposed unnecessary restrictions on access to abortion services, which had the effect of harming the health of women who sought to make important personal life decisions regarding their reproductive health.

2755. The majority of the Court in *Chaoulli* considered *Morgentaler* as a controlling precedent with respect to violations of security of the person, and as Professor Hogg observed, "surely they were right".[1947]

2756. In *Chaoulli*, the majority drew the critical links between the constitutional violation in that case and the violation in *Morgentaler*, and explained how prohibitions on access to private care impinge security of the person under section 7. As explained by McLachlin CJ and Major J:

> In this appeal, delays in treatment giving rise to psychological and physical suffering engage the s. 7 protection of security of the person just as they did in *Morgentaler*. In *Morgentaler*, as in this case, the problem arises from a legislative scheme that offers health services. In *Morgentaler*, as in this case, the legislative scheme denies people the right to access alternative health care. (That the sanction in *Morgentaler* was criminal prosecution while the sanction here is administrative prohibition and penalties is irrelevant. The important point is that in both cases, care outside the legislatively provided system is effectively prohibited.) In *Morgentaler* the result of the monopolistic scheme was delay in treatment with attendant physical risk and psychological suffering. In *Morgentaler*, as here, people in urgent need of care face the same prospect: unless they fall within the wealthy few who can pay for private care, typically outside the country, they have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails. As in *Morgentaler*, the result is interference with security of the person under s. 7 of the *Charter*. (...).[1948]

2757. The majority in *Chaoulli* found that prohibitions on private insurance "results in psychological and emotional stress and a loss of control by an individual over her own health". Therefore, "because

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[1946] Peter W. Hogg, *Constitutional Law of Canada* (Toronto: Thompson Carswell, looseleaf) [**Hogg, "Constitutional Law"**] at §32.6.
[1947] Hogg, *Constitutional Law*, *supra* at §32.6.
[1948] ***Chaoulli v. Quebec (Attorney General)***, 2005 SCC 35 [***Chaoulli***] at paras 119, 121 (emphasis added).

patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged."[1949]

2758. This was also the conclusion of the other judges in *Chaoulli*, all of whom agreed that the restrictions on access to private care infringed the right to security of the person.

2759. Justice Deschamps observed, with reference to *Morgentaler,* that "Canadian jurisprudence shows support for interpreting the right to security of the person generously in relation to delays" in accessing health care treatment, and that security of the person was infringed because "Quebeckers are denied a solution that would permit them to avoid waiting lists, which are used as a tool to manage the public plan."[1950]

2760. Binnie and LeBel JJ. stated that "(l)ike our colleagues McLachlin C.J. and Major J., we accept the trial judge's conclusion that in some circumstances some Quebeckers may have their life or 'security of the person' put at risk by the prohibition against private health insurance".[1951]

2761. Notably, the apparent skepticism expressed by the dissenting judges regarding the extent of this harm has been completely resolved by the evidence in this case, which demonstrates the direct and severe impact on patients who are deprived access to private treatment options, and the fact that these impacts are faced by thousands of patients across all surgical areas.[1952]

2762. As in *Morgentaler* and *Chaoulli*, the legislative regime at issue in this case leaves most individuals facing a lack of timely medical care with no meaningful options to obtain treatment, unless they are wealthy enough to travel outside the country to seek treatment.[1953] Thus, because patients in B.C. "may be denied timely health care for a condition that is clinically significant to their current and future health", security of the person is engaged.[1954]

2763. Consistent with *Morgentaler* and *Chaoulli*, the Supreme Court has since found that other restrictions preventing individuals from accessing "lifesaving and health-protecting services" infringe upon security of the person.[1955]

[1949] ***Chaoulli***, *supra* at paras 122-123.
[1950] ***Chaoull***, *supra* at paras 43-45.
[1951] ***Chaoulli***, *supra* at para 191.
[1952] See **Section X(B),** 'How the Asserted Justifications Were Dealt with in *Chaoulli*', above.
[1953] ***Chaoulli***, *supra* at para 121, McLachlin CJ & Major J.
[1954] ***Chaoulli***, *supra* at para 123 [emphasis added]
[1955] ***Canada (Attorney General) v. PHS Community Services Society***, 2011 SCC 44 [***PHS Community Services***] at paras 91-92.

2764. For instance, the Court in *PHS Community Services* cited *Morgentaler* and *Chaoulli* for the proposition that "(w)here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out".[1956]

2765. Similarly, in *Bedford,* the Court held that laws preventing individuals "from taking steps to reduce the risks" of physical harm they face violated their security of the person.[1957]

2766. And in *Carter*, the Court found that security of the person was breached because the laws in question imposed "pain and psychological stress and depriving her of control over her bodily integrity", caused the individual to "suffer physical or psychological pain and imposed stress" and "to endure intolerable suffering".[1958]

2767. Finally, an interference with the *psychological* integrity of the person can be so severe as to constitute a violation of security of the person under section 7. In *G.(J.)*, for instance, the Court found that while ordinary stresses and anxieties will not constitute an infringement, a "serious and profound effect on a person's psychological integrity" will.[1959]

2768. As described before, even beyond the significant harm imposed on individual's bodily integrity and physical health by the prohibitions on accessing timely care, the impugned provisions also impose a significant degree of psychological harm upon those unable to access timely and medically necessary treatment.

2769. Therefore, as all of the judges found in *Chaoulli*, the restrictions on access to private care in this case clearly constitute an infringement upon security of the person.

(iii) The Right to Life is Infringed

2770. While a majority of section 7 cases involve a breach of the right to liberty or the right to security of the person, this is among the rare cases where state action will also engage the right to life, the most basic and fundamental right in the *Charter.*

2771. The fundamental importance of the right to life is obvious, as noted by the South African Constitutional Court:

[1956] ***PHS Community Services***, *supra* at para 93.
[1957] ***Bedford,*** *supra* at para 66.
[1958] ***Carter,*** *supra* at paras 65-66.
[1959] ***New Brunswick (Minister of Health and Community Services) v. G. (J.)***, [1999] 3 SCR 46 [***G.J.***] at 77.

> The right to life is, in one sense, antecedent to all the other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them.[1960]

2772. As such, this right is understood broadly. The unanimous Court in *Carter* explained that the right to life will be engaged where laws or state action "impose death or an increased risk of death on a person, either directly or indirectly".[1961]

2773. On the evidence reviewed above, it is clear that the restrictions on access to private treatment can, in at least some cases, impose an increased risk of death on a person, where they are prevented from obtaining surgeries or other necessary treatment.

2774. For instance, as reviewed in detail above, patients who have cancer and wait too long for diagnostic treatments, such as Ms. Martens, are clearly at a greater risk of a premature death.

2775. Again, the Court in *Chaoulli* unanimously recognized the potential for a violation of right to life caused by the restrictions on accessing private care.[1962] Put simply, "(w)here lack of timely health care can result in death, s. 7 protection of life itself is engaged".[1963]

2776. Therefore, there can be no doubt on the evidence in this case that precluding access to private health care serves to not only jeopardize individual liberty and security of person, but also can pose an increased risk to an individual's right to life.

2777. Laws which may deprive a person of their life, or that increase the risk to a person's continued survival, must be subject to the most rigorous possible scrutiny by the courts.

(iv) The Impugned Provisions Cause the Breach of Section 7

2778. As can be seen, the evidence in this case fits perfectly within the most recent and leading section 7 cases available. It follows the exact same pattern as *PHS Community Services*, *Bedford*, and *Carter*, in that all of these cases involved state action that prevented individuals from avoiding physical and psychological harm.

[1960] ***S. v. Makwanyane and Another*** [1995] ZACC 3 at para 325, O'Regan J, cited in ***Carter v. Canada (Attorney General)***, 2013 BCCA 435 at para 87, Finch CJ, dissenting.
[1961] ***Carter,*** *supra* at para 64 (emphasis added).
[1962] ***Chaoull,*** *supra* at para 40, Deschamps J; at para 123, McLachlin CJ & Major J; paras 191, 200, Binnie & LeBel JJ.
[1963] ***Chaoulli,*** *supra* at para 123 (emphasis added). And see ***Carter,*** *supra* at para 62.

2779. However, the Defendant has claimed that there is no section 7 violation in this case, because it says that the harm people suffer are not caused by the impugned laws.

2780. In particular, the Defendant tries to blame the physicians, or the health authorities, or the patients themselves, for the systemic failures of the public system to provide timely care to those who need it, and therefore the harms suffered by patients prohibited from obtaining access outside of that system.

2781. Leaving aside that the physicians and health authorities are integral to the public health care system administered and provided by the Government, and that there is no compelling evidence that the endemic problem of long wait lists could be avoided by the physicians or health authorities,[1964] this submission reflects a fundamental misunderstanding of the applicable constitutional analysis in this case.

2782. That is because the breach of section 7 does not require the Government to be the immediate cause of the harm to section 7 interests. Section 7 will be violated if the Government enacts laws that prevent people from avoiding that harm, whatever its immediate cause or source.

2783. As noted repeatedly above, this is not a challenge to the Government's unwillingness or inability to provide timely access to treatment in the public system. That failure is well established on the evidence, but it is not the immediate focus of the legal analysis.

2784. The focus of the inquiry is on the impact of the impugned provisions on the section 7 interests of British Columbians, in light of the harm caused by the failure of the Government to provide timely services in the public system.

2785. The relevant constitutional harms are imposed by the laws prohibiting access to private treatment options, which options would allow them to avoid the harms caused by their medical conditions and the failure of the public system to treat those conditions in a timely way.

2786. The harms that flow from long wait times in the public system demonstrate the gravity of the harm actually caused by preventing people from obtaining treatment outside that system, which is what the impugned provisions do.

[1964] See generally **Section VII(B),** "Response to Allegation that Wait Times are Caused by Physicians", above.

2787. The same fundamental structure was also at play in a number of leading section 7 cases, including *Morgentaler, Adams, PHS Community Services, Bedford* and *Carter.*

2788. The question in all of these cases, as in this case, is whether the impugned laws prevent individuals from avoiding a harm, or a risk of harm, that they are subjected to, whatever the immediate source of that harm may be.

2789. In *Morgentaler*, the applicants challenged section 251 of the *Criminal Code,* which required a women seeking a therapeutic abortion to obtain a certificate from an accredited hospital committee before she was lawfully able to terminate a pregnancy. This created "a clear risk of damage to the physical well-being of a woman", and interfered with the "psychological integrity of women seeking abortions".[1965]

2790. The Government neither directly caused the pregnancy, nor was the question whether the delays in getting hospital committee approval were too lengthy, or could have been expedited under some hypothetical state of affairs.

2791. Rather, the question was whether, in light of the fact that women did become pregnant and the fact that delays were caused by a requirement for a certificate, the prohibition on accessing treatment without a certificate violated section 7. The Court found that it did.

2792. The same approach was followed by the BC Court of Appeal in *Adams*, which was a challenge to a municipal ordinance that prevented homeless persons from erecting temporary overhead structures to protect themselves from the elements.

2793. The government in that case neither caused the individuals in question to be homeless, nor were they responsible for inclement weather. Nevertheless, by preventing affected individuals from avoiding the risks to their physical integrity caused by exposure to the elements, the municipality was responsible for the deprivation of life, liberty and security of the person.[1966]

2794. Similarly, in *PHS Community Services*, the immediate physical and psychological harm in question was caused by the use of prohibited drugs, particularly in dangerous and unsanitary contexts.

2795. The Government did not force people to use drugs that created a risk of overdose and other negative health consequences, nor did it directly require people to use such drugs in unsafe conditions.

[1965] ***Morgentaler***, *supra* at 60, Dickson CJ.
[1966] ***Adams***, *supra* at para 88.

In that sense, the Government was not the immediate source of the bodily or psychological harm suffered by drug users.

2796. What the laws in question did was prevent individuals from avoiding those harms by prohibiting them from accessing a method of harm reduction. The fact that the government did not cause anyone to use drugs in the first place did not justify it in preventing people from addressing the resulting risk of harm.

2797. The same pattern was followed in *Bedford*. The physical and psychological harms at issue were caused directly by third parties entirely unrelated to the government, namely exploitative pimps, dangerous or violent customers, and other sexual predators.

2798. As the Court explained, the laws in question did not impose the harms or risk of harm directly, rather, they prevented people "from taking steps to protect themselves from the risks".[1967]

2799. The applicants in *Bedford* were "not asking the government to put into place measures making prostitution safe", but rather "are asking this Court to strike down legislative provisions that aggravate the risk of disease, violence and death". And as such, it "makes no difference that the conduct of pimps and johns is the immediate source of the harms suffered by prostitutes".[1968]

2800. The very same analysis was followed in *Carter*. The immediate cause of the harm to the security of the person of impacted individuals was their medical conditions, which caused intolerable suffering and a lack of independence. Needless to say, the Government did not cause these medical conditions. What the Government did was prevent people from avoiding the harm caused by those medical conditions, and in particular, from accessing assisted suicide.

2801. Thus, in all of these cases, the laws in question were found to cause a deprivation of section 7 interests, not because the government was responsible for the underlying or immediate source of the harm to those interests, but because it prevented people from avoiding these harms.

2802. The same analysis applies here, as it did in *Chaoulli*, where no member of the Court found, as the Defendant argues in this case, that the government was not responsible for the deprivation of life, liberty or security of the person under section 7.

[1967] ***Bedford***, *supra* at para 60.
[1968] ***Bedford***, *supra* at paras 88-89 (emphasis added).

2803. In both cases, the immediate physical harms are caused by the underlying medical condition, and the inability of individuals to alleviate those harms without access to private medical treatment, in light of the long wait times in the public system. That is the factual background against which the impugned provisions operate.

2804. The fact that there might be a hypothetical state of affairs where public sector waiting lists did not subject patients to harm or a risk of harm is irrelevant to the fact that, as they actually operate on the evidence tendered, those long wait lists exist, have existed for decades, and significant harms have been caused as a result.

2805. The impugned provisions breach section 7 because they prevent people from alleviating those harms, and avoiding a greater risk of irreversible physical damage or even death.

2806. In this sense, the harms caused by the failure of the public system to provide care in this case are like harms caused by dangerous pregnancies in *Morgentaler*, homelessness and exposure to the elements in *Adams,* addiction and risky drug use in *PHS Community Services,* third party sexual predators in *Bedford*; and the underlying medical conditions in *Carter.*

2807. And the question in this case, as in those cases, is whether the Government's laws prevent people from alleviating or avoiding those harms. In this case, they clearly do.

2808. As such, the Defendant's argument that the Government is not responsible for any of the harms suffered by patients because long wait lists in the public system are someone else's fault, and therefore there is no breach of section 7, is fundamentally misguided.

2809. It is not only inconsistent with the evidence in this case, but is fundamentally inconsistent with the analytical approach adopted in all of the leading section 7 cases.

(v) Summary - Infringement of Life, Liberty, and Security of the Person

2810. As all of the judges found in *Chaoulli*, this is among the unique cases in which a law infringes all of the section 7 interests: life, liberty and security of the person.

2811. Overall, an individual's choice about medical care "is rooted in their control over their bodily integrity", and their decisions with respect to treatment will often represent a "deeply personal

response to serious pain and suffering".[1969] In *PHS Community Services*, the Court helpfully summarized the state of the law with respect to such treatment as follows:

> "(w)here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out... Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer".[1970]

2812. This formulation precisely captures the deprivation of section 7 interests in the case at bar. The prohibitions in the *MPA* prevent individuals from making inherently personal life decisions about their health and bodily integrity, and condemns them to physical and psychological pain and suffering, and the risk of permanent disability or even premature death, that they would not need to suffer in the absence of the impugned laws.

2813. As such, the first stage of the section 7 analysis is overwhelmingly met in this case.

C. The Deprivation of the Right to Life, Liberty and Security of the Person is not in Accordance with the Principles of Fundamental Justice

(i) Overview of the Principles of Fundamental Justice

2814. Laws that jeopardize a person's life, liberty or security of person must be tailored in such a way that they do not interfere with basic values that the Courts must uphold under the *Charter*. As explained by the Court in *Bedford*:

> The *Motor Vehicle Reference* recognized that the principles of fundamental justice are about the basic values underpinning our constitutional order. The s. 7 analysis is concerned with capturing inherently bad laws: that is, laws that take away life, liberty, or security of the person in a way that runs afoul of our basic values. The principles of fundamental justice are an attempt to capture those values. Over the years, the jurisprudence has given shape to the content of these basic values. (...)
> The overarching lesson that emerges from the case law is that laws run afoul of our basic values when the means by which the state seeks to attain its objective is fundamentally flawed, in the sense of being arbitrary, overbroad, or having effects that are grossly disproportionate to the legislative goal. To deprive citizens of life, liberty, or security of the person by laws that violate these norms is not in accordance with the principles of fundamental justice.[1971]

2815. In *Bedford*, the Court explained that these principles of fundamental justice are directed against "two different evils". The first "is addressed by the norms against arbitrariness and overbreadth, which target the absence of connection between the law's purpose and the s. 7 deprivation". The second

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[1969] ***Carter,*** *supra* at para 68.
[1970] ***PHS Community Services,*** at para 93 (emphasis added).
[1971] ***Bedford,*** *supra* at paras 96, 105 (emphasis added).

evil is addressed by gross disproportionality, where a "law's impact on the s. 7 interest is connected to the purpose, but the impact is so severe that it violates our fundamental norms."[1972]

2816. If a law violates the rights to life, liberty or security of person in a way that is arbitrary, overbroad, or grossly disproportionate, it undermines these basic pillars of our legal and constitutional order.

2817. This is because the law causes harm to persons in a manner that does not advance or is unnecessary to achieve the objectives of the legislation in question, or because the harms caused to section 7 interests are out of proportion to the purported purpose of the law.

2818. The Court described the arbitrariness principle in *Bedford*, making specific reference to *Morgentaler* and *Chaoulli* as examples:

> Arbitrariness was used to describe the situation where there is no connection between the effect and the object of the law. In *Morgentaler*, the accused challenged provisions of the *Criminal Code* that required abortions to be approved by a therapeutic abortion committee of an accredited or approved hospital. The purpose of the law was to protect women's health. The majority found that the requirement that all therapeutic abortions take place in accredited hospitals did not contribute to the objective of protecting women's health and, in fact, caused delays that were detrimental to women's health. Thus, the law violated basic values because the effect of the law actually contravened the objective of the law. (...)
>
> In *Chaoulli*, the applicant challenged a Quebec law that prohibited private health insurance for services that were available in the public sector. The purpose of the provision was to protect the public health care system and prevent the diversion of resources from the public system. The majority found, on the basis of international evidence, that private health insurance and a public health system could co-exist. Three of the four-judge majority found that the prohibition was "arbitrary" because there was no real connection on the facts between the effect and the objective of the law.
>
> Most recently, in *PHS*, this Court found that the Minister's decision not to extend a safe injection site's exemption from drug possession laws was arbitrary. The purpose of drug possession laws was the protection of health and public safety, and the services provided by the safe injection site actually contributed to these objectives. Thus, the effect of not extending the exemption — that is, prohibiting the safe injection site from operating — was contrary to the objectives of the drug possession laws.[1973]

[1972] ***Bedford***, *supra* at paras 108-109.
[1973] ***Bedford***, *supra* at paras 98-100 (emphasis added).

2819. It is not a coincidence that each of the paradigmatic examples of arbitrariness given by the Court – *Morgentaler*, *Chaoulli* and *PHS Community Services* – involved cases addressing government imposed restrictions on access to necessary health care and medical treatment.

2820. As noted above, those rights are so fundamental that the laws must be very closely tailored to their objectives in order to withstand constitutional scrutiny. Such laws will not be constitutionally sound if they cause harm to constitutional interests in a manner that, on the facts, is insufficiently connected or unnecessary to achieve the government's objective.

2821. Therefore, as the Court explained in *Bedford*, with specific approval of *Chaoulli,* a prohibition will be arbitrary where there is no real or direct "connection on the facts between the effect and the objective, and the effect is therefore "unnecessary".[1974]

2822. As this suggests, the analysis cannot be undertaken in the abstract, by looking at whether there is a hypothetical or theoretical connection between the means chosen and the purposes sought to be achieved; it must focus on the actual or expected impacts of the law in question.[1975]

2823. As the majority held in *Chaoulli*, "(t)he task of the courts, on s. 7 issues as on others, is to evaluate the issue in the light, not just of common sense or theory, but of the evidence."[1976] This is especially important in this case, given the severe impacts of the law in question.

2824. In addition, a law will be found to be arbitrary where the effects on at least some persons are in fact inconsistent with, contradict, or undermine, the purpose of the law.[1977]

2825. For instance, in *Smith*, the Court found that the law prohibiting patients from using liquid, topical or ingestible marijuana, instead of dried marijuana, was arbitrary because the impact on at least some patients undermined the purpose of the law, the protection of health and wellbeing. The prohibitions contradicted their objective, rendering them arbitrary.[1978]

[1974] ***Bedford***, *supra* at para 119.
[1975] As Professor Stewart has explained, "applying the norm against arbitrariness requires not only a determination of the purposes of the law but an empirical assessment of the effectiveness of the law or decision in serving those purposes." Stewart, *Fundamental Justice, supra* at 177.
[1976] ***Chaoulli***, *supra* at para 150, per McLachlin CJ & Major J.
[1977] See e.g. ***Bedford***, *supra* at para 119; ***PHS Community Services***, *supra* at paras 131, 136.
[1978] ***Smith***, *supra* at para 25.

2826. Therefore, a law will be arbitrary where there is an insufficient connection on the facts between the law and its underlying objectives, rendering the law unnecessary, or where its impacts on at least some persons undermine the purpose of the law.

2827. The principle of overbreadth is similar to arbitrariness, in that it prevents governments from imposing harm to a person's life, liberty or security of the person that can be avoided by a law that is more directly tailored to the government's purpose.

2828. While arbitrariness involves laws that are generally not connected to their objectives, that undermine their objectives, or are not necessary to achieve those objectives, overbreadth involves laws which achieve their objectives in some respects but also capture conduct that does not advance or are unnecessary to achieve those objectives.

2829. Professor Hamish Stewart summarized the law on overbreadth as follows:

> A law is overbroad if it restricts the section 7 interests more than necessary for the achievement of its purpose, indeed if it restricts the section 7 interests of even a single person to whom, in light of its own purpose, it should not apply.[1979]

2830. Put another way, if the law prohibits conduct that does not relate to the achievement of its objective, it will be overbroad, because it unnecessarily sweeps in conduct that does not advance the objective in question. In order to comply with the principle of overbreadth, "the law must not go further than reasonably necessary to achieve its legislative goals".[1980]

2831. In this way, both the principle of arbitrariness and the principle of overbreadth will be violated by laws that cause more harm than is necessary to achieve the objectives of the laws, in that they capture conduct that does not meaningfully advance the legislative purpose.

2832. Finally, a law will violate section 7 where the harm caused is grossly disproportionate to the law's objectives.

2833. Thus, unlike arbitrariness and overbreadth, which focus the connection between the means chosen and the law's objectives, gross disproportionality requires the Court to ensure that the harm caused is roughly proportionate to the benefit to be achieved.

[1979] Stewart, *Fundamental Justice, supra* at 155; ***Carter,*** *supra* at para 85.
[1980] ***R. v. Safarzadeh-Markhali,*** 2016 SCC 14 [***Safarzadeh-Markhali***] at para 50. See also ***R. v. Demers,*** 2004 SCC 46 [***Demers***] at para 43.

2834. However, the essence of all of these principles of fundamental justice is to ensure that laws which deprive someone of fundamental interests protected by section 7 do not impose unnecessary, avoidable, or unwarranted harms.

2835. A number of additional observations are important to emphasize, given recent clarifications to the case law under section 7 that have occurred after the Court decided *Chaoulli*.

2836. First, as noted above, the Supreme Court has recently confirmed that if the impact of the law is arbitrary, overbroad, or grossly disproportionate to the legislative objective, with respect to even a single person, it will violate section 7.[1981]

2837. Therefore, the fact that a law may be reasonably well tailored to an objective, or that only a few people have their rights unnecessarily infringed, does not mean that the law is not arbitrary, overbroad, or grossly disproportionate.

2838. This reflects the critical importance of these fundamental interests to an individual's physical and psychological integrity, autonomy, dignity, and overall well-being, and the unremitting protection such interests are rightly afforded by the courts.

2839. This is consistent with the principle, noted above, that section 7 ensures that individuals "must be able to be, and to see themselves as, more than mere means or resources for the state to use in its pursuit of public objectives".[1982]

2840. For the same reason, the *Charter* does not state or imply that the government can deprive a person of his or her life, liberty, or security of person so long as it deprives everyone of those interests equally. The fact that the deprivation of these important interests is relatively widespread – as in this case – makes the constitutional harm more egregious, rather than less.

2841. Second, any allegedly ancillary benefits to society flowing from the *MPA* that are not connected to the purpose underlying the impugned provisions are not relevant in determining whether a law violates the principles of fundamental justice.

[1981] ***Bedford***, *supra* para 123 (emphasis added)
[1982] Stewart, *Fundamental Justice, supra* at 373.

2842. The Court made this point clear in both *Bedford* and *Carter*, where the Court emphasized that any competing moral claims or broad societal benefits are considered at the stage of justification under section 1.[1983]

2843. Finally, in assessing the constitutionality of a law under section 7, the Court is not limited to evidence with respect to the specific claimants before the Court.

2844. This was confirmed in *Appulonappa*, where there was no individual before the Court who claimed his situation matched the circumstances that rendered the law overbroad – namely, someone who assisted someone entering the country unlawfully in the course of providing humanitarian or family assistance.

2845. Nevertheless, the Supreme Court in *Appulonappa* held that it could consider "reasonable hypotheticals" in determining whether the law breached section 7:

> The appellants argue that s. 117 is overbroad, not as it applies to the conduct alleged against them, but as it applies to other reasonably foreseeable situations. It is indeed established that a court may consider "reasonable hypotheticals" to determine whether a law is consistent with the Charter: see *R. v. Nur*, 2015 SCC 15, [2015] 1 S.C.R. 773.[1984]

2846. As the Court noted in *Appulonappa,* this is consistent with the principle applied in other *Charter* context: that as long as a party has standing before the Court, the party is entitled to rely on harms to others in establishing that a law is unconstitutional. [1985]

2847. We now apply these principles to the case at hand, beginning with the purpose underlying the impugned provisions.

(i) Legislative Purpose of the Impugned Provisions

a) The Proper Analysis

2848. Properly defining the objective of the impugned provisions is important, both to the section 7 analysis, as well as to the analysis under section 1.

2849. As the Supreme Court has cautioned, the Court need not accept the government's purported objectives, either as stated in legislation (e.g. a purpose clause),[1986] or on the basis of statements upon

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[1983] ***Carter***, *supra* at paras 79-81; ***Bedford***, *supra* at paras 124-129.
[1984] See ***R. v. Appulonappa***, 2015 SCC 59 [***Appulonappa***] at para 28. See also Stewart, *Fundamental Justice, supra* at 163.
[1985] ***R. v. Ferguson***, 2008 SCC 6 at para 59; ***R. v. Nur***, 2015 SCC 15 at para 5.
[1986] ***Chatterjee v. Ontario (AG)***, 2009 SCC 19 [***Chatterjee***"] at para 19.

introducing the legislation.[1987] Rather, it must determine the purpose or purposes that the law, "by its words and how it operates", is actually designed to achieve.[1988]

2850. In identifying the relevant purpose, the Court should be focussed primarily on the impugned provisions themselves. The question is not what is the purpose of the statute, as a whole, but rather what is the purpose of the specific provisions in question.

2851. These basic principles were outlined by the Supreme Court in *Safarzadeh-Markhali*, as follows:

> [26] First, the law's purpose is distinct from the means used to achieve that purpose: *Moriarity*, at para. 27. A law's means may be helpful in determining its objective, but the two must be treated separately.
>
> [27] Second, the law's purpose should be characterized at the appropriate level of generality, which "resides between the statement of an 'animating social value' — which is too general — and a narrow articulation" that amounts to a virtual repetition of the challenged provision, divorced from its context: *Moriarity*, at para. 28.
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> [28] Third, the statement of purpose should be both precise and succinct: *Moriarity*, at para. 29. Precision requires that courts focus on the purpose of the particular statutory provision subject to constitutional challenge: *ibid.*; see also *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 144.
>
> [29] Fourth, the analysis is not concerned with the appropriateness of the legislative purpose. The court must take the legislative objective "at face value" and assume that it is appropriate and lawful: *Moriarity*, at para. 30. The appropriateness of a legislative objective may be relevant to its constitutionality under other *Charter* provisions. But it has no place in the s. 7analysis of overbreadth.[1989]

2852. As can be seen, the legislative purpose can neither be too broad so as to amount to an animating social value, nor can it be too narrow so as to amount to a description of the means by which the legislative purpose is sought to be achieved.

2853. If the purpose of the law is defined too broadly as the animating social value, it would effectively "immunize" the challenged provision from meaningful scrutiny, and the section 7 analysis becomes "foreordained". Such a broad purpose would make it difficult to determine whether "the means used to further it are overbroad or grossly disproportionate".[1990]

[1987] See e.g. ***Safarzadeh-Markhali***, *supra* at paras 40-44, where the Court rejected the statements of the Minister contained in Hansard with respect to purposes of the impugned provision.
[1988] ***Safarzadeh-Markhali***, *supra* at para 44.
[1989] ***Safarzadeh Markhali***, *supra* at paras 26-29 (emphasis added).
[1990] ***Carter***, *supra* at para 77.

2854. At the other end of the spectrum, if the purpose of the clause is defined as the means used to accomplish it, this would also serve to undermine the Court's analysis at the section 7 stage. The court would be scrutinizing the degree of connection between two identical subjects, which makes nonsense out of the arbitrariness and overbreadth analyses.

2855. In ascertaining the purpose of the law between these two poles, the courts will look to both the 'intrinsic' evidence, including the purpose clause, and the text, context, and scheme of the legislation; as well as the 'extrinsic' evidence, such as evidence relating to the background or concerns animating the passing of the law in question, as well as how the law actually operates in practice.

2856. For instance, in a recent decision involving changes to credit for pre-sentence custody, *Safarzadeh-Markhali*, the government argued that the sentencing law had a broad range of objectives, including to enhance public confidence in the integrity of the justice system, to enhance public safety, to ensure adequate punishment, and to promote rehabilitation.

2857. The Court rejected that submission, finding that a close review of the actual legislation – "by its words and how it operates" – showed that the real purpose or objective was more narrow: to "enhance public safety and security by increasing violent and chronic offenders' access to rehabilitation programs".[1991]

2858. *Carter* provides another useful example of how the courts will identify the purposes of challenged legislation. In *Carter*, the federal government argued that the purpose of the prohibition on assisted dying was the "preservation of life".

2859. The Court rejected this vague, abstract, and symbolic purpose, noting that describing the purpose of the law in those terms was so broad that it "has the potential to short-circuit the analysis" at section 7.[1992]

2860. The Court in *Carter* emphasized that the object of the impugned provision must "be defined precisely" for the purposes of section 7, and therefore will require the court to look at exactly what the provision is designed to achieve.[1993]

[1991] ***Safarzadeh-Markhali,*** *supra* at paras 44, 47.
[1992] ***Carter,*** *supra* at para 77.
[1993] ***Carter,*** *supra* at para 78.

2861. The Court found that the prohibition on assisted suicide was "not directed at preserving life" generally. Rather, the "direct target of the measure is the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness".[1994]

2862. In other words, the Government cannot design a law to achieve a relatively narrow or specific objective, and then try to justify that on the basis of a broader purpose that it has not in fact tried to achieve through the provisions being challenged.

2863. Nor can the Government pass a law for a given purpose, and then seek to rely on a broad aspirational or animating value (as in *Carter*), or a laundry list of potential justifications for the law (as in *Safarzadeh-Markhali*), both of which will undermine the necessary section 7 analysis. The focus must remain on the precise objective of the impugned provisions themselves.

b) The Purpose of the Impugned Provisions

2864. In this case, the purpose of the impugned provisions is to protect the accessibility and viability of the public system, by ensuring that patients can receive treatment in the public system without financial barriers, and that sufficient physicians are available to provide treatment in the public system.

2865. Defining the purpose of the impugned provisions more broadly, such as the creation of a just and equal health care system, or the desire to achieve "a health system where access is governed by need rather than wealth or status",[1995] is contrary to the analysis outlined by the courts.

2866. At best, these kinds of statements would amount to an "animating social value", like defining the objective of the prohibition on assisted suicide as "the preservation of life" in *Carter*. This type of vague and symbolic purpose was properly rejected in *Carter,* because it was inconsistent with the actual scope of the law, and because adopting such a broad and general purpose would short circuit the section 7 analysis.

2867. Conversely, describing the purpose of the law as "limiting access to private health care" would be too narrow, because it amounts to "a virtual repetition of the challenged provision[s]".[1996]

[1994] ***Carter,*** *supra* at paras 76-78 (emphasis added).

[1995] This appeared to be one of the purposes ascribed to the prohibition on private insurance by the dissenting judges in ***Chaoulli***, *supra* at para 239.

[1996] ***Safarzadeh-Markhali,*** *supra* at para 27.

2868. Describing the purpose of the impugned measures as "limiting access to private care" would be the equivalent of describing the objective of the assisted dying provision in *Carter* as "prohibiting assisted dying". While that is the direct and intended legal effect of the provisions in question, it is not their legislative purpose under section 7.

2869. Given the similarities of the provisions challenged in *Chaoulli*, this Court should be guided by the legislative purpose in that case. As the majority decisions in that case correctly understood, the purpose of the impugned provisions is "to preserve the integrity of the public health care system", "preserving the public plan", or "preserving the public health system".[1997]

2870. This is consistent with the legislative history described above, including the underlying purposes of both the *CHA* and the *MPA*, in which the objective of measures designed to prohibit access to private treatment were based on concerns that allowing private treatment would undermine the operation of and access to the public health care insurance system.[1998]

2871. It is also consistent with the purpose provision in the *MPA,* which states as follows:

> **2.** The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay. [emphasis added]

2872. As this, and the title of the legislation, suggests, the purpose of the *MPA* generally is to preserve and protect a universal and accessible, publicly-funded health care system, "in which" public system necessary medical care is based on need and not ability to pay.

2873. Therefore, the Plaintiffs say that the clear purpose of the impugned provisions are to protect the viability of and access to the public health care system, which public system is to be available to all based on need and not ability to pay.

2874. The Defendant contends that the purpose of the impugned provisions are not only to protect the viability and accessibility of the public health care system, but also to ensure that everyone in the province has identical access to health care treatment.

2875. That is, the Defendant effectively seeks to ignore the opening phrase of section 2 of the *MPA* – "to preserve a publicly managed and fiscally sustainable health care system" – and rely only on the

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[1997] ***Chaoulli,*** *supra* at para 56, Deschamps J.; para 152, McLachlin C.J. & Major J.
[1998] See generally **Section III,** "Background, History, and Purpose of the Legislation", above.

second half – "in which access to necessary medical care is based on need and not an individual's ability to pay".

2876. This argument must be rejected, because it is inconsistent with both the clear purposes underlying the prohibitions on access to private care, and importantly, with the way the BC medicare system operates in practice.

2877. Contrary to the Defendant's argument, there is no indication – either in the law itself, or how it is applied – to suggest that the objective of the impugned provisions is to ensure that every resident in the province receives identical access to health care.

2878. The purpose clause and legislative history suggests that the purpose is preserving a publicly-funded health care system that is accessible to users without financial or other impediments, but not to the exclusion of all other health care options.

2879. It also suggests that private care options have been effectively prohibited to ensure the viability of the public health care system, on the inaccurate assumption that permitting private treatment would deprive the public system of physicians or otherwise cause harm to the ability to provide universal and reasonable treatment through the public system.

2880. The true purpose of the impugned provisions is also clear from how the law operates in practice, which as noted above, is a key guide to its actual purpose. In particular, neither the impugned provisions nor the *MPA* generally seeks to ensure that everyone in the province has the same access to medically necessary health care treatment.[1999]

2881. First, it permits the truly wealthy British Columbians to obtain more timely private care in other jurisdictions. This is directly inconsistent with a law that was intended to ensure identical access to the entire population of British Columbia to health care treatment.

2882. By contrast, it is consistent with a law that seeks to limit access to private care options in BC, on the Government's (inaccurate) assumption that permitting private care options within the province will pose a threat to the viability of or resources available to the public system.

[1999] See generally **Section X(D)(vi),** "The Equity Justification", above.

2883. Second, the law permits exemptions from the prohibitions in the *MPA*, which allow patients who are injured at work or in car accidents to obtain more timely treatment, as well as those British Columbians who are covered under a federal health care plan.

2884. These types of exemptions are directly inconsistent with a law that seeks to ensure everyone has identical access to medically necessary treatment, but are again consistent with the goal of ensuring access to and the viability of a public health care system for BC residents.

2885. Third, the scheme of the *MPA* does not cover a wide range of medically necessary services, all of which are covered by private health care plans.[2000] Under the *MPA,* the Government could decide at any moment to eliminate any type of treatment or any type of condition from the public health care system, in which case it would fall outside the scope of the *MPA* entirely. That is inconsistent with a law intended to ensure that everyone in the province receives the same health care treatment in respect of medically necessary services.

2886. Finally, the law does not seek to ensure that everyone has equal access to care. Individuals have differential access to treatment not only based on their region, but even within their region, in which some individuals are able to access timely care, while others are not.

2887. In short, the *MPA* currently permits differential access to health care treatment based on wealth, based on the source of an injury, based on location, based on condition, and based on happenstance. All of this is inconsistent with a law that seeks to ensure everyone is provided with identical access to medically necessary treatment.

2888. Therefore, the objective of the impugned provisions in this case – for the purposes of the section 7 and section 1 *Charter* analysis – must be to protect the viability and accessibility of the public health care system, in which system access is based on need and not ability to pay.

(ii) The Impugned Provisions Are Arbitrary

2889. As discussed above, the legislation in this case does not advance, and in fact undermines, the objective of preserving the accessibility and viability of the public health care system.

2890. As the majority of the Court in *Chaoulli* found, while there may be a hypothetical or theoretical connection between the means chosen by the act – effectively prohibiting access to private care – and

[2000] See generally **Section IV,** "Scope of the Public Health Care System", above.

the purpose – maintaining an accessible and viable the public system – that alleged connection disappears upon a consideration of the evidence.

2891. In other words, "there is no real connection in fact between prohibition of health insurance and the goal of a quality public health system". That is because maintaining a public sector monopoly "is not necessary or even related to the provision of quality public health care".[2001]

2892. Indeed, even the Government's own experts confirm this. For instance, Professor Marmor opined that the argument that private care options are incompatible with a viable and universal public system is based on a theory no credible expert would support.[2002]

2893. The Defendant has previously argued that the articulation of the arbitrariness standard in *Chaoulli* should be disregarded, in light of the "no connection" language used in *Bedford.* This is impossible to maintain, given that the *Chaoulli* decision was specifically cited in *Bedford* as an example of a law that was arbitrary, within the meaning of section 7.[2003] As the Court explained:

> The evidence may, as in *Morgentaler*, show that the effect actually undermines the objective and is therefore "inconsistent" with the objective. Or the evidence may, as in *Chaoulli*, show that there is simply no connection on the facts between the effect and the objective, and the effect is therefore "unnecessary". Regardless of how the judge describes this lack of connection, the ultimate question remains whether the evidence establishes that the law violates basic norms because there is *no connection* between its effect and its purpose. This is a matter to be determined on a case-by-case basis, in light of the evidence.[2004]

2894. This is consistent with Professor Stewart's observation that there have been many different ways in which the Court has described the essence of the arbitrariness analysis over the years, all of which point in the same general direction:

> The test for arbitrariness has been stated in several ways. It has been said that a law is arbitrary if it is not necessary to achieve the objective of the legislation in question, if "it bears no relation to, or is inconsistent with, the objective that lies behind the legislation," if there is no "real connection on the facts to the purpose the interference is said to serve", if it is "not rationally connected to a reasonable apprehension of harm", if it "imposes limits on [the section 7] interests in a way that bears *no connection* to its objective,", if it is "not capable of fulfilling its objectives,", or (more colloquially) if there is a "total disconnect between the limit on liberty an security of the person imposed by the prohibition and its object".[2005]

[2001] ***Chaoulli,*** *supra* at paras 139-140.
[2002] See Section X(C), "Permitting Private Care is Compatible with a High Quality Public Care System", above.
[2003] ***Bedford,*** *supra* at para 99.
[2004] ***Bedford,*** *supra* at para 119.
[2005] Stewart, *Fundamental Justice, supra* at 168. See also ***Rodriguez v. British Columbia (Attorney General)***, [1993] 3

2895. Thus, as the Court confirmed in *Bedford*, what matters is not the particular verbal formulation adopted in the abstract, or how a judge describes the lack of connection. Rather, the proper approach to apply in determining whether there is a sufficiently close connection between the impugned law and the achievement of the legislative objective is to be determined on the basis of the facts and evidence in each case.[2006]

2896. In this case, the evidence is even clearer than it was in *Chaoulli* that the law has 'no connection on the facts' to the purpose of the provisions, because BC has had 20 years of experience with enrolled physicians without in any way impacting the viability of or accessibility to the public health care system.

2897. Similarly, the fact that the elimination of the restrictions on private care in Quebec following the *Chaoulli* decision did not result in any harms to the public system the Defendant alleges would occur in this case further demonstrates the absence of any connection between the impugned provisions and protecting the viability of a public health care system.

2898. It is also proven by international jurisdictions that have been able to maintain high quality and equitable – indeed, higher quality and more equitable – universal health care systems without prohibiting private treatment options.[2007]

2899. All of this shows that there is 'no connection' in fact between a prohibition on private insurance and dual practice and the objective of maintaining a viable, universal public health care system. This makes the impugned provisions arbitrary.

2900. Moreover, although it is not necessary for the Plaintiffs to show that removing the impugned provisions will reduce wait times in the public system, the provisions in question are also arbitrary because they undermine and are inconsistent with the underlying objective of ensuring reasonable and accessible care within the public health care system.[2008]

2901. That is because maintaining a viable and accessible public system that provides care to patients in need is actually advanced to the extent that some patients are able to obtain treatment outside of that system, if they choose to do so.

S.C.R. 519 at 595, per Sopinka J. (laws will be 'arbitrary' where they do "little or nothing to enhance the state's interest" sought to be achieved).

[2006] See also Stewart, *Fundamental Justice*, *supra* at 180-182.

[2007] See generally **Section IX**, "Lessons from Other Jurisdictions", above.

[2008] ***Bedford***, *supra* at para 119; ***PHS Community Services***, *supra* at para 136.

2902. While this may not reduce wait times in the public sector due to built-up (and unmet) need for treatment, it unquestionably reduces the overall pressure on the public system, as at least some medically necessary surgeries are performed outside of that system.

2903. Forcing all patients in need of treatment into an already overburdened public system, as the impugned provisions do, undermines the accessibility and viability of that system, and its ability to provide reasonable and timely care to those who need it.

2904. In this way, prohibiting access to private care is not only unconnected, and unnecessary, to achieve the objectives of the impugned provisions, it actually undermines them, by undermining the ability of the public system to provide timely care, which confirms their arbitrariness in light of the provisions' purpose.

2905. Prohibiting patients from receiving the care they need is also fundamentally inconsistent with the overall purpose of the *MPA*, in a number of ways.

2906. First, the overall health of British Columbians is unquestionably improved by having additional diagnostic and surgical services performed within the province, rather than limiting the number of such services to only those that can be performed within the public system.

2907. This ensures that more surgeries and treatments will be provided in the province overall than would be the case if all medically necessary surgeries were performed within the public system, and better allows the public system to treat those in need of treatment in a timely manner.

2908. As noted above, the provisions in question force all patients in need of treatment into a public system that has failed – even in light of the reduced pressure on the public system caused by the availability of private treatments over the past 20 years –to provide reasonable medical care in a timely manner. The actual effect of the provisions is to make it more difficult to meet the medical needs of the population, rather than less difficult.

2909. Second, the impugned provisions only have the effect of prohibiting patients from obtaining services that are necessary to protect their health.

2910. Despite claiming that the prohibitions are necessary to ensure that a sufficient number of physicians are available to provide treatment within the public system, the provisions do not seek to prevent physicians from providing medically unnecessary treatments, or spending their time not

addressing the medical needs of the population (such as medical-legal opinions). In this sense, they are fundamentally arbitrary.

2911. Third, the government has sought to prohibit access to private treatment, based on fears that if private care was a viable option, physicians would opt-out of the public plan entirely, and hence not be available to provide any services in the public system.

2912. However, physicians would not be put to such a choice but for the provisions which prohibit dual practice. The Government cannot create an entirely unnecessary and avoidable problem – the prohibition on dual practice – and then harm the section 7 interests of British Columbians in an attempt to solve the unnecessary and avoidable problem it has created.

2913. Finally, while an abstract, symbolic commitment to 'equal care for all' is not part of the purpose of the impugned provisions, as described above, the prohibitions on access to private treatment are arbitrary as measured against this purpose as well.

2914. That is because the *MPA* currently permits a number of classes of patients – such as those who are wealthy enough to easily pay out of pocket or to travel to another jurisdiction, or whose injury or illness was contracted at work – access to more timely private treatment. It also provides some patients with timely access to medical treatment within the public system, while others are left to wait and suffer beyond maximum acceptable wait times.[2009]

2915. By prohibiting more patients from having this same ability to obtain timely treatment, the impugned provisions contradict the purported purpose of ensuring equal care for all.

2916. Indeed, as the experience of other jurisdictions has shown, the overall equity of access to health care would be improved, rather than harmed, by permitting more patients the same opportunity made readily available to those currently able to get timely access to care, including some through the public system. This renders the provisions arbitrary, even as measured against the Government's purported purpose.

2917. For all of the above reasons, the impugned provisions are arbitrary as measured against their purpose, and therefore must be struck down unless they are justified under section 1.

(iii) The Impugned Provisions Are Overbroad

[2009] See generally **Section X(D)(vi),** "The Equity Justification", above.

2918. The impugned provisions also go far beyond what is necessary to achieve the purpose of the impugned provisions, and are therefore overbroad as well as arbitrary.

2919. As described above, a law will be overbroad where it captures conduct which is not connected or necessary to achieve the purpose of the legislation. The fundamental question is "whether the law affects the section 7 interests more than necessary for its own purposes".[2010] As Professor Stewart has explained, recent cases have demanded "a tight fit between a law and its purpose for compliance with section 7".[2011]

2920. The experience in both British Columbia and other jurisdictions has shown that it is possible to maintain a viable and universal public health care system, with health care available to all regardless of their ability to pay, while at the same time permitting individuals to access private insurance and treatment.

2921. Moreover, the impugned provisions capture conduct entirely unrelated to the preservation of a viable and accessible public health care system. In particular, they prevent physicians from privately providing medically necessary treatment even if those physicians have already fulfilled all of the operating time provided to them in the public system.

2922. This does not in any way protect the viability or accessibility of the public health care system, because using excess surgical time to provide additional surgeries privately does not take physician resources away from the public system.

2923. As the evidence in this case establishes, specialists have been able to provide medically necessary treatments after having provided all of the treatments that the BC Government's allocation of resources would permit them to perform in the public system.

2924. Prohibiting physicians from performing private diagnostic and surgical procedures in addition to fulfilling all of their allotted time in the public system does not in any way advance the purpose of protecting an accessible and viable public healthcare system. It actually undermines that purpose, by preventing physicians from reducing pressure on their public sector waiting list by treating at least some patients privately.

[2010] Stewart, *Fundamental Justice, supra* at 190.
[2011] Stewart, *Fundamental Justice, supra* at 151.

2925. Put another way, forcing doctors to sit idle, and refrain from treating patients in need, is not connected in any sense to protecting the viability and accessibility of the public health care system, and actually undermines that purpose. This renders the law overbroad, as well.

(iv) The Impugned Provisions Are Grossly Disproportionate

2926. Finally, in light of the severity of the impact on those denied effective treatment within a reasonable time – including the potential deprivation of life for those prevented from accessing timely life-saving treatment – the harms inflicted by the impugned laws are grossly disproportionate to the purpose of the impugned provisions as described by either the Plaintiffs or the Defendant.

2927. As noted above, rationing health care in the public system, while prohibiting access elsewhere, can harm an individual's physical and psychological health in profound ways. It forces individuals to languish for months and years waiting for treatment; can cause serious and irreversible physical harms that could be avoided by more timely treatment; and ultimately may jeopardize a person's continued survival.

2928. From the perspective of the impact of the impugned provisions on the individual harmed, the effects of the impugned provisions on someone waiting for treatment under these conditions is nothing short of torturous.

2929. The Plaintiffs do not dispute that the objective of maintaining a viable and universal health care system is an important objective, but this purpose must be understood in the context of the facts and evidence in this case.

2930. Causing enormous and widespread pain and suffering, or depriving someone like Ms. Martens of her ability to take steps to save her life, is grossly disproportionate to the Government's objective of preserving a viable and universal public health care system, when the prohibitions are not necessary to achieve that objective.

2931. This is consistent with the Supreme Court of Canada's case law with respect to gross disproportionality. In particular, the Court in *PHS Community Services* held that the purpose of the laws in question – the general prohibition on possessing illegal drugs – was the "protection of public health

and safety".[2012] That is obviously a very important government objective, stated in the abstract and without reference to the evidence in the case.

2932. However, the Court in *PHS Community Services* did not presume that such a purpose was actually advanced by the law in question. Rather, in applying the gross disproportionality analysis, the unanimous Court then went on to consider how the laws operated in reality:

> [133] The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.

2933. The Court in *Bedford* identified *PHS Community Services* as a paradigmatic illustration of the principle of "gross disproportionality", as follows:

> In *PHS*, this Court found that the Minister's refusal to exempt the safe injection site from drug possession laws was not in accordance with the principles of fundamental justice because the effect of denying health services and increasing the risk of death and disease of injection drug users was grossly disproportionate to the objectives of the drug possession laws, namely public health and safety.[2013]

2934. This suggests that the proper approach, at least where there is a severe deprivation of section 7 interests as in this case (and *PHS Community Services*), is to take into account whether or not there is evidence to support the conclusion that the law actually achieves or is necessary to achieve its objectives in determining whether the harm caused is grossly disproportionate.[2014]

2935. On that analysis, the severe, permanent, and sometimes even lethal impact of the impugned provisions on members of the public is clearly grossly disproportionate to the purpose of the impugned provisions, given that they do not directly contribute to the objective of preserving an accessible and viable public health care system, and certainly are not necessary to do so.

[2012] ***PHS Community Services***, *supra* at paras 52, 110, 129, 131, 136

[2013] ***Bedford***, *supra* at para 104 (emphasis added).

[2014] While some statements in *Bedford* may seem inconsistent with this approach, the Court in *Bedford* did not question the analysis or conclusion in *PHS Community Services* – to the contrary, it relied on *PHS Community Services* as an example of gross disproportionality. See ***Bedford***, *supra* at para 104.

2936. The fact that the laws are grossly disproportionate is even clearer if the Government's proposed objective – ensuring identical access to health care treatment for all – is accepted.

2937. That is, if it is found that the objective of the legislation is to support a vague principle of absolute equality in accessing health care treatment in the province – which, as noted above, is entirely inconsistent with the way that the law is designed and actually operates – the harm caused is clearly grossly disproportionate to this objective.

2938. This type of vague, abstract, and symbolic objective cannot be used to justify the imposition of real, concrete, and widespread physical and psychological harms on the population.

2939. Given that the impugned measures create a risk of severe and prolonged suffering, permanent disability, or even death, and that "a grossly disproportionate effect on one person is sufficient to violate the norm",[2015] this harm is clearly grossly disproportionate to the Defendant's proposed objective.

2940. This is also supported by the Supreme Court's decision in *PHS Community Services* where, in addition to the public health and safety rationale, the Court also considered whether it was possible to justify a breach of s.7 interests on the basis of a commitment to a symbolic principle – the importance of presenting a uniform stand against the use and possession of illegal drugs.

2941. The Court unanimously found that causing a risk of bodily harm and a greater risk of death was grossly disproportionate to this symbolic objective, observing that "(t)he effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics".[2016]

2942. Similarly, in this case, the devastating impact imposed by the restrictions on accessing timely health care in this case is concrete, real, and proven. By contrast, the objective of ensuring 'equal treatment for all based on need' is not only symbolic, vague, uncertain, and unattainable, but is not consistent with the way the system actually operates, as noted above.

2943. Therefore, the real life harms people suffer being forced to languish on wait lists, risking their physical and mental health, and sometimes even their lives, is out of all proportion to the Defendant's alleged symbolic purpose, further confirming the breach of section 7.

[2015] ***Bedford***, *supra* at para 122.
[2016] ***PHS Community Services***, *supra* at para 133.

D. Summary – Violation of the Rights to Life, Liberty and Security of Person Are Inconsistent with the Principles of Fundamental Justice

2944. For all the reasons described above, it is clear that the impugned laws impose a serious harm upon individuals, and that these harms are unconnected to or unnecessary to achieve the objective of maintaining a viable and accessible universal public health care system, and grossly disproportionate to the purpose of the provisions.

2945. The Supreme Court of Canada has already found in *Chaoulli* that prohibitions on private health care, where the public health care system fails to deliver adequate care, violate the fundamental rights of Canadians. This holding was summarized by McLachlin CJ and Major J. as follows:

> The *Canada Health Act*, the *Health Insurance Act*, and the *Hospital Insurance Act* do not expressly prohibit private health services. However, they limit access to private health services by removing the ability to contract for private health care insurance to cover the same services covered by public insurance. The result is a virtual monopoly for the public health scheme. The state has effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. This virtual monopoly, on the evidence, results in delays in treatment that adversely affect the citizen's security of the person. Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so.[2017]

2946. In light of the even stronger evidence in this case, it follows that the serious deprivation of these critical *Charter* rights is not in accordance with the principles of fundamental justice, and must be justified by the Government under section 1.

2947. Professor Hogg has described the majority holding in *Chaoulli* as part of a number of cases – including *Morgentaler*, *PHS Community Services*, *Bedford* and *Carter* - in which the legislative restrictions at issue were properly found to violate section 7.

2948. In the course of that analysis, Professor Hogg explained why it was necessary for the courts to step in and vindicate these fundamental *Charter* rights in cases like *Chaoulli*:

> A law that restricts life, liberty or security of the person, when subjected to an evidence-based review of its operation, may be shown to be not in fact fulfilling the law's objective, or even to be undermining the law's objective by doing more harm than good. That was the thrust of the evidence in the abortion, drug addiction, assisted suicide, prostitution and health care cases. In an ideal world, such failures of policy would be remedied by the responsible legislative body. But if the persons harmed by the dysfunctional law have little popular appeal or political power, then legislators may be uninterested in their problems and disinclined to take any

[2017] ***Chaoulli,*** *supra* at paras 105-106 (emphasis added).

> action, especially if they believe that a remedial law is likely to be unpopular. In that situation, there is a case for judicial review of the deprivation of life, liberty or security of the unpopular minority.[2018]

2949. Essentially the same point was made by Justice Deschamps in *Chaoulli*:

> For many years, the government has failed to act; the situation continues to deteriorate. This is not a case in which missing scientific data would allow for a more informed decision to be made. The principle of prudence that is so popular in matters relating to the environment and to medical research cannot be transposed to this case. Under the Quebec plan, the government can control its human resources in various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services (s. 30 HEIA) or by implementing less restrictive measures, like those adopted in the four Canadian provinces that do not prohibit private insurance or in the other OECD countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebeckers' right to security. The government has not given reasons for its failure to act. Inertia cannot be used as an argument to justify deference.[2019]

2950. For many years, the prohibitions on non-exempt British Columbians obtaining private diagnostic and surgical services to alleviate their suffering and protect their health have not been enforced given the lengthy wait times for these services in the public system.

2951. That is why the Government permitted private clinics to operate, and why it provides exemptions to the restrictions set out in the *MPA* for certain privileged groups of people.

2952. However, the Government has now decided to enforce this harmful and unjustifiable law, which prohibits persons caring for their health and wellbeing outside of the public system, while it continues to ration medically necessary health care as a means of cost control.

2953. In doing so, the Government seeks to sacrifice the autonomy, health, and life of British Columbians in a way that is unnecessary given the purpose of protecting the public system, or in pursuit of an abstract, symbolic principle of "equal treatment for all", that is both unattainable and inconsistent with the actual system we have.

2954. In effect, the Defendant argues that merely affirming a commitment to a purely symbolic principle is more important than the actual impact of the law, which is not to ensure that everyone

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[2018] Peter W. Hogg, "The Brilliant Career of Section 7" (2012) 58 SCLR 195 at 209 (emphasis added).
[2019] ***Chaoulli,*** *supra* at para 97 (emphasis added).

has reasonable access to health care, but to ensure that everyone suffers equally by preventing persons from getting treatment outside of the public system.

2955. This is precisely the type of situation that section 7 of the *Charter* was designed to remedy.

E. The Impugned Provisions Breach Section 15

2956. In addition to the violation of section 7, the impugned provisions also violate section 15 of the *Charter*.

2957. The underlying purpose of the *Charter's* equality rights is to promote "a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration".[2020]

2958. In *Andrews*, the Court explained that a law will violation section 15 if it imposes unequal treatment on the basis of an enumerated or analogous ground.[2021]

2959. The enumerated grounds are listed in the text of the section, and include race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

2960. Analogous grounds are those that are similar to those enumerated in that they involve "a personal characteristic that is immutable or changeable only at unacceptable cost to personal identity".[2022]

2961. According to the traditional section 15 test, in order to demonstrate that a law or statute violates section 15(1) of the *Charter*, the law must (i) draw a distinction based on, or impose a disproportionate effect connected to, a prohibited or analogous ground; and (ii) the distinction is substantively discriminatory, in that it has the effect of perpetuating arbitrary disadvantage based on an individual's membership in an enumerated or analogous group.[2023]

2962. A law or scheme of laws will draw a distinction, at the first stage of the section 15(1) analysis, where the law "has the effect of imposing burdens, obligations, or disadvantages on such individual

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[2020] ***Andrews v. Law Society of British Columbia***, [1989] 1 SCR 143 [***Andrews***] at 171.
[2021] ***Andrews***, *supra* at 180-181.
[2022] ***Corbiere v. Canada (Minister of Indian and Northern Affairs)***, [1999] 2 SCR 203 [***Corbiere***] at para 13
[2023] ***R. v. Kapp***, 2008 SCC 41 [***Kapp***] at para 17; ***Kahkewistahaw First Nation v. Taypotat***, 2015 SCC 30 [***Taypotat***] at paras 17-21.

or group not imposed upon others", or if it "imposes obligations [on some] that are not imposed on others".[2024]

2963. A law will have a substantively discriminatory impact, at the second stage of the analysis, where it "fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage":[2025]

2964. The focus of the section 15 analysis is on these harmful and disadvantaging effects of a law, where they are imposed unequally in a manner linked to a protected ground. As the Supreme Court of Canada explained in *Taypotat*:

> The focus of s. 15 is therefore on laws that draw discriminatory distinctions — that is, distinctions that **have the effect** of perpetuating arbitrary disadvantage based on an individual's membership in an enumerated or analogous group: (...). The s. 15(1) analysis is accordingly concerned with the social and economic context in which a claim of inequality arises, and **with the effects** of the challenged law or action on the claimant group (...)[2026]

2965. The objective of a section 15 analysis is therefore to determine the effect of impugned provisions as they operate in the real world, and in the entire legislative scheme at issue, on the persons or groups effected.

2966. Importantly, section 15 is not only concerned with laws which directly impose unequal benefits or burdens, or that do so by drawing a distinction explicitly on the basis of prohibited or analogous grounds.

2967. Rules that are not based directly on membership in a protected group can have a disproportionate impact or negative effect linked to a prohibited or analogous grounds that can constitute discrimination under section 15.[2027]

(i) Breach on the Basis of Age, Disability, and Type of Disability

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[2024] ***Quebec (Attorney General) v. A***, 2013 SCC 5 [***Quebec v. A***] at para 187.
[2025] ***Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux***, 2018 SCC 17 [***Alliance***] at paras 73, 94.
[2026] ***Taypotat***, *supra* at para 18 (emphasis added).
[2027] See ***Alliance***, *supra* at para 70; ***Withler v. Canada (Attorney General)***, 2011 SCC 12 at para 64; ***Eldridge v. British Columbia (Attorney General)***, [1997] 3 SCR 624 [***Eldridge***] at paras 60-66; see also ***Canadian National Railway Co. v. Canada (Canadian Human Rights Commission)***, [1987] 1 S.C.R. 1114 at 1139.

2968. In this case, the effect of the impugned provisions of the *Act* is to impose an unequal burden in a manner linked to protected grounds of discrimination, specifically age, disability, and type of disability. That is because the *Act* prohibits access to private treatment for many BC residents, but exempts others from this harmful restriction – such as those injured at work.

2969. A distinction drawn on the basis of workplace or worker status is not necessarily discriminatory. However, in this case, the impugned provisions have a substantively discriminatory effect on the basis of age, disability, and type of disability because:

i. members of the workforce are disproportionately between the ages of 18 and 65;

ii. individuals must be physically and mentally able to enter the workforce in order to benefit from the exemptions; and

iii. workers will only require medical treatment for workplace injuries that can be caused in the course of work (i.e. physical trauma, workplace-related diseases), and not injuries and illnesses that arise from other sources (e.g. genetic disabilities)

2970. Therefore, the effect of applying the impugned provisions generally, but not to individuals who are injured at work, is to impose a disproportionate impact on individuals who:

i. because of their age, do not or cannot work;

ii. because of a mental or physical disability, do not or cannot work; and

iii. because their mental or physical disability is caused by non-work related factors, will not have the same access to timely and necessary medical treatment as those whose disabilities stem from workplace related illnesses or injuries.

2971. In effect, the Government has said that if you do not work, because you are either too young or too old, or because of your disability, you cannot qualify for the exemptions that are available to ensure that workers get the health care that they need in a timely fashion.

2972. And it has said that if your mental or physical disability is of the type caused by non-work related circumstances (e.g. a genetic disorder), then you will not be eligible for the exemptions, which apply only to those whose injury or illness is caused by participation in the workforce.[2028]

[2028] See e.g. ***Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board)***

2973. The Plaintiffs' claim under section 15 is therefore quite simple: enforcing the impugned provisions against some, but not others, has the effect of imposing a significant burden on some persons that is not imposed on all.

2974. And by tying exemptions to that burden to an individual's participation in the workforce, as this legislative scheme does, it discriminates against those who are unable to enter the workforce due to their age or disability, or whose injuries or illnesses are caused by factors unrelated to work.

2975. For instance, had Mr. Chiavatti been an adult teacher instead of a teenage student at the time of his injury, he would have been covered to receive expedited treatment privately through WorkSafeBC insurance.

2976. These distinctions in turn have the effect of perpetuating or causing arbitrary and substantive disadvantage, with respect to a matter of fundamental importance: protecting one's health.

2977. Children and those of an advanced age are subject to disadvantage in today's society. Effectively preventing those groups from accessing timely medical treatment due to their inability to work, or due to the type of their disability, perpetuates this disadvantage.

2978. Similarly, individuals with disabilities that preclude them from working are clearly a disadvantaged group in society, and enforcing the impugned provisions against them exacerbate this disadvantage, by preventing them from obtaining the timely access to care that they need as compared to individuals in the relatively advantaged group of persons.

2979. And persons whose disabilities arise from pre-existing or genetic disability are generally disadvantaged as compared to those whose injuries or illnesses are contracted, as they are wholly and completely unable to avoid the injuries or illnesses in question.

2980. In short, the effect of the impugned provisions is to exacerbate the disadvantage of everyone who does not fall into a particular, privileged group: able-bodied persons who are of working age, and are without pre-existing genetic or non-workplace related injuries or illnesses.

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v. Laseur, 2003 SCC 54 [***Martin***] at paras 75-83 (confirming that "distinctions drawn between various disabilities" can violate section 15).

2981. Unlike this privileged group, the young, the old, the severely disabled, and those with pre-existing or genetic disabilities, are all categorically prohibited from accessing more timely medical treatment in British Columbia, and therefore disproportionately harmed by the impugned provisions.

2982. Because this adverse treatment is both linked to protected grounds of discrimination and is substantively discriminatory, it violates the right to substantive equality under section 15. It therefore can only be upheld, if at all, under section 1.

(ii) Breach on the Basis of Fundamental *Charter* Interests

2983. In addition to significant harms imposed that are tied to protected grounds of age and disability, the *MPA* also treats people unequally on the basis of a fundamental personal interest: namely, the interest in one's bodily integrity, personal health and well-being, and the need for access to timely medical care.

2984. Where the Government unequally deprives people of a fundamental *Charter* interest – like equal access to timely and necessary health care – that constitutes a breach of section 15, even if the unequal treatment is not directly tied to a protected ground of discrimination. [2029]

2985. The courts have historically required that discrimination be linked to a protected ground of discrimination, and have not yet recognized an additional 'interest-based' route to finding a breach of section 15. But that does not prevent this court from doing so.

2986. As the Supreme Court of Canada has recently stressed, past precedents may be revisited by trial courts "if new legal issues are raised as a consequence of significant developments in the law, or if there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate".[2030]

2987. This case is a perfect example of why adding a second, 'interest-based' route to our understanding of equality rights in Canada is appropriate.

2988. Under the enumerated and analogous grounds approach, governments could deprive persons of access to critically important benefits, institutions and relationships – such as marriage, education

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[2029] See Robin Elliot & Michael Elliot, "The Addition of an Interest-Based Route into Section 15 of the Charter: Why It's Necessary and How It Can Be Justified" (2014) 64 SCLR (2d) 462 [**Elliot & Elliot**]; see also Brian Langille & Benjamin Oliphant, "The Legal Structure of Freedom of Association" (2014) 40 Queen's LJ 249 at 284-285.
[2030] ***Bedford***, *supra* at para 42.

or health care – because of their name, hair colour, political views, or occupation, without violating the equality rights under the *Charter*.

2989. That is because an individual's name, hair colour, political views, and occupation are not protected grounds of discrimination, under the traditional analysis.

2990. But the impact of the unequal treatment of such persons is so severe when it comes to interests of fundamental importance, like access to medically necessary health care, that the government should have to justify the unequal and discriminatory treatment under section 1.

2991. While this approach is novel, in the sense that an 'interest based' route to discrimination has not yet been formally recognized by the courts, it is fully consistent with the purposes underlying section 15. As explained by Professor Robin Elliot and Michael Elliot:

> An interest-based conception of equality has deep roots within the liberal democratic philosophical tradition, is reflected in the constitutional jurisprudence of other liberal democratic countries, has been adopted as the governing approach in international human rights instruments with which Canada has aligned itself, is being championed by leading equality rights theorists here in Canada and has already found favour with one of its former members. It furthers the underlying purpose of section 15. It would allow the courts to assess the merits of claims… on the basis of the true gravamen of the concern underlying them. And in part for that reason, it would also allow for a more consistent and coherent approach to the *Charter* as a whole, freeing other provisions from bearing a burden which section 15 is much better suited to carry.[2031]

2992. The essence of the unequal treatment in this case is that the government has decided that certain persons – those who are not exempt from the restrictions in the *Act* – are not entitled to the same access to timely and potentially lifesaving private treatment as others.

2993. It creates the impression that working people are more 'productive', and hence more 'important', to society than those unable to work. This fundamentally undermines the purpose of section 15, which is to affirm the equal dignity and value of all persons.

2994. As such, in addition to the unequal and discriminatory impact linked to age, disability, and type of disability, this Court should additionally recognize a breach of section 15 on the basis that a fundamental interest (here, the ability to access timely and effective health care) has been distributed in a substantively unequal manner.

[2031] See Elliot & Elliot, *supra* at 530.

(iii) Summary – The Impugned Provisions Breach Section 15

2995. However they are considered, and whatever test is applied, the impugned provisions result in a grossly unequal outcome, because a person's ability to access necessary medical treatment is premised on whether one is injured or becomes ill at work. This fails to achieve substantive equality, on any plausible definition of that term.

2996. The *MPA* does not reflect the recognition that all are equally deserving of concern and respect – it rather creates a privileged group who are exempted from the harmful restrictions in the law, while depriving most others of this fundamental right.

2997. All persons should have equal opportunity to access to necessary and essential health care, particularly where that care is not being adequately provided by the public system.

2998. This does not mean that the Government cannot treat people differently when it comes to laws in relation to health care, which impose a burden on some not imposed on others.

2999. It only means that when it does so, and when doing so has an impact on the basis of either protected grounds or truly fundamental interests, it must justify those distinctions under section 1.

3000. The Government must, in other words, show that in drawing the distinctions with respect to fundamental interest of access to timely health care, it has treated everyone as equally deserving of concern and respect. The *MPA* fails to meet this standard.

3001. In this case, the infringements of sections 7 and 15 are not saved by section 1, for the reasons given below.

F. The Impugned Provisions Are Not Justified Under Section 1

(i) Overview of the Oakes Test

3002. For the purposes of the section 1 analysis, the focus is on the objective of the impugned provisions – maintaining an accessible and viable public health care system – and whether the costs of the measures in terms of the *Charter* rights violated are worth the benefits derived to society as a whole.

3003. The *Oakes* test under section 1 is well known. It requires the government to demonstrate that the law has a pressing and substantial objective, and that the means chosen by the law are proportionate to the objective.

3004. Laws that are not rationally connected to their objectives, have a greater impact on rights than is necessary to achieve their objectives, or have negative consequences on rights that are not outweighed by the benefits to be achieved by the law, will not be justified under section 1.

3005. The *Oakes* analysis varies depending on the context of the case, and in particular, the types of harms being caused by government action. In this case, it is particularly important that one of the *Charter* breaches is of section 7 of the *Charter*.

3006. The Courts have recognized that a law which violates a person's life, liberty or security of person in a manner not in accordance with the principles of fundamental justice is unlikely to be saved under section 1. That is the case for two reasons.

3007. First, as noted above, the rights protected by section 7 are among the most fundamentally important in a free and democratic society, and are therefore "not easily overridden by competing social interests".[2032] Second, as the Court recently stated in *Bedford*, a law which violates section 7 is "inherently flawed", and will therefore not easily provide a justification under section 1.[2033]

3008. In fact, the Supreme Court of Canada has never found that a law which violated section 7 has been justified under section 1.[2034] Indeed, some judges have questioned whether it is even legally possible to uphold a breach of section 7 under section 1.[2035]

3009. Although the Court has more recently confirmed that it is at least theoretically possible for a breach of section 7 to be justified under section 1, for instance, in "exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like",[2036] it is clear that such a justification will be incredibly rare.

3010. This is reflected in the fact that in most of the leading section 7 cases – including *Chaoulli, PHS Community Services, Bedford, Safarzadeh Markhali*, and *Smith* – the majority of the analysis is under section 7, with only a cursory analysis at the section 1 stage after a breach of the principles of fundamental justice has been established.[2037]

[2032] ***G.(J.)***, *supra* at para 98; ***Charkaoui***, *supra* at para 66.
[2033] ***Bedford***, *supra* at para 96.
[2034] Hogg, *Constitutional Law*, *supra* at §38.14(b).
[2035] See e.g. ***BC Motor Vehicle Reference***, *supra* at 523, *per* Wilson J.
[2036] ***BC Motor Vehicle Reference***, *supra* at 518, *per* Lamer J.
[2037] ***Chaoulli***, *supra* at paras 154-158, McLachlin & Major J.; ***PHS Community Services***, *supra* at paras 137-140; ***Bedford***, *supra* at paras 161-163. See also ***Safarzadeh-Markhali***, *supra* at paras 61-66; ***Smith***, *supra* at para 29.

3011. In the absence of the Government suggesting ancillary or societal benefits that are different from those addressed at the section 7 stage, that should resolve the case, as it did in *Bedford*.[2038]

3012. Similarly, in this case, the Government's primary arguments in favour of the impugned provisions, namely that they are necessary to protect the public health care system, has been thoroughly addressed at the section 7 stage of the analysis.

3013. Unless the Government seeks to justify the arbitrary, overbroad, and grossly disproportionate imposition of severe bodily harm and death on the basis of any ancillary benefits the law may provide – such as a reduced administrative burden or the need to manipulate the voting preferences of the population – that should be the end of the analysis.

3014. Nevertheless, the Plaintiffs will undertake the section 1 analysis, which shows how the same fundamental flaw – a fundamental disconnect between the laudable purposes underlying the impugned provisions and the severe and entirely avoidable harms they impose in reality – demonstrate that the impugned provisions cannot be justified in a free and democratic society.

(ii) Pressing and Substantial Objective

3015. In this case, the Plaintiffs concede that the preservation of a viable and effective public health care system available to all regardless of ability to pay is a pressing and substantial objective under section 1. The primary problem with the law, as discussed above and below, is that it is not directly connected to and is unnecessary to achieve these objectives.

3016. However, to the extent that the Defendant seeks to define the purpose of the impugned provisions as ensuring absolute equality in the provision of health care – which is inconsistent with the actual design and operation of the laws – this cannot be accepted as an objective of sufficient importance to override the *Charter* rights of those affected.

3017. In *Sauve*, for instance, the Court cautioned against accepting such a broad, symbolic objective as a justification for a limitation on rights, finding that it did not even provide a pressing and substantial objective that could justify a limit on *Charter* rights. As the Court explained:

> If Parliament can infringe a crucial right such as the right to vote simply by offering symbolic and abstract reasons, judicial review either becomes vacuously constrained or reduces to a contest of "our symbols are better than your symbols". Neither

[2038] ***Bedford***, *supra* at para 163.

> outcome is compatible with the vigorous justification analysis required by the *Charter*.[2039]

3018. An objective that amounts to "equal health care for all" has exactly this type of vague and uncertain nature, and bears no connection to the way the law actually operates in practice. It is effectively a symbolic mantra, not a pressing and substantial objective under the *Charter*.

3019. Moreover, as noted above, if this were the objective of the impugned measures, the Government would effectively be saying that - notwithstanding the considerable and sometimes catastrophic harm caused by preventing individuals from accessing private care - it is nevertheless justified in prohibiting access to medical care so that all may *suffer equally*.

3020. With respect, this cannot be an objective sufficiently pressing and substantial to justify the significant deprivation of section 7 rights demonstrated above.

3021. As such, the following proportionality analysis must take place on the basis of the actual legislative purpose underlying the impugned provisions: protecting the viability and accessibility of the public health care system.

(iii) No Rational Connection

3022. The impugned measures fail at the rational connection stage of the analysis.

3023. While the section 7 and section 1 analyses differ in certain respects, the arbitrariness and rational connection tests are effectively the same. As Justice Beetz stated in *Morgentaler*: "(a) rule which is unnecessary in terms of Parliament's objectives cannot be said to be 'rationally connected' thereto or to be 'carefully designed to achieve the objective in question'".[2040]

3024. As noted above, there is no basis in the evidence or in logic for concluding that the prohibitions on access to private treatment, particularly where there is both unmet need *and* additional capacity to provide for that need, are rationally connected to preserving a universal public health care system.

3025. For the same reasons given above in relation to arbitrariness, and particularly in light of the fact that a viable and universal public system can co-exist with the option to obtain private treatment,

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[2039] ***Sauvé v. Canada (Chief Electoral Officer)***, 2002 SCC 68 at paras 22-23 (emphasis added).

[2040] ***Morgentaler***, *supra* at 125, per Beetz J. And see Stewart, *Fundamental Justice, supra* at 361 ("(i)f the law in question is arbitrary, it cannot be rationally connected" to its purpose.")

there is simply no rational connection between the impugned laws and the Government's objective. This is sufficient to dispose of the section 1 argument.

(iv) Not Minimally Impairing

3026. However, even if there were a rational connection between the restrictions and the purpose of the impugned provisions, the Government has not chosen the least restrictive means to accomplish its objective.

3027. The Court has recently confirmed that the Government cannot rely on mere assertions of risk or speculation regarding exaggerated negative outcomes to justify a breach under section 1.[2041]

3028. The Government must show that there is no other way that could reasonably accomplish its pressing and substantial objectives of the law, which in this case, is the maintenance of a viable and universal public health care regime.

3029. And it is not the Plaintiffs' burden to show that some other regime will perfectly achieve the Government's chosen objectives. As the unanimous Supreme Court recently explained in *Carter*, with specific reference to *Chaoulli*:

> A theoretical or speculative fear cannot justify an absolute prohibition. As Deschamps J. stated in *Chaoulli*, at para. 68, the claimant "d[oes] not have the burden of disproving every fear or every threat", nor can the government meet its burden simply by asserting an adverse impact on the public. Justification under s. 1 is a process of demonstration, not intuition or automatic deference to the government's assertion of risk (RJR-MacDonald, at para. 128).
>
> (...) The resolution of the issue before us falls to be resolved not by competing anecdotes, but by the evidence. The trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide. We should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse.[2042]

3030. As discussed above, there are many other means available to the Government to ensure a viable, universal and high quality public health care system, available to all regardless of their ability to pay. This was confirmed by the Defendant's own experts, such as Professor Marmor, both in his writing and in his testimony.

[2041] ***Carter***, *supra* at para 119.
[2042] ***Carter***, *supra* at paras 118-120 (emphasis added).

3031. And if there were any legitimate concern supported by evidence – as opposed to speculation – that permitting dual practice and private insurance would lead to a 'flight' of capacity (i.e. doctors) out of the public system, the Government could put in place measures which required that all doctors must provide treatment in the public system, before providing services outside of that system.

3032. The Cambie situation is a perfect example. The doctors at the Cambie Surgery Centre are not providing private services instead of publicly funded services. They are providing all of the publicly funded services that the Government is willing to pay for.

3033. The problem is simply that the Government can, or will, only pay for a portion of that capacity, because it must ration its funding of services to keep the system affordable. This leaves considerable capacity to provide more surgeries, faster, and to alleviate the strain on wait lists in the public sector.

3034. As noted in the Asserted Justifications section above, the same can be said about all of the other justifications that the Defendant has attempted to advance – they are either not supported by the evidence, entirely unnecessary in light of the ability of the Government to enact measures more narrowly targeted at those specific harms, or both.

3035. As the evidence in this case shows, there are many other ways that jurisdictions across the OECD are able to maintain a viable public health care system without prohibiting persons from accessing care outside of that system, particularly where there is unmet need and capacity in the public system, some of which are canvassed above.[2043]

3036. Indeed, the fact that the vast majority of OECD countries are able to maintain strong and viable public health care systems – and indeed, more equal and effective public health care systems than Canada – without resorting to the drastic prohibitions contained in the *MPA*, shows that those prohibitions are not necessary to achieve the Government's objectives.

3037. Moreover, the ability of the Government to impose more limited and targeted measures to address any valid concerns, as detailed previously, demonstrates that the impugned provisions which seek to eliminate access to private care entirely, are not minimally impairing of the section 7 rights at issue.

[2043] See generally **Section IX,** "Lessons from Other Jurisdictions", above.

3038. For all these reasons, the blanket prohibition on private insurance and on blended practice is not the most minimally impairing way to accomplish the Government's objectives of protecting the accessibility and viability of the public system.

(v) Deleterious Effects Disproportionate to Any Benefit Derived

3039. Finally, in light of the severity of the deprivation, and the minimal salutary effects of the law, if any can be found, any speculative or hypothetical benefits do not outweigh the grave deleterious impact on those who are prevented from protecting their health.

3040. The severe deprivation caused by the prohibitions on accessing medical care is described above. Cases like the ones surveyed above are not aberrations – they are endemic to a system where demand far outstrips the capacity to fund all medically necessary procedures.

3041. The lack of benefits achieved by the law have been discussed above, in some detail. These prohibitions do not create a more effective system; they do not create a more efficient system; and they do not create a more equitable system. They produce worse, not better, health outcomes for the population. There are simply no salutary effects to speak of.

3042. In the words of McLachlin CJ & Major J. in *Chaoulli*:

> Finally, the benefits of the prohibition do not outweigh the deleterious effects. Prohibiting citizens from obtaining private health care insurance may, as discussed, leave people no choice but to accept excessive delays in the public health system. The physical and psychological suffering and risk of death that may result outweigh whatever benefit (and none has been demonstrated to us here) there may be to the system as a whole.[2044]

3043. This is why the Government has, until very recently, permitted clinics like Cambie to co-exist with the public system. It realized that private clinics and private medical treatment are an integral and necessary adjunct to the public system. However, it now refuses to publicly acknowledge what it has known for years – that access to private health care is part of the solution, not the problem.

3044. For the above reasons, the Government is not able to meet its burden under section 1, to justify the breach of the rights of BC residents under sections 7 and 15. As such, the impugned provisions of the *Medicare Protection Act* must be struck down.

[2044] ***Chaoulli***, *supra* at para 157 (emphasis added).

XII. REMEDY

3045. The Plaintiffs submit that the appropriate remedy for the constitutional breach in this case is for the Court to strike down the impugned prohibitions in their entirety, but to suspend the declaration of invalidity for an extended period, with the condition that the injunction remain in place during the period of suspension to maintain the status quo.

3046. As Justice Lamer stated in *Rodriquez*:

> [L]egislation subjected to a suspended declaration of invalidity will not necessarily be left operative in all of its violative aspects... the Court has jurisdiction under s. 52 to make the declaration subject to such conditions as it considers just and necessary to vitiate the impact of the violation during the period of the suspension.[2045]

3047. Suspending the declaration of invalidity, but with conditions to protect *Charter* rights in the interim, will protect the constitutional rights of patients, while the "ball is thrown back into the [Legislature's] court to revise the law, should it choose to do so, so that it no longer produces unconstitutional effects."[2046]

3048. This remedy will immediately vindicate the *Charter* rights of patients, who will continue to be able to protect their health through access to private procedures and surgeries, both during and after the suspension period. This should be the primary objective of a constitutional remedy:

> In selecting an appropriate remedy under the *Charter* the primary concern of the court must be to apply the measures that will best vindicate the values expressed in the *Charter* and to provide the form of remedy to those whose rights have been violated that best achieves that objective. This flows from the court's role as guardian of the rights and freedoms which are entrenched as part of the supreme law of Canada.[2047]

3049. At the same time, this remedy will meet the other fundamental objective of *Charter* remedies, to respect the role of the legislature. Suspending the declaration will give the Legislature time to fully study the matter, review the full spectrum of alternative options, and consult with stakeholders and the public, before enacting replacement provisions.

[2045] ***Rodriguez v. British Columbia (Attorney General)***, [1993] 3 SCR 519 at 571-572. See also ***R. v. Swain***, [1991] 1 SCR 933 at 1021-1022; ***R. v. Jordan***, 2016 SCC 27 at para 93 (noting that remedies including "transition periods", "are part of the discretionary remedial framework of our constitutional law").

[2046] ***R. v. Ferguson***, [2008] 1 SCR 96, 2008 SCC 6 at para 65.

[2047] ***Osborne v. Canada (Treasury Board)***, [1991] 2 SCR 69 at 104 (emphasis added). See also ***Doucet-Boudreau v. Nova Scotia (Minister of Education)***, 2003 SCC 62 at para 25.

3050. The condition of maintaining the existing injunction will not impact the Government's ability to prohibit any extra-billing or user changes over and above payments under the public plan during the suspension period, thus ensuring access to the public health care system without financial or other barriers and avoiding any risk to the public interest.

3051. Because this proposed remedy meets the twin guiding principles of *Charter* remedies - "respect for the purposes and values of the *Charter*, and respect for the role of the legislature" - it achieves the proper balance in this case.[2048]

ALL OF WHICH IS RESPECTFULLY SUBMITTED ON BEHALF OF THE PLAINITFFS BY

Date: September 16, 2019

Peter A. Gall, Q.C.
Counsel to the Plaintiffs

[2048] See ***Corbiere v. Canada (Minister of Indian and Northern Affairs)***, [1999] 2 SCR 203 at para 110; ***Schachter v. Canada***, [1992] 2 S.C.R. 679 [***Schachter***], at 700-701; ***Vriend v. Alberta***, [1998] 1 SCR 493 [***Vriend***] at para. 148.