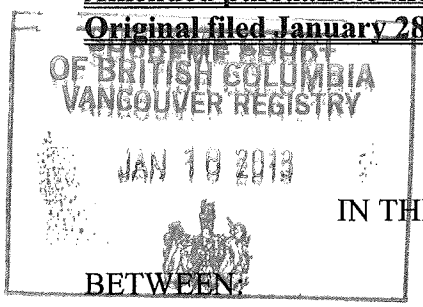
Amended pursuant to the order of Chief Justice Bauman, dated January 10, 2013
~~Original filed January 28, 2009~~



No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI by his litigation guardian RITA CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO by her litigation guardian ANTONIO CORRADO, ERMA KRAHN, WALID KHALFALLAH, by his litigation guardian Debbie Waitkus, and SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH ~~SERVICES~~ OF BRITISH COLUMBIA and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

~~**SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.**~~

~~DEFENDANT BY COUNTERCLAIM~~

AND:

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

INTERVENERS

FURTHER AMENDED NOTICE OF CIVIL CLAIM

This action has been started by the Plaintiff(s) for the relief set out in Part 2 below.

If you intend to respond to this action, you or your lawyer must

(a) file a response to civil claim in Form 2 in the above-named registry of this court within the time for response to civil claim described below, and
(b) serve a copy of the filed response to civil claim on the plaintiff.

If you intend to make a counterclaim, you or your lawyer must

(a) file a response to civil claim in Form 2 and a counterclaim in Form 3 in the above-named registry of this court within the time for response to civil claim described below, and
(b) serve a copy of the filed response to civil claim and counterclaim on the plaintiff and on any new parties named in the counterclaim.

JUDGMENT MAY BE PRONOUNCED AGAINST YOU IF YOU FAIL to file the response to civil claim within the time for response to civil claim described below.

Time for response to civil claim

A response to civil claim must be filed and served on the plaintiff(s),

(a) if you reside anywhere in Canada, within 21 days after the date on which a copy of the filed notice of civil claim was served on you,
(b) if you reside in the United States of America, within 35 days after the date on which a copy of the filed notice of civil claim was served on you,
(c) if you reside elsewhere, within 49 days after the date on which a copy of the filed notice of civil claim was served on you, or
(d) if the time for response to civil claim has been set by order of the court, within that time.

CLAIM OF THE PLAINTIFFS

Part 1: STATEMENT OF FACTS

The parties

1. The Plaintiff Cambie Surgeries Corporation (hereinafter "Cambie") is a corporation duly incorporated pursuant to the laws of British Columbia, with a registered address at 2836 Ash Street, Vancouver, British Columbia.

2. The Plaintiff Chris Chiavatti (hereinafter "Chiavatti") is an individual who resides at 8170 Greenlake Place, Burnaby, British Columbia.

3. The Plaintiff Mandy Martens (hereinafter "Martens") is an individual who resides at 23915 36A, Langley, British Columbia.

4. The Plaintiff Krystiana Corrado (hereinafter "Corrado") is an individual who resides at 2595 Kitchener Street, Vancouver, British Columbia.

5. The Plaintiff Erma Krahn (hereinafter "Krahn") is an individual who resides at #401-1685 152A Street, Surrey, British Columbia.

6. The Plaintiff Walid Khalfallah (hereinafter "Khalfallah") is an individual who resides at 664 Morrison Avenue, Kelowna, British Columbia.

7. The Plaintiff Specialist Referral Clinic (Vancouver) Inc. (hereinafter "SRC") is a company incorporated under the *Canada Business Corporations Act* on March 18, 2002. SRC was registered as an extra-provincial company under the B.C. *Business Corporations Act* on April 9, 2002, with a head office of 2800 Park Place, 666 Burrard Street, Vancouver B.C. V6C 2Z7

~~6~~8. The Defendant Medical Services Commission (hereinafter the "MSC") is a nine member statutory body continued pursuant to the *Medicare Protection Act*, R.S.B.C. 1996, c. 286 (hereinafter the "*Act*"). The function of the MSC is to facilitate reasonable access to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan (hereinafter the "MSP") continued under the *Act*.

~~7~~9. The Defendant Minister of Health Services of British Columbia is the provincial Minister responsible for the MSP and the MSC, pursuant to the *Act* and the *Ministry of Health Act*, R.S.B.C. 1996, c. 301, as amended.

~~8~~10. The Defendant Attorney General of British Columbia is the law officer of the Crown.

Standing

~~9~~11. The individual Plaintiffs seek the relief sought in this Statement of Claim based upon violations of their individual rights under section 7 and 15 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982* (hereinafter the "*Charter*"), which are not justified under section 1 of the *Charter*.

~~10~~12. To the extent that it is necessary in order to fully present to this Honourable Court the significant constitutional questions raised by this case, the individual and corporate Plaintiffs also seek the relief in the public interest on the following grounds: this proceeding raises serious legal questions; the Plaintiffs have a genuine interest in the resolution of the questions posed; and there is no other reasonable and effective manner in which the full scope of these legal questions may be brought before this Honourable Court.

The independent facilities in British Columbia

~~11~~13. Cambie owns and operates the Cambie Surgery Centre (hereinafter the "Surgery Centre") in the City of Vancouver, British Columbia. The Surgery Centre is a multi-specialty surgical and diagnostic facility, containing six operating rooms, recovery beds and overnight stay rooms. The Surgery Centre is equipped and accredited to standards that equal or exceed the standards of a major public hospital in British Columbia. Operations and diagnosis and treatments are performed by highly qualified physicians, who are independent professionals and not employees of the Surgery Centre.

14. SRC owns and operates a medical clinic at 555 West 12th Avenue, in the City of Vancouver, British Columbia. SRC was established in 2002 by a group of orthopaedic and other specialist physicians in British Columbia in order to improve their ability to provide medical assessment and expedite treatment for British Columbia patients. SRC provides expedited assessments and consultations to a large spectrum of client groups. SRC also arranges for diagnostic testing ordered by its specialists, and provides patients with access to the Surgery Centre if they choose to pursue surgery as a treatment option. If a patient subsequently undergoes surgery at the Surgery Centre, SRC performs the billing function for Cambie in relation to the surgery, pursuant to an administrative services agreement between SRC and Cambie.

~~12~~15. Private medical facilities are beneficial for overall health care in the Province. They provide needed additional assessment, consultation, operating and diagnostic facilities; attract specialist doctors to the Province and help retain them by providing them with additional access to operating time, which is rationed in the public hospitals; offer flexible work hours to nurses and have helped to attract nurses back into the workforce and retain them in the Province; encourage improvements and efficiencies in the public health care system; and provide patients with speedier access to health care, resulting in reduced pain and disability, improved health outcomes and increased life expectancy.

~~13~~16. Patients who have assessments, consultations, operations or diagnostic procedures at independent surgical or diagnostic facilities in British Columbia, like the Surgery Centre and SRC, rather than in a public hospital, radiology clinic or laboratory, may do so for a number of reasons, which are exempt from the MSP and the *Act*:

(a) The operations may be funded under agreements between provincial health authorities and the independent surgical or diagnostic facilities.

(b) The operations or diagnostic procedures may be arranged for the patient pursuant to provincial, federal or territorial workers' compensation schemes.

(c) The patients may be the beneficiaries of other statutory health care schemes, such as those in place for the benefit of the Royal Canadian Mounted Police, members of the Canadian Armed Forces, inmates of federal penitentiaries, and others.

(d) The patients are from out of Province or out of country and seek access to timely and quality health care in Canada.

(e) The patients may be undergoing cosmetic procedures or other procedures not considered as medically required services, and thus not covered under MSP.

(f) The patients may be seeking consultations and assessments for their own individual purposes and privately pay a fee for such service;

(g) The patients may attend for a consultation or assessment at the request of their lawyer, who is seeking a medical-legal assessment or opinion for the purpose of litigation;

(h) The patients may attend for a consultation or assessment at the request or direction of employers or insurers, who are seeking an assessment or opinion as to the individuals' fitness to work, treatment review, and/or prognosis for recovery.

~~14~~17. However, as will be demonstrated, the vast majority of ordinary British Columbians, who are facing unacceptable wait times for consultations, assessments, surgeries ~~of~~for

diagnostic procedures that would be considered "benefits" under MSP, are not exempt from the MSP and the *Act*, and cannot have access to needed private care under the current legislative and regulatory framework.

The circumstances of the Individual Plaintiffs

Chris Chiavatti

~~15~~18. Chiavatti is a grade 12 student at Burnaby Secondary School, and will begin studies at McGill University in the fall of 2012. On January 14th, 2009, Chiavatti suffered an injury to his knee in a physical education class at school. He attended Emergency at the Royal Columbian Hospital, on the day of the injury, where x-rays were taken to look for bone-chips. No bone-chips were found. Chiavatti was advised by the medical practitioners on staff that he should follow up with his family physician. Chiavatti saw his family physician and was referred to Dr. Chris Reilly, an Orthopaedic surgeon at BC Children's Hospital.

~~16~~19. Chiavatti was able to be seen by Dr. Reilly for a consultation at the end of February, 2009. Dr. Reilly told Chiavatti that he would need to attend for an MRI appointment, as Dr. Reilly would need to review an MRI for a diagnosis. Dr. Reilly believed that Chiavatti may have had a discoid meniscus, which is a congenital disorder.

~~17~~20. Two months later, on April 1st 2009, Chiavatti was called in for an MRI. Chiavatti was advised that he would need to return for a further consultation with Dr. Reilly to discuss the results of the MRI. Unfortunately, Chiavatti was advised that the earliest available date for this consultation was September 2010.

~~18~~21. Previous to his injury, Chiavatti was an active student, athlete and community member. Chiavatti was on the Ski Team at school, was the Reach for the Top captain for several consecutive years, and was involved in a variety of clubs at his school. Following his injury, Chiavatti continued to experience pain in his knee and had difficulty sleeping due

to discomfort. Straightening his leg in any way caused him extraordinary pain. He was unable to participate in sporting activities or engage fully in physical activities of any kind. The pain from his injury also interfered with his ability to attend and enjoy school and extra-curricular activities, and walking around the large school campus was difficult and uncomfortable. Chiavatti experienced pain even when resting, as his knee would lock every second day.

~~19~~22. Chiavatti's mother called the Orthopaedic surgeon's office frequently to inquire about cancellations in order to get an earlier date and was eventually asked not to call again.

~~20~~23. In June 2009 Chiavatti was called by the Orthopaedic surgeon's office and told he was put on a waiting list of 400 people for diagnostic consultation. Chiavatti was surprised that he was not already on a waiting list. When Mr. Chiavatti inquired which position on the waiting list he had, he discovered he was near the end of the list.

~~21~~24. By October 2009, Chiavatti was still on a wait list for a diagnostic consultation. After approximately eight months of attempting to obtain further care through the public system with no success and no upcoming appointment set, Chiavatti, with the support of his parents, booked an appointment at the Specialist Referral Clinic with Dr. Brian Day on October 28th, 2009. Based on a clinical evaluation and the MRI previously done at BC Children's Hospital, Dr. Day was able to immediately diagnose a tear in the meniscus. Within a few weeks, on November 19th, 2009, Chiavatti had day surgery on his knee at the Surgery Centre. Chiavatti was able to schedule his surgery for the day immediately preceding a school holiday and consequently Chiavatti missed only one day of school.

~~22~~25. At surgery there was noted to be softening of the articular cartilage adjacent to where the torn meniscus had been impinging. This softening represents joint damage and is likely related to delayed treatment. Further delay would likely have resulted in further, irreversible, joint damage.

~~23~~26. Following the surgery, Chiavatti underwent physiotherapy for several weeks and returned to normal functioning within one month. Chiavatti was able to sleep again, engage in extra-curricular activities, and focus on his studies. His academic achievements helped him to obtain an offer for placement at Yale University.

~~24~~27. If the injury that Chiavatti suffered had been sustained by his physical education teacher – rather than Chiavatti the student – the teacher would have been eligible for expedited treatment because of his status as an injured worker, covered by WCB.

~~25~~28. The Surgery Centre did not bill Chiavatti's family for the cost of the surgery, except for a facility fee. Had Chiavatti's family been required to pay for the full cost of the surgery, the family would have undergone financial duress.

~~26~~29. By providing timely and medically required medical services to Chiavatti in a situation where the wait time in the public system was clinically unreasonable, SRC, the Surgery Centre and Dr. Day are in breach of the *Act*.

Mandy Martens

~~27~~30. In April 2011, at age 35, Martens observed blood and mucus in her stool. She attended at her general practitioner's office where she saw a physician, Dr. Divink, who was substituting for her regular family doctor, Dr. Steven Hansen. The physician referred her to a specialist in Langley Memorial Hospital for a diagnostic colonoscopy. Martens contacted the specialist's office and was informed that the first available appointment was 7 months later, in November 2011.

~~28~~31. In May 2011, Martens began to experience pain. She went to a walk-in clinic on May 28, 2011, and was advised to go to Emergency if the pain became worse. On May 29, 2011 Martens experienced elevated pain symptoms and went to Emergency at Langley Memorial Hospital. At Langley Memorial Hospital, blood-work was done and an out-

patient ultrasound was scheduled for the following week. Martens' family doctor also scheduled a CT scan for Martens.

~~29~~32. Martens attended for the ultrasound as well as a CT scan which Dr. Hansen had arranged at Langley Memorial hospital. Following the CT scan, Dr. Hansen told Martens that three masses had been found on her liver. He advised that a biopsy was urgently needed as her medical condition was suspected to be stage 4 cancer. In the case of colorectal cancer, early screening, diagnosis, and treatment is critical – survival rates for early stage detection is approximately 5 times higher than late stage cancer detection.

~~30~~33. Martens contacted the specialist's office to see if she could be seen earlier, and asked to be placed on a cancellation list, but was told by the receptionist at the office that it was unlikely that the process would be expedited. Dr. Hansen advised Martens that she should consider seeking private care to expedite her diagnosis and treatment, if she could afford the cost.

~~31~~34. Martens made a decision to seek assistance through the private system. She contacted the Specialist Referral Clinic on June 6th, 2011, and arranged an expedited consultation and colonoscopy with Dr. Jean Lauzon at the Surgery Centre on June 20th, 2011. Dr. Lauzon performed a biopsy that confirmed the diagnosis of colon cancer. Having been diagnosed, Martens was subsequently able to book an emergency appointment with Dr. Phang at St. Paul's Hospital where she was admitted for a colon resection on June 28th, 2011.

~~32~~35. Post-surgery and after a short recovery period, Martens commenced three rounds of chemotherapy at Abbotsford Cancer Agency in September, 2011. Each round of chemotherapy lasted two weeks. Martens was then admitted for liver surgery at Vancouver General Hospital with Dr. Steven Chang on October 11th, 2011.

~~33~~36. Martens' treatments were a success. As a result of the colon resection, liver surgery and chemotherapy, all cancer cells are believed to have been removed. Marten's diagnosis at

the Surgery Centre, subsequent surgeries, and three rounds of chemotherapy all occurred prior to November 2011, when Martens had been originally scheduled to have her first diagnostic colonoscopy in the public health care system.

~~34~~37. All medical practitioners who have dealt with Martens' case have advised her that this early diagnostic intervention was critical to the success of her treatment. Martens' has just completed a follow-up examination and series of tests which show that she remains free of cancer. Had she waited until November 2011 for the diagnostic colonoscopy in the public system, the likelihood of a successful outcome of her treatment would have been dramatically reduced.

~~35~~38. Martens paid for the medical services she received at the Surgery Centre, but was subsequently reimbursed by the Surgery Centre.

~~36~~39. By providing timely and medically required medical services to Martens in a situation where the wait time in the public system was clinically unreasonable, SRC, the Surgery Centre and Dr. Day are in breach of the *Act*.

Krystiana Corrado

~~37~~40. The Plaintiff Corrado is currently 17 years of age and is a grade 11 student at Notre Dame High School in Vancouver. Corrado is an elite level soccer player and is hoping to obtain a soccer scholarship to attend university. During her grade 10 year in 2010-2011, Corrado played on both a school soccer team and a city-wide Metro level team. To keep up her level of sport, Corrado practiced with her teams a minimum of three times a week.

~~38~~41. On April 14th 2011, while playing in a soccer game, Corrado twisted her knee, and experienced immediate intense pain. Corrado was rushed to Emergency at Eagle Ridge Hospital in Port Moody where x-rays were taken. The Emergency physicians did not find evidence of bone-chips and did not suspect ligament damage. They prescribed painkillers and sent Corrado home with crutches.

~~39~~42. Corrado's knee was extremely swollen and the pain did not subside despite taking painkillers. Corrado went to her family doctor, Dr. Mary Weckworth, later that same day, April 14th, for further examination. Dr. Weckworth advised that Corrado should return for further consultation once the swelling subsided. By mid-May, although the swelling and pain had not subsided, Corrado returned to visit Dr. Weckworth. Dr. Weckworth was concerned with the level of swelling and pain and arranged for an MRI two weeks later, on June 2nd, 2011 at Burnaby Hospital. Dr. Weckworth referred Corrado to an Orthopaedic Surgeon, Dr. Reilly, at BC Children's Hospital. Dr. Reilly was unable to accommodate Corrado for a consultation until October 2011.

~~40~~43. In the spring and summer of 2011, Corrado remained on crutches for several months, missed the soccer playoffs, missed out on playing or practicing with her summer team, and was unable to try-out for the grade 11 school team or the City league team. She continued to experience severe pain and instability in her knee, as well as sleeping difficulty.

~~41~~44. On October 19th 2011, Dr. Reilly assessed Corrado's MRI results and determined that she had a torn anterior cruciate ligament and would require surgery. However, Dr. Reilly would not put Corrado on his waitlist because by the time she would be eligible for admission for surgery, she would be over the age limit for surgery at BC Children's Hospital.

~~42~~45. Corrado asked Dr. Reilly to refer her to Dr. Fadi Tarazi at Burnaby General Hospital. Two months later, on December 2nd, 2011 Corrado saw Dr. Tarazi in Burnaby. He advised that his first available date for surgery was in July 2012.

~~43~~46. In the intervening period, Corrado was unable to play soccer in her grade 11 season, which undermined her chances for a soccer scholarship for university. She was experiencing pain and instability in her knee. Her only remaining opportunity to qualify for a soccer scholarship would be based on her performance in the 2012-2013 soccer

season. If she was not able to have surgery to repair her anterior cruciate ligament until July 2012, she would be unable to play in the 2012-2013 season and would therefore be ineligible for a scholarship. Corrado's pain had made her concentration skills weaker, and her studies were being affected. She was also generally depressed due to her injury.

~~44~~47. Corrado's parents were concerned and decided that they should expedite her treatment by having her anterior cruciate ligament repair done at the Surgery Centre. She was referred to Dr. Brian Day, who saw her in consultation at the Surgery Centre on January 12th 2012. Dr. Day was able to schedule Corrado in for surgery just a few days later. On January 19th, 2012, Corrado underwent knee surgery at the Surgery Centre to repair her knee injury, including reconstruction of the anterior cruciate ligament. Corrado will now have an opportunity to obtain a scholarship, since she will be able to play in the summer of 2012. This would not have been the case if Corrado had remained on the public system waitlist.

~~45~~48. The services that Corrado received at the Surgery Centre were provided on a partially *pro bono* basis. The Corrado family was only asked to cover the costs of materials, such as dissolvable screws and medication. Had Corrado's family been required to pay for the full cost of the surgery, the family would have undergone extreme financial duress.

~~46~~49. By providing timely and medically required medical services to Corrado in a situation where the wait time in the public system was clinically unreasonable, the Surgery Centre and Dr. Day are in breach of the *Act*.

Erma Krahn

~~47~~50. The Plaintiff, Krahn is presently 79 years of age, and lives independently in an apartment in White Rock, Vancouver. Krahn is retired and enjoys golfing and walking. Krahn lives predominantly on the money that she has saved from previous part-time work. She needs to be cautious with her limited savings and accordingly, no longer takes vacations away from home.

~~48~~51. On May 16th, 2008 Krahn was diagnosed with Lung Cancer. On June 12, 2008 Krahn underwent a right lower lobectomy. Krahn began chemotherapy on August 22, 2008 under the supervision of Dr. Barbara Melosky at the Vancouver Cancer Clinic.

~~49~~52. On September 10th, 2008 Krahn felt a popping sensation in her left knee. After suffering extreme pain throughout the night, Krahn attended at a walk in clinic in White Rock and was sent directly to Emergency at Peace Arch Hospital for x-rays. The x-rays did not show any damage to her knee, and Krahn was advised that her knee was simply inflamed.

~~50~~53. Krahn had continued pain in her knee and continued to have difficulty walking. Krahn asked her family physician to arrange an appointment with an orthopedic specialist. Krahn was examined by an Orthopedic specialist, Dr. Arno Smidt, on February 2nd, 2009. Krahn paid for an MRI privately in Abbotsford to expedite the process of obtaining a diagnosis. On May 28th, 2009 Dr. Smidt advised Ms. Krahn that she had a torn meniscus and needed surgery. Dr. Smidt also told Krahn that she should expect to wait at least one year for the surgery, which would mean she would have surgery on her knee in or around May 2010. Because of her pain and lack of mobility, she did not want to wait that long, but she did not think she had any realistic alternative.

~~51~~54. On September 28th, 2009, Krahn called Dr. Smidt's office to inquire about the schedule for her surgery. She was advised that there was now a three year wait for surgery. Krahn was shocked by the news. She did not want to endure a three year wait in a painful and incapacitated state, and therefore she decided to inquire into private surgical services. On October 20th, 2009 Krahn met with Dr. Day at the Cambie Clinic. Dr. Day operated on her knee at the Cambie Clinic just over a week later on October 29th, 2009. Krahn recovered quickly, and was surprised to discover that she was able to drive again without pain within two days.

~~52~~55. For the next few years, Krahn was able to enjoy her life without the limited mobility and pain she had previously experienced with her torn meniscus. Had Krahn waited for

surgery in the public system, she would have remained largely incapacitated and in pain throughout the duration of the three year period.

~~53~~56. On April 10th, 2012 Krahn was diagnosed with terminal stage four Lung Cancer. On April 24th, 2012 Krahn began chemotherapy again at the BC Cancer agency. On May 02, 2012 Krahn awoke in the middle of the night with a terrible pain in her right knee. She was not able to get out of bed and walk to the washroom due to the pain. Krahn believed that she had torn the meniscus in her right knee as the pain she was experiencing was similar to that which she had felt in her left knee in 2008. Both injuries resulted after chemotherapy. Krahn paid for an MRI at a Private Clinic in Richmond on June 13th, and was then immediately diagnosed with a torn meniscus in her right knee.

~~54~~57. On July 25th, 2012 Krahn attended a consultation at the Cambie Clinic with Dr. Day and is scheduled to have surgery on her right knee on August 13th, 2012.

~~55~~58. Krahn's lifestyle was severely affected in 2009 when she suffered a torn meniscus in her left knee. She was not able to play golf, walk without pain, or exercise. In 2012, because of her advanced lung cancer, Krahn did not want to delay the treatment of her right knee, as was the case in 2009 when she first attempted to obtain surgery on her left knee through the public health care system. She wants to be mobile and pain free as soon as possible so she can enjoy her remaining life to the fullest extent. Krahn's life expectancy has been estimated to be between several months and up to two years. Despite her illness, Krahn is feeling well apart from the pain and immobility caused by her knee injury and wants to remain active as long as possible. That can only be achieved by having her surgery done outside of the public health care system.

~~56~~59. The Surgery Centre fees for its services with respect to Krahn's left knee were reduced to accommodate Krahn's financial circumstances. The fees will be similarly reduced for the surgery on her right knee.

~~57~~60. By providing timely and medically required medical services to Krahn in a situation where the wait time in the public system was clinically unreasonable, the Surgery Centre and Dr. Day are in breach of the Act.

Walid Khalfallah

61. The Plaintiff, Khalfallah is 16 years old. He is a parapalegic being cared for full time by his mother, Debbie Waitkus.

62. At age 8, Khalfallah was diagnosed with kyphosis, a medical condition that involves abnormal curving of the spine. Whereas a normal spine can bend from 20 to 45 degrees in the upper back, kyphosis is defined as a curvature of 50 degrees or more as measured on an x-ray.

63. Kyphosis can cause pain, mobility restrictions, deformed posture, and in severe cases, permanent damage to internal organs.

64. Kyphosis can develop rapidly during periods of bone growth such as puberty. Khalfallah's condition worsened significantly after his 13th birthday.

65. In or about June 2009, Khalfallah saw his pediatrician, Dr. Tom Warshawski, who arranged an urgent consultation with an orthopaedic surgeon at B.C. Children's Hospital ("BCCH").

66. Despite the urgency of the consult, Khalfallah's appointment was not scheduled until August of 2010. By that point the curvature of his spine had worsened to 100 degrees.

67. At the August 2010 appointment, the orthopaedic surgeon, Dr. Christopher Reilly, advised that Khalfallah needed surgery, and that there was a two-year waitlist for this

surgery. He also advised that in advance of the surgery, Khalfallah would need an MRI and CT scan to visualize his kyphosis in preparation for surgery.

68. Between August 2010 and his next appointment, Khalfallah began to suffer pain in his back and legs and his deformity developed beyond his hunched back to a distinct barrel chest and forward head thrusting. Ms. Waitkus asked about alternatives to treatment at BCCH, but was advised that there were no alternative options.

69. A follow-up appointment with Dr. Reilly took place in February 2011. At that time, Khalfallah's curvature had worsened to 110 degrees. At that point, Dr. Reilly advised that he would expedite Khalfallah's surgery. As of that time, no MRI or CT scan had taken place.

70. In or about June 2011 a nurse from BCCH advised Ms. Waitkus that, despite the fact that the surgery had been expedited, Khalfallah's surgery had not been scheduled for that summer. As well, the MRI and CT scan had still not been scheduled.

71. Through the Waitkus family's media and social networking advocacy efforts, the Shriner's International became aware of Khalfallah's condition. In July, 2011 Shriner's International contacted Ms. Waitkus and advised they could arrange for free surgical care for Khalfallah at Shriner's Hospital in Spokane, Washington. As no surgery or imaging had yet been scheduled at BCCH, Ms. Waitkus made arrangements to have Khalfallah cared for at Shriner's Hospital.

72. Immediately before leaving for the U.S., Ms. Waitkus was advised by Dr. Reilly that Khalfallah's surgery had been scheduled for November 27, 2011. Since Khalfallah and his mother were already scheduled to leave for the U.S., Ms. Waitkus advised they would be proceeding with the surgery at Shriner's Hospital.

73. Khalfallah underwent diagnostic testing at Shriner's Hospital, which was completed by October, 2011. He was admitted to Shriner's Hospital on November 1, 2011 at which point his spinal curvature was 127 degrees. Khalfallah began a 10-week course of traction therapy which halted advancement of his kyphsosis.

74. Khalfallah received surgery for his kyphosiss at Shriner's Hospital on January 9, 2012. Because of the undue waitlists and waiting times in the public system, Khalfallah had already been waiting for 30 months since his pediatrician's original urgent consult to BCCH.

75. Because of the delays in Khalfallah's treatment, there was a significantly increased risk to Khalfallah of an adverse outcome. Due to complications during surgery, Khalfallah was left a parapalegic. If Khalfallah had obtained medical services in a timely and reasonable way, there is far less likelihood that Khalfallah would have suffered the spinal cord injury which left him paralysed below the navel.

The *Act* and the restrictions on access to health care

~~58~~76. The *Act*, in its Preamble and in sections 2 and 5.1, sets out the guiding principles of the health care system of British Columbia: universality, comprehensiveness, accessibility, portability, public administration, and sustainability. This is in accord with section 3 of the *Canada Health Act*, RSC 1985, c. C-6, which states 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 and to facilitate reasonable access to health services without financial or other barriers".

~~59~~77. The *Act*, in its Preamble, states that the public health care system is founded on the values of individual choice, personal responsibility, innovation, transparency, and accountability.

~~60~~78. MSP is a statutory health insurance scheme, and the residents of the Province entitled to coverage are described as "beneficiaries" and the payments that they must make to the government are described as "premiums".

~~61~~79. The medical services provided by medical and other health practitioners that are covered by MSP are referred to as "benefits" in the *Act*. A "medical practitioner" is defined in section 29 of the *Interpretation Act* R.S.B.C. 1996, c. 238 as a registrant of the College of Physicians and Surgeons of British Columbia entitled under the *Health Professions Act* to practice medicine and use the title "medical practitioner". Sections 1 and 5.3(a) of the *Act* provide, in part, that a "benefit" is a medically required service rendered by a medical practitioner who is enrolled under section 13 of the *Act*, unless the service is determined under section 5 by the MSC not to be a benefit. There is no statutory definition of a "medically required" service. The MSC may determine whether a service is a benefit under sub-paragraph 5(1)(j) of the *Act*.

~~62~~80. The public hospitals and clinics in the Province are operated by various health authorities established pursuant to the *Health Authorities Act*, R.S.B.C. 1996, c. 180, and are funded by block grants made by the provincial government to the health authorities pursuant to the *Hospital Insurance Act*, R.S.B.C. 1996, c. 204.

~~63~~81. Under the *Act*, medical practitioners may choose to be enrolled in the MSP or not. Section 14 of the *Act* requires an enrolled practitioner to choose between receiving reimbursements from MSP or from the patient directly.

~~64~~82. The MSC has established a payment schedule pursuant to section 26 of the *Act* for the amount that will be paid by the MSC to an enrolled medical practitioner for the provision of a "benefit" to a beneficiary.

~~65~~83. Section 17 of the *Act* prohibits a medical practitioner from charging a beneficiary for a service that is within the definition of "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", unless the medical practitioner is not enrolled or has elected to be paid by patients directly, pursuant to section 14 of the *Act*:

> 17 (1) Except as specified in this Act or the regulations or by the commission under this Act, a person must not charge a beneficiary
>
> > (a) for 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.
>
> (2) Subsection (1) does not apply:
>
> > (a) if, at the time a service was rendered, the person receiving the service was not enrolled as a beneficiary;
> > (b) if, at the time the service was rendered, the service was not considered by the commission to be a benefit;
> > (c) if the service was rendered by a practitioner who
> > (i) has made an election under section 14 (1), or
> > (ii) is subject to an order under section 15 (2) (b);
> > (d) if the service was rendered by a medical practitioner who is not enrolled.

~~66~~84. The effect of Section 18 of the *Act* is twofold. Section 18 of the *Act* prohibits a medical practitioner who is not enrolled under the *Act*, but who provides services in a hospital or community clinic that would be "benefits" under MSP, from charging an amount greater than the amount payable under the MSP tariff for that service. Section 18 of the *Act* also contains a more stringent limit on the amount that may be charged to a patient by a medical practitioner who has elected, pursuant to section 14 of the *Act*, to be paid directly by patients rather than by MSP – it limits extra billing in all cases, not only for services rendered in a hospital or community clinic:

> 18 (1) If a medical practitioner who is not enrolled renders a service to a beneficiary and the service would be a benefit if rendered by an enrolled medical practitioner, a person must not charge the beneficiary for, or in relation to, the service an amount that, in total, is greater than
>
> > (a) the amount that would be payable under this Act, by the commission, for the service if rendered by an enrolled medical practitioner, or
> > (b) if a payment schedule or regulation permits or requires an additional charge by an enrolled medical practitioner, the total of the amount referred to in paragraph (a) and the additional charge.

(2) Subsection (1) applies only to a service rendered in

(a) a hospital as defined in section 1 of the *Hospital Act*, or
(b) a community care facility as defined in section 1 of the *Community Care and Assisted Living Act*.

(3) If a medical practitioner described in section 17 (2) (c) renders a benefit to a beneficiary, a person must not charge the beneficiary for, or in relation to, the service an amount that, in total, is greater than

(a) the amount that would be payable under this Act, by the commission, for the service, 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.

~~67~~85. Section 45 of the *Act* prohibits private insurance for the payment, reimbursement or indemnification to British Columbia residents for all or part of the cost of services that would be "benefits" under the MSP, if performed by an enrolled practitioner:

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.

(2) Subsection (1) does not apply to

(a) all or part of the cost of a service
(i) for which a beneficiary cannot be reimbursed under the plan, and
(ii) that is rendered by a health care practitioner who has made an election under section 14 (1),
(b) insurance obtained to cover health care costs outside of Canada, or
(c) insurance obtained by a person who is not eligible to be a beneficiary.

(3) A contract that is prohibited under subsection (1) is void.

~~68~~86. Section 27 of the *Medical and Health Care Services Regulation*, B.C. Reg. 179/2011 (hereinafter the "*Regulation*"), provides that "benefits", for the purposes of the *Act*, do not include services rendered by a health care practitioner to which a patient is entitled under a number of other referral, provincial health insurance or health care provision schemes. The statutory schemes listed in section 27 of the *Regulation* include the schemes for health care under:

- The *Aeronautics Act*, RSC 1985, c. A-2;

- The *Civilian War Pensions and Allowances Act*, now the *Civilian War-Related Benefits Act*, RSC 1985 c. C-31;

- The *Government Employees Compensation Act*, RSC 1985 c. G-5;

- The *Merchant Seaman Compensation Act*, RSC 1985 c. M-6;

- The *National Defence Act*, RSC 1985 c. N-5;

- The *Penitentiary Act*, now the *Prisons and Reformatories Act*, RSC 1985 c. P-20;

- The *Pensions Act*, RSC 1985 c. P-6;

- The *Royal Canadian Mounted Police Act*, RSC 1985 c. R-10; and the *Royal Canadian Mounted Police Superannuation Act*, RSC 1985 c. R-11;

- The *Workers' Compensation Act*, RSBC 1996 c. 492;

- The *Insurance (Vehicle) Act*, RSBC 1996 c. 231.

The persons who are entitled to treatment under the statutory schemes listed in section 27 of the *Regulation* or pursuant to Minute #97-068 or other Commission exemptions are collectively referred to herein as "Preferred Beneficiaries".

~~69~~87. Although neither section 27 nor any other part of the *Act* or *Regulation* expressly excludes services provided to Preferred Beneficiaries by medical practitioners, the MSC has, pursuant to its powers under s. 5(1)(c) of the *Act*, excluded from the definition of

"benefits" under the *Act* services rendered by an enrolled medical practictioner or performed in an approved diagnostic facility for persons entitled to treatment under the statutes set out in paragraph 70, above, with the exception of the *Insurance (Vehicle) Act* (Minute #97-068). The Defendants have ~~invariably~~also treated services provided by medical practitioners to ~~Preferred Beneficiaries~~beneficiaries under the *Insurance (Vehicle) Act* as not being subject to the restrictions contained in sections 14, 17, 18 and 45 of the *Act*. These various exclusions are referred to hereinafter as the "Defendants' Preferential Policy". From time to time, the Commission excludes other services from the definition of "benefits" in the *Act*, or includes services previously excluded.

The wait times and other impediments to access in the British Columbia public health system

~~70~~88. Wait times throughout the British Columbia public health system are unacceptably long, and prevent ordinary British Columbians from having access to a reasonable standard of healthcare within a reasonable time.

~~71~~89. Wait times in the British Columbia public health system have markedly deteriorated over the last fifteen years, and continue to deteriorate, with an increase of wait times in the public health system in British Columbia in 2010, as compared to 2009.

~~72~~90. Wait lists are not only an issue in terms of access to a surgeon or a specialist to perform a required medical treatment. In the British Columbia public health system, there are unacceptable delays to receive diagnostic procedures or to see a specialist for an initial consultation.

~~73~~91. From the perspective of the patients' health, wait times are not assessed as the interval between the time a patient is booked in a public health facility and the time of delivery of treatment by a specialist, as measured by the Ministry of Health Services in British Columbia. Rather, actual wait time includes the time between referral by a general practitioner to a specialist and the time of an appointment with the specialist, the delay

for receiving any diagnostic procedures, and the time until the delivery of treatment by a specialist.

~~74~~92. The actual wait time between the initial referral by a general practitioner and the delivery of treatment by a specialist can lead to complications, a decrease in the likelihood of success with respect to needed medical procedures and irreparable damage. In many cases, unacceptable wait time for treatment will be further associated with prolonged pain, suffering, discomfort, stress and limited ability to function or carry on activities of daily life, thus seriously impacting the physical and psychological security of a person.

~~75~~93. Children may not even be placed on a wait list at all, if they are at an age where, by the time they clear the wait list, they are too old to receive treatment in a Children's hospital, like in Corrado's case.

~~76~~94. For diagnostic procedures, the longer patients wait to obtain the diagnosis for their condition, the more likely they are to suffer complications or experience a decrease in the likelihood of success with respect to their required medical procedures. With respect to some illnesses, there can be dramatic differences in survival rates depending on the time of diagnosis.

~~77~~95. Actual wait times in British Columbia – the time from the initial referral by a general practitioner to the time of treatment by a specialist – are in many instances much longer than the time medical practitioners themselves would consider to be clinically reasonable, and are therefore neither reasonable nor acceptable from a clinical perspective. In that regard, benchmarks adopted by the Ministry of Health Services of British Columbia are inaccurate as they do not reflect the wait times medical practitioners themselves would consider to be clinically reasonable.

~~78~~96. Independent facilities, such as the Surgery Centre and SRC, have the capacity to accept patients, if not immediately, then certainly within a shorter time than they would have if they stayed in the public system.

~~79~~97. Due to significant and unacceptable delays in obtaining medical care and diagnosis through the public health care system, the individual Plaintiffs chose to obtain medical care from an independent, or in the case of Khalfallah, out of country, medical care provider to relieve their pain and suffering, to obtain diagnosis or treat their illness or injury, improve their health outcomes, or extend their lives. For the Plaintiff Khalfallah, this treatment was obtained only after 30 months on a waitlist, during which time his condition, and his chances of a positive outcome, significantly deteriorated.

Part 2: RELIEF SOUGHT

~~80~~98. A declaration that sections 14, 17, 18 and 45 of the *Act*, to the extent that those provisions are designed and have the effect preventing or severely limiting the development and availability of private health care to ordinary British Columbians, particularly when the public health system cannot guarantee reasonable health care within a reasonable time, is contrary to section 7 and section 15 of the *Charter* and is not demonstrably justified under section 1.

~~81~~99. An order pursuant to section 52(1) of the *Constitution Act 1982* that sections 14, 17, 18 and 45 of the *Act* are of no force and effect to the extent of the *Charter* violation.

~~82~~100. Alternatively, a declaration pursuant to section 52(1) of the *Constitution Act, 1982* that sections 14, 17, 18 and 45 of the *Act* are inconsistent with section 7 and section 15 of the *Charter* and are therefore of no force and effect to the extent of the inconsistency, with a suspension of the declaration on the condition that the Province amend the *Act* to bring it into compliance with the *Charter* within six months.

~~83~~101. Costs; and;

~~84~~102. Such further and other relief as this Court may deem just.

Part 3: LEGAL BASIS

Section 7 of the *Charter*

~~85~~103. Section 7 of the *Charter* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

~~86~~104. To establish a breach of section 7 of the *Charter*, the ~~Petitioners~~ Plaintiffs must therefore establish: (1) a deprivation of the right to life, liberty and security of the person by the Legislature or the Government, and (2) that such deprivation is not consistent with the principles of fundamental justice.

Deprivation of the rights to life and the security of the person

~~87~~105. The rights to life and security of the person include the right to access ~~reasonable~~ necessary and appropriate healthcare within a reasonable time.

~~88~~106. Sections 14, 17, 18 and 45 of the *Act* prevent or severely limit the development and availability of private health care to ordinary British Columbians.

~~89~~107. The combined effect of sections. 14, 17, 18, and 45 of the *Act*, directly or indirectly, is to impede the ability of ordinary British Columbians to access health care of a reasonable standard within a reasonable time.

~~90~~108. Under section 17 of the Act, enrolled medical practitioners cannot bill patients directly for a medical service that would be a "benefit" or for "materials, consultations, procedures, use of an office, clinic [...] that relate to the rendering of the benefit", unless the medical practitioner is not ~~enroller~~enrolled or has opted to bill patients directly.

~~91~~109. Pursuant to paragraph 18(3) of the Act, a medical practitioner who has opted under section 14 to be paid directly by patients, cannot charge facilities fees.

~~92~~110. Although, in theory, a medical practitioner who is not enrolled would have the liberty to charge facility fees, except in the circumstances described in paragraph 18(2) of the *Act*, the prohibition on private medical insurance under section 45 of the *Act* renders access to private medical care illusory for ordinary British Columbians who would not have the financial means to pay for the real cost of private medical services. ~~The net effect is that, for the fiscal year 2010-2011, MSP only had 5 non-enrolled physicians.~~

~~93~~111. For consultations and surgeries within the public health care system, the fees for the surgeon or specialist physician are covered by MSP while the cost of the hospital facilities is covered by the Government through the *Hospital Insurance Act*. The costs associated with operating a medical facility and purchasing surgical and diagnostic equipment are tremendous.

~~94~~112. Sections 14, 17, and 18 of the *Act* have the effect of very significantly limiting the options for medical practitioners in terms of offering private medical services to ordinary British Columbians, other than Preferred Beneficiaries, because in their case, independent medical practitioners cannot off-set the operational costs of running a private clinic.

~~95~~113. Most medical practitioners in independent medical facilities, such as those at the Surgery Centre and SRC, are enrolled medical practitioners – which means that they may provide services in public facilities, and also in independent facilities but in the latter case only for Preferred Beneficiaries and other patients not subject to the restrictions of the *Act*.

~~96~~114. Because of the restrictions of the *Act* on direct and extra-billing, combined with the prohibition of private insurance, private medical practitioners in British Columbia are prohibited or seriously limited in offering needed medical care to a large segment of the population. The most important consequences of those measures are felt by ordinary

British Columbians themselves, as they are prevented from having access to needed medical care.

~~97~~115. British Columbia patients facing unacceptable wait times for surgery or diagnostic procedures in the public system cannot have access to private care under the current legislative and regulatory scheme unless, either the independent facilities assume the costs of the use of their medical facilities – which would not be commercially viable, or private medical practitioners and clinics provide patients with medically required services in contravention to the *Act*.

~~98~~116. The combined effect of sections 14, 17, 18 and 45 of the *Act* results in a serious disincentive to independent facilities accepting ordinary patients, which could otherwise alleviate the delays within the public system. Even if those facilities were allowed to charge facility fees, ordinary British Columbians patients who do not have sufficient financial means would be unable to obtain access to health care in the private system unless private insurance is allowed.

~~99~~117. In the circumstances where the public health system cannot provide reasonable health care within a reasonable time, and patients are precluded from choosing to obtain healthcare privately, sections 14, 17, 18 and 45 of the *Act* constitute a deprivation of the rights to life and security of the person guaranteed by section 7 of the *Charter*.

Principles of fundamental justice

Arbitrariness

~~100~~118. It is a recognized principle of fundamental justice that laws should not be arbitrary. A law is arbitrary if it bears no relation to, is inconsistent with or is unnecessary to the objective that lies behind it.

~~101~~119. The prohibition or severe restriction on access to private medical care for ordinary citizens by the operation of sections 14, 17, 18 and 45 of the *Act* are not necessary or related to the objective of the Government in preserving a publicly managed health care system in which individual access to necessary medical health care is based on need and not on an individual's ability to pay.

~~102~~120. Based on comparison with other health systems in Canada and internationally, permitting and facilitating access to a private healthcare system does not jeopardize the existence of a strong public healthcare system. The experiences in other jurisdictions demonstrate that a hybrid private-public health care system allows the public system to thrive and provide better care to patients. There are options available which allow maintaining a vigorous public health system supported by private health services which, together, would allow the provision of reasonable health care within a reasonable time, and thus ensure the protection of *Charter* rights of all British Columbians.

~~103~~121. The exceptions to the *Act*'s restrictions against private insurance and extra billing in section 27 of the *Regulation* and the Defendants' Preferential Policy demonstrate the arbitrary nature of the impugned provisions as they do not apply on a uniform basis. The prohibitions and restrictions do not apply, pursuant to section 27 of the *Regulation* and the Defendants' Preferential Policy, to the beneficiaries of numerous other insurance or health care programs. They have an effect that varies according to the occupation or status of patients, the circumstance that led to the injury or illness, and in their geographic limitations.

~~104~~122. The effect of section 27 of the *Regulation* and the Defendants' Preferential Policy is that British Columbians who fall within the categories of Preferred Beneficiaries receive preferential access to medical diagnosis and treatment at independent surgical or diagnostic facilities in the Province because of their occupation or status in society (as in the case of prison inmates and the RCMP), or the circumstances in which their injury or illness arose (as in the case of WCB or ICBC claimants).

~~105~~123. British Columbians who do not fall into one of the special classes of Preferred Beneficiaries are not permitted to access timely medical diagnosis and treatment through a private medical clinic or to have their diagnosis or treatment paid for through a short term or long term disability insurer or other insurance.

~~106~~124. The arbitrariness of these exceptions is demonstrated through the following example. If a physical education teacher injured one knee while teaching and the other knee while playing recreational sports, both identical injuries requiring surgery, he would be able to have surgery on the one knee immediately, in a private facility paid for by WCB. However, he would have to remain within the public system, and its associated wait times, to have surgery on the knee not injured in the workplace.

~~107~~125. Workers who are injured or become as a result of their jobs are exempted from the Act because it is in their best interests to return to work as soon as possible as well as in the interests of their employers who pay for workers compensation insurance. The same is true for workers who become injured or ill outside of work. They have at least the same interest in returning to work as soon as possible, and maybe even a greater interest if they are not covered by private disability insurance provided by their employers. And their employers have the same interests in reducing their disability insurance and other costs to their businesses resulting from injuries and illnesses off the job by getting their employees back to work as soon as possible.

~~108~~126. Patients seeking medical care who are not Preferred Beneficiaries under section 27 of the *Regulation* and/or the Defendants' Preferential Policy are subject to arbitrary prohibitions and restrictions on reasonable and timely access to medical care, including diagnosis and treatment at critical points in their medical history. Patients who are not Preferred Beneficiaries suffer at least as much, if not more, because of wait times than do patients who are Preferred Beneficiaries.

~~109~~127. The provisions of the *Act* that prohibit and restrict reasonable access to medical care are unnecessary or are inconsistent with the purpose of the *Act*, are prejudicial to a majority

of British Columbians and fail to take into account the actual needs and circumstances of people with health conditions who are not Preferred Beneficiaries.

~~110~~128. These provisions are arbitrary and inconsistent with the public interest in providing timely and effective health care to all British Columbians, regardless of their status, occupation or the circumstances of their injury or illness.

~~111~~129. Indeed, it is Non-Preferred British Columbians who are most in need of timely access to medical diagnosis and treatment that are most prejudiced by the impugned provisions of the *Act*, which prevent them from having the same access to timely and effective medical care as the Preferred Beneficiaries.

~~112~~130. In this context, the guiding principles of the health care system of British Columbia – universality, comprehensiveness, accessibility, portability, public administration and sustainability, and its values – individual choice, personal responsibility, innovation, transparency and accountability, do not require, as a matter of law or fact, that patients be restricted or prohibited from accessing private health care, particularly when the public system does not provide reasonable health care within a reasonable time. On the contrary, these principles and values are enhanced, not diminished, by the availability to patients of private health care options.

~~113~~131. The restrictions or limitations to private medical care under sections 14, 17, 18, and 45 of the *Act*, which deprive the right to life and security of the person, bear no relation to, are inconsistent with or are unnecessary to their stated objective, and therefore violate section 7 of the *Charter*. The provisions are not demonstrably justified under section 1 of the *Charter*.

Overbreadth and disproportionality

~~114~~132. Under the principles of fundamental justice, laws should not be overbroad and disproportional.

~~115~~133. A law is overbroad when the restrictions imposed by the law are broader than necessary to accomplish their purpose.

~~116~~134. Where there is a legitimate state interest, the restrictions imposed by a law to the life, liberty or security of the person will not accord with the principles of fundamental justice when the law is grossly disproportionate to the state interest.

~~117~~135. The prohibition or severe restriction on access to private medical care for ordinary citizens in British Columbia by the operation of sections 14, 17, 18 and 45 of the *Act* are broader than necessary to accomplish the objective of preserving a publicly managed health care system in which individual access to necessary medical care is based on need and not on an individual's ability to pay.

~~118~~136. The class of persons to whom the restrictions on access to private medical care apply is extremely wide – all Non-Preferred British Columbians. There are options available which would allow maintaining a vigorous public health system supported by private health services which, together, would allow the provision of reasonable health care within a reasonable time.

~~119~~137. The prohibition or severe restriction on access to private medical care for ordinary citizens in British Columbia are also grossly disproportionate to the interest of preserving a publicly managed health care system in which individual access to necessary medical health care is based on need and not on an individual's ability to pay.

~~120~~138. As demonstrated by the circumstances of the individual Plaintiffs, the costs for prohibiting or severely restricting access to private medical care for ordinary citizens in British Columbia far outweigh the benefits of allowing the public health system to be supported by private health services.

~~121~~139. The restrictions or limitations to private medical care under sections 14, 17, 18, and 45 of the *Act*, which deprive the right to life and security of the person, are overbroad and disproportional, and therefore violate section 7 of the *Charter*. The provisions are not demonstrably justified under section 1 of the *Charter*.

Vagueness

140. The restrictions or limitations to private medical care under sections 14, 17, 18 and 45 are in many cases, vague and unclear. The Commission's powers under s. 5(1)(c) to determine whether certain services are benefits under the *Act* are often exercised in a manner which makes it difficult for a medical practitioner or a patient to determine whether or not a particular service is a benefit under the *Act*. Further, the Commission's practice of altering this determination from time to time for reasons unrelated to whether the service is actually "medically required" from a medical perspective renders the definition of this term and of benefits under the *Act* impermissibly vague.

Section 15 of the *Charter*

~~122~~141. Section 15 (1) of the *Charter* provides:

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

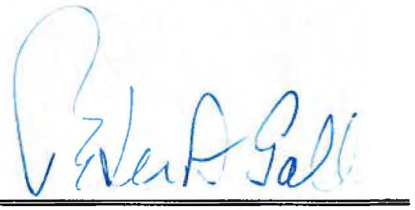
~~123~~142. The exceptions to the *Act*'s restrictions against private insurance and extra billing in section 27 of the *Regulation* and the Defendants' Preferential Policy discriminate between British Columbians based on physical disability.

~~124~~143. Some injured or ill persons in B.C. are exempted from the provisions of the Act and are therefore able to access timely medical treatment outside of the public system. Other injured or ill persons are not entitled to do so. There is no sound public policy rationale for this discriminatory treatment.

~~125~~144. All British Columbians who are disabled should have the equal benefit of health care in the conditions offered to Preferred Beneficiaries, and no one should be left on wait lists with potentially tremendous health consequences, because of irrational distinctions, e.g. a patient's occupation or status in society, or the circumstances in which an injury or illness arose.

~~126~~145. The restrictions or limitations to private medical care under sections 14, 17, 18, and 45 of the *Act*, which discriminates between British Columbians on the basis of physical disability, therefore violate section 15 of the *Charter*. The provisions are not demonstrably justified under section 1 of the *Charter*.

Date: January 10, 2013



Peter A. Gall, Q.C.
Lawyer for ~~Petitioners~~ Plaintiffs

Plaintiffs' address for service:	Heenan Blaikie LLP 2200 - 1055 West Hastings Street Vancouver, BC V6E 2E9 Attention: Peter A. Gall, Q.C.
Fax number address for service (if any):	604 669 5101
E-mail address for service (if any):	pgall@heenan.ca
Place of trial:	Vancouver
The address of the registry is:	800 Smithe Street Vancouver, BC V6Z 2E1

Rule 7-1 (1) of the Supreme Court Civil Rules states:

(1) Unless all parties of record consent or the court otherwise orders, each party of record to an action must, within 35 days after the end of the pleading period,

(a) prepare a list of documents in Form 22 that lists

(i) all documents that are or have been in the party's possession or control and that could, if available, be used by any party at trial to prove or disprove a material fact, and

(ii) all other documents to which the party intends to refer at trial, and

(b) serve the list on all parties of record.

APPENDIX

[*The following information is provided for data collection purposes only and is of no legal effect.*]

Part 1: CONCISE SUMMARY OF NATURE OF CLAIM:
Constitutional challenge to provisions of the *Medicare Protection Act*.

Part 2: THIS CLAIM ARISES FROM THE FOLLOWING:
[*Check one box below for the case type that best describes this case.*]

A personal injury arising out of:

[ ] a motor vehicle accident
[ ] medical malpractice
[ ] another cause

A dispute concerning:

[ ] contaminated sites
[ ] construction defects
[ ] real property (real estate)
[ ] personal property
[ ] the provision of goods or services or other general commercial matters
[ ] investment losses
[ ] the lending of money
[ ] an employment relationship
[ ] a will or other issues concerning the probate of an estate
[X] a matter not listed here

Part 3: THIS CLAIM INVOLVES:
[*Check all boxes below that apply to this case*]

[ ] a class action
[ ] maritime law
[ ] aboriginal law
[X] constitutional law
[ ] conflict of laws
[ ] none of the above
[ ] do not know

Part 4:
[*If an enactment is being relied on, specify. Do not list more than 3 enactments.*]

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*