No. S-090663
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 OF BRITISH COLUMBIA, and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

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, CAROL WELCH, and the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY

INTERVENORS

NOTICE OF APPLICATION

[Re: Request to Appear-A/Chief Justice Cullen(Seized)-VA S-090663-Cambie Surgeries Corporation et al v. Medical Services Commission, et al – CONF#120141118070]

Names of applicants: The Defendants Medical Services Commission of British Columbia, Minister of Health of British Columbia, and Attorney General of British Columbia

To: Dr. Jean Lauzon, Dr. Michael Gilbart, Dr. Jordan Leith, Dr. Trevor Stone, Dr. Farhad Moola, and their solicitors.

On Notice To: The Plaintiffs, and their solicitors; the Intervenors, and their solicitors

TAKE NOTICE that an application will be made by the applicants to the Associate Chief Justice at the courthouse at 800 Smithe Street, in the City of Vancouver, in the Province of British Columbia, on **6 February 2014 at 9:45 a.m.** for the orders set out in Part 1 below.

Part 1: ORDERS SOUGHT

1. That Dr. Lauzon, Dr. Gilbart, Dr. Leith, Dr. Stone, and Dr. Moola (the "Respondent Physicians") attend to be examined on oath on the matters in question in the action within 14 days of the hearing of this application.

Part 2: FACTUAL BASIS

1. In this action, the plaintiffs seek declarations that ss. 14, 17, 18, and 45 of the *Medicare Protection Act*, R.S.B.C. 1996, c. 248 (the "Act") infringe sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*; and an order pursuant to s. 52(1) of the *Constitution Act*, 1982, that ss. 14, 17, 18, and 45 of the Act are of no force or effect to the extent of the inconsistency.

2. The plaintiffs include two corporate entities, Cambie Surgeries Corporation ("Cambie") and Specialist Referral Clinic (Vancouver) Inc. ("SRC"), which operate respectively a "multi-specialty surgical and diagnostic facility" and a "medical clinic".

3. The Further Amended Notice of Civil Claim, filed 10 January 2013, among other facts and assertions, pleads the following:

    a. Diagnosis and treatments at Cambie are performed by physicians who are independent professionals and not employees (para. 13);

    b. Private medical facilities are beneficial for overall health care in British Columbia; they attract specialist doctors to the province, offer flexible work hours to nurses, and help to attract nurses back into the workforce (para. 15);

    c. Permitting access to a private healthcare system does not jeopardize the existence of a strong public healthcare system (para. 120).

4. The defendants, in their response to the further amended claim, plead the following:

    a. Private for-profit medical clinics like Cambie and SRC exist for the purpose of maximizing the income of their owners and of the physicians who practise there (para. 61);

b. Physicians are able to earn more money for the same or less effort in private clinics such as Cambie and SRC as compared with the public system (para. 62);

c. As a result there is a tendency for physicians to prefer private over public practice, with a corresponding reduction in the quantity and quality of care available in the public system (para. 63);

d. There is an incentive for physicians who practice in both private and public systems to encourage patients to seek treatment from them privately (para. 65);

e. There is an incentive for physicians with an ownership interest in a private clinic to refer patients to the private clinic for treatment that is not appropriate (para. 66);

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 (para. 70(f));

g. Ethical concerns may arise when physicians have ownership interests in the private clinics to which they refer privately insured patients (para. 70(g)); and

h. Private clinics restrict their practices to less complicated cases, leaving public hospitals with a relatively more complex and expensive case mix (para. 70(h)).

5. These assertions of fact are central to the defendants' response to the plaintiffs' *Charter* claim, which includes the following assertions:

a. 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 emergent medical conditions (para. 59);

b. This unavailability interferes with the ability of the public health care system to provide appropriate and timely medical care to beneficiaries (para. 60);

c. 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 (para. 64);

d. The Impugned Provisions are intended to, and do, inhibit the development of such inequitable provision of medical care to British Columbian beneficiaries (para. 67);

e. Striking down the Impugned Provisions would neither create, nor compel the creation of, a health care system similar to a supposedly preferable system in some other jurisdiction. Instead, it would simply create a health care system in which medical care is provided preferentially to those who are more able to pay for it (para. 71);

f. The Impugned Provisions are both related to and consistent with the objective of the Act, [and as such are not "arbitrary"] (Part 3, para. 7);

g. The purpose of the Act, and of the Impugned Provisions, ... cannot be effectively realized by some narrower prohibition [so the Impugned Provisions are not overbroad] (para. 11); and

h. The Impugned Provisions are not disproportionate to the purpose of the Act [and as such are not grossly disproportionate] (para. 14).

6. The academic literature provides ample support for these assertions:

a. Claims that increased private payment will improve access to the public system are economic nonsense. When practitioners can work simultaneously in the public and in the private systems, and/or can extra-bill some of their patients, they will focus their attention on the more remunerative patients. Public patients go to the back of the queue. None of this is hypothetical: the "wallet biopsy" has been a feature of the British National Health Service throughout its existence. People, even doctors, respond to economic incentives. ... Surgeons who have an equity interest in a private clinic as well as admitting privileges in the public system have a direct economic interest in referring the "cheap and cheerful" cases to their private clinics, while admitting the more complex and costly cases to the public hospitals. ... There are further problems if surgeons working in both systems are able, directly or indirectly, to extra-bill their private patients. This creates an obvious and readily understandable economic incentive both to steer patients to their private clinics and to devote more time and effort to those private patients. ... The incentives to over-treatment embodied in the fee-for-service system, memorably described by Shaw a century ago, have been noted for millennia. Each professional must reconcile these incentives with his or her own ethical standards. But the evidence is quite clear that, when the incentives and the motivations change, so does (average) provider behaviour. Substituting private fee-for-service clinics

for hospitals increases the weight of economic motivations in this balance. (Robert G. Evans, "Reform, Re-Form, and Reaction in the Canadian Health Care System" (2008) *Special Ed. Health L.J.* 265 at 272, 276-277, 278)

b. Despite the theoretical argument that increased private funding in Canada will relieve demand for care in the public sector and shorten public waiting lists, there are several potential reasons why public waiting lists might actually grow longer as the role of private funding for medically necessary services increases:

- If remuneration for services is greater in the private sector than in the public sector, healthcare providers may be preferentially attracted to the private sector and have an incentive to keep their public sector waiting lists long so that patients may be shifted from the public sector to the private sector when the wait-time guarantee expires.
- If complications experienced by private patients are managed in public hospitals, the resources available for elective operations such as joint replacements in public sector hospitals may decrease.
- The supply of physicians, nurses and other healthcare professionals in Canada is not easily increased; if the health human resource shortage in public sector hospitals is exacerbated by the growth of private clinics, then public waiting lists may lengthen. (Irfan Dhalla, "Private Health Insurance: An International Overview and Considerations for Canada" (2007) 5:3 *Longwoods Review* 89 at 94)

c. US data suggest that physician ownership of [independent health facilities] increases the number of referrals and leads to higher costs. Physicians who owned and operated diagnostic imaging equipment in their offices were up to 7 times more likely to obtain radiologic examinations than were physicians who always referred patients to radiologists. In addition, the charges per episode of care were significantly higher for self-referring physicians. (Sujit Choudhry, Niteesh K. Choudhry, & Adalsteinn D. Brown, "Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral" (2004) *Canadian Medical Association Journal* 1115)

d. Recent years have witnessed important public investments in physicians' compensation across Canada. The current paper uses data from Quebec to assess the impact of those investments on the volumes of services provided to the population. While total physician compensation costs, average physician compensation and average unit cost per service all rose extremely fast, the total number of services, number of services per capita and average number of services per physician either stagnated or declined. ...

These observations are highly convergent with the target income hypothesis: as the unit price of service rose, physicians adjusted their work practice and, overall, limited the number of services provided. (Damien Contandriopoulos & Melanie Perroux, "Fee Increases and Target Income Hypothesis: Data from Quebec on Physicians' Compensation and Service Volumes" (2013) 9:2 *Healthcare Policy* 30 at 30, 33)

e. This study has confirmed the findings of previous overseas studies that suggest that increased private sector activity is associated with increased public sector waiting times, the reverse of the rhetoric supporting policies to increase support for the private sector in order to "take the burden off the public sector". ... Occam's razor would also suggest that a simple proposition, that more public activity would reduce public waiting times, should be preferred over the complex, 'trickle down' hypothesis that more private activity will somehow flow through to benefits to those reliant on the public sector. (Stephen J. Duckett, "Private care and public waiting" (2005) 29:1 *Australian Health Review* 87 at 92, 93)

f. The mountain of evidence against parallel private healthcare underscores some logical flaws in arguments for it. First, since healthcare practitioners can't be in more than one place at the same time, creating a parallel private system simply takes badly needed doctors and nurses out of our public hospitals. Given that most people believe we already have a shortage of both, it's hard to see how removing them from the public system will help alleviate public waits. Second, since doctors earn more in the private sector, they have what economists call a "perverse incentive" to keep public waiting lists long, to encourage patients to pay for private care. (Canadian Health Services Research Foundation, "Myth: A parallel private system would reduce waiting times in the public system" (2005) online: < http://www.cfhi-fcass.ca/Migrated/PDF/myth17_e.pdf>)

g. There are a number of serious dangers associated with permitting doctors to "double dip", which is why Ontario currently forces doctors to decide which system in which they wish to practice ... [G]iven that there is a finite pool of health professionals, where parallel public and private systems exist, the private system tends to siphon doctors and nurses away from the public system, thereby lengthening waits in the public system. (Dr. Michael Rachlis, *Privatized Health Care Won't Deliver* (Toronto: Wellesley Institute, 2007) at 19)

h. [I]n theory, doctors do not need to sacrifice time devoted to public hospital patients to treat patients in private hospitals. ... Private cover may nonetheless create incentives for differentiated access and treatment according to insurance status because doctors and public hospitals treat both public and private insures, and they are better paid when treating private patients. (Francesca Colombo & Nicole Tapay, *Private Health Insurance in Australia: A Case Study* (Paris: OECD, 2003) at 33)

i. The findings indicate that private patients are treated differently than public patients in public hospitals. While there are no discrepancies in the outcomes of care, private patients are assigned higher urgency and tend to jump the queue. Similar findings were reported by Johar and Savage (2010). When admitted, they are more likely to spend time in ICU and to receive more procedures, both in overnight and same-day separations. Since the private patients are generally healthier, this finding is probably due to the higher marginal revenue received by the hospital combined with the [fee for service] reimbursement of doctors for treating private patients. ... Two patients, one being private and probably healthier and the other being public admitted to the same ward (after different waiting time) with similar problems are expected to receive different care, and furthermore, the healthier private patient is likely to get more care. (Amir Shmueli & Elizabeth Savage, "Private and public hospitals in public hospitals in Australia" (2014) *Health Policy*)

Affidavit #2 of Christine Jackson, sworn 23 January 2014, Exs. "A" through "I".

7. The representatives of the plaintiffs have confirmed in the course of their examination for discovery that, because the physicians offering services at their clinics are independent contractors, they (the clinics) cannot provide information about the physicians' own practices. They have also declined to seek answers from the physicians to requests made during the examinations for discovery.

Affidavit #4 of Carol Brossard, sworn 24 January 2014, paras. 29-33, Exs. "BB" through "EE".

8. As a result, the defendants cannot obtain the evidence they require without interviewing the physicians themselves.

9. The Respondent Physicians all provide services at the clinics operated by the corporate plaintiffs, the Cambie Surgery Centre and the Specialist Referral Clinic, respectively.

10. The Respondent Physicians are all shareholders of SRC. Dr. Leith also appears to be a shareholder of Cambie, through Dr. J.M. Leith Inc.

Brossard Affidavit #4, Exs. "FF" and "GG".

11. All of the Respondent Physicians are also enrolled with the Medical Services Commission, and provide services in the B.C. public health care system.

12. On 21 November 2013 counsel for the defendants wrote to each of the Respondent Physicians regarding the material evidence it appears they have in their possession, and requested their response to certain questions that will help the defendants to understand all of the facts relevant to the allegations made in the pleadings.

Brossard Affidavit #4, Exs. "A," "G," "K," "O," and "T".

13. The Respondent Physicians, through their counsel, have refused to respond to the questions.

Brossard Affidavit #4, Exs. "E," "J," "N," "R," and "AA".

Part 3: LEGAL BASIS

1. The applicants rely on:

   a. *Supreme Court Civil Rules*, Rule 7-5

   b. *Black v. Gust*, 2000 BCSC 991;

   c. *Sinclair v. March*, 2002 BCCA 65;

   d. *Swirski v. Hachey* (1995), 16 B.C.L.R. (3d) 281 (S.C.);

   e. *Yemen Salt Mining Corp. v. Rhodes-Vaughan Steel Ltd.* (1977), 3 B.C.L.R. 98 (S.C.); aff'd 1977 CarswellBC 761 (C.A.); additional reasons at 1977 CarswellBC 762 (C.A.).

2. Rule 7-5(1) of the Supreme Court Civil Rules, B.C. Reg. 168/2009 allows the court to order that a person who is not a party of record to the action who may have material evidence be examined on oath on the matters in question in the action.

3. The applicant need only establish that the person in question may have material evidence, and that he or she has refused to give a responsive statement, either orally or in writing.

4. As set out above, there is reason to believe that the Respondent Physicians have material evidence in their possession relating to the matters in question in the action. The defendants have squarely raised in the pleadings the effects that the existence of a "private" health care option can have on the behaviour of physicians, particularly when those physicians have an ownership interest in a private clinic.

5. The Respondent Physicians have, in effect, been practising simultaneously in the public health care system and in a private health care setting, and are uniquely placed to provide evidence with respect to their engagement with both systems. They all also have an ownership interest in one or both of the plaintiff clinics.

6. Furthermore, the plaintiffs have made it clear that, because the physicians who provide services at the clinics are independent contractors, they are unable to answer questions about those physicians' practices, even questions relating to their provision of services at the clinics.

7. The Respondent Physicians have also refused to answer the questions that the applicants have put to them.

8. The applicants therefore say that they have satisfied the requirements of Rule 7-5, and ask that the court exercise its discretion to order the Respondent Physicians to attend and be examined under oath in relation to the matters in issue in this litigation.

9. The only parties with standing to speak to this application are the applicants and the Respondent Physicians.

Part 4: MATERIAL TO BE RELIED ON

1. Affidavit #4 of Carol Brossard, sworn 24 January 2014;

2. Affidavit #2 of Christine Jackson, sworn 23 January 2014.

The applicant estimates that the application will take 2 hours.

[ ] This matter is within the jurisdiction of a master.

[X] This matter is not within the jurisdiction of a master.

TO THE PERSONS RECEIVING THIS NOTICE OF APPLICATION: If you wish to respond to this notice of application, you must, within 5 business days after service of this notice of application or, if this application is brought under Rule 9-7, within 8 business days after service of this notice of application,

(a) file an application response in Form 33,

(b) file the original of every affidavit, and of every other document, that

(i) you intend to refer to at the hearing of this application, and

(ii) has not already been filed in the proceeding, and

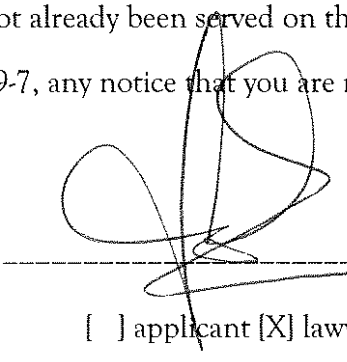
(c) (c) serve on the applicant 2 copies of the following, and on every other party of record one copy of the following:

(i) a copy of the filed application response;

(ii) a copy of each of the filed affidavits and other documents that you intend to refer to at the hearing of this application and that has not already been served on that person;

(iii) if this application is brought under Rule 9-7, any notice that you are required to give under Rule 9-7 (9).

Date: **24 January 2014**



Signature of
[ ] applicant [X] lawyer for applicant(s)
Jonathan Penner

To be completed by the court only:

Order made

[ ] in the terms requested in paragraphs ..... of Part 1 of this notice of application

[ ] with the following variations and additional terms:

.....

.....

.....

Date: .....[*dd/mmm/yyyy*]..... .....

Signature of [ ] Judge [ ] Master

APPENDIX

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

THIS APPLICATION INVOLVES THE FOLLOWING:

[Check the box(es) below for the application type(s) included in this application.]

[ ] discovery: comply with demand for documents

[ ] discovery: production of additional documents

[ ] other matters concerning document discovery

[ ] extend oral discovery

[X] other matter concerning oral discovery

[ ] amend pleadings

[ ] add/change parties

[ ] summary judgment

[ ] summary trial

[ ] service

[ ] mediation

[ ] adjournments

[ ] proceedings at trial

[ ] case plan orders: amend

[ ] case plan orders: other

[ ] experts

This **NOTICE OF APPLICATION** is prepared by **Jonathan Penner**, Barrister & Solicitor, of the Ministry of Justice, whose place of business and address for service is 6th Floor – 1001 Douglas Street, Victoria, British Columbia, V8W 9J7; Telephone: (250) 952-0122; Facsimile: (250) 356-9154; Email Address: jonathan.penner@gov.bc.ca.