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 Services of British Columbia, and Attorney General of British Columbia

Defendants

AND:

Dr. Duncan Etches, Dr. Robert Woolard, Glyn Townson, Thomas McGregor, British Columbia Friends of Medicare Society, Canadian Doctors for Medicare, Mariel Schooff, Daphne Lang, Joyce Hamer, Myrna Allison, and the British Columbia Anesthesiologists' Society

Intervenors

AND:

The Attorney General of Canada
(Pursuant to the *Constitutional Amendment Act)*

OPENING STATEMENT OF THE PATIENT INTERVENORS
September 14, 2016

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Table of Contents

The Patient Intervenors

1. We, Marjorie Brown, Allison Tremblay and Craig Bavis, represent the following individuals named in the style of cause: Mariel Schooff, Daphne Lang, Joyce Hamer and Myrna Allison (herein collectively referred to as the "Patient Intervenors"). The Patient Intervenors have a unique interest and perspective on the issues raised in this trial and support the single payer public healthcare model that the Plaintiffs challenge. The position of the Patient Intervenors is that there is no breach of the *Charter* in the *Medicare Protection Act* ("*MPA*").

2. The Patient Intervenors will provide evidence of a variety of patient experiences with both the public healthcare system and the private user-pay model and will demonstrate the difficulties posed when the two models compete. The Patient Intervenors will also provide significant contextual background to this litigation that will demonstrate the corporate Plaintiffs, Cambie Surgeries Corporation and Specialist Referral Clinic (Vancouver) Inc., have a large pecuniary interest in the private healthcare model, which we submit is the motivation for the this challenge.

Background to this Action

3. In order to understand the role and perspective of the Patient Intervenors, it is important to understand the genesis of this action. This trial is rooted in events that occurred almost 15 years ago, starting in 2002, when the British Columbia Nurses' Union (the "BCNU") first began to raise concerns over the growth of private surgical clinics and their impact on patients.

4. The BCNU is a trade union representing over 42,000 professional nurses and allied healthcare workers, providing care in hospitals, long-term care and in the community, including registered nurses, registered psychiatric nurses and licensed practical nurses. BCNU is a key stakeholder in the BC healthcare system, representing workers in the public health care system and in some private healthcare worksites.

5. The primary mandate of the BCNU is to secure reasonable working conditions for its members through the collective bargaining process, including appropriate compensation, workload, hours of work, training, health and safety, and other conditions of employment. Beyond collective bargaining, the BCNU works to ensures standards of work and maintained and the workers -and-patients have a safe healthcare environment. The public healthcare system thrives when it has an appropriately staffed and competent workforce working under reasonable conditions. It is the BCNU that speaks out on professional standards issues, ensuring safe practice environments for its patients and union members. The BCNU has a long history of bringing matters up in any forum, from this court to before the College of Registered Nurses of BC to attend to and defend nursing safety.

6. The BCNU is also committed to the public healthcare model and ensuring its continuation by supporting the principles of the *Canada Health Act*. In addition to collective bargaining, BCNU plays an active role in public policy discussions about the role of government and health authorities in healthcare and engages in the discourse about budgetary and social policy decisions that impact health.

The BCNU Petition

7. As part of this mandate, BCNU became concerned about private surgical clinics and wrote to physicians who provided services at the Plaintiff Cambie Surgeries Corporation ("Cambie") and other private clinics, including the False Creek Surgical Clinic, and advised they were in breach of the *MPA.* In 2002 the BCNU wrote to various clinics, including False Creek, advising that they were in breach of the *MPA* by charging patients for surgeries and consultations while also charging MSP.

8. The BCNU wrote to the Provincial Government in 2003 advising of the breaches it had discovered. The BCNU requested that the Provincial Government enforce the *MPA* and cease the now acknowledged illegal action of Cambie and other private clinics. When letters to the Government did not result in any action, BCNU started a legal action as a public interest litigant seeking a petition to require the BC Government to enforce the *MPA*.

9. The Defendant opposed this petition on the grounds that the BCNU did not meet the criteria for public interest standing. This position was upheld on the basis that the while the BCNU has a genuine interest in the issue, the matter was best raised by private litigants: *British Columbia Nurses' Union v. Attorney General of British Columbia*, 2008 BCSC 321. **[Appendix A]**

> [37] In the present case the continued viability of the Medicare Protection Act affects the Union and its members in a multitude of direct and indirect ways. The petitioner has had extensive involvement in the dispute. I am satisfied that the petitioner has a genuine interest in ensuring that the Commission remains accountable for its actions.
>
> [44] In this case, the petitioner argues that the Commission has failed to perform a statutory duty imposed by the Medicare Protection Act, namely to ensure that physicians who impose a user charge are not also paid for procedures performed under the Act. Those directly affected by the Commission's failure to perform this duty include those patients who have accepted illegal treatment, as well as patients who have not accepted illegal treatment but who have suffered as a result of those who have infringed the Act, in the form of longer waiting times, delayed appointments, or reduced quality of care. Medical practitioners may also be directly affected by the Commission's failure to perform its statutory duty. As set out in Canadian Council of Churches and Canadian Bar Association, those private litigants who are directly affected by the Commission's actions are in a better position to initiate a lawsuit. In making decisions, the court benefits from a clear and concrete factual underpinning. A private litigant who is directly affected by proposed litigation can raise arguments and provide a more precise factual scenario than a public interest litigant. In evaluating whether to grant public interest standing, it is important to ensure that the views of public litigants do not displace the views of private litigants.

The Patient Petition

10. After the BCNU was denied standing, a group of patients, including the Patient Intervenors in this action, drafted a similar petition to the BCNU's, seeking to hold the Government accountable and requiring it to enforce the *MPA* and further seeking a declaration that the Medical Services Commission and the Ministry of Health were not acting in accordance with their obligations under the *MPA*. In particular, the Patient Intervenors alleged that the Commission and Ministry failed to enforce the legislative prohibition against direct and extra billing for medically required services rendered by medical practitioners, contrary to ss. 17(1) and 13(6) of the *MPA*.

11. However, due to the increasing public significance of the issue of private surgical clinics, the Medical Services Commission sought to audit the clinics, leading to the Plaintiffs to commence this action. The BC Supreme Court dealt with the two actions and a trial judge was appointed to case manage the petition and the current action. The trial judge determined the appropriate way to deal with the issue was to allow the current action and to stay the Patient Intervenors's petition and the Plaintiffs' action in *Schooff v. Medical Services Commission*, 2009 BCSC 1596. **[Appendix B]**

> [35] These proceedings are at an early stage, and there must be some flexibility as they evolve. However, this much is already clear. It will be necessary to find facts in a complex area, on the basis of rigorously-contested evidence, in order to consider properly the Constitutional Issues that the Plaintiffs raise, both as to whether there is a section 7 Charter infringement, and, if so, whether such infringement is justifiable under s. 1. Although I do not doubt that the experienced counsel involved in this case could devise ways to present the case through affidavits including those of experts, with exhibits and written arguments, there is every prospect that the volume of material will be very extensive. I note the difficulties inherent in summary proceedings where there are complex issues and a large volume of material (see Simon Fraser Student Society v. Canadian Federation of Students at para. 16-22). I further note that significant expert evidence can sometimes be more effective in assisting the Court when given by the expert in the courtroom because there is the opportunity for responses to questions by the Court. Further, the pleadings in the Action squarely raise the Constitutional Issues; on the other hand, the Petition does not (although it is true that the Notice of Constitutional Question has been filed in the Petition.)

The Present Action

12. As this action proceeded, the BCNU applied for intervenor status and the Patient Intervenors applied for party status. As is evident from their participation here, the Patient Intervenors were granted intervenor status, but not the BCNU: *Canadian Independent Medical Clinics Association v. British Columbia (Medical Services Commission)*, 2010 BCSC 927. **[Appendix C]**

> [48] Their perspective on the issues, as patients who have had involvement with privately delivered health care and who support the constitutionality of the MPA, will not otherwise be brought before the Court. I think they can make a valuable contribution and I will grant their application for intervenor status.

> [49] As for the terms upon which the individual applicants are permitted to intervene, I have concluded that they should be permitted to submit evidence as well as legal argument in this proceeding. This is for two reasons. First, it appears that they will be able to bring forward evidence that would enhance the evidentiary record. Second, if their petition had not been stayed, they would have been able to lead such evidence in that proceeding. Their submissions of evidence and legal argument will be in a form and with such limits as are determined at a later stage

13. As illustrated, the Patient Intervenors have had a long role in these proceedings and a significant interest in public healthcare. It is critical to hear the voice of patients, independent from both the Defendant and the patients who are enlisted by Cambie to support its claim.

Perspective of the Patient Intervenors

14. The Patient Intervenors take the position that the *MPA* is a dignified way by which to lawfully ensure equal access to necessary medical care, regardless of one's ability to pay, or financial and/or social circumstances.

15. The Plaintiffs claim the *MPA* breaches sections 7 & 15 of the *Charter*. One of the purposes of canvassing the manner in which this was brought to court is to underline what we submit is the audaciousness of the Plaintiffs' position. The Plaintiffs did not, of their own accord, seek to challenge the *MPA* under the *Charter* as a result of deeply held convictions about the lawfulness of the *MPA* in 2002, although they may indeed hold that view. Rather, they willingly and blatantly breached the *MPA* throughout this litigation (and prior) to the point of obtaining a stay, which allowed them to continue to violate the law pending the outcome of this case.

16. This contrasts so starkly with many other cases brought under the *Charter*, particularly those under sections 7 & 15, which influence the social, economic and health conditions of Canadians, such as *R. v. Morgentaler*, [1988] 1 SCR 30, *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519 and *B.(R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315. These are all cases brought virtually in the first instance of discovering the perceived conflict between the law, as it stood, and the *Charter*.

17. Instead, there is 20 years of flagrantly unlawful profiteering that was brought to the attention of these very Plaintiffs 14 years ago by the BCNU. This case is really about advancing the self-interest of the Plaintiff Clinics at the expense of the continuation of the public healthcare system that by and large delivers the very medical care to Canadians when they need it.

18. As with any government program, there is a balance of interests that can result in less emergent cases not advancing as quickly through the system. The cancer patient is seen before the hip replacement. The heart attack patient receives an operation before the knee replacement. There are other challenges in the system: for example, the public system is has suffered from a shortage of Operating Room nurses, a resource the Cambie Centre actively seeks out to staff its clinics.

19. The government, and not the free market advocated by the Plaintiffs, is better suited to balance these interests and, as a result, Canadians have both the *Canada Health Act* and the *MPA* to ensure the fair delivery of healthcare in the interests of Canadians, and not a small group of private clinic owners, who's intentions merit a degree of scepticism given the manner in which they have come before this Court.

20. All people worry about their health. It is one of the aspects of being human. But in Canada, we have the right to worry about our health without that worry being compounded by concerns about the cost of necessary medical care. That is the promise of the *Canada Health Act* and universal medicare. And that is the promise of the impugned *Medicare Protection Act*. No one will go bankrupt because of medical care for a heart attack. No one will forego necessary cancer treatment because they cannot afford the treatment. No one need choose between going to the hospital and feeding their children – hospital and physician services are insured by a single payer: the Province of British Columbia.

21. At its base, the public healthcare system considers all people equal. It refuses to be influenced by arbitrary non-medical concerns like income. This system does necessarily entail some choices, however. When two people arrive for care at the same time, instead of choosing who obtains priority care based on who is willing to pay more, the medical professionals prioritize

according to the most urgent care need. Yet that alternate system, of prioritizing on the basis of ability to pay, is exactly what the Plaintiffs advocate. Although the Plaintiffs maintain that they will assist the system by increasing capacity, the evidence from patients with experience in both the public and private systems is that in that alternate system, patients who can pay jump to the front of the line.

22. There is only one pot of money in British Columbia to pay for healthcare. Currently the majority of that pot goes to the public system, but some of that money has been syphoned off for the illegal practices of Cambie and related clinics. That is, wealthy individuals who are able to pay the user fees and extra billing charged by the clinics can jump the queue to see specialists (and thereby move up in the surgery queue) or jump the queue for surgery itself.

23. In the Plaintiffs' opening, after describing the financial pressures on the public system, the Plaintiffs offered up private clinics as a new source of funding for the system. Nothing could be further from the truth. Money for private clinics comes from the same pot of money for healthcare; however, instead of being distributed equitably after collection through taxation, it is distributed in a manner which favours the wealthy at the expense of the poor.

24. The provisions the Plaintiffs seeks to strike are all about the ability to charge money for services. Section 14 of the *MPA* requires practitioners to opt in or out of MSP. Section 17 prohibits enrolled practitioners from charging beneficiaries directly. Section 18 prohibits extra charges for medically necessary services. Section 45 prohibits purchase and sale of private insurance. In this sense, the Plaintiffs section 7 argument is not about liberty or security of the person, but rather about the right to profit for a private corporation.

25. None of these provisions prohibit patients from accessing available healthcare services. None of these provisions prohibit sympathetic practitioners from establishing facilities that provide healthcare services within the constraints of the *MPA*. What they do prevent is practitioners from benefitting financially from providing those services outside the public system.

26. In the language of *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 SCR 307, there is no sufficient causal connection between the provisions enacted by the state and the prejudice – wait time – suffered by citizens in need of healthcare. The prohibition on private clinics making money does not cause wait time. Wait time may arguably be lessened by the existence of private clinics, but this does not prove causation. Further, if the prohibition was lifted, there is no guarantee of the continued existence of private clinics: if none operate, there would be no impact on waits. Therefore, the Plaintiffs' cannot prove any violation of even the first half of section 7.

27. As regards to section 15, the distinctions in the *MPA* and *Canada Health Act* are based on occupation or other status, not protected grounds under section 15 of the *Charter*. The Plaintiffs' claim states the basis is disability for Worker's Compensation cases, but that is not the distinction. It is not the disability itself, but rather the cause of the disability that is determinative, and so it is an occupation-based distinction.

28. In addition to the acknowledged breach of the *Medicare Protection Act*, the very notion of what it means to be a British Columbian and a Canadian is even further offended by the queue-jumping, the bait and switch tactics, the cream-skimming of patients and the referral of patients with medical complications back to the purely public system, all of which is done by the Plaintiff Clinics.

29. The Patient Intervenors take the position that the provision of universally accessible, comprehensive, portable, publicly administered healthcare is a government choice that has been implemented in a demonstrably justified manner through the *MPA*. The *MPA* is minimally impairing to citizens and private clinics; is rationally connected to the objective of providing necessary medical care freely and equally to all citizens and overwhelmingly maintains immense salutary benefits for British Columbians that far outweigh any claims of deleterious effects.

30. While the Plaintiffs may recall anecdotal stories where people were given lower priority due to a non-medical characteristic, or a medical characteristic unrelated to that person's current need for medical care, despite the characterization of the Plaintiffs, this case is not just about individual stories or individual patients. The remedy sought is constitutional and the outcome of this case could

determine the fate of medicare for all Canadians across the country. This case is about the future of the public healthcare system, in its ideal and actual forms.

31. It may seem incongruous that the Patient Intervenors begin with a description of a system and an assertion that this case is not about individual plaintiffs when the Patient Intervenors are themselves individuals with individual stories and will introduce as evidence affidavits that tell individual stories. The difference between the Patient Intervenors and the patient Plaintiffs is that the patient Plaintiffs support changes to a nation-wide system based on their unique, and particularly negative experiences within that system.

32. Some of the Patient Intervenors had a negative experience with the public healthcare system too, but their evidence shows the dangers of the alternative the Plaintiffs propose, and belie their claims that their proposal is a panacea to cure what they say are the constitutional ills plaguing the universal access system.

Scope of the Patient Intervenors' involvement in the parties' evidence

33. The Patient Intervenors are aware that this action is control of the parties and will restrict their participation in the adducing of evidence to that necessary to make its arguments, avoiding duplication. The Patient Intervenors anticipate the need to conduct some cross-examination of witnesses, particularly related to the above themes, including the impact of private healthcare on the pubic healthcare system and patients.

Evidence of the Patient Intervenors

34. The Patient Intervenors will present the following facts. In this action, the Plaintiffs claim portions of the *Medicare Protection Act* violate the section 7 right to life, liberty and security of the person by precluding some people from accessing necessary medical services within a particular time frame. The Plaintiffs do not propose to cure that violation for all people – only those who can afford the high costs of private care or private insurance.

35. The Patient Intervenors have prepared nine affidavits that describe the affiants' individual experiences as patients, or in one case, the husband of a patient, in the public and private systems. These affidavits demonstrate the troubling aspects of the Plaintiffs' proposal namely:

(i) Cream Skimming

(ii) Bait and Switch

(iii) Queue-Jumping, and

(iv) Complication Referral.

(i) Cream Skimming

36. The first aspect, **cream skimming**, relates to the Plaintiff Clinic's choice to treat uncomplicated patients, leaving the more complex cases for the public system. They do this by selecting certain procedures to offer at the private clinics: knees and hips, cataracts and colonoscopies for example. In the vast majority of cases, these are relatively less complex day surgeries or procedures.

37. Private clinics do not offer brain or heart surgery or surgery for medically-complex patients. In selecting for the less complex procedures, the private clinics skim the most "profitable" (and least stressful) patients, leaving the public system to address all complex and difficult cases. The procedures described by the affiants reflect this reality, as, we suggest, do the experiences described by the Patient Plaintiffs.

(ii) Bait and Switch

38. The second aspect is **bait and switch tactics**. They are selling tactics. According to one affiant, it works as follows. The doctor tells the patient what the approximate wait is in the public system, but if the patient goes to the physician's private clinic, for a fee, the patient can have the procedure much more quickly. Ms. Welch filed an affidavit about her experience with a doctor selling medical services. Another tactic is to give a patient a quote for a procedure and then when the patient arrives ready for surgery, the price is higher. Ms. Schooff filed affidavit evidence about

this bait and switch tactic. Ms. Lang filed an affidavit describing a situation where she did not know she was referred to a private facility and would have to pay a fee for her medically necessary colonoscopy.

(iii) Queue-Jumping

39. **Queue-jumping** is simple, but can wreak havoc on a system that is based upon triaging patients according to their displayed symptoms. Obviously it includes cases where a patient skips the public wait list to have surgery faster in a private clinic. It also can include patients who pay for diagnostic testing, skipping the line for the test, and then use the test results to get an earlier appointment for treatment in the public system. Private- pay colonoscopies are examples of this kind of queue-jumping.

(iv) Complication Referral

40. The final category of problematic features of the system proposed by the Plaintiffs is **referrals of complications**. Private clinics are not equipped to address the many problems that can occur in surgeries. If an emergency occurs, instead of dealing with it in the private clinic, the patient is sent to public hospital, placing the burden of addressing that emergency on the public system. While the public system is able to address emergencies that follow public surgeries, it is not equipped to act as a backup or emergency valve for a higher volume of surgeries that result from a dual system. Moreover, the patient who suffered the complications would then be bumping the longest waiting patients from the public queue as the hospital addresses their medical situation, stemming from a procedure that could have waited, but due to complications requires immediate attention. Ms. Morrison's affidavit describes such a situation.

(v) Mariel Schooff

41. Ms. Schooff suffered from chronic sinus issues. She was referred to a specialist, Dr. Javer. At her consultation, Dr. Javer told her that it could be up to 5 years to have an operation publically, but he could see her more quickly at a private clinic for a fee. She opted for private care and paid $6125.75 for her surgery. She requested reimbursement from Dr. Javer upon learning that the fee she paid was in contravention of the MPA, but did not receive same.

(vi) Myrna Allison

42. Ms. Allison's prosthodontist, Dr. Shupe, referred her to a specialist, Dr. Naito, for a biopsy. Dr. Shupe's secretary told Ms. Allison that she could see Dr. Naito for a fee in several weeks, or she could wait longer to see him publically. Ms. Allison elected to wait on the public wait list. Dr. Shupe then referred her to another specialist, Dr. Stevens. Dr. Stevens informed Ms. Allison that Dr. Shupe's referral was insufficient as she needed one from her family doctor. She received an urgent referral from her family doctor and saw Dr. Stevens for a consultation approximately one month after her first referral to Dr. Naito. She had a biopsy one week later. She did not pay a fee.

(vii) Carol Welch

43. Ms. Welch had bursitis in her leg. She was referred to a specialist, Dr. Chan. She was given an appointment seven and a half months later. She learned that she could see Dr. Chan for a fee at False Creek and made an appointment for the following week. At her appointment, Dr. Chan told her she could have surgery for a $5000 fee within two weeks, or could have surgery in 4-6 months publically for no fee. Ms. Welch could not afford the $5000 fee so waited. She had her surgery performed publically approximately five months later (and before the referral appointment would have occurred).

(viii) Linda Morrison

44. Ms. Morrison was referred to Dr. Chan for localized spinal stenosis. While on the public wait list, she obtained an earlier consultation at False Creek for a $450 fee. She then had a second consultation one or two months later publically without payment of a fee. Ms. Morrison elected to pay $5500 to obtain faster surgery at False Creek. She attended Dr. Chan's office for a follow-up appointment, where Dr. Chan noticed a haematoma which required emergent care. Dr. Chan took her to the hospital and cared for the haematoma publically. Ms. Morrison attempted to recover the fees she paid but to date has not recovered those fees.

(ix) Peggy Eburne

45. Ms. Eburne had glaucoma and cataracts. She required surgery to have the cataracts removed. Her opthalmologist, Dr. Parkinson, told her that she could have surgery in a few days for a fee. She declined and remained on the public waitlist. She called Dr. Parkinson's office regularly to inquire about her surgery date and was told each time that there was no date set but if she wanted to pay she could have surgery right away. She chose to wait. When she eventually had her surgery, she was convinced to pay $500 for "premium diagnostic procedures", which she was told would improve surgical outcome but were not covered by MSP. Ms. Eburne believes that she may have gotten faster surgery because she complained to her MLA.

(x) Kyle Doyle

46. Mr. Doyle had prompt and efficient emergency care in the public system following a bowel obstruction.

(xi) Larry Cross

47. Mr. Cross had prompt and efficient emergency care in the public system following a sepsis attack and cancer.

Conclusion

48. The Patient Intervenors will argue in support of the constitutionality of the *Medicare Protection Act*. They submit that the legislature has struck an appropriate balance under the principles set out in the *Canada Health Act* and respect for the equality and dignity of all Canadians. The principles of accessibility, universality, comprehensiveness, portable and publicly administered healthcare has been described correctly in the AG of Canada's evidence as a principle of citizenship in this country.

49. To conclude, one of the core values of Canadians is at issue in this case, the evidence overwhelmingly favours the preservation of this value.

All of which is respectfully submitted this 14th day of September, 2016.