No. S-090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

Between:

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

Plaintiffs

And:

ATTORNEY GENERAL OF BRITISH COLUMBIA

Defendant

And:

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

Intervenors

And:

THE ATTORNEY GENERAL OF CANADA

Pursuant to the *Constitutional Question Act*

WRITTEN SUBMISSIONS of the INTERVENOR the BRITISH COLUMBIA ANESTHESIOLOGISTS' SOCIETY

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A. OVERVIEW

1. This litigation concerns wait times for health care in British Columbia and whether, given those wait times, four provisions of the *Medicare Protection Act*, RSBC 1996, c 286 (the "***MPA***"), are contrary to ss. 7 and 15 of the *Canadian Charter of Rights and Freedoms* (the "***Charter***"). If these provisions contravene the *Charter*, the issue is then whether they can be saved under s. 1 of the *Charter*.

2. The intervenor, British Columbia Anesthesiologists' Society (the "**BCAS**"), is a voluntary association representing anesthesiologists in British Columbia. It is also a provincial division of the Canadian Anesthesiologists Society.[1]

3. Anesthesiologists are specialist physicians who are closely involved in the medical care of virtually every patient undergoing surgery, in every surgical discipline, throughout the province.[2]

4. Anesthesiologists have a breadth of experience and directly care for several hundred thousand British Columbians every year within the public health care system.[3]

5. On October 15, 2012, Chief Justice Bauman (as he then was) granted the BCAS intervenor status in this action "on the same basis as did Justice Smith in the case of the BC Health Coalition intervenors". One of these bases was that the BCAS was representative of a particular point of view or perspective that may be of assistance to the court.[4]

6. As an intervenor in this action, the BCAS has sought to provide the Court with an important and distinct perspective and a more complete understanding of the facts and the issues brought forth by the parties.

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[1] **Exhibit 458A, 458B**: Affidavit #6 of Dr. Orfaly ("Aff #6 of R. Orfaly") at para. 9 (TAB 4)
[2] **Exhibit 458A, 458B:** Aff #6 of R. Orfaly at para. 12 (TAB 4)
[3] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at para. 16 (TAB 4)
[4] Affidavit # 10 of Roland Orfaly ("Aff #10 of R. Orfaly") at para. 3, Ex. A

B. EVIDENCE OF THE BCAS

1. Summary of evidence adduced by the BCAS

7. On July 30, 2014, Associate Chief Justice Cullen (as he then was), ordered that the BCAS "may adduce affidavit evidence at trial regarding the factual information and experience of BC anesthesiologists in the planning and delivery of health care services in British Columbia… as described in the BCAS's "Synopsis of Intervenor's Evidence" submitted on 30/JUN/2014 pursuant to the Order made 09/JUN/2014" (the "**Evidence Order**").[5]

8. In accordance with the Evidence Order, the BCAS adduced the following affidavit evidence in this action:

   a. affidavit #1 of Dr. Kallie Honeywood (the "**Honeywood Affidavit**") sworn on January 27, 2015;

   b. affidavit #6 of Dr. Roland Orfaly sworn January 30, 2018; and

   c. affidavit #9 of Dr. Roland Orfaly sworn April 4, 2019. This affidavit updates the evidence presented in Dr. Orfaly's affidavit #6.

2. The public's access to anesthetic and surgical care in British Columbia is not reasonable, even for emergency surgeries

9. The evidence in this trial shows that the provincial Ministry of Health has, on multiple occasions, reported publicly that more than 500,000 surgeries are performed in the province annually, and that more than half of these surgeries are emergencies and are completed immediately, without delay.[6]

10. These latter statements are contradicted by other evidence in this trial that a much smaller number of surgeries are performed annually in British Columbia, and that

[5] Aff #10 of R. Orfaly at para. 6, Ex. C, D
[6] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 19-25 and 28-29, Ex. 1, 2, 4 (TAB 4); **Exhibit 576:** Perioperative Services Strategy Presentation, April 2017, Slide 4 (TAB 7)

the proportion of surgeries which are urgently completed without delay is also much smaller.[7]

11. Further, while the provincial Ministry of Health has developed wait time "targets" for various surgical procedures, these targets have not been met, even for emergency surgeries such as hip fracture fixation.[8]

12. Evidence also shows that the Ministry of Health has, without explanation, corrected the publicly reported size of the 2001/02 surgical waitlist by an additional 18,000 patients, from 37,436 patients to 55,436 patients, on the Surgical Wait Times website.[9]

13. The Ministry of Health often refers to an increasing number of "priority" procedures being completed, such as cataract surgery. However, the number of other surgeries performed, in other words, those surgeries that are not classified as "priority" by the government, has decreased, even while the waitlist has increased. For example, the number of non-cataract surgeries performed in British Columbia decreased from 168,539 in 2001/02 to 166,473 in 2013/14, a reduction of 2,066 annual procedures performed. In 2016/17, the number of non-cataract surgeries performed in British Columbia was 167,445.[10]

14. The surgical wait times reported by the Ministry of Health show a progressive increase over time in the median and 90th percentile wait times. For example, the provincial median wait time for all adult procedures increased from 4.3 weeks in 2001/02 to 5.6 weeks in 2013/14. As of February 2013, in at least one health region (Fraser Health), over half of the patients waiting for surgery (54%) had already exceeded the Ministry of Health's "target" maximum wait time.[11]

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[7] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 51-60, 69, 71, Ex. 13-15 (TAB 4)
[8] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 26-30, 66, Ex. 3, 4 (TAB 4)
[9] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 35-45, 68, Ex. 6-11 (TAB 4)
[10] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 46-50, 70, Ex. 4, 12 (TAB 4); **Exhibit 459:** Aff # 9 of R. Orfaly at paras. 2-6, Ex. 1 (TAB 5)
[11] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 31-34, 67, Ex. 4, 5 (TAB 4)

15. The wait times reported for patients who have already obtained surgery are statistically shorter than for other important patient populations, such as those who are still on the waitlist. Therefore, wait times reported for procedures that have been completed do not reflect the wait times experienced by other relevant populations of patients, including but not limited to: patients who are currently still on the waitlist, patients whose conditions have deteriorated to the point of needing emergency surgery, and patients who have died while on the waitlist.[12]

16. As of Q1 2018, 85,468 British Columbians were waiting for medically necessary surgeries. Of these, 35,335 patients, or 41.3%, had already waited longer than the Ministry of Health's "benchmark" maximally acceptable wait time.[13]

17. Many patients are also dying while on the waitlist for surgeries. In 2015-2016 in Fraser Health alone, there were 308 patient deaths amongst those waitlisted for scheduled surgery.[14]

3. Patient care guarantees related to medically necessary surgery have been contemplated, but never implemented

18. In March 2007, the federal government committed over $1 billion to support provinces and territories in the implementation of Patient Wait Time Guarantees. British Columbia agreed to establish a patient wait time guarantee for access to radiation therapy, but not for any surgical procedures.[15]

4. While public funding to the health authorities has increased significantly, this has not prevented rationing and reduction in surgical services

19. The allocation of public funds to the province's health authorities has increased from almost $6 billion in 2001-2002 to over $12 billion in 2016-2017.[16]

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[12] **Exhibit 458A, 458B**: Aff # 6 of R. Orfaly at paras. 61-63, 72, Ex. 16 (TAB 4)
[13] **Exhibit 322**: Feltham Exhibits, pp. 13, 21, 29 (TAB 3)
[14] **Exhibit 3A**: Health Authorities, Prima Facie Facts, p. 54, para. 126 [Fraser Health Authority] (TAB 2)
[15] **Exhibit 2A**: Ministry of Health, Prima Facie Facts, pp. 134-135, paras. 317-321 (TAB 1)
[16] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 73-74, Ex. 17-18 (TAB 4); **Exhibit 459:** Aff #9 of R. Orfaly at para. 9, Ex. 3 (TAB 5)

20. Despite what the health authorities refer to as “Record Funding” in 2009-2010, their service plans that year included drastic reductions in surgical services. These cuts to surgical services were known by the health authorities to include reductions in cancer surgery procedures.[17]

5. There is a shortage of anesthesiologists in British Columbia, which is a key barrier to improving the wait times for surgery

21. The Ministry of Health has been aware of a shortage of anesthesiologists in the province for at least 15 years, since November 2004. Specifically, a briefing note from the provincial Ministry of Health at that time states that:[18]

> …health authorities have reported that, in a number of facilities, the lack of increased availability of anaesthetists is, or is threatening to become, a significant impediment to achieving increased surgical throughput.

22. In January 2015, then Minister of Health, the Honourable Dr. Terry Lake, publicly acknowledged that there was a province-wide shortage of anesthesiologists.[19]

23. In a 2015 discussion paper on surgical services, the provincial Ministry of Health again acknowledged the “undersupply” of anesthesiologists in British Columbia and cited this shortage as a reason why only 82% of operating rooms were regularly staffed.[20]

24. There is more specific evidence before the Court related to the magnitude of operating room slate cancellations in Fraser Health. During the span of five reported fiscal periods (20 calendar weeks) in 2013-2014, there were 246 surgical slates cancelled. Of these, 211 surgical slates were cancelled because there were no anesthesiologists available. Each slate typically represents an 8-hour schedule which would include several surgeries.[21]

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[17] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 75-79, Ex. 19-22 (TAB 4); **Exhibit 459:** Aff #9 of R. Orfaly at paras. 10, Ex. 4 (TAB 5)
[18] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at para. 105, Ex. 36 (TAB 4)
[19] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at para. 136, Ex. 61 (TAB 4)
[20] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 11-12, Ex. 5 (TAB 5)
[21] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 106-112, Ex. 37-42 (TAB 4)

25. Similarly, surgical slate cancellations due to the shortage of anesthesiologists also began appearing in the Vancouver Coastal Health region as early as 2011 and in the Interior Health region as early as 2013.[22]

26. The shortage of anesthesiologists has become so severe that sometimes entire acute care hospitals may be on "diversion" for periods of time. This means that any patients requiring emergency surgery, as well as labouring patients who might require the care of an anesthesiologist, would be transferred to alternative facilities.[23]

27. While the shortage of anesthesiologists is both long-standing and province-wide, evidence before the Court also shows that other provinces are not having the same physician supply problems. Both Ontario and Alberta attract multiple anesthesiologist candidates for both temporary ("locum") and permanent vacancies, even in rural communities. Each of these anesthesiologist candidates are fully certified to Canadian standards.[24]

28. In contrast to other provinces, the shortage of anesthesiologists in British Columbia has resulted in hospitals recruiting anesthesiologists who are not yet certified to Canadian standards, either because they have been trained outside of Canada, or because they were trained in Canada but had yet to pass their Canadian certification exams. Until they successfully complete their Canadian exams, these anesthesiologists are provisionally licensed and credentialed to provide patient care in hospitals under the "supervision" of other anesthesiologists who must be Canadian certified.[25]

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[22] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 113-114, Ex. 43-44 (TAB 4); **Exhibit 460:** Aff #1 of K. Honeywood at para. 28, Ex. H (TAB 6)
[23] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at para. 115, Ex. 45 (TAB 4); **Exhibit 460:** Aff #1 of K. Honeywood at paras. 29-30, Ex. I-J (TAB 6)
[24] **Exhibit 460:** Aff #1 of K. Honeywood at paras. 11-15, Ex. A-B (TAB 6)
[25] **Exhibit 460:** Aff #1 of K. Honeywood at paras. 17-21, Ex. D-E (TAB 6)

29. The College of Physicians and Surgeons of British Columbia describes its position on International Medical Graduates as follows:[26]

> There is significant variation in entry requirements to medical schools from country to country.
>
> …
>
> There is also very significant world-wide variation in the quality, scope and length of undergraduate medical education leading to an MD degree.
>
> …
>
> In summary, all MD degrees are not the same but vary significantly in content and quality and admission criteria.

6. Taxpayer funding for physician services in British Columbia has increased substantially, but has not been allocated in a manner that effectively addresses the province's ability to compete with other jurisdictions for needed physician resources

30. Between 2001 and today, several compensation agreements have been reached between the provincial government and the British Columbia Medical Association.

31. In the decade from 2001 to 2011, the physician services budget for the province increased from $1.8 billion to over $3.6 billion; and it has increased further since 2011. Each provincial physician agreement highlights the importance of being competitive inter-provincially in order to successfully recruit, retain, and ensure an adequate supply of physicians for British Columbians.[27]

32. The most recent Physician Master Agreement in 2014 included $55 million in new annual government funding to address fee disparities for specialist physicians. In its proposal for the allocation of these funds, the provincial Ministry of Health advocated as follows:[28]

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[26] **Exhibit 460:** Aff #1 of K. Honeywood at para. 16, Ex. C (TAB 6)
[27] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 80-104, Ex. 23-35 (TAB 4)
[28] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 13-16, Ex. 6-7 (TAB 5)

> The surgical policy paper points to the current supply of anesthesiologists as a potential barrier to increasing access to surgery. The Ministry therefore strongly endorses a potential award to the Section of Anesthesiology, as the Ministry firmly believes such an award would help reduce surgical wait times in BC.

33. The Ministry of Health's own data, which it presented in April 2017, demonstrates that while the availability of medical procedures not requiring an anesthesiologist has rapidly increased, the availability of surgeries requiring an anesthesiologist have increased very little. In the decade between 2006/07 and 2016/17, the number of procedures not requiring an anesthesiologist increased by 65.3% (from 154,536 to 255,490). During the same decade, however, the number of outpatient surgeries requiring an anesthesiologist increased by only 7.9% (189,409 to 204,450), and the number of inpatient surgeries requiring an anesthesiologist increased by only 2.4% (110,593 to 113,251).[29]

7. Government can improve patients' access to medical care through collaborative work with the medical profession

34. In February 2009, the BCAS partnered with the provincial government and the B.C. Medical Association to undertake a review, which included an examination of the supply of anesthesiologists and reasons for the shortage.[30]

35. This tripartite Anesthesia Joint Review Committee arrived at 17 consensus recommendations. It was also agreed that there would be a tripartite implementation agreement for these recommendations. These recommendations were never implemented.[31]

36. In October 2015, the BCAS again partnered with the provincial government to undertake a review of anesthesiology services under the Provincial Anesthesiology Services Working Group.[32]

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[29] **Exhibit 576:** Surgical Demand and Anaesthesiology Presentation, April 12, 2017, Slides 4-5 (TAB 8)
[30] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 137-153, Ex. 62-70 (TAB 4)
[31] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 137-153, Ex. 62-70 (TAB 4); **Exhibit 459:** Aff #9 of R. Orfaly at paras. 22-23 (TAB 5)
[32] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 24-27, Ex. 9 (TAB 5)

37. The terms of reference for this working group contemplated a report and recommendations by January 2016 “on a compensation model to support recruitment and retention of anesthesiologists”. The terms of reference further provided:[33]

> The Working Group recognizes that recruiting additional anesthesiologists to BC will be an important goal of its recommendations, and that the process towards reaching that goal will require additional time.

38. No report or recommendations were ever created by the working group.[34]

39. In order to further improve patients’ access to needed care, the BCAS also supports increasing the availability of non-physician anesthesia assistants who assist in delivering safe, high quality care to patients. Anesthesia assistants increase the efficiency of surgical patient care and the productivity of existing anesthesiologists.[35]

40. The BCAS has advocated for proper training and the hiring of additional anesthesia assistants. However, in August 2014, the only training program in British Columbia for anesthesia assistants announced that it would be suspending all intake into its program.[36]

C. LEGAL ANALYSIS

41. The preamble of the *MPA* makes it clear that its purpose was first and foremost to ensure “reasonable access to medically necessary services consistent with the *Canada Health Act*” for all British Columbians, and not to effectively deny reasonable access to care through statutory restrictions or any other measures.[37]

[33] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 24-25, Ex. 9 (TAB 5)
[34] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 26-27 (TAB 5)
[35] **Exhibit 460:** Aff #1 of K. Honeywood at paras. 31-33 (TAB 6)
[36] **Exhibit 460:** Aff #1 of K. Honeywood at paras. 33-35, Ex. K (TAB 6)
[37] *Medicare Protection Act*, RSBC 1996, c 286, preamble

42. Sections 3, 5 and 26 of the *MPA* are clear that the Medical Services Commission (the "**Commission**"):

    a. must establish payment schedules for benefits under the Medical Services Plan ("**MSP**");

    b. that these MSP payment schedules should achieve "supply management and optimum distribution of medical care, health care and prescribed diagnostic services throughout British Columbia";

    c. must not establish payment schedules or otherwise act in a manner that does not satisfy the criterion of accessibility; and

    d. more generally, that the function of the Commission is to ensure reasonable access to medical care for British Columbians throughout the province.[38]

43. In the BCAS' submission, the latter responsibilities of the Commission reflect the statutory rights for all patients under the *MPA*. Reasonable access to medical care is a responsibility of the Commission and a right of all patients under the *MPA*. It cannot simply be viewed as an administrative target or an occasional political priority.

44. To the extent the evidence shows that even some patients are not achieving reasonable access to medical care, there has been a breach of patients' rights and the Commission's responsibilities under the *MPA*. As demonstrated by the evidence above, there are currently more than just a few patients lacking reasonable access to medical care within the province.

45. The undisputed evidence in this trial demonstrates that patients are not achieving reasonable access to the medical care of anesthesiologists. Evidence of this lack

[38] *Medicare Protection Act*, RSBC 1996, c 286, ss. 3, 5, 26

of reasonable access has included facts about closed operating rooms, cancelled surgeries, excessive wait times, and growing waitlists.[39]

46. The evidence shows that the provincial government has been aware of the shortage of anesthesiologists for at least 15 years, beginning in November 2004.[40]

47. Further, the evidence also shows that the provincial government considers the MSP payment schedule to be a major factor contributing to the shortage of anesthesiologists, and thereby contributing to surgical wait times.[41]

48. The government could have facilitated the Commission's ability to meet its responsibilities under the *MPA* and address this "supply management" problem through adjustments to the payment schedule under s. 26 of the *MPA*.

49. The right to reasonable access to care must be ensured for <u>all</u> British Columbians and not just an arbitrary subset who have been selected by the government to be on waitlists for "priority" procedures.

50. In other words, even if there was reasonable access to the government's "priority" surgeries of hip and knee replacements, and of cataract surgeries, a fact which is certainly in dispute in this trial; that alone does not meet the statutory requirements of the *MPA* to ensure reasonable access for all patients, including those patients who require other types of medically-necessary surgeries.

D. <u>CONCLUSION</u>

51. British Columbians in need of health care, including surgical and anesthetic care, have a right both under the *Charter* and the *MPA* for reasonable access to care. Their health, and sometimes their lives, depend on this timely care.

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[39] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 105-115 and 136, Ex. 36-45 and 61 (TAB 4); **Exhibit 459:** Aff #9 of R. Orfaly at paras. 11-16, Ex. 5-7 (TAB 5); **Exhibit 460:** Aff #1 of K. Honeywood at paras. 28-30, Ex. H-J (TAB 6)
[40] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at para. 105, Ex. 36 (TAB 4)
[41] **Exhibit 459:** Aff #9 of R. Orfaly at paras. 13, Ex. 6 (TAB 5)

52. Far too many British Columbians are waiting too long for surgery. The evidence at trial demonstrates that hundreds (or possibly even thousands) of patients are dying annually on the waitlist for surgery.[42]

53. Due to the Commission's breach of its duties under the *MPA*, there is a shortage of anesthesiologists in British Columbia which has created a further barrier to timely care. This supply shortage has been known by the provincial government for at least 15 years.[43]

54. The effect of the impugned provisions of the *MPA* is to deny these same patients effective alternatives, even as they suffer and die while on a waitlist for surgery.

55. The BCAS submits that all British Columbians should have a patient care guarantee consistent with the requirements of the *MPA* to ensure reasonable access to medical care. Whether that guarantee is honoured entirely within British Columbia's public health care system, with the help of resources from outside of British Columbia, through a hybrid public-private system as advocated by the plaintiffs, or by some other means, what is most important is simply that patients get the quality care that they need in a timely fashion.

56. A patient care guarantee is necessary and must apply not just to "priority" populations selected unilaterally by government. Similarly, the guarantee cannot take the form of meeting the needs of only a percentage of patients (i.e. only 90% or 95% of waiting patients). *Charter* rights apply to all British Columbians and must be respected.

57. Without the patient care guarantees, and without timely access to care, the rights of patients under the *MPA* and under the *Charter* are being violated. In these harmful circumstances, the impugned provisions of the *MPA* serve only to impose

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[42] **Exhibit 322:** Feltham Exhibits, pp. 3-29 (TAB 3); **Exhibit 3A**: Health Authorities, Prima Facie Facts, p. 54, para. 126 [Fraser Health Authority] (TAB 2)

[43] **Exhibit 458A, 458B**: Aff #6 of R. Orfaly at paras. 105-115 and 136, Ex. 36-45 and 61 (TAB 4); **Exhibit 459:** Aff #9 of R. Orfaly at paras. 11-16, Ex. 5-7 (TAB 5); **Exhibit 460:** Aff #1 of K. Honeywood at paras. 28-30, Ex. H-J (TAB 6); **Exhibit 576:** Surgical Demand and Anaesthesiology Presentation, April 12, 2017, Slides 4-5 (TAB 8)

restrictions on the care that impacted British Columbians can access, using the very same legislation whose provisions for timely care are being violated.

58. Patients need and deserve access to timely and high-quality anesthetic and surgical care. That primary goal should take precedence over any rigid ideological views regarding who controls health care.

All of which is respectfully submitted:

Date: November 1, 2019

Signature of Dr. Roland Orfaly for the British Columbia Anaesthesiologists Society