This is the 13th affidavit
of Dr. Brian Day in this case
and was made on 3 JULY 2018

No. S-090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

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

PLAINTIFFS

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANT

AND:

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

INTERVENORS

AND:

THE ATTORNEY GENERAL OF CANADA

PURSUANT TO THE *CONSTITUTIONAL QUESTION ACT*

AFFIDAVIT #13 OF DR. BRIAN DAY

I, DR. BRIAN DAY, of 2836 Ash St, Vancouver, BC V5Z 3C6, in the City of Vancouver, in the Province of British Columbia, Canada, AFFIRM THAT:

1. I am an orthopaedic surgeon and the President and Medical Director of Cambie Surgery Centre ("**Cambie**") and the Specialist Referral Clinic, which are two of the Plaintiffs in this action. As such, I have personal knowledge of the facts and matters deposed to in this affidavit, save and except where they are stated to be made on information and belief, and where so stated, I believe them to be true.

A. My Background

2. I have been a Fellow of the Royal College of Physicians and Surgeons of Canada and the Royal College of Surgeons of England since 1974, and was certified by the American Board of Orthopaedic Surgery in 1981, becoming a Fellow of the American Academy of Orthopedic Surgery in 1983.

3. In 1979, I received the Canadian Orthopedic Association's Edouard Samson Award for outstanding orthopedic research in Canada.

4. I was a clinical fellow and an instructor at UBC from 1977 to 1979. I was Assistant Professor at UBC's Medical School from 1979 to 1987, and Associate Professor from 1987 to the present, my current title being Honorary Associate Professor.

5. I was the Chairman of the Academic Program for Residents at the Department of Orthopedics at UBC from 1978 to 1994, and served as the national Chairman of the Royal College of Surgeons of Canada Orthopaedic Test Committee, responsible for specialist certification in Canada, from 1989 to 1994.

6. I was instrumental in introducing arthroscopic joint surgery and other minimally invasive surgical techniques and performed the first hip, wrist, elbow and ankle arthroscopic surgeries in Canada. I performed the first arthroscopic knee ligament repair procedures in Canada, and the first arthroscopic shoulder repairs in Western Canada. I also introduced minimally invasive trauma techniques such as closed intramedullary fixation of factures.

7. I was also involved in other innovations in the Canadian health system, including the development of surgical robotics and performed the first surgery in the world using a surgical robot in 1983. I was also instrumental in the early adoption of electronic medical records, and in pioneering other new medical technologies.

8. I am a former Secretary-Treasurer and Vice President of the Canadian Orthopaedic Foundation, a national charity that has raised over $20 million for charitable causes, a past Director of the Canadian Orthopaedic Association ("**COA**"), and I have served on the Executive of the Canadian Orthopaedic Research Society. All of these were voluntary, unpaid positions.

9. I served as President of the Chicago-based Arthroscopy Association of North America ("**AANA**"), the world's leading academic society in my area of specialization. I served as President of the AANA in 2004-2005, and held duties as Past President for two years afterwards.

10. I was President of the Canadian Medical Association ("**CMA**") between 2007 and 2008. I am the only orthopedic surgeon in its 150 year history to be elected as the President of the CMA.

11. As former CMA President, I know that the CMA has many roles. For example, it is the body that initiated, and still remains involved in, the accreditation of Canadian Medical Schools (and fifteen other health professions). During my term as CMA President, the CMA celebrated its 70th year as an accreditation body for health professionals. The CMA has also established the Code of Ethics guiding all Canadian doctors, which the provincial medical colleges have adopted as their ethical guidelines, including the College of Physicians and Surgeons of BC.

12. The CMA focuses on health care system improvement, professional guidelines and ethical issues that matter to the profession and the public.

13. During my tenure as CMA President, I personally promoted a range of initiatives, many of which were directed at ensuring guarantees for timely medical treatment and expanding the coverage of the public health care system.

14. In particular, I was personally involved in the following initiatives which were undertaken by the CMA during my tenure as either President-elect, President, or Past President of the CMA:

    a. Continuing to advocate for the wait time guarantees;

    b. Advocating for a patient focused public health system that includes a move from block (global) funding of hospitals, which encourages rationing, to patient focused funding, in which payments are made for treating patients;

    c. The creation of an independent Canadian Patient Alliance to advocate for patient rights;

    d. Spearheading a CMA mission to Europe to study and learn from best practices of their hybrid health systems;

    e. Promoting the expansion of insured services to cover various other medically necessary services, such as physiotherapy, dentistry, eye care, mental health, ambulance care, artificial limbs, and braces;

    f. Promoting enhanced public funding for prescription drugs for the 30% of Canadians that lack such coverage;

g. Publishing a CMA-commissioned study entitled "The economic cost of wait times in Canada", dated January 15, 2008, that looked at the economic impact and the costs incurred by waiting for care and found that the economic cost of waiting was billions of dollars annually, a copy of which is attached as **Exhibit "A"**;

h. Corresponding with the Auditor General of Canada asking for an audit of the direct and indirect costs related to waiting patients;

i. The continuation of the annual Taming of the Queue conference, which brings together physicians, hospital administrators, policy makers, politicians, academics, and national and international experts, to discuss policy matters relating to waiting times. Attached as **Exhibit "B"** is a copy of a Research Report arising out of the 2008 Taming of the Queue Conference, which references my involvement on behalf of the CMA at the conference; and

j. Continued support for the Wait Time Alliance ("**WTA**") initiative, which brought together various medical associations to measure the extent and impact of wait times within the Canadian health care system. Attached as **Exhibit "C"** is a copy of a 2007 Report of the Wait Time Alliance, entitled "Times Up! Achieving meaningful reductions in wait times", which was published and prepared by the CMA on behalf of the Wait Time Alliance partners during my time as CMA President.

15. In addition to being on the faculty at UBC for over forty years, I have been involved in the teaching of medical students, post graduate students, physicians and practicing surgeons internationally, including in underdeveloped countries, through visiting professorships and lectureships.

16. I have been a visiting professor, lecturer, and speaker at many universities worldwide, including McGill, Manitoba, Cambridge, Yale, Columbia, Dartmouth, Manila, Mexico and Havana, and I have taught arthroscopic techniques internationally.

17. Beginning in the early 1980's, I organized and chaired four UBC sponsored international seminars in arthroscopic surgery, which were the first in North America to be sanctioned by a university. Surgeons from around the world attended these seminars to learn newer and less invasive techniques of arthroscopic surgery.

18. I have also authored numerous articles and chapters in books in the areas of orthopedics and orthopedic surgery, sports medicine, and health policy.

19. I have been offered high paying positions in the U.S. and elsewhere on multiple occasions, but turned them down because my goal has always been to improve the provision of surgical services in British Columbia and Canada.

20. For example, I was actively recruited to work in the Middle East by Interhealth Canada, owners of the Shaikh Khalifa Medical Centre in Abu Dhabi. Attached as **Exhibit "D"** is a copy of a letter dated January 17, 2001, and sent to me by a healthcare management company, requesting that I apply for a position at an Interhealth facility in Abu Dhabi.

21. Interhealth was partly owned by the federal and BC governments, and its mandate was the creation and operation of private hospitals in other countries, including China, Abu Dhabi, and England. Interhealth sought to recruit doctors and nurses in Canada, such as myself, to work in these hospitals in other countries.

22. Attached as **Exhibit "E"** is a copy of a news story from the National Post, dated December 9, 2005, which discusses Interhealth and its connection to Canadian governments, including the BC Government.

23. I was personally offered a $500 referral fee by the employment agency contracted by Interhealth Canada for referring any successful candidates to Interhealth, as stated in the letter attached above as Exhibit "D".

B. Background to Cambie and Private Health Care

24. As I explained in the affidavit containing my evidence in the trial of the Plaintiffs' constitutional claims (Affidavit #9 of Dr. Brian Day), Cambie and other private surgical clinics were established in response to the lengthy wait times for surgical services in the public health care system, which began in or about the late 1980's with the introduction of financial global budgets for the provision of public health care services.

25. Until wait times and rationing of physician and patient access became a serious problem, there was no need for private facilities, but as wait times grew and access became limited, I observed increased suffering as patients waited for care. Attached as **Exhibit "F"** is a book chapter I wrote, entitled "The Consequences of Waiting", which discusses the medical and other harms to patients caused by waiting.

26. Prior to the introduction of global budgets, hospitals were financed to a significant degree on a pay-per-service basis; that is, they received payment from the Government for every surgery performed. As such, there was no incentive to ration the number of surgeries performed by physicians.

27. Under that model, I and my colleagues had essentially all of the operating room time that was necessary to care for patients in a timely manner. I had approximately 17 to 22 hours of operating room time every week, and as a result, patients who needed urgent surgery could be scheduled immediately and would typically obtain their surgeries within a few days or, if the surgery was not urgent, within a few weeks.

28. When surgeries ran longer than anticipated, patients were not "bumped", but were treated the same day by prolonging the use of operating room time the same day or on weekends. As a result, I and my colleagues had very short, or non-existent, wait lists for scheduled surgeries, and could easily accommodate more urgent or emergency cases in a timely manner. There were also no, or very short, wait times for specialist consultations after referral from a family doctor.

29. This changed with the introduction of global budgets, which placed a cap on the funding of hospitals. This meant that the funding of hospitals was no longer tied to how many

patients needed surgery (and therefore how many surgeries were performed). Instead, the total number of surgeries was limited to the funds allocated in fixed annual budget.

30. When fixed global budgets were introduced, operating time for surgeons was greatly reduced and surgeries were thereby rationed. This led to lengthy wait times, which I personally experienced. I went from having a very short wait list in the 1980s when there were no fixed global budgets, to having over 400 patients on my wait list for surgeries in the 1990s with fixed global budgets. The colleagues with whom I worked closely and personally observed had similar experiences.

31. Many surgeons, myself included, did not want to sit idle, letting our surgical skills decline, and watching our patients wait for long periods before they obtained the surgeries they needed. We wanted to use our available capacity to meet the health care needs of British Columbians that were not being addressed in a timely manner in the public system.

32. This led to the establishment of private surgical clinics starting in or about 1996, which is when Cambie began operating.

33. These clinics needed to use enrolled doctors to provide the surgeries, given that, to the best of my knowledge, all actively practising surgeons in BC were enrolled in the public system. The surgeons supported the public system and would continue to perform public surgeries to the full extent they were provided with operating time in the public system.

34. Also, the College of Physicians and Surgeons required surgeons to have privileges in public hospitals to deal with any complications that may occur during a private surgery (private clinics are not permitted to operate as emergency centres). But physicians had to be enrolled in order to have hospital privileges. This meant that physicians had to be enrolled to work at private surgical or diagnostic centres.

35. That rule has recently changed, but it is still the case, in my experience, that surgeons in British Columbia do not want to abandon the public system and only provide surgeries privately.

36. The *Medicare Protection Act* prohibits doctors who provide medical services in the public system, even after using all of their allocated public operating room time, from also providing medical services privately to British Columbians, unless the patient falls within an exemption under the *Act* that allows them to obtain private medical services from an enrolled doctor. This is often colloquially called the prohibition against "dual practice".

37. The main exemption from the prohibition in the *Medicare Protection Act* is contained in a minute of the Medical Services Commission, which allows British Columbians injured at work to benefit from employer funded private insurance coverage through WorkSafeBC, as well as those who are covered by federal health insurance (e.g. inmates of federal penitentiaries or federal workers, including RCMP and Canadian Armed Forces), to obtain timely medical services privately by deeming their surgical services not to be "benefits" under the *MPA*.

38. Under the WorkSafe exemption, thousands of injured workers are taken out of the public system and provided with expedited treatment in the private system, which allows them to return to work much sooner than would be otherwise the case in the public system. WorkSafe pays all of the medical costs of the private surgeries, diagnostics and treatments.

39. There is no legislative exemption for most British Columbians who are not injured at work or do not have insurance provided by the federal government. The vast majority of British Columbians are not permitted to obtain private surgeries from enrolled doctors to meet their personal medical needs in a timely way.

40. Despite the prohibitions in the *MPA*, private surgical clinics like Cambie have been providing private surgeries to non-exempt British Columbians through enrolled doctors for many years. In the case of Cambie, it has been for the past 22 years.

41. This was because the Government – beginning in 1996 with the establishment of the first surgical clinics – did not enforce the prohibitions in the *Medicare Protection Act*, and instead supported and encouraged private surgical clinics to use enrolled doctors to provide surgeries to both non-exempt British Columbians as well as exempt British Columbians.

42. We would not have established our private surgical clinic without the support of the BC Government.

43. Premier Dosanjh publicly stated in 2000 that his Government would not enforce the prohibitions in the *Medicare Protection Act* as long as the wait times in the public system remained long. Attached as **Exhibit "G"** is a copy of an article in the Vancouver Province, dated October 17, 2000, in which former-Premier Dosanjh is quoted as saying "(i)t would do us no good to shut down (Dr. Brian) Day's (Cambie Surgical Centre) clinic if we can't provide those services elsewhere."

44. When the Liberal Government took over in 2001, Premier Campbell told me that he would continue to support our use of enrolled doctors to provide private surgeries – and not enforce the prohibitions on dual practice in the *MPA* – given the long waiting lists for surgeries in the public health care system.

45. After the 2003 *Medicare Protection Amendment Act* (the "*2003 Amendment Act*") was enacted by the legislature, I was told by Premier Campbell that the *2003 Amendment Act* would not be proclaimed into force.

46. Minister Hansen and Premier Campbell also informed me that the Government would continue to act only in response to complaints from patients, and that it would not act proactively to prevent clinics from providing private surgeries to non-exempt British Columbians.

47. Minister Hansen stated the same thing publicly in the legislative assembly; that the Government would only be responding to specific complaints:

> The process we have is one that is complaint-driven. From time to time we do see

letters from patients who feel that these may have been a violation of the *Canada Health Act*, they are free to write to the Ministry of Health Services, and it will be investigated to the full extent possible.

48. Attached as **Exhibit "H"** are excerpts from Hansard, dated Monday, May 10, 2004 (5th Session, 37th Parliament), involving questions asked by NDP MLA Kwan in relation to the Canada Health Act, and Minister Hansen's responses including his statement quoted above.

49. I was also told by Premier Campbell and Minister Hansen that this was the position the Provincial Government was taking with the Federal Government with respect to the transfer payment issue.

50. I attended a separate meeting with Minister Hansen, along with other representatives of private surgical clinics in British Columbia, at or around the time of the introduction of the 2003 Amendment Act.

51. At that meeting, Minister Hansen told us that it was his view that if a non-exempt British Columbian opted for a private surgery in a shorter timeline, this should not be considered medically necessary, which would mean that the prohibitions in the *MPA* on access to private surgeries would not apply.

52. Minister Hansen told me that this was an additional argument that the Province would be making with the Federal Government with respect to transfer payments.

53. In 2004, Minister Hansen told me that making the payment of facility fees unlawful was unfair to the clinics because there was no definition of what "medically necessary" means, a position that he also stated publicly.

54. Minister Hansen also stated to me that what was considered to be medically necessary under the *MPA* was arbitrary, and not related to medical need but rather budgetary constraints.

55. Six months after the January 2009 initiation of the current constitutional challenge, BC Health Minister Kevin Falcon gave a July 2009 interview to Pamela Fayerman that was published by the Vancouver Sun. The following extract confirms the view of the Minister:

> **Q:** "But the vast majority of what people go to private clinics for is (service and treatment) for which they pay for out of pocket."
>
> **A:** "That's right, it's elective or optional or what have you."
>
> **Q:** "So what you are saying sounds nice in principal, but people are going there because they want expedited care and expedited care is not paid for by the Medical Services Plan. So is there any reason why people can't use their own money to pay for their health care? They can buy private school education but not private care."

A: "That's right and I don't have an objection to people using their own money to buy private services, just as they do with dentists, just as they do with other decisions they make, sending their kids to private school or what have you. I think choice is always a good thing actually. Reducing choice, I don't think is a particularly good thing."

56. Attached as **Exhibit "I"** is a copy of a transcript setting out the Vancouver Sun's interview of Minister Falcon, dated July 7, 2009, and which is available online on the Vancouver Sun website.

57. The Government also took the position that because so-called "extra-billing" and user fees were prohibited by the *MPA*, that they should not be denied transfer payments for being in breach of the *Canada Health Act*. Attached as **Exhibit "J"** is a letter sent by the BC Government to the Government of Canada, dated January 22, 2013, that sets out the BC Government's position.

58. Attached as **Exhibit "K"** is an excerpt from the 2016-2017 Canada Health Act Annual Report, which shows the amount of deductions, reductions and reconciliations made in respect of federal transfer payments to the provinces since 1984/85, on page 26. On page 25 of the report, it notes that the amount initially deducted from Quebec in 2016/17 was subsequently returned to Quebec by the Government of Canada.

59. As can be seen from the chart on page 26 of Exhibit "K", the BC Government has never been deducted more than $300,000 in any given year between 1995/96 (when private clinics began operating) up until 2016/17, with the deduction for most years since 1996 being less than $100,000.

60. Therefore, for the past 22 years, non-exempt British Columbians – that is, those who suffer injuries outside of the workplace and are not covered by federal, out of province, or WorkSafe BC insurance – have also been able to obtain more timely access to consultations and procedures, including MRI's and surgeries, in the face of lengthy wait lists in the public system.

61. The wait times for specialist assessments, procedures, and surgeries in the public system have worsened significantly since 2000, despite increased funding of the public system and the Government's attempts to measure and improve performance against maximum acceptable wait time targets.

C. Increased Funding for Medicare

62. Over the past four decades, both federal and provincial spending on health care has increased significantly.

63. This was recognized in the Ministry of Health's 2012/13 Annual Service Plan Report:

> Spending on health has steadily increased from 9.7 billion in 2001/02 to 15.9 billion in 2012/13, and is expected to keep growing. In fact, health spending is growing

faster than the economy, and continued growth at this rate could affect funding for other important government services.

64. Attached as **Exhibit "L"** is the BC Ministry of Health's "2012/13 Annual Service Plan Report", dated June 28, 2013, which sets out this statement at page 10.

65. Over the 2007 to 2011 period, spending increases on health care in British Columbia consistently outstripped inflation, at 6.4% in 2007/08, 3.0% in 2008/09, 5.7% in 2009/10, 4.9% in 2010/11, 6.3% in 2011/12. Attached as **Exhibit "M"** is Ministry of Health report from February of 2014, entitled "Setting Priorities for the B.C. Health System", which sets out these increases at page 20.

66. Some more recent indicators of these increases in health care spending – in both relative and absolute terms – over the past few decades are set out in the recent National Health Expenditure Trends report ("CIHI Report (1975-2017) of the Canadian Institute for Health Information ("**CIHI**") and an excerpt from the CIHI source data ("Table B 4.1"), which are attached to this affidavit as **Exhibit "N"**.

67. The CIHI Report (1975-2017) notes, at pages 8 and 10, that Canada's per capita health care spending is among the highest of all OECD countries, and that, as a share of GDP, Canada's total health expenditures have increased from approximately 7.0% in 1975 to 11.5% in 2017.

68. With respect to BC health expenditures, set out in Table B 4.1, those have increased from approximately $0.9 billion (in current dollars) in 1975, to $19.9 billion in 2017. According to these CIHI statistics, between 2000 and 2017, BC's health expenditures more than doubled, from $9.2 billion in 2000 to $19.9 billion in 2017.

69. In the most recent provincial budget, these numbers are projected to continue to grow. Attached as **Exhibit "O"** is an excerpt from the BC Budget and Fiscal Plan, dated February 20, 2018 ("2018 Budget"), and the summary of the attached Estimates ("2018 Estimates"). The 2018 Estimates state, at page 6, that there are approximately $20.82 billion in health related expenses forecast for 2017/18, scheduled to rise to $21.65 billion in 2018-19. This is approximately 42.5% of total program spending.

70. Federal contributions to provincial health care spending have also grown significantly over the past decade. Since 2009/10, the Canada Health Transfer to the provinces has increased by approximately 50%, from $24.4 billion in 2009/10 to a projected $38.6 billion in 2018/19. Attached as **Exhibit "P"** is a chart available on the Federal Government's website, entitled "Federal Support to Provinces and Territories", which contains these figures.

71. BC's most recent budget states that the Canada Health Transfer from the federal government to British Columbia is projected to continue to increase, from $4.9 billion in fiscal year 2017/18, to $5.5 billion in fiscal year 2020/21 [see 2018 Budget, Exhibit "O", at p. 15].

72. As discussed below, despite these increases in funding for health care over the past twenty years, wait times for surgeries and diagnostic procedures have generally gotten worse over this period.

D. Overview of Wait Times and Wait Times Benchmarks or Targets

i. Measurement of Wait Times

73. Following their assessment by a family doctor (which is a pre-requisite to a specialist referral in BC), patients in need of specialist assessment and care typically experience three levels of waits.

74. First, once a general practitioner identifies a health problem that requires further assessment by a specialist, a patient waits to see that specialist. This is commonly referred to as "Wait One".

75. Second, when surgical or other specialized treatment is required, there is a wait between the time the surgery or treatment is requisitioned by the specialist and the patient is ready, and the time when the treatment is carried out. This is commonly referred to as "Wait Two".

76. Third, there are waits for diagnostic testing – such as magnetic resonance imaging ("MRI"), computed tomography ("CT scans") – that is recommended either prior to, or after, seeing a specialist, but is necessary before a final treatment decision can be made. This is sometimes referred to as "Wait Three".

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

78. Wait times data for surgeries and some treatments in British Columbia for both "Wait One" and "Wait Two" are compiled in a central Government computer database, called the Surgical Patients Registry ("**SPR**").

79. The Defendant described the SPR as follows in its *Prima Facie* Facts – Ministry of Health, which has been admitted into evidence in the trial:

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

> 325. The purpose of the SPR is to provide clinically relevant, accurate, and comprehensive information on patients waiting for surgery identified by surgeon, by diagnosis/clinical condition, by procedure, by priority level, by hospital, and by Health Authority. Wait time data is also collected for performed surgical cases.
>
> 326. The SPR captures adult and pediatric surgical procedures that are typically completed in an operating room or another room that requires similar equipment and human resources and are scheduled in the hospital's operating room booking system.
>
> *Defendant's Prima Facie Facts – Ministry of Health* ("**PFF - MOH**"), at paras 322-326.

80. The Health Authorities enter this information directly into the SPR on a daily basis (PFF – MOH, at para 327).

81. The Wait One information in the SPR is provided by the specialist to the Health Authority, along with the information relating to when a decision is made by the patient and the surgeon that the patient is ready for surgery. This Wait One information has been entered into the SPR since 2014 (PFF – MOH, at paras 327, 333).

82. As discussed in more detail below, the BC Government also collects some wait times data for so-called "Wait Three", that is, diagnostic procedures, including for MRIs, CT scans, and colonoscopies, however it appears to do so on a less systematic basis than for Wait Ones and Wait Twos.

83. Once this wait time data has been collected by the BC Government it can be measured against evidence-based wait time benchmarks that have been established by groups of national or provincial experts, which have been accepted by the BC Government.

84. There have been no national or provincial benchmarks established for adult Wait One times, although there are benchmarks for Wait Ones for paediatric patients established by the Canadian Paediatric Surgical Wait Times (CPSWT) Project, which have been accepted in British Columbia.

85. With respect to Wait Two times, the BC Government has developed maximum acceptable wait times for surgical procedures, through the use of "patient priority codes", which are used by physicians to categorize patients based on their diagnoses and conditions, and the urgency with which they require treatment.

86. The Wait Two maximum acceptable wait times do not take into account the time it took a patient to see a specialist (Wait One) or the time it took for a specialist to make a decision that a surgery is required, which includes the time it takes to obtain the necessary diagnostic testing (Wait Three).

87. The priority levels for Wait Two surgical procedures indicate the maximum acceptable wait times for patients experiencing particular conditions: level 1 (2 weeks maximum),

level 2 (4 weeks maximum), level 3 (6 weeks maximum), level 4 (12 weeks maximum), and level 5 (26 weeks maximum).

88. According to the BC Government, the target wait times set out in the priority codes indicate "the time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences". This is set out at page 7 of a BC Government report entitled "Patient Prioritization Code Review Project: Phase 3 and 4 - Final Report" and dated March 26, 2015 ("PPCRP Final Report"), a copy of which is attached as **Exhibit "Q"**.

89. Attached as **Exhibit "R"** is a copy of a BC government report, entitled the "BC Surgical Patient Registry (SPR) Communications Backgrounder", updated September 2015, which discusses the patient prioritization codes and the collection of wait time data through the SPR, and is available on the Provincial Health Services Authority website ("SPR Backgrounder (2015)").

90. Attached as **Exhibit "S"** is an overview of the BC patient prioritization codes, which has been distributed by at least some of the Health Authorities to physicians in the province, and which is available on the Interior Health Authority website ("Patient Priority Codes – Overview"). Attached as **Exhibit "T"** are letters from the Interior Health Authority and the Fraser Health Authority to surgeons to which this overview was attached.

91. Although there are significant wait times for both Wait One and Wait Three as well, the focus of Canadian governments has generally been on Wait Twos – the time it takes to obtain treatment after a patient sees a specialist, has obtained diagnostic testing, if required, and a decision to proceed with a surgery has been made.

92. With respect to the Wait Two times, the Province's data shows that many British Columbians are waiting past "clinically acceptable wait time benchmarks" (see Patient Prioritization Codes – Overview, Exhibit "S", above, at page 1) or "maximum recommended wait time" (PFF – MOH, at para 363).

93. In particular, the provincial government has produced data from the Surgical Patient Registry for 2013-2018, in a report entitled "Surgical Volumes and Wait Times (weeks) by Diagnosis and Priority Level" ("**2013-2018 Wait Times Report**").

94. To illustrate the information contained in this report, I have separately attached excerpts from the original spreadsheets contained in the 2013-2018 Wait Time Report, which show the wait times from the 11 areas of adult and paediatric treatment covered by patient prioritization codes, and the extent to which the Province is meeting its maximum acceptable wait times.

95. These extracts are attached to this affidavit as follows:

- **Exhibit "U1"** – Extracts for urology treatments;
- **Exhibit "U2"** – Extracts for gynecology treatments;

- **Exhibit "U3"** – Extracts for dental surgeries treatment;
- **Exhibit "U4"** – Extracts for general surgery;
- **Exhibit "U5"** – Extracts for neurosurgery;
- **Exhibit "U6"** – Extracts for ophthalmology treatments;
- **Exhibit "U7"** – Extracts for orthopaedic surgeries;
- **Exhibit "U8"** – Extracts for plastic surgery;
- **Exhibit "U9"** – Extracts for thoracic surgery;
- **Exhibit "U10"** – Extracts for vascular surgery;
- **Exhibit "U11"** – Extracts for otolaryngology; and
- **Exhibit U12** – Extracts for various procedures, showing 50th and 90th percentile.

96. In addition, the Government has created the following extracts and charts, in respect of wait times for diagnostic services, including MRIs, CT scans, and colonoscopies:

- **Exhibit "V1"** – "Medical Imaging Outpatient Completed Patient Encounters & Wait Times" (March 20, 2017);
- **Exhibit "V2"** – "Diagnostic Imaging Volumes and Wait Times, British Columbia (Fiscal Years 2010/11 to 2016/17)" (April 24, 2017); and
- **Exhibit "V3"** – "Colonoscopy – Wait Time for Cases Waiting, as of March 1st, 2017".

97. The Government's SPR and other wait time data shows that patients are waiting longer than the Government's own maximum acceptable time for many diagnoses/conditions that cause pain, loss of functioning or mobility, as well as for conditions in which waiting can lead to permanent disability or be life threatening.

ii. Wait Times for Surgeries ("Wait Two")

98. As discussed in more detail below, recent CIHI data – which is based on SPR data shared with CIHI – shows that over the past 5 years, British Columbia has gone from:

- meeting the pan-Canadian benchmark target for hip replacement surgeries 80% of the time in 2013 to meeting it only 62% of the time in 2017;

- meeting the pan-Canadian benchmark target for knee replacement surgeries 71% of the time in 2013 to meeting it only 46% of the time in 2017; and

- meeting the pan-Canadian benchmark target for cataract treatment 83% of the time in 2013 to meeting it only 63% of the time in 2017.

99. Based on my experience and observations, waiting for treatment for these and other conditions – including joint replacements, severe ligament and joint dysfunction, failed prosthetic joints, cartilage disorders of joints – can cause prolonged pain, suffering and functional disability in patients, as well as the risk of permanent harm to British Columbia patients.

100. BC patients are also waiting beyond the benchmark times for life saving medical treatment.

101. For instance, as discussed in more detail below, provincial figures from 2017/2018 demonstrate significant and increasing wait times for life threatening illnesses like cancer:

- only 22% of patients in need of immediate treatment for cancer of the ovary, fallopian tube, or peritoneum, are treated within the benchmark wait time, which is down from a high of 49.6% in 2013;

- only 16% of patients in need of immediate treatment for "Bladder Cancer With Risk Of Cancer Progression" are treated within the benchmark time, which is down from a high of 31.1% in 2015; and

- only 37.6% of patients in need of treatment for "Prostate Cancer With High Risk Of Cancer Progression" are treated within benchmark time, which is down from a high of 55% in 2014.

102. As can also be seen, the wait times for these treatments are increasing, despite the steady increases in funding.

103. The Government has acknowledged that increased funding and increased numbers of surgeries performed in the public system has not eliminated the problem of patients waiting for surgeries. For instance, a briefing note provided to the Minister of Health, states as follows:

> As of March 31, 2017 there were 79,507 adult cases waiting for surgery in B.C. For comparison, there were 55,367 cases waiting as of March 31, 2002.
>
> This is despite a significant increase in the number of surgeries done – there were 572,063 surgical procedures done in 2015/16 up from 407,318 in 2001/2002.

104. Attached as **Exhibit "W"** is a copy of that briefing note, entitled "Surgical/MRI wait times Foundational", and dated May 2, 2017.

iii. Wait Times for Diagnostic Services ("Wait Three")

105. The wait times for diagnostic testing are also increasing, such as for MRIs, which are necessary for diagnoses purposes prior to many surgeries, as well as colonoscopies to rule out cancer.

106. For instance, in British Columbia, the 90th percentile wait times for MRIs have increased steadily over the past 5 years, across all levels of urgency, from the most urgent (priority 1) to the least urgent (priority 4), as set out at pages 6 and 7 of Exhibit "V2":

- **Priority 1** (immediately to 24 hours maximum) – increased from approximately 7.5 days in 2011/12 to approximately 18 days in 2016/17;
- **Priority 2** (2 to 7 days maximum) – from approximately 66 days in 2011/12 to approximately 84 days in 2016/17;
- **Priority 3** (8 to 30 days maximum) – from approximately 145 days in 2011/12 to approximately 262 days in 2016/17; and
- **Priority 4** (31 to 60 days maximum) – from approximately 230 days in 2011/12 to approximately 333 days in 2016/17.

107. Similarly, while the 90th percentile wait time for the most urgent (priority 1) CT scans have decreased between 2015/16 to 2016/17 – from 11 to 7 times the maximum acceptable wait time of 24 hours – the 90th percentile wait times for all other priorities for CT scans have increased, sometimes markedly (see Exhibit "V2, page 8).

108. For priorities 3 and 4, the 90th percentile wait time for CT scans has increased from 75 to 90 days, and from 99 to 120 days, respectively. That is triple and double the maximum acceptable wait times for those procedures, respectively.

109. Similarly, while wait time statistics for colonoscopies in BC are limited, the data in the SPR shows many patients waiting beyond the maximum benchmark time, which can increase the mortality rate for cancer.

110. For instance, the maximum wait time for patients following a positive fecal blood test is 8 weeks, as set out in the patient priority codes. This is consistent with the evidence-based maximum wait times established by the Canadian Gastroenterologists Association, and accepted by the BC Cancer Agency.

111. The available SPR data for patients receiving a colonoscopy following a positive fecal occult blood test outside of the BC Cancer agency screening program, contained in Exhibits "U4" and "U12", shows that:

- only 27.7% of BC patients received their colonoscopy following a positive test received their colonoscopy within the 8 week benchmark wait time in 2017, and this is down to 21.1% of patients in 2018 so far;
- 50% of BC patients with a positive test waited more than 15.4 weeks in 2017 (about twice as long as the maximum acceptable wait time), which is up to more than 27

weeks so far in 2018 (over three time as long as the maximum acceptable wait); and

- 10% of BC patients with a positive test waited over 28 weeks in 2017, which is up to 44.7 weeks in 2018 (over five times longer than the maximum acceptable wait).

112. In light of the importance of early detection for diseases like colorectal cancer, these delays not only cause psychological suffering, but are life-threatening.

113. These lengthy delays in obtaining necessary diagnoses – like MRIs, CT scans and colonoscopies – not only delay treatment and necessary surgeries, with any attending pain, suffering, and risk of permanent damage, but can compromise a patient's ability to obtain lifesaving treatments in time, such as the case in diagnoses for cancer.

114. These Government statistics regarding lengthy waits in the public system for both surgical and diagnostic services are confirmed in a recent Fraser Institute Report, entitled "Waiting Your Turn: Wait Times for Health Care in Canada (2017 Report)", attached as **Exhibit "X"** ("Waiting Your Turn").

115. The Waiting Your Turn report shows cumulative statistics across all surveyed procedures, and reaches the following conclusions:

- BC's total average wait times (from referral by general practitioner to treatment) have grown from approximately 10.4 weeks in 1993 to 26.6 weeks in 2017 (at page v);

- BC's total average wait times for 2017 are the 7th highest among the provinces, and approximately 10 weeks longer than in Ontario (at page 1);

- BC's average wait times for MRIs (24 weeks) and CT Scans (6 weeks) are the highest in Canada in 2017, and approximately four and two times longer than Ontario, respectively (at page 9);

- BC average Wait One times for 2017 are 7th highest among the provinces, and approximately twice as long as average Wait One times in Ontario (at pages 20, 36); and

- BC's average wait times between appointment with a specialist and treatment for 2017 are 6th highest among the provinces, and approximately 7 weeks longer than the average wait times for that period in Ontario (at page 21, 36).

116. Similarly, the March 2018 Vancouver Coastal Health Authority report, entitled "Our Health Care Report Card", a copy of which is attached as **Exhibit "Y"** ("VCHA, "Report Card"), reveals at page 10 that only 49% of their surgical patients meet maximum medically acceptable wait times.

117. The overall result is that despite large increases in funding for health care provision over the past two decades, the statistics show that wait times for surgeries and diagnostics in the

public system are generally not improving, and in many important respects are getting worse.

E. The Creation of Maximum Acceptable Wait Times in Five Priority Areas

i. Pan-Canadian Benchmarks in Five Priority Areas

118. The process of establishing medically acceptable surgical Wait Two times began in the early 2000s with various First Ministers initiatives, leading to benchmark targets for wait times in five priority areas.

119. As summarized in the Final Report of the Federal Advisor on Wait Times:

> In recent years Canadians have expressed concern about the health care system in general. This concern has grown out of a waning confidence in governments' ability to support and sustain the system as well as Canadians having direct experience with wait times for diagnostic tests and surgical procedures that they consider too long. Cancer patients waiting for radiation treatments and individuals suffering from pain or increasing disability due to hip and knee conditions grow understandably frustrated with lengthy waits to receive care. "Consistently, Canadians identify long wait times as the number one barrier in accessing health services." This barrier has become the focus for the federal, provincial and territorial governments who are working diligently to address these concerns.

120. Attached as **Exhibit "Z"** is a copy of the Final Report of the Federal Advisor on Wait Times, Dr. Brian Postl, dated June 2006 ("Postl Report"), which contains the above passage on page 18.

121. In 2004, the Federal, Provincial and Territorial Ministers of Health agreed to the "10-Year Plan to Strengthen Health Care", which included a commitment to create:

> Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.

122. Attached as **Exhibit "AA"** is a copy of the communique issued by the First Ministers in 2004, entitled the "A 10-year Plan To Strengthen Health Care", dated September 16, 2014 ("10-Year Plan").

123. The First Ministers' announcement prompted a number of initiatives to create evidence-based medically acceptable wait time benchmarks in the five priority areas in various provinces.

124. In February 2005, the Western Canada Waiting List Project ("WCWLP") proposed wait time benchmarks for hip replacements, knee replacements and cataract surgery based on their reviews of research evidence as well as input from clinical experts, patients, and the public. Attached as **Exhibit "BB"** are the appendices to a report produced by the WCWLP, entitled "Western Canada Waiting List Project: Moving Forward", dated February 28, 2005 ("WCWLP Report"), which provides information about the WCWLP.

125. The proposed benchmarks in the WCWLP Report ranged from four weeks for the most urgent cases in all areas, to 12 weeks for the least urgent cataract cases, and 20 weeks for the least urgent hip/knee replacement cases. The WCWLP report defined benchmarks as the "Maximum Acceptable Wait Times (MAWT)".

126. In March 2005, the Wait Time Alliance ("WTA"), made up of medical specialists and the Canadian Medical Association released an interim report entitled "No More Time to Wait: Toward benchmarks and best practices in wait time management". The report proposed various "medically acceptable wait time benchmarks", which it defined at page 31 as "[t]he threshold wait time for a given health service and level of severity beyond which the best available evidence and clinical consensus indicate that the patient's health is likely to be adversely affected". Attached as **Exhibit "CC"** is a copy of that report.

127. The final WTA report, "It's About Time: Achieving benchmarks and best practices in wait time management" issued in August 2005, identified benchmarks which reflect clinical consensus and (where available) research evidence as to what is a "medically reasonable" wait time. Attached as **Exhibit "DD"** is a copy of the Wait Time Alliance report from August 2005.

128. Attached as **Exhibit "EE"** is a Health Council of Canada document dated November 2005, and entitled "A Background Note on Benchmarks for Wait Times", which discusses the WTA and WCWLP projects, amongst others.

129. In July 2005, Dr. Brian Postl was appointed the Federal Advisor on Wait Times in order "identify and continue to develop consensus on establishing comparable indicators and evidence-based benchmarks" in the five priority areas identified by the First Ministers: cancer (curative radiotherapy), heart (coronary artery bypass graft), diagnostic imaging procedures (mammograms and cervical screening), joint replacements (hip fractures, hip replacement, and knee replacement) and sight restoration (cataract) [Postl Report, Exhibit "Z" above, at pages 5, 19-21].

130. In developing the appropriate benchmarks, the office of the Federal Advisor on Wait Times was assisted by an initiative that came to be known as the Canadian Wait Times Project ("**CWTP**"), the funding for which was provided by Health Canada [see Postl Report, Exhibit "Z", above, at page 19].

131. As the Postl Report explains, the primary object of Phase One of the Canadian Wait Times Project (July-December 2005) was to assist in finalizing the work begun by the provincial

and territorial governments to establish evidence-based wait time benchmarks in the five priority areas.

132. The establishment of the benchmarks was informed by previous studies (such as the WCWLP and WTA studies, discussed above), and the research funded by the Canadian Institute of Health Research ("**CIHR**"), which is the Government of Canada's lead agency for health research.

133. In particular, the CIHR funded and supported a number of Canadian teams to undertake studies that would form the development of the first set of benchmarks, including:

(a) The group led by Dr. Tom Noseworthy, which produced two reports, entitled "Towards Establishing Evidence-based Benchmarks for Acceptable Waiting Times for Joint Replacement Surgery", Reports 1 and 2. Attached as **Exhibit "FF"** are copies of the two reports, produced in July and October of 2005, respectively ("Noseworthy Reports"), which notes the following at pages 3 and 7 of the first report:

> "While priority-setting tools may help to direct limited resources to those patients most in need, they will not correct the mismatch between the demand for and supply of joint replacement surgery
>
> Why this is important is because, at best, it is unfair to patients. Worse still, it may be bad for their health. It is bad for the economy in terms of lost productivity while patients wait. Furthermore, it is burdensome for providers and sufficiently visible to the public that they are genuinely losing confidence in the health care system's timeliness and capacity, and their ability to access it. Canadians have identified long waits as the primary barrier to specialized services. All of this is brought into even sharper focus with the recent Supreme Court of Canada's Decision."
>
> "It is for these compelling reasons that more can and must be done. Priority-setting has to broaden across Canada, such that order in the queue is based on degree of urgency. Yet, there is little point in being in the correct order, if the line moves too slowly. As one component of this important undertaking, it was agreed to formulate evidence-based benchmarks for medically acceptable waiting times for joint replacement (as well as cancer, heart, diagnostic imaging, and sight) by December 31, 2005, following which multi-year targets would be established to achieve priority benchmarks in each jurisdiction by December 31, 2007. [references omitted]
>
> (...)
>
> Hip and knee osteoarthritis is by far the commonest reason for arthroplasty. This condition and its consequences are not going away, any time soon. While the way arthroplasties are done may change, the need for them will

not. This is particularly true because arthroplasty works and there is a demographic bulge on the horizon. To manage this challenge, there will need to be waiting time benchmarks based on the best available information and evidence. Furthermore, they will have to be met."

(b) The group led by Dr. Bassam Masri, which prepared three reports funded by CIHR, the first of which conducted a comprehensive literature review, which informed the decisions regarding wait times and benchmarks. Attached as **Exhibit "GG"** is a copy of the Masri Group's first report, entitled "Priority Criteria for Hip and Knee Replacement: Addressing Health Service Wait Times, Report 1 Literature Review: Waiting, Consequences and Benchmarks for Joint Replacement", and dated July 21, 2005 ("Masri Report #1").

134. The Masri Report #1 discussed "Maximum Waits" or "maximum acceptable wait times", and acknowledged that the Western Canada Waiting List Project had been setting the pace for establishing both priority criteria scores (PCS) and waiting time benchmarks for hip and knee replacement as well as other common procedures (see pages 2, 13-14, 19, 22-29, 63-65 of Masri Report, Exhibit "GG", above).

135. As can be seen, there were a number of scientific studies and reports that were designed to create agreed upon benchmarks for certain procedures, after which there was a risk of negative health consequences, in addition to any harm caused by waiting for treatment itself in terms of pain or a lack of mobility. This research to establish benchmarks was evidence-based as well as expert consensus-based and peer reviewed.

136. With the aid of these scientific studies, the First Ministers set out to determine maximum acceptable "benchmark" wait times for procedures within the five priority areas. There were provincial initiatives in addition to the Canadian Institute for Health Research (CIHR) funded research such as that of the Masri and Noseworthy Groups.

137. The Federal Advisor described these benchmarks as follows:

> Wait time benchmarks are evidence-based goals that express the amount of time that clinical evidence shows is appropriate to wait for a particular procedure or diagnostic test. A benchmark may be identified when scientific evidence shows that the outcome of an intervention is negatively affected after a certain period of waiting has elapsed. [see Postl Report, Exhibit "Z", above, at page 24]

138. As set out in the Postl Report (Exhibit "Z", at pages 20-21), the following ten specific benchmarks in the five priority areas were publicly announced and accepted unanimously by the First Ministers on December 12, 2005:

- Cancer (curative radiotherapy) – within 4 weeks of being ready to treat;
- Cardiac (coronary artery bypass graft) – Level 1 (within 2 weeks), Level 2 (within 6 weeks), Level 3 (within 26 weeks)

- Sight restoration (cataract) – within 16 weeks for patients who are high risk;
- Hips and knees
    - Fixation of hip fractures – within 48 hours
    - Hip replacement – within 26 weeks
    - Knee replacement – within 26 weeks
- Diagnostic services
    - Mammograms – women aged 50-69 every two years
    - Cervical screening – women starting at 18 years old, every three years to age 69 after two normal pap smears.

139. These benchmarks remain the current maximum acceptable wait times for Canadians in all provinces and territories in these ten procedures within five priority areas identified. However, as discussed below, the benchmarks in some of these areas have been further refined in BC to account for varying levels of urgency in treatment through BC's patient priorities codes.

ii. BC's Performance Against the Benchmarks in the Five Priority Areas

140. In February of 2006, CIHI started to report on wait times across jurisdictions in relation to five of the priority procedures established by the First Ministers: hip replacement, knee replacement, hip fracture repair, cataracts, and radiation therapy.

141. As stated on the CIHI website under "Wait Times in Canada – A Comparison by Province", a copy of which is attached as **Exhibit "HH"**, as the prelude to the available reports:

> In 2004 Canada's First Ministers agreed to reduce wait times in five priority areas: cancer treatment, cardiac care, diagnostic imaging, joint replacement, and sight restoration. They also agreed to work towards meeting evidence-based benchmarks - or targets - for medically acceptable waits, which were established in late 2005 for some priority procedures.
>
> CIHI was mandated to collect and annually report on wait time information and monitor provincial progress in meeting benchmarks.

142. CIHI reports yearly on the percentage of cases meeting the pan-Canadian benchmarks in these areas, for Canada and in each province and territory.

143. The most recently available CIHI Report is "Wait Times for Priority Procedures in Canada, 2017", dated March 2017 ("CIHI Report (2017)"), which provides wait times data for

2016. A copy of this report is attached as **Exhibit "II"**. At page 13 of the CIHI Report (2017), CIHI refers to the pan-Canadian wait time benchmarks as "medically acceptable timeframes" for the priority procedures.

144. Although not produced in a full report, CIHI has collected and published similar information for 2017, the charts and summaries for which are available on CIHI's website: http://waittimes.cihi.ca/. Copies of a number of the charts and summaries available on the CIHI website from the most recent comparison are attached as part of Exhibit "II" above ("CIHI Data (2017)").

145. Although the data in CIHI Data (2017) only covers part of the overall wait of patients, the latest data shows that many British Columbians are waiting past the maximum wait times with respect to each of the priority procedures for which BC has provided data:

- 38% of BC patients in need of a hip replacement are not receiving treatment within benchmark;
- 54% of BC patients in need of a knee replacement are not receiving treatment within benchmark;
- 16% of BC patients in need of a hip fracture repair are not receiving treatment within the benchmark;
- 37% of BC patients in need of cataracts are not receiving treatment within the benchmark; and
- 7% of BC patients in need of radiation therapy do not receive it within the benchmark time.

146. In addition, the CIHI Data (2017) for British Columbia shows no improvement in wait times for either hip fracture repair or radiation therapy since 2013, and a steady increase in BC patients wait times for the other three priority procedures:

- hip replacements – from a high of 80% patients receiving treatment within the benchmark in 2013, to a new low of 62% in 2017;
- knee replacements – from a high of 71% patients receiving treatment within the benchmark in 2013, to a new low of 46% in 2017; and
- cataract surgery – from a high of 83% receiving treatment within the benchmark in 2013, to a new low of 63% in 2017.

147. As the charts attached to Exhibit II show, there is regional variation within BC in the percentage of patients receiving surgeries within these benchmarks.

148. However, even the health authority with the highest percent in these benchmarks for hip and knee replacement shows that 24% of patients in need of hip replacements in 2017, and 33% of patients in need of knee replacements, are receiving that treatment beyond the maximum acceptable wait time established by the First Ministers.

149. In the lowest performing health authority regions in BC, approximately 51% of patients are not receiving surgery within the benchmark time for hip replacements, and 68% of patients in need of knee replacements in 2017 are not receiving their surgery within the benchmark time.

150. It should be emphasized that the pan-Canadian target wait time measurements for hip and knee replacements, which CIHI uses for its statistics, is a 26 weeks benchmark target, which is a priority 5 (i.e. the lowest priority) under BC's patient prioritization levels.

151. However, in BC, the treatments for these priority procedures have been further specified by using the patient prioritization codes, which can account for the level of urgency of treatment.

152. A large number of patients are in higher priority levels based on them experiencing moderate to severe pain and functional disability, as illustrated in Chart #1.

153. For instance, in 2017, three out of four hip replacement patients were in a priority level with maximum wait time of 12 weeks or less, rather than 26 weeks, as set out in the below Chart #1 (see Exhibit "U7").

154. In other words, many of the patients who receive their treatment within the pan-Canadian benchmark time of 26 weeks will have exceeded the maximum medically acceptable wait time for their personal condition under the BC patient priority codes.

Chart #1 – Hip Replacement Surgery – Percentage Treated Within Benchmark 2017-2018

Year			**2017**	**2017**	**2018**	**2018**
Diagnostic Code	Diagnosis Description	Priority Code	Total Cases	Percent Performed Within Target	Total Cases	**Percent Performed Within Target**
34VAAK	Hip - Arthritis/ Joint Degeneration – Severe Pain, Patient Cannot Self-Care Or Delay May Lead To Serious Harm	1 (2 weeks)	79	22.8%	16	12.5%

34VAAL	Hip - Arthritis/Joint Degeneration – Severe Pain And/Or Urgent Impairment/Disability, Immediate Threat To Role Or Independence - E.G. Collapsed Femoral Head, Avn	2 (4 weeks)	381	13.7%	111	11.7%
34VAAM	Hip - Arthritis/Joint Degeneration – Severe Constant Pain Or Constant Functional Deficit, Imminent Threat To Role Or Independence	3 (6 weeks)	926	19.2%	233	21.0%
34VAAN	Hip - Arthritis/Joint Degeneration - Moderate To Severe Pain With Significant Or Severe Functional Limitation	4 (12 weeks)	2,790	24.8%	743	27.5%
34VAAO	Hip - Arthritis/Joint Degeneration – Mild Pain, But Tolerable Functional Deficit	5 (26 weeks)	1,290	49.8%	519	51.8%

155. Therefore, the fact that a patient was treated within the pan-Canadian benchmark time of 26 weeks does not mean that they were treated within what the BC Government considers a "maximum acceptable" wait time.

156. That is because the pan-Canadian maximums (as reported by CIHI) do not differentiate between patients who are ascribed a higher priority by their treating physician, based on the patient's personal medical needs, considering their pain, disability, and risk of harm status. That is the purpose of the BC patient prioritization codes, which are reviewed in the next section of this affidavit.

157. Therefore, even for those patients who are treated within the pan-Canadian target of 26 weeks, they may still be waiting up to six months with reduced mobility or in severe pain, and significantly longer than is required under the BC patient prioritization codes.

158. For those patients who are not treated within that 6 months – for instance, over half of patients waiting for a knee replacement – the amount of pain and suffering they experience, and their lack of mobility, inability to work and economic harm, and inability to lead a

fully functioning life, is that much greater, in addition to the increased risk of permanent harm or reduced functioning as a result of being treated outside of the target period.

159. Finally, the wait times measured by CIHI only begin after the patient has already waited to see the specialist (i.e. Wait One is not counted), the necessary diagnostics have been performed (i.e. Wait Three is not counted), a decision is made to proceed with a surgery, and the hospital has received and accepted the booking package.

160. By the time the patient begins their Wait Two, they may have already been suffering or have had reduced mobility for a significant period of time, including the wait to obtain diagnostic imaging or other diagnostic services prior to starting Wait Two.

F. Measuring Wait Two Times Beyond the Five Priority Procedures

i. BC Patient Prioritization Codes

161. As can be seen, pan-Canadian benchmarks were established in five priority areas on a national level, and only set out the overall maximum, without differentiating between patients based on their individual needs.

162. As the CIHI data summarized above shows, BC has consistently failed to meet those benchmark times and targets, and its performance is getting worse.

163. However, there are thousands of other medical procedures that patients need for a wide range of medical reasons, in addition to these few selected procedures and conditions with established national maximum wait time benchmarks that are reported annually by CIHI.

164. Moreover, as noted above, the pan-Canadian benchmarks were set out as the absolute maximum that any patient with the particular diagnosis should wait – however, there is often differentiation within each of the procedures that make treatment more urgent for particular patients.

165. As such, in 2010, the Ministry of Health and BC's health authorities developed and implemented a system to prioritize patients waiting for scheduled surgery, using "patient prioritization codes".

166. The genesis of the patient priority codes in BC is described in the Defendant's *Prima Facie* Facts document as follows:

> 362. The Provincial Surgical Advisory Council ("PSAC") was established in 2009 to provide clinical and strategic advice and leadership in acute care and surgical access in the Province. It was initially established by PHSA following a surgical services conference in January 2009 (entitled "Access to Surgery in British Columbia – The Cutting Edge"), and included Medical Practitioners, Health Authority surgical services representatives, and Ministry representatives.

363. PSAC led the development and implementation of the Patient Prioritization Initiative ("PPI") in 2010. PPI was a Province-wide project that introduced a standardized approach to prioritizing adult patients waiting for Scheduled Surgeries in the Province. Surgeons use their assessment of the patient to select a diagnosis/clinical condition from a standardized list. Each diagnosis/clinical condition is assigned one of five priority levels and a corresponding maximum recommended wait time in weeks. (...)

364. In the event that, in the surgeon's opinion, the diagnosis/clinical condition code does not appropriately prioritize the specific patient's surgery, the surgeon may assign a code to the patient that ascribes a different (more appropriate) priority level.

365. Surgeons are required to assign a patient prioritization code when booking a patient for surgery. The patient prioritization code is recorded in the Surgical Patient Registry. Surgeries are then expected to be completed, in part, on the basis of their priority and within the wait time benchmarks associated with the priority level.

PFF - MOH, at paras 362-365.

167. The codes, initially adopted and implemented in 2010, were later reviewed and updated in 2014/15 by the "BC Patient Prioritization Codes Review Project", which was aimed at producing "clinically acceptable benchmarks" (see PPCRP Final Report, Exhibit "Q" above, at page 7).

168. As the Defendant states in its *Prima Facie* Facts, the goal of the prioritization codes is to assign a priority level – i.e. "maximum recommended wait time in weeks" – to a list of standard conditions and diagnoses (see PFF- MOH, at para 363).

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

- **Priority Level 1** requires treatment within **2 weeks**, and is applied to codes that involve severe pain or acute conditions, risk of permanent functional impairment, tumour/carcinoma/cancer/high risk of malignancy, or time sensitivity;
- **Priority level 2** requires treatment within **4 weeks**, and the condition involves severe pain or severe/progressive condition, tumour/carcinoma/cancer/suspected malignancy, or 'moderate symptoms';
- **Priority level 3** requires treatment within **6 weeks**, and is for conditions with moderate pain or benign condition, functional compromise, and cancers that are slow growing/malignancy not suspected, or 'stable symptoms';

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

- **Priority level 5** requires treatment within **26 weeks**, is for conditions with mild pain or mild/stable condition, a 'moderate' impact on lifestyle, non-time sensitive conditions, and benign tumour/masses. [see PPCRP Final Report, Exhibit "Q" above, at page 12 and PFF – MOH, at para 363]

170. These priority levels are then ascribed to a standard list of descriptions of diagnoses / clinical condition. Each description has a code assigned to it, along with a priority level and corresponding maximum wait time target.

171. For example, "cataracts" are a general eye condition that can manifest differently for different patients, which may indicate greater or lesser urgency for care.

172. The pan-Canadian benchmark wait time is only set for a single category of cataract patients, namely, 16 weeks "for patients who are high risk".

173. However, in BC, it is recognized that this maximum wait time is not medically acceptable for many patients with cataracts. Thus, the patient prioritization codes for cataracts in BC include:

- Cataract – unable to function without assistance – Priority 3 (6 weeks);

- Cataract – second eye to avoid anisometropia – Priority 3 (6 weeks);

- Cataract – work driving impairment or impairment in the ability to function in the workplace – Priority 4 (12 weeks); and

- Cataract – with functional impairment – Priority 5 (26 weeks).

174. The Ministry of Health and the Health Authorities have produced a document that lists all of these conditions and diagnoses, with their corresponding priority levels and wait time targets (in weeks), dated July 23, 2015, a copy of which is attached as **Exhibit "JJ"** ("Adult Priority Codes – List"). The cataracts codes are listed on page 8 of this document.

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

176. As noted above, the target wait times produced by the BC Patient Prioritization Code Project are defined by the Government as "the time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences" [see PPCRP Final Report, Exhibit "Q", above, at page 7].

177. The purpose of establishing diagnosis codes was described by the Ministry of Health as follows, in relation to the participants in the Patient Priority Code Review Project:

> "Participants were reminded that the purpose of the diagnosis codes is to... [p]rovide a clear and consistent picture of clinically acceptable benchmarks for patients using a standard methodology..." [see PPCRP Final Report, Exhibit "Q", above, at page 7]

178. Similarly, the March 2018 "Our Health Care Report Card" document, prepared by Vancouver Coastal Health Authority and Providence Health Authority, describes the purpose of the patient prioritization codes, and that health authority's performance against them as follows:

> "We monitor the percentage of elective (non-emergency) surgeries we complete within the [Patient Prioritization Code Project] benchmark wait time assigned by a patient's surgeon.... We want to ensure patients have timely access to surgery and do not wait beyond the maximum medically acceptable wait times." [VCHA, "Report Card", Exhibit "Y", above, at page 9]

179. Therefore, the purpose of these prioritization codes, like the pan-Canadian benchmarks accepted by the First Ministers, is to ensure patients do not wait longer than the maximum wait time indicated by the priority level attached to the codes, after which they are at an increased risk of suffering negative health consequences.

180. Although the prioritization codes are useful guides to determine when patients experience an unacceptable risk of suffering adverse health consequences as a result of waiting, they are defined as the maximum acceptable wait times targets because individual patients may suffer harmful consequences even *within* these benchmarks.

181. By necessity, even the patient priority code maximum acceptable wait time targets cannot account for each individual patients' unique circumstances, nor does it address the amount of time patients have been waiting prior to seeing a surgeon, obtaining any necessary diagnostic tests, and a decision is made that a surgery is required.

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

ii. BC's Performance Against the Benchmarks

a. Overview

183. The BC Government's SPR data show a high percent of patients waiting past the maximum clinically acceptable benchmark wait times, in all health authorities, and for a large number of surgical procedures.

184. The data from the 2013-2018 Wait Times Report, referenced above, includes data with respect to:

- Wait One: total cases booked and 50th, 90th, and 99th percentile wait times by diagnosis and priority level.

- Wait Two: Total cases completed, percent within benchmark, 50th, 90th, and 99th percentile wait times by diagnosis and priority level calculated from the surgical Decision Date (DD) and from the Booking Form Received Date (BFRD).

- For the Wait 2 completed cases, data are provided for General Surgery, and Gynaecological Surgery, Neurosurgery, Ophthalmology, Dental Surgery, Orthopaedic Surgery, Plastic Surgery, Thoracic Surgery, Urology, and Vascular Surgery, for both adults and paediatric patients.

185. The data are provided for the Province of BC overall, and are also broken down for each Health Authority (i.e. Interior Health, Fraser Health, Vancouver Coastal, Vancouver Island, Northern Health, and the Provincial Health Services Authority ("PHSA")).

186. As just noted, the 2013-2018 Wait Times Report includes data on the 50th, 90th, and 99th percentiles, measured from both the "Decision Date" (DD) and "Booking Form Received Date" (BFRD).

187. However, the cumulative SPR data in the "Percentage of Cases Completed within the Targets" spreadsheet – from which Exhibits "U1" through "U11" were taken – are only from Booking Form Received Date (BFRD).

188. The distinction between the two dates is as follows:

- "Decision Date" measures the Wait Two time between a patient being both ready and recommended for surgery, and the time the patient receives the necessary treatment; and

- "Booking Form Received Date" measures the Wait Two time from the date that the hospital receives the booking information, which may be much later than the date on which the patient has signed consent for surgery and is ready to receive treatment.

189. CIHI defines Wait Two as "(t)he number of days a patient waited, between the date when the patient and the appropriate physician agreed to the surgery, and the patient was ready to receive it, and the date the patient received" the surgery. This definition was established in 2005, by the Comparable Indicators of Access Sub Committee, who developed this pan-Canadian definition for wait time measurement that was adopted by the federal/provincial/territorial ministries. Attached as **Exhibit "KK"** is an April 2018 CIHI document, entitled "Wait Time Information in Priority Areas: Definitions", which includes this definition at, for instance, pages 6, 8, and 12.

190. Measurements from the Decision Date best fit this definition, and a number of other provinces are providing data to CIHI by using Decision Date rather than Booking Form Received Date.

191. The BC Government has considered measuring Wait Two times based on the "Decision to Treat" or "Ready to Treat" date instead of "Booking Form Received Date." Attached as **Exhibit "LL"** is a 2017 Ministry of Health report entitled "Wait Two Reporting Using the New Data Definition – Data Issues and Implications for Reporting Wait Times" ("Wait Two Measurements Report") that discusses this option.

192. This document notes that Decision Date in the Surgical Patient Registry (SPR) is defined as the date that the surgeon and the patient mutually agree to proceed with surgery and the patient is "ready, willing and able" to proceed. As such, any days after the ready to treat date during which the patient is unavailable are excluded from the patient's overall wait time.

193. This Wait Two Measurements Report also notes that reporting the Decision Date for treatment has been mandatory since 2010, that "(r)eporting compliance has been very close to 100% since 2012/13", and that outlier cases make up approximately 1% of the reported times.

194. The same document confirms that using the date on which a patient is ready to be treated (i.e. the Decision Date) instead of the Booking Form Received Date, will show that for all cases waiting as of December 31, 2016:

- the median wait times for cases waiting is 17.6 weeks, instead of the 12.7 weeks under the Booking Form Received Date; and
- the 90th percentile wait times for cases waiting are 49.7 weeks, rather than the 42.1 weeks according to the Booking Form Received Date.

195. Similarly, the same document states that using the Decision Date for "cases completed" as of December 31, 2016, shows that:

- the median wait time for cases completed increases to 11.4 weeks instead of the 7.0 weeks under the Booking Form Received Date;
- the 90th percentile wait times for cases completed is 41.3 weeks instead of 31.4 under the Booking Form Received Date.

196. This data confirms that using the "Booking Form Received Date" for Wait Two underestimates the full wait time.

197. Despite the fact that the data in the Government spreadsheet "Total Cases Completed – Percent Performed Within Target" – from which the data in Exhibits "U1" through "U11" are taken – is measured from Booking form Received Date and therefore underestimates the overall Wait Two, they still show a large percentage of British Columbians are not receiving their surgery within the "clinically acceptable benchmarks" or the wait time

target described as "the time beyond which patients presenting with the particular diagnosis / condition could suffer negative consequences" [see PPCRP Final Report, Exhibit "Q", above, at page 7].

198. The number of cases not completed within target, or well past the target, is high and widespread across all the surgical specialties.

b. Wait Times for Life Threatening Conditions

199. First, BC patients are waiting longer than the maximum acceptable wait time for procedures where delayed treatment is life threatening, as seen in the data from the 2013-2018 Wait Times Report, as excerpted in Exhibits "U1" to "U11".

200. For example, many surgeries to treat cancers of the colon, lung, stomach, rectum, skin, ovary, liver, uterus, cervix, bladder, prostate and breast are not being completed within target, as well as some procedures necessary to avoid strokes. Some of these are illustrated in Chart #2 below, from data found in Exhibits "U1", "U2", "U9", and "U10".

Chart #2 – Life Threatening Conditions – Percentage Treated within Benchmark in 2017 and 2018

Year			**2017**	**2017**	**2018**	**2018**
Diagnostic Code	**Diagnosis Description**	**Priority Code**	**Total Cases**	**Percent Performed Within Target**	**Total Cases**	**Percent Performed Within Target**
36GTCG	Lung Cancer - Confirmed Or Suspected	1 (2 weeks)	999	**33.1%**	201	**31.3%**
50RDCA	Cancer Ovary, Fallopian Tube Or Peritoneum	1 (2 weeks)	158	**22.2%**	41	**22.0%**
50 RNCA	Invasive cancer of the cervix	1 (2 weeks)	55	**29.1%**	11	**45.5%**
39PMCB	Bladder Cancer - Bladder Fulguration With Cystoscopy	2 (4 weeks)	159	**37.1%**	13	**30.8%**
39PMCF	Bladder Cancer With Risk Of Cancer Progression - Cystectomy-Radical With Urinary Diversion	1 (2 Weeks)	184	**16.3%**	54	**13.0%**

39QTCA	Prostate Cancer With High Risk Of Cancer Progression - Radical Prostatectomy	2 (4 weeks)	603	**41.0%**	149	**37.6%**
37 JEAA	Symptomatic carotid stenosis – strokes, TIA	1 (2 weeks)	255	**61.2%**	54	**72.2%**

201. To use one example, for bladder cancer with risk of cancer progression (Code 39PMCF), the priority code is 1 (2 weeks), and only 16.3% of patients in 2017 were treated within that time.

202. Therefore of 184 patients booked for surgery to remove bladder cancer with risk of cancer progression in 2017, 83.7% waited a time "beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences", according to the BC Ministry of Health [see PPCRP Final Report (March 2015), Exhibit "Q" above].

203. This is not a matter of patients receiving their treatment a day or two after the benchmark wait time.

204. As set out in Exhibit "U12", the 50th percentile wait time for bladder cancer treatment with risk of cancer progression (Code 39PMCF) was 4.4 weeks (from Booking Form Received Date) and 6.1 weeks (from Decision Date), which meant that half of the patients in need of treatment in 2017 were waiting between two and three times the maximum acceptable benchmark time.

205. The 90th percentile wait time for this priority code in 2017 was 9.7 weeks (based on Booking Form Received Date), or 15 weeks (based on Decision Date), which means that one out of every ten patients is waiting between 10 and 15 weeks for this surgery, or five to seven times the maximum (see Exhibit "U12").

206. In addition, the number of patients treated within benchmark time has steadily decreased for some of these lifesaving surgeries.

207. For instance, as set out in Exhibit "U9", the percentage of patients being treated within benchmark time for lung cancer (Code 36GTCG) has steadily decreased over the last four years, from 47.8% in 2015, to 36.7% in 2016, to 33.1% in 2017, to 31.3% in 2018.

208. This means that there are hundreds of patients every year whose chances of successful recovery from life threatening cancer is compromised as a result of long waits in the public system that exceed the medically acceptable maximum wait, and this number is increasing every year.

c. Wait Times with a Risk of Severe Pain or Permanent Damage

209. Second, patients are also waiting where the delay causes:

- a risk of serious non reversible harms such as permanent disability and functional impairment (see e.g. Code 35 UZAD);
- suffering or severe pain (see e.g. Codes 37JEAA, 91FKAF, 30ODAB, 34TAAN, 34TAAM, 37 KGDA);
- a risk of narcotics dependency (see e.g. Codes 50RMEC and 50RZDF); or
- a lack of mobility and independence (see e.g. 62 CLAC, Codes 62CLAG, 37KGDA, 37KGDA, 34TAAM).

210. The following 2017 examples set out in Chart #3, from the 2013-2018 Wait Times Report, as excerpted in Exhibits "U2", "U3", "U6", "U7", "U8", and "U10", show how widespread the wait times problem is in B.C., where many patients are waiting well beyond the maximum wait times for many procedures across many different surgical specialties:

Chart #3 – Various Diagnoses – Percentage Treated Within Benchmark for 2017 and 2018

Year			**2017**	**2017**	**2018**	**2018**
Diagnostic Code	**Diagnosis Description**	**Priority Code**	**Total Cases**	**% within Target**	**Total Cases**	**% within Target**
91 FKAF	Dental disease Severe pain/infection with severe medical risk	2 (4 weeks)	78	**43.6%**	22	**31.8%**
30 ODAB	Biliary Colic – severe daily pain	1 (2 weeks)	547	**32.4%**	147	**29.3%**
50 RMEC	Endometriosis: severe, laparoscopic, debilitating requiring narcotics	3 (6weeks)	59	**35.6%**	18	**50.0%**
50 RZDF	Pelvic pain (regular narcotics +/or frequent ER visits/admissions)	3 (6weeks)	221	**57.9%**	52	**57.7%**
62 CLAC	Cataracts unable to function without assistance	3 (6 weeks)	9,067	**40.2%**	2,580	**45.8%**
62 CLAG	Cataracts – work / driving impaired or unable to function at work	4 (12 weeks)	4,856	**51.0%**	950	**55.7%**
37 JEAB	Asymptomatic carotid stenosis progressive over 70%	2 (4 weeks)	129	**34.9%**	40	**47.5%**
37 KGDA	Claudication – severe pain with	2 (4 weeks)	201	**60.7%**	70	**68.6%**

	minimal walking, bed ridden, threat to Role and independence					
34 TAAN	Shoulder - Arthritis/Joint Degeneration – Moderate To Severe Pain With Significant or Severe Functional Limitation, Threat to role and independence	4 (12 weeks)	298	**30.2%**	77	**28.6%**
34TAAM	Shoulder - Arthritis/Joint Degeneration - Severe Constant Pain Or Constant Functional Deficit, Imminent Threat To Role Or Independence	3 (6 weeks)	122	**34.4%**	23	**34.8%**
35UZAD	Hand Condition: Severe Pain - Patient Cannot Self-Care - Delay Will Lead To Serious Harm (E.G. Loss Of Nerve Function)	1 (2 weeks)	167	**82.6%**	61	**62.3%**

211. Third, the data also shows poor performance meeting the priority targets for the five priority procedures addressed in the CIHI reports, particularly hip replacement, knee replacement, and cataract surgery.

212. The data from the 2013-2018 Wait Times Report shows that BC patients are not just waiting longer than the maximum acceptable wait time for Priority 5 cases (26 weeks), but are waiting for longer than the maximum acceptable wait time for much more urgent priority codes as well.

213. For instance, as reviewed in Chart #1 above, the number of patients waiting beyond the BC patient prioritization code target for hip replacement surgery in 2017 shows the following:

- 77% of priority 1 patients, which includes patients in "severe pain" and who "cannot self-care", or where the "delay might lead to serious harm", were treated after the maximum acceptable wait time of 2 weeks;

- 86% for priority 2 patients, which includes "severe pain" and/or "urgent impairment/disability" and "immediate threat to role or independence", were treated after the maximum acceptable wait time of 4 weeks; and

- 81% of priority 3 patients, which includes patients in "severe constant pain" or "constant functional deficit", with an "imminent threat to role or independence", were treated after the maximum acceptable wait time of 6 weeks.

214. The Government's data shows long waits for many other orthopaedic surgeries.

215. For example, Code 34TAAM (contained in Chart #3 above) involves patients in need of shoulder surgery where the patient is in "severe constant pain" or a "constant functional deficit" with an "imminent threat to role or independence".

216. The maximum acceptable wait time for patients in this condition is 6 weeks. In 2017, only 34.4% of these patients received this semi-urgent operation within the 6 week benchmark target.

217. That means that approximately two thirds of individuals suffered in severe pain or with severe functional deficiencies for over 6 weeks.

218. Again, the statistics show that this is not a majority of patients waiting a few days past the benchmark wait time:

- 50% of patients waiting longer than 14.4 weeks from Booking Form Received Date, and 21.6 weeks from Decision Date, until treatment (see Exhibit "U12", Code 34TAAM), and

- 10% of patients waiting longer than 49 weeks from Booking Form Received Date, and nearly 51 weeks from Decision Date, until treatment (see Exhibit "U12", Code 34TAAM).

219. Many of these conditions also prevent people from living normal, functioning lives. For instance, with respect to individuals with cataracts who are "work/driving impaired or unable to function at work", approximately 49% of patients in 2017 did not receive treatment with a maximum acceptable wait time of 12 weeks (Code 62 CLAG).

220. With respect to patients with more severe forms of cataracts, such as those who are "unable to function without assistance" (Code 62 CLAC), approximately 60% did not receive their treatment within the maximum acceptable wait time of 6 weeks.

221. As discussed below, Cambie treats over 750 cataract patients a year, most of whom are "beneficiaries" under the *MPA*, that it will not be able to treat if the 2003 amendments to the *MPA* are made effective.

222. Harmful waits are therefore widespread in many specialties and in all areas, and in many cases the diagnostic descriptions correlate with proven harm, pain, and suffering, while in the case of certain conditions like various forms of cancer, waiting exposes patients to life threatening risks according to the government's own criteria.

G. Paediatric Wait Times Targets

i. Paediatric Wait Times Benchmarks

223. As a surgeon who treats teenage athletes, such as plaintiffs Krystiana Corrado and Chris Chiavatti, and based on my personal knowledge from direct involvement with wait time initiatives as CMA President, I am aware that wait times for children can present unique risks of harm.

224. Dr. Geoffrey Blair, as chief of surgery at B.C. Children's Hospital and spokesman for a consortium of surgical chiefs from more than a dozen pediatric hospitals in the country, reported that 65% of Canadian children in need of treatment wait a "medically unacceptable" period of time. This statistic is based on a 2005 audit conducted by staff at B.C. Children's Hospital, which was described in a Canadian Medical Association Journal (CMAJ) letter by Dr. Blair, dated December 6, 2005. Copies of the letter and a follow up CMAJ article by Dr. Blair, dated November 4, 2008, are attached as **Exhibit "MM"**.

225. This issue was also addressed in the Final Report of the Federal Advisor on Wait Times, which contained the following conclusions:

> There is however a significant difference for children in that their growth and development is rapid. For some conditions the opportunity to intervene clinically or surgically is brief - the window opens and closes quickly. To miss that opportunity is to miss getting the most from the procedure over time. Related to this are of course the social, educational and psychological effects associated with illness, hospitalization and the inability of the child to participate in the real work of growing up. The failure to progress with their cohort can affect a child's life for a long time.
>
> (...)
>
> Addressing wait times for children's clinical and surgical interventions is therefore a moral responsibility - a trust responsibility - that needs to be shared by society at large. [see Postl Report, Exhibit "Z", above, at pages 55-56]

226. Wait time benchmarks for children were not specifically included in the mandate of the Federal Advisor on Wait Times. However, as Dr. Postl commented in his Final Report, meeting clear and evidence-based benchmarks are particularly important for children:

> Yet the timing of interventions may be particularly critical for children for two reasons. First, there may exist in the normal development of a child a limited window of opportunity in which an intervention can have the most beneficial effect. Second, the delay of an intervention can cause normal growth and development to be impeded. We need to ensure that wait times for children are given due consideration. [Postl Report, Exhibit "Z", above, at page 13]

227. As such, in the 2006 Final Report, the Federal Advisor recommended:

> The provincial and territorial governments give consideration to the access targets developed by the National Youth and Child Health Coalition and consult as required with clinical leaders in children's health care, in order to consider their implementation. Further, that the conditions affecting children be included alongside adult-related conditions at the outset of future benchmarking processes to ensure that children receive equitable attention to their time-sensitive needs. [See Postl Report, Exhibit "Z", above, at page 14].

228. As with the priority areas identified by the Federal Advisor, the first step to developing a central database for paediatric wait times was to create common standards on acceptable wait times.

229. The Canadian Paediatric Wait Times Project ("CPWTP") was announced in 2007 by the federal government to ensure more children requiring surgery would receive timely access to care. The CPWTP was funded by Health Canada.

230. This initiative led to the creation of the Pediatric Canadian Access Targets for Surgery ("**P-CATS**"), which sets out priority codes for children in need of surgeries, similar to the BC patient priority codes discussed above. Attached as **Exhibit "NN"** is a copy of all of the original paediatric codes for both Wait One and Wait Two ("Original P-CATS Codes").

231. The P-CATS were developed by over 100 Canadian pediatric surgeons with expertise (2008 P-CATS), and is currently governed by the Pediatric Surgical Chiefs of Canada with input from National Expert Panels.

232. Attached as **Exhibit "OO"** is a document produced by the CPWTP entitled "Paediatric Canadian Access Targets for Surgery (P-CATS)", and dated November 5, 2008, which provides background information about the P-CATS and their development.

233. Attached as **Exhibit "PP"** is an article in the Canadian Medical Association Journal from June 14, 2011, entitled "Waiting for children's surgery in Canada: the Canadian Pediatric Surgical Wait Times project", which discusses the Canadian Paediatric Wait Times Project, and makes preliminary findings in terms of whether the provinces are meeting these benchmarks ("CMAJ – P-CATS (June 2011)").

234. As set out in the P-CATS, these targets represent "the maximum acceptable waiting periods for the completion of specific types of surgery" [see CMAJ – P-CATS (June 2011), Exhibit "PP", above, at E559].

235. Attached as **Exhibit "QQ"** is a report prepared by the CPWTP entitled "Paediatric Canadian Access Targets for Surgery (P-CATS) Update Project", dated April 1, 2016.

236. P-CATS have priority levels I through VI for both Wait One and Wait Two, with priority level 1 being the highest urgency (requiring treatment within 24 hours), and priority VI being the lowest urgency (requiring treatment within 12 months). Therefore, like the adult patient prioritization codes in BC, the P-CATS codes are linked to a maximum wait time.

237. The P-CATS targets are recognized as the nationally accepted, standardized methodology for measuring and comparing surgical wait times across the country – they are pan-Canadian.

238. In December 2009, the BC Children's Hospital adopted P-CATS as the provincial BC standard. Trial Exhibit 0026(j) is a letter from Dr. John Chritchley of the Provincial Health Services Quality Review Board, dated May 1, 2012, which discusses the adoption of the P-CATS targets by the BC Children's Hospital, at page 3.

239. BC adopted the national Pediatric Canadian Access Targets for Surgery all pediatric patients in BC during the implementation of the diagnosis prioritization methodology for adult patients, as confirmed in the SPR Backgrounder (2015), Exhibit "R" above, at page 10.

240. Unlike how the SPR normally measures adult wait times, which is typically based on Booking Form Received Date, paediatric wait times were to be calculated from the Decision Date to the date of the surgery.

241. According to the Government's SPR Backgrounder (2015), attached as Exhibit "R" above, at page 11, while adult wait time is typically calculated from the booking form received date, "paediatric wait time is calculated from the decision date (DD) to the date of surgery performed".

242. This is also confirmed in the P-CATS charts, which define Wait Two as "the time between the date on which a decision is made to proceed with surgery and the surgery date" (see Original P-CATS Codes, Exhibit "NN" above, on page 1).

243. However, despite this, some Health Authorities continue to report paediatric wait time data based on the Booking Form Received Date, rather than the government mandated Decision Date.

244. According to the Wait Two Measurements Report cited above as Exhibit "LL", the Decision Date is not being used in 57% of cases of paediatric cases, which artificially makes the wait times appear better (i.e. shorter) than the Decision Date method.

245. As noted above, when the 50th, 90th, and 99th percentile wait times are measured from Decision Date they are often significantly longer than the measure from Booking form Received Date. For many conditions and diagnoses, wait times from Decision Date are 2-4 weeks longer, and in some cases much longer than that.

246. For instance, as indicated in the Wait Two Measurements Report, attached above as Exhibit "LL", in 26% of adult procedures and 15% of paediatric cases, the time between the two dates (BFRD and Decision Date) is longer than 4 weeks.

247. Therefore, because the Booking Form Received Date is used for Wait Two Data in the Government's "Percentage of cases Performed within Target" spreadsheet, including the paediatric codes contained in Exhibits "U1" through "U11", the actual wait times

experienced by paediatric patients will often be longer than they appear in this Government data.

248. In March of 2016, Ministry of Health and the Health Authorities released updated Pediatric Canadian Access Targets for Surgery (P-CATS) list of patient condition and diagnosis condition, which list is attached to this affidavit as **Exhibit "RR"** ("Paediatric Priority Codes – List").

249. Surgeons in British Columbia were informed about the newly completed national updated paediatric codes in March of 2016. To my knowledge, the updated P-CATS document was sent out to all paediatric physicians in the province in or around March of 2016, as set out in the letter available on the Fraser Health Authority website addressed to their surgeons, attached as **Exhibit "SS"**.

ii. BC's Performance Against Paediatric Wait Times Targets

250. In 2011, an article in the CMAJ reported that the treatment for child patients regularly exceeded acceptable wait times for surgery and procedures, and that delay has real and detrimental effects on surgical outcomes. This document is attached above as Exhibit "PP".

251. The CMAJ – P-CATS (June 2011) article explains the P-CATS as follows:

> "The Canadian Paediatric Surgical Wait Times project developed a pan-Canadian standardized approach to evaluating pediatric surgical wait times within all pediatric surgical subspecialties. The pediatric access targets have now been adopted as a provincial standard by British Columbia and Alberta, which means that two provinces now use a uniform and standard approach to measuring wait times for surgery based on clinical need. [CMAJ – P-CATS (June 2011), at E561]

252. As set out in the below chart, the report concluded that, overall, 27% of pediatric patients (representing 17,411 of 64,012 completed surgeries, and ranging from 15% to 45% by surgical subspecialty) received their surgeries past target during the stipulated period:

Table 1: Numbers of surgeries not completed as of December 2009 and surgeries completed past the target period in all surgical areas from January to December 2009

Area	Current waiting	Total completed	No. (%) completed past target
Dentistry	4 672	9 784	4 409 (45)
Ophthalmology	1 818	5 172	2 227 (43)
Plastic surgery	1 725	4 833	1 684 (35)
Cancer surgery	83	1 075	304 (28)
Neurosurgery	121	989	232 (23)
Cardiac surgery	297	1 572	365 (23)
Otolaryngology	5 809	17 567	3 793 (22)
General surgery	1 892	10 368	1 998 (19)
Urology	2 302	6 055	1 162 (19)
Orthopedic surgery	2 150	6 317	1 196 (19)
Gynecology	41	280	41 (15)
Total	20 910	64 012	17 411 (27)

253. This data is set out in pages E561 to E563 of the CMAJ – P-CATS (June 2011), attached as Exhibit "PP", above.

254. The fact that many children continue to wait beyond the maximum acceptable wait times for surgeries is confirmed by more recent data collected in the SPR.

255. As noted above, this data underestimates the full wait time, because many of the Health Authorities continue to use Booking Form Received Dates instead of Decision Dates for paediatric patients.

256. Nevertheless, the recent BC government data show harmful waits for children in many specialties, especially orthopaedics, dental surgery, otolaryngology, and ophthalmology, which place children at risk for negative consequences, as set out in Chart #4 below and Exhibits "U3", "U6", "U7" and "U11":

Chart #4 – Paediatric Waits – Percentage Treated Within Benchmark for 2017 and 2018

Year			**2017**	**2017**	**2018**	**2018**
Diagnostic Code	Diagnosis Description	Priority Code	Total Cases	**Percent Performed Within Target**	Total Cases	**Percent Performed Within Target**
95FEAF	Advanced Dental Caries: Moderate/Severe Carious Lesions And/Or Pain - High Risk Medical Status	IIA (1 week)	31	**25.8%**	5	**40.0%**
95FEAE	Advanced Dental Caries: Moderate/Severe Carious Lesions And/Or Pain – Moderate Risk Medical Status	III (6 weeks)	160	**27.5%**	62	**45.2%**
63CQAA	Stabismus: < 2 years	III (6 weeks)	39	**35.9%**	17	**47.1%**
61DKAB	Otitis Media With Effusion – Documented Moderate Hearing Loss & Speech Delay	III (6 weeks)	99	**46.5%**	24	**58.3%**
44VGJA	Meniscal Injuries – Acute	IIA (1 week)	22	**18.2%**	3	**33.3%**
44WZFA	Ligament Injury (Acl) – Acute	IV (12.86 weeks)	80	**81.3%**	15	**73.3%**

257. For instance, in the example of children with advanced dental caries (Code 95FEAF), which condition involves a "high risk medical status" and moderate or severe pain, nearly 75% of children in 2017 did not receive their treatments within the maximum acceptable wait time of 1 week.

258. Cambie has treated these patients since 1996, and now treats approximately 1,000 children annually who require general anaesthesia for their procedures, which we will be unable to continue if the proclamation of the new amendments to the *Medicare Protection Act* are brought into force this year.

259. Similarly, in ophthalmology, children are waiting unacceptable periods for vision sparing surgery, such as in the case of strabismus, which is a condition that causes the eyes to be misaligned (see Code 63CQAA). Approximately 64% of children in need of this treatment waited beyond the maximum acceptable wait time of six weeks.

260. Of children awaiting treatment for ear conditions leading to hearing loss and delayed speech – such as those with otitis media with effusion, causing moderate hearing loss and speech delay (Code 61DKAB) – only 46.5% of patients in 2017 received treatment within six week maximum target, and some waited significantly longer.

261. As discussed below, the three paediatric patient Plaintiffs in this constitutional challenge all waited well past the maximum wait time targets for orthopaedic procedures, and many BC children and adults continue to wait past targets for surgeries of the type the patient Plaintiffs underwent at Cambie.

H. Wait Ones

262. The longer patients wait before even being scheduled for surgery, or having their medical conditions identified through diagnostic testing, the longer their wait times and the greater risk of harm.

263. As the CIHI Report (2017) (Exhibit "II", above) emphasizes at page 13, the CIHI data for the priority procedures covers only Wait Two times, which is only part of the wait that patients experience:

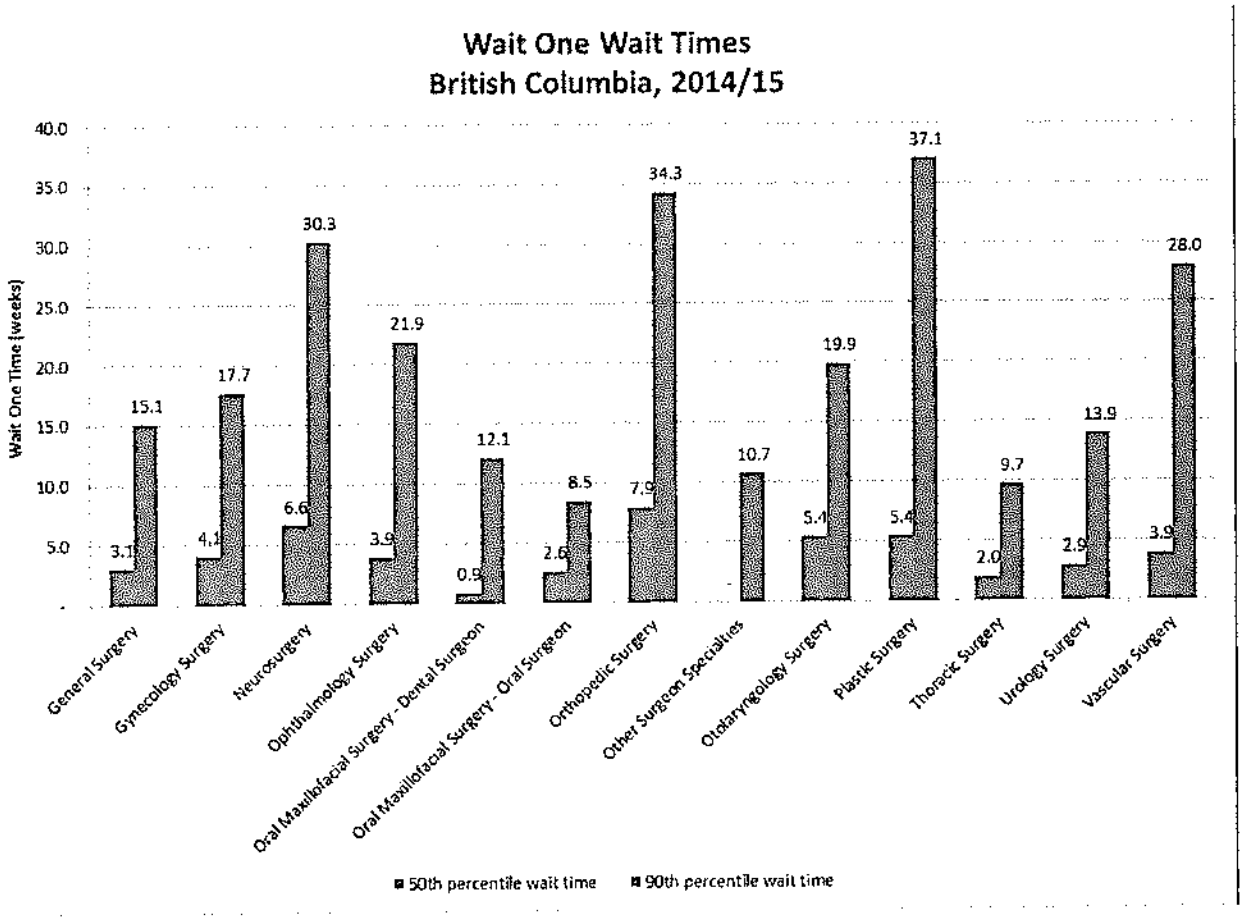
> That said, it is important to recognize that the wait times analyzed in this report focused on 5 priority areas; they represent just one part of the wait experienced by patients. A recent CIHI publication shows that Canadians continue to report longer waits to see their family doctors and specialists than adults in other peer countries. As efforts continue to expand the available information on wait times, a greater understanding of all waits experienced by Canadians will emerge.

264. Wait Ones are the time between the date the surgeon's office receives either a fax, email, or phone call from a referring doctor requesting a consultation, and the date of the patient's first visit to the specialist (see SPR Backgrounder (2015), Exhibit "R" above, on page 14).

265. The BC Government has not established benchmark targets for Wait Ones for adults, and therefore there is not equivalent Government data in terms of meeting or failing to meet specific benchmarks, as in the case of Wait Twos for adult and paediatric surgeries reviewed above.

266. However, the British Columbia does measure Wait One times, and according to the Defendant's *Prima Facie* Facts, it has been collecting this data since April 2014 [PFF – MOH, at para 270].

267. As of August 2015, the Wait One data from the Government shows long waits across surgical specialties, as set out in the Defendant's *Prima Facie* Facts (PFF – MOH, para 272):



268. While the Government has not produced similar charts since that time, there are a number of other sources of data.

269. As set out in the recent Fraser Institute Report, "Waiting Your Turn" (Exhibit "X", above, at pages v, 36), Wait One times in BC are approximately four times longer than they were in 1993: from 3.3 weeks in 1993 to 12.5 weeks in 2017.

270. As explained in my Affidavit #9, while some specialists could take on more surgical consultations, that would only increase Wait Two times, and lead to inefficiencies, given

the need to repeat and update consultations and diagnostics closer to the actual surgery date in those who experience a long Wait Two period.

271. That is why I worked with WorkSafeBC in 1999 to set up the Visiting Specialists Clinic, which was established in order to reduce long Wait Ones for patients who had been injured or contracted illnesses at work, and who could then receive treatments in private facilities, in light of the exemption created for patients insured through WorkSafeBC.

272. We established the Specialists Referral Clinic to give the same benefit to other British Columbians, with the expectation that individuals who obtained consultations outside of the public health care system would then obtain their surgeries privately from clinics like Cambie.

273. Mr. Marshal Van de Kamp is a witness in our constitutional challenge. He is a patient of mine whom, when I first met him, was working as a welder. His work was very physical. He had injured his right knee at work. He worked in a remote camp location.

274. He received a private MRI, expedited and funded by WCB, which showed a torn anterior cruciate ligament and meniscus. However, he told me that continuing to work was difficult. The camp site was approximately 8 square kilometers, and he walked 6 to 10 kilometers a day. He said he experienced pain every day from his knee problem, and his knee would occasionally dislocate while walking or in his sleep. During this time, he took various analgesics that caused some problems with his liver. I saw and examined him at the VSC (WorkSafeBC) on January 21, 2015. I confirmed the meniscal tear and ACL rupture and advised that he could not work due to his injury.

275. On February 12, 2015, I performed ACL surgery on his right knee. This was expedited and fully funded at Cambie by WorkSafeBC. As part of the rehabilitation process, he engaged in intensive physiotherapy, funded by WorkSafeBC. WorkSafeBC arranged for him to receive training for a Heavy Machine Operator's Course. Mr. Van de Kamp was able to return to some of his usual sports activities and remained on WCB benefits during his retraining.

276. On August 6, 2016, Mr. Van de Kamp was playing football and fell, twisting his left (opposite) knee. He had landed awkwardly on his left leg and felt immediate pain in his left knee and suspected he had torn the ACL. He told me that he was advised of a 6 to 8 month wait for an MRI in the public system and that instead of waiting he decided to obtain a private MRI with funds he had received by WCB as compensation for the prior right knee injury. Mr. Van de Kamp could not work. He received the MRI on August 10, 2016. The MRI confirmed that he had a meniscal tear and ACL rupture in his left knee.

277. On September 27, 2016, he explained the situation to me and his decision to pay for surgery privately. Mr. Van de Kamp told me he felt very stressed about having to wait a long time for surgery. WorkSafeBC had stopped his VR benefits. He said he was receiving EI benefits. I completed a physical examination on Mr. Van de Kamp and reviewed the MRI which confirmed the left ACL and meniscus tear. He required surgery. He was upset at the

inequitable situation with respect to identical injuries being handled so differently, solely on the basis that his right knee injury occurred at work and his left did not.

278. Mr. Van de Kamp was billed and paid for an independent assessment at SRC on Sept 27th 2016. He had surgery (an ACL reconstruction and partial meniscectomy on his left knee) on Sept 29th. We waived his surgery facility fee at the time of booking on September 27th 2016, after he told me he was using some of his WCB award from the first surgery to pay for it. He is one of hundreds of patients for whom we have waived or reduced surgery facility fees over the last 22 years.

279. At the end of his post-surgery follow up on October 24th we discussed the legal challenge for the first time. I had never discussed it with him before that. It is then that he volunteered to be a witness.

280. Mr. Van de Kamp went for physiotherapy, but had to pay for it himself because it was necessary to his rehabilitation, but not classified by the government as "medically necessary". He went one day a week for the first few months and then not at all. He tried to do the physiotherapy exercises at home. He could not afford to access a rehabilitation program like that offered by the WCB. I have followed him after surgery and his knee is recovering well, albeit more slowly than it would have under the higher level of rehabilitation and physiotherapy services.

281. If the new penalties, that are planned to be in force as of October 1st, 2018, had existed, Mr. Van de Kamp would have had no choice but to wait a long period in order to obtain his MRI, specialist assessment, and surgical repair.

282. Mr. Van de Kamp's MRI for acute joint symptoms is a Priority 3 urgent category with a Maximum Wait Target of 30 days. As Exhibit "V2" above shows, the 50th percentile wait time in 2016/17 for Priority 3 MRIs was 52 days, and the 90th percentile wait was 266 days.

283. Even if the MRI had not been prolonged, he would, in addition, have faced another wait for surgery. Even in Priority 4 (12 weeks), in 2016 only 62% of patients were treated in 12 weeks, and in 2017 only 56.9% were treated in the maximum wait time for Priority 4. No health authorities completed over 90% of cases within target in 2017.

I. "Wait Threes" – Diagnostic Services

284. Outside of the SPR, the Province also collects wait times data with respect to various diagnostic procedures, which are an integral part of the course of medical treatment.

285. Generally, the Government data with respect to diagnostic services is not as systematic as with respect to Wait Two times for surgeries or Wait One times for consultations, since the harmonized reporting from the health authorities is more recent.

286. However, BC is collecting some wait time data on magnetic resonance imaging (MRI scans), computed tomography (CT scans), and colonoscopies. While other provinces report this data to CIHI, British Columbia does not.

i. MRI Data

287. Magnetic Resonance Imaging ("MRI") involves taking a scan of a patient using magnetic forces and radio-frequency waves to make detailed pictures of organs, soft tissues, bone and other internal body structure. These images are three dimensional, which provides a great deal of detail to treating physicians.

288. MRIs are particularly useful in diagnosing certain cancers, as well as injuries to ligaments, tendons, spinal cords, the neurological system, and many other systems.

289. In the Defendant's *Prima Facie* Facts (MRI & CT Services) ("PFF – MRI/CT"), it reports that as of April 2015, approximately 40% of all MRI machines in the province – 17 out of 42 – were privately owned (at para 17).

290. In addition, many of the publicly-owned MRI machines used by the health authorities are at or past their expected lifespan.

291. Attached as **Exhibit "TT"** is a copy of a Government briefing note, entitled "MRI Wait Time Strategy", dated January 26, 2017, which suggests at page 2 that of the 25 MRI machines that were publicly owned as of January 2017, "11 are at or beyond the expected functional lifespan" based on Canadian Association of Radiologists guidelines.

292. Attached as **Exhibit "UU"** is a copy of a Government-produced "Backgrounder: MRI Wait Times and Actions", which notes that:

- MRI has the longest wait times among imaging modalities in BC.
- MRI is also a very scarce medical imaging resource in the province, with scanners located in only the largest hospitals. This has led to concerns about equitable geographic access and excessive travel requirements.

  (...)

- Wait times are expected to increase in the short term, as very long waiters are cleared from wait lists. Wait times will also be impacted by expected increases in MRI demand, which is due to two factors:
  - Some exams which are now being done inappropriately as CT will be switched to MRI (the recommended modality); and
  - Demand for MRI has been kept artificially low due to physicians' reticence about referring patients for a service with a very long wait time.

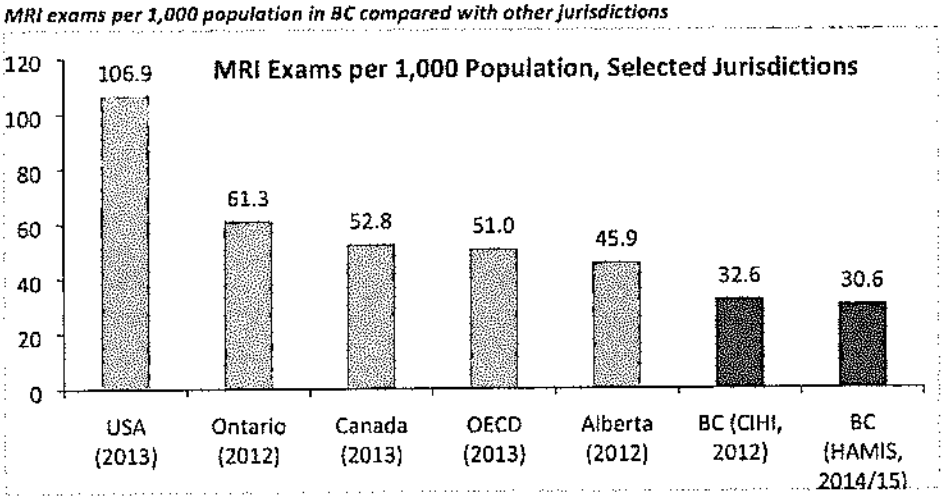
293. The Defendant's PFF – MRI/CT document also provides the following detail about the availability of publicly owned MRI machines in the province:

21. Since 2001/2002, the Province has acquired 16 additional MRI machines (a 178% increase) and 31 additional CT machines (a 100% increase) for publicly-funded procedures.

22. However, compared to other provinces, British Columbia ranks amongst the lowest in MRI machines per 1 million in population...

23. The number of exams performed per 1,000 population in selected jurisdictions is illustrated in the table below:

MRI exams per 1,000 population in BC compared with other jurisdictions



294. With respect to medically acceptable benchmarks for MRIs and CT scans, the BC government has adopted the "National Maximum Wait Time Access Targets for Medical Imaging (MRI and CT)" developed by the Canadian Association of Radiologists in 2013. Attached as **Exhibit "VV"** is a copy of the 2013 Report.

295. The Defendant's PFF – MRI/CT document describes the prioritization framework developed by the Canadian Association of Radiologists and adopted in British Columbia as follows:

> 73. The prioritization framework was developed based on the recommendations of a panel of participating experts using unsystematic and undocumented experience since a literature search failed to identify any articles relevant to patient outcomes and access to MRI/CT. It provides a 5-point priority classification system with maximum benchmark wait times. The wait times are defined as the time between the date that the MRI/CT requisition is received and the date on which the MRI/CT scan is completed. (It does not include the time for the radiologist to complete the report after interpreting the MRI/CT scan).
>
> 74. The priority categories are as follows:

a) P1: Emergent – an examination necessary to diagnose and/or treat disease or injury that is immediately threatening to life or limb;

Maximum Interval Target for MRI and CT: same day – maximum 24 hours

b) P2: Urgent – an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan that is not immediately threatening to life or limb. Based on provided clinical information, no negative outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period;

Maximum Interval Target for MRI and CT: maximum 7 calendar days

c) P3: Semi-urgent – an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan, where provided clinical information requires that the examination be performed sooner than the P4 benchmark period;

Maximum Interval Target for MRI and CT: maximum 30 calendar days

d) P4: Non-urgent – an examination necessary to diagnose and/or treat disease or injury, where, based on provided clinical information, no negative long-term medical outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period;

Maximum Interval Target for MRI and CT: maximum 60 calendar days

e) P5: Specified Procedure Date: The MRI or CT scan appointment date requested by the ordering physician for the purpose of disease surveillance.

76. Using the framework established by the Canadian Association of Radiologists, the BC Radiological Society worked with radiologists in the Province to develop a consensus on how a variety of patient conditions should be assigned to urgency categories. The framework was then endorsed by the BC Medical Imaging Advisory Committee and implemented by all Health Authorities.

77. The provincial framework is outlined in the table below:

PRIORITY	PRIORITY CATEGORY DEFINITIONS	MAXIMUM WAIT TARGET	SAMPLE INDICATIONS
Priority 1 (P1)	***Emergent***: an examination necessary to diagnose and/or treat disease or injury that is immediately threatening to life or limb. Note: for emergent / life-threatening conditions, some patients require imaging in less than an hour; these decisions are based on the clinical team's judgment.	P1: Same day – maximum 24 hrs.	**MRI** • Acute stroke (neuro) • Acute abdominal aortic aneurysm (body) **CT** • Stroke (head & neck) • Acute shortness-of-breath (chest)
Priority 2 (P2)	***Urgent***: an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan that is not immediately threatening to life or limb. Based on provided clinical information, no negative outcome related to delay in treatment is expected for the patient if the examination is completed within P2, maximum 14 calendar days.	P2: maximum 7 calendar days	**MRI** • Acute Multiple Sclerosis, considering therapy (neuro) • Assessment of cardiac mass / thrombus (chest) **CT** • Pancreatitis, complications (abdomen) • Tumor- primary bone or soft tissue (MSK)
Priority 3 (P3)	***Semi-urgent***: an examination necessary to diagnose and/or treat disease or injury and/or alter treatment plan where provided clinical information requires that the examination be performed sooner than the P4 benchmark period.	P3: maximum 30 calendar days	**MRI** • Orbital mass- no clinical deficits (neuro) • Acute joint symptoms (i.e. ACL, meniscus) (MSK) **CT** • Hearing loss or tinnitus (head & neck) • Non-resolving pneumonia on chest x-ray (chest)
Priority 4 (P4)	***Non-urgent***: an examination necessary to diagnose and/or treat disease or injury where, based on provided clinical information, no negative long-term medical outcome related to delay in treatment is expected for the patient if the examination is completed within the benchmark period.	P4: maximum 60 calendar days	**MRI** • Dementia (neuro) • Chronic joint and spine symptoms (MSK) **CT** • Dementia (head & neck) • Assessment of painful prosthesis (MSK)
Specified Procedure Date	The MRI or CT scan appointment date requested by the ordering physician for the purpose of disease surveillance.		

296. BC's performance against these evidence-based targets has been poor, particularly with respect to MRIs.

297. The Defendant's has provided statistics showing that, as of April 2015, wait times for MRIs in BC were the highest in Canada (see PFF – MRI/CT, at paras 81-83).

298. At that time, the 90th percentile wait times for non-emergency MRIs in BC was 245 days, compared to 214 in Alberta, 172 in Prince Edward Island, 167 in Manitoba, 163 in Nova Scotia, and 73 in Ontario.

299. This information provided by the Defendant in its *Prima Facie* Facts has been confirmed by more recent statistics, which provides some indication of the extent to which the province has failed to meet its own maximum acceptable wait time targets in this area.

300. The performance of the BC public system against the diagnostic benchmarks is set out in various examples and sources, such as in Exhibits "V1" and "V2", attached above.

301. This data shows that while the wait times for MRIs in 2014/15 were already the highest in Canada, those numbers have continued to increase.

302. As noted above, the 90th percentile wait time in BC across all priority groups was 245 days for MRIs in 2014/15. This has increased to 271 days in 2015/16, and 277 days in 2016/17 (see Exhibit "V2", at page 8).

303. As set out in the Canadian Association of Radiologists Report (at page 3, of Exhibit "VV", above), the priority 1 benchmark of 24 hours maximum wait applies where the examination is necessary to diagnose and/or treat disease or injury that "is immediately threatening to life or limb", while for other priority categories, the report suggests that "no negative outcome related to delay in treatment is expected for the patient *if the examination is completed within the benchmark period*" (emphasis added).

304. Thus, as the Report indicates, patients treated beyond the maximum wait time may suffer negative health outcomes in relation to the delay in treatment.

305. As the Exhibits "V1" and "V2" show, at least some BC patients are waiting for MRI's past the benchmarks in all priority levels in 2016/2017.

306. The majority of patients in need of an MRI are given the priority level 3 (semi-urgent). This has a benchmark of between 8 to 30 days, but the data show the 50th percentile wait time (i.e. the time within which half of patients receive their MRI) for priority level 3 at 52 days, and the 90th percentile at 266 days (Exhibit "V1", at pages 34, 40).

307. This means that 50% of patients wait at least 1.7 times longer than the benchmark time, and 10% of patients wait over 8 times longer than the maximum wait (Exhibit "V1", above).

308. The 90th percentile wait times for MRIs have also increased steadily over the past 5 years, across all levels of urgency, from the most urgent (level 1) to the least urgent (level 4), and are all well above the evidence-based benchmarks developed by the province (see Exhibit "V2", at pages 6-7):

Priority Level	**BC Maximum Wait**	**2011/12**	**2016/17**
Level 1	**Immediately to 24 hours**	7.5 days (approx.)	**18 days**

Level 2	**2 to 7 days**	66 days (approx.)	**84 days**
Level 3	**8 to 30 days**	145 days (approx.)	**262 days**
Level 4	**31 to 60 days**	229 days (approx.)	**333 days**

309. CIHI statistics show that these wait times remain the highest in Canada among the provinces reporting these statistics.

310. For instance, as set out at page 17 of the CIHI Report (2017) (Exhibit "II", above), the 2016 data from other provinces shows that the 90th percentile wait for MRIs was 242 days in Alberta, 208 days in Saskatchewan, 203 days in Nova Scotia, 183 days in Manitoba, 181 days in Prince Edward Island, 99 days in Ontario, as compared with the 277 days in BC.

311. The long wait times and harms from have been confirmed by Government documents and statements, in addition to those listed above.

312. The following extract from Hansard highlights some questions and answers between the former Minister of Health, Terry Lake, and the current Minister of Mental Health Services, Judy Darcy, who was at that time the opposition critic on the Health portfolio:

> Monday, November 2, 2015, Afternoon (Volume 30, Number 9), at 9961
>
> **J. Darcy**: Last week the official opposition revealed that patients in Fraser Health are waiting as long as a year and a quarter for medically necessary MRIs. But the reality is that thousands of other patients are also waiting unacceptably long times to get absolutely necessary medical procedures.
>
> The government's own clinical benchmark says that no patient should have to wait more than two months for an MRI, but Vancouver Coastal Health and Providence Health Care's figures reveal that they are only meeting this standard in 13 percent of the cases.
>
> Our health care system has the capacity to do something about this and shorten the wait-list. Why does the minister feel it's acceptable that patients across the Lower Mainland have to wait as long as a year or more to get a medically necessary MRI?
>
> **Hon. T. Lake**: First of all, I don't think it's acceptable. We have to do better. We have long wait-lists for MRIs, even though we are doing three times as many as we did in 2001. The reality is that we do need to do better. I will say, however, that if a physician feels there is an urgent need for an MRI, it will be prioritized and that patient will be seen. But the fact is that we need to do better on MRIs.
>
> (...)

J. Darcy: Well, once again the minister blames everybody else instead of taking responsibility himself. The minister claims that urgent or emergent cases do get the attention they need, and the minister knows that that's not the case. Vancouver Coastal and Providence Health Care's own figures show that patients who are classified as so urgent that they need an MRI within seven days are waiting an average of 40 days, and some are waiting 117 days for an urgent MRI.

According to the B.C. society of radiologists, we're talking about patients with tumours that could be benign or malignant, or patients who will require treatment for prostate cancer, among others. That is simply not acceptable. Surely we can do better than that in the province of British Columbia.

Hon. T. Lake: I vehemently agree with the member opposite. We can do better. We have to do better.

Even though we have tripled the number of MRIs done since 2001, the reality is, with an aging population, a growing population and the technology that changes, we need to do better. I've asked our ministry to work with all of the health authorities on a provincial MRI strategy, ensuring that we work with radiologists and expert clinicians to understand the appropriateness, to make sure that this technology is being used appropriately and that we're not seeing redundancies in imaging, whether it's x-rays, whether it's CT scans and then MRI.

We need to do better, and we're committed to doing better.

Wednesday, October 28, 2015, Afternoon (Volume 30, Number 5), at 9847

J. Darcy: Peter McQuade, who lives in Surrey, has been in severe pain since April of this year. His doctors said from the very start that he needs an MRI to diagnose the source of his pain, but because the wait-lists in Fraser Health are so long, he's going to have to wait until April 2016.

My question is to the Minister of Health. Why does Peter have to wait almost a year in order to find out why he's suffering from such unbearable pain?

Hon. T. Lake: As always, physicians have the ability to ensure that if someone needs an emergent diagnostic procedure, they will have it right away. In Fraser Health, we have performed an additional 800 surgeries and an additional 3,400 MRIs between January and March of this year.

We do recognize, however, that there are people waiting longer than we would like for some of these procedures. We're working very hard with all of our health authorities to make sure we can reduce those wait times, and I'm confident that we can do that.

(...)

> **J. Darcy**: Peter McQuade is not alone. There are thousands of other British Columbians like him, and many of them are waiting even longer than Peter. Some are being booked into 2017. In fact, the notification that Peter and other patients receive for their booking says, "Please note the year of the appointment" — the year. Why? Because some patients are actually showing up a year earlier than the time of their appointment.
>
> The government's own benchmarks say that no one should have to wait more than 60 days for an MRI, and that's for the least urgent cases. Yet according to an FOI request about Fraser Health filed by the official opposition, the government is only meeting its own benchmark in Fraser Health in 15 percent of the cases — 15 percent.
>
> Surely, we can do better. Peter McQuade is suffering. And it's not a laughing matter. Peter McQuade is suffering. He can't get treatment until he gets a proper diagnosis.
>
> My question is to the Minister of Health. Why is this government not even meeting its own benchmark for MRI wait times?

313. Attached as **Exhibit "WW"** are excerpts from Hansard containing these exchanges.

314. Currently, I am aware from my practice that patients with soft tissue and other musculoskeletal conditions who are in need of an MRI study are receiving CT Scans rather than an MRI, because it takes much longer (often up to 10 times longer) to obtain an MRI than a CT Scan.

315. This subjects patients to an unnecessary risk of harm from radiation, as there is no radiation risk with an MRI.

316. Diagnostic imaging is accepted as an essential component of the surgical process. As set out at paragraph 5 of the Defendant's PFF – MRI/CT document:

> Diagnostic imaging is an essential part of the patient pathway for many conditions and presentations. Accurate diagnosis is required for medical practitioners to make appropriate clinical decisions about patient treatment. For example, approximately 30% of MRI scans result in either avoidance of surgery or a decision to operate.

317. As stated in the Defendant's PFF – MRI/CT document, at paragraphs 22-23, "compared to other provinces British Columbia ranks amongst the lowest in MRI machine per 1 million in population" and B.C. performs the lowest number of publicly paid MRI's per 1000 population in the country.

ii. CT Scan Data

318. Computed Tomography (or "CT") scans involve the use of a computer to put a series of special x-ray images together to create a detailed three-dimensional image of organs, tissues, bones and blood vessels in the body.

319. For CT scans, the same priority codes apply as with MRIs.

320. The Defendant's *Prima Facie* Facts report that as of April 2015, 90th percentile wait times for CT scans were the second highest in BC as compared to other provinces that collected the data: approximately 64 days wait in BC, as compared with 46 in PEI, 44 in Alberta, 40 in Manitoba, and 30 in Ontario (PFF – MRI/CT, at para 82).

321. As with MRIs, patients living within the catchment area of lower performing health authorities wait longer. For instance, the 90th percentile waits for CT scans in Interior Health and Fraser Health Authority in 2014/15 was approximately 78 and 79 days in 2014/2015, respectively, which is longer than the maximum wait time for the lowest priority code (PFF – MRI/CT, at para 82).

322. The wait for CT scans across all priority areas has increased since then, from 64 days in 2014/15, to 75 days in 2015/16, and to 86 days in 2016/17 (Exhibit "V2", at page 9).

323. The CT Scan data trend for British Columbia shows that the 50th percentile wait time increased by 35.7% between 2016/2017 and 2015/2016, and the 90th percentile, wait time increased by 18.7% during the same period (Exhibit "V2", at page 9).

324. As Exhibit "V2" shows, while the 90th percentile wait time for the most urgent (priority 1) CT scans have decreased marginally in BC between 2015/16 to 2016/17 – but remain well above the benchmark of 24 hours – the 90th percentile wait times for all other priority levels have increased, sometimes markedly:

Priority Level	**BC Maximum Wait**	**2015/16**	**2016/17**
Level 1	**Immediately to 24 hours**	11 days	**7 days**
Level 2	**2 to 7 days**	41 days	**42 days**
Level 3	**8 to 30 days**	75 days	**90 days**
Level 4	**31 to 60 days**	99 days	**120 days**

325. The Defendant has set out the following reasons for the long wait lists for MRIs and CT scans in the public system in its PFF – MRI/CT document:

85. The Ministry of Health has identified a number of underlying issues that lead to increasing MRI/CT Waitlists:

a) Governance and service models limit publicly funded services to hospital settings, and are not integrated with the broader service delivery system for diagnostics;

b) The current funding model has resulted in under-servicing (for example, Health Authorities must fund volume increases from existing funding envelopes. As such, there is no routine method for increasing capacity as demand increases);

c) There are barriers to appropriate orderings (for example, Health Authorities report that due to long wait times for MRIs, physicians are ordering CT scans as a substitute);

d) There are challenges to capital and service planning at the Health Authority level (for example, the process required for the replacement of aging equipment), and at the Provincial level (health authorities, other than the LMMIP group, are not mandated to coordinate capital planning or service planning for medical imaging with other Health Authorities); and

e) The information management and information technology infrastructure is not in place to support the Ministry in monitoring quality, planning and accountability.

86. The Health Authorities have not reported any difficulties in obtaining the necessary human resources for Advanced Imaging Services.

326. Since 1997, when the Commission passed Minute 97-068 permitting private access to diagnostic services in facilities not approved by the Commission, patients have been able to obtain these diagnostic services privately in light of the lengthy wait for these services in the public system.

327. The newly proclaimed amendments to the *Medicare Protection Act* will mean that British Columbians will not have a choice to access private MRI and CT Scans after October 1st 2018, even though the public system is not even close to meeting their own benchmarks which define their own maximum acceptable wait times.

iii. Colonoscopies

328. Colonoscopy is essential for the diagnosis, assessment and management of cancer of the colon. The survival rate for colon cancer is high if the cancer is diagnosed early, and patients risk spread and progression of their cancer if waiting for colonoscopy.

329. Cambie normally provides between 50 and 75 colonoscopies a year. Of the last 240 colonoscopies performed at Cambie, biopsies have revealed that 40% have polyps showing

adenomatous or dysplastic features (i.e. potentially pre-malignant). If the October 1st 2018 penalties are imposed, these patients will be added to the public wait list, and patients with undetected cancers will be denied early diagnosis and treatment.

330. These statistics are comparable to those of the BC Cancer Agency, as reported in a report entitled "Colon Screening Program: Program Report", with reported data from November 2013 to December 2015 ("BCCA Report"), which was updated in June 2017, a copy of which is attached as **Exhibit "XX"**. This report shows that in over 50% of cases, the BCCA is not meeting the government's recommended maximum acceptable target times.

331. The Canadian Association of Gastroenterologists ("CAG") established a Wait Time Consensus Group, with the objective of developing "evidence- and expertise-based recommendations for medically appropriate maximal wait times for consultation and procedures by a digestive disease specialist". Attached as **Exhibit "YY"** are the conclusions of this group, published in the Canadian Journal of Gastroenterology and entitled "Canadian consensus on medically acceptable wait times for digestive health care" (2006) ("CAG Report").

332. This report sets out "acuity categories" for colonoscopies, ranging from a maximum acceptable wait time of within 24 hours to six months, depending on the nature of the need for a colonoscopy (CAG Report, Exhibit "YY", at page 413).

333. There are also a number of BC patient prioritization codes established for colonoscopies, which range from priority 1 (2 weeks), to priority 5 (26 weeks). The data attached as Exhibit "V3" provides examples of the BC patient priority codes for colonoscopies, and the wait times for Interior Health Authority for cases waiting as of March 1, 2017.

334. For instance, the wait time benchmark after a positive colon cancer faecal blood screening test ("FIT test") is 8 weeks. The BC codes for colonoscopy after positive FIT test are 30NMDE in the BC Cancer Agency screening programme, and 30NMDD outside the BC Cancer Agency screening programme.

335. Both of these priority codes have the wait time target of 8 weeks, which is consistent with the CAG Wait Time Consensus Group recommendation (CAG Report, "Exhibit "YY" above, at 413). It is also consistent with the BC Cancer Agency's report, which indicates that the maximum acceptable wait time following a positive FIT test is 60 days (see BCCA Report, Exhibit "XX", above).

336. This BC priority code target is defined as the "time beyond which patients presenting with the particular diagnosis/condition could suffer negative consequences", as indicated in the Patient Priority Code Review Project Final Report (see PPCRP Final Report, Exhibit "Q", above, at page 21).

337. According to the BC Cancer Agency, this wait should be measured "as the number of days elapsed between positive FIT result and date of follow-up colonoscopy (see BCCA Report, Exhibit "XX", above, at page 24).

338. In addition, the data that the Government has produced shows that many British Columbians are consistently waiting past benchmarks for colonoscopy procedures:

- Attached as **Exhibit "ZZ"** is a Government report entitled "2016 Cancer System Performance Report, Q&As for British Columbia", dated July 20, 2016, which suggests at page 3 that in 2013 and 2014, "of the seven reporting provinces, British Columbia had the second longest wait time from an abnormal fecal test result to a follow-up colonoscopy at 150 days";

- Attached as **Exhibit "AAA"** is a briefing note, entitled "Colonoscopy Wait Times" and dated February 2, 2017, which states at page 3 that only "half of all (Colonoscopy Screening Program) patients with a positive FIT result are getting their colonoscopy within 50 days – which is within the 60 day target"; and

- Attached as **Exhibit "BBB"** is a Government report entitled "Magnetic Imaging and Colonoscopy Data, November 24, 2017", which states that no health authorities in British Columbia are meeting the benchmark wait times for colonoscopies.

339. The SPR data that is available suggests that many BC patients are waiting longer than the maximum wait time following a positive FIT test outside of the BCCA screening program, as well as for other categories of colonoscopies (see Exhibit "U4"):

Chart #6 – Colonoscopy Wait Times – Percent Performed Within Target in 2017 and 2018

Year			**2017**	**2017**	**2018**	**2018**
Diagnostic Code	Diagnosis Description	Priority Code	Total Cases	**Percent Performed Within Target**	Total Cases	**Percent Performed Within Target**
30NMDD	Positive Fit (Fecal Occult Blood Test) – Outside BCCA Screening Program	3B (8 weeks)	202	**27.7%**	23	**21.7%**
30OZDG	Short Interval Surveillance Where Reassessment Required Under 1 Year; Wait Time Starts At Date Surveillance Is Due	3B (8 weeks	298	**27.9%**	24	**12.5%**
30OZDD	Bright Red Rectal Bleeding; Documented	3B (8 weeks)	101	**61.4%**	28	**60.7%**

	Iron Deficiency Anemia, Chronic Unexplained Abdominal Pain; For Confirmation Of Diagnosis Of Celiac Disease; Stable Dysphagia That Is Not Severe					
30OZZA	GI Symptoms Other P1	1 (2 weeks)	59	**74.6%**	16	**68.8%**
30OZZB	GI Symptoms Other P2	2 (4 weeks)	133	**35.3%**	29	**51.7%**
30OZZC	GI Symptoms Other P3	3B (8 weeks)	52	**67.3%**	30	**70.0%**

340. According to this SPR data, only 27.7% of patients received their colonoscopy following a positive FIT test within the 8 week benchmark wait time in 2017, and this is down to 21.1% of patients in 2018.

341. The Government document, entitled "Colonoscopy Wait Times for Cases Waiting, March 1, 2017", attached above as Exhibit "V3", shows that even the median wait time of patients in the Interior Health Authority are well past the benchmark of 8 weeks for a positive FIT test.

342. The same chart – limited to the Interior Health Authority – shows that in the BC Cancer Agency colon screening programme of 2,443 patients waiting for colonoscopy after a positive FIT test, only 29% were within target time of 8 weeks.

343. Similarly, the SPR data shows that for other patients waiting for a colonoscopy (Code 30OZDD) – some of whom show "bright red rectal bleeding" or "chronic unexplained abdominal pain" – approximately 40% of patients are not receiving their colonoscopies within the maximum acceptable wait time benchmark of 8 weeks (see Exhibit "U4", above).

344. The Government document "Magnetic Imaging and Colonoscopy Data November 24, 2017", attached above as Exhibit "BBB", outlines the Government's proposed target for colonoscopy in BC, which is:

> "By March 31, 2019, not more than 15% of cases waiting have waited longer than their benchmark wait time".

345. The target of no more than 15% waiting over the maximum benchmark "results from analysis of data currently available and is less onerous than the typical surgical target of no more than 5% waiting over benchmark".

346. The report also states that the Health Authority planned volumes are not enough to meet the 2018/2019 year-end target, with a projected shortfall of 15,599 colonoscopies in just three of the Health Authorities.

347. However, even if this target were met, it would, by definition, mean that 15% of colonoscopy patients would be waiting past the maximum wait time, and the choice to obtain earlier colonoscopies where there is a risk of cancer will not be an option after October 1st 2018.

J. Additional Indicators of Wait Times in BC

348. There are indications that wait times are experienced in other areas of the health care system as well, most notably in access to a general practitioner or primary care.

349. Needless to say, before a patient can access the stream for a wait one (wait to see specialist after referral by the general practitioner), or wait two (between the date the patient is ready for surgery and treatment), they must first get in to see a general practitioner.

350. Another recent CIHI publication shows that Canadians continue to report longer waits to see their family doctors and specialists than adults in other peer countries. Attached as **Exhibit "CCC"** is a copy of the CIHI report entitled "How Canada Compares: Results from the Commonwealth Fund's 2016 International Health Policy Survey in Adults in 11 Countries", which sets out this data at pages 10-12, as well as the accompanying Chartbook.

K. Benchmarks Applied to the Patient Plaintiffs

351. Applying the 2017 data, extracted from the 2013-2018 Wait Times Report, to some of the patient Plaintiffs in the underlying action shows that the Plaintiffs would have exceeded maximum acceptable wait times, or would have exceeded maximum accepted wait times by an even greater margin, had they waited in the public system.

i. Krystiana Corrado

352. Ms. Corrado was just over 16 years old when referred to Dr. Reilly at BC Children's Hospital. The Diagnostic Code for her condition was 44 WZFA (Ligament Injury (ACL) – Acute), and is associated with a maximum acceptable waiting time of 12.86 weeks for Wait Two.

353. According to P-CATS, the maximum acceptable Wait One from GP to specialist consultation is 3 weeks. Ms. Corrado was referred to specialist Dr. Reilly in early June 2011, and received her consultation on October 19, 2011, well over 4 months after her MRI and her family physician had referred her.

354. Statistics from 2017 show that 81.3% of paediatric cases in BC were completed within the Wait Two period for Code 44WZFA, with 90th percentile waits showing 19.3 weeks from

Booking Form Received Date (which should not be used for children) and 22.2 weeks from Decision Date (see Exhibit "U12").

355. For the PHSA (which covers BC Children's Hospital), 45.5% of cases were performed within the target, with the 90th percentile showing 45.6 weeks from Decision Date (Exhibit "U12").

356. Because Ms. Corrado would have turned 17 years of age (the age at which BC Children's Hospital classifies patients as "adults") by the time she could receive her operation (i.e. Dr. Reilly told her it could not be performed before April of 2012), she was referred out of BC Children's Hospital. Ms. Corrado was operated on at Cambie before her 17th birthday, in January of 2012.

357. Ms. Corrado was born on April 5 1995. If the government P-CATS standard had been applied, the government mandated maximum wait time for her priority level would have been under 16 weeks from GP referral to surgical treatment by the specialist, as opposed to the projected minimum of 10 months based on Dr. Reilly's estimate.

358. Had Ms. Corrado been 17 in the public system, and therefore treated as an adult, her diagnosis code would be 34VGIN, which has a maximum acceptable benchmark time of 12 weeks. The Government's SPR data shows that in 2017:

- only 56.9% of patients with that that code had their surgery performed within that maximum benchmark (see Exhibit "U7");
- patients within the 90th percentile waited 35.3 weeks from Booking Form Received Date, and 40.2 weeks from Decision Date (see Exhibit "U12"); and
- patients within the 50th percentile waited 8.9 weeks from Booking Form Received Date and 15.8 weeks from Decision Date (see Exhibit "U12").

359. The SPR data also shows that none of the Health Authorities complete over 90% of cases within target for this prioritization code; Fraser Health was highest at 81%, Vancouver Island was the lowest with 31%.

ii. Chris Chiavatti

360. Mr. Chiavatti was 14 years old when he was referred to Dr. Reilly at BC Children's Hospital. The diagnostic code for his condition was 44VGJA – Meniscal Injuries Acute, with a maximum Wait One time of 1 week (Priority IIA) and a maximum Wait Two time of 1 week (Priority IIA).

361. In BC in 2017, only 18% of these cases were performed within the Wait Two Target of one week (see Exhibit "U7"), and many waited well beyond the target:

- Children within the 50th percentile waited 4.9 weeks from Decision Date (which should be used), which is five times the maximum acceptable wait time benchmark;

- Children within the 90th percentile waited 20.9 weeks from Decision Date (which should be used), which is over 20 times the maximum acceptable wait time.

362. The P-CATS priority level was changed from a maximum Wait Two time target of IIB of (3 weeks) to IIA (1 week) in 2016. In 2015, even with this longer wait time target, only 37.5% of cases with Code 44VKAA were performed within target (note that Code 44VGJA was Code 44VKAA prior to 2015).

363. Mr. Chiavatti was injured on January 14th 2009 and waited over a month (rather than the maximum Wait One time of one week) to see Dr. Reilly, who ordered an MRI. The MRI was performed on April 1, 2009. The follow up consultation with Dr. Reilly to discuss surgery following the abnormal MRI was not scheduled until September 2010. Mr. Chiavatti underwent his surgery at Cambie on November 19, 2009. His injury occurred in a gym class at school; had his physical education teacher suffered the same injury in the same class, the teacher would be eligible, under WorkSafeBC insurance, for an immediate private MRI, and expedited private surgery within 30 days.

iii. Walid Khalfallah

364. Walid's diagnosis was "Kyphosis – likely to progress (unstable)", which has diagnosis code 44SCFB. The Wait One maximum acceptable target for this code is priority III (6 weeks), and the Wait Two is a priority code IV (90 days, or 12.86 weeks).

365. The recent government data documents show very few cases for these codes. In 2017, they provide data for only 1 case of Code 44SCFA and 3 of Code 44SCFB in BC.

366. Dr. Reilly has testified that patients with Walid's diagnosis are now waiting for approximately 9 months at BC Children's Hospital, which is 6 months longer than the maximum wait time for kyphosis – likely to progress and 3 months longer than the maximum wait time for kyphosis – unlikely to progress.

367. In a May 1, 2012 report from the BC Government's Patient Care Quality Review Board ("**PCQRB**"), written by Chair of the PCQRB, Dr. John Chritchley, made note of Dr. Reilly's consultation record that "(c)ertainly our wait list is going to be a problem for this boy because his kyphosis will progress drastically as we wait" [Trial Exhibit 0026(j), page 3].

368. As set out in the May 1, 2012 report, the BC PCQRB had found the initial BC Patient Care Quality Office response to Walid's mother on July 15, 2011, "to be primarily comprised of standardized messaging lacking in empathy for the extensive wait that Walid had already experienced at the time of the letter ..." [Trial Exhibit 0026(j), page 6].

369. Dr. Chritchley also noted the scientific evidence specifying risk of harm faced by patients with Walid's condition, as follows:

> The Board noted that, as stated in the article "Empirically derived maximal acceptable wait time for surgery to treat adolescent idiopathic scoliosis", from the

Canadian Medical Association Journal on June 14, 2011, "the highest risks of adverse events due to prolonged wait times occurred in patients who were skeletally immature and had larger curvatures of the spine." [Trial Exhibit 0026 (j), page 3]

370. The Patient Care Quality Review Board concluded, with respect to Walid's treatment, that "(t)he health authority did not meet the Paediatric Canadian Access Targets for Surgery (P-CATS) and did not follow provincial and health authority policy" and also wrote that "Walid did not receive quality care. The delay in treatment allowed Walid's condition to unnecessarily deteriorate and increased the risk to his health." [Trial Exhibit 0026(j), at page 3 (emphasis added)]

371. In the June 12, 2012 response from Mr. Wynne Powell, PHSA Board Chair, Mr. Powell acknowledged the two waits that Walid faced, as follows:

> In respect of the specific delay Walid and his mother faced there were two critical delay elements. The initial delay was 13 months and was in regards to Walid's wait from referral by his pediatrician to his consultation with an orthopedic surgeon and BCCH. This is a direct result of the limited number of orthopedic specialists with the specific skills that were needed in BC at the time of Walid's wait.
>
> The second delay at BCCH was wait time for a sedated MRI scan that he needed prior to surgery. Due to Walid's complex care needs, a high quality scan would require Walid to be sedated. BCCH Radiology faces challenges in meeting current needs. [Trial Exhibit 0026(w), page 2].

372. Mr. Powell's letter concluded with an acknowledgment of the harm caused to Walid: "we take this issue seriously and greatly regret this delay in Walid's care" [Trial Exhibit 0026(w), page 3].

373. The PCQRB report also made the following recommendation, as summarized in the June 12, 2012 response from PHSA Board Chair, Mr. Wynne Powell:

> "That the Provincial Health Services Authority ensures that BC Children's Hospital review the Paediatric Canadian Access Targets for Surgery (P-CATS) versus current service delivery in orthopaedic surgery. If BC Children's Hospital is unable to meet the targeted timelines, then as part of a patient-centred care a process to refer patients to another suitable service provider who can provide care in a timely manner should be established." [Trial Exhibit 0026(w), page 3]

374. Mr. Powell responded to this recommendation as follows:

> "Accepted as written.
>
> Each period members of the BCCH leadership team will continue to review the waitlist reports and PCATS Targets and cross reference these targets with current paediatric wait lists. Review with applicable Division heads will occur to provide detailed reports and to develop appropriate action plans for patients who fall outside of those targets.

Anticipated Completion: Process exists now-will continue.

Finally, I want to assure you that we take this issue seriously and greatly regret this delay in Walid's care. We are sincerely committed to continuing our efforts to reduce wait times." [Trial Exhibit 0026(w), page 3]

375. It should also be noted that in the May 1st 2012 letter from Dr. Chritchley, the following statement was made under the heading of "Accountability", referring to accountabilities laid out in the Ministry of Health's Surgical Waitlist Management Policy:

> "Health authorities must ensure that all wait time data are being managed in accordance with the policy and standards outlined in this communique. The Ministry of Health Services will review each HA's implementation plan and monitor compliance with this policy within its overall performance monitoring plan. [Trial Exhibit 0026(j), page 5]

376. Despite numerous requests from counsel for the Plaintiffs to the PHSA and BC Children's Hospital, requesting the above described "cross reference" data, and the "detailed reports", with a view to correlating the materials with the waits and harms suffered by Walid Khalfallah, Krystiana Corrado, and Chris Chiavatti, no documents have been provided.

377. If these documents do not exist, then the Ministry, which stated it would "monitor compliance", will also have failed to fulfill its commitment.

378. The paediatric patient plaintiffs were examples of many children across BC waiting for medically necessary surgeries past the maximum wait time targets according to the pan-Canadian P-CATS (which have been adopted as the BC Standard).

iv. Erma Krahn

379. Ms. Krahn had a knee injury that required treatment. Ms. Krahn's diagnosis code would have been Code 34VGRN "Cartilage Disorder – Moderate to Severe Pain with significant or severe functional limitation". This Code has a maximum acceptable wait time of 12 weeks.

380. For Code 34VGRN, in 2017, the SPR data show only 63% of cases are completed within target, with the 90th percentile wait time at 31.3 weeks from Booking Form Received Date, and 34.4 weeks from Decision Date (see Exhibit "U12").

L. Harms of Increased Wait Times – Surgical and Diagnostic Procedures

381. From a medical standpoint, the impacts of wait times on patients are very significant, and are addressed in the expert evidence filed in the trial.

382. However, I have witnessed first-hand the significant problems – medical, financial, and personal – that patients suffer when their assessments, investigations, procedures and surgeries are delayed.

383. Perhaps the most immediately obvious impact of wait times for diagnostics and surgeries, which I have personally observed in my patients, is that many will suffer mentally and physically during the wait for assessment, investigation and then treatment.

384. When I provided surgeries in the public system in the late 1990s and early 2000s, I observed the deterioration that many of my patients experienced as they waited in pain and suffered progressive functional loss. Many of my patients waited long periods for access to care that 10 years earlier would have been provided within a reasonable and acceptable period of time.

385. I see the same thing in my patients that attend Cambie after waiting longer than the benchmark times in the public system.

386. My patients have often been on strong addictive narcotic pain killers and often needed surgery to reduce pain and give them the best chance of regaining functioning without suffering harm or permanent damage.

387. In addition, some of my patients were unable to work without the necessary surgeries, and therefore the longer they waited for surgery, the longer they were out of work and the greater their financial and other hardships. I observed that this caused a great deal of stress and anguish for my patients.

388. It was also frequently the case in my practice that patients whose surgeries were cancelled in the public system had family members with them who had taken time off work or school, and/or had travelled long distances to be with the patients on day of their scheduled surgeries.

389. Often, from my personal experience, there was a lengthy delay in obtaining a new date for my patients' surgeries when the original booking was cancelled by the hospital.

390. From my experience in the public health care system, it is usually not possible to reschedule the patient's surgery quickly without further bumping back another patient's scheduled surgery, in light of the strict restrictions on operating room time in the public system.

391. At Cambie, we sometimes receive acute surgical bookings of patients who, after long waits in the public system, are cancelled at the last moment, even as they are in the hospital and have been prepared for surgery.

392. This was not the case in the early to mid-1980s, because physicians and nursing staff would be allowed by the hospitals to continue and provide surgeries into the evening or on weekends to accommodate overruns. Now, operating room time is strictly rationed, as described above and in my previous affidavit.

393. There are also more serious impacts of wait times on individuals.

394. Even the patient plaintiffs, who were able to obtain faster treatment at Cambie, suffered irreversible harm due to delays in receiving timely care in the public system before accessing Cambie.

395. In the case of Krystiana Corrado, she had a torn ACL, but a normal meniscus, based on her June 2, 2011 MRI study (done almost 7 weeks after her injury). She was found at surgery on January 19, 2012 to have suffered additional damage and had a defect in the lateral meniscus. This additional necessarily occurred during the prolonged waiting period. The meniscus is the shock absorber of the joint and damage of this nature in a child is known to significantly increase the risk of degenerative arthritis in later life.

396. Similarly, Mr. Chiavatti was observed to have softening and damage to the articular surface of his joint following his wait, representing irreversible joint damage, and very likely to lead to arthritis when suffered during childhood.

397. Walid Khalfallah suffered progressively increasing spinal curvature and, as sworn in the affidavit of Dr. Dvorak, "if patients wait longer than three to six months, they face unnecessary and increasing levels of pain, risk of neurological deterioration, and significant distress about the lack of access to timely care". Walid's BC specialist, Dr. Reilly, has reported on the harms of waiting for this type of surgery. Attached as **Exhibit "DDD"** are abstracts of reports that Dr. Reilly co-authored, entitled "Larger curve magnitude is associated with increased perioperative health care resource utilization: a multicentre analysis of 422 adolescent idiopathic scoliosis curves" and "Impact of surgical wait list times on scoliosis surgery: surgeons' perspectives".

398. Walid Khalfallah, who was previously riding his bike and playing football, is now paralyzed for life following a 27 month wait for access to surgery.

399. With respect to diagnostic procedures, many serious conditions have a better prognosis and survival rate if diagnosed early and treated early. Patients waiting for cancer diagnosis or treatment, for instance, suffer both physical and psychological harm.

400. With respect to many surgeries patients may suffer medical deterioration, increased risks of complications, and slower or incomplete recovery if treatment is unduly delayed. This fact is acknowledged in the government's own criteria referenced above relating to priority levels, targets, and benchmarks.

401. For example, patients waiting long periods for musculoskeletal disorders that cause pain or functional loss will lose strength and conditioning. That will impair not only their ability to function during the wait time, but will also result in slower or incomplete recovery of function.

402. In particular, as the Federal Advisor on Wait Times indicated in his report, growing children may suffer permanent functional loss, deformity and disability if, as they wait for care, irreversible developmental abnormalities develop. There is often a short window within which a child patient can be treated without exposing them to the risk of permanent harms.

403. Finally, the impact of wait times for life threatening diseases and conditions, such as those with cancer, are obvious.

404. For instance, the serious nature of individual patients waiting for colonoscopy have been acknowledged by the current BC Minister of Mental Health and Addictions, while in opposition, as noted in Hansard, February 25, 2015, Afternoon (Volume 20, Number 5), at 6095:

> **J. Darcy**: British Columbians are being asked to pay more for medical services premiums, but many people are discovering that the services they need aren't there for them when they need them.
>
> Last October in this House we raised the case of Last October in this House we raised the case of Michael Goldman from Qualicum Beach. He had surgery for colon cancer in January 2011. A colonoscopy in June of 2013 showed that Michael had a 40 percent chance of recurrence of his cancer. According to the government's own guidelines, Michael should have had a follow-up colonoscopy within six months. It has now been 20 months, and Michael Goldman has still not had the colonoscopy that he needs. And it's been four months since we raised this issue in this House.
>
> Can the minister explain to Michael Goldman, a high-risk patient at severe risk of recurrence of his cancer, why he's had to wait 20 long and very worrying months for his follow-up treatment?

405. This Hansard excerpt is attached to Exhibit "WW", referred to above.

406. It is precisely these various types of harms from waiting that initially led our group to pursue other options and that led to the development of Cambie, and which caused us to bring this constitutional challenge.

M. The Constitutional Challenge

407. We began this constitutional challenge after the Nurses Union and its surrogate, Ms. Mariel Schooff, commenced legal proceedings to compel the BC Government to enforce the prohibition on dual practice in order to prevent non-exempt British Columbians in need of care from having the same access to private care and surgeries to which exempt British Columbians are entitled.

408. Our objective was to allow all British Columbians suffering on wait lists to protect their own health by accessing private health care, for Wait Ones, Wait Twos and Wait Threes, whether or not they were within an exemption under the *Medicare Protection Act*.

409. To my knowledge, the prohibition on dual practice has never been enforced during the past 22 years.

410. On April 4, 2018, the Government announced the proclamation of amendments to the *Medicare Protection Act* effective October 1, 2018, which is well before a decision will be rendered in our case.

411. Those amendments will prevent non-exempt British Columbians from obtaining private surgeries and private diagnostic testing starting October 1, 2018 – because of the severe financial penalties, ranging from $10,000 to $20,000 per patient treated, that they impose on enrolled doctors who provide these services to non-exempt British Columbians, as well as the risk of being charged with an offence.

412. These amendments were enacted in 2003, but were not proclaimed by the Government at that time.

413. As noted above, at a meeting with private clinic operators shortly after the enactment of the amendments in 2003, which I attended, Premier Gordon Campbell and Health Minister Colin Hansen told us that these amendments would not be proclaimed because they would harm the health of British Columbians who needed access to private medical services given the lengthy wait times in the public health care system.

414. Access to private diagnostic testing performed by enrolled doctors had not previously been prohibited, as a result of minutes of the Commission which deemed these services not to be "benefits" when performed outside of an approved facility.

415. And as with surgical services, it is a practical necessity for these diagnostic services to be performed by enrolled doctors – because radiologists and other diagnostic specialists support and do not want to leave the public system, despite the fact that their skills are under-utilized in that system.

416. Diagnostic testing goes hand in hand with surgical services. If there is a delay in obtaining diagnostic testing, this will necessarily delay the diagnosis of serious medical conditions and delay the provision of urgent surgical services whether provided in the public system or privately, as discussed above.

417. And, as also discussed above, there are very long wait times for diagnostic testing in the public system in British Columbia, which has been admitted by the current Health Minister, Mr. Adrian Dix. Mr. Dix stated as follows in a recent CBC radio interview:

> "We've done very few [MRIs] in the public system or not enough MRIs. In BC, if we did the national average, we'd do about 260,000 MRIs every year. We did 188,000 last year, in the last year of the Liberal government. So that means that a lot of people are waiting a long time for MRIs."

418. In a March 27th 2018 press release, a copy of which is attached **as Exhibit "EEE"**, the BC Health Ministry stated that the "overall wait times for MRI's exceed 41 days for half of

all patients, with 10 per cent waiting more than 199 days". Even with the added numbers of MRIs, BC will perform 35,000 less per year than the national average.

419. The harmful consequences of these amendments extend beyond denying British Columbians who suffer injuries, or suffer from painful or disabling conditions outside of the workplace to obtain timely care.

420. These amendments will deny British Columbians the ability to access timely procedures to diagnose life threatening conditions, such as colon cancer, when the wait in the public system is longer than medically acceptable, therefore putting their health at risk.

421. The proclamation of the amendments will also negatively affect the ability of private surgical and diagnostic facilities to continue to provide services.

422. Even the government's future 2019 target for MRI exams, announced earlier this year (see Exhibit "BBB", above), would leave 15% of BC patients waiting past the maximum acceptable benchmark.

N. The Services Provided by Cambie and Private Clinics

423. Cambie and its shareholders and directors have always supported the public health system. As outlined in my Affidavit #9, over the years they have donated tens of millions of dollars in philanthropic support of hospitals, and have also donated time and funds to support medical education both in Canada and internationally.

424. We also believe that it is important that patients who are forced to wait as a result of rationed treatment in the public system, to the extent that it harms their health and wellbeing, should have a right to access that treatment elsewhere, without leaving the province or country.

425. Today, Cambie provides a broad range of surgical procedures, including orthopedic surgery, general surgery, neurosurgery, plastic surgery, urology, gynaecology, eye surgery and children's dentistry, as well as colonoscopies and other diagnostic procedures.

426. Based on data we have filed with the BC College, I estimate that Cambie has treated approximately 3,800 patients per year on average over the past 10 years, and approximately 70,000 patients in total since it opened in 1996.

427. More specifically, over the past six years, Cambie has performed the following number of procedures:

a. In 2012, Cambie performed **2,852** privately funded surgeries, **0** surgeries funded by the Health Authorities, and **933** surgeries performed to exempt British Columbians, that were funded by WCB, ICBC, the federal government, and the insurers of other exempt groups;

b. In 2013, Cambie performed **2,663** privately funded surgeries, **0** surgeries funded by the Health Authorities, and **1,230** surgeries provided to exempt British Columbians that were funded by WCB, ICBC, the federal government, and the insurers of other exempt groups;

c. In 2014 statistics, **2,783** privately funded surgeries, **0** surgeries performed that were funded by the Health Authorities, and **1,056** surgeries provided to exempt British Columbians that were funded by WCB, ICBC, the federal government, and the insurers of other exempt groups;

d. In 2015, Cambie performed **3,226** privately funded surgeries, **0** surgeries performed that were funded by the Health Authorities, and **780** surgeries provided to exempt British Columbians, that were funded by WCB, ICBA, the federal government and the insurers of other exempt groups.

e. In 2016, Cambie performed **3,116** privately funded surgeries, **0** surgeries performed that were funded by the Health Authorities, and **900** surgeries provided to exempt British Columbians, that were funded by WCB, ICBC, the federal government, and the insurers of other exempt groups;

f. In 2017, Cambie performed **3,353** privately funded surgeries, **0** surgeries performed that were funded by the Health Authorities, and **780** surgeries provided to exempt British Columbians, that were funded by WCB, ICBC, the federal government, and the insurers of other exempt groups.

428. While we have always treated surgeries funded by ICBC as being for 'exempt' patients, the Defendant has taken the position in this litigation that ICBC funded surgeries (unlike WCB) are not exempt under the Act. If that is correct, the numbers of private pay surgeries would be higher at Cambie in each of the above years.

429. By way of example, between September 2016 and August 2017, which represents a typical annual period at Cambie, Cambie provided 381 surgeries to non-exempt British Columbians that were medically necessary services, i.e., benefits under the *MPA*.

430. Cambie also provided a number of "hybrid procedures" over the September 2016 to August 2017 period. Hybrid procedures occur when MSP approves a "medically necessary" component of a procedure, for example when a nasal fracture treatment or eye surgery is simultaneously combined with a cosmetic or uninsured procedure to the nasal or eye region.)

431. We have estimated that Cambie provided approximately 750 cataract procedures over the September 2016 to August 2017 period, a large majority of which were provided to non-exempt BC residents, and approximately 998 dental surgeries involving general anaesthesia, which included a paediatric anaesthesiologist component of the service that is treated as a "benefit" under the *MPA*.

432. We therefore provide many surgeries and procedures a year to British Columbians that we will no longer be able to perform if the 2003 amendments come into force, and we may not be able to treat the vast majority of the approximately 1,000 young children each year who require dental surgery under anaesthesia.

433. Cambie also will no longer be able to provide the 50 to 75 colonoscopies a year that it provides, which are subject to long wait times in the public system, as discussed above.

434. The closure of, or reduction in services provided by, private clinics will force those patients to be added to the public wait list.

435. Non-hospital facilities that provide surgical procedures, like Cambie, require accreditation from the BC College of Physicians and Surgeons under the Non-hospital Medical and Surgical Facilities Program ("NHMSFP").

436. According to the College's most recent annual report, there are currently 57 private medical / surgical facilities and 737 physicians who provide services at those private facilities in British Columbia. The College reported that 69,516 procedures were provided in these facilities in 2017. Attached as **Exhibit "FFF"** is the most recent annual report of the BC College, which contains these statistics at page 18.

437. The private clinics have expanded the available workforce through allocating operating facilities and OR time to some of the over 200 young Canadian orthopaedic surgeons who would otherwise be underemployed and be forced to leave the province. Attached as **Exhibit "GGG"** is a recent Canadian Orthopaedic Association bulletin (Winter 2016/17), which discusses the difficulty many orthopaedic surgeons have finding work in Canada.

438. Cambie's surgeons fulfill all of their operating room time in the public system, and use the additional time available through Cambie to provide additional surgeries to patients who would otherwise have to wait for surgery in the public system.

O. The Costs of Operating Private Clinics

439. In my experience, the revenue margins on which the private clinics (like Cambie) operate are small, given the costs of the physician fees (which go to the treating physicians) and the high costs of maintaining a modern medical facility.

440. The major costs of operating Cambie include the salaries and benefits of employees, costs associated with the facility (e.g. electricity), the cost of maintaining and updating medical equipment, and taxes paid to municipal, provincial and federal governments.

441. Cambie must maintain a positive revenue stream in order to maintain its equipment and provide patient care at the level of excellence that is required.

442. Cambie provides some very complex procedures, in that they involve state of the art medical technology and require a high degree of surgical skill.

443. Indeed, since 1996, when Cambie opened, we have ensured that it had the most advanced equipment and facilities available.

444. In 2003, we spent $5 million to expand Cambie Surgery Centre, more than doubling its size to 17,000 square feet.

445. Two of the operating rooms at Cambie are "digital", and they are among the most technologically advanced operating rooms in North America.

446. When these rooms were opened, they attracted visits from European and North American hospital managers, as well as from hospitals in Eastern Canada looking to upgrade their hospital operating rooms.

447. Cambie has been accredited with exemplary status (the highest rating available) by Accreditation Canada – which accredits all of the teaching hospitals and most of the other hospitals in Canada. Only a minority of hospitals in British Columbia and Canada have received this high level of accreditation.

448. Cambie has some equipment that is not available in the public health care system in BC. For instance, Cambie has a femtosecond laser which allows for more advanced and precise cataract surgery, and which does not exist in any public hospital.

449. In addition, my colleagues at Cambie and I have frequently used Cambie-purchased and Cambie-owned surgical equipment to perform surgeries in public hospitals under the public health care system, rather than outdated equipment available at the public hospitals. I have personally transported some of this equipment to UBC in order to use it for surgeries performed there.

450. Cambie has also frequently loaned equipment, including technologically advanced equipment not available in the public system, to public hospitals, at no cost. This has made more advanced technology available to B.C. residents (and other Canadians) than they would otherwise have access to.

451. Examples of these equipment loans include equipment for fracture fixation and arthroscopic hip surgery.

452. Similarly, I have personally treated injured workers from as far away as Ontario, Nova Scotia and Newfoundland at Cambie because the procedures or equipment were not available in their home jurisdiction.

453. Provincially insured non-residents from other provinces are able to access Cambie, but BC insured residents are to be prevented from doing so by the new *MPA* amendments, and in

many cases the non-resident patients receive some reimbursement of funding from their provincial plan for the physician component of their care.

454. Like any other venture that does not receive government funding, Cambie has to generate sufficient revenues in order to remain viable.

455. As a result of the high cost of maintaining a modern surgical clinic, and the fact that the individual surgeons receive a portion of the fees charged for services performed at Cambie and SRC, Cambie's overall profit margin is small.

456. Cambie's revenue and expense calculations show that Cambie makes approximately $65.00 profit per $5,000.00 of revenue, and there have been years in which Cambie has suffered a significant loss, most recently in 2014.

457. I have been informed by the owners of two of the largest private surgical clinics in BC, Delbrook Surgical Centre and Comox Valley, that those clinics have declared bankruptcy within the past year, and I am aware that two others – South Fraser and Langley Surgery Centre – have recently ceased operations. Even a relatively modest percentage decrease in revenue may affect the viability of a clinic.

458. BC College of Physicians' data show that last year approximately 70,000 patients were treated in private facilities and since the mid 1990's, private clinics in BC have treated over a million patients.

459. As a result, if the amendments to the *MPA* are enacted, tens of thousands of patients will be added to an already overburdened public system which, by its own published benchmarks and criteria as documented and referenced above in their own Surgical Patient Registry, are already causing medically unacceptable harm and suffering to many patients.

SWORN BEFORE ME at the City of Vancouver, in the Province of British Columbia, this 3rd day of July, 2018.

A Commissioner for taking affidavits for British Columbia

DR. BRIAN DAY

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