Affidavit #1 of Dr. Bassam Masri
Sworn October 2, 2012
No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CAMBIE SURGERIES CORPORATION, CHRIS CHIAVATTI by his litigation guardian RITA CHIAVATTI, MANDY MARTENS, KRYSTIANA CORRADO by her litigation guardian ANTONIO CORRADO and ERMA KRAHN.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH SERVICES OF BRITISH COLUMBIA AND ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

AND:

SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

DEFENDANTS BY COUNTERCLAIM

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

INTERVENERS

AFFIDAVIT #1 OF DR. BASSAM MASRI

I, Bassam Masri, surgeon, of 1428 Balcour Avenue, Vancouver, BC, V6H 1Y1, MAKE OATH AND SOLEMNLY AFFIRM THAT:

1. I am a surgeon who works within public hospitals in British Columbia and at the Cambie Surgeries Corporation (herein referred to as "**CSC**") and the Specialist Referral Clinic ("**SRC**"). As such, I have personal knowledge of the information stated herein, except where stated to be on information and belief, in which case I believe it to be true.

2. I make this affidavit in support of SRC's and CSC's opposition to the injunction sought by the Medical Services Commission (the "**Commission**") to prohibit SRC and CSC from providing medical services in contravention of certain provisions of the *Medicare Protection Act* (the *"Act"*) (specifically sections 17(1) and 18(3), which relate to billing practices for benefits under the *Act*) prior to a ruling on the constitutionality of these provisions.

3. As I explain below, I believe that if the residents of British Columbia are not able to pay a facility fee for surgeries at CSC or obtain timely medical assessments at SRC, just as residents, for example, of Alberta can lawfully do, it will have a negative impact on the ability of the residents of British Columbia to access timely health care.

My Professional Qualifications

5. I am fully licensed as an orthopaedic surgeon in British Columbia.

6. I obtained a B.Sc. in Chemistry in 1985 and a medical degree in 1988, both at the University of British Columbia.

6. Following this, I completed an orthopaedic surgery residency at the University of British Columbia, becoming a Fellow of the Royal College of Surgeons of Canada in 1994.

7. I further specialized in orthopaedics through sub-specialty training. I completed a fellowship in Musculoskeletal Oncology and Reconstructive Orthopaedics, at the

University of British Columbia in 1994. I completed a second fellowship in Reconstructive Orthopaedics (Hip and Knee Service) at Cornell University, New York, in 1995.

8. I am a Professor in Orthopaedics at the University of British Columbia.

9. In 2007, I was appointed the Head of the Department of Orthopaedics at the University of British Columbia, and the Head of the Department of Orthopaedics at Vancouver Acute (Vancouver General and University Hospitals).

10. I have been affiliated with the B.C. Cancer Agency Musculoskeletal Oncology as a surgical oncologist and as the former the Head of the Musculoskeletal Tumor Group for the Surgical Oncology Network since 1995.

My work as a surgeon in public health care system in British Columbia

11. Following my training, in 1995 I started to work as an orthopaedic surgeon at Vancouver General Hospital, and in 2006 at UBC Hospital as well.

12. My surgical practice primarily consists of adult Hip and Knee Reconstruction and Replacement.

13. Prior to 2004, the access to medical services within a reasonable time frame was very poor. I was allocated approximately 1.5 Operating Room ("OR") days per week, and performed approximately 240 surgeries per year.

14. Following the 2004 First Minister's meeting on health care, the provincial and federal governments adopted the '10-Year Plan to Strengthen Health Care' to address the unreasonable wait times. Following the wait time initiatives established in 2004, there was an attempt to address the barriers to the access of timely health care by establishing

wait time goals, known as benchmarks, in five priority areas of health care. One of the benchmarks established was for my specialty area, namely, knee and hip replacements.

15. The government-designated benchmark for hip and knee replacements is six months, and is measured from specialist diagnosis to treatment. However, in reality, patients wait up to a year from first referral before receiving the treatment. In my practice field, when a patient is referred by their family physician to consult a specialist, the wait time is approximately four to six months. Following the specialist consultation, the wait time to undergo the hip or knee replacement surgery is four to six months. This means the patient has been waiting for 8 to 12 months to complete the treatment from the time they see their family physician to the time they receive the treatment. Therefore, the government established benchmarks do not properly reflect the actual time it takes from the time an individual seeks medical attention to the time that individual receives treatment.

16. Even though following the 2004 initiatives I have been able to increase the amount of surgeries I perform (I perform approximately 500 per year); many of my patients are unwilling and unable to wait six months or longer to receive medically necessary care.

17. Many of my patients ask for their surgery to be performed before their scheduled date.

18. There are a number of reasons that a patient cannot wait for their surgery. Patients with hip and knee issues have restricted mobility and significant pain. They cannot work, and risk losing their jobs while they wait for care in the public system. In order to return to their normal lives, patients are willing to pay for their medical care. However, this option is not legally available to them.

19. I have had patients come to my office in tears, because the bank is going to foreclose on their home. They cannot make their mortgage payments, as they are unable to work or have lost their job while waiting for an essential medical procedure. In order to try to help these patients, I have pushed back other cases (by changing surgical priority) so that I can treat these patients sooner.

20. The patients who are bumped back have also been waiting for their surgery for months. Re-scheduling their surgery can be problematic, as patients often arrange for family to come into town to provide assistance during the post-operation period. Unexpected rescheduling can leave patients without a caregiver during their recovery time.

21. Lengthy wait times can create new medical problems. For example, most patients take prescription narcotics to alleviate the significant pain they are in while waiting for care. The long wait times have led to an increase in patient tolerance (physical addiction) to painkillers, which makes recovery from surgery more difficult and more painful and required a protracted phase of weaning from narcotics after the operation. In addition to addiction, there are many detrimental side effects following the long-term use of other non-narcotic painkillers, such as kidney disease and stomach ulcers.

My work as a surgeon at SRC and CSC

22. In addition to my work in the public system, I also work in the private health care system through SRC and CSC.

23. At SRC, I see patients for consultations or medical assessments for hip and knee procedures. Of the patients who receive medical assessments at SRC, and are found to require partial knee replacements, some choose to have this surgical treatment performed at CSC.

24. The main procedure I conduct at CSC is partial knee replacement. In the public health care system, a patient would typically wait for 6 months before receiving this procedure. In contrast, this procedure can be provided within 2 weeks at CSC.

25. The provision of more timely surgeries provides patients with a peace of mind and a quicker end to their suffering.

26. My work at SRC and CSC does not impact my availability to treat patients in the public health care system. This is due to the fact that I am currently fully utilizing the OR time available to me in the public hospitals and only operate at CSC or see patients for assessments at SRC outside my regular work hours.

27. If CSC and SRC were to be prohibited from charging beneficiaries for facility fees under the *Medical Services Plan*, this would not free up my time and allow me to provide more medical services through the public health care system. To the contrary, those patients would be added to the public waiting list and will make waiting times longer for consultation for all patients. Therefore, there is no advantage to the health care system in prohibiting SRC or CSC from continuing its current practice. I am committed to the public health care system and always make every effort to utilize all resources available to me before I consider using private resources.

28. On the other hand, if surgeons were to spend less time in the public system, this would allow new surgeons to be hired. In many specialties, orthopaedics included, there are numerous surgeons looking for work and currently they cannot access employment due to the lack of positions available in the public health care system.

29. Since patients who choose to pay to receive health care services, and receive those services very quickly in the private sector, have no need to go on public health care wait lists, the number of patients on the public health care wait lists is reduced. If SRC and CSC were to be prohibited from billing beneficiaries, a great number of these patients would be placed on the public health care wait lists. Not only would this prolong their suffering, but also it would undoubtedly congest the public health care system.

AFFIRMED BEFORE ME at the City of Vancouver, in the Province of British Columbia, this 2nd day of October, 2012

A Commissioner for taking affidavits in the Province of British Columbia

DR. BASSAM MASRI

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