



Affidavit #1 of Dr. William Regan
October 29th, 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**

INTERVENORS

AFFIDAVIT #1 OF DR. WILLIAM REGAN

I, Dr. William Regan, surgeon, of 4180 Crown Crescent, Vancouver, BC, MAKE OATH AND SOLEMNLY AFFIRM THAT:

1. I am a surgeon who works both 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 CSC’s opposition to the injunction sought by the Medical Services Commission (the “**Commission**”) to prohibit CSC and SRC 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 receive 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 and effective health care.

My Professional Qualifications

4. I am a licensed orthopaedic surgeon, with sub-specialty training in surgery of the upper extremity and knee.
5. I completed a B.A. in Biochemistry and Classics from Bowdoin College in Maine, USA in 1977, and I received my medical degree from the University of Toronto in 1981.
6. I completed an Orthopaedic Surgery residency at the University of Western Ontario, in London Ontario, and became a Fellow of the Royal College of Surgeons of Canada in 1986.

7. I received sub-specialty training in orthopaedics through three fellowships: namely a fellowship in Sports Medicine at the University of British Columbia in 1987; a fellowship in Upper Extremity Medicine at St. Michael's Hospital in Toronto in 1987; and a fellowship in Upper Extremity (Elbow) Surgery at the Mayo Clinic in 1998.
8. I am an Associate Professor of Orthopaedic Surgery at the University of British Columbia.
9. I currently serve as the head of the Division of Arthroscopic, Reconstructive Surgery and Joint Preservation in the Department of Orthopaedics at the University of British Columbia Hospital ("UBCH").
10. I have worked as a consultant to WorkSafe BC since 1994.
11. I serve as a team surgeon to the Vancouver Canucks Hockey Club, and have done so since 1999.

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

12. I have been working as an orthopaedic surgeon since 1998. My practice is focused on repairing and reconstruction of the upper extremity and the knee.
13. The majority of my work in public hospitals is at UBCH. I also work at Vancouver General Hospital, and the Ambulatory Surgical Centre in Vancouver ("ASC"), a private surgical centre which conducts surgeries delegated from the Vancouver Coastal Health Authority.
14. As the head of the Division of Arthroscopic, Reconstructive Surgery and Joint Preservation at UBCH, I am involved in the recruitment of new orthopaedic surgeons.

15. While I receive many applications from highly qualified orthopaedic surgeons who would like to work at UBCH, I am unable to bring them onto our team, given the limited facility time and resources our team already faces. These young specialists are unable to find work despite the fact that there is a great demand for their services.
16. This is particularly frustrating, as I also experience repeated communications from frustrated family physicians, therapists and patients regarding the extremely long wait times for consultation and treatment of orthopaedic procedures.
17. The solution to the rationed access to specialist care in my field would be for the hospital authorities to increase operating room (“OR”) time at the hospital, which would allow us to accept applications from these highly qualified young surgeons. However, I understand that they are unable to do this due to funding constraints.
18. Due to the limited availability of facility time and resources, I am allocated, on average, one OR day per week, for a total of five OR days each month. Depending on the complexity of the cases scheduled, I complete, on average, four to five orthopaedic surgeries during my weekly OR allocation.
19. Most of my surgeries are done at UBCH or ASC. I use the Vancouver General Hospital ORs on average once every three months, for patients who have challenges with the use of anesthesia.
20. Due to the rationing in the public health care system, and my limited OR time within the public health care system, I am restricted in the number of patients to whom I can provide surgical treatment within the public health care system.
21. A patient who requires surgery experiences two wait times. The first wait time is from when the patient visits their family physician until the consultation with the surgeon. The second wait period is from the time of diagnosis following the consultation, to the time when a surgery occurs.

22. I severely restrict the number of patients I accept for surgical consultation at any given time in order to try to keep my operative wait lists at a manageable length. This restriction also limits the difficulty of handling the disappointment and despair patients feel when they are informed they will be waiting over a year for a medically necessary consultation and possible surgery. It is taxing to deal with patients and families constantly phoning the office to request their consultation and/or surgery be expedited, particularly when there is nothing that can be done for them.
23. Accordingly, the present wait time to see me for a surgical consultation in the public health care system is, on average, two years. Once I see a patient and the decision to have surgery is made, the patient will wait another four to six months for surgery.
24. This means that a patient can wait up to two and a half to three years for a procedure after first experiencing symptoms that indicate surgery is required.
25. In 2004, the First Ministers held an Accord on Health Care. Following this, the provincial and federal governments adopted a '10-Year Plan to Strengthen Health Care,' to address the extremely lengthy wait times in the public health care system. Part of this initiative included the establishment of wait time goals, known as benchmarks, in five 'priority' areas of health care, including hip and knee replacement surgery.
26. The government of British Columbia has made a public commitment to meeting these benchmarks. The provincial health authorities can lose their funding if the benchmarks and targets are not met.
27. In order to meet the benchmarks, the public health care system in British Columbia gives priority to completing knee and hip replacement surgeries over other similar orthopaedic surgeries, including shoulder and elbow arthroplasties. Accordingly, knee and hip replacement surgeons are given priority access to funds and facility resources. For example, on my OR day at UBCH, I am given one room to use. With these resources, I

can complete four upper extremity procedures. At the same time, a knee and hip replacement surgeon is running two concurrent ORs with dedicated OR nursing teams, and thus is able to complete ten surgeries in the same timeframe.

28. This system allows the British Columbia government to give the incorrect impression that the public health care system is achieving national benchmarks. Meanwhile, I have a wait list of six months or more for my procedures, despite the fact that the benchmark for these procedures is three months.
29. During their extended wait time, my patients have restricted use of their upper extremity and are in a great deal of pain. Often, they cannot work. These symptoms and experiences parallel the difficulties that patients requiring hip and knee replacements face. I do not see the difference between a patient requiring a total shoulder or elbow replacement compared to a total hip or knee replacement in terms of medical need. However, due to administrative decisions, the hip and knee replacement patients receive faster access to care.
30. Recently, the government has been purchasing surgical time at private clinics for patients within the Vancouver Coastal Health region. Specifically, the public health care system has contracted out 50% of the less acute orthopaedic surgeries to ASC.
31. I spend a great deal of time at ASC. For example, while I officially have five OR days per month in the public health care system, in September 2012, four of my operating days were done at ASC, a private facility.
32. The surgeries that I am conducting at ASC are not for patients who are paying additional money. These are Vancouver Coastal Health patients. The government has decided to purchase OR time at a private clinic for public health care system procedures for some patients.
33. My professional time is not fully utilized by the public health care system. Not only do I

have limited OR time, but there are other factors that restrict my time from being fully productive. For example, the designation of UBCH was recently changed, and the government eliminated the funding necessary to have OR nurses and anesthesiologists available for 'after-hours' surgery. This means that surgeries can only be done during the day.

34. If I am on call at UBCH, and someone comes into the Emergency Department with a torn knee ligament or a locked knee, I am prevented from using the empty ORs and my available time that evening to provide care at UBCH, unless it is a surgical emergency which must be done within 12 hours.
35. Instead, I have been instructed to go through the cases scheduled for the upcoming week, and cancel another patient's procedure to accommodate the urgent case. The patient who is 'bumped' has already been waiting for months. They will now have their surgery rescheduled to accommodate the more urgent procedure that I could have taken care of immediately, during my first interaction with the patient, if 'after-hours' procedures were permitted at UBCH.

My work as a surgeon at CSC

36. I have worked as an orthopaedic surgeon at CSC since it opened in 1996. I am a minority shareholder in CSC.
37. I also see patients for consultations or assessments at SRC. I am able to see a patient for a consultation at SRC within one week of the patient requesting it and to provide surgical treatment at CSC within two weeks after that.
38. I currently utilize one OR day per week at CSC. I complete approximately six to seven surgeries per OR day, and do on average 300 surgeries per year at CSC. Therefore, I complete approximately 50 more surgeries a year at CSC than I do within the public health care system, despite the fact that I have the same amount of OR time at CSC (one

day) as I do within the public system.

39. Approximately 75% of my patients at CSC are individuals whose medical services are paid for through the Worker's Compensation Board or through their work, such as the Royal Canadian Mounted Police. The remaining 25% of my patients pay a facility fee for their procedure at CSC. These patients are generally middle class citizens who have decided that receiving expedited care is worth the cost.
40. For example, one of my recent patients at CSC was a young man who had received a baseball scholarship, allowing him to pursue studies in the United States. He tore an elbow ligament and required surgery to repair the damage. If this patient had waited to receive care in the public system, it would have taken two years before he received the surgery. During this wait, he would have lost his scholarship. His family supported him to have the surgery through CSC. To this family, paying for the expedited care was worth it because his career, and the course of his future would be significantly altered if he had to wait for care in the public health care system. His case was not a "surgical emergency." As a result, the expected wait time in the public health care system would have been too long to support his career aspirations.

The consequences of not having surgeries done in a timely manner

41. There are major psychological issues that come with living with ongoing pain. The pain can lead to an addiction to painkillers. Patients who are addicted to painkillers may take up to 100 Oxycodone per week, which can tax their liver and create secondary health issues.
42. This level of narcotic drug use not only poses major problems for the patient, but also affects health care delivery. I have had to cancel surgeries on the day they are scheduled, because the patient has become addicted to painkillers and is therefore not eligible for surgery at a low acuity hospital like UBCH.

43. Performing surgery on a high-risk individual like this would be too risky or complicated for the facilities at UBCH. Cases involving patients who are addicted to painkillers are complex because, following surgery, the patient experiences massive withdrawal symptoms and therefore requires intense monitoring and post-operative care. Because of the limited nursing staff and lack of anesthesiologists at night at UBCH, these cases must be performed at Vancouver General Hospital. Therefore, due to such safety issues, the case is rebooked, either to put it on my Vancouver General Hospital operative schedule (where my wait list for surgery is longer), or to try to break the addiction prior to the surgery.

Consequences of an Injunction

44. If an injunction were to be issued before the constitutionality of the restrictions in issue are adjudicated, the long standing status quo (about 16 years) will be altered in a way which will have negative consequences for the residents of British Columbia. Patients who have booked surgeries at CSC will be added to the wait lists in the public system. Other patients who want to pay a facility fee for timely treatment at CSC or receive an expedited consultation at SRC will not be able to so. This will have a detrimental impact on the health care system in British Columbia because it will increase the wait times for everyone and put a further strain on the public health care system, without any benefit to that system.

AFFIRMED BEFORE ME at the City of)
Vancouver in the Province of British)
Columbia, this *9th* day of October, 2012)

[Signature])
A Commissioner for taking affidavits)
in the Province of British Columbia)

William D. Regan md

DR. WILLIAM REGAN