Affidavit #1 of Dr. Mark Adrian
October 5, 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. MARK ADRIAN

I, Dr. Mark Adrian, physician, of Vancouver, British Columbia MAKE OATH AND SOLEMNLY AFFIRM THAT:

1. I am a physician 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 and effective health care.

My Professional Qualifications

4. I am a physician specializing in interventional spinal medicine.

5. I completed a B.Sc. in Physiotherapy at the University of Saskatchewan in 1987, and obtained an M.D. qualification from the University of Manitoba in 1993. Following this, I completed a Family Practice Residency at the University of British Columbia from 1993-1995. I further completed a Physical Medicine and Rehabilitation Residency conjointly at the University of Texas and the University of British Columbia in 1998. I also completed sub-speciality fellowship training in Spine, Musculoskeletal & Occupational Medicine at the Mayo Clinic in Minnesota from 1999-2000.

My work as a physician in public hospitals in British Columbia

6. Since 2001, I have worked as a physician at the Spine Centre, in the Department of Orthopaedics (Division of Spine) and Division of Physical Medicine and Rehabilitation, at Vancouver General Hospital ("**VGH**"). Since 2001, I have simultaneously worked as a physician in Musculoskeletal Medicine and Interventional Spinal Medicine at Burnaby General Hospital.

7. I work in the British Columbia public health care system as a specialist in Physical Medicine and Rehabilitation with subspecialty training in Spine and Musculoskeletal Medicine. I have a special interest in the evaluation and non-operative management of spinal disorders, including minimally interventional, image guided, injection treatments for lumbar disc herniations, stenosis and sciatica. These procedures can be done in a radiology or surgical suite.

8. On average, I see 50-70 patients a week in the public health care system for the assessment and management of musculoskeletal and spinal disorders. My practice includes performing minimally invasive spinal injection procedures. My patients are referred to me by family physicians and by other specialists.

9. In the public hospitals where I work, I use a radiology suite to conduct my interventional procedures which involve x-ray guidance techniques.

10. The availability of radiology suites is limited in the public hospitals where I work. I am restricted to two, two-hour blocks of suite time per week at Burnaby Hospital. There is no radiology time available at VGH; therefore I am limited to four total hours a week of access to radiology suites.

11. The waitlist for my patients in the public health care system is presently 4-6 months. When my wait-list becomes excessive, I could and often do try to refer patients to other

similar physicians at Royal Columbian Hospital in New Westminster, British Columbia, the University of British Columbia Hospital and VGH, however their wait lists are generally as long as mine, or longer.

12. The general wait time goal, known as a benchmark, set for the procedures I provide is 2-4 weeks.

13. I receive multiple calls every day from patients pleading for earlier appointments. Patients who are in acute pain are desperate to expedite their treatment. A good portion of my day is spent fielding requests from patients for expedited treatment. Handling these requests is not only emotionally difficult for me as their designated physician, but it also consumes a large portion of the limited time that I have that to treat patients. It is an inefficient use of my time to manage wait lists.

14. My experience with prolonged waitlists is that delays in treatment have negative impacts on the overall well-being of my patients.

15. I perform treatments on patients with disabling acute and painful conditions. The goal of my practice is pain management and optimizing patient function. The unnecessary, ongoing pain and suffering of my patients, which could be alleviated with timely treatment, is detrimental to the well-being of my patients in a number of ways.

16. First, the pain my patients live with while waiting for treatment significantly impairs their functional capability. This reduced capacity leads to secondary health issues, exacerbates present health concerns, and negatively affects their health overall.

17. As an example, on my last clinic day, two of my diabetic patients reported that they could not perform exercise as a result of the pain created by their condition. My patients' lack of exercise leads to their deconditioning and the advancement of their disease. Similarly, many of my patients experience aggravated secondary ailments, and the advancement of other harmful conditions.

18. Generally, when my patients are in pain, they become inactive and their condition and health, as a result, will deteriorate dramatically. Even in instances where my patients' original condition does not deteriorate while waiting for treatment in the public system, they may not be able to function normally, stay social and fit, or meet employment obligations. This, in turn, can lead to unnecessary emotional and psychological suffering.

19. Second, many of my patients are in pain and are required to take pain medications during the duration of their wait time, and as a result, these patients suffer from side effects related to the prolonged use of painkillers, such as addiction.

20. As an example, one of my patients was suffering from severe withdrawal symptoms. This patient had been taking morphine for a prolonged period of time, and, as a result of discontinuing with the pain medication, had gone into drug withdrawal. Many of my patients have similarly suffered from the side effects of pain medications or addictions to painkillers.

21. Timely medical treatment is crucial to avoiding unnecessary pain and suffering as well as harmful medical consequences.

My work as a physician at SRC and CSC

22. In 2003, I began working at SRC and CSC as a physician in interventional spinal medicine.

23. At SRC, I see patients for consultations or medical assessments. The patients who receive medical assessments at SRC often choose to receive treatment at CSC.

24. I perform intervention procedures, such as image-guided spinal procedures, out of a surgical suite for patients at CSC.

25. At CSC, I am able to access available surgical suites to perform procedures for my patients more readily than I am able to access available procedural suites in the public hospitals where I also work.

26. I presently perform procedures for approximately 5-10 patients a month at CSC. The surgical suite access at CSC is not restricted, and I could increase my caseload as necessary.

27. I believe that CSC provides beneficial and much needed access to surgical suites, which allows greater access to timely services for my patients.

28. My work at SRC and CSC does not reduce my work in public hospitals. I continue to provide as many procedures as I am allowed in public hospitals. By being able to work at SRC and CSC, I can treat more patients and reduce overall wait times for all patients.

29. If an injunction were to be granted, wait list times in the public system will be even further overburdened, which would cause all of my patients to have longer wait times for consultations and medically necessary procedures. Furthermore, our patients who have elected to proceed with the services offered at SRC and CSC will be added to the public health care system wait lists.

30. This will also increase wait times generally in British Columbia, with the result from the provision of health care services will be harmed, not helped, by an injunction.

31. It is essential, in my view, particularly given the lengthy period of time that SRC and CSC have been allowed to provide private medical assessments or charge a facility fee for surgical services, that the constitutional issues relating to a resident's ability to pay for medically necessary services is adjudicated before any decision is made to enjoin SRC or CSC.

AFFIRMED BEFORE ME at the City of Vancouver, in the Province of British Columbia, this 5th day of October, 2012

A Commissioner for taking affidavits in the Province of British Columbia

DR. MARK ADRIAN

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