

# IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Cambie Surgeries Corporation v. British Columbia (Medical Services Commission)*,  
2014 BCSC 1028

Date: 20140609  
Docket: S090663  
Registry: Vancouver

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, Walid Khalfallah by his litigation guardian  
Debbie Waitkus and Specialist Referral Clinic (Vancouver) Inc.**

Plaintiffs

And

**Medical Services Commission of British Columbia,  
Minister of Health of British Columbia,  
and Attorney General of British Columbia**

Defendants

And

**Dr. Duncan Etches, Dr. Robert Woollard, Glyn Townson, Thomas  
McGregor, British Columbia Friends of Medicare Society, Canadian  
Doctors for Medicare, Mariel Schooff, Daphne Lang, Joyce Hamer,  
Myrna Allison, Carol Welch, and the British Columbia  
Anesthesiologists' Society**

Intervenors

Before: Associate Chief Justice Cullen

## Reasons for Judgment

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For the British Columbia Anesthesiologists' Society:

Dr. Roland Orfaly  
(as Agent)

Place and Date of Hearing:

May 12-14, 2014

Place and Date of Judgment:

Vancouver, B.C.  
June 9, 2014

[1] Several groups have been granted Intervenor status in this action:

(1) Dr. Duncan Etches , Dr. Robert Woollard, Glyn Townson, Thomas McGregor, the British Columbia Friends of Medicare Society, and Canadian Doctors for Medicare (the “Coalition Interveners”), were denied party status but granted Intervenor status by Smith J. on November 20, 2009: *Schoof v. Medical Services Commission*, 2009 BCSC 1596.

(2) Mariel Schooff, Daphne Lang, Joyce Hamer, Myrna Allison and Carol Welch (the “Patient Interveners”), were denied party status but granted Intervenor status by Smith J. on July 2, 2010: *Canadian Independent Medical Clinics Association v. British Columbia (Medical Services Commission)*, 2010 BCSC 927.

(3) The British Columbia Anesthesiologists' Society (“BCAS”) was granted Intervenor status by Bauman CJSC (as he then was) on October 15, 2012, “on the same basis” as Smith J. did for the Coalition Interveners: *Cambie Surgeries Corporation v. British Columbia (Medical Services Commission)*, 2012 BCSC 1511.

Each of these three Interveners seeks to adduce evidence.

[2] BCAS’s application was heard first and seeks:

1. An order granting the BCAS the right to adduce affidavit evidence at trial regarding the factual information and perspective of BC anesthesiologists in the planning and delivery of health care services in British Columbia (“BCAS Evidence”). This evidence shall include - but is not necessarily limited to: collection and management of administrative health data; evidence concerning surgical wait times; evidence concerning administrative efficiencies: evidence of the rationing of surgical resources; challenges related to the implementation of collaborative recommendations for improvement of the public health care system.
2. A direction that the BCAS Evidence be served and filed no later than 60 days prior to the commencement of trial.
3. An order that the BCAS may submit written argument seven days after the Defendants submit their written arguments, subject to the limit

that except as necessary to develop its argument, the BCAS' argument will not duplicate submissions made by any party.

4. An order that the BCAS may make oral submissions at trial, subject to the limit that except as necessary to develop its argument, the BCAS' submissions will not duplicate submissions made by any party.

5. An order that there be no costs to the BCAS in any event of the cause.

[3] The plaintiffs oppose the orders set out in paras. 1, 2 and 4 but take no position on the orders set out in paras. 3 and 5 of the BCAS application. The defendants take no position on any of the orders set out in Part 1 of the BCAS application.

[4] The Coalition Interveners' application was heard second and seeks:

1. An order granting them the right to adduce expert reports by the experts identified in paragraphs 9 to 42 of Affidavit #1 of Adam Lynes-Ford, made April 1, 2014 (the "Expert Evidence").
2. A direction that the Expert Evidence be filed on or before June 1, 2014.
3. Such further and other relief as this Honourable Court seems just.

[5] The plaintiffs oppose and the defendants consent to all of the orders sought in the Coalition Interveners' application.

[6] The Patient Interveners' application was heard third and seeks:

1. An order granting the Patient Interveners the right to adduce affidavit evidence at trial regarding
  - (a) patients' experiences of health care delivery in British Columbia (the "Patient Affidavit Evidence"); and
  - (b) regarding the role and function of the Medical Services Commission (together, the "Affidavit Evidence").
2. An order that the Patient Affidavit Evidence be admitted notwithstanding that it was made in one of the following BC Supreme Court files;
  - (a) *British Columbia Nurses' Union v. Attorney General of British Columbia*, Vancouver Registry File No. L051005;

- (b) *British Columbia Nurses' Union v. Medical Services Commission*, Vancouver Registry File No. S-068256; and
  - (c) *Schooff and Others v. Medical Services Commission*, Vancouver Registry File No. S-088484 (the "Patient Petition").
3. A direction that the Affidavit Evidence be served and filed on or before June 30, 2014.
  4. An order that the Patient Interveners may submit written argument seven days after the Defendants submit their written arguments, subject to the limit that except as necessary to develop its argument, the Patient Interveners' argument will not duplicate submissions made by any party.
  5. An order that Patient Interveners may make oral submissions at trial, subject to the limit that except as necessary to develop its argument, the Patient Interveners' submissions will not duplicate submissions made by any party,
  6. An order that there be no costs to the Patient Interveners in any event of the cause.

[7] The plaintiffs oppose the orders sought in paras. 1 - 3 and 5 of the Patient Interveners' application but take no position on the orders sought in paras. 4 and 6. The defendants' consent to all the orders sought in the Patient Interveners' application.

[8] The plaintiffs raise the threshold question of whether the three Interveners are entitled to lead evidence at all. As this issue was first raised in the BCAS application (but argued in respect of each subsequent application too), I will deal with it compendiously but in the context of addressing the BCAS application.

### **BCAS**

[9] The BCAS was represented by its Executive Director, Dr. Roland Orfaly, who submits that because of their involvement in a very broad range of surgical procedures, anesthesiologists have a unique perspective on the BC health care system and have a significant interest in the disposition of this action, which challenges the constitutionality of the *Medicare Protection Act*, [MPA] and implicates BC's present health care regime.

[10] Dr. Orfaly submits that while the plaintiffs contend that the present health care regime does not provide patients with health care in a timely way, thus infringing their s. 7 and s. 15 *Charter* rights, the defendants contend that the *MPA* is necessary to achieve the overall common good of health care for BC citizens. He submits that these opposing positions conceal what may be common ground between their respective positions which needs exploration. He submits that the BCAS can contribute to the evidentiary record by focusing on the common ground between the parties but not addressed by them: specifically, that by better adherence to the provisions and regulations of the *MPA*, the time-lines for health care can be improved to meet constitutional standards. BCAS' position is that the broad-based experience of its membership can furnish evidence that is necessary to complete the record.

[11] Dr. Orfaly relies on the ruling granting BCAS Intervenor status, and the order resulting from that ruling, as a foundation for applying to adduce evidence. Chief Justice Bauman held as follows in 2012 BCSC 1511 at paras. 4-8:

[4] The Court has already granted intervenor status to the named intervenors in decisions pronounced by Justice L. Smith and indexed at 2009 BCSC 1596 and 2010 BCSC 927. Essentially, my colleague concluded that these interventions would significantly add to the range of perspectives that would be brought before the Court in this litigation, which is said to go to the "constitutional validity of public health care in British Columbia".

[5] Justice Smith conveniently summarized the law in British Columbia at para. 188 of her judgment at 2009 BCSC 1596. She did so by borrowing Justice Rowles' discussion of the principles in *Gehring v. Chevron Canada Limited*, 2007 BCCA 557, 75 B.C.L.R. (4th) 36 (Chambers).

[6] I adopt that summary of the principles. I must consider the nature of the issue before the Court, in particular, whether it is a public law issue; whether the case legitimately engages the interests of the would-be intervenors; the representativeness of the applicant of a particular point of view or "perspective" that may be of assistance to the Court; and whether the proposed intervenor is likely to "take the litigation away from those directly affected by it".

[7] All of these considerations here favour the applicant. While the defendants submit that the proposed intervenor's history of interactions with the government, on issues arguably irrelevant to those raised in the pleadings in this case, would suggest that it will allow these issues to improperly intrude in these proceedings, to "hijack" the proceedings in the language of the cases, I am satisfied that conditions can be imposed on the nature of any

evidence that may be led by the BCAS at the appropriate time in these proceedings.

[8] Accordingly, I would allow the application on the same basis as did Justice Smith in the case of the BC Health Coalition intervenors (see paras. 207-210, 2009 BCSC 1596).

[12] Because of uncertainty as to the scope of the order made in that ruling, the parties attended a Case Planning Conference before Chief Justice Bauman on January 10, 2013, to settle the order.

[13] The relevant portion of the settled order reads:

This court orders that the order of Madam Justice L. Smith dated November 20, 2009, the order of Madam Justice L. Smith dated July 2, 2010 and the order of Chief Justice Bauman dated October 15, 2012 are varied, and the rights of the Patient Interveners, the Coalition Interveners, and the BCAS (together the “Interveners”) to participate in this action as Interveners are as follows:

1. the Interveners
  - (a) will receive copies of all pleadings, submissions and lists of documents exchanged or produced by the parties;
  - (b) may apply for access to specific documents from the list of documents exchanged or produced by the parties;
  - (c) may apply to participate in any cross-examination on affidavits;
  - (d) may submit evidence at the hearing of this action in a form and with such limits as are determined by the court;
  - (e) may submit legal argument at the hearing of this action in a form and with such limits as are determined by the court;
  - (f) may apply to participate in examinations for discovery.

[14] BCAS contends that it is alive to the restraints put on Interveners’ participation in an action by the pertinent authorities and that it has no interest in hijacking the case from the parties. BCAS does not propose to call any expert or *viva voce* evidence, but would submit any affidavit evidence allowing for cross-examination as may be necessary in a manner equivalent to the Patient Interveners. Dr. Orfaly noted that BCAS has not applied to participate in examinations for

discovery or to cross-examine. He submits that BCAS has a valuable perspective and evidence to bring, and ought to be allowed to contribute to the evidentiary record.

[15] In his affidavit supporting BCAS' application, Dr. Orfaly deposed at paras. 18 to 26:

- 18) I have reviewed the pleadings for this case and believe my background and knowledge - both as a physician practicing as a specialist anesthesiologist in British Columbia, and as Executive Director of the BCAS - would provide the Court with valuable information and perspectives on these important constitutional and public interest issues.
- 19) As affiant of the intervener, I intend to provide the Court with substantial evidence that the Government of BC has failed and continues to increasingly fail to meet the public interest in its administration of the health care system,
- 20) I intend to provide the Court with evidence that administrative data has been manipulated in a significant way, so as to provide less than a fair picture of the public health system's failure to meet the needs of British Columbians,
- 21) I intend to provide the Court with evidence that despite growing surgical waitlists, there are many closed operating rooms in B.C., and that budgeting decisions (such as forced operating room closures, and administrative bans on nursing overtime) have resulted in added inefficiencies and cancelled surgeries, and a rationing effect on surgery wait times.
- 22) I intend to provide the Court with evidence that the Government of BC abandoned the AJRC process and the consensus recommendations which would have resulted in a more efficient health care system and shorter wait times for patient care,
- 23) While the availability of anesthesiologists is critical to the delivery of all surgical services, I intend to provide the Court with evidence that the Government of BC has been aware for at least the last eight years that a shortage of anesthesiologists was further rationing patients' access to necessary surgeries.
- 24) I intend to provide the Court with evidence that the Government of BC has otherwise acted against the public's interests - both in the manner of managing large sums of taxpayer funds which are spent by the Ministry of Health, and in denying British Columbians timely access to quality care.

- 25) The issues that are raised in these proceedings are important ones, not just from a legal perspective, but also from the personal health perspective of all members of our society. The outcome will have a direct effect on the members of the BCAS.
- 26) The outcome of these proceedings will be of significant public interest. The BCAS does not have an official position concerning the relief sought in the Plaintiffs application. The BCAS, however, has significant information about the current health care system, and particularly concerning surgical wait times, which would be of assistance to the Court in making determinations related to the public's interests.

[16] A threshold question is whether Chief Justice Bauman's order of January 10, 2013, grants the three Intervenors the right to adduce evidence at trial, subject of course to the Court's determination of the limits to and the form of the evidence, or whether the order contemplates the Intervenors requiring leave to adduce any evidence at all.

[17] That question arises because the plaintiffs contend that as the context of the proceedings changed, so did the Court's approach to and orders governing the participation of the three Intervenors. The plaintiffs submit that an important part of the change in context is that the Patient Intervenors initially launched a petition seeking to compel the Ministry to enforce the *MPA* against the plaintiffs. That action was ultimately stayed by Smith J. in November 2009 as part of the application in which the Coalition Intervenors were granted Intervenor status. Since then, and since the Patient Intervenors were granted Intervenor status in July 2010, the plaintiffs contend that the action has developed significantly, to the point where the parties have set aside 18 weeks for trial and between them have in excess of 35 expert witnesses, five for the plaintiffs and 30 for the defendants. The plaintiffs say that Chief Justice Bauman's variation of Smith J.'s orders and his own order of October 15, 2012, has the effect of requiring the Intervenors to apply to adduce evidence. In other words, the plaintiffs argue that Chief Justice Bauman's order of January 10, 2013, does not convey on the Intervenors the right to adduce evidence.

[18] The plaintiffs contend that when Smith J. made the original orders granting Intervenor status to the Coalition Interveners in 2009 and the Patient Interveners in 2010, the action was not sufficiently advanced between the parties to assess the required degree of the Interveners' participation, but because the Patient Interveners lost their status as a party through the stay of their petition, the circumstances required granting them the right to adduce evidence. The plaintiffs contend, however, that with the development of the case and the contemplation of a full evidentiary record created by the parties, the context has changed and Bauman C.J.'s order of January 10, 2013, requires an application for leave to adduce evidence at all, not merely to determine the form and the limits of the evidence to be adduced.

[19] Having read Smith J. and Bauman C.J.'s judgments granting the Interveners status, and the settled order relating to those judgments, I am satisfied on this threshold issue that the latter order gives the Interveners the right to adduce evidence, subject of course to the court's determination of the form of and limits to that evidence.

[20] In relation to the Coalition Interveners, it is clear that Smith J. declined to determine the issue of leading evidence "until the proceedings are further advanced and until it is better known what evidence the parties themselves intend to bring forward" (2009 BCSC 1596 at para. 208).

[21] In relation to the Patient Interveners, Smith J. ruled that: "they should be permitted to submit evidence as well as legal argument in this proceeding. This is for two reasons. First, it appears that they will be able to bring forward evidence that would enhance the evidentiary record. Second, if their petition had not been stayed, they would have been able to lead such evidence in that proceeding. Their submissions of evidence and legal argument will be in a form and with such limits as are determined at a later stage" (2010 BCSC 927 at para. 49).

[22] In relation to the BCAS, it is apparent that Chief Justice Bauman initially ruled that BCAS participation should be subject to the same constraints as the Coalition

Intervenors; that is to suspend any determination of their right to call evidence “until the proceedings are further advanced and it is better known what evidence the parties themselves intend to bring forward” (2012 BCSC 1511 at para. 8).

[23] When counsel could not agree on the effect of Chief Justice Bauman’s ruling, it was revisited at a Case Planning Conference on January 10, 2013. That ruling and Smith J.’s two earlier orders were varied to provide, among other things, that BCAS “may submit evidence at the hearing of this action in a form and with such limits as are determined by the court.” That portion of the order is consistent with language used by Smith J. in granting the Patient Intervenors permission to submit evidence.

[24] Other portions of the January 10, 2013, order varied Smith J.’s order in relation to the Patient Intervenors. Each of the November 20, 2009, July 10, 2010 and October 15, 2012, orders were “varied” by the January 10, 2013, order, although not in the same way. What is clear, however, is that the orders made in relation to the Coalition Intervenors and BCAS were varied to make them consistent with the order permitting the Patient Intervenors to call evidence, albeit “in a form and with such limits as” determined later.

[25] Thus, I conclude that although each of the Intervenors has already been granted leave to call evidence, the task that confronts me is to determine whether the evidence that each Intervenor proposes to adduce meets the criteria for admission or falls beyond the permissible limits of an Intervenor’s participation in this action.

[26] In response to the BCAS application, the plaintiffs submit that to allow the BCAS to adduce the evidence it seeks would substantially encumber a “full and heavy record”, would prejudice the conduct of the trial, and would expand the proper role of an Intervenor. The plaintiffs say the proposed evidence would widen the lis between the parties, add cost to the proceedings, and delay and complicate them. The plaintiffs say that what BCAS proposes to adduce appears quite substantial and while there may be some relevance to it, there are other ways of addressing the issue. The plaintiffs’ submissions focused on the changing context of the

proceedings since Bauman C.J. heard the BCAS application for Intervenor status and settled the order. The plaintiffs say they are facing very substantial evidence to be called by the defendants, including approximately 30 expert witnesses, and they should not have to contend with substantial new evidence and issues at the instance of Intervenors whose participation should be limited. As to BCAS' application to make oral submissions at trial, the plaintiffs contend it is simply premature to decide that issue at this stage. The plaintiffs did not oppose no costs being awarded in BCAS' application to adduce evidence, but were opposed to an order that no costs be imposed against BCAS in respect of the proceedings as a whole in any event of the cause, if they were to adduce evidence. The plaintiffs submit that leaving the question of costs open at this stage is consistent with Bauman C.J.'s order of January 10, 2013, that "[a]ny order as to costs shall be at the direction of the trial judge."

[27] The defendants agree that it is premature to make any order as to oral submissions. They contend that Bauman C.J.'s order clearly permits the Intervenors to adduce evidence (as I have concluded) and do not oppose BCAS adducing evidence. Rather, they submit that the issue is what limits should be imposed on the evidence to be adduced and argue that on the present state of the record it is impossible to know what the proposed evidence to be adduced will consist of, either quantitatively or qualitatively.

### **CONCLUSION - BCAS**

[28] I accept both parties' submissions that it is premature to consider or resolve the question of whether the Intervenors should be permitted to make oral submissions. I also accept the plaintiffs' submission that it is premature to resolve the issue of costs in relation to the Intervenors, except insofar as this application is concerned, in which I order no costs in any event of the cause.

[29] I reviewed the BCAS application and Dr. Orfaly's affidavit filed in support. The focus of the proposed evidence appears to be on deficiencies in the manner in which the BC Government administers the provincial health care regime, leading to

shortages of human and physical resources, increased surgical wait times, and mismanagement of taxpayer funds. Dr. Orfaly deposes at paragraph 26 of his affidavit that “The outcome of these proceedings will be of significant public interest. The BCAS does not have an official position concerning the relief sought in the plaintiffs’ application. The BCAS, however, has significant information about the current health care system, and particularly concerning surgical wait times, which would be of assistance to the Court in making decisions related to the public’s interests.”

[30] The difficulty which arises from the BCAS’ application is that it appears to contemplate a very substantial body of evidence about the BC health care regime. Dr. Orfaly’s affidavit describes six very broad areas of evidence which BCAS proposes to adduce. I am unable to determine from the BCAS’ materials anything about the quantity or quality of evidence to be adduced. Does it involve 1 witness or 20? Does it involve anesthesiologists’ personal experiences or compendious reports or studies? Is there a significant body of documentary evidence to be adduced? If so, what sources of documents are to be relied on and what evidentiary value do they have? There is simply no way of gauging the potential impact on the upcoming trial of permitting the BCAS’ prospective evidence to be adduced without limits. At the same time, without knowing more about what is contemplated, it is not possible to know what limits can usefully or effectively be placed on the evidence.

[31] The materiality of the evidence appears to be that the cause of long surgical wait times, which the plaintiffs attribute to the impugned legislation, may have another cause and another solution. However, it is very difficult for the parties to assess or address the utility of the proposed evidence against its impact on the trial so as to enable a hearing on what form it should take and how it should be limited. I thus adjourn the BCAS’ application with a direction that it provide to the parties and the Court a synopsis of the evidence it proposes to call. The synopsis should include an indication of the number and identity of witnesses, a summary of the evidence to be deposed by each witness, a description of any documentary evidence to be relied on, including any reports or studies, and a summary of what issue or issues it is anticipated the evidence will address.

[32] While I recognize this direction places a burden on the BCAS, it is clear that evidence that duplicates or merely corroborates other evidence should not be permitted. Moreover, some understanding of the nature and extent of the evidence proposed is necessary to ensure it is relevant. It is also necessary to ensure that the prospective evidence is not such as to “take the litigation away from those directly affected by it”: *Canada (Attorney General) v. Aluminum Company of Canada Ltd.* (1987), 10 B.C.L.R. (2d) 371, 35 D.L.R. (4th) 495 (C.A.). Put shortly, the Court needs to have a greater understanding of what the BCAS proposes before determining what, if any, limits should be placed on it. The synopsis I have directed should be provided by June 30, 2014.

### **THE COALITION INTERVENERS**

[33] The Coalition Intervenors, supported by the defendants, seek to adduce six expert reports.

[34] The first expert is Scott Sinclair, “an expert in international trade law who has written extensively about the impact of Canada’s international trade obligations on health care policy and law in Canada” (Adam Lynes-Ford’s affidavit, sworn April 1, 2014, at para. 10). His proposed evidence concerns “the risks that are presented by amendments to Canadian law that might facilitate the privatization of health care services by allowing for greater private investment in the delivery of health care services, and/or private insurance for such services” (Mr. Lynes-Ford’s affidavit at para. 12).

[35] The second expert is Marie Claude Prémont, an expert in health care and law, with particular knowledge of Quebec law and regulation as it applies to the “delivery of physician and hospital services” (Mr. Lynes-Ford’s affidavit at para. 15). She was “retained to describe and comment on the reforms implemented by the Province of Quebec following the decision of the Supreme Court of Canada in *Chaouli v. (Attorney General)* 2005 1 S.C.R. 791...” (Mr. Lynes-Ford’s affidavit at para. 17) She is expected “to describe the extent to which these reforms affected the essential features of a health care system that accords universal access to

comprehensive physician and hospital services according to a patient's need, not her or his ability to pay" (Mr. Lynes-Ford's affidavit at para. 17)

[36] The third expert is Dr. David Himmelstein, a professor at the CUNY School of Public Health at Hunter College and a visiting professor of medicine at Harvard Medical School who will prepare a report describing "the similarities and differences between the Canadian and American health systems" and describing "the potential impact of facilitating the type of privately funded and privately insured health care the plaintiffs are advocating ..." (Mr. Lynes-Ford's affidavit at para. 22). He would also describe "the importance and influence of U.S. based health care insurance companies and service providers in an increasingly integrated North American economy in the event that greater opportunity for private investment in the Canadian health sector arises along the lines promoted by the plaintiffs" (Mr. Lynes-Ford's affidavit at para. 23).

[37] The fourth expert is Jim Stanford, an economist and the director of Economic, Social and Sectoral Policy for Unifor who would prepare a report describing:

- i. The importance of Canada's 'single payer' health care system to its industrial and manufacturing economy and to Canadian international competitiveness.
- ii. The role that negotiating health insurance plan benefits plays in the collective bargaining process and the potential impact of expanding private insurance coverage for health care services on labour/management relations in Canada.
- iii. The importance of Canada's publicly funded health care system to social and distributive equity.

[Mr. Lynes-Ford's affidavit at para. 30]

[38] The fifth expert is Dr. Robert Woollard, who is a physician with 35 years of experience practicing in British Columbia and as well is a tenured professor at the University of British Columbia, Faculty of Medicine. He would "address the potential effect of increased privatization on the medical education system, and the values of the physicians who are being educated for future practice ...". His evidence would focus on:

1. the lesser inclination of physicians practicing in private clinics to participate in the education and training of students;
2. the increased likelihood of students and physicians being drawn to more affluent communities where an extra premium for care may be charged;
3. the greater challenge in persuading medical students to become family doctors; and
4. the potential erosion of the “value of professionalism” which underlie a willingness to serve the needs of all regardless of where they live or their income.

(Mr. Lynes-Ford’s affidavit at para. 34).

[39] The sixth expert is Dr. Duncan Etches who is also a practising physician of long-standing, a clinical professor at the University of British Columbia, and the director of the BC Women’s Hospital Family Practice Centre. He proposes to provide evidence of the impacts “privatization” would likely have “on physicians who remain committed to the medicare model and who will continue to provide services to patients according to their needs, rather than their ability to pay.” The impacts include:

1. an increase in the administration and cost of conducting medical practices because of dealing with a number of health care insurance providers (a multi-payor system);
2. the challenges of arranging timely referrals for patients who cannot afford to pay for the medical services they require because of gaps created by physicians opting to do private work;
3. maintaining a “balanced roster of patients” because of the “cream-skimming” effect of a public/private system – in which easier more remunerative work is coveted by physicians doing private work while the more arduous but less profitable work is left to the public system.

(Mr. Lynes-Ford’s affidavit at paras. 39-40).

[40] The Coalition Interveners take the position that this expert evidence is not duplicative or merely just corroborative of the evidence to be called by the defendants. Rather, they assert that it is probative of both the issue of whether the

impugned provisions breach s. 7 of the *Charter* and, if so, whether the provisions are saved by s. 1 of the *Charter*.

[41] The defendants consent to this expert evidence being adduced, and take the position that it is relevant and neither duplicative nor merely corroborative. They agree with and adopt the Coalition Interveners' argument.

[42] The plaintiffs resist the Coalition Interveners' application on the grounds that the proposed evidence is either not relevant to the lis between the parties, expands the lis, or is either duplicative or merely corroborative of the evidence to be tendered by the defendants. The plaintiffs also submit that to allow the evidence engages significant complexity costs and will potentially delay proceedings. They point out that the defendants already have about 30 expert reports which they intend to adduce in evidence. If the Coalition Interveners are permitted to advance their experts, the plaintiffs will then need to respond to about seven times as many expert reports as they intend to submit themselves. They contend that to review, assess and respond to the Coalition Interveners' reports at this relatively late date places a significant burden on them, and in view of the issues of relevance and duplication it would be prejudicial to compel that result.

[43] The plaintiffs take issue with the Coalition Interveners' contention that the expert reports are relevant. They submit that Interveners should not be able to take away the litigation from the parties citing *Ward v. Clark*, 2001 BCCA 264 at para. 6, which quoted from *Canada (Attorney General) v. Aluminum Company of Canada Ltd., supra*. They contend that the Coalition Interveners were granted the right to adduce evidence at an earlier stage in the proceedings before a fuller understanding of the evidentiary record was available.

[44] They further contend that the essential defence to the plaintiffs' action is that the impugned legislation enforces the precept that need, not the ability to pay, is the organizing principle of the health care regime in Canada, and that that legislative objective either militates against finding a s.7 or s. 15 breach or justifies a breach under s. 1 of the *Charter*. The plaintiffs say the scope of the defence is shaped by

the pleadings, which do not raise any issue of the collateral benefits (to international trade or collective bargaining) as an objective behind the impugned provisions and, accordingly, Mr. Scott's evidence of the risks that amending the law to facilitate privatization of health care poses for constraining "policy program and regulatory options" available to the Government of British Columbia is irrelevant and beyond the lis between the parties. Similarly, the plaintiffs say that Mr. Stanford's evidence on the implications of a change in the health care system to Canada's "international competitiveness" and its industrial and manufacturing economy, as well as for labour management relations in Canada, is irrelevant. The plaintiffs say, in effect, that it is the objectives of the impugned legislation that determine its constitutional validity, not its collateral or unintended effects.

[45] The plaintiffs also submit that Dr. Himmelstein's proposed evidence concerning the United States health care system and its comparison to Canada, as well as the potential cost of such a system in Canada, is irrelevant as the plaintiffs are neither advocating for any specific health care regime nor one akin to the US health care system.

[46] The plaintiffs say that Professor Prémont's proposed evidence is essentially duplicative of the defendants' expert Damien Contandriopoulos, an assistant professor in the Faculty of Nursing at the Université de Montreal, who has sworn two affidavits, one of which describes the impact of *Chaouli* on questions of access to and the equity of health care services.

[47] Although the Coalition Intervenors contend Professor Prémont brings a different prospective to the issue, the plaintiffs say that can always be said about evidence that is duplicative or merely corroborative.

[48] The plaintiffs produced a book of excerpts from the defendants' expert reports which they say illustrate the duplication inherent in some or all aspects of the expert reports proposed by the Coalition Intervenors.

[49] The plaintiffs also contend that the defendants' experts, Dr. Dennis Kendel and Professor Iy Bourgeault, address essentially the same concerns/issues as those which Dr. Woollard raises as to "the potential effect of increased privatization on the medical education system and the values of the physicians who are being educated for future practice."

[50] They compare Dr. Etches' evidence as to the likely effect of "privatization on physicians who remain committed to the medicare model and who will continue to provide services to patients according to their needs rather than their ability to pay" with the evidence of the defendants' experts, Dr. Kendel and Professor Colleen Flood. Professor Flood expressly describes the partial focus of her expert report as "the conflict of interest that arises when physicians have obligations to both the public system and to private patients", concerns about access to health care for those left within the public system, and the quality of those services due to professionally induced demand for private services and "cream-skimming".

[51] The plaintiffs also submit that some aspects of Dr. Himmelstein's proposed evidence is duplicative, citing Dr. Kendel's opinion, who specifically addresses the US health care regime as a comparator and Dr. Robert McMurtry who cites and appends an article co-authored by Dr. Himmelstein titled "The High Cost of For Profit Health Care".

### **CONCLUSION - THE COALITION INTERVENERS**

[52] Having reviewed the Coalition Interveners' proposed evidence and the excerpts from the defendants' expert reports, I am satisfied that there is some duplication which needs to be avoided in order to bring the Coalition Interveners' evidence within the limits established by the case law.

[53] I conclude that Professor Prémont's proposed evidence of health care in post *Chaouli* Quebec is sufficiently broad to admit of various distinct perspectives, including from Professor Contandriopoulos, an opinion filed by the defendants, and potentially Professor Prémont.

[54] In *Mr. Pawn Ltd. v. Winnipeg (City)* (1998), [1999] 2 W.W.R. 521, 132 Man. R. (2d) 211 (Q.B.), Steele J. articulated an approach to granting intervenor status in *Charter* cases at paras. 35 and 36:

35 Depending on the circumstances, it may not be necessary for the proposed intervenor to put forward a substantially different issue. In *Charter* cases, for example, different nuances in argument may be important to be heard, not because they affect the outcome of the case but because they may affect the reasons for decisions and therefore the precedential authority of the case. Where policy issues are being decided within a *Charter of Rights* framework, presentations that provide different perspectives and assist in identifying consequences and ramifications can be especially helpful to the courts.

...Judicial decisions do not only resolve disputes but also provide legal norms that guide future conduct. Their precedential effect, therefore, transcends the discrete dispute before the court and touches the interests of many people who are not connected to the lawsuit. While there are self-imposed limitations on judicial law- making, it remains true that judges make law and, in doing so, determine important social, economic and political issues.... (*Busby, supra*, pp. 385, 386)

36 Yet, no purpose is served by having intervenors duplicate the arguments of the parties. At a minimum, the applicants must be able to show how their submissions will be useful and different from those of the other parties in some way.

[55] Although there is only a bald assertion from Professor Prémont that she “will offer a different and more contextual perspective on post-*Chaouli* health care reform in Quebec”, there is some reason to accept that her evidence will be “useful and different” from that of Professor Contandriopoulos. In my view, however, as Steele J. makes clear in the passage above, there is some burden on the applicant “to show” the utility and distinctiveness of the proposed evidence so as to avoid creating a record burdened with duplicative or merely corroborative evidence. In the event that Professor Prémont’s evidence is not sufficiently useful and different from Professor Contandriopoulos’, the plaintiffs have liberty to apply to have it struck.

[56] I am not similarly disposed towards the evidence of Drs. Woollard and Etches, and that aspect of Dr. Stanford’s evidence touching on the importance of a publicly funded health care system to social and distributive equity. In my view, without commenting on the likely quality of their proposed evidence, at best it provides only minor variations on major themes directly and variously addressed by

the defendants' evidence through Dr. Kendel, Professor Bourgeault and Professor Flood. Therefore it does not meet the criteria of being "useful and different".

[57] I am satisfied that Dr. Himmelstein's does address subjects of relevance to the matters at issue that are not directly or comprehensively addressed by the defendants' experts. The plaintiffs concede that there is no defence expert that compares the US health care regime to the Canadian regime, or that assesses the implications of "an increasingly integrated North American economy" in the event of greater opportunity for private investment in the Canadian health sector.

[58] In my view, opinions on those subjects may contribute to the evidentiary record and could potentially affect the precedential authority of the ultimate decision. Accordingly, this evidence should be permitted.

[59] The issue with Mr. Sinclair and Dr. Stanford's evidence is relevance not duplication. As I understand the plaintiffs' argument, they say this evidence does not relate to any defence that naturally arises from the pleadings or the asserted purpose of the impugned legislation, which the defendants describe as:

... to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay. (paragraph 11 Response to Third Amended Civil Claim).

[60] The defendants also assert that the purpose is:

... central to the preservation of the public health care system and the *Canada Health Act's* principles of universality, comprehensiveness, accessibility, portability, public administration, and sustainability. (paragraph 12 Response to Third Amended Civil Claim).

[61] The defendants' pleadings relating to s. 1 of the *Charter* are found in Part III of the Response to Civil Claim at paragraphs 33 to 36, which read:

33. In the alternative, if the Impugned Provisions constitute a breach of either section 7 or section 15 of the *Charter*, any such breach is a reasonable limit prescribed by law that can be demonstrably justified in a free and democratic society.

34. The Impugned Provisions were enacted in furtherance of the objective of ensuring that access to medical care in British Columbia is based on need and not on individual ability to pay, as set out in paragraph 11 of Part 1 above.

35. The Impugned Provisions are rationally connected to that objective as set out in paragraphs 29, 30 and 47 - 78 of Part 1 above, and impair the rights protected by sections 7 and 15 of the *Charter* no more than necessary to achieve that objective.

36. Finally, the Impugned Provisions do not have a disproportionately severe effect on the persons to whom they apply.

[62] I am not persuaded by the Coalition's submissions that either Mr. Sinclair's evidence or the remaining evidence of Dr. Stanford is relevant. It is clear that the purposes or objectives of the impugned legislation are an important consideration in determining its constitutionality.

[63] What is not clear to me is on what basis or foundation the Coalition Interveners seek to adduce the evidence of Mr. Sinclair or Dr. Stanford which does not deal with the asserted objectives or purposes of the *Medicare Protection Act* in the defendants' response to the third amended civil claim, but rather deals with its effects.

[64] In *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, Dickson J., as he then was, grappled with the submission that the impugned legislation in that case, the *Lord's Day Act*, R.S.C. 1970, c. L-13, was a reasonable limit under s. 1 of the *Charter* because of "the secular justification for a day of rest in the Canadian context" (at 353). In repudiating that argument, Dickson J. held as follows at 353:

The first and fatal difficulty with this argument is, as I have said, that it asserts an objective that has never been found by this court to be the motivation for the legislation. It seems disingenuous to say that the legislation is valid criminal law and offends s. 2(a) because it compels the observance of a Christian religious duty, yet is still a reasonable limit demonstrably justifiable because it achieves the secular objective the legislators did not primarily intend. The appellant can no more assert under s. 1 a secular objective to validate legislation which in pith and substance involves a religious matter than it could assert a secular objective as the basis for the argument that the legislation does not offend s. 2(a). ...

[65] It seems to me that the logical application of these comments in *R. v. Big M Drug Mart* is that any beneficial effects of the impugned legislation which fall outside what the legislators primarily intended to achieve by its provisions cannot be used either to contend no infringement of a *Charter* protected right, or that the infringements are “reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society” under s. 1 of the *Charter*.

[66] In my view, Mr. Sinclair’s proposed evidence regarding the potential consequences of health care privatization in light of Canada’s international trade obligations and Dr. Stanford’s proposed evidence respecting the importance of the legislative regime to Canada’s industrial and manufacturing economy, and the impact of changes to it on labour management relations in Canada, asserts objectives for the impugned legislation that fall beyond what the legislature intended to achieve through the legislation.

[67] The defendants do not contend that the purposes of the impugned legislation or the demonstrated justification for the limits it prescribes have anything to do with Canada’s international trade obligations, its industrial and manufacturing economy, or labour/management relations in Canada. That being so, I conclude the proposed evidence of Mr. Sinclair and Dr. Stanford is not legally relevant or material to the lis between the parties and I decline to permit it.

[68] I order that the expert reports which I have ruled admissible, or provisionally admissible, will be exchanged by June 30, 2014.

### **THE PATIENT INTERVENERS**

[69] In my view, despite the plaintiffs’ submissions to the contrary, the Patient Interveners have established a foundation to adduce evidence as to their “perspective on the issues, as patients who have had involvement with privately delivered health care and who support the constitutionality of the *MPA*.” (2010 BCSC 927 at para. 48).

[70] As already noted, Smith J. granted the Patient Interveners status in July 2010 for two reasons: first, because she concluded their evidence would enhance the evidentiary record; and second, because had their petition proceeded instead of this action, they would have been able to lead such evidence.

[71] In my view, although this case has progressed since July 2010 as the plaintiffs argue, there is nothing to suggest that either of the rationales cited by Smith J. have been overtaken by events. The Patient Interveners have evidence to give that is unique to their experiences in the private health care regime and, as with the plaintiff patients, their evidence will assist in understanding what the advantages and disadvantages a dual health care system might be.

[72] I do not, however, see how evidence of a former Chair of the Medical Services Commission regarding the role and functions of the Commission could be anything but duplicative of what the defendants will adduce in evidence and I will not permit it.

[73] In my view, the Patient Interveners' evidence should be in affidavit form and each affidavit should not exceed six pages. Counsel for the Patient Interveners indicated that she anticipated eight to 12 witnesses. I would limit the number of Patient Interveners' witnesses to that number. The affidavits filed under the style of cause of other earlier actions may be adduced.

[74] I agree with both parties' submissions that it is premature to determine whether the Patient Interveners should be permitted to make oral submissions, and I decline to make any order in respect of that application at this time. The Patient Interveners' evidence shall be provided to the parties by June 30, 2014.

“A.F. Cullen ACJ.”

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Associate Chief Justice Cullen