



Health Services Preferential Access Inquiry – Alberta

The Hon. John Z. Vertes, Commissioner

Volume 1: Inquiry Report

August 2013

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**HEALTH SERVICES  
PREFERENTIAL ACCESS INQUIRY**

August 21, 2013

The Honourable Gene Zwozdesky  
Speaker of the Alberta Legislative Assembly  
Legislative Assembly of Alberta  
Edmonton, Alberta

Dear Mr. Speaker:

I have inquired into the issues identified in Order in Council 80/2012 (as amended by Order in Council 40/2013) and respectfully submit my report to you.

Hon. John Z. Vertes  
Commissioner



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## Executive Summary

### Introduction – Origins of this inquiry

The Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services without regard to one's ability to pay for those services. Equitable access involves ensuring that patients who have the same medical conditions have the same opportunity to access the same services.

Still, there exists a pervasive belief that Canada has a two-tiered health care system, where advantage is secured, not necessarily through wealth, but through connections or status. In short, some believe that others get faster access to health care for reasons other than medical need. This perception is likely widespread, but evidence showing the existence of a two-tiered system is largely anecdotal. Nonetheless, this perception corrodes faith in the claim that Canadian health care is premised on equitable access.

The Alberta government established the inquiry under the *Health Quality Council of Alberta Act* in February 2012. The inquiry's terms of reference ordered it to consider the following:

- 1) Whether improper preferential access to publicly funded health services is occurring; and
- 2) If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Several events precipitated the call for this inquiry. In June 2011 Alberta media reported claims by the former Chief Executive Officer of Alberta Health Services (AHS), Dr. Stephen Duckett, that some of his predecessors had designated "go-to guys" who would manipulate wait lists for medical procedures. The media also referred to a 2009 document distributed to senior AHS executives claiming that it was "not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for 'prominent' individuals or the family and acquaintances of 'prominent' people."

## Executive Summary

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The media also cited claims by Dr. Raj Sherman, MLA for Edmonton-Meadowlark and an emergency room physician, that it was common for rich and well-connected Albertans to jump wait lists for medical care. He was quoted as saying that he personally received requests from hospital executives for certain patients to get preferential treatment.

The allegations of these individuals and the claim that it was not uncommon for senior executives to receive requests for expedited care proved to be unfounded. However, the inquiry's terms of reference called on it to explore any preferential access that may be occurring within the health care system. The inquiry did in fact learn of incidents of improper preferential access and also identified several systemic issues that could foster an environment conducive to such improper access.

This inquiry was able to examine only one small corner of Alberta's complex health care system. Even for this limited review, Commission counsel interviewed more than 150 individuals. The inquiry received hundreds of emails, letters and telephone calls from the public. In total, 68 witnesses testified and the inquiry received 172 exhibits. Ten parties presented written submissions at the end of the hearings. Still, the inquiry's findings must not be taken as findings about the system as a whole.

While this inquiry uncovered instances of improper preferential access, it did not find specific evidence that anyone had been medically harmed as a result. It would be almost impossible in any event to show that giving one person improper preferential access directly harmed another – that is, short of actually seeing a patient bumped to make way for someone with the right connections.

The more significant question is whether improper preferential access causes harm to the principles underlying publicly funded health care in Alberta.

### **Preferential access – a definition**

This inquiry has focused on actions that lead to preferential access that is improper within the context of the Canadian health care system. Yet a recurring theme throughout this inquiry has been the lack of an accepted definition of improper preferential access. Hence, there is a need to explain preferential access and the meaning of improper.

Normal access involves physicians using their professional judgment to prioritize patients based on medical necessity. This is not preferential access.

Preferential access is a type of access that, for the patient, is advantageous to that warranted by medical necessity. Whether such preferential access is proper or improper requires an examination of the specific context in which it occurs. Improper preferential access is any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining priority access over others similarly situated. For an act of preferential access to be improper, there is no need to demonstrate actual harm. First, harm would be impossible to prove. Second, if it is improper, harm can be assumed – harm to the health care system, to its fairness, predictability and efficiency, to the public’s confidence in its integrity, and harm through reinforcing the improper behaviour by its example to others.

**Socially justifiable preferences:** There may be tolerance within society for certain types of preferential access. However, the public needs to be involved in determining what is tolerable. This will help the provision of health care become better aligned with societal values.

The public may, for example, accept preferential access for leaders of the government. Similarly, there may be broad acceptance of preferential access of patients enrolled in research protocols. Public tolerance for providing preferential access to athletes or other celebrities may not be as great.

An individual’s or profession’s social utility may also be a factor in determining whether preferential access is publicly acceptable. A good argument can be made that in urgent circumstances, such as a pandemic, front-line health care workers should be inoculated first, along with their families, on the theory that sick family members would compel the health care workers to leave their duties to care for the family members. Similarly, in civil emergencies, police and firefighters should be given priority. Such preferential access would not be regarded as improper.

Determining whether preferential access is proper for those providing some other types of essential services is more challenging. There must be a clear definition of what constitutes an essential service, and in what circumstances. This can only be achieved when health care

professionals and administrators, government officials and the public collaborate in setting this definition.

### **Queue-jumping and multiple entry points**

There are multiple entry points into the health care system, each with its own opportunities for preferential access. Circumstances that constitute improper preferential access in one situation may not be improper in another. The following examples demonstrate that there are many ways to access the health care system and, more significantly, that preferences are built into the system.

**Workers' compensation:** The *Canada Health Act* and the *Alberta Health Care Insurance Act* exclude from the definition of insured services those services that a person is entitled to under federal or provincial workers' compensation legislation.

There is no doubt that this practice amounts to preferential access. The exclusion of people entitled to receive workers' compensation benefits is only one of a long list of exclusions contained in the regulations enacted by the Alberta government and all other provinces and territories. Residents of Alberta who fall within one of the excluded categories can receive preferential access to services through payment for those services because of their occupation or, as with workers' compensation claimants, the circumstances in which their injury or illness arose. Whether this distinction is proper is a matter of public choice, expressed through elected representatives.

**Private diagnostic imaging:** A person who pays for diagnostic imaging at a private facility, instead of waiting for the same service through publicly funded channels, can receive a prompt diagnosis. If the diagnosis indicates a need for treatment, that person can immediately step into line for treatment. The person waiting for a diagnosis through the publicly funded system cannot step into that line for treatment, since he or she has not received a diagnosis. By circumventing the long wait for diagnosis, a patient who steps outside the public system for diagnosis obtains preferential access to treatment when he or she rejoins the public system.

The proliferation of private diagnostic services poses a true ethical dilemma in the context of access to health care. It undermines the principles of fairness and equity in access to health care and provides

an advantage to those who can pay for this service. On the other hand, the practice is not illegal. It is accepted by governments and by physicians' regulating bodies. Physicians may even have an ethical and legal obligation to advise a patient of the private option where they consider it to be in the medical interests of the patient and there is delay in obtaining the service in the public system.

There is no correct answer, practically or ethically, in the debate over the role that private diagnostic services play in permitting preferential access. It is a question for public discussion to define what is acceptable.

**Medical tourism:** Medical tourism means going out of the country for services or tests that patients could obtain in Canada but choose to pay for and get faster elsewhere. If patients pay for treatment abroad and that treatment leads to complications, they can then return to Canada where they remain entitled to publicly funded health care services to deal with those complications. They cannot ethically or legally be denied treatment or be prioritized on a different basis than others who have completed their entire medical journey in the public health care system here.

Medical tourism does not in itself constitute preferential access. It is only if the publicly funded health care system in Alberta has to respond to the consequences of medical tourism that it could become preferential access. But, because at that point there is medical necessity for the service, it cannot be labelled as improper.

### **Enhancing legislation on queue-jumping**

Section 3 of the *Health Care Protection Act* prohibits financial incentives “for the purpose of giving any person priority for the receipt of an insured surgical service.” The statutory prohibition only applies to giving priority to insured surgical services. There is no legislation or policy governing queue-jumping when no material benefit is offered. Furthermore, the prohibition does not extend to all insured health services.

**Recommendation 1:****Strengthen the queue-jumping provisions of the *Health Care Protection Act***

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith.

**Physician advocacy and ethics**

Advocating within the health care system for individual patients is a basic function of a physician. Besides this primary responsibility to the patient, physicians also have a responsibility to “consider the well-being of society in matters affecting health” and specific duties to “promote equitable access to health care resources,” provide services without discrimination on a number of grounds, including socioeconomic status, and “use health care resources prudently.”

Ethical advocacy, that being advocacy to ensure that patients receive the care that is due to them based on their medical needs, cannot be regarded as facilitating improper preferential access. It is the proper role of the physician. However, not all physicians are equally adept at this complex exercise, with its competing ethical responsibilities.

Education about ethical advocacy and development of clear guidelines will go far towards eliminating the circumstances that may lead to improper preferential access. In addition, the government’s recently enacted whistleblower legislation would help if it were extended to protect independent contractors such as physicians or other health care providers. This would help protect them when they speak out about resource or policy issues or challenge improper procedures.

## **Recommendation 2:**

### **Expand whistleblower protection**

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection) Act* to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services.

## **Professional courtesy**

The inquiry heard evidence about professional courtesy, a practice where physicians in particular give priority to requests for care by other physicians, health care workers and their families. Professional courtesy produces a form of preferential access.

In Canada, professional courtesy has come to mean seeing a colleague or their family member more quickly than would occur if they were a typical patient. This is done by seeing them before or after the treating physician's regular working hours. There is, however, a lack of consensus about how far professional courtesy extends, and to whom.

The inquiry also heard evidence that professional courtesy was being used to justify providing priority access to care for doctors, nurses, and other health care workers and their families in emergency departments. Priority access for health care professionals to emergency department services is improper preferential access, even when calling it professional courtesy. The only exception would be priority access for essential health care workers where failure to give them priority would prevent them from carrying out their duties and would place others in danger. But any such exception should be clearly spelled out in a protocol.

Professional courtesy can and should encompass services by one physician to another physician or to other professional colleagues, such as nurses. This is not improper. However, there is no justification for labelling as professional courtesy consultations conducted as favours for friends or other contacts. Regulatory bodies have a role to play in bringing clarity to the boundaries of professional courtesy.

**Recommendation 3:****Clarify the scope and application of professional courtesy**

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals.

**Wait lists for medical procedures**

The mandate of this inquiry was not to examine wait lists *per se*. However, wait lists and the excessive time people may wait for assessment and treatment can be important motivators for patients to try to expedite access by improper means.

In Canada, wait times are usually measured from the time of the patient's consultation with the specialist to the time of treatment. Canada has one of the narrower measures of wait times among developed countries. If the goal is to reduce the patient's total wait time, looking at the entirety of the patient's period of contact with the health care system would be more appropriate. It should also enable greater co-ordination of care throughout the patient's journey to treatment.

Alberta is tracking, benchmarking and reporting on wait times for a number of programs and services. In addition, the Alberta Wait Time Reporting System was launched on the Alberta Health website in May 2011. That reporting system shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services, as reported by Alberta specialists and facilities.



AHS has acknowledged the need to improve access and reduce wait times. At a minimum, AHS should consider developing a wait time measurement system that takes into account the four principal categories of waits:

- The wait to see a primary care provider;
- The wait for diagnostic tests and examinations;
- The wait to see the specialist after referral by the primary care provider; and
- The wait for treatment.

There should also be a system for tracking procedures and their health outcomes. This data would provide a much more comprehensive and patient-centred picture of the true nature of waits in the health care system.

#### **Recommendation 4:**

##### **Reduce wait times**

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system.

**Wait list management:** In 1998 Health Canada reported that, with rare exceptions, wait lists were non-standardized, capriciously organized and poorly monitored. For some time there has been interest in standardizing data and in coordinating and integrating wait lists. Wait list management should therefore be part of any discussion about equitable access and the potential for improper preferential access.

**Recommendation 5:****Develop and implement wait list management strategies**

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies which include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialties, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital).

**Referrals by physicians:** Patients typically obtain access to specialist physicians and procedures through referrals from primary care physicians. Referrals vary greatly in quality and thoroughness. Specialists use the information provided by the referring physician to prioritize patients on their own wait lists.

Alberta Health Services is attempting to standardize the referral process for each clinical specialty and introduce a system of electronic referrals. Efforts to achieve this should continue, with physicians, program administrators and the public collaborating in all aspects of program design and implementation.

**Recommendation 6:****Develop standardized referral procedures and booking systems**

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be given to service providers about how to use new systems.

**Transparency and accountability:** Decision-making in health care needs to be more transparent to the public, to help the public understand how the system works and its limitations. Better public education about health care options could help alleviate some recurring pressures in the system. Most important, if the public sees that the decision-making criteria in the health care system are fair, transparency can enhance public confidence in the system.

Health literacy is also an issue. A large majority of Canadians lack sufficient health literacy to make appropriate health decisions.

Unlike in several other countries, there is no real accountability in Canada for failing to meet standards for wait times. Many countries have introduced wait time guarantees or sanctions for those health care providers who fail to meet wait time targets. These sanctions and guarantees have produced mixed results. Countries that introduced strong sanctions in conjunction with wait time guarantees had some success in reducing wait times. But there is also evidence that guarantees have led to patients being prioritized improperly.

If there are to be benchmarks for wait times or guidelines for prioritizing referrals, there must also be meaningful tools to evaluate their effectiveness. The public must be part of any discussion about such measures.

Accountability comes in part from appropriate complaint mechanisms. AHS has a process for receiving complaints from patients. The College of Physicians & Surgeons of Alberta also has a formal complaints process about professional conduct issues. The College offers a form of alternative dispute resolution where staff members, called patient

advocates by the College, are available to work with complainants and attempt a satisfactory resolution.

These complaint processes are useful but they are still internal mechanisms and do not provide the type of independent advisory or advocacy services that patients may require. In 2010, the Alberta legislature enacted the *Alberta Health Act*, but the Act is still not in force. The Act provides for the appointment of a Health Advocate to review complaints that a person working in the health care system failed to act in a manner consistent with a Health Charter.

There is merit in considering a system of independent advocates for patients in Alberta. This advocate role would complement efforts at more effective wait list management and assist in achieving equitable access.

**Recommendation 7:****Consider creating the position of Health Advocate**

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints.

**Alleged improper preferential access – case studies**

The inquiry reviewed several possible incidents of improper preferential access. Some pre-dated the creation of AHS in 2008. The inquiry also heard about circumstances and practices that could lead to improper preferential access.

***MLA advocacy***

There was no evidence before the inquiry proving that any MLA used influence or other means to enhance his or her own care or that of family or friends. The inquiry heard about the type of advocacy in fact carried out by MLAs and considers such advocacy an appropriate function for elected representatives. MLAs have a responsibility to

ensure that constituents receive the level of publicly funded service they deserve.

### *Courtesy calls*

The inquiry heard about the alleged improper preferential treatment of so-called VIP patients – politicians, health board members, donors, or their families – as well as two incidents involving the treatment of high-profile athletes. One incident involved Calgary Flames hockey players and their families receiving vaccinations at a private clinic during the H1N1 pandemic in 2009. The other involved an Olympic athlete obtaining urgent radiology services in 2011.

The evidence relating to VIP treatment generally focused on certain practices in the Capital Health and Calgary Health regions before AHS was created. These practices involved courtesy calls – also described as heads-up calls – where someone in the office of the health region CEO would call a senior administrator in a hospital facility or, if it was after hours, the executive on call that day. The caller would pass on information that a certain patient was in the facility or would seek information about the status of the patient.

The examples before the inquiry all related to the period before the creation of AHS. This suggests that this practice was never very common and is even less common now. In addition, the evidence did not reveal any improper preferential access. In no case was there evidence that the VIP who was the subject of one of these courtesy calls actually received expedited or preferential care. Still, the absence of a clearly-defined protocol on how front-line staff are to respond to heads-up calls may lead to misunderstandings.

AHS should develop a policy that clearly defines when such courtesy calls can be made, to whom they can be made and how those receiving such calls should respond to them. The policy should distinguish between calls relaying patient concerns and those alerting staff to the presence of high-profile patients.

**Recommendation 8:****Develop a policy on courtesy calls**

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them.

***The Paula Findlay case***

An Olympic athlete, the daughter of an Edmonton neurosurgeon, was in Edmonton in July 2011 for a World Cup triathlon race. The race was to be held on July 10. On July 7, the athlete had a medical problem that saw her end up at the University Hospital for magnetic resonance imaging (MRI) later that day. Her father became actively involved in arranging for the MRI and in fact wrote the requisition for his daughter to have the MRI. At issue was whether his actions led to improper preferential access to the MRI for his daughter.

The athlete clearly received preferential access over others in one sense, since she had a much shorter wait for an MRI than most people. However, that preference was based on clinical considerations – the potential of a worsened injury if not diagnosed and treated promptly. That placed her in a more urgent category than many other patients. The preference was therefore proper.

***Calgary Flames and the H1N1 vaccine***

In October 2009 a controversy erupted after the media reported that Calgary Flames hockey players and their families had received the H1N1 vaccination at a private facility, avoiding the lineups at the four public vaccination locations in Calgary. This episode is a clear-cut case of improper preferential access since the Flames' players, family and staff avoided the long lineups at the public vaccination clinics.

The Calgary Flames vaccination incident may have been one of a kind. Still, this problem might never have arisen if AHS had a policy on dealing with requests for special accommodations.

**Recommendation 9:**

**Develop a policy on special accommodation during a pandemic**

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation.

*Nurses and the H1N1 vaccine*

The inquiry heard evidence about other issues arising from the H1N1 vaccination program in 2009. Some of it concerned nurses working in the Edmonton area who:

- expedited the vaccination of family members at the public immunization clinics;
- vaccinated individuals after hours;
- vaccinated individuals after the program had been halted; or
- took vaccine home to vaccinate family and friends.

The conduct of the nurses in immunizing family and friends outside of clinic hours and away from clinic premises, and expediting the vaccination of family members at clinics while nurses were on breaks, without permission from superiors, constituted improper preferential access.

*Red Deer immunizations*

The inquiry also heard evidence about possible improper preferential access through the H1N1 vaccination of AHS employees at their place of employment in Red Deer, rather than at a public clinic. About 100 AHS employees worked at the Michener Bend Building in Red Deer. No front-line doctors or nurses worked there, though some of the administrators were nurses. On the lower level of the building was the

Emergency Operation Centre dedicated to helping to coordinate the H1N1 vaccination program in the region.

Staff working in the Emergency Operation Centre received their vaccinations on site, instead of being forced to wait in lengthy lineups at public vaccination clinics. Other AHS personnel in the Michener Bend Building also received vaccinations on site even though they were not involved in emergency operations.

It may have been appropriate to make special efforts to immunize those working in the Emergency Operation Centre on site, but there was no justification for doing so for non-essential administrative personnel. Such vaccinations constituted improper preferential access.

### *Emergency care and triage procedures*

The inquiry heard about possible improper preferential access involving emergency room procedures. It also heard about a practice, referred to as the private patient path, whereby emergency departments were used to facilitate access for some patients.

**Emergency and triage:** When patients arrive at an emergency department, they are triaged and then treated according to the urgency of the care they require.

The limited testimony before the inquiry on this subject did not disclose improper preferential access in emergency departments in Alberta. None of the witnesses provided examples of improper preferential access. The evidence consistently showed that procedures used in emergency departments – and, indeed, the professional culture of emergency personnel – serve to limit the potential for improper preferential access. The instances described, where some patients may have been attended to more quickly than they appeared to warrant, were in fact justifiable on a practical and ethical basis. There was no evidence that giving priority to the patients involved in the incidents described to the inquiry delayed the assessment or treatment of any other emergency patient.

**Private patient path:** The private patient path refers to the practice of physicians directing their patients to the emergency department to see them or another particular physician.



There was no evidence of any policy, system-wide or local within a facility, to regulate this practice. It was not clear from the evidence when the private patient path is acceptable and when it constitutes improper preferential access. It was also not clear why it is necessary or desirable to have a private patient path within the health care system.

An in-depth analysis of the benefits and drawbacks of the private patient path phenomenon would be useful. The analysis must, besides examining procedures, examine the ethical issues that the phenomenon raises.

#### **Recommendation 10:**

##### **Develop policies for the private patient path**

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private patient path and develop appropriate policies for emergency department personnel and physicians.

### *Colon Cancer Screening Centre*

The inquiry heard testimony from 15 witnesses over several days about the alleged preferential treatment of some patients at the Colon Cancer Screening Centre (CCSC), also known as the Forzani & MacPhail Clinic. The CCSC opened in 2008. Its goal was to move screening colonoscopies from acute care facilities to the CCSC. Screening colonoscopies are those done, for example, when a person reaches a threshold age, even if the person has no symptoms suggesting the need for a colonoscopy.

The evidence on this topic was complex. Nevertheless, patterns of behaviour emerged and clearly demonstrated how procedures instituted at CCSC to ensure equitable queues for colonoscopies were bypassed for certain patients. A significant volume of evidence showed that patients of one physician and of one private clinic received much faster screening at CCSC than was the norm.

These patients received improper preferential access to CCSC screening colonoscopies. The lengthy typical waits for routine screenings were bypassed by deliberately marking these referrals as

urgent and booking the earliest appointment possible. This process violated established CCSC booking procedures.

There was no conscious effort by the private clinic's staff and physicians to circumvent CCSC booking practices. However, the end result, regardless of the lack of motive, was that the referrals sent to one physician were booked for screening sooner than the norm. This constituted improper preferential access.

The improper preferential access was facilitated in two ways: (1) by the physician giving referrals directly to an administrative assistant or a booking clerk; and (2) by the manager of the CCSC telling the clerks that arranged patient bookings to give priority to those patients.

**Recommendation 11:****Strengthen access, triage and booking procedures**

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation.

***Policies on improper preferential access***

The inquiry heard evidence that AHS has under consideration a draft policy on preferential access. The policy that eventually emerges should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be

disseminated to the public and health care professionals to make the AHS position clear to all.

### **Recommendation 12:**

#### **Develop a policy on preferential access**

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with Alberta Health Services staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all.

### **Conclusion**

Improper preferential access to publicly funded health services undermines the principles that access to health care should be determined by medical need and that health care should be distributed in an egalitarian manner.

This inquiry has investigated incidents that revealed improper preferential access. These incidents may not be representative of the health care system as a whole. However, they demonstrate the opportunities that may exist within the system for improper preferential access.

The inquiry has also examined various practices that may open up avenues for improper preferential access – such as professional courtesy and what has been called the private patient path. These practices could benefit from a more considered analysis, and policies about them need to be clear.

This inquiry has clearly demonstrated that myriad opportunities exist for improper preferential access. This is because of the multiple ways to access the health care system and the broad discretion regarding

management of wait lists granted to physicians, other health care professionals and administrators.

Several questions remain. Is it realistic to think that measures can be put in place to eliminate improper preferential access altogether? Are there simply too many holes to plug? What will plugging those holes cost? Even if a system could be designed to prevent improper preferential access, what would be the impact on how physicians, hospitals and clinics operate and organize their workloads? There is, after all, merit in maintaining flexibility to meet the differing needs of patients. That is why most of the recommendations of this inquiry promote collaboration among various groups interested in health care to improve policies and guidelines. The literature review conducted for this inquiry found a lack of empirical evidence on the impact of improper preferential access on the health care system as a whole. The inquiry found no evidence that improper preferential access in the cases it examined had led to harm to any patient. What improper preferential access exists in the system – apart from in areas such as workers' compensation cases, where legislation creates a system of preferential access – involves an extremely small percentage of the total cases handled in the public health care system. It is a minor phenomenon in the public health care system.

However, the perception remains that some receive faster access to health care because of status or connections, not medical need. This is just as damaging to confidence in the public health care system as the actual cases of queue-jumping identified in this report. Those who deliver health care must be prepared to challenge the perception as well as address the reality.

## Acknowledgements

I wish to express my thanks to all whose work and dedication were helpful to me as I undertook my inquiry and prepared this report. In addition to those individual experts whose contributions aided me significantly, I would like to acknowledge and thank the following people in particular.

I was fortunate to retain **Sheila-Marie Cook, CVO**, to act as my executive director and Commission secretary. Ms. Cook brought years of experience working with several commissions of inquiry appointed by the federal government. She undertook responsibility for all aspects of our administrative needs. She retained the staff and secured the premises for our work. She served as my principal communicator with personnel in the office of the Minister of Health and with the Health Quality Council of Alberta (HQCA), as well as serving as the main media contact.

I was particularly pleased that Ms. Cook made arrangements with the Department of Policy Studies at Mount Royal University to have two students join our staff as interns. The two, **Pat Quinn** and **Jayeful Islam**, assisted the inquiry in many ways, including providing research assistance.

In the early months of the inquiry I was greatly assisted by two lawyers, **Laura Snowball**, a sole practitioner in Calgary, and **Anne Kirker, Q.C.**, of the firm of Norton Rose Canada. Subsequently, I appointed **Michele Hollins, Q.C.**, of the Calgary firm of Dunphy Best Blocksom LLP, as chief Commission counsel. Assisting her were **Jason Wilkins** as associate Commission counsel and their associates, **Ellen Embury, Ryan Penner, Gordon Sterchi** and **Saarah Shivji**.

The inquiry benefitted greatly from the work of its director of research, **John McGurran**, adjunct professor at the Dalla Lana School of Public Health at the University of Toronto.

In order to comply with the requirement for a budget monitoring system, the Commission retained the services of KPMG Chartered Accountants. Auditors **Sharlene Wilson** and **Maxime Duguay**, of the KPMG Calgary office, provided excellent service to the inquiry.

## Acknowledgements

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I was assisted in the preparation of the report by **Eugene Oscapella**, a public policy consultant and solicitor from Ottawa, who brought to the task his extensive experience working on other commissions of inquiry.

I am also grateful for the assistance provided to me by **Dr. John Cowell**, Chief Executive Officer of the HQCA, and his staff.

By mentioning these people I do not want to minimize the important role played by all the people who worked on the inquiry staff and whose names are listed in an appendix to this report. My task would have been more difficult without their assistance and dedication. Again, I express my gratitude to everyone who helped to fulfill the Commission's mandate.

## SECTION I: INTRODUCTION

### CHAPTER ONE: REASONS FOR THE INQUIRY

Section 17 of the *Health Quality Council of Alberta Act*<sup>1</sup> permits the Lieutenant Governor in Council to order an inquiry concerning a matter relating to the health system when it considers such an inquiry to be in the public interest. This inquiry was established by an order in council issued on February 28, 2012. The inquiry's terms of reference were to consider:

- i. Whether improper preferential access to publicly funded health services is occurring; and
- ii. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

The inquiry's terms of reference did not define improper preferential access or, as it was commonly called during the inquiry, queue-jumping.

#### ***A. A question of access***

The Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services without regard to one's ability to pay for those services. This ideal incorporates the principle that those with the greatest medical need should receive priority access to the system.

When I speak of equitable access, I do not mean equality of access. Both are important concepts, but the distinction between them is also important. I adopt the definitions proposed by one of our expert witnesses, Prof. John Church of the University of Alberta. He defined equality of access as "everybody should have access to health care services."<sup>2</sup> Equity of access he defined as "ensuring that patients who have the same medical conditions have the same opportunity to access the same services." Both equality of access and equity of access are essential pillars of health care in Canada, but the task of this inquiry has

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<sup>1</sup> S.A. 2011, c. H-7.2.

<sup>2</sup> Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3375.

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been to focus on equity – whether some people are getting access, without medical justification, ahead of others similarly situated.

In the 2002 report of the federal Commission on the Future of Health Care in Canada, the Hon. Roy Romanow wrote that Canadians strongly support the core values of equity, fairness and solidarity on which our health care system is premised. He noted that Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth.<sup>3</sup> Yet there exists a pervasive belief that we in Canada have a two-tiered health care system, where advantage is secured not necessarily through wealth but through connections or status. In short, some believe that others get faster access to health care for reasons other than medical need. This perception is likely widespread, but evidence showing the existence of a two-tiered system is predominantly anecdotal.

The belief that some receive publicly funded services faster because of who they are or who they know corrodes faith in the claim that Canadian health care is premised on equitable access. Yet it must also be acknowledged that most people, faced with a serious medical need of their own or of a loved one, would use whatever influence or connection they could to see that need addressed as quickly as possible. This is so even if that means securing advantage – jumping the queue – over others with similar medical needs. That is human nature. And that natural tendency becomes more pronounced if there are long waits for medical attention.

Achieving timely access to care has been a priority policy goal for many years, particularly as the public has become better informed about lengthy wait times for medical procedures that are in great demand. Numerous studies have demonstrated that all provinces, including Alberta, have long wait times for many procedures despite the significant public funds spent on health care.

The *Canada Health Act*<sup>4</sup> states that one of the primary objectives of Canadian health care policy is to facilitate “reasonable access” to health services without financial or other barriers. But if access becomes

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<sup>3</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at xvi.

<sup>4</sup> R.S.C., 1985, c. C-6, s. 3.



unreasonable – or publicly unacceptable – the natural inclination will be to look for ways to bypass that unreasonable and unacceptable situation.

This issue of reasonable access is neither new nor unique to Alberta. For the past decade, *Canada Health Act* annual reports have cited queue-jumping as among the most prominent concerns with respect to compliance under the Act. A 2010 survey of Albertans by the Health Quality Council of Alberta (HQCA) noted that “from the public’s perspective, access – the ease of obtaining health care services – continues to be the most important factor associated with [Albertans’] overall satisfaction with health care services received.”<sup>5</sup> Recent surveys in 11 high-income countries conducted in 2010 and 2011 by the Commonwealth Fund, a private foundation, revealed considerable dissatisfaction among Canadians with numerous aspects of provider access. The 2010 survey also revealed that Canada had among the poorest outcomes in access to a doctor or nurse, wait times for elective surgery or to see a specialist, and the highest reliance on emergency departments for care.<sup>6</sup>

The Commission on the Future of Health Care in Canada spoke about the importance of timely access:

Providing timely access to quality health care services is a serious challenge in every province and territory. Consistently, the Commission heard concerns from Canadians about waiting for diagnostic tests, waiting for surgeries or waiting to see specialists. In the minds of many Canadians, the quality of our health care system should be judged, first and foremost, by its ability to provide timely access to the care people need.<sup>7</sup>

The Supreme Court of Canada referred to accessibility in its 2005 judgment, *Chaoulli v. Quebec*.<sup>8</sup> The Court noted that the *Canada Health Act* does not provide benchmarks for the length of wait times that might be regarded as consistent with the principle of real

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<sup>5</sup> *Satisfaction and Experience with Health Care Services: A Survey of Albertans 2010* (December 2010) at 5.

<sup>6</sup> Gregory P. Marchildon, “Canada: Health System Review,” (2013) 15:1 *Health Systems in Transition* at 57.

<sup>7</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 137.

<sup>8</sup> [2005] 1 S.C.R. 791.

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accessibility.<sup>9</sup> It concluded further that a provincial prohibition on private health insurance in circumstances where the government fails to deliver health care in a reasonable manner and, by so doing, increases the risk of complications and death, interferes with the rights to life and security of the person as protected by section 7 of the *Charter*.<sup>10</sup>

It is not surprising that ordinary people who may be facing long waits for care become upset on hearing that others may have received expedited access. These long waits are exacerbated by the apparent lack of national or provincial standards for managing wait lists, that being left primarily in the hands of the service provider, be it a surgeon or a clinic. And this situation exists with a backdrop of anecdotes that health care professionals are routinely being approached to expedite care for politicians, sports stars, other prominent individuals and relatives of colleagues.

### ***B. The allegations prompting the inquiry***

This inquiry was established primarily as a fact-finding body because of specific allegations that received widespread media and political attention. It is important to restate those allegations at the outset to show the context for the inquiry's work.

The order in council establishing this inquiry did not set out any established facts or specific allegations to justify calling the inquiry. It merely contained the general comment that "allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services." Despite the generality of this statement, the events leading to the establishment of this inquiry give a clear picture of the allegations behind the calling of this inquiry.

In June 2011, Alberta media reported on a speech given by Dr. Stephen Duckett, the former Chief Executive Officer of Alberta Health Services (AHS), at a meeting of senior health officials in Toronto on May 5, 2011. Dr. Duckett spoke about the challenges he encountered in 2009 as the first CEO of the newly-created AHS, an integrated health care system that brought together several formerly separate regional boards

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<sup>9</sup> [2005] 1 S.C.R. 791 at para. 16, Deschamps J.

<sup>10</sup> [2005] 1 S.C.R. 791 at para. 124, McLachlin C.J.C. and Major J.

and health entities. One line in that speech caught the media’s attention: “I’m told some of my predecessor CEOs had designated ‘go-to’ guys for discrete waiting list adjustments on request from MLAs, a practice I discontinued.” The media also reported on a December 6, 2010, speech by Dr. Duckett, shortly after the termination of his appointment with AHS, where he said that his predecessors had “Mr. Fix-its” on staff whose role was to respond to external pressures and sometimes to manipulate wait lists.

These news stories also referred to a memo from Dr. Duckett that had been distributed to senior AHS executives on June 11, 2009. Attached to the memo was a policy document entitled “Requests for Preferential or Expedited Care.” That document contained the following statement under the heading “Background”:

It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for “prominent” individuals or the family and acquaintances of “prominent” people.

These same news stories cited claims by emergency room doctors that, before AHS was created, it was common for rich and well-connected Albertans to jump wait lists for medical care.<sup>11</sup> Dr. Raj Sherman, the MLA for Edmonton-Meadowlark, then sitting as an independent MLA and himself an emergency room doctor, was quoted as saying that he personally received requests from hospital executives that certain patients get preferential treatment.<sup>12</sup>

On February 28, 2011, Dr. Sherman said in the legislature that he knew of about 1,200 Albertans who were on a wait list for lung surgery, and “250 died waiting on that list, many with lung cancer.” He also stated that “physicians who raised these issues were either punished or driven out of the province or paid out in millions to buy their silence.”<sup>13</sup>

On March 12, 2011, the Minister of Health responded by directing the HQCA to examine wait times for emergency department services and cancer care services. This direction was later amended to include a

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<sup>11</sup> M. McClure, Tories in new health scandal, *Calgary Herald*, June 7, 2011; No hospital wait for buddies of Alberta politicians, *CBC News*, June 7, 2011.

<sup>12</sup> No hospital wait for buddies of Alberta politicians, *CBC News*, June 7, 2011.

<sup>13</sup> Legislative Assembly, *Alberta Hansard*, No. 4 (February 28, 2011) at 65 (Dr. Raj Sherman).

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review of the possible intimidation of physicians who advocate in the interests of their patients. The HQCA released a comprehensive report in February 2012. The report concluded that the more inflammatory allegations about 1,200 people on a wait list for lung surgery and 250 people dying were unfounded.<sup>14</sup> The report did not look at preferential access and made no suggestion for an inquiry into the subject. The examination of physician intimidation focused on one aspect of that subject, intimidation directed by governments and governing bodies against physicians who advocate in their patients' interests or in the interests of communities and the population as a whole. It did not, however, examine intimidation of physicians by those attempting to secure improper preferential access to health care for themselves or others.

The controversy generated by Dr. Duckett's statements grew when the leader of the New Democratic Party in the legislature, Mr. Brian Mason, asked the Royal Canadian Mounted Police in June 2011 to investigate the allegations of queue-jumping. Mr. Mason also set up a hot-line and invited people who knew of queue-jumping to call in confidence. Mr. Mason eventually concluded that this exercise generated no information worth pursuing.

In August 2011, the RCMP announced that there would be no criminal investigation. A news article quoted an RCMP spokesperson as follows:

“We were not able to substantiate even a single specific incident of queue-jumping,” Sgt. Patrick Webb said....  
“People talked about it, but no one was able to provide specifics that this actually happened. Anecdotal stories, rumours, are not enough to justify a criminal investigation, criminal charges and court proceedings.”<sup>15</sup>

The opposition parties, however, continued to press for a judicial inquiry, one with a broad mandate. The medical profession called for a judicial inquiry into physician intimidation, something the HQCA

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<sup>14</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 20, 136.

<sup>15</sup> T. Cook, No criminal investigation into queue-jumping in Alberta health care, RCMP find, *The Globe and Mail*, August 10, 2011.

report expressly recommended not be done. In late February 2012, after release of the HQCA report, the government established this inquiry.

Following is a detailed examination of the allegations prompting this inquiry.

### **(i) The Duckett allegations**

Dr. Stephen Duckett was President and Chief Executive Officer of AHS from March 2009 to November 2010.

Commission counsel asked Dr. Duckett about comments he made in a farewell speech to senior AHS personnel on December 6, 2010.<sup>16</sup> Counsel read two paragraphs from that speech. The first paragraph, under the heading *Paradise Lost?*, read:

An early challenge I faced was the issue of AHS legitimacy. When I arrived there were still many (inside and outside AHS) who lamented the demise of the predecessor entities, and they looked back on the good old days when everything was perfect.<sup>17</sup>

The second paragraph read:

This perception that the predecessor entities were perfect was achieved by aggressive media management, restricting transparency, ducking key commentators, and in some former entities, by having a “Mr. Fix-it” whose role was to respond to external pressures, including manipulating waiting lists. Unfortunately for me, these strategies were not consistent with either my values or those of AHS.<sup>18</sup>

Commission counsel asked Dr. Duckett to explain what he meant by a “Mr. Fix-it.” He said:

So some of the – the larger entities, and in particularly in my mind was Capital Health, had a person in the CEO’s office who was sort of a go-to person, a single point of contact, if you will, for dealing with MLAs or prominent people, I guess,

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<sup>16</sup> Exhibit 21.

<sup>17</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 288.

<sup>18</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 289.

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sometimes to fix problems. And the problems to be fixed might involve – could range across a range of areas but included preferential access is my – is what people told me. So that’s what I was referring to.<sup>19</sup>

Counsel asked who he understood filled that role in Capital Health before the amalgamation. Dr. Duckett said it was Mr. Brian Hlus.<sup>20</sup> Counsel asked, “And who told you that Brian’s role included arranging for preferential access?” Dr. Duckett responded:

The number of people who told me about those sorts of roles and who told me, for example, that I should have someone who did those things, that it was to fix practically anything. So it was a criticism of me that fix-it people weren’t kept in the organization.<sup>21</sup>

Counsel asked, “And who levelled that criticism?” Dr. Duckett said, “A number of MLAs, but amongst others that I recall is Raj Sherman.”<sup>22</sup>

Counsel then asked, “You’ve said that Dr. Sherman and other MLAs registered complaints with you for having done away with this fix-it role, as you’ve described it. But you also said that people had told you about the range of services provided by these fix-it people, which included, to your understanding, arranging for preferential care. Who were those people that told you that that position had included that kind of conduct?” Dr. Duckett said:

So I had discussions with a number of senior leaders within AHS over the time about how the previous organization was working and didn’t work. Also, as I said, there was a lot of criticism of the lack of clarity of the organizational structure and there was a lot of – especially from MLAs who said, you know, they don’t know who to go to. So I wanted to find out what was it that they went to people about. And, in general, it was about changing priorities. And the change in priorities might be all sorts of priorities. It might be they want me to spend more money on this rather than that, or it might be that there were particular people who were having problems

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<sup>19</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 289.

<sup>20</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.

<sup>21</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.

<sup>22</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 290.

getting access to the system. And that sort of example was given to me a few times, but I cannot tell you precisely which of the internal people in AHS were giving me that sort of information, nor can I tell you the MLAs who were complaining to me. But, as I said, it was a general criticism at the time that they didn't have the fix-it people.<sup>23</sup>

Commission counsel asked, "Sir, this go-to person or single point of contact, as you described it, you said that you understood in the Capital Health Region, at least, that that person performed a range of services. Would you agree that among those services would be the legitimate provision of advice and navigational assistance?" Dr. Duckett said:

There are a couple of roles you can have.... So I would make a distinction between providing advice about how to navigate and even providing advice about how you might have your clinical need reassessed from actually saying we're going to change your position on a waiting list or we're going to give you a management decision which is not consistent with evidence or principles or whatever.<sup>24</sup>

Commission counsel then asked Dr. Duckett about the following paragraph from a speech he gave in Toronto in May 2011:

In a large organization the decision-making paths are often unclear to outsiders. Faced with a significant budget crunch, we centralized power, taking decision-making autonomy away from local managers. This often meant that MLAs didn't know to whom to turn to obtain information (a legitimate goal) or to get fixes (not so legitimate). I'm told some of my predecessor CEOs had designated 'go-to' guys for discrete waiting list adjustments on request for MLAs, a practice I discontinued.<sup>25</sup>

Counsel then asked, "Sir, the reference there to "go-to guys", is that the same – a reference to the same role or position that you've just described for us previously?" He said it was a "rephrasing."<sup>26</sup> Counsel asked, "In this version of the speech you specifically refer to requests

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<sup>23</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 291.

<sup>24</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 293-94.

<sup>25</sup> Exhibit 22.

<sup>26</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 295.

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from MLAs. What information did you have that MLAs had made these types of requests?" Dr. Duckett said:

Again, the same issue that people had raised with me when I was finding out about these go-to guys and the Mr. Fix-it and so on. And so it was exactly the same process. So this is just the same issue but phrased slightly differently.<sup>27</sup>

Counsel asked, "And do you, sir, have any knowledge, or did you at the time that you gave this speech, of specific MLAs who had made requests for preferential or expedited treatment?" Dr. Duckett said:

No, I didn't have the names. I didn't seek the names of specific people. As I said earlier in my evidence, what I was keen to do in all of this was to stop the practice going forward. It didn't seem to me to be productive to do a witch hunt to find out who had done this in the past. It was someone else's responsibility, not mine. What was my responsibility was to ensure that the practice going forwards was an appropriate one.<sup>28</sup>

Counsel for AHS asked, "Now, you did reference Mr. Fix-it. I take it you never spoke to this individual?" Dr. Duckett said that was correct. Counsel asked, "And you only had hearsay or second-hand reports about what this individual might have done in a legacy organization?" Dr. Duckett said, "Yes. He wasn't working in AHS when I arrived."<sup>29</sup> Counsel asked, "I take it you never did or had any way to test the veracity of these hearsay allegations?" Dr. Duckett said:

...My view was what was in the past was in the past, and it wasn't my style to try and dig up dirt from the past. It just – you know, it was not productive ....

We wanted to move forward. And there was enough on our plate that, you know, why bother doing that. So what I was keen to do was to draw a line and say this is the new way of doing things. And we did that in all sorts of areas of AHS.

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<sup>27</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 295-96.

<sup>28</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 296.

<sup>29</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 308.



And we didn't – what we said was, henceforth and forward, don't do those sorts of things that were done in the past.<sup>30</sup>

Dr. Duckett was also asked about when he first learned about the so-called “go-to guys” or “Mr. Fix-its.” He said:

I suppose this was over a period of time. Certainly the longer I was in AHS, the more there was the criticism that I didn't have such a person. Whether I had heard about those roles before the memo or not, I cannot recall, but certainly it was a constant criticism of my style in AHS structure that we didn't have such a role.

You know, there were a number of issues that were raised with me, not necessarily the waiting list manipulation ones, but other issues where MLAs or the minister or whoever would seek to have issues dealt with, I guess, outside the normal processes.<sup>31</sup>

When asked what he meant by normal processes, Dr. Duckett replied:

... In most cases, despite the reputation in the media that we – essentially we had an organization, with zone vice-presidents and so on would – or vice-presidents, senior vice-presidents would make decisions within their area of delegation. And, in some circumstances, there would be lobbying to change those decisions or to influence those decisions in a particular way, not related to the preferential access necessarily, but resource allocation-type decisions. And so they're often ... people wanted to have a point of influence where that influence could be channelled. We resisted that and were keen for those things to be brought up the chain because, in the context of the budget cuts we were facing for most of my tenure, we couldn't afford to allow that sort of thing to happen. Subsequently it was still an issue where resource allocation questions are preferred to be dealt with more at the senior levels of the organization just so that we could make sure our priorities were being maintained.<sup>32</sup>

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<sup>30</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 308.

<sup>31</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 311-12.

<sup>32</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 312.

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The “go-to person” named by Dr. Duckett, Mr. Brian Hlus, was also mentioned by Dr. Sherman in his testimony. He knew Mr. Hlus as the director of government relations for one of the AHS predecessor entities, the Capital Health Region. Counsel asked Dr. Sherman if he, in his role as an MLA, ever had occasion to call Mr. Hlus on behalf of any of his constituents. Dr. Sherman responded:

Typically if I had any constituency concerns, even now today, my usual advice to my staff is [to] thank the constituent for the concern and to get their consent to advocate on their behalf if that’s what they would like, and whichever department, whichever ministry, is after we got their consent, to pass the request on to the appropriate ministry and the appropriate person, whether it’s a government relations person for whatever issue that the constituents were interested in having advocacy for. But I personally did not phone Mr. Hlus about constituency issues.<sup>33</sup>

Counsel asked, “Do you have any information, Dr. Sherman, of Brian Hlus arranging for expedited or preferential access to health care for any other MLA?” He said:

I have no direct knowledge that any expedited care was provided, but I do have knowledge that if there were health care issues, the issues would go through the government relations people, whether it’s Mr. Hlus or government relations people, people for the other health regions.<sup>34</sup>

The evidence before the inquiry was that Brian Hlus served as the director of government relations for the Capital Health Region from 1999 to 2008. Ms. Lynn Redford held a similar position in the Calgary Health Region until 2008. Both Mr. Hlus and Ms. Redford were called as witnesses. Both denied any involvement in adjusting or manipulating wait lists at the request of politicians or anyone else.

Mr. Hlus testified that he had never heard anyone refer to his position as a “go-to guy,” “fix-it guy” or “fixer” prior to Dr. Duckett’s speech and had never described himself in such terms to anyone. Furthermore,

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<sup>33</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 843-44.

<sup>34</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 844.

he had no idea how Dr. Duckett formed the opinion that he might have been a person in a position to make discrete adjustments to wait lists.

Mr. Hlus described his work as in part dealing with inquiries from MLA constituency offices requesting advice on behalf of constituents. He was asked whether he would make calls to a physician or to the operating room booking staff to see if something could be done. Mr. Hlus answered “No” to both questions, and said constituency offices made no requests like that of him. He was asked whether his office received calls from constituency offices identifying someone as a prominent person in connection with any inquiries about the system. He said he had not. Asked whether any constituency offices contacted him with inquiries on behalf of MLAs themselves or their family members, he answered “No.” Mr. Hlus denied ever asking anyone else to contact any health service provider directly or indirectly on behalf of Capital Health and said that he knew of no one in the Capital Health office who did so.<sup>35</sup>

Ms. Redford’s evidence was to the same effect. Part of her duties involved providing information and assistance to MLA constituency offices. She referred to this as strictly navigational advice. She never contacted physicians or health facilities on anyone’s behalf, nor was she asked to do so by anyone in a position of power or influence.<sup>36</sup>

Several witnesses, including past and present MLAs, also testified about their interactions with Mr. Hlus and Ms. Redford. These witnesses did not perceive the roles of Mr. Hlus and Ms. Redford to include adjusting wait lists. Instead, the witnesses saw them as facilitators, providing information to help people navigate the health care system.<sup>37</sup> There was no evidence from anyone that Mr. Hlus or Ms. Redford fulfilled any role beyond providing appropriate navigational advice.

The Minister of Health, the Hon. Fred Horne, also testified about Dr. Duckett’s allegations. Mr. Horne was elected in 2008 and served as parliamentary assistant to the Minister of Health from 2010 until his appointment as minister in 2011.

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<sup>35</sup> Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 668-70.

<sup>36</sup> Testimony of Lynn Redford, Transcripts, vol. 9, December 11, 2012, at 633-37.

<sup>37</sup> Testimony of Brian Mason, Transcripts, vol. 12, December 13, 2012, at 912; testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 980.

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Mr. Horne testified that, as an MLA, he would often contact Mr. Hlus to get help for constituents seeking access to health care. Mr. Horne said that the help Mr. Hlus provided involved such matters as “getting information or navigational issues.” Typically, Mr. Horne’s staff would make the call to seek advice. Mr. Horne had no recollection of what arrangements were made after Mr. Hlus left his position in 2009 and AHS decided not to replace “a contact person like that” to respond to MLA enquiries.<sup>38</sup>

What does all this evidence demonstrate? First, it shows that Dr. Duckett was willing to make accusations about people who worked in the entities that preceded AHS without having any direct knowledge of what he was talking about. Even if he did hear some allegations that wait lists were being manipulated, he did nothing to verify that information. He did not call for any investigation. He appeared to take these allegations seriously – seriously enough to repeat them on two occasions. If he did take the allegations seriously, it seems to me that Dr. Duckett, as a leader responsible for a new organization, would have taken some steps to determine (i) who did this, to make sure that they were either no longer in the organization or were trained sufficiently about the unacceptability of the practice, and (ii) how this was done, to implement systems to prevent its recurrence. What I conclude is that if Dr. Duckett received such information, he did not consider it sufficiently important or credible at the time to take these further steps.

The second point that Dr. Duckett’s evidence demonstrates is that his primary concern was not about someone in Capital Health who might have manipulated wait lists. His primary concern was the complaints he was receiving from MLAs about no longer having a single point of contact for navigational advice on constituents’ issues. These points of contact – Mr. Hlus and Ms. Redford, for example – were the source for assistance in navigating the health care system, something that no one called improper and, in my view, is clearly not improper.

In conclusion, I found no evidence to support Dr. Duckett’s allegations.

### **(ii) The Duckett memo**

The two speeches by Dr. Duckett received widespread publicity. Shortly after, the media also published reports about a memo

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<sup>38</sup> Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1507-09.

distributed by Dr. Duckett on June 11, 2009, to senior AHS executives. The subject of the memo was a policy document approved at an AHS board meeting the previous month. The policy document is worth setting out in full:

## **Requests for Preferential or Expedited Care**

### **Background**

It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for “prominent” individuals or the family and acquaintances of “prominent” people.

### **Definition**

In this context, “Prominent” persons include, but are not limited to:

- Other executives and senior leaders of the health care organization
- Members of the organization’s Board of Directors
- Politicians and other government officials
- Philanthropists who have previously donated to the organization or its foundations
- Individuals prominent in local or provincial society or business

Preferential or expedited care includes, but is not limited to, care that is:

- Rendered more quickly than medically indicated or required
- Rendered more quickly than the current norm of the organization
- Of a higher quality and/or is more extensive/“thorough” than the currently provided norm of the organization
- Offered at a lower cost than is the current norm (i.e. for services or equipment that are non-insured or must be purchased by the patient)

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### **Issue**

Providing preferential and/or expedited care based on societal status or personal relationship to health care executive or officials, rather than on medical indications and accepted prioritization pathways for care, creates a conflict-of-interest for the organization and an ethical dilemma for the health care executive or official receiving a request to do so. By its very nature, such a scenario:

- Represents “queue-jumping”, a practice that a public health care organization cannot defend or support
- Delays or otherwise adversely affects the care of other persons awaiting or requiring care, especially when the organization has limited and inadequate capacity or resources
- Implies that not all individuals in society are considered “equal,” or are entitled to equal treatment
- Suggests that the organization’s current norms of care do not meet acceptable standards
- Exposes the organization to negative public and/or media opinion

### **Principles**

- Alberta Health Services strives to provide high quality, safe, and timely care to all Albertans
- Alberta Health Services treats all clients and citizens with the same high degree of respect regardless of societal status, occupation, personal relationships, income, ethnicity, or gender

### **Process**

- Preferential or expedited care is not endorsed or encouraged by Alberta Health Services, or any of its representatives, staff, or physicians
- Requests for preferential or expedited care must be directed to the President and Chief Executive Officer of Alberta Health

Services. Other representatives, leaders, or staff of the organization are not authorized to receive or address such requests

- However, it is acceptable for representatives, leaders, and staff of Alberta Health Services to provide advice as to how to most effectively access and navigate the provincial health care system to any individual who enquires how to do so.

This policy document was prepared by Dr. David Megran, the Senior Physician Executive at AHS in 2009 and now Executive Vice-President and Chief Medical Officer for Clinical Operations. In their testimony, Drs. Duckett and Megran disagreed about which of the two first raised the issue of preferential access and about the events that led to the preparation of the AHS policy document.

Dr. Duckett told the inquiry that Dr. Megran raised preferential access in a one-on-one meeting. Dr. Duckett recollected Dr. Megran saying that he had been approached by individuals curious about Dr. Duckett's views on preferential access. Dr. Duckett said that Dr. Megran did not name these individuals. Dr. Duckett also recollected<sup>39</sup> Dr. Megran saying that previous CEOs or previous leaders had accepted the practice of preferential access. Dr. Duckett later explained that although he could not verify Dr. Megran's exact words, Dr. Megran had "certainly intimated" that previous health authorities had accepted the practice. Dr. Duckett said that Dr. Megran did not detail the predecessor entities to AHS in which the preferential access issue arose. Dr. Duckett said that he told Dr. Megran that he was opposed to preferential access and that he asked Dr. Megran to draft a memo to make Dr. Duckett's views explicit. Dr. Duckett said that Dr. Megran sent the resulting draft to him by email.

Dr. Megran had no recollection of raising preferential access – or "expedited care," as he described it – with Dr. Duckett. Dr. Megran said<sup>40</sup> that it would be difficult for him to accept Dr. Duckett's claim that he raised the issue. This was because Dr. Megran "had no knowledge of events of expedited care occurring at the time." He said,

<sup>39</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 262-64.

<sup>40</sup> Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 170-71.

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“I had no personal experience. I have no recollection of people elsewhere in Alberta Health Services alerting me to that.” Dr. Megran stated that he had never received a request for preferential or expedited health care during his time at the Calgary Health Region or AHS. He testified that at the time he prepared the document, in May 2009, he had never had anyone in Calgary Health Region or AHS receive such a request and report it to him.

Dr. Megran stated that it was his recollection that Dr. Duckett asked him to draft the policy document. He explained:

But I think the straightforward, honest answer is I have no recollection of exactly how or why he asked me, and I have no recollection that I alerted him to rumours or concerns or any information I might have had since I didn't have that kind of information with respect to expedited care being an issue anywhere in Alberta Health Services or the previous health regions.<sup>41</sup>

Dr. Megran had no recollection of the specific parameters that Dr. Duckett set for the memorandum, but said that it was hard to believe that Dr. Duckett did not give guidance about its length. Dr. Megran was sure that Dr. Duckett had conveyed that he wanted the memorandum to indicate that this practice was unacceptable.

Dr. Megran characterized the memorandum that he then prepared as a draft that would undergo later consultation or revision. However, it was treated as complete by Dr. Duckett.<sup>42</sup>

Commission counsel asked Dr. Duckett about the apparent conflict between Dr. Megran's recollection of the sequence of events and Dr. Duckett's own recollection. Dr. Duckett was asked whether it was possible that, instead of Dr. Megran first raising the preferential access issue, it was Dr. Duckett's initiative to ask Dr. Megran to draft the memorandum. Dr. Duckett stated that he was “pretty sure ... I can't be a million percent sure that my memory is better than Dr. Megran's, but I'm sure ... I'm pretty sure” that Dr. Megran first raised the issue. Dr. Duckett explained that this was not the sort of issue that he himself would have raised because it would not have occurred to him that “this

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<sup>41</sup> Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 171.

<sup>42</sup> Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 194-95.



sort of behaviour” was happening in Alberta. He said, “... there were plenty of other things to be working on in Alberta Health Services at the time, and it just wouldn’t have occurred to me that this sort of practice was happening.”<sup>43</sup>

In my opinion, the conflict in the testimony about who first raised the issue of preferential access is not significant. It merely illustrates a profound lack of recollection about something that should have been far more memorable. This was, after all, the development of a new policy for a new organization. The fact that the process to develop this policy was not so memorable undermines the suggestion that expediting access was a common occurrence – the very phenomenon alleged by Dr. Duckett in his speeches.

The key point is that neither Dr. Duckett nor Dr. Megran had any knowledge about past wait list manipulation. They agreed that preferential or expedited care was improper and that it should not be permitted. And Dr. Duckett requested the preparation of the policy statement and instructed Dr. Megran to insert the key process point – that all requests for preferential access must be directed to the president and CEO of the organization.

Dr. Megran was asked about the first sentence of the policy document headed “Background”: “It is not uncommon for executive members or other leaders of health care organizations to receive requests to provide preferential or expedited care for ‘prominent’ individuals or the family and acquaintances of ‘prominent’ people.”

Dr. Megran was asked why he used the expression “it is not uncommon” if he had no personal knowledge of such requests, either during the then-short history of AHS or his earlier tenure with the Calgary Health Region. Dr. Megran could not explain his use of that expression other than to suggest that it might have been confusion on his part by not clearly differentiating between requests for preferential care, something unacceptable, and requests for information and navigational advice, something that is common and acceptable.<sup>44</sup>

The AHS board approved the document produced by Dr. Megran. The document appeared to generate very little discussion at the board level.

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<sup>43</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 266-67.

<sup>44</sup> Testimony of David William Megran, Transcripts, vol. 3, December 4, 2012, at 171-73.

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Minister Horne testified that he first became aware of the Duckett memo through the media. He said he had no awareness of preferential or expedited access as an issue in any of his government positions. When the memo became public, there were general discussions about it within the health ministry, but nothing of a formal nature. There were no inquiries or investigations initiated by the government as a result of the memo or the other allegations levied by Dr. Duckett.<sup>45</sup>

Those witnesses who were leaders and staff of AHS or former entities testified about their awareness of and reaction to the Duckett memo. Their evidence was consistent that the Duckett memo provided clarity and direction to the staff since there had been no policies on the issue previously. It was welcomed by staff and supported as a statement of principle. There was, however, little discussion about it since this was not something that concerned people, particularly as it was not within their knowledge or experience.<sup>46</sup>

In 2011, Dr. Duckett claimed to have put a stop to the practice of manipulating wait lists through the use of “go-to guys.” The 2009 policy statement specifically directed that all requests for preferential or expedited care be directed to him. During his testimony, Dr. Duckett was asked if, between the time he distributed the policy statement and his departure from AHS, he had received any such requests. He answered “No.”<sup>47</sup>

### **(iii) The Sherman allegations**

On June 7, 2011, Dr. Raj Sherman, formerly a Progressive Conservative MLA but then sitting as an independent, gave two interviews. One aired on CTV<sup>48</sup> and the other on CBC.<sup>49</sup> In the CTV interview, he said that he “saw it first-hand,” as an emergency room physician, that people were moved up on wait lists. He claimed that for patient confidentiality reasons it was inappropriate for him to name anybody. In the CBC interview, he said he personally experienced

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<sup>45</sup> Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1519-21.

<sup>46</sup> Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 426; testimony of David Shawn Diamond, Transcripts, vol. 7, December 6, 2012, at 448-49; testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 486; testimony of Kathy Taylor, Transcripts, vol. 8, December 10, 2012, at 516; and testimony of Lynn Redford, Transcripts, vol. 9, December 11, 2012, at 632.

<sup>47</sup> Testimony of Stephen John Duckett, Transcripts, vol. 4, December 4, 2012, at 303-04.

<sup>48</sup> Exhibit 59.

<sup>49</sup> Exhibit 60.

requests from hospital executives for certain patients to get preferential treatment. He added, however, that no one in critical condition was ever denied treatment because a queue-jumper was getting medical help.

When questioned, Dr. Sherman admitted that he had no first-hand knowledge of these allegations, stating that he had not called for an inquiry into improper preferential access because his information was based on hearsay and anecdotes. He admitted that he did not experience or see for himself any of the matters he mentioned. He said he based his comments on his conversations with others.<sup>50</sup>

In his testimony, Dr. Sherman referred repeatedly to a conversation with Dr. Paul Parks (now the chief of emergency medicine at Medicine Hat Regional Hospital) as the source of his information:

Those are comments based on the conversation I had with Dr. Paul Parks. In fact, hardly anybody could get into care in ... time. So Dr. Parks and I had a good chat. Before I did that interview, I said, “Paul, does this happen in your department?” Those comments were based on the conversation that I had with Paul. Paul did not give specific cases, but he said, “Hey, this is happening in our department.” So that’s what I was referring to.<sup>51</sup>

Prior to going to Medicine Hat, and until mid-2009, Dr. Parks was an emergency physician at the University of Alberta Hospital. When he testified, Dr. Parks was not specifically asked about any conversations he may have had with Dr. Sherman or information he may have given to Dr. Sherman. This may in part be due to the fact that Dr. Parks testified before Dr. Sherman and counsel were not aware of what Dr. Sherman would say. However, Dr. Parks was asked for any examples of improper preferential access or requests for such access after 2007. (Dr. Parks earlier testified about one incident that occurred that year.) He too could not provide examples from his personal knowledge. He said:

So, again, none that I’ve specifically been involved in or that I was present for. I’ve heard of some general examples in my

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<sup>50</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 850-52.

<sup>51</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 851.

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role as the section president of emergency medicine, but, in reality, I think, as far as I'm aware, there was a cease-and-desist order by Dr. Duckett in AHS.

And as far as I know, in my own view, as much as I know, I don't know that it's still going on or that there is access. But prior to this, and in this time frame, I was aware of things happening, but it would be in the general sense that someone would be in the department, but I never took note of the details or knew any specifics.<sup>52</sup>

Dr. Sherman also referred to informal conversations – “the type of chatter that can happen in a lunchroom” – with health care workers as the source for one of his claims about government officials receiving preferential treatment.

Dr. Sherman referred to an incident involving the treatment of Ralph Klein while he was premier at the emergency department of an Edmonton hospital in 1997 or 1998. Dr. Sherman believed that, while his own 92-year-old patient with broken bones was denied admission because there was no room, Mr. Klein was admitted and also received some pain treatment while waiting.<sup>53</sup> Dr. Sherman admitted he did not see this first-hand but heard about it from another emergency room doctor, Dr. Terry Sosnowski. Dr. Sherman acknowledged he had no personal knowledge of Mr. Klein's injury, did not review his chart and knew nothing about how long the premier waited to be seen, his triage score or his treatment.<sup>54</sup>

Dr. Sosnowski was not called as a witness and so gave no evidence about this incident. Dr. Sherman, however, also referred to his knowledge of this incident being based on “general conversations amongst the staff.”<sup>55</sup>

The next example Dr. Sherman gave involved a call from then-MLA Mr. Thomas Lukaszuk one Friday evening in the fall of 2009. Mr. Lukaszuk, who also testified about this incident, said someone who had been physically assaulted contacted his office. He was concerned because the patient and her family were illegal immigrants and did not

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<sup>52</sup> Testimony of Paul Parks, Transcripts, vol. 5, December 5, 2012, at 388.

<sup>53</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 808.

<sup>54</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 811-12.

<sup>55</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 809.

have Alberta Health Care Plan Insurance coverage, so he called Dr. Sherman. Dr. Sherman said the woman should be taken to the emergency department, explaining that no one would be turned away at an Alberta emergency department based on an inability to pay.

Dr. Sherman testified that he reluctantly agreed to meet Mr. Lukaszuk at the hospital. One of the reasons for that reluctance was the possible perception that, as a physician and a recognizable elected official, he was there to obtain preferential treatment for somebody.<sup>56</sup> However, he confirmed that Mr. Lukaszuk did not ask him to intervene in the patient's care or speed up her treatment in any way.<sup>57</sup>

Dr. Sosnowski was on shift in the emergency department that evening. He confirmed in an affidavit filed with the inquiry that neither Dr. Sherman nor Mr. Lukaszuk requested any preferential or expedited treatment for this patient.<sup>58</sup>

It is pertinent to ask what the point is of bringing this particular incident before the inquiry since nothing untoward happened. I do not draw any conclusions as to Dr. Sherman's motive in doing so. Dr. Sherman appeared to be most concerned about the request for his attendance at the emergency department. Counsel asked, "So what was your conclusion as to why your personal attendance was requested?" He said, "Well, my concern after – was whether my presence would expedite care. That was a concern. It wasn't expressed by Mr. Lukaszuk, but I felt like I might have been duped."<sup>59</sup>

Mr. Lukaszuk, in his testimony, said he contacted Dr. Sherman to get some advice and Dr. Sherman volunteered his assistance. He claimed that Dr. Sherman suggested the facility where he should take the patient. Mr. Lukaszuk said, "He offered his help, and I was very grateful for it."<sup>60</sup>

Counsel asked Mr. Lukaszuk if he called Dr. Sherman that evening in order to seek faster or better treatment for the patient than might be the case if Dr. Sherman was not involved. Mr. Lukaszuk replied:

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<sup>56</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 817-18.

<sup>57</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 819-20.

<sup>58</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 861.

<sup>59</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 861.

<sup>60</sup> Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1976-77 and 1982.

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Let me answer this in two ways. The first answer is no, and the second part of this answer would be I had no reason to do so. This person was in no way related to me. This person was not a voter, nor a constituent. It was a random person not affiliated in any way to me or my office who just presented herself in my office with this unusual circumstance.<sup>61</sup>

The third instance cited by Dr. Sherman was an email he received in June 2011 from Mr. Dennis Loughlin, alleging that Mr. Lukaszuk had helped a woman known to Mr. Loughlin receive expedited surgery.<sup>62</sup> An employee at Dr. Sherman's constituency office tried to confirm the details with the woman but she refused to speak with him and then reported the call to Mr. Lukaszuk's office. Mr. Lukaszuk raised the call with Dr. Sherman, demanding an apology. Mr. Lukaszuk, in his testimony, denied any involvement with the constituent named in the email in accessing health care on her behalf<sup>63</sup> and in fact denied ever contacting a health care provider in order to advocate for a constituent.<sup>64</sup>

Dr. Sherman drafted a memo about this incident to the Ethics Commissioner, Mr. Neil Wilkinson,<sup>65</sup> but Mr. Wilkinson testified that his office had no record of receiving it.<sup>66</sup> The memo that Dr. Sherman drafted to the Ethics Commissioner contained the following statement:

Unfortunately, this is not the only allegation of this nature being made against the honourable Member. I have first-hand knowledge [of] an incident, the details of which I would be willing to discuss with you in confidence.<sup>67</sup>

Mr. Lukaszuk did not know which incident Dr. Sherman meant.<sup>68</sup> If his memo did go to the Ethics Commissioner, there was no evidence of Dr. Sherman passing on any other information. At this inquiry, Dr. Sherman did not share any such information and I can only conclude that he has none.

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<sup>61</sup> Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1984-85.

<sup>62</sup> Exhibit 54.

<sup>63</sup> Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1990.

<sup>64</sup> Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1992-93.

<sup>65</sup> Exhibit 55.

<sup>66</sup> Testimony of Neil Rudell Wilkinson, Transcripts, vol. 18, January 10, 2013, at 1487.

<sup>67</sup> Exhibit 55.

<sup>68</sup> Testimony of Thomas Lukaszuk, Transcripts, vol. 25, January 16, 2013, at 1995.

Finally, Dr. Sherman provided evidence regarding the care of his own father at the University of Alberta Hospital emergency department on February 15, 2008. On February 22, 2008, Dr. Sherman sent Ms. Sheila Weatherill (the Capital Health CEO) an email about the extremely long wait in the emergency department. It also stated:

My main concern lies in the fact that someone (unknown) called and asked him [Sherman's father] to be moved up in the queue, in front of other patients. Had this not happened, he likely would not have survived as his wait likely would have been 7-9 hours.<sup>69</sup>

Dr. Sherman was unable to identify who called to ask that his father be moved up in the queue. I find it curious, however, that in his draft memo to the Ethics Commissioner, Dr. Sherman makes reference to his father's suffering, but says that he "refused to accept preferential treatment."

In the end, it is not very productive to sort through the many inconsistencies in this evidence. The conclusion I draw is that, like Dr. Duckett, Dr. Sherman was quick to make allegations about which he had no personal knowledge or documentation. It appears that his only first-hand experience with preferential care is the treatment received by his father in 2008, and the treatment he gives to his MLA colleagues in his office, something that will be discussed later in this report.

I have no doubt that Dr. Sherman is a compassionate and caring physician. He is obviously concerned about the state of the health care system in Alberta. But no facts have been presented at this inquiry to allow me to substantiate any of his allegations.

The result is that the allegations that prompted this inquiry have not been proven. And it is clear to me that if a modicum of effort had been put into investigating these allegations when they were first made, their lack of substance would have become readily apparent.

I do not say that the type of conduct alleged could not happen. Members of the legislature may very well try from time to time to exert their influence, which in turn may lead some front-line staff to feel pressure to accommodate their demands. But there was no evidence of

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<sup>69</sup> Exhibit 58; Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 837-38.

that happening now or back when these allegations were made. Gossip, rumour, hearsay – or “lunchroom-type chatter” as Dr. Sherman described it – are not evidence.

### ***C. The inquiry’s role***

It is not for me to comment on the arguments for or against establishing this inquiry, or its specific terms of reference. Those are obviously matters of some controversy. But this brief overview should reveal the fundamental difficulty that confronted this inquiry.

The impetus for calling the inquiry was allegations by Dr. Duckett of a system whereby political insiders were able to manipulate wait lists for necessary medical services. Yet when Dr. Duckett testified during the earliest days of this inquiry’s public hearings, he admitted he had no first-hand evidence to support his allegations. He could not identify any instance of preferential treatment. Similarly, Dr. Sherman acknowledged in his testimony that he also had no first-hand evidence to support his claims. He could not identify a single incident of preferential access to health care. The senior AHS executive who authored the policy document attached to Dr. Duckett’s June 2009 memo, Dr. David Megran, testified that he knew of no instances of preferential care.

Understandably, the testimony of Drs. Duckett, Sherman and Megran led the media to question the value of this inquiry. As one commentator put it, “Sadly, the careless way Duckett levelled his unsupported accusations, without evidence or foundation, means that the inquiry itself has lost its own foundation, and much of its credibility, at its very start.”<sup>70</sup>

This is a perceptive comment. It reminds us that this inquiry sprang from certain allegations and that, once those appeared to be unfounded, people naturally questioned continuing this time-consuming and expensive process. But the inquiry’s terms of reference did not limit it to examining just those allegations about political insiders. The inquiry was called to examine whether improper preferential access is occurring anywhere within the public health system.

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<sup>70</sup> P. Simons, \$10-million queue-jumping inquiry off to troubled start, *Edmonton Journal*, December 6, 2012.



Even though the allegations that led to this inquiry quickly proved to be without substance, evidence of other activities and attitudes within the Alberta health care system warranted investigation. This inquiry's terms of reference were broad enough for it to explore whatever kind of preferential access may be occurring within the health care system. The terms of reference offered the opportunity to examine an issue that has significant ethical and practical implications, yet one that has been inadequately studied. Such a study would be particularly important, given the likely perception that improper preferential access occurs throughout the health care system in Alberta and elsewhere in Canada.

It is possible to look at preferential access issues at a macro level, focusing for example on the divide between urban and rural populations in access to health care, what is and is not covered by provincial health care programs, and growing income inequality and its repercussions in health care. Doing a macro-allocation analysis would reveal disparities in any system.

But this inquiry was asked to conduct a fact-finding exercise on a micro level – for example, looking at who will be next in line for surgery and how they get there.<sup>71</sup> This micro-level exercise might lead to conclusions and recommendations useful on a broader, societal level. While some of the specific incidents examined during this inquiry may not be representative of the health care system as a whole, they may well illustrate some of the kinds of problems to be found within the system.

Research on preferential access as a systemic issue is very limited and most of the information available is anecdotal. As a result, it became necessary for the inquiry to examine specific incidents to see if patterns emerge. A specific instance of preferential treatment may be a one-off, not amenable to or meriting policy intervention. On the other hand, several instances may indicate systemic problems – overtly or tacitly accepted – that may warrant regulation or attention through policy measures.

This inquiry faced a difficult task. Unlike other inquiries preceded by a specific event, this inquiry had as its starting point bare, unexamined and untested allegations reported by the media. There had been no preliminary investigation into those allegations – no legislative

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<sup>71</sup> Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3374.

## Reasons for the Inquiry

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committee hearing, for example, to test statements made in the legislature. And, of course, even if there were instances of improper preferential access, there would be little likelihood of an accompanying paper trail.

The work of this inquiry was even more difficult to pursue because there is very little empirical evidence showing improper preferential access to health care. As one of this inquiry's researchers, Dr. Nishan Sharma of the University of Calgary, stated in a review of academic literature on the subject:

Even as the popular media highlight well-publicized incidents of individuals "jumping the queue", the academic literature does not provide any evidence-based proof of preferential access that might be targeted by anti-queue-jumping measures. The studies cited that fit within the scope of this review are based on surveys, opinion and subjective data. At this point, it would be difficult to design and implement a means to limit preferential access that could be backed up with "before and after" and data to confirm the efficacy of the strategy.<sup>72</sup>

Commission counsel interviewed more than 150 people during their investigations. The inquiry received hundreds of emails, letters and telephone calls from the public. Whatever the source of the information, Commission counsel pursued the lead. Not all information was relevant and in some cases it related to issues beyond the inquiry's mandate. Some information was not sufficiently reliable to merit extensive examination. Many witnesses, even though called to testify under oath, exhibited a regrettable failure to recollect events and activities that should not have slipped so easily from memory. In total, 68 witnesses testified, generating over 3,700 pages of transcripts. There were 172 exhibits totalling another 1,700 pages. Ten parties presented written submissions at the end of the hearings.

Is improper preferential access occurring? This inquiry has uncovered instances where it is. Is there evidence that anyone has been medically harmed by such instances? This inquiry uncovered no specific evidence of this. It would be almost impossible in any event to show that

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<sup>72</sup> Nishan Sharma, *Academic Literature Review of Preferential Access to Healthcare in Canada: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta* (November 2012) at 14.

preferential access given to one person specifically harmed another – that is, short of actually seeing a patient bumped to make way for someone with the “right” connections.

The more significant question is whether improper preferential access causes harm to the principles underlying publicly funded health care in Alberta. It is my hope that the efforts of those involved with this inquiry have shed light on an important issue and that our recommendations lead to measures that will justify public confidence in the equity of our health care system.



## CHAPTER TWO: THE INQUIRY'S MANDATE

### A. *The terms of reference*

A commission of inquiry owes its existence to the order in council creating the inquiry and the terms of reference that set out the scope of the inquiry's work. The terms of reference define an inquiry's jurisdiction. However, it is my responsibility as commissioner to interpret those terms of reference.<sup>73</sup>

Order in Council 80/2012 contained the following preamble:

WHEREAS:

- Allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services;
- Access to publicly funded health services is properly based on patient need and the relative acuity of a patient's condition;
- It is improper to gain access to publicly funded health services through threat, influence or favour;
- It is in the public interest to assure Albertans that the publicly funded health care system provides for fair and appropriate access to health services; and
- The Lieutenant Governor in Council considers it to be in the public interest that a public inquiry be held to make recommendations to prevent the possibility of any person being given improper preferred access to publicly funded health services.

And the order in council directed as follows:

Pursuant to section 17 of the *Health Quality Council of Alberta Act*, the Lieutenant Governor in Council orders that a public inquiry be held concerning the possibility of improper preferential access being given to publicly funded health

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<sup>73</sup> Ed Ratushny, *The Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 141.

services and, specifically, the terms of reference for the inquiry shall be to consider:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

The terms of reference should speak for themselves. This does not, however, prevent consideration of the background circumstances that led to the establishment of the inquiry.

In Chapter 1, I highlighted the allegations made by Drs. Duckett and Sherman, as reported in the media in 2011, and the allegations in the memo distributed by Dr. Duckett in 2009 entitled “Requests for Preferential or Expedited Care.” The inquiry’s terms of reference did not mention these specific allegations. The preamble of the order in council merely contained the general statement that “allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services.” But it is reasonable to conclude that the allegations are those reported in 2011. It was therefore reasonable to consider those allegations as falling within the ambit of the inquiry’s work even though they relate to conduct that occurred several years ago, even before the creation of Alberta Health Services (AHS) in 2009.

The terms of reference are very general. The inquiry is to consider the “possibility of improper preferential access being given to publicly funded health services.” This suggests a mandate to review systems, policies, procedures and prevailing attitudes. Specifically, the inquiry was mandated to consider “whether improper preferential access to publicly funded health services is occurring.” This demands a fact-finding exercise, investigating specific incidents – incidents that are not mentioned in the order in council, but ones that may come to light as part of the inquiry’s investigations.

### **B. *Scope in time***

The use of the verb “is” in “whether improper preferential access ... is occurring” has proved particularly controversial. When the inquiry was

first announced, much of the media coverage – as well as opposition politicians and the medical community – criticized the terms of reference as unduly limiting the scope of the inquiry’s work. They complained that the inquiry could only examine current queue-jumping, not past incidents.<sup>74</sup>

This necessarily led to arguments during the hearings about how far back the inquiry should look in its work.

Three of the four interveners – the Government of Alberta, AHS and the Alberta Medical Association – took the position that use of the phrase “is occurring” limited the evidentiary scope of the inquiry to current policies and procedures, and generally to events occurring after the creation of AHS. That seemed to be the commonly held cut-off point for these interveners and coincided with the creation of Dr. Duckett’s 2009 memo. A particular concern of these interveners (and of counsel representing some witnesses) was that going back earlier than the creation of AHS in 2008 meant bringing in evidence from people who were involved in entities that no longer exist and who may no longer be playing an active role in the health care system. This evidence, it was argued, could not be relevant to what may or may not be occurring in the current system, especially since practices and procedures are constantly evolving.

The fourth intervener, the Consumers’ Association of Alberta, argued for a liberal interpretation of any temporal limit. Its counsel submitted that information about past events can give a context for what may be currently happening and could inform any recommendations I might make.

Commission counsel Michele Hollins, in her submissions on this point, noted that the words “is occurring” cannot literally mean “contemporaneously.” Otherwise, there would be a very narrow window within which to examine practices. So if it does not mean contemporaneous, it must mean a period with some flexibility built into it. And the test of how flexible it may be is relevance.

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<sup>74</sup> See, for example, R. Bell, Alberta docs say health care probe doesn’t go far enough, *Calgary Sun*, February 29, 2012; D. Braid, Throw away the rule book for health care inquiry, *Calgary Herald*, March 1, 2012; an editorial, headlined Examining the past: Scope of health care inquiry seems too restricted, *Calgary Herald*, March 1, 2012.

When confronted with deciding where to begin, Commission counsel quite rightly started with the 2009 Duckett memo. That was appropriate because the allegations that prompted the creation of this inquiry dated back to that time, when Dr. Duckett took over as CEO of AHS and claimed to have put a stop to political manipulation of wait lists. But, as Commission counsel noted, because AHS was itself a newly created body at the time, counsel examined both the periods before and after the creation of AHS to understand the concerns that precipitated that memo.

I do not know how one can examine the possibility of improper preferential access without looking at incidents in the past and present. This inquiry is of a type that can best be described as a mixed investigative/advisory one. The essence of such a type of inquiry lies in examining past events to determine whether current practices or legislation are adequately addressing systemic problems. As one noted expert, Mr. Simon Ruel, has written:

In many cases, a public inquiry will be mandated to address both aspects, namely to investigate and report on a factual situation, together with making related policy recommendations for change. Such public inquiries will be both looking back and looking forward. Those mixed investigative and policy inquiries may, at the same time, assess a factual situation, review institutional policy and practices, address systemic problems and look at the adequacy of legislation and regulations.<sup>75</sup>

There is no question that the words “is occurring” are important and must be given a rational meaning. They provide a temporal framework. But I think it fair to say that all the participants in this inquiry recognized that the terms of reference are sufficiently broad to allow a wide temporal scope for the evidence. To determine whether something is occurring requires me to determine if something has occurred and whether the circumstances under which it occurred are continuing. However, engaging in a historical review would stretch the bounds of the terms of reference unreasonably. Commission counsel had to draw to some extent on past events to illustrate patterns of behaviour or types of systems. Those events may or may not continue now but they may still be relevant to the question of the “possibility of improper

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<sup>75</sup> Simon Ruel, *The Law of Public Inquiries in Canada* (Toronto: Carswell, 2010) at 7-8.



preferential access being given.” In a broad sense one can say that this evidence of past events and behaviours helps advance this inquiry’s work.

The answer does not lie in setting some artificial cut-off date and saying that evidence preceding that is of no relevance at all. Instead, the answer lies in weighing the evidence for its cogency and probative value. The further back an incident occurred, the less weight it will have in helping to assess the current situation. And, if something occurred in the past and there is evidence that it is not occurring now, it may be useful as an object lesson in what could happen. However, it is otherwise of little use in identifying recommendations for the future.

### ***C. Scope in scale***

The other aspect of this inquiry’s mandate worth noting is its limited scope vis-à-vis the health system as a whole. This was emphasized by all parties, but in particular in the submissions of the AHS as intervener. The publicly funded health care system is extremely large and complex. Health services are provided and received through a complex variety of pathways. Access issues may arise at numerous points: seeing a general practitioner; referral to a specialist; diagnostic measures; specialized medical services such as surgery; emergency room assessment and treatment.

It is also necessary to consider the volume of services provided. The final AHS submission provided examples of the numbers of individuals and services involved:

- Between September and December 2012, some 521,914 emergency department visits took place province-wide;
- In 2011-12, there were nearly 200,000 urgent care service visits among the six urgent care centres that were operational at the time;
- An estimated 250,000 main operating room procedures occur in AHS annually;
- Some 2,370,568 diagnostic imaging procedures (MRI, CT and X-ray examinations) were performed province-wide by AHS in 2011-12, including 166,645 MRI examinations;

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- The system oversaw 547,093 cancer patient visits in 2011-12; and
- Over 350,000 patient discharges took place in AHS hospitals in 2011-12.<sup>76</sup>

However, this inquiry was not authorized to review the health care system comprehensively. Nor was it charged with trying to determine theoretically how improper access could be gained to different parts of the system. There are other and better vehicles for such analyses, such as the Health Quality Council of Alberta.

This inquiry was asked to look at a narrow aspect of this massively complex system. Specifically, the inquiry was to engage in a fact-finding exercise to determine if improper preferential access is occurring. As noted earlier, the Duckett and Sherman allegations had no facts to support them. But other incidents came to light and the only way to conduct the fact-finding was to examine those incidents. These incidents obviously provided a narrow glimpse of only certain parts of this complex health care system. Still, as I said previously, these examples may not represent the system as a whole, but they may be illustrative of problems that could arise in different parts of the system.

Nevertheless I recognize, as a number of the interveners have reminded me, that I have seen only a very limited picture of the overall health system in this province. Drawing broad conclusions from what may be isolated instances of improper preferential access risks leading to inappropriate recommendations for the system as a whole. I must therefore take this limitation into account when formulating my findings and recommendations.

### **D. *Wait lists***

This inquiry's terms of reference do not mention an examination of wait lists. However, one cannot overlook that the very existence of wait lists, and the excessive time people may wait for assessment and treatment, can be important motivators for attempting to expedite access by improper means.

Wait lists are a fact of life in Canadian health care due to the constantly increasing demand for services, coupled with a limited supply of those

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<sup>76</sup> Closing Submissions of Alberta Health Services, April 1, 2013, at 7-8 (Exhibit 164).

services. So it is also accurate to observe – accurate but trite – that if there were no queues there would be no need to examine queue-jumping. Clearly, wait lists for necessary medical services are serious organizational issues that merit a multi-pronged attack. In part, this means examining the allocation of resources and how the health care system is managed. It also means discussing wait times and wait list management to some extent in this report, even though this inquiry was not established to focus on these issues.

### ***E. The issue of inferior access***

This inquiry is focused on whether people are getting improper preferential access to publicly funded health care. In other words, are people getting access that is superior to the norm? The events leading to the establishment of this inquiry, along with its terms of reference, meant that it did not focus on the other side of the preferential access issue: systemic barriers and discrimination that may result in access that is inferior to the norm. In both cases – preferential access and inferior access – the result detracts from the ideal of equitable access at the core of Canada’s approach to publicly-funded health care.

I readily acknowledge that an examination of systemic or discriminatory barriers is not within this inquiry’s mandate. But I would be doing a disservice if I did not at least emphasize that, for many in Alberta, the prevailing norm of access is superior to what they can hope to receive. That norm of access, when it is beyond the reach of some populations, becomes a type of preferential access in their eyes.

In its submission, the Consumers’ Association of Alberta argued that barriers to access to publicly funded health services are equal to if not more deserving of examination than preferential access. Several groups can be identified as facing some discrimination or systemic barrier to access in Alberta:

- Rural populations;
- Individuals without family doctors, particularly individuals with complex medical issues;
- Individuals with addictions and/or mental health issues;
- The poor;

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- The elderly;
- Individuals whose first language is not English;
- Those with hearing or vision loss or mobility issues; and
- First Nations communities.

What leads to inferior access? There may be systemic issues such as the allocation of resources – as may be typified by the situation of the members of the Rimbeiy and Area Renal Dialysis Support Group, who argued that rural residents have inferior access to health care. Inferior access could also flow from discrimination against a particular group in society – dependent users of alcohol and other drugs or the mentally ill, for example.

Generally, there is a strong correlation between socio-economic status and health outcomes: the lower the status, the poorer the health outcomes. There is also considerable evidence in Canada of a relationship between socio-economic status and health care utilization. The lower the income and education level of individuals, the more likely they are to use health services at the primary level, while those with higher income and education levels tend to make greater use of specialist services.<sup>77</sup>

The Organisation for Economic Co-operation and Development (OECD) conducted a multi-country health policy review that included Canada. It found that even in public health care systems such as ours, there are inequities in access due to socio-economic status. Individuals with higher income and education tend to wait less time for publicly funded hospital care than the less well-off and less well-educated. The report identified some possible explanations for this:

Individuals with higher socioeconomic status may engage more actively with the system and exercise pressure when they experience long delays. They may also have better social networks (“know someone”) and use them to gain priority over other patients, and they may have a lower probability of missing scheduled appointments (which would increase the waiting time). This negative gradient between waiting time

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<sup>77</sup> W. McIsaac, V. Goel and C.D. Naylor, “Socio-economic status and visits to physicians by adults in Ontario” (1997) 2 *J Health Serv Res Policy* 94.

and socioeconomic status may be interpreted as evidence of inequity within publicly funded systems and suggests that waiting lists may be less equitable than they appear.<sup>78</sup>

The submission by the Rimbey and Area Renal Dialysis Support Group highlighted the barriers to access and the consequences confronting rural populations:

- Urban planning has dominated the planning of rural health care programs, to the detriment of rural populations. The predominance of urban approaches meets the needs of large hospitals in major urban centres, but does not meet the needs of rural communities.
- The centralization of health services and rural hospital closures has had a severe impact on rural residents.
- If rural residents require more specialized care they must travel longer distances and incur additional expenses that are not fully reimbursed. During some parts of the year, travel may be impossible due to weather conditions, leading to poor health outcomes.
- Rural residents have lower health status than urban residents, higher overall mortality rates and shorter life expectancies, as well as higher rates of long-term disability and chronic illness. Rural Canadians are limited to a smaller range of health providers.
- The most serious problem for residents of rural and remote areas is access to the health care services they need closer to their own communities.
- If rural patients cannot gain adequate access to non-emergent (routine) and frequently required health care services such as renal dialysis, they face the prospect of having to sell their homes and move to an urban centre, as has been the case for numerous rural families. Having to leave communities and community networks imposes both financial and social costs on individuals, their families, their friends and their community. If one partner dies after relocation to an urban

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<sup>78</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 29.

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setting, the other partner is often left isolated because of lost connections to their rural community.<sup>79</sup>

I commend the Rimbey submission for the careful consideration of the government and AHS. It can be a useful resource in developing rural health initiatives to provide equity in both access to health care and in health outcomes.

The Romanow report also gave prominence to access to publicly funded health services in rural and remote areas and made several recommendations.<sup>80</sup> It did the same for Aboriginal health issues, calling the disparities between Aboriginal and non-Aboriginal Canadians – both in their overall health and their ability to access health care services – unacceptable.<sup>81</sup> How much or little has been done since the Romanow report to address these concerns is beyond my mandate to examine.

These examples of what I call inferior access are prevalent in Alberta and across Canada. Indeed, they pose much bigger challenges to attain and preserve an equitable public health care system than does improper preferential access. Examining improper preferential access was this inquiry's task. It is not within my mandate to make recommendations about how to allocate resources to redress inferior access to health care. But I can quote from a 1998 article and endorse its message: "Implementing measures to provide better care for the socially or geographically disadvantaged may be more feasible and constructive than enforcing rigid rules to impede preferential access for advantaged persons."<sup>82</sup>

I recognize that in a country as large as Canada, and a province as large and diverse as Alberta, there may always be some disparities in the distribution of resources and people's ability to access them. However, I cannot submit this report without pointing to the need to acknowledge

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<sup>79</sup> Exhibit 152, Rimbey and Area Renal Dialysis Support Group, *Submission to the Alberta Health Services Preferential Access Inquiry*, February 27, 2013 (prepared by Dr. John Church).

<sup>80</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 159-69.

<sup>81</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 211-31.

<sup>82</sup> D.A. Alter, A.S. Basinski and C.D. Naylor, "A survey of provider experiences and perceptions of preferential access to cardiovascular care in Ontario, Canada" (1998) 129 *Annals of Internal Medicine* 567 at 572.

and address the converse of preferential access – inferior access – a phenomenon which is arguably more widespread and at least as damaging to a health care system premised on equity.





## CHAPTER THREE: PRINCIPLES OF INQUIRIES

All inquiries, whether appointed federally or provincially, share certain fundamental principles and objectives. As developed through the jurisprudence and the experience of recent inquiries, they are fairness, openness to the public, thoroughness and expedition.<sup>83</sup> This inquiry has been guided by these principles and objectives throughout its work.

The appointment of an inquiry is an act of the executive branch of government and the inquiry's jurisdiction is circumscribed by the terms of reference stipulated in the executive's order in council. Yet an inquiry is, and must be, independent. The executive cannot direct the inquiry about how to carry out its mandate. That is one distinct advantage of a commission of inquiry. It is independent of government and thus it can retain the confidence of the public, particularly if a part of government is the focus of the inquiry. There are other advantages. An inquiry is transparent since the public sees what it is doing; it can bring expertise to the investigation of the subject matter by retaining experts and allocating necessary resources; and, through its extraordinary investigative powers, an inquiry can compel the production of documents and witnesses that might otherwise be out of reach. The other significant advantage is that an inquiry is impartial, free from partisan political constraints or pressures.

However, an inquiry faces a significant limitation. Unlike a civil or criminal trial, it cannot make findings of liability or culpability. The *Health Quality Council of Alberta Act*<sup>84</sup> (*HQCA Act*) specifically prohibits me from issuing a report that contains any findings of legal responsibility or any conclusion of law. This also accords with common law elaborations of the powers of public inquiries. But this does not prevent me from finding facts and reaching conclusions, even if my findings reflect adversely upon individuals.<sup>85</sup> That is, after all, the primary purpose of this inquiry – to find facts and reach conclusions.

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<sup>83</sup> See Ontario, *Report of the Walkerton Inquiry*, Part One (2002) at 472; Canada, Commission of Inquiry into Certain Allegations respecting Business and Financial Dealings between Karlheinz Schreiber and the Right Honourable Brian Mulroney, *Report: Volume 2 – Factual Inquiry* (Minister of Public Works and Government Services Canada, 2010) at 7.

<sup>84</sup> S. 22(3).

<sup>85</sup> See *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System)*, [1997] 3 S.C.R. 440 at para. 57.

Throughout this report, I have attempted to keep in mind that a public inquiry has the potential to tarnish the reputations of those who are compelled to testify and whose names are mentioned. It is easy to get caught in the media glare and publicity that follow such proceedings. The solution lies in ensuring that the inquiry's procedures are fair. And while inquiries are not bound by the ordinary rules of evidence or procedure that apply to civil or criminal trials, each inquiry establishes rules of procedure that must be fundamentally fair to all who appear before it and whose reputations may be affected by it.

The *HQCA Act* and the *Public Inquiries Act* stipulate that if it is intended that a commissioner's report will allege misconduct by any person, or may adversely affect a person, that person shall be given reasonable notice and the opportunity to give evidence or make representations on the matter before the report is issued.<sup>86</sup>

No such "notices of misconduct" were issued during this inquiry. I do make findings in this report about the conduct of certain individuals, but I am satisfied that the requirements of procedural fairness, as reflected in these statutory provisions, have been met. The inquiry's rules of procedure and the process adopted by all parties protected every witness. In particular, all parties with standing and all witnesses appearing before the inquiry had the right to counsel, both at the inquiry and during pre-testimony interviews. Each party with standing and each witness affected by the testimony of another witness had the right to cross-examine that witness through their counsel. All parties and witnesses had the right to receive copies of all documents to be referred to during their testimony. Commission counsel undertook to identify specific lines of questioning or events prior to any pre-testimony interviews. Finally, Commission counsel provided written summaries based on those interviews to any witness called by Commission counsel and his or her counsel.

All of these procedures were fair and provided witnesses with ample notice of the lines of inquiry and adequate protection for their interests. I do not think any witness can complain about being taken by surprise by any of the findings in this report.

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<sup>86</sup> *Public Inquiries Act*, R.S.A. 2000, c. P-39, s. 13; *Health Quality Council of Alberta Act*, S.A. 2011, c. H-7.2, s. 22(2).

I wish to emphasize, however, that any findings of fact and conclusions contained in this report should not and cannot be taken as findings of criminal or civil liability. Nor should they be taken as conclusions as to breaches of professional ethical or practice standards. Wherever I use such terms as “improper” or “inappropriate” or any word of a similar nature, it should be understood that I do not intend to indicate any conclusion of law by using those terms or to equate them with how they may be used in a professional discipline context. My intention is simply to give them the usual non-legal meaning that the public would ordinarily attach to them.

Finally, respecting the process I followed, it is important to recognize, as I said earlier, that this inquiry was of a type described as a mixed investigative/advisory inquiry. The terms of reference call for a fact-finding inquiry into whether improper preferential access is occurring and, if it is, a policy-focused inquiry leading to recommendations to prevent it from occurring again. Such inquiries are common, since merely investigating an event without looking at systemic or policy issues surrounding that event would not be very useful. Such an inquiry would ordinarily occur in two phases, the first being confined to witnesses and other evidence relevant to the fact-finding exercise and then, if the facts warrant it, a second phase consisting of expert evidence on policies and procedures.

It was apparent from the start of this inquiry that such a divided process would take much more time than was available under the deadline set by the initial order in council. To save time and costs, I decided to have the two phases overlap. The process must try to balance fairness and thoroughness with efficiency. This required all participants to keep in mind the distinction between evidence related to fact-finding and expert evidence relating to policies, a distinction made easier to grasp because the expert witnesses testified in the last days of the inquiry’s public hearings.



## CHAPTER FOUR: THE INQUIRY PROCESS

### A. General

This inquiry was established pursuant to section 17 of the *Health Quality Council of Alberta Act*<sup>1</sup> (*HQCA Act*) on February 28, 2012, when the Lieutenant Governor in Council issued Order in Council 80/2012.

That order directed the Health Quality Council of Alberta (HQCA) to appoint a panel of one or more persons to conduct the inquiry. On March 16, 2012, the HQCA board appointed me the sole commissioner for the panel for this inquiry.

Creating this inquiry under the provisions of the *HQCA Act* had certain organizational ramifications that I discuss in Appendix 1. However, the *HQCA Act* did not dictate my powers as commissioner other than to provide that the panel appointed to conduct an inquiry has all the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*<sup>2</sup> (something repeated expressly in the order in council).

### B. Organization

Every inquiry must handle multiple administrative tasks in its work. Staff have to be recruited, counsel retained, office premises and communication systems established, rules of procedure drafted and public hearings arranged. This work is primarily the responsibility of the inquiry's executive director.

I think it is fair to say that this inquiry encountered quite a few organizational issues, due in no small part to this being the first public inquiry conducted in Alberta in many years and the very first inquiry called under section 17 of the *HQCA Act*. There were delays in setting up the administrative apparatus due to the election called on March 26, 2012. From that date until the provincial election on April 23, 2012, very little could be done because the initial budget approval and advance of funds to finance the inquiry operations could not occur until after the election and the swearing-in of a new cabinet. In addition, financial arrangements were made more complicated by the three-party relationship contemplated by the Act and the order in council – that of

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<sup>1</sup> S.A 2011, c. H-7.2.

<sup>2</sup> R.S.A. 2000, c. P-39.

the government, the HQCA and the inquiry. I discuss some of these difficulties in Appendix 1 to this report. Since this inquiry will help to serve as a template for future inquiries under section 17 of the Act, I also offer suggestions there on how future inquiries can be organized.

### ***C. Commission counsel***

The role of commission counsel is particularly important since counsel are responsible for ensuring that matters bearing on the mandate of the inquiry are brought forward. Commission counsel identify the issues to be investigated, supervise the investigations and witness interviews, obtain disclosure of documents, determine who will be called as witnesses and lead the evidence at hearings.

As has often been said, a commission of inquiry is not a trial. The role of commission counsel is not like that of a prosecutor in an adversarial process. Commission counsel, like a commissioner of inquiry, must be objective and impartial. The role was aptly described by Justice Dennis O'Connor in a 2003 paper:

The role of commission counsel is quite different from that of a lawyer in most other legal proceedings.... The difference stems from the relationship between commissioner and commission counsel. That relationship is altogether different from the usual one between a judge and a lawyer. The commissioner appoints his or her counsel and it is often said, aptly I think, that a commission counsel becomes the alter ego of the commissioner.

As a result, commission counsel's role is not to advance any particular point of view, but rather to investigate and lead evidence in a thorough, but also completely impartial, and balanced, manner. In this way, the commissioner will have the benefit of hearing all of the relevant facts or evidence unvarnished by the perspective of someone with an interest in a particular outcome.<sup>3</sup>

When making their final submissions before this inquiry, some counsel for the participants raised concerns about the approach of Commission counsel. They criticized Commission counsel for going beyond

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<sup>3</sup> Justice Dennis O'Connor, "The Role of Commission Counsel in a Public Inquiry" (2003) 22(1) *Advocates' Soc. J.* 9-11.

summarizing the evidence and drawing conclusions and making recommendations. Some criticized Commission counsel for a lack of objectivity because of some selective choice of evidence.

These criticisms are totally unwarranted. Commission counsel, throughout this process and particularly during the hearings, exhibited those traits identified in the extract above: impartiality and fairness. The decision as to what evidence to call is precisely the responsibility of Commission counsel. If at times Commission counsel appeared to take a less-than-passive approach to a witness, it must be remembered that counsel sometimes has to be a bit more active and persistent to obtain a thorough and truthful account from a witness.

I also reject the criticism of Commission counsel for drawing conclusions and making suggestions as to recommendations. Commission counsel acts in the public interest and no one has a more comprehensive knowledge of the evidence. The final submissions of Commission counsel can therefore be highly valuable in identifying the important points in the evidence, what conclusions may or may not be drawn from them, and what recommendations may appropriately be made based on those conclusions. This is no different than the submissions of counsel for the other inquiry participants, who also showed no hesitation in urging me to come to certain conclusions and arguing for certain recommendations. This is all proper advocacy. And, as I stated at the time of the final submissions, no one should doubt that the conclusions I reach and the recommendations I make are my own.

#### ***D. Witnesses and evidence***

The work of Commission counsel and her associates was particularly demanding. The only information counsel had at the outset came from press reports of the queue-jumping allegations and the Duckett memo of 2009 dealing with requests for preferential or expedited care.

Unlike most investigative inquiries, there was no specific event to examine, and certainly no earlier investigations to start from. Counsel began their investigation with the time period and events leading up to the Duckett memo. They also had lists of the senior employees and board members of the nine health regions that existed prior to the creation of AHS and contacted most of those people. Counsel also interviewed the current senior management people at AHS and the health ministers and deputy health ministers in place during what

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counsel considered to be the relevant period. Some events counsel wanted to examine – for example, the Calgary Flames H1N1 vaccination issue – had been widely reported, so counsel began investigations with the individuals or organizations that would have relevant information. In other cases, the initial information came from people contacting the inquiry through its website or contacting Commission counsel directly.

As well, in the early days of organizing the inquiry, a website was established that provided the inquiry's contact details and invited anyone with pertinent information to contact the inquiry on a confidential basis. The inquiry received hundreds of emails, letters and website responses from members of the public. Counsel examined all of these communications.

Commission counsel, with the co-operation of counsel for the Alberta Medical Association, also posted a letter to Association members on its website. The letter sought assistance in uncovering instances of improper preferential access to publicly funded health services. Physicians were asked to contact Commission counsel if they had relevant information.

Witnesses generally came to the attention of Commission counsel in one of the following ways: (i) they responded through the inquiry website and were then contacted by Commission counsel or inquiry staff; (ii) they were presented or suggested to counsel by interveners or interveners' counsel; or (iii) individuals became known to Commission counsel during investigations, including reviews of media reports, website information, document production and analysis, or during interviews of other witnesses.

Commission counsel developed an agreed-upon pre-hearing witness interview protocol with intervener counsel. The interviews were not recorded by audio or video, but Commission counsel took notes. Following the interview, Commission counsel would create an interview summary and circulate that to counsel for the witness. The witness could correct inaccuracies in the summary so that his or her evidence before the inquiry could largely accord with the summary. Once the form of the interview summary was agreed between Commission counsel and counsel for the witness, it was then circulated to other intervener counsel and counsel for any other parties who might have an interest in that anticipated testimony, along with any



documents referred to in the summary or later identified as being relevant to the testimony of that witness.

Almost all interviews were conducted in person, although some had to be done by telephone because of distance or shortage of time. The interviews were almost always conducted with other counsel present. Because most witnesses were current or former members of either AHS or the Government, it was usually counsel for those interveners who were present. However, some witnesses obtained their own counsel and many witnesses came directly to Commission counsel and did not want separate counsel for their interviews.

Further, where a person was simply providing Commission counsel with second-hand information about an event or another person who might be involved in queue-jumping, counsel investigated that information to identify the primary actors and attempted to elicit first-hand evidence at the hearings.

### ***E. Limits and proportionality***

One difficulty confronting Commission counsel lay in establishing reasonable limits on gathering evidence. Counsel could go on and on uncovering instances where some conduct could be said to constitute improper preferential access. But the principle of proportionality must come into play at some point. Decisions have to be made about the relative importance of any piece of evidence. As well, counsel had to decide when enough evidence was heard to allow meaningful conclusions. We did not, and should not, have the luxury of carrying on our work indefinitely in some expectation that more evidence would necessarily be better evidence. Evidence needed to be presented in a manner proportionate to its significance to our mandate. Participants in this process had to be mindful of the cost and the time expended.

### ***F. Budget***

The order in council establishing this inquiry required me to prepare a budget and submit it to the Lieutenant Governor in Council through the Minister of Health for review and approval. It also required me to put a system of budget monitoring and reporting in place, such reporting to be to the Minister of Health. I comment about some of the implications of this last requirement in Appendix 1 to this report.

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My executive director worked extensively with HQCA personnel to prepare the budget. Many standard budget items are common to all commissions of inquiry, such as fees for legal counsel, administration and personnel costs, office and equipment, hearing facility costs and report production. This was a difficult process considering we had little knowledge when the budget was being prepared as to how extensive our work would need to be or how many hearing days would be required.

Order in Council 264/2012 approved the budget on July 25, 2012, allocating \$8,258,000, with an additional \$1,742,000 as a contingency fund. The order in council also called for the HQCA to administer the funds.

The funding conditions required a grant agreement between the provincial government and the HQCA. That in turn required the implementation of a second agreement between me (as the panel for the inquiry) and the HQCA. These agreements were not finalized until mid-September 2012, delaying the advance of funds until then. This caused significant delays in the inquiry's work (notwithstanding the interim administrative and financial support – eventually repaid from the inquiry budget – provided by the HQCA).

I am pleased to report that this inquiry carried out its mandate within its budget, without requiring contingency funds, and with a surplus to be sent to the provincial treasury.

### ***G. Standing and funding***

The inquiry's initial order in council also required me to develop and submit a policy to the Lieutenant Governor in Council on whether assistance would be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel. To develop a policy on funding, a policy on grants of standing was necessary first. One goes with the other since standing as an intervener, or being called as a witness, are prerequisites to an application for financial assistance.

Canadian jurisprudence about commissions of inquiry recognizes the importance of allowing interventions by parties who have a direct and substantial interest in the proceedings. This helps ensure that an inquiry is able to fulfill its mandate by having before it all the relevant facts and circumstances. It also ensures fairness, both procedurally and

substantively. The jurisprudence also recognizes that funding may be necessary for those parties who show an inability to participate meaningfully without financial assistance. This also helps ensure fairness.

With respect to grants of standing as an intervener, the policy I implemented required applicants to satisfy me that:

- a) the applicant was or might be directly or substantially affected by the inquiry; or
- b) the applicant had or represented a clearly ascertainable interest or perspective, which ought to be separately represented at the inquiry, and which would assist the inquiry to fulfill its mandate.

My policy on funding set out that an intervener, or a witness called to testify before the inquiry, might apply for funding by submitting:

- a) a sworn statutory declaration proving that the applicant did not have sufficient financial resources from any source to enable it to meaningfully participate in the inquiry;
- b) a written budget outlining the applicant's proposed involvement in the inquiry and the estimated costs to be incurred by the applicant; and
- c) a written proposal as to how the applicant would account for funds received.

The criteria by which I was to consider each application, as outlined in the policy, were as follows:

- a) whether the applicant was a witness, intervener or both;
- b) in the case of applicants who were witnesses, whether the applicant's testimony was being compelled by Commission counsel;
- c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the inquiry report;
- d) whether the applicant had a demonstrated record of concern for and commitment to the interest it sought to represent;

## The Inquiry Process

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- e) whether the applicant had special experience or expertise relevant to the inquiry's mandate; and
- f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

The policy also stipulated that, after consideration and approval of an application for funding, I would make a recommendation about funding to the Lieutenant Governor in Council. This procedure followed well-established precedents from inquiries in other Canadian jurisdictions. In this manner, the government retained ultimate control over the expenditure of public funds.

My funding policy for witnesses and interveners was approved by Order in Council 264/2012 on July 25, 2012.

On October 17 and 18, 2012, I heard applications for standing and funding. I issued rulings on October 19, 2012. I granted standing, with full intervener rights, to four organizations: Alberta Health Services, the Government of Alberta as represented by the Ministry of Health, the Alberta Medical Association and the Consumers' Association of Alberta. The first three play significant roles in delivering publicly funded health services in Alberta. I concluded that the fourth, the Consumers' Association, could bring a valuable public perspective to the inquiry's work, a perspective different from that of health providers, government and professional organizations.

"Full intervener rights" means that each intervener had participation rights as follows:

- a) the right to be present and represented by counsel throughout the inquiry;
- b) the right to make submissions;
- c) the right to receive advance disclosure of evidence to be called, and documents to be referred to, by Commission counsel in accordance with the inquiry's rules of procedure;
- d) the right to suggest to Commission counsel the names of witnesses who should be called or evidence that should be presented and, in the event of a dispute, the right to apply to me for directions; and

- e) the right to cross-examine witnesses.

I recommended funding of up to \$120,000 for the Consumers' Association of Alberta to assist with its representations. (On March 15, 2013, I recommended additional funding of \$28,000). I also recommended funding of \$5,000 for the Renal Dialysis Rimbey Support Group, a community-based, non-profit organization from Rimbey, Alberta, to obtain expert assistance in preparing a submission to the inquiry.

I subsequently communicated my recommendations on funding to the Minister of Health and on October 29, 2012, the Lieutenant Governor in Council issued Order in Council 383/2012 approving the funding.

### **H. Rules of procedure**

Commission counsel examined numerous precedents for procedural rules from other commissions of inquiry and prepared a draft for my consideration. Counsel also consulted interveners' counsel for comments on the draft rules. Commission counsel also created forms entitled Notice to Disclose Records and Notice to Attend, reflecting my powers under the *Public Inquiries Act* and the *HQCA Act*.

The Rules of Practice and Procedure I ultimately adopted were meant to ensure fairness and efficiency in inquiry proceedings. A copy of those rules was posted on the inquiry website with all other policy documents and rulings. (Copies are reproduced in Appendix 4 to this report).

### **I. Privacy and confidentiality issues**

Any inquiry involving health matters raises significant concerns about privacy and confidentiality, particularly of patient health records. Alberta has strong mechanisms in the *Health Information Act*<sup>4</sup> and the *Freedom of Information and Protection of Privacy Act*<sup>5</sup> to protect the privacy of individuals with respect to their health information and to preserve the confidentiality of that information. This presented challenges to the inquiry in compelling production of documents containing personal health information.

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<sup>4</sup> R.S.A. 2000, c. H-5.

<sup>5</sup> R.S.A. 2000, c. F-25.

Early in our proceedings, Commission counsel retained Mr. Sean Ward of the firm of Reynolds Mirth Richards & Farmer of Edmonton to provide an opinion on these privacy issues. I was satisfied, after receiving that opinion, that the powers granted to me as the commissioner of inquiry pursuant to both the *Public Inquiries Act*<sup>6</sup> and the *HQCA Act*<sup>7</sup> were sufficient to overcome, if necessary, the restrictions imposed by these two privacy statutes. Even so, Commission counsel was careful to preserve confidentiality of personal health information during these proceedings.

The Rules of Practice and Procedure used by the Inquiry provided that all documents provided to Commission counsel would remain confidential unless and until made exhibits in the course of the inquiry. The exception was Commission counsel's obligation to provide documents to any participants whose interests the documents might affect. Interveners and participants who received advance copies of documents in this way signed undertakings acknowledging their obligations of non-disclosure.

For witness interviews, Commission counsel did not provide assurances of confidentiality (other than those relating to personal health information) or grant anyone immunity from testifying. Because of the nature of a public inquiry, Commission counsel felt that she had to retain the ability to call evidence from any witness whose testimony was relevant to the questions before the inquiry. However, counsel did not generally disclose the identity of interviewees or the information they possessed unless calling them as witnesses.

#### **J. *Research and expert witnesses***

Under the guidance of the inquiry's director of research, Mr. John McGurran, a group of 13 experts was consulted for preliminary views on the concepts raised by the issue of improper preferential access. This group included clinicians, medical ethicists, academics and health administrators. Six individuals from this larger group were asked to elaborate on their opinions and testify. Those were:

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<sup>6</sup> In particular, s. 9.

<sup>7</sup> In particular, s. 17(7).

- Dr. H. Brian Goldman, MD
  - Staff emergency physician, Mount Sinai Hospital, Toronto
  - Assistant Professor, Department of Family and Community Medicine, University of Toronto
  - Host, *White Coat, Black Art*, a CBC Radio One show about the culture of modern medicine
  
- Lynette Reid, PhD
  - Associate Professor, Department of Bioethics, Faculty of Medicine, Dalhousie University
  - Member, Division of Medical Education, Dalhousie University
  - Member, Faculty of Graduate Studies, Dalhousie University
  
- Pam Whitnack, MBA
  - President, Whitnack and Associates Ltd.
  - Executive Vice-President, Rural, Public and Community Health, Alberta Health Services, 2008-11
  - Chief Executive Officer, Chinook Health Region, 2005-08
  
- Dr. David A. Alter, MD, PhD, FRCPC
  - Cardiologist, Toronto Rehabilitation Institute – University Hospital Network
  - Associate Professor, Department of Medicine, University of Toronto
  - Senior Scientist, Institute for Clinical Evaluative Sciences

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- John Church, PhD
  - Associate Professor, Department of Political Science and Centre for Health Promotion Studies, University of Alberta
  - Principal, JC Paragon Consulting Services Ltd.
  
- Dr. Owen Robert Heisler, MD, MSc, MBA, FRCSC, FACS, FCCHL, FACPE
  - Assistant Registrar, College of Physicians & Surgeons of Alberta
  - General Surgeon, Red Deer, Alberta 1988-2008
  - Assistant Clinical Professor, University of Alberta
  - Site Medical Director Red Deer Regional Hospital, December 2004 - March 2006

Two additional experts testified at the start of our hearings. Prof. William Lahey, associate professor at the Schulich School of Law and former director of the Health Law Institute at Dalhousie University, presented a report explaining the *Canada Health Act* and the legislative framework governing access to publicly funded health services in Alberta. Mr. James L. Saunders, a consultant with over 30 years' experience in the Alberta health care system, presented a report on the delivery of health care in Alberta and the organizational relationship between government and service providers.

Mr. McGurran also arranged for an academic literature review of preferential access to health care in Canada. The review was authored by Dr. Nishan Sharma of the Faculty of Medicine at the University of Calgary. Dr. Sharma and his associate, Ms. Garielle Brown of W21C, a research team at the University of Calgary, later prepared a compilation and categorization of the expert oral and written testimony provided to the inquiry.

### **K. Public hearings**

Public hearings were held in Edmonton (December 4 to 13, 2012) and Calgary (January 7 to 18 and February 19 to 27, 2013), with final submissions heard in Edmonton (April 3 and 4, 2013). The hearings were open to the public and the press. Closed-circuit television links



were provided to a separate media room so reporters could work as the hearings progressed.

Real-time reporting was provided at the hearings, with transcripts prepared overnight. Transcripts of each day's testimony and copies of all exhibits entered into the record were promptly posted on the inquiry website.

Arrangements were made for live webcasts of the hearings over the inquiry website. There were over 3,770 webcast views during the public hearings. Viewers from Canada predominated, but there were also viewers from the United States, Europe, Australia and Asia.

#### ***L. Delivery of the report***

Order in Council 80/2012 directed me to submit a report of my findings and recommendations to the Speaker of the Legislative Assembly by April 30, 2013. That deadline was subsequently extended, at my request, to August 31, 2013 by Order in Council 40/2013. The primary reason for the extension request was the need to schedule more hearing dates than originally anticipated, which in turn delayed the making of final submissions. It became apparent that meeting the original deadline was not feasible given the time required to review the evidence and draft, print and publish the report.

Section 22 of the *HQCA Act* speaks specifically to the delivery of the report in subsections (5), (6), (7) and (8):

- 5) On completion of the report, the Panel shall submit the report to the Speaker of the Legislative Assembly.
- 6) On receiving a report under subsection (5), the Speaker of the Legislative Assembly shall lay the report before the Legislative Assembly if it is then sitting or, if it is not then sitting, within 15 days after the commencement of the next sitting.
- 7) The Legislative Assembly may refer a report tabled under subsection (6) to a special committee of the Legislative Assembly to review the report and make recommendations to the Assembly.

- 8) If the Legislative Assembly is not sitting when the report is submitted to the Speaker, the Speaker shall make copies of the report available to the public.

The recommendations in this report are of course just that – recommendations. My hope is that the legislature will consider them carefully, touching as they do on one of Alberta's most important assets, its publicly funded health care system.

## SECTION II: CONCEPTS, DEFINITIONS, AND SYSTEMS

### CHAPTER ONE: HEALTH CARE SERVICES IN ALBERTA: LAWS AND STRUCTURES

Obtaining a complete sense of how the health care system in Alberta operates is almost an impossible task. The provincial health care system is enormously complex and involves service to millions of Albertans through a multitude of mechanisms. It is regulated by a range of federal and provincial legislation and professional codes.

The final submissions of the Government of Alberta described the vehicles for providing health care services in Alberta. These serve to highlight the complexities involved in delivering health care in the province:

Publicly funded health services are provided through a wide range of institutional and community settings across Alberta. Those settings include Hospitals (including emergency departments, cancer clinics and other types of clinics), urgent care centres, public health centres, ambulatory care centres, primary care networks, family care clinics, physicians' offices, supportive living facilities, long-term care facilities (such as nursing homes and auxiliary hospitals), non-hospital surgical facilities ("NHSFs"), diagnostic imaging clinics, labs, pharmacies, correctional centres and other specific types of clinics established to address particular health conditions.<sup>1</sup>

While it may be next to impossible to understand every aspect of the health care system, this inquiry needed a basic explanation of the system's legislative and organizational framework. To this end, Commission counsel engaged two experts identified earlier. The first was Prof. William Lahey, who examined the legislative framework governing access to health services that are "insured health services" under the *Canada Health Act*<sup>2</sup> and "insured services" under Alberta legislation.<sup>3</sup> The second was Mr. James L. Saunders, who prepared a

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<sup>1</sup> Closing Submissions of the Government of Alberta, March 28, 2013, at 7 (Exhibit 168).

<sup>2</sup> R.S.C. 1985, c. C-6.

<sup>3</sup> William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the Canada Health Act and "Insured Services"*

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study on how health care is delivered in Alberta.<sup>4</sup> In essence, he described the organizational relationship between government and service providers, explaining the basics of what health care is available to Albertans and through which channels. Both Prof. Lahey and Mr. Saunders elaborated on their written reports in oral testimony before the inquiry in December 2012.

The inquiry also benefitted from submissions by various interveners, including the closing submissions of the Government of Alberta, which described the interaction between various pieces of provincial and federal legislation and also summarized the governance structure for publicly funded health care in Alberta. The 2002 report of the Hon. Roy Romanow, *Building on Values: The Future of Health Care in Canada: Final Report*, also helped to paint a broad picture of the legislative background and structural framework of Canada's publicly funded health care system as a whole.

This chapter merely seeks to give readers a brief overview of the legislation and governance structures relating to publicly funded health care in Alberta. The goal is to help understand the context in which issues relating to preferential access arise. If readers need a more complete understanding of the legislation behind the organization of health care in Alberta and in Canada as a whole, they can refer to the sources cited above.

This section relies heavily on the research of Prof. Lahey and Mr. Saunders. I have not inserted detailed references to their work, but it can be understood that much of the following text is based on their research.

### **A. *The legislative framework***

#### **(i) *The Canada Health Act***

Health care in Canada is a shared provincial-federal responsibility. Federal legislation, the *Canada Health Act*, entitles Alberta to its share of cash transfers that the federal government makes each year to the provinces and territories for expenses they incur in funding health care.

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*under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012 [Exhibit 11] [Lahey Report].

<sup>4</sup> J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta*, November 29, 2012 [Exhibit 12] [Saunders Report].

The *Canada Health Act* is primarily a funding mechanism. Section 4 of the Act makes this clear:

The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

This funding mechanism means paying 100 per cent of the cost of what the Act defines as insured health services. It defines these in part as “hospital services, physician services and surgical-dental services provided to insured persons...” Essentially, this means those services that are medically necessary or medically required. To obtain that 100-per-cent funding, the health care insurance plan in Alberta must satisfy the following five criteria set out in the *Canada Health Act*:

- 1) public administration;
- 2) comprehensiveness;
- 3) universality;
- 4) portability; and
- 5) accessibility.

The Romanow report notes that the principles of the *Canada Health Act* – which are known as the Five Criteria – began as simple conditions attached to federal funding for medicare. “Today,” the report continues, “they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of health care.”<sup>5</sup>

In addition, for the health services that the provincial health plans insure, the *Canada Health Act* prohibits extra-billing and user charges. There are some exceptions to the obligation to comply with the Five Criteria. Some groups receive access to health care through other means and the Act therefore does not include them in the definition of “insured persons.” These are members of the Canadian Forces, inmates in federal penitentiaries and, until recently, members of the RCMP. As well, the “insured health services” covered by the Act do not include

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<sup>5</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 60.

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services relating to workers' compensation that are available under provincial or other federal legislation.

The annual transfer provides a significant financial incentive to the provinces to comply with the *Canada Health Act*. Prof. Lahey cites estimates that provincial and territorial government health expenditures would reach \$135 billion in 2012 and notes that spending on health care is one of the largest budget items for all provinces.

In short, medicare seeks to ensure access to necessary physician and hospital services (as well as some dental services) regardless of each individual's wealth. In this sense, medicare seeks to ensure equality of access generally to the health services it encompasses.

### **(ii) Alberta health legislation**

Alberta residents are generally entitled to the categories of health service identified in the *Canada Health Act* without being charged for the service:

- 1) medically required services provided by a physician;
- 2) medically necessary services provided by a hospital; and
- 3) surgical-dental services that are medically or dentally required if performed in a hospital where the service is one that must be provided in a hospital.<sup>6</sup>

The *Canada Health Act* requires provinces and territories to have a publicly administered health care insurance plan. The Alberta version of the health care insurance plan that the Act requires in fact consists of two plans, one established under the *Alberta Health Care Insurance Act*<sup>7</sup> and the other under the *Alberta Hospitals Act*.<sup>8</sup>

Under the *Alberta Health Care Insurance Act*, the payment of benefits for insured services depends on the physician or dentist who provides the service being "opted in" to the health insurance plan.<sup>9</sup> No physician or dentist and no resident may receive the payment of benefits under

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<sup>6</sup> *Canada Health Act*, R.S.C. 1985, c. C-6, s. 2.

<sup>7</sup> R.S.A. 2000, c. A-20.

<sup>8</sup> R.S.A. 2000, c. H-12.

<sup>9</sup> R.S.A. 2000, c. A-20, s. 6(1).

the plan in respect of insured services unless the physician or dentist had opted in to the plan when the services were provided.<sup>10</sup> The prohibition on extra billing only applies to physicians or dentists who have opted in to the plan.

Opting out allows doctors and dentists in Alberta to make services that are available to all Albertans through medicare available on different and possibly preferential terms to Albertans who are able and prepared to pay for those services. Still, opting out is a rarity in Alberta. The 2010-11 annual report of Health Canada on the *Canada Health Act* says that “as of March 31, 2011, there were zero opted out physicians in [Alberta].”<sup>11</sup>

In addition, the Alberta *Health Care Protection Act*<sup>12</sup> deals with the funding and delivery of insured and uninsured surgical services and with the role of private surgical facilities in the provision of those services.

### **B. Structure and governance of health care in Alberta**

In Alberta, publicly funded health services are delivered by the following providers:

- 1) Health care practitioners who bill fee-for-service for the health services provided (for example, physicians);
- 2) Alberta Health Services (AHS) through the health care practitioners it employs directly in its facilities (for example, nurses);
- 3) Health care practitioners who are employed or under contract with AHS to provide health services (for example, the Chief Medical Officer of Health);
- 4) Health care practitioners who contract with AHS to provide health services (for example, physicians in non-hospital surgical facilities); and

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<sup>10</sup> R.S.A. 2000, c. A-20, ss. 6(1) and (2).

<sup>11</sup> Health Canada, *Canada Health Act – Annual Report 2010-2011* (Ottawa: Health Canada, 2011) at 96.

<sup>12</sup> R.S.A. 2000, c. H-1.

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- 5) Health care practitioners who operate under Government of Alberta programs (for example, physicians under Alternative Relationship Plans).<sup>13</sup>

The Minister of Health, Alberta Health and AHS have roles in the Alberta health care system. Alberta Health sets strategic direction for the health system through the following:

- Legislation, policy and standards;
- Allocation of public funding; and
- Administration of provincial programs.<sup>14</sup>

The Government of Alberta sets funding levels. In recent decades it has also overseen a major restructuring of health boards in the province.

In May 1994 there were 193 health care boards in Alberta: 128 acute care hospital boards, 25 public health boards and 40 long-term care boards. In June 1994, under the authority of the *Regional Health Authorities Act*,<sup>15</sup> the Minister announced a reduction in the number of health care boards from 193 to 17 new health region boards. In addition, the Alberta Cancer Board and the Alberta Mental Health Board would remain in place, with province-wide responsibilities. The goal of the change was to increase the efficiency of the health system.<sup>16</sup>

In April 2003 the number of health regions was reduced from 17 to 9. The Alberta Cancer Board and the Alberta Mental Health Board remained in place. This change enabled the boundaries of the large and medium-sized health regions to expand to include smaller rural health regions whose populations were already accessing and depending on health services from the larger regions. The 2003 changes were based on the assumption that fewer health regions with more resources, larger budgets and responsibility for managing health services for larger catchment areas and service populations would achieve efficiencies within the system. The greater scope was expected to streamline government interaction with the health system and improve the

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<sup>13</sup> Closing Submissions of the Government of Alberta, March 28, 2013, at 7 (Exhibit 168).

<sup>14</sup> Closing Submissions of the Government of Alberta, March 28, 2013, at 6 (Exhibit 168).

<sup>15</sup> R.S.A. 2000, c. R-10.

<sup>16</sup> Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta's Health System, May 15, 2008.



management of the health regions, quality of care, standardization of policies and procedures and coordination of services.

In May 2008 the Minister announced that Alberta would be moving to one provincial governance board to coordinate the delivery of health services across Alberta. This would be done through AHS. Now the regional health authority, AHS is responsible for overseeing the planning and delivery of health supports and services in the province.

The goal of this restructuring was, as the minister of the time stated, “to improve the way health care is administered in this province...”<sup>17</sup>

A background document released at the time stated that the new governance model was intended to strengthen a provincial approach to managing health care services, including surgical access, long-term care, chronic disease management, addictions and mental health services as well as health workforce and access to primary care.<sup>18</sup>

Under section 8 of the *Regional Health Authorities Act*, the Minister may give directions to AHS for the purpose of (a) providing priorities and guidelines for it to follow in the exercise of its powers, and (b) coordinating the work of the regional health authority with the programs, policies and work of the government and public and private institutions in the provision of health services in order to achieve the best health outcome and to avoid duplication of effort and expense. AHS reports to the Minister through its board. The Minister appoints each member of the AHS board, and board members hold office for a specified term or until removed earlier, at the discretion of the Minister.

Section 5 of the *Regional Health Authorities Act* sets out the obligations of AHS:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;

<sup>17</sup> Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta’s Health System, May 15, 2008.

<sup>18</sup> Government of Alberta, News Release and Backgrounder, One Provincial Board to Govern Alberta’s Health System, May 15, 2008.

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- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

These changes to the organization of the health care system in 1994, 2003 and 2008, had serious repercussions for the people working in the system. In its 2012 report, the Health Quality Council of Alberta noted that the magnitude and frequency of the organizational changes created a sense of “chaos and instability.”<sup>19</sup> That report recommended that the government and AHS undertake no further restructuring without first having a clear rationale for the change and an effective process of consultation with stakeholders and the public.<sup>20</sup>

One further change in the governance of the Alberta health system in 2008 was the creation of a contractual relationship between Covenant Health and AHS. Covenant Health (formerly Caritas Health) is an Alberta-based Roman Catholic organization that provides acute care, continuing care, assisted living, hospice, rehabilitation, respite care and seniors housing in 12 communities across Alberta. Covenant Health operates about 950 acute care beds and about 1,350 continuing care beds in the province. Before 2008, Covenant Health had a working relationship with the (former) Capital Health Region. In 2008, it was agreed that Covenant Health would continue to operate with its own board but that it would sign a formal cooperation and services agreement with AHS.<sup>21</sup> As a result, AHS maintains the overall accountability for the health care system.

Covenant Health is a contractor that, according to Mr. Saunders, works “in harmony” with AHS to ensure that the services provided by Covenant Health meet the expectations of AHS.<sup>22</sup>

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<sup>19</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 185.

<sup>20</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 186.

<sup>21</sup> AHS Board Meeting Minutes, December 2, 2010, at 7-8.

<sup>22</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 96-97.

## CHAPTER TWO: DEFINING ACCESS: PREFERENTIAL, PROPER AND IMPROPER

### A. *General*

A recurring theme throughout this inquiry has been the lack of an accepted definition of improper preferential access. The Canadian health care system is designed to ensure that residents have reasonable access to medically necessary physician and hospital services. That “reasonable access,” however, can be facilitated or inhibited in any number of different ways – by policy decisions on the allocation of resources, by geography or socio-economic factors, and by discretionary decision-making on the part of health care providers and administrators, to name a few. The focus of this inquiry is actions that lead to preferential access that is improper within the context of the Canadian health care system. Hence there is a need to define preferential access and what is improper.

In essence, preferential access implies an advantage, a priority, over that which would be regarded as normal access, access that meets accepted clinical and organizational norms. What is reasonable is very much a contextual concept, dependent on the circumstances of the particular situation. Conferring a preference, however, assumes that one is making a choice to benefit one individual over others who are similarly situated. The issue is whether that preference can be justified on medical or ethical grounds or on the basis of some broad social principle. And if it cannot be justified, then it likely cannot be proper or reasonable.

There are a number of examples of attempts to define improper preferential access and queue-jumping. These terms have been used interchangeably but they are not necessarily the same. Getting a better hip implant than others might be considered preferential access, or at least preferential treatment, but it need not involve getting faster service. An article from 2007 defined queue-jumping as “the favourable placement or prioritization of a patient in a waiting list for reasons other than medical need.”<sup>1</sup> One expert who appeared before the inquiry, Dr. Brian Goldman, described the common elements of the definition in the medical literature to include “preferred access to and

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<sup>1</sup> Steven Marc Friedman, Lee Schofield & Sam Turkos, “Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access” (2007) 14 *Eur. J. of Emergency Medicine* 260 at 260.

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utilization of medical services for different patients of equivalent medical need based on factors other than medical need.”<sup>2</sup> Another expert witness, Dr. Lynette Reid, defined improper preferential access as “*differential access* to any of a comprehensive set of medically necessary health care services, where that differential access is *based on medically and/or ethically inappropriate criteria*.”<sup>3</sup> All of these are helpful but perhaps not necessarily complete.

I previously noted how little research has been done on the subject matter of this inquiry. This is in part due to lack of data. What little has been done demonstrates some interesting attitudes toward improper preferential access or queue-jumping by both the public and physicians.

A survey conducted in 2005 of randomly selected households in Toronto revealed ambivalence on the subject.<sup>4</sup> Of the people surveyed, 95 per cent expressed a commitment to the principle of equal access to health care based on need. But about half also said they would consider contacting a colleague to improve their position in a queue. Some 16 per cent reported that they did use connections in the past to improve their position on a wait list. As the authors of the survey article note, such inconsistencies between stated beliefs and actual practice simply reflect human nature when confronted by illness. However, there may also be signs of increasing strain on the health care system.<sup>5</sup> As wait lists for medical services grow, it is not unlikely that even those who support principles of equity and fairness will increasingly attempt to gain improper preferential access when under stress.

A survey of cardiac surgeons and hospital chief executives in Ontario in 1997 reported that 80 per cent of physicians and 53 per cent of chief executives said that they had been personally involved in managing a patient who had received preferential access on the basis of factors

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<sup>2</sup> Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 1.

<sup>3</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 4 [emphasis in original].

<sup>4</sup> Steven Marc Friedman, Lee Schofield & Sam Turkos, “Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access” (2007) 14 *Eur. J. of Emergency Medicine* 260.

<sup>5</sup> Steven Marc Friedman, Lee Schofield & Sam Turkos, “Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access” (2007) 14 *Eur. J. of Emergency Medicine* 260 at 262.

other than medical need.<sup>6</sup> The most likely factors leading to preferential access were identified as personal ties to the treating physician or the fact that the patient was a high-profile public personality such as a politician or a hospital board member or significant donor. The survey respondents also noted that preferential access was more likely to be provided if the patients or their families were particularly well-informed about the procedure, or were aggressive and perceived as potentially litigious, or where there was pressure from the referring physician. There is no reason to think that these results are not generalizable across Canada or still pertinent, notwithstanding that the survey was conducted 15 years ago.

The reference above to the factor of a well-informed patient was highlighted by the experts who testified at the inquiry. For some, the fact that Canadians possess varying degrees of health literacy and abilities to advocate for themselves creates preferential access. Dr. Goldman said, “If somebody happens to be more educated and they know their options and they’re more likely to ask about options. Absent a central triage system that would field these requests in an equitable way ... then they’re probably more likely to get them because they know they exist.”<sup>7</sup> Dr. David Alter, another expert witness, said, “The biggest driver of health care utilization and getting to the queue is health-seeking behaviours of individuals.... People behaviours will vary.”<sup>8</sup>

A news article in 2007 published the revelation by the then-president of the Canadian Medical Association, Dr. Brian Day, that he had used his status to help a family member jump the wait list for a CT scan. He also admitted using his personal friendship with a surgeon to bypass the wait list when he needed knee surgery. Dr. Day used the story to highlight his concerns about long wait times. He was quoted as saying that it was not realistic to expect people not to use their connections to jump the queue when their own or their family’s health is at stake.<sup>9</sup>

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<sup>6</sup> David A. Alter, Antoni S.H. Basinski, and C. David Naylor, “A Survey of Provider experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada” (1998) 129 *Annals of Internal Medicine* 567.

<sup>7</sup> Testimony of Brian Goldman, Transcripts, vol. 37, February 26, 2013, at 3178-79.

<sup>8</sup> Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3369.

<sup>9</sup> K. Jaimet, Top doctor admits to queue-jump, *CanWest News Service*, December 3, 2007.

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The news story about Dr. Day simply illustrates what I said before about the continuing applicability of the survey results reported previously. Also, the fact that something may be done regularly or may be accepted as a given does not necessarily mean it is either proper or improper.

In this chapter, I want to explore some different types of preferential access, proper and improper, as well as discuss some concepts, such as physician advocacy and professional courtesy, that are well known to health care professionals but less well understood by the general public.

I also want to emphasize what I am not examining. I exclude from this discussion the everyday clinical decision-making that physicians (as well as others such as nurses) do on a regular basis. I recognize that health care professionals are required to exercise their professional judgment in a multitude of ways. No two patients are the same, even though they may be categorized the same on an acuity scale. There will always be a need for the exercise of professional judgment and, when that occurs in a responsible and credible manner, no one should label it as improper.

Witnesses cited numerous examples where considerations may come into play besides medical need. For example, in deciding when to schedule a patient, a physician might have to consider the social circumstances of the patient. Is the patient responsible for the care of others? Is support readily available for the patient after treatment? These are factors affecting patient individuality since they recognize how treatment may affect their lives.<sup>10</sup> Another example involves an ER doctor giving priority assessment to a highly agitated patient to avoid disrupting the smooth flow of work in an emergency room.<sup>11</sup>

Another example would be practical decisions prompted by the need to make full use of available resources. If a scheduled operation is cancelled at the last minute, it would be senseless to waste the time set aside for it. The operating room is available and staff have been assigned. Slotting someone else into that now open space may depend more on the ready availability of the new patient as opposed to that patient's acuity relative to others on the wait list.<sup>12</sup>

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<sup>10</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 3.

<sup>11</sup> Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 2.

<sup>12</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 7-8.

The witnesses offered other examples, but the point is that factors are taken into account in the proper exercise of clinical judgment that simply cannot be quantified or effectively regulated. The system needs some flexibility to function well. Dr. Alter put it as follows:

In reality, no queue is organized as a lineup – there are always circumstances, some of which are resource-based, while others [are] administrative or personal, which will result in some patients being serviced ahead of others, even where clinical severity can be measured, and be deemed objectively comparable.<sup>13</sup>

This is not to say that standardized criteria would not be beneficial; it merely recognizes that no two patients are alike in all circumstances and that multiple factors come into play when assessing the needs of a given patient.

So I am not concerned about the physicians’ role in determining medical necessity using their professional judgment. I do not therefore consider the prioritization of patients according to medical need as an example of preferential access, proper as it may be. That is the very essence of what I call normal access.

What I am concerned about is preferential access on the basis of non-clinical criteria, whether it be by design, or by common acceptance, or by corruption of the system.

### ***B. Medical necessity as the foundation for a definition***

It is always helpful to go back to first principles in the search for any definition.

One of the Five Criteria of the *Canada Health Act* is accessibility. This requires provinces and territories to provide insured health services (i) on uniform terms and conditions, and (ii) on a basis that does not impede or preclude reasonable access to those services.<sup>14</sup> The term “reasonable access” is not defined. But other aspects of applicable legislation can assist in this regard.

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<sup>13</sup> Exhibit 149, Expert Reports, report of Dr. David Alter (February 7, 2013) at 3.

<sup>14</sup> *Canada Health Act*, R.S.C. 1985, c. C-6, s. 12(1)(a).

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Another of the Five Criteria in the *Canada Health Act* is comprehensiveness. This requires provinces and territories to insure all “insured health services.” Those include (i) hospital services (defined in part as services that are medically necessary), and (ii) physician services (defined in part as services that are medically required).<sup>15</sup> Similarly, the *Alberta Health Care Insurance Act* defines insured services to include all services provided by physicians that are medically required.<sup>16</sup> The *Health Care Protection Act* defines facility services as any one of a list of services that are medically necessary.<sup>17</sup>

Taking into account all these sources, it seems that the defining criterion for reasonable access is medical necessity. This was a point made by Prof. Lahey in his research paper:

Given ... that medical necessity is the basis on which a service becomes a service that must be insured, it would seem that the reasonableness of access to those services would also depend on what is medically necessary.<sup>18</sup>

So the place to start is by saying that proper access is access governed by medical necessity. Preferential access is therefore a type of access that, for the patient, is advantageous to that governed by medical necessity. Whether such preferential access is proper or improper requires an examination of areas of the health care system where preferences already exist and those areas governed by attitudes and practices of the professionals in the health care system.

### C. *The issue of corruption*

This inquiry was prompted by allegations of corruption. Drs. Duckett and Sherman alleged that political insiders were able to obtain preferential access for themselves and their friends. This type of behaviour would be an abuse of power; it would be the seeking of self-advantage over the rules and regulations governing health care; it would therefore be corruption, although not necessarily corruption in a criminal sense. The preamble to this inquiry’s terms of reference

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<sup>15</sup> *Canada Health Act*, s. 2.

<sup>16</sup> R.S.A. 2000, c. A-20, s. 1(n).

<sup>17</sup> R.S.A. 2000, c. H-1, s. 29(g).

<sup>18</sup> William Lahey, *The Legislative Framework Governing Access to Health Services that are “Insured Health Services” under the Canada Health Act and “Insured Services” under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 19 [Exhibit 11].



contains the statement that “it is improper to gain access to publicly-funded health services through threat, influence or favour.” These are also corrupt acts. I do not need to engage in a detailed analysis to conclude that enhanced access by such means would be improper preferential access.

There is Alberta legislation prohibiting queue-jumping with respect to insured surgical services. The *Health Care Protection Act* provides as follows:

3. No person shall:
  - (a) give or accept any money or other valuable consideration,
  - (b) pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or
  - (c) provide an uninsured surgical service

for the purpose of giving any person priority for the receipt of an insured surgical service.<sup>19</sup>

A person convicted of contravening this section faces a maximum fine of \$10,000 for a first offence and a maximum of \$20,000 for a second or subsequent offence.<sup>20</sup>

The statutory prohibition deals with financial incentives and only applies to giving priority to insured surgical services. There is no legislation or policy in effect to govern queue-jumping when no material benefit is offered, or governing the wide array of insured health services provided.

The limitations in the legislation can be contrasted with a similar queue-jumping prohibition enacted in Ontario in that province’s *Commitment to the Future of Medicare Act, 2004*:

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<sup>19</sup> R.S.A. 2000, c. H-1, s. 3.

<sup>20</sup> R.S.A. 2000, c. H-1, s. 26(3).

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17. (1) No person or entity shall,
- (a) pay or confer a benefit upon any person or entity in exchange for conferring upon an insured person a preference in obtaining access to an insured service;
  - (b) charge or accept payment or a benefit for conferring upon an insured person a preference in obtaining access to an insured service;
  - (c) offer to do anything referred to in clause (a) or (b).<sup>21</sup>

The advantages to this prohibition are that it uses the term “confer a benefit,” which arguably encompasses a wider variety of things than merely money or other valuable considerations. It also applies to an insured service, meaning all insured services under Ontario legislation, and it makes it an offence to offer to do any of the prohibited acts. Another advantage to the Ontario statute is that it includes a mandatory requirement for any prescribed person (which by regulation includes physicians, nurses, any person employed in a hospital who provides an insured service, or contractors performing insured services<sup>22</sup>) to report any violation of the statutory prohibition to the general manager of the plan appointed under Ontario’s *Health Insurance Act*. The *Commitment to the Future of Medicare Act, 2004* also contains complementary protections against liability or employment retaliation for reports made in good faith.<sup>23</sup> The benefit of such provisions is self-evident.

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<sup>21</sup> S.O. 2004, c. 5, s. 17(1).

<sup>22</sup> O. Reg. 288/04, s. 7.

<sup>23</sup> S.O. 2004, c. 5, ss. 17(2), (4) and (5).

**Recommendation 1:**
**Strengthen the queue-jumping provisions of the *Health Care Protection Act***

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith.

**D. *Many ways into the system***

One of the major themes that emerged from the inquiry testimony was that there are multiple entry points into the health care system, each with its own opportunities for preferential access. That is, there are multiple ways to find out you are sick, and lots of ways into the system, all providing ways to get ahead in line. Given these circumstances, considering preferential access in one situation does not necessarily extend to another situation. The same rules may not apply at every point of entry. The following are some examples.

**(i) *Workers' compensation***

Obvious examples are the provisions in the *Canada Health Act*<sup>24</sup> and the *Alberta Health Care Insurance Act*<sup>25</sup> excluding from the definition of insured services those services that a person is entitled to under federal or provincial workers' compensation legislation. The historical justification for special treatment of workers injured on the job is that it is better to have these people treated quickly so they can get back to work, rather than drawing compensation while waiting in a queue for treatment. Also, the compensation paid to injured workers usually comes from funds to which employers contribute, so there is pressure on workers' compensation boards to get workers treated quickly.

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<sup>24</sup> S. 2.

<sup>25</sup> S. 1(n).

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This exclusion, however, has led to what the Romanow report labelled a form of officially sanctioned queue-jumping.<sup>26</sup> Because these services are not considered insured services, workers' compensation boards can purchase them directly from hospitals and physicians rather than receiving them through the public health care system. This arrangement for workers almost inevitably leads to prompt access to health care. Despite this preferential service and access, and the fact that physicians and hospitals charge for these services, there is no jeopardy to a province's funding under the *Canada Health Act*.<sup>27</sup>

There is no doubt that this practice amounts to preferential access. But is it improper? Mr. Romanow thought so. He viewed it as being incompatible with the principle of equal access and argued that it should be reconsidered:

... [T]he vast majority believe that all Canadians are equally entitled to timely service, regardless of their employment status. The elderly and children, for example, are just as deserving of prompt diagnosis as injured workers. For the same reasons that private payment for diagnostic services is contrary to the basic principle of medicare, this "public" form of queue-jumping should be redressed in a modernized *Canada Health Act*.<sup>28</sup>

The exclusion of injured people receiving workers' compensation benefits is a policy choice made by both levels of government. To my knowledge, no government has acted on Mr. Romanow's invitation to redress the inequality created thereby. It is proper preferential access only because duly elected legislators have accepted it. If, however, there is sufficient public disagreement with this policy choice, it may very well become improper preferential access. The ethical justification for this exclusion can only come from the fact that it is a democratically arrived-at policy choice.

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<sup>26</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 64-65.

<sup>27</sup> William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the Canada Health Act and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 17 [Exhibit 11].

<sup>28</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 8.

The exclusion of people entitled to receive workers' compensation benefits is only one of a long list of exclusions contained in the regulations enacted by the Alberta legislature<sup>29</sup> (and all other provinces and territories). Part of the rationale is a constitutional one since individuals who fall within the legislative competence of the Parliament of Canada cannot have their health care benefits restricted by provincial legislation. So individuals entitled to health care benefits under any of a list of federal statutes (such as military personnel and federal inmates) are excluded from the provincial system. But the result is that residents of Alberta who come within one of the excluded categories can receive preferential access to services through payment for those services because of their occupation or, as we see with workers' compensation claimants, the circumstances in which their injury or illness arose. Whether this distinction is proper is a matter of public choice as evidenced by the decisions of their elected representatives.

**(ii) *Private diagnostic imaging***

Another example of an avenue into the system is private diagnostic imaging services, which may enable people to get diagnosed more quickly than under the publicly funded system. A person who purchases diagnostic imaging at a private facility, instead of waiting for the same service through publicly funded channels, receives the diagnosis more quickly. If the diagnosis indicates a need for treatment, that person can step into line for treatment. The person waiting for a diagnosis through the publicly funded system cannot step into line for treatment, since he or she has not received a diagnosis. Stepping outside the public system for diagnosis results in preferential access to treatment when one rejoins the public system.

Prof. Lahey traces the origins of this public-private dichotomy in diagnostic imaging services in his paper prepared for this inquiry.<sup>30</sup> There is no express mention of diagnostic services in the definition of insured health services in the *Canada Health Act*, but they come within its ambit in two ways. First, diagnostic procedures are a hospital service if they are provided to a hospital patient. Second, if they are ordered by

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<sup>29</sup> See *Alberta Health Care Insurance Regulation*, Alta. Reg. 76/2006, s. 12; *Hospitalization Benefits Regulation*, Alta. Reg. 244/1990, s. 4(2).

<sup>30</sup> William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the Canada Health Act and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 14-16 [Exhibit 11].

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a physician as a medically required service, then they come within the scope of physician services under the definition of insured health services.

However, since the *Canada Health Act* came into force in 1984, developments in diagnostic technology and procedures have facilitated testing in private clinics outside of hospitals. But Health Canada took no steps to deal with diagnostic procedures purchased by or on behalf of a patient with no public funding involvement. This is in contrast to the threat by Health Canada to withhold federal funding to provinces that allowed facility fees or user charges to patients obtaining insured services. Prof. Lahey explained how privately funded diagnostic imaging can stand beside a publicly financed system. He said this can occur in two situations:

In the first situation, the procedure is not thought to be strictly necessary from a medical point of view but the patient wants and is willing to pay for it nevertheless. This is a scenario that is more likely with some kinds of diagnostic procedures than it will be with other kinds of medical procedures. In the second situation, the procedure is medically necessary and therefore available through the public system but the patient is prepared and able to pay for it personally, usually to get it faster than he or she can get it in the public system. In that situation, the argument for regarding the service as being outside of the *Canada Health Act* is that the patient is paying to have the service more quickly than the public system, given factors such as prevailing waiting lists and clinical prioritization decisions, deems it to be medically necessary.... In both situations, there is a concern that privately funded access to a diagnostic procedure can result in preferential access in the public system to the treatments that the diagnostic procedure may reveal are indicated.<sup>31</sup>

The Romanow Commission considered this scenario to be incompatible with the principle of equitable access:

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<sup>31</sup> William Lahey, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the Canada Health Act and "Insured Services" under the Legislation of Alberta: A Report to the Health Services Preferential Access Inquiry of the Province of Alberta*, November 30, 2012, at 15 [Exhibit 11].

Medicare rests on the principle that an individual's financial resources should not determine access to services. In the Commission's view, governments have a responsibility to guarantee that the public system has sufficient resources to ensure appropriate access to advanced technology. Increased investment within the public system for new diagnostic technology can remove the temptation to "game" the system by individuals and health care providers through the private purchase of diagnostic tests that could allow them to jump the queue.<sup>32</sup>

Mr. Romanow recommended that all medically necessary diagnostic services be included explicitly in the definition of insured health services in the *Canada Health Act*. This recommended change to the Act has not been implemented.

There is no question that the temptation to use private diagnostic services can be great, even for people of modest means. Another of our expert witnesses, Mr. James Saunders, testified that in Alberta the standard wait time for a private MRI is inside of a week and a half, while the median wait time for a publicly funded MRI is 13 weeks for routine cases. Urgent cases would be seen faster.<sup>33</sup>

The proliferation of private diagnostic services poses a true ethical dilemma when considering it in the context of access to health care. It is possible to argue, as Mr. Romanow did, that this parallel private service should be banned for medically necessary testing. It undermines the principles of fairness and equity in access to health care and provides an advantage to those who can pay for this service.

On the other hand, the practice is not illegal. It is accepted by governments and by physicians' regulating bodies. Dr. Trevor Theman, the Registrar of the College of Physicians & Surgeons of Alberta, testified that the College worked with Alberta Health and AHS to ensure that the standards of diagnostic imaging were proper.<sup>34</sup>

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<sup>32</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 8.

<sup>33</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 115 and 132-33.

<sup>34</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2309.

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There may even be an ethical and legal obligation on a physician to advise a patient of the private option where the physician considers it to be in the interests of the patient.<sup>35</sup> I will discuss the ethical dilemmas for physicians later in this chapter when I discuss physician advocacy. For now, I want to give one example of the potential legal obligation that I mentioned earlier in this paragraph.

In the 1995 case of *Law Estate v. Simice*,<sup>36</sup> the British Columbia Court of Appeal upheld a finding of negligence against a physician who denied a CT scan to a patient because of his concern for cost containment. The patient died due to a burst cerebral aneurism. The Court recognized that governments and health boards make decisions about resource allocation, but physicians generally act as the gatekeepers of medical resources, as it is physicians who make the decisions regarding each patient's care. In this case the defendant doctor stated that he felt restricted in his ability to access diagnostic tests and tools because of the provincial health care plan's restrictive standards. The Court concluded unequivocally that health care providers must not allow cost containment considerations to inhibit their decisions as to whether otherwise necessary tests and procedures should be performed.

As a result, it is not inconceivable to argue that a physician could be found liable for not recommending a private option where it is available, as in Alberta. This liability could arise, for example, where insufficient resources and high demand produce long waits for publicly funded diagnostic procedures and the physician concludes that such testing is not only necessary but should be done as soon as possible. The law could in effect compel the physician to push his or her patient into private diagnostics.

Some will argue that the private option relieves pressure on the publicly funded service. That may be so in theory, but there is a lack of empirical evidence to substantiate the theory.<sup>37</sup> On the other hand,

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<sup>35</sup> N. Cunningham *et al.*, "Ethics in Radiology: Wait Lists Queue Jumping" (2012) *Canadian Association of Radiologists J.* 1 at 4.

<sup>36</sup> (1995) 17 B.C.L.R. (3d) 1.

<sup>37</sup> The OECD found that incentives introduced in a number of countries to increase the use of the private sector and remove pressure from the public sector had mixed results and did not necessarily reduce wait times: L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 65.



some might well argue that the availability of private services merely relieves the pressure on government to add the public resources needed to satisfy the demand in a timely manner.

There is no correct answer, practically or ethically, in the debate over private diagnostic services. These services can reveal a patient's condition earlier than is the case with the patient's counterpart in the publicly funded system. Paying for a diagnostic test will put the private-option patient ahead in the queue for treatment – anathema to the goal of access to health care that does not depend on wealth.

Some might argue that the patient going to the private sector for an earlier diagnosis should not be allowed to profit from the advantage that his or her money bought. But one cannot ethically ignore a condition once it is diagnosed, even if the diagnosis was paid for privately. In any event, if the patient with the publicly funded test is later diagnosed with a more urgent condition than the private-option patient, that public-option patient will be moved ahead of the private-option patient.

Is the answer in effect to ban private diagnostic services by putting all such medically necessary services under the *Canada Health Act* as insured health services? This is a policy choice that has to be made with full knowledge of the ramifications. Would the public system be able to cope with the demand in a reasonable timely manner? I do not have the evidence to say one way or the other.

Publicly available information indicated that there are 15 private diagnostic services operating in 70 locations in Alberta. Diagnostic services are not, however, the only private services outside the provincial health insurance plan. Much more health care than that is being delivered outside of the traditional cores of the public system, hospitals and doctors' offices. Fewer important medical services are receiving public coverage. But once a serious condition is discovered through the private system and the patient has to return to the public system for treatment, the preferential access issue will arise again, as it did with privately paid diagnostics discussed above.

Private diagnostic and other services can lead to preferential access to treatment because they permit patients to circumvent the wait for publicly funded services. From an ethical perspective, looking at the principles underlying Canada's medicare system, this is improper. But

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we do not operate in a purely ethical paradigm. These services are allowed and presumably have a measure of public acceptance. As long as policy decisions about these private diagnostic and other services are made in a transparent and democratic manner then I cannot label them as improper.

*(iii) Medical tourism*

Medical tourism also creates opportunities for preferential access. This phenomenon is not about going outside Canada to get treatment that is not available in Alberta. There is in Alberta an Out-of-Canada Health Services Committee that will consider requests for reimbursement of services beforehand if one has to go to another country for a service that might not be available in Canada.<sup>38</sup> Medical tourism means a person going out of the country to get services or tests that they could get here but which they choose to pay for and get faster elsewhere.

Several of the expert witnesses commented on the effect on access of medical tourism. Dr. Heisler said:

In my practice, I'd have a patient go to the U.S. They're vacationing. They got a CT colonography done.... They now come back to me saying, "Here's my test. I have a polyp in my colon." So I know if there's a polyp in the colon, they've got an increased risk of cancer.<sup>39</sup>

Dr. Alter testified:

There isn't a time, you know, during the week on call for a hospital service, for example, that you don't get a call from an insurance company trying to ... get their patients who, by the way, are covered under their insurance policy and are vacationing down south back into the hospitals.<sup>40</sup>

Dr. Goldman commented:

People are travelling to other parts of the world to get kidney transplants, hip replacements, the MS liberation treatment.... So these people get treatment. They return to Canada with a

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<sup>38</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 118-19.

<sup>39</sup> Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3417.

<sup>40</sup> Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3419.

complication. And, to my knowledge, it has been articulated as an ethical obligation by Canadian physicians to provide care for those individuals. You can't say, "I'm sorry, you had your treatment elsewhere, go elsewhere."<sup>41</sup>

These descriptions highlight the dilemma that medical tourism poses for the health care system in Canada. The dilemma is similar to that resulting from access to private diagnostic services. Patients have the freedom to choose. If they choose to spend their money on services abroad, they are still Canadian residents and if their treatment abroad leads to complications later, they are entitled to publicly funded health services in Canada. They cannot, ethically or legally, be denied treatment or prioritized on a different basis than others who have completed their entire medical journey in the public health care system here.

The phenomenon of medical tourism is not in and of itself preferential access. Only if the publicly funded health care system in Alberta has to respond to the consequences of medical tourism could it become preferential access. But, because at that point there is medical necessity for the service, it cannot be labelled as improper.

These examples demonstrate that there are many ways to access the health care system and, more significantly, that preferences are built into the system. Some are built in by design – workers' compensation, for example. Other preferences are the by-product of medical tourism, private diagnostics or access to some other service through the private sector that eventually advantageously positions the patient at the doorstep of the public health care system.

### ***E. Socially justifiable preferences***

Is it acceptable for certain groups in society to receive preferential access? I imagine most people would say they already do, especially when referring to politicians, celebrities or athletes. But the question of status is much more multi-dimensional. People may defer to an important or famous person because there is a natural tendency to do so. The question in this section, however, is whether there can be categories of people who should receive preferential access because

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<sup>41</sup> Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3260.

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society agrees they should or whether any such preference should be considered improper.

The question is really one of social acceptance or tolerance. The expert witnesses who appeared at this inquiry agreed that there likely is a level of tolerance within society for certain types of preferential access, but they emphasized the fact that this is another argument in favour of the need to engage the public in discussions surrounding issues related to health care. This engagement would allow the provision of health care to be aligned with societal values.

During the experts' testimony, I asked whether the prime minister of Canada should be dealt with immediately, regardless of the level of medical need, if he or she showed up at an emergency department. Dr. Reid answered from the ethicist's perspective:

... the prime minister of Canada, I suppose, came up as an example. And maybe a hard-core egalitarian like myself might say that a good health care system is one where the prime minister of Canada is happy to receive care on the same terms and conditions as any other Canadian. That would be an ideal.<sup>42</sup>

Dr. Goldman emphasized the need to try to determine the public response to that question:

You touched in a number of remarks on what the public would find acceptable. And I think that's a really important question to ask because I don't think the public should defer 100 percent to medical judgment. I think the public's footing the bill for medicare.

The public has the right to decide that yes, we don't have a problem with the prime minister being given preferential access or we do have a problem with professional courtesy or we don't have a problem with professional courtesy. And I think these are scenarios that can be clarified with the public, and we can get some answers and some wisdom from them.

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<sup>42</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3293.

I don't think the public wants to be in the business of deciding who should get the new hip or who should receive the latest chemotherapy drug, but there are other fundamental questions that I think the public should be consulted on.<sup>43</sup>

Despite agreement on the need for public input, Drs. Heisler, Reid and Alter pointed out that determining what social values are important and what is socially acceptable is inherently difficult. Dr. Reid stated, "society doesn't speak with one voice"<sup>44</sup> and "you can't run things on a majority opinion because minorities will be disadvantaged."<sup>45</sup> Dr. Heisler noted that the concept of ethical and moral correctness relates to an individual's perspective. "The challenge is when individuals say something is 'ethically' or 'morally' right this typically relates to their own unique perspective (most often shared within their local culture) which itself is often inconsistent as it is not unusual for individuals to flip-flop on paradigms."<sup>46</sup> Dr. Alter also stated, "The social acceptability has to be there, but we have to define what it is – what's the stakeholder perspective that we're actually anchoring."<sup>47</sup>

How to go about determining the public's attitude is problematic. Attempts have been made with some surprising results. A 2005 survey of Toronto households presented a list of different types of patients and asked who should be able to move ahead in line at an emergency department.<sup>48</sup> Respondents favoured triage based on medical need, but not status (indeed 20 per cent responded that a homeless person should be able to jump ahead of a government official or politician). The full results were as follows:

<sup>43</sup> Testimony of Brian Goldman, Transcripts, vol. 37, February 26, 2013, at 3189-90.

<sup>44</sup> Testimony of Lynette Reid, Transcripts, vol. 37, February 26, 2013, at 3188.

<sup>45</sup> Testimony of Lynette Reid, Transcripts, vol. 37, February 26, 2013, at 3220.

<sup>46</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 2.

<sup>47</sup> Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3394.

<sup>48</sup> Steven Marc Friedman, Lee Schofield & Sam Turkos, "Do as I say, not as I do: a survey of public impressions of queue-jumping and preferential access" (2007) 14 *Eur. J. of Emergency Medicine* 260 at 262.

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Which of the following people should be able to jump ahead in the waiting line in the Emergency Department? (Y/N)

Patient demographic	Yes (percent)
Person with a medical emergency	100
Person in severe pain	90
An infant or child	83
Police officer on duty	50
Homeless person	20
Doctor	12
Hospital benefactor or philanthropist	12
Hospital administrator	6
Religious leader	5
American (paying U.S. \$)	5
Government official or politician	3
Celebrity	0

There may indeed be broad social tolerance for certain people receiving preferential access provided, of course, that no one with a life-threatening condition is bumped out of line. The leaders of the government might be one category. Another category might be patients enrolled in research protocols (considering the ultimate benefits to be gained from such research). The level of public tolerance may not be so high for athletes or other celebrities.

Tied to the idea of social acceptability is the concept of an individual's or profession's social utility or value. In this area the expert witnesses disagreed as to what extent the examples of medical professionals or first responders receiving expedited care constituted proper or improper preferential access and where the boundaries of social acceptability lay. Dr. Alter pointed out that professional courtesy, allowing preferential access to health care for doctors, nurses and other health care providers, may be considered an example of proper preferential access because of social utility,<sup>49</sup> while Dr. Reid contended that social utility or social value was "rarely, if ever, an ethically justifiable criteria for access."<sup>50</sup> In her written submission, Dr. Reid defined social value as "status-

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<sup>49</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3444.

<sup>50</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 10.

based or tied to particular conceptions of greater or lesser human value.”<sup>51</sup>

A good argument can be made that front-line health care workers, in a situation of urgent circumstances such as a pandemic, should be inoculated first along with their families (on the theory that sick family members will compel the health care workers to leave their duties to care for the family members). Similarly, in civil emergency circumstances, police and firefighters should be given priority. Such incidents of preferential access would not be regarded as improper.

There are other essential services that are much more up for debate for gaining preferential access because of their role in society. Dr. Goldman suggested that “society has to decide what are essential services and what aren’t” in relation to the discussion of the social utility of different professions.<sup>52</sup> Again, Dr. Reid cautioned:

Where scarce resources are allocated on the basis of social need (or society’s medical needs), a careful, transparent and multi-dimensional assessment should be made to ensure that a fair judgment is made about who is at risk (e.g. are teachers or transit workers also highly exposed?) and who is essential (e.g. are hospital housekeeping staff also essential workers?), and who is not (e.g. is an administrator who works offsite during an outbreak especially at risk?).<sup>53</sup>

There has to be a clear definition of what constitutes an essential service and in what circumstances. This can only be achieved through a collaborative effort involving health care professionals and administrators, government officials and the public.

### **F. *Physician advocacy and ethics***

Advocating for the health of the individual patient is a basic function of a physician. It is one of the fundamental competencies for physicians identified by the Royal College of Physicians and Surgeons of Canada.<sup>54</sup> The Canadian Medical Association Code of Ethics has, as a

<sup>51</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 10.

<sup>52</sup> Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3284.

<sup>53</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 26.

<sup>54</sup> “Canadian Medical Education Directions for Specialists” (The CanMEDS Framework), available at [www.royalcollege.ca/canmeds/framework](http://www.royalcollege.ca/canmeds/framework).

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fundamental responsibility of physicians, to “consider first the well-being of the patient.”<sup>55</sup>

There is, however, an ethical tension created by the Code of Ethics. While a physician has a primary responsibility to the patient, there is also a fundamental responsibility to “consider the well-being of society in matters affecting health”<sup>56</sup> and specific duties to “promote equitable access to health care resources,”<sup>57</sup> to provide services without discrimination on a number of grounds, including socio-economic status,<sup>58</sup> and to “use health care resources prudently.”<sup>59</sup>

This tension between advocacy for the specific patient and the interests of the community was highlighted by some of the expert witnesses. It is highly complex because when advocating for the well-being of the individual patient, physicians may be simultaneously at odds with advocating for the health of others in the community or population. Physicians are taught to be advocates for their patients but, as Dr. Heisler said, “you do need to have responsibility to a population as well.”<sup>60</sup>

Balancing the needs of the individual patient versus advocating for your patient population is difficult. Dr. Heisler stated, “Unless you can monitor the outcomes of the whole population or the panel of patients that a given individual is seeing, it’s hard to sort out and say, ‘Well, you’re not advocating hard enough.’”<sup>61</sup> Prof. Reid expanded on the spectrum of advocacy: “Without a lot of touchstones for what’s fair or not fair in the system as a whole, some physicians might take the responsibility of advocacy more towards the end of doing everything possible to get your own individual patient as fast as possible access to the best services, as opposed to getting them fair access to services that anyone would have a right to. So that’s kind of somewhere in there. I’m not saying it’s black and white. It’s absolutely grey and a continuum.”<sup>62</sup>

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<sup>55</sup> Canadian Medical Association, *Code of Ethics* (Update 2004), art. 1.

<sup>56</sup> Canadian Medical Association, *Code of Ethics* (Update 2004), art. 4.

<sup>57</sup> Canadian Medical Association, *Code of Ethics* (Update 2004), art. 43.

<sup>58</sup> Canadian Medical Association, *Code of Ethics* (Update 2004), art. 17.

<sup>59</sup> Canadian Medical Association, *Code of Ethics* (Update 2004), art. 44.

<sup>60</sup> Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3454.

<sup>61</sup> Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3455.

<sup>62</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3252.



Dr. Alter presented his view of balancing individual patients and societal needs when treating patients: “I mean as docs, we advocate for our patients for a variety of reasons. They are our primary stakeholder. When I’m at a bedside, I’m not thinking about the health system and the cost effectiveness. That’s for allocation. I’m thinking about the individual, and all of these individual social needs do come into play.”<sup>63</sup>

Physicians are expected to perform a balancing act with multi-dimensional decisions every day and with every patient. Dr. Heisler noted, “So it’s a balance not only of your responsibilities but of your obligations and your rights within a society that you need to balance. So that’s the point I’m making here is this is a massive balancing act that is really hard to codify in books because, as has been said by colleagues, every patient is very individual and unique... And that’s your challenge with medical need. It’s not just the patient. It’s a whole lot of other issues that are often involved.”<sup>64</sup>

Some physicians are more effective and enthusiastic advocates for their patients than others. The question was put to the expert witnesses: “What do we do with the fact that physicians will vary, sometimes widely, in their ability to advocate for their patients or their effectiveness?”<sup>65</sup> Dr. Alter replied, “Absolutely. Some physicians advocate more strongly for patients than others.”<sup>66</sup> Dr. Heisler described how he handles calls from some physicians versus others, expanding on the fact that individual abilities to advocate for patients is complicated by the referring physician’s ability to deal with different medical conditions. “Some are really comfortable doing things, some aren’t. So when some docs called me about something, I saw that person the next day because I know they called only when it’s really bad and they’ve tried everything. There are other people that I would give them some coaching. ‘Have you tried this?’ ‘Have you done that as a go-forward?’”<sup>67</sup>

When asked whether there was room for processes to provide clarity on issues such as advocacy, Dr. Heisler said, “So the short answer is yes. I think that one of the responsibilities of a self-regulating profession is

<sup>63</sup> Testimony of David Alter, Transcripts, vol. 39, February 27, 2013, at 3395.

<sup>64</sup> Testimony of Owen Heisler, Transcripts, vol. 39, February 27, 2013, at 3385.

<sup>65</sup> Question by Commission counsel, Transcripts, vol. 40, February 27, 2013, at 3450.

<sup>66</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3452.

<sup>67</sup> Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3454-55.

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the responsibility to manage things of the nature that you [the Commissioner] spoke of.”<sup>68</sup> Dr. Heisler continued, “I do think that there is an opportunity for regulatory bodies of whichever nature to help in establishing what that [advocacy] might look like.”<sup>69</sup> Dr. Alter said, “I do think there are...regulatory bodies that can help form and clarify.”<sup>70</sup>

Ethical advocacy, that being advocacy to ensure that patients receive the care that is due to them, based on their medical needs, cannot be regarded as facilitating improper preferential access. It is the proper role of the physician. But as I have already noted in the excerpts quoted from the testimony, it is a complex exercise, with competing ethical responsibilities, and one that not all physicians are equally equipped to carry out.

In its 2012 report, the HQCA conducted an extensive review and survey of physicians in Alberta on the subject of advocacy. It reported several significant findings:

- 56 per cent of physicians surveyed reported that their ability to advocate is limited by unclear processes for advocacy;
- 37 per cent were not aware of a process for advocacy;
- 69 per cent reported no formal training in advocacy;
- 20 per cent of physicians who advocated experienced “active harmful obstruction;”
- 51 per cent felt their ability to advocate had been limited; and
- many of the physicians interviewed also reported experiencing intimidation of themselves or colleagues as a result of advocacy.<sup>71</sup>

Many of these comments related specifically to attempts by physicians to advocate for patients whose quality of care they believed could be compromised due to system resources or policies. But the fact that such

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<sup>68</sup> Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3462.

<sup>69</sup> Testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3463.

<sup>70</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3463.

<sup>71</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 28-30.

a high proportion of respondents reported no formal training or knowledge of any process for advocacy is quite concerning, having regard to the ethical mandate to advocate.

The HQCA went on to make three specific recommendations on the subject:

1. (That) Alberta Health Services, in collaboration with Alberta universities, the Alberta Medical Association, the College of Physician & Surgeons of Alberta, and other organizations develop and implement clear policies and procedures to guide physicians on how to ethically, appropriately, responsibly, and effectively advocate;
2. (That) Alberta Health Services, Alberta universities, the Alberta Medical Association, the College of Physicians & Surgeons of Alberta, and other organizations explore the need for and feasibility of a provincial independent process for physicians who, despite exhausting all internal processes, believe their advocacy efforts have not been adequately addressed; and
3. (That) the faculties of medicine in Alberta ensure that the Royal College of Physicians and Surgeons of Canada CanMEDS 2005 physician competency framework be the foundation for an advocacy curriculum for undergraduates and postgraduates and that it be made available for continuing medical education.<sup>72</sup>

I express my complete support for these recommendations and reiterate the importance of acting on them. Education on the principles of ethical advocacy and development of clear guidelines will go a long way in eliminating the circumstances that may lead to incidents of improper preferential access.

There is a further recommendation that I have considered at the urging of a number of the parties who appeared at the inquiry.

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<sup>72</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 193-94.

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The government recently enacted what is commonly referred to as whistleblower legislation.<sup>73</sup> That statute applies only to employees of the government or a public entity. It does not apply to independent contractors such as physicians or other health care providers, yet their careers may be equally at risk without whistleblower protection. Such a provision would give added safety to professionals in the health care system who speak out about resource or policy issues or challenge improper procedures.

**Recommendation 2:**

**Expand whistleblower protection**

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection) Act* to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services.

**G. Professional courtesy**

There was evidence before the inquiry about the concept of professional courtesy, where physicians in particular give priority to requests for care by other physicians, health care workers and their families. It is a commonly accepted practice, with deep roots in medical practice. Professional courtesy is therefore another entry point into the health care system. Significantly, however, it is not available generally to the public since it is a matter of physician discretion. Professional courtesy therefore produces a form of preferential access.

At one time, professional courtesy consisted of a physician providing medical care to colleagues or their families for free or at a reduced rate. This is still how professional courtesy manifests itself in the United States.<sup>74</sup> In part, it arose because of the ethical limitations on treating oneself (for example, by writing oneself a prescription) and one's family members.<sup>75</sup> In part it is an expression of professional solidarity.

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<sup>73</sup> *Public Interest Disclosure (Whistleblower Protection) Act*, S.A. 2012, c. P-39.5.

<sup>74</sup> See American Medical Association, *Code of Medical Ethics*, Opinion 6.13 – Professional Courtesy.

<sup>75</sup> In the Canadian context, see, for example, the Canadian Medical Association, *Code of Ethics* (Update 2004), art. 20.

In Canada today, where health services are generally publicly funded, professional courtesy is not about waiving or discounting a fee. Instead, it is about accommodating requests for consultations. Professional courtesy has come to mean seeing a colleague or their family member more quickly than would occur if they were a typical patient. This is done by seeing them outside regular hours.

The clinicians who testified at this inquiry, including those who appeared as expert witnesses, expressed the view that this is an acceptable practice, provided it did not bump another patient waiting in line, and that it is therefore not preferential access.<sup>76</sup> One of our expert witnesses, Dr. Lynette Reid, disagreed. She argued that professional courtesy was nothing more than insider privilege and could impede access to the system by others.<sup>77</sup> Even if no other patient is bumped from a physician's wait list when the physician agrees to see a colleague after work, it will damage the health care system as a whole if the practice is sufficiently prevalent. With about 75,000 physicians and a quarter-million nurses in Canada, Dr. Reid noted, "this is not a small number of people.... And so I would doubt that any form of queue-jumping for insiders to the health care system would not affect care to others in a substantial way."<sup>78</sup>

As I noted previously, professional courtesy is not associated with waiving or discounting fees in Canada. Physicians seeing other health care professionals or their family members can and do charge the Alberta health insurance plan for these consultations.<sup>79</sup>

Although professional courtesy is very much a part of medical culture, there seems to be no consensus on how wide the net of professional courtesy should be cast.

Dr. Trevor Theman, the Alberta College registrar, viewed professional courtesy as extending to other health care professionals, but he did not know of a commonly accepted definition. He thought it might be broad enough to encompass people with whom physicians work on a regular basis but who are not necessarily themselves health care providers – for

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<sup>76</sup> See, for example, the testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3246-47.

<sup>77</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3253-54.

<sup>78</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3255.

<sup>79</sup> See, for example, the testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2355.

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example, a clinic manager or someone who the physician sees at the request of another physician. He said he would not be surprised if some physicians considered professional courtesy to include friends.<sup>80</sup>

Dr. Nicholas Mohtadi testified that in his practice he is often asked to see a particular person as a favour and does so. These requests might come from friends or people affiliated with organizations that he works with (such as the University of Calgary, where he maintains a sports medicine clinic and holds an appointment as a clinical professor). The people he sees might be athletes, a university donor or someone else who might be important in that environment.<sup>81</sup>

Dr. Raj Sherman testified about how he, as a member of the legislature, helped his MLA colleagues avoid long waits for a doctor's appointment by assisting them with simple prescription refills and treatment for minor complaints. He said he did this in his MLA office and he described this activity as professional courtesy.<sup>82</sup>

As can be seen from such testimony, professional courtesy is a very elastic concept. Dr. Theman acknowledged that there is nothing in the College's Standards of Practice or the Code of Ethics regulating professional courtesy. Nor was he aware of any instance where a college of physicians and surgeons elsewhere had attempted to regulate it.<sup>83</sup> To him, as well as to the other physician witnesses, exercising professional courtesy was a matter of discretion for the individual physician:

I think the practice of medicine, like many areas in health care, has the expectation that our members will use discretion, that they will act wisely. To a degree, we can create some guidance, but regulating some kinds of behaviour is very difficult. And when we get to ethical decision-making, in particular, one often needs to understand all of the facts that surround it to know whether that was a reasonable thing or not a reasonable thing .... [I]t's very difficult, then, to write rules, except for those extreme situations, that this you must not do, but it

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<sup>80</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2346-60 and 2368.

<sup>81</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1340-41 and 1362.

<sup>82</sup> Testimony of Raj Sherman, Transcripts, vol. 12, December 13, 2012, at 856-860.

<sup>83</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2347, 2367.

becomes much more difficult in those grey areas or those areas of discretion where I think discretion is reasonable.<sup>84</sup>

I also heard evidence about professional courtesy as a justification for providing priority access to care for doctors, nurses, other health care workers, and their families in emergency departments.

Mr. Donald Christensen is an area manager for the Sheldon Chumir Urgent Care Centre. He was asked to describe the expectations about professional courtesy within the Centre:

If an urgent care staff member came to work and they had a sore throat or they had a sore back or they had a minor sprain to the ankle, they would have a conversation with one of the physicians working. The discussion would be [to] generate a chart, so triage chart generation; take it directly back to the physician, and the physician and the employee would do a quick medical assessment. If they needed a throat swab or if they needed an x-ray, it would be ordered at that time. The tests would be completed. The person – the employee – would be back to work, and the physician would be taken out of service for a very short period of time. So that is not new to our business.<sup>85</sup>

Mr. Christensen said this practice was once considered professional courtesy, but no longer. As a member of the provincial urgent care executive, he said an item was put on the agenda for the September 2012 urgent care committee meeting, to discuss access by staff members to urgent care services. The discussion at the meeting, held on September 18, was brief and direct. As he testified before the inquiry, “We all knew that this process was happening, and it was no longer considered professional courtesy. It was considered a form of queue-jumping and that we were to cease and desist this behaviour immediately.” All managers then returned to their respective teams to discuss with their staff how to stop this behaviour.<sup>86</sup>

Mr. Christensen said he was initially advised (he did not indicate by whom) not to do a written communication about this. He accepted this advice until he had “hints” that some people were still attempting to get

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<sup>84</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2360.

<sup>85</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 539.

<sup>86</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 539-40.

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preferential access, but it was being stopped either at triage or by the charge nurses. That is when he sent an email on October 11, 2012, requesting all staff stop this behaviour. The email reads in part:

AHS [has] **zero tolerance** for preferential treatment and/or queue-jumping. I trust that none of you would ever put yourself in the situation where you would request that one of our UCC physicians would see you out of order based on CTAS [Canadian Triage and Acuity Scale] score and existing REDIS [a tracking system] priority number.

My expectation is that if you are sick enough to require physician attention while at work, then you are no longer able to function in the role of a staff member and you become a patient of the UCC, obtaining a CTAS score from triage and an appropriate REDIS priority number based on presenting complaint and that you wait your turn to be seen by one of the physicians.<sup>87</sup>

Mr. Christensen was asked if he had any experience with doctors trying to expedite treatment of their own families or friends. He had, but their attempts were unsuccessful. Physicians would bring family members in and present them for triage and ask the triage nurse to make a chart so that they could speak to whomever was working in urgent care. The triage nurse would be very clear that if physicians want their children examined, they must follow procedure.<sup>88</sup>

Mr. Kyle Cridland performs a number of nursing roles at the Calgary Foothills Emergency Department, including acting as a triage nurse. He was asked how doctors, nurses and their families are treated when they come to the emergency department:

[T]ypically if a colleague shows up ... [who] needs medical attention [for themselves] or a family member, we will triage them accordingly; give them their proper acuity score. And then, generally speaking, we will do one of two things: Either bump them up in the priority level ... so they get seen quicker, or we will go and find an emergency doctor and just say,

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<sup>87</sup> Exhibit 32 [emphasis in original].

<sup>88</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 544-45.



“Hey, this person so-and-so is here. Do you mind seeing them just when you have a minute?”<sup>89</sup>

Mr. Cridland had seen colleagues come in the front door, wait in line with everyone else and get triaged. Sometimes colleagues will come through a back door and “kind of just come up to triage quietly and say, ‘Hey, I’m here. Can you triage me?’” Staff who become injured or ill while on shift would simply report to triage and identify the problem. However, sometimes when workers get injured at work in the hospital, they come through the front door and wait like everyone else.<sup>90</sup>

Mr. Cridland explained that, when moving a patient ahead in the queue, they might be put to the front of the queue of those at the same acuity level. They would not be moved ahead of anyone with a higher acuity level.<sup>91</sup>

Dr. Francois Paul Belanger is senior vice-president and zone medical director for the Calgary zone. He also has a clinical practice as a pediatric emergency physician at the Alberta Children’s Hospital and South Health Campus.

Dr. Belanger was asked if, in his experience as a physician in the emergency room of the Children’s Hospital, staff or family of staff can be seen more quickly. He replied that he had seen this happen on occasion, but that in such situations it was more often the staff’s children rather than the staff members themselves who were the patients. He said that in his experience, the children of staff or family of staff were sometimes seen faster in the emergency room. This happened not at the demand of staff, but as a matter of professional courtesy.<sup>92</sup>

The expert witnesses who testified at the inquiry deemed the provision of priority access through the emergency department to be preferential access, but disagreed somewhat as to whether it was improper. Dr. Heisler wrote, “It is incumbent on all health care workers to appropriately utilize the emergency department and work within the system to ensure that the ED is appropriately utilized for emergency

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<sup>89</sup> Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2505.

<sup>90</sup> Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2505.

<sup>91</sup> Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2512.

<sup>92</sup> Testimony of Francois Belanger, Transcripts, vol. 26, January 16, 2013, at 2176.

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and urgent care – not as a way to facilitate more rapid access to care.”<sup>93</sup> Drs. Goldman and Alter agreed that the practice was preferential access, but did not explicitly deem it improper. Dr. Goldman wrote that he believed it would be “churlish” to deny physicians the right to provide special access to colleagues and that “the same courtesy should be extended to immediate family members of a colleague.”<sup>94</sup> Dr. Church wrote that allowing access through the emergency department was appropriate “if clear criteria for medical necessity and severity of illness relative to other patients in the emergency room at the time were met.”<sup>95</sup>

I agree with those witnesses who describe priority access for health care professionals to emergency department service as improper preferential access, even if one labels it as merely professional courtesy. The only exception I can think of would be the case of an essential worker where failure to expedite care for that worker would prevent them from carrying out their duties and would place others in danger. But there should be clearly defined protocols for these circumstances. I am also confident that health care staff injured on the job can be treated in the normal emergency department manner, barring unusual circumstances, without an impact on the functioning of the organization.

Emergency departments are arguably a special category when considering the extent of professional courtesy. But what about the usual situation where a physician will see someone outside their regular hours?

The Alberta Medical Association gave a vigorous defence of professional courtesy in its submissions to the inquiry. It argued that there is nothing improper or unethical because all it does is give another entry point into the queue. If further treatment is required, the patient is simply put into the system and prioritized according to his or her medical acuity. The Association’s position was that this was no different than the situation where a patient might be seen faster by a specialist when that patient’s physician is able to write a more fulsome referral letter.

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<sup>93</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (Supplementary Questions, February 2013) at 1.

<sup>94</sup> Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 6; see also Expert Reports, report of Dr. David Alter (February 7, 2013) at 6.

<sup>95</sup> Exhibit 149, Expert Reports, report of Dr. John Church (February 15, 2013) at 5.

The difficulty with this argument, of course, is that a physician can be trained to write better referrals. However, it is impossible to learn how to be in a special relationship where courtesies or favours are extended. A person either has insider status or he or she does not. It also ignores the clear evidence about lengthy wait times from the referral to the consultation with the specialist or for diagnostic tests. To say that the queue starts only when the specialist has determined that something further needs to be done ignores the reality for the vast majority of Canadians. Dr. Mohtadi acknowledged quite frankly that what he does under the label of professional courtesy is preferential access.<sup>96</sup>

The majority of the expert witnesses agreed that providing service to friends and colleagues, if it is done outside normal office hours, is a proper form of preferential access.<sup>97</sup> Some viewed it as an issue of physician autonomy and the responsibility physicians exercise in organizing their practices.<sup>98</sup>

Dr. Reid analyzed the question within the framework of the Canadian publicly funded system and submitted that the insider access provided to health care professionals and their families under the guise of professional courtesy is ethically unjustifiable. She expressed the following opinion in her testimony:

There may be this history of physicians providing care for one another without pay before the system was a public pay system. We now are in a situation where physicians have direct access to and control over a taxpayer-funded service which is a service that's not just like any other taxpayer-funded service but particularly important to each one of us individually – health and health care. And I have a hard time seeing people who are insiders to that system deciding that they themselves have a particular call on quicker access within that system as anything but improper.<sup>99</sup>

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<sup>96</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1364.

<sup>97</sup> Exhibit 149, Expert Reports, report of Dr. David Alter (February 7, 2013) at 8-9; Exhibit 149, Expert Reports, report of Dr. Owen Heisler (Supplementary Questions, February 2013) at 2-3.

<sup>98</sup> Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 7; see also Exhibit 149, Expert Reports, report of Ms. Pam Whitnack (undated) at 6-7.

<sup>99</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3253-54.

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In answer to the argument that nobody waiting on a specialist's referral is prejudiced because the specialist is choosing to see the "courtesy" patients outside regular office hours, Dr. Reid responded that because the system is chaotic it is not easy to identify who is being bumped or disadvantaged by this practice. She stated:

I have a hard time kind of squaring a wheel on this one to see where you could offer someone closer access or preferential access to a publicly funded necessary service because of a relationship they have with you, a personal relationship they have with you, that would not be in and of itself raise questions about harm, about appropriate management of a public resource.<sup>100</sup>

Dr. Reid also highlighted a systemic objection to professional courtesy, that being the disincentive to insiders to effect change in the system: "The people who are considering and contemplating preferential access, in a sense queue-jumping, the insider privilege ... are the people who, if anyone, (are) in a position of power to change the system," she said. "A widespread practice of jumping the queues means that they're not confronting the problem themselves." That means they are not experiencing the same access troubles as most Canadians: "When everyone is in the same boat and everyone experiences the same access, then ... those with voice and power in the system have more of an incentive to see to its good functioning."<sup>101</sup>

I recognize the attraction of the concept of professional courtesy to the professionals. I have no doubt that all doctors consider it an honour to care for other doctors and their health care colleagues. Professional courtesy can help solidify bonds between physicians and working relationships. There are also practical arguments in favour of the practice.

In support of professional courtesy, Dr. Goldman put forward the idea that physicians have "aggravated or exaggerated apprehensions" when it comes to their own health, because of their intimate medical knowledge. They are more susceptible to fearing the worst-case scenario at the first sign of a symptom than perhaps a regular patient might be. Whereas a physician might spare a patient unnecessary

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<sup>100</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3297-98.

<sup>101</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3256-57.

anguish until a diagnosis can be made, a physician, noticing a symptom in himself or herself, does not have that option. In such a situation, Dr. Goldman opined, “It would be cruel to make the physician, who instantly knows that they could be dealing with a death sentence, wait and wait and wait and wait.”<sup>102</sup>

In a 2012 publication the president of the Calgary and Area Medical Staff Society, Dr. Lloyd Maybaum, defended professional courtesy as a way of avoiding distractions for physicians:

Now let us ponder what would happen if we did not have professional courtesy. You now have a physician that has an ill family member and they must wait six months to see the specialist. They are now increasingly distracted, anxious and stressed as they run their loved ones back and forth to appointments forcing them to curtail or even miss work. The increasingly distracted physician can lead to delays in work and the lengthening of wait times for all of his or her patients. Perhaps more alarmingly, we are forbidden by the College of Physicians and Surgeons to treat our own family members. Thus, without professional courtesy one can imagine how all the more tempting it would be to take matters into our own hands and treat our own family members in order to avoid all the hassles one might otherwise encounter.<sup>103</sup>

There are also professional and personal arguments against the practice. Over 30 years ago, two medical professors outlined the disadvantages extensively in an article published by the American Academy of Pediatrics:

There are numerous disadvantages inherent in the care of physicians and their families. Physician-patients and their spouses are slow or even reluctant to seek health care. Many feel it is an imposition or that they should be able to care for their own complaints. There are gaps and variations in record keeping. A parent or patient-physician may have special but hidden anxieties in view of his medical knowledge. The treating physician may rely on the patient-physician for part or all of the diagnosis and treatment. Self-referral and self-treatment are

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<sup>102</sup> Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3250.

<sup>103</sup> Calgary and Area Medical Staff Society, *Vital Signs* (November 2012) at 7.

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common. History taking may occur in the hospital corridor or at cocktail parties. The treating physician may treat not only anxiously but more cautiously if he feels under scrutiny. The patient-physician may feel unable to complain about care or be reluctant to change physicians. In general, both treating- and patient-physicians are more likely to behave in ways that are contrary to or deviate from the behaviors prescribed by their traditional roles. Carey and Sibinga state that treating families of your social friends carries with it the disadvantage of (1) unrealistic expectation and hidden motivations, (2) trouble keeping social and medical relationships separate, (3) difficulty handling dissatisfaction on the part of both parties involved. There are the advantages to the physician-patient of (1) knowing more about who is competent and (2) being able to seek competent attention promptly, but these advantages are far outweighed by the above mentioned disadvantages. Although professional courtesy is not necessarily the sole underlying difficulty, its role is instrumental in allowing the above disadvantages to occur.<sup>104</sup>

These itemized disadvantages to the practice of professional courtesy may or may not be present in every circumstance. They are primarily psychological, as are the purported advantages. But professional courtesy raises a broader concern, one like the availability of private diagnostic services. An individual, for reasons other than just medical need, gains access to a service far sooner than others. In one case, it is because of who they are or who they know; in the other, it is their financial means. Then, if further treatment is required, that person is placed on a priority list, admittedly according to his or her medical acuity, but before those who are still waiting to be diagnosed. The fact that the speedy consultations are done outside regular hours seems to me to be irrelevant to this fact. Access through professional courtesy is undoubtedly preferential access.

I accept that physicians are under an ethical duty preventing them from treating themselves or their family members. They must get care from others. So I can also accept that professional courtesy can and should encompass services by one physician to another. In practical terms, that

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<sup>104</sup> L.W. Bass & J.H. Wolfson, "Professional Courtesy" (1980), 65 *Pediatrics* 751 at 755, referencing Carey and Sibinga, "Should you provide pediatric care to your friends?" (1968), 42 *Pediatrics* (106).

usually means a direct and personal referral. I do not consider this to be improper. I would include in this professional colleagues, such as nurses. But the real question is how widely this practice should apply.

I see no justification in labelling as professional courtesy consultations conducted as favours for friends or other contacts. That does beg the question of a two-tiered system (particularly since those services are still charged to the public system). There is no ethical rationale, as in the case of physicians, for extending preferential accommodation to others – at least not under the pretext of professional courtesy. Furthermore, while personal and professional loyalties may be positive values in some contexts, requests for preferential access can pose an ethical dilemma for the health care provider and even create a conflict of interest.

The Alberta Medical Association, as well as the physicians who testified at the inquiry, were strongly opposed to any type of regulation that might limit the exercise of a physician’s discretion to decide how professional courtesy is to be extended. But I think there is a role for regulatory bodies to play in bringing some definition and clarity to the boundaries of professional courtesy.

### **Recommendation 3:**

#### **Clarify the scope and application of professional courtesy**

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals.

### **H. *Increased clarity on access issues***

Another recommendation suggested by a number of parties was to promote education about these issues. Several of the expert witnesses commented on how issues of professional courtesy and improper access should be part of the curriculum of medical and nursing schools. I agree. But the lead must be taken by the regulators and professional associations. They are the ones that set the standards of practice.

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Dr. Reid pointed out that medical and nursing students are exposed to two sources of information – what is taught in the classroom and what they see around them in practice: “So education of future practitioners is always a one-sided approach and insufficient. If you don’t change actual practice, students don’t believe what you’re saying.”<sup>105</sup> Dr. Goldman added that there is a concept in medicine called “the hidden curriculum.” This is the gap between what is taught and what is learned. “Learners learn very quickly that solidarity with their colleagues may involve sticking together, an us-versus-them policy, attitude, and ... that might include professional courtesy as well.”<sup>106</sup>

At the beginning of this report, I quoted Dr. John Church’s distinction between equality of access and equity of access. He defined the latter as “ensuring that patients who have the same medical conditions have the same opportunity to access the same services.”<sup>107</sup>

There are many reasons why everybody does not have the same opportunity to access health services. But who you are or who you know should not be one of those reasons. If there is to be equity of access, then the impediments to that should be identified and set forth in a transparent and definable manner. Hence, my recommendation for clarity and guidance from the regulators and professional associations with respect to professional courtesy, as well as my reinforcement of the HQCA’s recommendations about physician advocacy.

### ***I. A proposed definition***

As the previous discussion in this chapter illustrates, there is a multi-dimensional nature to the issue of improper preferential access. There are preferences that are built into the system through legislation. There is the opportunity of preferential access through circumventing wait lists for diagnostic procedures by resorting to the private system. There is a similar opportunity to circumvent the wait to see a specialist by a physician’s discretion to extend professional courtesy, however she or he may define it. Whether any of these are improper is something that cannot be decided without knowing the context.

In only one instance can it be said definitively that an act is improper preferential access. That would be the type of conduct prohibited by

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<sup>105</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3320.

<sup>106</sup> Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3320-21.

<sup>107</sup> Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3375.



section 3 of the *Health Care Protection Act*. Giving priority to publicly funded health services by accepting money or other valuable consideration, or trying to get priority by such means, are corrupt acts. They are not only improper but also illegal in the context of that statute.

This inquiry's terms of reference in the preamble state that "it is improper to gain access to publicly funded health services through threat, influence or favour." Gaining priority through threats would also certainly qualify as a corrupt act and therefore be improper. But is it completely accurate to say that gaining priority through influence or favour are similarly corrupt and improper when, for example, the evidence as to professional courtesy revealed that some professionals extend the concept to include favours for friends and persons of influence? If a political official attempted to gain priority for himself or herself, or a friend, through the influence of their position, that would be improper. But influence and favour can also have different connotations depending on the context. My point is that this is a highly nuanced issue.

At the beginning of this chapter I wrote that preferential access implies an advantage, a priority over that which would be regarded as normal. So preferential access is a differentiation in access. That difference could be in either how quickly a service is made available – whether it is a diagnostic test, a consultation or a surgical procedure – or in the quality or extent of the service. But what makes it preferential is that the differentiation is between similarly-situated individuals.

If the faster or better access provided to an individual is based on medical necessity, then it is not a question of bestowing preference since that is the operative principle behind access to all publicly funded health services. It is only if the differential access is based on something other than medical necessity that we can call it preferential. But, as we have seen, there are varied types of preferential access.

Some types of preferential access may be ethically justifiable even if they may not satisfy the test of medical necessity, if by ethical we mean conforming to the accepted standards of society. If something is approved by legislation, it can be said that it is accepted by society. Democratic principles require us to accept that legislation duly enacted by elected legislators expresses the will of the people. If not, the people can elect others to represent them. So it can be said that any preferential access that arises as a result of legislation is ethically justified. A

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similar comment might be made for accepted customs of a profession, professional courtesy perhaps, that do not violate that profession's codes of conduct and provided that those customs do not result in actual harm to others. And that becomes the ultimate test for ethical justification, that no harm be caused.

In my opinion, improper preferential access is any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining access in priority to others similarly situated.

This definition respects the clinical judgment of physicians and accepts the function of ethical advocacy by physicians for their patients. It can include policy choices arrived at through a transparent and democratic process. The definition can encompass categories of people whose preferential access is socially accepted or tolerated. It can even include aspects of professional courtesy grounded in a defined standard of practice.

Is it necessary to include "harm" in this definition? If a decision to grant preferential access to one patient actually harms another, then it cannot be ethically justified. Here, I am referring to a deliberate act in choosing to prefer one patient knowing that another's health would be harmed – demonstrable health consequences caused by the delay in obtaining treatment.

For some act of preferential access to be improper, however, there is no need to demonstrate actual harm. First, it would be nearly impossible to prove. But second, if it is improper then harm can be assumed. Here I am speaking of harm to the health care system, to its fairness, predictability and efficiency, to the public's confidence in its integrity, and by reinforcing the improper behaviour by its example to others.

## CHAPTER THREE: RESPONDING TO THE PROBLEM OF QUEUES

Earlier, I stated that this inquiry was not mandated to examine the broad policy questions surrounding wait lists for treatment and their management. But no discussion of access, preferential or otherwise, can be complete without reference to wait lists.

### A. *Wait Lists*

There are numerous rationales for wait lists. A primary goal of a publicly funded health care system is to provide the necessary care to each patient according to need, and those with the greatest need should be served first. One rationale for using wait lists to allocate health care is that it is a means to regulate access to services that is based only on need, not on ability to pay or any other criteria.

But that is not the only reason why wait lists exist. They are also a result of supply and demand. When the demand for services outstrips supply, the system must find ways to effect fair access based on the need for the service. There are a limited number of specialists and facilities.

Policy-makers may use wait lists to ration health services to ensure that those services – services that are expensive – are fully utilized. In hospitals, for example, wait lists mean that operating theatres can be used at full capacity. They reduce the possibility that supply will exceed demand, which would leave excess capacity, with operating rooms empty and staff without anything to do. Wait lists, of course, may also simply be the result of ineffective management of demand coupled with insufficient supply.

Wait lists may be a useful management tool, but lengthy wait times harm patients. A lengthy wait for treatment can reduce the patient's quality of life and limit their ability to return to work; it can prolong suffering and require medical management of pain and other symptoms; it can increase stress and anxiety; it may also lead to increased morbidity and even death. Studies suggest that longer wait times may lead to worse clinical outcomes in terms of physical and social functioning.<sup>1</sup> Lengthy waits can also exacerbate other resource

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<sup>1</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 27.

scarcities – for example, when patients use up hospital beds while waiting for backlogs in surgery to clear.

## **B. Wait time measurement**

### **(i) Policy initiatives**

For the general public and health system policy makers, wait times took prominence during the last decade as a major indicator of the quality of the Canadian health care system.<sup>2</sup>

In 2004, the federal, provincial and territorial governments committed themselves to a 10-year plan to strengthen health care.<sup>3</sup> Among the principal commitments was the development of evidence-based benchmarks for medically acceptable wait times, starting with cancer, heart, diagnostic imaging procedures, joint replacements and cataract surgery. These were identified as priority areas for meaningful wait time reductions. In its 2012 review of the 2004 health accord, the Standing Senate Committee on Social Affairs, Science and Technology found that wait time commitments in priority areas had “largely been met” but that the development of benchmarks was not sufficiently evidence-based or patient-centred:

The committee also heard that the wait time agenda had certain limitations, including that the benchmarks established were not based upon sufficient research, which in some cases, led to questioning of their appropriateness by health care providers and policy makers. Moreover, they were not patient-centred in that they did not reflect the complete wait times experienced by patients across the continuum of care, with witnesses emphasising the lack of timely access to primary care physicians as being of particular concern.<sup>4</sup>

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<sup>2</sup> Gregory P. Marchildon, “Canada: Health System Review,” (2013) 15:1 *Health Systems in Transition* at 139.

<sup>3</sup> Health Canada, “First Ministers’ Meeting on the Future of Health Care 2004;” <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>.

<sup>4</sup> Senate of Canada, Standing Senate Committee on Social Affairs, Science and Technology, *Time for Transformative Change: A Review of the 2004 Health Accord* (March 2012) at viii:

<http://www.parl.gc.ca/Content/SEN/Committee/411/soci/rep/rep07mar12-e.pdf>; Health

The Canadian Institute for Health Information describes patient-centred care:

To date, patient-centred care has not been well defined. The World Health Organization views patient-centered care as ‘a means to improve services in relation to access, quality, user satisfaction and efficiency.’ Researchers have also identified some of its key attributes. One is respect for patients’ values, preferences and expressed needs; another is coordination and integration of care. As patients often wait during the transitions between care settings, better integration of health care services may reduce wait times and improve patient experiences.<sup>5</sup>

The Canadian Institute for Health Information recently reported progress in reducing wait times in the five priority areas, but said that much work remains to be done, both in those and other areas.<sup>6</sup> One concern was that identifying and concentrating on five priority areas might result in fewer resources being allocated to improve access in other areas.

### **(ii) Tracking wait times**

One significant source of confusion in tracking wait times is the period of time they cover. In Canada, wait times are usually measured only from the point of the patient’s consultation with the specialist to the time of treatment. Where there are several consultations, the clock may not start until the patient is added to the specialist’s wait list for the procedure. Canada has one of the narrower measures of wait times among developed countries. For example, the Alberta Wait Times Reporting website defines a wait time as “the time between when a patient and [specialist] decide that a procedure or diagnostic test is required and the date the procedure or test is performed.”<sup>7</sup> In contrast, England, Sweden and Finland begin calculating wait times as of the

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Council of Canada, *Progress Report 2013: Health Care Renewal in Canada* (Ottawa, 2013) at 9.

<sup>5</sup> Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 75.

<sup>6</sup> Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 6.

<sup>7</sup> Alberta Health and Wellness (available at <http://waittimes.alberta.ca>).

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patient's initial contact with a physician. Other countries measure the time from physician referral to a specialist to treatment.<sup>8</sup>

If the goal is to reduce the patient's total wait time, looking at the entirety of the patient's contact with the health care system is more appropriate. It should enable greater coordination of care throughout the patient's journey to treatment. By measuring only part of the patient's encounter with the system – wait times that occur later in the encounter – there is a risk of ignoring the equally important wait times at the front end of the system and not having an accurate picture of wait times as a whole. As one witness, Dr. Nicholas Mohtadi, put it, "We are measuring health care based on what we can measure and ... ignoring what we are not measuring or what is difficult to measure."<sup>9</sup>

The Wait Time Alliance, a group composed of the Canadian Medical Association and 13 national medical specialty organizations, contends that several stages should be considered part of any wait time monitoring system, including finding and seeing a family physician, waiting to see a specialist and waiting for diagnostic procedures.<sup>10</sup> This underlines the fact that patients may encounter multiple wait times within the health care system.

Alberta is tracking, benchmarking and reporting on wait times for a number of programs and services (not just the five priority areas identified in the 2004 federal-provincial-territorial accord). A summary of these reports is published in the current Alberta Health Services (AHS) health and business plan.<sup>11</sup> Some of the wait times benchmarked by AHS include:

- cardiac surgery
- hip replacement surgery
- knee replacement surgery
- cataract surgery

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<sup>8</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 35-36.

<sup>9</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1319.

<sup>10</sup> Wait Time Alliance, *Shedding Light on Canadians' Total Wait for Care: Report Card on Wait Times in Canada* (June 2012) at 5.

<sup>11</sup> Alberta Health Services, *Health Plan and Business Plan: 2012-2015* (Section 3.1: "Improve Access and Reduce Wait Times").

- cancer treatment
- emergency department length-of-stay
- children's mental health
- wait in community for continuing care placement, and
- wait in acute/sub-acute care for continuing care placement.

The Alberta Wait Time Reporting System was launched on the Alberta Health website in May 2011. That reporting system shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services, as reported by Alberta specialists and facilities. The site allows the public to search wait times by procedure, by specialist and by facility. It also provides wait time trends over the most recent 13-month period.<sup>12</sup>

### **(iii) Demands on the system**

Another important factor in this discussion is the ever-increasing demand placed on health services. More than 538,000 Canadians underwent surgical procedures in one of the five priority areas in 2012, an increase of about 21,000 over the previous year. Data from across Canada suggests that the demand for some procedures, such as joint replacements, is rising faster than the ability of health care systems to meet the demand.<sup>13</sup> As a result, the reductions in wait times that occurred during the first few years after the 2004 accord (which had a goal of treating 90 per cent of patients within the benchmarked times) have levelled off.

Within these national trends, however, there is evidence of medical prioritization at work. A recent pan-Canadian survey of health care system performance by the Conference Board of Canada found that wait times for non-emergency procedures have remained constant or increased in recent years. However, wait times for emergency procedures such as radiation therapy and cardiac bypass surgery remain within national benchmarks. As the Conference Board of Canada report states:

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<sup>12</sup> Alberta, Ministry of Health and Wellness, *Health and Wellness Annual Report 2011-2012* at 21.

<sup>13</sup> Canadian Institute for Health Information, *Wait Times for Priority Procedures in Canada, 2013* (February 2013) at 2.

The good news is that even as resources have become scarcer due to a growing and aging population, which increases demand for health care, wait times for procedures for the most life-threatening illnesses have not increased.<sup>14</sup>

#### **(iv) Alberta benchmarks**

Is Alberta meeting national wait time benchmarks? My report is not the appropriate vehicle for an in-depth analysis, but certain indicators are instructive.

Alberta is neither the best nor the worst among provinces in meeting the benchmarks set for the five priority areas.<sup>15</sup> For radiation therapy, 97 per cent of patients were treated within the benchmark wait times in the 2010-2012 period. This is comparable to national rates. With respect to cataract surgery, 69 per cent of Alberta patients were treated within the benchmark wait time of 112 days, compared with 83 per cent nationally. For knee replacements, 79 per cent of Alberta patients were treated within the benchmark wait time of 182 days, compared with 75 per cent nationally. Similarly, for hip replacements, 84 per cent of Alberta patients were treated within the benchmark wait time of 182 days in 2010-2012, compared with 80 per cent nationally.

AHS has adopted performance measures for treatment and discharge from emergency departments (four hours) and for treatment and admission to hospital from the emergency department (eight hours). For the fiscal year 2011-12, for the 16 busiest sites in the province, 65 per cent of treatments and discharges occurred within the four-hour benchmark and 45 per cent of treatments and admissions to hospital were within the eight-hour benchmark. The health plan proposed by Alberta Health Services is aiming at a 90 per cent compliance rate for both benchmarks by 2014-15.<sup>16</sup>

#### **(v) Financing**

The question frequently arises whether putting more money into the health care system will improve performance. Numerous national and international studies say “not necessarily.” Alberta, with a population

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<sup>14</sup> Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 39.

<sup>15</sup> Canadian Institute for Health Information, *Health Care in Canada, 2012: A Focus on Wait Times* (Ottawa, 2012) at 5-6.

<sup>16</sup> Alberta Health Services, *Health Plan and Business Plan: 2012-2015* at 27.



of approximately 3.8 million, allocated \$16.6 billion for health care in its 2012-13 budget. That amounts to per capita spending of \$4,606 (not the highest in Canada, that being Newfoundland and Labrador at \$5,190).<sup>17</sup> The recent Conference Board of Canada report argues that spending more does not necessarily lead to better performance. Good performance can be achieved at various levels of spending and it is possible to achieve good health care system performance with limited resources. The report summarizes its arguments:

Spending larger sums of money on health care does not necessarily translate into better health care performance.... It is *how* the money is spent, rather than *how much*, that will translate into better value for Canadians. And before governments make decisions on health care spending, they would do well to take stock of their own systems relative to others and adopt best practices found in Canada and in the world.<sup>18</sup> [Emphasis in original]

In all likelihood, long-term stability of financing would be far more conducive to good management practices and planning than short-term fluctuations.

#### **(vi) Plans for enhanced access**

AHS has acknowledged the need to improve access and reduce wait times.<sup>19</sup> At a minimum, AHS should consider developing a wait time measurement system that takes into account the four principal categories of waits:

- 1) The wait to see a primary care provider;
- 2) The wait for diagnostic tests and examinations;
- 3) The wait to see the specialist after referral by the primary care provider; and
- 4) The wait for treatment.

<sup>17</sup> Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 6.

<sup>18</sup> Conference Board of Canada, *Paving the Road to Higher Performance: Benchmarking Provincial Health Systems* (May 2013) at 54.

<sup>19</sup> Alberta Health Services, *Health Plan and Business Plan: 2012-2015* at 25.

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There should also be a system for tracking of procedure and health outcomes. Without that, all there would be is information about process. Together this combined data would provide a much more comprehensive patient-centred picture of the true nature of waiting in the health care system.

As I have said elsewhere, the mandate of this inquiry was not to examine wait lists *per se*. However, it is impossible to overlook the fact that the very existence of wait lists and the excessive time people may wait for assessment and treatment can be important motivators for attempting to expedite access by improper means.

As previously noted, AHS has developed plans to enhance access to health services and reduce wait times. Since improper preferential access is an aspect of access generally, and enhanced access generally would tend to reduce the impetus for seeking improper preferential treatment, it is within my mandate to recommend that AHS continue with those plans, incorporating the best evidence-based practices, and that it do so transparently in consultation with all sectors of the health care system and with the public.

Ultimately, ensuring equitable access to health care within a reasonable time comes down to good planning. As noted by the Health Quality Council of Alberta in its 2012 report, “Queuing is not just a symptom of the mismatch between capacity and demand or even a ‘simple’ lack of sufficient capacity. Queuing is often a symptom of incomplete planning to address the variability of demand.”<sup>20</sup>

### **Recommendation 4:**

#### **Reduce wait times**

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system.

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<sup>20</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 49.

### ***C. Wait list management***

Wait times for medical services obviously implicate the question of access. Two other issues also directly affect access and the potential for improper preferential access. The first is how wait lists are managed (dealt with here); the second is physician referrals (dealt with in the following section).

In 1998 Health Canada reported that, with rare exceptions, wait lists were non-standardized, capriciously organized and poorly monitored. It observed that there was widespread interest in standardizing data and in coordinating and integrating wait lists.<sup>21</sup>

In 2002, the Romanow Commission criticized wait list management in Canada as inconsistent, uncoordinated and haphazard. It went on to recommend several steps that provincial and territorial governments should take:

- Implement procedures for managing wait lists in a centralized manner either within specific regions of a province, in the province or territory as a whole, or between provinces depending on the particular service involved;
- Implement standardized and objective criteria for assessing patients to ensure that the time they wait between when they are diagnosed and when they are treated depends only on the seriousness of their health needs. This work should be done with the full participation of health care professionals involved in providing the services;
- Provide health professionals with the necessary training to ensure that patients' needs are objectively assessed according to the standardized criteria; and
- Provide patients with a clear and understandable assessment of:
  - Why a particular service or procedure is being suggested and the options and alternatives that are available on an interim and longer term basis, including the option of seeing another physician;

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<sup>21</sup> P. McDonald *et al.*, *Waiting lists and waiting times for health care in Canada* (Health Canada, 1998).

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- The relative seriousness of their needs for the particular services based on an objective assessment by health professionals and reflecting the standardized criteria;
- The approximate time they should expect to be on the wait list for a particular service given the severity of their medical need; and
- Any changes to a patient's condition or developments in the health care system that could either lengthen or shorten the wait time.<sup>22</sup>

To a great extent these recommendations remain as valid today as when they were first made. Wait lists generally do not have standardized criteria for deciding the priority of any given patient. There are few rules or guidelines as to when a patient should be put on a wait list. There is no standard way to account for non-medical factors such as age or family and employment circumstances when attempting to determine the appropriate patient priority on a wait list. There is no auditing of wait lists to see if those on the list are appropriately placed, whether a change in their condition requires a change in their position on, or removal from, the list, or whether they are on more than one list for the same procedure. The lack of standardized criteria for placement on wait lists for many health care services leaves people on wait lists vulnerable to queue-jumping. As the Western Canada Waiting List Project noted in a 2001 report:

The absence of standardized criteria and methods to prioritize patients waiting for care means that patients may be placed and prioritized on waiting lists based on a range of clinical and non-clinical criteria that may vary across institutions, health regions, and provinces. This situation inevitably leads to concerns regarding unnecessary risks faced by patients who may not be getting necessary care in a timely fashion. If patients are not receiving such care on the basis of relative need and capacity to benefit, then the principle of equitable access to care is violated. It is imperative, therefore, that one of the key policy initiatives to address the issue of waiting lists

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<sup>22</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 145.

focuses on the development of standard criteria that may be universally adopted to prioritize patients.<sup>23</sup>

One of the major points that came out in the evidence presented to this inquiry was that wait lists are generally managed by individual physicians or hospitals. There is little or no coordination of lists among physicians or hospitals. Specialists keep their own wait lists and generally do not merge or compare them with colleagues' lists. As a result, a patient may sit far down a long list kept by a particular specialist while other specialists may have shorter lists and could help the patient more quickly.

Specialists have wide discretion in deciding what priority a patient should have on a wait list. So do hospital operating theatre committees that decide what blocks of time to allocate to the different surgical specialities. One of the inquiry's expert witnesses, Mr. James Saunders, described them as "points of discretion":

There are points of discretion where professional judgment of the specialist comes into play, certainly in the selection of where they place an individual in their priority list as well as in the scheduling of the operating theatres and the system and process that goes along with that. There are value judgments made there about the relative importance of the amount of time required based on work loads of both the individual physicians as well as groups of physicians by specialty.<sup>24</sup>

As a result, in Mr. Saunders' opinion, these two areas of decision-making, one by the specialist and the other by the hospital committee, can be prone to manipulation for reasons other than medical need.

There was evidence, however, from other witnesses that the procedures for booking operating rooms, while differing to some extent between facilities, limit any opportunity for outside interference in the operating room booking process. The common point in this evidence, however,

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<sup>23</sup> Western Canada Waiting List Project, *From Chaos to Order: Making Sense of Waiting Lists in Canada: Final Report* (March 31, 2001) at 5.

<sup>24</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 136.

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was that each surgeon submitting booking forms to a facility manages his or her own lists.<sup>25</sup>

Mr. Saunders also spoke about the potential benefits of a central or coordinated booking system for managing wait lists.<sup>26</sup> Such a system could provide better coordination of specialists' workloads through establishing standardized priorities for each type of treatment. A referral would be assessed against others on the wait list and a merged priority list would result, leading to more efficient patient flow. When a patient reaches the top of the list, the first available surgeon would be assigned to that patient. Decisions would be based on supply and demand within the system as a whole, instead of just within the narrow confines of one physician's practice. All this should reduce wait times.

Many examples exist of efforts to create central booking schemes and standardized criteria for prioritizing patients on wait lists. In Ontario, long wait lists for coronary artery bypass surgery in the 1990s led to the generation of explicit clinical criteria for prioritizing patients on wait lists, along with a centralized wait list management system. This led to reduced wait times and a more appropriate priority system.<sup>27</sup>

The Western Canada Waiting List Project, established in 1999, is a partnership among four western provinces, health authorities, academic health sciences centres, and medical associations to address wait list issues in five clinical areas. Its work led to practical and transparent measures for prioritizing patients waiting for service in those areas. Its research also showed that clinicians, administrators and the public were receptive to these wait list management tools.<sup>28</sup>

In 2007 Health Canada funded an initiative that led to the development of the Paediatric Canadian Access Targets for Surgery (P-CATS), which developed standardized priority classifications across a spectrum

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<sup>25</sup> Testimony of Shawn Hillhouse, Transcripts, vol. 15, January 9, 2013, at 1182; testimony of Skyla Lungren, Transcripts, vol. 15, January 9, 2013, at 1213; testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1242.

<sup>26</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 112-13.

<sup>27</sup> D.A. Alter, A.S.H. Basinski and C.D. Naylor, "A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada" (1998) 129 *Annals of Internal Medicine* 567.

<sup>28</sup> Western Canada Waiting List Project, *From Chaos to Order: Making Sense of Waiting Lists in Canada: Final Report* (March 31, 2001) at 25.

of paediatric surgical procedures.<sup>29</sup> P-CATS enables tracking of the wait time from the decision to refer the patient to a specialist to the initial consultation, as well as the time between the date when a decision is made to proceed with surgery and the surgery date.

New Brunswick initiated the New Brunswick Surgical Care Network based on work first done in Saskatchewan. This program, developed with the participation of clinicians, administrators and patients, created a province-wide registry for patients requiring any of 30 surgical procedures. The registry offers real-time data organized as follows: by surgical specialty; acuity of the patient's condition; expected health outcomes and benefits of surgery; clinical benchmarks identified for the procedure; type of procedure (in-patient or day surgery); and patient availability, along with a recommended date for surgery. The registry is used for scheduling surgeries, allocating operating room time and communicating with patients. The Department of Health also created an "access manager" position in each hospital to facilitate communication among patients, surgeons and the hospital.<sup>30</sup>

Central booking systems are also being developed in Alberta in some specialities – knee and hip replacements among them.<sup>31</sup> In its 2012 report, the Health Quality Council of Alberta recommended developing standardized approaches for the creation of surgical waiting lists, with priority given to surgical oncology.<sup>32</sup>

Several expert witnesses before the inquiry commented on standardized wait lists and centralized booking practices. Some argued that centralized list management practices alter the traditional relationship between the specialist and the referring physician, but acknowledged that they result in greater efficiency for patients. Still, such innovations

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<sup>29</sup> J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta* (November 29, 2012) at 14 [Exhibit 12].

<sup>30</sup> Report of the Taming of the Queue 2013 Conference, *Beyond the Queue: A systems approach to addressing the root causes of wait times* (March 21-22, 2013, Ottawa) at 11; see also [www1.gnb.ca/0217/surgicalwaittimes](http://www1.gnb.ca/0217/surgicalwaittimes).

<sup>31</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 112-13.

<sup>32</sup> Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012) at 23.

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must be addressed systematically, using evidence-based clinical guidelines, to achieve a more rational and effective use of resources.<sup>33</sup>

Dr. David Alter explained one drawback to centralized wait lists. Assigning individual patients a ranking number based on their clinical condition is difficult and provides an imperfect indicator of their need. The individual patient's complaint cannot be treated in isolation. "It's imperfect because we can never really account for every clinical scenario. Patients do not read textbooks, nor do their symptoms. It's imperfect because it doesn't encompass social values, and it's imperfect because it doesn't always encompass other markers of clinical severity that we know, as physicians, we respond to – cancer, dialysis, other comorbid or other ailments that we think will impact on the effectiveness of the service in question."<sup>34</sup> Despite seeing explicit management systems as imperfect, Dr. Alter suggested that they have been very helpful for system surveillance by bringing attention to regions or services where wait times are excessive or patient outcomes unsatisfactory.<sup>35</sup>

The Alberta Medical Association raised another concern about centralized wait lists in its submissions to the inquiry. It argued that centralization can limit physician autonomy and potentially interfere with a patient's continuity of care, harming the patient's health. The answer to this concern, in my opinion, is to focus on a patient's autonomy and right of choice rather than on physician autonomy. Any system of centralized management must give patients the right to choose. A patient should be permitted to stay with a specialist with whom they have a rapport or who comes highly recommended, but the patient should also be told that such a choice might entail a longer wait. And specialists must also accept that their patients have a right to choose a different specialist to reduce their wait time.

It is evident that standardizing clinical prioritization criteria and introducing consistent wait list procedures would assist physicians, hospitals and patients by better organizing various stages of health care and making them more understandable. In particular, if patients are to be served in order of need, physicians need evidence-based tools to

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<sup>33</sup> Testimony of Lynette Reid, Transcripts, vol. 38, February 26, 2013, at 3322-24; testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3324; testimony of Owen Heisler, Transcripts, vol. 40, February 27, 2013, at 3482-83.

<sup>34</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3473-74.

<sup>35</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3476.



help them prioritize patients in their own practices and collectively prioritize patients on pooled lists. And no one in the health care system, managers or clinicians, can make knowledgeable decisions without complete, accurate and up-to-date information about wait lists and wait times.

Wait list management should therefore be part of any discussion about equitable access and the potential for improper preferential access. As stated in a 2000 article in the *Canadian Medical Association Journal*:

Why should we worry about how waiting lists – especially those for elective procedures – are organized and managed? The main reason is fairness or equity. A core underpinning of publicly financed health care systems is “to each according to his or her need.” Assuming that a health care intervention offers a reasonable probability of tangible benefit, those with the greatest need for the intervention should be served first, if all else is equal. The probability that tens of thousands of individual, uncoordinated decisions taken in a large, complex and diverse system will combine to yield fairness for all is vanishingly low.<sup>36</sup>

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<sup>36</sup> Steven Lewis *et al.*, “Ending waiting-list mismanagement: principles and practice” (2000) 162 *Canadian Medical Association Journal* 1297 at 1297.

**Recommendation 5:****Develop and implement wait list management strategies**

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies that include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialities, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital).

**D. Referrals**

Access to specialist physicians and procedures typically occurs through referrals from primary care physicians. Specialists then prioritize patients on a wait list based on information from the referring physician. The wait to see the specialist could be and often is longer than the subsequent wait for the actual procedure.<sup>37</sup>

The Standards of Practice issued by the College of Physicians & Surgeons of Alberta are meant to set out the minimum standards of professional behaviour and ethical conduct expected of physicians. One component is a standard called The Referral Consultation Process.<sup>38</sup> This outlines various steps that physicians are expected to follow when referring a patient to a specialist, including the requirement (except in urgent

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<sup>37</sup> See also Wait Time Alliance, *Shedding Light on Canadians' Total Wait for Care: Report Card on Wait Times in Canada* (June 2012) at 7.

<sup>38</sup> College of Physicians & Surgeons of Alberta, *Standards of Practice*, Standard 6 (The Referral Consultation Process), January 1, 2010.

circumstances) to request the consultation in writing and providing all pertinent clinical information. But the practice is still not standardized.

I heard considerable testimony about the variable quality of referrals.<sup>39</sup> If the referring physician provides a thorough description of the clinical information available, as well as an assessment of the relative urgency of the consultation, the specialist can more accurately prioritize the patient. However, many referrals simply do not give the necessary information. Dr. Nicholas Mohtadi, an orthopedic surgeon, testified that the majority of referrals he receives do not give sufficient information for him to prioritize the referral in an evidence-based fashion.<sup>40</sup>

Incomplete referrals can lengthen the interval before treatment and increase frustration for the patient. Dr. Mohtadi testified that out of somewhere between 1,000 and 1,500 referrals he receives a year, he can see at most 500 patients.<sup>41</sup> He explained what he does when a referral lacks the necessary information:

Q. In those sort of instances, do you follow up with that referral physician and say, “Look, I need more information” or do you get back to them with some sort of a standard as to what you are expecting?

A. Sometimes, yes. And sometimes I will pick up the phone. Sometimes I will put a message on the referral and have it sent back. And, in certain circumstances, that becomes an overwhelming process, and it’s actually very difficult. So frankly, it’s easier for me to say I won’t see the patient than to go through that process. And sometimes it would be easier just to close my practice and not accept referrals.

Q. In the example I just gave, though, the quality of that referral itself could be a holdup for that patient actually getting a chance to see you.

A. Absolutely.<sup>42</sup>

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<sup>39</sup> Testimony of James Saunders, Transcripts, vol. 2, December 3, 2012, at 111.

<sup>40</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1306-07.

<sup>41</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1320.

<sup>42</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1374.

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A routine practice is for referring physicians to mark consultation requests as “urgent” to secure a consultation earlier. This can result in more truly needy patients being pushed down the wait list. A gastroenterologist explained why: “We regularly receive information regarding referred patients that overstates the severity of symptoms or that reports ‘alarm symptoms’ that are entirely absent on evaluation. Assessment of patients with less-than-urgent problems delays evaluation and treatment of patients with serious symptoms who truly require urgent care.”<sup>43</sup>

Personal relationships (as between the referring physician and the specialist) can also affect referrals. So can the quality of advocacy of the referring physician. As I outlined previously, advocating for individual patients has long been recognized as a basic role of the physician. Physicians should try to expedite investigation or treatment for their patients when medical need requires. The point, however, is that whenever guidelines or procedures are lacking, there arises the opportunity to game the system. A lack of standardized prioritization criteria here can also motivate some to obtain improper preferential access. Ultimately, the rationale for standardizing the referral process is to have a clinically coherent and transparent method to determine who should be seen next.

There is ample evidence of the benefits of standardizing the referral process. Dr. Mohtadi described those benefits:

[I]t’s always a benefit to standardize things for the majority of patients, but the people – the proponents of standardizing the process – would say that consistency leads to better care overall; and the antagonists of that approach will say, well, there are always exceptions, and therefore, there are people that would not want to standardize.

But it’s absolutely clear that the majority of who we see, irrespective of our specialty or subspecialty area, are similar to the people that we saw before. So most of us have a consistent practice, and the variance within that practice is relatively small.

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<sup>43</sup> Guido M.A. Van Rosendaal, “Queue jumping: Social justice and the doctor-patient relationship” (2006) 52 *Canadian Family Physician* 1525 at 1526.

So standardization would improve the process of referral, and indeed, there is every intention to do that in Alberta.<sup>44</sup>

What Dr. Mohtadi was referring to at the end of his comment is an initiative by AHS to standardize the referral process and introduce a system of electronic referrals. Path to Care: Referral and Wait Time Measurement and Management is a multi-year project to develop provincial guidelines for each clinical specialty, specifying what information is required in a referral, defining an urgency scale, and identifying the appropriate timeline for a patient to be seen and the tests that should be done before a physician makes a referral. Central intake clinics will also be introduced in many specialty areas.<sup>45</sup> This is a worthwhile initiative. Efforts to further this project should continue, with physicians, program administrators and the public collaborating in all aspects of program design and implementation.

#### **Recommendation 6:**

##### **Develop standardized referral procedures and booking systems**

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be given to service providers about how to use new systems.

#### **E. Accountability**

One of the puzzling aspects of the efforts to reduce wait times across the country, and in particular efforts to set benchmarks, is the lack of real accountability for not meeting standards. There are no penalties for failing to reach a target – except of course for the patient who continues to wait with reduced quality of life. Some accountability is achieved by making information public. Data on wait times and use of services, as well as patient health outcomes, can lead to public pressure for change. It can also motivate health care administrators to improve their operations.

<sup>44</sup> Testimony of Nicholas Mohtadi, Transcripts, vol. 17, January 10, 2013, at 1324-25.

<sup>45</sup> Information available at [www.departmentofmedicine.com/MAS](http://www.departmentofmedicine.com/MAS).

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The lack of penalties in Canada contrasts with the situation in several other countries. The United Kingdom, for example, introduced strong sanctions. If wait time targets were not met, administrative action resulted in budget cuts and personnel changes.<sup>46</sup>

A common method in many countries to reduce wait times is a wait time guarantee. Simply stated, no patient in need of care should wait more than a set period of time. If the wait is longer, the patient can choose to have the procedure done at public expense in a private hospital (in countries where there is a parallel private system) or be treated in another country (for example, for European Union countries that adopted a directive in 2011 to eliminate obstacles to patients seeking treatment in other countries).<sup>47</sup>

The results of such measures – sanctions and guarantees – are mixed. Countries that introduced strong sanctions on health care providers in conjunction with wait time guarantees had some success in reducing wait times. But there is also evidence that guarantees led to prioritizing patients improperly. This could happen, for example, by giving priority to patients with less urgent clinical needs to avoid them going over the wait time limit. The resources to do so might be taken from the care of patients with more pressing needs but whose wait times are not yet approaching the limit.<sup>48</sup> In other words, wait time guarantees could sometimes shortchange those patients in greatest need of attention.

In its 2002 report, the Romanow Commission rejected wait time guarantees. It argued that health care authorities need the flexibility to manage different procedures effectively. That flexibility could be lost with rigid time guarantees. It also expressed concern that provincial and territorial health care systems could take resources from life-saving treatments to meet the guarantees for other services, if tied to care guarantees for elective or non-life saving services.<sup>49</sup>

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<sup>46</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at chapter 16.

<sup>47</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 51-58.

<sup>48</sup> L. Siciliani, M. Borowitz and V. Moran, eds., *Waiting Time Policies in the Health Sector: What Works?*, OECD Health Policy Studies (OECD Publishing, 2013) at 56.

<sup>49</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa, 2002) at 144.

Given the limited mandate of this inquiry, it is not for me to say whether such measures would be effective. I mention them only to illustrate that, if there are to be benchmarks for wait times or guidelines for prioritizing referrals, there must also be meaningful tools to evaluate their use and effectiveness as well as to hold health care providers and governments accountable.

The impetus for gaming the system becomes greater when the system is viewed as disorganized, incoherent and arbitrary. By implementing the measures set out in the recommendations in this section, the health care system will be seen as far more comprehensible and fairly managed, reducing the incentives for queue-jumping.





## CHAPTER FOUR: TRANSPARENCY AND PUBLIC ADVOCACY

### A. *Transparency*

In recent years, Canadians have benefitted from far more public reporting on indicators and performance measures than in the past. This has helped hold governments accountable. The Government of Alberta and Alberta Health Services (AHS) have a wide array of information available on their websites. But there is still little engagement with the public on more fundamental issues related to the health care system, including those about access.

Transparency of the processes that drive Canadian health care, such as resource allocation and decision-making at all levels of the system, was frequently mentioned by the experts testifying before this inquiry as lacking in the current system. Prof. John Church, an expert in health policy from the University of Alberta, stated, “The work that I have done for this particular inquiry has further underlined this sense that decision-making has become very centralized and that access to basic information, both for researchers and also for the public, seems to be lacking in transparency, and just basic access to information seems to be lacking.”<sup>1</sup> He explained that Alberta’s current system has changed from being largely decentralized, with decisions made with input from the public, to a more centralized system with the creation of AHS. Prof. Church suggested that, because there are no mechanisms in place for transparency and because of the lack of information in this more centralized system, “we seem to be reeling from one crisis to another in the health care system.”<sup>2</sup>

Echoing the call for transparency, Dr. David Alter stated, “I’m of the mind that transparency is always good, generally speaking, as long as it’s managed responsibly in terms of people understanding the information that they read. So I can’t see a downside of transparency because it builds in accountability.”<sup>3</sup> Prof. Church suggested that a lack of transparency creates confusion for the public because of its lack of understanding about the health care system: “I think that that’s mainly

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<sup>1</sup> Testimony of John Church, Transcripts, vol. 40, February 27, 2013, at 3485.

<sup>2</sup> Testimony of John Church, Transcripts, vol. 40, February 27, 2013, at 3486-87.

<sup>3</sup> Testimony of David Alter, Transcripts, vol. 40, February 27, 2013, at 3488.

because nobody has sat down and been transparent about some of those complexities.”<sup>4</sup>

Dr. Brian Goldman commented that publishing wait times for services online or making them transparent in other ways would “be helpful in the same way that we’ve found ... that posting ER wait times, emergency department wait times, either online, smartphone, or computer at home or in the waiting room, is resulting in patients making different decisions.”<sup>5</sup> These different decisions by patients can decrease the flow into very busy emergency rooms and lead patients to rely on family physicians or less busy hospitals. Similarly, publishing wait times for a given service could lead patients to make choices that may decrease the pressure on that particular service, for example, by choosing a different physician or clinic with a shorter wait list in order to take pressure off a busier physician or clinic.

The expert witnesses agreed that decision-making in health care needs to be more transparent for the public. Increased knowledge can help the public understand both how the system works and its limitations. Increased public education about health care options could help alleviate some recurring pressures in the system. Most important, if the public sees that the decision-making criteria in the health care system are fair, transparency can enhance public confidence in the system.

### **B. *Health literacy***

Transparency, however, means more than simply loading data onto a website. Many, if not most, Canadians still need help navigating what is clearly a complex health care system.

Health literacy is clearly an issue. Studies have shown that a large majority of Canadians lack sufficient health literacy – the capacity to obtain, understand and act on information about services that will help them make appropriate health decisions.<sup>6</sup> This deficit is even greater among immigrant populations whose first language is neither English nor French. There should be readily accessible sources of advice and even advocacy for patients who are not capable or confident enough to contact their MLA or someone in authority in the health care system, or

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<sup>4</sup> Testimony of John Church, Transcripts, vol. 39, February 27, 2013, at 3386.

<sup>5</sup> Testimony of Brian Goldman, Transcripts, vol. 38, February 26, 2013, at 3325-26.

<sup>6</sup> Gregory P. Marchildon, “Canada: Health System Review,” (2013) 15:1 *Health Systems in Transition* at 54.

who may not have a long-time personal physician with whom they can discuss their health care.

### **C. Health advocacy**

Alberta Health Services has a process for receiving complaints from patients. The *Patient Concerns Resolution Process Regulation*, enacted in 2006, requires health authorities to maintain a system for processing, considering and responding to complaints. The College of Physicians & Surgeons of Alberta (College) also has a formal complaint process for issues relating to professional conduct. The College also has a form of alternative dispute resolution where staff members, called patient advocates by the College, are available to work with complainants and attempt a satisfactory resolution.<sup>7</sup>

These complaint processes are fine and necessary but they are still internal mechanisms controlled by AHS or the College. They do not provide the type of independent advisory or advocacy services that patients may require.

In her final submissions, counsel for the Consumers' Association of Alberta recommended that consideration be given to establishing a formal health advocate position dedicated to patient and family advocacy. She suggested modelling the role on that of the Commissioner of Health and Disabilities in New Zealand.<sup>8</sup> That Commissioner, established as an independent statutory position, is responsible for promoting and protecting the rights of health services consumers and facilitating the fair and efficient resolution of patients' complaints. The Commissioner is supported by a network of independent advocates who can advise and represent patients.

In 2010, the Alberta legislature passed the *Alberta Health Act*,<sup>9</sup> but it has not been proclaimed into force. That statute provides for the appointment of a Health Advocate who would review complaints that a person working in the health care system failed to act in a manner consistent with a Health Charter. The Health Charter would be established by the Minister of Health to guide the actions of health authorities, health providers, professional colleges and, according to the Act, Albertans.

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<sup>7</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2318-20.

<sup>8</sup> Information available at [www.hdc.org.nz](http://www.hdc.org.nz).

<sup>9</sup> S.A. 2010, c. A-19.5.

I have no information why the Act has not been proclaimed. But the position advocated by the Consumers' Association of Alberta, and as I envision it, would have much broader responsibilities than responding to lack of compliance with the dictates of an aspirational health charter.

There is merit in considering a system of independent advocates for patients in Alberta. This would likely do more to enable patients to navigate the health care system than all the data and information posted on websites. It is good to have targets and plans in place to meet those targets, but if individuals are to make informed decisions about their health care, they need someone assisting them whose only interest is their health. This advocate role would complement efforts to attain more effective wait list management and assist in achieving equitable access.

I recognize that there are two arguments that could be made against such a proposal.

The first is that it would interfere with the traditional doctor-patient relationship. After all, a patient's primary advocate, and usually the best one, should be his or her physician. But sometimes the issue at the root of a patient's complaint is the information, or lack of it, provided by his or her physician. In addition, if there is conflict in that relationship, or if the patient simply does not understand what the physician is doing or recommending, the patient needs someone independent to go to for advice and assistance.

The second argument is that a separate complaints avenue could lead to conflict with the College in its professional disciplinary role. There are two answers to this. First, if a patient's communication with the independent advocate reveals something that might be a question of professional misconduct, the advocate can turn it over to the College to investigate. Second, the independent advocate does not need to work in an adversarial relationship with the College. Indeed such advocates could work with the College's patient advocates in the resolution of concerns.

One of the questions that should be considered is who should take the lead in establishing such an office. On the one hand, since AHS is a centralized province-wide organization, it might make sense for it to become the source of advice and assistance for patients. The obvious advantage is that AHS deals with all aspects of health service. On the

other hand, the College could expand the role of its patient advocates into a more robust and independent advocate. The drawback here is that the College has no authority over, or a relationship with, all the different players in the health care system other than physicians.

**Recommendation 7:**

**Consider creating the position of Health Advocate**

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints.



## SECTION III: CASE STUDIES

The inquiry received evidence about several possible incidents of improper preferential access. Some pre-dated the creation of Alberta Health Services (AHS) in 2008, and some occurred after. I also heard evidence regarding circumstances and practices with the potential for improper preferential access. This section investigates nine specific allegations of queue-jumping or preferential access. In each instance, I determine whether the allegation is justified and, if it is, offer recommendations to address the situation.

### 1. *MLA advocacy*

As I discussed earlier, the allegation by Dr. Stephen Duckett of primary concern to this inquiry was of “Mr. Fix-its” or “go-to guys” in executive or administrative positions in the health care system. Among other duties, these individuals allegedly arranged improper preferential access to health care for politicians. Two individuals in particular were the subject of discussion: Mr. Brian Hlus and Ms. Lynn Redford.

In the case of both of these people, their own testimony and that of others made it clear to me that Mr. Hlus and Ms. Redford did not arrange preferential access for individuals. Rather, their duties included assisting members of the legislature and others with information about the health care system. In particular, they provided what many call “navigational advice” to help MLAs address constituent concerns.

There was no evidence proving that any MLA had used influence or other means to enhance his or her own care or that of family or friends. All current and former politicians who testified before this inquiry denied knowledge of any instances where they or any other MLA requested or demanded improper preferential or expedited care for themselves or others. However, the inquiry heard evidence about how some MLAs advocated on behalf of constituents who encountered problems in the health care system.

Witnesses who testified about this type of advocacy considered it an appropriate part of MLAs’ duties. This is important and legitimate advocacy for patients, families and groups, particularly in helping people to navigate the health care system and identify changes needed to the system.

Mr. Harry Chase, an MLA representing Calgary Varsity from 2004 to 2012, described the significance of the advocacy role:

It's extremely important. And I take it as an MLA's elected responsibility to the best of their ability, to represent their constituents in an attempt to meet their needs. There were a number of individuals who had a wide variety of health-related needs within the constituency, such as trying to find a general practitioner who would take on new patients. Trying to have the results that a family doctor would provide the Workmen's Compensation Board validated by doctors within the Workmen's Compensation Board. Trying to get coverage for certain medications has been brought up on the floor of the legislature; would the government cover them after many of the services – such as physiotherapy – were greatly restricted. Trying to get access at various points into the system so that they could begin to receive help. And of course, that has to begin with a family doctor. And if you don't have one, you are at a dead end.<sup>1</sup>

Mr. Chase emphasized that at no time did his role extend to arranging improper preferential access. Counsel asked, "Did you ever have one of your constituents approach you to get expedited or preferential access to health services that their situation didn't warrant?" He said, "No. The constituents had a variety of questions and a variety of concerns; whether it be home care, whether it be how could they get the services of a GP or a family physician. But no one ever asked me, 'Can you bump my position up in a line?'" Counsel then asked, "Are you then saying that you are not aware of any instances of queue-jumping occurring?" Mr. Chase responded, "I'm not aware of any existence of queue-jumping occurring not only within Calgary Varsity, limited to constituency experience, but I am not aware of any specific examples in general."<sup>2</sup>

However, there is a distinction between an MLA advocating for a constituent who is encountering difficulties with the health care system and an MLA interfering in a course of treatment or using his or her authority to obtain improper preferential treatment or expedited care for a family member, a friend or political supporter. The expert witnesses

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<sup>1</sup> Testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 989.

<sup>2</sup> Testimony of Harry Chase, Transcripts, vol. 13, January 7, 2013, at 982-83.



at the inquiry considered any direct communication between an MLA and a health care provider to request special consideration to be inappropriate. Dr. Owen Heisler wrote, “There is no natural or expected relationship between an MLA and the health care provider. Such a request would suggest there would be an inappropriate *quid pro quo* implied which would be wrong.”<sup>3</sup>

There was no evidence before the inquiry of any MLA or MLA’s staff contacting a health care provider directly to advocate for a constituent or interfere with the constituent’s treatment. The evidence was that calls were made – usually by staff in the MLA’s constituency office – to individuals in regional health board offices (before AHS came into being) such as Mr. Brian Hlus and Ms. Lynn Redford, or to the office of the Minister of Health.

Several witnesses described the circumstances in which these contacts occurred. The Hon. Fred Horne testified that during his years as an MLA before becoming Minister of Health in 2011 he, or more likely a staff member, would often contact Mr. Hlus at Capital Health to get help for constituents. Mr. Horne said he received many calls from constituents who had questions and concerns about getting access to health care. He described two categories of calls:

The first is what I’d call sort of navigational concerns; so people looking for information about health services that are available. Quite often looking for information about support services. So, for example, someone that’s in need of – a senior that’s in need of transportation that’s recently discharged from the hospital, those sorts of community supports our office would maintain inventories of those services, and we would assist patients in acquiring that information. The second type of inquiry, I guess I would describe it best as a constituent calling and believing they’re in urgent need of a particular health service and wanting to draw attention to their belief – the urgency of their need and their concern that it’s not being met.<sup>4</sup>

The second category of calls would be from those placed on a wait list for a medical procedure. He would get in touch with Mr. Hlus or

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<sup>3</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 31.

<sup>4</sup> Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1505-06.

contact the Minister's office for assistance. Mr. Horne stated that these efforts never went beyond asking for information and never involved contacting a health care provider directly or asking for a constituent to be moved ahead on a wait list.<sup>5</sup>

Mr. Hlus testified about the service he provided as director of government affairs at Capital Health when he received calls from MLAs or their staff:

Quite often there [were] discussions and questions, concerns that were coming up to MLAs' offices, and they would ask, for example, "An individual has been trying to get into a specialist. It's located in Edmonton, and it's been over six months and you haven't seen – and my constituent has not come in." Well, what we would do in the conversation that we would have – and it didn't matter whether or not it was somebody within Capital Health, the Capital Health region, or if it was a northern constituency, but it would come to us because the specialist was in Edmonton. Well, even though it wasn't the responsibility of Capital Health, we weren't going to sit there and say, "Sorry, it's not under our responsibility. You have to go phone someone else."

Through the experience and that that we had come, quite often – or what we know is that if an individual has gone to see their GP, they're going to be referred to a specialist through their GP or general practitioner.... If an individual waiting for six months hasn't yet been able to see the specialist, we would ask them, "Has the patient gone back to the GP to get an updated medical assessment?" Because based on that assessment is how you're going to be getting in to see the specialist. If they didn't, that's what we would suggest to them.<sup>6</sup>

Mr. Hlus explained that he did not consider it appropriate or helpful to contact a health care provider directly: "[I] didn't even consider it because ... I'm not a medical person. And just knowing how the system worked because it's a doctor-to-doctor relationship, that's where it has to occur."<sup>7</sup> Counsel asked Mr. Hlus, "Did any MLA constituency

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<sup>5</sup> Testimony of Fred Horne, Transcripts, vol. 18, January 10, 2013, at 1507-08.

<sup>6</sup> Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 663-64.

<sup>7</sup> Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 665.

offices ask you to make those calls directly to service providers?” He said no. “Did your office receive any calls from MLA constituency offices identifying someone as a prominent person in connection with any inquiries about the system?” He said no. Counsel asked, “Did any MLA constituency offices contact you with inquiries on behalf of MLAs themselves or their family members?” He said no.<sup>8</sup>

Mr. Hlus was asked if he was ever given patient-identifying information when contacted by an MLA or an MLA’s staff member. He said, “Likely no, because usually if it got to that point, if it was something specific as it related to a patient, then it would be directed to patient relations.”<sup>9</sup> “Patient relations” was a team within the Capital Health system that would deal with individual patient health concerns.

Mr. Ron Liepert, former MLA and Minister of Health and Wellness (as the position was then called) from 2008 to 2010, described how a staff member from his department was assigned to handle issues that MLAs addressed to the Minister’s office. Depending on the concern, the inquiries would be forwarded to this individual in the department or to AHS for response.

Counsel asked Mr. Liepert, “Were you ever advised of any such calls that came to your office requesting preferential or expedited care? For example, you said that you might get calls from an MLA for a constituent wanting long-term care.... Did you ever hear of any requests being made to your office by MLAs or anyone else, for example, to move that person up the wait list? Is there anything you could do to get them in faster?” He said:

There’s nothing that I recall that was ever raised with me by my staff that was felt was a concern. A typical call would probably be from an MLA that a particular constituent has been waiting a number of months for long-term care and they’re just trying, on behalf of their constituent, to find out how much longer they’re going to have to wait or whether there’s an opportunity that there might be another facility that could accommodate them. So when I say “navigating the system,” that’s what I’m talking about.<sup>10</sup>

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<sup>8</sup> Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 669.

<sup>9</sup> Testimony of Brian Hlus, Transcripts, vol. 10, December 11, 2012, at 671-72.

<sup>10</sup> Testimony of Ron Liepert, Transcripts, vol. 9, December 11, 2012, at 585.

There was other evidence to similar effect. Members of the legislature would contact personnel in the region or the Minister's office with a variety of constituent issues.

One incident of MLA involvement became the subject of evidence and submissions by some participants at the inquiry. Mr. David Diamond was Chief Operating Officer (COO) and Vice-President for suburban and rural communities for Capital Health from 2006 to 2008. He is now Senior Vice-President for human resources at AHS. Mr. Diamond testified that, while COO, he received a call from someone in the CEO's office and was told that an MLA had contacted that office for a constituent. The constituent was unhappy about a clinical assessment that the constituent did not need continuing care. Mr. Diamond was asked if there was anything that could be done to obtain a reassessment or verify that the assessment was accurate. The clinician was contacted (Mr. Diamond did not say whether he or someone else he directed made the contact) and the constituent was reassessed. The reassessment concluded that the constituent did indeed qualify for continuing care. Mr. Diamond said that incident was the only type of MLA patient advocacy he experienced in Capital Health but that such advocacy was "likely not uncommon within the system and not uncommon in previous jurisdictions" where he had worked.<sup>11</sup>

Ms. Sheila Weatherill, the CEO of Capital Health at the time, was asked about this incident. She had no prior knowledge about it, but she characterized it as an issue that was dealt with appropriately.<sup>12</sup>

### ***Inquiry findings***

I found no inappropriate advocacy by MLAs in the situations described in the evidence. I also find no inappropriate conduct in the incident described by Mr. Diamond. The MLA passed along a constituent's concern. That concern was communicated to the person in a position to address it (the clinician) and the matter was resolved. There was no evidence of pressure or influence to produce the end result for the constituent.

In my opinion, the type of advocacy carried out by MLAs, as described in this chapter, is an appropriate function for elected representatives. It

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<sup>11</sup> Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 441-42.

<sup>12</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1085-86 and 1134-35.

is part of their responsibility to constituents to ensure that every constituent receives the level of publicly funded service that he or she deserves – nothing more and nothing less.

## 2. *Courtesy calls*

The inquiry heard evidence relating to certain practices in the Capital Health and Calgary Health regions before AHS was created. These practices involved courtesy calls – or what were described as “heads-up calls” – where someone in the office of the health region CEO would call a senior administrator in a hospital facility or, if it was after hours, the responsible executive on call<sup>13</sup> at the time. The call would pass on information that a certain individual was in the facility, or would seek information about the status of such an individual.

Ms. Deborah Gordon, Vice-President and Chief Operating Officer at the University of Alberta Hospital in 2007 and 2008, testified about the practice. She said that her office would on occasion receive calls from the CEO of Capital Health, Sheila Weatherill, or one of Ms. Weatherill’s staff members. Ms. Gordon said, “I don’t remember specifics, but I do remember calls to our office saying, ‘just so you’re aware’ – and I can’t come up with a name – ‘individual so-and-so is in the hospital.’”<sup>14</sup>

Ms. Gordon was asked if these were prominent people or family members of health executives. Ms. Gordon could only remember that they were “people who had, for whatever reason, contacted the CEO’s office in Capital Health to let them know that they were in the system.... I don’t believe that we were asked to do anything. It was like a heads-up notification that the individual was in our presence.”<sup>15</sup>

When pressed why the hospital would need such a heads-up, Ms. Gordon said, “I don’t think it did.” She said she made this point

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<sup>13</sup> Ms. Deborah Gordon, former Vice-President and Chief Operating Officer at the University of Alberta Hospital, explained that the executive on call at the site or facility level assisted staff and physicians with any major issues that arose in the off hours when the regular supports were not all in place. The executive on call would deal with “unusual patient concerns or complaints, any crises that arose, disasters that arose, unusual clinical events that arose.” At the University Hospital, executives on call were drawn from a pool of “clinical program directors and perhaps one senior operating officer and two physician leaders”: Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 458.

<sup>14</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 481.

<sup>15</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 482.

“numerous times” to the CEO’s office, but that the office “continued to provide us the information.”<sup>16</sup>

Ms. Gordon said that the heads-up provided by the CEO’s office was passed along to the staff “just as a courtesy.”<sup>17</sup> When asked what the staff were to do with that information, she replied, “In fact, I don’t believe there was direction given to them. I think we would have been quite specific that we were not expecting them to do anything, other than to be aware.”<sup>18</sup>

Ms. Gordon was also asked about significant or foundational donors to the hospital. She testified that on occasion she would receive a call from a foundation leader “indicating that one of their significant donors was in the facility.” It was Ms. Gordon’s feeling that the foundation leaders were asking staff to be aware, and that it was also “their hope that things would go smoothly” with the donor’s care. Ms. Gordon testified she often took the information and “did nothing with it.” She acknowledged she felt pressure “from time to time” to ensure a special level of treatment was given to the VIP but stated, “I wanted to buffer our staff and physicians from it.”<sup>19</sup>

Ms. Brigitte McDonough served in various senior positions with Capital Health until taking on a strategic planning role with AHS in 2009. Ms. McDonough testified she would receive calls from Ms. Gordon’s office that someone important was in the Capital Health system. Such calls would come only if prominent citizens were being admitted after hours. During regular hours, Ms. Gordon would go directly to the directors in the areas where the VIPs were being admitted. In Ms. McDonough’s case, the calls came exclusively from Ms. Gordon, with the exception of an incident on November 30, 2007 that will be addressed in detail later. That time, the call came directly from the CEO’s office.<sup>20</sup>

Ms. McDonough described the typical communication between Ms. McDonough and Ms. Gordon regarding VIPs in the system as follows:

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<sup>16</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 482.

<sup>17</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 483.

<sup>18</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 484.

<sup>19</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 484-85.

<sup>20</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 751 and 778.

Well, first of all, I would be called and I would be provided with the patient's name and their current location, which was most times in the Emergency Room, and I would be asked just to call down to the Emergency Room and to see how long it was going to be before they got a stretcher. . . . If they had already been admitted, then I would be asked to find out what unit they would be transferring to and what time . . . did I think they would be admitted. So I would call down, speak to the charge nurse, and get that information, and then I would call Deb back.<sup>21</sup>

Ms. McDonough testified that Ms. Gordon would provide, as she called it, "some context":

She would tell me that she got a call from [CEO] Sheila's office and that Sheila [Weatherill] is in need of this information. Or she would tell me: "Do you remember Mr. So and So? He was a donor, helped us, you know, to raise funds for such and such. I've just heard he's going to be admitted. Can you just check and see how he's doing?" So it would never be for any confidential information. It would be just how he's doing, in general.<sup>22</sup>

These calls also asked Ms. McDonough to follow the progress of VIPs as they moved through the system, following admission to one of her units. Throughout the course of her day, and rounds, she would ask the unit manager for an update on the VIP's condition. If the unit manager did not know, she would ask them for an update by the end of the day. She would then pass along the information to Ms. Gordon.<sup>23</sup>

Ms. McDonough was asked about her communications with the staff on the unit following such a call from Ms. Gordon:

Deb was transparent with me and I was transparent with the staff. So I would say: "As you know, this individual is on the unit, and I have been asked by Deb just to provide her with a bit of an update on how the patient is doing. So can you just tell me have there been any difficulties? Do they seem happy with the care that they're receiving? How are you guys doing?"

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<sup>21</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 752.

<sup>22</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 753.

<sup>23</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 753.

Are they making any unnecessary demands on you?” And they would relay that information to me, and I would share it with Deb. And very honestly I can say that there never were any issues.... The staff were aware that they had a prominent person on the unit, and they treated them as they did any other patient that was on that unit.<sup>24</sup>

Ms. McDonough testified that, in her opinion, the staff was gracious in dealing with these requests but was still somewhat resentful since it took staff away from other work. However, staff accepted the practice because, as Ms. McDonough described it, “it was part of the culture of the organization that we worked in, that we receive these directions and that we had to follow through.”<sup>25</sup>

Ms. McDonough emphasized that she reassured employees that they were not expected to provide better or different care for these patients. She said she was always conscious that staff was aware these calls were not about asking for one person to receive better care than another:

What I would do with the managers is that we would have our team meetings and if there was somebody that we were keeping tabs on, then I always made sure... that they let the staff know how much we appreciate all of the good care that they give everybody. And I don't believe that anybody received better care because they were a more well-known individual than somebody who wasn't.<sup>26</sup>

Ms. McDonough acknowledged that these heads-up calls were infrequent. The CEO, Ms. Weatherill, apparently did not know about any concerns the staff may have had about these calls. She testified that nothing was said to her by her senior managers.<sup>27</sup>

Ms. Weatherill testified that most of the calls her office received were “navigational calls, advice calls.” On occasion, she would make calls to advise front-line staff “for their awareness that someone would be coming in.” The largest proportion of calls that came into her office were about a specific concern, something that needed to be addressed.

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<sup>24</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 758.

<sup>25</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 759-60.

<sup>26</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 794.

<sup>27</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1072.



When asked why staff needed to be made aware, she explained that this was a piece of information to be factored into the general knowledge of what was happening at the facility: “There would be no expectation, no direction given, no expectation of any extra service. That’s the role of physicians and clinicians to decide. And [the calls] would just simply be for awareness for them to have that additional piece of knowledge.” She gave as examples individuals who had privacy or security concerns or who could be arriving at a health care facility accompanied by security people.<sup>28</sup>

Ms. Weatherill also said that she made “many” courtesy calls on behalf of patients who were in no way connected with people considered to be prominent or VIPs. She gave as an example a call from a northern region facility that was sending a patient to the University of Alberta Hospital. Things had not gone well for that patient. The family was quite upset and was coming in a group with the patient to the hospital. Ms. Weatherill received a call asking her to pass along this information. Such calls were “not infrequent” she said. Ms. Weatherill would usually pass such information on to the COO or the VP of medical affairs if it were “primarily a medical situation” and she would not direct staff on how to behave or what to do.<sup>29</sup>

Ms. Weatherill testified that there was no protocol in place for these heads-up types of calls. She described these calls as simply “a matter of courtesy ... and it would have been just a simple call with no expectation of any improper extra care provided.”<sup>30</sup>

Mr. David Diamond also testified about such a “courtesy call” when he was on an executive on call shift. He received a call from his supervisor, the Executive Operating Officer of Capital Health, Ms. Michele Lahey. She told him a board member had a family member in the emergency department. Ms. Lahey asked that a manager drop by out of courtesy to “make sure that they were doing well and just to check in with them.” Mr. Diamond phoned the local site. A manager then checked in on the VIP’s family, phoned Mr. Diamond back later that night and indicated all was fine.<sup>31</sup>

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<sup>28</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1062-63.

<sup>29</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1120-21.

<sup>30</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1079.

<sup>31</sup> Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 442-43.

Mr. Diamond testified that he had never been asked to do this before. He questioned why he was being asked to do so now, and was told it was a “courtesy call.” Mr. Diamond did not speak with front-line staff nor did he give any direction that staff should do anything different than normal. When asked where courtesy stops, Mr. Diamond said he could not answer because he was aware of no policy or protocol about this: “It’s not the kind of thing that was a very common call. In my two years in Capital Health it was the only time I was asked to do that.” He said nothing changed with the creation of AHS. Things only changed when Dr. Duckett sent out the 2009 memo articulating the policy of the new organization.<sup>32</sup>

Ms. McDonough also testified that she noticed that the courtesy or heads-up calls stopped shortly after the creation of AHS.<sup>33</sup>

There was similar evidence of this practice going on, or at least attempted, in the Calgary Health Region. Ms. Janice Stewart was a senior executive in that region prior to the creation of AHS. She testified that she received a number of what she called “special requests for VIPs” who were either known to senior administration personnel or who were public figures. Ms. Stewart said these calls came from her vice-president at the time, Ms. Janet Umphrey, asking her to go and say hello to these people if they had been admitted under her care. She declined those requests because, she said, she did not think it appropriate if she did not know the person in question.<sup>34</sup>

Ms. Stewart believed the purpose of the calls was “to give us a heads-up that there was somebody – a public figure that had been admitted and would we make a social visit to say hello and [see] how were things going.” She said it was a “fairly common practice at that time.” She was direct in refusing the requests, saying she did not feel comfortable. She commented, “I didn’t know those individuals personally, and I would not have visited them under any other circumstance. And I really felt that their hospitalization and whatever health concerns they were dealing with at the time, was private.”<sup>35</sup>

Ms. Stewart had no reason to believe these calls were anything more than “a courtesy call to say: ‘Hello’ and ‘How were things going?’”

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<sup>32</sup> Testimony of David Diamond, Transcripts, vol. 7, December 6, 2012, at 445-48.

<sup>33</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012 at 794-95.

<sup>34</sup> Testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1252.

<sup>35</sup> Testimony of Janice Stewart, Transcripts, vol. 15, January 9, 2013, at 1254-55.

The CEO of the Calgary Health Region at the time, Mr. Jack Davis, did not dispute or take issue with Ms. Stewart's testimony. He said, however, that he could not recall the practice.<sup>36</sup>

There were some other specific incidents described in the evidence but they are much more dated and really do not add to the picture provided by this evidence.

There was one incident, however, dating from 2007 that bears describing for the purpose of this chapter.

Ms. Brigitte McDonough testified about an occurrence on November 30, 2007, when she was the executive on call. She placed a call to the emergency department at the University of Alberta Hospital and asked that a VIP be moved out of the waiting room. She recounted what happened in her testimony:

I, as exec on call, had received a call from Sheila Weatherill's office and it was either the executive assistant or the executive associate that called me. I don't recall which title she used. And she told me that there was an individual in the ER who had been in the ER for some time and that their spouse was saying that they were having a lot of pain and would I please call the ER and see if there was anything I could do.<sup>37</sup>

Apparently the spouse of the patient in emergency had gone to the CEO's office to complain. Ms. Weatherill did not recall the incident and, as she testified, she did not think she was in the office that day. But she said that even if she was not there, her staff would have known that the procedure was to contact the executive on call with any patient complaints.<sup>38</sup>

Ms. McDonough went on to relate what happened when she made the call to the emergency department. She asked the nurse in charge if she anticipated "this individual was going to be able to get in soon to be seen?" The nurse responded that it "didn't look likely." Most of the stretchers in ER were already full of patients waiting to be admitted. The nurse did not know how the patient was doing and directed the

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<sup>36</sup> Testimony of Jack Davis, Transcripts, vol. 21, January 14, 2013, at 1681-83.

<sup>37</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 778-79.

<sup>38</sup> Testimony of Sheila Weatherill, Transcripts, vol. 14, January 7, 2013, at 1093-95.

inquiry to the triage nurse. The triage nurse refused to go see the patient. Ms. McDonough testified:

She became quite defensive and she told me that the waiting room was full of patients and that she didn't have time to go and see every patient and that what they do is they'll check on patients every 15 minutes or so and she would have done her last check just shortly before that. I said, "Well, I really appreciate that and I know how busy you are, however, I received this call from Sheila's office and this individual's spouse is really concerned about the amount of pain that he's in and I need you to please go and check that patient." And she said, you know, she made a comment that, you know, she didn't care if the request came from Sheila's office or not, that she was too busy.

So I said, "Are you refusing to see this patient?" And she said, 'Are you telling me I have to?' And I said: "Yes, I'm directing you to please go and see this patient. And if this patient is in any pain, then could you please have one of the Emergency Room physicians come out and take a look at them to see if their pain is manageable or not."<sup>39</sup>

The nurse agreed to do so and hung up. Ms. McDonough testified it was within the scope of her authority to give those directions to the nurse who resisted taking them. Ms. McDonough said she was aware that the emergency room was busy, but also admitted that she did not know the medical condition of the other patients waiting, or where they scored in the CTAS priority.

The triage nurse on duty that day, Ms. Lori Jobson, did not testify in person but provided an affidavit. In it, she stated:

I explained to Ms. McDonough that there had been people waiting all day, some since 9 a.m., and stating something to the effect of "Should my no-fixed address guy from 9 a.m. wait longer because he doesn't know Sheila Weatherill?" ... I advised Ms. McDonough that I had just re-assessed the patient. She asked if a doctor could look at the person. I did

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<sup>39</sup> Testimony of Brigitte McDonough, Transcripts, vol. 11, December 13, 2012, at 780-82.

not need her to tell me to reassess a patient, as that is part of our normal practice.<sup>40</sup>

The patient was reassessed and it was determined that the patient was stable and able to wait until appropriate space became available.

This incident was made the subject of a complaint by Dr. Brian Holroyd, the Chief of Emergency Medicine at the time, and Dr. Paul Parks, an emergency physician. The complaint was made to the Chief Operating Officer. The doctors were particularly concerned about the overwhelming pressures confronting the emergency department at the time. Dr. Holroyd felt that the executive on call should have tried to help address the inability of the emergency department to meet patient demands, not pressure the triage nurse to expedite one patient's care.<sup>41</sup>

When asked about Ms. McDonough's conduct with respect to requesting or directing expedited care for this patient, the Chief Operating Officer, Ms. Gordon, stated this would not be something that would have been supported then or now.<sup>42</sup> However, there was no discussion about the possibility of expedited care for a VIP. Indeed, the evidence is far from clear that the patient in question was a VIP of any sort, that being an assumption made by one or more of the participants in this incident.

### ***Inquiry findings***

What can I conclude from this evidence? First, all of the examples are drawn from the period before the creation of AHS and the distribution of the Duckett memo of June 11, 2009. This says to me that this practice is no longer as widespread or common as it once was. I use the terms "widespread" and "common" carefully, not in the sense that these calls were frequent but that it was an accepted practice.

The other important point to draw from this evidence is that it does not reveal any actual incidents of improper preferential access. In no case was there evidence that the VIP who was the subject of one of these courtesy calls actually received expedited or preferential care. That says to me that the front-line staff made an effort to treat all patients with the same degree of care.

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<sup>40</sup> Exhibit 68.

<sup>41</sup> Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 411-12.

<sup>42</sup> Testimony of Deborah Gordon, Transcripts, vol. 7, December 6, 2012, at 466.

This is not to say that there are no potential problems with this practice. The key one was illustrated by the evidence of Mr. Gordon Self, Vice-President of Covenant Health responsible for mission, ethics and spirituality. Covenant Health is the Roman Catholic-based organization that provides hospital and other care under contract and financing arrangements with AHS.

Mr. Self was involved in drafting a policy in 2007 on accommodating special requests. The policy was prompted by calls from the CEO of Capital Health to the CEO of Covenant Health (or Caritas, as it was then known) and these calls were sufficiently frequent that it was felt that a policy was necessary. Mr. Self testified:

What we had noticed, there was a number of times where one of the issues that we brought forward as a senior team for debrief was related to on call and receiving a phone call or some other – like another inquiry, either in person or through the paging – related to accommodating a special request.<sup>43</sup>

The nature of such calls was to give Caritas's executive on call a heads-up that a VIP, perhaps a board member or some other person of significance in the community, was in one of the facilities. Mr. Self testified he personally received such calls. He remembers being on call at Providence Renewal Centre one evening when he received a heads-up sort of call. He did not remember who the VIP was or what made that person prominent, but said it was an example of a call he would have reported to the executive team. He testified the calls never went beyond making the team aware that a VIP was in the facility.<sup>44</sup>

Still, it was unclear what such information was meant to achieve, which is the primary reason Caritas wanted to develop a formal policy. A policy would, in Mr. Self's words:

... acknowledge that there's a power imbalance when a funder is asking the funding – the agency that's been funded by the funder to – letting us know that there's a heads-up, giving us a heads-up about a person being in our facility. We weren't quite sure what to do with that. We certainly couldn't ignore

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<sup>43</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 705.

<sup>44</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 706-07.

it. And that's what led us to kind of try to develop some sort of clarity about what our response will be to this....<sup>45</sup>

Mr. Self emphasized the need for clarity and consistency:

These are our staff. These are physicians appointed to work within our facilities. And so we did not want to leave our physicians and staff alone to try to figure it out on their own. And whenever you don't – in the absence of clear policy, you always run the risk of having varied practice. So we wanted to have a uniform, singular sort of approach.<sup>46</sup>

Mr. Self testified that he did not know of any calls that explicitly requested preferential or expedited treatment. Yet, there was still ambivalence felt about these calls. Mr. Self explained:

There is a power imbalance.... But just given the significance of the funding, our dependence on the funding, we were kind of left wondering, is there more to the request? It was unclear if we were to – if we were to not go to great lengths to make sure that this person was whatever, had some additional care, would there be a consequence? I think that would be a question that I had. I can't speak for my colleagues, but you kind of wonder if it is a benign request, heads-up, or just a courtesy call, or are there other expectations that go with that?<sup>47</sup>

This highlights the concern about these types of courtesy calls. What is the recipient of the call to think? Is the purpose of the call merely a heads-up or is there an implicit expectation that something more than the usual level of care and supervision is required? The absence of a clearly defined protocol on how front-line staff are to respond may lead to such calls being misinterpreted. As one expert witness, Dr. Lynette Reid, wrote, "It would be irresponsible to make such a call without a defined and stated goal; front-line staff would reasonably conclude they are being asked to deliver special treatment."<sup>48</sup>

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<sup>45</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 708.

<sup>46</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 711.

<sup>47</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 737-38.

<sup>48</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 32.

It is important to draw two distinctions in this discussion. First, there is nothing inappropriate about senior administrative officials asking front-line staff about the status of a patient when it is truly a patient concern – in other words, a response to a complaint about the treatment of any patient. I distinguish between calls regarding patient concerns and mere informational or heads-up calls that someone in particular is in the system.

It would obviously be much better to have complaints and calls about patient concerns directed to a central point – such as the office of the Patient Concerns Officer established by AHS. Such complaints and calls could then be tracked and systematically documented.

Second, one must also distinguish between mere informational calls and those whose purpose is to alert front-line workers, for a legitimate reason, of the need for special measures. A high-profile patient may cause disruption to the care of others. There may be intense media interest or security issues associated with the presence of such an individual. In these cases, it is appropriate and even necessary to notify front-line staff of the person's presence. As another of our expert witnesses, Dr. Owen Heisler, wrote: "VIPs bring an interest and entourage that impede not only their care but [that] of others in the same ward.... [F]ront line staff's being aware is very reasonable so they can appropriately respond to events or comments in this context."<sup>49</sup>

The Covenant Health policy on accommodating special requests speaks to the need to take special steps in some circumstances. It states that, "[g]iven the public status or profile of certain individuals, it may be ethical to assign the person a private room to mitigate breaches of confidentiality and to protect their dignity and privacy." This, however, is preceded by the general admonition that "it is *unethical and wrong* to allocate resources to an individual of influence or celebrity status when someone else may be disadvantaged or harmed."<sup>50</sup>

There is a distinction therefore between calls that merely inform front-line staff that someone important is in the system and those that alert staff to the need to consider special arrangements. With calls about special arrangements, physicians and clinical professionals are usually

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<sup>49</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 31.

<sup>50</sup> Exhibit 48 [emphasis in original].



best able to determine what measures to take and how those measures may affect clinical operations or the well-being of other patients. Physicians and clinical professionals should be the ones to decide what, if anything, to do in response to a call.

In closing submissions for AHS, counsel submitted that I should consider a recommendation to the effect that AHS staff and professionals working in the public health care system be educated on how “to avoid actions and behaviours that might inadvertently be interpreted ... as an expectation to offer or provide improper preferential access, including routine ‘notification’ about ‘persons who may attract public or media attention’ receiving care within the health care system.”<sup>51</sup> AHS should develop a policy that clearly defines the circumstances under which such notification or courtesy calls should be made, to whom they can be made, and how those receiving such calls should respond to them. Such a policy should distinguish between calls relaying patient concerns and those alerting staff to the presence of high-profile patients.

#### **Recommendation 8:**

##### **Develop a policy on courtesy calls**

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them.

### **3. *The Paula Findlay case***

Paula Findlay, the daughter of Dr. Max Findlay, a neurosurgeon who practises at the University Hospital in Edmonton, was in Edmonton in July 2011 for a World Cup triathlon race. The race was to be held on July 10. On July 7, Ms. Findlay had a medical problem that saw her end up at the University Hospital for magnetic resonance imaging (MRI) later that day. Dr. Findlay became actively involved in arranging for the MRI and in fact wrote the requisition for his daughter to have the MRI. This gave rise to two concerns – whether he had acted

<sup>51</sup> Closing Submissions of Alberta Health Services, April 1, 2013, at 24 (Exhibit 164).

improperly in treating a member of his own family and whether his actions led to improper preferential access to the MRI for his daughter.

Dr. Findlay explained how the events unfolded:

I was in my clinic that morning and received a phone call from [Paula Findlay's] coach ... informing me that she had had a problem. And it was one that I wasn't fully aware of and that it was getting worse; and he was suspicious that she might have an important injury, and that he thought it should be looked at.<sup>52</sup>

Dr. Findlay told the inquiry that high on the list of possible injuries was either a stress fracture or avascular necrosis. At the time, Paula Findlay's main team doctor was in Victoria and was not available. The coach had also not been able to reach her sports/family doctor in Edmonton.

Dr. Findlay told the coach that he would "look into it":

[F]irst of all, I phoned Paula to find out if ... she was OK with all of this, and I really wasn't aware that she was having just that amount of pain. But she told me she, that day, was almost unable to walk, it hurt so much. And so with that information, I went down to the radiology department to talk this over with one of my colleagues because I wasn't sure which investigation would be the best. I know that it's either a nuclear bone scan or a magnetic resonance image. So I wanted to get his opinion.<sup>53</sup>

Dr. Findlay was accustomed to working with MRIs. He would write requisitions for MRIs in his practice every working day. He explained the process:

MRI requisitions go in different ways. If it's a routine follow-up or an entirely non-urgent MRI, it would go in through hospital mail or electronically; but if it's a more urgent

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<sup>52</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1532.

<sup>53</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1534-35.

situation, I hand deliver the MRI requisition down to the MRI area after talking to the radiologist.<sup>54</sup>

He would speak to radiologists directly by going down to the MRI facility, where they have a reporting station. The urgency of an MRI is a joint decision between him and whichever physician or whoever else has referred the patient to him. He would also take the requisition and discuss the patient's condition with the radiologist.<sup>55</sup>

In the case of his daughter, Dr. Findlay spoke with a radiologist by the name of Dr. Naik:

I just explained the situation and the concern we had and the type of injury we were looking for, and what did he think was the best test. And it was a magnetic resonance image, yes. And then we talked about that.<sup>56</sup>

Dr. Naik asked Dr. Findlay to get a requisition into the radiology department and to have his daughter come to the hospital.<sup>57</sup>

Dr. Findlay did not send his daughter to the emergency room because, "We don't send patients to the emergency room if they don't have an emergency that requires emergency room assessment ... or [are] in need of an emergentologist, and she didn't."<sup>58</sup> Dr. William Anderson, a radiologist who later investigated the incident for AHS, was asked whether it was necessary for Paula Findlay to go to the emergency room:

No ... absolutely not. There's ... nothing that people in an emergency room can do for her. This is not an emergency room issue. That is, does she need surgery or not? And so, she needs a diagnosis. And the diagnosis is simple. She has a stress fracture or an AVN [avascular necrosis] of the hip or she doesn't.<sup>59</sup>

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<sup>54</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1528-29.

<sup>55</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1529.

<sup>56</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1535-36.

<sup>57</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1537.

<sup>58</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1539.

<sup>59</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1412.

Commission counsel asked Dr. Findlay if there was any discussion with Dr. Naik about the urgency of this MRI request. He said there was:

And I think he agreed it should be done urgently that day because I thought it should be done, well, either that day or the next day, just from my father's point of view, but he felt that it could be done, should be done that day.<sup>60</sup>

Dr. Findlay did not speak with any other doctor before arranging the MRI:

The bottom line was that she needed imaging of the joint to find out what the injury was, which would have been more important than a physical examination at that point. It hurt.<sup>61</sup>

Dr. Anderson also confirmed to this inquiry the importance of an MRI in this case. He had heard about the Findlay MRI because a media relations officer at AHS had asked him to look into the case "to see whether Paula Findlay had, quote unquote, jumped the queue...."<sup>62</sup> Dr. Anderson knew that Paula Findlay was a world-class triathlete and was the daughter of Dr. Findlay.<sup>63</sup>

Dr. Anderson contacted Dr. Naik for details about the incident:

And I said, "So what's the story?" And he said, "Well, it's Max's daughter, and Max came and talked to me and said ... someone thought she either had a stress fracture or an avascular necrosis of the hip." And so I thought we should do it.

He's a neuroradiologist like me ... and it seemed perfectly reasonable to me, if that's what they were worried about, that they should have it. But I wanted to be sure ... about that.<sup>64</sup>

Commission counsel asked whether a stress fracture or an avascular necrosis of the hip would be highly significant in a high-functioning

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<sup>60</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1536.

<sup>61</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1534.

<sup>62</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1405.

<sup>63</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1402-03.

<sup>64</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1408.

athlete. Dr. Anderson answered that it would depend on where the problem was:

In the hip, it's very important because it's weight bearing and it's a significant bone. And if it does fracture, a stress fracture can go on to a fracture. So if it does fracture, it means major surgery and complications thereof, and a whole bunch of other things, including, perhaps, a slightly shorter leg and [the] long-term outcome is not very good.<sup>65</sup>

Dr. Anderson also said that the presence of a stress fracture in an athlete was more significant than in an ordinary person:

So in fairness to Paula, she has a couple of things that most of us don't have. One, she's pretty talented. But two, she is also in a sport that is repetitive and jarring.... And those elite athletes are different again than, for instance, me. And that is that, if I have pain, I typically quit. Elite athletes are trained to run through or train through their pain. That's part of the deal of being an elite athlete. You don't get there if you can't do that. So their mentality would drive them to push harder than the average person would so that chances of her completing a fracture if it was a fracture would be much higher than me....<sup>66</sup>

Commission counsel asked Dr. Anderson if it was appropriate to compare Paula Findlay's case to anybody who has a possible diagnosis of a stress fracture. Dr. Anderson replied, "Absolutely not." A fracture of the foot, for example, was not nearly as grave as a fracture of the hip. He continued that a hip fracture would be serious in his 13-year-old daughter, who is heavily involved in dance:

She dances 20 hours a week. And if she had a similar sort of question coming from her physician, then ... I would say that it's time to get her in for an MRI. And I would say we should be doing it urgently.<sup>67</sup>

Commission counsel asked what Dr. Anderson would do in the case of a non-competitive dancer with the same possible diagnosis of hip fracture:

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<sup>65</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1408-09.

<sup>66</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1409.

<sup>67</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1425-26.

A similar young lady ... who is not a dancer would not fit into the same category. And it's because she is not going to go and potentially fracture that hip. So there is a big difference.

And I think that's where the physicians have to talk to each other, and that's why we say you must phone me to get this done within an urgent category ... you know, right away.<sup>68</sup>

Counsel for the Consumers' Association of Alberta asked the following question:

I understand some criteria were applied to Paula's case and the clinical assessment coming from the requisition and perhaps a telephone call or an in-person discussion with Dr. Naik, and the consideration of what she does were the deciding factors.

Who has prioritized high-functioning athletes as being more important than the farmer who is injured in his work and has the same injury and needs to work to support his family?

Dr. Anderson replied:

[W]ith respect to the farmer, we would have to understand what that farmer does in his work. So if the farmer happens to be driving his tractor around, which is equivalent to me sitting and doing my work, then he would fall into that category of being an elective urgent, the OP1 category, like I would. If ... the physician knows that farmer ... and gives us some reason why it needs to be done sooner, we will do it sooner if we can. We will get it in.

So it's the individual in their life and what are the factors that come [into] play that drive our decision, and we generally are a bit of a wall because we have limited resources. We tend to put up barriers rather than take them down. But if that farmer is doing something that potentially would injure – maybe it's hay baling season. I don't know, I think they pick them up in machines now, but when they lift them, maybe – and it's the one where they were turning that particular – I don't know. But if the physician had that discussion with the patient and

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<sup>68</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1427.

phoned and gave a case to us as to the urgency, it becomes that urgency.

So it's not the fact that you are an elite athlete. The other factors are in there. What is she doing that's different? What is her mindset that is different? What is driving that person to complete the fracture rather than staying off it?

So if you are telling me that the farmer – it's the end of the season, he's got crops that have to come off, and he's got to do these things and that was the story, we would try and do something to get him in sooner. We would try.<sup>69</sup>

Commission counsel pointed out that the decision to give Paula Findlay an immediate MRI was made “without documentation from the trainer in any form ... of his assessment or ability to assess ... and without documentation on the requisition of why this is important for this person.” Dr. Anderson said:

We do that every day. That's a daily occurrence. I do not have time in my day to write everything down, to keep track of the discussions I have on the phone or person to person. I'm lucky, or our system is lucky enough if we can get the patient name, where they are and what their UNI number or unique identifier in these discussions [is]. So the fact that we don't have documentation to me is irrelevant. The fact that there is ... a face-to-face discussion between Dr. Naik and Dr. Findlay. And that occurred.<sup>70</sup>

Dr. Findlay testified that he discussed with Dr. Naik the possibility of sending Paula Findlay outside the public system. Dr. Findlay said, “That was something ... that I was quite willing to undertake.” However, his colleague thought the MRI would be better done at the University Hospital “because the sub-specialist in musculoskeletal magnetic resonance imaging was actually working at the University Hospital that day. And he also felt confident that the schedule was such that they would be able to slide in an extra patient later in the day.”<sup>71</sup>

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<sup>69</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1439-40.

<sup>70</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1442-43.

<sup>71</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1536.

In contrast, Dr. Anderson argued that the better course of action would have been to go to the private sector for the MRI:

[A] lead athlete such as Paula, being world class, and being in a competition coming up, you don't want anybody to know that she potentially has an injury if she was going to compete. I would have told him, "Go have it done privately," and it's done, doesn't affect anybody. Nobody knows about [it] and, more importantly, you wouldn't see her in a hospital walking in getting registered, you know, walking down the hallway. People may recognize her. "Oh, here is Paula Findlay."

You know, from a competitor's perspective, if anybody knows that she's got an injury, there's an advantage to them.

So, you know, sheer fact it was in the paper is a disadvantage to Paula Findlay for sure, but I would have highly recommended to Max, "Go to the private system."<sup>72</sup>

Dr. Findlay testified about the time involved in securing his daughter's MRI:

If memory serves, I'm sure it was in the early afternoon [that his daughter arrived at the hospital]. I know that she was there for hours and hours. So again, from the timeline that ... was forwarded to me from, I guess, from yourself ... her MRI scan was done late in the afternoon, and she was there for hours before that.<sup>73</sup>

He himself did not decide when his daughter's MRI would occur. He did not know who made that decision.

Counsel asked Dr. Findlay if he was concerned about anyone being bumped to make way for his daughter. He was not, he said:

Well, because the way the scheduling works with the MRI is that there are opportunities to get emergency or urgent cases done between normally scheduled patients.<sup>74</sup>

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<sup>72</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1415-16.

<sup>73</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1540.

<sup>74</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1542-43.



Counsel asked Dr. Anderson who makes the decision about when in the day an emergency patient such as Paula Findlay is seen. He replied that it was the triage radiologist, in this case Dr. Naik. Openings during the day could result from patients not showing up or cancelling their MRI appointments. Counsel pointed out that Paula Findlay's requisition for an MRI was sent from Dr. Findlay's office at 11:39 a.m. The MRI was completed at 5:09 p.m., about 5 ½ hours later. Dr. Anderson said this was a normal wait in such cases:

That would be typical for what would happen for one of these urgent outpatients. We tell them to get there as soon as you can, bring a book, and we will put you in whenever we can put you in. And so 5:00 would have been a reasonable time.<sup>75</sup>

Dr. Anderson said it appeared Paula Findlay waited about an hour and a half from the time of her arrival at the hospital to when the procedure began. That waiting time was not unusual for an urgent case "at that time of day." The radiology clinic, he said, was busiest in the morning while it dealt with inpatients and emergency patients. By early afternoon, the clinic tends to have caught up with its patient load.<sup>76</sup> Counsel asked if seeing Paula Findlay in the urgent slot would have put extra pressure on staff. Dr. Anderson said he did not believe this had happened. There was less pressure in the summer and, in any case, he understood that "... it wasn't an overly busy day that day, that they could squeeze her in."<sup>77</sup> Asked if he thought this was a case of queue-jumping, Dr. Anderson said no. Asked why he thought so, he said, "I think it's appropriate care for an individual who had a potential problem."<sup>78</sup>

Dr. Anderson also provided some background information about triaging for MRIs. He described the categories assigned to patients that determine, in principle, how quickly they need to receive diagnostic imaging. OP1 means the patient should be seen within one week; OP2 within a month; and OP3 within two or three months (two months for CT scans and three months for MRIs).<sup>79</sup> Dr. Anderson said that 90 per cent of patients in the OP1 category – who should be seen within a week – were seen within five weeks in Edmonton, and within 12 weeks

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<sup>75</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1418-19.

<sup>76</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1421.

<sup>77</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1422.

<sup>78</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1422-23.

<sup>79</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1389.

in Calgary.<sup>80</sup> Ninety per cent of OP2 patients – who should be seen within a month – were seen within 19 weeks in both Edmonton and Calgary. The corresponding figure for OP3 patients who need MRIs – who should be seen within three months – was 30 weeks in Edmonton and 39 weeks in Calgary.<sup>81</sup>

Dr. Anderson explained that, with certain urgent cases, communication between referring physicians and radiologists cannot be done on paper because it might take too long; in such cases, physicians communicate directly with radiologists. He said, “Anything that must be done ... really urgently, like within 48, 72 hours, should require a phone call.”<sup>82</sup> Or, where clinics are located in hospitals, physicians often speak to radiologists directly: “[The physicians] will oftentimes wander down and talk to [the radiologist].”<sup>83</sup>

Counsel asked Dr. Anderson what proportion of patients seen in the radiology department in a typical day needed urgent service. He said roughly 20 per cent.<sup>84</sup> Dr. Anderson said that it virtually never happened that someone among the 80 per cent of less urgent patients was bumped to accommodate an urgent patient:

Even if it’s a pretty routine sort of thing, they’re looked at as being urgent patients to get them done as fast as we can. They have waited their time. So we do not bump them. And if we do, we may reschedule, but we would never bump them to do an inpatient. They may wait in our facility. They may wait for an hour or two hours or, unfortunately, maybe a little bit longer, depending on what’s happening in emergency, but they will be done that day.<sup>85</sup>

The College of Physicians & Surgeons of Alberta investigated the Paula Findlay MRI incident. Dr. Findlay stated, “They reminded me that it was against our code of ethics to treat members of our own family unless it’s an emergency and there is no other physician

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<sup>80</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1390-91.

<sup>81</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1391-92.

<sup>82</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1389-90.

<sup>83</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1398.

<sup>84</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1400.

<sup>85</sup> Testimony of William Anderson, Transcripts, vol. 17, January 10, 2013, at 1402.

available.” He said that he “certainly acknowledged that that ... was contrary to our code,” and apologized.<sup>86</sup>

Dr. Trevor Theman, the registrar of the College, said that a news article had led the complaints director to initiate the investigation.<sup>87</sup> Dr. Theman was referred to a letter of apology of August 3, 2011, signed by Dr. Findlay and directed to the College’s resolution advisor. Counsel asked how this letter came about. Dr. Theman said, “I believe it was at the request of [the resolution advisor].” The College’s complaints director considered the apology contained in Dr. Findlay’s letter sufficient to resolve the matter.<sup>88</sup>

### *Inquiry findings*

This incident raises two significant questions. One is the ethical question as to the propriety of Dr. Findlay inserting himself into his daughter’s care. There are standards of practice prohibiting such conduct except in certain circumstances. That issue was addressed by the College and is not within my mandate.

The second question is, however, within my mandate. Does this incident reveal a case of improper preferential access? Commission counsel submitted that, even if we accept that it was medically urgent to conduct an MRI, there remains the question about whether the average Albertan with the same injury, but not a recognizable high-profile athlete and with no family connections, would receive the same care.

It might be possible to look at this incident through the lens of professional courtesy. There is no doubt that Dr. Findlay facilitated the service received by his daughter. But the evidence demonstrates that Dr. Findlay did what he normally does with any other patient – speak directly with a radiologist. In the Findlay case, the radiologist had times set aside for urgent cases and Ms. Findlay was seen during one of those times. No professional courtesy was involved.

The evidence also demonstrates that usual procedures were followed. The radiologist, after a discussion with Dr. Findlay, concluded that an urgent MRI was warranted. The assessment was based on the overall

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<sup>86</sup> Testimony of Max Findlay, Transcripts, vol. 19, January 11, 2013, at 1544.

<sup>87</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2322.

<sup>88</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2323-24.

clinical presentation. Earlier in this report, I said that physicians must be able to take into account all sorts of factors to enable good clinical judgment. Some of those factors do not involve acuity. In this case, the other factors were that a patient such as Paula Findlay was accustomed to putting repeated stress on her joints, accustomed to working through the pain, and thus more likely to cause even more severe damage in the absence of a timely diagnosis and treatment, if treatment was necessary. As Dr. Findlay's counsel stated in his submissions, "The evidence was that the fact that she was a world-class triathlete was relevant, not because of any 'status' it conferred, but as part of her clinical picture...."<sup>89</sup>

Ms. Findlay clearly received preferential access over others in one sense, since she had a much shorter wait for an MRI than most people. However, that preference was based on clinical considerations – the potential of a worsened injury if it was not diagnosed and treated promptly. That placed her in a more urgent category of patients than many other patients. The preference was therefore proper.

We can conclude that she received improper preferential access only if we decide that elite athletes are not entitled to have that one factor – the prospect of an injury worsening if not diagnosed and treated promptly – taken into account in their placement on a wait list. Society must make this judgment. That is not the role of this inquiry. We, as Canadians, take pride in the achievements of our athletes on the world stage. We support the expenditure of public funds to sponsor and support many of them. But whether we, as a society, accept such athletes receiving preferential access to publicly funded health services has yet to be determined.

#### **4. *The Calgary Flames and the H1N1 vaccine***

In 2009, AHS and every health organization on the continent faced a need to respond to the H1N1 pandemic. This was a major challenge in Alberta as elsewhere. Mass immunizations against the virus began at public clinics in October 2009. Lineups were long and sometimes chaotic. At the end of the first week, AHS closed the clinics temporarily due to a shortage of vaccine. A controversy then erupted over news reports that Calgary Flames hockey players and their

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<sup>89</sup> Closing Submission re Dr. Max Findlay, March 28, 2013, at 3 (Exhibit 168).

families had been immunized at a private facility, avoiding the lineups at the four public vaccination locations in Calgary.

The Calgary Flames' team doctor, Dr. James Thorne, and several nurses involved in the Flames' vaccinations described the incident to the inquiry.

Dr. Thorne started working as a physician with the Calgary Flames during the 2002-03 hockey season. He rents a clinic, the LifeMark clinic, located in the Father David Bauer Arena. Dr. Thorne stated that, in the summer of 2009, the National Hockey League was planning to respond to the H1N1 epidemic, fearing that games and cross-border travel would have to be cancelled. The players were not medically high-risk since they did not, for example, have cancer or compromised immune systems, but they were high-risk in one sense because they had frequent contact with the public through handshaking, signing autographs and moving through crowds. As well, the team environment – being in a locker room together or travelling by plane together – put the whole team at risk.<sup>90</sup>

Dr. Thorne was also concerned because on the Saturday before the Monday (October 26) when the clinics opened, the Flames had played the Edmonton Oilers, and two Edmonton players were playing with an influenza-like illness. One Flames player also had an influenza-like illness. Because of this, he saw some urgency in getting the vaccine. However, it was quickly apparent that lineups were long at the four public clinics. The long lineups made him think that it would “probably be a bad idea if the Calgary Flames showed up unannounced to one of these lineups.” He thought some preparation was needed.<sup>91</sup>

Ms. Debbie Hyman, the clinic manager in October 2009 at one of the public clinics, the Brentwood clinic, confirmed the challenges facing public clinics. The clinics functioned on a first-come, first-served basis. She described the H1N1 vaccination process as chaotic. She said there were long waits and the waiting crowd was very angry and very impatient. At times, she felt that staff members were being threatened. She even called Calgary Police for support at one point because she did

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<sup>90</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1564-65.

<sup>91</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1567-68.

not feel safe.<sup>92</sup> Sometimes those waiting for a vaccination were turned away at the end of the day.<sup>93</sup>

One of Dr. Thorne's patients was a public health nurse, Ms. Michelle Bosch. Because she was one of the front-line nurses at the public clinics, he thought she might be a point of contact. He described his conversation with Ms. Bosch as follows:

I'm a little bit concerned about the Calgary Flames showing up unannounced to one of your lineups. There should be some preparation. I have some concerns that people won't respect their space; that people won't respect their privacy; that there could be lineup control issues in an already stressed lineup; that innocent bystanders might be victims of some crowd issues.

I just thought that knowing these guys, when they go to a restaurant or a public place, that all of a sudden there's a crowd there. And to be in a crowd for five hours I thought should take some planning. So that's why I placed a call to the nurse and asked what we could do about it. And she said she would take it to her supervisor and get back to me with a possible solution.

I told her at that time that we want to be safe in the lineup. We do not want to be marched past the lineup. That can't be one of the solutions. You can't get us there and take us by ... people who have waited five hours. I said that wasn't a solution. And just left it with her to take my concerns to her superiors, and that we were totally willing to line up; and if need be, the Calgary Flames would bring their own security to mitigate any crowd-control issues....<sup>94</sup>

Dr. Thorne told Ms. Bosch that he was concerned about the Flames being in a public lineup for five hours and that it would take some planning. He said, "It was never my intention to ask for a private clinic, an offsite clinic. I was just requesting how we get in this lineup safely." He also wanted Ms. Bosch to know that the Flames were coming and that, if she thought there would be a problem, the Flames would bring

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<sup>92</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1770-72.

<sup>93</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1773-74.

<sup>94</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1568-69.

their own security. He said he merely wanted Ms. Bosch to take these concerns to her supervisors.<sup>95</sup>

He said that Ms. Bosch responded to his concerns by saying, “I’ll take this to my supervisors and see what they think about it and I’ll get back to you.”<sup>96</sup>

Michelle Bosch had begun working as a public-health nurse for AHS in 2008. In 2009 she was assigned to the Brentwood clinic. She knew that the H1N1 vaccine would be available beginning October 26 and that it would be available only through four designated clinics. Ms. Bosch stated that, sometime early in the week beginning October 26, she received a phone call from Dr. Thorne, who was a colleague of her husband. She said that Dr. Thorne wanted to have the Calgary Flames vaccinated and wanted to know how to go about it. She said his main concerns about the vaccinations were security for the team and people within the clinic, and privacy. Ms. Bosch said that, on hearing the request for help, her first reaction was “when he said he was thinking of bringing 50 people down for the vaccination, was: ‘Oh, man, please don’t come here.’ Truly that was my original gut reaction.”<sup>97</sup> She testified that her concern was the distraction that would be caused by the hockey team showing up at a public clinic. She told Dr. Thorne she would find out what he needed to do to have the team vaccinated.<sup>98</sup>

Ms. Bosch said she talked about security issues with Dr. Thorne because he raised that “first thing” in their conversation. And she replied, “Yes, security would definitely be an issue, and the security we had would not be adequate.” She understood, however, that the Flames had security personnel and she said that Dr. Thorne told her that he could bring those security personnel. She told the inquiry that, even having Flames security personnel present would not “change the sideshow that was going on.”<sup>99</sup>

She told Dr. Thorne she would have to check with someone higher up, since she had worked as an influenza nurse for only three weeks and “didn’t know what the situation was or how things worked.” Ms. Bosch stated that neither she nor Dr. Thorne suggested during their

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<sup>95</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1570-71.

<sup>96</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575.

<sup>97</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1722-23.

<sup>98</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1724-25.

<sup>99</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1726-27.

conversation that an alternative might be to administer the vaccine at a private or off-site clinic.<sup>100</sup>

Ms. Bosch first discussed the option of holding off-site vaccinations with Ms. Hyman. As noted, this did not come up in Ms. Bosch's initial conversation with Dr. Thorne, but she raised it with him in another conversation later that day. Ms. Bosch said it was her idea to do the vaccinations at Dr. Thorne's office.<sup>101</sup> Ms. Bosch said that she explained to Ms. Hyman that the Flames wanted to come as a group and be vaccinated. She said that Ms. Hyman told her that she [Hyman] was in no position to make any decisions about how the Flames would be vaccinated and that she would take the information higher and see what her superiors said.<sup>102</sup> Ms. Bosch said that she told Ms. Hyman of her idea about off-site vaccinations, so Ms. Hyman would have known about this idea when she called her superiors.<sup>103</sup>

Ms. Hyman said that vaccinating the Flames at the Brentwood clinic did not even enter her mind as a possibility because of the chaos at the clinic. Ms. Hyman approached the clinic's influenza manager, Ms. Sharon Berry, explained the request to vaccinate the Flames off-site, and asked her opinion. Ms. Hyman stated that Ms. Berry told her that this was something that Ms. Hyman should discuss with Micheline Nimmock, Ms. Hyman's director. Ms. Hyman telephoned Ms. Nimmock, but there was no answer. Ms. Hyman left a voicemail indicating that she had received a request to vaccinate the Flames off-site and that she was uncertain whether "we're able to go ahead and do this, but if you [Ms. Nimmock] have any issue with this, please call me and let me know." She testified that she thought she made the call to Ms. Nimmock the same day that Ms. Bosch approached her with the request about the Flames – Tuesday, October 27.<sup>104</sup>

Ms. Hyman did not receive a call back from Ms. Nimmock between the time of Ms. Hyman's call (Tuesday) and the day the vaccinations occurred (Friday). She recalled letting Ms. Bosch know that "there weren't any concerns and we were OK to go ahead." She stated that what she meant was that she had not heard from Ms. Nimmock to the contrary. If Ms. Nimmock had called and said not to proceed, Ms.

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<sup>100</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1727.

<sup>101</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1730.

<sup>102</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1728-29.

<sup>103</sup> Testimony of Michelle Bosch, Transcripts, vol. 21, January 14, 2013, at 1730-31.

<sup>104</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1777-80.



Hyman would have “pulled the plug.”<sup>105</sup> Ms. Hyman stated that, other than the message left for Ms. Nimmock and the discussion with Ms. Berry, she made no attempt to speak to any other superior for approval. Ms. Hyman reiterated later that she thought she had approval to proceed with the vaccination because she had not received any response to her voicemail for Ms. Nimmock.<sup>106</sup>

Ms. Lori Anderson, who later headed the investigation of the Flames incident for the AHS, largely confirmed this version of the attempt to obtain approval for the Flames vaccination:

Well, what we determined was that there ... were some inconsistencies, but that the manager [Hyman] had called and left a phone message stating to the effect that we’re going to be holding a private clinic for the Flames and if you have any problems with that, let me know. If I don’t hear, I’ll assume it’s OK.<sup>107</sup>

Ms. Anderson testified that no one above Ms. Nimmock was aware of the special clinic for the Flames.<sup>108</sup>

Meanwhile, Dr. Thorne believed that Ms. Bosch had taken the issue to her supervisors. He said that Ms. Bosch told him “they” took it to a higher level and another level. He said, “And a day later, Alberta Health Services conveyed to me that maybe being in a lineup isn’t a good thing and is your clinic available?” Dr. Thorne said that Ms. Bosch conveyed this information to him.<sup>109</sup> No one else from AHS called him before the Flames’ immunizations and he never asked to speak to anyone above Ms. Bosch about this. He assumed that people at a high enough level made the decision that it was OK, and that he did not have to talk to anyone else to confirm the decision to release flu shots for an off-site location.<sup>110</sup>

When Dr. Thorne made his initial request about the vaccine, he was planning only to vaccinate the players and the travelling staff – the managers and trainers who go on road trips with the team. He said this

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<sup>105</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1780-81.

<sup>106</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1799-1800.

<sup>107</sup> Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1807.

<sup>108</sup> Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1807-08.

<sup>109</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575.

<sup>110</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1575-76.

would be between 50 to 70 people. However, he said, sometime during the week, Ms. Bosch suggested vaccinating the families. He did not think it was Ms. Bosch's idea. He thought she was conveying the views of AHS. He testified that AHS had suggested that any leftover vaccine would deteriorate very quickly.<sup>111</sup> He then let the players know that they could bring their families the same day if they wanted them to receive the vaccine. A sign-up sheet was placed in the training room and that gave an idea of how many people would come to his Friday clinic. He received this list on the Friday morning and passed it on to Ms. Bosch before those wanting the vaccine arrived at his clinic. The vaccines were administered at LifeMark, the clinic rented by Dr. Thorne. Dr. Thorne estimated that about 150 people were vaccinated, including him and his daughter.<sup>112</sup>

He summarized the chronology of events:

It's the end of October. So the vaccine was released on Monday to the big lineups. On Tuesday I had the conversation with Michelle [Bosch]. On Wednesday she got back that we could have the clinic. Wednesday night, I talked to the Flames management about it. Thursday my office was jam-packed. I was busy, busy, busy that day. And then had patients Friday morning, and then Friday afternoon we had the players and their families come.<sup>113</sup>

Dr. Thorne said that, since the nurses were volunteering and were not scheduled to be at the Brentwood clinic that Friday afternoon, the Flames' vaccinations did not reduce manpower at Brentwood. Two nurses came, one of whom was Ms. Bosch. Two nurses from his office and the receptionist also volunteered their time to help.<sup>114</sup>

Ms. Hyman stated that patient records created as part of the normal vaccination process were stamped ahead of time with Brentwood clinic, not LifeMark. She did not consider scratching out the Brentwood clinic stamp and putting in LifeMark as the clinic where the vaccinations occurred because the vaccine came from Brentwood. She did not tell any of the vaccine recipients that, if they were asked, they should say

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<sup>111</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1579-80.

<sup>112</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1583 and 1588-89.

<sup>113</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1578.

<sup>114</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1586-87.

they received their vaccinations at Brentwood. Nor did she hear Ms. Bosch give such instructions. Ms. Hyman also stated that no one attending the clinic that day expressed concerns to her about whether it was proper to be receiving the vaccines at a private clinic.<sup>115</sup> However, Ms. Hyman said, she overheard Dr. Thorne telling people, “If you’re asked, just say that you ... received your vaccine at Brentwood.” She said she did not know that this was the message he wanted delivered until she heard him say this. She said she asked him why he was telling people to say this, “because we have received approval to ... be here and to do this.” She was “really confused” as to why Dr. Thorne would be saying this. She said that Dr. Thorne did not give her a response.<sup>116</sup>

Ms. Anderson testified that, in conducting the investigation: “Everybody was told that if you’re asked, that you say you were – you received your immunization at the Brentwood clinic. And ... somebody expressed that we do not want this to get out to the media. And I think that it wasn’t to trace for adverse reactions; I think it was that they didn’t want it to be known that they held a private clinic for the Flames.” Ms. Anderson said she did not accept the explanation that the vaccination forms were stamped Brentwood clinic because that is where the vaccine originated.<sup>117</sup>

Dr. Thorne’s recollection of how the Brentwood stamp was being explained differs from that of Ms. Hyman and Ms. Anderson. Dr. Thorne knew that obtaining the vaccine was “a big process” and that the vaccine and syringes came from the Brentwood clinic. He understood that paperwork was completed to show the Brentwood clinic as the location at which the vaccines had been given. The staff members who volunteered their time to vaccinate the players came from that clinic. The supplies were from that clinic and the paperwork would appear as if “we” got the vaccine at the Brentwood clinic. He was asked if he spoke with Ms. Bosch or any of the other nurses about the part of the forms saying that the vaccine had been given at Brentwood. Dr. Thorne said that he had and that they said, “We’re the nurses from there; the vaccines [are] from there; the paperwork’s going to be from there.” Dr. Thorne did not see the paperwork mentioning Brentwood as an issue at the time.<sup>118</sup>

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<sup>115</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1789-90.

<sup>116</sup> Testimony of Debbie Hyman, Transcripts, vol. 22, January 14, 2013, at 1790-91.

<sup>117</sup> Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1809-10.

<sup>118</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1583-86.

Dr. Thorne stated that there was no type of payment by him or the Flames organization beforehand to the nurses for their work or the vaccine. However, because people had worked so hard for three hours, he asked if he could do anything for them. He said, “So there might have been something [as] an appreciation token after the fact.” He offered some game tickets. He said, “I can’t remember if it was money. I know it was probably tickets ... after the fact.”<sup>119</sup> Dr. Thorne said the nurses refused the tickets, saying they were just volunteers. “They wouldn’t take anything,” he said.<sup>120</sup>

Dr. Thorne first realized the potential for controversy about the Flames’ vaccinations the following day. He read in the newspaper that the vaccine was being withdrawn due to shortages and that they were going to prioritize who received the vaccine. He had no prior knowledge of a shortage.<sup>121</sup> On learning of the shortage, he concluded “this is going to be bad,” because the Flames were not in a lineup and now there was a shortage. He thought that news of the Flames’ vaccination would reach the public. He said that, if he had known there would be a shortage, he would not have proceeded with the Flames’ vaccination.<sup>122</sup>

Dr. David Megran was the lead of three executive members designated to head the AHS response to the H1N1 epidemic and the recovery phase that would follow. He said he first learned of the Flames’ vaccinations on Monday, November 2, when AHS communications staff alerted him that the media had reported the vaccinations that day.<sup>123</sup>

Dr. Megran stated that an AHS investigation quickly followed because of the media attention and the seriousness of the issue. The conclusions of the investigation were relayed to him orally on November 4 or 5. The vice-president in charge of the investigation, Ms. Lori Anderson, reported to Dr. Megran that two people directly involved in how the vaccinations unfolded had been fired.<sup>124</sup> There was also a referral to the College of Physicians and Surgeons asking it to consider investigating Dr. Thorne’s involvement.

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<sup>119</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1589.

<sup>120</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1591.

<sup>121</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1593.

<sup>122</sup> Testimony of James Thorne, Transcripts, vol. 19, January 11, 2013, at 1593.

<sup>123</sup> Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 214.

<sup>124</sup> Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 215-16.

The results of the College investigation were reported in a letter of December 21, 2009, to Dr. Megran. The investigation concluded as follows:

The Investigation Chairman has reviewed this matter and concluded that Dr. Thorne's decision constitutes an error in judgment, not professional misconduct or lack of judgment. It is noted that Dr. Thorne's intent was to help his patients. As a result, the Investigation Chairman has directed that this complaint be closed. The public reaction to this incident as well as the complaint has served as very useful feedback to Dr. Thorne regarding the ethics of seeking preferred services for an elite group of individuals in a publicly funded health care system....<sup>125</sup>

### ***Inquiry findings***

This episode is a clear-cut case of improper preferential access, since the Flames' players, family and staff avoided long lineups at the public vaccination clinics. It is interesting to note that, while the public understood this to be queue-jumping, the College did not view it that way. It was merely an "error in judgment" on Dr. Thorne's part. Similarly, the AHS investigation that resulted in the termination of Ms. Hyman's employment as well as that of her director, Ms. Nimmock, characterized the event as "exceedingly poor judgment" on their part. However, AHS did not directly describe this incident as one of improper access. Ms. Anderson testified that these two individuals were not terminated for holding the clinic.<sup>126</sup>

The public reaction to this incident demonstrated that the popularity of these athletes in the community does not translate into public acceptance of their entitlement to preferential access to publicly funded health services.

I understand Dr. Thorne's interest in finding some way to vaccinate the players with a minimum of bother. I also understand the reaction of the clinic nurse and manager that led them to accommodate this request. In their view, having the players attend a public clinic would create further chaos in an already difficult environment. On the other hand, as Ms. Anderson suggested in her testimony, having the players line up

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<sup>125</sup> Exhibit 85.

<sup>126</sup> Testimony of Lori Anderson, Transcripts, vol. 22, January 14, 2013, at 1811.

with the public would have sent a positive message to all Albertans to get vaccinated despite the inconvenience.

I mention this because there are different ways to view the problems posed by vaccinating these high-profile athletes. If Ms. Bosch, Ms. Hyman and Ms. Nimmock had taken steps to notify senior AHS management of this request, management would at least have had an opportunity to reflect on the options. If a decision were then made to hold a private clinic, it might have been possible to justify the decision to the public. As it was, the private clinic process clearly violated AHS restrictions limiting vaccinations to the four designated public clinics.

The Calgary Flames vaccination incident may be a one-of-a-kind occurrence. Still, this problem might never have arisen if AHS had a policy at the time on dealing with special requests. That, of course, begs the question of how prepared AHS was for the H1N1 pandemic, something beyond my mandate to examine.

**Recommendation 9:****Develop a policy on special accommodation during a pandemic**

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation.

**5. Nurses and the H1N1 vaccine**

The inquiry heard evidence about other issues arising from the H1N1 vaccination program in 2009. Some of it concerned nurses working in the Edmonton area who:

- expedited the vaccination of family members at the public immunization clinics;
- vaccinated individuals after hours;
- vaccinated individuals after the program had been halted; or
- took vaccine home to vaccinate family and friends.

The inquiry also heard evidence about possible improper preferential vaccination of AHS employees in Red Deer.

**a) *Nurses vaccinating friends and family***

Linda Duffley is the director of public health programs for the Edmonton area, a position she held in 2009 during the H1N1 crisis. Ms. Duffley testified that the H1N1 vaccination program was rolled out on October 26, 2009. The vaccine had never been administered before and involved an “adjuvanted vaccine.” Nurses were unfamiliar with this type of vaccine, which had to be reconstituted, or mixed together, before being administered. Once it was reconstituted, it had to be used within 24 hours or it was no longer usable.<sup>127</sup>

In the initial week of the vaccination program, the H1N1 vaccine was to be administered at eight large urban sites within the Edmonton zone. Some sites were located in existing clinics, but the majority were in leased space within large public areas to accommodate the expected volumes. Ms. Duffley described long lineups, altercations in the lineups, the use of threats to get to the front, an anxious public and, in general, a stressful situation, the likes of which she had never experienced in her nursing career.<sup>128</sup> Other witnesses gave similar descriptions.

Ms. Joy Lohan is the manager of the province-wide immunization program, standards and quality, a position she has held since July 2009. During the H1N1 crisis, Ms. Lohan’s responsibilities included managing the vaccine supply from central depots in both Edmonton and Calgary. On October 31, 2009, she learned that all clinics would be temporarily closed for an indefinite period due to an apparent shortage of vaccine supply. At that point, Ms. Lohan turned her mind to what to do with the vaccine that was still on hand.

On a typical day, both the mixed and unmixed vaccine would remain at the clinics and be put in fridges for use the next day. With the clinics closed indefinitely, Ms. Lohan was concerned about the safety of the vaccine supply if this protocol were followed. These sites did not have backup generators or alarms on the refrigerators that would activate if the electricity was cut off. The central depots, though, did have backup generators and alarm systems to ensure the vaccine would not be

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<sup>127</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2188-89.

<sup>128</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2189-93.

wasted in a power outage. For that reason, she decided to have all the unconstituted vaccine brought back to the central depots. She said, “I did not know when we were going to start the clinics again, and I didn’t want to risk a cold chain break at one of the public health centres.”<sup>129</sup> Her instruction was communicated to the clinics, either directly by Ms. Lohan to the clinical development nurses in charge (CDC) or by one of her staff members.

She gave no instructions about what to do with already-mixed vials of vaccine. Ms. Lohan’s concern lay in making sure that the supply on hand was secured. Asked if she had told the nurses anything that could have suggested they had permission to take the mixed vials for their personal use, either to inoculate family or others after the public lines closed, Ms. Lohan replied, “not that I recall.” She added, “To be honest with you, I was so concerned about getting the unconstituted product back, I didn’t think about it.”<sup>130</sup>

Judy Brosseau is the manager of the Northgate clinic in Edmonton and has been since 1995. During the first four days of the mass H1N1 immunization clinic, Ms. Brosseau worked Wednesday through to Saturday. She described the atmosphere as busy, especially the Saturday, when the mall was full of people and “unfriendly.” She recalled one incident before October 31 involving a staff member she encountered in the hallway, who was accompanied by her family. She was introduced to the family. After the family left, Ms. Brosseau asked the nurse what they were doing there. She discovered they were there to get vaccinated, outside of the public line. It did not cause her concern because the nurse “would have been doing it on her own time,” said Ms. Brosseau, referring to a lunch or 15-minute break or after the centre had closed. Counsel asked her if, from her perspective as clinic manager, nurses had approval to bring in and vaccinate their families, and as long as they were doing so on a break, it was not an issue. She replied, “That’s right.”<sup>131</sup>

Ms. Brosseau testified that Linda Duffley contacted her and asked whether nurses were immunizing family members outside the line. Ms. Brosseau responded that she was aware of one incident. While she could not remember the exact words, she said the direction from Ms.

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<sup>129</sup> Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2244-45.

<sup>130</sup> Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2251.

<sup>131</sup> Testimony of Judy Brosseau, Transcripts, vol. 28, January 18, 2013, at 2270-72.



Duffley was “to the effect of ‘Not to do that again,’ or ‘To let staff not to do that.’” She said the communication was oral and there was no documentation. Asked if it surprised her to be told this, Ms. Brosseau said, “Nothing surprised me in H1N1 at any point because everything was changing hourly at times. So nothing surprised me in H1N1.” No one was disciplined because there was no written policy to enforce.<sup>132</sup>

Ms. Duffley testified about a rumour that family members had bypassed the line at the Northgate clinic. Upon investigating, she received confirmation from the operations manager of the clinic that nurses’ family members had bypassed the line. “Her understanding was that we had permission for that to be occurring,” she testified.<sup>133</sup> Ms. Duffley informed her executive director, who said the manager needed to be told that this could not continue. Ms. Duffley told the executive director that she had already explained this to the manager. No further effort was made at the time to inform other clinics. A memorandum was issued to all clinics, but months after the incident. The memo, dated January 25, 2010, said in part:

This memo is to communicate expectations regarding immunization of family members by staff.

Family members of staff are to access immunization in the same manner as the public. Family members are not to receive preferential or special treatment.

Under no circumstances is vaccine to be taken home or administered outside of established Public Health programs, clinical settings and clinic hours.<sup>134</sup>

Asked why she waited so long to send the memo, Ms. Duffley responded, “Because, again, things were very hectic – this was sent out after the [alleged third] incident at the Westmount site when we determined that maybe we had a pattern rather than just one or two single situations.” She also explained that the memo applied to all immunization programs, not just H1N1.<sup>135</sup>

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<sup>132</sup> Testimony of Judy Brosseau, Transcripts, vol. 28, January 18, 2013, at 2273-74.

<sup>133</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2210.

<sup>134</sup> Exhibit 114.

<sup>135</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2212.

Ms. Christine Westerlund was the southeast regional manager in the primary care division during the H1N1 crisis. She testified that nurses at some sites were vaccinating their families during breaks. She had no concerns at the time “because there was no clear direction that that was not an acceptable practice. And we were really actually focused on trying to have as many, I’m going to say, the manpower available to serve the public.” Ms. Westerlund said this rationale included the attempt to prevent nurses from being home with a sick child in their immediate family, or off for half a day or longer, standing in line to get their children immunized.<sup>136</sup>

Ms. Brosseau also testified that she personally vaccinated friends of her daughter after the clinics were closed on October 31. She described the day as “very chaotic,” with 3,000 to 4,000 people in and outside the mall where the clinic was located. As the 4 p.m. closing time neared, Ms. Brosseau was paying close attention to the number of unused vials. She did not want to waste any vaccine. The clinic then received a supply of mixed vaccine from another site. Ms. Brosseau could not recall the number of vials that remained at 4 p.m., but believed there were about 86 doses, “which really troubled me because they would then all be discarded.”<sup>137</sup>

Ms. Brosseau testified she took one vial home and did not know what happened to the rest. The CDC nurse would have been responsible for the remaining doses, she said. Wanting to use the vaccine, she thought she would use them on “contacts” of her daughter. Asked if this were fair, administering doses to her daughter’s friends, that evening at home, Ms. Brosseau replied yes. She added, “I considered it like a home visit, which we do do with vaccinations.” She believes she documented the vaccinations on the required forms and later submitted them with the other counting sheets.<sup>138</sup>

Ms. Duffley was asked if she believed it appropriate for a clinic manager to take vaccine home and vaccinate her daughter’s friends. She replied:

Well, we were in a situation where we had a national shortage and we didn’t want to waste any doses of vaccine. So I don’t

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<sup>136</sup> Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2290-91.

<sup>137</sup> Testimony of Judy Brosseau, Transcripts, vol. 28, January 17, 2013, at 2277-80.

<sup>138</sup> Testimony of Judy Brosseau, Transcripts, vol. 28, January 17, 2013, at 2279-81.

know if that makes it more correct, but we have always, in public health, been very, very concerned about our vaccine supply and not wasting any doses of vaccine.<sup>139</sup>

Ms. Duffley confirmed she had never authorized any clinic manager to take vaccines home after the lines shut down.<sup>140</sup>

Ms. Westerlund was also asked if Ms. Brosseau's conduct was acceptable. She replied:

I was not aware of that at the time, so I probably can't comment if that would be acceptable or not. We do not like to waste vaccine. That is something that's ingrained in us all the way throughout, not just in an H1N1 campaign, that we were always cautious not to waste vaccine.<sup>141</sup>

Ms. Susan Smith is the clinical development nurse of communicable disease control at the Bonnie Doon Public Health Centre in Edmonton. Her job at the mass clinic during the week of October 26 to 31, 2009 was quality assurance of the vaccine supply.

Ms. Smith testified about what happened at the clinic on November 1, 2009, the day after the vaccine program shut down indefinitely at the mass clinics. She said she returned to the clinic with the leftover vaccine that was going to expire at 1 p.m., and opened the doors to 15 people – who did not wait in line to be inoculated. She testified she would do the same thing again today under similar circumstances because the situation was a crisis and she did not want vaccine to go to waste. It was instilled in her on a daily basis not to waste vaccine. She testified her instructions were clear: “Whatever you do, minimize wastage. We are short. Don't waste vaccine.”<sup>142</sup>

As the person responsible for bringing the vaccine to the site, Ms. Smith was directed, she believes by her supervisor Joy Lohan, to bring the remaining vaccine back to the vaccine depot at the central location on October 31. She does not recall if she was clearly directed to bring back all the vaccine, including the vials that were already mixed. Those mixed vials she left at the clinic in the “biological” fridge. The rest she

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<sup>139</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2214-15.

<sup>140</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2215.

<sup>141</sup> Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2289.

<sup>142</sup> Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2222-29.

took back to the central depot. The next day, her day off, she went back to the clinic “so the vaccine would not go to waste.” To ensure it was used, she spoke with staff “to see if we could get people in; or if they had received vaccine, that we could use the vaccine before it was discarded.” The doors were locked and the clinic was not open to the public, but staff were there working, by appointment only, with mothers and their newborn babies.<sup>143</sup>

Ms. Smith could not remember calling friends or family, or how they got people to the clinic, but she documented 15 vaccinations on the morning of November 1.<sup>144</sup> She did not immunize her own children, as they had already received their vaccine. She did not recall if the others were acquaintances, or how she knew them. According to her records, she vaccinated one AHS employee, five children between the ages of five and nine, three children between the ages of 10 and 18, and seven adults between 19 and 64.<sup>145</sup> She documented the cases but backdated the report to October 31, even though the immunizations occurred November 1. Ms. Smith said that backdating documentation was not an uncommon practice.

Ms. Smith was asked if she had any concerns at the time that unlocking the door and letting people get vaccinated who had not stood in line was unfair to those who had been turned away the day before. She replied:

We were in a crisis. We were in an emergency situation, and we had a very limited resource that we did not want to waste. My feeling was not to waste the vaccine, and that was more important than anything, really, and it concerned me gravely that we may be wasting vaccine that people could use.<sup>146</sup>

Ms. Lohan recalled having a discussion with Ms. Susan Smith, who contacted her by telephone on Saturday, October 31, to give her a heads-up that clinics would close at day’s end. She does not remember

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<sup>143</sup> Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2228-29.

<sup>144</sup> Exhibit 116.

<sup>145</sup> Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2230; Exhibit 116.

<sup>146</sup> Testimony of Susan Smith, Transcripts, vol. 27, January 17, 2013, at 2234.

saying anything to Ms. Smith that would indicate Ms. Smith could use the mixed vaccine after the clinics closed.<sup>147</sup>

Ms. Westerlund also testified about the November 1 incident. She went to the Bonnie Doon site on October 31, but did not discuss what to do with the open vials of vaccine until near the end of the day. She spoke with Ms. Smith about the plan to use up the vaccine so there would not be wastage.<sup>148</sup> She recalled discussing with Ms. Duffley what should be done with the vaccine that was open, and having a conversation about how it might be used the next day, but did not recall the outcome of that discussion. Ms. Westerlund admitted that she might have left Ms. Smith with the impression that it was fine to use the vaccine the next morning. About the November 1 incident, Ms. Westerlund explained there “was no real clear direction and that was probably why, when the question came and there was a discussion, I didn’t have a clear answer and had wanted to consult with someone else.”<sup>149</sup>

As previously noted, by October 30 there were concerns of a vaccine shortage and it was decided to close the clinics indefinitely at end of day on Saturday, October 31. Nurses were being asked to share vials of vaccine to prevent wastage. They were also being told to use up each vial before reconstituting more vaccine.

At some point, Ms. Duffley and her counterpart on the standards and quality side, Ms. Lohan, had a conversation in which they discussed what to do with the partly used vials of mixed vaccine. They discussed the possibility of immunizing the staff who had not yet been vaccinated, who could be immunized “because we had permission for our staff to be immunized.” Asked if that permission extended to family, friends or acquaintances of staff, Ms. Duffley said, “Not that I can recall. I know we did talk about what public health programs might be running on the Sunday, and we tried to look to see whether there was a way for any of those patients or clients to have the service, and we really weren’t able to come up with a solution.” Ms. Duffley

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<sup>147</sup> Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2251-52.

<sup>148</sup> Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2287-88.

<sup>149</sup> Testimony of Christine Westerlund, Transcripts, vol. 28, January 17, 2013, at 2287-89.

accepted that there would be small amounts of wastage because they were not able to open the lines “safely.”<sup>150</sup>

Asked if it was acceptable for nurses to use the vaccine for family or acquaintances, Ms. Duffley said there was no policy one way or the other. She clarified that she had never intended to convey otherwise to Ms. Lohan or to suggest that it would be acceptable for nurses to take the vaccine for personal use. She said her “personal belief” is “that we should not benefit from our own – from our employment situation.”<sup>151</sup>

In contrast, Ms. Lohan said she believes that provincial pandemic plans should be rewritten with a clause that says staff and their family should be protected because staff is a “very important resource” when it comes to immunizing 3.3 million Albertans in a pandemic. She said:

We need our staff to provide immunization, we need our staff to provide health care. We know that with influenza, children are transmitters of the virus. And I feel – and this is just my personal opinion – that we should write into our pandemic plan how our staff and families should be protected so that we have that resource to use to provide care and to provide immunization programs.<sup>152</sup>

### ***Inquiry findings***

Here we have several instances of preferential access to immunization. Nurses gave that preferential access when they vaccinated family and friends by helping them bypass lines at the public clinics, by vaccinating them after hours or on their breaks, and by taking vaccine home. The rationale in some cases was a desire to avoid wastage of the reconstituted vaccine. In other cases, the rationale was simply that there was no policy or direction to govern the situation. There was also no consensus among supervisory staff. It was not until January 2010, when shortage of vaccine was no longer an issue, that a directive was issued specifying that family members of staff were to be immunized in the same manner as the public.

Given the limited shelf life of the vaccine, it can be argued that the nurses’ actions, at least after the announcement that the clinics were

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<sup>150</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2202.

<sup>151</sup> Testimony of Linda Duffley, Transcripts, vol. 27, January 17, 2013, at 2204-05.

<sup>152</sup> Testimony of Joy Lohan, Transcripts, vol. 27, January 17, 2013, at 2253.

closing, were pragmatic actions designed to immunize as many people as possible before the vaccine became unusable. But, of course, the choice of who received the vaccine was solely at the discretion of the nurses. Besides, they had an alternative. They could have kept the public lines open longer until all the reconstituted vaccine had been used.

The closing submissions of AHS describe these incidents as “an illustration of how extraordinary circumstances raise questions and demand judgments that do not always have policies readily available for guidance.”<sup>153</sup> These were circumstances that could and should have been foreseen.

In December 2010 the Health Quality Council of Alberta released its report reviewing Alberta’s response to the H1N1 pandemic.<sup>154</sup> That report noted that designated staff immunization clinics were established within AHS facilities as soon as the vaccine was available. These clinics opened on October 22, 2009, and closed temporarily on October 31 when the mass public clinics closed. The rationale for immunizing health care workers early was to prevent an infected health care worker from spreading the infection to others and to minimize absenteeism.<sup>155</sup>

The report also refers to an “ethics framework” that uses an application of principles to help guide clinical and operational decision-making instead of a prescribed set of policies. This type of tool would have helped health care workers resolve the questions raised by extraordinary circumstances (as they were described in the AHS submission). The AHS Rapid Response Clinical Ethics Consultation Service was apparently developed to provide resources for difficult decision-making during the pandemic but, according to the report, was not used. Instead, individuals sought out those familiar to them to help resolve problems or were referred to an individual ethicist.<sup>156</sup>

The Health Quality Council of Alberta report recommended that Alberta Health and AHS develop and maintain an ethical framework

<sup>153</sup> Closing Submissions of Alberta Health Services, April 1, 2013, at 16 (Exhibit 164).

<sup>154</sup> Health Quality Council of Alberta, *Review of Alberta’s Response to the 2009 H1N1 Influenza Pandemic* (December 2010).

<sup>155</sup> Health Quality Council of Alberta, *Review of Alberta’s Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39 and 50.

<sup>156</sup> Health Quality Council of Alberta, *Review of Alberta’s Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 61-62.

and strategies to guide operational and clinical decision-making.<sup>157</sup> I support this recommendation. Two considerations should go into such a framework: (1) the extent of discretion that a front-line health care worker, such as a nurse at an immunization clinic, should have to make the type of decisions that the nurses involved in these incidents made; and (2) whether the families of such front-line workers, especially since children should be considered high-risk,<sup>158</sup> should be given priority for immunization like health care workers. Without such a framework, front-line workers are left to make difficult decisions on the spur of the moment and without guidance.

The conduct of the nurses in immunizing family and friends outside of clinic hours and away from clinic premises, and expediting the vaccination of family members at clinics while nurses were on breaks, without permission from superiors, constituted improper preferential access. Ethically, it was no different in essence than the private immunizations of the Calgary Flames discussed earlier.

#### **b) *Red Deer immunizations***

The inquiry heard conflicting evidence about an incident involving possible improper preferential vaccination of AHS employees in Red Deer. The conflict was between the evidence of two individuals. Ms. Kelly Marie Hawken was the executive assistant to the executive director of rural hospitals for AHS at around that time. Ms. Jennifer Currie was Director, Central Zone Emergency Operation Centre (EOC), during the first 13 days of the H1N1 emergency and for several days in the weeks that followed. Ms. Hawken testified before the inquiry, while Ms. Currie submitted a statutory declaration.<sup>159</sup>

Ms. Hawken said that about 100 AHS employees worked at the Michener Bend Building in Red Deer. No front-line doctors or nurses worked there, though some of the administrators were nurses. On the lower level of the building was an emergency centre dedicated to H1N1 vaccinations. She understood the centre had arranged the original setup

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<sup>157</sup> Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 62.

<sup>158</sup> The Health Quality Council of Alberta's report noted that the Public Health Agency of Canada identified children from six months to less than five years of age as falling within the high-risk population for the H1N1 pandemic: *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 34-35.

<sup>159</sup> Exhibit 158.



of the public vaccination clinics and was taking calls if emergencies happened in the clinics. She understood that those working in the centre did not deal with the public and were not front-line workers. According to Ms. Hawken, only about four or five people worked there.<sup>160</sup>

Ms. Currie stated that most of those working in the EOC worked long hours, from very early in the morning to late at night, six days a week. These people ensured that staff required for emergency responses in communities were recruited, deployed, assigned and trained to care for patients and to work in immunization clinics. The EOC staff also arranged procurement and distribution of supplies under demanding conditions. They arranged to move supplies and vaccines across Central Zone, booked and rebooked venues and arranged to move equipment in and out of clinics. They responded to each crisis as it was reported to them and coordinated communications of all kinds. According to Ms. Currie, workers at the EOC during this time often went back to their offices after the working day to respond to inquiries that they could not manage during normal hours.

Ms. Hawken said that the lineups in the early days of the H1N1 vaccination program in Red Deer were “huge.”<sup>161</sup> At about the time the lineups were occurring, the executive assistant to the vice-president of Central Zone announced to those in the Michener Bend Building that public health nurses would be coming to vaccinate everyone. Ms. Hawken said she was told that, because those in the EOC did not have time to stand in line to be vaccinated, public health nurses were coming to vaccinate them and everyone else in the building. She understood from the nurses doing the vaccinations that Ms. Currie gave the order to vaccinate.<sup>162</sup>

Ms. Currie said she became involved in discussions about how those involved in the Central Zone EOC could get immunized. The rationale was that the staff were critical to support a pandemic response and that the hours they were working did not in many cases allow them to get access to the mass clinics for immunization. She stated, “Based on information available at the time, I approved the implementation of arrangements to provide on-site immunization.”

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<sup>160</sup> Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2802-06.

<sup>161</sup> Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2803.

<sup>162</sup> Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2807-08.

### *Inquiry findings*

Ms. Currie's statutory declaration is consistent with Ms. Hawken's recollection, although Ms. Currie did not indicate that the vaccinations were to be for everyone in the building. Her declaration stated that the immunization clinic was held at the building for EOC members. She said that other members of the AHS staff in the building may have had access to the immunizations as well. In fact, Ms. Hawken said she too received the immunization there.<sup>163</sup>

What is clear from both of these versions of this incident is that there were other AHS personnel in the Michener Bend Building besides those working in the EOC and they received vaccinations. Again, there was no policy about who should be vaccinated, in what priority, or about which circumstances would justify an exception to the arrangements made for ordinary members of the public. According to Ms. Hawken, three nurses showed up at the building, apparently on their way to the public clinics, but instructed to immunize the people working there first.<sup>164</sup>

The Health Quality Council of Alberta's report on the H1N1 pandemic response noted how it is critical in a pandemic to have an understanding of which individuals are considered as first responders and essential services and whether they comprise part of the high-risk group for immunization. This was not clear during the immunization campaign in Alberta. Emergency medical service personnel who were AHS staff or contracted service providers received immunization at the AHS staff clinics starting October 22, 2009.<sup>165</sup> My assessment of the evidence of this incident is that it occurred during the first week of the mass immunization clinics, the week of October 26. The Health Quality Council of Alberta recommended that Alberta Health and AHS collectively define those groups who should be considered high priority and then achieve consensus on their prioritization. More important, this

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<sup>163</sup> Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2809.

<sup>164</sup> Testimony of Kelly Marie Hawken, Transcripts, vol. 34, February 20, 2013, at 2808-10.

<sup>165</sup> Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39.

exercise must be based on facts and supported by public health experts.<sup>166</sup>

I support these recommendations. It may have been appropriate to make special efforts to immunize those working in the Emergency Operation Centre in Red Deer, but there was no justification for doing so for non-essential administrative personnel. Such vaccinations constituted improper preferential access.

## **6. *Emergency care and triage procedures***

Emergency department care, and in particular an ever-increasing demand on emergency services and unacceptable wait times for service, has been a major concern for public health care systems in Canada for years. The Health Quality Council of Alberta has conducted two reviews of these issues in the past six years.<sup>167</sup> The inquiry heard evidence about emergency room procedures with a view to identifying possible improper preferential access. It also heard evidence about a practice, referred to in the inquiry as the private patient path, whereby emergency departments can be used to facilitate access for some patients.

When patients arrive at an emergency department, they are prioritized and then treated according to the urgency of the care they require. The initial assessment is usually done by a triage nurse. This assessment includes checking vital signs, getting a medical history and calculating a level of illness category under the Canadian Triage and Acuity Scale (CTAS) system. The CTAS has five levels of acuity. Patients requiring immediate supervision and possibly resuscitation are assessed as CTAS level 1. CTAS 2 (emergent) and CTAS 3 (urgent) categories represent patients needing more timely attention than those categorized as CTAS 4 (less urgent) and CTAS 5 (non-urgent).<sup>168</sup> Once a CTAS number is assigned, patients wait to be seen by an emergency department physician who co-ordinates the necessary care.

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<sup>166</sup> Health Quality Council of Alberta, *Review of Alberta's Response to the 2009 H1N1 Influenza Pandemic* (December 2010) at 39-40.

<sup>167</sup> Health Quality Council of Alberta, *Review of Emergency and Urgent Care Services in the Calgary Health Region* (September 2007); Health Quality Council of Alberta, *Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy* (February 2012).

<sup>168</sup> J.L. Saunders & Associates Inc., *How Health Care is Delivered in Alberta* (November 29, 2012) at 12 [Exhibit 12].

I heard evidence from several witnesses, all of them with many years of experience in emergency departments either as nurses, directors or managers, or as physicians. All the witnesses testified to similar procedures in emergency departments.

Patients are triaged in the same manner no matter how they arrive at the emergency department – by ambulance, accompanied by police or arriving on their own. Still, the triage process is a source of confusion and patient complaints. Ms. Sheri Drozda, a nurse clinician at the Foothills Hospital emergency department in Calgary, explained that patients often perceive triage as queue-jumping. They complain about it “all the time,” despite her efforts to explain the triage system.<sup>169</sup>

Ms. Drozda believes some confusion results from the procedural work done in the emergency area. The waiting rooms are close together “and everybody is watching everybody because you’re sitting there and waiting, and that’s pretty much what you’re doing.” They see the nurse-initiated protocols, such as blood testing, X-rays being ordered, or IV hook-ups, and believe those people are moving through the system more quickly. She said, “That generally isn’t the case. Sometimes we’re just starting treatment, but they’re still waiting in order of their priority of when they came in.”<sup>170</sup>

The perception of the triage process as queue-jumping stems from the fluidity of the triage system, said Ms. Drozda. This perception arises particularly when someone with an urgent condition comes in and bumps someone with a less urgent condition down the list. She said she often hears complaints to this effect: “I was told an hour ago that I was fourth to be seen and now I’m seventh. Why is that? I’ve already been here for four hours.”<sup>171</sup> She explained, “Generally it’s because somebody has come into the department that was sicker than them and so they’ve been bumped down. That’s usually why there’s a wait.”<sup>172</sup>

The witnesses also described common unwritten practical considerations, apart from CTAS ranking, in determining a patient’s position in the queue. Ms. Kathy Taylor, a triage nurse and manager at the Peter Lougheed Medical Centre in Calgary, talked about preferential service for infants and young children. She said, “Part of

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<sup>169</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 330.

<sup>170</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 330-31.

<sup>171</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 331.

<sup>172</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 331.

our preferential [access] for children is that we don't want them in our world because it's not a clean world, and so ... a lot of our children, we do get through quicker. Plus crying babies are not a good thing to have in your waiting room. It's very upsetting to other people."<sup>173</sup>

Patients arriving with emergency medical services (EMS) personnel or police officers may be triaged before others. However, they are triaged in the same way as other patients. They are not put in special categories or given a higher category than any other patient of similar acuity. Their quicker access to triage does not give them any priority over other patients in seeing a physician. Getting these patients triaged as quickly as possible simply frees up police officers and EMS staff to return to duty.<sup>174</sup> Injured police, EMS and other emergency personnel may themselves be given priority in getting access to triage and treatment over comparable cases, but not more critical cases, for the same reason.<sup>175</sup>

In some situations, emergency patients may be placed in an area separate from the main waiting room. These may be mentally ill patients, those with a contagious condition or those who pose a security risk, such as criminals. They may also be individuals whose identity needs to be kept confidential, such as victims of domestic violence, or those who are highly recognizable such as celebrities, athletes or politicians.

None of the witnesses provided any example of improper preferential access. This is explained in part by how the triage system operates. The system requires charts to be prepared with notes about the CTAS priority level. Attempts to give improper preferential access would be very evident from the charts. Because of the triage system, people cannot easily jump the queue. As Ms. Taylor said, "So you see it, and that's why people don't do it."<sup>176</sup>

Another reason why improper preferential access does not occur in emergency rooms is a form of internal policing, as described by Mr. Donald Christensen, area manager at the Sheldon Chumir Urgent Care

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<sup>173</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 511.

<sup>174</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 533-34; testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2507.

<sup>175</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 342-43;

testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2509.

<sup>176</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 512.

Centre in Calgary. If the physician wants to “cherry pick” and put through a lot of patients in a hurry, the nurses very quickly put an end to this. They are very good at saying that this cannot be done and that physicians must see patients according to their CTAS priority. As well, if nurses are trying to speed up the physician, the physicians are very good at saying that they will only take care of one person at a time. Mr. Christensen described this as a sort of policing between professional groups.<sup>177</sup>

Ms. Taylor described a 2012 incident to illustrate how, as she said, decisions are based on the need for treatment, not other influences. Ms. Taylor came into work that morning and found a prominent politician waiting for a bed. She said, “He waited overnight in emergency. So if he was going to get preferential treatment, he would have actually been the first person to get a bed, but he just waited in his line.” This person was given confidentiality, meaning his name would not have been put on the REDIS system for others to see. The curtains were pulled so that others walking by would not see him “because he was a very recognizable person.”<sup>178</sup>

Ms. Taylor explained that REDIS is the database that sorts patients coming in, and tells staff the patients’ priority and the pathway for their treatment. The politician’s condition warranted admission and he was hospitalized for a few days. With no bed available, the politician stayed overnight in emergency, which Ms. Taylor said “isn’t always the best [place] because we don’t turn off the lights and we don’t slow down.”<sup>179</sup>

Ms. Taylor also testified that she has never received preferential treatment when injured or sick. She said that in January 2012 she fell and tore a ligament, went to triage and was treated like any other patient. She could think of only one incident during her years as an emergency department nurse where somebody was seen or treated more quickly than they should have been. A patient had been taken off a flight and had to be seen quickly to get back on the flight.<sup>180</sup>

Ms. Jill Woodward, the executive director at the Alberta Children’s Hospital, described an incident in 2010 where a nurse attempted to get

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<sup>177</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 10, 2012, at 546-47.

<sup>178</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 506-07.

<sup>179</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 507-08.

<sup>180</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 508 and 517-19.

preferential treatment for her child at the emergency department. The nurse insisted that her child be seen before any of the other children in the waiting room because she was a nurse at that hospital. The triage nurse gave the appropriate CTAS score to the patient and the patient was seen in the normal manner. The nurse in question was “spoken to.” She later apologized and acknowledged that her behaviour was unacceptable.<sup>181</sup>

### ***Inquiry findings***

The evidence before the inquiry consistently showed that procedures used in emergency departments – and, indeed, the professional culture of emergency personnel – serve to limit the potential for improper preferential access. The instances described in which some patients seem to have been attended to more quickly than they appeared to warrant were in fact justifiable on a practical and ethical basis. There was no evidence that giving priority to the patients involved in these incidents delayed the assessment or treatment of any other emergency patient.

In conclusion, I found no evidence, from the admittedly limited testimony before the inquiry on this subject, that improper preferential access is occurring in emergency departments in Alberta.

### ***7. The private patient path***

Emergency departments were implicated in another potential type of improper preferential access – a phenomenon known as the private patient path. This refers to patients who have been directed to the emergency department by their physician for the purpose of seeing that physician or another specific physician.

One variant of this practice was described by Dr. Brian Holroyd, a practising emergency physician at the University of Alberta Hospital and one of the leaders of a strategic planning group formed by AHS for emergency services in Alberta. He spoke about what he called a direct patient – a patient typically under the care of a specialist at the hospital and who needs care urgently. The specialist would tell the patient to come to the emergency department. The specialist would alert the department that the patient was coming. The patient would be triaged by the emergency department staff on arrival but would not be placed in

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<sup>181</sup> Testimony of Jill Woodward, Transcripts, vol. 16, January 9, 2013, at 1273-74.

the same queue for treatment as other emergency patients. Instead, the specialist would come to the emergency department to assess the patient.<sup>182</sup>

Mr. Kyle Cridland, an emergency room nurse at the Foothills Hospital, gave another example of the private patient path phenomenon. Patients would arrive at the emergency department with a letter from their doctor. The emergency room (ER) nurse would call the doctor to attend to the patient in the emergency department. The patient would be assessed by the triage nurse but not put in a queue to see an emergency physician. Instead, the patient would be designated a private patient. Mr. Cridland explained the procedure for handling private patients:

[G]enerally speaking, a communication has been made from the primary health doctor to the specialist doctor. So they're expecting the patient and they'll usually send a letter in just so that we're aware of what's happening and which doctor to call and that kind of thing.... [A]t the Foothills we have two rooms in the waiting room that have stretchers in them [in which] physicians can assess patients. So they're used mainly for the private patients that come in so that they don't take up actual beds inside our department.<sup>183</sup>

Mr. Cridland also testified that "every now and then" another patient would see this treatment of private patients and become upset. He would usually tell them the truth and explain that the private patient was there to see a doctor and "everyone is here for different reasons. Some people are here to see certain doctors. Some people are here to see emergency doctors. I just kind of explain to them what's going on, with no specific patient details, obviously."<sup>184</sup>

Ms. Sheri Drozda, a nurse clinician, explained the private patient path as involving private patients who come from various places – perhaps a clinic on another floor of the hospital – where they have been assessed and deemed to need admission. Sometimes patients seeing a particular specialist will be told to meet the doctor at triage. The triage nurse usually gives that doctor a call to confirm that the doctor is expecting the patient. Once this is confirmed, the triage nurse checks in the

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<sup>182</sup> Testimony of Brian Holroyd, Transcripts, vol. 6, December 5, 2012, at 404-05.

<sup>183</sup> Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2501.

<sup>184</sup> Testimony of Kyle Cridland, Transcripts, vol. 31, February 19, 2013, at 2502.



patient and makes an emergency department treatment chart, but for treatment as a private patient. These patients are triaged under the CTAS system but they are not put in any sort of priority. They are labelled a private patient, according to Ms. Drozda. Still, she said, they are considered emergency department patients to be looked after by ER staff. The physician they see will use ER resources such as ER examination rooms, and these private patients will be admitted or discharged through the ER.<sup>185</sup>

While this appears to be an accepted practice among ER staff and physicians, the inquiry also heard evidence about how some similar practices were not considered acceptable. For example, Mr. Donald Christensen described how one physician at the Sheldon Chumir Urgent Care Centre attempted to fast-track patients from his outside clinic. The physician was working in urgent care and had told clients to come to urgent care to see him. They were told to speak to the triage nurse and tell the nurse to send them back to the physician. The triage nurse blocked this.<sup>186</sup> Similarly, Ms. Kathy Taylor described how a physician routinely told his surgical patients to meet him at the Peter Loughheed Centre's emergency department for lap band adjustment procedures following weight surgery. She considered this an inappropriate use of emergency department resources, and told the physician so.<sup>187</sup>

### ***Inquiry findings***

It is certainly not clear from the evidence I heard as to when the private patient path is acceptable and when it constitutes improper preferential access. It is also not clear why it is necessary or desirable to have a system involving a private patient path. There was no evidence of any policy, either system-wide or a local policy within a facility, to address this practice.

The final submissions on behalf of AHS argued that this practice may more accurately be described as “situations where community and specialist physicians with privileges to admit and treat their patients in a hospital, arrange to assess personal patients with urgent needs in the [emergency department] at times when they cannot do so in their

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<sup>185</sup> Testimony of Sheri Drozda, Transcripts, vol. 5, December 5, 2012, at 338-39.

<sup>186</sup> Testimony of Donald Christensen, Transcripts, vol. 8, December 6, 2012, at 545.

<sup>187</sup> Testimony of Kathy Taylor, Transcripts, vol. 8, December 6, 2012, at 519.

community offices or hospital-based clinics.”<sup>188</sup> That is one way of looking at it. It may also simply be convenient for the physicians. I can understand how it may sometimes be an effective way to manage a high volume practice. One of our expert witnesses, Ms. Pamela Whitnack, referred to it by focusing on the situation in rural Alberta:

In many cases in rural Alberta, you have a very small physician base in a particular community. For these individuals to function in a practice and maintain service in an (emergency room) and in an outpatient area and so on, it’s very difficult/taxing on their time, and it’s a matter, perhaps, of some convenience. I would not ever mean to suggest that the people that they would have meet them in emergency don’t have clinical urgency. It is just simply a matter of perhaps the best way to organize, dealing with the volume of patients and the volume of service that’s required in that particular area, and they’re professionals doing their best to treat the people that need to be seen.<sup>189</sup>

As with several other situations examined in this report, one cannot draw definitive conclusions without knowing the context in which the issue arises. If a procedure or assessment is not urgently needed, it would be improper preferential access to arrange for a patient to go to the emergency department to receive it sooner than if the patient attended the physician’s office. On the other hand, if a patient requires services but cannot reasonably obtain those services through scheduling an appointment at a physician’s office or specialist clinic, it may be necessary to obtain those services through the emergency department. Both cases involve a potential misuse of emergency resources and demonstrate a lack of coordination of services in the health care system.

An in-depth analysis of the benefits and drawbacks of the private patient path phenomenon would be useful. That analysis must go beyond simply examining procedures and include the ethical implications of the private patient path. I have no doubt that personnel working in emergency departments, as well as physicians and nurses in general, would benefit from having clear protocols.

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<sup>188</sup> Closing Submissions of Alberta Health Services, April 1, 2013, at 14 (Exhibit 164).

<sup>189</sup> Testimony of Pamela Whitnack, Transcripts, vol. 38, February 26, 2013, at 3279-80.

**Recommendation 10:****Develop policies for the private patient path**

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private patient path and develop appropriate policies for emergency department personnel and physicians.

**8. *The Colon Cancer Screening Centre***

The inquiry heard testimony from 15 witnesses over several days about the alleged preferential treatment of some patients at the Colon Cancer Screening Centre (CCSC), also known as the Forzani & MacPhail Clinic. The CCSC opened in 2008. It was established to enable screening colonoscopies to be moved out of acute care facilities. Screening colonoscopies are those done, for example, when a person reaches a threshold age, even if the person has no symptoms suggesting the need for a colonoscopy. Acute care facilities such as the University of Calgary Medical Clinics (UCMC) would then be freed up to handle colonoscopies for patients who were symptomatic – for example, those with gastrointestinal symptoms or bleeding. As well, the CCSC established a central triage process, leading to a common queue in the Calgary region for screening colonoscopies. The inquiry heard evidence about several incidents relating to the CCSC that might constitute improper preferential access:

- that some patients from a private executive medical clinic, Helios Wellness Centre, were allegedly obtaining much faster access to screening colonoscopies at the CCSC than the norm;
- that one physician in particular was allegedly instrumental in achieving this;
- that some of that physician's other patients were allegedly receiving preferential access;
- that membership in Helios was allegedly intended to reward donors to the University of Calgary, possibly by facilitating preferential access; and

- that the CCSC clinic manager may have had a special relationship with Helios that could have enhanced access by Helios patients to the CCSC or that could give the impression of favouritism.

All participants in the inquiry found the evidence on this topic complex and at times difficult to grasp. Nevertheless, patterns of behaviour emerged, clearly demonstrating that procedures instituted at CCSC for arranging colonoscopies were circumvented for certain patients. This enabled them to bypass the normally long waiting periods faced by those in the common queue.

### **a) *Establishment of the CCSC***

The CCSC sought to bring all asymptomatic patients under one roof for screening colonoscopies. The CCSC was intended to provide family physicians a way to refer patients for colonoscopies directly, without sending them to individual specialists. It was also intended to facilitate a common queue for screening colonoscopies. Having screening colonoscopies handled through the CCSC would also free up hospital space for those who truly needed it, such as patients who were symptomatic.

The CCSC was initially operated by the University of Calgary under contract with the Calgary Health Region. In 2010, administration was transferred from the University to AHS.

When the CCSC first opened, it took over the University of Calgary Medical Clinics (UCMC) gastroenterology wait list for routine screening. That list contained approximately 15,000 names. In addition, every day after it opened, the CCSC received about 200 new referrals.<sup>190</sup> Ms. Darlene Pontifex, manager of the CCSC since its beginning, described the files inherited from UCMC as a “clerical nightmare.” They were out of order and simply stacked in filing cabinets.<sup>191</sup>

Ms. Pontifex testified that, in its early days, the CCSC had difficulty filling its endoscopy slots (available appointment times) despite this backlog. The clinic did not have sufficient clerical staff and the nurses,

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<sup>190</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2025 and 2029-2030; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2717-18.

<sup>191</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2717-18.

who were new to gastroenterology, were taking a long time – up to an hour – for screening consultations with patients. For that reason, the CCSC clinic was unable to book all the endoscopy slots. In addition, patient information from some UCMC files was inaccurate. Phone numbers had changed and addresses were wrong. Mailing appointment times to patients worked, but was very labour intensive.<sup>192</sup>

### **b) *The process at the CCSC***

The CCSC adopted a formal policy for referrals early on. The policy is contained in a document entitled Colon Cancer Screening Centre – Referral, Triage and Pre-Assessment.<sup>193</sup> The effective date of the policy was October 31, 2007, and its latest revision is dated August 3, 2012. The policy was in place when the CCSC opened.<sup>194</sup>

The process for colonoscopies at the CCSC begins with a physician – typically a family physician – sending a referral, a standardized form requesting a colonoscopy. Referrals are sent to CCSC by fax. A triage clerk reviews them. The triage clerk takes referrals requesting screening for an average risk patient directly to another clerk who makes a data entry and files them. Anything involving a referral other than routine average risk is reviewed by the triage clerk. If the form is incomplete, the clerk returns it to the physician for the required information. The clerk gives the properly completed referral to the triage nurse who assesses it as average risk, moderate, urgent or urgent priority. Then they are given to the booking clerks. The booking clerks then contact the patient to set up a pre-screen – the appointment that precedes the actual colonoscopy – at the clinic.<sup>195</sup>

The wait to obtain a pre-screen in moderate or urgent cases is less than eight weeks. Routine cases take much longer, more than 18 months.<sup>196</sup> Routine cases go into a filing cabinet in chronological order according to the date they were received. When booking pre-screens for routine referrals, the CCSC takes the oldest referrals first.

Referrals triaged as urgent and moderate are given directly to a clerk to be booked for the next available pre-screen. Once the urgent and

<sup>192</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2723-24.

<sup>193</sup> Exhibit 105.

<sup>194</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013 at 2050.

<sup>195</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2732-33.

<sup>196</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2733.

Case Studies

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moderate cases are booked, clerks at the CCSC turn to the routine referrals that are filed in chronological order in the filing cabinets.<sup>197</sup>

At the pre-screen, the colonoscopy procedure is explained and a nurse obtains medical information from the patient. Patients then go to the front desk and book the actual colonoscopy procedure. The procedure normally takes place from two weeks to a few months after the pre-screen.<sup>198</sup> There are 40 to 45 endoscopists – it varies over time – on the clinic roster performing colonoscopies.

The CCSC medical director, Dr. Alaa Rostom, testified that priority was always given to the moderate, urgent, and urgent priority categories. On any given day, slots would be filled first with those patients. Remaining slots would be used for routine patients, who would be scheduled based on the time they had spent on the referral list.<sup>199</sup> Dr. Rostom stated that the clinic never discouraged a patient from seeing a particular endoscopist, but that the referral form said something to the effect that a patient choosing a specific physician might wait longer for the procedure.<sup>200</sup> He agreed with counsel's suggestion that it was certainly never intended that clients could achieve a shorter waiting time by choosing their own endoscopist.<sup>201</sup>

When the CCSC first opened, endoscopists were allowed to book patients who were on their own wait lists. This meant that they were allowed to bring their own patients to the CCSC for colonoscopy procedures while at the same time doing procedures on patients from the CCSC wait list. Dr. Rostom explained that this initial practice was viewed as “a fair compromise ... because these people [endoscopists] had their own backlog, that we would say, ‘Look, you do four patients from our backlog list and then you can bring four patients from your own.’<sup>202</sup> Normally, procedures are grouped by lists. A list is a half day of procedures – a total of eight, given that each procedure normally

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<sup>197</sup> Testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1884-86.

<sup>198</sup> Testimony of David Beninger, vol. 23, January 15, 2013, at 1837-38; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2734.

<sup>199</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013 at 2075.

<sup>200</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2076. Two versions of the referral form, Exhibit 90 and 92, say nothing about a longer wait time in the situation Dr. Rostom described. However, Dr. Rostom may have been referring to Exhibit 93, also a referral form, which contains wording about possibly longer wait times for patients who request to see a particular gastroenterologist.

<sup>201</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2077.

<sup>202</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2055.

takes half an hour. Endoscopists who did a list could therefore perform four procedures on their own patients and four from the CCSC list. If the endoscopists did two lists – a full day of procedures – they could perform eight procedures on their own patients. Dr. Rostom said that these endoscopists would have triaged their own lists and that the clinic accepted their decisions about triage.<sup>203</sup>

The inquiry heard evidence about operational difficulties encountered by CCSC in its first year or so. There was a shortage of clerical staff and an insufficient and faulty technological infrastructure to process the volume of referrals. As noted earlier, referrals on the UCMC wait list the clinic inherited often contained incorrect patient contact details. As a result, the CCSC could not locate the patients from these inherited referrals to fill all the available appointment slots. The clinic resorted to filling these slots with private patients or more recent referrals whose contact information was up to date. Still, Ms. Pontifex emphasized in her testimony that the goal was to organize the CCSC list so that patients were seen according to level of urgency and date of referral.<sup>204</sup>

The purpose behind allowing endoscopists to book their private patients was to get them involved with the CCSC. However, this concession was meant to be temporary. In August 2009 the CCSC adopted a policy to end this practice. The policy, entitled Endoscopist Responsibilities at the Centre, stated that the colonoscopy procedure slots do not belong to individual endoscopists and that the clinic will distribute the slots to best fulfill its mandate. It also contained the following provision:

Endoscopists can refer their private patients to the centre. However, these patients will be triaged and prioritized along with the rest of the referred patients. Patients have the option to select an individual endoscopist, but doing so may result in a longer wait time. Endoscopists cannot directly schedule patients from their office into CCSC slots.

Dr. Rostom said that in 2010 the clinic stopped allowing endoscopists to bring in patients from their private lists. He gave two reasons. First, the governing view was that there should be a common queue for colonoscopies. Second, the process had become administratively unwieldy. This policy change was achieved gradually, mostly through

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<sup>203</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2056 and 2058.

<sup>204</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2720.

educating family physicians to use the CCSC referral form so that cases could be triaged appropriately at the CCSC.<sup>205</sup>

c) *Allegations of queue-jumping*

On March 19, 2012, Dr. Rostom sent an email to several recipients. Entitled “Concerns over Endoscopy Queue-Jumping – CCSC policy on the subject,”<sup>206</sup> the email expressed concern that queue-jumping could occur if endoscopists tried to book private patients onto their CCSC lists. The email stated, in part:

Recently the issue of “Queue jumping” has taken prominence with government and AHS. I want to take a moment to reiterate CCSC policy on the subject....

“Queue jumping” is a broad term which can encompass legitimate reasons for advancing a patient’s appointment for medical reasons, as well as cases for which the reasons are not medically related.

...

It is acknowledged that all examples of “queue jumping” are a very small percentage of the volume handled at CCSC.

I would however like to explicitly state CCSC policy on endoscopist initiated “queue jumping” – which can occur, for example, if endoscopists try to book private patients in their CCSC lists. In this context, private patients mean patients that have been referred to; or are known to; an endoscopist who historically would have been scoped by the endoscopist at their acute care sites prior to opening of CCSC.

CCSC policy for the last few years has been that CCSC cannot take patients for direct booking with the requesting endoscopist.

The following policy statement indicates CCSC protocol on this issue:

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<sup>205</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2060-61.

<sup>206</sup> Exhibit 109.



1. CCSC cannot accept endoscopists' private patients to be booked directly with that endoscopist.
2. CCSC endoscopists can refer private patients to CCSC if:
  - a. the endoscopist fills out a standard CCSC referral;
  - b. the referral is sent to CCSC triage (not a booking clerk);
  - c. the endoscopist acknowledges that the referral will be triaged with the rest of the CCSC referrals and given a priority based on our triage policy;
  - d. the endoscopist acknowledges that the patient may not be booked with the requesting endoscopist.
3. The preferred route for referral to CCSC is for the endoscopist to ask the referring family physician to refer the patient to CCSC directly (as we do with referrals to central GI triage).

It is critical that all CCSC endoscopists and staff follow this policy. There may be extraneous or unexpected circumstances that we have not covered by this policy. If you have such examples, please let me know so it can be incorporated into the policy statements.

Dr. Rostom said that, shortly before he wrote his email, he had received a telephone call from Ms. Barbara Kathol, one of the executive directors at the Foothills Hospital. She told him of rumours that Dr. Ronald Bridges was directly booking patients at the CCSC.<sup>207</sup> She was in effect telling him that Dr. Bridges was booking patients through a booking clerk rather than putting the referrals through the CCSC central triage process.<sup>208</sup>

Dr. Ronald Bridges is a gastroenterologist as well as the senior associate dean of the University of Calgary Faculty of Medicine. He was instrumental in preparing the original plan for the establishment of CCSC and played a prominent role in its early development. He was the CCSC medical director from its founding until early 2008. He was described by Ms. Pontifex as a founder of CCSC and by another

<sup>207</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2119-20.

<sup>208</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2140-41; testimony of Barbara Joan Kathol, Transcripts, vol. 30, January 18, 2013, at 2429.

physician as its “de facto director.”<sup>209</sup> He was and is by all accounts a highly influential leader in the Calgary medical community.

Some of the allegations relating to Dr. Bridges involve a private medical clinic that some might describe as an executive medical clinic. This is the Helios Wellness Centre. Helios was founded in 2007 by Dr. T. Chen Fong. It is a medical clinic that provides both insured and non-insured services, such as massage and physiotherapy, diet counselling, exercise testing and yoga. Insured services are provided by physicians on staff who bill AHS for those services. The Centre charges a fee of \$10,000 per year for a single adult membership, \$15,000 for a couple, and \$3,000 for dependents. The fee is said to cover the non-insured services provided at the Centre. There are currently 260 memberships covering 700 people.<sup>210</sup> Helios, according to its founder, is a not-for-profit organization, although it is not a registered charity. Dr. Fong stated that he established it to fund a fellowship program at the University of Calgary Faculty of Medicine.<sup>211</sup> At a leadership forum meeting at the Faculty of Medicine on April 2, 2012, Helios was described as “a corporate centre [started] to provide a relationship between the downtown community and the University of Calgary.”<sup>212</sup> Dr. Bridges was not on staff at Helios, but he and Dr. Fong have known each other for many years.

Ms. Kathol was prompted to call Dr. Rostom by information she received in March 2012 from Dr. Jonathan Love, the gastroenterology site chief at Foothills Medical Centre and one of the endoscopists who performed colonoscopy procedures at CCSC. He had told her that preferential access to colonoscopy care was continuing at CCSC even though there was a centralized triage system.<sup>213</sup> I say “continuing” because Dr. Love had raised the same concern with Ms. Kathol in early 2011 after he had noticed discrepancies in how Dr. Bridges’ patients were booked. He also brought to her attention a delivery of wine at Christmas 2010 to CCSC as a gift from the Helios management. Both

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<sup>209</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2714; testimony of Mark Gordon Swain, Transcripts, vol. 29, January 18, 2013, at 2398.

<sup>210</sup> Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2524; testimony of Douglas Caine, Transcripts, vol. 31, February 19, 2013, at 2565-66; testimony of T. Chen Fong, Transcripts, vol. 32, February 19, 2013, at 2665-66 and 2671.

<sup>211</sup> Testimony of T. Chen Fong, Transcripts, vol. 32, February 19, 2013, at 2658-62.

<sup>212</sup> Exhibit 146.

<sup>213</sup> There was evidence that Ms. Kathol was also alerted by Dr. Mark Swain in March 2012 about a physician maintaining a private list at CCSC: see testimony of Mark Gordon Swain, Transcripts, vol. 29, January 18, 2013, at 2390-91.

he and Ms. Kathol thought that was highly unusual and inappropriate.<sup>214</sup>

Dr. Love testified that he had experienced an earlier discrepancy regarding the treatment of a Helios patient referred to Dr. Bridges at the UCMC endoscopy clinic. The patient was booked to see Dr. Love since he was available and he examined the patient on November 1, 2010. Dr. Love noted that the patient's chart was marked as "urgent priority," but the examination revealed that the patient did not fit that triage designation. He said that the patient was moderate risk by any criteria.<sup>215</sup> He was disturbed by this because the referral letter was dated Friday, October 28, and the patient was booked and seen just a few days later, on Monday, November 1. Ordinarily, the wait for a moderate risk patient to have a consultation was 10 months.<sup>216</sup>

I mention this only because it illustrates in part what motivated Dr. Love to raise the issue with Ms. Kathol in the first place. I recognize that physicians may differ about the appropriate triage status of a patient. This patient's family physician may see a condition as being an urgent priority while another physician may conclude the risk merely to be moderate. It is undisputed, however, that the consultation was booked and the patient was seen for a consultation within three days of receipt of the referral letter.

Ms. Kathol testified that she spoke to Dr. Rostom when Dr. Love first raised his concerns in early 2011. She told Dr. Rostom about the rumour connecting Dr. Bridges and patients of the Helios Centre being booked in advance of the queue. However, according to Ms. Kathol, Dr. Rostom was adamant that there was no improper preferential access occurring at CCSC.<sup>217</sup>

Ms. Kathol said that her conversation with Dr. Rostom in 2012 took place on Friday, March 16. Dr. Rostom was going to look into the rumours and tell her what he had found. He did not get back to her. Instead, the following Monday (March 19), he distributed the email

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<sup>214</sup> Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2430-33; testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2453-54 and 2460.

<sup>215</sup> Testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2448.

<sup>216</sup> Testimony of Jonathan Richard Love, Transcripts, vol. 30, January 18, 2013, at 2444-48.

<sup>217</sup> Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2429-30.

cited earlier. Ms. Kathol concluded that Dr. Rostom clearly articulated the CCSC policy in the email and, whether the rumours of queue-jumping were true or not, the email should have put an end to the matter.<sup>218</sup>

Dr. Francois Belanger, senior vice-president and Calgary zone medical director for AHS, first saw the Rostom email on March 19, 2012. He then spoke with several people, including Ms. Kathol, Dr. Rostom and Dr. Mark Swain, head of the gastroenterology division at the University of Calgary, to get an understanding of the issue. Dr. Belanger testified that his impression, after these discussions, was that charts coming primarily from the Helios Wellness Centre were being flagged and ended up on a private booking list for Dr. Bridges. The concern was that these patients would be seen ahead of others. He understood from Dr. Swain that this rumoured queue-jumping had been going on for a period of time, possibly years.<sup>219</sup>

Dr. Belanger asked Dr. Rostom whether a further review of queue-jumping was needed. Dr. Rostom replied that if there were any irregularities, they had already been fixed and there were no further issues. Dr. Belanger said he was reassured by Dr. Rostom's statement and by Dr. Rostom's email, which Belanger said clearly stated the procedure and the expectations for physicians in terms of booking.<sup>220</sup>

Dr. Belanger spoke with colleagues about whether a further review of the process and of the actions of any particular physician was needed. He discussed this with his superiors at the time, Dr. David Megran and Dr. Chris Eagle. After this discussion, he felt assured that irregularities had been fixed and that there was now a clear policy for physicians.<sup>221</sup>

Dr. Belanger acknowledged that he did not speak with Dr. Bridges or look at any patient charts for evidence relating to the concerns raised by the Rostom email. Dr. Belanger said that to investigate under the AHS bylaws, he would need stronger evidence – someone coming forward, putting their name on a document and agreeing to have their identity disclosed. He said he could investigate without this evidence, and so

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<sup>218</sup> Testimony of Barbara Kathol, Transcripts, vol. 30, January 18, 2013, at 2435-37.

<sup>219</sup> Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2154, 2159-61 and 2166-67.

<sup>220</sup> Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2167-72.

<sup>221</sup> Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2172.

could AHS, but they would still need something of substance to proceed. Dr. Belanger stated that he respected Dr. Rostom's judgment and that, besides, he could not substantiate any information elsewhere.<sup>222</sup>

#### **d) Evidence of improper preferential access**

Witnesses gave a significant volume of testimony demonstrating that patients of Dr. Bridges or of the Helios Wellness Centre received much faster appointments for screening procedures at CCSC than was the norm. Documents filed with the inquiry supported this conclusion.

From the CCSC's opening in 2008 to 2012, the typical wait time in a routine referral for a pre-screening appointment was two to three years.<sup>223</sup> Today the wait time for routine cases is "greater than 18 months."<sup>224</sup> The evidence revealed that many patients referred to Dr. Bridges or those who were clients of the Helios Wellness Centre received pre-screening appointments within weeks, and often days, of CCSC receiving a referral. This occurred over a period of several years – at least until late 2011.

CCSC records filed with the inquiry show that in most cases the entries for these patients were marked "urgent priority," even when the original referral form had identified their case as routine. These entries noted explicitly that the individual involved was a "Helios patient" or a "Dr. Bridges patient."<sup>225</sup>

Several witnesses gave evidence about the procedures for booking these patients. The Helios clinic manager spoke about how referrals would be hand-delivered to CCSC in its early days (something that was easy to do because the Helios Centre is in the same university building as the CCSC). Then Helios started faxing the referrals but, because of administrative difficulties within CCSC that resulted in some referrals being lost, Helios management decided to email the referrals. The emails were sent to Ms. Pontifex, the CCSC manager, with a copy to

<sup>222</sup> Testimony of Francois Paul Belanger, Transcripts, vol. 26, January 16, 2013, at 2173-75.

<sup>223</sup> Testimony of Samantha Jane Mallyon, Transcripts, vol. 24, January 15, 2013 at 1946; testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1887; testimony of David Beninger, Transcripts, vol. 23, January 15, 2013, at 1839; testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2720.

<sup>224</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2733.

<sup>225</sup> See Exhibits 91-101.

Dr. Bridges. Sometimes they were sent to Dr. Bridges directly, with a copy to Ms. Pontifex.<sup>226</sup> It was acknowledged at the inquiry that Ms. Pontifex was a patient of one of the doctors who worked at the Helios Centre, although she did not pay the fee charged ordinarily since she did not access any of the clinic's non-insured services.

There was evidence as well that Dr. Bridges would email requests for screening colonoscopies directly to Ms. Pontifex and an administrative assistant at CCSC.<sup>227</sup> The assistant testified that she would receive these emails and, even though this was not the normal booking procedure and her job did not involve booking patients, she would book them anyway. She said she did this "out of respect" for Dr. Bridges.<sup>228</sup>

These bookings were either for Helios patients or for those patients that Dr. Bridges would attend to personally; in other words, they were on a list dedicated specifically to Dr. Bridges.

Several individuals who served as clerks at CCSC also testified about Helios patient referrals. These referrals would come to the clerks specially marked as either Helios patients or Dr. Bridges' private patients. The referrals were consistently treated as an urgent priority. They said they knew this was not the normal booking procedure, but this was the practice regarding these referrals. They also said they were directed to do this by Ms. Pontifex.<sup>229</sup>

Dr. Rostom was asked about evidence that the clerks had standing instructions from Ms. Pontifex to book Helios patients as urgent cases. He said, "There was no direction given on that. And I would also say that I work very closely with Darlene Pontifex, and I can't imagine that she has any direction that would have said that either."<sup>230</sup>

Ms. Pontifex also testified about these allegations. She stated that until the practice ended in 2010, Helios patients were given the same treatment for bookings as private patients in that they had their own

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<sup>226</sup> Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2526-28 and 2532.

<sup>227</sup> See Exhibits 131-133 and 145.

<sup>228</sup> Testimony of Olga Koch, Transcripts, vol. 35, February 25, 2013, at 2892-94.

<sup>229</sup> Testimony of Dayna Sutherland, Transcripts, vol. 23, January 15, 2013, at 1887-90; testimony of Dayna Sutherland, Transcripts, vol. 24, January 15, 2013, at 1937-38; testimony of Samantha Jane Mallyon, Transcripts, vol. 24, January 15, 2013, at 1946-50.

<sup>230</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2097-98.

booking folder and they were booked in faster than those on the regular waiting list. She said:

But it was a problem for us ... for booking patients because the information we had was so outdated on our referrals from UCMC, that that's where the private patients from the physicians came in handy because they were up to date with their phone numbers and addresses. And that's the same thing with Helios patients. They were up to date and easy to contact.<sup>231</sup>

Ms. Pontifex claimed that Helios patients were treated in this manner to help CCSC fill its endoscopy spaces. Helios patients were booked into regular slots that had not been filled. However, Ms. Pontifex could not recall any other private or public clinic receiving similar treatment. She said no one at CCSC had ever approached other clinics to get patients.<sup>232</sup> The question of whether Ms. Pontifex was influenced in filling these available slots with Helios patients because she was herself a patient at Helios (albeit not a fee-paying one) was not explored at the hearing.

But all this, Ms. Pontifex said, occurred when CCSC was still taking private referrals from endoscopists. She maintained that this practice stopped in 2010 when CCSC switched completely to its standard booking procedure. She claimed to be unaware of the email traffic between Helios and Dr. Bridges (because she did not read her emails, she explained) and was unaware that Dr. Bridges was giving referrals directly to the administrative assistant. When confronted with the evidence, Ms. Pontifex had to acknowledge that this practice of preferential treatment for certain patients had not been discontinued as she had thought. She confirmed that this was contrary to the expected CCSC booking procedure.<sup>233</sup>

When asked who decided to give priority to the Helios files, with its own folder and its own booking procedure, Ms. Pontifex said that such a directive may have been "implied" by Dr. Bridges. She said that Dr. Bridges had a management role with the CCSC as an advisor, although

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<sup>231</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2747.

<sup>232</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2747-48.

<sup>233</sup> Testimony of Darlene Pontifex, Transcripts, vol. 33, February 20, 2013, at 2740-41.

his role was informal. She said she took direction from him because he had this role.<sup>234</sup>

Dr. Bridges was asked to respond to the testimony that the referrals he forwarded to CCSC were to be booked in priority to other patients. He said he did not know CCSC was treating the files this way. He never gave any thought to the possibility that when he – founder of the clinic – handed a referral to someone of lower status, he might be creating an expectation about how the referral was to be handled. He said he “did not appreciate that” at the time. He said that when he gave information to the clinic, he highlighted the high-risk cases to ensure they received priority. He expected that average risk cases would be dealt with like the rest of the referral base.<sup>235</sup>

It should be made clear that we are talking here about a very small number of patients out of the more than 60,000 that have been screened at CCSC since its opening.

### ***Inquiry findings***

The evidence satisfies me that, for a significant period of time, some patients identified as Helios patients or Dr. Bridges’ private patients received improper preferential access to CCSC screening colonoscopies. The preference consisted in bypassing the lengthy typical waits for routine screenings by deliberately marking these referrals as urgent and booking them for the earliest moment possible. This process violated the established CCSC booking procedures.

Therefore, there was no medical or ethical justification for this preferential treatment.

I am also satisfied that this improper preferential access was facilitated in two ways: (1) by Dr. Bridges giving referrals directly to an administrative assistant or a booking clerk; and (2) by Ms. Pontifex directing booking clerks to give priority to these referrals. They did so, in my opinion, simply because of the status and respect enjoyed by Dr. Bridges.

This evidence illuminates a problem that is not unique to the health care system: people of status or superior position using their authority

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<sup>234</sup> Testimony of Darlene Pontifex, Transcripts, vol. 34, February 20, 2013, at 2756-58.

<sup>235</sup> Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3018-19.



to bypass established systems for the benefit of themselves or their clients; and people in inferior positions doing as they are asked because of that status even when aware that they themselves will not then be following established procedures. This does not require overt intimidation by the superior. All that it requires is an atmosphere where front-line workers are either insufficiently equipped to deal with such demands or do not feel they have the backing of management to stand up to these demands. In this situation, it was apparent to me that the CCSC clerks who testified did not know who to talk to about their questions or concerns regarding Dr. Bridges' booking procedures.

The best way to address these types of issues is to ensure that staff members at every level of the organization are familiar with the organization's procedures and that senior management supports them in applying those procedures.

I want to address two issues that were highlighted in some of the closing submissions. One is why the Helios Centre emailed referrals to Dr. Bridges. Commission counsel submitted that this was a way to circumvent the normal booking process and thus obtain improper preferential access to CCSC screening procedures. The other relates to a submission by Commission counsel that allegations regarding queue-jumping at CCSC were consistently dismissed without investigation.

Why were emails being sent to Dr. Bridges? The Helios lead physician, Dr. Douglas Caine, and its clinic manager, Ms. Leah Tschritter-Pawluk, explained that this was a response to the administrative problems being encountered at CCSC in handling referrals. They hoped that their concerns could be addressed more effectively by involving a physician in the referral process.<sup>236</sup> They considered this action the next step up the chain in raising their concerns.<sup>237</sup>

The system of emailing referrals began in late 2010 and continued until early 2012. Dr. Caine viewed it as a way of advocating for Helios patients in a system that was inefficient. He said, "That's where the email came up." Helios was being told by CCSC to re-fax referrals that CCSC could not locate. "At some point you have to stop re-faxing it and try and find a different way to advocate for your patients so that

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<sup>236</sup> Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2527-28; testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2604.

<sup>237</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2655-56.

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you don't leave them at risk.”<sup>238</sup> Also, he stated, “We had a problem. And the problem was that we were sending referrals that were never entered into their database.”<sup>239</sup>

As to why the emails were sent specifically to Dr. Bridges, Dr. Caine said that he had been referring patients to Dr. Bridges for gastroenterology consultations for several years. He had a comfortable relationship with Dr. Bridges.<sup>240</sup> And Helios was not alone in emailing Dr. Bridges. As Dr. Bridges testified, “Some people were always emailing with requests and attaching referral notes. It wasn't just Helios. There were physicians throughout the community.”<sup>241</sup>

Ms. Tschritter-Pawluk said that in emailing Dr. Bridges, it was “absolutely not” her hope that he would be able to get Helios patients into the CCSC faster. Her hope was to experience less mismanagement and loss of referrals that Helios sent to CCSC.<sup>242</sup> Dr. Caine was asked if he was aware “at any time of any arrangement between Helios and CCSC by which Helios patients, who were at average risk for colorectal cancers, would be scheduled for their pre-screening appointments and/or their colonoscopies in priority to other average-risk patients.” Dr. Caine said he was not aware.<sup>243</sup> Dr. Bridges confirmed in his testimony that no one at Helios asked him to obtain preferential treatment for their clients.<sup>244</sup>

I accept that there was no conscious effort by Helios staff and physicians to circumvent CCSC booking practices. Dr. Caine testified that he had no knowledge of the wait times at CCSC<sup>245</sup> and there was no reason for him to make note of how quickly his patients were being seen at CCSC.<sup>246</sup> However, I have no doubt that the emails were sent to Dr. Bridges in part because of his stature at CCSC and the expectation that he would help navigate those referrals through the CCSC system.

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<sup>238</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2607.

<sup>239</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2610.

<sup>240</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2608.

<sup>241</sup> Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3039.

<sup>242</sup> Testimony of Leah Dawn Tschritter-Pawluk, Transcripts, vol. 31, February 19, 2013, at 2533.

<sup>243</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2612.

<sup>244</sup> Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3090.

<sup>245</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2599.

<sup>246</sup> Testimony of Douglas Caine, Transcripts, vol. 32, February 19, 2013, at 2615-16.

The end result, regardless of the motives of the staff and physicians at Helios, is that the referrals sent to Dr. Bridges were booked faster for the reasons I have already outlined. This constituted improper preferential access. The current system of booking procedures at CCSC (not permitting endoscopists to book their private patients without going through CCSC central triage) came into place as early as 2010. If there were problems in the administration of referrals at CCSC, the response should have been for CCSC management to commit to solving those problems, not facilitate ways to circumvent the established triage and booking procedures.

I must also mention another item of evidence that was presented during testimony about the CCSC.

Dr. Mark Swain, the Calgary zone gastroenterology clinical section chief for AHS, testified that the evidence presented to the inquiry about the concerns at CCSC prompted him and Ms. Barbara Kathol to conduct a review of clinic and endoscopy booking practices for all physicians in the gastroenterology division who see patients through the UCMC clinics.<sup>247</sup> The results of that review were entered as exhibits at the inquiry.<sup>248</sup>

Dr. Swain's evidence was that referrals sent to the UCMC are triaged by a triage nurse or a physician based on medical acuity or need and placed with a physician who can see the patient the soonest for that particular triage status. This would occur whether or not the referral was addressed to a particular physician.<sup>249</sup> The review revealed that Dr. Bridges' patients were being booked outside the UCMC central access and triage system, some without the usual referral documents, earlier than other patients. Some of these patients (16 per cent) were clients of the Helios Wellness Centre.<sup>250</sup>

Dr. Bridges testified that, to his knowledge, there was no AHS policy requiring all referrals to UCMC to go through the central access and triage system.<sup>251</sup> He also explained that many of the patient

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<sup>247</sup> Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2903-05.

<sup>248</sup> Exhibits 140 and 141.

<sup>249</sup> Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2951.

<sup>250</sup> Testimony of Mark Swain, Transcripts, vol. 35, February 25, 2013, at 2960-67; Testimony of Mark Swain, Transcripts, vol. 36, February 25, 2013, at 2972-83; Exhibit 141.

<sup>251</sup> Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3060.

consultations noted in the review were arranged by nurse clinicians and he did not have any direct input into them. Others were procedures for colleagues or involved following up on patients he had seen before. He stated that he never gave his nurse clinicians direction to give preference to Helios patients at UCMC.<sup>252</sup>

It is not for me to draw any firm conclusions about this evidence. The findings of Dr. Swain's and Ms. Kathol's review are, I was told, under further review by AHS. But they do reveal a pattern. Whether deliberately or inadvertently, Dr. Bridges has demonstrated a pattern of circumventing established procedures for triaging and booking procedures for patients at these facilities. This is inappropriate and creates the means to gain improper preferential access.

As noted earlier, Commission counsel submitted that allegations of queue-jumping at CCSC, which she said were raised as early as 2010, were consistently dismissed without investigation. Several items of evidence show that concerns were raised before Dr. Rostom's email of March, 2012.

Dr. Valerie Boswell, a general practitioner who started on contract with CCSC in 2009 to do the pre-screening that preceded the actual colonoscopies, testified that in early 2010 she was seeing a number of Helios patients quite quickly even though they were marked as routine referrals. She raised her concerns at two CCSC administrative meetings, one on March 22, 2010, and another in November 2011. She recalled that Dr. Rostom and Ms. Pontifex were at both meetings. Both times she did not think her concerns were addressed.<sup>253</sup>

As I described earlier, Ms. Kathol testified that she had a conversation in January or February 2011 with Dr. Rostom in which she raised concerns about Dr. Bridges' patients being fast-tracked at CCSC. Dr. Rostom, it must be noted, recalled no such conversation.<sup>254</sup> He said that Ms. Kathol first raised the issue with him on March 16, 2012, which led to his email of March 19. Dr. Rostom may not recall that earlier conversation, but the evidence clearly suggests to me that it took place. The actions of Dr. Love and Ms. Kathol, as described in their evidence, are consistent with this conclusion.

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<sup>252</sup> Testimony of Ronald Bridges, Transcripts, vol. 36, February 25, 2013, at 3073.

<sup>253</sup> Testimony of Valerie Boswell, Transcripts, vol. 30, January 18, 2013, at 2475-77 and 2484-85.

<sup>254</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2116.

Dr. Rostom testified that after Ms. Kathol raised her concerns with him in March 2012, he did not try to determine if the allegations of preferential access were true. He said he lacked the resources for an extensive investigation and did not investigate on his own. He had received no formal letter of complaint or formal statement on the matter. No matter who was involved, the most appropriate response, he believed, was to send out an email to ensure such conduct would no longer happen.<sup>255</sup>

Dr. Rostom said that he was not sure whether the rumours related only to Dr. Bridges, but that Dr. Bridges was the only individual Ms. Kathol named in their conversation. He did not deny to Ms. Kathol that this conduct was occurring because he felt he had to trust what she was saying. He did not care whether the rumours were true or not because, true or false, he wanted to make the point, through the email, that such conduct was not acceptable.<sup>256</sup>

I cannot accept that Dr. Rostom was unaware prior to 2012 of the allegations that Dr. Bridges' patients and Helios patients were being fast-tracked at CCSC. He may have disregarded those allegations since they were presented only as rumours. Perhaps he may not have wanted to check into them out of deference to Dr. Bridges as his colleague and predecessor. It makes no difference. The point is that there was no investigation undertaken by Dr. Rostom, not after speaking to Ms. Kathol and not before he issued his email of March 19. Indeed, the only investigation to date into these allegations has been the one done by this inquiry.

I accept that Dr. Belanger and his superiors in AHS did not know of these allegations until Dr. Rostom's email. This is likely due to the lack of avenues available for staff to raise concerns to higher levels of authority. There was ample evidence of front-line staff and physicians discussing concerns about queue-jumping among themselves, yet not having any clear idea what the appropriate response would be.

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<sup>255</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2124-25.

<sup>256</sup> Testimony of Alaa Rostom, Transcripts, vol. 26, January 16, 2013, at 2121-23.

**Recommendation 11:****Strengthen access, triage and booking procedures**

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation.

**9. *Executive medical clinics***

The evidence relating to the Helios Wellness Centre raised several issues that are beyond my mandate to examine in detail.

The *Canada Health Act* prohibits both extra-billing by physicians and user charges for any medical and related service that is defined as an insured service within the province's health care insurance plan. However, Albertans can legally pay for certain health services in several situations. The private diagnostic imaging services discussed early in this report is one example. Another example is the private executive medical clinic, or wellness clinic, which, like Helios, offers a range of health-related consultations and non-insured services for a fee. They also offer access to a physician, but those services are charged to the provincial health insurance plan.

The controversy surrounding these types of clinics is whether the membership fee actually constitutes paying for access to a physician. The policy of the College of Physicians & Surgeons of Alberta says that there can be no economic barrier to access to insured medical services. Standards of Practice also speak to accepting patients and

non-discrimination.<sup>257</sup> According to the College's registrar, Dr. Trevor Theman, the direction given to their members who are in such clinics is that access to the physician for primary care medicine must be separate from the basket of uninsured services provided for the fee.<sup>258</sup> In other words, a client should be able to access the physician without having to pay the fee or take up the uninsured services on offer.

In March 2013, Dr. Theman gave an interesting viewpoint on this issue in a College publication:

In April 2006 – almost 7 years ago – I wrote an article in the Messenger about boutique medical clinics. At the time the issue was the advertising of expedited access for a fee. More recently the issue has simply been one of access, the suggestion that patients who seek access to a family physician at one of these clinics must agree to buy the basket of uninsured services available at many of these clinics.

Typically, this suggestion comes to us as an advertising issue and, as we did in years past, we work with the physicians and the clinics to ensure their advertising is clear that access to a family physician cannot be tied to buying the uninsured services. Otherwise, access would be based on the ability to pay, on socioeconomic status, and that is contrary to ethical principles and to our Standard of Practice on establishing a doctor/patient relationship.

While I am reassured, to a degree, that the clinics with whom we've worked are not barring access based on ability to pay, in part because a significant fraction of the patient population (30% for example) buys none of the uninsured services, I am not completely reassured. Logically, the business could not run if 100% of the family medicine patients opted out of the uninsured services. Is it reasonable to think that the business model and basket of services is so appealing that a majority of enrolled patients want the uninsured services? Or is it more likely that there is a quota in place, a minimum number of patients who must buy the package of services as, otherwise, the cost of providing them would exceed the revenue? I don't

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<sup>257</sup> Exhibit 122.

<sup>258</sup> Testimony of Trevor Theman, Transcripts, vol. 29, January 18, 2013, at 2343.

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know the answer, but think we will need to know as we sort our way through this issue.<sup>259</sup>

The inquiry's expert witnesses were asked whether membership-based private health care facilities constitute an example of preferential access and, if so, whether that access is proper or improper. Some of the experts cited such clinics as a means of gaining preferential access, but said that the access was proper. Dr. Goldman wrote that such clinics are proper if limited to non-insured services. However, if membership in the clinic allowed members to contact the physician outside of office hours, and the physician was billing the patient and the province, that would "blur the boundaries between public and private services." It would be highly likely that at some point the patient would be receiving improper preferential access.<sup>260</sup> Dr. Heisler suggested that the practice was consistent with current norms: "Private health care facilities have indicated that the membership fees they charge [are] for 'non-insured' services and not for access to insured services such as physician fees. The membership fee is therefore an example of preferential access to these non-insured services. It is no worse than what currently exists."<sup>261</sup> Dr. Reid wrote that there is nothing to prevent health care professionals from providing services such as physiotherapy, massage therapy, nutritional counselling or chiropractic care. However, Dr. Reid wrote, "Regulatory colleges have typically, and appropriately in my view, clarified that where a funding for a service falls under the *Canada Health Act*, offering access or expedited access to this service based on the payment of a fee is a form of improper preferential access ... a form of extra billing."<sup>262</sup> She continued that the *Canada Health Act* "envisions eliminating financial barriers to access to care by prohibiting physicians from adding extra fees to what they bill the provincial insurer. It does not envision or adequately control for making access conditional on bundling of insured and non-insured services."<sup>263</sup>

Except for Helios, the inquiry heard no evidence about private executive or wellness clinics. There was no evidence about their operations or clientele that would enable me to make any reasonable evaluation for purposes of this inquiry. Certainly these clinics merit

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<sup>259</sup> Trevor Theman, "Alberta's Health Services Preferential Access Inquiry," College of Physicians & Surgeons of Alberta, 186 *The Messenger* (March 2013).

<sup>260</sup> Exhibit 149, Expert Reports, report of Dr. Brian Goldman (February 7, 2013) at 18-19.

<sup>261</sup> Exhibit 149, Expert Reports, report of Dr. Owen Heisler (January 2013) at 19.

<sup>262</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 31.

<sup>263</sup> Exhibit 149, Expert Reports, report of Dr. Lynette Reid (February 15, 2013) at 22.



further analysis. I can think of some obvious issues. Can there be a viable business model for these clinics, as Dr. Theman asks in his article, if patients are able to refuse the fee-based services? If physicians in these clinics limit their number of patients, what strain does this put on the health care system as a whole? Does it limit the supply of primary care physicians for the public at large? Finally, is the College's policy truly enforceable? This inquiry does not have the mandate or evidence before it to address these issues. These are issues best examined by the medical professional associations and the regulators, with public involvement, since it is the public which has the greatest interest in our health care system.



## **SECTION IV: COMPARISON OF POLICIES ON PREFERENTIAL ACCESS: ALBERTA HEALTH SERVICES, COVENANT HEALTH AND DUCKETT**

Earlier, I described the origins of the policy statement entitled Requests for Preferential or Expedited Care prepared at Dr. Stephen Duckett's direction and distributed to senior Alberta Health Services (AHS) personnel on June 11, 2009.<sup>1</sup> I also described how Covenant Health came to adopt a policy of its own, entitled "Accommodating Special Requests."<sup>2</sup> During the inquiry, I also heard evidence from Dr. David Megran that AHS has under consideration a draft policy on improper preferential access.<sup>3</sup>

This section analyzes these three policy documents. An item-by-item comparison is difficult since the policies have different origins, are structured differently and also vary in the level of detail they contain. Even so, it is possible to compare their major tenets. I also offer some commentary on certain aspects of them.

### **1. *Origins of the policies***

As I explained in the discussion of courtesy or heads-up calls in the previous section, the Covenant Health policy stemmed from actual events. Dr. Gordon Self, now Vice-President of Covenant Health, was intimately involved in drafting the 2007 policy of Caritas that became the Covenant Health policy. He explained that the Caritas policy flowed from the need to respond to a number of instances in which Caritas received a heads-up call from Capital Health. The heads-up would be that "somebody ... like a board member or some other individual of a VIP status, [or] some person of significance in the community would have been in our building, for whatever reason, and they were letting us know and just wanting us to be aware of that."<sup>4</sup> These calls would come from Capital Health's executive on call and be directed to the equivalent person at Caritas.

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<sup>1</sup> Exhibit 16.

<sup>2</sup> Exhibit 48.

<sup>3</sup> Exhibit 18; Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 223-24.

<sup>4</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 705.

Dr. Self said that these calls did not go beyond a heads-up. However, he was concerned that there might be consequences for Caritas if it did not “go to great lengths so that this person [identified by Capital Health] had some additional care,” although he did not know of any instance where this concern led to “special things” being done for such patients.<sup>5</sup> He and others did not know what to do with the information, particularly because it came from Capital Health, which funded Caritas, and Capital Health had power over Caritas as a result. This uncertainty led to the development of the Caritas policy, which later became, in virtually identical form, the 2010 Covenant Health policy.

In contrast to the Caritas/Covenant Health policy, the Duckett policy appears to be based almost completely on speculation, exaggeration, or both, about the occurrence of preferential access. The draft AHS policy is based in part on the Duckett memo and so has the same evidentiary weakness as its foundation. However, unlike the Duckett memo, the draft AHS policy makes no claim about the supposed extent of preferential access.<sup>6</sup> The Covenant policy also makes no claims about the frequency of requests for special accommodation.

## ***2. Scope and purpose of the policies***

Both the AHS draft policy and the Duckett memo focus on preferential access or expedited care. The Covenant Health policy appears to cover a broader range of activities, speaking of “responding to special requests.” It is clear from the testimony of Dr. Self that the perceived pressure to provide some form of “additional care” was the concern that led to the drafting of the policy. That “additional care” conceivably might be something other than preferential access or expedited care.

The Covenant Health policy also presents a much more extensive philosophical and ethical explanation of its positions than do the other two policies. The Covenant Health policy speaks of the Health Ethics Guide discussion of rationing resources and also delves into the ethical precept of *nonmaleficence* (do no harm). The document describes the

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<sup>5</sup> Testimony of Gordon Self, Transcripts, vol. 11, December 13, 2012, at 737-38.

<sup>6</sup> Dr. Megran recollected that, after this inquiry was announced, Dr. Eagle, the current CEO of Alberta Health Services, “suggested that we were likely overdue in terms of taking the position paper I had written for Dr. Duckett and taking it to the step of having a formal policy.” The paper Dr. Megran prepared was provided to the corporate policy section of AHS: Testimony of David Megran, Transcripts, vol. 3, December 4, 2012, at 224.

aim of the policy as being to clarify what is expected when Covenant Health is asked to accommodate special requests, and to provide an ethical framework to determine the moral legitimacy of each request. It also describes how the Health Ethics Guide affirms the equal value and dignity of all persons and the need to provide persons with the services they need, while ensuring that the common good is achieved.

The AHS draft policy states as its purpose “to establish direction for the management of requests for *improper preferential access* to publicly funded health services.” This begs the question of why anyone would request something improper. The request presumably would be for preferential access of some type, with the hope that it would not be considered improper. It also begs the question of how one can manage requests for something improper other than by saying no. Since the draft policy requires that the CEO be notified of all requests for improper preferential access, is it contemplated that the CEO could decide that something improper would be allowed? Or, is the aim of the policy to send all requests for preferential access to the CEO so that he or she can decide whether it is proper or improper?

The Duckett policy document simply speaks of requests for preferential or expedited care generally. The inference is clear that all requests for preferential or expedited care are improper (since the document states that preferential or expedited care is not endorsed or encouraged by AHS and represents a practice that cannot be defended or supported). It is a much more direct statement of policy.

### **3. Definitions**

The Covenant Health policy contains no definition of improper preferential access. It casts the issue more broadly in terms of “accommodating special requests.” The Duckett and AHS policies set out definitions, but differ significantly in those definitions.

The Duckett policy defines preferential or expedited care as care that is rendered more quickly than medically indicated or more quickly than the current norm of the organization (meaning AHS), or care of a higher quality than the current norm. It therefore encompasses more than just the timeliness of access within its policy.

The Duckett policy does not use the term “improper preferential access” although, as noted, its description of preferential or expedited

## Comparison of Policies on Preferential Access

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care can only mean improper care. All requests for such care are to be addressed to the CEO of AHS. The policy does not appear to explain how to deal with requests for *proper* preferential or expedited care.

The Duckett policy appears to suffer the same flaw as the draft AHS policy. Both, in their wording, seem to envision sending requests for improper preferential access to senior officials. If the request is for improper access, it should be rejected out of hand. Both policies could benefit from clearer wording.

The draft AHS policy sets out a definition of improper preferential access as follows:

Improper preferential access to publicly funded health services means using threat, influence or reward to get faster access to publicly funded health services or access to better publicly funded health services where the:

- publicly funded health service is a finite resource; and
- access is at the expense of other patients.

Clearly, this definition draws on the preamble to this inquiry's terms of reference by the use of the phrase "threat, influence or reward." And it suffers from the same limitation. As I discussed earlier, there are many ways of viewing improper preferential access. Not all of them constitute what I referred to as "corrupt" acts, such as the use of threats, influence or reward. There are also cases where preferential access is proper, or at least ethically or socially justifiable, even if not necessarily justifiable on medical grounds. For that reason, I chose to define improper preferential access in a more general manner as any policy, decision or action that cannot be medically or ethically justified, resulting in someone obtaining access in priority to others who are similarly situated.

The other difficulty with the AHS definition is that it limits itself by using qualifiers: *where* the publicly funded health service is a finite resource and *where* the access is at the expense of other patients. The first qualifier is almost meaningless since no publicly funded health service can be an infinite resource. The second raises the difficulty I spoke about as well in my discussion of a definition – the near

impossibility of proving that improper preferential access causes actual harm to others. As I explained there, even if there is no provable harm to a patient, there is harm to the system of publicly funded health care. The inability to demonstrate that someone's faster access or better care is at the expense of other patients should be no excuse for giving such preferential treatment, unless there is a medical or ethical justification.

The potential delays or other adverse effects on the care of patients should always be a factor when making health care decisions. It should not be a qualifier in the definition, as AHS has done. As I said before, if access is improper, harm can be assumed.

#### **4. *Health care workers***

Both the Covenant Health policy and the draft AHS policy accept priority treatment for health care workers, generally where there is some public benefit. The Covenant Health policy speaks of the appropriateness of providing priority treatment where a person has the special skills and ability to serve the common good during a mass casualty event. It gives as an example an infectious disease specialist. Along lines similar to the Covenant Health policy, the draft AHS policy accepts that during a public emergency or disaster, timely access to health services may be appropriate and required for first responders and essential public workers. The Duckett memo is silent about preferential treatment for health care workers.

#### **5. *Special treatment of board members and other VIPs***

The Duckett memo is directed at excluding preferential access for prominent individuals. In contrast, the Covenant Health policy seems to contemplate special treatment of some individuals "who may significantly contribute to the overall well-being and viability of the organization." It says that the principle of the common good "strives to find that balance where care for the good of the individual and care for the well-being of the organization are both considered." At least on the surface, this suggests that Covenant Health might consider accommodation based on the elevated status of the requester. At the same time, the policy speaks of the equal value and dignity of all persons. In its ethical analysis, it speaks of the Church considering the poor to be the ultimate special needs population deserving attention. Absent further explanation, the Covenant Health policy is confusing.

The draft AHS policy makes no mention of the special treatment of board members or other VIPs, although it does have a section on treatment of visiting dignitaries. It simply states that the provision of emergency care or service for a visiting dignitary (meaning a senior political or state official) is to be based on medical indications with “appropriate protocols” (whatever that means) to be followed.

### **6. *Who decides in preferential access cases***

The Covenant Health policy refers to the principle of subsidiarity, which acknowledges that decision-making should occur as close to the grass roots as possible. Only if there is disagreement about accommodating a special request should the request rise to a higher level, such as the executive on call. On the other hand, both the Duckett memo and the draft AHS policy move the initial decision-making responsibility higher up the organizational chain. The AHS policy says that the office of the AHS President and CEO must be notified of requests for preferential access. The Duckett memo similarly states that requests for preferential access or expedited care must be directed to the President and CEO.

### **7. *Discretion***

The Covenant Health policy does not constitute a blanket rejection of special requests. As noted above, the policy does not seek to dictate responses, but rather tries to provide an ethical/religious/moral framework to determine the legitimacy of requests. The goal is to allow those working closest to the issue to make decisions about accommodating special requests. This gives considerable discretion to different individuals, creating the potential for inconsistency in the application of the policy within the organization.

As noted, the procedures envisaged by the Duckett memo and AHS policy move decision-making responsibility higher up the organizational chain. This would promote greater consistency in the application of the policy than if different people lower down the chain made the decisions.

### **8. *Acceptable activities***

Both the Duckett policy and the AHS draft policy expressly approve of those in the health care system providing advice on how to navigate the system. The AHS policy goes on to say that such advice to any



individual who requests or requires such information is not only acceptable, but is endorsed and expected.

In my opinion, such advice is to be encouraged. No one has ever suggested that it would be improper.

**Recommendation 12:**

**Develop a policy on preferential access**

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with AHS staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all.



## SECTION V: CONCLUSIONS AND RECOMMENDATIONS

I started this report by saying that the Canadian health care system is premised in part on the ideal of equitable access to necessary physician and hospital services – the principle that access should be determined by medical need. This principle is really a subset of a much larger conception of health care as a vehicle of distributive justice – the idea that health care should be distributed in an egalitarian manner so that no one is denied the care he or she needs simply because of non-medical criteria, such as an inability to pay.

Improper preferential access to publicly funded health services undermines those principles. However, as I discussed in this report, certain types of preferential access may be proper – that is, ethically or socially justifiable – despite the equitable access principle. One example may be front-line health workers receiving vaccinations ahead of the general public during an influenza outbreak so they remain healthy enough to vaccinate others. But society has yet to determine most of the situations where it will accept preferential access as being proper. The broadly based public discourse needed for such determinations has not yet occurred.

This inquiry has investigated incidents that revealed improper preferential access – the vaccination of professional hockey players during the H1N1 pandemic in 2009, some nurses vaccinating friends and family during that same period, and patients being fast-tracked for screening colonoscopies. These incidents are not representative of the health care system as a whole. However, they show certain parts of the system and the opportunities that may exist within it for improper preferential access.

The inquiry has also examined various practices that may open up avenues for improper preferential access – such as professional courtesy and what has been called the private patient path. These are practices that could benefit from a more considered analysis, and policies about them need clarification.

The recommendations in this report address the systemic issues arising from the incidents and practices examined by this inquiry. Some recommendations may be regarded as going beyond the strict

## Conclusions and Recommendations

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parameters of this inquiry's mandate. However, one cannot examine improper preferential access without looking at some of the systemic circumstances that lead to it – primarily lengthy wait times for consultations and procedures – and the possible measures available to address those circumstances.

This inquiry has clearly demonstrated that myriad opportunities exist for improper preferential access in the health care system because of the multiple ways to access that system and the wide discretion granted to physicians, other health care professionals and administrators. Lengthy wait times throughout the system also foster the motivation to jump the queue. That is human nature. And, as was repeatedly said during this inquiry, there would be no need to examine queue-jumping if there were no queues.

One must ask whether it is realistic to think that measures can be put in place to eliminate improper preferential access altogether. Are there simply too many holes to plug? And a further question must be asked – at what cost? Even if a system could be designed to guarantee that there would be no improper preferential access, there would certainly be an impact on how physicians, hospitals and clinics operate and organize their workloads. There is merit in maintaining the flexibility needed to meet the differing needs of patients. That is why most of the recommendations of this inquiry promote collaboration among various groups interested in health care to improve policies and guidelines, not mandatory rules and procedures.

The mere fact that this inquiry has been held may very well have caused people working in health care to consider the issue of improper preferential access more carefully and, if necessary, to modify their behaviour.

The literature review conducted for this inquiry found a lack of empirical evidence regarding the impact of improper preferential access on the health care system as a whole. The inquiry found no evidence that a patient had suffered adverse health consequences as a result of any of the incidents and practices of improper preferential access examined. What improper preferential access exists in the system – apart from areas such as workers' compensation cases, where legislation creates a system of preferential access – involves an extremely small percentage of the total cases in the public health care system. If very few persons benefit from improper preferential access,

and there is no evidence of others being harmed by it, there may be no significant threat in practice to the egalitarian aims of our health care system.

However, the perception remains that some receive faster access to health care because of status or connections, not medical need. This is just as damaging to confidence in the public health care system as the actual cases of queue-jumping identified in this report. Those who deliver health care must be prepared to challenge the perception as well as address the reality.

The expert witnesses who testified at this inquiry cited education as a means to reduce improper preferential access and increase public knowledge about the workings of the health care system. Education can help medical professionals understand the potential harm that can be caused by improper preferential access and the systemic harm that results from public perceptions of the extent and unfairness of improper preferential access. It can help distinguish between ethical physician advocacy and advocacy that crosses the line into pressure for some improper preference. Educating the public can help alleviate misunderstandings about how the health care system functions and also spur greater public involvement in discussions about all aspects of the health care system. The sustainability of Alberta's public health care system depends in large measure on involving the public in addressing the challenges facing the system and developing solutions for those challenges.

Improper preferential access is a minor component of the public health care system. However, because of the public perception about the extent of improper access, this issue corrodes public trust in the system. I hope that, with this report and these recommendations, the work of this inquiry will lead to measures that will reinforce that trust.

## RECOMMENDATIONS

### Recommendation 1

#### **Strengthen the queue-jumping provisions of the *Health Care Protection Act***

The Government of Alberta should amend section 3 of the *Health Care Protection Act* to:

- broaden the scope of the prohibited forms of inducement;
- have it apply to all types of insured health services; and
- include a mandatory reporting requirement with provisions for the protection of people who make a report in good faith. (Section II, Chapter 2, Part C)

### Recommendation 2

#### **Expand whistleblower protection**

The Government of Alberta should amend the *Public Interest Disclosure (Whistleblower Protection) Act* to include health care professionals, such as physicians, who are not employees but who are contracted by Alberta Health Services and/or the government to provide health care services. (Section II, Chapter 2, Part F)

### Recommendation 3

#### **Clarify the scope and application of professional courtesies**

The College of Physicians & Surgeons of Alberta, working with the Alberta Medical Association, the College & Association of Registered Nurses of Alberta and other representative bodies, as well as public representatives, should closely examine the practice and ethical implications of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals. (Section II, Chapter 2, Part G)

## **Recommendation 4**

### **Reduce wait times**

Alberta Health Services should continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system. (Section II, Chapter 3, Part B)

## **Recommendation 5**

### **Develop and implement wait list management strategies**

Alberta Health Services, in consultation with appropriate sectors of the health care system and the public, should develop and implement consistent and comprehensive wait list management strategies which include:

- standardized concepts and terms;
- standardized prioritization criteria, both within a given specialty and among different specialties, to better organize the allocation of shared resources (such as operating room time);
- centralized referral and booking systems;
- a system of audit and evaluation; and
- publicly accessible information on wait times, referrals and bookings, and service availability by provider (physician, clinic or hospital). (Section II, Chapter 3, Part C)

## **Recommendation 6**

### **Develop standardized referral procedures and booking systems**

Alberta Health Services should continue to develop standardized referral procedures and centralized triage and booking systems to improve access and reduce referral wait times. Any such systems should be audited and evaluated, and education programs should be

given to service providers about how to use new systems. (Section II, Chapter 3, Part D)

### **Recommendation 7**

#### **Consider creating the position of Health Advocate**

The Government of Alberta, in consultation with Alberta Health Services and the College of Physicians & Surgeons of Alberta, should consider establishing an independent office of Health Advocate. The role of the Health Advocate would be to provide advice and advocacy assistance to patients and to help resolve patient complaints. (Section II, Chapter 4, Part C)

### **Recommendation 8**

#### **Develop a policy on courtesy calls**

Alberta Health Services, in consultation with other sectors of the public health care system, should develop a policy on information or courtesy calls that clearly defines the circumstances under which such calls should be made, to whom they can be made, and how those receiving such calls should respond to them. (Section III, Chapter 2)

### **Recommendation 9**

#### **Develop a policy on special accommodation during a pandemic**

As part of any pandemic preparedness plan, Alberta Health Services should develop a policy on how to address requests for special accommodation. (Section III, Chapter 4)

### **Recommendation 10**

#### **Develop policies for the private patient path**

Alberta Health Services, in consultation with appropriate stakeholders, should analyze the ethical and practical implications of the private



patient path and develop appropriate policies for emergency department personnel and physicians. (Section III, Chapter 6)

## **Recommendation 11**

### **Strengthen access, triage and booking procedures**

Alberta Health Services should put measures in place to ensure that:

- access, triage and booking procedures at each Alberta Health Services facility are clearly designated as procedures that must be followed by all medical professionals and staff members;
- staff members are trained about access, triage and booking procedures;
- senior management at each facility is trained on procedures to receive and handle staff concerns regarding non-compliance with procedures by anyone; and
- staff members are aware of the protections available under applicable whistleblower legislation and the procedures for using the legislation. (Section III, Chapter 8)

## **Recommendation 12**

### **Develop a policy on preferential access**

Alberta Health Services should complete its draft policy on preferential access, after taking into consideration this inquiry's findings and recommendations and after consultation with Alberta Health Services staff, health care professionals and the public.

The policy should clearly describe which forms of preferential access are improper and should not be allowed, and how to respond to requests or attempts to obtain preferential access that is proper. The policy should be disseminated to the public and health care professionals to make the AHS position clear to all. (Section IV)



## APPENDIX 1: ADMINISTRATIVE LESSONS LEARNED FOR FUTURE INQUIRIES

I want to comment on certain aspects of the establishment and organization of the inquiry. My aim is to explain some of the logistical and organizational difficulties this inquiry encountered and to suggest how to avoid such difficulties in future inquiries. This is the first inquiry held pursuant to section 17 of the *Health Quality Council of Alberta Act*. I hope that my comments will be useful to the government when it establishes future inquiries under this or other legislation.

### *A. Establishment of the inquiry*

I noted in the body of the report that, unlike most inquiries, this inquiry was not established to investigate a specific event. The allegations that prompted the inquiry were widely reported in the media, but no investigation into those allegations preceded the inquiry. If the government's aim was to examine just those allegations, there were alternatives available to it, including departmental investigations, internal inquiries within Alberta Health Services (AHS) or a ministerial task force. Also, if the government wanted to limit the inquiry's mandate to examining just those allegations, it could have said so in the inquiry's terms of reference. But the terms of reference were worded in much more general terms as I discussed earlier.

I say this because a public inquiry is a significant undertaking. It is time-consuming and costly. The decision to establish a public inquiry should be taken with these factors in mind. And it makes no difference whether it is a public inquiry under the *Health Quality Council of Alberta Act* or the *Public Inquiries Act*. Both acts stipulate that it must be in the public interest for an inquiry to be called. A noted Canadian expert, Prof. Ed Ratushny, describes commissions of inquiry as "residual institutions" because they are invoked as the remaining alternative when other institutions or processes are inadequate.<sup>1</sup>

The traditional Canadian view is that a public inquiry is an exceptional measure and that only matters of very significant public importance should be entrusted to such a body.<sup>2</sup> This is because a public inquiry –

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<sup>1</sup> Ed Ratushny, *The Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 20.

<sup>2</sup> Simon Ruel, *The Law of Public Inquiries in Canada* (Toronto: Carswell, 2010) at 6.

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## Administrative Lessons Learned for Future Inquiries

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even with its positive attributes of independence and transparency – is highly coercive. It can compel the attendance of witnesses and the production of documents. For this reason, the focus of the inquiry should be something of sufficient public concern to warrant use of these coercive powers.

I have already commented in the report on the difficulties caused by the lack of any prior investigation into the allegations made by Drs. Stephen Duckett and Raj Sherman. The long list of recent commissions of inquiry in Canada shows that in practically every case the inquiry was triggered by some event that raised a matter of vital public concern. Usually the event had already been investigated by some government agency. Take, for example, the 2008 Commission of Inquiry into Certain Allegations Respecting Business and Financial Dealings between Karlheinz Schreiber and the Right Honourable Brian Mulroney. That inquiry, too, had as its origin certain allegations. But before the decision was made to order the inquiry, a solid body of evidence existed, including depositions from a civil suit, reports from police investigations and parliamentary committee hearings and an independent review of the allegations.

My point is simply that a great deal of thought needs to be put into the decision to proceed with a public inquiry. Any decision should be informed by some preliminary investigation. A cursory investigation of the Duckett and Sherman allegations would have quickly revealed them to be groundless.

### ***B. Consultation***

The order in council establishing this inquiry was issued on February 28, 2012. I was appointed as the “panel” to conduct the inquiry on March 16, 2012. There was no opportunity for me to discuss the inquiry’s terms of reference before the order in council was issued.

It is now accepted practice for the intended commissioner of an inquiry to review the terms of reference with government prior to the terms being formalized in the order in council.<sup>3</sup> In its protocol concerning the appointment of federally appointed judges to head commissions of inquiry, the Canadian Judicial Council urges a review of the terms of reference before the judge is appointed and the terms are set. As the

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<sup>3</sup> Ed Ratushny, *The Conduct of Public Inquiries: Law, Policy and Practice* (Toronto: Irwin Law, 2009) at 150-154.

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protocol states, “Even in the face of perceived urgency, taking the time to structure the inquiry properly is important for the government, the judiciary and the public interest.”<sup>4</sup>

Prior consultation is important primarily because the commissioner’s principal task is to ensure that it is possible to carry out the work described in the terms of reference. Consultation provides an opportunity to correct any ambiguity in the terms of reference; ensure that any time limit on the inquiry’s work is realistic and sufficient for the inquiry to carry out its work; and outline administrative and funding arrangements satisfactory to both government and commissioner.

This inquiry faced a major delay because administrative and financial arrangements had not been elaborated and agreed upon until well after my appointment. This delay was compounded by the provincial election. Some of the initial proposals for the financial arrangements for the inquiry involved procedures I thought could be problematic for the inquiry’s independence. I do not think these procedures were intended to do that. They merely reflected the insufficient planning that preceded the order in council. That also meant that it took several months for the inquiry to receive funds to finance its operations. This delayed its work and eventually was one of the causes that necessitated a request to extend the reporting deadline.

I received a great deal of assistance from the Health Quality Council of Alberta and its CEO, Dr. John Cowell, in the early weeks after my appointment, as did my executive director once she was retained in mid-April 2012. But the inquiry’s funding was not advanced until September. Because of this, the inquiry could not get fully up to speed for several months after it was officially established. In the future, advance planning and consultation could help avoid these delays.

### ***C. The tripartite arrangement***

The main administrative condition imposed by the government was that the Health Quality Council of Alberta administer the inquiry’s funding. This resulted in what I call a tripartite arrangement between the inquiry, the Council and the government.

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<sup>4</sup> Canadian Judicial Council, *Protocol on the Appointment of Judges to Commissions of Inquiry* (August 2010) at 5.

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## Administrative Lessons Learned for Future Inquiries

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The inquiry's terms of reference, as I noted elsewhere, required me to prepare a budget and submit it to the government for approval. That was done on June 11, 2012. Cabinet approved it on July 25, 2012. A lengthy process followed, leading to two agreements. The first, executed in late August, was between the province and the Council. It provided for advancing the amount of the inquiry's budget to the Council and the disbursement of those funds to the inquiry after it submitted invoices. The second agreement, between the Council and me as "the panel," was not completed until September 17, 2012. Only then were funds released to the Council and made available for the inquiry's work.

These agreements led to a considerable duplication of effort in monitoring the inquiry's finances. The agreement between the Council and "the panel" required the inquiry to establish an internal system of financial controls. The inquiry was also required to submit quarterly financial reports to the Council. The agreement between the Council and the province required the Council to also establish an internal control system for the disbursement of funds. The Council was also required to provide quarterly financial reports to the province in addition to transmitting to the province the reports provided by the inquiry. As I said, this resulted in a duplication of effort. It also unnecessarily increased the call on the inquiry budget, since the inquiry had to pay for the administrative services provided by the Council.

These arrangements were imposed on the inquiry without meaningful prior consultation. The government is ultimately responsible for the expenditure of public funds and can and should demand strict financial accountability. But arrangements such as these simply increased the burden on the inquiry executive director and her staff without any increase in already strong measures of financial accountability.<sup>5</sup>

I understand that the Privy Council Office has developed policies and procedures to guide federally appointed commissions of inquiry on organizational matters including contracts, procurement of goods and services and employment of staff, and to assist on interactions with the federal government.<sup>6</sup> It would be extremely helpful if the Alberta

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<sup>5</sup> The inquiry's books and records were also available for audit and examination at any time by the Auditor General of Alberta.

<sup>6</sup> Commission of Inquiry into the Decline of Sockeye Salmon in the Fraser River, *The Uncertain Future of Fraser River Sockeye, Final Report*, vol. 3 (Ottawa: Public Works and Government Services Canada, 2012) at 116.

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government were to establish general procedures and guidelines for public inquiries. That way, each new inquiry would not need to start from scratch.

#### ***D. Senior contact person for public inquiries***

It would also be helpful to have a senior official in the cabinet office designated as the contact person for any provincial inquiry. That official might even be as senior as the Secretary to Cabinet. Someone must have sufficient authority to make prompt decisions on inquiries' administrative and financial matters and to respond to emerging issues before they become a needless distraction for the inquiry. When an inquiry faces a deadline, issues (such as the finalization of financing agreements) must be addressed quickly. By that, I mean less time than the almost two months to finalize the agreements for this inquiry. Furthermore, since cabinet must approve any change to the inquiry's terms of reference and implement the change through an order in council, it only makes sense to have a senior cabinet official who is fully familiar with the inquiry's operations available to facilitate this. This is imperative if an inquiry, whether under the *Health Quality Council of Alberta Act* or under the *Public Inquiries Act*, sets up an independent administrative structure to support its work.

This inquiry did not have the benefit of such a senior official. The main contact was a senior counsel in the office of the Minister of Health. While this individual was very helpful, it was not the same as having someone at a cabinet secretary or deputy minister level.

#### ***E. A suggestion for the future***

One of the more troublesome issues in the early days after my appointment was the extent of the role to be played by the Health Quality Council in support of this inquiry. The terms of reference enabled me "from time to time" to request administrative and other support from the Council or government. However, the information communicated to me at the time of my appointment was that the inquiry should be completely independent and therefore the role of the Council was to be minimized.

The government had contemplated the question of the role of the Council in inquiries when it introduced Bill 24, which became the *Health Quality Council of Alberta Act*. During the legislative debates on the Bill in November 2011, questions were raised about the extent of

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## Administrative Lessons Learned for Future Inquiries

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Council involvement in an inquiry called under section 17 of the Act. The Minister of Health said as follows:

Once a panel is appointed by the council, the panel will be authorized to hire its own staff resources, including lawyers to advise it. *I also want to reiterate that once the panel is appointed, the council has no further role in the inquiry.*<sup>7</sup>  
[Emphasis added]

However, the present inquiry saw the Council take a very active role in the inquiry's operations because of the funding agreements I described earlier. The Council certainly never attempted to interfere with how the inquiry pursued its mandate. But it played a significant oversight role in the financial arrangements for the inquiry. The government directed it to assume this role. It cannot be said that the Council played no further role in the inquiry after it appointed the Panel, as the Minister in 2011 promised of the relations between the Council and public inquiries under the Act.

The tripartite arrangement, as I call it, has caused me to consider whether it is strictly necessary to keep the Council separate from the work of an inquiry such as this one. Traditionally public inquiries, such as ones appointed under the *Public Inquiries Act*, are designed to be independent in all respects, including their administration. But there is no reason to equate an inquiry under section 17 of the *Health Quality Council of Alberta Act* with an inquiry under the *Public Inquiries Act* in all aspects. They share the same powers but they do not have to mirror each other in all administrative aspects.

An inquiry under section 17 must be related to a health matter. The Council has expertise in investigating health matters. The Council itself enjoys a great degree of independence. It is not an agent of the Crown and its board (appointed by the Lieutenant Governor in Council) has control over its business and management.

Therefore, I suggest that an inquiry under section 17 – even though headed by an individual or group, possibly a judge or judges, acting as “the Panel,” independent of the Council – have the option of using the administrative apparatus of the Council. The inquiry would still be

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<sup>7</sup> Legislative Assembly, *Alberta Hansard*, No. 43e (November 29, 2011) at 1480 (Fred Horne).

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independent provided that the Panel is seen as independent and behaves accordingly. The advantage would be that the Panel could draw extensively on the resources of the Council, particularly its experience in conducting investigations and quality assurance reviews. There would be no need to establish a completely separate administrative structure for such an inquiry and no need then for complicated and duplicative financial arrangements. This should at least be an option for the Panel. There need not be an assumption that a section 17 inquiry must be administratively separate from the Council.

If a matter is of such vital public concern that a completely independent inquiry is warranted, the inquiry should be appointed under the *Public Inquiries Act*. Then, as is traditional for commissions of inquiry, the inquiry can set up a separate administrative and financial structure. Most important, the inquiry can establish a direct relationship with a senior cabinet official, as I suggested previously, without a government department or, as with this inquiry, the Council playing an intermediary role.

I offer this as a suggestion for future inquiries with a view to avoiding some of the difficulties this inquiry encountered.

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Inquiry Staff

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**Network Administrator**

Steve Belter (Belter Computer Consulting)

**Security and Investigation Services**

Brian Sinclair (Sinclair Investigations Services Ltd.)

**Records Clerk**

Christopher MacMurdo

**Receptionist**

Leezanne Hupe

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## APPENDIX 3: APPEARANCES

### COUNSEL

<b>COMMISSION COUNSEL</b>	<b>WITNESSES REPRESENTED</b>
Michele H. Hollins, Q.C. Lead Counsel Jason L. Wilkins, Co-Counsel Ellen K. Embury Ryan Penner Saarah Shivji	
<b>INTERVENER COUNSEL</b>	
<b>Alberta Consumers' Association</b> Deborah Prowse	
<b>The Alberta Medical Association</b> Jonathan P. Rossall, Q.C. Tara Argent	
<b>Government of Alberta (Alberta Health)</b> Vivian Stevenson, Q.C. John Hope, Q.C. Diane Talarico	

## Appearances

<p><b>Alberta Health Services</b> Brent Windwick, Q.C. Mark Raven-Jackson Dana Adams</p>	<p>Ms. Sheri Drozda, Dr. David Diamond, Ms. Deborah Gordon, Ms. Kathy Taylor, Mr. Don Christensen, Ms. Patty Grier, Ms. Lynn Redford, Ms. Brigitte McDonough, Ms. Jill Woodward, Ms. Michelle Bosch, Ms. Debbie Hyman, Ms. Lori Anderson, Dr. Francois Belanger, Ms. Linda Duffley, Ms. Susan Smith, Ms. Joy Lohan</p>
<p><b>OTHER COUNSEL</b></p>	<p><b>WITNESSES REPRESENTED</b></p>
<p>Simon Johnson</p>	<p>Dr. Paul Parks, Dr. Brian Holroyd, Dr. Bill Anderson, Dr. Max Findlay</p>
<p>Perry Mack</p>	<p>Mr. Ron Liepert</p>
<p>Josh Stachniak</p>	<p>Dr. Gordon Self</p>
<p>Brian Beresh</p>	<p>Dr. Raj Sherman</p>
<p>Mona Duckett, Q.C.</p>	<p>Ms. Sheila Weatherill</p>
<p>Jim Bancroft, Q.C.</p>	<p>Mr. Neil Wilkinson</p>
<p>Taryn Burnette</p>	<p>Dr. Jonathan Love, Dr. Valerie Boswell</p>



## LIST OF WITNESSES

<p><b>Prof. William Lahey</b>, <i>Associate Professor of Law at Dalhousie University in Halifax</i></p> <p><b>Dr. James Saunders</b>, <i>Health Consultant</i></p> <p><b>Dr. David Megran</b>, <i>Executive Vice-President and Chief Medical Officer, Alberta Health Services</i></p> <p><b>Dr. Stephen Duckett</b>, <i>former President and Chief Executive Officer, Alberta Health Services</i></p> <p><b>Ms. Sheri Drozda</b>, <i>Charge Nurse, Foothills Medical Centre</i></p> <p><b>Dr. Paul Parks</b>, <i>Chief Emergency Physician, Medicine Hat</i></p> <p><b>Dr. Brian Holroyd</b>, <i>Chair, Department of Emergency Medicine, University of Alberta</i></p> <p><b>Dr. David Diamond</b>, <i>Senior Vice-President, Human Resources, Alberta Health Services</i></p> <p><b>Ms. Deborah Gordon</b>, <i>Senior Vice-President, Chief of</i></p> <p><b>Minister Fred Horne</b>, <i>Minister of Health</i></p> <p><b>Dr. Max Findlay</b>, <i>Surgeon, Edmonton</i></p>	<p><i>Nursing, Alberta Health Services</i></p> <p><b>Ms. Kathy Taylor</b>, <i>Emergency Manager, Lougheed Hospital</i></p> <p><b>Mr. Donald Christensen</b>, <i>Area Manager, Urgent Care, Sheldon Chumir Health Centre</i></p> <p><b>Mr. Ron Liepert</b>, <i>former Minister of Health</i></p> <p><b>Ms. Patty Grier</b>, <i>AHS Chief of Staff, Corp. Secretary</i></p> <p><b>Ms. Lynn Redford</b>, <i>former Calgary Health Region Employee</i></p> <p><b>Mr. Brian Hlus</b>, <i>Director of Government Affairs, Capital Health 1999-2008</i></p> <p><b>Dr. Gordon Self</b>, <i>Vice President, Missions, Ethics and Spirituality, Covenant Health</i></p> <p><b>Ms. Brigitte McDonough</b>, <i>Director of Critical Care, University of Alberta Hospital, Alberta Health Services</i></p> <p><b>Dr. Raj Sherman</b>, <i>MLA for Edmonton-Meadowlark</i></p> <p><b>Mr. Brian Mason</b>, <i>MLA for Edmonton-Highlands-Norwood</i></p> <p><b>Mr. Harry Chase</b>, <i>Former Liberal MLA</i></p>	<p><b>Mr. Nikola Juric</b>, <i>Retired, Former Nurse, University of Alberta Hospital</i></p> <p><b>Ms. Sheila Weatherill</b>, <i>President and Chief Executive Officer, Capital Health 1996-2008</i></p> <p><b>Mr. Shawn Hillhouse</b>, <i>Patient Care Manager, Stollery Childrens' Hospital</i></p> <p><b>Ms. Skyla Lungren</b>, <i>Manager of Operating/Bookings, Foothills Hospital</i></p> <p><b>Ms. Janice Stewart</b>, <i>Executive Director of Surgery, Rockyview Hospital</i></p> <p><b>Ms. Jill Woodard</b>, <i>Executive Director, Emergency &amp; Surgery Services, Alberta Childrens' Hospital</i></p> <p><b>Dr. Nicholas Mohtadi</b>, <i>Orthopaedic Surgeon, Sports Injury Epidemiology, Clinical Trials, University of Calgary</i></p> <p><b>Dr. William Anderson</b>, <i>Alberta Health Services: JLW</i></p> <p><b>Mr. Neil Wilkinson</b>, <i>former Board Chair, Capital Health Services</i></p> <p><b>Dr. Trevor Theman</b>, <i>Registrar, College of Physicians &amp; Surgeons of Alberta</i></p>
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## Appearances

<p><b>Dr. James Thorne</b>, <i>Primary Care Physician/Sports Medicine, Calgary Flames</i></p> <p><b>Minister Ken Hughes</b>, <i>former AHS Board Chair</i></p> <p><b>Mr. Jack Davis</b>, <i>former Chief Executive Officer, Calgary Health Region</i></p> <p><b>Ms. Michelle Bosch</b>, <i>Public Health Nurse, Rockyview Hospital</i></p> <p><b>Ms. Debbie Hyman</b>, <i>former Clinic Manager, Brentwood Clinic</i></p> <p><b>Ms. Lori Anderson</b>, <i>Vice-President, South Health Campus</i></p> <p><b>Mr. David Beninger</b>, <i>Clerk 3 Casual, Colon Cancer Screening Centre</i></p> <p><b>Ms. Dayna Sutherland</b>, <i>Off-Site Data Entry Clerk, Colon Cancer Screening Centre</i></p> <p><b>Ms. Samantha Mallyon</b>, <i>Clerk 3, Colon Cancer Screening Centre</i></p> <p><b>Ms. Kelly Hawken</b>, <i>Executive Assistant to the Executive Director of Rural Hospitals, Alberta Health Services</i></p> <p><b>Dr. Ronald Bridges</b>, <i>Founder, Helios Wellness Centre</i></p>	<p><b>Deputy Premier Thomas Lukaszuk</b>, <i>MLA for Edmonton-Castle Downs, Minister of Enterprise and Advanced Education</i></p> <p><b>Dr. Alaa Rostom</b>, <i>Gastroenterologist, Colon Cancer Screening Clinic</i></p> <p><b>Dr. Francois Belanger</b>, <i>Senior Vice President, Medical Director - Calgary Zone, Alberta Health Services</i></p> <p><b>Ms. Linda Duffley</b>, <i>Director of Public Health Programs, Edmonton Zone, Alberta Health Services</i></p> <p><b>Ms. Susan Smith</b>, <i>Clinical Development Nurse, Communicable Disease Control, Bonnie Doon Public Health Centre, Edmonton Zone, Alberta Health Services</i></p> <p><b>Ms. Arlene Lohan</b>, <i>Manager, Province-wide Immunization Program, Standards and Quality, Alberta Health Services</i></p> <p><b>Ms. Judy Brosseau</b>, <i>Operations Manager, North Gate Clinic, Edmonton, Alberta Health Services</i></p> <p><b>Ms. Christine Westerlund</b>, <i>Director of Critical Care and Operative Services, Stollery Childrens' Hospital, Alberta</i></p>	<p><b>Ms. Barb Kathol</b>, <i>Executive Director, Foothills Hospital</i></p> <p><b>Dr. Jonathan Love</b>, <i>Gastroenterology Site Chief - Foothills Medical Centre, Regional Chair of Endoscopy and Head of the Therapeutic Endoscopy Group</i></p> <p><b>Dr. Valerie Boswell</b>, <i>General Practitioner and Contractor with Forzani &amp; Macphail Colon Cancer Screening Centre</i></p> <p><b>Mr. Kyle Cridland</b>, <i>Triage Nurse, Foothills Medical Centre</i></p> <p><b>Ms. Leah Tschritter-Pawluk</b>, <i>Clinic Operator, Helios Wellness Centre</i></p> <p><b>Dr. Douglas Caine</b>, <i>Physician, Helios Wellness Centre</i></p> <p><b>Dr. Chen Fong</b>, <i>Founder, Helios Wellness Centre</i></p> <p><b>Ms. Darlene Pontifex</b>, <i>Clinic Manager, Colon Cancer Screening Centre</i></p>
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<p><b>Ms. Olga Koch,</b> <i>Administrative Assistant, Colon Cancer Screening Centre</i></p> <p><b>Dr. Mark Swain,</b> <i>Professor of Medicine – University of Calgary, Section Chief (Gastroenterology) – Calgary Zone, Alberta Health Services</i></p> <p><b>Dr. Lynette Reid,</b> Panelist <i>– Associate Professor, Department of Bioethics, Faculty of Medicine, Dalhousie University</i></p> <p><b>Ms. Pam Whitnack,</b> Panelist – <i>President – Whitnack and Associates Ltd., Former Executive Vice President – Rural, Public and Community Health, Alberta Health Services</i></p>	<p><i>Health</i></p> <p><b>Dr. Brian Goldman,</b> Panelist – <i>Assistant Professor, Department of Family and Community Medicine, University of Toronto</i></p> <p><b>Dr. David Alter,</b> Panelist – <i>Associate Professor, Department of Medicine, University of Toronto</i></p> <p><b>Dr. John Church,</b> Panelist – <i>Associate Professor, Department of Political Science and Centre for Health Promotion Studies, University of Alberta</i></p> <p><b>Dr. Owen Heisler,</b> Panelist <i>– Assistant Registrar – College of Physicians and Surgeons of Alberta and Assistant Clinical Professor, University of Alberta</i></p>	
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## **APPENDIX 4: RELEVANT DOCUMENTS**

### **(a) ORDERS IN COUNCIL**

#### *i. February 28, 2012*

O.C. 80/2012

February 28, 2012

The Lieutenant Governor in Council makes the Order in the attached Appendix.

For Information only

Recommended by: Minister of Health and Wellness

Authority: Health Quality Council of Alberta Act  
(section 17)

## **APPENDIX**

### **ORDER**

#### **PUBLIC INQUIRY INTO HEALTH SYSTEM MATTERS**

##### **WHEREAS:**

- Allegations have been made that some individuals are, or have been, given improper preferential access to publicly funded health services;
  - Access to publicly funded health services is properly based on patient need and the relative acuity of a patient's condition;
  - It is improper to gain access to publicly funded health services through threat, influence or favour
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Relevant Documents

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- It is in the public interest to assure Albertans that the publicly funded health care system provides for fair and appropriate access to health services; and
- The Lieutenant Governor in Council considers it to be in the public interest that a public inquiry be held to make recommendations to prevent the possibility of any person being given improper preferred access to publicly funded health services.

**THEREFORE:**

Pursuant to section 17 of the *Health Quality Council of Alberta Act*, the Lieutenant Governor in Council orders that a public inquiry be held concerning the possibility of improper preferential access being given to publicly funded health services and, specifically, the terms of reference for the inquiry shall be to consider:

- 1) Whether improper preferential access to publicly funded health services is occurring; and
- 2) If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

**Further**, the board of the Health Quality Council of Alberta is directed to appoint a Panel of one or more qualified persons to have conduct of the inquiry, including a chair of the Panel if the Panel includes more than one person, and:

- 3) In accordance with section 17 of the *Health Quality Council of Alberta Act*, the Panel shall have all the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*.
  - 4) The Panel shall conduct the inquiry, prepare a report setting out the findings and recommendations of the Panel and submit the report to the Speaker of the Legislative Assembly no later than April 30, 2013
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- 5) The Panel may retain such experts and advisors as are reasonably required to assist it in achieving the objective of the inquiry.
  - 6) The Panel is directed to prepare a budget and submit it to the Lieutenant Governor in Council, through the Minister of Health and Wellness, for review and approval. The Panel shall put a system of budget monitoring and reporting in place. Budget and expenditure reporting shall be to the Minister of Health and Wellness, and the Minister shall make provision for funding the inquiry, including the compensation of Panel members, in accordance with the approved budget.
  - 7) The Panel is directed to develop and submit a policy to the Lieutenant Governor in Council, through the Minister of Health and Wellness, on whether or not assistance will be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel. Costs for legal counsel must only be provided in accordance with the Government of Alberta's established rates for retaining external legal counsel.
  - 8) The Panel is directed to provide prior notice to the Lieutenant Governor in Council, through the Minister of Health and Wellness, at any point where it considers it advisable to make budget adjustments that are reasonably required to assist it in achieving the objective of the inquiry.
  - 9) The Panel may from time to time request administrative and other support from the Health Quality Council of Alberta or from the Government of Alberta, through the Minister of Health and Wellness, if it considers it appropriate and necessary for the proper conduct of the inquiry.
  - 10) The Panel may request the Lieutenant Governor in Council, through the Minister of Health and Wellness, to clarify any provision of this Terms of Reference or to modify any provision of this Terms of Reference if the
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Relevant Documents

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Panel is of the opinion clarification or modification is necessary for the proper conduct of the inquiry.

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*ii. July 25, 2012*

O.C. 264/2012

July 25, 2012

The Lieutenant Governor in Council

- 1) approves the Panel's budget, with the modifications and conditions set out in Appendix 1, for the Health Services Preferential Access Inquiry;
- 2) accepts the Panel's Funding Policy for Witnesses and Interveners set out in Appendix 2.

For Information only

Recommended by: Minister of Health

Authority: O.C. 80/2012

**Appendix #1 – Modifications and Conditions to Inquiry Budget 2012-2013**

- 1) The Panel's proposed \$10,000,000.00 budget, less the 20% contingency allotted in the inquiry budget for cost overruns, is approved. The Panel may submit a request to the Lieutenant Governor in Council, through the Minister of Health, for the additional \$1,742,000.00, at a later date, if necessary.
  - 2) The executive director for the inquiry, in conjunction with the Health Quality Council of Alberta, must establish and implement a system of internal budget monitoring and spending oversight to conduct the inquiry and prepare reports as required by the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by the Minister of Health and the Health Quality Council of Alberta.
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- 3) The Panel may submit a second budget to the Lieutenant Governor in Council, through the Minister of Health, for funding for interveners and witnesses, at a later date, if necessary.

## **Appendix #2 - Funding Policy for Witnesses and Interveners**

Witnesses and interveners may apply for financial assistance

- 7-2.1 Upon application by any witness or intervener who the Commissioner has recognized as having standing at the Inquiry, or for any part of the Inquiry, the Commissioner may make a decision that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry (a "Funding Decision").

Funding Decisions may be made in any amount and subject to terms and conditions

- 7-2 The Commissioner may make a Funding Decision in any amount, whether or not the Funding, as recommended, would fully indemnify the applicant for all costs of participating at the Inquiry.
  - 7-3 The Commissioner may make a Funding Decision subject to any terms and conditions, including that financial assistance should be available to an applicant only as part of a group comprised of two or more persons, groups of persons or entities whose interests and perspectives overlap. How to apply for financial assistance
  - 7-4 An application for financial assistance may be made by a proposed witness or intervener concurrently with an application for standing.
  - 7-5 An application for financial assistance must be made in writing, and will be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner.
  - 7-6 An application for financial assistance must be supported by:
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- (a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;
- (b) a written budget outlining the applicant's proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and
- (c) a written proposal as to how the applicant will account for funds received.

What the Commissioner will consider

- 7-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:
- (a) whether the applicant is a witness, an intervener or both;
  - (b) in the case of applicants who are witnesses, whether the applicant's testimony is being compelled by Commission Counsel;
  - (c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the report of the Commissioner;
  - (d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;
  - (e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and
  - (f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

Financial assistance is not available for the following

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Relevant Documents

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- 7-8 Notwithstanding Rule 7-7, the Commissioner will not endorse financial assistance:
- (a) for costs of legal counsel other than in accordance with the Government of Alberta's established rates for retaining external legal counsel (attached);
  - (b) for costs incurred by the applicant before the application for a funding recommendation was made and considered; and
  - (c) for disbursements other than in accordance with the Court of Queen's Bench Costs Manual.
- 7-9 The Commissioner will make a request to the Lieutenant Governor in Council for the allocation of funds in respect of any Funding D
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**iii. November 21, 2012**

O.C. 383/2012

November 21, 2012

The Lieutenant Governor in Council

- 1) approves the budget for funding for interveners and witnesses for the Health Services Preferential Access Inquiry as set out in Appendix 1;
- 2) 2 accepts the process for allocation of funds for interveners and witnesses approved by the Inquiry Panel at the hearings as set out in Appendix 2.

For Information only

Recommended by: Minister of Health

Authority: Orders in Council 80/2012 and 264/2012

**Appendix #1 – Budget for Funding for Intervenors and Witnesses**

- 1) The Panel's proposed budget for \$125,000, as set out in the Panel's Rulings on Standing and Funding, dated October 19, 2012, is approved.
  - 2) In anticipation of further applications for funding for intervenors and witnesses, acknowledged in the Panel's Rulings on Standing and Funding dated October 19, 2012 as well as the Panel's letter to the Minister of Health dated October 22, 2012, an additional \$200,000, to be used for any future financial assistance rulings for intervenors and witnesses, is approved.
  - 3) The executive director for the inquiry, in conjunction with the Health Quality Council of Alberta, will utilize a system of internal budget monitoring and spending oversight to ensure the disbursement and reporting on the
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financial assistance is in compliance with the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by the Minister of Health and the Health Quality Council of Alberta and is consistent with the financial assistance policy

- 4) If the Panel exceeds the total amount approved under sections 1 and 2, the Panel may submit a third budget to the Lieutenant Governor in Council, through the Minister of Health, for additional funding for interveners and witnesses, at a later date, if necessary.

#### **Appendix #2 - Process for Allocation of Funds for Interveners and Witnesses**

- 5) The sum of \$325,000 will be advanced to the Health Quality Council of Alberta in accordance with the terms of the grant agreement between Her Majesty the Queen in Right of Alberta as represented by Minister of Health and the Health Quality Council of Alberta and will be held in a separate account pending further documentation from the Panel.
  - 6) The Panel will submit any rulings authorizing financial assistance for an intervener or witness to the Health Quality Council of Alberta with a copy to the Minister.
  - 7) The Panel will submit the necessary invoices and documentation to the Health Quality Council of Alberta when requesting payment of the authorized financial assistance for interveners and witnesses. The Health Quality Council of Alberta shall disburse the funds as requested from the monies available, subject to compliance with the grant agreement and the financial assistance policy.
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*iv. March 6, 2013*

O.C. 40/2013

March 6, 2013

The Lieutenant Governor in Council amends Order in Council numbered O.C. 80/2012 by striking out paragraph 4 of the Appendix and substituting the following:

- 4) The Panel shall
  - (a) conduct and complete the inquiry by April 30, 2013,
  - (b) complete its review of the evidence and prepare a report setting out its findings and recommendations by August 31, 2013, and
  - (c) submit the report to the Speaker of the Legislative Assembly on or before August 31, 2013.

For Information only

Recommended by: Minister of Health

Authority: Health Quality Council of Alberta Act (section 17)

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**(b) FUNDING POLICY**

*Witnesses and interveners may apply for financial assistance*

- 1-1 Upon application by any witness or intervener who the Commissioner has recognized as having standing at the Inquiry, or for any part of the Inquiry, the Commissioner may make a decision that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry (a "Funding Decision").

*Funding Decisions may be made in any amount and subject to terms and conditions*

- 1-2 The Commissioner may make a Funding Decision in any amount, whether or not the Funding, as recommended, would fully indemnify the applicant for all costs of participating at the Inquiry.
- 1-3 The Commissioner may make a Funding Decision subject to any terms and conditions, including that financial assistance should be available to an applicant only as part of a group comprised of two or more persons, groups of persons or entities whose interests and perspectives overlap.

*How to apply for financial assistance*

- 1-4 An application for financial assistance may be made by a proposed witness or intervener concurrently with an application for standing.
- 1-5 An application for financial assistance must be made in writing, and will be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner.
- 1-6 An application for financial assistance must be supported by:
- a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;
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Relevant Documents

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- b) a written budget outlining the applicant's proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and
- c) a written proposal as to how the applicant will account for funds received.

*What the Commissioner will consider*

- 1-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:
- a) whether the applicant is a witness, an intervener or both;
  - b) in the case of applicants who are witnesses, whether the applicant's testimony is being compelled by Commission Counsel;
  - c) the nature and extent of the applicant's interest, including whether the applicant might be adversely affected by the report of the Commissioner;
  - d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;
  - e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and
  - f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

*Financial assistance is not available for the following*

- 1-8 Notwithstanding Rule 1-7, the Commissioner will not endorse financial assistance:
- a) for costs of legal counsel other than in accordance with the Government of Alberta's established rates for retaining external legal counsel (attached);
  - b) for costs incurred by the applicant before the application for a funding recommendation was made and considered; and
  - c) for disbursements other than in accordance with the Court of Queen's Bench Costs Manual.
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- 1-9 The Commissioner will make a request to the Lieutenant Governor in Council for the allocation of funds in respect of any Funding Decisions.



## (c) RULES OF PRACTICE & PROCEDURE

### I. General

1. These Rules of Practice and Procedure govern the public inquiry established by Order in Council, O.C. 80/2012 of February 28, 2012.
2. These Rules may be dispensed with or amended from time to time, in the discretion of the Commissioner, to ensure fairness and efficiency. The Commissioner may make any direction necessary to deal with any issue arising during the course of the Inquiry which is not addressed in these Rules.

### II. Definitions

3. In these Rules:
    - a) "Commissioner" means the Honourable John Z. Vertes, who has been appointed to conduct the Inquiry pursuant to subsection 17(2) of the *Health Quality Council of Alberta Act*;
    - b) "Commission" means the Public Inquiry into Health System Matters established by O.C. 80/2012;
    - c) "Commission Counsel" means Dunphy Best Blocksom LLP, including the lawyers of that firm and its agents, if any;
    - d) "Commission Offices" means the offices of the Commission located at:  
  
217, 811 – 14<sup>th</sup> Street N.W.  
Calgary, Alberta  
T2N 2A4
    - e) "Intervener" means a person, group of persons or organization that has been granted standing by the Commissioner pursuant to the Commission's Policy on Standing;
    - f) "Participant" means all Interveners and witnesses, and any other persons who are granted a right to make submissions or present or test evidence at the Inquiry;
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- g) "Record" includes a representation of any writing, picture, audio, video or data, howsoever recorded.

### **III. Investigation**

4. Any person with knowledge, information or Records relevant and material to the Inquiry is encouraged to make such knowledge, information or Records known to the Commission or Commission Counsel at the earliest possible opportunity, including the names and addresses of any potential witnesses who may have knowledge or information relevant and material to the Commission's mandate.

#### ***Pre-Hearing Interviews***

5. Commission Counsel may request that any person attend one or more interviews. Attendance at these interviews is voluntary. Any person interviewed by or on behalf of Commission Counsel is entitled to have counsel present for the interview. No right to financial assistance for counsel flows from this right to counsel.

#### ***Records***

6. Any Participant who knows of the existence of any relevant Record or other evidence which may be relevant and material to the Commission's mandate must bring it to the attention of Commission Counsel at the earliest opportunity.
7. The Commission may serve any person or organization with a Notice to Produce Records in substantially the form attached to these Rules as **Schedule A**. Originals of relevant Records must be provided to the Commission upon request but otherwise copies of Records are sufficient.
8. With reference to sections 9 of the *Public Inquiries Act (Alberta)*, any Participant who possesses a Record which may be relevant and material to the Commission's mandate but believes that Record to be privileged will disclose the existence and description of that Record to Commission Counsel. If no agreement can be reached regarding the treatment of a Record over which privilege has been claimed, Commission Counsel may apply *in camera* to the
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Commissioner for direction as to the admissibility of such a Record.

9. Unless and until a Record is marked as an exhibit in the public hearings, Commission Counsel will not use or disclose the Record for any purposes other than the purposes of the Inquiry. Commission Counsel will provide copies of Records to other Participants where it determines those Records are relevant to their interests on the condition that counsel for a Participant and the Participant itself/themselves provide to Commission Counsel a written undertaking in the form attached to these rules as **Schedule B**.
10. The Commissioner may, upon application, release any person in whole or in part from the provisions of his or her undertaking in respect of any particular Record(s).
11. In the event that the Commissioner so directs, counsel for a Participant must return to the Commission any or all Records provided to them by Commission Counsel including all copies made.
12. Any Participant can, prior to or during the public hearings before the Commissioner, apply to the Commissioner in writing for a direction that a particular Record be subject to a publication ban or other similar protections even if the Record becomes an exhibit at the public hearings.

#### **IV. Public Hearings**

13. The Commission is committed to a process of public hearings.
14. The Commission will set the dates, hours and locations of hearings and can amend those as required, on reasonable notice to all Participants.
15. Anything that detracts from proper decorum may be prohibited, and the Commissioner may exclude any person from the hearing room at any time in his discretion.

#### ***Notices to Attend***

16. Commission Counsel may serve any person with a Notice to Attend at the Inquiry on reasonable notice for the purpose of
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being questioned as a witness in substantially the form attached to these Rules as **Schedule C**.

17. The payment of any allowance for such attendance will be determined by Commission Counsel generally in accordance with the Alberta Rules of Court. If any person served with a Notice to Attend disagrees with the amount proposed by Commission Counsel, he or she or his or her counsel may apply to the Commissioner in writing to set the amount of such payment.
18. Any person served with a Notice to Attend must attend at the inquiry at the date, time and place specified by Commission Counsel to be questioned as a witness, and must bring to the inquiry any Records identified in the Notice to Attend which have not already been produced to Commission Counsel.

## **V. Evidence**

19. The Commissioner is entitled to hear and rely on any evidence he considers to be required for the full investigation of the matters into which he has been appointed to inquire, whether or not that evidence would be admissible in a court of law. The strict rules of evidence do not apply at the Inquiry, although the rules of evidence may influence the Commissioner's weighing of evidence.

### ***Witnesses***

20. All questioning of witnesses will be under oath or affirmation and will be transcribed.
  21. Commission Counsel will determine who will be called for questioning at the Inquiry, subject to Rule 22.
  22. No person or Participant other than the Commissioner may compel the attendance of a witness. If Commission Counsel declines to call or to question a particular witness, any Participant may apply to the Commissioner for leave to do so. The application must include the name and address of the proposed witness, a summary of the anticipated evidence of the proposed witness, and copies of any documents which the applicant intends to have marked as exhibits during the questioning of the proposed witness.
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23. If an application under Rule 22 is granted, the Commissioner may direct Commission Counsel to coordinate the attendance of the subject witness to be questioned at the Inquiry, including by directing Commission Counsel to serve the witness with a Notice to Attend and may impose any other conditions he deems fit upon the calling of such evidence.

### ***Notice of Relevant Records***

24. Commission Counsel will endeavor to provide reasonable notice to the witness' counsel and any Participants with an interest in the testimony of a particular witness of any Records that will likely be referred to during the course of a witness's testimony
25. Similarly, any Participant who is permitted to call or cross-examine a witness will endeavor to provide reasonable notice to Commission Counsel, witness' counsel and any Participants with an interest in the testimony of a particular witness of any Records they anticipate putting to the witness in the course of that witness's testimony.

### ***Evidence Taken Outside the Public Hearings***

26. Where it proves impractical or impossible to question a witness at a public hearing, Commission Counsel or any other person appointed by the Commissioner may question a witness other than at a public hearing, in which event, subject to the outcome of any application for evidence to be heard *in camera*, a transcript of the questioning will be made public within a reasonable time.
27. If a Participant wishes to cross-examine a witness whose evidence has been taken under Rule 26, that Participant may apply to the Commissioner for directions as to the conduct of that cross-examination.

### ***In Camera Hearings***

28. Any Participant may apply to the Commissioner for a determination that, in accordance with sections 18 and 19 of the *Health Quality Council of Alberta Act*, the hearing or a part of the hearing will be held *in camera*.
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29. All transcripts of evidence taken *in camera* will be marked, both in hard copy and electronically as “Confidential” and will not be released, published or disclosed, by or to any person, although the Commissioner may still report on such evidence.

***Order and Conduct of Questioning a Witness***

30. Subject to an agreement with Commission Counsel or a contrary direction by the Commissioner, Commission Counsel will first adduce the evidence from the witness. Counsel for the witness may then examine the witness, followed by any Participants whose grant of standing allows a right of cross-examination. If they cannot agree on the order of cross-examination, the Commissioner will determine the order. Commission Counsel and counsel for the witness may reexamine the witness if appropriate at the conclusion of any cross-examination.
31. The Commissioner may, at his sole discretion, change the order of questioning for a witness.
32. Commission Counsel may question any witness with either leading or non-leading questions. Unless otherwise permitted by the Commissioner, all other Participants are limited in their questioning, including of their own witnesses, by the ordinary rules of evidence.
33. The Commissioner may require a witness to answer questions from the Commissioner, which the Commissioner deems to be relevant.
34. A witness may be questioned more than once throughout the course of the Inquiry.
35. A witness must answer all questions asked of him or her subject to the Commissioner sustaining an objection made by the witness's counsel.
36. No Participant or counsel may speak to a witness about the witness's evidence while the witness is under oath or affirmation, except by leave of the Commissioner.
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## **VI. Applications**

37. Any Participant may seek a direction or determination from the Commissioner by making an application.
38. Any application must be made in writing at the earliest possible opportunity, and may be decided by the Commissioner based solely on the written record, without an oral hearing, unless an oral hearing is directed by the Commissioner. Even if the Commissioner elects to have an oral hearing, he may dispense with the public hearing of the application in his discretion.
39. Unless otherwise provided in these Rules or by the Commissioner, all applications and any supporting affidavits must be served on the offices of Commission Counsel and the Commission at least five days before presentation. The written application and any supporting affidavits must also be served on all Participants or their counsel, unless otherwise directed by the Commissioner.
40. The written application must outline the nature of the determination or direction that the applicant is seeking from the Commissioner and the grounds upon which the application is being made.
41. Subject to any terms or conditions on a Participant's standing or any direction by the Commissioner, any Participant may make submissions, or present or challenge the evidence, in response to an application brought by any other Participant.

## **VII. Judicial Review**

42. Any application by a Participant or Commission Counsel for judicial review of a decision of the Commissioner made during the course of the public hearings will be brought before Chief Justice N. A. Wittmann of the Court of Queen's Bench or his designate.
  43. Any notice of an application for judicial review and any supporting material must be filed and served upon Commission Counsel and any affected Participants within 5 days of the decision being challenged.
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44. Any application for a stay of proceedings pending the hearing of an application for judicial review may be brought before either the Commissioner or Chief Justice N. A. Wittmann of the Court of Queen's Bench or his designate.

### **VIII. Access to Transcripts and Exhibits**

45. All evidence entered as exhibits and all transcripts of the proceedings shall be identified and marked "P" for public sittings in numerical order and, if necessary, "C" for confidential exhibits or transcripts of *in camera* hearings for which non-disclosure, a non-publication or non-communication orders have been issued.
46. Copies of the final version of the "P" transcripts and exhibits will be posted on the Commission's website and will be available at the hearing room.
47. Only the Commissioner or Commission Counsel can authorize and give access to "C" transcripts and exhibits (under whatever conditions they determine necessary).

### **IX. Service**

48. Unless otherwise provided in these Rules:
- a) service of any document or Notice may be effected on the Commission by e-mail, facsimile, courier or personal delivery provided that delivery is made to the Commission Offices and Commission Counsel; and
  - b) service of any document or Notice may be effected on any Participant by e-mail, facsimile, courier or personal delivery to the Participant or to the Participants counsel, or in any manner directed by the Commissioner.
49. Materials may be served between 9:00 a.m. and 4:00 p.m. on weekdays, excepting holidays, and so serving is effective upon delivery of the materials. Service of materials outside of these dates and times will be deemed effective on the following weekday which is not a holiday.

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The Honourable John Z. Vertes, Commissioner

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**SCHEDULE “A”**

IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)

**NOTICE TO PRODUCE RECORDS**

TO: \_\_\_\_\_

The terms of reference for this Public Inquiry (Order in Council 80/2012) are as follows:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Pursuant to section 17 of the *Health Quality Council of Alberta Act* and section 9 of the *Public Inquiries Act (Alberta)*, you are required, within ten (10) days of service of this notice on you or your solicitor, to produce to the office of Commission Counsel all records relevant and material to the issues in the Inquiry.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2012.

\_\_\_\_\_  
The Honourable John Z. Vertes, Commissioner

**CONTACT INFORMATION**

Michele H. Hollins, Q.C.  
Commission Counsel

Dunphy Best Blocksom LLP  
Barristers & Solicitors  
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Telephone: (403) 750-1117  
Facsimile: (403) 269-8911  
Email: [hollins@dbblaw.com](mailto:hollins@dbblaw.com)

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**SCHEDULE “B”**

*IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)*

**UNDERTAKING**

I, \_\_\_\_\_ OF THE City of \_\_\_\_\_ in the Province of Alberta, hereby acknowledge and undertake to the Commission established by the Order in Council O.C. 8.2012, as follows:

I have been and/or will be provided with Records produced as part of the investigation and conduct of this Inquiry.

I hereby agree and undertake that I will not use or disclose any Record(s) so provided to me, other than for the purposes of my involvement in the Inquiry or that of my client. If I am counsel to a Participant, I undertake to obtain and provide to Commission Counsel a copy of this Undertaking signed by my client.

I understand that my failure to comply with the terms of this Undertaking may affect my ability to participate in the Inquiry and/or may attract other sanctions by the Commission.

DATED this \_\_\_\_ day of \_\_\_\_\_, 2012.

\_\_\_\_\_

Witness

\_\_\_\_\_

Signatory

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## SCHEDULE “C”

*IN THE MATTER OF A PUBLIC INQUIRY INTO ALBERTA HEALTH SERVICES PREFERENTIAL ACCESS PURSUANT TO THE PUBLIC INQUIRIES ACT, R.S.A. 2000, c. P-39 AND THE HEALTH QUALITY COUNCIL OF ALBERTA ACT, c. H-7.2 (ORDER IN COUNCIL 80/2012)*

### NOTICE TO ATTEND AS WITNESS AT HEARING

TO:

The terms of reference for this Public Inquiry (Order in Council 80/2012) (the “Inquiry”) are as follows:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

Pursuant to s.17 of the *Health Quality Council of Alberta Act* and s. 4 of the *Public Inquiries Act* (Alberta), this notice requires you to attend at a hearing before the Panel appointed to conduct the Inquiry and to testify. You must attend on December 3, 2012 or as directed by Commission Counsel and must bring with you any Records in your possession or control and which are relevant to the terms of reference of this Inquiry, unless otherwise directed by Commission Counsel.

An allowance will be paid to you for attending as a witness, the amount to be calculated by Commission Counsel in accordance with Schedule B, Division 3 of the Alberta Rules of Court.

Dated this \_\_\_ day of \_\_\_\_\_, 2012.

The Honourable John Z. Vertes, Commissioner

CONTACT INFORMATION

Michele H. Hollins, Q.C.  
Commission Counsel  
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Barristers & Solicitors  
#2100, 777 - 8<sup>th</sup> Avenue S.W.  
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Email: [hollins@dbblaw.com](mailto:hollins@dbblaw.com)





**(d) MEDIA POLICY*****Message from the Executive Director***

Journalists and other media representatives play an important role in the democratic process – providing the public with news and information about government initiatives and reporting on the views and opinions of all parties involved. The Health Services Preferential Access Inquiry wishes to establish a positive relationship with the media to promote public awareness and understanding of its Public Hearings process associated with the responsibility it has been given by the Government to investigate the serious allegations of preferential access to medical services in Alberta (commonly referred to as ‘queue jumping’). To this end, rules and procedures have been proposed while ensuring that the participants engaged in the judicial process remain unimpeded in their work and responsibilities.

The Public Hearings will take place in Edmonton from December 3<sup>rd</sup> to 13<sup>th</sup> at the Shaw Convention Centre. The general public is invited to attend.

A tentative schedule of witnesses to appear at the Hearings will be released by the Inquiry on November 30<sup>th</sup>, 2012.

Sheila-Marie Cook, CVO  
Executive Director

**Media Contact**

Samantha Beckett  
Phone: 403-270-2059 ext. 110  
Cell: 403-804-9239  
Email: [sbeckett@abhealthinquiry.ca](mailto:sbeckett@abhealthinquiry.ca)

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***MEDIA POLICY***

The Commissioner has authorized the sound and visual recording of the public hearings.

A Media Centre will be established at the site of the public hearings and the Inquiry Media Staff will assist in providing these services to any duly accredited member of the media. Members will be asked to check into the Centre and present their credentials at the beginning of each day's hearings.

The Media Centre will be equipped with photocopying/fax facilities, wireless-internet, audio/visual feed services and access to the Inquiry's website which will feature a webcast of the proceedings for the public. In addition, copies of the daily transcripts and the registered exhibits will be made available for reference purposes within the Media Centre. Daily transcripts will be made available on the Inquiry's website within three hours of the closing of the hearings for the day. Remote visual coverage of the proceedings in the hearing room will be available on screens in the Centre.

- Cameras and microphones will be located at pre-determined places in the hearing rooms. Only fixed cameras and the fixed lighting system will be allowed.
  - Copies of the recorded and visual proceedings will be made available at the end of each day to members of the media who have made prior arrangements with the Inquiry for this service.
  - No media scrums, interviews, or reporting will be allowed in the hearing rooms or within the distance of ten (10) meters from the hearing room entrances.
  - Should the Commissioner decide to proceed *in camera* or to issue a publication, disclosure or communication ban, the Inquiry Media Staff will take all necessary measures to ensure that all tape recording or sound recording machines have been turned off.
  - Interview requests should be directed to the Inquiry Media Staff. Interviews will be conducted during breaks in the hearings. The Inquiry Media Staff will not schedule
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interviews with Intervenors however, where possible, may direct the Media to the appropriate media representative for the parties.

### ***The Use of Personal Electronic Devices in the Hearing Room***

Any personal electronic device (PED) using cellular GSM-based or other wireless technology set so as to receive or transmit information, data or other signals via radio frequency, including mobile telephones, iPhones, BlackBerrys, Palm Treos, and portable computers, must, subject to the terms of this Notice, be turned off while the Inquiry is in session.

Notwithstanding the above, an individual user of such a PED who is a journalist from a recognized media organization may obtain permission in writing from the Inquiry to use the PED to “TWEET” or otherwise transmit digital information concerning the proceedings from within the hearing room in pursuance of the users’ journalistic responsibilities.

### ***Terms and Conditions***

User will identify himself/herself and the PED to be used to Inquiry Media Staff upon entering the hearing room

- User will sit in the back three rows in the hearing room
  - User will not use the audio capacity, including the sounds and signals, of the PED in the hearing room
  - User will not take or create any photograph or video in the hearing room
  - User will comply with any publication ban imposed by the Commissioner
  - User will not transmit or disseminate information at all from the hearing room during the testimony of any person where so ordered by the Commissioner
  - Use of PED by user will at all times be unobtrusive and silent and will not disrupt the proceedings or other persons or interfere with the digital recording system in the hearing room
  - User undertakes to comply with any other direction from the Commissioner relating to the dissemination of information about the proceedings or the use of PEDs in the hearing room.
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**e(i) RULINGS ON STANDING AND FUNDING**

IN THE MATTER OF A PUBLIC INQUIRY INTO ALLEGATIONS  
OF IMPROPER PREFERENTIAL ACCESS TO PUBLICLY  
FUNDED HEALTH SERVICES PURSUANT TO THE *HEALTH  
QUALITY COUNCIL OF ALBERTA ACT, C. H-7.2*  
(ORDER-IN-COUNCIL 80/2012)

The Honourable John Z. Vertes, Commissioner

**RULINGS ON STANDING AND FUNDING****I. INTRODUCTION**

I have been appointed to conduct a public inquiry concerning the possibility of improper preferential access to publicly funded health services. The terms of reference, as set out by Order-in-Council 80/2012, issued on February 28, 2012, are to consider:

1. Whether improper preferential access to publicly funded health services is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, make recommendations to prevent improper access in the future.

There will be two phases to this inquiry. The first will be a fact-finding inquiry to determine if improper preferential access is occurring. The second will be directed to policies and procedures that will assist in formulating recommendations to prevent such activities in the future.

The Order-in-Council also directed me to develop and submit to the Lieutenant Governor in Council a policy on whether assistance will be provided to witnesses or interveners to prepare submissions or for the costs of legal counsel.

Canadian jurisprudence, particularly with respect to commissions of inquiry, has recognized the importance of allowing interventions by parties who have a direct and substantial interest in the proceedings. This helps to ensure that an inquiry is able to fulfill its mandate by having before it all the relevant facts and circumstances. It also ensures

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## Relevant Documents

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fairness, both procedurally and substantially. The jurisprudence also recognizes that funding may be necessary for those parties who establish an inability to meaningfully participate in the inquiry process without financial assistance. This too helps to ensure fairness.

This inquiry has been established under the provisions of the *Health Quality Council of Alberta Act*. Section 17(5) of that Act gives me the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*. Neither statute expressly addresses grants of standing to interveners or the funding of witnesses and interveners. There are sections in both that require notice be given to persons who may be the subject of negative comment or findings and then those persons are to be given an opportunity to address the allegations (see Section 22(2) of the *Health Quality Council of Alberta Act* and Section 13 of the *Public Inquiries Act*). But whether this inquiry will be required to issue such a notice to any person is irrelevant to a grant of standing or funding. The purpose of such notices is simply to ensure that an inquiry complies with the principle of fairness. A public inquiry issues notice to the persons affected so that the recipients of such notice may provide a response to potential adverse findings.

With these principles in mind, I issued first a “Policy for Standing” that sets out the necessary criteria for a grant of standing and the procedure to be followed. In order to properly develop a policy on funding one has to know the basis on which a party may be given standing. That “Policy on Standing” sets out two criteria:

- a) the applicant is or may be directly or substantially affected by the Inquiry; or
- b) the applicant has or represents a clearly ascertainable interest or perspective, the representation of which ought to be separately represented at the Inquiry, and the representation of which will assist the Commissioner in fulfilling the mandate of the Inquiry.

A grant of standing will permit that party (called an “intervener”) to participate in the inquiry, or parts of the inquiry, with the right to make submissions, the right to cross-examine witnesses, the right to advance notice of documents and the provision of evidence statements, the opportunity to suggest witnesses to be called by Commission counsel,

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all subject to such terms and conditions as I may prescribe and the rules of procedure established for the inquiry.

I also issued a “Funding Policy” which was approved by Order-in-Council 264/2012 issued on July 25, 2012. The fundamental aim of that policy is to establish financial need as the primary consideration and then to balance that need along with the applicant’s interest and anticipated contribution to the inquiry against the need to exercise care in the expenditure of public funds. The policy specifies that I may make a funding decision whether the funding wholly indemnifies the applicant or only partially and I may set conditions on the grant of funding.

The requirements that an applicant for funding must satisfy and the considerations that go into my decision are set out in the policy as follows:

1-6 An application for financial assistance must be supported by:

- a) a sworn statutory declaration proving that the applicant does not have sufficient financial resources from any source to enable it to meaningfully participate in the Inquiry;
- b) a written budget outlining the applicant’s proposed involvement in the Inquiry and the estimated costs to be incurred by the applicant; and
- c) a written proposal as to how the applicant will account for funds received.

1-7 In addition to the submissions of an applicant, the Commissioner will also consider other factors when deciding the application for financial assistance, including:

- a) whether the applicant is a witness, an intervener or both;
  - b) in the case of applicants who are witnesses, whether the applicant’s testimony is being compelled by Commission Counsel;
  - c) the nature and extent of the applicant’s interest, including whether the applicant might be adversely affected by the report of the Commissioner;
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## Relevant Documents

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- d) whether the applicant has a demonstrated record of concern for and commitment to the interest it seeks to represent;
- e) whether the applicant has special experience or expertise relevant to the Inquiry's mandate; and
- f) whether the applicant could reasonably be included in a group with others of similar or overlapping interests.

The funding policy does not, and I do not in these rulings, address the question of payment of expert witnesses. The primary responsibility for calling any witness, including experts, lies with Commission Counsel. Experts called by Commission Counsel will be paid by this Commission. The funding policy is restricted to providing financial assistance to witnesses and interveners to prepare submissions or for the costs of legal counsel.

I also take the view that any funding decision be for a limited amount as opposed to open-ended funding on the basis of time spent. This will encourage efficiency and moderation. The policy also adopts the tariff on counsel fees set by the Government of Alberta for the retention of external counsel.

Finally, the funding policy enables me to make a "funding decision" but that decision must still be communicated to the Lieutenant Governor in Council with a request for the funding. This too accords with recent inquiries where the commissioner merely makes a recommendation to government for the funding of interveners. This is a reflection of the government's ultimate responsibility for the expenditure of public funds. But, of course, the public interest in a full, open and fair inquiry is a major consideration in the ultimate grant of funding by the government.

## **II. APPLICATIONS**

This Commission announced its intention to hold public hearings into standing and funding applications when it issued the policies on those two subjects. A Notice was published and distributed inviting interested parties to apply by August 31, 2012. A further Notice was published setting out the time and place for the hearings, which were held in Edmonton on October 15 and 16, 2012.

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I heard six (6) applications for standing, of which four (4) also applied for funding. I cannot comment on why there were not more applications but Commission Counsel did make contact with a large number of organizations that were thought to have an interest in the subject-matter of this inquiry.

The applicants, and my decision with respect to each, are as follows:

**1. *Alberta Health Services:***

This applicant delivers and administers most of the publicly-funded hospital, health facility and community health services in Alberta. In light of its clear interest in the issues raised in the Order-in-Council, I am satisfied that Alberta Health Services meets the criteria for standing. It is not applying for funding.

This applicant will have participation rights as follows and subject to the following limitations:

- a) the right to be present and represented by counsel throughout the inquiry;
- b) the right to make submissions;
- c) the right to receive advance disclosure of evidence to be called, and documents to be referred to, by Commission Counsel in accordance with the Commission's rules of procedure;
- d) the right to suggest to Commission Counsel the names of witnesses that should be called or evidence that should be presented and, in the event of a dispute, to apply to me for directions;
- e) the right to cross-examine witnesses, subject only to any agreement between counsel or my directions with respect to the cross-examination of expert witnesses.

These rights are to be read in accordance with and as complementary to the Commission's rules of procedure as promulgated from time to time and any directions from me as the Commissioner.

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## ***2. Government of Alberta:***

The government, through the Ministry of Health, plays a key role in Alberta's health care system and has a direct interest in the subject-matter of this inquiry. It clearly meets the criteria for standing. It is not applying for funding.

The government will have standing and have the same participation rights as those previously set out for Alberta Health Services.

## ***3. Alberta Medical Association:***

The Alberta Medical Association applies for both standing and funding.

This Association represents over 11,000 Alberta physicians, medical residents and medical students and serves as an advocate for its physician members. In my opinion they clearly meet the criteria for standing and I so informed their counsel at the hearing.

Therefore, this Association will have the same participation rights as I outlined for Alberta Health Services.

With respect to funding, the Association filed a statutory declaration from its Executive Director stating that (i) the Association depends on membership dues to fund its activities; (ii) the funds required for legal assistance for this inquiry have not been budgeted for in its current budget and were not taken into account in setting this year's membership dues; (iii) funding assistance would allow the Association to continue funding existing programs as opposed to reducing expenditures; (iv) having to fully fund their legal expenses would prejudice other programs; and (v) the Association will incur additional in-house costs due to its participation in the inquiry. What this applicant did not do was either file a financial statement or be able to tell me, at the hearing, what their revenues and reserves were.

Subsequent to the hearing, the Association filed, on a confidential basis, its consolidated financial statements for the fiscal year ended September 30, 2011. In my opinion, having regard to the requirement in the funding policy for an applicant to establish it does not have sufficient financial resources to meaningfully participate in the inquiry, it would have been helpful to disclose this from the outset. What even a cursory examination of those statements reveals is that the

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Association, in 2011, had a significant net revenue and has significant reserve funds. It has the resources to adequately fund its participation in this inquiry.

Therefore, the application for funding is denied.

#### ***4. Consumers' Association of Canada (Alberta):***

This Association has applied for standing and funding.

The Association was incorporated in Alberta in 1978. It is a non-profit, non-partisan provincial association. It relies on donations and ad-hoc grants to carry out its work. Its mandate is to improve the quality of life by protecting and promoting consumer rights including health and safety. The Association has investigated various issues relating to the delivery of health services in Alberta and made recommendations to legislative committees and others. Its aim in participating in this inquiry is to make sure that the voice of the “consumer” of health services is incorporated in its work.

I think this Association can bring a valuable perspective to the inquiry's work, one different from that of health providers, government and professional organizations. Preferential access to health services can have an impact on all consumers of those services. I indicated at the hearing that I was not convinced that this organization needs full standing in all aspects of the inquiry to make its perspective known and to contribute to our work. I thought that perhaps the Association's contribution should be limited to the second phase of the inquiry's work, that being the formulation of recommendations to prevent the occurrence of such improper access.

On reflection I am satisfied, notwithstanding my earlier comments, that the Association should be granted standing for the entire inquiry. The nature and extent of this organization's interest with respect to health care relate to the broad consumer public interest, particularly in relation to access and patient safety. It could bring a different perspective to the consideration of fair and appropriate access to health care services. This applicant meets the policy criterion of representing a clearly ascertainable interest or perspective which ought to be separately represented and would assist this Commission in fulfilling its mandate.

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## Relevant Documents

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Therefore, I grant standing to the Association with the same participation rights as I previously set out for Alberta Health Services.

With respect to the funding application, I am satisfied that the Association has no financial resources available to it so as to fund the services necessary for meaningful participation. The Association has a demonstrated record of concern and commitment for the interests of Alberta consumers. There is no group that has already been granted standing with which this organization could reasonably be included.

The Association has presented a budget anticipating full participation throughout the inquiry (an anticipated 20 days of hearings, preparation and research). It is not for me to second-guess the amount of research and preparation time that will be required but, as I noted previously, my funding decisions will not provide an open-ended financing but be capped at a maximum amount and all payments will only be for actual work done and reasonable disbursements incurred.

I therefore recommend a sum up to \$120,000.00 as financial assistance to this Association. The funds will be used to pay accounts submitted by its counsel. Those accounts must include (a) the date the activity was undertaken; (b) a description of the activity undertaken; (c) the time incurred with respect to each service; and (d) the amount charged according to the tariff appended to the funding policy. The accounts are to be first approved by a duly-authorized board member of the Association and then submitted to the Commission's Executive Director who will also review and authorize them for payment.

### ***5. Project International Hope Institute for Human Rights:***

This organization filed an application for standing and funding. Its spokesperson, Dr. C. Paula van Nostrand, appeared at the hearing. This organization purports to speak for a network of volunteers who look after the various needs of people living in urban poverty. Their intent, as gleaned from their written submission, is to protect the interests of the disadvantaged and prevent the privatization of community health care.

It is undeniably the case that the voices of the poor, the disabled, and other marginalized groups, need to be heard in any discussion about the allocation of government resources and especially how health services are provided. But these issues are beyond the scope of this inquiry's

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mandate. Improper preferential access may arise because of someone's influence or wealth, and that may have an impact on others waiting for health services, but this is a narrower scope, and a more focused one, than how the health system addresses the needs of the poor generally. Also, I have grave concerns that this is a self-created organization of one and that it lacks the credibility necessary to speak for a sizeable constituency within the community. There is no demonstrated and objective track record of its work.

For these reasons, I do not find that this organization meets the criteria for standing or funding. The application is denied.

### ***6. Renal Dialysis Rimbey Support Group:***

This applicant is a community-based, non-profit organization from Rimbey, Alberta. Its mission is to represent area residents who require renal dialysis and its goal is to bring a renal dialysis unit to the Rimbey General Hospital. Currently, patients have to go to Red Deer for dialysis treatments.

As I explained at the public hearing, it is not the mandate of this inquiry to examine the allocation of government resources. While I certainly sympathize with the concerns of this group I cannot make recommendations as to how government should allocate services, even essential services such as renal dialysis.

Therefore, I am not granting standing to this organization.

Nevertheless, this organization can bring a helpful perspective on the more general question of preferences in the health care system, and in particular, whether preferential access arises because of geographic distinctions, such as people living in urban areas having more readily accessible services than people living in rural areas. I therefore encourage this organization, as I did at the hearing, to prepare a written submission on this issue and the impact on its community. In order to assist this organization to do so, and since they have no sources of revenue, I have decided that this organization be granted financial assistance in a sum up to \$5,000.00. This is in accordance with this inquiry's Funding Policy which provides that financial assistance may be provided for the purpose of preparing submissions. This amount is to be used to retain the services of a suitable individual (perhaps a graduate student in a relevant field of study) to assist in the preparation

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## Relevant Documents

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of this submission. The name and professional qualifications of that individual are to be provided to the Commission's Executive Director and ultimately all invoices are to be submitted to the Executive Director.

**III. CONCLUSION**

I will be communicating to the Lieutenant Governor in Council, through the Minister of Health and Wellness, my decisions as to funding. I expect, however, that there may be further applications for standing and funding depending on the evidence that will be presented at the upcoming public hearings, especially if statutory notices are issued. I will address any such further applications if and when they are presented to me.

DATED this 19<sup>th</sup> day of October, 2012.

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Honourable John Z. Vertes, Commissioner

**Appearances:**

Commission Counsel	Michele H. Hollins, Q.C. Jason L. Wilkins
Alberta Health Services	Brent F. Windwick, Q.C.
Government of Alberta	Vivian R. Stevenson, Q.C.
Alberta Medical Association	Jonathon P. Rossall, Q.C. Dr. William Hyndyk
Consumers Association of Canada (Alberta)	Deborah E. Prowse, Q.C.
Project International Hope Institute for Human Rights	Dr. C. Paula van Nostrand
Renal Dialysis Rimbey Support Group	Irene Kurta-Lovell Lorna Diggie

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**e(ii) RULING ON AN APPLICATION FOR FURTHER INTERVENER FUNDING**

IN THE MATTER OF A PUBLIC INQUIRY INTO ALLEGATIONS  
OF IMPROPER PREFERENTIAL ACCESS TO PUBLICLY  
FUNDED HEALTH SERVICES PURSUANT TO THE *HEALTH  
QUALITY COUNCIL OF ALBERTA ACT, C. H-7.2*  
(ORDER-IN-COUNCIL 80/2012)

The Honourable John Z. Vertes, Commissioner

**RULING ON AN APPLICATION FOR FURTHER INTERVENER FUNDING**

On October 19, 2012, I issued rulings respecting various applications for standing and funding pursuant to the policies established by this Commission and approved by a subsequent Order-in-Council. Among those rulings was the grant of standing to the Consumers' Association of Canada (Alberta). I also granted funding for Association for legal representation of up to \$120,000.00. The Association has now made a request for additional funding.

When I made my initial rulings, the schedule for this inquiry anticipated four weeks of hearing evidence and an additional week for submissions. In January it became apparent that additional weeks would be required for the hearing of evidence. As a result, two further weeks were added to our schedule.

The original grant of funding to the Association was premised on the original schedule. With the addition of further weeks of hearing the budget initially proposed by the Association has proven to be inadequate to provide for the necessary legal representation. Without additional funding it cannot continue to participate meaningfully in this inquiry. As I stated in my earlier rulings, the Association has a demonstrated record of concern and commitment to the interests of Alberta consumers and it has, to date, played a helpful role in this inquiry. I am therefore satisfied that additional funding is appropriate.

The Association has provided a further detailed budget for the additional days of hearing. It is in my opinion a reasonable one that is within the parameters established by this inquiry's policies.

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Relevant Documents

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I am therefore granting to the Association additional funding up to the sum of \$28,000.00. These funds, as before, will be used to pay the accounts submitted by legal counsel. The accounts must be in the form stipulated in my earlier ruling. The accounts are to be first approved by a duly-authorized board member of the Association and then submitted to the Commission's Executive-Director for review and authorization for payment.

DATED this 15<sup>th</sup> day of March, 2013.

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Hon. John Z. Vertes

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**(f) OPENING STATEMENT**

October 15, 2012

Today we begin the public proceedings of the Health Services Preferential Access Inquiry.

This inquiry was established by the cabinet's Order-in-Council issued on February 28, 2012. Section 17 of the *Health Quality Council of Alberta Act* provides that the Lieutenant-Governor in Council may order an inquiry into a matter relating to the health system and may direct the Board of the Health Quality Council to appoint a panel to conduct such an inquiry. On March 5, 2012, I was appointed as a one-person panel.

The Inquiry's terms of reference are two-fold:

1. To assess whether improper preferential access to publicly funded health services in Alberta is occurring; and
2. If there is evidence of improper preferential access to publicly funded health services occurring, to make recommendations to prevent such improper access in the future.

This Inquiry is independent of the government and independent of the Health Quality Council. My mandate is to examine the evidence, if there is evidence, relative to the terms of reference and to report my findings to the Speaker of the Legislative Assembly by April 30, 2013. As the panel for this inquiry, I will be guided only by the evidence and representations presented to me, in public, in the course of this inquiry, keeping in mind my over-arching responsibility to be fair and impartial.

I realize that there have been numerous complaints aired in the press and elsewhere to the effect that this inquiry's mandate is too narrow. That is not something for me to comment on. Let me simply say that I take the Premier at her word when she was quoted as saying that this inquiry can follow the evidence wherever it leads.

I should also note that this is the first inquiry ever to be held under the *Health Quality Council of Alberta Act*. This will explain some of the

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## Relevant Documents

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delay in getting things started as administrative details had to be worked out so as to ensure the independence of this inquiry.

The background to this inquiry is well-known.

Allegations have been made that some individuals are being given, or have been given, preferential access to publicly funded health services in Alberta. This is commonly labeled “queue-jumping” in the media. Such a practice is improper and reprehensible. We all accept that access to publicly-funded health services should be based on patient need and the relative acuity of a patient’s condition. It is improper to gain access to publicly funded health services through threat, influence or favour. It is in the public interest to assure our citizens that the publicly funded health care system enables Albertans to have fair and appropriate access to health services.

In 2002, the Honourable Roy Romanow issued his Royal Commission Report on the Future of Health Care in Canada. He wrote then that Canadians strongly support the core values of equity and fairness on which our health care system is premised. Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Allegations of improper preferential access strike at these values and that is why such allegations, if substantial, have to be investigated.

This Inquiry will be conducted in accordance with the statutory provisions contained in the *Health Quality Council of Alberta Act*. As the panel appointed to carry out this inquiry, I have the powers of a Commissioner under the *Public Inquiries Act*.

This Inquiry has broad powers of subpoena, but it is not a court of law. I cannot find individual fault. Indeed, Section 22 of the *Health Quality Council of Alberta Act* prohibits any findings of legal responsibility or any conclusions of law. What I can and must do is to find the facts and make recommendations.

I will now tell you a bit about myself and the senior staff who will be working with me. I am John Vertes, recently retired as the Senior Judge of the Supreme Court of the Northwest Territories. I was appointed in September, 1991 as a judge of the Supreme Court of the Northwest Territories as well as a justice of the Court of Appeal of

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Yukon and Northwest Territories. In 1999, I was appointed to the Nunavut Court of Justice and the Nunavut Court of Appeal. I retired from the bench on July 1, 2011, and now live in Calgary.

The administrative management of this Commission will be the responsibility of Sheila-Marie Cook CVO, whom I have appointed to be Executive Director and Commission Secretary. Mrs. Cook is the former Deputy to the Governor General of Canada and also has extensive experience with major public inquiries and Royal Commissions. I am confident that everything related to our inquiry will be done in a timely and effective manner to support our hearings and the eventual production of our final report.

The Commission's lead counsel is Michele H. Hollins, Q.C., a partner in the firm of Dunphy Best Blocksom LLP in Calgary. Ms. Hollins has a varied civil and commercial litigation practice and extensive court room experience at all levels of Alberta Courts. Jason Wilkins, a partner of the same firm, will act as associate counsel for this inquiry. He has experience in mediations, both judicial and private, and advocacy experience at all levels of Court in Alberta, including significant trial and appellate work.

We are anxious to have input from Albertans who may have information to share on a confidential basis. The inquiry has established a website to enable individuals to submit such information during the fact-finding stage now underway. We are interested in anything that might support our investigation. It will be up to Commission Counsel to determine whether any of this information will be used in the public hearings. I am hopeful that this technology will allow Albertans, no matter where they may be located, to participate in this public process. Of course, they can also contact the Commission by telephone, fax or mail.

Today we are here to consider applications for standing and funding.

The Commission has adopted a policy regarding applications for standing. Essentially, any person or entity may apply for full or partial standing, which, if granted, permits them to participate in the hearings as an intervener. This term has no adversarial implications. Grants of standing may be subject to such terms and conditions as I consider appropriate.

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## Relevant Documents

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My decisions regarding applications for standing will be based on two sets of criteria: First, whether the applicant is or may directly or substantially be affected by the Inquiry; and second, whether the applicant represents a clearly ascertainable interest or perspective which ought to be represented separately at this Inquiry and which will assist me in fulfilling the Inquiry's mandate.

This part of our hearings are only being held in Edmonton since all applicants are Edmonton-based. I did not think it prudent or cost-effective therefore to hold standing hearings in Calgary.

The Government approved a budget for this inquiry through an Order-in-Council on July 25, 2012, and accepted the Panel's Funding Policy for Witnesses and Interveners which is set out in Appendix 2 of that document.

Essentially, any witness or intervener can apply for funding for legal assistance. I have the authority to make a "funding decision" – that the applicant should receive financial assistance for the purpose of preparing submissions, or for the costs of legal counsel, to facilitate participation in the Inquiry.

If I decide that an applicant should receive funding then I will request those funds from cabinet.

I will also establish a set of rules governing practice and procedure for this public inquiry. The rules are designed to ensure fairness and efficiency in the inquiry process for the evidentiary part of these hearings, which will be held in Edmonton and Calgary in December and January.

To summarize these proposed rules without going into all the details, they provide, among other things, that:

1. All parties and witnesses have the right to counsel both at the Inquiry and at any pre-testimony interviews;
  2. Commission counsel have the primary responsibility to call and question witnesses. Any party may apply to me for leave to have any witness called whom Commission counsel elects not to call;
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3. Each witness and party shall be provided with copies, in paper or electronic form, of documents and evidence which are relevant to the party's or witness' interest, to the extent it is appropriate to do so, together with the documents which Commission counsel expects to put to him or her in the course of his or her testimony, and will have the right to introduce their own documentary evidence;
4. All hearings will be held in public unless an application is granted for a publication ban or for a portion of the hearing to be held *in camera* in conformity with the statutory provisions that apply;
5. Parties are encouraged to provide to Commission counsel the names and addresses of all witnesses they feel ought to be heard, and to provide all relevant documents, at the earliest opportunity;
6. Although evidence may be presented that might not ordinarily be admissible in a court of law, I shall be mindful of the danger of admitting such evidence and, in particular, its possible effect on someone's reputation.

Transcripts of each day's testimony and copies of filed exhibits will be posted on the Commission website.

I urge all interested parties and their counsel to read the rules once they are finalized and become familiar with them. To the extent that all participants in this important public process adhere to the rules, the process will be more efficient and the Commission's work will be done more effectively.

I have also promulgated a media policy and I encourage members of the press to review that with my Executive Director. I am committed to an open and transparent process so the co-operation of the media will be vital.

The work that lies ahead is most challenging and of great importance to the citizens of Alberta as well as to the integrity of our health care system. I have been entrusted to oversee this process and to ensure that the Commission's work is thorough and results in meaningful recommendations. I am confident that the administrative and legal aspects will be handled with skill and efficiency by the team I have

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Relevant Documents

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assembled. I look to all participants for their cooperation and dedication so that, at the end of this process, the public will be satisfied that the issues have received a full and fair examination.

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**(g) EXHIBIT LIST**

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

The inquiry proceeding under sections 17 and 22 of the *Health Quality Council of Alberta Act*

Before The Hon. J.Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry

INQUIRY EXHIBIT LIST					
Date	Exhibit #	Description	Submitting Party	Triage#	Notes
<b>October 15, 2012</b>	1	Order in Council- February 28, 2012	Commission Counsel	EXH-001-000001	4 pages
	2	Order in Council - July 25, 2012	Commission Counsel	EXH-001-000005	4 pages
	3	Letter- August 31, 2012	Alberta Health Services	EXH-001-000009	2 pages
	4	Letter- August 31, 2012	Government of Alberta	EXH-001-000011	4 pages
	5	Letter- September 30, 2012	Alberta Medical Association	EXH-001-000015	6 pages
	6	Statutory Declaration – M Gormley	Alberta Medical Association	EXH-001-000021	6 pages
	7	Letter- October 13, 2012	Alberta Consumers Association	EXH-001-000027	1 page
	8	Application – October 14, 2012	Alberta Consumers Association	EXH-001-000028	7 pages
	9	Package of Documents	Project Hope – Dr. van Nostrand	EXH-001-000035	19 pages
<b>October 16, 2012</b>	10	Package of Documents	Renal Dialysis of Rimbev	EXH-001-000054	20 pages
<b>December 3, 2012</b>	11	Report of Professor William Lahey,	Commission Counsel	EXH-001-000074	Red Binder, (65 pages)
	12	Report of J.L. Saunders	Commission Counsel	EXH-001-000139	White Binder, (148 pges)
<b>December 4, 2012</b>	13	Curriculum Vitae of D.W. Megran	Commission Counsel	EXH-001-000287	31 pages
	14	"Request for Preferential or Expedited Care" by D.W. Megran	Commission Counsel	EXH-001-000318	May 10, 2009 (1 page)
	15	Email from Megran to Duckett	Commission Counsel	EXH-001-000319	May 10, 2009, (5 pages)
	16	Memo from Duckett to Executives	Commission Counsel	EXH-001-000321	June 11, 2009, (2 pages)
	17	Email from J. Robinson to D.W. Megran (re: Caritas Policy)	Commission Counsel	EXH-001-000323	June 16, 2009 (10 pages)
	18	Draft Policy "Request for Preferential or Expedited Care"	Commission Counsel	EXH-001-000333	November 30, 2012 (3 pages)

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Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	19	Curriculum Vitae of Stephen Duckett	Commission Counsel	EXH-001-000336	15 pages
	19A	Procedural Order #1: Video Conferencing Testimony Dr. Duckett	Commission Counsel		1 page
	20	Minutes of Meeting, Chief Executive Officer Report	Commission Counsel	EXH-001-000351	May 2009, (6 pages)
	21	Duckett speech	Commission Counsel	EXH-001-000357	Dec 6, 2010 (2 pages)
	22	Duckett speech	Commission Counsel	EXH-001-000359	May, 2011 (1 page)
<b>December 5, 2012</b>	23	Emergency Admission Flow Chart	Commission Counsel	EXH-001-000360	2 pages
	24	Curriculum Vitae Paul Parks	Commission Counsel	EXH-001-000362	6 pages
	25	Letter from B. Holroyd to D. Gordon and K. Gardener	Commission Counsel	EXH-001-000368	"Paul Parks" letter, (6 pages)
	26	Curriculum Vitae of Brian Holroyd	Commission Counsel	EXH-001-000374	35 pages
	27	Letter from B. Holroyd to D. Gordon and D. Taylor	Commission Counsel	EXH-001-000409	With addresses, Dec 5, 2007, (5 pages)
<b>December 6, 2012</b>	28	Resume of David S. Diamond	Commission Counsel	EXH-001-000414	2 pages
	29	Curriculum Vitae of D. Gordon	Commission Counsel	EXH-001-000416	7 pages
<b>December 10, 2012</b>	30	Resume of Kathy Taylor	Commission Counsel	EXH-001-000423	2 pages
	31	Resume of Donald Christensen	Commission Counsel	EXH-001-000425	3 pages
	32	Memo from D. Christensen to Nicole Farago	Commission Counsel	EXH-001-000428	October 11, 2012 (1 page)
<b>December 11, 2012</b>	33	Hansard Excerpt March 17, 2009	Commission Counsel	EXH-001-000429	1 page
	34	November 3, 2009 email to K. King	Commission Counsel	EXH-001-000430	1 page
	35	November 3, 2009 email from Caloary West to Health Minister	Commission Counsel	EXH-001-000431	1 page
	36	Letter to Hon. Ron Liepert, (fax date on top November 3, 2009)	Commission Counsel	EXH-001-000432	1 page
	37	AR77491 Action Request November 20, 2009	Commission Counsel	EXH-001-000433	1 page



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Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	38	AR77708 Action Request December 10, 2009	Commission Counsel	EXH-001-000434	1 page
	39	Resume of Ms. Patty Grier	Commission Counsel	EXH-001-000435	2 pages
	40	Professional Experience (Resume) of Lynn Redford	Commission Counsel	EXH-001-000437	1 page
	41	Email from Debbie Korzeniewski	Commission Counsel	EXH-001-000438	1 page
<b>December 13, 2012</b>	42	Caritas Health Group Act (June 26, 1992)	Commission Counsel	EXH-001-000439	3 pages
	43	Bill Pr2 (Caritas H.G. Statutes Amendments Act-2009)	Commission Counsel	EXH-001-000442	13 pages
	44	Patient Care Manual Procedure	Commission Counsel	EXH-001-000455	2 pages
	45	Patient Care Manual Policy	Commission Counsel	EXH-001-000457	7 pages
	46	Mission Discernment Case Study 5 – Accommodating Special Requests (VIP treatment)	Commission Counsel	EXH-001-000464	1 page
	47	Memo from Patrick Dumelie to Caritas Managers and Physician Leaders	Commission Counsel	EXH-001-000465	October 1, 2007, (2 pages)
	48	Covenant Health – Accommodating Special Requests (Corporate Policy & Procedures Manual)	Commission Counsel	EXH-001-000467	7 pages
	49	Patient Care Manual Policy – Request for Specific Gender of Healthcare Provider	Commission Counsel	EXH-001-000474	2 pages
	50	Patient Care Manual Procedure – Request for Specific Gender of Healthcare Provider	Commission Counsel	EXH-001-000476	4 pages
	51	Mission Discernment Case Study 4 – Patient requests for specific health care provider	Commission Counsel	EXH-001-000480	1 page
	52	Patient Request for Specific Health Care Provider – Corporate Policy & Procedures Manual	Commission Counsel	EXH-001-000481	2 pages
	53	December 5, 2007 letter from Dr. Holroyd to D. Gordon and D. Taylor	Commission Counsel	EXH-001-000483	5 pages
	54	Email from Dennis Laughlin to Edmonton Meadowlark (June 8, 2011)	Commission Counsel	EXH-001-000488	1 page
	55	Letter to Ethics Commissioner Legislative Assembly (June 10, 2011)	Commission Counsel	EXH-001-000489	2 pages

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INQUIRY EXHIBIT LIST					
Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	56	Email from Paul Parks (October 16, 2012)	Commission Counsel	EXH-001-000491	3 pages
	57	Portion of Power Point presentation "Alberta's Health Legislation: Moving Forward"	Commission Counsel	EXH-001-000494	Cover, slide 23 and 24, (3 pages)
	58	Email from Raj Sherman to Shelia Weatherill (February 22, 2008)	Commission Counsel	EXH-001-000497	2 pages
	59	CTV Edmonton Interview transcript (June 7, 2011)	Commission Counsel	EXH-001-000499	2 pages
	60	CBC Interview/No hospital wait for "buddies" (June 7, 2011)	Commission Counsel	EXH-001-000501	2 pages
	61	Letter to Steve Sabey (September 30, 2010)	Counsel - Raj Sherman	EXH-001-000503	10 pages
	62	Letter dated September 13, 2010 from Kim Shulha to Dr. Sherman	Counsel - Raj Sherman	EXH-001-000513	4 pages
	63	Letter to Premier Alison Redford (November 3, 2011) from opposition leaders	Counsel - Raj Sherman	EXH-001-000517	2 pages
	64	Letter to D/Comm. McGowan RCMP (June 7, 2011)	Commission Counsel	EXH-001-000519	1 page
	65	Interoffice Memorandum to B. Mason from R. Liebrecht (10/09/2012)	Commission Counsel	EXH-001-000520	2 pages
January 7, 2013	66	Hansard Excerpt from April 8, 2009	Commission Counsel	EXH-001-000522	2 pages
	67	Procedural Order #2: Witness Statement of Lori Jobson	Commission Counsel	EXH-001-000525	1 page
	68	Witness Statement of Lori Jobson	Commission Counsel	EXH-001-000526	Note: typo for sworn date, sb 2013. (1 page)
	69	Curriculum Vitae: Shelia Weatherill	Commission Counsel	EXH-001-000528	3 pages
January 10, 2013	70	Curriculum Vitae: Dr. Nicholas G.H. Mohtadi	Commission Counsel	EXH-001-000531	46 pages
	71	Surgical Booking Request: AHS	Commission Counsel	EXH-001-000577	1 page
	72	The Referral Consultation Process Standard 6	Commission Counsel	EXH-001-000579	3 pages
	73	Alberta Netcare Website Excerpt	Commission Counsel	EXH-001-000582	5 pages
	74	Physician Patient Relationship: Establishing the Physician Patient Relationship in Office Based Settings: Standard 7	Commission Counsel	EXH-001-000587	duplicate exhibit #122 (3 pages)

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INQUIRY EXHIBIT LIST					
Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	75	Quality of Life Assessment in Anterior Cruciate Ligament Deficiency	Commission Counsel	EXH-001-000590	5 pages
	76	Quality of Life Assessment in Rotator Cuff Patients	Commission Counsel	EXH-001-000595	10 pages
	77	Hip – QOL: Quality of Life Questionnaire for Young Active Patients with Hip Problems	Commission Counsel	EXH-001-000605	6 pages
	78	Curriculum Vitae of William (Bill) Anderson M.D.	Commission Counsel	EXH-001-000611	2 pages
	79	News Article Global Edmonton, July 12, 2011 (re: Paula Findlay)	Commission Counsel	EXH-001-000613	3 pages
	80	Email from July 12, 2011 to Edmonton Mill Creek (GOV-001-0210)	Commission Counsel	EXH-001-000616	1 page
	81	Email from July 13, 2011 to Stoney Plain (GOV-001-0212)	Commission Counsel	EXH-001-000617	1 page
	82	Biographical Notes Neil R. Wilkinson	Commission Counsel	EXH-001-000618	1 page
January 11, 2013	83	Curriculum Vitae of Dr. James Thorne	Commission Counsel	EXH-001-000619	2 pages
	84	Letter to Dr. Trevor Theman from Dr. D. Megran (Nov 6, 2009)	Commission Counsel	EXH-001-000621	2 pages
	85	Letter to Dr. D. Megran from Dr. Karen Mazurek (Dec 21, 2009)	Commission Counsel	EXH-001-000623	3 pages
	86	Media Statement – November 4, 2009: AHS H1N1/Flames	Commission Counsel	EXH-001-000626	1 page
	87	Alberta Legislative Hansard – November 29, 2010	Government of Alberta	EXH-001-000627	16 pages
January 14, 2013	88	Resume of Lori Anderson	Commission Counsel	EXH-001-000643	3 pages
	89	Investigation Summary – November 4, 2009 (Re: Calgary Flames H1N1)	Commission Counsel	EXH-001-000646	3 pages
January 15, 2013	90	Referral Form from Colon Cancer Screening Centre	Commission Counsel	EXH-001-000649	1 page
	91	CCSC data base spread sheet	Commission Counsel	EXH-001-000650	7 pages
	92	CCSC referral sheet (#10)	Commission Counsel	EXH-001-000657	1 page
	93	CCSC referral form (#11)	Commission Counsel	EXH-001-000659	1 page
	94	CCSC referral form (#2)	Commission Counsel	EXH-001-000660	1 page
	95	CCSC referral form (#17)	Commission Counsel	EXH-001-000661	1 page
	96	CCSC referral form (#9)	Commission Counsel	EXH-001-000662	1 page

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Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	97	CCSC referral form (#15)	Commission Counsel	EXH-001-000663	1 page
	98	CCSC referral form (#7)	Commission Counsel	EXH-001-000664	1 page
	99	CCSC referral form (#18)	Commission Counsel	EXH-001-000665	1 page
	100	CCSC referral form (#12)	Commission Counsel	EXH-001-000666	1 page
	101	CCSC referral forms (#1,3,4,5,8 [2pgs],14,16)	Commission Counsel	EXH-001-000667	8 pages
	102	Sworn statement of Shelia Weatherill	Commission Counsel	EXH-001-000675	1 page
<b>IN CAMERA APPLICATION EXHIBIT</b>	A	Letter dated November 22, 2013	Commission Counsel	Confidential	
<b>IN CAMERA APPLICATION EXHIBIT</b>	B	Letter dated January 13, 2013	Commission Counsel	Confidential	
<b>January 16, 2013</b>	103	New for 2008, Clinical Practice Guideline: Screening for Colorectal Cancer	Commission Counsel	EXH-001-000676	18 pages
	104	CCSC Reporting structure Organization chart	Commission Counsel	EXH-001-000693	1 page
	105	CCSC Referra l, triage and Pre-Assessment Departmental Procedure	Commission Counsel	EXH-001-000694	6 pages
	106	!!Referral Received" organization flow chart (black and white)	Commission Counsel	EXH-001-000699	1 page
	107	Forzani & MacPhail CCSC "Triage Clerk picks up..." organization flow chart (color)	Commission Counsel	EXH-001-000700	1 page
	108	AHS CCSC: Department Policy: Endoscopist Responsibilities at the Centre	Commission Counsel	EXH-001-000701	5 pages
	109	Documents: FW: Concerns over endoscopy que jumping – CCSC policy on the subject	Commission Counsel	EXH-001-000706	4 pages
	110	Email from Joanne Zinter to Alaa Rostom, June 17, 2011	Commission Counsel	EXH-001-000709	1 page
	111	Letter, February 3, 2012 From Joanne Zinter (addressee redacted).	Commission Counsel	EXH-001-000710	2 pages
	112	Email: Re: Concerns over endoscopy que jumping – CCSC policy on the subject- from Shawna Syverson	Commission Counsel	EXH-001-000712	1 page
<b>January 17, 2013</b>	113	Email from Linda Duffley to CHS Influenza Site Leads – October 31, 2009	Commission Counsel	EXH-001-000713	1 page

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Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	114	AHS Memorandum – January 25, 2010 from Linda Duffley	Commission Counsel	EXH-001-000714	1 page
	115	Letter received December 31, 2009	Commission Counsel	EXH-001-000715	1 page
	116	Reporting form (Daily) for Pandemic H1N1 2009 Influenza vaccine	Commission Counsel	EXH-001-000716	2 pages
	117	Edmonton Zone, H1N1/Seasonal Influenza/Pneumococcal Immunization 2009/2010 spreadsheets	Commission Counsel	EXH-001-000718	2 pages
<b>January 18, 2013</b>	118	CMA Policy: CMA Code of Ethics	Commission Counsel	EXH-001-000720	4 pages
	119	Letter to Dr. Max Findlay from Ms. Dawn Sunde (July 20, 2011)	Commission Counsel	EXH-001-000724	1 page
	120	Letter to Ms. Dawn Sunde from Dr. Max Findlay (August 3, 2011)	Commission Counsel	EXH-001-000725	1 page
	121	Memorandum to Dr. Karen Mazurek from Ms. Dawn Sunde (August 11, 2011)	Commission Counsel	EXH-001-000726	1 page
	122	Establishing the Physician Patient relationship in Office Based Settings Standard #7	Commission Counsel	EXH-001-000727	Duplicate exhibit #74 (2 pages)
	123	Charging for Uninsured Medical Services Standard 18	Commission Counsel	EXH-001-000729	1 page
	124	Email from Karen Mazurek sent May 01, 2012 to (redacted) cc'd Ken Gardener	Commission Counsel	EXH-001-000730	1 page
	125	Conflict of Interest Involving Financial or Personal gain by Physicians standard 29	Ms. Prowse Q.C	EXH-001-000732	2 pages
	126	Ms. Rita Nieman application and documentation	Commission Counsel	EXH-001-000734	8 pages
	127	fax cover to Dr. Love from Dr. Caine with referral forms, billing sheet and booking notes	Commission Counsel	EXH-001-000742	4 pages
	128	GI Central Triage Status – August 2010 and Roles in GI Central Triage	Commission Counsel	EXH-001-000746	6 pages
	129	Letter (referral package) from Dr. Caine to Dr. Bridges (October 26, 2010)	Commission Counsel	EXH-001-000752	10 pages
	130	photocopy of Dr. Boswell notes (March 22, 2010)	Commission Counsel	EXH-001-000762	7 pages
<b>February 20, 2013</b>	131	Email from R. Bridges to Olga Koch and Darlene Pontifex (January 4, 2011)	Commission Counsel	EXH-001-000769	1 page
	132	Email from R. Bridges to Olga Koch and cc'd to Darlene Pontifex (January 4, 2011)	Commission Counsel	EXH-001-000770	1 page

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INQUIRY EXHIBIT LIST					
Date	Exhibit #	Description	Submitting Party	Triage#	Notes
	133	Email from R. Bridges to Olga Koch and Darlene Pontifex and Alaa Rostom (December 16, 2011)	Commission Counsel	EXH-001-000771	1 page
	134	Copy of one page of notes, November 22, 2010	Commission Counsel	EXH-001-000772	1 page
	135	Curriculum Vitae Dr. R. Bridges	Commission Counsel	EXH-001-000773	26 pages
<b>February 25, 2013</b>	136	Email dated January 18, 2012 From R. Bridges cc: Olga Koch (2pg)	Commission Counsel	EXH-001-000799	2 pages
	137	Email dated December 16, 2011, From R. Bridges cc: Olga Koch	Commission Counsel	EXH-001-000801	1 page
	138	AHS Medical Staff By-laws (excerpt)	Mr. David Steele	EXH-001-000802	7 pages
	139	Blank Individual Service Agreement forms	Commission Counsel	EXH-001-000809	2 pages
	140	Letter To Francois Belanger From Dr. Mark Swain dated February 17, 2013	Commission Counsel	EXH-001-000811	3 pages
	141	Appendix 1: GI Chart Review February 17, 2013	Commission Counsel	EXH-001-000814	17 pages
	142	Clinical Tally Sheets for 2011	Commission Counsel	EXH-001-000830	6 pages
	143	Individual Service Agreement, Dr. Bridges	Commission Counsel	EXH-001-000836	3 pages
	144	Recommendation for Administrative Appointment (December 6, 2012)	Commission Counsel	EXH-001-000839	1 page
	145	Set of emails from Helios to Bridges	Commission Counsel	EXH-001-000840	18 pages
	146	Minutes of April 2, 2012 Faculty of Medicine Leadership Forum	Commission Counsel	EXH-001-000858	3 pages
<b>February 26, 2013</b>	147	Ethics in Radiology: Wait Lists Queue Jumping	Alberta Health Services	EXH-001-000861	6 pages
	148	Do As I say, Not As I Do: a survey of public impressions of queue jumping and preferential access	Alberta Health Services	EXH-001-000867	5 pages
	149	Bound document containing Curriculum Vitae and reports of all panel participants (for both days of panel hearings)	Commission Counsel	EXH-001-000872	183 pages
	150	National Post Article: Top Doctor Admits to Queue-jump	Alberta Health Services	EXH-001-001050	2 pages
	151	"Alter Article": A Survey of Provider Experiences and Preceptions.. ."	Alberta Health Services	EXH-001-001052	6 pages
	152	Renal Dialysis Rimbey Support Group Application Report	Commission Counsel	EXH-001-001058	24 pages
	153	Response to Renal Dialysis Rimbey Support Group Application and Report	Alberta Health Services	EXH-001-001082	7 pages

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Appendix 4



In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

The inquiry proceeding under sections 17 and 22 of the *Health Quality Council of Alberta Act*

Before The Hon. J.Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry

INQUIRY EXHIBIT LIST					
Date	Exhibit #	Description	Submitting Party	Triage#	Notes
February 28, 2013	154	Sworn Statement of Heather Stubley	Commission Counsel	EXH-001-001088	2 pages
	155	Package of documents pertaining to Helios Wellness Centers	Commission Counsel	EXH-001-001090	24 pages
	156	Statutory Declaration of Dr. Terry Sosnowski	Commission Counsel	EXH-001-001114	1 page
	157	Affidavit of Monica Ulmer	Commission Counsel	EXH-001-001115	11 pages
	158	Statutory Declaration of Ms. Jennifer Currie	Commission Counsel	EXH-001-001127	2 pages
April 4, 2013	159	Helios Wine List	Commission Counsel	Not loaded into Triage as of April 3, 2013	1 page
	160	Letter from Shannon Wray, March 27, 2013 re: Helios Donors	Commission Counsel	Not loaded into Triage as of April 3, 2013	1 page
	161	Statutory Declaration of Leahann McElveen	Commission Counsel	Not loaded into Triage as of April 3, 2013	16 pages
	162	Statutory Declaration of Lee Tkaczyk	Commission Counsel	Not loaded into Triage as of April 3, 2013	2 pages
	163	Written submissions of Commission Counsel	Commission Counsel	Not loaded into Triage as of April 3, 2013	83 pages
	164	Written Submissions for Alberta Health Services	Brent Windwick, QC	Not loaded into Triage as of April 3, 2013	26 pages
	165	Written Submissions for Alberta Medical Association	Jonathan P. Rossall, Q.C	Not loaded into Triage as of April 3, 2013	17 pages
	166	Written Submissions for Government of Alberta	Vivian R. Stevenson, Q.C.	Not loaded into Triage as of April 3, 2013	56 pages
	167	Written Submissions for The Consumers Association of Alberta	Deborah Prowse, Q.C	Not loaded into Triage as of April 3, 2013	21 pages
	168	Written Submissions for Dr. Max Findlay	Simon Johnson	Not loaded into Triage as of April 3, 2013	4 pages
	169	Written Submissions for Dr. Rostom and Dr. Bridges	David Steele	Not loaded into Triage as of April 3, 2013	17 pages
	170	Written Submissions for Sheila Weatherill	Mona T. Duckett, Q.C.	Not loaded into Triage as of April 3, 2013	22 pages

## Exhibit List

In the Matter of the HEALTH SERVICES PREFERENTIAL ACCESS INQUIRY, by Order in Council, dated February 28, 2012.

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<b>INQUIRY EXHIBIT LIST</b>					
<b>Date</b>	<b>Exhibit #</b>	<b>Description</b>	<b>Submitting Party</b>	<b>Triage#</b>	<b>Notes</b>
	171	Written Submissions for Helios Wellness Centre	Shannon Wray	Not loaded into Triage as of April 3, 2013	19 pages
	172	Written Submissions for College of Physicians and Surgeons of Alberta	Craig Boyer	Not loaded into Triage as of April 3, 2013	278 pages
				<b>Total pages:</b>	<b>1699</b>