This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect third party personal information.

Hospital Appeal Board

Fourth Floor 747 Fort Street
Victoria British Columbia
Telephone: (250) 387-3464
Facsimile: (250) 356-9923

Mailing Address:
PO Box 9425 Stn Prov Govt
Victoria BC V8W 9V1
Website: www.hab.gov.ca

E-mail: hab@gov.bc.ca

DECISION NO. 2013-HA-003(a)

In the matter of an appeal under section 46 of the *Hospital Act*, R.S.B.C. 1996, c. 200.

BETWEEN:	Dr. Randy Walker	**APPELLANT**
AND:	Fraser Health Authority	**RESPONDENT**

BEFORE: A Panel of the Hospital Appeal Board
David G. Perry, Chair
Joanna Nemrava, Member
Rick Riley, Member

DATE: December 2, 3, 4 and 5, 2013

PLACE: Surrey, BC

APPEARING: For the Appellant: James H. MacMaster, Counsel
For the Respondent: Penny A. Washington, Counsel

APPEAL

[1] This is an appeal brought by the Appellant against a decision of the Fraser Health Authority ("FHA") Board dated February 1, 2013. The FHA Board refused to grant operating privileges in the ophthalmology department of Chilliwack General Hospital ("CGH") and the Appellant seeks to have that decision overturned.

[2] The Appeal is brought pursuant to section 46 of *Hospital Act*. R.S.B.C. 1996 c.200 (the "Act").

[3] A hearing before the Hospital Appeal Board ("HAB") is *de novo* (section 46(2.3)) and the HAB has broad jurisdiction to consider relevant evidence and substitute its decision for that of the decision maker below: Act section 46(2) and (3).

[4] The parties helpfully provided the Panel a Statement of Agreed Facts which for ease of reference is reproduced in Appendix "A" at the end of this decision.

[5] The Appellant seeks an order from the HAB (to be effective the date of its decision) that the Chilliwack General Hospital site be added to the Appellant's privileges pursuant to the application made by the Appellant on October 12, 2012 and that the Appellant be included in the 2014 slate allocation when and to the extent his wait list makes it possible.

This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect third party personal information.

ISSUE

[6] The issue to be determined in this appeal is whether or not there is a need in the community for an additional ophthalmologist surgeon at CGH and if so whether the Appellant should be granted privileges.

BACKGROUND

Parties' position on remedy

[7] In its argument the FHA says that because no vacancy was declared for the privileges that the Appellant seeks to have granted to him that the Panel must follow the procedure in the Medical Staff Rules of Fraser Health. These require at Article 3.2. that the FHA will first determine whether or not there is a need for an application and if so follow the procedures set out in Article 4 of the *Medical Staff Bylaws*.

[8] Prior to this Appeal being brought to the HAB, the parties had agreed to a separate process which in effect held that the application of the Appellant for surgical privileges could be considered without first declaring a vacancy: Statement of Agreed Facts paragraphs 6 and 7.

[9] The Panel is not convinced that it must first declare a vacancy in this Appeal before considering whether or not the Appellant should be granted surgical privileges. As was noted in *Behn v. Vancouver Island Health Authority*, Hospital Appeal Board, (May 19, 2010) at paragraph 82-83:

> ...Given the time this has taken, together with the fact that we are entitled to make any decision that the VIHA board could make, we do not believe it would be in the public interest to remit the matter to the board with a direction that it follow the formal process... and order that VIHA grant Dr. Behn's application for appoint to the active medical staff of the division of ophthalmology, effective this date.

[10] If the Panel is convinced there is a need then it can appoint the Appellant to the Ophthalmological Department at CGH without the need to first declare a vacancy and follow the extensive procedure as set out in the *Medical Staff Bylaws.*

[11] For reasons set out below, the Panel is convinced that there is a need for an additional ophthalmological surgeon at CGH and accordingly upholds the appeal and orders that the Appellant be granted privileges in ophthalmology at CGH including participation in the on-call rota further to his application dated October 12, 2012.

Factors to determine "Need"

[12] The FHA says that the sole criteria to determine whether or not surgical privileges should be granted is need. In order to assess that need the FHA emphasized that there is sufficient on call coverage in the Chilliwack Area, CGH has the lowest waitlists for surgery in the region, and there is no unused operating time at Chilliwack General Hospital.

[13] The Appellant in his closing argument says that the Panel should consider the best interest of the community, including whether there is an unmet need of the

This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect third party personal information.

community. The Appellant refers to a number of prior HAB cases setting out various factors that should also be considered:

a. A sub-specialization or unique skill set: *Dr. Braun v. Surrey Memorial Hospital*, Medical Appeal Board, (January 23, 1989), page 14;

b. Man power plans: *Dr. Fox v. Kelowna General Hospital*, Hospital Appeal Board, (July 18, 1997), page 12;

c. Letters of support from physicians in the community: *Dr. Donna Cuthbert v. Royal Jubilee Hospital*, Medical Appeal Board, (April 22, 1986), page 5;

d. A lowered standard of care available for a practitioner who does not have surgical privileges: *Dr. Doreen Aitkin v. Penticton Regional Hospital*, Medical Appeal Board, (April 15, 1986), page 11; and

e. Whether there is unused operating room time: *Behn v. Vancouver Island Health Authority*, Hospital Appeal Board, (May 19, 2010) paragraph 75.

[14] The Panel agrees that these factors are useful in determining need in this appeal.

[15] Although the parties stress the differences in their approach to assessing need, the Panel finds that the tests urged by both parties are essentially the same. When need is considered in the context of the obligation of the FHA to provide efficient, high quality and cost effective care to all the residents of its region, it is apparent that the broad list of factors cited by the Appellant must be taken into account when assessing need.

[16] The Panel, as noted below, has some concerns with the reliance on waiting lists and in particular the assessment of the existing members of the Ophthalmological Department of CGH as tools to assess whether or not there is a need. As Dr. W, the Vice President of Medicine for FHA, on behalf of the FHA testified, the needs of the community must not be considered on a silo basis for each hospital but in terms of the overall needs of a large and diverse community.

History

[17] The Appellant is a graduate from the University of Saskatchewan, finishing his residence in June 2011 after which time he moved to Langley, B.C.

[18] His spouse is a specialist Veterinarian Pathologist and moved to the Fraser Valley Region in order to work at a Level 3 lab in the Abbotsford area which the Panel was advised is one of only 3 in Canada. Both the Appellant and his spouse plan to make their careers in the Fraser Valley region.

[19] The Appellant began working with a local ophthalmologist, Dr. N, in June of 2011 and eventually purchased his practice December 1, 2011.

[20] At the time of purchasing the practice, Dr. N did not have surgical privileges but did have outpatient or ambulatory privileges at Abbotsford Hospital. The Appellant used those privileges on a temporary or ad hoc basis while working with Dr. N. As noted in the Statement of Agreed Facts, the Appellant was eventually granted outpatient privileges at Abbottsford Regional Hospital on October 5, 2012.

[21] It was not made clear to the Panel when Dr. N lost his surgical privileges. Even having been deprived of surgical privileges, he continued to provide on-call services as a member of the ophthalmological community but on an outpatient basis only.

[22] CGH Eye Centre is an innovative and perhaps unique facility in British Columbia. It is called a "swing room" because two operating rooms are set up adjacent to one another. The advantage of this is that inpatient and O.R. clean-up can take place while surgeries are being undertaken in the second O.R. As a result, one surgeon can perform up to 28 cataract surgeries a day, compared with around 16 to 20 in a single room. There are also significant savings in staff time and hence cost.

[23] As a result of this efficiency the CGH has actually exceeded the number of surgeries allocated to it under its budget. The FHA has had to impose limits to the number of surgeries undertaken to achieve financial goals.

[24] Until early in 2011 there were 5 members of the surgical ophthalmological department at CGH. In February 2011, Dr. B had his O.R. days reduced from four to two, as he no longer wished to participate in on-call duty.

[25] This was an apparent breach of Section 5.8.5 and 5.8.6 of the *Medical Staff Rules* of the Fraser Health Authority which provide as follows:

> All Members shall participate equitably in Regional Department on-call rosters including weekend call rosters, except in special circumstances as approved by the regional department head and HAMAC.
>
> The facility or community resources assigned to a member should be reduced proportionally with the reduction of call responsibilities unless there is an agreement between Members of the Regional Department not to enact this article.

[26] Although Dr. B was not participating in on-call at all, he continued to use half of the O.R. privileges that he had before.

[27] Of interest is that no vacancy was declared by the FHA when allocating these two additional O.R. days. As will be seen below they were simply taken up by the remaining four members of the department. In addition, no vacancy was declared apparently when Dr. N lost his surgical privileges, nor when he retired and gave up his ambulatory privileges.

[28] In all three cases the time available, whether in the O.R. or on an ambulatory basis, appears to have been divided up with other members of the department without following the vacancy provisions of the *Medical Staff Rules*.

DISCUSSION AND ANALYSIS

[29] The Appellant testified that there is a need for him to obtain surgical privileges because he has a rapidly growing practice and he has been required to refer out well over a 100 surgical cases. Without surgical privileges he is unable to provide surgical services and in order to maintain his admitted high level of skills, he has travelled to Saskatoon in order to carry out cataract surgery.

[30] The Appeal of Dr. Walker was supported by a broad range of members of the local medical community, representatives of the U.B.C. Department of Medicine, local optometrists and members of the public as noted in the Statement of Agreed Facts.

[31] The Appellant is a man at the commencement of his career who intends to remain in the Fraser Valley. Perhaps somewhat unfairly to Saskatchewan, B.C. now has the benefit of his lengthy and excellent education.

[32] The Appellant has become very involved in training for family residents and among the letters of reference are those from physicians training in that program and the family residence program head in Abbotsford.

[33] The FHA says on the contrary that there is no need for an additional surgeon in the Ophthalmological Department.

[34] Dr. W on behalf of the FHA testified it is important that it controls hospital privileges after taking into account limited resources and the need for services across the region.

[35] FHA can control the allocation of OR time to individual surgeons and achieve its goal to operate within the resources available. This would not preclude the appointment of an additional surgeon.

[36] The Panel heard from Dr. W and from JH, the Executive Director for Fraser Health Surgery Program, that a system known as program management has been implemented which, quoting from the closing argument of the FHA, is meant to "manage the resources and delivery of services across the region, seeking to ensure that services are delivered consistently across the region."

[37] Program Management is just being considered for implementation by FHA. This has not stopped FHA from appointing a new ophthalmologist at Maple Ridge Hospital. When and if implemented at CGH all surgeons would be expected to work within the program.

[38] The FHA says that wait times are a particularly valuable tool to determine need. As the CGH Eye Centre is a unique facility that allows these procedures to be completed in a fraction of the historic time, the number of procedures carried out there is so high that they are exceeding its budget. Accordingly, the additional surgeon would only add to pressure on that budget.

[39] As part of the program for allocating resources, JH says the FHA is considering a hub and spoke model which would create specialized surgical sites and allocate unused time to surgeons from other areas which have longer waiting times. This is apparently a very new idea that has been used at CGH on a few occasions in the months leading up to this Appeal and one doctor from another community has been allocated a few operating room days.

[40] The FHA is also considering a form of centralized referrals rather than having each doctor maintain their own list. Referrals would be maintained by the FHA and allocated to specialized surgeons and hospitals.

[41] There were some questions raised in the evidence from the FHA about the efficacy of cataract surgery. Dr. W in his testimony said that the system of fee for

service for physicians has a distorting affect on the use of medical resources. In the current Appeal, it has the effect of creating an incentive for surgeons to minimize the number of members of the department in order that existing members can maximize their operating room time and revenue.

[42] Although Dr. W did not testify to this explicitly, it is well established that the fee for service system of compensation also tends to encourage the provision of more services. Dr. W did cite studies that showed 25% of patients who have undergone cataract removal did not experience any improvement in their vision.

[43] The FHA has a difficult balancing act. The evidence of their witnesses stated it is in the sole purview of the FHA to determine surgical privileges and that this is done on the basis of the needs of the community as a whole. However, it is clear from the evidence led at this hearing that the interests of the entrenched members of a surgical department have a disproportionate role in determining the threshold question i.e. is there a need for additional surgical privileges.

[44] For the purpose of this Appeal the FHA produced a comprehensive service analysis showing that four surgeons would be sufficient to meet the needs of the Chilliwack General Hospital. It is of considerable interest to the Panel that a similar service analysis was not conducted when Dr. B had his operational dates reduced, nor when Dr. N retired.

[45] The Panel was also advised that a comprehensive review of the surgical needs at CGH has been commissioned and will be completed in February 2014.

[46] The Panel supports the efforts of the FHA to implement program management and agrees that it is important to conduct periodic reviews of surgical needs in each of its hospitals and departments. However this is a new approach that will take years, if not decades, to implement. The Panel finds that it would be unfair to the Appellant to force him to await the outcome of these studies when there is apparently no such barrier to, for example, extending privileges to a new surgeon in Ridge Meadows Hospital. As noted below, the Panel is convinced that there exists a need in the community now for the Appellant's surgical services which can be easily accommodated within existing institutions and infrastructure without undermining the FHA's policy goals expressed in program management.

[47] The Panel also supports the concept of exploring the possibility of central booking for surgeries and creating specialized surgical centres. Again this long-term plan will not be undercut by granting privileges to the Appellant. There is ample surgical time available at CGH both for existing surgeons, the Appellant and any surgeons in the region found to have extensive wait lists. Policy development does not mean preserving a status quo where surgical privileges have been monopolized by a small group of insiders who have allocated to themselves additional surgical time without considering the normal vacancy procedure or the negative effect on the Appellant's patients of his lack of access to CGH, as will be discussed further below.

[48] JH testified that there is a 95% utilization of the CGH ophthalmological O.R.s whereas the goal is 98%. The Panel was advised that there had been 11 unused O.R. days in 2012 and another four in 2013. There had also been other additional

days picked up by members of the department over and above their usual share of four O.R. days per month.

Role of Fraser East Group

[49] Other than Dr. B there are 4 other members of the Ophthalmology Department at CGH. They have styled themselves the Fraser Valley Ophthalmology Association and for the purpose of this Appeal, the Panel will adopt the nomenclature of the Appellant and refer to the four physicians as the Fraser East Group (the "FEG").

[50] Although the FHA was adamant that the decision whether or not to grant surgical privileges remained with its medical staff and ultimately the Board of Directors, it is apparent that the FEG had a significant, if not decisive role in determining whether or not there were vacancies at Chilliwack General Hospital.

[51] A series of emails between members of the Senior Management at Fraser Health Authority and the Regional Department Head for Surgery were produced at the hearing which confirmed the role of FEG in influencing decisions related to privileges at CGH.

[52] When considering whether or not to grant the Appellant ambulatory privileges at Abbotsford Regional Hospital there was an exchange where it was pointed out by PB on behalf of FHA that one of the members of the FEG did not want the Appellant to have outpatient privileges. The response from ST in an email dated May 30, 2012 states:

> ...however we have to balance need versus protectionism... this is one of the flaws of our system in that it allows territoriality and protectionism to fashion the perception of true community need...

[53] This discussion continued in August 2012, where ST states:

> ...To simply allow the current ophthalmologists to say there is no need for a new person, does not account for the lack of service delivery left by Sam [Dr. N] and filled now by Randy [the Appellant]...my concerns are more for the patients than the game playing and often times protectionism that is apparent in the group...

[54] Around this time, a member of the FEG notified Fraser Health that they wished to add an ophthalmologist to deal with on-call issues.

[55] For reasons unclear to the Panel and perhaps to the parties, the FEG subsequently reversed position and opposed any granting of further privileges to the Appellant including on-call services.

[56] In preparation for the application for reconsideration to the Board of the FHA, the senior management of FHA had to consider whether or not there was a vacancy. Dr. S wrote to a group including senior management and assessed the question of whether or not there is a need as follows:

> [Dr. B] 's time has been used by other surgeons with long waitlists. Whether there is a vacancy or not depends on the local ophthalmologists. Given that they now want to advertise a position, there is a vacancy. These questions are best answered by the local

> Division Head, who would appear to be [Dr. H], as these decisions are left to them to make.

[57] This appears to directly contradict the evidence of the FHA at this hearing that the decision whether or not to determine a vacancy is one based on a community need. It is apparent that assessing whether or not there is a vacancy is largely determined by the existing members of the department, who as noted above, have an obvious pecuniary interest in ensuring that they have as much O.R. time for themselves as possible.

[58] This also appears to contradict # 9(b) from the Statement of Agreed Facts where the FEG say "they cannot use the time released from Dr. B because they do not have long enough wait lists to justify it."

[59] Senior management seemed to be alert to these issues as in an email from the Director of Medical Affairs, he said in preparing for the reconsideration to the FHA Board:

> On the economic interest issue, we may have to be prepared to answer further questions about how vacancies are declared… Ans: by the ophthal group… Qu: based on what criteria …Ans ___? (is there some way to skate on the economic interest part of this answer…?) (sic)

[60] The Regional Department Head of Surgery also reflected this same process in an email dated March 9, 2012 where he said:

> There is no declared vacancy. I spoke to [the] Reg. Div. Head for ophthalmology, and he did not think there was much support locally to declare a vacancy…

[61] As further evidence of the very strong role played by the FEG in the appointment process is the fact that they were granted standing before the Board of the FHA in the Appellant's application for reconsideration. Two members of the FEG actually attended the hearing before the FHA Board, as did their counsel. Again this strongly suggests that the determination of a vacancy and need is based very largely on the input provided by the existing members of the department.

[62] In fact it appears to this Panel that although the jurisdiction to make such a determination clearly rests with the FHA, on a practical basis the local Surgical Department has a veto which was effectively exercised in this case.

[63] Both parties raised the issue of the apparent lucrative nature of cataract surgery including the Appellant bringing forward evidence about the total billings by members of the FEG and the fact that they have their own private clinics. JH also testified that until recently the fee for cataract surgery had not changed even though technological advances have reduced the time required from two hours to 15 minutes. The FHA attacked the credibility of the Appellant saying that his Appeal was brought for pecuniary purposes not for any perceived need. The Panel is not prepared to make any findings on this score against either the Appellant or members of the FEG other than to note the evidence of Dr. W cited above that one of the perverse consequences of the fee for service system is that physicians can only be compensated based on the number of procedures that they carry out.

[64] There was striking evidence as to the apparently proprietary position the FEG takes over the surgical privileges at Chilliwack General Hospital. An advertisement placed by the members of the FEG was produced as evidence published in the local newspaper on November 22, 2012. The ad states "Shorter wait time for cataract surgery, modern cataract surgeries are typically being booked at the Chilliwack Hospital in less than 2 months. For additional information please contact the Fraser Valley Ophthalmology Association" with contact information being provided for each member of the group.

[65] The advertisement is astonishing in that private physicians are advertising the availability of short wait lists at a public facility. This facility is operated by the FHA and privileges are granted in order to service the community as a whole. Those privileges are not granted for the purpose of those having them being able to lure patients away from other physicians who are not so fortunate as to have a foot in the door.

[66] The Panel finds that the advertisement is contrary to the official policy of the FHA that operating room privileges are granted by the FHA on the basis of general need; the existing surgeons at CGH perceive a vested interest in their surgical privileges and have fought a successful turf war to prevent expansion to other surgeons, in particular the Appellant.

Conclusion

[67] The Panel is convinced that a need has been demonstrated for further surgical privileges at CGH.

[68] The community was historically serviced by 5 if not 6 surgeons (including Dr. N). The surgical privileges of Dr. B were reduced in February 2011 without any consideration for the need to have a physician replace him. The emails state simply that his privileges were absorbed by other members of the FEG with "long waitlists" but it is entirely unclear what analysis was done to determine that the members of the FEG had such different waitlists that those additional O.R. times should be allocated to them.

[69] The Panel is convinced that for reasons including successorship i.e. having a young and highly trained physician step in to take over the practice of a retired physician, the needs of the growing community, the additional services that would be available for the Appellant's large and growing practice, and the lack of any evidence to show that there would be a detriment to the FHA in granting those services to the Appellant all support the finding that there is a need.

[70] The Panel finds the evidence that an additional surgeon will add to costs to be speculative. We were advised that new surgeons on occasion request their own equipment but no evidence of additional demands from the Appellant was lead on this point. There were also general comments from Dr. W that fee for service payments to physicians tends to skew the health care system towards additional procedures. However this is a complex problem that will continue whether or not the Appellant is granted privileges and there was no specific evidence lead that shows the addition of another surgeon would have a detrimental effect on FHA surgical budgets. If it is necessary to restrict the number of procedures at CGH to meet budget targets, as JH testified has already been necessary, then access to the

operating room can be reduced on a pro rata basis for all of the members of the department which will now include the Appellant.

[71] The Panel also notes that one of the main reasons given by the FEG for resisting the extension of surgical privileges to the Appellant was that they said they were unable to use the time allocated to them. This strongly suggests that the O.R. is being underutilized which is another strong factor in terms of finding there is need for an additional surgeon.

DECISION

[72] Accordingly the Appeal is granted and the Panel orders that the Chilliwack General Hospital site, including participation in the on-call rota, be added to the Appellant's privileges pursuant to the application made by the Appellant on October 12, 2012 and that the Appellant be included in the 2014 slate allocation when and to the extent his wait list makes it possible.

"David Perry"

David G. Perry, Chair

"Joanna Nemrava"

Joanna Nemrava, Member

"Rick Riley"

Rick Riley, Member

June 9, 2014

This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect third party personal information.

APPENDIX "A"

STATEMENT OF AGREED FACTS

History of the Application and the Decision

1. On April 2, 2012, pursuant to an agreement amongst counsel, Dr. Randy Walker ("the Appellant") requested that his July 19, 2011 application for a locum tenens position (Tab 1) be changed to an application (the "Initial Formal Application") for appointment to the Provisional Category of the medical staff of the Fraser Health Authority ("FHA").

2. The FHA Board of Directors (the "FHA Board") did not approve the Initial Formal Application on June 25, 2012.

3. The Appellant commenced an appeal to the FHA Board, which was set to be heard on September 26, 2012.

4. On September 26, 2012 following discussions amongst the parties, the hearing of the appeal was adjourned by consent.

5. On October 5, 2012, the FHA Board passed a motion appointing Dr. Randy Walker ("the Appellant") to the Provisional Category of the medical staff of FHA. The Appellant was appointed to the Division of Ophthalmology in the Department of Surgery with privileges at Abbotsford Regional Hospital ("ARH") to provide ophthalmology services in the outpatient clinic. The appointment to the FHA medical staff was confirmed by letter dated December 4, 2012 from Dr. W, V.P. Medicine, to the Appellant. (Tab 2)

6. On October 12, 2012, the Appellant submitted an Application for Addition of Site and/or Privileges to FHA (the "Application") (Tab 3).

7. The Application was made pursuant to the agreement made on September 26, 2012 to pursue a separate process. The separate process agreement is confirmed in the following documents:

   a. An email dated September 27, 2012 from Jim MacMaster, counsel for the Appellant, to Penny Washington, counsel for FHA, which attached a letter dated September 27, 2012 confirming the agreement (both the email and the letter are at Tab 4); and

b. An email dated October 2, 2012 from Ms. Washington to Mr. MacMaster confirming whom the Appellant should contact in order to obtain the form required for the Application (Tab 5).

8. On November 9, 2012, through communications between legal counsel, the Appellant was informed that the separate process of applying to add CGH to his privileges was not working because four of the five ophthalmologists at CGH opposed the appointment.

9. On November 19, 2012, via email communications between legal counsel, the reasons for refusing to further process the Application to add the CGH site to the Appellant's privileges were confirmed to be as follows:

"The reasons OR time at CGH will not be added to the Appellant's medical staff appointment are that the Fraser East Group (as defined in the Notice of Appeal) has told the administration:

a. "there is not enough work even for them."

b. "they cannot use the time released from [Dr. B] because they do not have long enough wait lists to justify it."

c. "They are even prepared to let other divisions that have lengthy delays have this time."

10. The Appellant was asked by FHA if he wished to reconvene his appeal hearing. The Appellant reconvened his appeal to the FHA Board, which was then scheduled for February 1, 2013.

11. The appeal hearing proceeded as scheduled on February 1, 2013 (Tab 6 – Board minutes of hearing)

12. The FHA Board dismissed the Appellant's appeal to the FHA Board. The FHA delivered a letter to the Appellant with the reasons for its decision on February 20, 2013 (Tab 7).

History of the Appellant in the Community

13. The Appellant was born and raised in Saskatoon, where he completed his undergraduate training, medical school, and ophthalmology residency.

This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect third party personal information.

14. The Appellant attained a bachelor of science in physiology in 2002 at the University of Saskatchewan. He entered medical school at the University of Saskatchewan, graduating in 2006.

15. He then went on to complete his residency in ophthalmology at the University of Saskatchewan, which he finished in June, 2011.

16. The Appellant is the owner of Mayfair Ophthalmology, an ophthalmology practice located at 33477A Mayfair Avenue in Abbotsford.

17. The Appellant came to the Fraser Valley in July 2011. At that time, Dr. N had an ophthalmology practice. Dr. N had expressed an intention to retire. The Appellant began working with Dr. N to explore the idea of taking over Dr. N's practice. (Tab 8 - Reference Questionnaire completed by Dr. N dated July 15, 2011)

18. Dr. N retired effective December 1, 2011. The Appellant assumed Dr. N's practice as of that date.

19. Until December 1, 2011, Dr. N was a member of the local ophthalmology community. Dr. N did not have operating room time for the purpose of performing cataract surgery for several years (subsequent to restrictions placed upon on him by the College of Physicians & Surgeons of B.C.) Specifically, Dr. N did not have privileges to use the ophthalmology operating room facilities at Chilliwack General Hospital ("CGH"). Dr. N participated in the on-call schedule with support from other ophthalmologists with operating privileges at CGH.

20. The Appellant knew that Dr. N did not have operating room time. Neither Dr. N nor anyone else represented to the Appellant that the Appellant would be appointed to the medical staff anywhere or that the Appellant would receive any time at an operating room facility anywhere simply because he purchased Dr. N's practice. At no time did the Appellant consider that he had any entitlement as the result of taking over another physician's practice.

History of the Appellant's Appointment to Medical Staff

21. Since July 25, 2011, the Appellant has had a series of temporary and locum appointments at CGH and ARH for the purposes of either covering Dr. N's non-surgical practice or performing ambulatory day care services at ARH.

22. On October 5, 2012 the Board appointed the Appellant to the provisional medical staff with privileges at ARH as set out in paragraph 5 above.

23. On or about May 29, 2013 FHA posted a notice inviting applications for an ophthalmologist to be appointed to Ridge Meadows Hospital ("RMH") to replace a retiring ophthalmologist. On June 3, 2013 the Appellant applied to fill the vacancy at RMH. On August 27, 2013, the Appellant was advised that he was shortlisted for the position and would be interviewed. Interviews were originally planned for October but have been postponed. The Appellant is now scheduled to be interviewed at 9:30 pm on December 12, 2013.

Ophthalmology Services at the CGH Eye Centre

24. The two OR rooms at CGH, which are used by ophthalmologists have been dedicated to ophthalmology. They are not equipped or suitable for use by other Divisions, and are referred to as the CGH Eye Centre.

25. The CGH Eye Centre is an outpatient surgical service. It was established over 10 years ago. It runs two parallel operating theatres which are simultaneously used by one Ophthalmologic surgeon. This is a "swing-room" model where the surgeon starts in Room A with Patient 1, then moves to Room B with Patient 2, once complete. Room A is then prepared for Patient 3, and once the surgeon is done in Room B with Patient 2, the surgeon returns to Room A with Patient 3, and so on.

26. There are five ophthalmologists who are members of the medical staff at CGH and who are entitled to provide services at the CGH Eye Centre.

27. Historically, Dr. B was entitled to utilize the CGH Eye Centre resource 1 day per week. In February 2011, on the direction of the Head of Department (local) for Surgery, the FHA reduced Dr. B's entitlement to use the CGH facilities by two days per month due to the absence of call coverage on the part of Dr. B.

28. Historically, [the other four doctors] have used the two OR days per month which Dr. B had previously been entitled to use.

29. [The five physicians] were allocated the use of the CGH Eye Centre resource provided by the FHA in 2013 according to the document shown in Tab 9.

30. Dr. B does not participate in on-call duties.

31. The following reference letters were submitted to and considered by the FHA Board:

    a. letter dated January 8, 2013 from Dr. B;

    b. letter dated January 2, 2013 and email dated January 24, 2013 from Dr. Z, General Ophthalmologist, in Langley and a member of the medical staff at FHA with privileges at Langley;

    c. letter dated December 28, 2012 from optometrist Dr. M;

    d. letter dated January 14, 2013 from optometrist Dr. SB ;

    e. letters dated January 15, 2013 and January 24, 2013 from the group of optometrists at Complete EyeCare Optometry in Abbotsford ;

    f. letter dated January 21, 2013 from Dr. L, Head of the Department of Family Medicine, at ARH ;

    g. letter dated September 22, 2012 from Dr. C, Site Director: UBC Family Practice Residency Program, Abbotsford Site ;

    h. letter dated January 8, 2012 from [four doctors], all second year residents in the UBC Family Medicine Program ;

    i. letter dated September 23, 2012 from patient IC;

    j. letter dated January 22, 2013 from Dr. KH, Head of the Department of Ophthalmology, Saskatoon District Health Region;

32. In addition, the Appellant has received two additional reference letters:

k. Letter dated October 3, 2013 from Dr. DH the President of the Abbotsford Division of Family Practice; and

l. Undated letter from patients JB and DT.

33. The reference letters will be presented at the hearing as a separate package, subject to argument.

34. For the purpose of dispensing with proof of the authenticity of documents referred to in the attached index (the "Documents"), the parties are agreed that the Documents may be admitted into evidence on the following basis, in all cases subject to proof to the contrary :

m. The Documents are accurate copies or photocopies of the originals;

n. If dated, the Documents were prepared on or about the date shown;

o. The Documents were prepared by or on behalf of the author;

p. Purported signatures appearing on the Documents are authentic;

q. If the Documents include a letter, memorandum or other form of correspondence the document was received by the intended recipient in the ordinary course on or about the date shown;