Hospital Appeal Board

Fourth Floor 747 Fort Street
Victoria British Columbia
V8W 3E9
Telephone: (250) 387-3464
Facsimile: (250) 356-9923

Mailing Address:
PO Box 9425 Stn Prov Govt
Victoria BC V8W 9V1

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DECISION NO. 2015-HA-003(b) and 2016-HA-001(a)
[Group file: 2016-HA-G01]

In the matter of an appeal under section 46 of the *Hospital Act*, RSBC 1996, c. 200.

BETWEEN:	Dr. Michael Butler	**APPELLANT**
AND:	Vancouver Coastal Health Authority	**RESPONDENT**
BEFORE:	M. Gwendolynne Taylor, Panel Chair Dr. Douglas H. Blackman, Member Lorraine Unruh, Member	
DATE:	April 18-22, April 25-28 and July 5, 2016	
PLACE:	Richmond, B.C. and Vancouver, B.C.	
APPEARING:	For the Appellant: Joseph J. Arvay, Q.C., Erica C. Miller and David Borins, Counsel	
	For the Respondent: Penny A. Washington and Melissa L. Perry, Counsel	

APPEAL

[1] This is an appeal brought by Dr. Michael Butler ("the Appellant") against a decision of the Board of Directors of the Vancouver Coastal Health Authority ("VCHA") dated December 9, 2015. VCHA refused the Appellant's application dated August 10, 2015, ("the August Application") for appointment to the medical staff of the Division of Ophthalmology in the Department of Surgery at Richmond Hospital ("RH").

[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:* Act, section 46(2.3). 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 Appellant requests that the HAB make the following orders:

a) reversing the December 9, 2015 Decision of the VCHA Board and substituting its own decision with respect to the August Application, appointing the Appellant to the medical staff at RH on appropriate terms;

b) that the Appellant be appointed to the VCHA-Richmond medical staff;

c) that the Appellant be provided with reasonable and equal access to the operating rooms ["OR"s] at RH and Mount St. Joseph's Hospital ["MSJ"]; and

d) such other terms as may be just and appropriate in the circumstances.

ISSUES

[5] The issues to be determined in this appeal are whether there is a need in the community for an additional ophthalmologist surgeon at RH and, if yes, whether the Appellant should be granted privileges without a further search and selection process.

BACKGROUND

[6] The Appellant is an ophthalmologist trained in Canada with certification by the Royal College of Physicians and Surgeons of Canada, with one additional year of fellowship training in vitreo-retinal surgery.

[7] VCHA is one of six regional health authorities in British Columbia. It is responsible for the delivery of health care services to residents in Vancouver, Vancouver's North Shore, Richmond, the Sea-to-Sky Highway, Sunshine Coast, Bella Bella, Bella Coola, the Central coast, and the surrounding areas. VCHA organizes its health services around three geographic communities of care: Coastal, Richmond and Vancouver. VCHA operates with approximately 14,300 staff and 2,100 physicians as members of its Medical Staff.

[8] Providence Health Care (PHC) operates health care facilities within VCHA's region. PHC is a partner and contracted service provider to VCHA.

[9] General ophthalmology services within VCHA are provided in each geographic community of care. There are four hospitals in the Vancouver Coastal Health region in which surgeons are granted privileges to perform ophthalmological procedures, including cataract surgery. One of the four hospitals, Mount St. Joseph's ("MSJ"), is owned and operated by PCH, not by VCHA.

[10] Sub-specialty ophthalmology services within VCHA, including retinal services, are provided at Vancouver General Hospital ("VGH") at the Eye Care Center. As of the hearing, VCHA did not have plans to expand surgical retinal services to RH.

[11] There are three ophthalmologists on the medical staff of the RH. Since 2000, all surgeons at RH, including the ophthalmologists, have been allocated Operating Room ("OR") time of a minimum of one half day per week, 2 days per

month. There is also a pediatric ophthalmologist, Dr. R, who has active privileges at RH. The majority of her practice is at BC Children's Hospital although she occasionally uses an OR at RH.

[12] The three RH ophthalmologists provide care, including cataract surgery, to adult patients living in the Richmond community. There are six additional ophthalmologists who have offices in the Richmond area who do not perform surgery at RH.

[13] In 2012, RH entered into an agreement with MSJ/PHC whereby the ophthalmologists with privileges at RH were allocated OR time at MSJ. As a result, each ophthalmologist has a minimum of one day per month of OR time at RH and one day of OR time at MSJ.

[14] In 2012, the Department of Surgery and the Division of Ophthalmology at RH recommended creating an ophthalmology position with a specialty in retina. At the time, Dr. DB, the father of the Appellant, was the head of Surgery and Ophthalmology. The Administration of RH acted upon this recommendation by posting and advertising this position in May, 2012. Dr. Michael Butler, the Appellant, expressed interest and was invited to participate in an interview for this position on October 11, 2012.

[15] In September, 2012, the RH ophthalmology/retina posting came to the attention of the VCHA Regional Department of Ophthalmology, Retina Surgery Division Health, and the Vice President of Medicine. The Vice President of Medicine advised RH Administration they could not provide surgical retina services because the regional retina services were centralized at the Eye Care Centre at VGH. The advertised posting was subsequently cancelled as of October 18, 2012. On November 26, 2012, the Appellant was formally advised the posting was cancelled.

[16] In the spring of 2013, the Appellant submitted an application pursuant to Article 6.6.1 of the Medical Staff Bylaws for locum tenens privileges to act as a locum for Dr. H, a RH staff ophthalmologist, who was on a temporary medical leave of absence. This was granted and was effective in June 2013.

[17] Hospital privileges are granted to locum Medical Staff only for the purpose of permitting them to admit patients, write orders and provide treatment including surgical treatment to the patients of the physician the locum is replacing.

[18] On May 20, 2013, the Appellant signed an agreement to assume responsibility for Dr. H's office staff and patient files and to pay for the office and diagnostic equipment in Dr. H's Vancouver and Richmond offices. Dr. H sent out letters to his referral sources identifying the Appellant as a "more permanent solution" for his practice. At the hearing, VCHA told the Panel that RH was unaware of these arrangements at the time, and throughout the Appellant's locum.

[19] Dr. H's medical leave of absence continued for over two years and the Appellant's locum tenens privileges at RH were renewed in July 2014, and July 2015, each time for one year. The Appellant acted as Dr. H's locum tenens from June 2013 to December 2015.

[20] With the locum privileges, the Appellant was granted the same surgical time as the other two Ophthalmologists and was required to fulfill the on-call responsibility as was previously assigned to Dr. H.

[21] Dr. H was advised by the RH Senior Medical Director that if his absence became permanent there would be a search and selection process to fill the vacancy and the current locum would not be automatically granted the position.

[22] The VCHA Medical Staff Rules (June 7, 2011), 6.7.5, states: "The granting of a locum tenens appointment provides no preferential access to an active, provisional, or other appointment at some later time."

[23] In May, 2014 Dr. H formally retired from his practice. Medical Administration sought input from Dr. RT and Dr. DB, the 2 remaining members of the Division of Ophthalmology at RH, regarding the vacancy. Input was also sought from optometrists and general practitioners, the Department of Family Practice and the Emergency Department regarding the ophthalmology vacancy. The general consensus was a need for a general ophthalmologist who would meet the ophthalmological needs of the community, not just perform cataract surgery. VCHA advertised for a permanent comprehensive ophthalmologist at RH in October, 2014.

[24] Pursuant to the RH policy, a search and selection process was undertaken and twenty six candidates submitted expressions of interest. The Appellant was one of the candidates, having submitted his letter of interest and resume dated December 9, 2014. The Selection Committee for Ophthalmology assessed the candidates for interviews using the following criteria: eligible for full licensure with the BC College; residency completed before June 2015; Richmond to be their primary location of practice; have sub-specialty training needed in Richmond; evidence of being a team player, good communicator and desire to contribute to the hospital; CV allows initial assessment of candidate; and not currently have a practice elsewhere in the lower mainland. If a candidate had current locum privileges it increased their ranking in the initial process.

[25] The Selection Committee identified four candidates for interviews, one of whom was the Appellant. The VCHA Regional Head for Ophthalmology, Dr. DM, and the RH Division Head for Ophthalmology, Dr. RT, who were involved in the initial screening on the Selection Committee agreed they would not participate with the final four interviews to ensure fairness in the selection process by obviating any perceived conflict of interest.

[26] The interview panel included a family physician, an anesthetist, the Senior Medical Director, an emergency physician, the Head of the Department of Surgery, and the interim Director Surgery and Medical Administration. The four candidates were interviewed on March 12, 2015.

[27] The Selection Committee identified two candidates, the Appellant and Dr. T, and agreed to check their references and to seek clarity on their commitment to working in Richmond.

[28] On April 13, 2015 the Selection Committee met, absent the two ophthalmologists who recused themselves, and determined Dr. T should be

offered the position based on her interview, her references and her commitment to a full time practice in Richmond.

[29] The Selection Committee's recommendation was taken to the Department of Surgery meeting on April 14, 2015. At the Department of Surgery meeting, the two staff ophthalmologists abstained from voting. The Selection Committee's recommendation to appoint Dr. T passed in a motion and was then forwarded on to the Area Medical Advisory Committee for approval.

[30] On April 14, 2015 the Senior Medical Director notified the Appellant via telephone that he was not the successful candidate; this was confirmed in writing in a letter dated April 29, 2015 written by the Chief of Surgery. At this time the Appellant was also notified that his appointment to the locum medical staff would end in July, 2016, and that his access to OR time and the on-call schedule requirement as locum for Dr. H would end when Dr. T's application was approved by the VCHA Board. The VCHA Board ultimately approved Dr. T's appointment on October 7, 2015.

[31] The Appellant continued to book patients for cataract surgery after April 14, 2015; in October 2015, he started to formally notify his patients and referral sources that he no longer had access to OR time at RH. As of the HAB hearing, the Appellant continued to maintain a personal surgical wait list at his office.

[32] As of July 23, 2015, the Ministry of Health increased the target wait time for patients with cataracts with functional impairment from 16 to 26 weeks.

[33] On August 10, 2015, the Appellant submitted an unsolicited application for appointment to the medical staff at RH.

[34] Following the Appellant's August 2015 application, Dr. P as the Department Head for Surgery sought to determine the need for a fourth ophthalmologist and the impact of such an appointment on the other surgical services at Richmond Hospital. He requested input from Dr. DM, Regional Site Head of Ophthalmology for PHC and VCHA; Dr. RT, RH Division Head for Ophthalmology; and Ms. CW, the Interim Director, Surgical and Medical Administration.

[35] Dr. DM provided his response to Dr. P by letter dated September 1, 2015, that data from the Ministry of Health show that "Vancouver Coastal has the shortest provincial wait lists" and that "within Vancouver Coastal, Richmond patients have the best access to cataract surgical care under the current surgical resource distribution." He concluded "[t]here is no evidence to support supplemental surgical staff in Richmond."

[36] In a letter dated September 4, 2015, Dr. DM also responded to a request from Dr. W, Senior Medical Director, regarding the need for surgical retinal services in Richmond Hospital:

> Surgical retinal services in BC are typically provided by a unified service at a designated site in each health authority (Kamloops for IHA, Victoria for VIHA, Vancouver for VCH, Prince George for NHA, Surrey for FHA). Comprehensive retina sub-specialty care in Vancouver Coastal is currently served by six surgeons working out of Vancouver General Hospital. These individuals have surgical time at Vancouver General and Mount St. Joseph's

> Hospital. There is no wait list for emergent, urgent or elective retina patients to access care via this group. In addition, there are four other medical retina specialists working in Vancouver who provide care for Richmond patients. This model has delivered timely and quality service to the Richmond patient population for over 40 years.
>
> Over the past 16 years, as a retina specialist providing care to Richmond patients, retina division head for VCH, ophthalmology site head at VGH, and regional head for ophthalmology, I have yet to hear of any access concerns for retina patients from Richmond. Based on this information, I do not believe there is any need for resources to be directed towards the development of a medical or surgical retina sub-specialty service in Richmond.

[37] Dr. RT wrote to Dr. P "to confirm the facts stated by the regional head of ophthalmology" [Dr. DM], referenced above. He also commented, "We do not have the necessary diagnostic or surgical equipment to provide any retinal surgery and have excellent access to specialized retinal services in Vancouver so there is no requirement for a retinal ophthalmologist."

[38] Ms. CW confirmed in her letter to Dr. P dated September 30, 2015 that "[b]ased on current OR allocation methodology, the total number of surgical patients currently waiting for cataract surgery does not exceed the surgical capacity of the existing three surgeons." She went on to point out that "80% of patients at Richmond Hospital (year to date Apr 1-Sept 10) have received their surgery within the more aggressive 16 week target. With the target now extended to 26 weeks, we have no concerns regarding the ability of the present complement of three surgeons to meet this requirement."

[39] In a subsequent letter to Dr. P dated October 15, 2015 Ms. CW stated that "the addition of another ophthalmologist would negatively impact other surgical services within Richmond Hospital." She also stated that "… patients waiting for certain types of orthopedic surgery (hip and knee replacement in particular), general surgery and plastic surgery are waiting beyond targets." She concluded, "… [b]ased on the data, RH would not be able to support an expansion of the Division of Ophthalmology without negatively impacting patients on other surgical services."

[40] On December 18, 2015, the Appellant was notified in a letter from the Chair of the VCHA Board that his August, 2015 application was rejected by the Board at its meeting of December 9, 2015. The following reasons for the rejection were identified in the letter:

a) there is no present vacancy in the Division of Ophthalmology at RH,
b) there was no identified need for an additional ophthalmologist at RH,
c) there is no identified need for a medical or surgical retina sub-specialty service in VCHA in Richmond.

[41] Due to unforeseen delays, Dr. T was unable to open her office practice in Richmond until January, 2016. Because of the delay, the Appellant continued to use OR time offered to him during November and December 2015. As of January 2016, Dr. T was assigned her scheduled OR time of 2 days a month and began

participating in the on-call schedule. As of the HAB hearing, Dr. T did not have a wait list for cataract surgery.

NOTICES OF APPEAL

[42] On September 23, 2015, the Appellant filed an appeal to the HAB against the Board of Directors of VCHA for failure to consider and decide his application of December 9, 2014; and an appeal against the decision of a board of management of VCHA to refuse his application of December 9, 2014. The appeal also included requested relief regarding the Appellant's August 10, 2015 application. A preliminary application regarding summary dismissal of this appeal was heard by the HAB Chair by written submissions in November 2015; the Chair issued a written decision dated December 9, 2015 [Decision No. 2015-HA-003(a)], dismissing those aspects of the Notice of Appeal in regard to the August 10, 2015 application for privileges as premature and deferring a determination of the other issues to the panel hearing the appeal on its merits.

[43] On January 19, 2016, the Appellant filed an appeal to the HAB against the December 9, 2015 decision of the Board of Directors of VCHA, requesting that it be heard together with the earlier appeal.

[44] Although both appeals were joined and scheduled to be heard together, the Appellant advised at the hearing that he was not pursuing the September 23, 2015 appeal and accordingly, it is hereby dismissed pursuant to section 17(1) of the *Administrative Tribunals Act*. Therefore, in this decision, the Panel has not provided details of that initial appeal. However, we refer to the process undertaken to fill the vacancy in the Division of Ophthalmology following Dr. H's retirement and the hiring, to the extent it is relevant to the issues raised in the second appeal.

SUMMARY OF THE POSITIONS OF THE PARTIES

The Appellant

[45] The Appellant submitted that the evidence demonstrates a clear need for an additional ophthalmologist at RH and that the HAB should appoint him to the active medical staff at RH with a full allocation of OR time as a member of the Division of Ophthalmology. As alternatives, if the HAB finds that such an appointment would adversely impact resources at RH, the Appellant submitted the HAB could

a) appoint him to the medical staff at RH and have the OR time for all members of the Division reduced on a *pro rata* basis;
b) if Dr. DB gives up his active medical privileges at RH within 60 days of the HAB decision, appoint the Appellant to the active medical staff at RH with a full allocation of OR time as a member of the Division of Ophthalmology; or

c) appoint him to the medical staff at RH with an allocation of OR time that is less than two full days per month, taken from flex time.[1]

[46] The Appellant submitted that the Respondent's assessment of 'need' by looking at the waitlists and the impact on other services is insufficient and that the HAB must consider other relevant factors, as discussed by the HAB in the most recent decision, *Walker v. Fraser Health Authority*,[2] "in the context of the obligation of the [VCHA] to provide efficient, high quality and cost effective care to all the residents of its region" (para 15). The factors listed at para 13 of the *Walker* case, which that Panel agreed were useful in determining need, are:

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[sic] 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.

[47] The Appellant asked this Panel to consider numerous factors in determining that the evidence establishes that there is 'need' for a fourth ophthalmologist:

a) Dr. T is a general ophthalmologist and not a replacement for Dr. H's cataract surgery;
b) the Appellant is the only ophthalmologist in Richmond with a sub-specialization in retina, which makes him uniquely able to treat patients with retina or combination issues;
c) the Appellant sees many cataract patients that he is able to treat, but must refer to other physicians due to a lack of OR access;
d) there are ongoing call issues at RH that an additional ophthalmologist could alleviate, resulting in better patient care;
e) the unreasonable waiting times for patients to get an appointment with an ophthalmologist, and/or receive surgery;
f) data on the increasing population in Richmond, particularly amongst the elderly population that requires cataract surgery and retina treatments, coupled with a decrease in the number of ophthalmologists that provide these services;
g) there is sufficient available OR time at RH and MSJ for an additional ophthalmologist;

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[1] When OR time is allocated, one slate per week is held back as 'flex time', to allow flexibility in the event of urgent cases which cannot be accommodated in the surgeon's regular time.

[2] HAB Decision No. 2013-HA-003(a) (June 9, 2014)

h) that two of the current ophthalmologists with privileges in Richmond are close to the ends of their careers, and that granting the Appellant privileges is investing in the future of ophthalmology in Richmond;
i) the Appellant has considerable support in the community from other ophthalmologists, optometrists, and general practitioners, and that believe that the community would be well served by the Appellant having privileges at RH; and
j) patients will receive a lower standard of care if the Appellant is not granted privileges, including as a result of disruptions to the continuity of their care.

The Respondent

[48] The Respondent's submission was that the evidence does not demonstrate a need for the Appellant's services at the RH; and, that to appoint the Appellant to the Medical Staff would adversely impact other departments and divisions, such as orthopedic surgery, general surgery and plastic surgery, which have more pressing needs than the Division of Ophthalmology, by increasing the demand on the fixed pool of OR time, which would in turn result in longer wait times for those other services.

[49] The Respondent referred to evidence related to manpower planning, current make-up of the Division of Ophthalmology, wait times for surgery in the Division of Ophthalmology and other departments and divisions, wait lists for surgery, surgical resources including five recently hired surgeons, allocation of OR time, unused OR time at RH, the agreement with PHC for cataract surgery at MSJ hospital, allocation of OR time via the RAM[3] , the impact of external factors on OR planning at RH, and the repatriation of orthopaedic surgeries from the UBC hospital to RH.

[50] With respect to the Appellant's retina sub-specialty, the Respondent submitted that although having a retina specialist in Richmond would be a bonus, it is not evidence of "need" because those services are available in VCHA's region. Further, although the Appellant originally submitted that it was necessary for him to have privileges at the hospital to secure his position in the Provincial Retinal Disease Treatment Program, there was evidence in the hearing that he has been grandfathered into the program without hospital privileges.

[51] The Respondent acknowledged the needs of the community are also the needs of the hospital, but underscored that demand does not necessarily equal need[4]. The Respondent further submitted:

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[3] **Resource Allocation Methodology** is a computer generated analysis of OR utilization and the allocation of OR days at RH, for the purpose of optimizing OR usage.

[4] The Respondent referred to the HAB's discussion in *Dr. Elizabeth Ricketts v. Bulkley Valley District Hospital*, (April 17, 1984) British Columbia Medical Appeal Board, at page 14.

> The Appellant has failed to demonstrate a need for his services beyond the artificial need he and his father have created through:
>
> (a) the manipulation of waitlist data at Richmond Hospital and MSJ by Dr. DB and his office staff;
> (b) the Appellant's pattern of referring the majority of his patients to his father since the end of his locum for Dr. H;
> (c) the Appellant's failure to advise his patients of other options for surgery, including Dr. T, until very late in the fall of 2015;
> (d) the Appellant's continued maintenance of an office waitlist despite the fact that he does not have surgical privileges at any hospital in the province;
> (e) the failure of Dr. DB to participate equitably in the on-call schedule on an ongoing basis.

DISCUSSION AND ANALYSIS

[52] The Appellant had acted as Dr. H's locum for almost two years when VCHA announced that he was not the successful candidate for the vacancy at RH. From what the Panel heard, it is fair to say that he was the heir apparent in the eyes of many medical professionals at RH and in the Richmond community. He is clearly well-qualified and, from various reports, had good working relationships at RH and with many medical professionals in the Richmond community. In May 2013, he assumed Dr. H's practice, taking over the patient lists as well as responsibility for the office staff and overhead. While acting as Dr. H's locum at the hospital, he developed a significant practice in general ophthalmology and in his sub-specialization in retina. As of the hearing, he was the only ophthalmologist in Richmond with the retina specialization.

[53] The Appellant did not appeal the appointment of Dr. T. Nor did he challenge her qualifications as a general ophthalmologist with a sub-specialization in glaucoma. He indicated respect for her skills. However, he submitted that her lack of experience performing cataract surgery was problematic for the community of Richmond, and he questioned her capability to develop a high volume cataract surgery practice because of her glaucoma specialty and her interest in pursuing research.

[54] The appeal before the HAB is based on the Appellant's assertion that there is need in the Richmond community for a fourth ophthalmologist with privileges at RH because of the inability of the current three ophthalmologists to meet the demand for cataract surgeries within reasonable wait times, and because of the demand in the Richmond community for a retina specialist with hospital privileges.

[55] In considering the appeal, the Panel is guided by the Medical Staff Bylaw 3.1.5:

> An appointment to the medical staff is dependent on the human resource requirements of the facilities and programs operated by VCHA and on the needs of the population served by the VCHA. Each appointment is contingent upon the ability of VCHA's resources to accommodate the appointment.

[56] The Panel fully acknowledges and accepts the proposition that the needs of the community are the needs of the hospital. The Respondent reiterated their view that the demands of the community do not necessarily equal need and quoted from the *Ricketts*' decision (above). The Medical Appeal Board in that decision found that the needs of the hospital and the needs of the community are synonymous, but accepted the principle that demand does not necessarily equal need. So, for example, it would not necessarily be reasonable to expect a hospital to provide a physician who speaks the language of each ethnic group in the community. What is required is to determine whether there is a need and the precise nature of the need.

[57] In the proceeding before this Panel, two examples of 'demands' in the evidence which may or may not equate to 'needs' are whether patients are entitled to the doctor of their choosing, and whether patients are entitled to be treated in Richmond, for office visits and for surgery, rather than travelling to Vancouver or elsewhere.

[58] The factors raised by the parties for consideration by the Panel include:

- wait lists and wait times for surgery in the Division of Ophthalmology and other departments and divisions at RH;
- allocation of OR time;
- unused OR time;
- the effect of the agreement with PHC for cataract surgery at MSJ;
- recent appointments of five surgeons at RH;
- manpower planning including potential additional surgeons at RH;
- the importance of sufficient personnel to handle the on-call requirements at RH;
- the impact of the repatriation of orthopedic joint replacement surgeries from the UBC hospital to RH estimated to be 240 surgeries per year;
- the impact of other external factors such as a regional nursing shortage;
- sub-specializations or unique skills; and
- planning for future needs of RH and of the community of Richmond.

[59] Concerning wait time for surgery, the Panel heard the evidence set out above in paragraphs 36 to 40 from Dr. DM, Dr. P and Ms. CW. The Panel was presented with more current surgical wait time data for the period Jan 1-Mar 31, 2016[5]:

> As at January 22, 2016:
>
> MSJ D. B. 339 patients 90% served within 23.7 weeks

[5] "Vancouver Coastal Health Authority Wait Times for Cataract Surgery", January 22, 2016 and "Cataract Surgery Wait Times in British Columbia – Cases Waiting as of March 31, 2016

	R. T.	22 pts	90% served within 15.5 weeks
RH	D. B.	17 pts	90% served within 6.7 weeks
	R. T.	76 pts	90% served within 19.1 weeks

As at March 31, 2016:

MSJ	D. B.	491 pts	90% served within 23.0 weeks
	R. T.	18 pts	90% served within 12.2 weeks
RH	D. B.	20 pts	90% served within 4.1 weeks
	R. T.	72 pts	90% served within 16.5 weeks

[60] The Respondent submitted that the wait time data is the only objective indicator VCHA has to rely on. The data also shows that VCHA had the second best, 90%, completion rate in the province and that RH had the best, 90%, completion rate in the VCHA region, with MSJ second. The data also shows that the wait times for many other equally or more needed surgical procedures are greater including cholecystectomy, hip and knee replacements, hernia repairs and rectal surgery. The Respondent noted that these are but a few examples of surgical services competing for needed operating room time.

[61] The Appellant submitted that the analysis of 'need' conducted in response to the August 2015 application was flawed because the wait time data relied on did not properly account for Dr. DB's wait times at MSJ; the fact that the December 2015 data (above, 'as at January 22, 2016') showed that Dr. DB had only 17 patients on his RH waitlist should have raised concerns as being far too low. Therefore the Appellant submitted that VCHA should have questioned that and should have taken Dr. DB's waitlist at MSJ into consideration.

[62] The evidence of Dr. DB was that he was working at a frenzied pace, extraordinary hours, basically, to cover the shortfall in cataract surgeons following the departures of Dr. H and the Appellant. Based on his data, he has a waitlist of over 500 patients who have to wait 6 or 7 months for surgery. The Appellant submitted that although that may meet the provincial 26 week target, it does not mean there is no need. He submitted that the provincial target of 26 weeks for cataract surgery is not a reasonable wait time; demand that is not met in a reasonable time is a need and, in this sense, demand does mean need.

[63] The panel acknowledges that the current workload Dr. DB has assumed is not sustainable in the medium or long term. However, clearly, the choice is Dr. DB's to make whether to limit that workload. He has willingly accepted the majority of the referrals from the Appellant rather than encouraging some of those patients to be referred to other ophthalmologists with shorter waiting lists, including Dr. T. Dr. DB testified that he would only refer patients to an ophthalmologist whom he trusted to provide a high level of care, and that did not include Dr. T. In fact, it seemed the only ophthalmologist he would refer to in the Richmond community was his son, the Appellant.

[64] According to Dr. DB's testimony, his office books the majority of his cataract surgery patients at MSJ so that he can maximize his operating time at that facility. If operating time becomes available at Richmond Hospital he will move patients from the MSJ list to the Richmond Hospital list on short notice to maximize his operating time overall. That explains why his wait list showed only 17 patients at RH in December 2015/January 2016.

[65] The Respondent submitted that the waitlists and wait times at MSJ were not available to VCHA and RH and that, regardless, it would not have been appropriate to consider those in assessing the need at RH. They pointed to the fact that MSJ recently appointed two ophthalmologists, one being the Appellant's sister, Dr. AB, who have assumed Dr. H's PHC privileges and operating time at MSJ. They also noted that the Appellant did not apply for the MSJ vacancy.

[66] The Panel finds that the data relied on by VCHA is the best and most reliable evidence of wait times. We do not accept the Appellant's contention that Dr. DB's wait list at MSJ should be included in the calculation of wait times at RH. The data from MSJ would have been taken into account when PHC determined its needs in filling the vacancy left by Dr. H. However, even with Dr. DB's very high wait list at MSJ, the evidence was that his patients could receive surgery within, or very close to, the provincial target. The vast majority of patients of RH were also receiving cataract surgery within the provincial target of 26 weeks, and many were within the previous target of 16 weeks.

[67] The Panel heard that the provincial target was set in consultation with ophthalmologists and that there was general agreement with the target of 26 weeks. The Appellant submitted that the Panel is not bound by the targets. The Panel finds that benchmarks are necessary and, where it appears they were reached through consultation, there is good reason to give weight to them.

[68] The Appellant submitted affidavit evidence from patients to demonstrate the impact of the current wait times for cataract surgery. One patient had cataract surgery on one eye in October 2015 by the Appellant. When it was time for the surgery in the other eye, the Appellant no longer had hospital privileges. The patient's optometrist, Dr. G, suggested he go to Dr. DB. As of March 23, 2016, he was still waiting for surgery. "I have been waiting so long for surgery on my left eye that I need it done as soon as possible, despite my comfort with Dr. Butler."

[69] Another patient was referred to the Appellant by Dr. G in November 2015. When the patient attended the Appellant's office in December 2015, his assistant informed her that she would have to wait a long time for surgery because the Appellant no longer had privileges at RH. The assistant suggested that she could pay for private surgery or that she could see Dr. DB. As of March 23, 2016, because Dr. G had recommended the Appellant, the patient had not seen another surgeon. However, she stated that her eyesight was getting worse and she might be forced to go to another surgeon. She also stated that she would be negatively affected if she could not have surgery by the Appellant at RH, and that she should not have to travel to another municipality or hospital to get surgery from the surgeon she trusts with her vision.

[70] These were the only patient affidavits that specifically touched on the waiting time for cataract surgery. As both relate to the wait time during which Dr. T was available to take cataract patients at RH and both patients could have been referred to her, the Panel finds that neither affidavit touches on the issue of whether the target of 26 weeks is meeting need.

[71] A related issue is whether patients should be entitled to the surgeon of their choice. The Appellant submitted that his preferred community for his practice is Richmond where he has established close connections, and that he wants to provide a hybrid practice of general ophthalmology and cataract surgery along with his sub-specialty in medical retina. If he is not able to provide cataract surgery in Richmond, he will need to look elsewhere for his practice because of the importance to him of practicing all the skills he has trained for. That would mean that his retina patients would have to travel outside their community for the intraocular injections.

[72] The Appellant noted that his cataract patients have to be referred to other physicians for surgery, and that his patients will receive a lower standard of care if he is not granted privileges at RH, including the disruption of the continuity of their care. As above, he referenced the *Aitken* decision for the proposition that patients of a practitioner without surgical privileges receive a lowered standard of care. The Appellant submitted affidavit evidence from patients and other doctors to demonstrate that there would be an adverse impact if his retina patients could not be provided with treatments in Richmond.

[73] The Panel is not satisfied that the Appellant's patients will receive a lower standard of care if he is not granted hospital privileges. We note that the *Aitken* decision was concerned with the patients of an obstetrician with much different patient care concerns than those of an ophthalmologist. We also note that standard of care or continuity of care did not seem to be a concern when the Appellant took over Dr. H's patients, or in the evidence of other ophthalmologists who do not have surgical privileges referring their patients for surgery. Concerning the Appellant's retina patients having to travel, that will only be the case if the Appellant does not maintain an office in Richmond.

[74] The Panel acknowledges that the Appellant's training in retinal diseases is a potential service to the community. However, medical retinal services are provided in a physician's office, not in the hospital. In addition, we were assured that the Appellant's position within the Provincial Retinal Disease Treatment Program was secure for as long as the program is operational. Thus, hospital privileges are not required for the Appellant to continue to provide medical retinal services in Richmond.

[75] The Appellant developed a full general ophthalmology practice with retina sub-specialty while having locum privileges at RH. Clearly, he is a capable, skilled ophthalmologist and is well respected in the Richmond community. However, that is not sufficient to satisfy the Panel that there is a need for a fourth ophthalmologist with RH hospital privileges, or that the Appellant should automatically be granted those privileges. There are other ophthalmologists with offices in Richmond who provide cataract surgery services to the population of

Richmond at other surgical sites, further meeting the needs of the community, including Dr. JM, Dr. AB and Dr. L. We further note that Dr. JM previously indicated her interest in being appointed to RH through applications, and remains interested if a vacancy is declared through this process.

[76] The Panel does not find the argument against patients travelling to Vancouver for medical attention compelling. Of course, most cataract and retina patients are considered 'seniors' as these tend to be age-related conditions. While it may be inconvenient for some to travel to Vancouver, in reality it is a short distance and, given the nature of the surgery, patients are not themselves driving a vehicle. Since 2012, with the advent of the agreement with PHC/MSJ, approximately fifty percent of RH cataract patients travel to MSJ for their surgeries.

[77] The Appellant's submissions on the need for a fourth ophthalmologist were based on the premise that, with the appointment of Dr. T instead of the Appellant, the needs of the Division of Ophthalmology were not met, primarily, because Dr. T does not have a high volume cataract surgery practice. Given that her practice is "focused on glaucoma" and her interest in pursuing research, the Appellant submitted that she will not have the capacity to provide the level of cataract surgery that Dr. H provided.

[78] The Appellant submitted that Dr. H performed 1000 cataract surgeries per year, between RH and MSJ. The maximum that Dr. T could perform at RH would be approximately 288, based on using her full allotment of 2 OR days per month, performing 12 cataract surgeries per day. Thus, the Appellant submitted, as Dr. T did not have a high volume of cataract surgery patients and would take considerable time to build a high volume practice, if ever, the appointment of Dr. T does not meet the needs of the Division of Ophthalmology. Rather, that need could be met by appointing a fourth ophthalmologist.

[79] The Panel accepts that Dr. H was a high volume cataract surgeon. He had surgical privileges at RH with operating time at MSJ through those privileges. He had additional operating time at MSJ through PHC, because of his prior privileges at St. Vincent's Hospital. The Panel finds that the bulk of his OR time was at MSJ, under his PHC contract. Since his retirement, those privileges and operating time at MSJ have been assumed by Dr. AB and the other ophthalmologist selected through the PHC search and selection process. Thus, the Panel finds it is unreasonable to expect the new appointee replacing Dr. H at Richmond Hospital to perform the same number of procedures annually as Dr. H, irrespective of who that appointee is. The Panel notes that prior to Dr. T's appointment, the staff ophthalmologists at RH had not suggested that a fourth was required.

[80] Dr. T was appointed to RH with surgical privileges as an ophthalmologist and commenced her practice in January 2016. She is a fully qualified ophthalmologist, certified by the Royal College of Physicians and Surgeons of Canada. The Appellant did not pursue his appeal from the decision appointing Dr. T to RH and he did not cast aspersions on Dr. T's skills.

[81] Dr. T has a sub-specialty in glaucoma. The Appellant has a sub-specialty in retina. There is ample evidence that the Appellant devoted time to treating his

retina patients in Richmond, Burnaby and Kamloops at the same time that he developed a relatively high volume cataract surgery practice at RH. We do not find it reasonable to suggest that Dr. T's "focus on glaucoma" will adversely affect her capacity to provide services to RH any more than the Appellant's "focus on retina" may have adversely affected his RH practice.

[82] Considerable evidence was led about the allocation of OR time and the amount of unused OR time, relative to the issues of whether there is sufficient OR time to support an additional surgeon, and whether there would be adverse impacts on other RH resources from an additional appointment to the Division of Ophthalmology. The Panel considers the recent hires at RH to be an important consideration in use of the OR time and possible adverse impacts if another surgeon was brought on. The evidence shows that, in 2015, RH appointed 5 new surgeons to its staff: general surgeon, plastic surgeon, urologist, orthopedic surgeon and gynecologist.

[83] As of the hearing, there were plans to develop a breast health centre at RH to improve access to reconstructive surgery for breast cancer patients. There was also a search and selection process underway to add a general surgeon to specialize in bariatric surgery. There had been some delay in this appointment because of a lack of anesthesia services, which had been resolved. There was also an impact analysis being undertaken, potentially, to add an orthopedic surgeon. The Panel heard that these areas have the greatest OR needs, greater than the Division of Ophthalmology.

[84] The Panel accepts that further compounding the demand for operating room time is the planned repatriation of Richmond Hospital joint replacement surgery currently being performed at UBC Hospital, estimated to be approximately 240 cases per year.

[85] If a fourth ophthalmologist were to be appointed, all of that individual's operating time would need to be at the Richmond Hospital as there is no additional time available at MSJ in accordance with the 2012 MSJ/RH Agreement. Thus, the Panel finds there would be double the impact on the demand for basic operating resources at Richmond Hospital compared with the other three ophthalmologists in the Division.

[86] Concerning the impact on the RH resources, the Appellant submitted that there is considerable unused OR time at RH and that a significant amount of time is returned. Between April 2, 2014 and January 31, 2015, 535 hours of OR time went unused, the equivalent of 74 regular slates. The evidence shows that the Division of Ophthalmology is well-suited to pick up the unused OR time. Contrary to the Respondent's submission that this time will be used once the newly hired surgeons are up to speed, the Appellant submitted there will continue to be unused OR time, in part, because RH has a utilization goal of just 95%.

[87] The Appellant relied on the HAB decisions in *Behn* and *Walker* (above) as examples of the HAB putting weight on unused OR time in granting the respective Ophthalmologist Appellants' applications for hospital privileges. The Panel has carefully considered those cases. Of particular importance in both cases, the hospitals had dedicated ophthalmological ORs and the HAB found that factor

reduced adverse impact on other surgical services. Additionally, in both cases, the HAB was concerned with the evidence of protectionism among the current ophthalmologists who had personal interest in blocking the Appellants' appointments. Neither of those were factors in this case.

[88] In this case, the Panel finds it is more likely than not that there were complicating factors over the past two years which increased the amount of unused OR time. One of those factors, lack of anesthesiology, has resolved. The Panel finds it is probable that there will be considerable uptake in OR time with the new surgeon hires coming up to speed.

[89] In reference to the ongoing 'call' issue, the Appellant suggested that it might be considered 'crisis'. He noted that surgeons who do not have privileges at RH are sometimes called upon to provide call services. He adamantly denied that he withdrew from call in May 2015, after being told he was not the successful candidate, and maintained that his other professional obligations prevented him from being present for certain months. On his return, he offered to take call but his offer was not acted on.

[90] The Panel has considered the evidence about the on-call services and whether there is a crisis and is satisfied that once Dr. T began her RH practice, the call was being adequately handled. The Panel finds that any ongoing issue around call is basically as a result of an historic disagreement Dr. DB has about the structure of the call, and that the issue does not constitute reason to consider the addition of a fourth ophthalmologist.

[91] The Appellant referred to demographic data and the decrease in ophthalmologists with privileges at RH since 1986. He referred to the future needs of Richmond with an aging population, an Asian population who are more prone to myopia and macular degeneration, and the upcoming retirements in the Division of Ophthalmology at RH because two of the three ophthalmologists are in their 60s.

[92] The Panel agrees with the submissions of VCHA that it is inappropriate to crystal-ball gaze at this point about potential future needs, particularly in light of the evidence before us which demonstrates that current needs are being met.

[93] The Panel acknowledges that consideration of successorship may be appropriate in some situations, but finds this is not one of those. Dr. DB had not given notice of any intention of retirement prior to his testimony in this hearing. Dr. RT, who is a few years younger than Dr. DB, has not indicated plans for retirement. Given their age difference, it does not seem likely they would retire at the same time, leaving the Division of Ophthalmology without adequate coverage. The Panel is of the view that if either of them decides to retire, the usual method of posting a vacancy and proceeding through search and selection would be appropriate.

[94] Concerning the need for a retina specialist in Richmond, as the Panel has said above, it is possible for the Appellant to maintain a practice in Richmond without privileges at RH, as a number of other ophthalmologists already do.

[95] The Panel finds that the evidence does not demonstrate need for a fourth ophthalmologist at the Richmond Hospital at this time. Further, the Panel finds that the appointment of a fourth ophthalmologist would negatively impact the provision of other needed surgical services given the current resources at the hospital. The RH administration is in the process of potentially increasing the number of surgeons for areas that have been identified as crucial. If these go ahead, the additions will have an impact on the OR time. If they do not go ahead, it will likely be the result of impact analyses indicating, in part, that the OR load cannot handle all of the proposed additions. The Appellant maintains that RH's current goal of 95% utilization is too low; it may well need to be revised in light of new demands on the resources, both from the recent hires and the proposed hires.

[96] The Appellant suggested that the Panel consider appointing him to the medical staff at RH on terms that would impact the OR time only of the surgeons within the Division of Ophthalmology and he referred to the arrangement made recently in Obstetrics and Gynecology. As the Respondent pointed out, that arrangement came about through agreement of the surgeons in the Department, and there was no similar agreement presented to the Panel. The Panel declines the Appellant's request.

[97] The Panel finds there is no merit to the suggestion that we structure an order for the Appellant to be appointed to RH if his father gives up his active medical privileges at RH. To appoint the Appellant if his father retired would have the overt appearance of nepotism which should have no place in the awarding of a permit to practice.

[98] The last alternative the Appellant asked the Panel to consider is appointing him on condition that he is allocated less than two full days per month of OR time, taken from flex time. This proposal was supported on the basis of the evidence of Dr. R who is a pediatric ophthalmologist with privileges at B.C. Children's Hospital. She has an appointment to the medical staff of RH to allow her to treat the very infrequent adult patient requiring surgery to correct diplopia. In the past, she was granted OR time of one half day of flex time at RH. Because she seldom used her OR time, this was recently changed. Now, Dr. R must contact RH to request OR time at which point she will be granted up to one half day of flex time. The Appellant submitted that the continued allocation of OR time to Dr. R is evidence that RH has the ability to accommodate another Ophthalmologist. The Panel finds that Dr. R uses her operating privileges so infrequently as to be irrelevant to the Panel's consideration of the OR usage. If the Appellant was granted privileges structured on this same arrangement, he would be using the flex time all the time, thus negating the purpose of "flex" time. The Panel finds no merit in this suggestion.

[99] In the event that the Panel found need for a fourth ophthalmologist, or found that the Appellant's services were needed in the Richmond community, the Appellant requested that the Panel appoint him directly to the medical staff at RH, without a further search and selection process. Although we have not found in the Appellant's favour, we think it advisable to address this request. In making this request, the Appellant stressed that he felt he would not receive fair

consideration if he went through the usual search and selection process because he would be viewed in a poor light as a result of having taken legal action against the decisions of the Board of Directors. In particular, the Appellant pointed to the comment, made in October 2015 by Dr. P, the RH Head of the Department of Surgery, to the Appellant's sister in an "unguarded" telephone conversation, that if the Appellant pursued the legal route he would "burn his bridges" and that it would not end well.

[100] The evidence before us was that the Appellant had a good working relationship with many professionals at RH, including the Head of the Department of Surgery, and that he was well respected at RH and in the Richmond community. Other than the one conversation alluded to above, there was no evidence before us to suggest that the Appellant would not be considered in a professional, unbiased manner in a subsequent search and selection process. Dr. P testified at the hearing. We were struck by how supportive he was of the Appellant whom he obviously regarded highly. He stressed that what he recalled from the conversation with the Appellant's sister was conveying his opinion that the Appellant was not acting in his own best interests in attempting to create a position that did not exist, by submitting his August 2015 unsolicited application, and reiterating that there was no position available.

[101] In the evidence before the Panel regarding the search and selection process which resulted in Dr. T's appointment, there was no evidence that the Appellant was not considered fairly. He was one of two candidates selected for interviews. Two ophthalmologists recused themselves because of potential conflict of interest, one arguably from being too close to the Appellant's father and being subject to pressure to act on the Appellant's behalf, and the other because of possible professional 'competition' in retinal surgery. When the Appellant submitted his August 2015 application, both of those doctors were consulted by Dr. P, Head of the Department of Surgery, as is set out above in the Background. Dr. P testified that he did not consult them about the Appellant's application. The Panel is satisfied from the evidence that he consulted them about the need for a fourth ophthalmologist and the impact of such an appointment on the other surgical services at Richmond Hospital. The point of those consultations, and with Ms. CW, was to determine whether to declare a vacancy.

[102] In the event that a future vacancy should arise in the Division of Ophthalmology, it is the Panel's view that a further search and selection process should be conducted. Considerable time has passed since the last process such that further qualified applicants will have completed training and would be seeking such a position in addition to the many qualified surgeons who expressed interest the last time. In fairness to all there must be an open, fair and transparent process.

DECISION

[103] As of January 2016, the vacancy created by Dr. H's retirement was effectively filled when Dr. T commenced her practice and assumed her responsibilities at RH. The HAB was not asked to rule on the VCHA Board of Directors' appointment of Dr. T. We were asked to find that there is ongoing need

for another Ophthalmologist at RH. After careful consideration of the evidence and submissions, we find that the Appellant has not demonstrated need for a fourth ophthalmologist to be appointed to the medical staff at Richmond Hospital, whether that be with full OR privileges, shared privileges, or partial privileges, for the reasons given above. The Panel also finds that there would be an adverse impact on other surgical services at Richmond Hospital if a fourth ophthalmologist was added.

[104] Accordingly, the appeal is hereby dismissed.

"M. Gwendolynne Taylor"

"M. Gwendolynne Taylor"

M. Gwendolynne Taylor, Panel Chair

"Douglas H. Blackman"

"Douglas H. Blackman"

Dr. Douglas H. Blackman, Member

"Lorraine Unruh"

"Lorraine Unruh"

Lorraine Unruh, Member

September 29, 2016