DECISION

Claim Number 15930

This is a review of the Administrator's decision denying the costs of a liver transplant in China and related expenses for the deceased. The deceased died some months following the liver transplant procedure and this claim is brought by the Executor of his estate.

An oral hearing was conducted on April 15, 2009.

The deceased had a long, complicated and tragic history which I will summarize.

He was involved in a serious motor vehicle accident in June 1988 at the age of 19. He contracted Hepatitis C from a blood transfusion during his treatment for his injuries in June 1988. His injuries from the motor vehicle accident included very severe orthopedic injuries and a significant head injury. His father, as Executor of his estate, alleges that the head injury, and ongoing pain from his orthopedic injuries, caused depression which led to alcohol dependency.

The deceased appears to have been advised some time in 2002 that he had tested positive for Hepatitis C.

He submitted a claim under the Transfused HCV Plan as a Primarily Infected Person which was approved and payments were made to him.

He went on to develop cirrhosis of the liver. By 2005, he had end stage liver disease. He was advised by Dr. Yoshida, his treating gastroenterologist, to stop alcohol immediately and he was to be referred to the BC Transplant Society for a potential liver transplant. He was assessed by the Transplant Society and advised that he would need to meet criteria regarding alcohol abuse and abstinence. He was unable to qualify for a transplant in British Columbia because of his admitted ongoing use of alcohol and apparent inability to abstain. It seems that all transplant programs in Canada adhere to similar criteria in this regard. The Transplant Society requirement is that there be a minimum period of 6 months of witnessed abstinence.

The Executor's position is that the deceased was, by reason of his disabilities caused by the motor vehicle accident, disabled and not therefore able to abstain from alcohol.

The deceased explored the prospect of having a liver transplant in the United States, and was assessed at the Mayo Clinic in Arizona in 2005. However, the criteria for eligibility for a transplant were similar to those in B.C. in that a 6 month period of abstinence from alcohol was needed.

Dr. Lichtenstein, the deceased's treating GP, noted on May 16, 2007 that he needed an urgent liver transplant, without which he would not likely survive a further 3 months.

The deceased traveled to China on April 10, 2007 for the purpose of having a liver transplant there. He underwent a liver transplant in China on September 11, 2007. He returned to

Vancouver on October 10, 2007. He was admitted to Vancouver General Hospital on October 11, 2007 and diagnosed with cytomegalovirus hepatitis. He was admitted again on December 27, 2007 with abnormal liver function tests.

He ultimately died on January 10, 2008. The cause of his death was eventually identified as a fungal infection.

None of the costs of the liver transplant were ultimately covered by the Medical Services Plan of British Columbia. The Medical Services Plan required a written recommendation for such a procedure out of the country from the tertiary care centre in BC (the BC Transplant Society). The Medical Services Plan indicated in February, 2008 that a submission was made to the Plan in October, 2007 in relation to the costs of the transplant in China. No funding request was apparently made prior to the transplant procedure. An application for funding was made following the procedure, but according to MSP, no medical recommendation from an attending specialist was provided and MSP denied the funding for the medical services in China. Based on the letter from MSP it also appears that there was nothing submitted from the BC Transplant Society with the post-procedure application.

The Executor is seeking reimbursement for his late son's expenses associated with cost of the liver transplant in China.

His claim was denied by the Administrator. The Administrator relied on Section 4.06 of the 1986-1990 Hepatitis C Settlement Agreement, Transfused Plan ("the Plan"), which provides as follows:

4.06. An approved HCV Infected Person who delivers to the Administrator evidence satisfactory to the Administrator that he or she has incurred or will incur costs for generally accepted treatment and medication due to his or her HCV infections which are not recoverable by or on behalf of the claimant under any public or private health care plan is entitled to be reimbursed for all reasonable past or present or future costs so incurred to the extent that such costs are not costs of care or compensation for loss of services in the home provided:

(a) the costs were incurred on the recommendation of the claimant's physician; and

(b) if the costs are incurred outside Canada, the amount of compensation cannot exceed the lesser of the amount of compensation payable if the costs had been incurred in the Province or Territory where the claimant resides or is deemed to reside and the actual costs.

Article 4.07 reads:

4.07. An approved HCV Infected Person who delivers to the Administrator evidence satisfactory to the Administrator that he or she has incurred or will incur out-of-pocket expenses due to his or her HCV infection that are not recoverable by or on behalf of the claimant under any public or private health care plan is entitled to be reimbursed for all reasonable costs so incurred provided:

(a) out-of-pocket expenses will include (i) expenses for travel, hotels, meals, telephone and other similar expenses attributable to seeking medical advice or generally accepted medication or treatment due to his or her HCV infection and (ii) medical expenses incurred in establishing a Claim; and

(b) the amount of the expenses cannot exceed the amount therefor in the guidelines in the Regulations issued under the *Financial Administration Act* (Canada) from time to time.

The Administrator rejected the claim of the Executor on the basis that there was no recommendation from the treating physician that the transplant had to take place out of the country. The Administrator also referred to the refusal of Health Insurance BC to cover the costs of the liver transplant on the basis that "appropriate standard of care (liver transplant services) was available in British Columbia and elsewhere in Canada and BCTS did assess [the deceased] as a candidate for liver transplant, however, BCTS subsequently refused to put [the deceased] on the transplant waitlist due to the results of the assessment."

It was also noted that Health Insurance BC refused coverage for elective out of country transplant services because there was no funding request made prior to the procedure and no medical recommendation was included in the post-procedure application.

The Administrator's position is that "the Settlement does not provide that the Administrator reimburse that part which in this case may have been covered by a public or private health care plan".

Submissions of the Executor

I summarize below the submissions and evidence led by the Administrator in the order they were presented.

The Executor submitted that his son was abandoned by various of his medical practitioners and indeed, "victimized by the medical profession" and characterized as a recidivist drunk. He tried very hard to deal with his alcohol problem but, according to the Executor, was unable to do so because of his head injury and chronic pain. The Executor submits that the "thin skull rule" is a large part of his case, and that the tortfeasor takes his victim as he finds him.

He submits that his son was the victim of malpractice and that some of his doctors let him down.

He referred to the medical report of Dr. Michael Vondette, filed as an Exhibit on the hearing of this matter and submitted that his son's alcoholism was the product of his head injury and encephalopathy resulting from his Hepatitis C.

Fund counsel did not take issue with the fact that the deceased had a mental impairment.

At the hearing the Executor called evidence by telephone from Dr. Eric Yoshida, whose affidavit dated January 23, 2009 was also in evidence. Dr. Yoshida is a specialist in gastroenterology. The deceased was referred to him by Dr. Reynolds. In 2005, Dr. Yoshida considered the deceased to have end stage liver disease. Dr. Yoshida, on endoscopic examination of the deceased, noted esophageal varices, which are a complication of portal hypertension and cirrhosis. Nothing else causes esophageal varices. Cirrhosis caused by Hepatitis C is usually painless until the end. Patients with Hepatitis C complain of "brain fog", fatigue, and of feeling unwell. Dr. Yoshida recalled that the deceased had a lot of discomfort when asked whether he had pain in his legs from his motor vehicle accident and there was no satisfactory way of dealing with it. Some patients with such pain use narcotics while others resort to marijuana with the physicians "turning a blind eye". Hepatitis C may exacerbate a patient's bone and joint pain

from other causes. Hepatitis C can also result in muscle and joint pain. A lot of patients with Hepatitis C will also have abdominal pain. It would not surprise Dr. Yoshida if the deceased's pain from osteomyelitis, and problems with his ankle and knee was exacerbated by his Hepatitis C. A severe strep infection resulting in osteomyelitis could have resulted from decreased immune function due to liver disease.

Dr. Yoshida's evidence was that the deceased's liver cirrhosis was caused by Hepatitis C.

Dr. Yoshida also explained the process of hepatic encephalopathy, which can affect a patient's thought processes.

Dr. Yoshida has been associated with the liver transplant program in British Columbia since 1991. He is aware that the deceased went to China for a liver transplant. He has reviewed the records of the deceased relating to what was done in China and described the deceased's liver transplant procedure there as "pretty standard", including the use of immunosuppressant drugs. Nothing struck him as out of the ordinary in terms of the liver transplant and associated treatment in China.

The deceased was not a candidate for Interferon treatment, according to Dr. Yoshida.

Liver transplant is a generally accepted treatment for Hepatitis C. Indeed, 50 % of all liver transplants are the result of Hepatitis C.

Dr. Yoshida also noted that the cause of death in this case was not the liver transplant, but a very unusual and difficult to control fungal infection, which he says the deceased likely picked up in China.

Fund Counsel, in his questioning, referred Dr. Yoshida to a letter of November 13 2007, indicating that the deceased did not meet the criteria of the BC Transplant Society and had decided to go to China for a transplant, against the advice of Dr. Yoshida, who had indicated that four patients had gone there for transplant and had since died.

Dr. Yoshida said he recalled that. When it was suggested to him that he did not recommend that the deceased go to China for the transplant Dr. Yoshida's answer was that China would not have been his first choice. Every Chinese centre doing transplants was somewhat different and he had had some bad experience with patients transplanted in China who had passed away, some from unusual infections not typically seen in Canada. In addition, he is not familiar with the quality of the various centers in China, or the quality of the surgery and post-transplant care.

Canada is a leader in terms of transplant surgery but if the opportunity to obtain an organ in Canada was not available, the next thing to do, according to Dr. Yoshida, is to go out of the country where there is a greater likelihood of an organ being available.

It would be appropriate to go out of the country if a transplant could not be obtained in Canada. If a patient was going to die without a transplant, he or she should look to where a transplant could likely be done in a timely fashion.

While this would include the U.S., US centres have a quota on the number of non-Americans eligible for transplant.

Dr. Yoshida did not recommend that the deceased go to China for transplant at the time he dealt with him in 2005. He does not specifically recall the deceased asking him if he should go to China. As I understand Dr. Yoshida's evidence, if a patient had been turned down in Canada for a transplant, and had the opportunity to go to China and receive a transplant, he would not say "no". He also said that perhaps things in China have improved based on the fact that several people he is aware of had transplants there and seem to be doing well.

His first choice for patients would be to have the transplant in Canada. No one would say no to a patient who went to China if that was what they had to do. While this was not a prohibition, it is different from a recommendation.

With regard to whether a transplant in China is generally accepted treatment, Dr. Yoshida says that it is "something we see" although he cannot say it is accepted practice. Most patients do not have the option of going to China for a transplant as they cannot afford the costs. Dr. Yoshida was asked whether going to China for transplant was generally accepted treatment in Canada, and he asked Fund Counsel to define "accepted". Counsel put the term "generally accepted by the medical profession" to him. He said that to the extent such patients are treated like anyone else when they return to Canada, he and his colleagues accept it. When it was suggested that he and his colleagues do not specifically tell patients to go to China for a transplant, he responded by saying "we don't say no to out of province transplant opportunities". He also said that no physician is going to say that a patient who needs a transplant should not get one and no one is going to say that is not acceptable. In most cases, transplant services are available in B.C.

He concurred with the Executor that the nature of the treatment given to the deceased in China was the type of treatment generally accepted in Canada.

The Executor asked Dr. Yoshida about the CMV infection for which the deceased was admitted to hospital on his return to Canada after the transplant, and said that such infections are problems in transplantation in general. He agreed that it would have been possible to contract both CMV and the fungal infection contracted by the deceased in Canada and he could have been exposed to the infection before leaving for China.

Dr. Yoshida noted that in the US, to be eligible for a liver transplant, the same rules generally apply in terms of the requirement for 6 months of alcohol abstinence. There is a 30% chance of mortality once a patient is placed on the transplant waiting list in Vancouver.

He would not be surprised if the costs of a liver transplant in the US exceeded $300,000 US.

In his affidavit of January 23, 2009, Dr. Yoshida deposed in paragraph 4 that he advised the deceased in 2006 that if he did not meet the Canadian criteria for a liver transplant that it would be "in his best interest to consider a liver transplant outside of Canada" He went on to say in

paragraph 5 that by reason of his ongoing use of alcohol, the deceased did not meet the criteria for a liver transplant in BC. In paragraph 6, he deposed as follows:

> In the situation of any patient who is not placed on the waiting list for a liver transplant and who wishes to explore the possibility of a liver transplant outside of Canada, I never recommend that these patients not seek another opinion. I would never discourage a patient who seeks out of country assessment. In [the deceased's] situation, the report of his ongoing alcohol consumption would have precluded him from a liver transplant in any Canadian centre and it would have been in his best interest to seek a liver transplant opinion in another country. Therefore, going to China in order to receive a lifesaving transplant would have been in his best personal interest as there was no centre in Canada that would have offered him a liver transplant given the policy with regards to alcohol.

The Executor referred to confirmed Referee Decision #82, involving a chiropractic device known as the activator. He referred to paragraph 15 of that decision. He suggested that by analogy to that case, the treatment in this case (liver transplant) was generally accepted and done on the recommendation of the treating physician. He submitted that the deceased was a victim of his Hepatitis C through no fault of his own and described in some detail the unfortunate circumstances resulting from the deceased's 1988 motor vehicle accident, including his severe brain injury. He submitted that the brain injury led to the deceased's alcohol abuse problem and that he was permanently disabled as a result of his traumatic brain injury. He referred to the report of Dr. Michael Vondette, marked as Exhibit 3 in the hearing.

The pain resulting from the deceased's injuries and his brain injury, it is submitted, led to his alcohol abuse and by October 2004 he was in "very serious trouble" and was referred to Dr. Hahn because of gastrointestinal problems. Dr. Hahn allegedly became disenchanted with the deceased as he would go back to alcohol use.

The Executor also referred to the Supreme Court of British Columbia decision of *Campbell v. Khani*, 1997 CanLII, which he says deals with foreseeability issues and the policy question of who should bear the loss.

The Executor also noted that at the behest of Dr. Yoshida, the deceased attended the Mayo Clinic in Arizona in 2005. The information provided there was that the cost of a liver transplant in the US was at least $300,000 US and could range as high as $500,000 US. The same criteria regarding alcohol abstinence which the deceased faced for a transplant in Canada existed in the US. The Mayo Clinic also advised that priority was given to American patients.

At this point, the deceased moved to Kelowna and married.

The Executor also referred to the deceased's apparent unwillingness to comply with advice in China about prevention of infection, in that he would leave hospital and go to a local marketplace. Helpers were hired to attend on him constantly. He was not able to fly to China without a doctor's letter and had to be accompanied by someone who had to fly first class.

The Executor described the treatment that the deceased received in China as extraordinary, in terms of the kindness of the staff and their infection control precautions.

In China, the deceased needed someone with him at all times, and was initially accompanied by his wife. In July, 2007, she was no longer able to handle the situation and returned to Canada. It was therefore necessary to find someone else to be his "watchdog".

An old school friend agreed to go to China to be with him and paid his own way, staying in modest accommodations. He is not a person of means. He is an artist, and according to the Executor, did not keep very good records of his expenses. The Executor takes the position that these expenses qualify for reimbursement under the terms of the Plan.

The Executor referred to Dr. Yoshida's affidavit, in which he deposes that he would not rule out a patient going to China and would not discourage a patient from going there

The Executor submits that Dr. Yoshida's opinion was that the deceased had to go to the US for a liver transplant if he could not quit drinking, that this proved to be unworkable as the criteria were the same as the Canadian criteria, and that he would not discourage a patient from going to China. He relies on Paragraph 4 of Dr. Yoshida's affidavit and says that is a recommendation from Dr. Yoshida that the deceased go to China for a transplant. .

The Executor continued his submissions by saying that he was disappointed in the Canadian medical system as his son was sent home to die with morphine. He says his son was someone with a "thin skull".

He submits that the settlement of the class action which gave rise to the Plan had to have anticipated that there would be both normal and subnormal people with HCV and that all are entitled to treatment as long as the treatment meets certain medical standards. He says the Plan should be interpreted as broadly as possible and the settlement must have contemplated that there would be disabled people who would not qualify for a transplant or other treatment in Canada. He also points out that in this case the treatment worked.

Based on the "activator" case, he submits that the circumstances of the individual must be considered and that the Plan cannot be interpreted in a way that would work an injustice. The medical community in this case did not recognize the difference between a "normal" case and a case like the deceased, who was unable to stop drinking and who was therefore below the norm. As I understand the submission of the Executor, a liver transplant in China might not be suitable for all claimants but was the only option in the case of the deceased.

The next issue arising from the "activator case", according to the Executor, is whether the proposed treatment is reasonable. The Executor says his son was in dire need of care at the time he went to China. He refers to the costs of $206,000 for a liver transplant in China, not including incidental expenses. The Executor submits that the costs of the transplant in China were reasonable and that the only reasonable thing for his son to do in his circumstances was to go to China for the transplant. He had to do something as the alternative was to die.

The Executor referred in his submissions to some media information describing alcoholism as a disease. He says his son was treated as a moral failure when in fact he was disabled.

He referred to Referee Decision 115. In that decision, the teenage claimant, a hemophiliac, attended a national hemophiliac conference in Anaheim, which included sessions on coping with HCV, on the recommendation of his psychologist, and he claimed the costs of travel expenses, which were allowed.

He says there was no evidence that similar treatment was available in the local area. His son's psychiatric circumstances were unique and comparatively rare.

He also referred to Referee Decision 184, in which the cost of spa therapy was rejected by the Administrator and subsequently allowed by a referee. The referee in that case noted that the Plan requires a large and liberal interpretation and that s. 4.06 should not be applied so as to work an injustice. Therapeutic spa treatment was recommended by the claimant's treating physician and in her unique circumstances, the annual costs of such treatments at a facility would be higher than the cost of purchasing her own spa.

The evidence of Dr. Tersia Lichtenstein was taken by telephone. Dr. Lichtenstein became the deceased's family doctor in early 2007. When she first saw him, he was very tired and in a lot of pain, secondary to advanced end stage liver disease. He could not eat properly. He was given long acting morphine for pain and his treatment was symptomatic to make him comfortable. Dr. Lichtenstein was aware that his liver problems were caused by the HCV. She became aware in March, 2007 that the deceased was planning to go to China for a liver transplant. He was in a lot of pain, tired and could not eat much at that point. He was on the verge of dying and there was nothing that could medically be offered to him. He had been declined for a liver transplant by the BCTS. He had recently been discharged from hospital and was quite despondent.

He was too ill for any treatment to make a real difference as his liver could not at that point have recovered. His mental condition may have been affected by hepatic encephalopathy. Dr. Lichtenstein says he was desperate and was trying to save his life. No help was available for him in B.C. Dr. Lichtenstein told him that if he had the means, he should go to China as he had nothing to lose at that stage.

Dr. Lichtenstein clearly recalls meeting with the deceased prior to final arrangements for the transplant in China being made and that he wanted to know what she thought. Dr. Lichtenstein's letter of February 26, 2009 was in evidence. In that letter, Dr. Lichtenstein says that the deceased presented to her in February 2007 with a diagnosis of end stage liver failure. She says "On March 29, 2007 he informed me that he is considering going to China for a liver transplant. I supported his decision as he was not eligible for the British Columbia Transplant Program. I understood that his time was running out and he was desperate and that was basically the only option that was left to him.

In cross-examination, Fund Counsel suggested to Dr. Lichtenstein that he did not see her February 26, 2009 letter as a recommendation that the deceased have a liver transplant in China. Her response was that she did not tell him to go, and that it was not an idea she recommended to him. As he did not need a referral from her, the issue did not come up.

Submissions of Fund Counsel

Fund counsel submitted that this matter involves the interpretations of Articles 4.06 and 4.07 of the Plain. His submission is that none of the medical records or letters from the deceased's doctors can be interpreted as recommendations that he have a transplant in China. Fund Counsel also submits that articles 4.06 and 4.07 provide recovery only for costs that are not recoverable by the Claimant under any public or private health care plan, and that the Plan is not a form of primary insurance.

The deceased needed a liver transplant, but no one specifically recommended that he travel to China for it. If there were such a recommendation, the first step would be for him to go to BC Health for approval of this, and the Administrator would then pick up the cost, according to the submission of fund counsel.

The Executor' s position in response is that the Hepatitis C Claims Centre simply adopted the position of BC Health (MSP).

The position of fund counsel is that there was no recommendation by the treating physician for the liver transplant in China. Carole Miller, on behalf of the Plan Administrator, explained that the Hepatitis C Claims Centre is the "second payer", and would only provide compensation if the services were not covered by MSP. Ms. Miller also explained that the claim was denied by the Administrator on the basis that the medical letters provided to the Administrator were not recommendations that the deceased have a liver transplant in China.

No Hepatitis C specialist recommended that the deceased go to China for a transplant. It is submitted by fund counsel that the Court approved protocol directs that such a recommendation be made by an HCV specialist.

The Executor submitted that Dr. Lichtenstein was the deceased's treating physician and also that Dr. Yoshida made a recommendation and in effect started the process for the deceased to go out of the country for a transplant.

Fund counsel again submitted that the Plan is secondary to the primary provincial health insurance. The requirement of reasonableness relates to generally accepted and respected measures.

Decision

I have considered the lengthy and detailed submissions of the Executor with regard to the deceased's mental state and his alcohol use. While I understand his submission with regard to the unique situation of the deceased, based on the conclusion I have reached concerning the question of whether the costs were incurred on the recommendation of the treating physician, I do not need to consider this further.

Based on Article 4.06 of the Settlement Agreement, for the costs of the liver transplant to be covered in this case, the treatment must be generally accepted, not recoverable under any public

or private health care plan, and incurred on the recommendation of the claimant's treating physician.

The first issue is whether the transplant costs were incurred on the recommendation of the deceased's treating physician.

While the CAP sets out definitions of a Treating Physician and an HCV Medical Specialist, I have not found it necessary to deal with this as I have considered the evidence of both Drs. Lichtenstein and Yoshida in coming to my conclusions.

Dr. Yoshida's evidence was that the liver transplant as carried out in China in this case was, based on the records, "pretty standard". His evidence was that a liver transplant *per se* was generally accepted for HCV infection and that in fact, HCV was a leading indicator for liver transplantation.

The submission of fund counsel is that while a liver transplant is, on the evidence of Dr. Yoshida, a generally accepted treatment for HCV infection, a liver transplant *in China* is not. The issue is whether Article 4.06 of the Plan to be read as if "generally accepted treatment and medication" includes consideration of the place where the treatment occurred. As I understand the submission of the Executor, one problem with this submission is that there is no specific language to this effect in the Plan.

In dealing with the issue of whether the costs in this case were incurred on the recommendation of the deceased's treating physician, the issue of place of the transplant, it seems to me, must be taken into consideration and this is contemplated by the wording of Article 4.06, which provides that the *costs* must be incurred on the recommendation of the claimant's physician.

Dr. Yoshida, did not recommend specifically that he go to China for a transplant, and says that China would not have been his "first choice". Nevertheless, he did say that if there was no opportunity to obtain an organ in Canada, the next step would be to go out of the country where there would be a greater likelihood of obtaining an organ. His evidence was that he was not specifically asked by the Plaintiff if he should go to China after he determined that the US criteria for transplant were essentially the same as those in Canada. His evidence was also that if there was no other choice, he would not say no to a transplant in China and that patients should do what they have to. Dr. Yoshida also did not specifically recall the deceased asking him if he should go to China for the transplant.

Dr. Yoshida's affidavit of January, 2009 was, in my opinion, very carefully worded, and specifically avoided the use of the word "recommendation" in regard to the liver transplant in China, although he did use the word "recommend" in the context of seeking a second opinion.

The evidence of Dr. Lichtenstein was that the deceased was desperate and trying to save his life by going to China for a liver transplant. She says she "supported his decision" and recommended that he do so as there was nothing that could be done for him in this province. She told him that if he had the means, he should go. She conceded that her February 26, 2009 letter was not a recommendation, as he came to her with the idea of going to China and as he did not

need a referral, the idea did not come up. She says the idea of going to China was not something she recommended to him.

Having heard the evidence of both Drs. Yoshida and Lichtenstein, both of them seemed uncomfortable with question of whether they recommended the liver transplant in China. They both indicated that there was no other choice for the deceased, but that is not the same thing as a recommendation on their part. In my opinion, the evidence of Drs. Yoshida and Lichtenstein falls short of establishing that the costs of the liver transplant in China were incurred "on the recommendation of the claimant's treating physician". Dr. Lichtenstein specifically said that she did not recommend the transplant as the patient had already made the decision to have it in China. Dr. Yoshida similarly said he would not have said "no" to the decision, but again, this, in my opinion, falls short of a recommendation.

I therefore conclude that the costs of the liver transplant in this case were not incurred on the recommendation of either Drs. Lichtenstein or Yoshida.

With regard to whether the costs "are not recoverable by or on behalf of the claimant under any public or private health care plan", the interpretation used by the Administrator is that if the costs of the procedure in general would have been covered by MSP, but have not been covered in the circumstances of the claimant, then they are not recoverable from the Plan.

In this case, it seems that the refusal of MSP to consider the post-procedure application was based on the lack of a recommendation from the treating medical specialist that the procedure take place out of the country The costs of the transplant are thus not covered by MSP, but to find that the Plan should pay the costs in these circumstances would allow claimants to look to the plan when they had been denied coverage by MSP because they had not complied with the MSP requirements. In other words, had there been recommendations from the deceased's doctors that he should go to China for a liver transplants, the costs may have been covered by MSP. To allow the claim for out of pocket expenses would allow claimants to claim from the Plan for expenses which would otherwise be recoverable from a provincial medical plan, but not having complied with procedures to obtain funding from such a plan.

The cases referred to by the Executor are distinguishable, in my view, from the present case. In those decisions, there were found to be recommendations from the treating physicians for out of pocket expenses, and in the case of the "activator", a recommendation from a treating physician for the treatment.

With regard to whether the liver transplant in China is generally accepted medical treatment, while there is no specific language in the Plan relating to place of treatment, it is my view that consideration of the place of treatment is required in dealing with this issue and that the evidence at the hearing did not establish that a liver transplant in China is generally accepted medical treatment. Indeed, the evidence of Dr. Yoshida relating to his advice to the claimant suggests otherwise. Dr. Yoshida referred to the fact that in China, for example, not all centres are similar and that he had seen patients who had gone to China pass away from unusual infections not seen in Canada. Again, Dr. Yoshida was not prepared to say that a liver transplant in China would be considered generally accepted medical treatment in Canada. In my view, given the likelihood

that there may be medical disagreement, as to whether a treatment or procedure in a particular country outside Canada is "generally accepted", it is reasonable to take into account the place of the treatment. For example, treatment in a particular country may indeed not be "generally accepted" because of infection issues there.

I note that in the "activator case" the Referee decided that "generally accepted treatment and medication had to be considered taking into account the unique circumstances of the claimant, and that there was no requirement that to be generally accepted, treatments had to be generally accepted for all claimants with both HCV and hemophilia". In the present case, I do not think the evidence, particularly that of Dr. Yoshida, goes so far as to suggest that a liver transplant in China would have been generally accepted medical treatment for the deceased.

Therefore, for the foregoing reasons, I agree with the submissions of Fund Counsel and uphold the decision of the Administrator.

Dated at Vancouver, British Columbia, this 20th day of October, 2009

Robin J. Harper
Referee