

# Comment: Cilinger C. Centre Hospitalier de Chicoutimi<sup>1</sup>

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According to the recent report of the Commission on the Future of Health Care in Canada, “[i]n the minds of many Canadians, the quality of our health care system should be judged, first and foremost, by its ability to provide timely access to the care people need.”<sup>2</sup> The issue of waiting times in health care will only become more significant in light of cost-constraints in the public system, the proliferation of medical technologies, and the aging population.

In addition to waiting times being the subject of public policy and debate, they are also at issue in a recently commenced class action. The action arose when Anahit Cilinger, who was diagnosed with breast cancer in October 1999, was still awaiting radiation treatment in January 2000. Frustrated with waiting, Ms. Cilinger returned to her native Turkey for the treatment, which cost her approximately \$12,000 USD.<sup>3</sup> Ms. Cilinger then initiated a class action on behalf of herself and other persons suffering from breast cancer who had been unable to obtain radiation therapy within eight weeks of surgery.

The action alleged that twelve Québec hospitals were liable for leaving patients waiting beyond what is medically recommended, in breach of their statutory obligations. The action also named the Québec government as a defendant, for its alleged failure to provide adequate funding, resulting in the hospitals being unable to hire an adequate number of radiologists or purchase sufficient equipment. Although Bishop J.C.S. certified the class action against the hospital defendants, the Court refused to allow the action to proceed against the Québec government, a decision that was upheld on appeal.<sup>4</sup>

## *Significance of the Case*

Although there have been numerous cases advancing claims against hospitals, this case is significant in a number of respects. Historically, the duties owed by a hospital to a patient were limited to providing adequate staff and properly maintaining the facility and equipment. Although these duties have been broadened to include a duty to establish systems for the safe operation of the hospital,<sup>5</sup> this has typically been limited to requiring the establishment of policies or procedures to protect against injuries. For example, in *Lacombe c. Hôpital Maisonneuve-Rosemont*, the defendant hospital was found liable for failing to have an alarm bell available for patients waiting for treatment, and failing to have a policy instructing emergency room nurses to re-evaluate the condition of patients waiting for care.<sup>6</sup> In comparison, *Cilinger* addresses the much broader issue of hospital waiting time policies and procedures, and the reasonableness of resource allocation decisions. The possible ramifications in *Cilinger* are also more far-reaching. For example, the *Lacombe* judgment might require that the hospital formulate new policies for monitoring patients and install alarm devices. Comparatively, the result of *Cilinger* might be that in order to avoid liability, a hospital has to determine what the appropriate waiting times are for every available procedure, and to implement policies to ensure these appropriate times are met.

In addition to examining the broader issue of hospital liability at the systemic level, this case also raises the issue of the defence of limited resources. Although the Court declined an application to join the Québec government as a party to



the proceedings, presumably the hospitals will defend any finding of negligence on the basis that limited resources precluded any higher standard of care than that which was delivered. With regard to physicians, Robertson notes that courts have accepted that the standard of care may take into account the resources and facilities available, and that if a hospital does not have a particular piece of equipment, a doctor cannot be liable for a failure to use it. However, there could be liability where a particular test is available at the hospital, but a doctor chooses not to avail herself of it for cost-containment reasons. In support of this, he cites *Law Estate v. Simice*, in which the British Columbia Supreme Court stated “[i]f it comes to a choice between a physician’s responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence...”<sup>7</sup>

However, with regard to hospitals, the case law is less clear whether the standard of care may take into account resources.<sup>8</sup> If a similar analysis to the one above was applied, it is unclear whether the failure to treat patients within a certain time would result in liability. One might argue that the cause of this failure is inadequate funds being allocated to the oncology department, something within the hospitals’ control, similar to the doctor who chooses not to use an available treatment for cost reasons. However, if one were to argue that the cause of this failure is an inadequate number of oncologists in Canada, this may be more analogous to a doctor who could not perform a particular procedure because the necessary equipment had not been purchased in her hospital.

In addition to the tort law cases discussed above, recent jurisprudence has also expanded in the area of subjecting health policy decisions to constitutional scrutiny. In the last eight years, the Supreme Court of Canada has ruled that a province’s failure to provide sign language interpreters constituted discrimination,<sup>9</sup> that a government’s failure to fund behavioural therapy for autistic children was not discriminatory,<sup>10</sup> and, more controversially, that legislation prohibiting private health insurance violated the guarantees under Quebec’s *Charter of human rights and freedoms* in *Chaoulli v. Quebec (Attorney General)*.<sup>11</sup>

Although *Cilinger* does claim the waiting times are contrary to both the Quebec *Charter of human rights and freedoms* and the Canadian *Charter of Rights and Freedoms*, unlike the above-mentioned cases, this is not the focus of the claim, but rather the plaintiffs focus on the violation of a statutory duty to provide care within an acceptable time.<sup>12</sup> Despite this, these recent cases, particularly *Chaoulli*, will be relevant to the outcome in *Cilinger*. One of the issues raised in *Chaoulli* was the appropriateness of courts adjudicating policy decisions. In this regard, the dissent in *Chaoulli* stated that “[t]he resolution of such a complex fact-laden policy debate dose not fit easily within the institutional competence or procedures of courts of law.”<sup>13</sup>

Clearly the issue of the reasonableness of waiting times is also complex and policy-related, although in a tort-based claim the Court may be willing to determine what constitutes a reasonable waiting time.

Although the dissent in *Chaoulli* also questioned: “[w]hat is treatment ‘within a reasonable time’? What are the benchmarks? How short a waiting list is short enough?”<sup>14</sup>

these questions did not have to be answered in *Chaoulli*. The Court merely had to determine whether waiting times in the public system violated the plaintiffs’ constitutional rights. In comparison, the Court in *Cilinger* will have to go further and answer these questions, in addition to questions about the appropriate allocation of health resources.

These determinations will be difficult given the paucity of evidence-based standards for wait times. A concern with this issue was raised by the dissent in *Chaoulli*: “[a] review of the expert evidence and the medical literature suggests that there is no consensus regarding guidelines for timely medical treatment,”<sup>15</sup> and “[t]he major studies concluded that the real picture concerning waiting lists in Canada is subject to contradictory evidence and conflicting claims.”<sup>16</sup> Similarly, in contesting the certification of the class action in *Cilinger*, the defendants made the argument that there does not exist clear and unequivocal scientific evidence establishing a specific recommended delay and the extent of the risks incurred due to a delay.<sup>17</sup> However, citing the medical literature, the Court found that the plaintiff established the *prima facie* existence of risks when the delay surpassed

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what was medically acceptable, sufficient to warrant certification.<sup>18</sup>

In addition to the argument about inadequate waiting times evidence, the hospitals in *Cilinger* argued that this question was too individualized for a class action, noting that what constitutes an appropriate waiting time will vary for individuals based on such factors as age, the type of the cancer cells and their origin, and the effect of the cancer on neighbouring organs. This concern was also raised by the dissent in *Chaoulli*, who noted it is difficult to “generalize about the potential impact of a waiting list on a particular patient.”<sup>19</sup> However, the Court in *Cilinger* found that this could be addressed by the use of sub-classes established according to the various delays suffered and an evaluation of the medical situations of the various class members.<sup>20</sup>

In *Chaoulli*, the difficulty in addressing this type of issue was acknowledged by McLauchlin C.J.C., who stated that the matter was “complex, contentious” and “laden with social values.”<sup>21</sup> Although that case dealt with these issues in a constitutional context, *Cilinger* may raise current debates in health care which question whether tort liability is appropriate at all as a means to improve quality and safety in the health care system.<sup>22</sup> Tort law is arguably particularly difficult in the area of allocating resources, because it is focussed on the claim of one individual plaintiff, or category of plaintiff, making it difficult to recognize the competing claims for resources in health care, all of which benefit different patients.

In *Chaoulli*, Deschamps J. raised counter-arguments to a lack of judicial activism in health care allocation, stating that “[t]he demand for health care is constantly increasing, and one of the tools used by governments to control this increase has been the management of waiting lists.”<sup>23</sup> She goes on to refer to waiting lists as “a more or less implicit form of rationing” which are “therefore real and intentional.”<sup>24</sup> However, this statement seems to ignore the fact that although governmental funding affects waiting times, ultimately, it is individual physicians which manage their own waiting lists. In addition, although hospitals are pro-

vided with global budgets, the allocation of which impacts waiting times, the fee-for-service remuneration structure may have a greater impact on how long a patient waits for treatment. Unfortunately, no claims were made in *Cilinger* against individual physicians, so their potential liability will not be examined by the Court.

The concerns associated with whether this is an appropriate question for judicial adjudication are illustrated by speculating on the potential impact of the decision. With the magnitude of this lawsuit being estimated at up to \$50 million,<sup>25</sup> a judgment for the plaintiffs could lead hospitals to make allocation decisions out of fear, rather than a balancing exercise between the various programs and patient groups within the institution. One might also speculate that the types of programs that would suffer cuts would be preventative programs, as there would be less concern with liability for a failure to fund these programs. For example, if a hospital were to implement a policy which stated that cardiologists were to

complete as many surgeries as possible to reduce waiting times instead of spending time educating patients post-operatively on how to prevent future heart attacks, it would be extremely difficult for a patient who has a subsequent heart attack to prove their injury was the result of the hospital’s decisions, rather than the numerous well-documented lifestyle contributors to heart disease or their pre-existing condition.

This case is also interesting from a damages perspective, as it may require the Court to quantify the monetary value of psychological suffering while on a waiting list. As noted by Allen M. Linden, the courts have refused “to allow tort damages for every emotional upset and insist upon some physical symptoms.”<sup>26</sup> In addition to the difficulties associated with convincing courts to allow an award for this type of damage and quantifying the damages, the plaintiffs may also have difficulty demonstrating that their injuries were caused by waiting for treatment. This concern is raised by the dissent in *Chaoulli*, who, quoting a report reviewing waiting list experiences, stated that patients “may experience ‘emotional strains such as increase levels of anxiety due to a range of factors including lack of information and

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uncertainty regarding the timeline for care...or the 'normal' anxiety or apprehension felt by anyone faced with a serious surgical procedure."<sup>27</sup>

As mentioned above, the Court refused to allow the class action to proceed against the government, a decision that is significant for a number of reasons. Considering the applicable case law, the Court noted that while governments may be liable for operational decisions, they will not be liable for policy decisions, which are generally those taking into account financial, economic, social or political factors or considerations, such as the allocation of resources to hospitals.<sup>28</sup> It is surprising that at this stage of the proceedings, given the relatively low burden to be met,<sup>29</sup> the Court refused to certify the action. This is somewhat in contrast to some recent jurisprudence, which has refused to strike statements of claim with governmental defendants.<sup>30</sup>

For example, in *Marble (Litigation Guardian of) v. Saskatchewan*, the Court found they could not determine at that stage of the proceedings whether the failure of the Saskatchewan government to require all physicians to carry liability insurance was a policy or operational decision, and thus allowed the action to proceed.<sup>31</sup> Similarly, in *Eliopoulos v. Ontario (Minister of Health & Long Term Care)*, it was alleged that the Ontario government's plan to combat West Nile Virus was negligently implemented. In response to an argument that one of the hallmarks of a policy decision is that it considers economic factors, an argument which was also discussed in *Cilinger*, the Court stated that "if the government has committed to and planned for the taking of certain steps, it cannot sidestep liability by claiming that implementation involves money."<sup>32</sup> In contrast, the Court in *Cilinger* did not address the issue that in addition to the provision of broad global funding to hospitals, the government may have also been involved in implementation level decisions.

In hearing the certification application in *Cilinger*, the Court did not have the benefit of the complete arguments on this complex issue, which would have been presented at the trial had the government been a party to that action. As noted by Lewis N. Klar:

...the policy/operational dichotomy has proven to be very difficult for courts to apply. This has produced a mass of inconsistent and seemingly irreconcilable judgments. This is attributable to the fact that one cannot clearly separate the policy or discretionary stages of an activity from its

operational or implementational stages. The two are intermeshed, with most activities containing elements of both in varying degrees. Numerous operational activities occur during the policy stages of governmental activity. Similarly, during the operational stages of an activity, matters of policy or discretion will invariably arise.<sup>33</sup>

It is also notable that although the Court did not allow the plaintiffs' claim that the government provided deficient resources to proceed, it was accepted that the hospitals might defend themselves based on insufficient funding. However, the decision did not consider this issue, as this stage of the proceedings only required the elimination of frivolous or unfounded claims.<sup>34</sup> However, the Court did state that to substantiate this argument, the hospitals would likely have to prove not only inadequate financing, but a reasonable utilization of the funds received, including providing appropriate amounts to the various departments.<sup>35</sup> The determination of not only what an appropriate waiting time is, but what constitutes reasonable funding by government and a reasonable allocation of funds by hospitals, would involve courts delving even further into issues of health care policy.

## Appliability in Other Jurisdictions

Although this action was filed in Quebec, similar cases could be initiated in other jurisdictions. With regard to the class certification itself, many jurisdictions have similar legislative requirements.<sup>36</sup>

As noted above, the claim in *Cilinger* is founded on the breach of a statutory duty. Section 5 of the *Act respecting health services and social services* states that "[e]very person is entitled to receive, with continuity and in a personalized and safe manner health services...which are scientifically, humanly and socially appropriate."<sup>37</sup> However, s. 13 states that s. 5 is to be "exercised within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the limits of the human, material and financial resources at its disposal."<sup>38</sup> Section 7 goes on to state that "[e]very person whose life or bodily integrity is endangered is entitled to receive the care required by his condition. Every institution shall, where requested, ensure that such care is provided."<sup>39</sup>



In other jurisdictions there is legislation which could be interpreted to relate to waiting times. For example, Alberta's *Regional Health Authorities Act* gives health regions the responsibility to assess health needs on an ongoing basis, determine priorities and allocate resources accordingly, ensure reasonable access to quality services, and promote the provision of services in a manner that is responsive to need and supports the integration of services.<sup>40</sup> However, unlike Quebec's legislation, this is not framed as an individual entitlement.

Despite there being no obvious legislative basis for a similar claim in other jurisdictions, potential plaintiffs could still argue that a hospital failed to monitor and create policies in relation to waiting times,<sup>41</sup> or that the waiting times constituted a breach of the acceptable standard of care. While the above-mentioned legislation would not be determinative of the standard of care, courts may still consider these legislative duties in assessing negligence.<sup>42</sup>

## Conclusion

The idea of governments and hospitals being accountable for the health care system, and even patient outcomes, has become widely discussed in recent years. For example, the report of the Commission on the Future of Health Care in Canada states:

Canadians no longer accept being told things are or will get better; they want to see the proof. They have a right to know what is happening with wait lists; what is happening with health care budgets, hospital beds, doctors and nurses, and whether the gaps in home and community care services are being closed; whether the number of diagnostic machines and tests is adequate; and whether treatment outcomes are improving.<sup>43</sup>

Because access to care is such a crucial issue in health care, there is a particular interest in holding governments and institutions accountable when immediate access to care is not given, and patients are placed on waiting lists. Although there has been some discussion of non-legal methods of waiting list accountability, such as the waiting list registries used in various provinces<sup>44</sup> or care guarantees,<sup>45</sup> lawsuits such as *Cilinger* indicate that people are also interested in pursuing legal methods of accountability. Although the government was not ultimately joined as a defendant, the com-

ment of Michael McBane of the Canadian Health Coalition that "governments in Canada have abdicated their duty of care, and citizens are going to hold their government to account"<sup>46</sup> illustrates this desire for accountability in health care. Unfortunately, because governments and physicians are not defendants in this action, any decision will do little to clarify the responsibilities of these groups, along with hospitals, in determining appropriate waiting times and managing waiting lists.

Even if the hospitals in *Cilinger* are not ultimately held liable for the plaintiffs' injuries, this and similar cases may have the effect of forcing governments and hospitals in Quebec and other jurisdictions to undertake the difficult task of examining their policies relating to waiting lists and their prioritization and allocation of funds, rather than continuing to allow physicians to control waiting lists. In addition, the awareness of these issues may encourage further research regarding acceptable waiting times, methods of managing waiting lists, and techniques to improve waiting lists.

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1. [2004] R.J.Q. 3083, [2004] J.Q. no. 2058 (Sup. Ct.) [*Cilinger* cited to QL].
2. Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 138, online: Commission on the Future of Health Care in Canada <<http://www.healthcarecommission.ca>>.
3. Mike King & Allison Hanes "Quebec breast cancer patients suing hospitals: Class-action lawsuit takes aim at delays in radiation treatments" *National Post* (11 March 2004), online: Charter Health Fund <<http://www.charterhealth.ca/news/2004mar11.html>>.
4. [2004] R.J.Q. 2943, [2004] J.Q. no 11627 (C.A.), leave to appeal to S.C.C. refused, [2004] C.S.C.R. no. 582.
5. For a list of direct duties owed by a hospital see e.g. Gerald Robertson, "Negligence and Malpractice" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2nd ed.



- (Markham: Butterworths Canada Ltd., 2002) 91 at 107.
6. (2004) J.E. 2004 — 459, [2004] J.Q. no 423 (Sup. Ct.) (In this case, the Court criticized the defendant hospital for leaving an 80-pound elderly woman with respiratory problems alone on a stretcher in a corridor for four hours, and awarded damages for her death). See also *Braun Estate v. Vaughan*, (2000) 145 Man. R. (2d) 35, [2000] M.J. No. 63 (C.A.) (in which a patient was not notified of her abnormal pap smear for 11 months, resulting in her death from cervical cancer. The Court recognized that the hospital ought to have had a procedure to ensure the receipt of test results, or to co-ordinate follow-up protocols).
  7. [1994] B.C.J. No. 979, 21 C.C.L.T. (2d) 228 (S.C.), aff'd (1995) 17 B.C.L.R. (3d) 1, [1995] B.C.J. No. 2596 (C.A.) cited in *supra* note 5 at 94-95.
  8. *Bateman v. Doiron*, [1993] N.B.J. No. 598, 141 N.B.R. (2d) 321 (C.A.), leave to appeal to S.C.C. refused, [1994] S.C.C.A. No. 53, cited in Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell Legal Publications, 1996) (in which a hospital was not found negligent for staffing its emergency department with part-time general practitioners rather than full-time emergency physicians at 207). However, other jurisdictions have sometimes adopted a different approach, such as *Bull v. Devon Area Health Authority* (1993), 4 Med. L.R. 117 at 141 (Eng. C.A.), in which Lord Justice Mustill stated “it is not necessarily an answer to allegations of unsafety that there were insufficient resources to enable the administrators to do everything which they would like to do.”
  9. *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, 151 D.L.R. (4<sup>th</sup>) 577.
  10. *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78.
  11. [2005] 1 S.C.R. 791, [2005] S.C.J. No. 33 (QL), 2005 SCC 35 [*Chaoulli* cited to QL].
  12. *Supra* note 1 at para. 155.
  13. *Supra* note 11 at para. 164.
  14. *Ibid.* at para. 163.
  15. *Ibid.* at para. 212.
  16. *Ibid.* at para. 217.
  17. *Supra* note 1 at para. 54.
  18. *Ibid.* at para. 64.
  19. *Supra* note 11 at para. 220.
  20. *Supra* note 1 at paras. 14 , 27.
  21. *Supra* note 11 at para. 107.
  22. See e.g. G. Javitt & E. Lu ,”Capping the Crisis: Medical Malpractice and Tort” (1992) 20 Law, Medicine & Health Care 258.
  23. *Supra* note 11 at para. 2.
  24. *Ibid.* at para. 39.
  25. *Supra* note 3.
  26. See e.g. Allen M. Linden, *Canadian Tort Law*, 7th ed. (Markham: Butterworths Canada Ltd, 2001) at 309.
  27. *Supra* note 11 at para. 220 [emphasis in original].
  28. *Supra* note 1 at para. 113.
  29. In *Comité régional des usagers des transports en commun de Québec v. Québec (Urban Community Transit Commission)*, [1981] 1 S.C.R. 424 at 429, 37 N.R. 608, the Court noted that “there must be in the judge’s view a good color of right in order for him to authorize the action, though he is not thereby required to make any determination as to the merits in law...” The purpose of this provision was to reject frivolous or manifestly improper actions.
  30. Although the certification test and the test for striking a claim differ, in *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959 at para. 33, [1990] S.C.J. No. 93, the Court discussed the jurisprudence relating to striking a statement of claim, noting that “assuming that the facts as stated in the statement of claim can be proved, is it ‘plain and obvious’ that the plaintiff’s statement of claim discloses no reasonable cause of action?”
  31. [2001] S.J. No. 286, 2001 SKQB 199.
  32. [2004] O.J. No. 3035 at para. 51, 132 A.C.W.S. (3d) 485 (Ont. Sup. Ct. J.), appeal dismissed [2005] O.J. No. 2225. See also *Decock v. Alberta*, [2000] A.J. No. 419, 2000 ABCA 122, leave to appeal to S.C.C. granted [2000] S.C.C.A. No. 301 (in which the Court did not strike allegations against the Premier and the Minister of Health, including failure to supervise the operation of a hospital, provide reasonable and proper health care services, and ensure the hospital was competently staffed and adequately equipped). However, see *Jamal Estate v. Scarborough Hospital — Grace Division*, [2005] O.J. No. 3506, 34 C.C.L.T. (3d) 271 (in which the plaintiff’s claim was not struck in its entirety, but the paragraph alleging that the government did not properly fund or staff hospitals to control infectious diseases, SARS in this case, was struck as being a policy matter).
  33. Lewis N. Klar, *Tort Law*, 3rd ed. (Toronto: Thomson Carswell, 2003) at 277.
  34. *Supra* note 1 at paras. 73, 75.
  35. *Ibid.* at para. 74.
  36. Stuart Kugler & Robert Kugler, “Quebec: The Class Action Haven” (2004) 1 Canadian Class Action Re-



view 155, note that in order to be certified in Quebec, there must be similar or related questions, the composition of the group must make it difficult or impractical to require individual lawsuits, the class representative must be an adequate representative, and the facts giving rise to the recourse must seem to justify the conclusions sought. Although this article suggests that Quebec may be the forum of choice for class actions, this is largely due to amendments which came into effect in January 2003, after the certification proceedings in *Cilinger*. Margaret A. Shone, “The Modern Class Action Comes to Alberta” (2005) 42 Alta. L.Rev. 913, outlines the requirements in Alberta: a cause of action, an identifiable class, a common issue, a class proceeding would be preferable for the fair and efficient resolution of the common issues, and a class representative who will fairly and adequately represent the class, has a workable plan for the proceeding, and does not have a conflicting interest.

37. R.S.Q. c. S-4.2, with the word “safe” having been added in 2002.
38. *Ibid.* at s. 13.
39. *Ibid.* at s. 7.
40. R.S.A. 2000, c. R-10, s. 5.
41. The problem with failing to study and monitor waiting lists is suggested by a commentary in the Canadian Medical Association Journal by Steven Lewis, cited in the dissent in *Chaoulli*, *supra* note 11 (“[t]here is a surfeit of nonstandardized data and a dearth of usable, policy-oriented information about waiting lists” at para. 218).

42. *Canada v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205, 143 D.L.R. (3d) 9, cited in *supra* note 25 (in which the Court “rejected the view that unexcused breach constitutes negligence per se giving rise to absolute liability, and the position that it furnished prima facie evidence of negligence, preferring instead the approach that proof of statutory breach be admissible as evidence of negligence” at 210-211)
43. *Supra* note 2 at xix.
44. See *e.g.* “Waiting Lists”, online: Quebec Ministry of Health and Social Services <<http://www.msss.gouv.qc.ca/sujets/listesdattente/index.html>>, and “Alberta Waitlist Registry” online: Alberta Health <<http://www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp>>.
45. See *e.g.* Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Final Report* (Ottawa: The Standing Senate Committee on Social Affairs, Science and Technology, 2002) (“[t]he Committee’s preferred approach to solve the problem of long waiting times, and thus avoid the development of a parallel private system, is twofold: first, more money must be invested in health care...and second, governments must establish a national health care guarantee—a set of nationwide standards for timely access...” at 108).
46. Ingrid Peritz “Quebec cancer patients sue over wait” *Globe and Mail* (11 March 2004) A6.

