Wait Times

Legal Issues - Patients Rights

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# TABLE OF CONTENTS

USE OF COURTS AND THE LEGAL SYSTEM ................................................................. 1

CANADA HEALTH ACT ............................................................................................................. 2

CASES ........................................................................................................................................... 3

1. CASES RELATING TO THE PAYMENT FOR ADDITIONAL HEALTH SERVICES ........................................................................................................................................... 3

   (i)  *Eldridge v. British Columbia (Attorney General)* ........................................... 3

   (ii) *Wynberg v. Ontario* .......................................................................................... 4

   (iii) *Auton (Guardian ad litem of) v. British Columbia (Attorney General)* ........... 4

2. CASES RELATING TO RIGHTS OF ACCESS TO ALTERNATIVE CARE ....... 5

   (i)  *Stein v Québec (Régie de l’Assurance - maladie)* ............................................. 5

   (ii) *Jacques Chaoulli and Georges Zéliotis v. The Attorney General of Québec and the Attorney General of Canada* ................................................................. 6

      (A) Motions Court ........................................................................................................ 8

      (B) Québec Court of Appeal ...................................................................................... 8

      (C) Supreme Court of Canada .................................................................................. 8

      (D) Intervenors and their Arguments ...................................................................... 8

      (I) In support of the Government position ......................................................... 9

      (II) In Support of Chaoulli and Zéliotis ............................................................. 9

      (III) Seeking a third way ....................................................................................... 9

   (E) Respondent’s Arguments ............................................................................... 10

   (F) Likely Outcome ................................................................................................. 10

CONCLUSION ..................................................................................................................... 10
USE OF COURTS AND THE LEGAL SYSTEM

Wait times for health care services has been identified as one of the most pressing health care issues of our time. However, as our governments pour more and more money into addressing the issue1; as experts in health care contemplate maximum clinically justifiable lengths of delay;2 and as extraordinary health care providers are relocated from the front lines of health care to the administrative backrooms to develop strategies to reduce wait times, some people think that this is one issue which will not be solved by governments. Rather, they believe that the only way to address the problem of unacceptable wait times is through court challenges.

Some of the arguments supporting this position are as follows:

(a) resources are limited, and the issue cannot be solved solely through the provision of additional funds;

(b) Canadian politicians will not make the controversial decisions that are required to eliminate the problem of wait times (in fact, it has been suggested, that governments see wait times as a necessary method of rationing health care);

(c) many people on waiting lists are desperate: understandably, they will seek whatever recourse they can to advance their position, including recourse to the courts; and

(d) the lack of a substantial vigorous individual patients rights movement in Canada3 willing to take this matter on at a political level, means that limited resources are

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1 The national Health Accord stated that the federal Government would invest $41 billion over the next ten years. Part of that amount is specifically to address wait time issues.

2 In a statement from Health Minister Ujjal Dosanjh, dated April 4, 2005, on the Wait Time Alliance’s Interim Report, the Minister indicated that he and the First Ministers are committed to achieving meaningful reductions in wait times in five priority areas such as cancer, heart, diagnostic imaging, joint replacements and sight restoration. A target of December 31, 2005 has been set for the establishment of evidence-based, pan-Canadian benchmarks in these priority areas.

3 We have numerous “collective” patient’s rights groups in Canada. Generally they are illness related (the Canadian Cancer Society, the Heart & Stroke Foundation of Canada, the Canadian Lung Association, etc.) or they are related to specific demographics within the Canadian population (women’s health organizations, parents of children with autism, etc.) Even some professional groups advocate on behalf of collective patients rights (the Canadian Medical Association, the Ontario Hospital Association, etc.) Why do we not have a viable movement in Canada that advocates individual rights in patient care? This could be the subject of an entire paper, but in short, to my mind, there are at least five reasons:

(a) Despite its many shortcomings, Canadians still tend to believe that their country’s health care system is superior to all others. Indeed, 79% of adult Canadians surveyed in POLLARA’s “1999 National Survey of Health Care Providers and Users” judged Canada’s health care system “the best in the world.” (This domestic perception contrasts with the World Health Organization’s finding that Canada’s health care system ranked just 30th in “overall health system performance”: World Health Report 2000 — Health Systems: Improving Performance.) Clearly though, there is growing dissatisfaction with waiting times. The “2001 Health Care in Canada Survey,” POLLARA, found 68% of respondents satisfied with the quality of care provided to patients, but 56% “very dissatisfied” or “somewhat dissatisfied” with timeliness of access to care. It is difficult to galvanize the public to seek alternatives to a system perceived as unsurpassed in the world.

(b) While it is not perfect, our health care system treats most people equally imperfectly. The system does not allow Canadians to see what a “better” system or “better” treatment might look like.
likely to be better expended in the legal system where a single plaintiff or intervenor, a good lawyer and comparatively less money can make a big difference.

**CANADA HEALTH ACT**

Imagine that you have been told that you require cataract surgery, that the wait time for the surgery is 18 months and that during that period you will not be able to carry on your livelihood or enjoy many of the pleasures of life. If based on that information you decide to commence a legal action where would you begin? To proceed under the *Canada Health Act* would be futile. As much as Canadians are told that the *Canada Health Act* grants us certain rights to health care, in fact it does not.

The *Canada Health Act* sets out the requirements that each of the provinces and territories must meet to receive the full federal contribution under the Canada Health and Social Transfer payment system. These criteria require each province and territory to establish a health care insurance plan that, among other things, is:

(a) publicly administered;

(b) comprehensive, in that it insures all hospital, physician and surgical-dental services required to be covered by the Act (“insured services”);

(c) universal, in that it entitles all insured persons in the province to the insured services on uniform terms and conditions;

(d) portable, in that it is generally available to insured persons notwithstanding temporary absences out of the province; and

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(c) The Canadian news media generally tend to support the country’s socialized system of health care, and to oppose any initiative perceived as “privatization,” “Americanization” or “for-profit” care. As a result, there was scant coverage of Canada’s dismal ranking in *World Health Report 2000* and the media rarely report on superior results achieved in the United States or elsewhere in the world. While the media increasingly draw attention to shortcomings and adverse outcomes in the Canadian health care system (Antonia Maioni, McGill Institute for the Study of Canada, “Is public health care politically sustainable?” December 5, 2002) these failings usually are presented as evidence of insufficient government funding or lack of commitment to free, universal health care — not the reverse.

(d) The public is unaware of the decisions that affect their individual health care rights that are being made every day by hospitals, physicians and politicians. Patients do not know, for example, that the drug they are being provided with in a hospital may be inferior to a more expensive brand that the hospital could not afford to purchase or that the hospital’s annual supply of drug alluding stents, for example, was used up the month before their surgery — let alone given the opportunity to purchase these drugs or products themselves.

(e) Finally, few politicians, Mario Dumont and Ralph Klein excepted, are ready to challenge existing delivery and payment models — the advocacy of which is generally seen as a political death wish — and prefer to suggest tinkering at the edges of our current system. This is in distinction of course to the other side of the political spectrum where status quo is trumpeted and made synonymous with our very identity as a nation.

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4 Generally, this means every resident of a province other than a member of the Canadian Forces, certain members of the RCMP, a person serving time in a penitentiary and a person who has not met the minimum period of residence or waiting period, not exceeding three months, as may be required by the province to establish entitlement. (CHA, Section 2)
accessible in that, among other things, it provides for insured services “on a basis that does not impede or preclude, either directly or indirectly...reasonable access to those services by insured persons”.

Under the *Canada Health Act*, non-compliance with any one of the five criteria is subject to discretionary penalties which could result in a deduction from the federal transfer payment. However, while it may be argued that a failure to ensure reasonable access to insured services violates the *Canada Health Act* to date the penalties levied by Health Canada have only dealt with extra billings and user charges. In addition, while issuing a complaint may result in the province being penalized, it will do little to address the immediate needs of the individual who issued the complaint.

**CASES**

Given the limitations of the *Canada Health Act* as a means by which individuals may address the issue of wait times, the question then becomes whether the Charter of Rights and Freedoms or other laws might be a more effective option to advance patients rights. To date, patient’s rights court challenges can generally be organized into two categories: (A) those relating to the right to payment for additional health services; and (B) those relating to rights of access to alternative care.

1. **CASES RELATING TO THE PAYMENT FOR ADDITIONAL HEALTH SERVICES**

The first category deals with cases where the plaintiffs seek to have the government pay for health services that the government does not wish to pay for. These are generally based on Section 15 arguments. Section 15 of the Charter of Rights and Freedoms provides as follows:

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

There are three leading cases in the area and the rulings have gone both ways.

(i) *Eldridge v. British Columbia (Attorney General)*

In *Eldridge*, the appellants, who were all deaf British Columbia residents, argued that the services of sign language interpreters rendered to them while they obtained health care services should be insured services under the British Columbia *Hospital Insurance Act* and the then *Medical and Health Care Services Act*, and hence paid for by the BC Medical Services

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5 CHA Section 12(1)(a)
6 [1997] 3 S.C.R. 624
Commission. Without the provision of such services the plaintiffs argued they were denied equal benefit of the law. The Supreme Court of Canada agreed with the plaintiffs and found the failure of the BC Medical Services Commission and hospitals to provide sign language interpretation where it is necessary for effective communication to be a violation of the Section 15 rights of deaf people.

(ii) **Wynberg v. Ontario**

In its conclusion, the *Eldridge* case was similar to the recent Ontario Superior Court decision relating to autism. In *Wynberg*, the court ruled that the Intensive Early Intervention Program (the “Program”) of the Ontario Ministry of Community and Social Services which provided or funded Intensive Behavioral Intervention (IBI) therapy for children with autism between the ages of 2 and 5 only, was contrary to their Section 15 rights. In addition, the court found that the Section 15 rights of these plaintiffs were further violated by the Ontario Minister of Education, who since 2002, had known that autistic children 6 years of age and older were generally not receiving appropriate special education programs within the public school system. Failure to provide these services to children beyond the age of 5 contravened the provisions of the *Education Act* which create a statutory duty to ensure that appropriate special education programs and special education services are available to all exceptional pupils without payment of fees. Accordingly, the court found that the Section 15 rights of the infant plaintiffs had been violated both on the basis of age with respect to the Program and on the basis of disability with respect to the special education programs and services. The Ontario government has announced its intention to appeal this decision.

(iii) **Auton (Guardian ad litem of) v. British Columbia (Attorney General)**

The Supreme Court of Canada came to a different conclusion in the British Columbia autism case known as *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*. In this case, released in the Fall of 2004, the Supreme Court of Canada overruled a decision of the British Columbia Court of Appeal which had similarly found the British Columbia Government to have violated the Section 15 rights of autistic children. In this instance, Applied Behavioural Analysis or Intensive Behavioural Intervention (“ABA/IBI”) therapy was not made available to autistic children through funded health care service programs. The Supreme Court of Canada found that neither the *Canada Health Act* nor the relevant British Columbia legislation promise that each Canadian will receive funding for all medical treatment. All that is conferred is core funding for services delivered by medical practitioners and, at a province’s discretion, funding or partial funding for non-core services, which in the case of British Columbia must be covered by classes of “health care practitioners” named by the province. The benefit claimed - funding for all medically required treatment - was not, therefore, a “benefit provided by law”, and therefore...
could not attract Section 15 scrutiny. ABA/IBI therapists were not designated as “health care practitioners” under the *Medical Protection Act*, and thus ABA/IBI therapy was not offered as a non-core health service. The court ruled that it is within the jurisdiction of a provincial government to determine which non-core services it will fund in whole or in part. The exclusion of ABA/IBI therapy for autistic children from non-core benefits did not amount to discrimination, as the exclusion of certain non-core services is an anticipated feature of the legislative scheme.

However, once a decision is made to provide and fund a non-core service, then that service must be made available to all insured persons without discrimination. The Court went on to note that even if ABA/IBI therapy had been designated as a non-core service provided as a benefit by law, the British Columbia Government still would not have contravened Section 15 of the Charter.

According to the Court, the petitioners were not being treated differently than those in the proper comparator group, (i.e. members of a non-disabled group or a person suffering a disability other than a mental disability) that requests or receives funding for non-core therapy important to present and future health, but which is emergent and only recently becoming recognized as medically required. There was no evidence that the government’s approach to funding ABA/IBI therapy was different than its approach to other comparable, novel therapies for non-disabled persons or persons with a different type of disability. Hence, a finding of discrimination could not be sustained.

2. **CASES RELATING TO RIGHTS OF ACCESS TO ALTERNATIVE CARE**

The second category of court challenges which advance individual patient rights involves cases where the plaintiffs attack the government’s ability to restrict their right of access to alternative care. The main line of argument is that provincial insurance laws or provincial health administrators prevent insured persons from receiving treatment outside the province’s publicly funded system even when waiting times prevent them from receiving the care they require and in doing so, actually threaten the patient’s life and security of person. These are the cases which have focused most directly on wait times. It is likely that all future cases of this nature will invoke Section 7 of the Charter of Rights and Freedoms.

Section 7 of the Charter provides as follows:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice

(i) **Stein v Québec (Régie de l’Assurance - maladie)**

Falling outside of the Section 7 analysis, but equally important in addressing the patient’s ability to obtain medical services, is the case of *Stein v. Québec (Régie de l’Assurance-maladie)*. In *Stein*, a patient sought reimbursement for the cost of medical treatment that he had obtained in the United States. Mr. Stein had been diagnosed with colon cancer that was found to have spread to his liver. The medical recommendation was that surgery be performed within four to eight weeks. Due to hospital overcrowding and the qualification of the liver surgery as “elective”, his surgery was rescheduled three times over the following 8 weeks at which point he

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sought treatment from an international expert in New York. The surgery was performed immediately. Nine months later, as a result of Mr. Stein’s intolerance to chemotherapy, a second surgery was performed.

The first surgery entailed a resection of the liver and was performed with the aid of an intraoperative ultra-sound machine, which was not available in Montreal. The second procedure involved cryosurgery (a technique for freezing and killing abnormal cells). In addition, an Infusaid pump was implanted for intraarterial administration of chemotherapy. The cryosurgery that Mr. Stien received was only performed by a limited number of practitioners in Canada. Due to the cost, the procedure for implanting an Infusaid pump was not available in Canada.

The Québec Health Insurance Act permits a beneficiary to be reimbursed for “medically required” services provided outside Québec by a health professional. The Régie denied Mr. Stein’s request for reimbursement, claiming that the cryosurgery should have been obtained in Canada, and that because the Infusaid pump procedure was not available in Canada, it was an “experimental” procedure and therefore not “medically required”. Mr. Stein applied for judicial review of the decision of the Régie. The Court found that, while unavailable in Canada, implantation of the Infusaid pump was not an experimental procedure. The Court further held that the Régie’s assertion that the procedure must be experimental because it was not known in the Canadian medical community, and because there was no Canadian standard for the procedure was irrational.

Moreover, cryosurgery preformed in conjunction with the insertion of an Infusaid pump was not available anywhere in Canada. The Court concluded that it would be logical for this procedure to be performed in New York by the same doctor, and that it should be covered under the Health Insurance Act, as the first operation had not been sufficient to remove the liver lesions. The Court found that it was patently unreasonable to refuse coverage for these treatments, which saved or at least prolonged the patient’s life. The Court stated that “to maintain that it was reasonable to make Stein continue to wait for surgery in Montreal when the danger to his well-being increased daily is irrational, unreasonable and contrary to the purpose of the Health Insurance Act, which is designed to make necessary medical treatment available to all Quebecers.” The Régie was ordered to reimburse Stein for the treatment received in New York.

In a later decision regarding costs, the Court further awarded Stein a “special fee” of $18,000.00 to signify the importance of this case. “Special fees” are available in limited circumstances under Québec taxation of costs provisions.

(ii) *Jacques Chaoulli and Georges Zéliotis v. The Attorney General of Québec and the Attorney General of Canada*

George Zéliotis, a patient of Dr. Jacques Chaoulli, required hip replacement surgery. In order to be treated immediately, Mr. Zéliotis wished to pay Dr. Chaoulli directly or through private medical insurance. However, Section 11 of the Québec Hospital Insurance Act and Section 15 of the Québec Health Insurance Act (which contain provisions substantially the same as those contained within the Health Insurance Act (Ontario) and other provincial health acts) prohibit this type of arrangement. The relevant provisions are as follows:
Section 11 of the Québec Hospital Insurance Act

11. (1) No one shall make or renew, or make a payment under a contract under which

(a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;

Section 15 of the Québec Health Insurance Act

15. No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or temporary resident of Québec or to another person on his behalf.

The hip replacement surgery which Mr. Zéliotis required constituted an insured service under the Québec public health care system and, as such, it could not be performed under a private payment arrangement.

In this matter, Chaoulli and Zéliotis, the Applicants, argued that:

1. the disputed provisions were ultra vires of the province because they were in pith and substance concerned with criminal law, not health care (i.e. these matters fell within the federal division of powers),

2. the prohibition from having private insurance constituted an infringement to the life and security of person of those who wished to participate in a parallel health system because, due to lengthy waiting times, they could not get services within a reasonable time period; (Section 7)

3. the inability of Dr. Chaoulli to provide care to his patients in shorter periods of time constituted cruel and unusual punishment and was therefore unconstitutional (Section 12); and

4. these sections contravene the equality rights of Dr. Chaoulli’s patients, in this case discrimination on the basis of being a Québec resident, which are protected by section 15 of the Canadian Charter of Rights and Freedoms and certain analogous provisions of the Charter of Human Rights and Freedoms11.

Specifically, the Appellants took the position that the scope of Section 7 encompasses a degree of personal autonomy over important decisions intimately affecting an individual’s health and private life. As such, they maintained that an individual’s rights to life, liberty and security of the person are infringed by prohibitions against the purchase of private insurance for publicly insured health services, and cannot be justified as being in accordance with the principles of fundamental justice. In particular, it was

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argued that the Section 7 right to choose how one’s body will be dealt with is necessarily violated by the denial of access to make choices as to medical treatment, in much the same way that state-imposed treatment would violate this fundamental right.

(A) **Motions Court**

At the motions court level (motion for declaratory judgment), and before the Québec Court of Appeal, the Applicants lost on all counts. With respect to Section 7, the Court acknowledged a trend that has developed in Supreme Court of Canada case law which extends the scope of Section 7 to guarantee a greater level of autonomy for individuals, in order to keep state interference in check. This opens the door to protecting relevant economic rights that are closely linked to the right to life, liberty and the security of persons. The Court found that the disputed provisions of the *Health Insurance Act* and the *Hospital Insurance Act* could violate rights protected under the Charter should the public system be unable to guarantee efficient access to health care. In addition, the Court found that Section 7 of the Charter could be used to prevent a *potential and imminent violation of rights*, including access to health care. However, the Court concluded that this violation of the Applicants’ rights would not contravene the *principles of fundamental justice*, since the intended goal is to ensure that Québec’s health care resources are used to benefit the province’s entire population.

(B) **Québec Court of Appeal**

At the Québec Court of Appeal, a panel of three justices upheld the decision of the Motions Court. However, with respect to the Section 7 analysis, the majority of the Court did not agree that Mr. Zéliotis’ right to life, liberty and security of person had been infringed. They held that the inability to enter into a contract for medical services does not trigger the life, liberty and security of person provisions set out under Section 7. They further asserted that violation of Section 7 requires proof of a real or potential and imminent infringement of a right. To be qualified as imminent, the infringement must be foreseeable and proximate. The Court asserted that Mr. Zéliotis’ health was not at issue, and there was no sense of real or imminent harm. The minority of the Court, on the other hand, agreed with the Motion Court’s analysis of Section 7. The minority decision noted that the “imminence” requirement of the Section 7 analysis should not be strictly applied, as forcing people to wait until they are seriously ill before taking measures to obtain adequate health care would make any recourse illusory.

(C) **Supreme Court of Canada**

Although it is expected imminently, the decision of the Supreme Court of Canada on the matter has yet to be released. Oral arguments on the appeal to the Supreme Court of Canada were heard June 8, 2004.

(D) **Intervenors and their Arguments**

Of particular interest in the Supreme Court of Canada case are the interveners. In support of the introductory remarks to this paper, the interveners included individuals and groups on both sides of the matter and were comprised of the following:

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In support of the Government’s position


In support of Chaoulli and Zéliotis


 Seeking a third way

Senator Michael Kirby, Senator Marjory Lebreton, Senator Catherine Callbeck, Senator Joan Cook, Senator Jane Cordy, Senator Joyce Fairbairn, Senator Wilbert Keon, Senator Lucie Pépin, Senator Brenda Robertson and Senator Douglas Roche, Canadian Medical Association and the Canadian Orthopaedic Association

The position of the Senators and that of the Canadian Medical Association and the Canadian Orthopaedic Association found some common ground. None supported the introduction of a private healthcare system. Rather, they argued that a single-payer, publicly funded system is in the public interest, but that in order to be constitutionally valid, it carries with it an obligation to deliver medically necessary health services in a timely fashion.

The Senators’ arguments centered on the premise that the lengthy and growing delays in providing medically necessary health care in the publicly funded system, combined with prohibitions on accessing privately funded options to obtain medically necessary health care in Canada constitute a violation of Section 7. The Senators argued that the current system could violate each of the rights set out in Section 7 namely, the right to life (including quality of life), the right to liberty (including the liberty to take decisions that are of fundamental importance to a person’s dignity and independence) and the right to security of the person (including both the physical and psychological integrity of the person which may result in a restriction of security of the person).

The Senators acknowledged that while there is no constitutional right to healthcare, when an individual’s health could be endangered because he or she cannot have access to medically necessary care in a timely manner then the “liberty” interest should prevail. This approach focuses on the asserted right of patients to access treatment in a timely way and the corollary constitutional requirement that medically necessary services in a public health system be delivered in a timely manner, not how treatment should be delivered. Recognizing the havoc that would be caused by the immediate striking down of the disputed provisions of the Health Insurance Act and Hospital Insurance Act of Québec (and by extension the similar provisions contained in all provincial health insurance legislation), the Senators argued that viable alternatives are available to the government. They proposed that if the Court agreed with their position, the Court should
give the provinces a specified period of time to address the wait list problem; three years was recommended. As an option available to the government, the Senators proposed that a Health Care Guarantee be implemented. A maximum waiting time for each procedure would be set and where a patient was not able to receive that procedure within that period of time within his or her own province, the government would be obliged to pay for the procedure to be performed elsewhere on a timely basis.

(E) Respondent’s Arguments

The Government of Canada’s position with respect to Section 7 was that the protection is limited to “intrinsically private decisions”, not public policy matters as was the case in point. Furthermore, the Government called on the Court to affirm the Government’s discretion regarding public funding of medical and hospital services, particularly as the courts did not have the institutional resources to assess the organization and funding of such health care services. It argued that Chaoulli and Zéliotis were asking the Court to review political and funding issues surrounding the design of the healthcare system. This claim was based on the assertion that Chaoulli and Zéliotis were putting forward an economic interest to permit them to order their economic affairs to obtain healthcare in the manner they desired. The Government took the position that such a review falls outside the purview of Section 7.

(F) Likely Outcome

Given the emerging body of case law that recognizes the application of Section 7 to economic rights as they pertain directly to life, liberty and security of person, and given the split at the Court of Appeal level, it is difficult to predict the outcome of this decision.

CONCLUSION

Whether Chaoulli and Zéliotis are successful at the Supreme Court of Canada, the Appellants and their supporters are optimistic that they will have made a big step forward in the movement to reduce waiting times and to advance individual patient rights. It is generally conceded that the facts at issue in the Chaoulli case may not be the most compelling for finding that Section 7 can be used to prevent a denial of life, liberty and the security of the person. However the supporters of the case see other cases coming through the system with “better” facts and are optimistic that they will be successful in using the Courts to reduce waiting lists.13

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13 An example is the class action suit being commenced by Anahit Cilliger on behalf of up to 10,000 Québec breast cancer suffers. Although the recommended wait time for treatment for Ms Cilinger was 8 weeks, she gave up waiting after 3 months and flew to Turkey for treatment.