

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">September 10, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Laura Brocklehurst/Ches Crosbie, Q.C. . . . Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>Exhibit entered and marked C-0246 Pg. 4</p> <p>Exhibit entered and marked P-2620 Pg. 201</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>DR. KARA LAING (CONT'D)</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 4 - 377</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 DR. KARA LAING, EXAMINATION BY SANDRA CHAYTOR, Q.C.</p> <p>2 (CONT'D)</p> <p>3 THE COMMISSIONER:</p> <p>4 Q. We seem to have a little high noise level.</p> <p>5 Would you mind taking care of that? Thank</p> <p>6 you. Ms. Chaytor.</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. Good morning, Commissioner. Good morning, Dr.</p> <p>9 Laing.</p> <p>10 DR. LAING:</p> <p>11 A. Good morning.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. Commissioner, we have a new exhibit this</p> <p>14 morning. It's C-246.</p> <p>15 THE COMMISSIONER:</p> <p>16 Q. Entered.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. I'm sorry, C-0246.</p> <p>19 THE COMMISSIONER:</p> <p>20 Q. 246, yes.</p> <p>21 EXHIBIT ENTERED AND MARKED C-0246</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. Thank you. Doctor, just a couple of points</p> <p>24 from yesterday. One, I would just like to ask</p> <p>25 you a couple of things about your interactions</p>

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<p>1 with Dr. Cliff Hudis from Sloan-Kettering.</p> <p>2 DR. LAING:</p> <p>3 A. Sure.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. And from your evidence yesterday, we</p> <p>6 understand that there was the e-mail exchange</p> <p>7 that you had with him, April 9th, 10th and</p> <p>8 11th, I believe it was, 2005.</p> <p>9 DR. LAING:</p> <p>10 A. That's correct.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. And then you indicated that the only other</p> <p>13 discussions that you had with him around this</p> <p>14 matter was discussions you had with him at a</p> <p>15 conference in the fall of 2005.</p> <p>16 DR. LAING:</p> <p>17 A. That's right.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. And do you recall when in the fall, when and</p> <p>20 where did that conference take place?</p> <p>21 DR. LAING:</p> <p>22 A. I'm not certain. I think it's one of two</p> <p>23 places. When I went back through my calendar</p> <p>24 to see where I had been, I went to a European</p> <p>25 conference, so it was called ECCO. It's a</p>	<p>1 CHAYTOR, Q.C.:</p> <p>2 Q. Discussion with him.</p> <p>3 DR. LAING:</p> <p>4 A. - the discussion with him.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Okay, and the only other alternative would</p> <p>7 have been December of 2005?</p> <p>8 DR. LAING:</p> <p>9 A. With the San Antonio, yes.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. And if I could have, please, C-0246? And</p> <p>12 Doctor, this is just the last page of a</p> <p>13 pathology report, and I gave you the full copy</p> <p>14 before we came out this morning. You've had a</p> <p>15 chance to review that?</p> <p>16 DR. LAING:</p> <p>17 A. Yes, I have had a chance to look at this.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. And this involves the patient that you had who</p> <p>20 had a biopsy sample or a specimen--sorry, an</p> <p>21 ER/PR test done on her biopsy specimen and</p> <p>22 then the repeat done on another specimen on</p> <p>23 the mastectomy specimen had another test.</p> <p>24 DR. LAING:</p> <p>25 A. Right.</p>
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<p>1 European oncology conference that year, and I</p> <p>2 also went to the San Antonio Breast Cancer</p> <p>3 Conference that year. But I do recall having</p> <p>4 had knowledge of my discussions with him by</p> <p>5 the time we had started into the panel</p> <p>6 process, which makes me feel that it was at</p> <p>7 the ECCO meeting, which would have been</p> <p>8 towards the end of that September of 2005.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. Okay, so that's in the end of September, and</p> <p>11 the San Antonio conference also is in the</p> <p>12 fall, I understand?</p> <p>13 DR. LAING:</p> <p>14 A. It's in December.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. In December, okay.</p> <p>17 DR. LAING:</p> <p>18 A. Yeah, so that year, it would have been in</p> <p>19 early December.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. So it was either the end of September and</p> <p>22 that's what you likely think it was, because</p> <p>23 when you started the panel process -</p> <p>24 DR. LAING:</p> <p>25 A. Right, I would have had -</p>	<p>1 CHAYTOR, Q.C.:</p> <p>2 Q. And they were conflicting, and you took that</p> <p>3 up with Dr. Chittal?</p> <p>4 DR. LAING:</p> <p>5 A. That's correct.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. And this is the last page of the report, which</p> <p>8 came out of Peninsulas Health Care</p> <p>9 Corporation, which would be Clarenville, and I</p> <p>10 just bring this to your attention today</p> <p>11 because on the bottom, it says "referred out.</p> <p>12 Sent to Mount Sinai (Mullen). Date sent</p> <p>13 02/07/2002. Reason sent ER/PR, specimen ID</p> <p>14 block three. Date returned, July 25th, 2002.</p> <p>15 All returned one block," and this is the</p> <p>16 addendum one from the Clarenville Hospital.</p> <p>17 DR. LAING:</p> <p>18 A. Yes.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. Which indicated the tumour to be 75 to 80</p> <p>21 percent of ER positivity, and you'll see here,</p> <p>22 it's entered July 26th, 2002, so the day after</p> <p>23 it's returned from Mount Sinai. So at the</p> <p>24 time of reviewing the--and noticing that there</p> <p>25 had been a discrepancy in the reports -</p>

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<p>1 DR. LAING: 2 A. Yes. 3 CHAYTOR, Q.C.: 4 Q. - did you notice that, in fact, the test had 5 been done at Mount Sinai? 6 DR. LAING: 7 A. No, I did not. 8 CHAYTOR, Q.C.: 9 Q. Okay. So this did not catch your attention? 10 DR. LAING: 11 A. Not at all, no. 12 CHAYTOR, Q.C.: 13 Q. Doctor, I'd like to go back then now to 2005, 14 when the retest or the discussions started to 15 come up about doing a retest on a broader 16 basis. 17 DR. LAING: 18 A. Yes. 19 CHAYTOR, Q.C.: 20 Q. I think that's where we left off yesterday. 21 DR. LAING: 22 A. Yes. 23 CHAYTOR, Q.C.: 24 Q. Did you contact any other pathologists outside 25 of St. John's to request retests?</p>	<p>1 A. Okay. 2 CHAYTOR, Q.C.: 3 Q. Do you have any recollection of that? 4 DR. LAING: 5 A. No. If it was Dr. Baker, it would have been a 6 patient who was from the Carbonear area, but I 7 can't recall right now who that might have 8 been. 9 CHAYTOR, Q.C.: 10 Q. All right, and you don't recall any discussion 11 with Dr. McCarthy about that? 12 DR. LAING: 13 A. No. 14 CHAYTOR, Q.C.: 15 Q. Do you recall the first meeting that you would 16 have attended regarding this matter, the first 17 time you sat down to discuss this issue with 18 anybody? 19 DR. LAING: 20 A. So the first formal meeting that we would have 21 had would have been in mid July of 2005, and 22 that was a meeting that was attended by Dr. 23 McCarthy and I, but also Dr. Cook, at that 24 time, and Mr. Gulliver and Mr. Dyer from the 25 lab. I believe that was sort of sometime in</p>
<p>1 DR. LAING: 2 A. No, the patients that I had requested the 3 early retests on were St. John's patients. 4 CHAYTOR, Q.C.: 5 Q. And do you know whether or not Dr. McCarthy 6 contacted any pathologists outside of St. 7 John's to request retests? 8 DR. LAING: 9 A. I don't know that, no. 10 CHAYTOR, Q.C.: 11 Q. Okay, and Dr. Baker from Carbonear has 12 indicated that he was contacted by either 13 yourself or Dr. McCarthy in the early weeks of 14 this. 15 DR. LAING: 16 A. Okay. 17 CHAYTOR, Q.C.: 18 Q. He thought before he had ever heard anything 19 about it from Dr. Cook. 20 DR. LAING: 21 A. Okay. 22 CHAYTOR, Q.C.: 23 Q. And that he had direct contact with one of the 24 oncologists requesting a retest. 25 DR. LAING:</p>	<p>1 the middle of July. I had been on leave for 2 the last two weeks of June and into the 7th, 3 8th, 9th, somewhere around there, of July. I 4 came back from my holidays and it was shortly 5 after that that we had a meeting with the 6 pathologists and personnel from the lab. 7 CHAYTOR, Q.C.: 8 Q. Did you attend a meeting--we've heard about a 9 meeting that took place May 17th 2005. Did 10 you attend that meeting? 11 DR. LAING: 12 A. Not that I recall. 13 CHAYTOR, Q.C.: 14 Q. That would have been a meeting with yourself, 15 Dr. Carter, yes, Bev Carter, Dr. McCarthy, Dr. 16 Cook and Barry Dyer. 17 DR. LAING: 18 A. Okay. I know that I did review the minutes 19 prior to coming here from the middle of July 20 meeting, but if it indicates that we had a 21 meeting in May, then I guess I was there as 22 well. 23 CHAYTOR, Q.C.: 24 Q. Okay, and I'm just wondering though, in fact, 25 if you attended that meeting. I mean, some</p>

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<p>1 people have recollection that you did, but I'm 2 just wondering if you have any recollection of 3 a meeting. So this would have been after the 4 telephone discussion, May 11th. 5 DR. LAING: 6 A. Right. 7 CHAYTOR, Q.C.: 8 Q. Between Dr. Cook and Dr. McCarthy. 9 DR. LAING: 10 A. Right. 11 CHAYTOR, Q.C.: 12 Q. And is it your recollection that you didn't 13 actually then sit down with Dr. Cook until the 14 middle of July? 15 DR. LAING: 16 A. No, then there was--when you started the 17 questioning, I thought that you were referring 18 to that July meeting, but yes, there was a 19 meeting after we had had an initial--Dr. 20 McCarthy had the initial discussion with Dr. 21 Cook. 22 CHAYTOR, Q.C.: 23 Q. And what do you recall then about the May 17th 24 meeting? 25 DR. LAING:</p>	<p>1 with people from the lab to discuss the issue? 2 DR. LAING: 3 A. That's correct. 4 CHAYTOR, Q.C.: 5 Q. Did you express your concerns? You explained 6 what the purpose of the test was and how you 7 used the test in your day-to-day treatment of 8 patients. 9 DR. LAING: 10 A. That's right. 11 CHAYTOR, Q.C.: 12 Q. Did you express concerns to Dr. Cook and Dr. 13 Carter? 14 DR. LAING: 15 A. Just to say that, you know, it was an 16 important piece of information that we would 17 have relied upon to make treatment decisions, 18 and which they were aware of. 19 CHAYTOR, Q.C.: 20 Q. Did they offer any explanation as to why these 21 changes could be occurring? 22 DR. LAING: 23 A. At that time, no, not that I recall. 24 CHAYTOR, Q.C.: 25 Q. And did you ask for any explanation?</p>
<p>1 A. That was a meeting that we had and we, as the 2 clinicians, were there and discussed how we 3 utilized this test in the clinic. I recall 4 having those discussions, indicating that this 5 was at test that we used as a predictive 6 marker to determine if a patient should be 7 considered for hormonal therapy, and there was 8 some discussion at one of the early meetings 9 about whether or not that was information that 10 was utilized in the clinic by the clinicians. 11 CHAYTOR, Q.C.: 12 Q. Okay, and the purpose of that meeting, who 13 called that meeting? Do you remember why that 14 meeting occurred? Was it done at your 15 request? Was it done at pathology's request? 16 DR. LAING: 17 A. I recall it was done at pathology's request. 18 CHAYTOR, Q.C.: 19 Q. Okay, and had you ever met Mr. Dyer prior to 20 that meeting? 21 DR. LAING: 22 A. Not that I can recall. 23 CHAYTOR, Q.C.: 24 Q. Okay, and in the meeting, so this is the first 25 time you've had an opportunity to sit down</p>	<p>1 DR. LAING: 2 A. No, that was, you know, in the very early days 3 of this process, and I think at that time we 4 were trying to decide what the next steps 5 would be, since we had had the index case and 6 by that time, we would have requested repeats 7 on just those few patients so far in the 8 clinic and we wouldn't have had all those 9 results back, and really it was one of the 10 early meetings to discuss where we were going 11 to go from there, and a decision was made that 12 we would, you know, keep our eyes and ears 13 open in the clinic and if there were other 14 cases, that we wished to bring forward to be 15 retested, we could send along a consult and 16 that, at the time, Dr. Carter and Dr. Cook 17 were going to look at some others, that they 18 would just pick from various times, just to 19 retest randomly to see if there were others 20 that would come back with a different result, 21 and at that time, the retesting was being done 22 on the Ventana system. 23 CHAYTOR, Q.C.: 24 Q. Yes. If we could have, please, P-2147? 25 REGISTRAR:</p>

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1 Q. I'm sorry, the exhibit again, please?
 2 CHAYTOR, Q.C.:
 3 Q. 2147. These are notes that Mr. Dyer took of
 4 the meeting.
 5 DR. LAING:
 6 A. Okay.
 7 CHAYTOR, Q.C.:
 8 Q. And he does indicate that Dr. McCarthy, Dr.
 9 Cook, Dr. Carter and yourself were present,
 10 May 17th, 2005, and he's indicated "ER/PR
 11 issue, Peggy Deane, sent out for second
 12 opinion, came back ER should be positive,"
 13 something about 2002. He also indicated that
 14 there was somewhat of a confrontation with Dr.
 15 McCarthy where she pointed her finger and told
 16 him "this is your fault." Do you recall
 17 anything of that nature happening in the
 18 meeting?
 19 DR. LAING:
 20 A. No, I do not.
 21 CHAYTOR, Q.C.:
 22 Q. Do you recall that happening in any meeting
 23 where blame or accusations were placed from
 24 one group or onto one individual?
 25 DR. LAING:

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1 A. No, not at all.
 2 CHAYTOR, Q.C.:
 3 Q. So have you ever attended a meeting where
 4 there was anything confrontational between
 5 either oncologists, pathologists, lab tech--
 6 the technical side of the lab or any other
 7 groups or individuals?
 8 DR. LAING:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. And it goes on to say, "May 2002," I'm not
 12 sure what that says, but "DAKO system from
 13 1996 to 2003, all negatives must be repeated.
 14 ER/PR" and then "ER/PR controls," and then
 15 there's a number of names blocked out here.
 16 So at this point in time, it seems to be that
 17 there had been a number of retests done at
 18 that point in time, and this is what Mr. Dyer
 19 recorded as having happened in the May 17th
 20 meeting. So I don't know if that assists in
 21 your recollection of the stage that you were
 22 at and what decisions may have come out of
 23 that meeting.
 24 DR. LAING:
 25 A. Yeah. No, you know, certainly I was asked

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1 this question after Mr. Dyer's testimony, did
 2 I recall that sort of confrontation between
 3 Dr. McCarthy and him at this meeting, and I
 4 certainly did not. I do not recall Dr.
 5 McCarthy pointing her finger or using any sort
 6 of accusing voice when speaking to him. As I
 7 said, we were there and explained how this
 8 test was utilized in the clinic. I recall
 9 that one of the questions was "well, is this
 10 really something that you rely upon or do you
 11 just give all patients Tamoxifen?" and we
 12 said, no, you know, this is a test that we use
 13 to help determine that. But I don't recall
 14 there being that sort of confrontation at that
 15 time, and really throughout all of our
 16 meetings and discussions with pathologists
 17 during this time, I don't recall ever that
 18 there was a sense of animosity or accusations
 19 between oncology and pathology or oncology and
 20 the laboratory personnel.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and Doctor, what's written here is that,
 23 it said "pointed finger, 'this is your
 24 fault.'" Did Dr. McCarthy use those words or
 25 any words to that effect?

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1 DR. LAING:
 2 A. Not that I recall, no.
 3 CHAYTOR, Q.C.:
 4 Q. And is that something you think that you would
 5 recall?
 6 DR. LAING:
 7 A. I believe that I would recall that. You know,
 8 over the years, as part of my role, I've
 9 attended many, many meetings and continue to
 10 do so, and certainly if that tone or, you
 11 know, that sort of accusation was made,
 12 particularly by one of my colleagues and a
 13 member of my staff, I would believe certainly
 14 that I would recall that, that type of
 15 incident.
 16 CHAYTOR, Q.C.:
 17 Q. And that's something, I take it, you would
 18 follow up with her on afterwards?
 19 DR. LAING:
 20 A. Yes, it certainly would be.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and I take it that didn't happen? You
 23 didn't speak to Dr. McCarthy about her
 24 demeanour or anything she said in the meeting
 25 following it?

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<p>1 DR. LAING: 2 A. No, because I didn't recall or witness 3 anything that would have made me call into 4 question her behaviour. 5 CHAYTOR, Q.C.: 6 Q. And how much recollection do you have, in any 7 event, of this meeting? When I first started 8 this morning asking questions, your 9 recollection was that the next meeting was in 10 fact the July 14th meeting. Do you have a 11 clear recollection of this meeting? 12 DR. LAING: 13 A. I do recall talking about the issue of how 14 this test was utilized in the clinic and 15 that's my recollection of that. This would 16 have, from my memory, been the first time that 17 I met with Mr. Dyer, as I had indicated, and 18 really, I guess, although I don't remember 19 this meeting, I think if it had been something 20 that, you know, has been described as it has 21 been described, I think I would remember that 22 part of it for sure. I can't imagine being in 23 that sort of meeting and it not leaving an 24 impression on me afterwards, if there was that 25 sort of confrontation going on at the time.</p>	<p>1 oncologist, informing me of an ER and PR 2 reported negative in a patient with 3 infiltrating lobular carcinoma of the breast, 4 diagnosed in 2002, and when retested," and it 5 says May of 2005, but we know that should be 6 April, correct, Doctor, it should be--the 7 retest was April 2005? 8 DR. LAING: 9 A. Yes. 10 CHAYTOR, Q.C.: 11 Q. "The ER and PR were reported as strongly 12 positive. Dr. McCarthy also expressed concern 13 over what appears to be a high rate of 14 infiltrating lobular carcinomas that were 15 reported as ER and PR negative." At this 16 point in time then, up until May 24th, 2005, 17 what evidence did you and Dr. McCarthy have of 18 a high rate of the infiltrating lobular 19 carcinomas having been reported as ER and PR 20 negative? 21 DR. LAING: 22 A. I don't know what that statement refers to. 23 CHAYTOR, Q.C.: 24 Q. So up to this point in time, you would have 25 pulled three or four cases and you were basing</p>
<p>Page 22</p> <p>1 CHAYTOR, Q.C.: 2 Q. Okay. And if I could have, please, P-0067? 3 And Doctor, were you present, do you know, 4 those meetings, were you present for all the 5 meetings or parts of the meetings? Were there 6 times when you were late arriving at meetings? 7 DR. LAING: 8 A. Yes, there was. Often the meetings were held 9 at 5:00 and I had--still have Monday afternoon 10 and Tuesday afternoon clinics, which often 11 don't finish until 6-6:30, so there certainly 12 were some meetings that I was late coming to 13 because of my clinical responsibilities. 14 CHAYTOR, Q.C.: 15 Q. And P-0067 is a letter that's written by Dr. 16 Cook, May 24th, 2005 to Dr. Williams, and let 17 me see here, it's a three-page letter, and 18 Doctor, I take it you've had an opportunity to 19 review this letter before? 20 DR. LAING: 21 A. Yes, but I did not receive it at that time. 22 CHAYTOR, Q.C.: 23 Q. Okay, and in this letter, Dr. Cook writes and 24 refers to the May 11th, 2005 phone call that 25 he received "from Joy McCarthy, a medical</p>	<p>Page 24</p> <p>1 them on lobular--you're originally identifying 2 patients as being lobular? 3 DR. LAING: 4 A. Oh, I understand what you mean. 5 CHAYTOR, Q.C.: 6 Q. And having retests. 7 DR. LAING: 8 A. So by this time, we have the index case. 9 CHAYTOR, Q.C.: 10 Q. Yes. 11 DR. LAING: 12 A. We have Peggy Deane's case. We have patient 13 one and patient two who we talked about 14 yesterday, who were lobular, and so we would 15 have had those patients. But when she--this 16 refers to--he's writing this letter, I'm 17 correct - 18 CHAYTOR, Q.C.: 19 Q. May 24th. 20 DR. LAING: 21 A. - May 24th, and but at the May 11th time, we 22 would have had information back on the index 23 case and we would have had the results from 24 the patient number one. 25 CHAYTOR, Q.C.:</p>

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<p>1 Q. I think that was May 13th.</p> <p>2 DR. LAING:</p> <p>3 A. Was it May 13th? Okay, all right. So then</p> <p>4 really it would have been the index case, and</p> <p>5 the only thing that I can assume, but I'm sure</p> <p>6 Dr. McCarthy would be able to answer this for</p> <p>7 you, was that she was referring to the e-mail</p> <p>8 from Dr. Hudis who said initially that it was</p> <p>9 very rare and then subsequently said that he</p> <p>10 had never seen it. You know, obviously</p> <p>11 yesterday we discussed my training and being</p> <p>12 taught sort of 85-90 percent, and speaking to</p> <p>13 my other colleagues across the country,</p> <p>14 everybody sort of talking about a 90 percent</p> <p>15 number, and certainly I've had this</p> <p>16 conversation with Dr. McCarthy and prior to</p> <p>17 this turn of events, 90 percent, 80 to 90</p> <p>18 percent would have been a number that she</p> <p>19 would have known as well.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. Yes, and that comes up in the next sentence,</p> <p>22 but right now, I was just wondering about at</p> <p>23 this point in time and it may not be that he's</p> <p>24 limiting it to the telephone call because -</p> <p>25 DR. LAING:</p>	<p>1 with the idea that "it's usually 95 percent of</p> <p>2 lobular carcinomas are ER and PR positive,</p> <p>3 while five percent are negative," and again,</p> <p>4 you've spoken to that and what your</p> <p>5 understanding was.</p> <p>6 DR. LAING:</p> <p>7 A. Um-hm.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. "Dr. McCarthy requested that two other</p> <p>10 patients with infiltrating lobular, who were</p> <p>11 reported as ER and PR negative in 2002, also</p> <p>12 be retested. I also expressed concern over</p> <p>13 this and suggested we might meet to discuss</p> <p>14 this further."</p> <p>15 DR. LAING:</p> <p>16 A. Sure.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. "On May 17th, 2005, a meeting was held which</p> <p>19 included myself, Dr. Carter, our resource</p> <p>20 person for breast pathology, Barry Dyer," and</p> <p>21 it does, he also confirms that -</p> <p>22 DR. LAING:</p> <p>23 A. I was there.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. - you and Dr. McCarthy were in attendance.</p>
<p>1 A. Right.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. - you, of course, would have had your meeting</p> <p>4 of May 13th.</p> <p>5 DR. LAING:</p> <p>6 A. That's right. So I'm assuming that this would</p> <p>7 include now one, two, three lobulars who we've</p> <p>8 just picked from our clinical practice and all</p> <p>9 of those had a change in their results.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. And so at this point in time then, that would</p> <p>12 have appeared to be a high rate to find three</p> <p>13 in the ones that you had picked, people coming</p> <p>14 before you even?</p> <p>15 DR. LAING:</p> <p>16 A. That's right, yes.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. Because that's how you were identifying them,</p> <p>19 coming before you.</p> <p>20 DR. LAING:</p> <p>21 A. That's correct.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. You were able to say at this point in time</p> <p>24 that appeared to be a high rate of lobulars</p> <p>25 which were ER/PR negative. She goes on then</p>	<p>1 DR. LAING:</p> <p>2 A. Um-hm.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. "During that meeting, I brought forth a second</p> <p>5 patient originally reported as ER and PR</p> <p>6 negative in 2002 were now strongly positive</p> <p>7 for breast receptors on retesting." Doctor,</p> <p>8 do you remember, did Dr. Cook also bring</p> <p>9 forward a patient or would this be referring</p> <p>10 to one of the patients you and Dr. McCarthy</p> <p>11 had identified? Remember him in the meet--did</p> <p>12 he actually say "well, I've also identified</p> <p>13 someone and retested as well"?</p> <p>14 DR. LAING:</p> <p>15 A. Not that I recall. I don't know if that would</p> <p>16 have been somebody that we had requested the</p> <p>17 retesting on by this point.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. Okay, and he indicates "much of the discussion</p> <p>20 at the meeting centred on the impact of the</p> <p>21 estrogen receptor on breast cancer treatment"</p> <p>22 and you've spoke about that.</p> <p>23 DR. LAING:</p> <p>24 A. That was my recollection, yeah.</p> <p>25 CHAYTOR, Q.C.:</p>

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<p>1 Q. "It is estimated that approximately 50 to 85 2 percent of all breast cancers, particularly 3 infiltrating ductal and lobular carcinomas, 4 exhibit estrogen receptors and that such 5 tumours are commonly found in post-menopausal 6 women." 7 DR. LAING: 8 A. Right. 9 CHAYTOR, Q.C.: 10 Q. Now is that information that you and/or Dr. 11 McCarthy would have provided to Dr. Cook? 12 DR. LAING: 13 A. No, I think that was probably knowledge that 14 he would have already had. And certainly, you 15 know, my understanding and some of the 16 references that I showed you yesterday, the 75 17 percent is a very common number that's 18 indicated for overall. But if you recall the 19 trend, it is more common as patients get older 20 and less common in younger patients who are 21 diagnosed with breast cancer. 22 CHAYTOR, Q.C.: 23 Q. And so do you agree with this range of 50 to 24 85 percent? 25 DR. LAING:</p>	<p>1 different therapies and that sort of instance. 2 So, you know, I'm not certain why he picked 50 3 to 85 percent but certainly, you know, 4 whenever you have a number then there's always 5 a, you know, a confidence interval around that 6 number and certainly, you know, 75 percent 7 would fall somewhere towards the middle to 8 upper range of that number, which would be 9 appropriate. 10 CHAYTOR, Q.C.: 11 Q. And do you recall following this any effort by 12 the group that was looking into this to then 13 try and identify what the percentage of 14 positives had been - 15 DR. LAING: 16 A. Yes. 17 CHAYTOR, Q.C.: 18 Q. - in the lab over a period of time? 19 DR. LAING: 20 A. Yes. 21 CHAYTOR, Q.C.: 22 Q. Okay. 23 DR. LAING: 24 A. Dr. Cook and Dr. Williams did that work and 25 subsequently I recall Dr. Williams revealing</p>
<p>1 A. When you look at where these numbers may have 2 been derived from, certainly if they came from 3 clinical trials, then there are clinical 4 trials in which the percentage of ER/PR 5 positivity in the patient population may be 6 biased by the patients who are chosen to go on 7 studies. And the reason I say that is that if 8 you look at many of the trials in chemotherapy 9 treatments, then the percentage of patients 10 with ER/PR positivity tends to be closer to 11 around the 60 percent, and that's for two 12 reasons. One is because they tend to be 13 younger patients who are enrolled on these 14 studies. And, in fact, some of the trials 15 that we've done, thinking of, for example, one 16 of our own Canadian studies had an age cutoff 17 of 60 years old because of the aggressiveness 18 of the therapy and so - 19 CHAYTOR, Q.C.: 20 Q. (Unintelligible) a random sample in some of 21 those trials? 22 DR. LAING: 23 A. Right. So I think if you--so the 75 percent 24 comes from when you would look at a grouping 25 of all patients from all different ages, all</p>	<p>1 to me the various results from the time 2 periods. 3 CHAYTOR, Q.C.: 4 Q. And what was the purpose at that point in 5 time, while the effort is under way to try and 6 identify patients and get them tested, what 7 was the purpose at that point in time to go 8 back and try and identify what your rates of 9 positivity would have been over the time 10 period? 11 DR. LAING: 12 A. My understanding is that they were looking for 13 some sort of signal or some sort of clue that 14 there may have been a particular time period 15 at which the rates of positivity would--fell 16 outside what they were normally used to 17 seeing. For example, if--and I'm not, I do 18 not believe that this was information that the 19 lab was tracking and following on a regular 20 basis. 21 CHAYTOR, Q.C.: 22 Q. And the Commissioner has heard that there's no 23 evidence that they were. 24 DR. LAING: 25 A. Yeah. And that, you know, when I subsequently</p>

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<p>1 did see those summary numbers, it was well on 2 into this process. And but I do recall that 3 my understanding of the rationale for looking 4 at those numbers and looking at them by year 5 period was to see if there may have been an 6 indication that there was a particular time 7 period - 8 CHAYTOR, Q.C.: 9 Q. That stood out? 10 DR. LAING: 11 A. That stood out. We've heard and we've had 12 discussions over the last couple of days about 13 what those two time periods would have been. 14 My subsequent knowledge about Dr. Ejeckam's 15 memo pointed to the year 2003. And the year 16 2002 was of interest because that was the year 17 that the--that Peggy was diagnosed, so that's 18 when the index case was. 19 CHAYTOR, Q.C.: 20 Q. And do you know whether or not the effort to 21 identify the rates of positivity identified 22 any other time periods which would have been 23 of concern? 24 DR. LAING: 25 A. I would have to look at them to remember the</p>	<p>1 chosen because that's when the technology was 2 introduced? 3 DR. LAING: 4 A. That's correct. 5 CHAYTOR, Q.C.: 6 Q. And were you consulted on that in terms of 7 whether or not it would be of any benefit to 8 the patients who were diagnosed in 1997 and 9 1998 as to whether or not they could benefit 10 from hormonal therapy? 11 DR. LAING: 12 A. Yes, absolutely. And if you'll recall the 13 discussions that we had yesterday regarding 14 the very--one of my--the patient number two, 15 that I had indicated by that time that I had 16 had the discussions with Dr. Pritchard and the 17 group to look to see if we may have some 18 knowledge of a late start of hormonal therapy. 19 And, of course, at this time in 2005 we had 20 had the results of our MA 17 clinical trial, 21 which is the one that showed a benefit to 22 extended adjuvant therapy, albeit a slightly 23 different patient population because these 24 would have been patients who had had five 25 years of treatment, but really, our first</p>
<p>1 numbers. There were two that I recall, you 2 know, in those what I'll call sort of the 3 earlier periods where the numbers were 4 certainly less than 70, 75 percent. 5 CHAYTOR, Q.C.: 6 Q. Um-hm. 7 DR. LAING: 8 A. I believe one was around the year 2000. But I 9 know I've seen those numbers, but I can't, I 10 can't recall them off the top of my head at 11 this exact moment. 12 CHAYTOR, Q.C.: 13 Q. In any event, the decision was undertaken to 14 go all the way back to 1997 and ultimately - 15 DR. LAING: 16 A. Yes. 17 CHAYTOR, Q.C.: 18 Q. - to 2005? 19 DR. LAING: 20 A. And of course, that was because that's when 21 the technology was introduced in the lab, in 22 1997 up until the Ventana system, well, up 23 until where we were, actually, in 2005. 24 CHAYTOR, Q.C.: 25 Q. So that's your understanding, that 1997 was</p>	<p>1 indication that there was advantages to 2 treating patients with hormonal therapy in the 3 five to ten year period. So although we 4 realized that many of these patients were now 5 approaching, well, from 1997 to 2005, eight 6 years from diagnosis, because they were still 7 in the five to ten year period, we felt that 8 they were worthwhile. And, of course, the 9 other reason when ultimately a decision was 10 made to retest the entire group was really to 11 have an idea of what was going on during the 12 entire period that the immunohistochemistry 13 test was being used in the lab. 14 CHAYTOR, Q.C.: 15 Q. Okay. So it was something broader than just 16 actually offering treatment to the patient? 17 DR. LAING: 18 A. Yes. 19 CHAYTOR, Q.C.: 20 Q. It was to try and determine what, in fact, was 21 happening? 22 DR. LAING: 23 A. That's exactly right. 24 CHAYTOR, Q.C.: 25 Q. Okay. And I take it so the decision to go</p>

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1 back to 1997 was not only because that's when
 2 the technology was introduced, because if you
 3 had said to them, well, you know, there's no
 4 need to go beyond 2000, I would take it they
 5 would have stopped at that point if it was
 6 just for patient treatment, but if it's to
 7 determine what's happening, then they'd go
 8 back further. But in any event, you indicated
 9 to them that we can perhaps help the people
 10 all the way back to '97?

11 DR. LAING:
 12 A. Right.

13 CHAYTOR, Q.C.:
 14 Q. There may be some benefit?

15 DR. LAING:
 16 A. Right. And, you know, we talked very briefly
 17 yesterday about the fact that even, you know,
 18 late recurrences, recurrences in the five to
 19 ten year period happen not infrequently in
 20 this disease, and even late recurrence. So
 21 that was, you know, that was part of the
 22 reason, as well.

23 CHAYTOR, Q.C.:
 24 Q. Okay. Doctor, the paragraph at the top of
 25 page 2, Dr. Cook writes, "Receptor status will

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1 influence at what stage chemotherapy will be
 2 given to a patient. Those patients that are
 3 ER and PR negative will be given chemotherapy
 4 with its side effects much earlier in the
 5 course of treatment. It is possible that the
 6 patient who is ER and PR positive and responds
 7 favourably to hormone manipulation may not
 8 require the full chemotherapeutic regime."
 9 Now, I know we spoke briefly on this issue
 10 yesterday.

11 DR. LAING:
 12 A. Um-hm.

13 CHAYTOR, Q.C.:
 14 Q. So is it possible that the patient who is ER
 15 and PR positive and responds favourably to
 16 hormone treatment, so to Tamoxifen, for
 17 example, that they would not--they may not
 18 require then to have the full chemotherapeutic
 19 regime, is that correct? What -

20 DR. LAING:
 21 A. When I read this, I would have to assume that
 22 Dr. Cook was referring to patients with
 23 metastatic disease.

24 CHAYTOR, Q.C.:
 25 Q. Okay.

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1 DR. LAING:
 2 A. Because in the adjuvant setting you don't know
 3 how people respond until you follow them over
 4 time and ensure that their cancer does not
 5 recur. And the starting point for adjuvant
 6 chemotherapy comes prior to adjuvant hormonal
 7 therapy.

8 CHAYTOR, Q.C.:
 9 Q. In the metastatic setting?

10 DR. LAING:
 11 A. No, in the adjuvant setting.

12 CHAYTOR, Q.C.:
 13 Q. In the adjuvant, sorry.

14 DR. LAING:
 15 A. So when I read this, I would take this to mean
 16 that to me this is talking about metastatic
 17 disease. And what he is saying is that if a
 18 patient with metastatic disease is ER/PR
 19 negative, then they're offered chemotherapy
 20 for their palliative treatments. However, if
 21 they're ER/PR positive and all the other
 22 factors that we discussed yesterday, where the
 23 disease is, how symptomatic they are, how long
 24 it's been between their diagnosis and their
 25 relapse, then those patient, yes, would be

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1 started on hormonal therapy. And really once
 2 we start someone with metastatic disease on
 3 hormonal therapy, as long as it appears that
 4 they are still responding and as long as
 5 there's not an indication evident to us in the
 6 clinic, ie, rapid progression of disease,
 7 etcetera, we will sort of run through the
 8 gamut of all the hormonal therapies that we
 9 have available to them before we will then go
 10 to chemotherapy.

11 CHAYTOR, Q.C.:
 12 Q. So this statement would be correct only with
 13 respect to patients with metastatic disease?

14 DR. LAING:
 15 A. Yes.

16 CHAYTOR, Q.C.:
 17 Q. So someone such as Peggy Deane who presented
 18 with metastatic disease, this might be correct
 19 in her case?

20 DR. LAING:
 21 A. Might be correct in her case. We discussed
 22 yesterday, and you know, of course, it's me
 23 looking back.

24 CHAYTOR, Q.C.:
 25 Q. Yes.

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<p>1 DR. LAING:</p> <p>2 A. And I guess perhaps the best way I can think</p> <p>3 about it is that, you know, when I go back to</p> <p>4 clinic next week, if somebody walks through</p> <p>5 the door, which is quite possible, a young</p> <p>6 patient who presents with newly diagnosed</p> <p>7 metastatic disease at the time of their</p> <p>8 initial presentation with liver metastasis, I</p> <p>9 may very, very likely decide to treat that</p> <p>10 person with chemotherapy up front and then if</p> <p>11 they were hormone receptor positive, they</p> <p>12 would go on hormones to try and maintain their</p> <p>13 response and to prolong their time to</p> <p>14 progression.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Okay. And Dr. Cook's letter continues with a</p> <p>17 bit of the history in terms of how the tests</p> <p>18 have been carried out with the DAKO machine</p> <p>19 and then switching to Ventana.</p> <p>20 DR. LAING:</p> <p>21 A. The new Ventana, yeah.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. And he talks in this paragraph about, "In</p> <p>24 early 2003 Dr. Gershon Ejeckam, our point man</p> <p>25 for immunoperoxidase testing at the General</p>	<p>1 sure that it would have been something that I</p> <p>2 would have recalled.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. So you may have been told it in May of 2005?</p> <p>5 DR. LAING:</p> <p>6 A. Right. But it wasn't in such a way that it</p> <p>7 really struck home with me.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. So the technique having been temporarily</p> <p>10 halted because of erratic staining which</p> <p>11 required adjustments of titration and staining</p> <p>12 times, once Dr. Ejeckam felt confident of the</p> <p>13 reliability of staining the test was</p> <p>14 reintroduced?</p> <p>15 DR. LAING:</p> <p>16 A. I would not have known that depth of knowledge</p> <p>17 of that incident.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. Okay. And if he had discussed that the tests</p> <p>20 had been halted for erratic staining and</p> <p>21 because Dr. Ejeckam needed to ensure the</p> <p>22 reliability of the staining, do you think</p> <p>23 that's something you would recall had it been</p> <p>24 discussed with you in May?</p> <p>25 DR. LAING:</p>
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<p>1 Hospital site, discontinued testing of the ER</p> <p>2 and PR receptors with the manual method for a</p> <p>3 six-week period." Was this discussed in the</p> <p>4 May 17th meeting?</p> <p>5 DR. LAING:</p> <p>6 A. Not that I can recall, no, not in any detail.</p> <p>7 And as I indicated yesterday, I did not see</p> <p>8 those memos at that time.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. So while Dr. Cook shared this with Dr.</p> <p>11 Williams on May 24th, you don't recall him</p> <p>12 sharing it with you in the May 17th meeting?</p> <p>13 DR. LAING:</p> <p>14 A. I don't recall that.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Okay. And do you think that's something given</p> <p>17 what unfolded, Doctor, do you think if he had</p> <p>18 shared that information with you and referred</p> <p>19 to the discontinuation of the tests at the</p> <p>20 time and the fact that memos were circulated,</p> <p>21 do you think you'd recall that now?</p> <p>22 DR. LAING:</p> <p>23 A. If I had read the memos, I think I would</p> <p>24 recalled it. If there had to been some</p> <p>25 discussion about it at that meeting, I'm not</p>	<p>1 A. Yes, I do.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. The letter goes on to say, "At the conclusion</p> <p>4 of the May 17th meeting it was decided to</p> <p>5 retest all ERs and PRs for the year 2002 and</p> <p>6 possibly 2001."</p> <p>7 DR. LAING:</p> <p>8 A. Um-hm.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. And, Doctor, at this point in time then was it</p> <p>11 the decision to--it was the decision to do all</p> <p>12 ERs and PRs?</p> <p>13 DR. LAING:</p> <p>14 A. Yes.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Not just ERs?</p> <p>17 DR. LAING:</p> <p>18 A. Yes.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. Okay. And was it a decision to identify all</p> <p>21 negative PRs as well? "Going to retest all</p> <p>22 negative ERs and PRs."</p> <p>23 DR. LAING:</p> <p>24 A. I don't recall. You know, that was we decided</p> <p>25 to look at the 2002 year as that was the year</p>

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<p>1 of the index case, but as to what group they</p> <p>2 were going to retest, my knowledge and my</p> <p>3 understanding had always been that it was</p> <p>4 going to be based on the ER test.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Okay. And did you agree with that, to</p> <p>7 concentrate only on the ERs as opposed to the</p> <p>8 PRs and, if so, why?</p> <p>9 DR. LAING:</p> <p>10 A. So the--so at this time when I think back to</p> <p>11 the early discussions, really what we were</p> <p>12 looking at was retesting patients who were</p> <p>13 negative for hormone receptors. I'm not sure</p> <p>14 that at that time we had an in depth</p> <p>15 discussion about what we were going to use as</p> <p>16 the cutoffs and whether we were just going to</p> <p>17 look at ER or whether we were going to look at</p> <p>18 both. And I believe that those are</p> <p>19 discussions that happened as time went on into</p> <p>20 July and ultimately into August of that year.</p> <p>21 The patients who we had identified had been</p> <p>22 negative with respect to being less than ten</p> <p>23 percent when that was the cutoff that we were</p> <p>24 using in the clinic up until this point.</p> <p>25 CHAYTOR, Q.C.:</p>	<p>1 as much benefit from treatment in the</p> <p>2 metastatic setting, eventually we decided that</p> <p>3 we would concentrate on the ER and not look at</p> <p>4 what the PR had been for pulling out patients</p> <p>5 and identifying them for the entire retesting</p> <p>6 process. However, we felt that it was</p> <p>7 important when the retesting occurred that, in</p> <p>8 fact, the ER and PR would be repeated at the</p> <p>9 outside lab.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. Regardless if the PR was positive or negative?</p> <p>12 DR. LAING:</p> <p>13 A. Regardless of what the PR was.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. The PR was retested?</p> <p>16 DR. LAING:</p> <p>17 A. Yes.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. Yes. And why, I'm just trying to understand</p> <p>20 the clinical basis for that, why would that</p> <p>21 be?</p> <p>22 DR. LAING:</p> <p>23 A. I think at that time because there were</p> <p>24 patients who, albeit, you know, we found out a</p> <p>25 larger proportion of patients, as I mentioned</p>
<p>1 Q. Yes. And we talked about that issue of the</p> <p>2 cutoff a bit yesterday and I will bring you</p> <p>3 back to an example of that in a few moments.</p> <p>4 So at this point in time, at the May 17th</p> <p>5 meeting, while a decision was made to retest</p> <p>6 in the year of 2002 and possibly into 2001,</p> <p>7 you don't remember any detailed discussion as</p> <p>8 to, well, what will be the parameters for who</p> <p>9 gets retested?</p> <p>10 DR. LAING:</p> <p>11 A. No, I don't remember those discussions.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. Okay. And eventually was it ever communicated</p> <p>14 to you that only the negative ERs would be</p> <p>15 concentrated on?</p> <p>16 DR. LAING:</p> <p>17 A. That we would--that looking at the patients</p> <p>18 who--so if you think about it, so there's the</p> <p>19 people that were ER negative, that would</p> <p>20 include the people that were ER negative, PR</p> <p>21 negative and the people that were ER negative,</p> <p>22 PR positive. Because of the discussions that</p> <p>23 we had yesterday about the metastatic disease</p> <p>24 and knowing that the group that are ER</p> <p>25 negative, PR positive were felt to not derive</p>	<p>1 yesterday, when we sat down and looked at</p> <p>2 everybody, we wanted to ensure that if there</p> <p>3 had of been patients that were ER negative and</p> <p>4 PR positive, that we weren't entirely sure how</p> <p>5 every clinician had used that information.</p> <p>6 And if there had of been people who had looked</p> <p>7 at that, I'm thinking more on the metastatic</p> <p>8 disease and had said, well, you know, this is</p> <p>9 someone who's ER negative, PR is positive, but</p> <p>10 we know that that group doesn't respond as</p> <p>11 well to hormonal therapy in the metastatic</p> <p>12 disease, that maybe someone would have made a</p> <p>13 decision not to treat that patient based on</p> <p>14 that profile. Which is why that we didn't</p> <p>15 want to sort of sit down and do a chart review</p> <p>16 at this time, because it would have taken an</p> <p>17 extensive period of time to go back and</p> <p>18 review, first of all, identify who were ER</p> <p>19 negative, PR positives, pull all of their</p> <p>20 charts, look through it and find out what</p> <p>21 treatment they had had, that we just felt that</p> <p>22 if we relied on the ER, that we would make</p> <p>23 sure that we were as all inclusive as we could</p> <p>24 to identify as many patients through this</p> <p>25 process, knowing that patients who were ER/PR</p>

<p style="text-align: right;">Page 49</p> <p>1 positive or patients that were ER positive, PR 2 negative, we felt that they would have been 3 considered likely to benefit from hormonal 4 therapy and would have been treated 5 appropriately with that information. So that 6 was the rationale for the decision to identify 7 patients for retesting based only on their ER 8 status. But again, I bring you back to the 9 point that we wanted both to be retested 10 because we felt that as time went on, as we 11 alluded to yesterday, there's more and more 12 interest in using these, you know, 13 combinations and the percent staining of these 14 predictive markers to determine how we treat 15 patients, maybe not so much now, but certainly 16 in the future.</p> <p>17 CHAYTOR, Q.C.: 18 Q. And so in that respect then would it have been 19 useful, as well, to do the ER positives? 20 DR. LAING: 21 A. To, well, you know, when we first discovered 22 this issue and we're starting to think, okay, 23 you know, is there something--and again, 24 remembering these are the early days. 25 CHAYTOR, Q.C.:</p>	<p style="text-align: right;">Page 51</p> <p>1 A. Pardon? 2 THE COMMISSIONER: 3 Q. How would you know they were false positive? 4 DR. LAING: 5 A. How would - 6 THE COMMISSIONER: 7 Q. You're saying the reason we did it was because 8 we knew there was a problem with false 9 negatives. We didn't know there was a problem 10 with false positives. How would you know 11 there was a problem with false positives? 12 DR. LAING: 13 A. So because if you look sort of historically at 14 this test, false positives has not been an 15 issue with this testing. And so at that time 16 our focus was on identifying the false 17 negatives. 18 THE COMMISSIONER: 19 Q. So the decision was not made on the fact that 20 there were no false positives because you 21 didn't know whether there was or not? 22 DR. LAING: 23 A. That's right. 24 THE COMMISSIONER: 25 Q. But on the basis of the literature which said</p>
<p style="text-align: right;">Page 50</p> <p>1 Q. Um-hm. 2 DR. LAING: 3 A. Is there something more going on. This was 4 something that indeed both, right from the 5 beginning the pathologists and the oncologists 6 started to act upon and look into. There was 7 our knowledge that this was a test that did 8 have problems with false negatives but not a 9 test that traditionally had had problems with 10 false positives. So were didn't, at that 11 time, consider a retesting of the entire group 12 of patients that had ever had a hormone 13 receptor test done because our concern was we 14 were saying, okay, this seems to be a problem 15 that we're having with false negatives. So 16 far all of our signals had been from people, 17 you know, that this was a problem with false 18 negatives in the lab, which we knew existed 19 with this test. And so that was the reason 20 why we tested patients who were negative. 21 CHAYTOR, Q.C.: 22 Q. And in doing - 23 THE COMMISSIONER: 24 Q. How would you know they were false positives? 25 DR. LAING:</p>	<p style="text-align: right;">Page 52</p> <p>1 that historically it was not a problem with 2 the test? 3 DR. LAING: 4 A. Yes. 5 CHAYTOR, Q.C.: 6 Q. And, Doctor, currently is there any plan in 7 order to be able to use the information as you 8 hope and contemplate, is there any plan to, in 9 fact, have all the positives retested? 10 DR. LAING: 11 A. No. 12 CHAYTOR, Q.C.: 13 Q. And in doing the review for the tumour panel, 14 there were a few retro converters identified? 15 DR. LAING: 16 A. There were. 17 CHAYTOR, Q.C.: 18 Q. Even though there were - 19 DR. LAING: 20 A. Right. 21 CHAYTOR, Q.C.: 22 Q. - very few positives retested, there were 23 some, I understand, that fell into the weak 24 positives? 25 DR. LAING:</p>

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1 A. Right.
 2 CHAYTOR, Q.C.:
 3 Q. That 30 percent issue which would have been
 4 retested and there were some that came out of
 5 that?
 6 DR. LAING:
 7 A. Right.
 8 CHAYTOR, Q.C.:
 9 Q. So even though there were relatively few
 10 retested, there were some patients which went
 11 from positive to negative?
 12 DR. LAING:
 13 A. The term retro converter was actually one that
 14 we coined through the process. But you're
 15 correct, the definition of these patients
 16 would be false positives. There were very few
 17 of those that were identified by us as part of
 18 the tumour panel. And when we examined those
 19 patients, these were patients who had been
 20 described as having very weak staining and the
 21 attending oncologist had looked at those
 22 patients and had made a decision to offer them
 23 hormonal therapy based on that. Some of them
 24 had a cutoff that was higher than what we were
 25 using at the time. For example, it might have

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1 said there was very weak staining in 15
 2 percent of the cells, and that was acted upon
 3 as a reason for treatment. The pathologists
 4 involved in this took out those original
 5 slides and reviewed them. And I'm certain
 6 that they could probably speak to this better
 7 than I could, but I do recall having
 8 conversations with them after to say when I
 9 went back and looked at those slides, I
 10 perhaps wouldn't have called that positive.
 11 They felt that the staining was more
 12 background staining than true staining of the
 13 cells. And I can assure you that this is an
 14 issue that we had thought about, that we
 15 thought about at the time, that we have had
 16 subsequent meetings about and that we have all
 17 put our heads together on to ask the very
 18 important question that you have asked, should
 19 we go back and retest all the positives. And
 20 because that was such a low number and because
 21 it had been in the people with very weak
 22 staining, we never felt that there was a
 23 signal or an indication strong enough that
 24 would warrant a review of all of the hormone
 25 receptor positive tests done over that time

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1 period.
 2 CHAYTOR, Q.C.:
 3 Q. And it was a low number. But again, it's low
 4 numbering in comparison in terms of there was
 5 only a few of them retested, anyhow.
 6 DR. LAING:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. So when you do the actual calculation as to
 10 what that percent of those might be, I would
 11 suggest to you that it's probably not such a
 12 low number in terms of the percentage of them
 13 that were tested and the ones that converted.
 14 But, Doctor, so what you're telling me is that
 15 the slides have been reviewed for those retro
 16 converters and the pathologists who have done
 17 the review have satisfied themselves it was
 18 more of an interpretation issue as opposed to
 19 any other issue with the test?
 20 DR. LAING:
 21 A. In some of those cases, yes, that's my
 22 understanding.
 23 CHAYTOR, Q.C.:
 24 Q. In some of those cases?
 25 DR. LAING:

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1 A. Yeah.
 2 CHAYTOR, Q.C.:
 3 Q. And who did that review, who looked at those
 4 slides?
 5 DR. LAING:
 6 A. The three main pathologists that were involved
 7 with reviewing the slides when such issues as,
 8 you know, the retro converters and we're going
 9 to talk about the DCIS cases, I'm sure, had
 10 been Dr. Carter, Dr. Denic and Dr. Cook.
 11 Those are the pathologists that I recall who
 12 were part of that review.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, and then perhaps we can take that up
 15 with Dr. Denic. Thank you. The letter--the
 16 letter says that it's going to be a
 17 concentration on the year 2000 and possibly
 18 2001, and I understand you to say 2002 was
 19 because that's the year of Peggy Deane's --
 20 DR. LAING:
 21 A. Uh-hm.
 22 CHAYTOR, Q.C.:
 23 Q. Test, and possibly 2001. Why was 2001 being
 24 considered?
 25 DR. LAING:

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1 A. I'm not certain.
 2 CHAYTOR, Q.C.:
 3 Q. You don't recall any discussion around that?
 4 DR. LAING:
 5 A. I can't recall what was said about 2001, no.
 6 CHAYTOR, Q.C.:
 7 Q. Was there any mention of any awareness of any
 8 problem in 2001/2002 time period?
 9 DR. LAING:
 10 A. No.
 11 CHAYTOR, Q.C.:
 12 Q. So the point in time when Dr. Cook mentioned
 13 to you of some issue regarding 2002, when did
 14 that happen?
 15 DR. LAING:
 16 A. So when we had some discussions yesterday
 17 related to the memo, it was my understanding
 18 that that was 2002, but, in fact, Dr. Ejeckam
 19 and all that happened early in 2003. So I
 20 don't know if I remember 2002 because it was
 21 the year of the index case or if that was my
 22 understanding from what I had been explained
 23 to because, as you'll recall, really this was
 24 something that I remember had been mentioned
 25 in these early meetings, but it wasn't until

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1 much later on that I actually did sit down and
 2 look at those reports thoroughly. So the 2002
 3 year, you know, I remember looking at this
 4 and, you know, it was--it was obviously the
 5 year of the index case, but I remember that
 6 there had been a problem in the lab that Dr.
 7 Cook had brought up and my initial
 8 recollections were that it had been 2002, but
 9 I suspect it was the 2003 issue related to Dr.
 10 Ejeckam, and his memo, and brief period of
 11 time that the testing was halted in the lab.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. Doctor, the letter goes on to say that,
 14 "For now we have agreed that if there is a
 15 receptor conversion, that the oncologist would
 16 inform the patient that we have retested the
 17 ER and PR receptors under our newer more
 18 sensitive technique".
 19 DR. LAING:
 20 A. Uh-hm.
 21 CHAYTOR, Q.C.:
 22 Q. And, Doctor, you would have been involved, I
 23 take it, in speaking to any of your patients
 24 who --
 25 DR. LAING:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. Converted in the first retesting that took
 4 place on the Ventana System?
 5 DR. LAING:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And is that, in fact, what the patients were
 9 told that they've been retested under the
 10 newer more sensitive technique?
 11 DR. LAING:
 12 A. You know, at that time we had had the Ventana
 13 System in place for about a year, and when I
 14 sat down with the patients to disclose this,
 15 my beginning was to explain to them the index
 16 case, so I explained to them, you know, we had
 17 a patient, for some reasons we decided to
 18 retest that patient, that patient's results
 19 came back as different, and if it was a
 20 lobular patient, I would say, you know, you
 21 had a similar histology in your cancer and,
 22 therefore, we have repeated your test and the
 23 test has come back to be this, and this is
 24 what it means to you. In terms of what we
 25 said about it, we said that, you know, that we

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1 had concerns that the problem was--we
 2 explained to them was done in the pathology
 3 lab, it was a testing done where a piece of
 4 the breast cancer tissue was stained to look
 5 for these receptors, that the testing was done
 6 on a newer type of equipment, but it was the
 7 same type of test, it was still an
 8 immunohistochemical test. You can imagine
 9 that for many patients this was information
 10 that was very new to them, information that it
 11 took them some time to understand and
 12 appreciate. We had people say, well, to
 13 retest me, do you need another sample, you
 14 know, those sorts of things. So that, you
 15 know, our disclosure to them was something, as
 16 I just said, you know, we were concerned that
 17 maybe there was some problem with the initial
 18 testing, but it was being redone on--with the
 19 same method, i.e. immunohistochemistry, but on
 20 a new machine, if you will.
 21 CHAYTOR, Q.C.:
 22 Q. So you agreed with that approach to inform the
 23 patients of that?
 24 DR. LAING:
 25 A. Yes.

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<p>1 CHAYTOR, Q.C.:</p> <p>2 Q. That it's being done on a newer more sensitive</p> <p>3 technique?</p> <p>4 DR. LAING:</p> <p>5 A. So this was--my understanding was the Ventana</p> <p>6 System, because it was semi-automated, was</p> <p>7 different in how things went through than in</p> <p>8 the older machine, but again we didn't--this</p> <p>9 was something that was a new machine, but it</p> <p>10 was still immunohistochemical testing. It was</p> <p>11 still a staining test to look for these</p> <p>12 receptors.</p> <p>13 CHAYTOR, Q.C.:</p> <p>14 Q. So at this point in time, is that what was</p> <p>15 being offered to you as an explanation by the</p> <p>16 pathologist that the reason for this may be</p> <p>17 that the Ventana is more sensitive?</p> <p>18 DR. LAING:</p> <p>19 A. That was one of the things that we considered</p> <p>20 that might be an explanation as to why,</p> <p>21 although still, you know, in the back of our</p> <p>22 minds was the understanding that it was the</p> <p>23 same--it was the same type of test. I guess</p> <p>24 we might use the analogy, if you will, of a</p> <p>25 new CT scanner. We often--now in oncology we</p>	<p>1 don't think we were led to believe that, nor</p> <p>2 did we believe that this was the only reason</p> <p>3 and we certainly did not communicate to the</p> <p>4 patients that this was the reason why there</p> <p>5 was a change. We simply said that this was a</p> <p>6 test that came from the lab, that they were</p> <p>7 looking into why there was a difference, but</p> <p>8 did explain to them that the retesting was</p> <p>9 done in the same lab, still was an</p> <p>10 immunohistochemical test, but that it was done</p> <p>11 on a--in a different way, I guess, is the best</p> <p>12 way I can think to describe it, as a different</p> <p>13 way to do it.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. So you felt comfortable in telling your</p> <p>16 patients if any of them asked, that--as to why</p> <p>17 this could happen, that they were retested on</p> <p>18 a more sensitive technique--through a more</p> <p>19 sensitive technique?</p> <p>20 DR. LAING:</p> <p>21 A. What I would have said to them was that it was</p> <p>22 done on a different machine, but that we</p> <p>23 didn't really know at that time what the</p> <p>24 problem was.</p> <p>25 CHAYTOR, Q.C.:</p>
<p>1 do a tremendous number of CT scans, as you can</p> <p>2 imagine, in the care of our patients, and we</p> <p>3 pick up things now on CT scans that we didn't</p> <p>4 see five years ago because the machines are</p> <p>5 more sensitive. It's still a CT scan, but you</p> <p>6 can see all sorts of little nodules and things</p> <p>7 that we only know what they are when we follow</p> <p>8 them over time.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. So is that what was being said at this point</p> <p>11 in time that this machine--because we</p> <p>12 understand the DAKO machine is what was used</p> <p>13 in Mount Sinai and continues to be used in</p> <p>14 Mount Sinai.</p> <p>15 DR. LAING:</p> <p>16 A. Yes.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. So is that what the pathologist, Dr. Cook, was</p> <p>19 telling you, that this is a good analogy to</p> <p>20 think of it in terms of a CT scan?</p> <p>21 DR. LAING:</p> <p>22 A. No. I guess what I'm trying to say is that,</p> <p>23 you know, this was not a different test, but</p> <p>24 it was a test done by a different method. So</p> <p>25 could this have been the only explanation, I</p>	<p>1 Q. So you told your patients you didn't know what</p> <p>2 the problem was?</p> <p>3 DR. LAING:</p> <p>4 A. Right, we said we were looking into it, that</p> <p>5 this was a test that was done in the lab and</p> <p>6 the results were given to us, that we didn't</p> <p>7 know what the problem was, but it was done on</p> <p>8 --it was the same test, but it was certainly</p> <p>9 done this time on a different machine than</p> <p>10 their test would have been done on.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. And if you didn't know what the problem was,</p> <p>13 why mention the machine?</p> <p>14 DR. LAING:</p> <p>15 A. Because patients would ask. So they would</p> <p>16 say, well, you've done this test before and</p> <p>17 you've done it again, what was different about</p> <p>18 the test that was being done, remembering that</p> <p>19 this would have been very few patients because</p> <p>20 ultimately the retest was done at another</p> <p>21 hospital.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. Using the same machine?</p> <p>24 DR. LAING:</p> <p>25 A. Using a DAKO --</p>

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<p>1 CHAYTOR, Q.C.:</p> <p>2 Q. A DAKO System?</p> <p>3 DR. LAING:</p> <p>4 A. Yeah, yeah, so we didn't really get to caught</p> <p>5 up in--subsequently when we were disclosing to</p> <p>6 patients on this machine versus that machine,</p> <p>7 but, of course, in the early days this was</p> <p>8 being done with a new machine compared to what</p> <p>9 their initial testing was done on, and, you</p> <p>10 know, this is important too because it comes</p> <p>11 to the issue that we were noticing that with</p> <p>12 the Ventana System that we were getting a lot</p> <p>13 of very strongly positive results.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. Now this is May 24th, Doctor?</p> <p>16 DR. LAING:</p> <p>17 A. Yes.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. Were you noticing that by May 24th?</p> <p>20 DR. LAING:</p> <p>21 A. No, we had those discussions subsequently in</p> <p>22 July.</p> <p>23 CHAYTOR, Q.C.:</p> <p>24 Q. Much later, yes.</p> <p>25 DR. LAING:</p>	<p>1 proficiency testing and a monitoring program</p> <p>2 for immunoperoxidase testing, the</p> <p>3 establishment of a separate immunoperoxidase</p> <p>4 service with at least three technologists</p> <p>5 dedicated to the testing".</p> <p>6 DR. LAING:</p> <p>7 A. Uh-hm.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. "The training of the technologists in a major</p> <p>10 immuno referral lab, and appropriate CME</p> <p>11 funding for the immuno technologists". Were</p> <p>12 any of those issues discussed with you?</p> <p>13 DR. LAING:</p> <p>14 A. No.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Okay, so that wasn't brought to your</p> <p>17 attention, the need for any of those?</p> <p>18 DR. LAING:</p> <p>19 A. No, this would be something that would be a</p> <p>20 discussion by the pathologists and within the</p> <p>21 laboratory department.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. And if I could have, please, P-2452. If we</p> <p>24 could just go back to that, though, for one</p> <p>25 moment, please, P-0067. Sorry, Registrar.</p>
<p>1 A. That's right.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. And your first full batch of people, of 25</p> <p>4 people, that happens June 29th. So those</p> <p>5 would be the people, the initial batch,</p> <p>6 anyhow, of the ones who are retested.</p> <p>7 DR. LAING:</p> <p>8 A. Yes.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. What else was offered by Dr. Cook, or I guess</p> <p>11 perhaps Dr. Carter, as to other--in the May</p> <p>12 17th meeting, other than, well, it's a new</p> <p>13 machine, what other explanation was offered?</p> <p>14 DR. LAING:</p> <p>15 A. I don't recall us having any in depth</p> <p>16 discussions about any other explanations at</p> <p>17 that time.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. And this letter goes on to speak about some</p> <p>20 recommendations.</p> <p>21 DR. LAING:</p> <p>22 A. Uh-hm, yes.</p> <p>23 CHAYTOR, Q.C.:</p> <p>24 Q. And again this is May 24th and "The need for</p> <p>25 the immediate establishment of external</p>	<p>1 There we go. It says, "For now we have agreed</p> <p>2 if there is a receptor conversion, that the</p> <p>3 oncologist would inform".</p> <p>4 DR. LAING:</p> <p>5 A. Right.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. Were the patients who did not have a</p> <p>8 conversion informed of the retesting in those</p> <p>9 early 58 patients, around 58 patients, that</p> <p>10 were done in-house on the Ventana? Was</p> <p>11 everybody informed or just the people who had</p> <p>12 a conversion?</p> <p>13 DR. LAING:</p> <p>14 A. I'm not certain if everybody was informed. I</p> <p>15 know that subsequently that that list was sent</p> <p>16 to Dr. McCarthy, and in the early days I</p> <p>17 cannot say for certain that patients who were</p> <p>18 confirmed negative would have been told that</p> <p>19 at that time.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. And were all the people who had a conversion</p> <p>22 told or just some of the people?</p> <p>23 DR. LAING:</p> <p>24 A. Later on there was a decision made that we</p> <p>25 would not inform patients of a change in their</p>

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1 test results until it was confirmed by an
 2 outside laboratory because of the concern that
 3 the Ventana System may be overcalling it. We
 4 didn't want to take ourselves from a position
 5 where we had concerns of a false negative test
 6 and to give patients a false positive test.
 7 So there was a decision made later on that we
 8 would actually stop telling patients and
 9 disclosing this information to them until we
 10 had gotten the results back from Mount Sinai,
 11 but this was after--this was later on.

12 CHAYTOR, Q.C.:

13 Q. Okay, if we could go now then, please, to P-
 14 2452. On page two is the first of those
 15 letters, June 29, 2005, and it's written to
 16 Dr. McCarthy by Dr. Carter and Dr. Cook.

17 DR. LAING:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. And I think your name appears--it's a list of
 21 patients. It says, "As per our previous
 22 discussions, repeat estrogen receptor and
 23 progesterone receptors has been carried out on
 24 the following patients initially identified as
 25 estrogen receptor negative".

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1 DR. LAING:

2 A. Right.

3 CHAYTOR, Q.C.:

4 Q. And the results are as follows, and there's a
 5 number, I think, close to 25 perhaps in this
 6 first batch, and you'll see your name by some
 7 of the patients, and the names, of course,
 8 have been redacted. Your name and some dates.

9 DR. LAING:

10 A. Uh-hm.

11 CHAYTOR, Q.C.:

12 Q. So, Doctor, I take it you met with some of
 13 those patients to give them the results?

14 DR. LAING:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. And to speak with them. How were they--how
 18 were they informed of their changes? How did
 19 you, first of all, become aware of this list
 20 and any patients you had on the list, and then
 21 how did you communicate that to your patients?

22 DR. LAING:

23 A. So the patients that are on this list that are
 24 identified towards the bottom --

25 CHAYTOR, Q.C.:

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1 Q. And there may be others that are your
 2 patients, but your name does appear by those
 3 couple.

4 DR. LAING:

5 A. Yes. If I had received--in addition to this
 6 being put on a list, there was an addendum
 7 attached to the pathology report, and what had
 8 happened was when we received that
 9 information, I would have called these
 10 patients and asked them to come in to the
 11 clinic to have a discussion regarding this
 12 issue, and at those clinic visits, this
 13 information would have been disclosed to the
 14 patients.

15 CHAYTOR, Q.C.:

16 Q. So you personally would have called your
 17 patient?

18 DR. LAING:

19 A. Either I would have called them personally, or
 20 I would have asked for them to be notified to
 21 attend a clinic visit.

22 CHAYTOR, Q.C.:

23 Q. And the actual information then would not have
 24 been given over the phone, it would have been
 25 given to the patient face to face?

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1 DR. LAING:

2 A. Yes, we tried to as time went on, and
 3 certainly in the early days, communicate this
 4 information to patients when at all possible
 5 with a face to face visit in the clinic to
 6 give the patients ample opportunity to discuss
 7 this information with us.

8 CHAYTOR, Q.C.:

9 Q. And those that were your patients that did not
 10 have a conversion, so for example, there's a
 11 patient here negative/negative, so confirmed
 12 negative, and there's a number of those up
 13 here.

14 DR. LAING:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. Those that didn't have any change, what
 18 happened to them, were they told?

19 DR. LAING:

20 A. Again as I said a few minutes ago, some of
 21 these patients were retested just as a random
 22 sample, so I'm not certain that if their test
 23 results didn't change at this time, that they
 24 would have been notified as such. Certainly
 25 if it was one of my patients and I had

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1 informed them that I was going to do this
 2 test, I would have communicated the results to
 3 them. I do recall some of my patients who had
 4 metastatic disease and in our discussions
 5 we've indicated that there were some patients
 6 who we decided to retest based on the fact
 7 that they had metastatic disease and we didn't
 8 have any other viable therapeutic options for
 9 them. So I do recall having some of my
 10 patients with metastatic disease and saying to
 11 them, you know, I'm going to ask for this test
 12 to be redone, and I will let you know when it
 13 comes back, and so if theirs didn't change,
 14 then I would have confirmed to them that they
 15 were negative.
 16 CHAYTOR, Q.C.:
 17 Q. So, Doctor, at what stage did you have those
 18 discussions with your patients, those that you
 19 did tell you were going to have retested? Was
 20 that before the matter became public
 21 discussion on October 2nd?
 22 DR. LAING:
 23 A. Yes, there would have been patients in my
 24 practice --
 25 CHAYTOR, Q.C.:

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1 Q. That you told.
 2 DR. LAING:
 3 A. That I would have said, you know, there's this
 4 issue going on that's called into question the
 5 reliability of the estrogen and progesterone
 6 receptor testing results that we have been
 7 receiving, and, you know, you've had lots of
 8 chemo and I think it might be worthwhile for
 9 us to ask for your sample to be retested to
 10 see if there's any change in your test result,
 11 and if there was, then we may think about some
 12 hormonal therapy. Of course, the very first
 13 instance of that was one of Dr. McCarthy's
 14 patients and she was a lady with quite
 15 extensive chest wall disease who really had
 16 run out of chemotherapy options. There was
 17 one other case, and I'm not sure if we're
 18 going to discuss that, but there were five
 19 patients.
 20 CHAYTOR, Q.C.:
 21 Q. Is it out of the five?
 22 DR. LAING:
 23 A. Yes, yeah, we didn't --
 24 CHAYTOR, Q.C.:
 25 Q. Do you remember which number?

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1 DR. LAING:
 2 A. -- finish that.
 3 CHAYTOR, Q.C.:
 4 Q. We went through the three and there was four
 5 and five we didn't finish.
 6 DR. LAING:
 7 A. Yes, do you want to talk about those some more
 8 now?
 9 CHAYTOR, Q.C.:
 10 Q. Sure, if--are they about--perhaps you can just
 11 tell me. We're running short on time and I
 12 would --
 13 DR. LAING:
 14 A. Sure, I'll just tell you very quickly.
 15 CHAYTOR, Q.C.:
 16 Q. Yes.
 17 DR. LAING:
 18 A. One of them was a lobular patient who had
 19 metastatic disease and she was my patient and
 20 I saw her on a regular basis. So every few
 21 weeks she'd come to see me in the clinic. She
 22 was quite unwell and I said to her, you know -
 23 and she was a lobular who was a very
 24 undifferentiated, very aggressive tumour. So
 25 I said to her, look, this has happened. This

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1 would have been sometime in June. This has
 2 happened--at this time, I had already had
 3 three lobulars change, and I said to her I
 4 think I should put you on this medication and
 5 I will retest you and I will let you know, but
 6 --you know, let's just get you on this pill
 7 and see if it can help you, and I'm very
 8 pleased to say that it did and she lived for
 9 another year and a half.
 10 CHAYTOR, Q.C.:
 11 Q. Is that patient number four?
 12 DR. LAING:
 13 A. That's patient number four. Patient number
 14 five, when you had called last week and asked
 15 us to pull this out, she was someone who had
 16 been seen, had been treated adjuvantly with
 17 chemotherapy and had high risk disease. She
 18 had lymph nodes involved. She was Dr.
 19 McCarthy's patient and what had happened was
 20 at that time--so in 2005 was when we were
 21 considering adjuvant Herceptin and there was
 22 some references made to that, as you know,
 23 through this whole course, but it just
 24 happened to be when the pivotal trials had
 25 come out showing an extreme benefit to

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<p>1 Herceptin in the adjuvant setting. Up until 2 that time we did not routinely test HER2 on 3 newly diagnosed patients. We would have done 4 it on patients with metastatic disease because 5 that's when we had utilized that therapy, but 6 there were some recommendations coming out 7 that patients who were deemed to be at high 8 risk of occurrence, we should start to think 9 about doing their HER2 testing. So Dr. 10 McCarthy had sent off a consult to have the 11 HER2 testing done, and her note indicates that 12 in August of that year - and the sample went 13 to Mount Sinai because Mount Sinai was doing 14 our HER2 testing at the time, and from what we 15 can gather, they just did ER/PR on it as well, 16 and it changed. This was a ductal patient, so 17 this was not someone who had had--who was 18 lobular, and she had just finished her 19 chemotherapy. So, of course, Dr. McCarthy had 20 this new information, it came from Mount Sinai 21 Hospital, so she recommended adjuvant hormonal 22 therapy as this lady had just completed her 23 chemotherapy. So this lady ended up being -- 24 CHAYTOR, Q.C.: 25 Q. So it was almost by accident that it was</p>	<p>1 to them. 2 CHAYTOR, Q.C.: 3 Q. Yes, and, Doctor, obviously that patient, even 4 though she was called patient number five, 5 wasn't the fifth patient that you had 6 identified to have retested? 7 DR. LAING: 8 A. No, that's right. 9 CHAYTOR, Q.C.: 10 Q. And I noticed that in the list when we 11 received it because she was quite late, August 12 29th. 13 DR. LAING: 14 A. Yes. 15 CHAYTOR, Q.C.: 16 Q. And she was someone who, I'm glad you 17 explained that, that you sent off for HER2/neu 18 testing and they also did the ER/PR? 19 DR. LAING: 20 A. Uh-hm. 21 CHAYTOR, Q.C.: 22 Q. Because, of course, there had been this whole 23 list of other patients prior to that. 24 DR. LAING: 25 A. Right.</p>
<p>1 retested at Mount Sinai? 2 DR. LAING: 3 A. We have looked very carefully at this, and 4 this is the conclusion that we had come. So 5 now we have in that small pool of patients, we 6 have the lobular people which we have 7 identified, but we now have two ductal people 8 --patients with ductal histology. 9 CHAYTOR, Q.C.: 10 Q. We understood what you meant. 11 DR. LAING: 12 A. Yes, and so, you know, I think that--and that 13 case was in August. 14 CHAYTOR, Q.C.: 15 Q. August 29th, late in August. 16 DR. LAING: 17 A. Yes, but certainly there are patients who I 18 can remember very, very vividly who I was 19 caring for metastatic disease that summer who 20 I did ask for retesting to be done, who came 21 back as still negative. 22 CHAYTOR, Q.C.: 23 Q. Yes, okay. 24 DR. LAING: 25 A. And I would have communicated that information</p>	<p>1 CHAYTOR, Q.C.: 2 Q. That had been retested. 3 DR. LAING: 4 A. Yes. 5 CHAYTOR, Q.C.: 6 Q. Doctor, in talking to those patients -- 7 DR. LAING: 8 A. Uh-hm. 9 CHAYTOR, Q.C.: 10 Q. Both the ones that are listed here on the 11 first batch of June 29th, as well as those 12 that you've just mentioned to us out of the 13 first five or patients one through five, and 14 you told them you were going to have them 15 retested, how did they respond to that when 16 you told them that you would be having them 17 retested? 18 DR. LAING: 19 A. They--you know, they would have said okay, 20 they were okay with that, and as you can 21 imagine, patients who have metastatic disease 22 to come in and say to them I have a new 23 treatment option for you would be something 24 that they would view in a very positive way. 25 CHAYTOR, Q.C.:</p>

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<p>1 Q. The way that--Peggy Deane, in fact, said she</p> <p>2 was full of hope.</p> <p>3 DR. LAING:</p> <p>4 A. Yes.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Okay. Doctor, I think my question had been</p> <p>7 looking at this list a while ago, and the ones</p> <p>8 who were confirmed negative, did you have any</p> <p>9 discussions with them?</p> <p>10 DR. LAING:</p> <p>11 A. Yes, so if--as I said, if I had said to a</p> <p>12 patient I'm going to retest you, then I would</p> <p>13 have followed up and said, you know, I've done</p> <p>14 that, it's come back, and it did not change.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. So are you saying that all of these patients</p> <p>17 were told, this 25 or so --</p> <p>18 DR. LAING:</p> <p>19 A. No.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. Were they all told?</p> <p>22 DR. LAING:</p> <p>23 A. I can't say that because I'm not sure who</p> <p>24 these patients are right now.</p> <p>25 CHAYTOR, Q.C.:</p>	<p>1 retest it at this point and the patient said,</p> <p>2 okay, Dr. Laing.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. Okay.</p> <p>5 DR. LAING:</p> <p>6 A. And, you know, there were sometimes when the</p> <p>7 patients said, you know, do I need to have a</p> <p>8 blood test and that sort of thing, and I said,</p> <p>9 no, this is something that's already on your</p> <p>10 tumour tissue. In fact, I recall many of the</p> <p>11 patients being very surprised that five/six</p> <p>12 years later that that tissue was still around</p> <p>13 and kept for many years in the lab.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. So, Doctor, the answer is that if you had told</p> <p>16 the patient beforehand that they were going to</p> <p>17 be retested, you certainly would have gotten</p> <p>18 back to them and told them the results.</p> <p>19 DR. LAING:</p> <p>20 A. Yeah.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. That they had not changed. Those that did</p> <p>23 change, whether they knew it beforehand or</p> <p>24 not, were all told?</p> <p>25 DR. LAING:</p>
Page 82	Page 84
<p>1 Q. If they were your patients, were they told</p> <p>2 before they were retested?</p> <p>3 DR. LAING:</p> <p>4 A. If they were my patients and they had</p> <p>5 metastatic disease, as time went on I would</p> <p>6 tell them that I was going to retest them.</p> <p>7 The very first lobular patient that I</p> <p>8 retested, patient number two in what we talked</p> <p>9 about yesterday, I don't think that I told her</p> <p>10 at the time what I was doing, although I did</p> <p>11 put it at the end of the clinic note and we</p> <p>12 reviewed that yesterday. As time went on, I</p> <p>13 would have said to the people, you know, I'm</p> <p>14 going to do this retest. You know, I wasn't -</p> <p>15 I didn't go into a whole lot of detail with</p> <p>16 them prior to it. You mentioned the word</p> <p>17 "hope" and we certainly--that's something that</p> <p>18 we do every day to try and give our patients,</p> <p>19 but I also didn't want to build patients up</p> <p>20 too much, so I just sort of went and said,</p> <p>21 look, we've done some retesting of the</p> <p>22 estrogen progesterone receptors, yours were</p> <p>23 negative in the beginning, which is why we</p> <p>24 haven't given you these treatments, and I have</p> <p>25 reason to think that it might be worthwhile to</p>	<p>1 A. Correct.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. If a patient had not been told beforehand that</p> <p>4 she or he were being retested and it was</p> <p>5 negative, were those patients told?</p> <p>6 DR. LAING:</p> <p>7 A. I'm not certain because I believe that some of</p> <p>8 the patients on this list were just randomly</p> <p>9 picked to be retested. I don't think that all</p> <p>10 of these 25 patients were brought forward by</p> <p>11 the attending oncologist to have the retesting</p> <p>12 done. In the early days, these patients who</p> <p>13 we later called to confirm negatives, I'm not</p> <p>14 certain that they would have been notified at</p> <p>15 this time that this had been done.</p> <p>16 CHAYTOR, Q.C.:</p> <p>17 Q. Okay. Doctor, was there any--and, of course,</p> <p>18 one of the issues that the Commissioner is</p> <p>19 looking at is the communications with the</p> <p>20 patients, so was there any consistency, was</p> <p>21 there any plan that here's how we're all going</p> <p>22 to handle this, here's what we're going to do</p> <p>23 with patients in certain circumstances, here's</p> <p>24 what we're going to do with patients who find</p> <p>25 themselves in other circumstances? Was there</p>

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<p>1 anything laid out in terms of a plan so that 2 there was consistency with how your patients 3 were treated, how Dr. McCarthy's were treated, 4 how Dr. Siddiqui's were treated? Was there 5 any consistency, any plan laid out so all 6 oncologists would know this is how we're going 7 to do it and we can track, in fact, the 8 patients that we have spoken with and those 9 who have not been spoken to?</p> <p>10 DR. LAING: 11 A. Right. So to answer the first part of the 12 question in terms of what we were going to say 13 and how we were going to explain the 14 situation, we certainly did have informal 15 conversations with the whole group of medical 16 oncologists. We all said how things went when 17 we disclosed to our patients, what kind of 18 reactions they had, and we all had a similar 19 explanation in that there was a problem in the 20 lab and this is why we've done the retesting. 21 In terms of a tracking system, I have to say, 22 no, we didn't have a very good tracking system 23 to ensure that patients were contacted, that 24 the follow-up had been done. This was 25 something that we got into much later in the</p>	<p>1 Q. And, Doctor, I understand, though, at the time 2 only 10 or 12 out of those 16 were told the 3 results at that time. Do you know why all of 4 the 16 would not have been told?</p> <p>5 DR. LAING: 6 A. I don't know why. 7 CHAYTOR, Q.C.: 8 Q. I'm not sure if that next letter is here. No, 9 I think I need P-0508. I apologize for the 10 quality of this, Doctor, it's a little 11 difficult to see, but this is July 18th, 2005, 12 and it's the next list of patients to Dr. 13 McCarthy, and it's signed again by Drs. Cook 14 and Carter?</p> <p>15 DR. LAING: 16 A. Yes. 17 CHAYTOR, Q.C.: 18 Q. And again it says, "As per our previous 19 discussions, repeat estrogen receptor and 20 progesterone receptor has been carried out on 21 the following patients and the results are as 22 follows". Did you follow the same procedure 23 when you received this list, did you follow 24 the same procedure, did you contact your 25 patients who had had a conversion or those</p>
<p style="text-align: right;">Page 86</p> <p>1 process and much later in the panel process. 2 CHAYTOR, Q.C.: 3 Q. And I take it there was no memo that went out, 4 or anything in writing, even an e-mail to send 5 out to all the oncologists saying here's our 6 plan, here's who needs to be told, and here's 7 the way in which we should all go about doing 8 it?</p> <p>9 DR. LAING: 10 A. No, the only communication that I have seen 11 that comes from that was the decision 12 subsequently that we decided that we would 13 wait on any further disclosure until we had 14 the testing from Mount Sinai to avoid a 15 problem of false positives.</p> <p>16 CHAYTOR, Q.C.: 17 Q. Doctor, back on the list of June 29th, 2005, 18 out of those 25 or thereabouts, I understand 19 16 of those--if we count them up, 16 of those 20 actually converted, and I take it that was a 21 subject of concern between yourself and Dr. 22 McCarthy certainly as treating oncologists?</p> <p>23 DR. LAING: 24 A. Yes. 25 CHAYTOR, Q.C.:</p>	<p style="text-align: right;">Page 88</p> <p>1 that you had already told would be retested 2 and give them the results?</p> <p>3 DR. LAING: 4 A. So this list is the one that contains all the 5 patients from 2002, so all these people have a 6 2002 surgical number. 7 CHAYTOR, Q.C.: 8 Q. That's right. 9 DR. LAING: 10 A. My understanding is this is a group of 11 patients that was decided to be retested for 12 the 2002 year. As you can see when you look 13 at the results, some just say positive and 14 some say 100 percent, 100 percent, 100 15 percent, 100 percent. 16 CHAYTOR, Q.C.: 17 Q. Uh-hm. 18 DR. LAING: 19 A. And my recollection is that after seeing this, 20 that this is the first time that we sort of 21 said look at all the 100 percent positives 22 that we're seeing with the Ventana System, or 23 certainly a high percent positivity which was 24 something that we talked yesterday a lot 25 about, looking at trends, this was something</p>

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1 that we noticed, possibly because this was,
 2 you know, we were looking at a whole bunch of
 3 patients together, but we did comment on the
 4 fact that there certainly were a high number
 5 of patients who had very strong staining for
 6 both.

7 CHAYTOR, Q.C.:

8 Q. I think there's only two with 100 percent.

9 DR. LAING:

10 A. But there's some with 80 --

11 CHAYTOR, Q.C.:

12 Q. Thirty something --

13 DR. LAING:

14 A. Strong, strong, 80, 80, strong, strong.

15 CHAYTOR, Q.C.:

16 Q. Three maybe is another 100 percent.

17 DR. LAING:

18 A. And some more down here that are strong,
 19 strong. So there are several that are strong
 20 staining in certainly 80 to 100 percent. Some
 21 patients just says positive, and, you know,
 22 some of the patients were still negative. So
 23 I'm not sure which percentage of these
 24 patients were mine, I'm not sure which
 25 percentage of these patients were ones that I

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1 had requested testing. My understanding was
 2 that this was the retest sample of the 2002
 3 year. Subsequent to this, and I'm not certain
 4 how many weeks later, we did have a discussion
 5 that we wouldn't disclose any more to patients
 6 until the results came back from Mount Sinai.

7 CHAYTOR, Q.C.:

8 Q. So to your knowledge, the patients on this
 9 list who were your patients, were not told in
 10 July 18th or around July 18th, or sometime
 11 shortly thereafter, about the change in their
 12 results?

13 DR. LAING:

14 A. Unless they were a patient who was--who I had
 15 requested the retesting because of their
 16 metastatic disease.

17 CHAYTOR, Q.C.:

18 Q. So those you would have had back in and told
 19 them the result?

20 DR. LAING:

21 A. Initially, and then towards the end of the
 22 summer, there were some patients who--I guess
 23 I should qualify it by saying that if I had a
 24 patient who had metastatic disease who I was
 25 looking for a new therapy and I got this

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1 result back, ten I would have acted upon it
 2 because of the urgency of the clinical
 3 situation. If I had someone who had
 4 metastatic disease who was receiving a course
 5 of chemotherapy and responding well to that,
 6 then I would have waited until I got the Mount
 7 Sinai results which we were expecting--we'll
 8 talk about that, but we were expecting to come
 9 in September of that year.

10 CHAYTOR, Q.C.:

11 Q. Doctor --

12 DR. LAING:

13 A. Because I--I mean, I can certainly recall
 14 clearly some of my patients who were retested
 15 and were said to be positive on the Ventana
 16 System and we acted upon that, and they would
 17 have been people that we were looking for a
 18 treatment option for them.

19 CHAYTOR, Q.C.:

20 Q. Doctor, I'm just looking down through this.
 21 Why was the decision made to hold off at this
 22 point in time in telling the people?

23 DR. LAING:

24 A. So these were--so this was a group of patients
 25 who had been selected because of the 2002

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1 year, and these were people that were
 2 eventually retested at Mount Sinai Hospital as
 3 well.

4 CHAYTOR, Q.C.:

5 Q. Yes, well, as were the first group as well,
 6 they were retested as well?

7 DR. LAING:

8 A. They were, yeah, yeah. So the only one that I
 9 think we determined yesterday that never
 10 really had a test at Mount Sinai was Peggy
 11 Deane.

12 CHAYTOR, Q.C.:

13 Q. Well --

14 DR. LAING:

15 A. Well, that I have knowledge of.

16 CHAYTOR, Q.C.:

17 Q. That we talked about yesterday that we have
 18 knowledge of up to this point in time, I
 19 guess.

20 DR. LAING:

21 A. Yeah.

22 CHAYTOR, Q.C.:

23 Q. Doctor, the reason for not telling these
 24 patients again, treating them differently from
 25 the June 29th group, what was the reason?

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1 DR. LAING:
 2 A. That we were waiting to have the retesting
 3 done at an outside lab.
 4 CHAYTOR, Q.C.:
 5 Q. So by July 18th, that decision had been made
 6 to use Mount Sinai?
 7 DR. LAING:
 8 A. No, hadn't been made to use Mount Sinai.
 9 CHAYTOR, Q.C.:
 10 Q. Or to use an outside lab?
 11 DR. LAING:
 12 A. This--this result with this number of patients
 13 having such strong positive results on the
 14 Ventana System called into question whether or
 15 not the retesting should be done on the
 16 Ventana System or at an outside lab. This was
 17 the start of those discussions. I'm not
 18 certain when the exact date when the decision
 19 was made to use an outside lab. Of course,
 20 once the decision was made to use an outside
 21 lab, there was correspondence between Dr. Cook
 22 and fellow directors and heads of pathology
 23 across the country to, in fact, find a lab who
 24 may be willing to do this service for us. Of
 25 course, as part of that over the next few

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1 weeks was a decision to suspend ER/PR testing
 2 at the lab in St. John's, which meant that we
 3 were looking for somebody who would do two
 4 tasks for us; one would be the retesting and
 5 the other would be the ongoing ER/PR
 6 interpretation.
 7 CHAYTOR, Q.C.:
 8 Q. The issue then from what I'm hearing you say
 9 is that this is--this group of results is what
 10 then caused some concern about the sensitivity
 11 of the Ventana machine and whether or not it
 12 was overcalling?
 13 DR. LAING:
 14 A. Uh-hm.
 15 CHAYTOR, Q.C.:
 16 Q. And when I look down through, and this is a
 17 group of patients, there's over 30 people
 18 here, I think it might be close to 35 or
 19 thereabouts, maybe even more than that. When
 20 I look at it, we have eight patients who are
 21 indicated to be strong positivity. We have
 22 this patient, and this one arguably, I guess,
 23 it's 60 to 80, I don't know if you're
 24 considering that to be strong, but in terms of
 25 the estrogen, we have this person, two, three,

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1 four, five, six, seven, eight, 70 percent if
 2 we include 70, nine--nine patients, Doctor.
 3 DR. LAING:
 4 A. So it wasn't just--it's hard to look at.
 5 CHAYTOR, Q.C.:
 6 Q. Sorry, I don't mean to make you dizzy.
 7 DR. LAING:
 8 A. So if you look at this list, there are some
 9 patients in which the actual percent is
 10 included and there are some patients in which
 11 it just says positive. I'm not certain as to
 12 why it was reported from the pathologist in
 13 this way, but I know that this was a point
 14 where we certainly started on these
 15 discussions of, you know, patients who were
 16 coming back with very strong positivity. In
 17 addition to what we were seeing here, we had
 18 become a group of people who were paying
 19 extreme attention to the results that we were
 20 receiving, so we were even looking at what was
 21 happening now in our clinical practice, and
 22 this is when we first had the discussions with
 23 Dr. Cook and Dr. Carter to say, you know, the
 24 Ventana System is reporting a lot of very
 25 strong staining and, of course, at that time

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1 we weren't certain if this was because of the
 2 machine itself, because of the antibodies
 3 being used, or what the reason was for quite a
 4 lot of these coming back with strong staining.
 5 It wasn't only what we were seeing in this
 6 group. I suspect, although without having the
 7 numbers there, that some more of these cases
 8 that were indicated as being positive would
 9 have been strong staining as well, plus what
 10 was going on in the clinic, and plus really
 11 some very careful thought, not solely by the
 12 oncologists, but some very careful thought by
 13 the pathologists as to, you know, if this was
 14 going--you know, we're leading up to sort of
 15 saying, okay, we started with an index case,
 16 we've got a few more, now we have two samples
 17 of which there is quite a significant change,
 18 16 out of 25, and whatever it is out of this
 19 one, that now people are saying to themselves,
 20 okay, we've got a problem, we're going to have
 21 to retest people, some very careful thought as
 22 to what's the best way to do that. When you
 23 do this sort of undertaking, you know, are you
 24 going to use your same laboratory or are you
 25 going to--is it better to have this done at an

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<p>1 outside facility. Whether or not we had any 2 sort of concerns about the Ventana System, I 3 think one of the questions was if you're going 4 to embark on a review of this type, is this 5 something that's best done by asking an 6 outside facility to do that kind of review. 7 Is it, I guess, more credible or is that the 8 best way to do it, and certainly there were 9 those discussions.</p> <p>10 CHAYTOR, Q.C.: 11 Q. So, Doctor, I take it by this point in time, 12 July 18th, 2005, you were confident there was 13 a problem?</p> <p>14 DR. LAING: 15 A. Yes.</p> <p>16 CHAYTOR, Q.C.: 17 Q. Okay. Doctor, the patients in June 29th list 18 that were did tell, they obviously weren't put 19 through any panelling process, there was no 20 panelling process at that point in time?</p> <p>21 DR. LAING: 22 A. Yes.</p> <p>23 CHAYTOR, Q.C.: 24 Q. And you felt confident in dealing with them 25 and giving them their results and making a</p>	<p>1 DR. LAING: 2 A. But not all of them.</p> <p>3 CHAYTOR, Q.C.: 4 Q. And did you consult outside experts outside 5 the province as to what to do with any of 6 those patients on the June 29th list?</p> <p>7 DR. LAING: 8 A. Not in the sense of that I specifically 9 discussed the cases to the same degree that I 10 did Peggy's case with Dr. Hudis, but you'll 11 recall that I had seen Dr. Pritchard and had 12 been in a meeting with some breast cancer 13 colleagues of mine from across the country and 14 discussed this issue, and this was when I had 15 my patient number two in this process, the 16 lady with a lobular disease who is now two 17 years after she completed her adjuvant 18 chemotherapy, and I have this new information 19 in hand, and that was a case that I discussed 20 generally with Dr. Pritchard and that was the 21 time which her assistant e-mailed me that 22 initial reference to the article, which became 23 a very important piece of information.</p> <p>24 CHAYTOR, Q.C.: 25 Q. About the delay in Tamoxifen?</p>
<p>1 determination as to what treatment they 2 required?</p> <p>3 DR. LAING: 4 A. So what we did in the early days, and I think 5 we mentioned this yesterday, was that we used 6 our own panelling process which was our tumour 7 board and, of course, we had discussions with 8 each other about what to do, and I had had 9 discussions with my colleagues across the 10 country, and this was all happening in May and 11 June So --</p> <p>12 CHAYTOR, Q.C.: 13 Q. I just want to be clear then. So did you put 14 your patients through your tumour board 15 rounds?</p> <p>16 DR. LAING: 17 A. Some of the patients -</p> <p>18 CHAYTOR, Q.C.: 19 Q. Those June 29th patients.</p> <p>20 DR. LAING: 21 A. Some of the patients on the June 29th list 22 would have been presented at tumour board 23 rounds.</p> <p>24 CHAYTOR, Q.C.: 25 Q. Okay.</p>	<p>1 DR. LAING: 2 A. The late start of Tamoxifen.</p> <p>3 CHAYTOR, Q.C.: 4 Q. Delayed start of Tamoxifen.</p> <p>5 DR. LAING: 6 A. That's right.</p> <p>7 CHAYTOR, Q.C.: 8 Q. And did -</p> <p>9 DR. LAING: 10 A. So even, you know, right from the very 11 beginning, this process was happening.</p> <p>12 CHAYTOR, Q.C.: 13 Q. Had Dr. Pritchard ever experienced such a 14 situation herself in her practice?</p> <p>15 DR. LAING: 16 A. Not that she mentioned to me at that time, or 17 subsequently, no.</p> <p>18 CHAYTOR, Q.C.: 19 Q. Okay. Doctor, the people then on the July 20 18th letter, they were subsequently sent to 21 Mount Sinai and panelled. So the earliest 22 time that any of these individuals would have 23 been panelled, I think the first meeting of 24 your panel was October 13th, 2005?</p> <p>25 DR. LAING:</p>

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. So the earliest any of them could have been
 4 told of their results would have been sometime
 5 in mid October?
 6 DR. LAING:
 7 A. Except for, as I alluded to, the patients who
 8 metastatic disease.
 9 CHAYTOR, Q.C.:
 10 Q. That you had told were being retested?
 11 DR. LAING:
 12 A. That myself or one of the other oncologists
 13 was, you know, relying on that information to
 14 make a treatment decision. If a treatment
 15 decision needed to be made in this time
 16 period, then we did do that.
 17 CHAYTOR, Q.C.:
 18 Q. And do you know whether or not these patients
 19 were ever told that, "in fact, you had
 20 originally been tested a few months before
 21 that but for the following reasons, we decided
 22 to wait and have you retested at Mount Sinai"?
 23 DR. LAING:
 24 A. I know that there were patients of mine that I
 25 did have that conversation with, yes.

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1 CHAYTOR, Q.C.:
 2 Q. And do you know whether or not that was done
 3 consistently with all patients?
 4 DR. LAING:
 5 A. No, I can't say that it was done consistently
 6 with all patients, but certainly our approach
 7 was to be very open and honest and disclose
 8 this information to our patients, which is
 9 how, you know, what we do and -
 10 CHAYTOR, Q.C.:
 11 Q. So whether or not in that regard then,
 12 wouldn't there have been instruction given to
 13 make sure that all results are given to the
 14 patient, both the ones that came out of the
 15 Ventana testing, retests back in June, as well
 16 as what subsequently was done at Mount Sinai?
 17 DR. LAING:
 18 A. I would think that that would be what would
 19 have been told to the patients. Certainly I
 20 can recall some instances -
 21 CHAYTOR, Q.C.:
 22 Q. But there was no direction as such given to
 23 make sure that that happened?
 24 DR. LAING:
 25 A. No. This was information that, you know, the

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1 oncologist would know and, you know, as
 2 physicians and as clinicians who would be
 3 involved in the care of patients would be used
 4 to telling the patients.
 5 CHAYTOR, Q.C.:
 6 Q. Doctor, you drafted most of the panel letters
 7 that went out. Do you know whether or not any
 8 of the panel letters, and panel letters that
 9 went out on those patients as well as the next
 10 batch that we'll look at, do you know whether
 11 or not any of the panel letters referenced
 12 anything other than the Mount Sinai testing?
 13 Did they reference the retest that was carried
 14 out on Ventana?
 15 DR. LAING:
 16 A. No. No, the panel letters were evolved during
 17 the first couple of panels and the letters
 18 were in a particular format that indicated the
 19 initial results, that indicated that the
 20 patient was diagnosed with breast cancer. It
 21 didn't go into the stage or nodal status. It
 22 said "the patient is diagnosed with breast
 23 cancer" and we put the date of the original
 24 diagnosis, which was based on what we would
 25 put in our database for the cancer registry,

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1 which is the date of the first biopsy. We
 2 then said that the--listed what their original
 3 report was, with as much information as we
 4 had, whether it was positive, negative or what
 5 that staining was. Following that, we
 6 indicated what the retest results were from
 7 Mount Sinai.
 8 The next paragraph indicated that the
 9 patient was reviewed at the tumour panel, the
 10 date of the panel and what the recommendations
 11 were. There were certainly some instances
 12 where those recommendations were a standard
 13 sentence or paragraph. For example, "panel
 14 has reviewed the patient. We recommend that
 15 this patient be offered Tamoxifen. If
 16 Tamoxifen is contraindicator or not tolerated,
 17 aromatase inhibitors for post-menopausal
 18 patients," and various other things. There
 19 certainly were some patients whose letters
 20 were a little bit more detailed, if they had
 21 had a left breast cancer and a right breast
 22 cancer and those sorts of things. And then,
 23 there was a paragraph indicating a request to
 24 notify the patients.
 25 If the letter was sent to an outside,

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1 somebody other than a medical oncologist or
 2 radiation oncologist, there was a statement
 3 said that the patient could be referred back,
 4 if required.
 5 CHAYTOR, Q.C.:
 6 Q. That's right, and I will take you through a
 7 number of those panel letters in a little
 8 while, and my question being then, Doctor, in
 9 the spirit of openness with your patients, why
 10 not also have included a paragraph for those
 11 58 patients saying that "you were also tested
 12 on our Ventana system on such and such a date,
 13 and here's the result of that retest"?
 14 DR. LAING:
 15 A. Have no idea. We never thought about doing
 16 that at the time. We did -
 17 CHAYTOR, Q.C.:
 18 Q. You do agree that the whole idea would be to
 19 be open and give the patients whatever
 20 information is available?
 21 DR. LAING:
 22 A. When I would disclose this information to the
 23 patients, I would have with me the new
 24 pathology report and if there had have been
 25 retesting done that was recorded on their

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1 chart at that time, it would have been as an
 2 addendum that indicated these test results and
 3 then there would have been an addendum from
 4 Mount Sinai, and we saw that, I think,
 5 yesterday when we looked at some results,
 6 where there was an additional addendum issued
 7 from the pathologist here and then there was
 8 the one that was issued with the Mount Sinai
 9 reports. Whether that happened in all of
 10 those cases, unless I saw those reports, I
 11 wouldn't be able to indicate to you that they
 12 had.
 13 CHAYTOR, Q.C.:
 14 Q. But there were no panel letters that
 15 referenced the retest, those 58 retests on the
 16 Ventana system?
 17 DR. LAING:
 18 A. No.
 19 CHAYTOR, Q.C.:
 20 Q. Even though a number of the patients, in fact,
 21 their testing or sorry, their treatment was,
 22 in fact, changed because of the result of the
 23 Ventana, as opposed to any result from Mount
 24 Sinai?
 25 DR. LAING:

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1 A. Right, and those panel letters often indicated
 2 something like the panel has looked at the
 3 chart, and the patient had been notified by
 4 Dr. Laing, Dr. McCarthy, Dr. Siddiqui, whoever
 5 on such and such a time, and have already had
 6 therapy instituted with Tamoxifen, or
 7 something like that. So we didn't want to
 8 exclude those patients. You know, if we
 9 talked about people at the panel, we still
 10 wanted to generate a letter, even though, if
 11 you will, those patients had already had
 12 disclosure and had already been started on
 13 whatever treatment, that the treating
 14 oncologist or family physician and the patient
 15 decided upon, we still felt that they should
 16 have a panel letter. But, we hadn't -
 17 CHAYTOR, Q.C.:
 18 Q. And I will ask you about the rationale for
 19 that too in a little while. I'm sorry, go
 20 ahead.
 21 DR. LAING:
 22 A. But we hadn't given any thought, and in fact,
 23 until you've just brought it up to me, I
 24 hadn't thought about the fact that maybe the
 25 initial Ventana results had been placed on the

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1 letter. It wasn't anything that we had
 2 considered.
 3 CHAYTOR, Q.C.:
 4 Q. And it wasn't anything that was formally then
 5 -
 6 DR. LAING:
 7 A. No.
 8 CHAYTOR, Q.C.:
 9 Q. - disclosed to the patient. Doctor, on that,
 10 in terms of panelling the people who had
 11 already had their treatment changed -
 12 DR. LAING:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. - and also on the point about what would have
 16 been before you at the tumour--at the panel
 17 review -
 18 DR. LAING:
 19 A. Right.
 20 CHAYTOR, Q.C.:
 21 Q. - you would have had, I take it, the full,
 22 access to the full patient chart?
 23 DR. LAING:
 24 A. Yes, we would have.
 25 CHAYTOR, Q.C.:

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<p>1 Q. And that would include, of course, all the 2 pathology reports? 3 DR. LAING: 4 A. I'll just--can I explain to you maybe just how 5 that whole process worked? Because I think 6 that that might - 7 CHAYTOR, Q.C.: 8 Q. And I'll ask you some questions about how that 9 whole process worked, but right now, I just 10 want to know that you would have had access to 11 all the pathology reports? 12 DR. LAING: 13 A. No. 14 CHAYTOR, Q.C.: 15 Q. You wouldn't? 16 DR. LAING: 17 A. No. 18 CHAYTOR, Q.C.: 19 Q. Okay. 20 DR. LAING: 21 A. What we had, in terms of charting, physical 22 paper chart, was the patient's Cancer Centre 23 chart. 24 CHAYTOR, Q.C.: 25 Q. Yes.</p>	<p>1 CHAYTOR, Q.C.: 2 Q. Okay, and I will ask you later about exactly 3 what you had in making your determination on 4 various patients. And there's a third letter. 5 If we could have, please, P-0535, and this is 6 July 29th, 2005 and this, Doctor, we 7 understand then is the third batch that was 8 done in house, and while this letter is not 9 signed, did you also receive a copy of this 10 letter or were you provided with a list of 11 your patients from this letter? 12 DR. LAING: 13 A. This is a July 29th letter. 14 CHAYTOR, Q.C.: 15 Q. And these are mostly '02s. I'll take you down 16 through. 17 DR. LAING: 18 A. Yeah, I suspect that the patients with the 19 different numbers would have likely been 20 requests that were still coming in, but I 21 can't be sure. 22 CHAYTOR, Q.C.: 23 Q. And we're now getting--actually there's a 24 significant number of other than '02s. From 25 here down appears to be other than '02s.</p>
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<p>1 DR. LAING: 2 A. Okay. In that Cancer Centre chart, we would 3 have most of the patient's pathology. 4 However, we did have the pathologist with us 5 and we did have a computer system set up so 6 that they could, in fact, go in and look at 7 all of the pathology reports that were 8 available on a patient, just in case there was 9 something that wasn't in the Cancer Centre 10 chart. This was placed on a very large 11 screen, you know, like the kind that you'd do 12 a presentation on, so that all patients--all 13 of the people in the room could, you know, 14 look and view this screen, and so that's how 15 we would have the pathology. 16 CHAYTOR, Q.C.: 17 Q. The point being though, any tests, any 18 pathology report that had the Ventana result 19 on it - 20 DR. LAING: 21 A. Oh yes, we would have had it. 22 CHAYTOR, Q.C.: 23 Q. - that would have been there before you? 24 DR. LAING: 25 A. Yes, yeah.</p>	<p>1 DR. LAING: 2 A. Yeah. 3 CHAYTOR, Q.C.: 4 Q. So it's about half probably. So these are a 5 mixture, it appears, and you can control the 6 mouse, if you wish, Doctor, to scroll down, 7 but this third batch then that was done in 8 house, did you--I take it, the same answer, 9 that you did not notify your patients. By 10 this point in time, you were waiting to have 11 them retested at Mount Sinai? 12 DR. LAING: 13 A. Right. So again, it would be the same. The 14 patients that would have been notified were 15 patients whom I needed a treatment to offer to 16 them at that point, so patients with 17 metastatic disease. 18 THE COMMISSIONER: 19 Q. Would these patients have been chosen by the 20 pathology department, by the oncologists, or 21 some combination thereof? 22 DR. LAING: 23 A. A combination thereof, but the majority of 24 them were chosen by the pathology department. 25 THE COMMISSIONER:</p>

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1 Q. Okay.

2 CHAYTOR, Q.C.:

3 Q. Doctor, the patient early on, your patient

4 number two was lobular.

5 DR. LAING:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. And how did she respond when you told her that

9 she had been retested and there was a change

10 and that she could then avail of the

11 treatment? How did she respond to that?

12 DR. LAING:

13 A. She responded in a positive manner. She was

14 appreciative of the fact that she could now

15 have an additional therapy that may add to the

16 benefit, in terms of preventing a breast

17 cancer recurrence for her. She has--she did

18 not have a breast cancer recurrence at that

19 time, and fortunately has not since either.

20 She was a patient who had received

21 chemotherapy and we had some discussions about

22 would that have still been necessary, and we

23 felt that it was, and she, of course, was at

24 that two-year mark. So I was able to provide

25 her with the information that I had received

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1 regarding that article that, you know, I could

2 say to her "look, although this information is

3 late coming, and yes, if I had have known this

4 information, I would have started this therapy

5 two years ago at the completion of your

6 chemotherapy, but now that we know it today, I

7 still believe that there'd be some benefit to

8 you," and she started on therapy at that time,

9 and if my memory is correct, I believe she

10 started for various reasons on an aromatase

11 inhibitor, on Arimidex, at that time, and not

12 Tamoxifen, because that was felt to be the

13 best therapeutic option for her.

14 CHAYTOR, Q.C.:

15 Q. And what reason was she told for her retest?

16 And again, that would have been early on?

17 DR. LAING:

18 A. The lobular histology.

19 CHAYTOR, Q.C.:

20 Q. The fact that she was lobular.

21 DR. LAING:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. And why would she--what explanation would be

25 given around that, in terms of she was always

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1 lobular, so why would she be being retested on

2 that basis? What was she told?

3 DR. LAING:

4 A. She was told about the index case, in such a

5 way that, of course, maintained the

6 confidentiality of Peggy, but to say that

7 there had been a patient with lobular cancer

8 as well that through--I just said that, you

9 know, I didn't go into the great detail, that

10 we had made a decision to retest her and that

11 we had some correspondence from another

12 oncologist who felt that, you know, lobular

13 disease should be, in most instances, positive

14 and that was the reason that we retested it.

15 I explained to her that the--you know, that my

16 understanding when I treated her back in--so

17 this was 2003, was that the majority of

18 patients were lobular, but because she

19 presented with a poorly differentiated tumour,

20 there was nothing at that time that made me

21 question her initial ER/PR. It was in light

22 of this new information from another patient,

23 and that was the reason that I had requested

24 the retesting.

25 CHAYTOR, Q.C.:

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1 Q. Okay. Doctor, why were only breast cancer

2 patients retested and not everyone who would

3 have had an ER/PR test regardless of whether

4 it was breast cancer or any other type of

5 cancer?

6 DR. LAING:

7 A. Because breast cancer patients are the

8 patients in whom we use this for determination

9 of therapy.

10 CHAYTOR, Q.C.:

11 Q. And what other--when else would an ER/PR test

12 be carried out? Is it used on any other types

13 of cancer?

14 DR. LAING:

15 A. It's used in gynecological malignancies

16 sometimes, but I don't--that's not an area of

17 my expertise. I'm not a gynecological

18 oncologist, so I know that they sometimes in

19 uterine cancer use things like megas as

20 treatment, not Tamoxifen for obvious reasons,

21 and sometimes in the determination of cancers

22 of unknown primary, I think we talked very

23 briefly about those yesterday. So these are

24 cancers that, at the time of initial

25 presentation of the patient, they have

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1 evidence of metastatic disease, but it is not
 2 clear on careful history and physical
 3 examination, nor CT scans and other
 4 investigations pointed to because of the
 5 symptoms where the primary cancer originated
 6 from, and that encompasses approximately five
 7 percent of all of the cancers that are seen.
 8 There are certain clusters and types
 9 that--and we alluded to those yesterday, and
 10 one, of course, is a female who presents with
 11 an axillary lymph node, think breast cancer
 12 until you've proven it otherwise, i.e. by your
 13 pathology coming back and suggesting that it
 14 is a lymphoma. If the pathology from an
 15 adenocarcinoma under, you know, in an axillary
 16 node, was present, people would treat that as
 17 breast cancer. We do not use, in that case,
 18 ER/PR testing would be done on that to try and
 19 give you an idea of whether or not it could be
 20 breast. If it was negative, it does not rule
 21 out that being breast cancer, because, of
 22 course, 25 percent are going to be -
 23 CHAYTOR, Q.C.:
 24 Q. It can be a breast cancer that's negative.
 25 DR. LAING:

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1 A. Exactly. So it's something that's not used to
 2 determine -
 3 CHAYTOR, Q.C.:
 4 Q. But if it had been positive, it would rule in
 5 breast cancer?
 6 DR. LAING:
 7 A. That's right. So that's how we think about it
 8 being used, except for in axillary lymph node
 9 recurrence, if it is negative, then we don't
 10 say "oh, it can't be breast cancer because
 11 it's ER/PR negative." We would still accept
 12 that anedocarcinoma like that in the axilla is
 13 there. You know, there are instances where we
 14 have recommended to patients, and certainly in
 15 my practice, this wouldn't be a common
 16 presentation of breast cancer, but certainly
 17 something that we would see. We would
 18 recommend to those patients that they actually
 19 go back and have a breast removed. In some
 20 instances, we do find a primary within the
 21 breast, but in some instances, the primary has
 22 regressed to the point that it is not evident
 23 on careful sectioning on the breast tissue by
 24 the pathologist. Now with MRI, we're hoping
 25 to be able to better, you know, go and find

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1 these areas. So the other instance then would
 2 be an evaluation of patients who present with
 3 unknown primary.
 4 THE COMMISSIONER:
 5 Q. Wait now, let's get back to the original
 6 question which is why only breast cancer
 7 patients were retested. Your answer initially
 8 was because in the case of breast cancers,
 9 it's used for the determination of therapy.
 10 DR. LAING:
 11 A. That's right.
 12 THE COMMISSIONER:
 13 Q. By implication that means that that is the
 14 only area in which it is used for the
 15 determination of therapy.
 16 DR. LAING:
 17 A. That's correct. Primary unknown cancers are
 18 treated with a certain type of chemotherapy
 19 treatment. That's just general to primary
 20 unknowns.
 21 THE COMMISSIONER:
 22 Q. So why would it not be useful to know, even at
 23 a later stage, that a cancer might have been
 24 breast cancer?
 25 DR. LAING:

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1 A. So when you're looking at someone with a
 2 cancer of unknown primary, you want to
 3 determine if you think that it's something
 4 that's curable or treatable. So if it looks
 5 like it's a breast cancer, by virtue of where
 6 the disease is, by virtue of how it presents,
 7 then what you do not want to do is you don't
 8 want to be led away from assuming that that's
 9 a breast cancer by getting a negative ER
 10 result, because not all breast cancer is ER
 11 negative. So that's why it's not recommended
 12 that you hang your hat on that in determining
 13 that that patient should be treated like a
 14 breast cancer patient. Maybe if I gave you an
 15 example, that would be helpful.
 16 THE COMMISSIONER:
 17 Q. Wait now, but then why do you do the test?
 18 DR. LAING:
 19 A. The pathologists do the test in terms of -
 20 THE COMMISSIONER:
 21 Q. Yes, but why? If you're not going to be led
 22 away from it being breast cancer--I recognize,
 23 I suppose, that you have the benefit of having
 24 a particular diagnosis confirmed.
 25 DR. LAING:

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1 A. Right.
 2 THE COMMISSIONER:
 3 Q. But even if it doesn't turn out that way,
 4 you're saying to me you don't assume it's not
 5 breast cancer. So I assume that you treat on
 6 the basis that perhaps it is.
 7 DR. LAING:
 8 A. Yes, you would still, in some instances, treat
 9 those patients based on the fact that it still
 10 may be a breast cancer. So for example, if
 11 you had someone who presented with--you know,
 12 who's a 60 something year old lady, she
 13 presents with metastatic disease to the bone,
 14 then the most common cause of that, even if
 15 you can't find the primary, is going to be
 16 breast cancer. So you think, okay, this is a
 17 primary unknown, but this looks like it's a
 18 breast cancer. The next thing that you may do
 19 is try and get out a specimen or something for
 20 biopsy and that biopsy may be taken from the
 21 bone. We know from our pathologists that
 22 doing ER/PR testing on bone is unreliable, so
 23 you know, even if they do it and it was
 24 negative, you're not going to take that piece
 25 of information and say okay, this is not a

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1 breast cancer. You're still going to decide
 2 to treat that patient as if they were a breast
 3 cancer, but you're not going to use hormonal
 4 therapy.
 5 If, for example, somebody presents with--
 6 I'll give you an example of a patient I saw a
 7 number of years ago who presented with pleural
 8 fluid, some metastases around the lung, some
 9 bony metastases. She herself had not had a
 10 history of breast cancer, but there was a
 11 family history, and so when a pleural biopsy
 12 was taken, this came back as being ER
 13 positive, so we thought, you know, this
 14 clinical situation fits and, as you said
 15 earlier, it rules in the diagnosis, but a
 16 negative one does not rule out the diagnosis.
 17 So it has to be used very carefully in that
 18 instance.
 19 When a pathologist has a piece of--and
 20 I'm sure they can speak to this better than
 21 me, but if they have a lymph node biopsy or a
 22 biopsy from a lung surface or something and
 23 they're trying to determine what this is, the
 24 very first thing they'll tell us is does this
 25 look like an adenocarcinoma or not. Sometimes

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1 these are very poorly differentiated tumours
 2 and you have no idea about what they might be,
 3 and they run a whole series of panels and
 4 immunohistochemical markers on those to try
 5 and help determine it, and they will put all
 6 that information together and sometimes we get
 7 back a report that says this is a poorly
 8 differentiated carcinoma, so you have no idea
 9 what this is. Sometimes they say it's a
 10 poorly differentiated adenocarcinoma, and by
 11 virtue of the panel, not just ER/PR, but all
 12 the things that they've looked at, they may
 13 say favour primary from stomach, breast,
 14 colon, and clinical correlation is advised,
 15 and then the clinical correlation would be
 16 well, what does this pattern of metastatic
 17 disease look like? Is this someone who has GI
 18 symptoms that lo and behold that ends up
 19 looking like a bowel cancer.
 20 However, these are the special instances
 21 and for the most part, in cancers of primary
 22 unknown, we never have any idea of what--where
 23 these cancers started and the teaching and the
 24 caution has always been not to over interpret
 25 the information that you receive, and in that

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1 instance, if we don't favour one of these over
 2 the other, then we treat them with protocols
 3 that have been shown to be effective in this
 4 disease, albeit not curable.
 5 THE COMMISSIONER:
 6 Q. Forgive me, Dr. Laing, but I'm not following.
 7 DR. LAING:
 8 A. Okay.
 9 THE COMMISSIONER:
 10 Q. If you have the usage of the ER/PR test for
 11 the purpose of, as I understand it, not ruling
 12 out that its primary source is breast cancer,
 13 but confirming it is, presumably if you
 14 confirm that the primary source is breast
 15 cancer, you follow a course of treatment.
 16 DR. LAING:
 17 A. That's correct.
 18 THE COMMISSIONER:
 19 Q. Would that be any different if you were
 20 confirmed that it was a primary source of
 21 breast cancer than if you were not confirmed?
 22 DR. LAING:
 23 A. Would the treatment that you would--no. If
 24 you decide that somebody has a clinical
 25 presentation that looks like breast cancer,

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<p>1 then you're going to treat that person like 2 breast cancer. 3 THE COMMISSIONER: 4 Q. Yes. 5 DR. LAING: 6 A. Yeah. 7 THE COMMISSIONER: 8 Q. Okay. But if you have a positive response? 9 DR. LAING: 10 A. A positive estrogen/progesterone receptor 11 test? 12 THE COMMISSIONER: 13 Q. Yes. 14 DR. LAING: 15 A. Okay, yeah. 16 THE COMMISSIONER: 17 Q. Then you're definitely going to treat it in a 18 particular way? 19 DR. LAING: 20 A. You're still definitely going to treat it as 21 breast cancer. 22 THE COMMISSIONER: 23 Q. Um-hm. 24 DR. LAING: 25 A. And depending on where the disease is and all</p>	<p>1 DR. LAING: 2 A. It would depend on where the biopsy was taken 3 from. 4 CHAYTOR, Q.C.: 5 Q. But there would be a number of those patients 6 who had tests done that if it came back ER 7 negative and that were to be a false negative 8 may not have received the hormonal treatment 9 they otherwise would have gotten had the test 10 come back positive? 11 DR. LAING: 12 A. In the subset of patients who presented as 13 carcinoma of unknown primaries that we made a 14 decision to treat as breast cancer, and that 15 would be an extremely small number of those 16 patients. 17 CHAYTOR, Q.C.: 18 Q. But even if there were one patient, Doctor - 19 DR. LAING: 20 A. Yeah. So then that would be - 21 CHAYTOR, Q.C.: 22 Q. - have those patients' charts been reviewed? 23 DR. LAING: 24 A. No. 25 CHAYTOR, Q.C.:</p>
<p>Page 126</p> <p>1 that, you'll decide whether or not you'll use 2 a hormone. If, however, your clinical 3 suspicion because of the presentation is that 4 it's breast cancer, the pathologist gives you 5 a report that says that they did ER/PR but it 6 came back negative, then that doesn't say to 7 you this is not a breast cancer, because 25 8 percent of breast cancers are going to be 9 negative. 10 THE COMMISSIONER: 11 Q. But when you're doing your decisions regarding 12 treatment? 13 DR. LAING: 14 A. It will play a role. So then they just come 15 to where we - 16 CHAYTOR, Q.C.: 17 Q. That person would not get the hormonal 18 therapy? 19 DR. LAING: 20 A. Hormonal therapy, that's right. 21 CHAYTOR, Q.C.: 22 Q. So your bone cancer patient that you spoke 23 about, for example, if that person had come 24 back ER negative, that person would not have 25 received the hormonal treatment?</p>	<p>Page 128</p> <p>1 Q. Is there any plan or intention to review their 2 charts to see if there's anyone else who could 3 potentially benefit from a retest? 4 DR. LAING: 5 A. In the case of primary unknown cancers, the 6 prognosis of these patients is extremely poor 7 and they live on average six months. So I'm 8 not certain that there would be any patients 9 who would be there for us to go and to do this 10 sort of a review. 11 CHAYTOR, Q.C.: 12 Q. Doctor, I understand the deceased have all 13 been retested as well. 14 DR. LAING: 15 A. The deceased that were breast cancer patients. 16 CHAYTOR, Q.C.: 17 Q. Breast cancer negative. 18 DR. LAING: 19 A. Yes. 20 CHAYTOR, Q.C.: 21 Q. So why would--even whether they're living or 22 deceased, if they're living, good, you know, 23 because perhaps there is a potential treatment 24 for them. 25 DR. LAING:</p>

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<p>1 A. Yeah.</p> <p>2 CHAYTOR, Q.C.:</p> <p>3 Q. But if they're deceased, wouldn't it be</p> <p>4 consistent to have everyone retested?</p> <p>5 DR. LAING:</p> <p>6 A. I would think that if I was going to think</p> <p>7 about that group of people that I would</p> <p>8 retest, I would think about it, okay, let's</p> <p>9 start with the patients of unknown primary, so</p> <p>10 five percent of the malignancies. Let's then</p> <p>11 look at those patients in whom something about</p> <p>12 their clinical presentation made us go down</p> <p>13 the road that we think that this is breast</p> <p>14 cancer, an extremely small number of those</p> <p>15 people. And then let's look and see how the</p> <p>16 ER/PR played out. So I think it would be a</p> <p>17 very small number of patients. We did have</p> <p>18 some discussions about this issue probably</p> <p>19 maybe about a year or so ago, I'm trying to</p> <p>20 remember exactly when it was, and, you know,</p> <p>21 all of us put our heads together and really</p> <p>22 couldn't think that this would, you know, that</p> <p>23 this would be something that we should go back</p> <p>24 and look at.</p> <p>25 CHAYTOR, Q.C.:</p>	<p>1 part of those discussion, but--because if my</p> <p>2 memory is correct, it was maybe even as far</p> <p>3 into the 2007 discussions around this issue</p> <p>4 that we talked about the primary unknowns.</p> <p>5 I'm not sure if you actually have--because I</p> <p>6 know that this perhaps was looked at one time</p> <p>7 in the lab, the number of tests that were run</p> <p>8 on tissues other than--was that something that</p> <p>9 the lab had looked at, how many times they had</p> <p>10 done the ER/PR test on tissue that was from</p> <p>11 patients being considered for primary</p> <p>12 unknowns? I don't know how often that would</p> <p>13 have been, would have been done.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. Doctor, was a year ago the first time that</p> <p>16 discussion was had as to doing any other tests</p> <p>17 other than the test or retest on anyone other</p> <p>18 than primary breast?</p> <p>19 DR. LAING:</p> <p>20 A. From what I can recall, yeah.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. That's the first time that discussion was had?</p> <p>23 DR. LAING:</p> <p>24 A. Yeah.</p> <p>25 CHAYTOR, Q.C.:</p>
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<p>1 Q. So who had those discussions? I take it</p> <p>2 that's come up since the -</p> <p>3 DR. LAING:</p> <p>4 A. Oh, yes, yes.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. - Inquiry process started happening?</p> <p>7 DR. LAING:</p> <p>8 A. So there were medical oncologists and</p> <p>9 pathologists that would have weighed into that</p> <p>10 discussion and other people at Eastern Health.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. And who ultimately made the decision not to go</p> <p>13 back and review?</p> <p>14 DR. LAING:</p> <p>15 A. I would think that it was a decision that was</p> <p>16 made by a consensus of those involved.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. And who might those people be besides</p> <p>19 yourself?</p> <p>20 DR. LAING:</p> <p>21 A. If I remember correctly, there would have been</p> <p>22 other people from Eastern Health there,</p> <p>23 perhaps, don't know if it was--I think it was</p> <p>24 sort of further on into the days that Dr.</p> <p>25 Howell was there, Mrs. Pilgrim may have been</p>	<p>1 Q. Doctor, in saying the other use of the ER/PR</p> <p>2 test, you also mentioned gynaecological</p> <p>3 cancer. And I realize and I hear what you're</p> <p>4 saying, you're not an expert in that type of</p> <p>5 cancer. But do you understand that the test</p> <p>6 for those patients would--could potentially</p> <p>7 also have ramifications in terms of treatment?</p> <p>8 DR. LAING:</p> <p>9 A. I'm not certain, I'm not certain that they</p> <p>10 utilize that test to determine how they treat</p> <p>11 patients.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. Okay. So you don't know the purpose for ER or</p> <p>14 hormonal receptor testing in gynaecological</p> <p>15 cancer patients?</p> <p>16 DR. LAING:</p> <p>17 A. No.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. Okay. And do you know whether or not any</p> <p>20 inquiries have been made to determine the</p> <p>21 answer to that question, whether or not those</p> <p>22 patients should be retested?</p> <p>23 DR. LAING:</p> <p>24 A. I don't know that.</p> <p>25 CHAYTOR, Q.C.:</p>

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<p>1 Q. Okay.</p> <p>2 THE COMMISSIONER:</p> <p>3 Q. Ms. Chaytor, wherever you can find a spot,</p> <p>4 we'll take the morning break.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Actually, this is a good place, please,</p> <p>7 Commissioner.</p> <p>8 THE COMMISSIONER:</p> <p>9 Q. All right, then, we'll take 15 minutes.</p> <p>10 (RECESS)</p> <p>11 THE COMMISSIONER:</p> <p>12 Q. Please be seated. Ms. Chaytor.</p> <p>13 CHAYTOR, Q.C.:</p> <p>14 Q. Thank you, Commissioner. Dr. Laing, just one</p> <p>15 other point on that last line of questioning</p> <p>16 about the other ER negative tests that were</p> <p>17 not repeated. If part of the purpose of the</p> <p>18 review was not only to identify people who</p> <p>19 could benefit from treatment, but to also have</p> <p>20 a full picture of what happened or what was</p> <p>21 happening, as you said, in the process all the</p> <p>22 way back to 1997, wouldn't it be important to</p> <p>23 have tested all ER negative patients?</p> <p>24 DR. LAING:</p> <p>25 A. I hadn't really given that any thought in</p>	<p>1 Q. It would be necessary to retest everyone, that</p> <p>2 was never discussed?</p> <p>3 DR. LAING:</p> <p>4 A. Not outside the context of breast cancer, no.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. If I could have, please, C-0056? Doctor, this</p> <p>7 is pathology report of one of your patients</p> <p>8 who have testified here, Daphne Coffin.</p> <p>9 DR. LAING:</p> <p>10 A. Yes.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. And we briefly mentioned her case yesterday.</p> <p>13 DR. LAING:</p> <p>14 A. Yes.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. And you'll see that the addendum number three-</p> <p>17 -sorry, just lost my place. Addendum number</p> <p>18 one is what I wanted to bring you to, sorry.</p> <p>19 DR. LAING:</p> <p>20 A. Yes.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. And it's September 20th, 2001. And it showed</p> <p>23 immunoperoxidase staining for estrogen and</p> <p>24 progesterone receptors, estrogen receptors 23</p> <p>25 percent positivity, progesterone receptors</p>
<p>Page 134</p> <p>1 terms of looking at it as, you know, overall.</p> <p>2 You know, I think that when we had the</p> <p>3 specific discussions and the only discussions</p> <p>4 that I were part of was the primary unknown</p> <p>5 patients, because it was such an uncommon</p> <p>6 thing and because we didn't use it to</p> <p>7 determine therapy except for in extremely rare</p> <p>8 cases in patients who determined to decide to</p> <p>9 treat as if they were breast cancer, then it</p> <p>10 wasn't something that we thought of in the</p> <p>11 overall picture. Our thinking and our</p> <p>12 knowledge and our reason to sort of include</p> <p>13 everybody was thinking about this test as it</p> <p>14 pertained to breast cancer.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Okay. So that issue was never discussed with</p> <p>17 the group in terms of -</p> <p>18 DR. LAING:</p> <p>19 A. The overall, yes -</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. - get a full picture, full picture and the</p> <p>22 extent of the issue?</p> <p>23 DR. LAING:</p> <p>24 A. Yeah.</p> <p>25 CHAYTOR, Q.C.:</p>	<p>Page 136</p> <p>1 negative, and in brackets, (no controls). And</p> <p>2 this issue, Doctor, when you would have</p> <p>3 reviewed the pathology report, the fact that</p> <p>4 it's indicated that there were no controls,</p> <p>5 would that have had any significance to you?</p> <p>6 DR. LAING:</p> <p>7 A. No.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. Okay. And then, of course, there's the</p> <p>10 addendum from Mount Sinai which is entered on</p> <p>11 her chart on March 21st, 2006. And the</p> <p>12 consultation from Mount Sinai found her to be</p> <p>13 estrogen receptor protein is seen in 95</p> <p>14 percent of cells.</p> <p>15 DR. LAING:</p> <p>16 A. Yes.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. And the progesterone receptor was seen in less</p> <p>19 than one percent. If we could have, please,</p> <p>20 C-0067? I'm sorry, 0067. And, Doctor, March</p> <p>21 14th, 2006 you see Ms. Coffin in clinic?</p> <p>22 DR. LAING:</p> <p>23 A. Yes.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. And you've written, "Her initial ER testing</p>

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<p>1 came back as 23 percent, that was in 2001. At 2 that time we considered that to be weakly 3 positive." 4 DR. LAING: 5 A. Yes. 6 CHAYTOR, Q.C.: 7 Q. "I did discuss Tamoxifen with her at that time 8 but we decided not to give it to her. I had 9 thought that she would be retested as her 10 staining was less than 30 percent, but this 11 has not been done. I have requested it today. 12 We have discussed what to do at this point and 13 agreed that if it was higher, that we would 14 certainly consider her for an" aromatase, I 15 take it, "inhibitor at this point." 16 DR. LAING: 17 A. That's right, yeah. 18 CHAYTOR, Q.C.: 19 Q. "I will wait and see what the retesting 20 shows." So, Doctor, in September of 2001 she 21 was 23 percent? 22 DR. LAING: 23 A. Yes. 24 CHAYTOR, Q.C.: 25 Q. Okay. And at that time you would have</p>	<p>1 was reported as being 23 percent for ER. I 2 then looked in the Meditech system and noticed 3 that she had not had any retesting done, and I 4 brought up the issue with her at that visit. 5 This is a lady that when I initially saw her 6 in 2001, so I would have seen her after 7 October, 2001 when I returned from my 8 maternity leave, and she had a two centimetre 9 tumour that was moderately differentiated and 10 because of the size of the tumour and her age 11 at the time I offered her adjuvant 12 chemotherapy, which she completed. And then 13 upon completion of her chemotherapy I did have 14 a discussion with her about the potential 15 risks and benefits of Tamoxifen therapy. As I 16 indicated yesterday in my review, certainly 17 one of the features that we use to determine 18 whether or not to offer hormonal therapy is 19 whether or not this patient is positive, and 20 this lady was positive. I did indicate it to 21 her at the time that there was a recent change 22 in thinking but that 23 percent was something 23 that we would consider positive. But because 24 of her concerns about potential side effects 25 of Tamoxifen, because of her family history,</p>
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<p>1 considered that weakly positive? 2 DR. LAING: 3 A. Yes. 4 CHAYTOR, Q.C.: 5 Q. And while you had a discussion with her about 6 Tamoxifen, it says at that time you decided 7 not to give it to her? 8 DR. LAING: 9 A. Yes, that's correct. 10 CHAYTOR, Q.C.: 11 Q. You also say that you had thought that she 12 would be retested as her staining was less 13 than 30 percent, but this has not been done. 14 What do you recall about this? Ms. Coffin 15 appears before you on March 14th, 2006. What 16 do you recall and how did it come to your 17 attention that her retesting had not been 18 done? 19 DR. LAING: 20 A. So when I saw her that day in the clinic, I 21 would have read--you know, picked up the chart 22 and looked at it before I went in and I 23 noticed that my comment had said that she was 24 weakly positive. I then reviewed the 25 pathology report that we just looked at and it</p>	<p>1 which included a lot of patients who had had 2 blood clots, through a balance discussion at 3 that time of the risks and benefits it was 4 decided that she would not take adjuvant 5 Tamoxifen therapy. When I realized that she 6 hadn't been part of the review, so she was 7 diagnosed, of course, in 2001, the decision 8 for retesting changed as of January 1st, 2001 9 and we discussed that yesterday, I said to 10 her, you know, look, we didn't give you 11 Tamoxifen back then in 2001, we didn't have 12 another option at that time, subsequently we 13 know that the aromatase inhibitors are 14 available in the clinic and can be effective 15 medications. And I remember discussing this 16 with her and saying, you know, we certainly 17 can ask for your retesting to be done at this 18 point. She at that time still wasn't 19 interested in Tamoxifen as a therapy but 20 because she knew that there was an aromatase 21 inhibitor as an option, agreed to having the 22 retesting done. And we had a discussion that 23 if it came back as being, you know, 24 significantly positive, we didn't sort of have 25 an absolute cutoff in our minds, but at this</p>

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1 time I was recalling many of the patients I
 2 had seen as part of the panel who had results
 3 that were negative or, you know, one to two
 4 percent who came back in the very high
 5 positive rate, that she would have a further
 6 discussion at that time regarding an aromatase
 7 inhibitor. So, I filled out the consult and
 8 asked for her ER/PR to be retested, and so
 9 that was done.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. And if we could go back to 0062,
 12 please, C-0062? And, Doctor, this is the
 13 discussion, I believe, you would have had with
 14 her January 28th, 2002, or the day you would
 15 have discussed the issue of Tamoxifen with
 16 her?
 17 DR. LAING:
 18 A. Yeah.
 19 CHAYTOR, Q.C.:
 20 Q. And I had--you indicate here, "Her initial
 21 tumour was only 23 percent positive for
 22 estrogen. In some labs this is considered to
 23 be negative if it is less than 30 percent
 24 staining."
 25 DR. LAING:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. "I would consider this to be a borderline
 4 result."
 5 DR. LAING:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. So, Doctor, at this point in time in 2002,
 9 January 28th, 2002, what cutoff was being used
 10 by you and the oncologists at then the Cancer
 11 Centre for positivity?
 12 DR. LAING:
 13 A. So this would have been following the meeting
 14 in 2000 and then so into 2001, we certainly--
 15 you know, our thinking had changed and we were
 16 using ten percent in a lot of cases. I refer
 17 to the 30 percent because, you know, when I
 18 had discussions at that point with this
 19 patient, we certainly, you know, I said to her
 20 this is something that's relatively new, this
 21 new threshold, that there was a time when 30
 22 percent was the cutoff, and that certainly was
 23 something that we had recently in this
 24 hospital had used, but that now, you know, I
 25 would consider her to be weakly positive or,

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1 you know, this was now greater than ten
 2 percent and that, you know, we again, as you
 3 can see from the next paragraph, had a
 4 discussion about the risks and benefits. And
 5 she had looked into this issue and had thought
 6 about it. And I think, you know, at the end
 7 of the day this was a decision that as most of
 8 the decisions that we make, we felt that the
 9 additive benefit to her on top of the fact
 10 that she had already had chemotherapy, and
 11 we've looked at this, you know, in terms of
 12 the kind of benefit we see on adjuvant on line
 13 would certainly be a few percent over that, as
 14 she had node negative disease. And you know,
 15 through a balanced discussion decided not to
 16 take the Tamoxifen.
 17 CHAYTOR, Q.C.:
 18 Q. Yes, okay. The idea that some labs, this is
 19 considered to be negative if it is less than
 20 30 percent staining, as of the end of January,
 21 2002 what labs were you aware of that were
 22 still using 30 percent?
 23 DR. LAING:
 24 A. In dictating this I would have been thinking
 25 about the past practice in our lab, but not--

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1 because I don't say in our lab or currently or
 2 anything like that. You know, we had had
 3 quite a long discussion about, you know, this
 4 23 percent and what it meant. And, you know,
 5 she had been aware of, you know, the fact
 6 that, you know, the side effects of the
 7 Tamoxifen and, you know, and really asking a
 8 lot of questions about, well, what real
 9 benefit do you think it is going to be to me.
 10 And so, you know, this was one of those
 11 instances where we did look at the percent
 12 staining, we did look at the therapy that she
 13 had already received and, you know, we made a
 14 decision at that time.
 15 CHAYTOR, Q.C.:
 16 Q. Doctor, did you tell Ms. Coffin that, in fact,
 17 your institution had moved to a ten percent
 18 cutoff by this point in time?
 19 DR. LAING:
 20 A. I suspect that I probably did during the
 21 discussions with her, although it's not, it's
 22 not recorded here in the note. Because I do
 23 remember, in fact, when this--when I was asked
 24 about this situation after she was one of the
 25 patients who testified at the beginning of the

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1 Commission, I did recall, I said, oh, yes, I
 2 remember that lady. She was one who came and
 3 it was, you know, during the time when we
 4 started to use ten percent and her level was
 5 not very high and that really at the end of
 6 the day the decision not to give her chemo--
 7 sorry, the decision not to give her Tamoxifen
 8 did not hinge on what that number was or what
 9 the cutoff was, the decision hinged in the
 10 risk/benefit ratio for this patient.
 11 CHAYTOR, Q.C.:
 12 Q. If we could go back, please, to 0067, C-0067?
 13 And on March 14th, 2006 most of what was
 14 intended to be retested at Mount Sinai up to
 15 this point in time had already been back and
 16 panelled by March 14th, 2006, Doctor. So she
 17 was, Ms. Coffin was missed in the original
 18 identification of patients for retesting?
 19 DR. LAING:
 20 A. She was not included in that because the
 21 decision to not give her hormonal therapy
 22 wasn't based on the fact that I thought her ER
 23 was negative, it was based on the fact that
 24 through a discussion regarding the risks and
 25 benefits that we decided that it wasn't a good

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1 treatment option for her.
 2 CHAYTOR, Q.C.:
 3 Q. So her chart was reviewed and a decision was
 4 made not to send her to Mount Sinai for
 5 retesting?
 6 DR. LAING:
 7 A. No, no. I'm saying that the decision that I
 8 made in 2002 not to offer her Tamoxifen wasn't
 9 because she had an ER/PR test result that came
 10 back as negative.
 11 CHAYTOR, Q.C.:
 12 Q. We understand that the criteria that was used
 13 for identifying patients for retesting would
 14 have been those who had, as of January 1st,
 15 2001 -
 16 DR. LAING:
 17 A. Yeah.
 18 CHAYTOR, Q.C.:
 19 Q. - the criteria changed. And you were aware of
 20 that at the time, that then it would be anyone
 21 ten percent or under?
 22 DR. LAING:
 23 A. Or less.
 24 CHAYTOR, Q.C.:
 25 Q. Or less?

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1 DR. LAING:
 2 A. That's right.
 3 CHAYTOR, Q.C.:
 4 Q. Right.
 5 DR. LAING:
 6 A. Yeah, so when I saw her and I was thinking
 7 about it, I was thinking about the 30 percent
 8 cutoff, I wasn't thinking about the time
 9 period when her pathology had come through.
 10 She was halfway through 2001. And I had
 11 indicated there that I thought she'd be
 12 retested as she was less than 30 percent.
 13 But, in fact, you know, when I went back and
 14 looked at it again, I said, well, she was in
 15 2001. It's just when I had looked at her,
 16 what had triggered me -
 17 CHAYTOR, Q.C.:
 18 Q. She was 2002.
 19 DR. LAING:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. January 28th, 2002.
 23 DR. LAING:
 24 A. No, her pathology, her pathology was from
 25 September, 2001.

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1 CHAYTOR, Q.C.:
 2 Q. Yes.
 3 DR. LAING:
 4 A. So she was actually a 2001.
 5 CHAYTOR, Q.C.:
 6 Q. Yes, that's right, you're right.
 7 DR. LAING:
 8 A. So, no, I guess what I -
 9 CHAYTOR, Q.C.:
 10 Q. September, sorry, it was September 20th 2001
 11 was her pathology.
 12 DR. LAING:
 13 A. Right. So when I decided to look at this, it
 14 was because of the word that I had placed in
 15 the diagnosis, which was that she was weakly
 16 positive. And then when I looked--and then
 17 when I had this discussion with her in March
 18 of 2006, it was centred around the fact that,
 19 you know, now that we have aromatase
 20 inhibitors and knowing that there had been
 21 some patients who had been positive or who had
 22 been, you know, how had been, for example,
 23 patients who had tested maybe ten or 20
 24 percent even in the years of 1997, '98, '99
 25 who had changed at Mount Sinai to coming back

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<p>1 very strongly positive, I recall saying to Ms. 2 Coffin, you know, if we retested you and you 3 came back as being, you know, 95 percent 4 positive for both or very high positivity for 5 both, would you then be interested in a 6 treatment. If at this time she had said to 7 me, look, I'm not interested, I never wanted 8 to take hormonal therapy, even if you retested 9 me and I came back as 100 and 100, it's not 10 going to change what I think, I probably 11 wouldn't have retested her. The decision to 12 retest her was based on the fact that we had 13 another treatment option. I did not wish to 14 give her Tamoxifen in 2002 and that was, as I 15 explained, because of all the things that we 16 looked at. And I certainly, you know, still 17 with that history and her concerns over this 18 medication our decision wasn't that we were 19 going to retest her and that we were going to 20 give her Tamoxifen, our decision was that we 21 were going to retest her because of my 22 experience in people's percentage positivity 23 changing significantly and also that we had a 24 different treatment option to offer her. 25 CHAYTOR, Q.C.:</p>	<p>1 point in time, perhaps other oncologists were 2 doing the same thing for the same sorts of 3 reasons that you have identified? 4 DR. LAING: 5 A. This is the discussion that we had when the 6 decision was made to go back and look at 7 those, the discussion that I alluded to 8 yesterday in the conference call with Dr. 9 Trudeau. 10 CHAYTOR, Q.C.: 11 Q. Yes. 12 DR. LAING: 13 A. Yeah. And this - 14 CHAYTOR, Q.C.: 15 Q. Which happened recently, just - 16 DR. LAING: 17 A. Right. And this came after this issue. Now, 18 as I said yesterday, this was something that, 19 you know, I picked up on when I saw Daphne 20 Coffin in the clinic. I alluded yesterday 21 that, you know, when I went back through and 22 would see people in the clinic during this 23 whole period of time we would look and see 24 what their ER was and to make sure that there 25 were instances where something like this might</p>
<p>Page 150</p> <p>1 Q. So, Doctor, then why would you write, "I had 2 thought that she would be retested as her 3 staining was less than 30 percent, but this 4 has not been done."? 5 DR. LAING: 6 A. Because in my mind I was thinking about 30 7 percent is being the cutoff. 8 CHAYTOR, Q.C.: 9 Q. Okay. But you knew that they had used the 10 cutoff of ten percent as of January 1, 2001. 11 And she's not--her test is well into - 12 DR. LAING: 13 A. Yeah, just it's not something that - 14 CHAYTOR, Q.C.: 15 Q. - September of 2001? 16 DR. LAING: 17 A. - that registered at the time I guess is what 18 I'm trying to say. It's not something that I 19 thought about when I said, you know, that--I 20 wasn't thinking about when the change was 21 between 2001 and the test before. 22 CHAYTOR, Q.C.: 23 Q. So, Doctor, if you had a patient into 2001 who 24 had tested less than 30 percent and a decision 25 had been made not to offer Tamoxifen at that</p>	<p>Page 152</p> <p>1 have happened. This is the only patient in my 2 practice. I haven't had--you know, we've had 3 this discussion with my colleagues. Nobody 4 else has identified through looking at their 5 charts and being very cognisant of this any 6 other such instances. But we felt that if 7 there were situations in which potentially, 8 you know, aromatase inhibitors could be 9 offered to people and whether or not the 10 percent staining made a difference to people, 11 then this would be the--through putting 12 patients in this database and then looking at 13 the charts to see if we could identify other 14 patients in this similar situation. 15 CHAYTOR, Q.C.: 16 Q. And, Doctor, that review that you're referring 17 to and the discussion with Dr. Trudeau has 18 just taken place in the past couple of months, 19 you've told us? 20 DR. LAING: 21 A. Yes, it was in April of 2008. 22 CHAYTOR, Q.C.: 23 Q. Yes, 2008? 24 DR. LAING: 25 A. Yeah.</p>

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1 CHAYTOR, Q.C.:

2 Q. In March of 2006 did you contact Dr. Cook or

3 anyone else to alert them to this issue that

4 possibly if Ms. Coffin was missed in the

5 initial identification of patients, that there

6 may be others?

7 DR. LAING:

8 A. No, I did not.

9 CHAYTOR, Q.C.:

10 Q. And why not?

11 DR. LAING:

12 A. Because I didn't consider this to be someone

13 who was missed in the original identification.

14 I consider her case to be a patient who was

15 not offered Tamoxifen at the time because we

16 felt that the risks and benefits were such

17 that she wasn't a good candidate for it. And

18 the reason for suggesting the retest was that

19 after my discussions with her, the patient,

20 Daphne Coffin, was that knowing that how some

21 of the tests had changed and became very

22 strongly positive, would she now consider an

23 aromatase inhibitor.

24 CHAYTOR, Q.C.:

25 Q. So, Doctor, why then were you checking charts

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1 after this was brought to your attention, why

2 were you checking charts, why did you alert

3 the other oncologists to it if you weren't

4 concerned there might be others that were

5 missed?

6 DR. LAING:

7 A. I don't know what you mean by checking charts.

8 This was someone who came to see me on the

9 clinic -

10 CHAYTOR, Q.C.:

11 Q. You said after this was brought to your

12 attention, after you'd seen her in the clinic

13 -

14 DR. LAING:

15 A. Oh, no, I think what -

16 CHAYTOR, Q.C.:

17 Q. - then when people would come -

18 DR. LAING:

19 A. Sure, okay.

20 CHAYTOR, Q.C.:

21 Q. - before you, you would check the chart and

22 that there was an informal discussion amongst

23 your colleagues and then they would do the

24 same.

25 DR. LAING:

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1 A. Oh, this was something that was going on. You

2 know, right from this whole process we would

3 all--you know, when patients were coming to

4 see us in the clinic, we would look at the

5 charts, see what had gone on in terms of their

6 ER/PR initially and were there other people

7 that perhaps hadn't been retested. So this

8 was something that was forefront in our minds

9 as, you know, as time went on to look at

10 people who were said to be ER/PR negative.

11 And, in fact--or weakly positive or some sort

12 of signal. In fact, subsequent to this whole

13 process we've tried to indicate in the charts

14 people that are negative who have been

15 confirmed negative. So if I have a patient

16 who's ER/PR negative, I would now dictate that

17 as confirmed negative so that when I'm seeing

18 patients in the clinic through this process on

19 through 2005, 2006, I mean, even today, would

20 always look and make sure that, you know, this

21 isn't someone who hadn't been missed by the

22 retesting -

23 THE COMMISSIONER:

24 Q. Dr. Laing, I'm sorry, I'm not following again.

25 It seems to me that as I have understood it up

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1 to this point, there was a procedure

2 established largely in consultation between

3 the oncologists and the pathologists about how

4 the review would be done?

5 DR. LAING:

6 A. Yes.

7 THE COMMISSIONER:

8 Q. And that in that process a determination was

9 made that people--that a particular cutoff

10 would be used, depending on the years, because

11 the facts were that as oncologists you would

12 be using a different percentage as a cutoff

13 over the course of the period of time which

14 you would be studying?

15 DR. LAING:

16 A. Yes.

17 THE COMMISSIONER:

18 Q. So a decision was made that the figure for the

19 cutoff will be 30 percent. Anyone below that

20 is considered negative up to a particular

21 point, beyond that it's people who are less

22 than ten percent would be considered negative?

23 DR. LAING:

24 A. Um-hm, yes.

25 THE COMMISSIONER:

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1 Q. I understood that with that guideline in mind
2 those who were in the lab went through the
3 laboratory records, pulled the appropriate
4 files?
5 DR. LAING:
6 A. Yes.
7 THE COMMISSIONER:
8 Q. They would know nothing about what was on the
9 chart except to the extent that the lab
10 records are reflected on the chart, ie, what
11 the result was?
12 DR. LAING:
13 A. Yes.
14 THE COMMISSIONER:
15 Q. So in that process nobody in the lab was
16 saying, well, look at that, but, ahh, gee,
17 that particular person refused Tamoxifen, in
18 any event, so we won't bother sending it?
19 DR. LAING:
20 A. No, they would not know any of that
21 information.
22 THE COMMISSIONER:
23 Q. Okay, so now in the case of Ms. Coffin given
24 the time frame in which her test was done in
25 your view given the particular guidelines,

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1 should the lab have pulled her slides or not?
2 DR. LAING:
3 A. No, they shouldn't have. She would have
4 fallen in--she was 23 percent in 2001, so the
5 lab personnel looking at her would have been
6 thinking the ten percent and would not have
7 pulled her.
8 THE COMMISSIONER:
9 Q. All right. So she came out of the--she was
10 not retested.
11 DR. LAING:
12 A. Right.
13 THE COMMISSIONER:
14 Q. In your view, consistent with the grand plan
15 that had been developed?
16 DR. LAING:
17 A. That's right.
18 THE COMMISSIONER:
19 Q. You pulled her out for another reason and
20 asked that she be retested?
21 DR. LAING:
22 A. Yes, that's right, yeah.
23 THE COMMISSIONER:
24 Q. Why did you--did you pull her out for a reason
25 related to her treatment?

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1 DR. LAING:
2 A. I pulled her out because when I had seen her
3 that day and then when I had gone back and
4 looked at our initial discussions and our
5 decisions, and I discussed that with her, we
6 felt that knowing what I knew about the
7 results that I had received, that she may be a
8 candidate for an aromatase inhibitor and she
9 would be agreeable to consider that if her
10 test came back in a stronger positivity than
11 it was in -
12 THE COMMISSIONER:
13 Q. So did you and Ms. Coffin have the discussion
14 about I now have another alternative which is
15 not Tamoxifen -
16 DR. LAING:
17 A. Yes, we did.
18 THE COMMISSIONER:
19 Q. It's another particular drug -
20 DR. LAING:
21 A. That doesn't have--that's right. So it would
22 be another hormonal therapy -
23 THE COMMISSIONER:
24 Q. And if the patient was just walking through
25 your door on that day and had 23 percent,

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1 presumably you would have offered it to her
2 anyway? What I'm asking is -
3 DR. LAING:
4 A. Oh, yes.
5 THE COMMISSIONER:
6 Q. - why did you both to have her retested, why
7 didn't you just say -
8 DR. LAING:
9 A. Because -
10 THE COMMISSIONER:
11 Q. - our numbers are now ten percent and here's
12 this new -
13 DR. LAING:
14 A. Okay, yeah, I understand -
15 THE COMMISSIONER:
16 Q. - option I have available to you?
17 DR. LAING:
18 A. Yeah, I understand exactly what you're asking.
19 And the reason is is because that she wasn't
20 keen on hormonal therapy. And I said to her,
21 but if it's one of these that comes back as
22 being very, very strongly positive, assuming
23 that the benefit would be greater to her,
24 would you then consider it. And so that was
25 the reason for the retest, because we wanted

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1 to see what the new result was going to be.
 2 So she was interested in knowing was she going
 3 to be someone who stayed at, you know, 30
 4 percent and zero percent from Mount Sinai or
 5 would she be somebody who came back as being
 6 very strongly positive or even perhaps both,
 7 because, of course, we had seen that happen,
 8 we had seen people who had been -
 9 THE COMMISSIONER:
 10 Q. Okay. So you're saying Ms. Coffin, you
 11 inquired whether she might be interested in -
 12 DR. LAING:
 13 A. Yes.
 14 THE COMMISSIONER:
 15 Q. And her response was I'm only 23 percent, why
 16 would I bother, and you said, maybe you're
 17 figures are different?
 18 DR. LAING:
 19 A. Yeah. So it says here, "We have discussed
 20 what to do at this point and agree that if it
 21 was higher, that we would consider an
 22 aromatase inhibitor at this point." Yeah, so
 23 that's why I retested -
 24 THE COMMISSIONER:
 25 Q. And that was a discussion you had with Ms.

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1 Coffin?
 2 DR. LAING:
 3 A. Yeah. And that's why we had retested it
 4 instead of me just sort of saying, you know,
 5 you were 23 percent, you know, through this
 6 whole review, you know, would you consider now
 7 going on aromatase inhibitor. We, in fact,
 8 you know, she had asked and she wanted to know
 9 if she was going to be someone who came back
 10 as being very strongly positive.
 11 THE COMMISSIONER:
 12 Q. Now, while I'm on the subject we might as well
 13 go down this road, as well. Can you tell me
 14 whether or not there have been any effort
 15 made to determine whether or not in that time
 16 frame, when you were switching from 30 percent
 17 to ten percent, and I understand it did not
 18 occur overnight.
 19 DR. LAING:
 20 A. That's correct.
 21 THE COMMISSIONER:
 22 Q. That some people were continuing to use 30
 23 percent long after others had switched to ten?
 24 DR. LAING:
 25 A. Um-hm.

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1 THE COMMISSIONER:
 2 Q. Has any effort been made to identify those
 3 patients in that time frame who may, in fact,
 4 have been missed for a retest on an assumption
 5 about the cutoff date that was being use but
 6 which, in fact, was not being used?
 7 DR. LAING:
 8 A. Yes. And that was the discussions that were
 9 had in April and May and a decision was made -
 10 CHAYTOR, Q.C.:
 11 Q. This year, 2008?
 12 DR. LAING:
 13 A. Yeah. The decision was made, that's when that
 14 -
 15 THE COMMISSIONER:
 16 Q. It had been done or is going to be done?
 17 DR. LAING:
 18 A. I believe that people were going to check with
 19 Mr. Miller to see where that was.
 20 THE COMMISSIONER:
 21 Q. That was the discussion from yesterday?
 22 DR. LAING:
 23 A. Yeah. So my understanding, and where I had
 24 left that after we were asked to give our
 25 opinion regarding that, was that, in fact that

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1 they had planned to identify those patients
 2 through putting all of the breast cancer
 3 patients into the database and identifying
 4 people that may have been in this transition
 5 period and to review those charts to see if
 6 there may be people that didn't get treatment.
 7 To date, I have not been asked to review
 8 charts and so I'm not sure where that process
 9 is.
 10 THE COMMISSIONER:
 11 Q. That I understand to be consistent in the
 12 sense of a testing laboratory view of the
 13 world, as it were. I mean, I can see the
 14 person who's coming along and saying "I'm
 15 doing this scientific study and these are the
 16 people who belong in and these are the people
 17 who don't belong in."
 18 DR. LAING:
 19 A. Yes.
 20 THE COMMISSIONER:
 21 Q. Putting myself in the position of a patient,
 22 then it would seem to me that if I was in that
 23 area and I were to discover that albeit
 24 correct in terms of the scientific study which
 25 is being carried out, I should not have been

<p style="text-align: right;">Page 165</p> <p>1 included in a retest because the particular 2 percentage was appropriately applied given the 3 numbers, but because of the luck of the draw 4 and the particular week I was seen, I missed 5 out on an opportunity for a potential therapy 6 that was offered to the person who came the 7 next week, I would be a tad ticked off.</p> <p>8 DR. LAING: 9 A. Well, the discussions that we had had leading 10 up to this and the reason for having the 11 conference call eventually that included Dr. 12 Trudeau was because we had all sort of stopped 13 and sat down and thought about this issue, and 14 in my practice and in reviewing all of the 15 patients that I have seen, this is the only 16 instance that I can tell you about that 17 happens to me. But I agree with you 100 18 percent, and that was why that reason had been 19 made for this, to look at this period again, 20 was just that, yeah, are there people that 21 haven't been picked up by their oncologist? 22 Are there people perhaps who are no longer 23 being followed at the Cancer Centre? Are 24 there people that haven't heard about this 25 issue and contacted us? Because as we'll--as</p>	<p style="text-align: right;">Page 167</p> <p>1 DR. LAING: 2 A. Yes. 3 THE COMMISSIONER: 4 Q. We're not quite sure. 5 DR. LAING: 6 A. Yes, so when I had left that issue, the 7 decision, and as I said yesterday, this was a 8 unanimous decision by all parties who were 9 present on that conference call, was that yes, 10 we were going to go back and have a look at 11 this time period in case there were somebody 12 there who had missed out that we would be able 13 to identify that particular patient or 14 patients. 15 CHAYTOR, Q.C.: 16 Q. And Doctor, so obviously your thinking was 17 that the degree of positivity could affect 18 treatment decisions and that it might be of 19 benefit to Ms. Coffin, should she come back 20 and have a higher ER/PR status. In reviewing 21 with the panel the Mount Sinai results, I 22 would suggest to you that you saw numerous 23 cases that started off weak or negative, zero 24 to ten percent range, which ended up being 25 quite strongly positive on retest.</p>
<p style="text-align: right;">Page 166</p> <p>1 you know, that some of the people who weren't 2 retested and were missed somehow in being 3 identified were sometimes the patients coming 4 forth and saying, you know, "I had breast 5 cancer during this time period. I've not 6 heard anything from anybody. What's my 7 situation?" and this happened because this 8 lady was coming to see me at this time and I 9 was obviously, you know, thinking about this 10 issue and she ended up being retested. Her 11 test results did change. She came back as 95 12 percent positive for ER and PR one percent. 13 She did have a trial of an aromatase 14 inhibitor, which she didn't tolerate very 15 well, and then decided not to take it any 16 further.</p> <p>17 THE COMMISSIONER: 18 Q. So come back to the ones that are going to be 19 ticked off because they were a week away, are 20 they included in the number that are now being 21 looked for under Mr. Miller's -</p> <p>22 DR. LAING: 23 A. Yes, they are. 24 THE COMMISSIONER: 25 Q. - task, whatever that happens to be?</p>	<p style="text-align: right;">Page 168</p> <p>1 DR. LAING: 2 A. Yes. 3 CHAYTOR, Q.C.: 4 Q. There were quite a number of those, and so if 5 during this time period and the cross over 6 period that other physicians were still 7 looking at a result such as 23 percent or 8 perhaps 12 percent, 13 percent as being, in 9 your words, borderline results or weakly 10 positive and similar decisions were made. So 11 if those people were 12 percent, say, or 15 12 percent or 22 percent back in 2001 and late 13 into 2001 and we are still in that grey 14 crossover period, those people were retested 15 and could end up to be strongly positive, as 16 the number of negatives that you saw were, 17 those people could be candidates now for 18 treatment? 19 DR. LAING: 20 A. We would have a discussion with them, just as 21 we did with Ms. Coffin and the other patients 22 who we've had changes in their results. 23 CHAYTOR, Q.C.: 24 Q. Upon realizing this in March of '06 and being 25 cognizant of the fact that there was no clear</p>

<p style="text-align: right;">Page 169</p> <p>1 cut off, there was no day in which everyone 2 agreed, okay, from this date henceforth, we're 3 all going to use ten percent, so you knew 4 that. By March 2006, you're clinical chief. 5 Did you think to send an e-mail, a memo, 6 anything to the other oncologists to say 7 "heads up, please pay attention. Be alerted 8 to the fact that are there people who were in 9 the category of what in 2001 we would have 10 called weakly positive. If any of those 11 people are coming through or perhaps, you 12 know, there's some way to review your charts, 13 because they may not have been part of the 14 retest and perhaps they should be." 15 DR. LAING: 16 A. Yeah. No, I did not send a memo or anything 17 at that time, but this was--I would not have 18 been the only oncologist who was looking at 19 patient's charts very carefully and reviewing 20 their ER/PR results during this time period. 21 All of us would have been doing that work. 22 CHAYTOR, Q.C.: 23 Q. So was there a direction, anything in writing 24 that went out to the oncologists to tell them 25 that they should, in fact, be doing that,</p>	<p style="text-align: right;">Page 171</p> <p>1 the tumour panel. It was prior to us 2 receiving, you know, all of the--or the large 3 majority of the test results back. It was 4 prior to us really observing the trends and 5 the changes that we had seen, and so I'd 6 suspect that that's why, at that time, it 7 doesn't--I can just tell by looking at this 8 note that certainly I wasn't thinking about it 9 in any event to do any sort of retesting on 10 her specifically at that time, no. 11 CHAYTOR, Q.C.: 12 Q. If we could have, please, C-0057, and you'll 13 recall that you did--it was March 14th, 2006 14 that you did discuss the issue with Ms. 15 Coffin. 16 DR. LAING: 17 A. Yes. 18 CHAYTOR, Q.C.: 19 Q. And you did order the retest, it appears, 20 quite quickly because this is actually the 21 result back from Mount Sinai on March 20th, 22 2006. 23 DR. LAING: 24 A. Yes. 25 CHAYTOR, Q.C.:</p>
<p style="text-align: right;">Page 170</p> <p>1 reviewing their charts to make sure that 2 everybody had been included in the retest? 3 DR. LAING: 4 A. No, there was no direction or formal memo to 5 that regard. 6 CHAYTOR, Q.C.: 7 Q. If we could go back, please, to C-0066? 8 Doctor, you in fact saw Ms. Coffin on 9 September 8th, 2005. So the retesting is well 10 underway at this point in time, and there's no 11 mention on that date of any discussion about 12 her potentially being a candidate for 13 retesting. 14 DR. LAING: 15 A. No. 16 CHAYTOR, Q.C.: 17 Q. And I'm sure the issue would have been on your 18 mind, as you say it was in March of 2006, I 19 would suggest that in September 2005, the 20 issue certainly would have been, and the issue 21 of retesting would have also been something 22 that you were thinking about and on your mind. 23 DR. LAING: 24 A. Yeah, certainly it would have been, but 25 September of 2005 was prior to the start of</p>	<p style="text-align: right;">Page 172</p> <p>1 Q. And if we could have, please, C-0068? And 2 this is the September 6th, 2006, next time 3 that Ms. Coffin is seen by you and "Daphne 4 returns to clinic today. I brought her back 5 today to discuss the issue of her ER again. 6 She had not been retested despite the fact 7 that she was less than 30 percent," so you're 8 still thinking that, less than 30 percent. 9 "But now that she has been, and it came back 10 so strongly positive, she comes to talk about 11 late hormonal therapy. I have reviewed the 12 study of the Tamoxifen and also the results of 13 MA17 clinical trial, including the benefits 14 seen to those who started Let"--is it 15 "Letrozole late"?) 16 DR. LAING: 17 A. Yes, Letrozole. 18 CHAYTOR, Q.C.: 19 Q. Thank you. "She does not really have any 20 contraindication to either Arimidex or 21 Tamoxifen." Doctor, it is September 6th, 22 2006. 23 DR. LAING: 24 A. Yes. 25 CHAYTOR, Q.C.:</p>

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1 Q. It's six months after her results came back.
 2 DR. LAING:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Why is Ms. Coffin only being informed of that
 6 on September 6th?
 7 DR. LAING:
 8 A. Because she had called in and she had been at
 9 the breast cancer retreat, and indicated that
 10 she hadn't heard anything back from me about
 11 the results, and when I, sometime in August,
 12 realized that the results had come back and
 13 had gone in her chart, contacted her and told
 14 her that they had changed and asked her to
 15 come in and so we scheduled an appointment for
 16 her to come in here on this visit on September
 17 6th of 2006.
 18 CHAYTOR, Q.C.:
 19 Q. So the results of a patient's test can arrive
 20 on a patient's chart, be filed away in that
 21 patient's chart without you, as treating
 22 oncologist, ever having seen that report?
 23 DR. LAING:
 24 A. It can, and in fact, I looked at this, and
 25 perhaps we could look at that report? Could

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1 you bring that up for me? I'm sorry, I don't
 2 remember the number.
 3 CHAYTOR, Q.C.:
 4 Q. The Mount Sinai one? Sure, yes.
 5 DR. LAING:
 6 A. No, not the Mount--yes, the report that came
 7 back.
 8 CHAYTOR, Q.C.:
 9 Q. C-0057.
 10 DR. LAING:
 11 A. Yes, and can I just--can I use the mouse?
 12 CHAYTOR, Q.C.:
 13 Q. Absolutely.
 14 DR. LAING:
 15 A. So as you can see, I'll just scroll down--
 16 actually, this is not the one that I was
 17 thinking about. This one doesn't actually
 18 have any signature of any physician on it.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, actually -
 21 DR. LAING:
 22 A. Is there another one that's--that's the
 23 addendum.
 24 CHAYTOR, Q.C.:
 25 Q. There are two. There's this report, which is

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1 on her chart from Mount Sinai, and there's
 2 also C-0056, please, Registrar? She'll bring
 3 it up for you, Doctor.
 4 DR. LAING:
 5 A. Okay.
 6 CHAYTOR, Q.C.:
 7 Q. Here you go.
 8 DR. LAING:
 9 A. This is the one that I was thinking about. So
 10 if you look at this report, at the top of the
 11 report, the attending doctor is listed as the--
 12 -sorry, the attending doctor is listed as the
 13 surgeon, because when patients have their
 14 initial pathology report done, they do not
 15 know who the subsequent oncologist is going to
 16 be. So the attending physician is always the
 17 surgeon at the top of--most always the surgeon
 18 at the top of these reports. Under comments,
 19 you can see it says "copy Dr. Greenland,
 20 Cancer Clinic, HSC." There's Dr. Greenland's
 21 signature and subsequently my signature, and
 22 then that's the end. So when I initially went
 23 and looked at this, what I realized had
 24 happened was that this was actually sent to
 25 Dr. Greenland's mail for filing and it was

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1 filed and placed on her chart, and then when I
 2 got the call to go and look, I realized that
 3 the test results had come back. I had not
 4 been aware of that and then arranged to meet
 5 subsequently with her and discuss it, the
 6 results, with her.
 7 CHAYTOR, Q.C.:
 8 Q. So who did you contact to get the consult to
 9 Mount Sinai?
 10 DR. LAING:
 11 A. I would have sent a consult to pathology.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. So you would have sent--you sent the
 14 consult to pathology?
 15 DR. LAING:
 16 A. I sent the consult, yeah.
 17 CHAYTOR, Q.C.:
 18 Q. So even though -
 19 THE COMMISSIONER:
 20 Q. You send a consult signed by you, but they
 21 don't send it back to you?
 22 DR. LAING:
 23 A. In the ideal world, this should have been sent
 24 back to me. I'm not certain why Dr.
 25 Greenland's name ended up on that, because I

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1 was the one who asked for it to be repeated.
 2 CHAYTOR, Q.C.:
 3 Q. Doctor, this was done by Dr. Carter, entered
 4 on her chart the day after it was received
 5 from Mount Sinai, March 21st. So both this
 6 addendum--you're saying this addendum on her
 7 pathology report was put in Dr. Greenland's
 8 mail box, not yours. If we could go back to
 9 C-0057, please? This is the consultation
 10 report which was also placed on her chart.
 11 Did you receive this document?
 12 DR. LAING:
 13 A. No, because if I had have received that--
 14 because what I had--where we had left things
 15 with Ms. Coffin was, and I had said at the end
 16 of my clinic note that I'd send it off, and
 17 I'll get the results back and if it--you know,
 18 if there's a change, I will let her know, and
 19 so without--there's no--usually when our
 20 information comes in from--I mean, we get
 21 information from all over, it's received in
 22 Health Records department and there's usually
 23 a date stamped as to when that is received.
 24 It then is placed for filing into a physician
 25 box for signing, and then we sign that and it

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1 subsequently is placed on a patient's chart.
 2 So I do not know how this got on the patient's
 3 chart. I do know that through Ms. Coffin's
 4 discussions by reading her testimony at the
 5 Commission and that she hadn't heard anything
 6 back, and then she, in fact, you know, made
 7 contact and once I was aware that these
 8 results were there and that I hadn't talked to
 9 her, I called her and said they're back and
 10 arranged for her to come and see me in the
 11 clinic.
 12 CHAYTOR, Q.C.:
 13 Q. So there were two possible ways that this
 14 could have been brought to your attention,
 15 through either the addendum on the pathology
 16 report or through the surgical pathology
 17 report from Mount Sinai. Neither of those
 18 documents came to your attention. You're
 19 saying they did come to Dr. Greenland's
 20 attention and Dr. Greenland filed it on her
 21 chart without notifying you or the patient?
 22 DR. LAING:
 23 A. Yes, that's my understanding.
 24 CHAYTOR, Q.C.:
 25 Q. Is there anything in place, Doctor, now in

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1 terms of a policy or procedure which would
 2 prevent that from happening in the future?
 3 DR. LAING:
 4 A. Well, the information that we receive through
 5 our filing system, if I identify information
 6 that I didn't request or on a patient that I'm
 7 not certain of, my policy now is to take that
 8 information and identify on it that I have
 9 forwarded this to the physician who is likely
 10 to have ordered that test. Probably one of
 11 the biggest examples of that is in our
 12 activities in the peripheral clinic. I often
 13 see a patient in a peripheral clinic, order a
 14 test, but I may not be the physician who's
 15 attending the next peripheral clinic. So now
 16 what we do, and our policy is, is that if you
 17 receive information on a patient that you did
 18 not order or that, sorry, that you're not
 19 going to follow up on, whether or not it was
 20 you who ordered it, and even to this day, I
 21 get information on patients that I didn't
 22 order that comes to me, then we identify who
 23 the most appropriate physician is and put that
 24 in that person's mail slot, and I usually
 25 would indicate a small note on that, "patient

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1 seeing Dr. Zulifqar, patient of Dr.
 2 McCarthy's" and that sort of thing.
 3 CHAYTOR, Q.C.:
 4 Q. And so, Doctor, that's your personal practice
 5 and what you do to safeguard against it, but
 6 is there anything that's been put in place to
 7 say that -
 8 DR. LAING:
 9 A. That would be the practice of -
 10 CHAYTOR, Q.C.:
 11 Q. Is that a written policy and procedure that
 12 everyone is directed to follow?
 13 DR. LAING:
 14 A. I'm not sure if it's a written policy or a
 15 procedure, but it certainly would be something
 16 that the physicians, from my understanding,
 17 would be following.
 18 CHAYTOR, Q.C.:
 19 Q. So what did you do in terms of alerting the
 20 other oncologists, and again, you're the
 21 clinical chief at that point in time, what did
 22 you do to alert them that "this is an issue
 23 and here's what we need to do to make sure
 24 this doesn't happen in the future"? Did you
 25 e-mail them, send a memo? There's no written

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1 policy. What did you do?
 2 DR. LAING:
 3 A. We would have had discussions at our
 4 divisional meetings and certainly my practice,
 5 and the practice that I know is from my
 6 colleagues because I get information in my
 7 mailbox that's from them, is that this is
 8 something that we do. Did this stem out of
 9 this incident; no, this is something that we
 10 do because with different people ordering
 11 results, particularly in the practice of the
 12 peripheral clinic, that we felt it was best
 13 that if you got a result on a patient and you
 14 looked at it and you thought I don't remember
 15 ordering this, then you would follow up and--
 16 so when I get mail in my mailbox for signing
 17 and health records, I go through that. Ninety-
 18 five percent of it is stuff that I have
 19 already seen because of the delay in reports
 20 being typed and sent over. So often they're
 21 CAT scan reports or blood work that I would
 22 have seen real time in the clinic. I sign
 23 those. They're placed for filing on a
 24 patient's chart. Often there's a small
 25 percentage of information that I'll look at

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1 and say I'm not sure who this patient is, I'm
 2 not sure why this result was received, and we,
 3 in fact, have instances where my name has been
 4 put on reports of people that are not my
 5 patients, and I have instance where I have
 6 called labs. Most recently I recall calling
 7 Gander to say that I had gotten a bone density
 8 report on a patient that I did not recall ever
 9 having seen, and it was an error. So, you
 10 know, the direction is and the understanding,
 11 if you will amongst the physicians, is that if
 12 they receive information and they're not--
 13 they look at it and say, well, I wonder what
 14 this is, then to direct it where they think is
 15 most appropriate for it to go to be dealt
 16 with.
 17 CHAYTOR, Q.C.:
 18 Q. Doctor, why not--you're hoping to have a
 19 couple of new people come on. Why not have a
 20 policy and procedure so that everyone knows
 21 that this is an issue, things can fall through
 22 the cracks, have a policy and procedure that
 23 everyone will follow?
 24 DR. LAING:
 25 A. Sure, I can certainly see if--we have various

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1 policies and procedures, some that belong to
 2 the old NCTRF, some that are Eastern Health
 3 policies and procedures, but, yes, I mean, I
 4 think in terms of the running of any program,
 5 be it the cancer program or otherwise, that
 6 there is a tremendous amount of work that
 7 needs to be done within Eastern Health in
 8 terms of policies, procedures, guidelines,
 9 standards, and I think that as a result of
 10 this whole process, that my belief is that
 11 ultimately various aspects of patient care are
 12 going to improve, not only excellence in ER/PR
 13 testing, but these sorts of issues that become
 14 highlighted with this sort of thing. At the
 15 day, if you were to list the lessons learned
 16 from such an exercise, then I think that this
 17 type of thing is a very good example of
 18 something that really needs to be set forth as
 19 a standard thing that people are aware of.
 20 Unfortunately, when we look back through, much
 21 of what we do in all aspects of health care
 22 are not things that have written policies and
 23 procedures around them, and we do recognize
 24 that as a deficiency, and I can assure that on
 25 a go forward basis that these are things that

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1 we will be identifying and addressing.
 2 CHAYTOR, Q.C.:
 3 Q. Doctor, were you ever told whether or not in
 4 the interim of you having seen Ms. Coffin in
 5 March of 2006 and September 2006, whether or
 6 not she placed any phone calls, or at any
 7 point in time whether or not she placed any
 8 phone calls or contacted Eastern Health to
 9 inquire as to whether she was being retested
 10 or the results of her retest?
 11 DR. LAING:
 12 A. I was not--I don't recall having received
 13 messages directly from her in that time
 14 period.
 15 CHAYTOR, Q.C.:
 16 Q. Okay, and you didn't receive them directly,
 17 but were you ever told that - whether or not
 18 she attempted or made any such contacts?
 19 DR. LAING:
 20 A. Only from what I read in her testimony. I
 21 believe she said that she did at one point
 22 contact--I'm not sure if it was Nancy Parsons
 23 or what number that she had called, and
 24 someone said that they would get back to her
 25 about her test results.

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1 CHAYTOR, Q.C.:

2 Q. And that was never brought to your attention?

3 DR. LAING:

4 A. Not that I recall, no.

5 CHAYTOR, Q.C.:

6 Q. Doctor, when you met with her in September,

7 knowing that this had not been brought to your

8 attention earlier, nor had it been brought to

9 her attention prior to September, 2006, was

10 she offered an apology?

11 DR. LAING:

12 A. I do recall that I had said to her, you know,

13 that the test results had been back for a

14 while, and certainly my practice would be in

15 such a situation to offer an apology to a

16 patient. Whether I can remember exactly if I

17 did it in this situation, I'm not certain.

18 CHAYTOR, Q.C.:

19 Q. So you recall telling her that, in fact, her

20 results had been back for a while?

21 DR. LAING:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. Did you tell her how long her results had been

25 back?

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1 DR. LAING:

2 A. I'm not certain.

3 CHAYTOR, Q.C.:

4 Q. Okay.

5 DR. LAING:

6 A. And I don't - and I'm not sure that she

7 actually asked me specifically when it came

8 back.

9 CHAYTOR, Q.C.:

10 Q. And would she have to specifically ask for

11 that or would you not offer that up to her and

12 say, you know, I'm really sorry, Mrs. Coffin,

13 but this has been sitting here now for six

14 months and you weren't contacted because this

15 sort of fell through our cracks, that kind of

16 discussion didn't happen?

17 DR. LAING:

18 A. I recall saying to her, you know, I know that

19 you have been looking for this, and now it's--

20 you know, it's back, and that--and she had

21 said to me, you know, I hadn't heard anything

22 for a while, and if someone had something like

23 that to me, I'd say, well, you know, I'm sorry

24 that we didn't connect before now, but--and

25 then I think really we moved on to discuss the

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1 information at hand.

2 CHAYTOR, Q.C.:

3 Q. So you don't have any distinct recollection as

4 to whether or not there was an apology offered

5 or whether she was told, in fact, how long her

6 results were back?

7 DR. LAING:

8 A. No, I don't remember specifically enough to be

9 able to tell you certainly that that's what

10 took place.

11 CHAYTOR, Q.C.:

12 Q. Can we have, please, P-0505, and these are

13 handwritten notes, Doctor, of a meeting of

14 July 14th, 2005, and these notes were taken by

15 Dr. Williams. Do you recall attending the

16 meeting on July 14th, 2005?

17 DR. LAING:

18 A. I do.

19 CHAYTOR, Q.C.:

20 Q. And what do you recall being the purpose of

21 that meeting?

22 DR. LAING:

23 A. This was a meeting that was held shortly after

24 I had returned, as I said, from leave and

25 attending a conference, and at this point--

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1 this was a meeting of various stakeholders

2 involved with this issue, really to have some

3 discussions about where we were going to go

4 from here. So as you can see, it included

5 myself and Dr. McCarthy.

6 CHAYTOR, Q.C.:

7 Q. Oh, sorry, page three--there you go.

8 DR. LAING:

9 A. This is much easier to look at. Doctors are--

10 we learned that in medical school how to write

11 like that. I was there, Dr. McCarthy was

12 there, and this was a meeting that was called

13 by Dr. Williams and that Dr. Cook, as you can

14 see, talked about sort of the background, and

15 we had some discussions from, you know, the

16 point of view of what this--what impact it was

17 having thus far clinically. We talked a

18 little bit about what we had done so far in

19 terms of the limited patient disclosure that

20 we had had. If you want to scroll down --

21 CHAYTOR, Q.C.:

22 Q. Doctor, I'm just wondering, in terms of you

23 being at this meeting --

24 DR. LAING:

25 A. Yes.

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<p>1 CHAYTOR, Q.C.:</p> <p>2 Q. Who invited you to attend?</p> <p>3 DR. LAING:</p> <p>4 A. Dr. Williams.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. In what capacity were you there, why were you</p> <p>7 at the meeting?</p> <p>8 DR. LAING:</p> <p>9 A. I was there because I was a medical oncologist</p> <p>10 who is involved in the care of patients with</p> <p>11 breast cancer.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. And that's the same reason, I take it, Dr.</p> <p>14 McCarthy was there?</p> <p>15 DR. LAING:</p> <p>16 A. Yes.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. And Dr. Gardiner at this point in time, he was</p> <p>19 there in what capacity?</p> <p>20 DR. LAING:</p> <p>21 A. At that time he was the Medical Director of</p> <p>22 the Newfoundland Cancer Treatment and Research</p> <p>23 Foundation.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. Okay, and there are some comments attributed</p>	<p>1 went from 75 percent to 100 percent positive".</p> <p>2 What's that in relation to?</p> <p>3 DR. LAING:</p> <p>4 A. I'm not certain.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. And this is a comment which is attributed to</p> <p>7 you.</p> <p>8 DR. LAING:</p> <p>9 A. Uh-hm.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. By Dr. Williams.</p> <p>12 DR. LAING:</p> <p>13 A. Yes.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. And Dr. Cliff Hudis is at Sloan Kettering?</p> <p>16 DR. LAING:</p> <p>17 A. He is indeed, yeah.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. So are you saying you have no recollection of</p> <p>20 what it is that you would have told the group</p> <p>21 and Dr. Williams recorded regarding this</p> <p>22 point?</p> <p>23 DR. LAING:</p> <p>24 A. When I look at that now, that relates to the</p> <p>25 issue that I spoke with Dr. Hudis about, but I</p>
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<p>1 to you at this meeting?</p> <p>2 DR. LAING:</p> <p>3 A. Yeah.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. And the first bullet is "New information,</p> <p>6 lobular CA should all be ER/PR positive".</p> <p>7 DR. LAING:</p> <p>8 A. Right.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. What's that referring to, Doctor?</p> <p>11 DR. LAING:</p> <p>12 A. That's referring to Dr. Hudis' communication</p> <p>13 with me regarding Peggy Deane.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. Okay, so you would have been telling the group</p> <p>16 about the e-mail you received from Dr. Hudis?</p> <p>17 DR. LAING:</p> <p>18 A. Yeah.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. Which indicated that he had never seen an</p> <p>21 ER/PR negative lobular cancer?</p> <p>22 DR. LAING:</p> <p>23 A. Uh-hm.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. The next bullet says that, "Sloan-Kettering</p>	<p>1 would--my recollection was that that was</p> <p>2 actually something that happened, as I told</p> <p>3 you, in the fall. This is the first time I've</p> <p>4 sort of looked at this and noticed that that</p> <p>5 bullet was there. So this was in July.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. This is July 14th, 2005.</p> <p>8 DR. LAING:</p> <p>9 A. Right.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. You didn't have your discussion until late</p> <p>12 September at the earliest with Dr. Hudis.</p> <p>13 DR. LAING:</p> <p>14 A. When I was asked to recall when that</p> <p>15 discussion may have happened, I felt that the</p> <p>16 only way I could do that was to look at my</p> <p>17 calendar from that year and have some sort of</p> <p>18 idea about where I might have seen Dr. Hudis.</p> <p>19 However, when I look at this now and this was</p> <p>20 something that I brought up and was in mid</p> <p>21 July, then perhaps it was earlier than that,</p> <p>22 you know, after the May or the April e-mail</p> <p>23 and prior to this discussion. Again I'd have</p> <p>24 to go back and look to see where I may have</p> <p>25 been at that time to interact with Dr. Hudis,</p>

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1 but I do recall quite specifically that the
 2 follow up conversation was not something that
 3 happened via telephone or not something that
 4 happened via e-mail, but was a face to face
 5 meeting with Dr. Hudis and I.
 6 CHAYTOR, Q.C.:
 7 Q. So, Doctor, you were--somewhere in between
 8 then the communications you had with him in
 9 April and July 14th, somewhere in between that
 10 time period, and discussed this issue further
 11 with Dr. Hudis?
 12 DR. LAING:
 13 A. Well, now that I look at this and see if I had
 14 said that then, then this sort of narrows even
 15 further at which point that I would have had
 16 that meeting--that meeting with him. What I
 17 do recall was that Dr. Hudis and I were
 18 attending the same meeting. We were not there
 19 --you know, this was not a meeting that was a
 20 small meeting, but this was a larger meeting
 21 where I happened to run into him. When I was
 22 asked to go back and try and remember when
 23 that may be, I looked at my calendar from that
 24 year and could identify two large
 25 international meetings that I had attended,

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1 but I wasn't certain, as I said earlier, that
 2 that's where I saw him.
 3 CHAYTOR, Q.C.:
 4 Q. Doctor, maybe what you could do is check again
 5 for us and let us know then when it would have
 6 been.
 7 DR. LAING:
 8 A. Sure, I have --
 9 CHAYTOR, Q.C.:
 10 Q. That you had your discussion.
 11 DR. LAING:
 12 A. I took my calendars out for that time period
 13 and I could certainly go back and look at that
 14 again.
 15 CHAYTOR, Q.C.:
 16 Q. Yes, and, Doctor, this reference to 75 to 100
 17 percent positive, what is that referring to?
 18 DR. LAING:
 19 A. I'm not certain. I don't recall having heard
 20 when I had that discussion with Dr. Hudis
 21 about, that he had given me a number. Perhaps
 22 this is how Dr. Williams recorded it, but, you
 23 know, the number that's important here was
 24 that when they had done their retesting on
 25 their tumour samples that they had, they got

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1 100 percent positivity for the lobular
 2 histology.
 3 CHAYTOR, Q.C.:
 4 Q. Yes, because you told us in your evidence
 5 yesterday that it was anonymous tumour bank
 6 that Sloan-Kettering had used in their review.
 7 DR. LAING:
 8 A. Right.
 9 CHAYTOR, Q.C.:
 10 Q. And it would not have been known whether or
 11 not the patients were originally negative or
 12 positive hormone receptor, and so the idea
 13 that they would have gone from 75 to 100
 14 percent, that can't be referencing, can it,
 15 what happened at Sloan-Kettering?
 16 DR. LAING:
 17 A. So specimens that were retested, from my
 18 understanding with the discussions with Dr.
 19 Hudis, were not done as part of a patient
 20 centred review. They may or may not have had
 21 some information on the tissue that they had
 22 there. So even though it's not patient
 23 related, perhaps they did know or have some
 24 idea about how that was initially interpreted.
 25 That was not something that I got into at any

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1 detail with Dr. Hudis. So I can tell you that
 2 I honestly am not certain why Dr. Williams
 3 wrote 75 percent to 100 percent.
 4 CHAYTOR, Q.C.:
 5 Q. Did Dr. Hudis tell you that they had at Sloan-
 6 Kettering any ER/PR tests which converted
 7 during that review that he undertook?
 8 DR. LAING:
 9 A. No, it wasn't--the discussion wasn't based
 10 around conversions. The discussion was based
 11 around that in their research lab on these
 12 tumour bank tissues, that they had run ER/PR
 13 testing on the lobular histology and all the
 14 lobular histologies came back as being
 15 positive. We didn't talk about what number
 16 they had had before, was this conversions,
 17 because this wasn't patient related. I had --
 18 CHAYTOR, Q.C.:
 19 Q. That's what I understood you to say yesterday.
 20 DR. LAING:
 21 A. Yes, yeah.
 22 CHAYTOR, Q.C.:
 23 Q. Did you then tell the group of people on March
 24 14th--sorry, July 14th, 2005, that at Sloan-
 25 Kettering they had, in fact, gone from 75

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1 percent to 100 percent positive?
 2 DR. LAING:
 3 A. No, no. The only thing that I can think this
 4 indicates was; one, that the follow up
 5 conversation I had with Dr. Hudis was prior to
 6 this; number two, that for some reason this
 7 was written down as 75 to 100, but that would
 8 not have been information that I had at any
 9 time other than that the lobulars in this
 10 particular review were 100 percent positive.
 11 CHAYTOR, Q.C.:
 12 Q. So you've never had this information, 75 to
 13 100 percent?
 14 DR. LAING:
 15 A. No, no, no.
 16 CHAYTOR, Q.C.:
 17 Q. And you did not tell it to the group on this
 18 date, nor have you ever told that to Dr.
 19 Williams or anyone else involved in this
 20 review?
 21 DR. LAING:
 22 A. That they went--no, I did not ever know a
 23 percentage that Memorial Sloan-Kettering would
 24 have started at or --
 25 CHAYTOR, Q.C.:

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1 Q. So wherever Dr. Williams got that idea, it
 2 didn't come from you, and I think my mouse is
 3 taking a break.
 4 DR. LAING:
 5 A. Maybe because I had used it before.
 6 CHAYTOR, Q.C.:
 7 Q. That's okay.
 8 THE COMMISSIONER:
 9 Q. It's about time for the luncheon break, so if
 10 you want to do that --
 11 CHAYTOR, Q.C.:
 12 Q. We'll just finish up this then, that's fine.
 13 The next point is that, "Dr. Laing requested
 14 retesting and strongly positive results", and,
 15 Doctor, I take it that's referring to the
 16 retesting that was going on up to this point?
 17 DR. LAING:
 18 A. That's correct.
 19 CHAYTOR, Q.C.:
 20 Q. There would have been the June 29th batch of
 21 patients, the first 25?
 22 DR. LAING:
 23 A. And also, I think, more referring to my own --
 24 CHAYTOR, Q.C.:
 25 Q. Your own patients.

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1 DR. LAING:
 2 A. My own patients, actually, yeah.
 3 CHAYTOR, Q.C.:
 4 Q. And then it goes on to say, "As a result, has
 5 to retest some patients".
 6 DR. LAING:
 7 A. I think actually if I look at bullet three,
 8 that would have been, I suspect, referring to
 9 Peggy Deane, to the index case, because I had
 10 requested the initial retesting and it was
 11 strongly positive. As a result, was asked to
 12 retest some other patients, and then follow up
 13 on a lot of patients from 2002 would have been
 14 that year, and then it talks about the 16 out
 15 of 25, so that's the first batch, and then
 16 doing another 38 patients in the process, I
 17 can only imagine that's the second batch.
 18 CHAYTOR, Q.C.:
 19 Q. That's the July 18th batch, yes.
 20 DR. LAING:
 21 A. "Farm out testing outside the province".
 22 CHAYTOR, Q.C.:
 23 Q. Were you suggesting at this point in time, the
 24 middle of July, that testing take place
 25 outside of Newfoundland and Labrador?

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1 DR. LAING:
 2 A. That is typed in under that--under my name,
 3 but I would suspect that that--my recollection
 4 was that that was something that had been
 5 initiated by Dr. Cook because if you look at
 6 the next bullet, it says, "Dr. Cook to follow
 7 up on who that is". So I actually think that
 8 if you look at the written one, mine sort of
 9 ends at the 38, and then there's a separation,
 10 so --
 11 CHAYTOR, Q.C.:
 12 Q. Yes. So there's a line skipped.
 13 DR. LAING:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. So you're thinking that was something
 17 suggested at that point in time by Dr. Book?
 18 DR. LAING:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. Thank you, Commissioner.
 22 THE COMMISSIONER:
 23 Q. We'll meet again at five after two.
 24 (BREAK)
 25 THE COMMISSIONER:

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<p>1 Q. Ms. Chaytor. 2 CHAYTOR, Q.C.: 3 Q. Thank you, Commissioner. Good afternoon, 4 Doctor. 5 DR. LAING: 6 A. Good afternoon. 7 CHAYTOR, Q.C.: 8 Q. Commissioner, we have a new exhibit this 9 afternoon. It's P-2620. I'd ask to have 10 entered, please. 11 THE COMMISSIONER: 12 Q. 2620. 13 CHAYTOR, Q.C.: 14 Q. Yes. 15 THE COMMISSIONER: 16 Q. Entered. 17 EXHIBIT MARKED AND ENTERED AS P-2620. 18 CHAYTOR, Q.C.: 19 Q. Doctor, did you get an opportunity to check 20 your calendar over the lunch hour? 21 DR. LAING: 22 A. No, because it's in my box of information 23 which is currently in my office, but I will go 24 there after and discuss that in the morning. 25 CHAYTOR, Q.C.:</p>	<p>1 not tell me that this had been published in 2 any journal, and I did do a search to see if I 3 could find this article and I couldn't, and 4 subsequently we have looked again and did not 5 find that any such publication of that 6 information exists. 7 CHAYTOR, Q.C.: 8 Q. And then if we could have, please, P-0513. 9 You are, Doctor, at this meeting by phone, 10 anyhow, or you participate in it by phone. 11 It's July 27th, 2005. They keep getting your 12 name wrong, or whoever typed it gets your name 13 wrong -- 14 DR. LAING: 15 A. I'm used to that. 16 CHAYTOR, Q.C.: 17 Q. You're used to that, okay, and Dr. Cook gave 18 results of discussion with Dr. Walters in 19 Montreal, and under the third bullet it says, 20 "Sloan-Kettering, no information". So I take 21 it, Doctor, you were never able to find 22 anything published in the way of any study or 23 article by Sloan-Kettering -- 24 DR. LAING: 25 A. Yes.</p>
<p>1 Q. Thank you. 2 DR. LAING: 3 A. You're welcome. 4 CHAYTOR, Q.C.: 5 Q. If we could have, please, P-0506. This is 6 again notes from Dr. Williams of a meeting, 7 and, Doctor, you're not in attendance at this 8 meeting, but again the issue of the research 9 from Sloan-Kettering is mentioned in the last 10 bullet. It's a meeting of July 15th, 2005, 11 "Dr. Cook to see if Dr. Laing can provide 12 article from Sloan-Kettering on research in 13 change of ER/PR receptor testing", and do you 14 recall Dr. Cook following up with you and 15 asking you for this information? 16 DR. LAING: 17 A. Yes, I do. 18 CHAYTOR, Q.C.: 19 Q. What do you recall about that? 20 DR. LAING: 21 A. That he asked if there was any published 22 review of the tumour bank slides from the 23 issue that I discussed with Dr. Hudis, and if 24 so, did I know if this was published. I had 25 said at the time that I did not--Dr. Hudis did</p>	<p>1 CHAYTOR, Q.C.: 2 Q. On this issue. Do you know if others at 3 Eastern Health also went looking for the 4 information? 5 DR. LAING: 6 A. I'm not certain. 7 CHAYTOR, Q.C.: 8 Q. Was the issue ever discussed with you after 9 this time period in July of 2005? 10 DR. LAING: 11 A. Yes, again somewhere in the last little while 12 people have said to me, you know, was there 13 ever anything found, and I said no. 14 CHAYTOR, Q.C.: 15 Q. And who has asked you about that? 16 DR. LAING: 17 A. I believe that it was through my preparations 18 with my legal counsel that they had said was 19 there ever anything found. 20 CHAYTOR, Q.C.: 21 Q. Okay, that's fine, if your discussions with 22 your lawyer. 23 DR. LAING: 24 A. Yeah, no, it wasn't -- 25 CHAYTOR, Q.C.:</p>

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<p>1 Q. I thought you meant people at Eastern Health.</p> <p>2 DR. LAING:</p> <p>3 A. No, no, sorry.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. Thank you. Now around this time period too, I</p> <p>6 understand, July 21st, 2005, there was a</p> <p>7 meeting with representatives of the Department</p> <p>8 of Health, including Minister Wiseman--sorry,</p> <p>9 Minister Ottenheimer. Did you take part in</p> <p>10 that meeting on July 21st?</p> <p>11 DR. LAING:</p> <p>12 A. No.</p> <p>13 CHAYTOR, Q.C.:</p> <p>14 Q. So you weren't at that. If we could have</p> <p>15 then, please, P-0520. Doctor, then I take it</p> <p>16 your first meeting with Minister Ottenheimer</p> <p>17 was sometime later, your first meeting with</p> <p>18 him on this issue. Do you recall when that</p> <p>19 was?</p> <p>20 DR. LAING:</p> <p>21 A. Yes, I was asked by Dr. Williams to attend a</p> <p>22 meeting with him to discuss the issue of</p> <p>23 disclosure.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. Okay.</p>	<p>1 are valid", and there's other things written</p> <p>2 there, but those are the key points that I</p> <p>3 wanted to point out to you. First of all, the</p> <p>4 issue--it's obvious here, the second bullet</p> <p>5 says, "Testing patients for 2002, and the</p> <p>6 results being 16 out of 24, 25 out of 32, 22</p> <p>7 or 23 to come. There may be a problem with</p> <p>8 methodology or with the lab", and then it</p> <p>9 says, "Dr. Laing not worried about weakly</p> <p>10 positives". So first of all, what is that in</p> <p>11 reference to?</p> <p>12 DR. LAING:</p> <p>13 A. Are these notes, I'm sorry, that Dr. Williams</p> <p>14 had taken?</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. Dr. Williams took these notes.</p> <p>17 DR. LAING:</p> <p>18 A. Okay, that's what I had understood and then I</p> <p>19 was curious as to why his name was in</p> <p>20 brackets.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. Yeah, sorry, these are Dr. Williams</p> <p>23 handwritten notes, yes, which he was kind</p> <p>24 enough to put in legible form for us.</p> <p>25 DR. LAING:</p>
<p>Page 206</p> <p>1 DR. LAING:</p> <p>2 A. And that was in August.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. Yes, I believe that was August 15th, is that</p> <p>5 correct?</p> <p>6 DR. LAING:</p> <p>7 A. Yes.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. So that's the first meeting or discussion you</p> <p>10 had with Minister Ottenheimer on the issue?</p> <p>11 DR. LAING:</p> <p>12 A. Yes.</p> <p>13 CHAYTOR, Q.C.:</p> <p>14 Q. Okay, thank you. This is a July 24th, 2005,</p> <p>15 meeting that you attended along with Mr.</p> <p>16 Tilley, Drs. Gardiner, Cook, Terry Gulliver,</p> <p>17 Susan Bonnell, Dr. Kwan, Heather Predham,</p> <p>18 Deborah Thomas, and Mr. Dan Boone, and Dr. Bob</p> <p>19 Williams whose name is in brackets, and it</p> <p>20 says here, "Dr. Laing not worried about weakly</p> <p>21 positives. Dr. Laing wants to be sure new</p> <p>22 system is accurate and not overly sensitive.</p> <p>23 Dr. Laing need database to capture different</p> <p>24 kinds of breast cancer with ER/PR results and</p> <p>25 need to wait until we know that our results</p>	<p>Page 208</p> <p>1 A. "Dr. Laing not worried about weakly</p> <p>2 positives". Do you know what, I think my</p> <p>3 understanding is that this is in reference to</p> <p>4 the discussion related to the Ventana System.</p> <p>5 I'm not really certain what that first bullet</p> <p>6 means, "Dr. Laing not worried about", I think</p> <p>7 it's supposed to be "weak".</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. Yes, we've all assumed that it's "weakly".</p> <p>10 DR. LAING:</p> <p>11 A. But I'm not sure--I know that the next one was</p> <p>12 when we started to have some discussions about</p> <p>13 the reliability of the Ventana results. We've</p> <p>14 looked at the retesting results from the first</p> <p>15 25 and from the subsequent 32, and then</p> <p>16 onwards, and we noticed that there were strong</p> <p>17 results reported quite frequently, particular</p> <p>18 in the third batch. So this is when we first</p> <p>19 had a discussion about wanting not to go from</p> <p>20 a situation where we were dealing with the</p> <p>21 false negatives to retesting on a system that</p> <p>22 would be overly sensitive and pick up--and</p> <p>23 give us false positive results.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. So in what context would you not be worried</p>

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<p>1 about the weakly positives, meaning they're 2 not strong, not strong positives? What 3 situation would you not be worried about the 4 weakly positives in terms of the Ventana 5 System? 6 DR. LAING: 7 A. I'm sorry, I have--as I said, you know, I have 8 no idea what that bullet is referring to. 9 CHAYTOR, Q.C.: 10 Q. So you have no recollection of the discussion 11 around that? 12 DR. LAING: 13 A. No. 14 CHAYTOR, Q.C.: 15 Q. The issue of you needing a database to capture 16 different kinds of breast cancers with ER/PR 17 results -- 18 DR. LAING: 19 A. Yes. 20 CHAYTOR, Q.C.: 21 Q. Is that--what's that about? Is that the issue 22 that we've also talked about here? 23 DR. LAING: 24 A. It certainly is. 25 CHAYTOR, Q.C.:</p>	<p>1 patients, there was also some discussion about 2 setting up an official database, not just for 3 breast cancer, but that would be probably an 4 obvious place to start, and I suggested that 5 Mr. Miller contact somebody from the BC Cancer 6 Agency to look at their database, to look at 7 the items or the data fields that are being 8 captured. Certainly when you set up a 9 database, it's important to think about all 10 the things you want to put in it from the 11 beginning, as opposed to getting half way 12 through and wishing that you added in 13 something else. So we thought that would be a 14 good place to start. On that phone 15 conversation as well, I had asked Dr. Trudeau 16 if they had a similar sort of extensive 17 database in Ontario and she said that they 18 hadn't thus far, but they were looking at that 19 as well, and she actually agreed and referred 20 us to have those discussions with the BC 21 Cancer Agency, so that was left with Mr. 22 Miller. 23 CHAYTOR, Q.C.: 24 Q. So in the intervening three years from July, 25 2005, until April, 2008, was there any</p>
<p>Page 210</p> <p>1 Q. So back in July of 2005, you identified that 2 as something that would be beneficial to the 3 cancer care program? 4 DR. LAING: 5 A. Certainly that was one of the issues, but the 6 other one was there was some discussion about 7 whether or not we could go back and pull out 8 all the lobulars or pull out all the ductals, 9 and I said, well, if you had a database, you 10 could do that sort of thing, or if you had a 11 database that captured histology, ER/PR 12 results, all that sort of stuff, it would be 13 easier to pull out that information if there 14 was a database there. 15 CHAYTOR, Q.C.: 16 Q. So looking to have a database which would do 17 that for you, capture the different types of 18 cancer and correlate that, or be able to 19 correlate that with ER/PR results, how far 20 along in terms of that, has there been any 21 progress on that since? 22 DR. LAING: 23 A. As part of the discussions with Mr. Miller, 24 not only related to the issue that we talked 25 about this morning for that transition period</p>	<p>Page 212</p> <p>1 progress on the issue? 2 DR. LAING: 3 A. No. 4 CHAYTOR, Q.C.: 5 Q. Doctor, we understand there was another 6 meeting on August 1st of a larger group of 7 people, August 1st, 2005. Did you attend that 8 meeting? 9 DR. LAING: 10 A. I did, and I believe that that was one of the 11 meetings that I was late in coming to. I 12 looked at my calendar. If my memory serves me 13 correctly, that was a Monday, and I noted in 14 my calendar that I had patients in the 15 afternoon, and so if I did come to that 16 meeting, and it's written there that I was, 17 then I would have been late in coming to that 18 meeting because according to the schedule, it 19 started at 5 p.m. 20 CHAYTOR, Q.C.: 21 Q. And what do you recall about that meeting? 22 DR. LAING: 23 A. Do you have minutes or -- 24 CHAYTOR, Q.C.: 25 Q. I take it you have no independent recollection</p>

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1 of differentiating between one meeting or the
 2 other?
 3 DR. LAING:
 4 A. That there was any sort of--you know, anything
 5 that stuck out in my mind that was different
 6 from that meeting.
 7 CHAYTOR, Q.C.:
 8 Q. This is a meeting that stuck out a bit in Dr.
 9 Carter's mind.
 10 DR. LAING:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. And so do you recall anything about that?
 14 DR. LAING:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. So you've heard what Dr. Carter had to say
 18 about that?
 19 DR. LAING:
 20 A. I have, I've been asked --
 21 CHAYTOR, Q.C.:
 22 Q. And the discussion about news releases.
 23 DR. LAING:
 24 A. I've been asked on several occasions about
 25 this meeting, and apparently there was some

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1 voices raised and shouting back and forth
 2 between people attending that meeting, and
 3 again as I said this morning, if that
 4 happened, I would think that I would remember
 5 such things to happen, it was not routine --
 6 CHAYTOR, Q.C.:
 7 Q. Or if it happened in your presence.
 8 DR. LAING:
 9 A. That's right, they're not routine to happen at
 10 staff meetings or meetings of this nature,
 11 and, so, no, I have no recollection of that.
 12 CHAYTOR, Q.C.:
 13 Q. Of anything controversial happening while you
 14 were in attendance?
 15 DR. LAING:
 16 A. While I was in attendance, no.
 17 CHAYTOR, Q.C.:
 18 Q. And do you recall at that meeting any
 19 discussion around disclosure and whether or
 20 not to be disclosing the information to
 21 patients; if so, when, and any discussion
 22 about disclosure more broadly to the general
 23 public? Do you recall that being discussed?
 24 DR. LAING:
 25 A. That would have been either that meeting or

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1 meetings prior to the meeting that I had with
 2 the Minister later that month. There would
 3 have been some discussion about the whole idea
 4 of when we would disclose this information to
 5 the patients, and there was certainly
 6 preliminary discussion about--I'm not sure if
 7 it was at this meeting or later on in August,
 8 as I said, we started to have some discussion
 9 about disclosing to patients. At this time, I
 10 and some of the other medical oncologists had
 11 already had some experience in disclosing
 12 information to the patients, and felt that the
 13 ability to have as much information as we
 14 could when we sat down with the patients to
 15 outline if there was going to be a change in
 16 the results, to have all the information about
 17 what that would mean would be the ideal
 18 situation.
 19 CHAYTOR, Q.C.:
 20 Q. And, Doctor, however, there had been patients
 21 and there continued to be patients that you
 22 disclosed the issue to without having their
 23 test results, patients that you told
 24 beforehand that they would be retested, and
 25 you said that they took the news fine, that,

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1 in fact, for those with metastatic disease --
 2 DR. LAING:
 3 A. Those with the metastatic disease, that's
 4 right.
 5 CHAYTOR, Q.C.:
 6 Q. It was hopeful, a hopeful situation for them.
 7 DR. LAING:
 8 A. Yeah.
 9 CHAYTOR, Q.C.:
 10 Q. That there may be another option for them. So
 11 you hadn't run into any issues in terms of
 12 telling two people that there's a potential to
 13 have a retest here, and what it may mean for
 14 them?
 15 DR. LAING:
 16 A. Up to that point, I hadn't had any issue. At
 17 that point, the retesting that I been doing
 18 had been on the Ventana System, so we were
 19 getting the results fairly readily back from
 20 the lab to give to the patients, and as I
 21 said, when I would broach it with them, I'd
 22 say, you know, I'm going to do a test to
 23 recheck your hormone receptors and see if
 24 there might be a change, and then if there
 25 was, then that's when we would have a much

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1 more lengthy discussion about, you know, what
 2 that meant and what change in treatment that
 3 we may offer to that patient at that
 4 particular time.
 5 CHAYTOR, Q.C.:
 6 Q. If we could have P-071, please. I take it,
 7 Registrar, did you find the notes, the version
 8 of it. Yes, 539, please, yes. I think this
 9 is--it's indicated to be a note, August 1st,
 10 2005, but there's no indication as to who
 11 attended.
 12 DR. LAING:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. But there are points from different people are
 16 attributed.
 17 DR. LAING:
 18 A. And there's no reference that I had made any
 19 comments at that meeting.
 20 CHAYTOR, Q.C.:
 21 Q. And we're not sure, in fact, that this is the
 22 larger meeting, this may have been a smaller
 23 meeting.
 24 DR. LAING:
 25 A. Okay.

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1 CHAYTOR, Q.C.:
 2 Q. At a different point during the day.
 3 DR. LAING:
 4 A. Yeah, okay, fair enough.
 5 CHAYTOR, Q.C.:
 6 Q. I think there's some discrepancy on that. So
 7 if we could have P-0071, please. Doctor, I
 8 hear what you're saying that you don't recall
 9 being present when there was any controversy,
 10 any voices raised, or any accusations or
 11 anything of that nature. Do you recall any
 12 discussion about news releases or what could
 13 potentially go into a news release?
 14 DR. LAING:
 15 A. At that--at the meeting on August 1st.
 16 CHAYTOR, Q.C.:
 17 Q. Any meeting around that time?
 18 DR. LAING:
 19 A. Not in any great detail, no.
 20 CHAYTOR, Q.C.:
 21 Q. What about in not such great detail?
 22 DR. LAING:
 23 A. No, I don't have any recollection if that was
 24 discussed at that time.
 25 CHAYTOR, Q.C.:

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1 Q. So you have no recollection of discussing with
 2 anyone what could potentially be said in the
 3 news releases?
 4 DR. LAING:
 5 A. No, they didn't ask my input as to what would
 6 go into a news release at that time, no.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. Or at any point in time, I take it?
 9 DR. LAING:
 10 A. At any point in time in this whole process or
 11 at -
 12 CHAYTOR, Q.C.:
 13 Q. No, after it becomes public, perhaps you're
 14 involved at that point?
 15 DR. LAING:
 16 A. Yes, yes.
 17 CHAYTOR, Q.C.:
 18 Q. But any time before it actually becomes an
 19 issue of public discussion were you consulted
 20 for your input into any draft media releases
 21 or anything that could possibly be said to the
 22 public on the issue?
 23 DR. LAING:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And P-0071. These are draft releases
 2 attached here. And they're dated July 18th,
 3 2005. And there's a number of different
 4 versions. Another one here, July of '05.
 5 Were you ever shown those?
 6 DR. LAING:
 7 A. No. They don't look familiar to me.
 8 CHAYTOR, Q.C.:
 9 Q. Okay.
 10 DR. LAING:
 11 A. At some point, and I believe it was later on
 12 in the process, I had some input to a draft,
 13 but that was for a letter, I believe, to
 14 physicians. And it may have been, you know,
 15 after the October 1st when it came in the
 16 media, but I don't recall.
 17 CHAYTOR, Q.C.:
 18 Q. And this one here is the one at page 9 that
 19 Dr. Carter said she took exception with, the
 20 idea of the public being told that the
 21 retesting was due to improved technology. Do
 22 you recall that ever being floated in your
 23 presence or in discussion with you the idea of
 24 saying that the changes, that somehow it was a
 25 technology issue?

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<p>1 DR. LAING: 2 A. No. 3 CHAYTOR, Q.C.: 4 Q. If we could have, please, P-0564? And this is 5 a meeting August 10th, 2005. And it appears 6 you are in attendance at this meeting with Mr. 7 Tilley, Ms. Pilgrim, Dr. Cook and Dr. 8 Williams. And there's an update given by Dr. 9 Cook? 10 DR. LAING: 11 A. Yes. 12 CHAYTOR, Q.C.: 13 Q. Where he indicates it'll be four to six weeks 14 for Mount Sinai to report the specimens. 15 DR. LAING: 16 A. Um-hm. 17 CHAYTOR, Q.C.: 18 Q. And your update is "All people who are ER 19 negative need to be retested. Treatment has 20 varied a lot over the years. ER positive and 21 PR negative cases may be suitable for 22 aromatase inhibitors. Need to know what their 23 true ER/PR status is. All patients will need 24 an individual reassessment. Find out who is 25 alive and who is dead. Dr. Laing has a</p>	<p>1 be a factor that we would have to consider. 2 CHAYTOR, Q.C.: 3 Q. Okay. And I guess that's what's meant, then, 4 further along where you--"ER positive and PR 5 negative cases may be suitable for aromatase 6 inhibitors." 7 DR. LAING: 8 A. Right. I don't know if you recall yesterday 9 we had a little bit of a discussion about this 10 idea of trying to look at predictive markers 11 in a way to determine who may benefit more or 12 less from things like the Tamoxifen and the 13 aromatase inhibitors. 14 CHAYTOR, Q.C.: 15 Q. Yes. 16 DR. LAING: 17 A. And one of those trials, which was the ATAC 18 trial, there had been a review of that done by 19 Dr. Mitch Dowsett who is an oncologist who 20 went back and looked at the ATAC trial, which 21 was the adjuvant anastrozole which is an 22 aromatase inhibitor versus Tamoxifen, and in a 23 retrospective analysis, so, you know, sort of 24 hypothesis generating look, there seemed to be 25 a clue that perhaps ER positive, PR negative</p>
<p>1 problem with sending out letters until we know 2 how much of a problem we have." So, Doctor, 3 perhaps you could tell us, I think it's 4 straightforward the first bullet. 5 DR. LAING: 6 A. Yes. 7 CHAYTOR, Q.C.: 8 Q. That you're saying all people ER negative need 9 to be retested. 10 DR. LAING: 11 A. Um-hm. 12 CHAYTOR, Q.C.: 13 Q. And what do you mean by "Treatment has varied 14 a lot over the years."? 15 DR. LAING: 16 A. So as part of this discussion I was giving an 17 update on how the treatment of hormone 18 receptor positive cancer had changed. We were 19 talking about a period of time going back to 20 1997 and just in relation to the fact that we 21 used to not treat pre-menopausal patients, we 22 used to only have Tamoxifen, we're getting 23 into the aromatase inhibitor era now in 2004 24 and 2005 and that, you know, this was going 25 to, in any sort of review, this was going to</p>	<p>1 patients benefitted more for the aromatase 2 inhibitors. Subsequently to this another of 3 the larger trials, the big one in '98 which is 4 the letrizole versus Tamoxifen trial has not 5 shown the same thing. And my point at the 6 time was because this is when there was some 7 discussion about whether if we were 8 identifying people by ER, did we really need 9 to check the PR, and it was my point that, 10 saying that, yes, because as time goes on, 11 that may be how we use these predictive 12 factors, not only in determining if somebody 13 needs hormonal therapy, but what type they 14 should be offered. 15 CHAYTOR, Q.C.: 16 Q. So it was important then to know each 17 patient's true ER/PR status? 18 DR. LAING: 19 A. That's right, yeah. 20 CHAYTOR, Q.C.: 21 Q. And that's what the next bullet says? 22 DR. LAING: 23 A. Yeah. 24 CHAYTOR, Q.C.: 25 Q. Okay. Then "And then all patients will need</p>

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<p>1 an individual reassessment." 2 DR. LAING: 3 A. Yes. 4 CHAYTOR, Q.C.: 5 Q. And you're suggesting "Find out who is alive 6 and who is dead." 7 DR. LAING: 8 A. Yes. 9 CHAYTOR, Q.C.: 10 Q. And why were you suggesting that at this point 11 in time? 12 DR. LAING: 13 A. Because I felt that we should give priority to 14 retesting the patients who were known to be 15 alive and to put the patients who had been 16 deceased to the side and retest them later, 17 that if there was any way as the retesting was 18 going under way, that we could ensure that the 19 patients that were still alive were being 20 retested. And also, you know, if you're 21 thinking about sending out a letter, stressing 22 - 23 CHAYTOR, Q.C.: 24 Q. No, before we leave that one, Doctor. 25 DR. LAING:</p>	<p>1 an effort made for that to happen? 2 DR. LAING: 3 A. I don't know that there was or not. Our 4 tumour registry, as I said yesterday, at that 5 time didn't have a good link to vital 6 statistics to do what's called death clearance 7 to make sure that people that were found to be 8 deceased, that that was noted in the tumour 9 registry. And in fact, in our cancer patient 10 charts, our OPUS system charts, it's not 11 always evident by picking up one of those 12 charts and looking at it whether or not a 13 patient is deceased unless there's some sort 14 of notification. And if there is a 15 notification made to the clinic either by a 16 family member of the deceased patient or 17 sometimes we'll come in and say, you know, I 18 know that, you know, my patient has died and 19 we'll ask for that death notification to go on 20 the chart, that we felt that in some instances 21 there may not be any way to know that these 22 people had, in fact, died of their breast 23 cancer or of other causes. 24 CHAYTOR, Q.C.: 25 Q. So in terms of there was no discussion about</p>
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<p>1 A. Okay, fair enough. 2 CHAYTOR, Q.C.: 3 Q. The idea about who is alive and who is dead, 4 so you were suggesting that, yes, the deceased 5 would be retested, as well, but that would 6 come later - 7 DR. LAING: 8 A. Later. 9 CHAYTOR, Q.C.: 10 Q. - give priority to those who are alive? 11 DR. LAING: 12 A. Exactly right. 13 CHAYTOR, Q.C.: 14 Q. And did you ever vary on that, that your 15 opinion that, yes, the deceased should also be 16 retested, was there ever a point in time when 17 you thought perhaps it wasn't necessary to 18 retest the deceased? 19 DR. LAING: 20 A. No. 21 CHAYTOR, Q.C.: 22 Q. Okay. And finding out who is alive so that 23 they could be given priority, did anyone run 24 with this suggestion afterwards? This is 25 August 10th, 2005. Do you know if there was</p>	<p>1 checking the provincial registry on that, to 2 check and see who - 3 DR. LAING: 4 A. I'm not sure at that time what process they 5 would have used. But, you know, one of the 6 things was if there was any way that we could 7 prioritize to deal with the living patients 8 first, I felt that that was a good idea. 9 CHAYTOR, Q.C.: 10 Q. Okay. And whether it was followed up on or 11 not, you're not sure? 12 DR. LAING: 13 A. I'm not sure. 14 CHAYTOR, Q.C.: 15 Q. Okay. And so the last bullet, "Dr. Laing has 16 a problem with sending out letters until we 17 know how much of a problem." First of all, 18 sending out letters to whom? 19 DR. LAING: 20 A. Letters to patients. 21 CHAYTOR, Q.C.: 22 Q. Okay. So what was being contemplated and what 23 was it that you had a problem with? 24 DR. LAING: 25 A. So what was being contemplated at this point</p>

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1 was whether or not a general letter should be
 2 sent out to all patients to say that this was
 3 an issue. And at this point my bias, if you
 4 will, was thinking that if we could have
 5 within a short period of time, a four to six
 6 week period, people retested and the results
 7 back, that it would be great to be able to sit
 8 down with people to say, you've had this
 9 testing redone, this is what your previous
 10 test was, if there was a change, this is what
 11 the change is, this is what it means to you
 12 and this is what we're going to do about it.
 13 At this time that was my feeling about that
 14 was very much contingent on the impression
 15 that we have that this was going to be a very
 16 short period of time, that this turnaround was
 17 going to be within four to six weeks. Looking
 18 back, knowing what I know now that, in fact,
 19 it took much longer for Mount Sinai to get
 20 through the test results, it took much longer
 21 for us to do the panel because honestly at
 22 that point I was not expecting the volume of
 23 work that was generated from this, then I
 24 would have, I would have changed my mind on
 25 that issue and I would have said, yes,

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1 knowing--and this is, you know, and this is
 2 the issue with disclosing things like this to
 3 patients, there are some people who, you know,
 4 want to know right away and there are some
 5 people who would say, I would like to know
 6 what that means for me. It was always our
 7 intention to disclose to patients. The big
 8 question was the timing. And because I had
 9 weighed in, I guess, at this point with that
 10 discussion, I was advised at that time by Dr.
 11 Williams that they had had discussions with
 12 the health minister and that there was some
 13 thought given to sending as letter at that
 14 time to the patients. And it was not, my
 15 recollection is not at this meeting, but very
 16 shortly after this meeting, whether it was the
 17 next day or the day after that I received a
 18 call from Dr. Williams saying, would you come
 19 and sit down with Minister Ottenheimer, he'd
 20 like to meet with you and he'd like to hear
 21 your opinion regarding this matter.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So, Doctor, the first time that you're
 24 informed of anything about the idea of sending
 25 a letter out to patients, the first time

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1 that's brought to your attention is at this
 2 meeting on August 10th, 2005, is that correct?
 3 DR. LAING:
 4 A. From what I recall, yes. I don't recall
 5 having had discussions with people prior to
 6 this point.
 7 CHAYTOR, Q.C.:
 8 Q. And is this the first time, then, that your
 9 opinion then a couple of days later, you're
 10 invited by Dr. Williams to go to meetings with
 11 the minister?
 12 DR. LAING:
 13 A. To go to a meeting with Minister Ottenheimer,
 14 yeah.
 15 CHAYTOR, Q.C.:
 16 Q. So any views you had on that prior to August
 17 10th, 2005, you would not have articulated
 18 that to anyone before August 10th, 2005?
 19 DR. LAING:
 20 A. Looking back, not that I recall. But I would
 21 assume that my opinion would not have been
 22 different two or three weeks before.
 23 CHAYTOR, Q.C.:
 24 Q. Yes.
 25 DR. LAING:

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1 A. As to what is now.
 2 CHAYTOR, Q.C.:
 3 Q. It's just that you weren't asked before and
 4 this is -
 5 DR. LAING:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. - the first time you would have voiced your
 9 opinion?
 10 DR. LAING:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. In terms of disclosure to patients?
 14 DR. LAING:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. And the manner of disclosure?
 18 DR. LAING:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. Doctor, in terms of then I hear what
 22 you're saying about thinking it was going to
 23 be a four to six week turnaround, in fact, as
 24 time went on, it took longer than four to six
 25 weeks even to get the samples from the out of

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1 town samples, to get them assembled and sent
2 off to Mount Sinai. So as time marched on and
3 it was realized--were you kept apprised as to
4 where things were and that, in fact, of course
5 it's going to take longer than that, we
6 haven't even got all the material in. Were
7 you kept apprised of that?

8 DR. LAING:
9 A. No, I don't recall anybody contacting me from
10 the lab or anything to say that it was taking
11 longer to get the slides together or any
12 issues like that.

13 CHAYTOR, Q.C.:
14 Q. And did you make it clear to Dr. Williams, Dr.
15 (sic.) Tilley and the others that your opinion
16 in terms of patient disclosure is contingent
17 on this being a short turnaround period?

18 DR. LAING:
19 A. Yes.

20 CHAYTOR, Q.C.:
21 Q. If this is going to take longer, the patients
22 should be told, did you--were they on--do you
23 feel you articulated that clearly to them?

24 DR. LAING:
25 A. Yes.

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1 THE COMMISSIONER:
2 Q. Ms. Chaytor, while we're on the subject I'm
3 just going to butt in here for a moment. Two
4 things, Dr. Laing. Was this a general
5 discussion and did other people give their
6 views and, if so, do you remember what other
7 people's views were or was it just a question
8 of someone asking you what's your opinion?

9 DR. LAING:
10 A. No, my recollection was that other people
11 weighed in on this discussion. I felt that
12 they were asking my views for two reasons: one
13 was because I had had some experience in
14 disclosing already to some patients; and the
15 second was because I had experience in, you
16 know, talking to patients about cancer and
17 diagnosis and prognosis and sort of what my
18 experience over the years had been in the
19 clinic in terms of helping people make
20 decisions and the idea that the more
21 information they had, the better they were
22 informed, the better it was to make a
23 decision.

24 THE COMMISSIONER:
25 Q. Yes, I think I understand why it is you took

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1 the position you did. At that meeting,
2 according to this note, there would have also
3 been Mr. Tilley, Ms. Pilgrim, Dr. Cook and Dr.
4 Williams?

5 DR. LAING:
6 A. Yes, that's correct.

7 THE COMMISSIONER:
8 Q. Do you recall the positions of the other
9 people in the room?

10 DR. LAING:
11 A. I don't recall them specifically. I don't
12 recall that anybody strongly disagreed with my
13 view. I think they were just asking me my
14 opinion and I gave that. But I do recall, the
15 only thing that I recall was--and this, when I
16 sat down and thought about it, I think, was
17 later, that Dr. Williams had said about coming
18 back to the health minister. But at that
19 meeting they did bring that up to say that
20 there had been a differing opinion sent--or
21 from Minister Ottenheimer at that point where
22 they felt that perhaps a letter should go out
23 at that time. But my recollection was that
24 was an opinion that came from Minister
25 Ottenheimer and the government and not

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1 necessarily the opinion of the people in that
2 room.

3 THE COMMISSIONER:
4 Q. You said you did not recall that anyone
5 strongly disagreed.

6 DR. LAING:
7 A. Yes.

8 THE COMMISSIONER:
9 Q. Does that mean that nobody said anything, that
10 there was a weak little voice in the corner
11 that said, not me, I wouldn't go that way, or
12 was it really just that nobody was voicing
13 anything that was in disagreement with your
14 view?

15 DR. LAING:
16 A. That nobody at that time raised something that
17 disagreed with my opinion.

18 THE COMMISSIONER:
19 Q. Okay, then. And did either Mr. Tilley, Ms.
20 Pilgrim, Dr. Cook or Dr. Williams say I agree
21 with your position?

22 DR. LAING:
23 A. No, not that I recall.

24 THE COMMISSIONER:
25 Q. So you gave your opinion and nobody else

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1 objected to it but neither did anybody say I
 2 agree?
 3 DR. LAING:
 4 A. My recollection doesn't allow me to say
 5 whether somebody said it very strongly, no, I
 6 don't think that's a good idea, I think that's
 7 crazy, I think we should do something else,
 8 nor did people say, okay, that's what we're
 9 going to do. This was still something that at
 10 that time I believe was under discussion and I
 11 don't feel that at the end of this that the
 12 discussion was at all closed.
 13 THE COMMISSIONER:
 14 Q. I thought I was following you until you had
 15 the last sentence. Okay, is it that you do
 16 not remember the positions of anybody else or
 17 just because they did not raise anything which
 18 you remember as being strongly in disagreement
 19 with your position that you're saying as far
 20 as I know nobody disagreed with me?
 21 DR. LAING:
 22 A. The latter.
 23 CHAYTOR, Q.C.:
 24 Q. All right, thank you.
 25 DR. LAING:

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1 A. You're welcome.
 2 THE COMMISSIONER:
 3 Q. And could you tell me why this meeting was
 4 called, why this group?
 5 DR. LAING:
 6 A. No, no, I can't tell you why -
 7 THE COMMISSIONER:
 8 Q. So it would have been called by whom?
 9 DR. LAING:
 10 A. Dr. Williams.
 11 THE COMMISSIONER:
 12 Q. Not Mr. Tilley?
 13 DR. LAING:
 14 A. Not that I would know.
 15 THE COMMISSIONER:
 16 Q. You saw it as being called by Dr. Williams, in
 17 any event?
 18 DR. LAING:
 19 A. Right. So during this whole period of time
 20 all of the requests that I had to attend
 21 meetings and all of the requests for my
 22 opinion and what I thought about things
 23 actually came from Dr. Williams. I would say
 24 that during this time period that there was
 25 often not a day that would go by that I might

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1 not get a phone call from Dr. Williams to ask
 2 me a question. Most often they were questions
 3 pertaining to the clinical management of
 4 breast cancer, and because for someone who was
 5 outside of this field, you know, there was a
 6 lot to learn in a short period of time. And
 7 often I'd be in the clinic and somebody would
 8 pop their head in the room and say, Dr.
 9 Williams is on the phone. And so I know that
 10 I, you know, talked to him, but mostly about
 11 clinical issues in terms of treatment and
 12 these sorts of issues surrounding breast
 13 cancer management.
 14 THE COMMISSIONER:
 15 Q. Did you see yourself as a part of this group
 16 or did you see--it's an interesting
 17 combination of people, put it that way. So
 18 I'm interested in whether you saw yourself as
 19 part of this group which met regularly or did
 20 you see yourself as an invitee on this
 21 occasion, not really part of that group?
 22 DR. LAING:
 23 A. I think really at this time I was starting to
 24 feel like I was becoming a part of this group
 25 and that if there were going to be meetings

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1 that were pertinent, that they wanted someone
 2 from the clinical aspect of things, that that
 3 person would be me or Dr. McCarthy who would
 4 be asked to come to these meetings. I felt
 5 that I was asked to be in this position
 6 because at this time, although I was director
 7 of medical oncology within the NCTRF, I felt I
 8 was there more as a physician who was
 9 knowledgeable about breast cancer. And in
 10 retrospect I've looked back and thought if
 11 this was perhaps an issue I had been asked to
 12 speak to about a cancer that I wasn't
 13 experienced in treating, like lung cancer,
 14 that I would have either brought someone along
 15 with me such as one of my colleagues who would
 16 be a lung cancer physician or sent them in my
 17 place.
 18 THE COMMISSIONER:
 19 Q. Okay, thank you. Sorry, Ms. Chaytor, I was
 20 interrupting again.
 21 CHAYTOR, Q.C.:
 22 Q. So Doctor, in this same meeting, August 10th,
 23 Heather Predham's update includes that the--
 24 she has a list of all people who need to be
 25 retested. First page shows people who are on

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<p>1 Tamoxifen. So do you know, was there any 2 effort to figure out the people who were 3 already on Tamoxifen and prioritize who was 4 retested on that basis, to not send off the 5 people who were on Tamoxifen first, to get the 6 other people retested? 7 DR. LAING: 8 A. No, I don't believe so at all. In fact, when 9 I look at this, I wonder if it meant that on 10 the list of people who--I'm wondering if this 11 included, perhaps, people that were already 12 retested and we knew that they had been 13 started on treatment, but no, there was never 14 any effort made to go to the records and 15 determine what therapy people had received 16 prior to deciding whether or not they needed 17 to be retested. 18 CHAYTOR, Q.C.: 19 Q. Okay, and then comments attributed to you at 20 this meeting, it says you "feel if this 21 happened over eight years, should be 22 approached in a systematic way. We can't fix 23 overnight." So first of all, you feel that it 24 happened over eight years. What, by August 25 10th, 2005, would give you that thought or</p>	<p>1 Q. No. 2 DR. LAING: 3 A. But that when I was looking at this now, 4 saying--because in the beginning, you know, 5 was this going to be a 2002, because of the 6 index case? Was this going to be 2003 because 7 of what we now know about Dr. Ejeckam's memo? 8 No, this was that this was something that was-- 9 -that we needed to look at all of those time 10 points. 11 CHAYTOR, Q.C.: 12 Q. Okay. Third bullet attributed to you is "she 13 doesn't feel we are trying to cover things 14 up." In what context would you make such a 15 comment? 16 DR. LAING: 17 A. I'm not certain what that was meant by. 18 Perhaps that was in reference to waiting to 19 disclose to people once we had all the 20 information. That's the only sort of context 21 I can think that perhaps it was in, but - 22 CHAYTOR, Q.C.: 23 Q. What discussion was had around that? Was 24 somebody suggesting that things could be 25 perceived in that manner, that there was some</p>
<p>1 that inkling that it's something that's 2 happened over eight years? 3 DR. LAING: 4 A. So the eight years would come back from 1997 5 to 2005. At this point, there had been 6 various people tested at different time 7 periods and it wasn't my--at least at this 8 point, there didn't seem to be any signal that 9 this was something that was isolated to a 10 specific period of time, and that which was a 11 reason for doing the retest for the entire 12 time period. 13 CHAYTOR, Q.C.: 14 Q. So it wasn't that you--are you saying that by 15 this point in time, you realize it's not an 16 issue that is pertinent to one or two years. 17 It's something that happened over the entire 18 time period? 19 DR. LAING: 20 A. That's right, yeah. 21 CHAYTOR, Q.C.: 22 Q. And you're of that view at this point in time? 23 DR. LAING: 24 A. Not that I had known about it for eight years. 25 CHAYTOR, Q.C.:</p>	<p>1 sort of cover up? 2 DR. LAING: 3 A. If there's--not that I recall, but you know, 4 again, these are notes that somebody took and 5 seems to indicate that there was some 6 conversation around that. It certainly wasn't 7 my feeling then and is now my feeling now. 8 CHAYTOR, Q.C.: 9 Q. And so whether or not that was spoke of at 10 this meeting and what was said around that, 11 you can't recall? 12 DR. LAING: 13 A. No. 14 CHAYTOR, Q.C.: 15 Q. Okay, and of course, you are aware that in the 16 October 2nd news story that runs, there is a 17 quote attributed to you at that point too 18 which uses the words "cover up" that this, we 19 weren't trying to cover anything up, a similar 20 statement is attributed to you in that story 21 on October 2nd. 22 DR. LAING: 23 A. Yes, the Independent article. 24 CHAYTOR, Q.C.: 25 Q. Yes. So you're not sure though what's being</p>

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1 discussed on August 10th in that regard?
 2 DR. LAING:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. "What is appropriate for patient care, testing
 6 of ER negative patients and when results come
 7 back, then tell patients individually and not
 8 create panic in patients at this point in
 9 time, can't tell them. It is too soon to tell
 10 the patients," and what is it that you're--
 11 what exactly was being discussed and does that
 12 appear to be accurate, in terms of what you
 13 would have been saying on the issue?
 14 DR. LAING:
 15 A. I believe this just relates back to what we
 16 had talked about earlier, that my position was
 17 that we would tell patients when we had all of
 18 the information in hand.
 19 CHAYTOR, Q.C.:
 20 Q. And Doctor, what--why would you think that
 21 informing patients that it was necessary to
 22 have a retest or was felt necessary to have a
 23 retest and that it could lead to them having
 24 to have hormonal treatment, what would make
 25 you feel that that could create panic in the

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1 patients?
 2 DR. LAING:
 3 A. That they would have some anxiety related to a
 4 change in their results, that they would be
 5 worried, that they would, you know, be
 6 concerned for a period of time without knowing
 7 what the answer was. You know, really when I
 8 look back at that time, my position was go to
 9 the patients individually with as much
 10 information as we could at the time. Again,
 11 back to the point that I thought that this was
 12 going to be over four to six weeks. One of
 13 the things that I was concerned about, and of
 14 course, you know, we're still in August of
 15 2005, and we really have no idea what the
 16 actual magnitude of this is going to be. Now,
 17 of course, looking back, we know that more,
 18 but even at this time, we weren't sure that
 19 this was going to be something that affected
 20 very many patients, and so you're trying to
 21 balance, you know, causing anxiety in a large
 22 group of people versus waiting until you have
 23 that information to be able to give to the
 24 patients, and really, in one step, if you
 25 will, address the issue.

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1 CHAYTOR, Q.C.:
 2 Q. The tests that you had run on the Ventana
 3 system in house indicated that it perhaps
 4 could involve a significant number of the
 5 patients who were being subject to the retest.
 6 DR. LAING:
 7 A. It did, but at this time, we had made a
 8 decision to think that the Ventana system was
 9 not necessarily the most reliable, because of
 10 our concern about the over call.
 11 CHAYTOR, Q.C.:
 12 Q. The idea of causing anxiety in the patients,
 13 the patients that you had spoken with and that
 14 Dr. McCarthy had spoken with, the patients
 15 that you had both from the June 29th list and
 16 the original patients, the five patients, they
 17 had taken it well? You told me this morning
 18 they had--when you told them there was a
 19 possibility to be retested, and again when you
 20 told them the results, that it was positive
 21 and they took the information well on both
 22 occasions.
 23 DR. LAING:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. You told me yesterday that it's your practice
 2 to keep your patients informed and have them
 3 to be decision makers in their own care and
 4 treatment plans.
 5 DR. LAING:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And that's the way you conduct your practice,
 9 to keep your patients informed.
 10 DR. LAING:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. And you encourage them to be informed and you
 14 encourage them to take part in the decision
 15 making.
 16 DR. LAING:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. So why, in this case, and with that
 20 information and the background of having
 21 already told some of the patients and their
 22 reactions, why would you not want to let all
 23 the patients know that this is happening and
 24 to tell it to them in a way that it would not
 25 induce anxiety?

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1 DR. LAING:
 2 A. Sure. I think in answer to that, there's a
 3 couple of points. One is that to that date,
 4 although I had some experience, it had been in
 5 a limited number of patients, and patients who
 6 I had already known and who were in my care.
 7 So I had already developed a rapport with
 8 them. And then the second part of that is to
 9 be--we were dealing with a very small number
 10 of patients at that time and that I felt that,
 11 you know, if the trend continued and if there
 12 was going to be a large number of patients
 13 that needed to be informed, that we may not be
 14 able to do that sitting down and spending the
 15 time and talking to them and disclosing them
 16 if, you know, all of a sudden we had a whole
 17 bunch to do on one day. Just the logistics of
 18 how that would unfold.
 19 I can tell you now that as I have gone
 20 through this process and have met with many,
 21 many, many more patients through this whole
 22 process, some of whom were mine from the very
 23 beginning and some of whom I was asked to see
 24 as a result of this, that there was a mix in
 25 what we have been told by patients. Some

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1 patients said "I'm so glad that I didn't know,
 2 because I wouldn't be able to sleep or eat or
 3 do anything else," and some people said "the
 4 minute you even contemplated retesting a
 5 sample of my breast tissue, I should have been
 6 informed." Those would be the two extremes,
 7 and there, of course, would be people that
 8 would fall in. That's something that we -
 9 CHAYTOR, Q.C.:
 10 Q. And people who might not be comfortable saying
 11 to you what their views are, one way or the
 12 other.
 13 DR. LAING:
 14 A. Right, and that's something that I can only
 15 draw on my experience as a physician.
 16 Although I certainly do my best to inform my
 17 patients, one of the things that--and here, we
 18 talked about this and thought about it a lot,
 19 about what experience and things I ever had in
 20 disclosure, and although that wasn't anything
 21 that I had ever had any training or up to this
 22 point and onwards that anybody had ever talked
 23 to me about, as a medical oncology resident
 24 and fellow, we were taught, and spent a lot of
 25 time talking about breaking bad news, telling

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1 patients things that are difficult for them to
 2 hear, and to this day, I do it every day in my
 3 practice, and one of the things that I was
 4 always taught, and the things that I always do
 5 and I remember is the first thing you do is
 6 you say to the patients, "what do you already
 7 know?" And if I see a new patient next week,
 8 I go through their history and physical and I
 9 sit down with them and I say "what have the
 10 doctors told you already?" And then you have
 11 that idea, and then you say to them, "what do
 12 you want to know?" And some people, through
 13 the course of treatment, for example, have
 14 said to me "I don't want to know how many--Dr.
 15 Kwan told me I had cancer in my breast and he
 16 told me that he took it out, and he told me
 17 that I had lymph nodes, but I don't want to
 18 know how many lymph nodes are involved." So
 19 there are actually people who, you know, don't
 20 even want to know that degree of information.
 21 Most of all, people though say, you know,
 22 that they know that and a lot of people want
 23 to know, right down to the actual percentage
 24 of what I think benefit is and those are the
 25 people that I'll often take out and sit down

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1 and do adjuvant online with them. But most
 2 patients just really want to know very basics.
 3 They say "don't tell me percentages. Don't
 4 tell me numbers. I'm not interested in that."
 5 And so really, you know, you get an idea from
 6 patients how much information they want to
 7 know and, you know, you have to put it in a
 8 context of where you are, and at this point,
 9 again, I was thinking "go to them, have all
 10 the information in hand" and I guess that's
 11 partly because that's what we do as
 12 clinicians. I mean, in our usual clinical
 13 practice, I wouldn't send somebody away for a
 14 CAT scan or something and have them come back
 15 before it came back, and you know, sometimes
 16 in the clinic, we're waiting for diagnostic
 17 tests and things to come back and if they're
 18 not ready or not available, I know that that's
 19 anxiety provoking to patients. So really I
 20 was drawing on my clinical experience in these
 21 days about making these decisions.
 22 CHAYTOR, Q.C.:
 23 Q. But I take it if you're going to have--if the
 24 patient--the patient is informed if she has
 25 her CAT scan done and it needs to be redone,

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1 she has to reattend to have it redone, so
 2 she's told in that situation, "there was
 3 something wrong, you need to have it done
 4 again. The film wasn't clear."
 5 DR. LAING:
 6 A. No, I sort of meant that the report wasn't
 7 back yet, not that it had to be redone, but,
 8 yeah.
 9 CHAYTOR, Q.C.:
 10 Q. But in that situation, going to draw an
 11 analogy, I mean, the patient is told if a test
 12 needs to be repeated and have it done again.
 13 Did you--you say you didn't--weren't trained
 14 on this and you didn't--in terms of how to
 15 deal with such a situation.
 16 DR. LAING:
 17 A. Um-hm.
 18 CHAYTOR, Q.C.:
 19 Q. I'm just wondering, did you seek advice from
 20 anyone else? You sought advice from Dr.
 21 Pritchard on the clinical issue about the
 22 benefit to delay in introducing the Tamoxifen.
 23 DR. LAING:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. Did you seek advice then from anyone else
 2 outside of Eastern Health, anyone who could
 3 stand back from the issue? Did you ask anyone
 4 "well, what should we do in this situation?
 5 I've never been--I've never had to deal with
 6 something like this. Can you help me?"
 7 DR. LAING:
 8 A. In relation to disclosure?
 9 CHAYTOR, Q.C.:
 10 Q. Disclosure issue, yeah.
 11 DR. LAING:
 12 A. No. No, not at that time.
 13 CHAYTOR, Q.C.:
 14 Q. Did you think of--did anyone discuss perhaps
 15 getting an ethical consult as to whether or
 16 not we should be retesting people without
 17 their consent or prior knowledge?
 18 DR. LAING:
 19 A. No, I had no recollection at this time of an
 20 ethical issue, of considering ethical
 21 consultation, and as you know, we did do that
 22 subsequently.
 23 CHAYTOR, Q.C.:
 24 Q. With respect to the deceased.
 25 DR. LAING:

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1 A. Correct, and that was the first time that -
 2 CHAYTOR, Q.C.:
 3 Q. And again in April, we hear.
 4 DR. LAING:
 5 A. - that I had--April, sorry?
 6 CHAYTOR, Q.C.:
 7 Q. This year, April '08 on an issue of--the
 8 apology letter apparently came out of that.
 9 You're not aware of that?
 10 DR. LAING:
 11 A. No, we actually had a meeting regarding the--
 12 we had an ethical consultation regarding the
 13 deceased patients prior to 2008.
 14 CHAYTOR, Q.C.:
 15 Q. Yes, in June 2006, yeah. Now there's another
 16 issue of another ethical consult, and it
 17 doesn't sound like you're aware of it.
 18 DR. LAING:
 19 A. Oh no.
 20 CHAYTOR, Q.C.:
 21 Q. That's much later on. But nothing at all, at
 22 this particular point in time, in terms of
 23 getting any kind of advice or an ethical
 24 consult in terms of disclosure to the
 25 patients?

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1 DR. LAING:
 2 A. No, we didn't.
 3 CHAYTOR, Q.C.:
 4 Q. Okay, and what about the patients that you had
 5 already told, the patients back from the June
 6 29th list, the patients that you had already
 7 told about the issue? The first five, what
 8 about--did you ask them? Did you say
 9 "actually, we're going to do a broader testing
 10 now. What do you think, as a patient? Do you
 11 think your fellow patients would want to
 12 know?"
 13 DR. LAING:
 14 A. That's a good idea, but no, I've never asked
 15 them that.
 16 CHAYTOR, Q.C.:
 17 Q. And the patients who were coming in still to
 18 see you who had metastatic disease and you
 19 were letting them know that the retesting was
 20 happening, what about them? Did you ask them
 21 their opinion as to--the patients you were
 22 seeing in July and August, September, the ones
 23 you were telling?
 24 DR. LAING:
 25 A. No, those few patients, I didn't ask them what

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1 they would--you know, what their point of view
 2 would be on this as a general--or in a more
 3 general sense or applying to a larger audience
 4 or larger number of patients.
 5 CHAYTOR, Q.C.:
 6 Q. And Doctor, so you knew that at least ten or
 7 12 from the first batch had been told. You
 8 knew that the--well, of course, Ms. Deane knew
 9 there had been a conversion in her case, and
 10 you knew that there were the three or five
 11 other patients who had been told, and some of
 12 those may overlap on your June list. So you
 13 knew that there were a number of patients who
 14 already knew, and were you concerned that the
 15 breast cancer patients within the province,
 16 and particularly within the St. John's area,
 17 are a fairly close knit group.
 18 DR. LAING:
 19 A. Um-hm.
 20 CHAYTOR, Q.C.:
 21 Q. They are part of a very strong network of
 22 people, support network. Were you concerned
 23 that "they're going to be speaking to one
 24 another; they are going to hear about this
 25 indirectly. It's better that they hear it from

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1 me, from us"? Did that occur to you?
 2 DR. LAING:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. Doctor, was there anyone advocating telling
 6 the patients? Commissioner Cameron asked you
 7 about the list of people who were in
 8 attendance at the meeting and whether or not
 9 anyone in that meeting was actually voicing
 10 anything different from your opinion, but was
 11 there anyone at Eastern Health advocating
 12 "we're concerned about this, Dr. Laing. We
 13 think perhaps we should be out there telling
 14 the patients"?
 15 DR. LAING:
 16 A. Not that I recall, at this point.
 17 CHAYTOR, Q.C.:
 18 Q. At any point in time?
 19 DR. LAING:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. If we'd just continue on then with the meeting
 23 of August 10th. "Dr. Laing not worried about"
 24 and I think there's some mix up in the words
 25 here, but "not worried about doing the right

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1 thing, given our current knowledge. She feels
 2 sending out information now until we can give
 3 them the answers." The idea of "not worried
 4 about doing the right thing, given our current
 5 knowledge," was there anybody expressing that
 6 there was concern that you were--that somehow
 7 it wasn't the right thing to be doing? Do you
 8 recall what's the context that these remarks
 9 are made?
 10 DR. LAING:
 11 A. I can't, I don't know what the context is.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. "Leave clinical management to
 14 oncologists." Do you recall what that was
 15 referring to?
 16 DR. LAING:
 17 A. No, unless they were talking about what we
 18 would do when the results came back.
 19 CHAYTOR, Q.C.:
 20 Q. And again, this is a comment being attributed
 21 to you. You're not sure what that refers to?
 22 DR. LAING:
 23 A. No.
 24 CHAYTOR, Q.C.:
 25 Q. "Dr. Laing feels we are creating unnecessary

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1 anxiety to a lot of patients. Need the
 2 information on hand before we go to these
 3 women."
 4 DR. LAING:
 5 A. I think we've addressed that.
 6 CHAYTOR, Q.C.:
 7 Q. Yes. "Need to strike a balance between
 8 waiting and giving good information we are
 9 giving now and causing anxiety unduly." What
 10 information was being given that--was there
 11 anything already happening, in terms of it
 12 says that "feels we are creating unnecessary
 13 anxiety to a lot of patients." It's written
 14 in the present tense, and "information we are
 15 giving now and causing anxiety unduly."
 16 DR. LAING:
 17 A. No, that doesn't--I find, you know, sort of
 18 the context or the way it's written is a
 19 little bit confusing, so I'm not really sure
 20 what these notes from Dr. Williams were
 21 referring to.
 22 CHAYTOR, Q.C.:
 23 Q. So you have no recollection of what other
 24 points you may have been making?
 25 DR. LAING:

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1 A. I think it just refers back to what I had just
 2 said about, you know, waiting to give them--I
 3 would interpret this to be waiting to give
 4 them all the information and say this is what
 5 you were, this is what you are now, and this
 6 is what we're going to do about it versus
 7 piece meal. You're going to be retested. We
 8 don't have your test results back, and so on
 9 and so forth. So I don't think it's any
 10 different than anything that I've already told
 11 you, Ms. Chaytor.

12 CHAYTOR, Q.C.:

13 Q. If we could have, please, P-0785? This is an
 14 e-mail exchange, August 8th, I believe, and
 15 it's Ms. Predham to Dr. Williams, Dr. Cook,
 16 Terry Gulliver and Patricia Pilgrim, August
 17 8th, 2005, and the point in this e-mail I was
 18 going to bring to your attention is the idea
 19 of the Hot Line is addressed. "Meeting with
 20 our staff re: the Hot Line and what needs to
 21 be put in place. The biggest thing, from our
 22 perspective, will be answers to the items
 23 identified in our script. Will work on those
 24 today." So there appears to have been
 25 contemplation at the beginning of August,

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1 first week of August, of setting up a Hot
 2 Line, and then "also, will we be informing GPs
 3 on this issue? I think Kara Laing suggested
 4 that the letter use wording like 'you will be
 5 notified by the physician following your
 6 cancer and an appointment made to discuss
 7 results.' I was thinking that if the
 8 specialist is no longer here, an individual
 9 may contact their GP in the interim. What do
 10 you think?" And so the idea of informing, it
 11 appears, general practitioners in advance in
 12 case the patients might contact them, and the
 13 idea of drafting a letter to inform the
 14 general practitioners that this was happening,
 15 what do you recall around that?

16 DR. LAING:

17 A. I recall that subsequently I was sent such a
 18 letter that Dr. Gardiner had drafted, just to
 19 put in the issue related to what we were going
 20 to say, but if I remember correctly, this was--
 21 that would have been much later on in this.
 22 This would have been -

23 CHAYTOR, Q.C.:

24 Q. There's another draft, October 6th, 2005, when
 25 it becomes a public issue.

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1 DR. LAING:

2 A. Right.

3 CHAYTOR, Q.C.:

4 Q. But this is back in the beginning of August,
 5 and it appears, according to Ms. Predham
 6 anyhow, that you were--you gave some input
 7 into what would, in fact, go into such a
 8 letter.

9 DR. LAING:

10 A. I wasn't copied on this e-mail and I haven't
 11 seen it before, and I don't recall those
 12 discussions.

13 CHAYTOR, Q.C.:

14 Q. Okay, and -

15 THE COMMISSIONER:

16 Q. Not only are (inaudible) but it seems to me -

17 CHAYTOR, Q.C.:

18 Q. It's probably a letter to the patient, now
 19 that I look at it.

20 THE COMMISSIONER:

21 Q. Yes, it seems to me that it's talking about a
 22 letter to a patient referring to -

23 CHAYTOR, Q.C.:

24 Q. Yes, that's right.

25 THE COMMISSIONER:

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1 Q. - the physician following up.

2 CHAYTOR, Q.C.:

3 Q. Yes, this appears -

4 DR. LAING:

5 A. Following up your cancer, oh, I see what--
 6 sorry, when I read that first -

7 CHAYTOR, Q.C.:

8 Q. No, that's my fault, Doctor. I think I got it
 9 wrong.

10 DR. LAING:

11 A. Okay, "you will be notified by the physician
 12 following your cancer." Okay, so the
 13 physician doing your follow up care for your
 14 cancer, okay.

15 CHAYTOR, Q.C.:

16 Q. And an appointment made to discuss. So it
 17 looks like it's a draft of a letter, thank
 18 you, Commissioner, that was intended to go to
 19 the patients. Do you recall being involved
 20 in, on August the 8th, by that point in time,
 21 it appears, according to Ms. Predham, that you
 22 had already given a suggestion for wording in
 23 a letter to go to patients.

24 DR. LAING:

25 A. No, at this point, I--you know, I had made my

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1 opinion within a couple of days as to when I
 2 thought, you know, what I thought that we
 3 should do in terms of sending a letter, and so
 4 I don't know what this was in reference to.
 5 Was this from some discussions that we had had
 6 at earlier meetings? But I don't recall being
 7 given a draft letter or asking to put anything
 8 into a draft letter or anything like that, as
 9 I said.
 10 CHAYTOR, Q.C.:
 11 Q. So by August 10th, you are of the opinion to
 12 wait?
 13 DR. LAING:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. And you don't recall at any point prior to
 17 that giving any suggestions as to wording for
 18 a letter?
 19 DR. LAING:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. To go to patients?
 23 DR. LAING:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. In giving your opinion as to what should
 2 happen, in the meeting on August 10th, the
 3 opinion to hold off, "it is only going to be
 4 four to six weeks, let's wait."
 5 DR. LAING:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. Did you consult anyone else? Was that just
 9 your opinion, Dr. Kara Laing's opinion, or did
 10 you ask anyone else as to what their opinion
 11 might be?
 12 DR. LAING:
 13 A. No, this was something that we had discussed
 14 amongst ourselves, amongst the group of
 15 oncologists. I would have had discussions
 16 with Dr. McCarthy. We would have had
 17 discussions with the larger group. I believe
 18 I had some discussions with Dr. Ganguly
 19 regarding this issue. You know, as I said,
 20 this was something that we, as a group, were
 21 talking about and, you know, I do recall
 22 sitting down with my colleagues and sort of
 23 saying, you know, "I think we should wait
 24 until we have all the information. We think
 25 it's going to be in a short period of time,

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1 and then we'll deal with getting that to the
 2 patients and deciding what to do at that
 3 point."
 4 CHAYTOR, Q.C.:
 5 Q. So did you call together all of the
 6 oncologists? Was there a meeting called in
 7 which you solicited their opinion?
 8 DR. LAING:
 9 A. Don't think we had a formal meeting, no.
 10 CHAYTOR, Q.C.:
 11 Q. So you talked to Dr. Ganguly and who else?
 12 DR. LAING:
 13 A. Oh, I'm not sure. I know that I talked to--I
 14 would have talked to several of my colleagues
 15 about this.
 16 CHAYTOR, Q.C.:
 17 Q. And they were all of the same mind?
 18 DR. LAING:
 19 A. As I said, that we would often have informal
 20 discussions every week about various issues
 21 and I do know that this was something that
 22 this wasn't just me making this decision on my
 23 own, but that we did have some discussions
 24 with the other oncologists, and that there was
 25 a consensus that we wait until we had the

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1 information together for the patients.
 2 CHAYTOR, Q.C.:
 3 Q. So a consensus of whom? It wasn't the entire
 4 group?
 5 DR. LAING:
 6 A. I don't think that I would be able to tell you
 7 specifically who all those oncologists were,
 8 without any sort of formal minutes, but you
 9 know, when we would all get together and
 10 discuss these issues, then there would be
 11 whoever happened to be together with us on
 12 Tuesday mornings would sit around and have
 13 these discussions.
 14 CHAYTOR, Q.C.:
 15 Q. So you remember bringing this up on one of
 16 your regular Tuesday morning get togethers?
 17 DR. LAING:
 18 A. Yeah.
 19 CHAYTOR, Q.C.:
 20 Q. This issue?
 21 DR. LAING:
 22 A. And I remember discussing it separately with
 23 Dr. Ganguly. Whether I talked about it with
 24 other radiation oncologists, I may have, but
 25 my recollection is having a discussion with

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1 more oncologists than just Dr. McCarthy about
2 this issue.
3 CHAYTOR, Q.C.:
4 Q. And did any oncologist descent?
5 DR. LAING:
6 A. No.
7 CHAYTOR, Q.C.:
8 Q. Dr. Williams testified that part of the
9 oncologists' reluctance to disclose to the
10 patients upfront was concern about the
11 oncologists' workload and it would be
12 difficult with coping with all of the phone
13 calls or patient contacts that may be
14 generated should the patients be told. So in
15 that interim period, if you were to notify the
16 patients, the number of phone calls and
17 contacts the oncologists would have to deal
18 with, in terms of their ongoing practice. Was
19 that a consideration in your discussions with
20 the oncologists?
21 DR. LAING:
22 A. I think that if that did come up, it certainly
23 wasn't the final decision. It wasn't a strong
24 point in the decision. As you can imagine
25 that through this whole process, there have

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1 been various periods of time where we have
2 gotten many, many phone calls from our
3 patients. It would have first started in
4 October of 2005 and continues on each time
5 this issue comes forth again, particularly in
6 the public. So you know, big issue in October
7 2005, again into December of 2006, again in
8 May of 2007, again when the letter came out
9 regarding from Marian Crawley that summer, I
10 can't even remember, I think that was 2007,
11 and even most recently after the apology
12 letter. So there have been times where we
13 have had quite an increase in the volume of
14 calls and inquiries from our patients
15 regarding this issue. We would of course have
16 some concerns, not only--not just about the
17 phone calls that this would generate, but as
18 time went on, about how we could see these
19 patients quickly and efficiently within the
20 clinic, because of our limitations in space
21 and in staffing.
22 CHAYTOR, Q.C.:
23 Q. So the answer to my question then is that
24 there was some discussion about that and the
25 amount of patient contact that may be

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1 generated, but it wasn't an overriding factor?
2 DR. LAING:
3 A. No, no. In other words, I can honestly tell
4 you that we wouldn't say "we're not going to
5 call the patients because we don't want to
6 deal with the phone calls." That's not the
7 impression I want to give at all.
8 CHAYTOR, Q.C.:
9 Q. What was your thinking that if it can be done
10 in four to six weeks, we won't tell them. But
11 if it's going to be longer than that, if it's
12 going to take a longer or protracted period of
13 time, then the patients should be told? Why
14 if it's going to take two months, three
15 months, the decision would be different in
16 your mind?
17 DR. LAING:
18 A. Because the basis of my decision was that I
19 wanted to be able to go in with as much
20 information as I could to the patients, to
21 settle--you know, say "this is what you were.
22 This is what it is now, and this is what we're
23 going to do about it." That was my thinking
24 in 2005, during all this deliberations.
25 CHAYTOR, Q.C.:

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1 Q. But if it's going to take longer, they're
2 going to have a longer period of time. If
3 you're concerned about anxiety or not knowing,
4 if it's going to take longer, they're going to
5 have a longer period of time to fret or be
6 anxious over it, if that in fact is how they
7 would feel.
8 DR. LAING:
9 A. No, I think that we realized if this was going
10 to go on for a longer and longer period of
11 time, that you would be getting back to the
12 point that you raised earlier that if we're
13 telling, you know, two or three patients this
14 week, two or three patients next week, that
15 eventually this would be something that would
16 get out there, in terms of being common
17 knowledge within the clinic or within support
18 groups and all that sort of stuff. To this
19 point, you know, although there had been
20 patients disclosed to, it was a very, very
21 small number. We didn't know what, at the end
22 of the day, was going to be the number of
23 patients that were going to be disclosed to,
24 and I guess I can only answer that in terms of
25 what I recall to be my thinking at the time,

1 for the reason for wanting to wait.
 2 THE COMMISSIONER:
 3 Q. So Dr. Laing, then you're saying you didn't
 4 know what the number of patients were who
 5 would be disclosed to, I'm reading that as you
 6 would be disclosing to those patients who had
 7 a change and you would not be disclosing to
 8 other patients? Was that your thinking at the
 9 time?
 10 DR. LAING:
 11 A. No, no, no. We would--eventually, this would
 12 be something that would be disclosed to all
 13 patients who had the testing repeated, because
 14 that would be the only way that they would
 15 know that they had been retested and what
 16 their results had been, but that the
 17 disclosure -
 18 THE COMMISSIONER:
 19 Q. So that was going to be a large number of
 20 people, which you would have known starting
 21 out, if you were going to run from 1997
 22 onwards, or 1998?
 23 DR. LAING:
 24 A. Yeah, but that disclosure would not
 25 necessarily have to have come from the medical

1 are we going to deal with this.
 2 DR. LAING:
 3 A. Sure.
 4 THE COMMISSIONER:
 5 Q. And what I'm trying to figure out is at that
 6 stage had you thought about a distinction
 7 between patients who would have what's been
 8 called a conversion, and those who would not,
 9 and whether or not the method of disclosure
 10 will be different for one or the other group?
 11 DR. LAING:
 12 A. No, I had not had that extensive thinking into
 13 this at that point.
 14 CHAYTOR, Q.C.:
 15 Q. Dr. Laing, was there any thought given to
 16 contacting the Canadian Cancer Society or any
 17 other patient advocacy group to ask their
 18 views on how disclosure of such an issue could
 19 take place or should take place?
 20 DR. LAING:
 21 A. No, not that I know of.
 22 CHAYTOR, Q.C.:
 23 Q. And did anyone considering referencing Eastern
 24 Health adverse event disclosure policy?
 25 DR. LAING:

1 oncologists. That disclosure may not
 2 necessarily have had to take--if there was
 3 going to be, at the end of the day a large
 4 percentage of patients in whom the test
 5 results didn't change, then that process of
 6 disclosure wouldn't be as long as it was for
 7 the patients who had new test results.
 8 THE COMMISSIONER:
 9 Q. So from the beginning, it was contemplating
 10 that there would be two different disclosure
 11 procedures?
 12 DR. LAING:
 13 A. I don't think from the beginning. I think as
 14 we started to get the test results back and
 15 tried to deal with who was going to disclose
 16 to what --
 17 THE COMMISSIONER:
 18 Q. Yeah, but what you got to remember, let's put
 19 ourselves with the hat on that we are in this
 20 time frame which is in August, and which you
 21 have no test results back from --
 22 DR. LAING:
 23 A. Yeah, no, I don't --
 24 THE COMMISSIONER:
 25 Q. From Mount Sinai, and you're considering how

1 A. In 2005, that would have been the Health Care
 2 Corporation's disclosure policy, so not that I
 3 know of.
 4 CHAYTOR, Q.C.:
 5 Q. Gerri Rogers is a patient of yours, and she
 6 testified that you had told her that you did
 7 want to disclose to patients that there was
 8 retesting underway. Do you have any
 9 recollection of that?
 10 DR. LAING:
 11 A. No.
 12 CHAYTOR, Q.C.:
 13 Q. And did you tell that to Ms. Rogers?
 14 DR. LAING:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. So if Ms. Rogers had that understanding, she
 18 misunderstood what you said to her on the
 19 issue?
 20 DR. LAING:
 21 A. Yes, that was part of her testimony, and she
 22 had said that I had wanted to disclose it and
 23 Eastern Health told me not to.
 24 CHAYTOR, Q.C.:
 25 Q. Or something to that effect.

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<p>1 DR. LAING: 2 A. Something to that effect. 3 CHAYTOR, Q.C.: 4 Q. She thought it may have been some committee, 5 or she wasn't quite sure who, but that there 6 was some influence that came to bear on you on 7 the issue? 8 DR. LAING: 9 A. Yes. 10 CHAYTOR, Q.C.: 11 Q. But -- 12 DR. LAING: 13 A. That wouldn't have been--no, that wouldn't 14 have been how I -- 15 CHAYTOR, Q.C.: 16 Q. So that's not correct. 17 DR. LAING: 18 A. Had said that, no. 19 CHAYTOR, Q.C.: 20 Q. And do you recall any discussion with Ms. 21 Rogers on the issue from which she could have 22 taken that impression? 23 DR. LAING: 24 A. No, only the discussions that I would have had 25 with her as part of her ongoing care. She</p>	<p>1 you have any independent recollection of this 2 meeting, Dr. Laing? 3 DR. LAING: 4 A. Yes, I remember going to the Department of 5 Health for this meeting. It would have been 6 the first time that I had been asked to do 7 such a thing. I remember meeting with 8 Minister Ottenheimer. We met -- 9 CHAYTOR, Q.C.: 10 Q. Is that the first time you met him? 11 DR. LAING: 12 A. Yes, it was. 13 CHAYTOR, Q.C.: 14 Q. So it sticks out, I take it, in your mind? 15 DR. LAING: 16 A. Yeah, it would have been the first time that I 17 had gone and signed myself in to Confederation 18 Building for a meeting like that with the 19 Minister. I had been to the Department of 20 Health for other meetings before, but this was 21 the first one that I had had with Minister 22 Ottenheimer, and I remember going in, being 23 there present, and really basically giving an 24 overview from the point of view of again my 25 clinical experience and how we use the testing</p>
<p>Page 278</p> <p>1 would have been disclosed her results when 2 they were available, but I wouldn't have had a 3 discussion with her that indicated one way or 4 the other whether I would have been told or 5 not told to disclose or not disclose to 6 patients. I don't remember that. 7 CHAYTOR, Q.C.: 8 Q. But in terms of telling her what your personal 9 preference was in terms of disclosure? 10 DR. LAING: 11 A. No, I don't remember having a conversation 12 with her regarding that. 13 CHAYTOR, Q.C.: 14 Q. And that you had wanted to disclose to 15 patients about the retesting? 16 DR. LAING: 17 A. No. 18 CHAYTOR, Q.C.: 19 Q. You didn't tell her that? 20 DR. LAING: 21 A. No. 22 CHAYTOR, Q.C.: 23 Q. If we could have, please, P-0138. This is 24 notes from the meeting of August 15th, 2005, 25 and it's the meeting with the Minister, and do</p>	<p>Page 280</p> <p>1 in the lab and what it means, and then really 2 reiterating what we have already discussed in 3 terms of my views in terms of disclosure, that 4 is let's get the retesting done and then sit 5 down and go over the results with the 6 patients, and that it was--you know, I recall 7 this interaction, and, in fact, every 8 interaction I've ever had with Minister 9 Ottenheimer has been very positive, he was a 10 very kind easy to talk to individual, and that 11 they listened to my opinion. There wasn't a 12 lot of discussion back and forth, nobody sort 13 of said, oh, I don't agree with that. I don't 14 believe that a final decision was made. I 15 felt as if I was asked to come there to sit 16 there, tell the Minister what I thought, I was 17 thanked, and I left. 18 CHAYTOR, Q.C.: 19 Q. Okay. 20 THE COMMISSIONER: 21 Q. Ms. Chaytor, whenever you want we'll take the 22 afternoon break. 23 CHAYTOR, Q.C.: 24 Q. Okay, I'll just continue with this exhibit 25 then, please, Commissioner. This indicates</p>

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1 that it was the Minister present, Dr. Fleming?
 2 DR. LAING:
 3 A. Uh-hm.
 4 CHAYTOR, Q.C.:
 5 Q. Dr. Blair Fleming, I take it?
 6 DR. LAING:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. Would you have known him before this?
 10 DR. LAING:
 11 A. Not well. I would have known him in the
 12 capacity that we would write to him on
 13 occasion to request out of province referrals
 14 and those sorts of things. Whether I had met
 15 him personally regarding discussions around
 16 that before then, I may have. I certainly had
 17 spoken to him on the phone several times
 18 before that.
 19 CHAYTOR, Q.C.:
 20 Q. And you may have met him or discussed the
 21 issue of ER/PR with him prior to this?
 22 DR. LAING:
 23 A. Not that I would remember at all. No, I don't
 24 think so at all.
 25 CHAYTOR, Q.C.:

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1 Q. And have you since had any discussions with
 2 Dr. Fleming --
 3 DR. LAING:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. On this issue?
 7 DR. LAING:
 8 A. No.
 9 CHAYTOR, Q.C.:
 10 Q. And did he--did he offer any opinion on the
 11 issue of patient disclosure?
 12 DR. LAING:
 13 A. Not that I recall.
 14 CHAYTOR, Q.C.:
 15 Q. And Ms. Hennessey, Moira Hennessey, Mr.
 16 Tilley, Dr. Cook, yourself, and Dr. Williams,
 17 and there was a background given. Do you
 18 recall who spoke to that? Is that Mr. Tilley
 19 doing the talking, or was it mostly Dr.
 20 Williams?
 21 DR. LAING:
 22 A. I'm not certain.
 23 CHAYTOR, Q.C.:
 24 Q. Issue of writing 400 patients who were testing
 25 negative, also reviewed that we would get

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1 Mount Sinai to retest these samples. There
 2 are issues in regards to test standardization.
 3 Do you recall what discussion was there around
 4 that?
 5 DR. LAING:
 6 A. "Issues in regard to test standardization".
 7 That must have been some discussion that Dr.
 8 Cook would have contributed to, I would think,
 9 around the fact that ER/PR testing wasn't a
 10 standardized test. That would be the only
 11 thing that I could think that that referred
 12 to.
 13 CHAYTOR, Q.C.:
 14 Q. Doctor, the next point is that Mount Sinai,
 15 the time period now for testing seems to have
 16 lengthened. It's now "Mount Sinai needs six
 17 to eight weeks to test. Given this issue
 18 arose, when consulted with Dr. Laing and her
 19 colleagues, the consensus re; concerns with
 20 what to say at this time". So it's now up to
 21 six to eight weeks, according to these notes,
 22 by August 15th, 2005, and did that change your
 23 opinion in terms of whether to wait it out or
 24 go ahead and tell the patients if it's going
 25 to be up to eight weeks?

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1 DR. LAING:
 2 A. No, I would have--my thinking at that time
 3 would have been still that it was a four to
 4 six week period.
 5 CHAYTOR, Q.C.:
 6 Q. So if there was discussion of six to eight
 7 weeks told to the Minister, you don't recall
 8 that or you didn't hear that, you were still
 9 thinking it's four to six weeks?
 10 DR. LAING:
 11 A. Yeah.
 12 CHAYTOR, Q.C.:
 13 Q. And if you had understood that it could be as
 14 much as eight weeks, would that have been
 15 enough for you to have pause to reflect and
 16 think, well, perhaps we should be telling the
 17 patients?
 18 DR. LAING:
 19 A. I would say probably not.
 20 CHAYTOR, Q.C.:
 21 Q. So how long would it--what would be the time
 22 period?
 23 DR. LAING:
 24 A. Oh, I don't know. I would have been thinking
 25 if it had been several months, but would that

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1 be, you know, 12 weeks maybe--I think it's a
 2 very arbitrary number.
 3 CHAYTOR, Q.C.:
 4 Q. And the point being because they might find
 5 out otherwise?
 6 DR. LAING:
 7 A. Right, so, you know--I guess looking back, you
 8 know, is this something that really, once you
 9 look at the numbers and the volume, could have
 10 been done in six to eight weeks, or seven to
 11 eight weeks, or four to six weeks, you know,
 12 looking back retrospectively, if you were to
 13 ask me that today, I would say, no, knowing
 14 what I know now, I don't think it could have
 15 been done during that time period. Some
 16 people have looked at me and said how could
 17 you think that this wasn't something that
 18 could, you know, be not public knowledge in
 19 this time period, I guess as I've said to you,
 20 trying to think about how I was thinking or
 21 what was going on at that time, my main focus
 22 was thinking about this as a medical
 23 oncologist, thinking about the number of
 24 people that would need to come back, and again
 25 just getting back to being able to disclose as

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1 much information to them at the same time. In
 2 addition to going to these meetings and doing
 3 all this stuff, I was continuing with a full
 4 busy practice, so, you know, I gave my
 5 opinions and didn't really sort of--knew that
 6 sometime soon, probably getting into October,
 7 that we would start to look at how we were
 8 going to deal with the results coming back and
 9 how we were going to deal with the changes and
 10 that sort of thing, and, you know, we'll get
 11 to how that unfolds over the next little
 12 while, but, you know, I think that once we had
 13 this meeting with the Minister, you know, I'm
 14 working away, the summer ends, you know, and
 15 it really--the next time that this becomes a
 16 very, very big issue for me is at the end of
 17 September.
 18 CHAYTOR, Q.C.:
 19 Q. Yes. Perhaps that's a good place,
 20 Commissioner, for us to take the break, and
 21 I'll come back to the rest of the exhibit.
 22 (BREAK)
 23 THE COMMISSIONER:
 24 Q. Ms. Chaytor.
 25 CHAYTOR, Q.C.:

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1 Q. Thank you, Commissioner. If I could have
 2 again, please, P-0138. This again are the
 3 notes that Dr. Williams took of the meeting of
 4 August 15th, 2005, with Minister Ottenheimer,
 5 and, Doctor, the next bullet in his notes says
 6 that, "Dr. Laing gave overview of the ER/PR
 7 testing, how things work in 2005 and how it
 8 has changed over the years. On retesting, a
 9 certain percentage will convert. How it
 10 impacts on therapy is an individual patient
 11 issue", and do you recall indicating to the
 12 Minister and the others that on retesting, a
 13 certain percentage will convert, and if so,
 14 what were you referring to?
 15 DR. LAING:
 16 A. I suspect that I was referring to our
 17 experience already, that we already had
 18 retested patients and that they had changed.
 19 The other thing that this may be in reference
 20 to was the false negatives, but I think it
 21 would have been stated in a different way had
 22 it been that. So I suspect that I was saying
 23 that, you know, based on our experience so
 24 far, we felt that once we did a larger review
 25 that we would have other patient cases in

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1 which we would have a new test results. In
 2 terms of giving an overview on ER/PR, I think
 3 that would have been more an overview, how we
 4 use that information, how it's used in the
 5 clinic. I'm not sure that I would have been
 6 the one who was speaking about how the testing
 7 is actually done. I suspect that that was
 8 done by Dr. Cook.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And then it goes on to say that "Dr.
 11 Laing says first samples for retesting biased,
 12 and also retested in Ventana system, therefore
 13 our problem, although undefined, at present
 14 may not be as bad as thought. Can't really
 15 have a value discussion until information
 16 available." Sorry.
 17 THE COMMISSIONER:
 18 Q. It's our Blue Tooth problem again. Don't
 19 worry about it.
 20 CHAYTOR, Q.C.:
 21 Q. Okay.
 22 THE COMMISSIONER:
 23 Q. I think.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. "Will notify everyone who is retested.

<p style="text-align: right;">Page 289</p> <p>1 Doesn't feel now is the time to write the 2 letter. Better to wait until we have more 3 information." Now, Doctor, the first part of 4 this paragraph where it says that "First 5 samples for retesting biased." what would 6 that be referring to? 7 DR. LAING: 8 A. I'm not certain. 9 CHAYTOR, Q.C.: 10 Q. And do you recall saying something along those 11 lines to the minister? 12 DR. LAING: 13 A. That the test results would be biased? 14 CHAYTOR, Q.C.: 15 Q. That the retesting was biased, the first 16 samples for retesting biased? 17 DR. LAING: 18 A. The only thing that I can think it refers to 19 is where the latter part of the sentence 20 refers to the Ventana System that, you know, 21 bringing up the issue about the lots of strong 22 positives and the issue of going from false 23 negative to false positive. 24 CHAYTOR, Q.C.: 25 Q. And could it be referring to it not--your</p>	<p style="text-align: right;">Page 291</p> <p>1 DR. LAING: 2 A. Right. So the middle was all 2002, the first 3 had differing years and the latter part of the 4 third, you recall we looked down through, 5 there was some '02, some '05s, some late 6 1990s. 7 CHAYTOR, Q.C.: 8 Q. Yes. And by - 9 DR. LAING: 10 A. But I think if you were to look at all those 11 three samples added together, that a large 12 percentage of them were from 2002. That year, 13 I guess what I would say is that that year was 14 the most represented in that initial three 15 sample sets. 16 CHAYTOR, Q.C.: 17 Q. And did you have any reason to suspect, by 18 August 15th, 2005, that there was a problem 19 with 2002? 20 DR. LAING: 21 A. No. I don't think anybody could have drawn 22 that conclusion until we saw the test results 23 from all the different years. 24 CHAYTOR, Q.C.: 25 Q. Okay. So the idea of the first samples for</p>
<p style="text-align: right;">Page 290</p> <p>1 first samples not being a random - 2 DR. LAING: 3 A. Oh, I know what you mean. 4 CHAYTOR, Q.C.: 5 Q. - sample, perhaps? 6 DR. LAING: 7 A. Okay. Yes, yes, perhaps that. Because these 8 patients were chosen initially on being 9 lobular and initially on being in the year 10 2002, related to the year of the index case 11 that maybe I was suggesting that once we did a 12 much wider sample, that although we did have 13 some sampling from '97 to 2005 and did see 14 some changes, that perhaps that on the retest 15 of all those years that we would come up with 16 different results. 17 CHAYTOR, Q.C.: 18 Q. And this is August 15th, however, the middle 19 of August, and by then all three of the first 20 batches had been retested, covering a broad 21 spectrum of people, of patients? 22 DR. LAING: 23 A. Yes, we looked at - 24 CHAYTOR, Q.C.: 25 Q. And a broad time period, not just 2002?</p>	<p style="text-align: right;">Page 292</p> <p>1 retesting being biased, is there anything else 2 that you could have been thinking of or 3 indicating? 4 DR. LAING: 5 A. No. 6 CHAYTOR, Q.C.: 7 Q. "And also retested on Ventana system, 8 therefore our problem, although undefined at 9 present, may not be as bad as thought." And 10 do you recall indicating something along those 11 lines to the minister? 12 DR. LAING: 13 A. No. I think this was a discussion about the 14 fact that the Ventana system was giving a lot 15 of very strongly positive results. 16 CHAYTOR, Q.C.: 17 Q. Did you have any reason to think that those 18 weren't accurate results? 19 DR. LAING: 20 A. At that point we felt that we didn't want to, 21 as I've said before, that we didn't want to 22 run into a system where we were getting false 23 positives. As a general overall feeling, did 24 I think that there was a definite problem with 25 the Ventana system, no. But again, embarking</p>

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1 on a retest, we wanted to, number one, ensure
 2 that we could--if we were going to do this
 3 again, that we could get the most accurate
 4 results and if even there was a very slight
 5 concern about the Ventana system reading
 6 things as too positive, that would be a reason
 7 to go to an outside lab. And also, the issue
 8 of looking to another institution to do this,
 9 clearly I had treated patients based on the
 10 Ventana system, so it wasn't a concern of mine
 11 to the point that the people that I had seen
 12 and changed their treatment, I was relying on
 13 the Ventana system for the first few, until,
 14 of course, we had made that decision that we
 15 would wait for the Mount Sinai results before
 16 we did any more disclosures except for in a
 17 clinical instance where we wanted to be able
 18 to use that information immediately to treat
 19 the metastatic patients who needed treatment
 20 then.
 21 CHAYTOR, Q.C.:
 22 Q. And I'm just trying to understand what
 23 information you could be relying on to
 24 indicate--well, first of all, did you indicate
 25 to the minister that the problem may not be as

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1 bad as thought? If you did do that, what did
 2 you originally think and then what new
 3 information did you have to now be of the
 4 opinion by mid August that it may not be as
 5 bad?
 6 DR. LAING:
 7 A. Oh, I wouldn't have had any new information to
 8 know that it may not have been as bad. Again,
 9 just sort of thinking about how the first--I
 10 mean, we had tested a small sample size, if
 11 you will, of all the ER/PR testing that was
 12 done. And so really at that point because we
 13 had populated the first section of that with
 14 the lobular patients, that--and the second
 15 part was populated a lot with the people from
 16 the 2002 year, that, you know, maybe at the
 17 end of the day once we had tested all those
 18 years, all those eight years, that this, you
 19 know, this may not be, you know, 16 out of 25,
 20 you know, it may not be that high of a rate of
 21 change once we got the whole sample retested
 22 and the results back.
 23 CHAYTOR, Q.C.:
 24 Q. Even though your third batch was from a broad
 25 spectrum of years?

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1 DR. LAING:
 2 A. Yes. But in that third batch you'd have to
 3 remind me of what the -
 4 CHAYTOR, Q.C.:
 5 Q. There were a number of 2002s, but at least of
 6 half of them were from others -
 7 DR. LAING:
 8 A. No, I mean the change, the change in results
 9 of that third batch. I'm not sure I can
 10 remember now.
 11 CHAYTOR, Q.C.:
 12 Q. I don't think there was a whole lot of
 13 difference between any of the three batches.
 14 DR. LAING:
 15 A. Between those and the--yes, yeah. No, this
 16 was the only thing was, you know, saying that
 17 at the end of the day once we retest
 18 everybody, then this may not--the change rate
 19 may not be as high as what we've seen in this
 20 first selection, be it some of them were
 21 randomly chosen and some of them were chosen
 22 for specific clinical reasons.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And you indicate that you will notify
 25 everyone who is retested. So I take it the

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1 plan was that regardless of outcome, every
 2 patient would be informed?
 3 DR. LAING:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. "Doesn't feel now is the time to write the
 7 letter." And I take it that's referring to
 8 the patient letter?
 9 DR. LAING:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. And the minister is indicated to say, "If
 13 people advised as soon as possible, then
 14 patients can do what he or she wishes to deal
 15 with the issues." Do you remember the
 16 minister raising this issue, that if the
 17 people, if the patients were advised up front,
 18 then they can take the information and make
 19 their own decisions as to how they wish to
 20 deal with the issue?
 21 DR. LAING:
 22 A. I don't recall what exactly he said at that
 23 time.
 24 CHAYTOR, Q.C.:
 25 Q. And do you--well, what do you recall in terms

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1 of what was the minister saying, was this a
 2 situation where the minister was of one point
 3 of view and that you were trying to convince
 4 him otherwise or was this a situation where
 5 you basically just went in, presented what you
 6 had to say and there was a consensus?
 7 DR. LAING:
 8 A. This was more the latter. However, I believe
 9 that there was discussion after I had left as
 10 to what ultimately the decision would be made
 11 to do. In other words, I came, I was asked to
 12 present to the minister similar to what I had
 13 done a few days before to the team at Eastern
 14 Health and I communicated that to him in the
 15 same way. The discussion that ensued between
 16 the minister was very brief. I don't remember
 17 somebody saying, I don't agree with you, I
 18 think that's not the way we should do it. It
 19 was more I came, gave my opinion, they thanked
 20 me and I left and I think that, you know, that
 21 the--that I'm sure that the minister went away
 22 afterwards and thought more about what I had
 23 said and you know, but -
 24 CHAYTOR, Q.C.:
 25 Q. But these are notes taken by -

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1 DR. LAING:
 2 A. They're notes, that's right.
 3 CHAYTOR, Q.C.:
 4 Q. - Dr. Williams.
 5 DR. LAING:
 6 A. Um-hm.
 7 CHAYTOR, Q.C.:
 8 Q. And it appears to be notes of the full group.
 9 And this comment about the minister is in
 10 between two different comments that he
 11 attributes to you. So it would appear, if Dr.
 12 Williams is taking his notes in order of
 13 what's happening, that you would still be
 14 present if the minister made such a comment
 15 and the idea of the minister expressing, well,
 16 let's let people know or what about telling
 17 people so they can decide for themselves, you
 18 don't recall the minister saying that?
 19 DR. LAING:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. Or anything along those lines?
 23 DR. LAING:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And what do you think of that idea,
 2 letting people make an informed decision and
 3 decide for themselves?
 4 DR. LAING:
 5 A. I think that going back to how I was feeling
 6 at this time my decision was based on my views
 7 then, that I felt that we should go to the
 8 patients when they had as much information as
 9 we could give them to say, you know, what
 10 their test results were and if they change,
 11 what we were going to do about it. So my, the
 12 things that we talked about earlier were the
 13 same opinion that I expressed. I can only
 14 think back to that time and recall that there
 15 didn't seem to be any great opposition that I
 16 can remember as to my views and that, you
 17 know, it goes on to say "The minister will
 18 accept the advice for now."
 19 CHAYTOR, Q.C.:
 20 Q. "Best advice for now."
 21 DR. LAING:
 22 A. I'm not--know what the for now means in Dr.
 23 Williams' notes. And it says that he wishes
 24 to meet again within the next two weeks. I
 25 was not asked to meet with the minister on

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1 this issue again in the ensuing two weeks.
 2 And it talks about developing what would go in
 3 a letter in the meantime, so it sounds as if
 4 the minister still, you know, that there was
 5 still some discussion about having a letter
 6 there for whenever a decision may or may not
 7 be made to send that letter.
 8 CHAYTOR, Q.C.:
 9 Q. Yes. So the idea, though, of having patients
 10 informed and then if the patients, for
 11 example, should decide, well they want to take
 12 matters into their own hands, perhaps have
 13 their retesting take place somewhere else, or
 14 doing, you know, speeding the process up for
 15 themselves, that idea, was that ever--was that
 16 a thought that ever came to you or was that
 17 anything that was ever discussed?
 18 DR. LAING:
 19 A. Not that I recall.
 20 CHAYTOR, Q.C.:
 21 Q. And then you also are noted here to have
 22 advised that "Dr. McCarthy, Dr. Ganguly agree
 23 with waiting to send something out until we
 24 have more information."
 25 DR. LAING:

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1 A. Okay.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. So do you recall advising the minister
 4 and the others that Dr. McCarthy and Dr.
 5 Ganguly agreed with waiting?
 6 DR. LAING:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. And did you advise them that others, in
 10 fact, other oncologists had been consulted
 11 other than Dr. McCarthy and Dr. Ganguly?
 12 DR. LAING:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. But it's just Dr. McCarthy and Dr.
 16 Ganguly's names that appear here. You would
 17 have said -
 18 DR. LAING:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. - other oncologists?
 22 DR. LAING:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. And "The minister will accept best

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1 advise for now." As you've already pointed
 2 out.
 3 DR. LAING:
 4 A. Um-hm.
 5 CHAYTOR, Q.C.:
 6 Q. Did you tell the minister that you had no
 7 experience in dealing with disclosure issues
 8 in this context or in such a situation?
 9 DR. LAING:
 10 A. No.
 11 CHAYTOR, Q.C.:
 12 Q. And why not?
 13 DR. LAING:
 14 A. It wasn't something that was asked and really
 15 wasn't something that I thought to bring forth
 16 at the time.
 17 CHAYTOR, Q.C.:
 18 Q. And again, it says, "He wishes to meet again"
 19 and you were not invited, you said, to meet
 20 subsequently with the minister on the issue.
 21 And "Will develop what should go in a letter
 22 in meantime." So at the end of this meeting
 23 where did you understand things had been left?
 24 DR. LAING:
 25 A. That a final decision would be made and that I

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1 would hear back if they wanted to discuss this
 2 issue with me again. And the fact that it
 3 says that there was a letter that was going to
 4 be developed, I took that to mean that, you
 5 know, maybe sometime in the ensuing weeks that
 6 a decision to send a letter would be made and
 7 so people, I guess, felt that it was--if that
 8 was going to happen, that perhaps one should
 9 be started. I guess that that's what that
 10 means. I don't have any strong recollection
 11 of that at the time.
 12 CHAYTOR, Q.C.:
 13 Q. Do you remember a letter being discussed at
 14 all, and a letter to whom?
 15 DR. LAING:
 16 A. We were talking about a letter to the
 17 patients.
 18 CHAYTOR, Q.C.:
 19 Q. So that was discussed?
 20 DR. LAING:
 21 A. Yes. That's what this--yes.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So that when it was left that there
 24 would still be a letter drafted to the
 25 patients?

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1 DR. LAING:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And was the intent that this letter would be
 5 to advise them that the retesting was
 6 happening?
 7 DR. LAING:
 8 A. I would think, yes, yeah. Because this was
 9 still the issue that we were discussing.
 10 CHAYTOR, Q.C.:
 11 Q. Okay.
 12 DR. LAING:
 13 A. This was before there was results coming back
 14 and all that.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. So I just want to be clear, at the end
 17 of the meeting then on August 15th there had
 18 not been a decision reached, no decision had
 19 been reached as to not telling patients that
 20 the retesting was happening and, in fact, the
 21 plan was to go away and draft a letter?
 22 DR. LAING:
 23 A. No, no, I think that the decision was made
 24 that we would not send a letter at this time.
 25 CHAYTOR, Q.C.:

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<p>1 Q. Yes.</p> <p>2 DR. LAING:</p> <p>3 A. And that--but I guess there was some</p> <p>4 discussion that should that opinion change for</p> <p>5 whatever reason over the next little while,</p> <p>6 that a letter would at least be drafted, I</p> <p>7 suspect not dissimilar to the drafts we saw</p> <p>8 for press releases and things that were never</p> <p>9 sent. But that contributing to the writing of</p> <p>10 such a letter was not something that I had</p> <p>11 been asked to do at that particular meeting.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. At this meeting, yes.</p> <p>14 DR. LAING:</p> <p>15 A. Yes.</p> <p>16 CHAYTOR, Q.C.:</p> <p>17 Q. And we saw earlier, it appears, that you may</p> <p>18 have had some input according to Ms. Predham's</p> <p>19 e-mail, into a draft of a letter for patients?</p> <p>20 DR. LAING:</p> <p>21 A. But not one that I had ever seen or written on</p> <p>22 or sent back or replied in e-mail to or</p> <p>23 anything like that, no.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. Anything like that. So at the end of this</p>	<p>1 Eastern Health?</p> <p>2 DR. LAING:</p> <p>3 A. It's hard for me to remember. I would think</p> <p>4 that we would have all left at the same time.</p> <p>5 Now, whether the minister and his staff stayed</p> <p>6 afterwards and had further discussions, I</p> <p>7 don't know.</p> <p>8 CHAYTOR, Q.C.:</p> <p>9 Q. Was there any discussion as to public</p> <p>10 disclosure in this meeting?</p> <p>11 DR. LAING:</p> <p>12 A. Not that I recall.</p> <p>13 CHAYTOR, Q.C.:</p> <p>14 Q. Were you ever present with government</p> <p>15 officials when the issue of public disclosure</p> <p>16 was discussed or did you have any discussions</p> <p>17 at any time with anyone from the department on</p> <p>18 the issue of public disclosure?</p> <p>19 DR. LAING:</p> <p>20 A. At this time, no.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. Okay.</p> <p>23 THE COMMISSIONER:</p> <p>24 Q. You said at this time, no. Does that mean at</p> <p>25 some subsequent date you did?</p>
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<p>1 meeting, on August 15th, the decision was that</p> <p>2 patients hold off on telling patients for now?</p> <p>3 DR. LAING:</p> <p>4 A. Yeah.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. But we'll work on a letter that can be written</p> <p>7 to them informing them that the retesting is</p> <p>8 taking place and we'll be back to touch base</p> <p>9 with the minister in two weeks? So was that</p> <p>10 the status at the end of this meeting on</p> <p>11 August 15th?</p> <p>12 DR. LAING:</p> <p>13 A. Yes.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. And what factors, what would cause the</p> <p>16 decision to be revisited and then for the</p> <p>17 letter to go to the patient, what would cause</p> <p>18 the opinion to change?</p> <p>19 DR. LAING:</p> <p>20 A. I'm not certain.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. Did you understand that--then you said that</p> <p>23 you presented. And did you then leave the</p> <p>24 meeting or did you leave the meeting at the</p> <p>25 same time as the other representatives from</p>	<p>1 DR. LAING:</p> <p>2 A. Have a meeting with government officials</p> <p>3 about public disclosure?</p> <p>4 THE COMMISSIONER:</p> <p>5 Q. Did you discuss public disclosure with</p> <p>6 government officials, yeah.</p> <p>7 DR. LAING:</p> <p>8 A. No.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. Doctor, given that a number of patients</p> <p>11 already knew and the other factors that we</p> <p>12 discussed earlier in terms of the support</p> <p>13 network amongst breast cancer patients within</p> <p>14 the province, were you at all concerned that</p> <p>15 it was only a matter of time that this would</p> <p>16 become a public issue?</p> <p>17 DR. LAING:</p> <p>18 A. When I think back to that time, that wasn't</p> <p>19 something that had crossed my mind, no.</p> <p>20 CHAYTOR, Q.C.:</p> <p>21 Q. So the idea of as time went on and if it were</p> <p>22 going to be a protracted period of time that</p> <p>23 patients should be informed, your thinking on</p> <p>24 that wasn't because, well, the longer it goes</p> <p>25 on, the more likely it is to come out or leak</p>

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1 out or -

2 DR. LAING:

3 A. Right, right. So again, the main reason why I

4 made this decision, I think I've stated, in

5 terms of it taking a long time, then, yes,

6 that would have been something that I

7 certainly would have considered, particularly

8 as the time went on. But really, before I can

9 honestly say I gave that a whole lot of

10 thought, it happened.

11 CHAYTOR, Q.C.:

12 Q. And was there any plan in place when it

13 happened, was there any plan in place for the

14 eventuality that patients would learn about it

15 indirectly?

16 DR. LAING:

17 A. The only plan that I can assume was what you

18 have shown me today about the draft media

19 releases, but I was not asked to contribute to

20 those. And I myself did not have any specific

21 plans to deal with that should it arise. And

22 in fact, the first time I was asked to speak

23 about this in the media, I certainly was not

24 prepared or didn't have anything ahead of time

25 to assist in that.

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1 CHAYTOR, Q.C.:

2 Q. Okay. And we'll talk about that in a moment.

3 DR. LAING:

4 A. Yes.

5 CHAYTOR, Q.C.:

6 Q. Okay. And if we could then have P-0588,

7 please? And I take it the meeting with the

8 minister in espousing the view that you put

9 forward, you were speaking on behalf of whom?

10 DR. LAING:

11 A. Sorry?

12 CHAYTOR, Q.C.:

13 Q. In the meeting -

14 DR. LAING:

15 A. I'm sorry, I was -

16 CHAYTOR, Q.C.:

17 Q. Okay. It's been a long day. And the meeting

18 -

19 DR. LAING:

20 A. I know. So the meeting, okay.

21 CHAYTOR, Q.C.:

22 Q. - with the minister on August 15th, the view

23 that you put forward, you were speaking on

24 behalf of whom?

25 DR. LAING:

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1 A. The oncologists.

2 CHAYTOR, Q.C.:

3 Q. The oncologists. And were you also speaking

4 on behalf of Eastern Health?

5 DR. LAING:

6 A. At that time, no.

7 CHAYTOR, Q.C.:

8 Q. Okay. And who in the room was speaking on

9 behalf of Eastern Health?

10 DR. LAING:

11 A. Dr. Williams.

12 CHAYTOR, Q.C.:

13 Q. Okay. And did Dr. Williams agree with the

14 position you put forward?

15 DR. LAING:

16 A. My recollection was yes.

17 CHAYTOR, Q.C.:

18 Q. Did Dr. Williams ever indicate to you that he

19 didn't agree with your view on the disclosure

20 issue?

21 DR. LAING:

22 A. No.

23 CHAYTOR, Q.C.:

24 Q. Doctor, P-0588 is an agenda for a meeting on

25 September 1st, 2005, the senior management of

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1 the Cancer, still referred to at this point in

2 time, the Newfoundland Cancer Treatment and

3 Research Foundation. And including on the

4 agenda for September 1st under "Business

5 arising" is "ER/PR testing." And would you be

6 the person who would speak to that issue with

7 respect to the management? If we look at who

8 attended -

9 DR. LAING:

10 A. This is the minutes.

11 CHAYTOR, Q.C.:

12 Q. September 1st.

13 DR. LAING:

14 A. Yeah.

15 CHAYTOR, Q.C.:

16 Q. Paul Gardiner is chairing, Andrea Avery, Dr.

17 Ganguly, yourself, Pat Pilgrim, Chris Power

18 and Diane Smith.

19 DR. LAING:

20 A. Right.

21 CHAYTOR, Q.C.:

22 Q. So in that group of people who would be

23 speaking to the ER/PR issue?

24 DR. LAING:

25 A. It would be both Dr. Gardiner and I. Prior to

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1 this meeting, as you can see, if you go back
2 to the minutes, ER/PR was actually a business
3 arising item, so this item had already been
4 discussed at senior management on July 28th,
5 2005 and I was not present at that meeting,
6 but as it indicates here, I was present at
7 this one. And -
8 CHAYTOR, Q.C.:
9 Q. And do you recall speaking to the issue on
10 this date?
11 DR. LAING:
12 A. Yes.
13 CHAYTOR, Q.C.:
14 Q. I believe on the top of the next page, page 3,
15 we have "ER/PR testing. Members were informed
16 this item has gone to the Department of Health
17 and Community Services." And so I guess you
18 would have been the person to advise of that,
19 having attended the meeting?
20 DR. LAING:
21 A. Yes.
22 CHAYTOR, Q.C.:
23 Q. "Slides and blocks are being reviewed
24 externally." And did you understand that
25 slides and blocks were being reviewed

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1 externally?
2 DR. LAING:
3 A. Sorry, the slides?
4 CHAYTOR, Q.C.:
5 Q. "Slides and blocks are being reviewed
6 externally."
7 DR. LAING:
8 A. They would have sent slides.
9 CHAYTOR, Q.C.:
10 Q. Okay. What was your understanding what was
11 being sent to Mount Sinai?
12 DR. LAING:
13 A. Not being a pathologist, I would have thought
14 that it would be slides. I wasn't sure if
15 they sent blocks, as well. I think a
16 pathologist could answer that better.
17 CHAYTOR, Q.C.:
18 Q. Okay. So you don't know?
19 DR. LAING:
20 A. No.
21 CHAYTOR, Q.C.:
22 Q. To this day you don't know what they sent to
23 Mount Sinai?
24 DR. LAING:
25 A. No.

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1 CHAYTOR, Q.C.:
2 Q. Okay. "Currently waiting for reanalysed
3 results of blocks relating to ER/PR testing."
4 DR. LAING:
5 A. I should say no, that my understanding is was
6 that it was slides which are made from the
7 blocks and that they would--because there was
8 some discussion about sending representative
9 slides. Why this would say slides and blocks
10 at that time, maybe simply that that was my
11 understanding at the time or it may have been
12 Dr. Gardiner who said that or -
13 CHAYTOR, Q.C.:
14 Q. But your understanding was and up to today was
15 that it was just slides that was sent?
16 DR. LAING:
17 A. Yeah.
18 CHAYTOR, Q.C.:
19 Q. The original slides that were made here in St.
20 John's were what were sent to Mount Sinai?
21 DR. LAING:
22 A. That would be my understanding, yeah.
23 CHAYTOR, Q.C.:
24 Q. So in giving advice on the issue of disclosure
25 did you understand that patient samples of the

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1 patient's tissue would be sent to Mount Sinai,
2 Mount Sinai would actually make their own
3 slides using the patient's tissue, make their
4 own slides and rerun the tests entirely?
5 DR. LAING:
6 A. I don't think I ever got into that sort of
7 detail about how that would happen. That
8 would be something that would have been
9 arranged and discussed between Dr. Cook and--
10 as a pathologist, I honestly, I've never been
11 in a lab, I don't know exactly what it is that
12 they sent or would send or what someone would
13 need or anything like that. My only sort of
14 recollection would have been, of course,
15 listening to the pathologists discuss this and
16 at times they were asked to send different
17 pieces of the patients' tissue, if you will,
18 particularly when there came into question
19 whether or not what had been sent to them was
20 representative and the issues regarding DCIS,
21 etcetera.
22 CHAYTOR, Q.C.:
23 Q. And does that make any difference to you if it
24 was just the slide that's already made up or
25 if it's an actual block with the patient's

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<p>1 tissue in it, does it matter to you in terms</p> <p>2 of your views on disclosure in terms of</p> <p>3 informing the patient beforehand?</p> <p>4 DR. LAING:</p> <p>5 A. Makes no difference whatsoever.</p> <p>6 CHAYTOR, Q.C.:</p> <p>7 Q. No difference to you?</p> <p>8 DR. LAING:</p> <p>9 A. No.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. Okay. "Currently waiting for reanalysed</p> <p>12 results of blocks relating to ER/PR testing."</p> <p>13 DR. LAING:</p> <p>14 A. Yeah.</p> <p>15 CHAYTOR, Q.C.:</p> <p>16 Q. So it refers to the blocks in the next</p> <p>17 sentence. "There are some patients coming</p> <p>18 forward with concerns." So at this point in</p> <p>19 time, September 1st, 2005 you were aware that</p> <p>20 some patients had already come forward with</p> <p>21 concerns?</p> <p>22 DR. LAING:</p> <p>23 A. Yes.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. Okay. And did that concern you, that there</p>	<p>1 plural, were the minutes revised or did you</p> <p>2 point out, no, this was only--what patients, I</p> <p>3 only know of one patient?</p> <p>4 DR. LAING:</p> <p>5 A. Well, no, I'm only speaking to this--you know,</p> <p>6 there were other people present at this</p> <p>7 meeting. I'm only trying to think back to</p> <p>8 that time as to what this particular item may</p> <p>9 have meant. And I can recall that we did have</p> <p>10 some discussions regarding this particular</p> <p>11 patient and her family and the concerns that</p> <p>12 they had expressed. Whether or not there were</p> <p>13 other ones, I can't recall at this exact</p> <p>14 moment what those specific instances would be,</p> <p>15 so I really can't shed any more light on that</p> <p>16 statement.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. Okay. So if they were discussed, that</p> <p>19 patients, more than one patient and patients</p> <p>20 were coming forward with concerns, do you</p> <p>21 recall anything about that, about patients who</p> <p>22 had not yet been retested -</p> <p>23 DR. LAING:</p> <p>24 A. No, that's not -</p> <p>25 CHAYTOR, Q.C.:</p>
<p>Page 318</p> <p>1 are already patients out there who have now</p> <p>2 heard about this and have come forward and</p> <p>3 voiced concerns?</p> <p>4 DR. LAING:</p> <p>5 A. Actually, my recollection of that statement</p> <p>6 was that it was related to someone who had</p> <p>7 already had retesting done and had already had</p> <p>8 disclosure of that to them.</p> <p>9 CHAYTOR, Q.C.:</p> <p>10 Q. So one person as opposed to some patients?</p> <p>11 DR. LAING:</p> <p>12 A. My recollection of an incident was related to</p> <p>13 a patient and her family.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. And what was that patient's concerns?</p> <p>16 DR. LAING:</p> <p>17 A. That this was a patient whose test results had</p> <p>18 changed and that they had concerns about that</p> <p>19 in terms of, you know, what it had meant for</p> <p>20 their treatments and for their disease and</p> <p>21 those issues.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. So the next time these minutes are reviewed</p> <p>24 and it says "some patients coming forward with</p> <p>25 concerns," and it's done obviously in the</p>	<p>Page 320</p> <p>1 Q. - coming forward?</p> <p>2 DR. LAING:</p> <p>3 A. My recollection of this wasn't that--wasn't,</p> <p>4 you know, the point that we discussed earlier</p> <p>5 that there may be patients sitting in the</p> <p>6 waiting room next to somebody else, it wasn't</p> <p>7 in that context. I remembered it to be in the</p> <p>8 context of people who had already had been</p> <p>9 disclosed to.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. Okay. And they were expressing concerns?</p> <p>12 DR. LAING:</p> <p>13 A. Yes.</p> <p>14 CHAYTOR, Q.C.:</p> <p>15 Q. And do you recall who were they expressing</p> <p>16 their concerns to?</p> <p>17 DR. LAING:</p> <p>18 A. The particular patient that I am referring to</p> <p>19 had expressed their concerns to Dr. McCarthy</p> <p>20 and she subsequently had discussed that with</p> <p>21 me.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. Okay. And what were the concerns?</p> <p>24 DR. LAING:</p> <p>25 A. As I said, you know, the family was concerned</p>

<p style="text-align: right;">Page 321</p> <p>1 about what this had meant. The family and the 2 patient were saying that they were concerned 3 because they had had a new test result come 4 back, what did this mean, was her diagnosis 5 correct, you know, similar to the types of 6 concerns that we've heard from others through 7 this whole process. 8 CHAYTOR, Q.C.: 9 Q. The next sentence says that "The Department, 10 the Department of Health and Community 11 Services have" should be has, I guess, 12 "delayed a public announcement on this item." 13 Did you advise the senior management of that? 14 DR. LAING: 15 A. I suspect this refers to the delay in a letter 16 to the patients. I wouldn't have considered 17 it to be a public announcement, but more of a 18 letter for patient disclosure. 19 CHAYTOR, Q.C.: 20 Q. Okay. And insofar as this says "delayed a 21 public announcement on this item", did you 22 have any discussions or any knowledge as to 23 any public announcement that may have been 24 contemplated that the department delayed? 25 DR. LAING:</p>	<p style="text-align: right;">Page 323</p> <p>1 patient notification? 2 DR. LAING: 3 A. Yes. 4 CHAYTOR, Q.C.: 5 Q. Wouldn't that be more accurate? 6 DR. LAING: 7 A. That would be more accurate. Whether or not 8 there was something that Dr. Gardiner had said 9 or whether or not he, as the medical director, 10 had had any dealings, I'm not certain. But I 11 would suspect, although, that if he had had 12 some discussions about the possibility of a 13 public announcement that maybe he had been 14 aware of the sample media release that we had 15 seen, because I wasn't, I wasn't contacted 16 about that, so whether he had been in those 17 early days. But I don't recall that when I 18 think back to this meeting or the minutes. 19 CHAYTOR, Q.C.: 20 Q. And do you have any reason to believe that the 21 Department of Health were even aware of those 22 media releases, those draft media releases? 23 DR. LAING: 24 A. Oh, I have no idea, no idea. 25 CHAYTOR, Q.C.:</p>
<p style="text-align: right;">Page 322</p> <p>1 A. No. 2 CHAYTOR, Q.C.: 3 Q. And is it correct to say that it was the 4 department that delayed any announcement on 5 this item? 6 DR. LAING: 7 A. It was ultimately my understanding that it was 8 their decision about whether or not to go 9 forth with a patient letter at that time. 10 CHAYTOR, Q.C.: 11 Q. So, Doctor, from what I've understood, you had 12 no discussions around any public disclosure on 13 the issue, your discussions with the 14 department concerned patient disclosure? 15 DR. LAING: 16 A. That's correct. (phonetic) 17 CHAYTOR, Q.C.: 18 Q. And would there be any reason why the minutes 19 wouldn't reflect that, that there had been a 20 meeting with the department, that you had put 21 forward your views, speaking as an oncologist? 22 DR. LAING: 23 A. Right. 24 CHAYTOR, Q.C.: 25 Q. And that a decision had been made to delay</p>	<p style="text-align: right;">Page 324</p> <p>1 Q. Okay. So what do you recall then of this 2 issue at the meeting, do you recall Dr. 3 Gardiner speaking to the issue of the 4 department having delayed a public 5 announcement? 6 DR. LAING: 7 A. No. 8 CHAYTOR, Q.C.: 9 Q. Okay. 10 DR. LAING: 11 A. I don't recall that. 12 CHAYTOR, Q.C.: 13 Q. And do you recall who spoke to that issue, was 14 this something you would have said? 15 DR. LAING: 16 A. No. 17 CHAYTOR, Q.C.: 18 Q. You didn't say this? 19 DR. LAING: 20 A. No. 21 CHAYTOR, Q.C.: 22 Q. And you don't know if Dr. Gardiner said it or 23 not? 24 DR. LAING: 25 A. No, I don't know.</p>

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1 CHAYTOR, Q.C.:

2 Q. And do you have any idea what it could be--

3 what that could mean?

4 DR. LAING:

5 A. The only thing that I can think that it means

6 was that there was a decision made not to send

7 the letters to the patients and whether that

8 was referred to as a public announcement

9 versus patient letters, I'm not sure. I'm not

10 sure if the person recording the minutes, you

11 know, put it down as a public announcement

12 versus disclosure to patients, I really, I'm

13 not certain.

14 CHAYTOR, Q.C.:

15 Q. Okay. And, Doctor, then we know that, of

16 course, the issue does become a matter of

17 public discussion.

18 DR. LAING:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. And there's a story in the Independent on

22 October 2nd, 2005.

23 DR. LAING:

24 A. Um-hm.

25 CHAYTOR, Q.C.:

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1 Q. And you're quoted in that story as having

2 participated. Perhaps you could tell us how

3 that came about and -

4 DR. LAING:

5 A. Certainly.

6 CHAYTOR, Q.C.:

7 Q. - why you participated in the story and how

8 you felt the interview went?

9 DR. LAING:

10 A. I certainly can. So there are some things

11 that you remember more vividly than others

12 than your life and this is one of those

13 instances of something that I remember quite

14 well and I suspect it was because of the

15 circumstances surrounding this interview. On

16 that Thursday and Friday, which would have

17 been September 30th and October 1st I was

18 attending a meeting in Toronto with some

19 colleagues of mine across the country

20 discussing the treatment approaches for

21 metastatic breast cancer. It was a meeting

22 funded by a pharmaceutical company, during

23 that meeting. So on the Friday of that

24 meeting, somebody from the hotel where we were

25 having the meeting came in and interrupted and

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1 said "is there a Dr. Kara Laing here?" and

2 said that there was an emergency telephone

3 call. So I managed to make it to the phone

4 and it was Dr. Williams' office on the other

5 end of the line, and he had called and found

6 out where I was and tracked me down to the

7 hotel and asked if they would interrupt

8 because he had had a request at that time for

9 a media interview.

10 He said that he felt that it would be

11 good if somebody from the clinical point of

12 view would be able to speak to the reporter

13 who had gotten some information about an issue

14 regarding breast cancer. I think in the

15 beginning it was screening and a problem with

16 mammography units and all sorts of different

17 takes on how--you know, what this little

18 signal that they got that there may be an

19 issue came about, and asked if I would do an

20 interview on the telephone with a reporter

21 from The Independent. My first response was

22 no. You know, I'm here in Toronto in the

23 middle of a meeting and you're down there and,

24 you know, do you think that this is something

25 that could wait until a) I got home, and b) I

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1 would have some time to sit down with--as we

2 usually do with media preparation, to meet

3 with our media relations people.

4 The impression that I got from Dr.

5 Williams was that The Independent was keen to

6 run this story and that, you know, really they

7 wanted the interview today. So after some

8 back and forth, I said okay. So Dr.

9 Williams connected me with the reporter and I

10 had--I did the interview over the telephone.

11 I spoke to Dr. Williams at the end of the

12 interview and indicated to him that I felt

13 that this was something that was likely going

14 to be in the paper, knowing that The

15 Independent comes out on Saturdays, and I

16 said, you know, "I'm going back to my meeting

17 in Toronto. I'm flying home, so I'll leave

18 that with you."

19 So that was the sort of story around how

20 all that happened. In terms of the actual

21 interview, up to this point, I had never done

22 a media interview that wasn't for a good

23 reason, if you will. You know, I had done

24 things related to announcements for new

25 projects or new fundings or new research

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1 opportunities and that sort of thing, so you
 2 know, I spoke with the reporter. I said to
 3 her, you know, "it would be great if you could
 4 wait until I got home and I'd certainly be
 5 happy to sit down and talk to you about this,"
 6 but she indicated to me that again, as I've
 7 said, that she was keen on running this story.
 8 I had told her about the fact that we had
 9 done--already had done some retesting, that
 10 there were some changes in results, and that
 11 you know, we were waiting for this larger
 12 retest to happen, and that we were waiting to
 13 inform the patients once we knew more
 14 information, and I was concerned that by
 15 printing such a story, that this was indeed
 16 how people were going to find out about this
 17 issue, and I was very concerned about what
 18 impact that was going to have, not only on
 19 breast cancer patients, but on anybody who was
 20 going to pick up this paper the next day and
 21 read it. But she wasn't interested in
 22 listening to my concerns.
 23 CHAYTOR, Q.C.:
 24 Q. At what point after in your discussions with
 25 her did you inform her of that concern and

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1 that the patients didn't already know?
 2 DR. LAING:
 3 A. Oh, right from the very beginning.
 4 CHAYTOR, Q.C.:
 5 Q. So before you spoke to her and told her
 6 anything which you've just told us about the
 7 retesting and all that, at the very beginning,
 8 you spoke to her and told her you were
 9 concerned -
 10 DR. LAING:
 11 A. About this being put out in such a way that
 12 would cause concern amongst patients.
 13 CHAYTOR, Q.C.:
 14 Q. That the patients had not been informed?
 15 DR. LAING:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And did you tell her that you would prefer
 19 that the story not run until you've had an
 20 opportunity to contact your patients?
 21 DR. LAING:
 22 A. Absolutely, yes.
 23 CHAYTOR, Q.C.:
 24 Q. And you said that to the reporter?
 25 DR. LAING:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And what was her response?
 4 DR. LAING:
 5 A. She wasn't interested in that. She said "I'm
 6 running this story tomorrow."
 7 CHAYTOR, Q.C.:
 8 Q. And what story did she have to run if you
 9 hadn't told her anything?
 10 DR. LAING:
 11 A. She already had some--you know, it was clear
 12 that she did already have some information.
 13 She knew that there was a problem with
 14 testing, and -
 15 CHAYTOR, Q.C.:
 16 Q. Did she think it was a problem with the
 17 mammogram machine? Was that what she thought
 18 the problem was, do you know?
 19 DR. LAING:
 20 A. In the -
 21 CHAYTOR, Q.C.:
 22 Q. Or had Susan Bonnell already spoken to her
 23 before you?
 24 DR. LAING:
 25 A. I think at this point they had already sort of

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1 had a little bit of a better idea of what was
 2 going on. I didn't have to clarify that point
 3 with her.
 4 CHAYTOR, Q.C.:
 5 Q. So she knew there was a problem with the
 6 hormone receptor testing?
 7 DR. LAING:
 8 A. ER/PR testing, yeah, and one of the things
 9 that she wanted to know was how we utilized
 10 the test. So you know, I went over that with
 11 her, and some of that came out in the article,
 12 and how big of a problem I thought this was,
 13 and I believe that there were numbers quoted,
 14 and I'm not sure if they were numbers that
 15 were given to her by me or by somebody else at
 16 Eastern Health. I think I talked about the 16
 17 out of 25 as the--well, I was thinking about
 18 sort of the first group, because that was the
 19 numbers that I could always remember, as
 20 opposed to the 32 or 33 in the second one, and
 21 I can't even still remember what the number
 22 was in the third one, and that I had said, you
 23 know, this is--we're waiting for the results.
 24 We don't know how big of a problem this is
 25 going to be. We don't want patients to panic,

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1 you know, and that's really what I can
2 remember as being what we discussed during
3 that interview. I remember ending the
4 interview upset, not content, if you will,
5 that this is how things had played out. But
6 you know, there we were, and -
7 CHAYTOR, Q.C.:
8 Q. And why were you upset?
9 DR. LAING:
10 A. Because it was very difficult to do such an
11 interview, you know, on the telephone with
12 somebody who I felt was not necessarily
13 listening to all the things that I was saying.
14 CHAYTOR, Q.C.:
15 Q. And I take it you knew, by the time you
16 finished the interview, this was not the ideal
17 way for this story to come out?
18 DR. LAING:
19 A. Absolutely not, no, and that was -
20 CHAYTOR, Q.C.:
21 Q. Or for your patients, more importantly for
22 your patients to learn about this.
23 DR. LAING:
24 A. That's what was so very upsetting to me. So
25 here I am, far away. You know, I couldn't go

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1 down the hall and have a conversation with Dr.
2 Williams and have any sort of way to deal with
3 that. I had to leave that and go back to the
4 meeting that I was attending and, you know, I
5 did have the support of my fellow Canadian
6 oncologists who happened to be at this
7 meeting, who by the time I had been gone out
8 of the room for an hour, had no idea what had
9 happened to me, but you know, it was a very
10 disconcerting, upsetting experience for me,
11 for sure.
12 CHAYTOR, Q.C.:
13 Q. And when you spoke, when you took the call
14 originally from Dr. Williams -
15 DR. LAING:
16 A. Yes.
17 CHAYTOR, Q.C.:
18 Q. - did you express concern to Dr. Williams that
19 you didn't think that you should be
20 participating in any story on the issue at
21 that point in time? Did you express concern
22 to him about the fact that the patients didn't
23 yet know?
24 DR. LAING:
25 A. Yes, my first words to him were, you know, "I

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1 think this is--you know, I'm not there. This
2 is going to be difficult to do over the
3 telephone. The patients don't know. What are
4 we going to do? And I don't really think this
5 should come from me. I think somebody who's
6 there on the ground should be doing this."
7 And he said, you know, "please, can you do it?
8 We'd really like to have somebody from the
9 clinical aspect speak to this reporter." And
10 so I said yes, I would do it. I mean,
11 ultimately I did make that decision to agree
12 to do it.
13 CHAYTOR, Q.C.:
14 Q. And why wouldn't Dr. Williams do the interview
15 himself?
16 DR. LAING:
17 A. He felt that somebody who had a better
18 knowledge of the use of this test in the
19 clinic, somebody who was involved in the care
20 of breast cancer patients may be the better
21 person to speak to such an issue, to explain,
22 you know, how this testing is used. Although
23 as you know, I had, on several different
24 occasions, discussed this with Dr. Williams, I
25 think he felt more comfortable that, you know,

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1 someone who was saying, you know, "this is a
2 predictive test. We use it in the clinic. It
3 helps us to determine treatment," that that
4 would be better coming from somebody with my
5 background than his.
6 CHAYTOR, Q.C.:
7 Q. And you say you called Dr. Williams back after
8 the interview?
9 DR. LAING:
10 A. Yes.
11 CHAYTOR, Q.C.:
12 Q. To advise him that you thought the reporter
13 would be running with the story?
14 DR. LAING:
15 A. Yes.
16 CHAYTOR, Q.C.:
17 Q. That weekend, and it came out, I believe, that
18 Sunday. Did you urge Dr. Williams to initiate
19 any kind of process to attempt to start
20 notifying the patients affected?
21 DR. LAING:
22 A. No. What I had said to Dr. Williams was--you
23 know, I hung up from the reporter. He had
24 asked if I would touch base with him again.
25 It was actually his office who kind of

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1 connected me through to the reporter, and he
 2 said "when you're finished the call, could you
 3 touch base with me again?" and I did, and all
 4 I recall saying to him was, you know, "I'm
 5 here in Toronto, as you know. I'm going back
 6 into my meeting, and I'll leave this in your
 7 hands, but my impression is the story is going
 8 to run this weekend."
 9 CHAYTOR, Q.C.:
 10 Q. And you participated in this story on Friday,
 11 is that correct?
 12 DR. LAING:
 13 A. Yes, it was the Friday of that -
 14 CHAYTOR, Q.C.:
 15 Q. Okay, and what time in the day?
 16 DR. LAING:
 17 A. Oh, I'd say it was in the--I know it was
 18 before we broke for lunch. So I think it was
 19 probably around lunch time Newfoundland time.
 20 I was an hour and a half ahead in Toronto,
 21 because I remember just as I got back to the
 22 meeting where I was in Toronto, it was just
 23 before we had a lunch break, and of course,
 24 everybody at the meeting came up to me at
 25 lunch and said, you know, "what went on? Is

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1 everything okay at home?" because I sort of,
 2 you know, left as an emergency and it was
 3 sometime before I came back, so I do recall
 4 that.
 5 CHAYTOR, Q.C.:
 6 Q. And you called Dr. Williams back, I take it
 7 immediately after the interview?
 8 DR. LAING:
 9 A. Right, before I went back into the meeting.
 10 CHAYTOR, Q.C.:
 11 Q. And Doctor, why didn't you ask Dr. Williams
 12 when you called him back, around midday on
 13 Friday, to start to initiate a process by
 14 which the patients could be contacted?
 15 DR. LAING:
 16 A. I didn't--that wasn't something that crossed
 17 my mind at the time. I assumed that that was
 18 something that the team back in St. John's
 19 would be dealing with.
 20 CHAYTOR, Q.C.:
 21 Q. Well, were you concerned that that happened,
 22 that the patients be told that--perhaps phone
 23 calls could start to be made within the next
 24 hours or day and a half that patients could
 25 be, at least a significant portion of them

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1 could be contacted?
 2 DR. LAING:
 3 A. I don't recall having had any conversations
 4 regarding that at that time, no.
 5 CHAYTOR, Q.C.:
 6 Q. Do you know if there was even a plan in place
 7 which would have enabled that to happen in an
 8 expedited manner, that there may have been a
 9 list of patients names and numbers ready to
 10 go?
 11 DR. LAING:
 12 A. Not that I was aware of at all.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And so Doctor, did you ultimately then
 15 read the article when you returned to the
 16 province?
 17 DR. LAING:
 18 A. I did.
 19 CHAYTOR, Q.C.:
 20 Q. And what did you think of the article?
 21 DR. LAING:
 22 A. I thought that there was items that were
 23 placed in the article as direct quotes from me
 24 that I didn't recall as having said. To me, a
 25 direct quote should be something that is

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1 verbatim from the person that you're
 2 interviewing and other than that, you know,
 3 say Dr. Laing said that there was a process
 4 underway, but there were things that were put
 5 in quotation marks in that article that were
 6 not things that I had recalled saying to this
 7 reporter. I did subscribe to The Independent
 8 and continued to do so until recently, and so
 9 it was in my mail box, and it's funny the
 10 things that you remember, but I remember my
 11 Mom calling me and saying that she heard that
 12 there was a story about me in the paper, and I
 13 told her to sit down, and because this was a
 14 different situation than previously.
 15 CHAYTOR, Q.C.:
 16 Q. And in fact, Doctor, you gave a--you
 17 participated in an article with this same
 18 reporter on this issue at a later date?
 19 DR. LAING:
 20 A. I did, yeah.
 21 CHAYTOR, Q.C.:
 22 Q. Doctor, did you have any discussions with
 23 Susan Bonnell before you participated in the
 24 interview with Clare-Marie Gosse?
 25 DR. LAING:

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<p>1 A. On that day in October? 2 CHAYTOR, Q.C.: 3 Q. Yes. 4 DR. LAING: 5 A. No, I didn't. 6 CHAYTOR, Q.C.: 7 Q. And I think the day was actually September 8 30th, wasn't it? September 30th? 9 DR. LAING: 10 A. Yes, sorry, because the Friday would be 11 September 30th. So the Saturday would be the-- 12 -I'm sorry, yes. No, no, I hadn't spoken to 13 any - 14 CHAYTOR, Q.C.: 15 Q. Just Dr. Williams? 16 DR. LAING: 17 A. Yeah. Now prior to this issue, I had met 18 Susan Bonnell. This was in 2005, so in the-- 19 you know, as we were still the NCTRF, she 20 wasn't someone who I had had a lot of dealings 21 with, in terms of media prior because the 22 NCTRF had its own separate media relations 23 people that were different than Eastern 24 Health's. So I had--although I had met her, 25 and subsequently came to know her quite well</p>	<p>1 had now sort of switched over to using Eastern 2 Health's media personnel, I'm not certain. 3 CHAYTOR, Q.C.: 4 Q. You never consulted any media relation person 5 at any point in time on the issue other than 6 Ms. Bonnell and her team? 7 DR. LAING: 8 A. Prior to this interview? 9 CHAYTOR, Q.C.: 10 Q. At any point, yes. 11 DR. LAING: 12 A. Or at any point regarding - 13 CHAYTOR, Q.C.: 14 Q. Any point? 15 DR. LAING: 16 A. No, no, no. So no, I didn't - 17 CHAYTOR, Q.C.: 18 Q. So the media relations people that were on - 19 DR. LAING: 20 A. Always - 21 CHAYTOR, Q.C.: 22 Q. - contract for the Cancer Centre, to your 23 knowledge, were not involved in this issue? 24 DR. LAING: 25 A. No, were never involved with ER/PR, that's</p>
<p>Page 342</p> <p>1 through this process, she wasn't someone that 2 I had dealt with on media issues before. 3 Before when we did press releases and 4 different things, yes, we would have had some 5 media contact and some pre-planned idea of 6 what people would say. But again, most of 7 those were around things like, you know, 8 positive stories, in terms of new initiatives 9 within the program or, you know, announcements 10 of funding and various things like that. So, 11 but no, prior to that day, to talking to the 12 reporter, the only person that I had talked to 13 was - 14 CHAYTOR, Q.C.: 15 Q. And so the only person you had talked to was 16 Dr. Williams? 17 DR. LAING: 18 A. Yes. 19 CHAYTOR, Q.C.: 20 Q. Okay, and I take it there was no media person-- 21 -was there still a media relations person with 22 the Cancer Centre at this point in time? 23 DR. LAING: 24 A. I'm not sure. That was somebody that we had 25 on a contractual basis, so whether or not we</p>	<p>Page 344</p> <p>1 correct. 2 CHAYTOR, Q.C.: 3 Q. Okay. If we could please have P-0086? And 4 this is a copy of the article that ran on 5 October 2nd in The Independent, and it's 6 called "Questionable results: Breast cancer 7 treatments in St. John's impacted by 8 inaccurate lab tests," Clare-Marie Gosse. I'm 9 just going to take you through parts of this, 10 Doctor, and ask you to comment, and if you 11 have any issue with what's being said and 12 perhaps along the way, you can point out the 13 places that you take exception to where you're 14 quoted. 15 DR. LAING: 16 A. Okay. 17 CHAYTOR, Q.C.: 18 Q. And--I didn't do that, right? Okay, that's 19 better. Thank you. 20 DR. LAING: 21 A. I don't have my mouse because if it would be 22 easier if I went through it? 23 CHAYTOR, Q.C.: 24 Q. You don't have a mouse now at all? 25 DR. LAING:</p>

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1 A. I don't know what happened to it.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. I'll scroll down.
 4 DR. LAING:
 5 A. That's okay.
 6 CHAYTOR, Q.C.:
 7 Q. I think we're having -
 8 THE COMMISSIONER:
 9 Q. The mice are not working, are they?
 10 CHAYTOR, Q.C.:
 11 Q. - problem with that.
 12 DR. LAING:
 13 A. Oh, okay.
 14 THE REGISTRAR:
 15 Q. They're still working on this.
 16 DR. LAING:
 17 A. Okay, fair enough, all right.
 18 CHAYTOR, Q.C.:
 19 Q. So I'll take you down, but if there's anything
 20 I skip over, by all means tell me.
 21 DR. LAING:
 22 A. Okay.
 23 CHAYTOR, Q.C.:
 24 Q. Tell me to stop. It says here that "Kara
 25 Laing, Director of Medical Oncology with the

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1 Health Care Corporation of St. John's says
 2 patients have been contacted recently on an
 3 individual basis as test results become
 4 available." So the idea that "patients have
 5 been contacted on an individual basis as test
 6 results become available," is that an accurate
 7 statement of what you would have told her?
 8 DR. LAING:
 9 A. Yes. The only thing that's not accurate in
 10 there is that it wasn't the Health Care
 11 Corporation of St. John's, but that's
 12 understandable.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. Go back to the paragraph before. "The
 15 test samples are being reassessed at the
 16 Health Sciences Centre, as well as the Mount
 17 Sinai Hospital in Ontario. The results are
 18 only now returning since the retesting began
 19 in May of this year." So let's go with "the
 20 test samples are being reassessed at the
 21 Health Science Centre, as well as Mount
 22 Sinai." Were the test samples being
 23 reassessed at both the Health Sciences and
 24 Mount Sinai?
 25 DR. LAING:

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1 A. No. I mean, I think this is speaking to what
 2 we had already known, that the first retesting
 3 was done on the Ventana system, and then a
 4 decision was made to send the test results to
 5 Mount Sinai Hospital.
 6 CHAYTOR, Q.C.:
 7 Q. Would you have told that to Clare-Marie Gosse?
 8 DR. LAING:
 9 A. No, I think that was something that she would
 10 have already known.
 11 CHAYTOR, Q.C.:
 12 Q. She would have gotten that from somewhere
 13 else?
 14 DR. LAING:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. And the fact that the test--not meaning that
 18 the test samples are being reassessed at both,
 19 both places are doing the same testing on the
 20 same samples, there was no discussion along
 21 those lines with the reporter?
 22 DR. LAING:
 23 A. Oh no, no, no, not at all.
 24 CHAYTOR, Q.C.:
 25 Q. "The results are only now returning since the

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1 retesting began in May this year." Doctor,
 2 did you have any results back on October 2nd,
 3 2005 from Mount Sinai?
 4 DR. LAING:
 5 A. Not that I know of, no.
 6 CHAYTOR, Q.C.:
 7 Q. Did you tell this to the reporter?
 8 DR. LAING:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. Do you know whether or not anyone at Eastern
 12 Health told her that?
 13 DR. LAING:
 14 A. No, I don't know. I don't know where that
 15 information came from.
 16 CHAYTOR, Q.C.:
 17 Q. And "since the retesting began in May this
 18 year," did you tell the reporter when the
 19 retesting began?
 20 DR. LAING:
 21 A. Not that I recall, because I think if I had
 22 have said that, I probably would have said
 23 April, just thinking back to the index case,
 24 but -
 25 CHAYTOR, Q.C.:

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<p>1 Q. So you would have said April, if she was</p> <p>2 referring to the index case?</p> <p>3 DR. LAING:</p> <p>4 A. Yes.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. And you don't know where the May would have</p> <p>7 come from?</p> <p>8 DR. LAING:</p> <p>9 A. No.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. And in terms of the test samples being</p> <p>12 reassessed at Mount Sinai, the index case</p> <p>13 never went to Mount Sinai, and "the results</p> <p>14 only coming back since the retesting began in</p> <p>15 May," the idea that someone could read that</p> <p>16 and understand that the retests to Mount Sinai</p> <p>17 began in May, do you know where that</p> <p>18 information would have come from?</p> <p>19 DR. LAING:</p> <p>20 A. No.</p> <p>21 CHAYTOR, Q.C.:</p> <p>22 Q. Did you have any discussion with her as to how</p> <p>23 long the retesting to Mount Sinai had begun,</p> <p>24 when that had actually initiated?</p> <p>25 DR. LAING:</p>	<p>1 DR. LAING:</p> <p>2 A. Yeah.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. And this is October.</p> <p>5 DR. LAING:</p> <p>6 A. Yeah.</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. The metastatic, the first few people?</p> <p>9 DR. LAING:</p> <p>10 A. Um-hm.</p> <p>11 CHAYTOR, Q.C.:</p> <p>12 Q. And the people retested in June?</p> <p>13 DR. LAING:</p> <p>14 A. And anybody else who we had done--because</p> <p>15 remember we talked then about that there were</p> <p>16 still some patients who, up until we stopped--</p> <p>17 so really it would have been maybe through to</p> <p>18 even July, would have been, you know, the</p> <p>19 patient from August whose result went to Mount</p> <p>20 Sinai through that sort of convoluted way, by</p> <p>21 the HER2 testing. So I would have been</p> <p>22 talking about -</p> <p>23 CHAYTOR, Q.C.:</p> <p>24 Q. There was one patient.</p> <p>25 DR. LAING:</p>
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<p>1 A. Not that I can recall, and if I had have told</p> <p>2 her then I would have said that the decision</p> <p>3 was made to retest at Mount Sinai in August of</p> <p>4 2005.</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Okay. "Kara Laing, Director of Medical</p> <p>7 Oncology with the Health Care Corporation St.</p> <p>8 John's, says patients have been contacted</p> <p>9 recently on an individual basis as test</p> <p>10 results become available." And the only issue</p> <p>11 you had with that was that the Health Care</p> <p>12 Corporation should in fact be Eastern Health.</p> <p>13 What patients had recently been contacted on</p> <p>14 an individual basis as the test results became</p> <p>15 available?</p> <p>16 DR. LAING:</p> <p>17 A. So I was talking about the people that we had</p> <p>18 already disclosed to.</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. The people that you had disclosed to when?</p> <p>21 DR. LAING:</p> <p>22 A. Through the index case, the people that we had</p> <p>23 retested, the metastatic patients.</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. So the index patient who was told in April?</p>	<p>1 A. Yeah, I would have been talking about that</p> <p>2 group of patients.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. That was August, the one--the patient who -</p> <p>5 DR. LAING:</p> <p>6 A. Yeah, so I would have been talking -</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. - was inadvertently tested at Mount Sinai in</p> <p>9 August?</p> <p>10 DR. LAING:</p> <p>11 A. Yeah, so I would have been talking about the</p> <p>12 patients that we have already discussed who</p> <p>13 were the ones that had the early disclosure.</p> <p>14 THE COMMISSIONER:</p> <p>15 Q. All of whom had been, except for the one that</p> <p>16 was retested -</p> <p>17 DR. LAING:</p> <p>18 A. Yeah, who had been retested in -</p> <p>19 THE COMMISSIONER:</p> <p>20 Q. - with the HER2/neu, all of whom would have</p> <p>21 been retested under the Ventana system in</p> <p>22 house?</p> <p>23 DR. LAING:</p> <p>24 A. That's correct.</p> <p>25 CHAYTOR, Q.C.:</p>

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1 Q. So none of them were part of the retests at
 2 Mount Sinai?
 3 DR. LAING:
 4 A. That's right.
 5 CHAYTOR, Q.C.:
 6 Q. And in terms of recently, that would--the most
 7 recent of those would have been the one in
 8 August?
 9 DR. LAING:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. "The Corporation has refrained from making a
 13 public statement to avoid raising concern.
 14 'The reason why we haven't gone public with
 15 this is we don't have all the answers,' Laing
 16 tells The Independent." Do you take any issue
 17 with that portion of the quote?
 18 DR. LAING:
 19 A. No.
 20 CHAYTOR, Q.C.:
 21 Q. "The last thing that you want to do or we want
 22 to do is make people afraid" and then she has
 23 "... is to cause some sort of mass hysteria."
 24 Do you have any problem with that portion of
 25 the quote?

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1 DR. LAING:
 2 A. The portion of that quote that I had problems
 3 with was "mass hysteria."
 4 CHAYTOR, Q.C.:
 5 Q. And what issue do you take with that?
 6 DR. LAING:
 7 A. I don't believe that that was the term that I
 8 had used.
 9 CHAYTOR, Q.C.:
 10 Q. And what do you think you said?
 11 DR. LAING:
 12 A. I'm not certain, but it's--you know, when you
 13 sort of think about things that you would say
 14 or terms that you would use to describe
 15 situations, mass hysteria is not something
 16 that would be a phrase that I would use. I
 17 would have said to her, and I do recall saying
 18 to her is that I had concerns about causing
 19 the patients anxiety, about making them
 20 concerned, but I didn't talk about starting
 21 some sort of mass hysteria or anything like
 22 that, and I remembered when I read this for
 23 the first time, I thought "I didn't say that.
 24 I didn't say mass hysteria" and I was struck
 25 by the fact that it actually is in quotation

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1 marks as if this was something that I had said
 2 directly.
 3 CHAYTOR, Q.C.:
 4 Q. And "Susan Bonnell, spokeswoman for the Health
 5 Care Corp, says a new more accurate piece of
 6 equipment was installed in the laboratory last
 7 year, providing clearer results, and current
 8 hormone receptor tests are also being double
 9 checked as part of the quality review. She
 10 adds the retesting is not impacting patients
 11 waiting for other laboratory results." When
 12 you read this, read the article and Ms.
 13 Bonnell's quoted as saying that "a new, more
 14 accurate piece of equipment was installed in
 15 the last year, providing clearer results, and
 16 current hormone receptor tests are also being
 17 double checked as part of the quality review,"
 18 did that cause you any concern?
 19 DR. LAING:
 20 A. Well, I mean, I think this speaks to the whole
 21 issue about what exactly the Ventana was as
 22 opposed to the old DAKO System, and the
 23 discussions about is it really a new--
 24 certainly not a new technology, it's still
 25 immunohistochemistry. Was it a new piece of

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1 equipment; yes, because it was semi-automated.
 2 Was it more accurate; you know, I think that
 3 that really remained to be seen. So, you
 4 know, that wasn't anything that I talked
 5 about. This was clearly a statement that Susan
 6 had made.
 7 CHAYTOR, Q.C.:
 8 Q. Yes, and I realize you didn't.
 9 DR. LAING:
 10 A. But --
 11 CHAYTOR, Q.C.:
 12 Q. And I take it, you didn't know whether or not
 13 that was going to be referenced in the
 14 article?
 15 DR. LAING:
 16 A. That's right.
 17 CHAYTOR, Q.C.:
 18 Q. But at the time you read it, did it cause you
 19 any concern that that was being stated?
 20 DR. LAING:
 21 A. Other than the discussions that we've already
 22 had to say that, you know, I didn't feel that
 23 that was--that we had enough information to
 24 say at this point that that was the reason why
 25 we had a change in test results, until we had

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1 the retest from the outside lab.
 2 CHAYTOR, Q.C.:
 3 Q. Doctor, on September 22nd, 2005, did you sit
 4 in on the exit interview with Trish
 5 Wegrynowski?
 6 DR. LAING:
 7 A. Yes, I did.
 8 CHAYTOR, Q.C.:
 9 Q. So you knew what Trish Wegrynowski had found
 10 in her review?
 11 DR. LAING:
 12 A. Oh, I did, yes, that's correct, I did, but I
 13 did not discuss this--as that was part of a
 14 peer review process, I did not discuss it at
 15 all during this interview.
 16 CHAYTOR, Q.C.:
 17 Q. But my question being would it concern you
 18 that this is what Ms. Bonnell is saying about
 19 the technology? Did that cause you any
 20 concern when you read that, knowing other
 21 information that you would have had on October
 22 2nd?
 23 DR. LAING:
 24 A. Sure, and I just said that because I--you
 25 know, even from the very beginning, although

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1 there was question raised as if, you know,
 2 were the changes in test results only because
 3 of the new machine, then I don't think that
 4 that was a view that we had enough information
 5 at that time that everybody agreed, oh, you
 6 know, this is just because we're using a
 7 different machine to do this
 8 immunohistochemical testing. I think that,
 9 you know, people were waiting to see what the
 10 new test results coming back from Mount Sinai
 11 would be, and, of course, the second part of
 12 that was this peer review including the lady
 13 from Toronto, and, of course, Dr. Banerjee.
 14 CHAYTOR, Q.C.:
 15 Q. Yes. Doctor, the idea that current hormone
 16 receptor tests are also being double checked
 17 as part of the quality review, was there even
 18 any current hormone receptor test taking place
 19 at the Health Sciences Centre on October 2nd,
 20 2005?
 21 DR. LAING:
 22 A. No, at that time they were being sourced out
 23 to Mount Sinai. So I think that that next
 24 paragraph is fine, you know, this was sort of
 25 saying how we had tested people, they changed

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1 to positive, it was the course of their
 2 treatment, they were still being treated for
 3 breast cancer, would just affect on how we
 4 would be treated--oh, sorry, how they would be
 5 treated.
 6 CHAYTOR, Q.C.:
 7 Q. That's fine.
 8 DR. LAING:
 9 A. So that was all okay.
 10 CHAYTOR, Q.C.:
 11 Q. And then I think the next quote attributed to
 12 you is this paragraph, "We're talking about
 13 the care of individual patients", says Laing,
 14 "so I can't really give you sort of a global
 15 statement other than to tell you, one;
 16 estrogen and progesterone receptors are very
 17 important piece of information, but they go
 18 with other things".
 19 DR. LAING:
 20 A. Sure.
 21 CHAYTOR, Q.C.:
 22 Q. "And number two is that this is very
 23 individualized".
 24 DR. LAING:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. So you take no issue with that?
 3 DR. LAING:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. "She says new information surrounding the
 7 hormone receptor test led to the decision to
 8 conduct a review". So, Doctor, what new
 9 information? Is that, first of all, an
 10 accurate quote or statement as to what you
 11 would have said, and if so, what was the new
 12 information?
 13 DR. LAING:
 14 A. I think what I would have been talking to her
 15 about was the--was the information from Dr.
 16 Hudis about the lobulars and how the index
 17 case started. I don't believe I gave her that
 18 detail of specific information, just to say
 19 that there was something new that came along
 20 that made us retest some patients, that one or
 21 two people had retesting done, and we noticed
 22 there was a difference. Then, of course, we
 23 did more and more, and that's where we were.
 24 CHAYTOR, Q.C.:
 25 Q. There were one or two patients, and again this

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<p>1 is in quotes, "there were one or two patients 2 that had had retesting done for another reason 3 where we noticed sort of a difference ... we 4 noticed some discrepancies and there was a 5 thought that maybe there was something going 6 on".</p> <p>7 DR. LAING: 8 A. Uh-hm. 9 CHAYTOR, Q.C.: 10 Q. What is the other reason? "The one or two 11 patients that had had retesting done for 12 another reason", what other reason were you 13 referring to? 14 DR. LAING: 15 A. I think what that came from was first of all 16 when I was referring to--although not 17 specifically about the index case in any 18 detail or about the lobular histology, was 19 that that was the first reason that we had 20 done the retest, and then the second one was 21 for the patients who had had metastatic 22 disease, so these were the people that would 23 have been the ductals that we had checked. So, 24 you know, I had sort of started to say to her 25 we had gone to ask for retesting on some</p>	<p>1 early patients, one, two, three, four and 2 five. 3 CHAYTOR, Q.C.: 4 Q. But why were they retested? Yes, they had 5 metastatic disease, but why in May of 2005 6 were those people retested? They weren't 7 retested in March of 2005 or any time prior to 8 that. 9 DR. LAING: 10 A. Because of what had happened with the index 11 case. 12 CHAYTOR, Q.C.: 13 Q. Okay, "Laing says any patients or past 14 patients found to have inaccurate readings 15 will be able to immediately discuss with their 16 physician any necessary change to their 17 treatment procedures. She adds there's no way 18 to judge at this point in time whether any 19 incorrect tests would have impacted recovery". 20 The idea that patients will immediately be 21 able to discuss with their physicians any 22 necessary change to their treatment, Doctor, 23 at this point in time had it been contemplated 24 that the retest results would first go through 25 a panelling process?</p>
<p>1 people, and then for other reasons, we checked 2 on other people and this would have been the 3 ductal cancer patients who had had the 4 metastatic disease, and that we noticed there 5 was differences in those, and then that's when 6 we started to put our heads together and say 7 this doesn't seem to be just lobular, this 8 doesn't seem to--there's some ductal patients. 9 Then, of course, as time went on and we did 10 the first full 25, and then so on and so on. 11 CHAYTOR, Q.C.: 12 Q. So what was the reason for the retesting of 13 any of those patients? 14 DR. LAING: 15 A. Well, it all started with the index case, and 16 the retesting was because of Dr. Hudis saying 17 that in their experience at Memorial Sloan- 18 Kettering was that when they retested the 19 lobulars, they were all 100 percent, that was 20 what had started it, but that there were 21 patients that were retested because of that, 22 but that the other reasons were the patients 23 who had metastatic disease that we were 24 looking for to see if there might be a new 25 treatment and those were some of the very</p>	<p>1 DR. LAING: 2 A. Yes, I believe at that time we had had some 3 preliminary discussions about a panelling 4 process. She uses words like "immediately". I 5 guess what I had tried to say to her was that 6 if there were patients who are identified as 7 having changes, that that would be discussed, 8 and if they required a change in their 9 treatment or their care, that that would be 10 discussed with them by their physician. She 11 said, well, do you know now if any of these 12 changes have had an impact on patients, and I 13 said, well, it was too early, we couldn't tell 14 at this point, you know, what difference that 15 would have made, and I really didn't get into 16 a detailed discussion with them--with her, 17 sorry, about that. 18 CHAYTOR, Q.C.: 19 Q. Doctor, over here it says, "Because results 20 are still incoming, Laing says it's impossible 21 to predict how many patients may be affected, 22 although she suggests that the number will be 23 relatively small. Of the ones that have been 24 coming back, I looked at maybe, I don't know, 25 40 or 50 the other day, and there were five or</p>

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1 six people that were there that it may have
2 had an impact, so it's not a huge thing".
3 What about--that's attributed as being a
4 direct quote, the second paragraph.
5 DR. LAING:
6 A. That's right, and so, you know, I think this
7 whole idea about the results still incoming,
8 we were--you know, we were just--this was
9 prior to before we sat down and looked at any
10 of the Mount Sinai tests, and to that, I meant
11 that we did not have the test results back
12 yet, and --
13 CHAYTOR, Q.C.:
14 Q. So Doctor --
15 DR. LAING:
16 A. So that's--no, I think that's referring,
17 though, to the--because 40 or 50, to me, is
18 not a number that I would have thought back to
19 the first 16 out of 25. So whether or not
20 this was the first Mount Sinai results, I'm
21 not entirely clearly.
22 CHAYTOR, Q.C.:
23 Q. Doctor, this is October 2nd, 2005.
24 DR. LAING:
25 A. Yes, I know that.

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1 CHAYTOR, Q.C.:
2 Q. Had the first results been received from Mount
3 Sinai at this point in time?
4 DR. LAING:
5 A. I'm not certain.
6 CHAYTOR, Q.C.:
7 Q. So what batch of patients could this be
8 referring to?
9 DR. LAING:
10 A. I'm not certain.
11 CHAYTOR, Q.C.:
12 Q. Do you recall there ever being 40 or 50
13 patients that you reviewed where only five or
14 six people may have had an impact?
15 DR. LAING:
16 A. I'm actually thinking that this was perhaps
17 the first results back from Mount Sinai
18 because those numbers don't correlate from my
19 recognition about the numbers that we would
20 have looked at already through the first,
21 second, and third batches.
22 CHAYTOR, Q.C.:
23 Q. So there may have been the first batch back
24 from Mount Sinai?
25 DR. LAING:

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1 A. May have been the first batch back from Mount
2 Sinai, and I know that when they did come
3 back, that I did look at those with Dr. Cook.
4 CHAYTOR, Q.C.:
5 Q. And your initial reaction was that there
6 weren't a lot of people in that batch that
7 came back that would be impacted?
8 DR. LAING:
9 A. Yeah, I do recall that the initial results
10 that we had back from Mount Sinai were not
11 similar to the numbers that we had seen
12 previously from our own review, and I can tell
13 you that I probably did use the word "huge"
14 because that is my word.
15 CHAYTOR, Q.C.:
16 Q. So it's not a "huge" thing, probably was your
17 word?
18 DR. LAING:
19 A. Yeah.
20 CHAYTOR, Q.C.:
21 Q. And the idea that "she suggests the number
22 will be relatively small", is that something
23 you would have suggested?
24 DR. LAING:
25 A. I don't think I told her that I thought that

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1 the number was definitely going to be small.
2 I think probably what I told her was that we
3 really didn't have any idea about how big this
4 was going to be, and that we hoped that it
5 wouldn't be as many--you know, that it
6 wouldn't be a lot of people affected, but, you
7 know, I suspect I was basing that--some sort
8 of statement to say that we hope that this is
9 not going to be something that impacts a lot
10 of patients, which, you know, certainly would
11 be a fair statement to have made, but, you
12 know, I guess that was the optimist in me
13 coming through at that point.
14 CHAYTOR, Q.C.:
15 Q. And you did mention earlier when you gave a
16 summary of what you had said to her, that you
17 thought you mentioned the 16 out of 25 that
18 was done in-house?
19 DR. LAING:
20 A. Yes.
21 CHAYTOR, Q.C.:
22 Q. Do you recall that you did tell her that?
23 DR. LAING:
24 A. I --
25 CHAYTOR, Q.C.:

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<p>1 Q. I don't see that quoted here.</p> <p>2 DR. LAING:</p> <p>3 A. No, she doesn't quote that.</p> <p>4 CHAYTOR, Q.C.:</p> <p>5 Q. Or referred to here at all.</p> <p>6 DR. LAING:</p> <p>7 A. I thought I did, but--because that to me was</p> <p>8 always the number that--you know, that first</p> <p>9 batch was always the number that sort of stuck</p> <p>10 in my mind as the initial patients that there</p> <p>11 was --</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. And that would have indicated something other</p> <p>14 than it was a relatively small number of</p> <p>15 patients if you were talking 16 out of 25.</p> <p>16 DR. LAING:</p> <p>17 A. Absolutely not.</p> <p>18 CHAYTOR, Q.C.:</p> <p>19 Q. That's not referred to. What's referred to</p> <p>20 here is a review of some patients that</p> <p>21 indicated to you --</p> <p>22 DR. LAING:</p> <p>23 A. That that was the --</p> <p>24 CHAYTOR, Q.C.:</p> <p>25 Q. It wasn't going to be a huge thing.</p>	<p>1 Q. And that you reviewed the results?</p> <p>2 DR. LAING:</p> <p>3 A. That we looked to see what--you know, that was</p> <p>4 sort of the first list of patients, looking at</p> <p>5 what the results were, and how they had</p> <p>6 changed, yeah.</p> <p>7 CHAYTOR, Q.C.:</p> <p>8 Q. I take it you didn't review any charts or</p> <p>9 anything --</p> <p>10 DR. LAING:</p> <p>11 A. No, no, no.</p> <p>12 CHAYTOR, Q.C.:</p> <p>13 Q. To see if you would need a change in</p> <p>14 treatment?</p> <p>15 DR. LAING:</p> <p>16 A. That's right.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. You would have been relying strictly on who</p> <p>19 had had a conversion according to the numbers?</p> <p>20 DR. LAING:</p> <p>21 A. That's exactly right, yes.</p> <p>22 CHAYTOR, Q.C.:</p> <p>23 Q. And then it goes on to say, "We're dealing</p> <p>24 with this as quickly as possible. I mean,</p> <p>25 you're dealing with people who are already in</p>
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<p>1 DR. LAING:</p> <p>2 A. Yeah.</p> <p>3 CHAYTOR, Q.C.:</p> <p>4 Q. And you think--when did you go to Toronto?</p> <p>5 September 30th you're in Toronto. When did</p> <p>6 you go to Toronto; how long had you been in</p> <p>7 Toronto up to this point?</p> <p>8 DR. LAING:</p> <p>9 A. Oh, just a couple of days.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. And you --</p> <p>12 DR. LAING:</p> <p>13 A. When I looked at my calendar those two days--</p> <p>14 so the Thursday and Friday were blocked off,</p> <p>15 so I probably flew up Thursday for the Friday</p> <p>16 meeting.</p> <p>17 CHAYTOR, Q.C.:</p> <p>18 Q. And do you recall then if results had come</p> <p>19 back late in September that you would have</p> <p>20 reviewed them before you went to Toronto?</p> <p>21 DR. LAING:</p> <p>22 A. Yes, because I do remember that when the first</p> <p>23 set of results came back from Mount Sinai,</p> <p>24 that I did speak to Dr. Cook about that.</p> <p>25 CHAYTOR, Q.C.:</p>	<p>1 a stressful situation who are going through</p> <p>2 cancer treatment, or who have recovered from</p> <p>3 cancer treatment. Laing stresses there is no</p> <p>4 need for breast cancer patients or any other</p> <p>5 cancer patients to get frightened because the</p> <p>6 results are a matter of patient care as</p> <p>7 opposed to cure".</p> <p>8 DR. LAING:</p> <p>9 A. No, I took--I had problems with the last part</p> <p>10 of that statement. I don't believe she</p> <p>11 understood what I was trying to convey.</p> <p>12 Certainly the first paragraph, "We are dealing</p> <p>13 with the situation", I would agree with that,</p> <p>14 acknowledging that having a breast cancer</p> <p>15 diagnosis and going through treatment was</p> <p>16 already stressful enough for patients, that</p> <p>17 this was patients who were currently on</p> <p>18 treatment and acknowledging that it was even</p> <p>19 patients who had already had their treatment,</p> <p>20 and that I really was concerned about this</p> <p>21 whole idea of patients being frightened or</p> <p>22 anxious because of this, and I think that she</p> <p>23 completely misunderstood because I think that</p> <p>24 this result--that this is a matter certainly</p> <p>25 of patient care--in the adjuvant setting, we</p>

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<p>1 had a long discussion yesterday about how, in 2 fact, it is important for risk reduction 3 recurrence and improvement in survival, so 4 care as opposed to cure would not be something 5 that I would have said at all. 6 CHAYTOR, Q.C.: 7 Q. And the last quote she has from you is, "We're 8 not trying to cover up anything here. We're 9 trying to take care of patients and we're 10 doing that and continue to do that. I don't 11 think a statement that this is something that 12 has negatively impacted on breast cancer 13 patients as a whole group can be said at all. 14 I think that's false". What about that last 15 quote that's attributed to you, Doctor? 16 DR. LAING: 17 A. Yeah. I know that during this interview that 18 she certainly accused--I guess that might be a 19 strong word, but suggested that there was--you 20 know, that we hadn't gone public because we 21 were trying to hide something, and I guess I 22 was trying to say to her, no, that wasn't the 23 reason for that decision, from my point of 24 view, that--you know, I would certainly say 25 something like we're trying to take care of</p>	<p>1 that's told to the public and to many breast 2 cancer patients through this mechanism. 3 DR. LAING: 4 A. Yeah. 5 CHAYTOR, Q.C.: 6 Q. So I thought it's important that -- 7 DR. LAING: 8 A. Yes, certainly. 9 CHAYTOR, Q.C.: 10 Q. That we go through it and clarify what you may 11 or may not have said. 12 DR. LAING: 13 A. Yeah. 14 CHAYTOR, Q.C.: 15 Q. Because this was the first--this was the first 16 publication on the issue. 17 DR. LAING: 18 A. Right, and as time goes on, you alluded to 19 earlier that I did have another interview with 20 The Independent, but I think it was a 21 different reporter at that time. I think it 22 was Stephanie Porter for the second one. 23 CHAYTOR, Q.C.: 24 Q. You did do one with her too, I think. 25 DR. LAING:</p>
<p>Page 374</p> <p>1 patients, we're continuing to do that, and, 2 you know, I--I would have said something that 3 --I think that she had an idea that this meant 4 that all of the breast cancer pathology was 5 incorrect, that all of the ER/PR testing 6 results were wrong, and I was saying that this 7 is something that didn't apply to the whole 8 group. I would say that definitely this 9 something that at the end of the day certainly 10 did negatively impact on all breast cancer 11 patients, on all cancer patients, regardless 12 of whether their test results changed or not. 13 Obviously, this did, but what I was trying to 14 get across by that was that she was saying, 15 well, you know, all breast cancer patients got 16 the wrong results, all breast cancer patients 17 have gotten the wrong treatment, and I was 18 telling her that it was not all of them, and 19 that we really didn't have an idea yet of what 20 percentage that was going to end up being. 21 CHAYTOR, Q.C.: 22 Q. Okay, thank you, Doctor. Is there anything 23 else then about the article, and the reason I 24 took you through that in some detail is that 25 this is the first--this is the first thing</p>	<p>Page 376</p> <p>1 A. Okay. 2 CHAYTOR, Q.C.: 3 Q. But I could be--I could be wrong. Maybe you 4 didn't do another one with Clare Marie. 5 DR. LAING: 6 A. Okay. 7 CHAYTOR, Q.C.: 8 Q. But I had thought along the way I had seen 9 that. 10 DR. LAING: 11 A. Because it -- 12 CHAYTOR, Q.C.: 13 Q. We've read a lot of material. I could be 14 mistaken. 15 DR. LAING: 16 A. I know that I did look at the second 17 interview, and I'm sure we'll talk about it, 18 and that was better. 19 CHAYTOR, Q.C.: 20 Q. Yes, yes, okay. 21 THE COMMISSIONER: 22 Q. Ms. Chaytor, it's after five. I suggest we 23 adjourn for the day. 24 CHAYTOR, Q.C.: 25 Q. Thank you, Commissioner.</p>

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1 THE COMMISSIONER:
2 Q. 9:30 in the morning.
3 COFFEY, Q.C.:
4 Q. If I could, Commissioner --
5 THE COMMISSIONER:
6 Q. Mr. Coffey is on his feet.
7 COFFEY, Q.C.:
8 Q. If I could, Commissioner, tomorrow morning we
9 plan to start at 9:30 with Dr. Denic. I think
10 everybody in the room--I think counsel is
11 aware of it, but we should let people know.
12 THE COMMISSIONER:
13 Q. All right, so we're switching off to Dr. Denic
14 for tomorrow and Friday.
15 COFFEY, Q.C.:
16 Q. Yes.
17 THE COMMISSIONER:
18 Q. All right, thank you, 9:30.

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1 CERTIFICATE
2 I, Judy Moss, hereby certify that the foregoing is
3 a true and correct transcript in the matter of the
4 Commission of Inquiry on Hormone Receptor Testing,
5 heard on the 10th day of September, A.D., 2008
6 before the Honourable Justice Margaret A. Cameron,
7 Commissioner, at the Commission of Inquiry, St.
8 John's, Newfoundland and Labrador and was
9 transcribed by me to the best of my ability by
10 means of a sound apparatus.
11 Dated at St. John's, Newfoundland and Labrador
12 this 10th day of September, A.D., 2008
13 Judy Moss

Inquiry on Hormone Receptor Testing

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