COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 10, 2008

Appearances:

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Peter Browne/Jane Hennebury . . . . . Doctors Kara Laing et al

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. . . . . Cancer Testing Class Action

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Blair Pritchett. . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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DR. KARA LAING, EXAMINATION BY SANDRA CHAYTOR, Q.C. (CONT'D)

THE COMMISSIONER:

Q. We seem to have a little high noise level. Would you mind taking care of that? Thank you. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Good morning, Commissioner. Good morning, Dr. Laing.

DR. LAING:

A. Good morning.

CHAYTOR, Q.C.:

Q. Commissioner, we have a new exhibit this morning. It's C-246.

THE COMMISSIONER:

Q. Entered.

CHAYTOR, Q.C.:

Q. I'm sorry, C-0246.

THE COMMISSIONER:

Q. 246, yes.

EXHIBIT ENTERED AND MARKED C-0246

CHAYTOR, Q.C.:

Q. Thank you. Doctor, just a couple of points from yesterday. One, I would just like to ask you a couple of things about your interactions

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with Dr. Cliff Hudis from Sloan-Kettering.
DR. LAING:
A. Sure.
CHAYTOR, Q.C.:
Q. And from your evidence yesterday, we understand that there was the e-mail exchange that you had with him, April 9th, 10th and 11th, I believe it was, 2005.
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:
Q. And then you indicated that the only other discussions that you had with him around this matter was discussions you had with him at a conference in the fall of 2005.
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. And do you recall when in the fall, when and where did that conference take place?
DR. LAING:
A. I'm not certain. I think it's one of two places. When I went back through my calendar to see where I had been, I went to a European conference, so it was called ECCO. It's a

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European oncology conference that year, and I also went to the San Antonio Breast Cancer Conference that year. But I do recall having had knowledge of my discussions with him by the time we had started into the panel process, which makes me feel that it was at the ECCO meeting, which would have been towards the end of that September of 2005.
CHAYTOR, Q.C.:
Q. Okay, so that's in the end of September, and the San Antonio conference also is in the fall, I understand?
DR. LAING:
A. It's in December.
CHAYTOR, Q.C.:
Q. In December, okay.
DR. LAING:
A. Yeah, so that year, it would have been in early December.
CHAYTOR, Q.C.:
Q. So it was either the end of September and that's what you likely think it was, because when you started the panel process -
DR. LAING:
A. Right, I would have had -

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CHAYTOR, Q.C.:
Q. Discussion with him.
DR. LAING:
A. - the discussion with him.
CHAYTOR, Q.C.:
Q. Okay, and the only other alternative would have been December of 2005?
DR. LAING:
A. With the San Antonio, yes.
CHAYTOR, Q.C.:
Q. And if I could have, please, C-0246? And Doctor, this is just the last page of a pathology report, and I gave you the full copy before we came out this morning. You've had a chance to review that?
DR. LAING:
A. Yes, I have had a chance to look at this.
CHAYTOR, Q.C.:
Q. And this involves the patient that you had who had a biopsy sample or a specimen--sorry, an ER/PR test done on her biopsy specimen and then the repeat done or another specimen on the mastectomy specimen had another test.
DR. LAING:
A. Right.

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CHAYTOR, Q.C.:
Q. And they were conflicting, and you took that up with Dr. Chittal?
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:
Q. And this is the last page of the report, which came out of Peninsulas Health Care Corporation, which would be Clarenville, and I just bring this to your attention today because on the bottom, it says "referred out. Sent to Mount Sinai (Mullen). Date sent 02/07/2002. Reason sent ER/PR, specimen ID block three. Date returned, July 25th, 2002. All returned one block," and this is the addendum one from the Clarenville Hospital.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Which indicated the tumour to be 75 to 80 percent of ER positivity, and you'll see here, it's entered July 26th, 2002, so the day after it's returned from Mount Sinai. So at the time of reviewing the--and noticing that there had been a discrepancy in the reports -

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. - did you notice that, in fact, the test had been done at Mount Sinai?
DR. LAING:
A. No, I did not.
CHAYTOR, Q.C.:
Q. Okay. So this did not catch your attention?
DR. LAING:
A. Not at all, no.
CHAYTOR, Q.C.:
Q. Doctor, I'd like to go back then now to 2005, when the retest or the discussions started to come up about doing a retest on a broader basis.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. I think that's where we left off yesterday.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Did you contact any other pathologists outside of St. John's to request retests?

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DR. LAING:
A. No, the patients that I had requested the early retests on were St. John's patients.
CHAYTOR, Q.C.:
Q. And do you know whether or not Dr. McCarthy contacted any pathologists outside of St. John's to request retests?
DR. LAING:
A. I don't know that, no.
CHAYTOR, Q.C.:
Q. Okay, and Dr. Baker from Carbonear has indicated that he was contacted by either yourself or Dr. McCarthy in the early weeks of this.
DR. LAING:
A. Okay.
CHAYTOR, Q.C.:
Q. He thought before he had ever heard anything about it from Dr. Cook.
DR. LAING:
A. Okay.
CHAYTOR, Q.C.:
Q. And that he had direct contact with one of the oncologists requesting a retest.
DR. LAING:

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A. Okay.
CHAYTOR, Q.C.:
Q. Do you have any recollection of that?
DR. LAING:
A. No. If it was Dr. Baker, it would have been a patient who was from the Carbonear area, but I can't recall right now who that might have been.
CHAYTOR, Q.C.:
Q. All right, and you don't recall any discussion with Dr. McCarthy about that?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Do you recall the first meeting that you would have attended regarding this matter, the first time you sat down to discuss this issue with anybody?
DR. LAING:
A. So the first formal meeting that we would have had would have been in mid July of 2005, and that was a meeting that was attended by Dr. McCarthy and I, but also Dr. Cook, at that time, and Mr. Gulliver and Mr. Dyer from the lab. I believe that was sort of sometime in

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the middle of July. I had been on leave for the last two weeks of June and into the 7th, 8th, 9th, somewhere around there, of July. I came back from my holidays and it was shortly after that that we had a meeting with the pathologists and personnel from the lab.
CHAYTOR, Q.C.:
Q. Did you attend a meeting--we've heard about a meeting that took place May 17th 2005. Did you attend that meeting?
DR. LAING:
A. Not that I recall.
CHAYTOR, Q.C.:
Q. That would have been a meeting with yourself, Dr. Carter, yes, Bev Carter, Dr. McCarthy, Dr. Cook and Barry Dyer.
DR. LAING:
A. Okay. I know that I did review the minutes prior to coming here from the middle of July meeting, but if it indicates that we had a meeting in May, then I guess I was there as well.
CHAYTOR, Q.C.:
Q. Okay, and I'm just wondering though, in fact, if you attended that meeting. I mean, some

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people have recollection that you did, but I'm just wondering if you have any recollection of a meeting. So this would have been after the telephone discussion, May 11th.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. Between Dr. Cook and Dr. McCarthy.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. And is it your recollection that you didn't actually then sit down with Dr. Cook until the middle of July?

DR. LAING:

A. No, then there was--when you started the questioning, I thought that you were referring to that July meeting, but yes, there was a meeting after we had had an initial--Dr. McCarthy had the initial discussion with Dr. Cook.

CHAYTOR, Q.C.:

Q. And what do you recall then about the May 17th meeting?

DR. LAING:

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A. That was a meeting that we had and we, as the clinicians, were there and discussed how we utilized this test in the clinic. I recall having those discussions, indicating that this was at test that we used as a predictive marker to determine if a patient should be considered for hormonal therapy, and there was some discussion at one of the early meetings about whether or not that was information that was utilized in the clinic by the clinicians.

CHAYTOR, Q.C.:

Q. Okay, and the purpose of that meeting, who called that meeting? Do you remember why that meeting occurred? Was it done at your request? Was it done at pathology's request?

DR. LAING:

A. I recall it was done at pathology's request.

CHAYTOR, Q.C.:

Q. Okay, and had you ever met Mr. Dyer prior to that meeting?

DR. LAING:

A. Not that I can recall.

CHAYTOR, Q.C.:

Q. Okay, and in the meeting, so this is the first time you've had an opportunity to sit down

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with people from the lab to discuss the issue?

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. Did you express your concerns? You explained what the purpose of the test was and how you used the test in your day-to-day treatment of patients.

DR. LAING:

A. That's right.

CHAYTOR, Q.C.:

Q. Did you express concerns to Dr. Cook and Dr. Carter?

DR. LAING:

A. Just to say that, you know, it was an important piece of information that we would have relied upon to make treatment decisions, and which they were aware of.

CHAYTOR, Q.C.:

Q. Did they offer any explanation as to why these changes could be occurring?

DR. LAING:

A. At that time, no, not that I recall.

CHAYTOR, Q.C.:

Q. And did you ask for any explanation?

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DR. LAING:

A. No, that was, you know, in the very early days of this process, and I think at that time we were trying to decide what the next steps would be, since we had had the index case and by that time, we would have requested repeats on just those few patients so far in the clinic and we wouldn't have had all those results back, and really it was one of the early meetings to discuss where we were going to go from there, and a decision was made that we would, you know, keep our eyes and ears open in the clinic and if there were other cases, that we wished to bring forward to be retested, we could send along a consult and that, at the time, Dr. Carter and Dr. Cook were going to look at some others, that they would just pick from various times, just to retest randomly to see if there were others that would come back with a different result, and at that time, the retesting was being done on the Ventana system.

CHAYTOR, Q.C.:

Q. Yes. If we could have, please, P-2147?

REGISTRAR:

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

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A. No, not at all.
CHAYTOR, Q.C.:
Q. So have you ever attended a meeting where there was anything confrontational between either oncologists, pathologists, lab tech-- the technical side of the lab or any other groups or individuals?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And it goes on to say, "May 2002," I'm not sure what that says, but "DAKO system from 1996 to 2003, all negatives must be repeated. ER/PR" and then "ER/PR controls," and then there's a number of names blocked out here. So at this point in time, it seems to be that there had been a number of retests done at that point in time, and this is what Mr. Dyer recorded as having happened in the May 17th meeting. So I don't know if that assists in your recollection of the stage that you were at and what decisions may have come out of that meeting.
DR. LAING:
A. Yeah. No, you know, certainly I was asked this question after Mr. Dyer's testimony, did I recall that sort of confrontation between Dr. McCarthy and him at this meeting, and I certainly did not. I do not recall Dr. McCarthy pointing her finger or using any sort of accusing voice when speaking to him. As I said, we were there and explained how this test was utilized in the clinic. I recall that one of the questions was "well, is this really something that you rely upon or do you just give all patients Tamoxifen?" and we said, no, you know, this is a test that we use to help determine that. But I don't recall there being that sort of confrontation at that time, and really throughout all of our meetings and discussions with pathologists during this time, I don't recall ever that there was a sense of animosity or accusations between oncology and pathology or oncology and the laboratory personnel.

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CHAYTOR, Q.C.:
Q. Okay, and Doctor, what's written here is that, it said "pointed finger, 'this is your fault.'" Did Dr. McCarthy use those words or any words to that effect?

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DR. LAING:
A. Not that I recall, no.
CHAYTOR, Q.C.:
Q. And is that something you think that you would recall?
DR. LAING:
A. I believe that I would recall that. You know, over the years, as part of my role, I've attended many, many meetings and continue to do so, and certainly if that tone or, you know, that sort of accusation was made, particularly by one of my colleagues and a member of my staff, I would believe certainly that I would recall that, that type of incident.
CHAYTOR, Q.C.:
Q. And that's something, I take it, you would follow up with her on afterwards?
DR. LAING:
A. Yes, it certainly would be.
CHAYTOR, Q.C.:
Q. Okay, and I take it that didn't happen? You didn't speak to Dr. McCarthy about her demeanour or anything she said in the meeting following it?

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DR. LAING:
A. No, because I didn't recall or witness anything that would have made me call into question her behaviour.
CHAYTOR, Q.C.:
Q. And how much recollection do you have, in any event, of this meeting? When I first started this morning asking questions, your recollection was that the next meeting was in fact the July 14th meeting. Do you have a clear recollection of this meeting?
DR. LAING:
A. I do recall talking about the issue of how this test was utilized in the clinic and that's my recollection of that. This would have, from my memory, been the first time that I met with Mr. Dyer, as I had indicated, and really, I guess, although I don't remember this meeting, I think if it had been something that, you know, has been described as it has been described, I think I would remember that part of it for sure. I can't imagine being in that sort of meeting and it not leaving an impression on me afterwards, if there was that sort of confrontation going on at the time.

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CHAYTOR, Q.C.:
Q. Okay. And if I could have, please, P-0067? And Doctor, were you present, do you know, those meetings, were you present for all the meetings or parts of the meetings? Were there times when you were late arriving at meetings?
DR. LAING:
A. Yes, there was. Often the meetings were held at 5:00 and I had--still have Monday afternoon and Tuesday afternoon clinics, which often don't finish until 6-6:30, so there certainly were some meetings that I was late coming to because of my clinical responsibilities.
CHAYTOR, Q.C.:
Q. And P-0067 is a letter that's written by Dr. Cook, May 24th, 2005 to Dr. Williams, and let me see here, it's a three-page letter, and Doctor, I take it you've had an opportunity to review this letter before?
DR. LAING:
A. Yes, but I did not receive it at that time.
CHAYTOR, Q.C.:
Q. Okay, and in this letter, Dr. Cook writes and refers to the May 11th, 2005 phone call that he received "from Joy McCarthy, a medical

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oncologist, informing me of an ER and PR reported negative in a patient with infiltrating lobular carcinoma of the breast, diagnosed in 2002, and when retested," and it says May of 2005, but we know that should be April, correct, Doctor, it should be--the retest was April 2005?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. "The ER and PR were reported as strongly positive. Dr. McCarthy also expressed concern over what appears to be a high rate of infiltrating lobular carcinomas that were reported as ER and PR negative." At this point in time then, up until May 24th, 2005, what evidence did you and Dr. McCarthy have of a high rate of the infiltrating lobular carcinomas having been reported as ER and PR negative?
DR. LAING:
A. I don't know what that statement refers to.
CHAYTOR, Q.C.:
Q. So up to this point in time, you would have pulled three or four cases and you were basing

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them on lobular--you're originally identifying patients as being lobular?
DR. LAING:
A. Oh, I understand what you mean.
CHAYTOR, Q.C.:
Q. And having retests.
DR. LAING:
A. So by this time, we have the index case.
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. We have Peggy Deane's case. We have patient one and patient two who we talked about yesterday, who were lobular, and so we would have had those patients. But when she--this refers to--he's writing this letter, I'm correct -
CHAYTOR, Q.C.:
Q. May 24th.
DR. LAING:
A. - May 24th, and but at the May 11th time, we would have had information back on the index case and we would have had the results from the patient number one.
CHAYTOR, Q.C.:

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Q. I think that was May 13th.
DR. LAING:
A. Was it May 13th? Okay, all right. So then really it would have been the index case, and the only thing that I can assume, but I'm sure Dr. McCarthy would be able to answer this for you, was that she was referring to the e-mail from Dr. Hudis who said initially that it was very rare and then subsequently said that he had never seen it. You know, obviously yesterday we discussed my training and being taught sort of 85-90 percent, and speaking to my other colleagues across the country, everybody sort of talking about a 90 percent number, and certainly I've had this conversation with Dr. McCarthy and prior to this turn of events, 90 percent, 80 to 90 percent would have been a number that she would have known as well.
CHAYTOR, Q.C.:
Q. Yes, and that comes up in the next sentence, but right now, I was just wondering about at this point in time and it may not be that he's limiting it to the telephone call because -
DR. LAING:

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A. Right.
CHAYTOR, Q.C.:
Q. - you, of course, would have had your meeting of May 13th.
DR. LAING:
A. That's right. So I'm assuming that this would include now one, two, three lobulars who we've just picked from our clinical practice and all of those had a change in their results.
CHAYTOR, Q.C.:
Q. And so at this point in time then, that would have appeared to be a high rate to find three in the ones that you had picked, people coming before you even?
DR. LAING:
A. That's right, yes.
CHAYTOR, Q.C.:
Q. Because that's how you were identifying them, coming before you.
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:
Q. You were able to say at this point in time that appeared to be a high rate of lobulars which were ER/PR negative. She goes on then

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with the idea that "it's usually 95 percent of lobular carcinomas are ER and PR positive, while five percent are negative," and again, you've spoken to that and what your understanding was.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. "Dr. McCarthy requested that two other patients with infiltrating lobular, who were reported as ER and PR negative in 2002, also be retested. I also expressed concern over this and suggested we might meet to discuss this further."
DR. LAING:
A. Sure.
CHAYTOR, Q.C.:
Q. "On May 17th, 2005, a meeting was held which included myself, Dr. Carter, our resource person for breast pathology, Barry Dyer," and it does, he also confirms that -
DR. LAING:
A. I was there.
CHAYTOR, Q.C.:
Q. - you and Dr. McCarthy were in attendance.

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DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. "During that meeting, I brought forth a second patient originally reported as ER and PR negative in 2002 were now strongly positive for breast receptors on retesting." Doctor, do you remember, did Dr. Cook also bring forward a patient or would this be referring to one of the patients you and Dr. McCarthy had identified? Remember him in the meet--did he actually say "well, I've also identified someone and retested as well"?
DR. LAING:
A. Not that I recall. I don't know if that would have been somebody that we had requested the retesting on by this point.
CHAYTOR, Q.C.:
Q. Okay, and he indicates "much of the discussion at the meeting centred on the impact of the estrogen receptor on breast cancer treatment" and you've spoke about that.
DR. LAING:
A. That was my recollection, yeah.
CHAYTOR, Q.C.:

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Q. "It is estimated that approximately 50 to 85 percent of all breast cancers, particularly infiltrating ductal and lobular carcinomas, exhibit estrogen receptors and that such tumours are commonly found in post-menopausal women."

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. Now is that information that you and/or Dr. McCarthy would have provided to Dr. Cook?

DR. LAING:

A. No, I think that was probably knowledge that he would have already had. And certainly, you know, my understanding and some of the references that I showed you yesterday, the 75 percent is a very common number that's indicated for overall. But if you recall the trend, it is more common as patients get older and less common in younger patients who are diagnosed with breast cancer.

CHAYTOR, Q.C.:

Q. And so do you agree with this range of 50 to 85 percent?

DR. LAING:

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A. When you look at where these numbers may have been derived from, certainly if they came from clinical trials, then there are clinical trials in which the percentage of ER/PR positivity in the patient population may be biased by the patients who are chosen to go on studies. And the reason I say that is that if you look at many of the trials in chemotherapy treatments, then the percentage of patients with ER/PR positivity tends to be closer to around the 60 percent, and that's for two reasons. One is because they tend to be younger patients who are enrolled on these studies. And, in fact, some of the trials that we've done, thinking of, for example, one of our own Canadian studies had an age cutoff of 60 years old because of the aggressiveness of the therapy and so -

CHAYTOR, Q.C.:

Q. (Unintelligible) a random sample in some of those trials?

DR. LAING:

A. Right. So I think if you--so the 75 percent comes from when you would look at a grouping of all patients from all different ages, all

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different therapies and that sort of instance. So, you know, I'm not certain why he picked 50 to 85 percent but certainly, you know, whenever you have a number then there's always a, you know, a confidence interval around that number and certainly, you know, 75 percent would fall somewhere towards the middle to upper range of that number, which would be appropriate.

CHAYTOR, Q.C.:

Q. And do you recall following this any effort by the group that was looking into this to then try and identify what the percentage of positives had been -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - in the lab over a period of time?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay.

DR. LAING:

A. Dr. Cook and Dr. Williams did that work and subsequently I recall Dr. Williams revealing

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to me the various results from the time periods.

CHAYTOR, Q.C.:

Q. And what was the purpose at that point in time, while the effort is under way to try and identify patients and get them tested, what was the purpose at that point in time to go back and try and identify what your rates of positivity would have been over the time period?

DR. LAING:

A. My understanding is that they were looking for some sort of signal or some sort of clue that there may have been a particular time period at which the rates of positivity would--fell outside what they were normally used to seeing. For example, if--and I'm not, I do not believe that this was information that the lab was tracking and following on a regular basis.

CHAYTOR, Q.C.:

Q. And the Commissioner has heard that there's no evidence that they were.

DR. LAING:

A. Yeah. And that, you know, when I subsequently

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did see those summary numbers, it was well on into this process. And but I do recall that my understanding of the rationale for looking at those numbers and looking at them by year period was to see if there may have been an indication that there was a particular time period -

CHAYTOR, Q.C.:

Q. That stood out?

DR. LAING:

A. That stood out. We've heard and we've had discussions over the last couple of days about what those two time periods would have been. My subsequent knowledge about Dr. Ejeckam's memo pointed to the year 2003. And the year 2002 was of interest because that was the year that the--that Peggy was diagnosed, so that's when the index case was.

CHAYTOR, Q.C.:

Q. And do you know whether or not the effort to identify the rates of positivity identified any other time periods which would have been of concern?

DR. LAING:

A. I would have to look at them to remember the

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numbers. There were two that I recall, you know, in those what I'll call sort of the earlier periods where the numbers were certainly less than 70, 75 percent.

CHAYTOR, Q.C.:

Q. Um-hm.

DR. LAING:

A. I believe one was around the year 2000. But I know I've seen those numbers, but I can't, I can't recall them off the top of my head at this exact moment.

CHAYTOR, Q.C.:

Q. In any event, the decision was undertaken to go all the way back to 1997 and ultimately -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - to 2005?

DR. LAING:

A. And of course, that was because that's when the technology was introduced in the lab, in 1997 up until the Ventana system, well, up until where we were, actually, in 2005.

CHAYTOR, Q.C.:

Q. So that's your understanding, that 1997 was

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chosen because that's when the technology was introduced?

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. And were you consulted on that in terms of whether or not it would be of any benefit to the patients who were diagnosed in 1997 and 1998 as to whether or not they could benefit from hormonal therapy?

DR. LAING:

A. Yes, absolutely. And if you'll recall the discussions that we had yesterday regarding the very--one of my--the patient number two, that I had indicated by that time that I had had the discussions with Dr. Pritchard and the group to look to see if we may have some knowledge of a late start of hormonal therapy. And, of course, at this time in 2005 we had had the results of our MA 17 clinical trial, which is the one that showed a benefit to extended adjuvant therapy, albeit a slightly different patient population because these would have been patients who had had five years of treatment, but really, our first

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indication that there was advantages to treating patients with hormonal therapy in the five to ten year period. So although we realized that many of these patients were now approaching, well, from 1997 to 2005, eight years from diagnosis, because they were still in the five to ten year period, we felt that they were worthwhile. And, of course, the other reason when ultimately a decision was made to retest the entire group was really to have an idea of what was going on during the entire period that the immunohistochemistry test was being used in the lab.

CHAYTOR, Q.C.:

Q. Okay. So it was something broader than just actually offering treatment to the patient?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. It was to try and determine what, in fact, was happening?

DR. LAING:

A. That's exactly right.

CHAYTOR, Q.C.:

Q. Okay. And I take it so the decision to go

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

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. There may be some benefit?

DR. LAING:

A. Right. And, you know, we talked very briefly yesterday about the fact that even, you know, late recurrences, recurrences in the five to ten year period happen not infrequently in this disease, and even late recurrence. So that was, you know, that was part of the reason, as well.

CHAYTOR, Q.C.:

Q. Okay. Doctor, the paragraph at the top of page 2, Dr. Cook writes, "Receptor status will

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

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

Q. So is it possible that the patient who is ER and PR positive and responds favourably to hormone treatment, so to Tamoxifen, for example, that they would not--they may not require then to have the full chemotherapeutic regime, is that correct? What -

DR. LAING:

A. When I read this, I would have to assume that Dr. Cook was referring to patients with metastatic disease.

CHAYTOR, Q.C.:

Q. Okay.

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DR. LAING:

A. Because in the adjuvant setting you don't know how people respond until you follow them over time and ensure that their cancer does not recur. And the starting point for adjuvant chemotherapy comes prior to adjuvant hormonal therapy.

CHAYTOR, Q.C.:

Q. In the metastatic setting?

DR. LAING:

A. No, in the adjuvant setting.

CHAYTOR, Q.C.:

Q. In the adjuvant, sorry.

DR. LAING:

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

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

CHAYTOR, Q.C.:

Q. So this statement would be correct only with respect to patients with metastatic disease?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. So someone such as Peggy Deane who presented with metastatic disease, this might be correct in her case?

DR. LAING:

A. Might be correct in her case. We discussed yesterday, and you know, of course, it's me looking back.

CHAYTOR, Q.C.:

Q. Yes.

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DR. LAING:
A. And I guess perhaps the best way I can think about it is that, you know, when I go back to clinic next week, if somebody walks through the door, which is quite possible, a young patient who presents with newly diagnosed metastatic disease at the time of their initial presentation with liver metastasis, I may very, very likely decide to treat that person with chemotherapy up front and then if they were hormone receptor positive, they would go on hormones to try and maintain their response and to prolong their time to progression.
CHAYTOR, Q.C.:
Q. Okay. And Dr. Cook's letter continues with a bit of the history in terms of how the tests have been carried out with the DAKO machine and then switching to Ventana.
DR. LAING:
A. The new Ventana, yeah.
CHAYTOR, Q.C.:
Q. And he talks in this paragraph about, "In early 2003 Dr. Gershon Ejeckam, our point man for immunoperoxidase testing at the General

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Hospital site, discontinued testing of the ER and PR receptors with the manual method for a six-week period." Was this discussed in the May 17th meeting?
DR. LAING:
A. Not that I can recall, no, not in any detail. And as I indicated yesterday, I did not see those memos at that time.
CHAYTOR, Q.C.:
Q. So while Dr. Cook shared this with Dr. Williams on May 24th, you don't recall him sharing it with you in the May 17th meeting?
DR. LAING:
A. I don't recall that.
CHAYTOR, Q.C.:
Q. Okay. And do you think that's something given what unfolded, Doctor, do you think if he had shared that information with you and referred to the discontinuation of the tests at the time and the fact that memos were circulated, do you think you'd recall that now?
DR. LAING:
A. If I had read the memos, I think I would recalled it. If there had to been some discussion about it at that meeting, I'm not

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sure that it would have been something that I would have recalled.
CHAYTOR, Q.C.:
Q. So you may have been told it in May of 2005?
DR. LAING:
A. Right. But it wasn't in such a way that it really struck home with me.
CHAYTOR, Q.C.:
Q. So the technique having been temporarily halted because of erratic staining which required adjustments of titration and staining times, once Dr. Ejeckam felt confident of the reliability of staining the test was reintroduced?
DR. LAING:
A. I would not have known that depth of knowledge of that incident.
CHAYTOR, Q.C.:
Q. Okay. And if he had discussed that the tests had been halted for erratic staining and because Dr. Ejeckam needed to ensure the reliability of the staining, do you think that's something you would recall had it been discussed with you in May?
DR. LAING:

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A. Yes, I do.
CHAYTOR, Q.C.:
Q. The letter goes on to say, "At the conclusion of the May 17th meeting it was decided to retest all ERs and PRs for the year 2002 and possibly 2001."
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And, Doctor, at this point in time then was it the decision to--it was the decision to do all ERs and PRs?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Not just ERs?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And was it a decision to identify all negative PRs as well? "Going to retest all negative ERs and PRs."
DR. LAING:
A. I don't recall. You know, that was we decided to look at the 2002 year as that was the year

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of the index case, but as to what group they were going to retest, my knowledge and my understanding had always been that it was going to be based on the ER test.

CHAYTOR, Q.C.:

Q. Okay. And did you agree with that, to concentrate only on the ERs as opposed to the PRs and, if so, why?

DR. LAING:

A. So the--so at this time when I think back to the early discussions, really what we were looking at was retesting patients who were negative for hormone receptors. I'm not sure that at that time we had an in depth discussion about what we were going to use as the cutoffs and whether we were just going to look at ER or whether we were going to look at both. And I believe that those are discussions that happened as time went on into July and ultimately into August of that year. The patients who we had identified had been negative with respect to being less than ten percent when that was the cutoff that we were using in the clinic up until this point.

CHAYTOR, Q.C.:

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Q. Yes. And we talked about that issue of the cutoff a bit yesterday and I will bring you back to an example of that in a few moments. So at this point in time, at the May 17th meeting, while a decision was made to retest in the year of 2002 and possibly into 2001, you don't remember any detailed discussion as to, well, what will be the parameters for who gets retested?

DR. LAING:

A. No, I don't remember those discussions.

CHAYTOR, Q.C.:

Q. Okay. And eventually was it ever communicated to you that only the negative ERs would be concentrated on?

DR. LAING:

A. That we would--that looking at the patients who--so if you think about it, so there's the people that were ER negative, that would include the people that were ER negative, PR negative and the people that were ER negative, PR positive. Because of the discussions that we had yesterday about the metastatic disease and knowing that the group that are ER negative, PR positive were felt to not derive

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as much benefit from treatment in the metastatic setting, eventually we decided that we would concentrate on the ER and not look at what the PR had been for pulling out patients and identifying them for the entire retesting process. However, we felt that it was important when the retesting occurred that, in fact, the ER and PR would be repeated at the outside lab.

CHAYTOR, Q.C.:

Q. Regardless if the PR was positive or negative?

DR. LAING:

A. Regardless of what the PR was.

CHAYTOR, Q.C.:

Q. The PR was retested?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Yes. And why, I'm just trying to understand the clinical basis for that, why would that be?

DR. LAING:

A. I think at that time because there were patients who, albeit, you know, we found out a larger proportion of patients, as I mentioned

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yesterday, when we sat down and looked at everybody, we wanted to ensure that if there had of been patients that were ER negative and PR positive, that we weren't entirely sure how every clinician had used that information. And if there had of been people who had looked at that, I'm thinking more on the metastatic disease and had said, well, you know, this is someone who's ER negative, PR is positive, but we know that that group doesn't respond as well to hormonal therapy in the metastatic disease,that maybe someone would have made a decision not to treat that patient based on that profile. Which is why that we didn't want to sort of sit down and do a chart review at this time, because it would have taken an extensive period of time to go back and review, first of all, identify who were ER negative, PR positives, pull all of their charts, look through it and find out what treatment they had had, that we just felt that if we relied on the ER, that we would make sure that we were as all inclusive as we could to identify as many patients through this process, knowing that patients who were ER/PR

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positive or patients that were ER positive, PR negative, we felt that they would have been considered likely to benefit from hormonal therapy and would have been treated appropriately with that information. So that was the rationale for the decision to identify patients for retesting based only on their ER status. But again, I bring you back to the point that we wanted both to be retested because we felt that as time went on, as we alluded to yesterday, there's more and more interest in using these, you know, combinations and the percent staining of these predictive markers to determine how we treat patients, maybe not so much now, but certainly in the future.

CHAYTOR, Q.C.:

Q. And so in that respect then would it have been useful, as well, to do the ER positives?

DR. LAING:

A. To, well, you know, when we first discovered this issue and we're starting to think, okay, you know, is there something--and again, remembering these are the early days.

CHAYTOR, Q.C.:

Page 50

Q. Um-hm.

DR. LAING:

A. Is there something more going on. This was something that indeed both, right from the beginning the pathologists and the oncologists started to act upon and look into. There was our knowledge that this was a test that did have problems with false negatives but not a test that traditionally had had problems with false positives. So were didn't, at that time, consider a retesting of the entire group of patients that had ever had a hormone receptor test done because our concern was we were saying, okay, this seems to be a problem that we're having with false negatives. So far all of our signals had been from people, you know, that this was a problem with false negatives in the lab, which we knew existed with this test. And so that was the reason why we tested patients who were negative.

CHAYTOR, Q.C.:

Q. And in doing -

THE COMMISSIONER:

Q. How would you know they were false positives?

DR. LAING:

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A. Pardon?

THE COMMISSIONER:

Q. How would you know they were false positive?

DR. LAING:

A. How would -

THE COMMISSIONER:

Q. You're saying the reason we did it was because we knew there was a problem with false negatives. We didn't know there was a problem with false positives. How would you know there was a problem with false positives?

DR. LAING:

A. So because if you look sort of historically at this test, false positives has not been an issue with this testing. And so at that time our focus was on identifying the false negatives.

THE COMMISSIONER:

Q. So the decision was not made on the fact that there were no false positives because you didn't know whether there was or not?

DR. LAING:

A. That's right.

THE COMMISSIONER:

Q. But on the basis of the literature which said

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that historically it was not a problem with the test?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And, Doctor, currently is there any plan in order to be able to use the information as you hope and contemplate, is there any plan to, in fact, have all the positives retested?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And in doing the review for the tumour panel, there were a few retro converters identified?

DR. LAING:

A. There were.

CHAYTOR, Q.C.:

Q. Even though there were -

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. - very few positives retested, there were some, I understand, that fell into the weak positives?

DR. LAING:

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

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

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period.
CHAYTOR, Q.C.:
Q. And it was a low number. But again, it's low numbering in comparison in terms of there was only a few of them retested, anyhow.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So when you do the actual calculation as to what that percent of those might be, I would suggest to you that it's probably not such a low number in terms of the percentage of them that were tested and the ones that converted. But, Doctor, so what you're telling me is that the slides have been reviewed for those retro converters and the pathologists who have done the review have satisfied themselves it was more of an interpretation issue as opposed to any other issue with the test?
DR. LAING:
A. In some of those cases, yes, that's my understanding.
CHAYTOR, Q.C.:
Q. In some of those cases?
DR. LAING:

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A. Yeah.
CHAYTOR, Q.C.:
Q. And who did that review, who looked at those slides?
DR. LAING:
A. The three main pathologists that were involved with reviewing the slides when such issues as, you know, the retro converters and we're going to talk about the DCIS cases, I'm sure, had been Dr. Carter, Dr. Denic and Dr. Cook. Those are the pathologists that I recall who were part of that review.
CHAYTOR, Q.C.:
Q. Okay, and then perhaps we can take that up with Dr. Denic. Thank you. The letter--the letter says that it's going to be a concentration on the year 2000 and possibly 2001, and I understand you to say 2002 was because that's the year of Peggy Deane's --
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Test, and possibly 2001. Why was 2001 being considered?
DR. LAING:

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A. I'm not certain.
CHAYTOR, Q.C.:
Q. You don't recall any discussion around that?
DR. LAING:
A. I can't recall what was said about 2001, no.
CHAYTOR, Q.C.:
Q. Was there any mention of any awareness of any problem in 2001/2002 time period?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. So the point in time when Dr. Cook mentioned to you of some issue regarding 2002, when did that happen?
DR. LAING:
A. So when we had some discussions yesterday related to the memo, it was my understanding that that was 2002, but, in fact, Dr. Ejeckam and all that happened early in 2003. So I don't know if I remember 2002 because it was the year of the index case or if that was my understanding from what I had been explained to because, as you'll recall, really this was something that I remember had been mentioned in these early meetings, but it wasn't until

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

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

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

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CHAYTOR, Q.C.:
Q. That it's being done on a newer more sensitive technique?
DR. LAING:
A. So this was--my understanding was the Ventana System, because it was semi-automated, was different in how things went through than in the older machine, but again we didn't--this was something that was a new machine, but it was still immunohistochemical testing. It was still a staining test to look for these receptors.
CHAYTOR, Q.C.:
Q. So at this point in time, is that what was being offered to you as an explanation by the pathologist that the reason for this may be that the Ventana is more sensitive?
DR. LAING:
A. That was one of the things that we considered that might be an explanation as to why, although still, you know, in the back of our minds was the understanding that it was the same--it was the same type of test. I guess we might use the analogy, if you will, of a new CT scanner. We often--now in oncology we

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do a tremendous number of CT scans, as you can imagine, in the care of our patients, and we pick up things now on CT scans that we didn't see five years ago because the machines are more sensitive. It's still a CT scan, but you can see all sorts of little nodules and things that we only know what they are when we follow them over time.
CHAYTOR, Q.C.:
Q. So is that what was being said at this point in time that this machine--because we understand the DAKO machine is what was used in Mount Sinai and continues to be used in Mount Sinai.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So is that what the pathologist, Dr. Cook, was telling you, that this is a good analogy to think of it in terms of a CT scan?
DR. LAING:
A. No. I guess what I'm trying to say is that, you know, this was not a different test, but it was a test done by a different method. So could this have been the only explanation, I

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don't think we were led to believe that, nor did we believe that this was the only reason and we certainly did not communicate to the patients that this was the reason why there was a change. We simply said that this was a test that came from the lab, that they were looking into why there was a difference, but did explain to them that the retesting was done in the same lab, still was an immunohistochemical test, but that it was done on a--in a different way, I guess, is the best way I can think to describe it, as a different way to do it.
CHAYTOR, Q.C.:
Q. So you felt comfortable in telling your patients if any of them asked, that--as to why this could happen, that they were retested on a more sensitive technique--through a more sensitive technique?
DR. LAING:
A. What I would have said to them was that it was done on a different machine, but that we didn't really know at that time what the problem was.
CHAYTOR, Q.C.:

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Q. So you told your patients you didn't know what the problem was?
DR. LAING:
A. Right, we said we were looking into it, that this was a test that was done in the lab and the results were given to us, that we didn't know what the problem was, but it was done on --it was the same test, but it was certainly done this time on a different machine than their test would have been done on.
CHAYTOR, Q.C.:
Q. And if you didn't know what the problem was, why mention the machine?
DR. LAING:
A. Because patients would ask. So they would say, well, you've done this test before and you've done it again, what was different about the test that was being done, remembering that this would have been very few patients because ultimately the retest was done at another hospital.
CHAYTOR, Q.C.:
Q. Using the same machine?
DR. LAING:
A. Using a DAKO --

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CHAYTOR, Q.C.:
Q. A DAKO System?
DR. LAING:
A. Yeah, yeah, so we didn't really get to caught up in--subsequently when we were disclosing to patients on this machine versus that machine, but, of course, in the early days this was being done with a new machine compared to what their initial testing was done on, and, you know, this is important too because it comes to the issue that we were noticing that with the Ventana System that we were getting a lot of very strongly positive results.
CHAYTOR, Q.C.:
Q. Now this is May 24th, Doctor?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Were you noticing that by May 24th?
DR. LAING:
A. No, we had those discussions subsequently in July.
CHAYTOR, Q.C.:
Q. Much later, yes.
DR. LAING:

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A. That's right.
CHAYTOR, Q.C.:
Q. And your first full batch of people, of 25 people, that happens June 29th. So those would be the people, the initial batch, anyhow, of the ones who are retested.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. What else was offered by Dr. Cook, or I guess perhaps Dr. Carter, as to other--in the May 17th meeting, other than, well, it's a new machine, what other explanation was offered?
DR. LAING:
A. I don't recall us having any in depth discussions about any other explanations at that time.
CHAYTOR, Q.C.:
Q. And this letter goes on to speak about some recommendations.
DR. LAING:
A. Uh-hm, yes.
CHAYTOR, Q.C.:
Q. And again this is May 24th and "The need for the immediate establishment of external

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proficiency testing and a monitoring program for immunoperoxidase testing, the establishment of a separate immunoperoxidase service with at least three technologists dedicated to the testing".
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. "The training of the technologists in a major immuno referral lab, and appropriate CME funding for the immuno technologists". Were any of those issues discussed with you?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay, so that wasn't brought to your attention, the need for any of those?
DR. LAING:
A. No, this would be something that would be a discussion by the pathologists and within the laboratory department.
CHAYTOR, Q.C.:
Q. And if I could have, please, P-2452. If we could just go back to that, though, for one moment, please, P-0067. Sorry, Registrar.

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There we go. It says, "For now we have agreed if there is a receptor conversion, that the oncologist would inform".
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. Were the patients who did not have a conversion informed of the retesting in those early 58 patients, around 58 patients, that were done in-house on the Ventana? Was everybody informed or just the people who had a conversion?
DR. LAING:
A. I'm not certain if everybody was informed. I know that subsequently that that list was sent to Dr. McCarthy, and in the early days I cannot say for certain that patients who were confirmed negative would have been told that at that time.
CHAYTOR, Q.C.:
Q. And were all the people who had a conversion told or just some of the people?
DR. LAING:
A. Later on there was a decision made that we would not inform patients of a change in their

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

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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

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DR. LAING:

A. Right.

CHAYTOR, Q.C.:

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

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

Q. So you personally would have called your patient?

DR. LAING:

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

CHAYTOR, Q.C.:

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

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DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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

DR. LAING:

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

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informed them that I was going to do this test, I would have communicated the results to them. I do recall some of my patients who had metastatic disease and in our discussions we've indicated that there were some patients who we decided to retest based on the fact that they had metastatic disease and we didn't have any other viable therapeutic options for them. So I do recall having some of my patients with metastatic disease and saying to them, you know, I'm going to ask for this test to be redone, and I will let you know when it comes back, and so if theirs didn't change, then I would have confirmed to them that they were negative.

CHAYTOR, Q.C.:

Q. So, Doctor, at what stage did you have those discussions with your patients, those that you did tell you were going to have retested? Was that before the matter became public discussion on October 2nd?

DR. LAING:

A. Yes, there would have been patients in my practice --

CHAYTOR, Q.C.:

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Q. That you told.

DR. LAING:

A. That I would have said, you know, there's this issue going on that's called into question the reliability of the estrogen and progesterone receptor testing results that we have been receiving, and, you know, you've had lots of chemo and I think it might be worthwhile for us to ask for your sample to be retested to see if there's any change in your test result, and if there was, then we may think about some hormonal therapy. Of course, the very first instance of that was one of Dr. McCarthy's patients and she was a lady with quite extensive chest wall disease who really had run out of chemotherapy options. There was one other case, and I'm not sure if we're going to discuss that, but there were five patients.

CHAYTOR, Q.C.:

Q. Is it out of the five?

DR. LAING:

A. Yes, yeah, we didn't --

CHAYTOR, Q.C.:

Q. Do you remember which number?

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DR. LAING:

A. -- finish that.

CHAYTOR, Q.C.:

Q. We went through the three and there was four and five we didn't finish.

DR. LAING:

A. Yes, do you want to talk about those some more now?

CHAYTOR, Q.C.:

Q. Sure, if--are they about--perhaps you can just tell me. We're running short on time and I would --

DR. LAING:

A. Sure, I'll just tell you very quickly.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. One of them was a lobular patient who had metastatic disease and she was my patient and I saw her on a regular basis. So every few weeks she'd come to see me in the clinic. She was quite unwell and I said to her, you know - and she was a lobular who was a very undifferentiated, very aggressive tumour. So I said to her, look, this has happened. This

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would have been sometime in June. This has happened--at this time, I had already had three lobulars change, and I said to her I think I should put you on this medication and I will retest you and I will let you know, but --you know, let's just get you on this pill and see if it can help you, and I'm very pleased to say that it did and she lived for another year and a half.

CHAYTOR, Q.C.:

Q. Is that patient number four?

DR. LAING:

A. That's patient number four. Patient number five, when you had called last week and asked us to pull this out, she was someone who had been seen, had been treated adjuvantly with chemotherapy and had high risk disease. She had lymph nodes involved. She was Dr. McCarthy's patient and what had happened was at that time--so in 2005 was when we were considering adjuvant Herceptin and there was some references made to that, as you know, through this whole course, but it just happened to be when the pivotal trials had come out showing an extreme benefit to

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Herceptin in the adjuvant setting. Up until that time we did not routinely test HER2 on newly diagnosed patients. We would have done it on patients with metastatic disease because that's when we had utilized that therapy, but there were some recommendations coming out that patients who were deemed to be at high risk of occurrence, we should start to think about doing their HER2 testing. So Dr. McCarthy had sent off a consult to have the HER2 testing done, and her note indicates that in August of that year - and the sample went to Mount Sinai because Mount Sinai was doing our HER2 testing at the time, and from what we can gather, they just did ER/PR on it as well, and it changed. This was a ductal patient, so this was not someone who had had--who was lobular, and she had just finished her chemotherapy. So, of course, Dr. McCarthy had this new information, it came from Mount Sinai Hospital, so she recommended adjuvant hormonal therapy as this lady had just completed her chemotherapy. So this lady ended up being --

CHAYTOR, Q.C.:

Q. So it was almost by accident that it was

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retested at Mount Sinai?

DR. LAING:

A. We have looked very carefully at this, and this is the conclusion that we had come. So now we have in that small pool of patients, we have the lobular people which we have identified, but we now have two ductal people --patients with ductal histology.

CHAYTOR, Q.C.:

Q. We understood what you meant.

DR. LAING:

A. Yes, and so, you know, I think that--and that case was in August.

CHAYTOR, Q.C.:

Q. August 29th, late in August.

DR. LAING:

A. Yes, but certainly there are patients who I can remember very, very vividly who I was caring for metastatic disease that summer who I did ask for retesting to be done, who came back as still negative.

CHAYTOR, Q.C.:

Q. Yes, okay.

DR. LAING:

A. And I would have communicated that information

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to them.

CHAYTOR, Q.C.:

Q. Yes, and, Doctor, obviously that patient, even though she was called patient number five, wasn't the fifth patient that you had identified to have retested?

DR. LAING:

A. No, that's right.

CHAYTOR, Q.C.:

Q. And I noticed that in the list when we received it because she was quite late, August 29th.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And she was someone who, I'm glad you explained that, that you sent off for HER2/neu testing and they also did the ER/PR?

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. Because, of course, there had been this whole list of other patients prior to that.

DR. LAING:

A. Right.

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CHAYTOR, Q.C.:

Q. That had been retested.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Doctor, in talking to those patients --

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. Both the ones that are listed here on the first batch of June 29th, as well as those that you've just mentioned to us out of the first five or patients one through five, and you told them you were going to have them retested, how did they respond to that when you told them that you would be having them retested?

DR. LAING:

A. They--you know, they would have said okay, they were okay with that, and as you can imagine, patients who have metastatic disease to come in and say to them I have a new treatment option for you would be something that they would view in a very positive way.

CHAYTOR, Q.C.:

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Q. The way that--Peggy Deane, in fact, said she was full of hope.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. Doctor, I think my question had been looking at this list a while ago, and the ones who were confirmed negative, did you have any discussions with them?
DR. LAING:
A. Yes, so if--as I said, if I had said to a patient I'm going to retest you, then I would have followed up and said, you know, I've done that, it's come back, and it did not change.
CHAYTOR, Q.C.:
Q. So are you saying that all of these patients were told, this 25 or so --
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Were they all told?
DR. LAING:
A. I can't say that because I'm not sure who these patients are right now.
CHAYTOR, Q.C.:

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Q. If they were your patients, were they told before they were retested?
DR. LAING:
A. If they were my patients and they had metastatic disease, as time went on I would tell them that I was going to retest them. The very first lobular patient that I retested, patient number two in what we talked about yesterday, I don't think that I told her at the time what I was doing, although I did put it at the end of the clinic note and we reviewed that yesterday. As time went on, I would have said to the people, you know, I'm going to do this retest. You know, I wasn't - I didn't go into a whole lot of detail with them prior to it. You mentioned the word "hope" and we certainly--that's something that we do every day to try and give our patients, but I also didn't want to build patients up too much, so I just sort of went and said, look, we've done some retesting of the estrogen progesterone receptors, yours were negative in the beginning, which is why we haven't given you these treatments, and I have reason to think that it might be worthwhile to

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retest it at this point and the patient said, okay, Dr. Laing.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. And, you know, there were sometimes when the patients said, you know, do I need to have a blood test and that sort of thing, and I said, no, this is something that's already on your tumour tissue. In fact, I recall many of the patients being very surprised that five/six years later that that tissue was still around and kept for many years in the lab.
CHAYTOR, Q.C.:
Q. So, Doctor, the answer is that if you had told the patient beforehand that they were going to be retested, you certainly would have gotten back to them and told them the results.
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. That they had not changed. Those that did change, whether they knew it beforehand or not, were all told?
DR. LAING:

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A. Correct.
CHAYTOR, Q.C.:
Q. If a patient had not been told beforehand that she or he were being retested and it was negative, were those patients told?
DR. LAING:
A. I'm not certain because I believe that some of the patients on this list were just randomly picked to be retested. I don't think that all of these 25 patients were brought forward by the attending oncologist to have the retesting done. In the early days, these patients who we later called to confirm negatives, I'm not certain that they would have been notified at this time that this had been done.
CHAYTOR, Q.C.:
Q. Okay. Doctor, was there any--and, of course, one of the issues that the Commissioner is looking at is the communications with the patients, so was there any consistency, was there any plan that here's how we're all going to handle this, here's what we're going to do with patients in certain circumstances, here's what we're going to do with patients who find themselves in other circumstances? Was there

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anything laid out in terms of a plan so that there was consistency with how your patients were treated, how Dr. McCarthy's were treated, how Dr. Siddiqui's were treated? Was there any consistency, any plan laid out so all oncologists would know this is how we're going to do it and we can track, in fact, the patients that we have spoken with and those who have not been spoken to?

DR. LAING:

A. Right. So to answer the first part of the question in terms of what we were going to say and how we were going to explain the situation, we certainly did have informal conversations with the whole group of medical oncologists. We all said how things went when we disclosed to our patients, what kind of reactions they had, and we all had a similar explanation in that there was a problem in the lab and this is why we've done the retesting. In terms of a tracking system, I have to say, no, we didn't have a very good tracking system to ensure that patients were contacted, that the follow-up had been done. This was something that we got into much later in the

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process and much later in the panel process.

CHAYTOR, Q.C.:

Q. And I take it there was no memo that went out, or anything in writing, even an e-mail to send out to all the oncologists saying here's our plan, here's who needs to be told, and here's the way in which we should all go about doing it?

DR. LAING:

A. No, the only communication that I have seen that comes from that was the decision subsequently that we decided that we would wait on any further disclosure until we had the testing from Mount Sinai to avoid a problem of false positives.

CHAYTOR, Q.C.:

Q. Doctor, back on the list of June 29th, 2005, out of those 25 or thereabouts, I understand 16 of those--if we count them up, 16 of those actually converted, and I take it that was a subject of concern between yourself and Dr. McCarthy certainly as treating oncologists?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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Q. And, Doctor, I understand, though, at the time only 10 or 12 out of those 16 were told the results at that time. Do you know why all of the 16 would not have been told?

DR. LAING:

A. I don't know why.

CHAYTOR, Q.C.:

Q. I'm not sure if that next letter is here. No, I think I need P-0508. I apologize for the quality of this, Doctor, it's a little difficult to see, but this is July 18th, 2005, and it's the next list of patients to Dr. McCarthy, and it's signed again by Drs. Cook and Carter?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And again it says, "As per our previous discussions, repeat estogen receptor and progesterone receptor has been carried out on the following patients and the results are as follows". Did you follow the same procedure when you received this list, did you follow the same procedure, did you contact your patients who had had a conversion or those

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that you had already told would be retested and give them the results?

DR. LAING:

A. So this list is the one that contains all the patients from 2002, so all these people have a 2002 surgical number.

CHAYTOR, Q.C.:

Q. That's right.

DR. LAING:

A. My understanding is this is a group of patients that was decided to be retested for the 2002 year. As you can see when you look at the results, some just say positive and some say 100 percent, 100 percent, 100 percent, 100 percent.

CHAYTOR, Q.C.:

Q. Uh-hm.

DR. LAING:

A. And my recollection is that after seeing this, that this is the first time that we sort of said look at all the 100 percent positives that we're seeing with the Ventana System, or certainly a high percent positivity which was something that we talked yesterday a lot about, looking at trends, this was something

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

CHAYTOR, Q.C.:

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

DR. LAING:

A. But there's some with 80 --

CHAYTOR, Q.C.:

Q. Thirty something --

DR. LAING:

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

CHAYTOR, Q.C.:

Q. Three maybe is another 100 percent.

DR. LAING:

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

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

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

CHAYTOR, Q.C.:

Q. Doctor --

DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

Q. Well --

DR. LAING:

A. Well, that I have knowledge of.

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

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

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

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

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

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

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outside facility. Whether or not we had any sort of concerns about the Ventana System, I think one of the questions was if you're going to embark on a review of this type, is this something that's best done by asking an outside facility to do that kind of review. Is it, I guess, more credible or is that the best way to do it, and certainly there were those discussions.

CHAYTOR, Q.C.:

Q. So, Doctor, I take it by this point in time, July 18th, 2005, you were confident there was a problem?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. Doctor, the patients in June 29th list that were did tell, they obviously weren't put through any panelling process, there was no panelling process at that point in time?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And you felt confident in dealing with them and giving them their results and making a

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determination as to what treatment they required?

DR. LAING:

A. So what we did in the early days, and I think we mentioned this yesterday, was that we used our own panelling process which was our tumour board and, of course, we had discussions with each other about what to do, and I had had discussions with my colleagues across the country, and this was all happening in May and June So --

CHAYTOR, Q.C.:

Q. I just want to be clear then. So did you put your patients through your tumour board rounds?

DR. LAING:

A. Some of the patients -

CHAYTOR, Q.C.:

Q. Those June 29th patients.

DR. LAING:

A. Some of the patients on the June 29th list would have been presented at tumour board rounds.

CHAYTOR, Q.C.:

Q. Okay.

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DR. LAING:

A. But not all of them.

CHAYTOR, Q.C.:

Q. And did you consult outside experts outside the province as to what to do with any of those patients on the June 29th list?

DR. LAING:

A. Not in the sense of that I specifically discussed the cases to the same degree that I did Peggy's case with Dr. Hudis, but you'll recall that I had seen Dr. Pritchard and had been in a meeting with some breast cancer colleagues of mine from across the country and discussed this issue, and this was when I had my patient number two in this process, the lady with a lobular disease who is now two years after she completed her adjuvant chemotherapy, and I have this new information in hand, and that was a case that I discussed generally with Dr. Pritchard and that was the time which her assistant e-mailed me that initial reference to the article, which became a very important piece of information.

CHAYTOR, Q.C.:

Q. About the delay in Tamoxifen?

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DR. LAING:

A. The late start of Tamoxifen.

CHAYTOR, Q.C.:

Q. Delayed start of Tamoxifen.

DR. LAING:

A. That's right.

CHAYTOR, Q.C.:

Q. And did -

DR. LAING:

A. So even, you know, right from the very beginning, this process was happening.

CHAYTOR, Q.C.:

Q. Had Dr. Pritchard ever experienced such a situation herself in her practice?

DR. LAING:

A. Not that she mentioned to me at that time, or subsequently, no.

CHAYTOR, Q.C.:

Q. Okay. Doctor, the people then on the July 18th letter, they were subsequently sent to Mount Sinai and panelled. So the earliest time that any of these individuals would have been panelled, I think the first meeting of your panel was October 13th, 2005?

DR. LAING:

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A. Yes.
CHAYTOR, Q.C.:
Q. So the earliest any of them could have been told of their results would have been sometime in mid October?
DR. LAING:
A. Except for, as I alluded to, the patients who metastatic disease.
CHAYTOR, Q.C.:
Q. That you had told were being retested?
DR. LAING:
A. That myself or one of the other oncologists was, you know, relying on that information to make a treatment decision. If a treatment decision needed to be made in this time period, then we did do that.
CHAYTOR, Q.C.:
Q. And do you know whether or not these patients were ever told that, "in fact, you had originally been tested a few months before that but for the following reasons, we decided to wait and have you retested at Mount Sinai"?
DR. LAING:
A. I know that there were patients of mine that I did have that conversation with, yes.

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CHAYTOR, Q.C.:
Q. And do you know whether or not that was done consistently with all patients?
DR. LAING:
A. No, I can't say that it was done consistently with all patients, but certainly our approach was to be very open and honest and disclose this information to our patients, which is how, you know, what we do and -
CHAYTOR, Q.C.:
Q. So whether or not in that regard then, wouldn't there have been instruction given to make sure that all results are given to the patient, both the ones that came out of the Ventana testing, retests back in June, as well as what subsequently was done at Mount Sinai?
DR. LAING:
A. I would think that that would be what would have been told to the patients. Certainly I can recall some instances -
CHAYTOR, Q.C.:
Q. But there was no direction as such given to make sure that that happened?
DR. LAING:
A. No. This was information that, you know, the

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

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

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somebody other than a medical oncologist or radiation oncologist, there was a statement said that the patient could be referred back, if required.

CHAYTOR, Q.C.:

Q. That's right, and I will take you through a number of those panel letters in a little while, and my question being then, Doctor, in the spirit of openness with your patients, why not also have included a paragraph for those 58 patients saying that "you were also tested on our Ventana system on such and such a date, and here's the result of that retest"?

DR. LAING:

A. Have no idea. We never thought about doing that at the time. We did -

CHAYTOR, Q.C.:

Q. You do agree that the whole idea would be to be open and give the patients whatever information is available?

DR. LAING:

A. When I would disclose this information to the patients, I would have with me the new pathology report and if there had have been retesting done that was recorded on their

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chart at that time, it would have been as an addendum that indicated these test results and then there would have been an addendum from Mount Sinai, and we saw that, I think, yesterday when we looked at some results, where there was an additional addendum issued from the pathologist here and then there was the one that was issued with the Mount Sinai reports. Whether that happened in all of those cases, unless I saw those reports, I wouldn't be able to indicate to you that they had.

CHAYTOR, Q.C.:

Q. But there were no panel letters that referenced the retest, those 58 retests on the Ventana system?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Even though a number of the patients, in fact, their testing or sorry, their treatment was, in fact, changed because of the result of the Ventana, as opposed to any result from Mount Sinai?

DR. LAING:

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A. Right, and those panel letters often indicated something like the panel has looked at the chart, and the patient had been notified by Dr. Laing, Dr. McCarthy, Dr. Siddiqui, whoever on such and such a time, and have already had therapy instituted with Tamoxifen, or something like that. So we didn't want to exclude those patients. You know, if we talked about people at the panel, we still wanted to generate a letter, even though, if you will, those patients had already had disclosure and had already been started on whatever treatment, that the treating oncologist or family physician and the patient decided upon, we still felt that they should have a panel letter. But, we hadn't -

CHAYTOR, Q.C.:

Q. And I will ask you about the rationale for that too in a little while. I'm sorry, go ahead.

DR. LAING:

A. But we hadn't given any thought, and in fact, until you've just brought it up to me, I hadn't thought about the fact that maybe the initial Ventana results had been placed on the

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letter. It wasn't anything that we had considered.

CHAYTOR, Q.C.:

Q. And it wasn't anything that was formally then -

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. - disclosed to the patient. Doctor, on that, in terms of panelling the people who had already had their treatment changed -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - and also on the point about what would have been before you at the tumour--at the panel review -

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. - you would have had, I take it, the full, access to the full patient chart?

DR. LAING:

A. Yes, we would have.

CHAYTOR, Q.C.:

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Q. And that would include, of course, all the pathology reports?
DR. LAING:
A. I'll just--can I explain to you maybe just how that whole process worked? Because I think that that might -
CHAYTOR, Q.C.:
Q. And I'll ask you some questions about how that whole process worked, but right now, I just want to know that you would have had access to all the pathology reports?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. You wouldn't?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. What we had, in terms of charting, physical paper chart, was the patient's Cancer Centre chart.
CHAYTOR, Q.C.:
Q. Yes.

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DR. LAING:
A. Okay. In that Cancer Centre chart, we would have most of the patient's pathology. However, we did have the pathologist with us and we did have a computer system set up so that they could, in fact, go in and look at all of the pathology reports that were available on a patient, just in case there was something that wasn't in the Cancer Centre chart. This was placed on a very large screen, you know, like the kind that you'd do a presentation on, so that all patients--all of the people in the room could, you know, look and view this screen, and so that's how we would have the pathology.
CHAYTOR, Q.C.:
Q. The point being though, any tests, any pathology report that had the Ventana result on it -
DR. LAING:
A. Oh yes, we would have had it.
CHAYTOR, Q.C.:
Q. - that would have been there before you?
DR. LAING:
A. Yes, yeah.

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CHAYTOR, Q.C.:
Q. Okay, and I will ask you later about exactly what you had in making your determination on various patients. And there's a third letter. If we could have, please, P-0535, and this is July 29th, 2005 and this, Doctor, we understand then is the third batch that was done in house, and while this letter is not signed, did you also receive a copy of this letter or were you provided with a list of your patients from this letter?
DR. LAING:
A. This is a July 29th letter.
CHAYTOR, Q.C.:
Q. And these are mostly '02s. I'll take you down through.
DR. LAING:
A. Yeah, I suspect that the patients with the different numbers would have likely been requests that were still coming in, but I can't be sure.
CHAYTOR, Q.C.:
Q. And we're now getting--actually there's a significant number of other than '02s. From here down appears to be other than '02s.

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DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. So it's about half probably. So these are a mixture, it appears, and you can control the mouse, if you wish, Doctor, to scroll down, but this third batch then that was done in house, did you--I take it, the same answer, that you did not notify your patients. By this point in time, you were waiting to have them retested at Mount Sinai?
DR. LAING:
A. Right. So again, it would be the same. The patients that would have been notified were patients whom I needed a treatment to offer to them at that point, so patients with metastatic disease.
THE COMMISSIONER:
Q. Would these patients have been chosen by the pathology department, by the oncologists, or some combination thereof?
DR. LAING:
A. A combination thereof, but the majority of them were chosen by the pathology department.
THE COMMISSIONER:

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Q. Okay.
CHAYTOR, Q.C.:
Q. Doctor, the patient early on, your patient number two was lobular.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And how did she respond when you told her that she had been retested and there was a change and that she could then avail of the treatment? How did she respond to that?
DR. LAING:
A. She responded in a positive manner. She was appreciative of the fact that she could now have an additional therapy that may add to the benefit, in terms of preventing a breast cancer recurrence for her. She has--she did not have a breast cancer recurrence at that time, and fortunately has not since either. She was a patient who had received chemotherapy and we had some discussions about would that have still been necessary, and we felt that it was, and she, of course, was at that two-year mark. So I was able to provide her with the information that I had received

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regarding that article that, you know, I could say to her "look, although this information is late coming, and yes, if I had have known this information, I would have started this therapy two years ago at the completion of your chemotherapy, but now that we know it today, I still believe that there'd be some benefit to you," and she started on therapy at that time, and if my memory is correct, I believe she started for various reasons on an aromatase inhibitor, on Arimidex, at that time, and not Tamoxifen, because that was felt to be the best therapeutic option for her.
CHAYTOR, Q.C.:
Q. And what reason was she told for her retest? And again, that would have been early on?
DR. LAING:
A. The lobular histology.
CHAYTOR, Q.C.:
Q. The fact that she was lobular.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And why would she--what explanation would be given around that, in terms of she was always

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lobular, so why would she be being retested on that basis? What was she told?
DR. LAING:
A. She was told about the index case, in such a way that, of course, maintained the confidentiality of Peggy, but to say that there had been a patient with lobular cancer as well that through--I just said that, you know, I didn't go into the great detail, that we had made a decision to retest her and that we had some correspondence from another oncologist who felt that, you know, lobular disease should be, in most instances, positive and that was the reason that we retested it. I explained to her that the--you know, that my understanding when I treated her back in--so this was 2003, was that the majority of patients were lobular, but because she presented with a poorly differentiated tumour, there was nothing at that time that made me question her initial ER/PR. It was in light of this new information from another patient, and that was the reason that I had requested the retesting.
CHAYTOR, Q.C.:

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Q. Okay. Doctor, why were only breast cancer patients retested and not everyone who would have had an ER/PR test regardless of whether it was breast cancer or any other type of cancer?
DR. LAING:
A. Because breast cancer patients are the patients in whom we use this for determination of therapy.
CHAYTOR, Q.C.:
Q. And what other--when else would an ER/PR test be carried out? Is it used on any other types of cancer?
DR. LAING:
A. It's used in gynecological malignancies sometimes, but I don't--that's not an area of my expertise. I'm not a gynecological oncologist, so I know that they sometimes in uterine cancer use things like megas as treatment, not Tamoxifen for obvious reasons, and sometimes in the determination of cancers of unknown primary, I think we talked very briefly about those yesterday. So these are cancers that, at the time of initial presentation of the patient, they have

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evidence of metastatic disease, but it is not clear on careful history and physical examination, nor CT scans and other investigations pointed to because of the symptoms where the primary cancer originated from, and that encompasses approximately five percent of all of the cancers that are seen.

There are certain clusters and types that--and we alluded to those yesterday, and one, of course, is a female who presents with an axillary lymph node, think breast cancer until you've proven it otherwise, i.e. by your pathology coming back and suggesting that it is a lymphoma. If the pathology from an adenocarcinoma under, you know, in an axillary node, was present, people would treat that as breast cancer. We do not use, in that case, ER/PR testing would be done on that to try and give you an idea of whether or not it could be breast. If it was negative, it does not rule out that being breast cancer, because, of course, 25 percent are going to be -

CHAYTOR, Q.C.:

Q. It can be a breast cancer that's negative.

DR. LAING:

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A. Exactly. So it's something that's not used to determine -

CHAYTOR, Q.C.:

Q. But if it had been positive, it would rule in breast cancer?

DR. LAING:

A. That's right. So that's how we think about it being used, except for in axillary lymph node recurrence, if it is negative, then we don't say "oh, it can't be breast cancer because it's ER/PR negative." We would still accept that anedocarcinoma like that in the axilla is there. You know, there are instances where we have recommended to patients, and certainly in my practice, this wouldn't be a common presentation of breast cancer, but certainly something that we would see. We would recommend to those patients that they actually go back and have a breast removed. In some instances, we do find a primary within the breast, but in some instances, the primary has regressed to the point that it is not evident on careful sectioning on the breast tissue by the pathologist. Now with MRI, we're hoping to be able to better, you know, go and find

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these areas. So the other instance then would be an evaluation of patients who present with unknown primary.

THE COMMISSIONER:

Q. Wait now, let's get back to the original question which is why only breast cancer patients were retested. Your answer initially was because in the case of breast cancers, it's used for the determination of therapy.

DR. LAING:

A. That's right.

THE COMMISSIONER:

Q. By implication that means that that is the only area in which it is used for the determination of therapy.

DR. LAING:

A. That's correct. Primary unknown cancers are treated with a certain type of chemotherapy treatment. That's just general to primary unknowns.

THE COMMISSIONER:

Q. So why would it not be useful to know, even at a later stage, that a cancer might have been breast cancer?

DR. LAING:

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A. So when you're looking at someone with a cancer of unknown primary, you want to determine if you think that it's something that's curable or treatable. So if it looks like it's a breast cancer, by virtue of where the disease is, by virtue of how it presents, then what you do not want to do is you don't want to be led away from assuming that that's a breast cancer by getting a negative ER result, because not all breast cancer is ER negative. So that's why it's not recommended that you hang your hat on that in determining that that patient should be treated like a breast cancer patient. Maybe if I gave you an example, that would be helpful.

THE COMMISSIONER:

Q. Wait now, but then why do you do the test?

DR. LAING:

A. The pathologists do the test in terms of -

THE COMMISSIONER:

Q. Yes, but why? If you're not going to be led away from it being breast cancer--I recognize, I suppose, that you have the benefit of having a particular diagnosis confirmed.

DR. LAING:

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

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breast cancer. You're still going to decide to treat that patient as if they were a breast cancer, but you're not going to use hormonal therapy.

If, for example, somebody presents with--I'll give you an example of a patient I saw a number of years ago who presented with pleural fluid, some metastases around the lung, some bony metastases. She herself had not had a history of breast cancer, but there was a family history, and so when a pleural biopsy was taken, this came back as being ER positive, so we thought, you know, this clinical situation fits and, as you said earlier, it rules in the diagnosis, but a negative one does not rule out the diagnosis. So it has to be used very carefully in that instance.

When a pathologist has a piece of--and I'm sure they can speak to this better than me, but if they have a lymph node biopsy or a biopsy from a lung surface or something and they're trying to determine what this is, the very first thing they'll tell us is does this look like an adenocarcinoma or not. Sometimes

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these are very poorly differentiated tumours and you have no idea about what they might be, and they run a whole series of panels and immunohistochemical markers on those to try and help determine it, and they will put all that information together and sometimes we get back a report that says this is a poorly differentiated carcinoma, so you have no idea what this is. Sometimes they say it's a poorly differentiated adenocarcinoma, and by virtue of the panel, not just ER/PR, but all the things that they've looked at, they may say favour primary from stomach, breast, colon, and clinical correlation is advised, and then the clinical correlation would be well, what does this pattern of metastatic disease look like? Is this someone who has GI symptoms that lo and behold that ends up looking like a bowel cancer.

However, these are the special instances and for the most part, in cancers of primary unknown, we never have any idea of what--where these cancers started and the teaching and the caution has always been not to over interpret the information that you receive, and in that

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instance, if we don't favour one of these over the other, then we treat them with protocols that have been shown to be effective in this disease, albeit not curable.
THE COMMISSIONER:
Q. Forgive me, Dr. Laing, but I'm not following.
DR. LAING:
A. Okay.
THE COMMISSIONER:
Q. If you have the usage of the ER/PR test for the purpose of, as I understand it, not ruling out that its primary source is breast cancer, but confirming it is, presumably if you confirm that the primary source is breast cancer, you follow a course of treatment.
DR. LAING:
A. That's correct.
THE COMMISSIONER:
Q. Would that be any different if you were confirmed that it was a primary source of breast cancer than if you were not confirmed?
DR. LAING:
A. Would the treatment that you would--no. If you decide that somebody has a clinical presentation that looks like breast cancer,

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then you're going to treat that person like breast cancer.
THE COMMISSIONER:
Q. Yes.
DR. LAING:
A. Yeah.
THE COMMISSIONER:
Q. Okay. But if you have a positive response?
DR. LAING:
A. A positive estrogen/progesterone receptor test?
THE COMMISSIONER:
Q. Yes.
DR. LAING:
A. Okay, yeah.
THE COMMISSIONER:
Q. Then you're definitely going to treat it in a particular way?
DR. LAING:
A. You're still definitely going to treat it as breast cancer.
THE COMMISSIONER:
Q. Um-hm.
DR. LAING:
A. And depending on where the disease is and all

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that, you'll decide whether or not you'll use a hormone. If, however, your clinical suspicion because of the presentation is that it's breast cancer, the pathologist gives you a report that says that they did ER/PR but it came back negative, then that doesn't say to you this is not a breast cancer, because 25 percent of breast cancers are going to be negative.
THE COMMISSIONER:
Q. But when you're doing your decisions regarding treatment?
DR. LAING:
A. It will play a role. So then they just come to where we -
CHAYTOR, Q.C.:
Q. That person would not get the hormonal therapy?
DR. LAING:
A. Hormonal therapy, that's right.
CHAYTOR, Q.C.:
Q. So your bone cancer patient that you spoke about, for example, if that person had come back ER negative, that person would not have received the hormonal treatment?

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DR. LAING:
A. It would depend on where the biopsy was taken from.
CHAYTOR, Q.C.:
Q. But there would be a number of those patients who had tests done that if it came back ER negative and that were to be a false negative may not have received the hormonal treatment they otherwise would have gotten had the test come back positive?
DR. LAING:
A. In the subset of patients who presented as carcinoma of unknown primaries that we made a decision to treat as breast cancer, and that would be an extremely small number of those patients.
CHAYTOR, Q.C.:
Q. But even if there were one patient, Doctor -
DR. LAING:
A. Yeah. So then that would be -
CHAYTOR, Q.C.:
Q. - have those patients' charts been reviewed?
DR. LAING:
A. No.
CHAYTOR, Q.C.:

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Q. Is there any plan or intention to review their charts to see if there's anyone else who could potentially benefit from a retest?
DR. LAING:
A. In the case of primary unknown cancers, the prognosis of these patients is extremely poor and they live on average six months. So I'm not certain that there would be any patients who would be there for us to go and to do this sort of a review.
CHAYTOR, Q.C.:
Q. Doctor, I understand the deceased have all been retested as well.
DR. LAING:
A. The deceased that were breast cancer patients.
CHAYTOR, Q.C.:
Q. Breast cancer negative.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So why would--even whether they're living or deceased, if they're living, good, you know, because perhaps there is a potential treatment for them.
DR. LAING:

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A. Yeah.
CHAYTOR, Q.C.:
Q. But if they're deceased, wouldn't it be consistent to have everyone retested?
DR. LAING:
A. I would think that if I was going to think about that group of people that I would retest, I would think about it, okay, let's start with the patients of unknown primary, so five percent of the malignancies. Let's then look at those patients in whom something about their clinical presentation made us go down the road that we think that this is breast cancer, an extremely small number of those people. And then let's look and see how the ER/PR played out. So I think it would be a very small number of patients. We did have some discussions about this issue probably maybe about a year or so ago, I'm trying to remember exactly when it was, and, you know, all of us put our heads together and really couldn't think that this would, you know, that this would be something that we should go back and look at.
CHAYTOR, Q.C.:

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Q. So who had those discussions? I take it that's come up since the -
DR. LAING:
A. Oh, yes, yes.
CHAYTOR, Q.C.:
Q. - Inquiry process started happening?
DR. LAING:
A. So there were medical oncologists and pathologists that would have weighed into that discussion and other people at Eastern Health.
CHAYTOR, Q.C.:
Q. And who ultimately made the decision not to go back and review?
DR. LAING:
A. I would think that it was a decision that was made by a consensus of those involved.
CHAYTOR, Q.C.:
Q. And who might those people be besides yourself?
DR. LAING:
A. If I remember correctly, there would have been other people from Eastern Health there, perhaps, don't know if it was--I think it was sort of further on into the days that Dr. Howell was there, Mrs. Pilgrim may have been

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part of those discussion, but--because if my memory is correct, it was maybe even as far into the 2007 discussions around this issue that we talked about the primary unknowns. I'm not sure if you actually have--because I know that this perhaps was looked at one time in the lab, the number of tests that were run on tissues other than--was that something that the lab had looked at, how many times they had done the ER/PR test on tissue that was from patients being considered for primary unknowns? I don't know how often that would have been, would have been done.
CHAYTOR, Q.C.:
Q. Doctor, was a year ago the first time that discussion was had as to doing any other tests other than the test or retest on anyone other than primary breast?
DR. LAING:
A. From what I can recall, yeah.
CHAYTOR, Q.C.:
Q. That's the first time that discussion was had?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:

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Q. Doctor, in saying the other use of the ER/PR test, you also mentioned gynaecological cancer. And I realize and I hear what you're saying, you're not an expert in that type of cancer. But do you understand that the test for those patients would--could potentially also have ramifications in terms of treatment?
DR. LAING:
A. I'm not certain, I'm not certain that they utilize that test to determine how they treat patients.
CHAYTOR, Q.C.:
Q. Okay. So you don't know the purpose for ER or hormonal receptor testing in gynaecological cancer patients?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay. And do you know whether or not any inquiries have been made to determine the answer to that question, whether or not those patients should be retested?
DR. LAING:
A. I don't know that.
CHAYTOR, Q.C.:

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Q. Okay.
THE COMMISSIONER:
Q. Ms. Chaytor, wherever you can find a spot, we'll take the morning break.
CHAYTOR, Q.C.:
Q. Actually, this is a good place, please, Commissioner.
THE COMMISSIONER:
Q. All right, then, we'll take 15 minutes.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Dr. Laing, just one other point on that last line of questioning about the other ER negative tests that were not repeated. If part of the purpose of the review was not only to identify people who could benefit from treatment, but to also have a full picture of what happened or what was happening, as you said, in the process all the way back to 1997, wouldn't it be important to have tested all ER negative patients?
DR. LAING:
A. I hadn't really given that any thought in

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terms of looking at it as, you know, overall. You know, I think that when we had the specific discussions and the only discussions that I were part of was the primary unknown patients, because it was such an uncommon thing and because we didn't use it to determine therapy except for in extremely rare cases in patients who determined to decide to treat as if they were breast cancer, then it wasn't something that we thought of in the overall picture. Our thinking and our knowledge and our reason to sort of include everybody was thinking about this test as it pertained to breast cancer.
CHAYTOR, Q.C.:
Q. Okay. So that issue was never discussed with the group in terms of -
DR. LAING:
A. The overall, yes -
CHAYTOR, Q.C.:
Q. - get a full picture, full picture and the extent of the issue?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:

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Q. It would be necessary to retest everyone, that was never discussed?
DR. LAING:
A. Not outside the context of breast cancer, no.
CHAYTOR, Q.C.:
Q. If I could have, please, C-0056? Doctor, this is pathology report of one of your patients who have testified here, Daphne Coffin.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And we briefly mentioned her case yesterday.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you'll see that the addendum number three--sorry, just lost my place. Addendum number one is what I wanted to bring you to, sorry.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And it's September 20th, 2001. And it showed immunoperoxidase staining for estrogen and progesterone receptors, estrogen receptors 23 percent positivity, progesterone receptors

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negative, and in brackets, (no controls). And this issue, Doctor, when you would have reviewed the pathology report, the fact that it's indicated that there were no controls, would that have had any significance to you?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay. And then, of course, there's the addendum from Mount Sinai which is entered on her chart on March 21st, 2006. And the consultation from Mount Sinai found her to be estrogen receptor protein is seen in 95 percent of cells.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And the progesterone receptor was seen in less than one percent. If we could have, please, C-0067? I'm sorry, 0067. And, Doctor, March 14th, 2006 you see Ms. Coffin in clinic?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you've written, "Her initial ER testing

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came back as 23 percent, that was in 2001. At that time we considered that to be weakly positive."

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. "I did discuss Tamoxifen with her at that time but we decided not to give it to her. I had thought that she would be retested as her staining was less than 30 percent, but this has not been done. I have requested it today. We have discussed what to do at this point and agreed that if it was higher, that we would certainly consider her for an" aromatase, I take it, "inhibitor at this point."

DR. LAING:

A. That's right, yeah.

CHAYTOR, Q.C.:

Q. "I will wait and see what the retesting shows." So, Doctor, in September of 2001 she was 23 percent?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And at that time you would have

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considered that weakly positive?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And while you had a discussion with her about Tamoxifen, it says at that time you decided not to give it to her?

DR. LAING:

A. Yes, that's correct.

CHAYTOR, Q.C.:

Q. You also say that you had thought that she would be retested as her staining was less than 30 percent, but this has not been done. What do you recall about this? Ms. Coffin appears before you on March 14th, 2006. What do you recall and how did it come to your attention that her retesting had not been done?

DR. LAING:

A. So when I saw her that day in the clinic, I would have read--you know, picked up the chart and looked at it before I went in and I noticed that my comment had said that she was weakly positive. I then reviewed the pathology report that we just looked at and it

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was reported as being 23 percent for ER. I then looked in the Meditech system and noticed that she had not had any retesting done, and I brought up the issue with her at that visit. This is a lady that when I initially saw her in 2001, so I would have seen her after October, 2001 when I returned from my maternity leave, and she had a two centimetre tumour that was moderately differentiated and because of the size of the tumour and her age at the time I offered her adjuvant chemotherapy, which she completed. And then upon completion of her chemotherapy I did have a discussion with her about the potential risks and benefits of Tamoxifen therapy. As I indicated yesterday in my review, certainly one of the features that we use to determine whether or not to offer hormonal therapy is whether or not this patient is positive, and this lady was positive. I did indicate it to her at the time that there was a recent change in thinking but that 23 percent was something that we would consider positive. But because of her concerns about potential side effects of Tamoxifen, because of her family history,

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which included a lot of patients who had had blood clots, through a balance discussion at that time of the risks and benefits it was decided that she would not take adjuvant Tamoxifen therapy. When I realized that she hadn't been part of the review, so she was diagnosed, of course, in 2001, the decision for retesting changed as of January 1st, 2001 and we discussed that yesterday, I said to her, you know, look, we didn't give you Tamoxifen back then in 2001, we didn't have another option at that time, subsequently we know that the aromatase inhibitors are available in the clinic and can be effective medications. And I remember discussing this with her and saying, you know, we certainly can ask for your retesting to be done at this point. She at that time still wasn't interested in Tamoxifen as a therapy but because she knew that there was an aromatase inhibitor as an option, agreed to having the retesting done. And we had a discussion that if it came back as being, you know, significantly positive, we didn't sort of have an absolute cutoff in our minds, but at this

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time I was recalling many of the patients I had seen as part of the panel who had results that were negative or, you know, one to two percent who came back in the very high positive rate, that she would have a further discussion at that time regarding an aromatase inhibitor. So, I filled out the consult and asked for her ER/PR to be retested, and so that was done.

CHAYTOR, Q.C.:

Q. Okay. And if we could go back to 0062, please, C-0062? And, Doctor, this is the discussion, I believe, you would have had with her January 28th, 2002, or the day you would have discussed the issue of Tamoxifen with her?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. And I had--you indicate here, "Her initial tumour was only 23 percent positive for estrogen. In some labs this is considered to be negative if it is less than 30 percent staining."

DR. LAING:

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A. Yes.

CHAYTOR, Q.C.:

Q. "I would consider this to be a borderline result."

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. So, Doctor, at this point in time in 2002, January 28th, 2002, what cutoff was being used by you and the oncologists at then the Cancer Centre for positivity?

DR. LAING:

A. So this would have been following the meeting in 2000 and then so into 2001, we certainly--you know, our thinking had changed and we were using ten percent in a lot of cases. I refer to the 30 percent because, you know, when I had discussions at that point with this patient, we certainly, you know, I said to her this is something that's relatively new, this new threshold, that there was a time when 30 percent was the cutoff, and that certainly was something that we had recently in this hospital had used, but that now, you know, I would consider her to be weakly positive or,

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you know, this was now greater than ten percent and that, you know, we again, as you can see from the next paragraph, had a discussion about the risks and benefits. And she had looked into this issue and had thought about it. And I think, you know, at the end of the day this was a decision that as most of the decisions that we make, we felt that the additive benefit to her on top of the fact that she had already had chemotherapy, and we've looked at this, you know, in terms of the kind of benefit we see on adjuvant on line would certainly be a few percent over that, as she had node negative disease. And you know, through a balanced discussion decided not to take the Tamoxifen.

CHAYTOR, Q.C.:

Q. Yes, okay. The idea that some labs, this is considered to be negative if it is less than 30 percent staining, as of the end of January, 2002 what labs were you aware of that were still using 30 percent?

DR. LAING:

A. In dictating this I would have been thinking about the past practice in our lab, but not--

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because I don't say in our lab or currently or anything like that. You know, we had had quite a long discussion about, you know, this 23 percent and what it meant. And, you know, she had been aware of, you know, the fact that, you know, the side effects of the Tamoxifen and, you know, and really asking a lot of questions about, well, what real benefit do you think it is going to be to me. And so, you know, this was one of those instances where we did look at the percent staining, we did look at the therapy that she had already received and, you know, we made a decision at that time.

CHAYTOR, Q.C.:

Q. Doctor, did you tell Ms. Coffin that, in fact, your institution had moved to a ten percent cutoff by this point in time?

DR. LAING:

A. I suspect that I probably did during the discussions with her, although it's not, it's not recorded here in the note. Because I do remember, in fact, when this--when I was asked about this situation after she was one of the patients who testified at the beginning of the

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Commission, I did recall, I said, oh, yes, I remember that lady. She was one who came and it was, you know, during the time when we started to use ten percent and her level was not very high and that really at the end of the day the decision not to give her chemo-- sorry, the decision not to give her Tamoxifen did not hinge on what that number was or what the cutoff was, the decision hinged in the risk/benefit ratio for this patient.

CHAYTOR, Q.C.:

Q. If we could go back, please, to 0067, C-0067? And on March 14th, 2006 most of what was intended to be retested at Mount Sinai up to this point in time had already been back and panelled by March 14th, 2006, Doctor. So she was, Ms. Coffin was missed in the original identification of patients for retesting?

DR. LAING:

A. She was not included in that because the decision to not give her hormonal therapy wasn't based on the fact that I thought her ER was negative, it was based on the fact that through a discussion regarding the risks and benefits that we decided that it wasn't a good

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treatment option for her.

CHAYTOR, Q.C.:

Q. So her chart was reviewed and a decision was made not to send her to Mount Sinai for retesting?

DR. LAING:

A. No, no. I'm saying that the decision that I made in 2002 not to offer her Tamoxifen wasn't because she had an ER/PR test result that came back as negative.

CHAYTOR, Q.C.:

Q. We understand that the criteria that was used for identifying patients for retesting would have been those who had, as of January 1st, 2001 -

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. - the criteria changed. And you were aware of that at the time, that then it would be anyone ten percent or under?

DR. LAING:

A. Or less.

CHAYTOR, Q.C.:

Q. Or less?

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DR. LAING:

A. That's right.

CHAYTOR, Q.C.:

Q. Right.

DR. LAING:

A. Yeah, so when I saw her and I was thinking about it, I was thinking about the 30 percent cutoff, I wasn't thinking about the time period when her pathology had come through. She was halfway through 2001. And I had indicated there that I thought she'd be retested as she was less than 30 percent. But, in fact, you know, when I went back and looked at it again, I said, well, she was in 2001. It's just when I had looked at her, what had triggered me -

CHAYTOR, Q.C.:

Q. She was 2002.

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. January 28th, 2002.

DR. LAING:

A. No, her pathology, her pathology was from September, 2001.

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CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. So she was actually a 2001.

CHAYTOR, Q.C.:

Q. Yes, that's right, you're right.

DR. LAING:

A. So, no, I guess what I -

CHAYTOR, Q.C.:

Q. September, sorry, it was September 20th, 2001 was her pathology.

DR. LAING:

A. Right. So when I decided to look at this, it was because of the word that I had placed in the diagnosis, which was that she was weakly positive. And then when I looked--and then when I had this discussion with her in March of 2006, it was centred around the fact that, you know, now that we have aromatase inhibitors and knowing that there had been some patients who had been positive or who had been, you know, how had been, for example, patients who had tested maybe ten or 20 percent even in the years of 1997, '98, ' 99 who had changed at Mount Sinai to coming back

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very strongly positive, I recall saying to Ms. Coffin, you know, if we retested you and you came back as being, you know, 95 percent positive for both or very high positivity for both, would you then be interested in a treatment. If at this time she had said to me, look, I'm not interested, I never wanted to take hormonal therapy, even if you retested me and I came back as 100 and 100, it's not going to change what I think, I probably wouldn't have retested her. The decision to retest her was based on the fact that we had another treatment option. I did not wish to give her Tamoxifen in 2002 and that was, as I explained, because of all the things that we looked at. And I certainly, you know, still with that history and her concerns over this medication our decision wasn't that we were going to retest her and that we were going to give her Tamoxifen, our decision was that we were going to retest her because of my experience in people's percentage positivity changing significantly and also that we had a different treatment option to offer her.

CHAYTOR, Q.C.:

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Q. So, Doctor, then why would you write, "I had thought that she would be retested as her staining was less than 30 percent, but this has not been done."?

DR. LAING:

A. Because in my mind I was thinking about 30 percent is being the cutoff.

CHAYTOR, Q.C.:

Q. Okay. But you knew that they had used the cutoff of ten percent as of January 1, 2001. And she's not--her test is well into -

DR. LAING:

A. Yeah, just it's not something that -

CHAYTOR, Q.C.:

Q. - September of 2001?

DR. LAING:

A. - that registered at the time I guess is what I'm trying to say. It's not something that I thought about when I said, you know, that--I wasn't thinking about when the change was between 2001 and the test before.

CHAYTOR, Q.C.:

Q. So, Doctor, if you had a patient into 2001 who had tested less than 30 percent and a decision had been made not to offer Tamoxifen at that

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point in time, perhaps other oncologists were doing the same thing for the same sorts of reasons that you have identified?

DR. LAING:

A. This is the discussion that we had when the decision was made to go back and look at those, the discussion that I alluded to yesterday in the conference call with Dr. Trudeau.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. Yeah. And this -

CHAYTOR, Q.C.:

Q. Which happened recently, just -

DR. LAING:

A. Right. And this came after this issue. Now, as I said yesterday, this was something that, you know, I picked up on when I saw Daphne Coffin in the clinic. I alluded yesterday that, you know, when I went back through and would see people in the clinic during this whole period of time we would look and see what their ER was and to make sure that there were instances where something like this might

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have happened. This is the only patient in my practice. I haven't had--you know, we've had this discussion with my colleagues. Nobody else has identified through looking at their charts and being very cognisant of this any other such instances. But we felt that if there were situations in which potentially, you know, aromatase inhibitors could be offered to people and whether or not the percent staining made a difference to people, then this would be the--through putting patients in this database and then looking at the charts to see if we could identify other patients in this similar situation.

CHAYTOR, Q.C.:

Q. And, Doctor, that review that you're referring to and the discussion with Dr. Trudeau has just taken place in the past couple of months, you've told us?

DR. LAING:

A. Yes, it was in April of 2008.

CHAYTOR, Q.C.:

Q. Yes, 2008?

DR. LAING:

A. Yeah.

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CHAYTOR, Q.C.:
Q. In March of 2006 did you contact Dr. Cook or anyone else to alert them to this issue that possibly if Ms. Coffin was missed in the initial identification of patients, that there may be others?
DR. LAING:
A. No, I did not.
CHAYTOR, Q.C.:
Q. And why not?
DR. LAING:
A. Because I didn't consider this to be someone who was missed in the original identification. I consider her case to be a patient who was not offered Tamoxifen at the time because we felt that the risks and benefits were such that she wasn't a good candidate for it. And the reason for suggesting the retest was that after my discussions with her, the patient, Daphne Coffin, was that knowing that how some of the tests had changed and became very strongly positive, would she now consider an aromatase inhibitor.
CHAYTOR, Q.C.:
Q. So, Doctor, why then were you checking charts

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after this was brought to your attention, why were you checking charts, why did you alert the other oncologists to it if you weren't concerned there might be others that were missed?
DR. LAING:
A. I don't know what you mean by checking charts. This was someone who came to see me on the clinic -
CHAYTOR, Q.C.:
Q. You said after this was brought to your attention, after you'd seen her in the clinic -
DR. LAING:
A. Oh, no, I think what -
CHAYTOR, Q.C.:
Q. - then when people would come -
DR. LAING:
A. Sure, okay.
CHAYTOR, Q.C.:
Q. - before you, you would check the chart and that there was an informal discussion amongst your colleagues and then they would do the same.
DR. LAING:

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A. Oh, this was something that was going on. You know, right from this whole process we would all--you know, when patients were coming to see us in the clinic, we would look at the charts, see what had gone on in terms of their ER/PR initially and were there other people that perhaps hadn't been retested. So this was something that was forefront in our minds as, you know, as time went on to look at people who were said to be ER/PR negative. And, in fact--or weakly positive or some sort of signal. In fact, subsequent to this whole process we've tried to indicate in the charts people that are negative who have been confirmed negative. So if I have a patient who's ER/PR negative, I would now dictate that as confirmed negative so that when I'm seeing patients in the clinic through this process on through 2005, 2006, I mean, even today, would always look and make sure that, you know, this isn't someone who hadn't been missed by the retesting -
THE COMMISSIONER:
Q. Dr. Laing, I'm sorry, I'm not following again. It seems to me that as I have understood it up

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to this point, there was a procedure established largely in consultation between the oncologists and the pathologists about how the review would be done?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. And that in that process a determination was made that people--that a particular cutoff would be used, depending on the years, because the facts were that as oncologists you would be using a different percentage as a cutoff over the course of the period of time which you would be studying?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. So a decision was made that the figure for the cutoff will be 30 percent. Anyone below that is considered negative up to a particular point, beyond that it's people who are less than ten percent would be considered negative?
DR. LAING:
A. Um-hm, yes.
THE COMMISSIONER:

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Q. I understood that with that guideline in mind those who were in the lab went through the laboratory records, pulled the appropriate files?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. They would know nothing about what was on the chart except to the extent that the lab records are reflected on the chart, ie, what the result was?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. So in that process nobody in the lab was saying, well, look at that, but, ahh, gee, that particular person refused Tamoxifen, in any event, so we won't bother sending it?
DR. LAING:
A. No, they would not know any of that information.
THE COMMISSIONER:
Q. Okay, so now in the case of Ms. Coffin given the time frame in which her test was done in your view given the particular guidelines,

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should the lab have pulled her slides or not?
DR. LAING:
A. No, they shouldn't have. She would have fallen in--she was 23 percent in 2001, so the lab personnel looking at her would have been thinking the ten percent and would not have pulled her.
THE COMMISSIONER:
Q. All right. So she came out of the--she was not retested.
DR. LAING:
A. Right.
THE COMMISSIONER:
Q. In your view, consistent with the grand plan that had been developed?
DR. LAING:
A. That's right.
THE COMMISSIONER:
Q. You pulled her out for another reason and asked that she be retested?
DR. LAING:
A. Yes, that's right, yeah.
THE COMMISSIONER:
Q. Why did you--did you pull her out for a reason related to her treatment?

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

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presumably you would have offered it to her anyway? What I'm asking is -
DR. LAING:
A. Oh, yes.
THE COMMISSIONER:
Q. - why did you both to have her retested, why didn't you just say -
DR. LAING:
A. Because -
THE COMMISSIONER:
Q. - our numbers are now ten percent and here's this new -
DR. LAING:
A. Okay, yeah, I understand -
THE COMMISSIONER:
Q. - option I have available to you?
DR. LAING:
A. Yeah, I understand exactly what you're asking. And the reason is is because that she wasn't keen on hormonal therapy. And I said to her, but if it's one of these that comes back as being very, very strongly positive, assuming that the benefit would be greater to her, would you then consider it. And so that was the reason for the retest, because we wanted

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to see what the new result was going to be. So she was interested in knowing was she going to be someone who stayed at, you know, 30 percent and zero percent from Mount Sinai or would she be somebody who came back as being very strongly positive or even perhaps both, because, of course, we had seen that happen, we had seen people who had been -

THE COMMISSIONER:

Q. Okay. So you're saying Ms. Coffin, you inquired whether she might be interested in -

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. And her response was I'm only 23 percent, why would I bother, and you said, maybe you're figures are different?

DR. LAING:

A. Yeah. So it says here, "We have discussed what to do at this point and agree that if it was higher, that we would consider an aromatase inhibitor at this point." Yeah, so that's why I retested -

THE COMMISSIONER:

Q. And that was a discussion you had with Ms.

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Coffin?

DR. LAING:

A. Yeah. And that's why we had retested it instead of me just sort of saying, you know, you were 23 percent, you know, through this whole review, you know, would you consider now going on aromatase inhibitor. We, in fact, you know, she had asked and she wanted to know if she was going to be someone who came back as being very strongly positive.

THE COMMISSIONER:

Q. Now, while I'm on the subject we might as well go down this road, as well. Can you tell me whether or not there have has been any effort made to determine whether or not in that time frame, when you were switching from 30 percent to ten percent, and I understand it did not occur overnight.

DR. LAING:

A. That's correct.

THE COMMISSIONER:

Q. That some people were continuing to use 30 percent long after others had switched to ten?

DR. LAING:

A. Um-hm.

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THE COMMISSIONER:

Q. Has any effort been made to identify those patients in that time frame who may, in fact, have been missed for a retest on an assumption about the cutoff date that was being use but which, in fact, was not being used?

DR. LAING:

A. Yes. And that was the discussions that were had in April and May and a decision was made -

CHAYTOR, Q.C.:

Q. This year, 2008?

DR. LAING:

A. Yeah. The decision was made, that's when that -

THE COMMISSIONER:

Q. It had been done or is going to be done?

DR. LAING:

A. I believe that people were going to check with Mr. Miller to see where that was.

THE COMMISSIONER:

Q. That was the discussion from yesterday?

DR. LAING:

A. Yeah. So my understanding, and where I had left that after we were asked to give our opinion regarding that, was that, in fact that

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they had planned to identify those patients through putting all of the breast cancer patients into the database and identifying people that may have been in this transition period and to review those charts to see if there may be people that didn't get treatment. To date, I have not been asked to review charts and so I'm not sure where that process is.

THE COMMISSIONER:

Q. That I understand to be consistent in the sense of a testing laboratory view of the world, as it were. I mean, I can see the person who's coming along and saying "I'm doing this scientific study and these are the people who belong in and these are the people who don't belong in."

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. Putting myself in the position of a patient, then it would seem to me that if I was in that area and I were to discover that albeit correct in terms of the scientific study which is being carried out, I should not have been

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included in a retest because the particular percentage was appropriately applied given the numbers, but because of the luck of the draw and the particular week I was seen, I missed out on an opportunity for a potential therapy that was offered to the person who came the next week, I would be a tad ticked off.

DR. LAING:

A. Well, the discussions that we had had leading up to this and the reason for having the conference call eventually that included Dr. Trudeau was because we had all sort of stopped and sat down and thought about this issue, and in my practice and in reviewing all of the patients that I have seen, this is the only instance that I can tell you about that happens to me. But I agree with you 100 percent, and that was why that reason had been made for this, to look at this period again, was just that, yeah, are there people that haven't been picked up by their oncologist? Are there people perhaps who are no longer being followed at the Cancer Centre? Are there people that haven't heard about this issue and contacted us? Because as we'll--as

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you know, that some of the people who weren't retested and were missed somehow in being identified were sometimes the patients coming forth and saying, you know, "I had breast cancer during this time period. I've not heard anything from anybody. What's my situation?" and this happened because this lady was coming to see me at this time and I was obviously, you know, thinking about this issue and she ended up being retested. Her test results did change. She came back as 95 percent positive for ER and PR one percent. She did have a trial of an aromatase inhibitor, which she didn't tolerate very well, and then decided not to take it any further.

THE COMMISSIONER:

Q. So come back to the ones that are going to be ticked off because they were a week away, are they included in the number that are now being looked for under Mr. Miller's -

DR. LAING:

A. Yes, they are.

THE COMMISSIONER:

Q. - task, whatever that happens to be?

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DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. We're not quite sure.

DR. LAING:

A. Yes, so when I had left that issue, the decision, and as I said yesterday, this was a unanimous decision by all parties who were present on that conference call, was that yes, we were going to go back and have a look at this time period in case there were somebody there who had missed out that we would be able to identify that particular patient or patients.

CHAYTOR, Q.C.:

Q. And Doctor, so obviously your thinking was that the degree of positivity could affect treatment decisions and that it might be of benefit to Ms. Coffin, should she come back and have a higher ER/PR status. In reviewing with the panel the Mount Sinai results, I would suggest to you that you saw numerous cases that started off weak or negative, zero to ten percent range, which ended up being quite strongly positive on retest.

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DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. There were quite a number of those, and so if during this time period and the cross over period that other physicians were still looking at a result such as 23 percent or perhaps 12 percent, 13 percent as being, in your words, borderline results or weakly positive and similar decisions were made. So if those people were 12 percent, say, or 15 percent or 22 percent back in 2001 and late into 2001 and we are still in that grey crossover period, those people were retested and could end up to be strongly positive, as the number of negatives that you saw were, those people could be candidates now for treatment?

DR. LAING:

A. We would have a discussion with them, just as we did with Ms. Coffin and the other patients who we've had changes in their results.

CHAYTOR, Q.C.:

Q. Upon realizing this in March of '06 and being cognizant of the fact that there was no clear

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cut off, there was no day in which everyone agreed, okay, from this date henceforth, we're all going to use ten percent, so you knew that. By March 2006, you're clinical chief. Did you think to send an e-mail, a memo, anything to the other oncologists to say "heads up, please pay attention. Be alerted to the fact that are there people who were in the category of what in 2001 we would have called weakly positive. If any of those people are coming through or perhaps, you know, there's some way to review your charts, because they may not have been part of the retest and perhaps they should be."

DR. LAING:

A. Yeah. No, I did not send a memo or anything at that time, but this was--I would not have been the only oncologist who was looking at patient's charts very carefully and reviewing their ER/PR results during this time period. All of us would have been doing that work.

CHAYTOR, Q.C.:

Q. So was there a direction, anything in writing that went out to the oncologists to tell them that they should, in fact, be doing that,

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reviewing their charts to make sure that everybody had been included in the retest?

DR. LAING:

A. No, there was no direction or formal memo to that regard.

CHAYTOR, Q.C.:

Q. If we could go back, please, to C-0066? Doctor, you in fact saw Ms. Coffin on September 8th, 2005. So the retesting is well underway at this point in time, and there's no mention on that date of any discussion about her potentially being a candidate for retesting.

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And I'm sure the issue would have been on your mind, as you say it was in March of 2006, I would suggest that in September 2005, the issue certainly would have been, and the issue of retesting would have also been something that you were thinking about and on your mind.

DR. LAING:

A. Yeah, certainly it would have been, but September of 2005 was prior to the start of

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the tumour panel. It was prior to us receiving, you know, all of the--or the large majority of the test results back. It was prior to us really observing the trends and the changes that we had seen, and so I'd suspect that that's why, at that time, it doesn't--I can just tell by looking at this note that certainly I wasn't thinking about it in any event to do any sort of retesting on her specifically at that time, no.

CHAYTOR, Q.C.:

Q. If we could have, please, C-0057, and you'll recall that you did--it was March 14th, 2006 that you did discuss the issue with Ms. Coffin.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And you did order the retest, it appears, quite quickly because this is actually the result back from Mount Sinai on March 20th, 2006.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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Q. And if we could have, please, C-0068? And this is the September 6th, 2006, next time that Ms. Coffin is seen by you and "Daphne returns to clinic today. I brought her back today to discuss the issue of her ER again. She had not been retested despite the fact that she was less than 30 percent," so you're still thinking that, less than 30 percent. "But now that she has been, and it came back so strongly positive, she comes to talk about late hormonal therapy. I have reviewed the study of the Tamoxifen and also the results of MA17 clinical trial, including the benefits seen to those who started Let"--is it "Letrozole late"?

DR. LAING:

A. Yes, Letrozole.

CHAYTOR, Q.C.:

Q. Thank you. "She does not really have any contraindication to either Arimidex or Tamoxifen." Doctor, it is September 6th, 2006.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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

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you bring that up for me? I'm sorry, I don't remember the number.
CHAYTOR, Q.C.:
Q. The Mount Sinai one? Sure, yes.
DR. LAING:
A. No, not the Mount--yes, the report that came back.
CHAYTOR, Q.C.:
Q. C-0057.
DR. LAING:
A. Yes, and can I just--can I use the mouse?
CHAYTOR, Q.C.:
Q. Absolutely.
DR. LAING:
A. So as you can see, I'll just scroll down--actually, this is not the one that I was thinking about. This one doesn't actually have any signature of any physician on it.
CHAYTOR, Q.C.:
Q. Okay, actually -
DR. LAING:
A. Is there another one that's--that's the addendum.
CHAYTOR, Q.C.:
Q. There are two. There's this report, which is

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

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filed and placed on her chart, and then when I got the call to go and look, I realized that the test results had come back. I had not been aware of that and then arranged to meet subsequently with her and discuss it, the results, with her.
CHAYTOR, Q.C.:
Q. So who did you contact to get the consult to Mount Sinai?
DR. LAING:
A. I would have sent a consult to pathology.
CHAYTOR, Q.C.:
Q. Okay. So you would have sent--you sent the consult to pathology?
DR. LAING:
A. I sent the consult, yeah.
CHAYTOR, Q.C.:
Q. So even though -
THE COMMISSIONER:
Q. You send a consult signed by you, but they don't send it back to you?
DR. LAING:
A. In the ideal world, this should have been sent back to me. I'm not certain why Dr. Greenland's name ended up on that, because I

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

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

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

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

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

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

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

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

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CHAYTOR, Q.C.:
Q. And that was never brought to your attention?
DR. LAING:
A. Not that I recall, no.
CHAYTOR, Q.C.:
Q. Doctor, when you met with her in September, knowing that this had not been brought to your attention earlier, nor had it been brought to her attention prior to September, 2006, was she offered an apology?
DR. LAING:
A. I do recall that I had said to her, you know, that the test results had been back for a while, and certainly my practice would be in such a situation to offer an apology to a patient. Whether I can remember exactly if I did it in this situation, I'm not certain.
CHAYTOR, Q.C.:
Q. So you recall telling her that, in fact, her results had been back for a while?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Did you tell her how long her results had been back?

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DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. And I don't - and I'm not sure that she actually asked me specifically when it came back.
CHAYTOR, Q.C.:
Q. And would she have to specifically ask for that or would you not offer that up to her and say, you know, I'm really sorry, Mrs. Coffin, but this has been sitting here now for six months and you weren't contacted because this sort of fell through our cracks, that kind of discussion didn't happen?
DR. LAING:
A. I recall saying to her, you know, I know that you have been looking for this, and now it's--you know, it's back, and that--and she had said to me, you know, I hadn't heard anything for a while, and if someone had something like that to me, I'd say, well, you know, I'm sorry that we didn't connect before now, but--and then I think really we moved on to discuss the

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information at hand.
CHAYTOR, Q.C.:
Q. So you don't have any distinct recollection as to whether or not there was an apology offered or whether she was told, in fact, how long her results were back?
DR. LAING:
A. No, I don't remember specifically enough to be able to tell you certainly that that's what took place.
CHAYTOR, Q.C.:
Q. Can we have, please, P-0505, and these are handwritten notes, Doctor, of a meeting of July 14th, 2005, and these notes were taken by Dr. Williams. Do you recall attending the meeting on July 14th, 2005?
DR. LAING:
A. I do.
CHAYTOR, Q.C.:
Q. And what do you recall being the purpose of that meeting?
DR. LAING:
A. This was a meeting that was held shortly after I had returned, as I said, from leave and attending a conference, and at this point--

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this was a meeting of various stakeholders involved with this issue, really to have some discussions about where we were going to go from here. So as you can see, it included myself and Dr. McCarthy.
CHAYTOR, Q.C.:
Q. Oh, sorry, page three--there you go.
DR. LAING:
A. This is much easier to look at. Doctors are--we learned that in medical school how to write like that. I was there, Dr. McCarthy was there, and this was a meeting that was called by Dr. Williams and that Dr. Cook, as you can see, talked about sort of the background, and we had some discussions from, you know, the point of view of what this--what impact it was having thus far clinically. We talked a little bit about what we had done so far in terms of the limited patient disclosure that we had had. If you want to scroll down --
CHAYTOR, Q.C.:
Q. Doctor, I'm just wondering, in terms of you being at this meeting --
DR. LAING:
A. Yes.

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CHAYTOR, Q.C.:
Q. Who invited you to attend?
DR. LAING:
A. Dr. Williams.
CHAYTOR, Q.C.:
Q. In what capacity were you there, why were you at the meeting?
DR. LAING:
A. I was there because I was a medical oncologist who is involved in the care of patients with breast cancer.
CHAYTOR, Q.C.:
Q. And that's the same reason, I take it, Dr. McCarthy was there?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And Dr. Gardiner at this point in time, he was there in what capacity?
DR. LAING:
A. At that time he was the Medical Director of the Newfoundland Cancer Treatment and Research Foundation.
CHAYTOR, Q.C.:
Q. Okay, and there are some comments attributed

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to you at this meeting?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And the first bullet is "New information, lobular CA should all be ER/PR positive".
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. What's that referring to, Doctor?
DR. LAING:
A. That's referring to Dr. Hudis' communication with me regarding Peggy Deane.
CHAYTOR, Q.C.:
Q. Okay, so you would have been telling the group about the e-mail you received from Dr. Hudis?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Which indicated that he had never seen an ER/PR negative lobular cancer?
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. The next bullet says that, "Sloan-Kettering

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went from 75 percent to 100 percent positive". What's that in relation to?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. And this is a comment which is attributed to you.
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. By Dr. Williams.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And Dr. Cliff Hudis is at Sloan Kettering?
DR. LAING:
A. He is indeed, yeah.
CHAYTOR, Q.C.:
Q. So are you saying you have no recollection of what it is that you would have told the group and Dr. Williams recorded regarding this point?
DR. LAING:
A. When I look at that now, that relates to the issue that I spoke with Dr. Hudis about, but I

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would--my recollection was that that was actually something that happened, as I told you, in the fall. This is the first time I've sort of looked at this and noticed that that bullet was there. So this was in July.
CHAYTOR, Q.C.:
Q. This is July 14th, 2005.
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. You didn't have your discussion until late September at the earliest with Dr. Hudis.
DR. LAING:
A. When I was asked to recall when that discussion may have happened, I felt that the only way I could do that was to look at my calendar from that year and have some sort of idea about where I might have seen Dr. Hudis. However, when I look at this now and this was something that I brought up and was in mid July, then perhaps it was earlier than that, you know, after the May or the April e-mail and prior to this discussion. Again I'd have to go back and look to see where I may have been at that time to interact with Dr. Hudis,

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but I do recall quite specifically that the follow up conversation was not something that happened via telephone or not something that happened via e-mail, but was a face to face meeting with Dr. Hudis and I.

CHAYTOR, Q.C.:

Q. So, Doctor, you were--somewhere in between then the communications you had with him in April and July 14th, somewhere in between that time period, and discussed this issue further with Dr. Hudis?

DR. LAING:

A. Well, now that I look at this and see if I had said that then, then this sort of narrows even further at which point that I would have had that meeting--that meeting with him. What I do recall was that Dr. Hudis and I were attending the same meeting. We were not there --you know, this was not a meeting that was a small meeting, but this was a larger meeting where I happened to run into him. When I was asked to go back and try and remember when that may be, I looked at my calendar from that year and could identify two large international meetings that I had attended,

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but I wasn't certain, as I said earlier, that that's where I saw him.

CHAYTOR, Q.C.:

Q. Doctor, maybe what you could do is check again for us and let us know then when it would have been.

DR. LAING:

A. Sure, I have --

CHAYTOR, Q.C.:

Q. That you had your discussion.

DR. LAING:

A. I took my calendars out for that time period and I could certainly go back and look at that again.

CHAYTOR, Q.C.:

Q. Yes, and, Doctor, this reference to 75 to 100 percent positive, what is that referring to?

DR. LAING:

A. I'm not certain. I don't recall having heard when I had that discussion with Dr. Hudis about, that he had given me a number. Perhaps this is how Dr. Williams recorded it, but, you know, the number that's important here was that when they had done their retesting on their tumour samples that they had, they got

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100 percent positivity for the lobular histology.

CHAYTOR, Q.C.:

Q. Yes, because you told us in your evidence yesterday that it was anonymous tumour bank that Sloan-Kettering had used in their review.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. And it would not have been known whether or not the patients were originally negative or positive hormone receptor, and so the idea that they would have gone from 75 to 100 percent, that can't be referencing, can it, what happened at Sloan-Kettering?

DR. LAING:

A. So specimens that were retested, from my understanding with the discussions with Dr. Hudis, were not done as part of a patient centred review. They may or may not have had some information on the tissue that they had there. So even though it's not patient related, perhaps they did know or have some idea about how that was initially interpreted. That was not something that I got into at any

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detail with Dr. Hudis. So I can tell you that I honestly am not certain why Dr. Williams wrote 75 percent to 100 percent.

CHAYTOR, Q.C.:

Q. Did Dr. Hudis tell you that they had at Sloan-Kettering any ER/PR tests which converted during that review that he undertook?

DR. LAING:

A. No, it wasn't--the discussion wasn't based around conversions. The discussion was based around that in their research lab on these tumour bank tissues, that they had run ER/PR testing on the lobular histology and all the lobular histologies came back as being positive. We didn't talk about what number they had had before, was this conversions, because this wasn't patient related. I had --

CHAYTOR, Q.C.:

Q. That's what I understood you to say yesterday.

DR. LAING:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. Did you then tell the group of people on March 14th--sorry, July 14th, 2005, that at Sloan-Kettering they had, in fact, gone from 75

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percent to 100 percent positive?
DR. LAING:
A. No, no. The only thing that I can think this indicates was; one, that the follow up conversation I had with Dr. Hudis was prior to this; number two, that for some reason this was written down as 75 to 100, but that would not have been information that I had at any time other than that the lobulars in this particular review were 100 percent positive.
CHAYTOR, Q.C.:
Q. So you've never had this information, 75 to 100 percent?
DR. LAING:
A. No, no, no.
CHAYTOR, Q.C.:
Q. And you did not tell it to the group on this date, nor have you ever told that to Dr. Williams or anyone else involved in this review?
DR. LAING:
A. That they went--no, I did not ever know a percentage that Memorial Sloan-Kettering would have started at or --
CHAYTOR, Q.C.:

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

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

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DR. LAING:
A. That is typed in under that--under my name, but I would suspect that that--my recollection was that that was something that had been initiated by Dr. Cook because if you look at the next bullet, it says, "Dr. Cook to follow up on who that is". So I actually think that if you look at the written one, mine sort of ends at the 38, and then there's a separation, so --
CHAYTOR, Q.C.:
Q. Yes. So there's a line skipped.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So you're thinking that was something suggested at that point in time by Dr. Book?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. Thank you, Commissioner.
THE COMMISSIONER:
Q. We'll meet again at five after two.
(BREAK)
THE COMMISSIONER:

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Q. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Good afternoon, Doctor.
DR. LAING:
A. Good afternoon.
CHAYTOR, Q.C.:
Q. Commissioner, we have a new exhibit this afternoon. It's P-2620. I'd ask to have entered, please.
THE COMMISSIONER:
Q. 2620.
CHAYTOR, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. Entered.
EXHIBIT MARKED AND ENTERED AS P-2620.
CHAYTOR, Q.C.:
Q. Doctor, did you get an opportunity to check your calendar over the lunch hour?
DR. LAING:
A. No, because it's in my box of information which is currently in my office, but I will go there after and discuss that in the morning.
CHAYTOR, Q.C.:

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Q. Thank you.
DR. LAING:
A. You're welcome.
CHAYTOR, Q.C.:
Q. If we could have, please, P-0506. This is again notes from Dr. Williams of a meeting, and, Doctor, you're not in attendance at this meeting, but again the issue of the research from Sloan-Kettering is mentioned in the last bullet. It's a meeting of July 15th, 2005, "Dr. Cook to see if Dr. Laing can provide article from Sloan-Kettering on research in change of ER/PR receptor testing", and do you recall Dr. Cook following up with you and asking you for this information?
DR. LAING:
A. Yes, I do.
CHAYTOR, Q.C.:
Q. What do you recall about that?
DR. LAING:
A. That he asked if there was any published review of the tumour bank slides from the issue that I discussed with Dr. Hudis, and if so, did I know if this was published. I had said at the time that I did not--Dr. Hudis did

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not tell me that this had been published in any journal, and I did do a search to see if I could find this article and I couldn't, and subsequently we have looked again and did not find that any such publication of that information exists.
CHAYTOR, Q.C.:
Q. And then if we could have, please, P-0513. You are, Doctor, at this meeting by phone, anyhow, or you participate in it by phone. It's July 27th, 2005. They keep getting your name wrong, or whoever typed it gets your name wrong --
DR. LAING:
A. I'm used to that.
CHAYTOR, Q.C.:
Q. You're used to that, okay, and Dr. Cook gave results of discussion with Dr. Walters in Montreal, and under the third bullet it says, "Sloan-Kettering, no information". So I take it, Doctor, you were never able to find anything published in the way of any study or article by Sloan-Kettering --
DR. LAING:
A. Yes.

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CHAYTOR, Q.C.:
Q. On this issue. Do you know if others at Eastern Health also went looking for the information?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. Was the issue ever discussed with you after this time period in July of 2005?
DR. LAING:
A. Yes, again somewhere in the last little while people have said to me, you know, was there ever anything found, and I said no.
CHAYTOR, Q.C.:
Q. And who has asked you about that?
DR. LAING:
A. I believe that it was through my preparations with my legal counsel that they had said was there ever anything found.
CHAYTOR, Q.C.:
Q. Okay, that's fine, if your discussions with your lawyer.
DR. LAING:
A. Yeah, no, it wasn't --
CHAYTOR, Q.C.:

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Q. I thought you meant people at Eastern Health.
DR. LAING:
A. No, no, sorry.
CHAYTOR, Q.C.:
Q. Thank you. Now around this time period too, I understand, July 21st, 2005, there was a meeting with representatives of the Department of Health, including Minister Wiseman--sorry, Minister Ottenheimer. Did you take part in that meeting on July 21st?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. So you weren't at that. If we could have then, please, P-0520. Doctor, then I take it your first meeting with Minister Ottenheimer was sometime later, your first meeting with him on this issue. Do you recall when that was?
DR. LAING:
A. Yes, I was asked by Dr. Williams to attend a meeting with him to discuss the issue of disclosure.
CHAYTOR, Q.C.:
Q. Okay.

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DR. LAING:
A. And that was in August.
CHAYTOR, Q.C.:
Q. Yes, I believe that was August 15th, is that correct?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So that's the first meeting or discussion you had with Minister Ottenheimer on the issue?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, thank you. This is a July 24th, 2005, meeting that you attended along with Mr. Tilley, Drs. Gardiner, Cook, Terry Gulliver, Susan Bonnell, Dr. Kwan, Heather Predham, Deborah Thomas, and Mr. Dan Boone, and Dr. Bob Williams whose name is in brackets, and it says here, "Dr. Laing not worried about weakly positives. Dr. Laing wants to be sure new system is accurate and not overly sensitive. Dr. Laing need database to capture different kinds of breast cancer with ER/PR results and need to wait until we know that our results

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are valid", and there's other things written there, but those are the key points that I wanted to point out to you. First of all, the issue--it's obvious here, the second bullet says, "Testing patients for 2002, and the results being 16 out of 24, 25 out of 32, 22 or 23 to come. There may be a problem with methodology or with the lab", and then it says, "Dr. Laing not worried about weakly positives". So first of all, what is that in reference to?
DR. LAING:
A. Are these notes, I'm sorry, that Dr. Williams had taken?
CHAYTOR, Q.C.:
Q. Dr. Williams took these notes.
DR. LAING:
A. Okay, that's what I had understood and then I was curious as to why his name was in brackets.
CHAYTOR, Q.C.:
Q. Yeah, sorry, these are Dr. Williams handwritten notes, yes, which he was kind enough to put in legible form for us.
DR. LAING:

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A. "Dr. Laing not worried about weakly positives". Do you know what, I think my understanding is that this is in reference to the discussion related to the Ventana System. I'm not really certain what that first bullet means, "Dr. Laing not worried about", I think it's supposed to be "weak".
CHAYTOR, Q.C.:
Q. Yes, we've all assumed that it's "weakly".
DR. LAING:
A. But I'm not sure--I know that the next one was when we started to have some discussions about the reliability of the Ventana results. We've looked at the retesting results from the first 25 and from the subsequent 32, and then onwards, and we noticed that there were strong results reported quite frequently, particular in the third batch. So this is when we first had a discussion about wanting not to go from a situation where we were dealing with the false negatives to retesting on a system that would be overly sensitive and pick up--and give us false positive results.
CHAYTOR, Q.C.:
Q. So in what context would you not be worried

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about the weakly positives, meaning they're not strong, not strong positives? What situation would you not be worried about the weakly positives in terms of the Ventana System?

DR. LAING:

A. I'm sorry, I have--as I said, you know, I have no idea what that bullet is referring to.

CHAYTOR, Q.C.:

Q. So you have no recollection of the discussion around that?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. The issue of you needing a database to capture different kinds of breast cancers with ER/PR results --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Is that--what's that about? Is that the issue that we've also talked about here?

DR. LAING:

A. It certainly is.

CHAYTOR, Q.C.:

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Q. So back in July of 2005, you identified that as something that would be beneficial to the cancer care program?

DR. LAING:

A. Certainly that was one of the issues, but the other one was there was some discussion about whether or not we could go back and pull out all the lobulars or pull out all the ductals, and I said, well, if you had a database, you could do that sort of thing, or if you had a database that captured histology, ER/PR results, all that sort of stuff, it would be easier to pull out that information if there was a database there.

CHAYTOR, Q.C.:

Q. So looking to have a database which would do that for you, capture the different types of cancer and correlate that, or be able to correlate that with ER/PR results, how far along in terms of that, has there been any progress on that since?

DR. LAING:

A. As part of the discussions with Mr. Miller, not only related to the issue that we talked about this morning for that transition period

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patients, there was also some discussion about setting up an official database, not just for breast cancer, but that would be probably an obvious place to start, and I suggested that Mr. Miller contact somebody from the BC Cancer Agency to look at their database, to look at the items or the data fields that are being captured. Certainly when you set up a database, it's important to think about all the things you want to put in it from the beginning, as opposed to getting half way through and wishing that you added in something else. So we thought that would be a good place to start. On that phone conversation as well, I had asked Dr. Trudeau if they had a similar sort of extensive database in Ontario and she said that they hadn't thus far, but they were looking at that as well, and she actually agreed and referred us to have those discussions with the BC Cancer Agency, so that was left with Mr. Miller.

CHAYTOR, Q.C.:

Q. So in the intervening three years from July, 2005, until April, 2008, was there any

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progress on the issue?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Doctor, we understand there was another meeting on August 1st of a larger group of people, August 1st, 2005. Did you attend that meeting?

DR. LAING:

A. I did, and I believe that that was one of the meetings that I was late in coming to. I looked at my calendar. If my memory serves me correctly, that was a Monday, and I noted in my calendar that I had patients in the afternoon, and so if I did come to that meeting, and it's written there that I was, then I would have been late in coming to that meeting because according to the schedule, it started at 5 p.m.

CHAYTOR, Q.C.:

Q. And what do you recall about that meeting?

DR. LAING:

A. Do you have minutes or --

CHAYTOR, Q.C.:

Q. I take it you have no independent recollection

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of differentiating between one meeting or the other?
DR. LAING:
A. That there was any sort of--you know, anything that stuck out in my mind that was different from that meeting.
CHAYTOR, Q.C.:
Q. This is a meeting that stuck out a bit in Dr. Carter's mind.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And so do you recall anything about that?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. So you've heard what Dr. Carter had to say about that?
DR. LAING:
A. I have, I've been asked --
CHAYTOR, Q.C.:
Q. And the discussion about news releases.
DR. LAING:
A. I've bene asked on several occasions about this meeting, and apparently there was some

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voices raised and shouting back and forth between people attending that meeting, and again as I said this morning, if that happened, I would think that I would remember such things to happen, it was not routine --
CHAYTOR, Q.C.:
Q. Or if it happened in your presence.
DR. LAING:
A. That's right, they're not routine to happen at staff meetings or meetings of this nature, and, so, no, I have no recollection of that.
CHAYTOR, Q.C.:
Q. Of anything controversial happening while you were in attendance?
DR. LAING:
A. While I was in attendance, no.
CHAYTOR, Q.C.:
Q. And do you recall at that meeting any discussion around disclosure and whether or not to be disclosing the information to patients; if so, when, and any discussion about disclosure more broadly to the general public? Do you recall that being discussed?
DR. LAING:
A. That would have been either that meeting or

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meetings prior to the meeting that I had with the Minister later that month. There would have been some discussion about the whole idea of when we would disclose this information to the patients, and there was certainly preliminary discussion about--I'm not sure if it was at this meeting or later on in August, as I said, we started to have some discussion about disclosing to patients. At this time, I and some of the other medical oncologists had already had some experience in disclosing information to the patients, and felt that the ability to have as much information as we could when we sat down with the patients to outline if there was going to be a change in the results, to have all the information about what that would mean would be the ideal situation.
CHAYTOR, Q.C.:
Q. And, Doctor, however, there had been patients and there continued to be patients that you disclosed the issue to without having their test results, patients that you told beforehand that they would be retested, and you said that they took the news fine, that,

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

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more lengthy discussion about, you know, what that meant and what change in treatment that we may offer to that patient at that particular time.

CHAYTOR, Q.C.:

Q. If we could have P-071, please. I take it, Registrar, did you find the notes, the version of it. Yes, 539, please, yes. I think this is--it's indicated to be a note, August 1st, 2005, but there's no indication as to who attended.

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. But there are points from different people are attributed.

DR. LAING:

A. And there's no reference that I had made any comments at that meeting.

CHAYTOR, Q.C.:

Q. And we're not sure, in fact, that this is the larger meeting, this may have been a smaller meeting.

DR. LAING:

A. Okay.

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CHAYTOR, Q.C.:

Q. At a different point during the day.

DR. LAING:

A. Yeah, okay, fair enough.

CHAYTOR, Q.C.:

Q. I think there's some discrepancy on that. So if we could have P-0071, please. Doctor, I hear what you're saying that you don't recall being present when there was any controversy, any voices raised, or any accusations or anything of that nature. Do you recall any discussion about news releases or what could potentially go into a news release?

DR. LAING:

A. At that--at the meeting on August 1st.

CHAYTOR, Q.C.:

Q. Any meeting around that time?

DR. LAING:

A. Not in any great detail, no.

CHAYTOR, Q.C.:

Q. What about in not such great detail?

DR. LAING:

A. No, I don't have any recollection if that was discussed at that time.

CHAYTOR, Q.C.:

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Q. So you have no recollection of discussing with anyone what could potentially be said in the news releases?

DR. LAING:

A. No, they didn't ask my input as to what would go into a news release at that time, no.

CHAYTOR, Q.C.:

Q. Okay. Or at any point in time, I take it?

DR. LAING:

A. At any point in time in this whole process or at -

CHAYTOR, Q.C.:

Q. No, after it becomes public, perhaps you're involved at that point?

DR. LAING:

A. Yes, yes.

CHAYTOR, Q.C.:

Q. But any time before it actually becomes an issue of public discussion were you consulted for your input into any draft media releases or anything that could possibly be said to the public on the issue?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

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Q. Okay. And P-0071. These are draft releases attached here. And they're dated July 18th, 2005. And there's a number of different versions. Another one here, July of '05. Were you ever shown those?

DR. LAING:

A. No. They don't look familiar to me.

CHAYTOR, Q.C.:

Q. Okay.

DR. LAING:

A. At some point, and I believe it was later on in the process, I had some input to a draft, but that was for a letter, I believe, to physicians. And it may have been, you know, after the October 1st when it came in the media, but I don't recall.

CHAYTOR, Q.C.:

Q. And this one here is the one at page 9 that Dr. Carter said she took exception with, the idea of the public being told that the retesting was due to improved technology. Do you recall that ever being floated in your presence or in discussion with you the idea of saying that the changes, that somehow it was a technology issue?

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DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. If we could have, please, P-0564? And this is a meeting August 10th, 2005. And it appears you are in attendance at this meeting with Mr. Tilley, Ms. Pilgrim, Dr. Cook and Dr. Williams. And there's an update given by Dr. Cook?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Where he indicates it'll be four to six weeks for Mount Sinai to report the specimens.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And your update is "All people who are ER negative need to be retested. Treatment has varied a lot over the years. ER positive and PR negative cases may be suitable for aromatase inhibitors. Need to know what their true ER/PR status is. All patients will need an individual reassessment. Find out who is alive and who is dead. Dr. Laing has a

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problem with sending out letters until we know how much of a problem we have." So, Doctor, perhaps you could tell us, I think it's straightforward the first bullet.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. That you're saying all people ER negative need to be retested.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And what do you mean by "Treatment has varied a lot over the years."?
DR. LAING:
A. So as part of this discussion I was giving an update on how the treatment of hormone receptor positive cancer had changed. We were talking about a period of time going back to 1997 and just in relation to the fact that we used to not treat pre-menopausal patients, we used to only have Tamoxifen, we're getting into the aromatase inhibitor era now in 2004 and 2005 and that, you know, this was going to, in any sort of review, this was going to

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be a factor that we would have to consider.
CHAYTOR, Q.C.:
Q. Okay. And I guess that's what's meant, then, further along where you--"ER positive and PR negative cases may be suitable for aromatase inhibitors."
DR. LAING:
A. Right. I don't know if you recall yesterday we had a little bit of a discussion about this idea of trying to look at predictive markers in a way to determine who may benefit more or less from things like the Tamoxifen and the aromatase inhibitors.
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. And one of those trials, which was the ATAC trial, there had been a review of that done by Dr. Mitch Dowsett who is an oncologist who went back and looked at the ATAC trial, which was the adjuvant anastrozole which is an aromatase inhibitor versus Tamoxifen, and in a retrospective analysis, so, you know, sort of hypothesis generating look, there seemed to be a clue that perhaps ER positive, PR negative

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patients benefitted more for the aromatase inhibitors. Subsequently to this another of the larger trials, the big one in '98 which is the letrizole versus Tamoxifen trial has not shown the same thing. And my point at the time was because this is when there was some discussion about whether if we were identifying people by ER, did we really need to check the PR, and it was my point that, saying that, yes, because as time goes on, that may be how we use these predictive factors, not only in determining if somebody needs hormonal therapy, but what type they should be offered.
CHAYTOR, Q.C.:
Q. So it was important then to know each patient's true ER/PR status?
DR. LAING:
A. That's right, yeah.
CHAYTOR, Q.C.:
Q. And that's what the next bullet says?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. Then "And then all patients will need

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an individual reassessment."
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you're suggesting "Find out who is alive and who is dead."
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And why were you suggesting that at this point in time?
DR. LAING:
A. Because I felt that we should give priority to retesting the patients who were known to be alive and to put the patients who had been deceased to the side and retest them later, that if there was any way as the retesting was going under way, that we could ensure that the patients that were still alive were being retested. And also, you know, if you're thinking about sending out a letter, stressing -
CHAYTOR, Q.C.:
Q. No, before we leave that one, Doctor.
DR. LAING:

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A. Okay, fair enough.
CHAYTOR, Q.C.:
Q. The idea about who is alive and who is dead, so you were suggesting that, yes, the deceased would be retested, as well, but that would come later -
DR. LAING:
A. Later.
CHAYTOR, Q.C.:
Q. - give priority to those who are alive?
DR. LAING:
A. Exactly right.
CHAYTOR, Q.C.:
Q. And did you ever vary on that, that your opinion that, yes, the deceased should also be retested, was there ever a point in time when you thought perhaps it wasn't necessary to retest the deceased?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay. And finding out who is alive so that they could be given priority, did anyone run with this suggestion afterwards? This is August 10th, 2005. Do you know if there was

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an effort made for that to happen?
DR. LAING:
A. I don't know that there was or not. Our tumour registry, as I said yesterday, at that time didn't have a good link to vital statistics to do what's called death clearance to make sure that people that were found to be deceased, that that was noted in the tumour registry. And in fact, in our cancer patient charts, our OPUS system charts, it's not always evident by picking up one of those charts and looking at it whether or not a patient is deceased unless there's some sort of notification. And if there is a notification made to the clinic either by a family member of the deceased patient or sometimes we'll come in and say, you know, I know that, you know, my patient has died and we'll ask for that death notification to go on the chart, that we felt that in some instances there may not be any way to know that these people had, in fact, died of their breast cancer or of other causes.
CHAYTOR, Q.C.:
Q. So in terms of there was no discussion about

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checking the provincial registry on that, to check and see who -
DR. LAING:
A. I'm not sure at that time what process they would have used. But, you know, one of the things was if there was any way that we could prioritize to deal with the living patients first, I felt that that was a good idea.
CHAYTOR, Q.C.:
Q. Okay. And whether it was followed up on or not, you're not sure?
DR. LAING:
A. I'm not sure.
CHAYTOR, Q.C.:
Q. Okay. And so the last bullet, "Dr. Laing has a problem with sending out letters until we know how much of a problem." First of all, sending out letters to whom?
DR. LAING:
A. Letters to patients.
CHAYTOR, Q.C.:
Q. Okay. So what was being contemplated and what was it that you had a problem with?
DR. LAING:
A. So what was being contemplated at this point

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

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knowing--and this is, you know, and this is the issue with disclosing things like this to patients, there are some people who, you know, want to know right away and there are some people who would say, I would like to know what that means for me. It was always our intention to disclose to patients. The big question was the timing. And because I had weighed in, I guess, at this point with that discussion, I was advised at that time by Dr. Williams that they had had discussions with the health minister and that there was some thought given to sending as letter at that time to the patients. And it was not, my recollection is not at this meeting, but very shortly after this meeting, whether it was the next day or the day after that I received a call from Dr. Williams saying, would you come and sit down with Minister Ottenheimer, he'd like to meet with you and he'd like to hear your opinion regarding this matter.

CHAYTOR, Q.C.:

Q. Okay. So, Doctor, the first time that you're informed of anything about the idea of sending a letter out to patients, the first time

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that's brought to your attention is at this meeting on August 10th, 2005, is that correct?

DR. LAING:

A. From what I recall, yes. I don't recall having had discussions with people prior to this point.

CHAYTOR, Q.C.:

Q. And is this the first time, then, that your opinion then a couple of days later, you're invited by Dr. Williams to go to meetings with the minister?

DR. LAING:

A. To go to a meeting with Minister Ottenheimer, yeah.

CHAYTOR, Q.C.:

Q. So any views you had on that prior to August 10th, 2005, you would not have articulated that to anyone before August 10th, 2005?

DR. LAING:

A. Looking back, not that I recall. But I would assume that my opinion would not have been different two or three weeks before.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

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A. As to what is now.

CHAYTOR, Q.C.:

Q. It's just that you weren't asked before and this is -

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. - the first time you would have voiced your opinion?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. In terms of disclosure to patients?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And the manner of disclosure?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. Doctor, in terms of then I hear what you're saying about thinking it was going to be a four to six week turnaround, in fact, as time went on, it took longer than four to six weeks even to get the samples from the out of

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

DR. LAING:

A. No, I don't recall anybody contacting me from the lab or anything to say that it was taking longer to get the slides together or any issues like that.

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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

DR. LAING:

A. Yes.

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THE COMMISSIONER:

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

DR. LAING:

A. No, my recollection was that other people weighed in on this discussion. I felt that they were asking my views for two reasons: one was because I had had some experience in disclosing already to some patients; and the second was because I had experience in, you know, talking to patients about cancer and diagnosis and prognosis and sort of what my experience over the years had been in the clinic in terms of helping people make decisions and the idea that the more information they had, the better they were informed, the better it was to make a decision.

THE COMMISSIONER:

Q. Yes, I think I understand why it is you took

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

DR. LAING:

A. Yes, that's correct.

THE COMMISSIONER:

Q. Do you recall the positions of the other people in the room?

DR. LAING:

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

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necessarily the opinion of the people in that room.

THE COMMISSIONER:

Q. You said you did not recall that anyone strongly disagreed.

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. Does that mean that nobody said anything, that there was a weak little voice in the corner that said, not me, I wouldn't go that way, or was it really just that nobody was voicing anything that was in disagreement with your view?

DR. LAING:

A. That nobody at that time raised something that disagreed with my opinion.

THE COMMISSIONER:

Q. Okay, then. And did either Mr. Tilley, Ms. Pilgrim, Dr. Cook or Dr. Williams say I agree with your position?

DR. LAING:

A. No, not that I recall.

THE COMMISSIONER:

Q. So you gave your opinion and nobody else

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objected to it but neither did anybody say I agree?

DR. LAING:

A. My recollection doesn't allow me to say whether somebody said it very strongly, no, I don't think that's a good idea, I think that's crazy, I think we should do something else, nor did people say, okay, that's what we're going to do. This was still something that at that time I believe was under discussion and I don't feel that at the end of this that the discussion was at all closed.

THE COMMISSIONER:

Q. I thought I was following you until you had the last sentence. Okay, is it that you do not remember the positions of anybody else or just because they did not raise anything which you remember as being strongly in disagreement with your position that you're saying as far as I know nobody disagreed with me?

DR. LAING:

A. The latter.

CHAYTOR, Q.C.:

Q. All right, thank you.

DR. LAING:

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A. You're welcome.

THE COMMISSIONER:

Q. And could you tell me why this meeting was called, why this group?

DR. LAING:

A. No, no, I can't tell you why -

THE COMMISSIONER:

Q. So it would have been called by whom?

DR. LAING:

A. Dr. Williams.

THE COMMISSIONER:

Q. Not Mr. Tilley?

DR. LAING:

A. Not that I would know.

THE COMMISSIONER:

Q. You saw it as being called by Dr. Williams, in any event?

DR. LAING:

A. Right. So during this whole period of time all of the requests that I had to attend meetings and all of the requests for my opinion and what I thought about things actually came from Dr. Williams. I would say that during this time period that there was often not a day that would go by that I might

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not get a phone call from Dr. Williams to ask me a question. Most often they were questions pertaining to the clinical management of breast cancer, and because for someone who was outside of this field, you know, there was a lot to learn in a short period of time. And often I'd be in the clinic and somebody would pop their head in the room and say, Dr. Williams is on the phone. And so I know that I, you know, talked to him, but mostly about clinical issues in terms of treatment and these sorts of issues surrounding breast cancer management.

THE COMMISSIONER:

Q. Did you see yourself as a part of this group or did you see--it's an interesting combination of people, put it that way. So I'm interested in whether you saw yourself as part of this group which met regularly or did you see yourself as an invitee on this occasion, not really part of that group?

DR. LAING:

A. I think really at this time I was starting to feel like I was becoming a part of this group and that if there were going to be meetings

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that were pertinent, that they wanted someone from the clinical aspect of things, that that person would be me or Dr. McCarthy who would be asked to come to these meetings. I felt that I was asked to be in this position because at this time, although I was director of medical oncology within the NCTRF, I felt I was there more as a physician who was knowledgable about breast cancer. And in retrospect I've looked back and thought if this was perhaps an issue I had been asked to speak to about a cancer that I wasn't experienced in treating, like lung cancer, that I would have either brought someone along with me such as one of my colleagues who would be a lung cancer physician or sent them in my place.

THE COMMISSIONER:

Q. Okay, thank you. Sorry, Ms. Chaytor, I was interrupting again.

CHAYTOR, Q.C.:

Q. So Doctor, in this same meeting, August 10th, Heather Predham's update includes that the--she has a list of all people who need to be retested. First page shows people who are on

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Tamoxifen. So do you know, was there any effort to figure out the people who were already on Tamoxifen and prioritize who was retested on that basis, to not send off the people who were on Tamoxifen first, to get the other people retested?

DR. LAING:

A. No, I don't believe so at all. In fact, when I look at this, I wonder if it meant that on the list of people who--I'm wondering if this included, perhaps, people that were already retested and we knew that they had been started on treatment, but no, there was never any effort made to go to the records and determine what therapy people had received prior to deciding whether or not they needed to be retested.

CHAYTOR, Q.C.:

Q. Okay, and then comments attributed to you at this meeting, it says you "feel if this happened over eight years, should be approached in a systematic way. We can't fix overnight." So first of all, you feel that it happened over eight years. What, by August 10th, 2005, would give you that thought or

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that inkling that it's something that's happened over eight years?

DR. LAING:

A. So the eight years would come back from 1997 to 2005. At this point, there had been various people tested at different time periods and it wasn't my--at least at this point, there didn't seem to be any signal that this was something that was isolated to a specific period of time, and that which was a reason for doing the retest for the entire time period.

CHAYTOR, Q.C.:

Q. So it wasn't that you--are you saying that by this point in time, you realize it's not an issue that is pertinent to one or two years. It's something that happened over the entire time period?

DR. LAING:

A. That's right, yeah.

CHAYTOR, Q.C.:

Q. And you're of that view at this point in time?

DR. LAING:

A. Not that I had known about it for eight years.

CHAYTOR, Q.C.:

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Q. No.

DR. LAING:

A. But that when I was looking at this now, saying--because in the beginning, you know, was this going to be a 2002, because of the index case? Was this going to be 2003 because of what we now know about Dr. Ejeckam's memo? No, this was that this was something that was--that we needed to look at all of those time points.

CHAYTOR, Q.C.:

Q. Okay. Third bullet attributed to you is "she doesn't feel we are trying to cover things up." In what context would you make such a comment?

DR. LAING:

A. I'm not certain what that was meant by. Perhaps that was in reference to waiting to disclose to people once we had all the information. That's the only sort of context I can think that perhaps it was in, but -

CHAYTOR, Q.C.:

Q. What discussion was had around that? Was somebody suggesting that things could be perceived in that manner, that there was some

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sort of cover up?

DR. LAING:

A. If there's--not that I recall, but you know, again, these are notes that somebody took and seems to indicate that there was some conversation around that. It certainly wasn't my feeling then and is now my feeling now.

CHAYTOR, Q.C.:

Q. And so whether or not that was spoke of at this meeting and what was said around that, you can't recall?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay, and of course, you are aware that in the October 2nd news story that runs, there is a quote attributed to you at that point too which uses the words "cover up" that this, we weren't trying to cover anything up, a similar statement is attributed to you in that story on October 2nd.

DR. LAING:

A. Yes, the Independent article.

CHAYTOR, Q.C.:

Q. Yes. So you're not sure though what's being

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

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

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CHAYTOR, Q.C.:
Q. The tests that you had run on the Ventana system in house indicated that it perhaps could involve a significant number of the patients who were being subject to the retest.
DR. LAING:
A. It did, but at this time, we had made a decision to think that the Ventana system was not necessarily the most reliable, because of our concern about the over call.
CHAYTOR, Q.C.:
Q. The idea of causing anxiety in the patients, the patients that you had spoken with and that Dr. McCarthy had spoken with, the patients that you had both from the June 29th list and the original patients, the five patients, they had taken it well? You told me this morning they had--when you told them there was a possibility to be retested, and again when you told them the results, that it was positive and they took the information well on both occasions.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:

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Q. You told me yesterday that it's your practice to keep your patients informed and have them to be decision makers in their own care and treatment plans.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And that's the way you conduct your practice, to keep your patients informed.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you encourage them to be informed and you encourage them to take part in the decision making.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So why, in this case, and with that information and the background of having already told some of the patients and their reactions, why would you not want to let all the patients know that this is happening and to tell it to them in a way that it would not induce anxiety?

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DR. LAING:

A. Sure. I think in answer to that, there's a couple of points. One is that to that date, although I had some experience, it had been in a limited number of patients, and patients who I had already known and who were in my care. So I had already developed a rapport with them. And then the second part of that is to be--we were dealing with a very small number of patients at that time and that I felt that, you know, if the trend continued and if there was going to be a large number of patients that needed to be informed, that we may not be able to do that sitting down and spending the time and talking to them and disclosing them if, you know, all of a sudden we had a whole bunch to do on one day. Just the logistics of how that would unfold.

I can tell you now that as I have gone through this process and have met with many, many, many more patients through this whole process, some of whom were mine from the very beginning and some of whom I was asked to see as a result of this, that there was a mix in what we have been told by patients. Some

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patients said "I'm so glad that I didn't know, because I wouldn't be able to sleep or eat or do anything else," and some people said "the minute you even contemplated retesting a sample of my breast tissue, I should have been informed." Those would be the two extremes, and there, of course, would be people that would fall in. That's something that we -

CHAYTOR, Q.C.:

Q. And people who might not be comfortable saying to you what their views are, one way or the other.

DR. LAING:

A. Right, and that's something that I can only draw on my experience as a physician. Although I certainly do my best to inform my patients, one of the things that--and here, we talked about this and thought about it a lot, about what experience and things I ever had in disclosure, and although that wasn't anything that I had ever had any training or up to this point and onwards that anybody had ever talked to me about, as a medical oncology resident and fellow, we were taught, and spent a lot of time talking about breaking bad news, telling

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

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and do adjuvant online with them. But most patients just really want to know very basics. They say "don't tell me percentages. Don't tell me numbers. I'm not interested in that." And so really, you know, you get an idea from patients how much information they want to know and, you know, you have to put it in a context of where you are, and at this point, again, I was thinking "go to them, have all the information in hand" and I guess that's partly because that's what we do as clinicians. I mean, in our usual clinical practice, I wouldn't send somebody away for a CAT scan or something and have them come back before it came back, and you know, sometimes in the clinic, we're waiting for diagnostic tests and things to come back and if they're not ready or not available, I know that that's anxiety provoking to patients. So really I was drawing on my clinical experience in these days about making these decisions.

CHAYTOR, Q.C.:

Q. But I take it if you're going to have--if the patient--the patient is informed if she has her CAT scan done and it needs to be redone,

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she has to reattend to have it redone, so she's told in that situation, "there was something wrong, you need to have it done again. The film wasn't clear."

DR. LAING:

A. No, I sort of meant that the report wasn't back yet, not that it had to be redone, but, yeah.

CHAYTOR, Q.C.:

Q. But in that situation, going to draw an analogy, I mean, the patient is told if a test needs to be repeated and have it done again. Did you--you say you didn't--weren't trained on this and you didn't--in terms of how to deal with such a situation.

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

Q. I'm just wondering, did you seek advice from anyone else? You sought advice from Dr. Pritchard on the clinical issue about the benefit to delay in introducing the Tamoxifen.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

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Q. Did you seek advice then from anyone else outside of Eastern Health, anyone who could stand back from the issue? Did you ask anyone "well, what should we do in this situation? I've never been--I've never had to deal with something like this. Can you help me?"

DR. LAING:

A. In relation to disclosure?

CHAYTOR, Q.C.:

Q. Disclosure issue, yeah.

DR. LAING:

A. No. No, not at that time.

CHAYTOR, Q.C.:

Q. Did you think of--did anyone discuss perhaps getting an ethical consult as to whether or not we should be retesting people without their consent or prior knowledge?

DR. LAING:

A. No, I had no recollection at this time of an ethical issue, of considering ethical consultation, and as you know, we did do that subsequently.

CHAYTOR, Q.C.:

Q. With respect to the deceased.

DR. LAING:

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A. Correct, and that was the first time that -

CHAYTOR, Q.C.:

Q. And again in April, we hear.

DR. LAING:

A. - that I had--April, sorry?

CHAYTOR, Q.C.:

Q. This year, April '08 on an issue of--the apology letter apparently came out of that. You're not aware of that?

DR. LAING:

A. No, we actually had a meeting regarding the--we had an ethical consultation regarding the deceased patients prior to 2008.

CHAYTOR, Q.C.:

Q. Yes, in June 2006, yeah. Now there's another issue of another ethical consult, and it doesn't sound like you're aware of it.

DR. LAING:

A. Oh no.

CHAYTOR, Q.C.:

Q. That's much later on. But nothing at all, at this particular point in time, in terms of getting any kind of advice or an ethical consult in terms of disclosure to the patients?

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DR. LAING:

A. No, we didn't.

CHAYTOR, Q.C.:

Q. Okay, and what about the patients that you had already told, the patients back from the June 29th list, the patients that you had already told about the issue? The first five, what about--did you ask them? Did you say "actually, we're going to do a broader testing now. What do you think, as a patient? Do you think your fellow patients would want to know?"

DR. LAING:

A. That's a good idea, but no, I've never asked them that.

CHAYTOR, Q.C.:

Q. And the patients who were coming in still to see you who had metastatic disease and you were letting them know that the retesting was happening, what about them? Did you ask them their opinion as to--the patients you were seeing in July and August, September, the ones you were telling?

DR. LAING:

A. No, those few patients, I didn't ask them what

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they would--you know, what their point of view would be on this as a general--or in a more general sense or applying to a larger audience or larger number of patients.

CHAYTOR, Q.C.:

Q. And Doctor, so you knew that at least ten or 12 from the first batch had been told. You knew that the--well, of course, Ms. Deane knew there had been a conversion in her case, and you knew that there were the three or five other patients who had been told, and some of those may overlap on your June list. So you knew that there were a number of patients who already knew, and were you concerned that the breast cancer patients within the province, and particularly within the St. John's area, are a fairly close knit group.

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

Q. They are part of a very strong network of people, support network. Were you concerned that "they're going to be speaking to one another; they are going to hear about this indirectly. It's better that they hear it from

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me, from us"? Did that occur to you?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Doctor, was there anyone advocating telling the patients? Commissioner Cameron asked you about the list of people who were in attendance at the meeting and whether or not anyone in that meeting was actually voicing anything different from your opinion, but was there anyone at Eastern Health advocating "we're concerned about this, Dr. Laing. We think perhaps we should be out there telling the patients"?

DR. LAING:

A. Not that I recall, at this point.

CHAYTOR, Q.C.:

Q. At any point in time?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. If we'd just continue on then with the meeting of August 10th. "Dr. Laing not worried about" and I think there's some mix up in the words here, but "not worried about doing the right

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thing, given our current knowledge. She feels sending out information now until we can give them the answers." The idea of "not worried about doing the right thing, given our current knowledge," was there anybody expressing that there was concern that you were--that somehow it wasn't the right thing to be doing? Do you recall what's the context that these remarks are made?

DR. LAING:

A. I can't, I don't know what the context is.

CHAYTOR, Q.C.:

Q. Okay. "Leave clinical management to oncologists." Do you recall what that was referring to?

DR. LAING:

A. No, unless they were talking about what we would do when the results came back.

CHAYTOR, Q.C.:

Q. And again, this is a comment being attributed to you. You're not sure what that refers to?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. "Dr. Laing feels we are creating unnecessary

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anxiety to a lot of patients. Need the information on hand before we go to these women."

DR. LAING:

A. I think we've addressed that.

CHAYTOR, Q.C.:

Q. Yes. "Need to strike a balance between waiting and giving good information we are giving now and causing anxiety unduly." What information was being given that--was there anything already happening, in terms of it says that "feels we are creating unnecessary anxiety to a lot of patients." It's written in the present tense, and "information we are giving now and causing anxiety unduly."

DR. LAING:

A. No, that doesn't--I find, you know, sort of the context or the way it's written is a little bit confusing, so I'm not really sure what these notes from Dr. Williams were referring to.

CHAYTOR, Q.C.:

Q. So you have no recollection of what other points you may have been making?

DR. LAING:

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

CHAYTOR, Q.C.:

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

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

DR. LAING:

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

CHAYTOR, Q.C.:

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

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DR. LAING:

A. Right.

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

Q. Okay, and -

THE COMMISSIONER:

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

CHAYTOR, Q.C.:

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

THE COMMISSIONER:

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

CHAYTOR, Q.C.:

Q. Yes, that's right.

THE COMMISSIONER:

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Q. - the physician following up.

CHAYTOR, Q.C.:

Q. Yes, this appears -

DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

CHAYTOR, Q.C.:

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

DR. LAING:

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

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opinion within a couple of days as to when I thought, you know, what I thought that we should do in terms of sending a letter, and so I don't know what this was in reference to. Was this from some discussions that we had had at earlier meetings? But I don't recall being given a draft letter or asking to put anything into a draft letter or anything like that, as I said.

CHAYTOR, Q.C.:

Q. So by August 10th, you are of the opinion to wait?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And you don't recall at any point prior to that giving any suggestions as to wording for a letter?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. To go to patients?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

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Q. In giving your opinion as to what should happen, in the meeting on August 10th, the opinion to hold off, "it is only going to be four to six weeks, let's wait."

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Did you consult anyone else? Was that just your opinion, Dr. Kara Laing's opinion, or did you ask anyone else as to what their opinion might be?

DR. LAING:

A. No, this was something that we had discussed amongst ourselves, amongst the group of oncologists. I would have had discussions with Dr. McCarthy. We would have had discussions with the larger group. I believe I had some discussions with Dr. Ganguly regarding this issue. You know, as I said, this was something that we, as a group, were talking about and, you know, I do recall sitting down with my colleagues and sort of saying, you know, "I think we should wait until we have all the information. We think it's going to be in a short period of time,

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and then we'll deal with getting that to the patients and deciding what to do at that point."

CHAYTOR, Q.C.:

Q. So did you call together all of the oncologists? Was there a meeting called in which you solicited their opinion?

DR. LAING:

A. Don't think we had a formal meeting, no.

CHAYTOR, Q.C.:

Q. So you talked to Dr. Ganguly and who else?

DR. LAING:

A. Oh, I'm not sure. I know that I talked to--I would have talked to several of my colleagues about this.

CHAYTOR, Q.C.:

Q. And they were all of the same mind?

DR. LAING:

A. As I said, that we would often have informal discussions every week about various issues and I do know that this was something that this wasn't just me making this decision on my own, but that we did have some discussions with the other oncologists, and that there was a consensus that we wait until we had the

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information together for the patients.

CHAYTOR, Q.C.:

Q. So a consensus of whom? It wasn't the entire group?

DR. LAING:

A. I don't think that I would be able to tell you specifically who all those oncologists were, without any sort of formal minutes, but you know, when we would all get together and discuss these issues, then there would be whoever happened to be together with us on Tuesday mornings would sit around and have these discussions.

CHAYTOR, Q.C.:

Q. So you remember bringing this up on one of your regular Tuesday morning get togethers?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. This issue?

DR. LAING:

A. And I remember discussing it separately with Dr. Ganguly. Whether I talked about it with other radiation oncologists, I may have, but my recollection is having a discussion with

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more oncologists than just Dr. McCarthy about this issue.

CHAYTOR, Q.C.:

Q. And did any oncologist descent?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Dr. Williams testified that part of the oncologists' reluctance to disclose to the patients upfront was concern about the oncologists' workload and it would be difficult with coping with all of the phone calls or patient contacts that may be generated should the patients be told. So in that interim period, if you were to notify the patients, the number of phone calls and contacts the oncologists would have to deal with, in terms of their ongoing practice. Was that a consideration in your discussions with the oncologists?

DR. LAING:

A. I think that if that did come up, it certainly wasn't the final decision. It wasn't a strong point in the decision. As you can imagine that through this whole process, there have

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been various periods of time where we have gotten many, many phone calls from our patients. It would have first started in October of 2005 and continues on each time this issue comes forth again, particularly in the public. So you know, big issue in October 2005, again into December of 2006, again in May of 2007, again when the letter came out regarding from Marian Crawley that summer, I can't even remember, I think that was 2007, and even most recently after the apology letter. So there have been times where we have had quite an increase in the volume of calls and inquiries from our patients regarding this issue. We would of course have some concerns, not only--not just about the phone calls that this would generate, but as time went on, about how we could see these patients quickly and efficiently within the clinic, because of our limitations in space and in staffing.

CHAYTOR, Q.C.:

Q. So the answer to my question then is that there was some discussion about that and the amount of patient contact that may be

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generated, but it wasn't an overriding factor?

DR. LAING:

A. No, no. In other words, I can honestly tell you that we wouldn't say "we're not going to call the patients because we don't want to deal with the phone calls." That's not the impression I want to give at all.

CHAYTOR, Q.C.:

Q. What was your thinking that if it can be done in four to six weeks, we won't tell them. But if it's going to be longer than that, if it's going to take a longer or protracted period of time, then the patients should be told? Why if it's going to take two months, three months, the decision would be different in your mind?

DR. LAING:

A. Because the basis of my decision was that I wanted to be able to go in with as much information as I could to the patients, to settle--you know, say "this is what you were. This is what it is now, and this is what we're going to do about it." That was my thinking in 2005, during all this deliberations.

CHAYTOR, Q.C.:

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Q. But if it's going to take longer, they're going to have a longer period of time. If you're concerned about anxiety or not knowing, if it's going to take longer, they're going to have a longer period of time to fret or be anxious over it, if that in fact is how they would feel.

DR. LAING:

A. No, I think that we realized if this was going to go on for a longer and longer period of time, that you would be getting back to the point that you raised earlier that if we're telling, you know, two or three patients this week, two or three patients next week, that eventually this would be something that would get out there, in terms of being common knowledge within the clinic or within support groups and all that sort of stuff. To this point, you know, although there had been patients disclosed to, it was a very, very small number. We didn't know what, at the end of the day, was going to be the number of patients that were going to be disclosed to, and I guess I can only answer that in terms of what I recall to be my thinking at the time,

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for the reason for wanting to wait.
THE COMMISSIONER:
Q. So Dr. Laing, then you're saying you didn't know what the number of patients were who would be disclosed to, I'm reading that as you would be disclosing to those patients who had a change and you would not be disclosing to other patients? Was that your thinking at the time?
DR. LAING:
A. No, no, no. We would--eventually, this would be something that would be disclosed to all patients who had the testing repeated, because that would be the only way that they would know that they had been retested and what their results had been, but that the disclosure -
THE COMMISSIONER:
Q. So that was going to be a large number of people, which you would have known starting out, if you were going to run from 1997 onwards, or 1998?
DR. LAING:
A. Yeah, but that disclosure would not necessarily have to have come from the medical

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oncologists. That disclosure may not necessarily have had to take--if there was going to be, at the end of the day a large percentage of patients in whom the test results didn't change, then that process of disclosure wouldn't be as long as it was for the patients who had new test results.
THE COMMISSIONER:
Q. So from the beginning, it was contemplating that there would be two different disclosure procedures?
DR. LAING:
A. I don't think from the beginning. I think as we started to get the test results back and tried to deal with who was going to disclose to what --
THE COMMISSIONER:
Q. Yeah, but what you got to remember, let's put ourselves with the hat on that we are in this time frame which is in August, and which you have no test results back from --
DR. LAING:
A. Yeah, no, I don't --
THE COMMISSIONER:
Q. From Mount Sinai, and you're considering how

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

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A. In 2005, that would have been the Health Care Corporation's disclosure policy, so not that I know of.
CHAYTOR, Q.C.:
Q. Gerri Rogers is a patient of yours, and she testified that you had told her that you did want to disclose to patients that there was retesting underway. Do you have any recollection of that?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And did you tell that to Ms. Rogers?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. So if Ms. Rogers had that understanding, she misunderstood what you said to her on the issue?
DR. LAING:
A. Yes, that was part of her testimony, and she had said that I had wanted to disclose it and Eastern Health told me not to.
CHAYTOR, Q.C.:
Q. Or something to that effect.

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DR. LAING:
A. Something to that effect.
CHAYTOR, Q.C.:
Q. She thought it may have been some committee, or she wasn't quite sure who, but that there was some influence that came to bear on you on the issue?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. But --
DR. LAING:
A. That wouldn't have been--no, that wouldn't have been how I --
CHAYTOR, Q.C.:
Q. So that's not correct.
DR. LAING:
A. Had said that, no.
CHAYTOR, Q.C.:
Q. And do you recall any discussion with Ms. Rogers on the issue from which she could have taken that impression?
DR. LAING:
A. No, only the discussions that I would have had with her as part of her ongoing care. She

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would have been disclosed her results when they were available, but I wouldn't have had a discussion with her that indicated one way or the other whether I would have been told or not told to disclose or not disclose to patients. I don't remember that.
CHAYTOR, Q.C.:
Q. But in terms of telling her what your personal preference was in terms of disclosure?
DR. LAING:
A. No, I don't remember having a conversation with her regarding that.
CHAYTOR, Q.C.:
Q. And that you had wanted to disclose to patients about the retesting?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. You didn't tell her that?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. If we could have, please, P-0138. This is notes from the meeting of August 15th, 2005, and it's the meeting with the Minister, and do

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you have any independent recollection of this meeting, Dr. Laing?
DR. LAING:
A. Yes, I remember going to the Department of Health for this meeting. It would have been the first time that I had been asked to do such a thing. I remember meeting with Minister Ottenheimer. We met --
CHAYTOR, Q.C.:
Q. Is that the first time you met him?
DR. LAING:
A. Yes, it was.
CHAYTOR, Q.C.:
Q. So it sticks out, I take it, in your mind?
DR. LAING:
A. Yeah, it would have been the first time that I had gone and signed myself in to Confederation Building for a meeting like that with the Minister. I had been to the Department of Health for other meetings before, but this was the first one that I had had with Minister Ottenheimer, and I remember going in, being there present, and really basically giving an overview from the point of view of again my clinical experience and how we use the testing

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in the lab and what it means, and then really reiterating what we have already discussed in terms of my views in terms of disclosure, that is let's get the retesting done and then sit down and go over the results with the patients, and that it was--you know, I recall this interaction, and, in fact, every interaction I've ever had with Minister Ottenheimer has been very positive, he was a very kind easy to talk to individual, and that they listened to my opinion. There wasn't a lot of discussion back and forth, nobody sort of said, oh, I don't agree with that. I don't believe that a final decision was made. I felt as if I was asked to come there to sit there, tell the Minister what I thought, I was thanked, and I left.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Ms. Chaytor, whenever you want we'll take the afternoon break.
CHAYTOR, Q.C.:
Q. Okay, I'll just continue with this exhibit then, please, Commissioner. This indicates

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that it was the Minister present, Dr. Fleming?
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Dr. Blair Fleming, I take it?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Would you have known him before this?
DR. LAING:
A. Not well. I would have known him in the capacity that we would write to him on occasion to request out of province referrals and those sorts of things. Whether I had met him personally regarding discussions around that before then, I may have. I certainly had spoken to him on the phone several times before that.
CHAYTOR, Q.C.:
Q. And you may have met him or discussed the issue of ER/PR with him prior to this?
DR. LAING:
A. Not that I would remember at all. No, I don't think so at all.
CHAYTOR, Q.C.:

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Q. And have you since had any discussions with Dr. Fleming --
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. On this issue?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And did he--did he offer any opinion on the issue of patient disclosure?
DR. LAING:
A. Not that I recall.
CHAYTOR, Q.C.:
Q. And Ms. Hennessey, Moira Hennessey, Mr. Tilley, Dr. Cook, yourself, and Dr. Williams, and there was a background given. Do you recall who spoke to that? Is that Mr. Tilley doing the talking, or was it mostly Dr. Williams?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. Issue of writing 400 patients who were testing negative, also reviewed that we would get

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

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DR. LAING:
A. No, I would have--my thinking at that time would have been still that it was a four to six week period.
CHAYTOR, Q.C.:
Q. So if there was discussion of six to eight weeks told to the Minister, you don't recall that or you didn't hear that, you were still thinking it's four to six weeks?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And if you had understood that it could be as much as eight weeks, would that have been enough for you to have pause to reflect and think, well, perhaps we should be telling the patients?
DR. LAING:
A. I would say probably not.
CHAYTOR, Q.C.:
Q. So how long would it--what would be the time period?
DR. LAING:
A. Oh, I don't know. I would have been thinking if it had been several months, but would that

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be, you know, 12 weeks maybe--I think it's a very arbitrary number.

CHAYTOR, Q.C.:

Q. And the point being because they might find out otherwise?

DR. LAING:

A. Right, so, you know--I guess looking back, you know, is this something that really, once you look at the numbers and the volume, could have been done in six to eight weeks, or seven to eight weeks, or four to six weeks, you know, looking back retrospectively, if you were to ask me that today, I would say, no, knowing what I know now, I don't think it could have been done during that time period. Some people have looked at me and said how could you think that this wasn't something that could, you know, be not public knowledge in this time period, I guess as I've said to you, trying to think about how I was thinking or what was going on at that time, my main focus was thinking about this as a medical oncologist, thinking about the number of people that would need to come back, and again just getting back to being able to disclose as

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much information to them at the same time. In addition to going to these meetings and doing all this stuff, I was continuing with a full busy practice, so, you know, I gave my opinions and didn't really sort of--knew that sometime soon, probably getting into October, that we would start to look at how we were going to deal with the results coming back and how we were going to deal with the changes and that sort of thing, and, you know, we'll get to how that unfolds over the next little while, but, you know, I think that once we had this meeting with the Minister, you know, I'm working away, the summer ends, you know, and it really--the next time that this becomes a very, very big issue for me is at the end of September.

CHAYTOR, Q.C.:

Q. Yes. Perhaps that's a good place, Commissioner, for us to take the break, and I'll come back to the rest of the exhibit.

(BREAK)

THE COMMISSIONER:

Q. Ms. Chaytor.

CHAYTOR, Q.C.:

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Q. Thank you, Commissioner. If I could have again, please, P-0138. This again are the notes that Dr. Williams took of the meeting of August 15th, 2005, with Minister Ottenheimer, and, Doctor, the next bullet in his notes says that, "Dr. Laing gave overview of the ER/PR testing, how things work in 2005 and how it has changed over the years. On retesting, a certain percentage will convert. How it impacts on therapy is an individual patient issue", and do you recall indicating to the Minister and the others that on retesting, a certain percentage will convert, and if so, what were you referring to?

DR. LAING:

A. I suspect that I was referring to our experience already, that we already had retested patients and that they had changed. The other thing that this may be in reference to was the false negatives, but I think it would have been stated in a different way had it been that. So I suspect that I was saying that, you know, based on our experience so far, we felt that once we did a larger review that we would have other patient cases in

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which we would have a new test results. In terms of giving an overview on ER/PR, I think that would have been more an overview, how we use that information, how it's used in the clinic. I'm not sure that I would have been the one who was speaking about how the testing is actually done. I suspect that that was done by Dr. Cook.

CHAYTOR, Q.C.:

Q. Okay. And then it goes on to say that "Dr. Laing says first samples for retesting biased, and also retested in Ventana system, therefore our problem, although undefined, at present may not be as bad as thought. Can't really have a value discussion until information available." Sorry.

THE COMMISSIONER:

Q. It's our Blue Tooth problem again. Don't worry about it.

CHAYTOR, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. I think.

CHAYTOR, Q.C.:

Q. Okay. "Will notify everyone who is retested.

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Doesn't feel now is the time to write the letter. Better to wait until we have more information." Now, Doctor, the first part of this paragraph where it says that "First samples for retesting biased." what would that be referring to?

DR. LAING:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. And do you recall saying something along those lines to the minister?

DR. LAING:

A. That the test results would be biased?

CHAYTOR, Q.C.:

Q. That the retesting was biased, the first samples for retesting biased?

DR. LAING:

A. The only thing that I can think it refers to is where the latter part of the sentence refers to the Ventana System that, you know, bringing up the issue about the lots of strong positives and the issue of going from false negative to false positive.

CHAYTOR, Q.C.:

Q. And could it be referring to it not--your

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first samples not being a random -

DR. LAING:

A. Oh, I know what you mean.

CHAYTOR, Q.C.:

Q. - sample, perhaps?

DR. LAING:

A. Okay. Yes, yes, perhaps that. Because these patients were chosen initially on being lobular and initially on being in the year 2002, related to the year of the index case that maybe I was suggesting that once we did a much wider sample, that although we did have some sampling from '97 to 2005 and did see some changes, that perhaps that on the retest of all those years that we would come up with different results.

CHAYTOR, Q.C.:

Q. And this is August 15th, however, the middle of August, and by then all three of the first batches had been retested, covering a broad spectrum of people, of patients?

DR. LAING:

A. Yes, we looked at -

CHAYTOR, Q.C.:

Q. And a broad time period, not just 2002?

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DR. LAING:

A. Right. So the middle was all 2002, the first had differing years and the latter part of the third, you recall we looked down through, there was some '02, some '05s, some late 1990s.

CHAYTOR, Q.C.:

Q. Yes. And by -

DR. LAING:

A. But I think if you were to look at all those three samples added together, that a large percentage of them were from 2002. That year, I guess what I would say is that that year was the most represented in that initial three sample sets.

CHAYTOR, Q.C.:

Q. And did you have any reason to suspect, by August 15th, 2005, that there was a problem with 2002?

DR. LAING:

A. No. I don't think anybody could have drawn that conclusion until we saw the test results from all the different years.

CHAYTOR, Q.C.:

Q. Okay. So the idea of the first samples for

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retesting being biased, is there anything else that you could have been thinking of or indicating?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. "And also retested on Ventana system, therefore our problem, although undefined at present, may not be as bad as thought." And do you recall indicating something along those lines to the minister?

DR. LAING:

A. No. I think this was a discussion about the fact that the Ventana system was giving a lot of very strongly positive results.

CHAYTOR, Q.C.:

Q. Did you have any reason to think that those weren't accurate results?

DR. LAING:

A. At that point we felt that we didn't want to, as I've said before, that we didn't want to run into a system where we were getting false positives. As a general overall feeling, did I think that there was a definite problem with the Ventana system, no. But again, embarking

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on a retest, we wanted to, number one, ensure that we could--if we were going to do this again, that we could get the most accurate results and if even there was a very slight concern about the Ventana system reading things as too positive, that would be a reason to go to an outside lab. And also, the issue of looking to another institution to do this, clearly I had treated patients based on the Ventana system, so it wasn't a concern of mine to the point that the people that I had seen and changed their treatment, I was relying on the Ventana system for the first few, until, of course, we had made that decision that we would wait for the Mount Sinai results before we did any more disclosures except for in a clinical instance where we wanted to be able to use that information immediately to treat the metastatic patients who needed treatment then.

CHAYTOR, Q.C.:

Q. And I'm just trying to understand what information you could be relying on to indicate--well, first of all, did you indicate to the minister that the problem may not be as

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bad as thought? If you did do that, what did you originally think and then what new information did you have to now be of the opinion by mid August that it may not be as bad?

DR. LAING:

A. Oh, I wouldn't have had any new information to know that it may not have been as bad. Again, just sort of thinking about how the first--I mean, we had tested a small sample size, if you will, of all the ER/PR testing that was done. And so really at that point because we had populated the first section of that with the lobular patients, that--and the second part was populated a lot with the people from the 2002 year, that, you know, maybe at the end of the day once we had tested all those years, all those eight years, that this, you know, this may not be, you know, 16 out of 25, you know, it may not be that high of a rate of change once we got the whole sample retested and the results back.

CHAYTOR, Q.C.:

Q. Even though your third batch was from a broad spectrum of years?

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DR. LAING:

A. Yes. But in that third batch you'd have to remind me of what the -

CHAYTOR, Q.C.:

Q. There were a number of 2002s, but at least of half of them were from others -

DR. LAING:

A. No, I mean the change, the change in results of that third batch. I'm not sure I can remember now.

CHAYTOR, Q.C.:

Q. I don't think there was a whole lot of difference between any of the three batches.

DR. LAING:

A. Between those and the--yes, yeah. No, this was the only thing was, you know, saying that at the end of the day once we retest everybody, then this may not--the change rate may not be as high as what we've seen in this first selection, be it some of them were randomly chosen and some of them were chosen for specific clinical reasons.

CHAYTOR, Q.C.:

Q. Okay. And you indicate that you will notify everyone who is retested. So I take it the

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plan was that regardless of outcome, every patient would be informed?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. "Doesn't feel now is the time to write the letter." And I take it that's referring to the patient letter?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And the minister is indicated to say, "If people advised as soon as possible, then patients can do what he or she wishes to deal with the issues." Do you remember the minister raising this issue, that if the people, if the patients were advised up front, then they can take the information and make their own decisions as to how they wish to deal with the issue?

DR. LAING:

A. I don't recall what exactly he said at that time.

CHAYTOR, Q.C.:

Q. And do you--well, what do you recall in terms

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of what was the minister saying, was this a situation where the minister was of one point of view and that you were trying to convince him otherwise or was this a situation where you basically just went in, presented what you had to say and there was a consensus?

DR. LAING:

A. This was more the latter. However, I believe that there was discussion after I had left as to what ultimately the decision would be made to do. In other words, I came, I was asked to present to the minister similar to what I had done a few days before to the team at Eastern Health and I communicated that to him in the same way. The discussion that ensured between the minister was very brief. I don't remember somebody saying, I don't agree with you, I think that's not the way we should do it. It was more I came, gave my opinion, they thanked me and I left and I think that, you know, that the--that I'm sure that the minister went away afterwards and thought more about what I had said and you know, but -

CHAYTOR, Q.C.:

Q. But these are notes taken by -

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DR. LAING:

A. They're notes, that's right.

CHAYTOR, Q.C.:

Q. - Dr. Williams.

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And it appears to be notes of the full group. And this comment about the minister is in between two different comments that he attributes to you. So it would appear, if Dr. Williams is taking his notes in order of what's happening, that you would still be present if the minister made such a comment and the idea of the minister expressing, well, let's let people know or what about telling people so they can decide for themselves, you don't recall the minister saying that?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Or anything along those lines?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

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Q. Okay. And what do you think of that idea, letting people make an informed decision and decide for themselves?

DR. LAING:

A. I think that going back to how I was feeling at this time my decision was based on my views then, that I felt that we should go to the patients when they had as much information as we could give them to say, you know, what their test results were and if they change, what we were going to do about it. So my, the things that we talked about earlier were the same opinion that I expressed. I can only think back to that time and recall that there didn't seem to be any great opposition that I can remember as to my views and that, you know, it goes on to say "The minister will accept the advice for now."

CHAYTOR, Q.C.:

Q. "Best advice for now."

DR. LAING:

A. I'm not--know what the for now means in Dr. Williams' notes. And it says that he wishes to meet again within the next two weeks. I was not asked to meet with the minister on

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this issue again in the ensuing two weeks. And it talks about developing what would go in a letter in the meantime, so it sounds as if the minister still, you know, that there was still some discussion about having a letter there for whenever a decision may or may not be made to send that letter.

CHAYTOR, Q.C.:

Q. Yes. So the idea, though, of having patients informed and then if the patients, for example, should decide, well they want to take matters into their own hands, perhaps have their retesting take place somewhere else, or doing, you know, speeding the process up for themselves, that idea, was that ever--was that a thought that ever came to you or was that anything that was ever discussed?

DR. LAING:

A. Not that I recall.

CHAYTOR, Q.C.:

Q. And then you also are noted here to have advised that "Dr. McCarthy, Dr. Ganguly agree with waiting to send something out until we have more information."

DR. LAING:

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A. Okay.
CHAYTOR, Q.C.:
Q. Okay. So do you recall advising the minister and the others that Dr. McCarthy and Dr. Ganguly agreed with waiting?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And did you advise them that others, in fact, other oncologists had been consulted other than Dr. McCarthy and Dr. Ganguly?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. But it's just Dr. McCarthy and Dr. Ganguly's names that appear here. You would have said -
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. - other oncologists?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And "The minister will accept best

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advise for now." As you've already pointed out.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Did you tell the minister that you had no experience in dealing with disclosure issues in this context or in such a situation?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And why not?
DR. LAING:
A. It wasn't something that was asked and really wasn't something that I thought to bring forth at the time.
CHAYTOR, Q.C.:
Q. And again, it says, "He wishes to meet again" and you were not invited, you said, to meet subsequently with the minister on the issue. And "Will develop what should go in a letter in meantime." So at the end of this meeting where did you understand things had been left?
DR. LAING:
A. That a final decision would be made and that I

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would hear back if they wanted to discuss this issue with me again. And the fact that it says that there was a letter that was going to be developed, I took that to mean that, you know, maybe sometime in the ensuing weeks that a decision to send a letter would be made and so people, I guess, felt that it was--if that was going to happen, that perhaps one should be started. I guess that that's what that means. I don't have any strong recollection of that at the time.
CHAYTOR, Q.C.:
Q. Do you remember a letter being discussed at all, and a letter to whom?
DR. LAING:
A. We were talking about a letter to the patients.
CHAYTOR, Q.C.:
Q. So that was discussed?
DR. LAING:
A. Yes. That's what this--yes.
CHAYTOR, Q.C.:
Q. Okay. So that when it was left that there would still be a letter drafted to the patients?

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And was the intent that this letter would be to advise them that the retesting was happening?
DR. LAING:
A. I would think, yes, yeah. Because this was still the issue that we were discussing.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:
A. This was before there was results coming back and all that.
CHAYTOR, Q.C.:
Q. Okay. So I just want to be clear, at the end of the meeting then on August 15th there had not been a decision reached, no decision had been reached as to not telling patients that the retesting was happening and, in fact, the plan was to go away and draft a letter?
DR. LAING:
A. No, no, I think that the decision was made that we would not send a letter at this time.
CHAYTOR, Q.C.:

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Q. Yes.
DR. LAING:
A. And that--but I guess there was some discussion that should that opinion change for whatever reason over the next little while, that a letter would at least be drafted, I suspect not dissimilar to the drafts we saw for press releases and things that were never sent. But that contributing to the writing of such a letter was not something that I had been asked to do at that particular meeting.
CHAYTOR, Q.C.:
Q. At this meeting, yes.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And we saw earlier, it appears, that you may have had some input according to Ms. Predham's e-mail, into a draft of a letter for patients?
DR. LAING:
A. But not one that I had ever seen or written on or sent back or replied in e-mail to or anything like that, no.
CHAYTOR, Q.C.:
Q. Anything like that. So at the end of this

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meeting, on August 15th, the decision was that patients hold off on telling patients for now?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. But we'll work on a letter that can be written to them informing them that the retesting is taking place and we'll be back to touch base with the minister in two weeks? So was that the status at the end of this meeting on August 15th?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And what factors, what would cause the decision to be revisited and then for the letter to go to the patient, what would cause the opinion to change?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. Did you understand that--then you said that you presented. And did you then leave the meeting or did you leave the meeting at the same time as the other representatives from

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Eastern Health?
DR. LAING:
A. It's hard for me to remember. I would think that we would have all left at the same time. Now, whether the minister and his staff stayed afterwards and had further discussions, I don't know.
CHAYTOR, Q.C.:
Q. Was there any discussion as to public disclosure in this meeting?
DR. LAING:
A. Not that I recall.
CHAYTOR, Q.C.:
Q. Were you ever present with government officials when the issue of public disclosure was discussed or did you have any discussions at any time with anyone from the department on the issue of public disclosure?
DR. LAING:
A. At this time, no.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. You said at this time, no. Does that mean at some subsequent date you did?

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DR. LAING:
A. Have a meeting with government officials about public disclosure?
THE COMMISSIONER:
Q. Did you discuss public disclosure with government officials, yeah.
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Doctor, given that a number of patients already knew and the other factors that we discussed earlier in terms of the support network amongst breast cancer patients within the province, were you at all concerned that it was only a matter of time that this would become a public issue?
DR. LAING:
A. When I think back to that time, that wasn't something that had crossed my mind, no.
CHAYTOR, Q.C.:
Q. So the idea of as time went on and if it were going to be a protracted period of time that patients should be informed, your thinking on that wasn't because, well, the longer it goes on, the more likely it is to come out or leak

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out or -
DR. LAING:
A. Right, right. So again, the main reason why I made this decision, I think I've stated, in terms of it taking a long time, then, yes, that would have been something that I certainly would have considered, particularly as the time went on. But really, before I can honestly say I gave that a whole lot of thought, it happened.
CHAYTOR, Q.C.:
Q. And was there any plan in place when it happened, was there any plan in place for the eventuality that patients would learn about it indirectly?
DR. LAING:
A. The only plan that I can assume was what you have shown me today about the draft media releases, but I was not asked to contribute to those. And I myself did not have any specific plans to deal with that should it arise. And in fact, the first time I was asked to speak about this in the media, I certainly was not prepared or didn't have anything ahead of time to assist in that.

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CHAYTOR, Q.C.:
Q. Okay. And we'll talk about that in a moment.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And if we could then have P-0588, please? And I take it the meeting with the minister in espousing the view that you put forward, you were speaking on behalf of whom?
DR. LAING:
A. Sorry?
CHAYTOR, Q.C.:
Q. In the meeting -
DR. LAING:
A. I'm sorry, I was -
CHAYTOR, Q.C.:
Q. Okay. It's been a long day. And the meeting -
DR. LAING:
A. I know. So the meeting, okay.
CHAYTOR, Q.C.:
Q. - with the minister on August 15th, the view that you put forward, you were speaking on behalf of whom?
DR. LAING:

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A. The oncologists.
CHAYTOR, Q.C.:
Q. The oncologists. And were you also speaking on behalf of Eastern Health?
DR. LAING:
A. At that time, no.
CHAYTOR, Q.C.:
Q. Okay. And who in the room was speaking on behalf of Eastern Health?
DR. LAING:
A. Dr. Williams.
CHAYTOR, Q.C.:
Q. Okay. And did Dr. Williams agree with the position you put forward?
DR. LAING:
A. My recollection was yes.
CHAYTOR, Q.C.:
Q. Did Dr. Williams ever indicate to you that he didn't agree with your view on the disclosure issue?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Doctor, P-0588 is an agenda for a meeting on September 1st, 2005, the senior management of

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the Cancer, still referred to at this point in time, the Newfoundland Cancer Treatment and Research Foundation. And including on the agenda for September 1st under "Business arising" is "ER/PR testing." And would you be the person who would speak to that issue with respect to the management? If we look at who attended -
DR. LAING:
A. This is the minutes.
CHAYTOR, Q.C.:
Q. September 1st.
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Paul Gardiner is chairing, Andrea Avery, Dr. Ganguly, yourself, Pat Pilgrim, Chris Power and Diane Smith.
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. So in that group of people who would be speaking to the ER/PR issue?
DR. LAING:
A. It would be both Dr. Gardiner and I. Prior to

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this meeting, as you can see, if you go back to the minutes, ER/PR was actually a business arising item, so this item had already been discussed at senior management on July 28th, 2005 and I was not present at that meeting, but as it indicates here, I was present at this one. And -

CHAYTOR, Q.C.:

Q. And do you recall speaking to the issue on this date?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. I believe on the top of the next page, page 3, we have "ER/PR testing. Members were informed this item has gone to the Department of Health and Community Services." And so I guess you would have been the person to advise of that, having attended the meeting?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. "Slides and blocks are being reviewed externally." And did you understand that slides and blocks were being reviewed

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externally?

DR. LAING:

A. Sorry, the slides?

CHAYTOR, Q.C.:

Q. "Slides and blocks are being reviewed externally."

DR. LAING:

A. They would have sent slides.

CHAYTOR, Q.C.:

Q. Okay. What was your understanding what was being sent to Mount Sinai?

DR. LAING:

A. Not being a pathologist, I would have thought that it would be slides. I wasn't sure if they sent blocks, as well. I think a pathologist could answer that better.

CHAYTOR, Q.C.:

Q. Okay. So you don't know?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. To this day you don't know what they sent to Mount Sinai?

DR. LAING:

A. No.

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CHAYTOR, Q.C.:

Q. Okay. "Currently waiting for reanalysed results of blocks relating to ER/PR testing."

DR. LAING:

A. I should say no, that my understanding is was that it was slides which are made from the blocks and that they would--because there was some discussion about sending representative slides. Why this would say slides and blocks at that time, maybe simply that that was my understanding at the time or it may have been Dr. Gardiner who said that or -

CHAYTOR, Q.C.:

Q. But your understanding was and up to today was that it was just slides that was sent?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. The original slides that were made here in St. John's were what were sent to Mount Sinai?

DR. LAING:

A. That would be my understanding, yeah.

CHAYTOR, Q.C.:

Q. So in giving advice on the issue of disclosure did you understand that patient samples of the

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patient's tissue would be sent to Mount Sinai, Mount Sinai would actually make their own slides using the patient's tissue, make their own slides and rerun the tests entirely?

DR. LAING:

A. I don't think I ever got into that sort of detail about how that would happen. That would be something that would have been arranged and discussed between Dr. Cook and--as a pathologist, I honestly, I've never been in a lab, I don't know exactly what it is that they sent or would send or what someone would need or anything like that. My only sort of recollection would have been, of course, listening to the pathologists discuss this and at times they were asked to send different pieces of the patients' tissue, if you will, particularly when there came into question whether or not what had been sent to them was representative and the issues regarding DCIS, etcetera.

CHAYTOR, Q.C.:

Q. And does that make any difference to you if it was just the slide that's already made up or if it's an actual block with the patient's

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tissue in it, does it matter to you in terms of your views on disclosure in terms of informing the patient beforehand?

DR. LAING:

A. Makes no difference whatsoever.

CHAYTOR, Q.C.:

Q. No difference to you?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay. "Currently waiting for reanalysed results of blocks relating to ER/PR testing."

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. So it refers to the blocks in the next sentence. "There are some patients coming forward with concerns." So at this point in time, September 1st, 2005 you were aware that some patients had already come forward with concerns?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. And did that concern you, that there

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are already patients out there who have now heard about this and have come forward and voiced concerns?

DR. LAING:

A. Actually, my recollection of that statement was that it was related to someone who had already had retesting done and had already had disclosure of that to them.

CHAYTOR, Q.C.:

Q. So one person as opposed to some patients?

DR. LAING:

A. My recollection of an incident was related to a patient and her family.

CHAYTOR, Q.C.:

Q. And what was that patient's concerns?

DR. LAING:

A. That this was a patient whose test results had changed and that they had concerns about that in terms of, you know, what it had meant for their treatments and for their disease and those issues.

CHAYTOR, Q.C.:

Q. So the next time these minutes are reviewed and it says "some patients coming forward with concerns," and it's done obviously in the

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plural, were the minutes revised or did you point out, no, this was only--what patients, I only know of one patient?

DR. LAING:

A. Well, no, I'm only speaking to this--you know, there were other people present at this meeting. I'm only trying to think back to that time as to what this particular item may have meant. And I can recall that we did have some discussions regarding this particular patient and her family and the concerns that they had expressed. Whether or not there were other ones, I can't recall at this exact moment what those specific instances would be, so I really can't shed any more light on that statement.

CHAYTOR, Q.C.:

Q. Okay. So if they were discussed, that patients, more than one patient and patients were coming forward with concerns, do you recall anything about that, about patients who had not yet been retested -

DR. LAING:

A. No, that's not -

CHAYTOR, Q.C.:

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Q. - coming forward?

DR. LAING:

A. My recollection of this wasn't that--wasn't, you know, the point that we discussed earlier that there may be patients sitting in the waiting room next to somebody else, it wasn't in that context. I remembered it to be in the context of people who had already had been disclosed to.

CHAYTOR, Q.C.:

Q. Okay. And they were expressing concerns?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And do you recall who were they expressing their concerns to?

DR. LAING:

A. The particular patient that I am referring to had expressed their concerns to Dr. McCarthy and she subsequently had discussed that with me.

CHAYTOR, Q.C.:

Q. Okay. And what were the concerns?

DR. LAING:

A. As I said, you know, the family was concerned

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about what this had meant. The family and the patient were saying that they were concerned because they had had a new test result come back, what did this mean, was her diagnosis correct, you know, similar to the types of concerns that we've heard from others through this whole process.

CHAYTOR, Q.C.:

Q. The next sentence says that "The Department, the Department of Health and Community Services have" should be has, I guess, "delayed a public announcement on this item." Did you advise the senior management of that?

DR. LAING:

A. I suspect this refers to the delay in a letter to the patients. I wouldn't have considered it to be a public announcement, but more of a letter for patient disclosure.

CHAYTOR, Q.C.:

Q. Okay. And in sofar as this says "delayed a public announcement on this item", did you have any discussions or any knowledge as to any public announcement that may have been contemplated that the department delayed?

DR. LAING:

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A. No.

CHAYTOR, Q.C.:

Q. And is it correct to say that it was the department that delayed any announcement on this item?

DR. LAING:

A. It was ultimately my understanding that it was their decision about whether or not to go forth with a patient letter at that time.

CHAYTOR, Q.C.:

Q. So, Doctor, from what I've understood, you had no discussions around any public disclosure on the issue, your discussions with the department concerned patient disclosure?

DR. LAING:

A. That's correct. (phonetic)

CHAYTOR, Q.C.:

Q. And would there be any reason why the minutes wouldn't reflect that, that there had been a meeting with the department, that you had put forward your views, speaking as an oncologist?

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. And that a decision had been made to delay

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patient notification?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Wouldn't that be more accurate?

DR. LAING:

A. That would be more accurate. Whether or not there was something that Dr. Gardiner had said or whether or not he, as the medical director, had had any dealings, I'm not certain. But I would suspect, although, that if he had had some discussions about the possibility of a public announcement that maybe he had been aware of the sample media release that we had seen, because I wasn't, I wasn't contacted about that, so whether he had been in those early days. But I don't recall that when I think back to this meeting or the minutes.

CHAYTOR, Q.C.:

Q. And do you have any reason to believe that the Department of Health were even aware of those media releases, those draft media releases?

DR. LAING:

A. Oh, I have no idea, no idea.

CHAYTOR, Q.C.:

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Q. Okay. So what do you recall then of this issue at the meeting, do you recall Dr. Gardiner speaking to the issue of the department having delayed a public announcement?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay.

DR. LAING:

A. I don't recall that.

CHAYTOR, Q.C.:

Q. And do you recall who spoke to that issue, was this something you would have said?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. You didn't say this?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And you don't know if Dr. Gardiner said it or not?

DR. LAING:

A. No, I don't know.

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CHAYTOR, Q.C.:
Q. And do you have any idea what it could be-- what that could mean?
DR. LAING:
A. The only thing that I can think that it means was that there was a decision made not to send the letters to the patients and whether that was referred to as a public announcement versus patient letters, I'm not sure. I'm not sure if the person recording the minutes, you know, put it down as a public announcement versus disclosure to patients, I really, I'm not certain.
CHAYTOR, Q.C.:
Q. Okay. And, Doctor, then we know that, of course, the issue does become a matter of public discussion.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And there's a story in the Independent on October 2nd, 2005.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:

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Q. And you're quoted in that story as having participated. Perhaps you could tell us how that came about and -
DR. LAING:
A. Certainly.
CHAYTOR, Q.C.:
Q. - why you participated in the story and how you felt the interview went?
DR. LAING:
A. I certainly can. So there are some things that you remember more vividly than others than your life and this is one of those instances of something that I remember quite well and I suspect it was because of the circumstances surrounding this interview. On that Thursday and Friday, which would have been September 30th and October 1st I was attending a meeting in Toronto with some colleagues of mine across the country discussing the treatment approaches for metastatic breast cancer. It was a meeting funded by a pharmaceutical company, during that meeting. So on the Friday of that meeting, somebody from the hotel where we were having the meeting came in and interrupted and

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said "is there a Dr. Kara Laing here?" and said that there was an emergency telephone call. So I managed to make it to the phone and it was Dr. Williams' office on the other end of the line, and he had called and found out where I was and tracked me down to the hotel and asked if they would interrupt because he had had a request at that time for a media interview.

He said that he felt that it would be good if somebody from the clinical point of view would be able to speak to the reporter who had gotten some information about an issue regarding breast cancer. I think in the beginning it was screening and a problem with mammography units and all sorts of different takes on how--you know, what this little signal that they got that there may be an issue came about, and asked if I would do an interview on the telephone with a reporter from The Independent. My first response was no. You know, I'm here in Toronto in the middle of a meeting and you're down there and, you know, do you think that this is something that could wait until a) I got home, and b) I

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would have some time to sit down with--as we usually do with media preparation, to meet with our media relations people.

The impression that I got from Dr. Williams was that The Independent was keen to run this story and that, you know, really they wanted the interview today. So after some back and forthing, I said okay. So Dr. Williams connected me with the reporter and I had--I did the interview over the telephone. I spoke to Dr. Williams at the end of the interview and indicated to him that I felt that this was something that was likely going to be in the paper, knowing that The Independent comes out on Saturdays, and I said, you know, "I'm going back to my meeting in Toronto. I'm flying home, so I'll leave that with you."

So that was the sort of story around how all that happened. In terms of the actual interview, up to this point, I had never done a media interview that wasn't for a good reason, if you will. You know, I had done things related to announcements for new projects or new fundings or new research

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opportunities and that sort of thing, so you know, I spoke with the reporter. I said to her, you know, "it would be great if you could wait until I got home and I'd certainly be happy to sit down and talk to you about this," but she indicated to me that again, as I've said, that she was keen on running this story. I had told her about the fact that we had done--already had done some retesting, that there were some changes in results, and that you know, we were waiting for this larger retest to happen, and that we were waiting to inform the patients once we knew more information, and I was concerned that by printing such a story, that this was indeed how people were going to find out about this issue, and I was very concerned about what impact that was going to have, not only on breast cancer patients, but on anybody who was going to pick up this paper the next day and read it. But she wasn't interested in listening to my concerns.

CHAYTOR, Q.C.:

Q. At what point after in your discussions with her did you inform her of that concern and

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that the patients didn't already know?

DR. LAING:

A. Oh, right from the very beginning.

CHAYTOR, Q.C.:

Q. So before you spoke to her and told her anything which you've just told us about the retesting and all that, at the very beginning, you spoke to her and told her you were concerned -

DR. LAING:

A. About this being put out in such a way that would cause concern amongst patients.

CHAYTOR, Q.C.:

Q. That the patients had not been informed?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And did you tell her that you would prefer that the story not run until you've had an opportunity to contact your patients?

DR. LAING:

A. Absolutely, yes.

CHAYTOR, Q.C.:

Q. And you said that to the reporter?

DR. LAING:

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A. Yes.

CHAYTOR, Q.C.:

Q. And what was her response?

DR. LAING:

A. She wasn't interested in that. She said "I'm running this story tomorrow."

CHAYTOR, Q.C.:

Q. And what story did she have to run if you hadn't told her anything?

DR. LAING:

A. She already had some--you know, it was clear that she did already have some information. She knew that there was a problem with testing, and -

CHAYTOR, Q.C.:

Q. Did she think it was a problem with the mammogram machine? Was that what she thought the problem was, do you know?

DR. LAING:

A. In the -

CHAYTOR, Q.C.:

Q. Or had Susan Bonnell already spoken to her before you?

DR. LAING:

A. I think at this point they had already sort of

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had a little bit of a better idea of what was going on. I didn't have to clarify that point with her.

CHAYTOR, Q.C.:

Q. So she knew there was a problem with the hormone receptor testing?

DR. LAING:

A. ER/PR testing, yeah, and one of the things that she wanted to know was how we utilized the test. So you know, I went over that with her, and some of that came out in the article, and how big of a problem I thought this was, and I believe that there were numbers quoted, and I'm not sure if they were numbers that were given to her by me or by somebody else at Eastern Health. I think I talked about the 16 out of 25 as the--well, I was thinking about sort of the first group, because that was the numbers that I could always remember, as opposed to the 32 or 33 in the second one, and I can't even still remember what the number was in the third one, and that I had said, you know, this is--we're waiting for the results. We don't know how big of a problem this is going to be. We don't want patients to panic,

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you know, and that's really what I can remember as being what we discussed during that interview. I remember ending the interview upset, not content, if you will, that this is how things had played out. But you know, there we were, and -

CHAYTOR, Q.C.:

Q. And why were you upset?

DR. LAING:

A. Because it was very difficult to do such an interview, you know, on the telephone with somebody who I felt was not necessarily listening to all the things that I was saying.

CHAYTOR, Q.C.:

Q. And I take it you knew, by the time you finished the interview, this was not the ideal way for this story to come out?

DR. LAING:

A. Absolutely not, no, and that was -

CHAYTOR, Q.C.:

Q. Or for your patients, more importantly for your patients to learn about this.

DR. LAING:

A. That's what was so very upsetting to me. So here I am, far away. You know, I couldn't go

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down the hall and have a conversation with Dr. Williams and have any sort of way to deal with that. I had to leave that and go back to the meeting that I was attending and, you know, I did have the support of my fellow Canadian oncologists who happened to be at this meeting, who by the time I had been gone out of the room for an hour, had no idea what had happened to me, but you know, it was a very disconcerting, upsetting experience for me, for sure.

CHAYTOR, Q.C.:

Q. And when you spoke, when you took the call originally from Dr. Williams -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - did you express concern to Dr. Williams that you didn't think that you should be participating in any story on the issue at that point in time? Did you express concern to him about the fact that the patients didn't yet know?

DR. LAING:

A. Yes, my first words to him were, you know, "I

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think this is--you know, I'm not there. This is going to be difficult to do over the telephone. The patients don't know. What are we going to do? And I don't really think this should come from me. I think somebody who's there on the ground should be doing this." And he said, you know, "please, can you do it? We'd really like to have somebody from the clinical aspect speak to this reporter." And so I said yes, I would do it. I mean, ultimately I did make that decision to agree to do it.

CHAYTOR, Q.C.:

Q. And why wouldn't Dr. Williams do the interview himself?

DR. LAING:

A. He felt that somebody who had a better knowledge of the use of this test in the clinic, somebody who was involved in the care of breast cancer patients may be the better person to speak to such an issue, to explain, you know, how this testing is used. Although as you know, I had, on several different occasions, discussed this with Dr. Williams, I think he felt more comfortable that, you know,

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someone who was saying, you know, "this is a predictive test. We use it in the clinic. It helps us to determine treatment," that that would be better coming from somebody with my background than his.

CHAYTOR, Q.C.:

Q. And you say you called Dr. Williams back after the interview?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. To advise him that you thought the reporter would be running with the story?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. That weekend, and it came out, I believe, that Sunday. Did you urge Dr. Williams to initiate any kind of process to attempt to start notifying the patients affected?

DR. LAING:

A. No. What I had said to Dr. Williams was--you know, I hung up from the reporter. He had asked if I would touch base with him again. It was actually his office who kind of

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connected me through to the reporter, and he said "when you're finished the call, could you touch base with me again?" and I did, and all I recall saying to him was, you know, "I'm here in Toronto, as you know. I'm going back into my meeting, and I'll leave this in your hands, but my impression is the story is going to run this weekend."

CHAYTOR, Q.C.:

Q. And you participated in this story on Friday, is that correct?

DR. LAING:

A. Yes, it was the Friday of that -

CHAYTOR, Q.C.:

Q. Okay, and what time in the day?

DR. LAING:

A. Oh, I'd say it was in the--I know it was before we broke for lunch. So I think it was probably around lunch time Newfoundland time. I was an hour and a half ahead in Toronto, because I remember just as I got back to the meeting where I was in Toronto, it was just before we had a lunch break, and of course, everybody at the meeting came up to me at lunch and said, you know, "what went on? Is

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everything okay at home?" because I sort of, you know, left as an emergency and it was sometime before I came back, so I do recall that.

CHAYTOR, Q.C.:

Q. And you called Dr. Williams back, I take it immediately after the interview?

DR. LAING:

A. Right, before I went back into the meeting.

CHAYTOR, Q.C.:

Q. And Doctor, why didn't you ask Dr. Williams when you called him back, around midday on Friday, to start to initiate a process by which the patients could be contacted?

DR. LAING:

A. I didn't--that wasn't something that crossed my mind at the time. I assumed that that was something that the team back in St. John's would be dealing with.

CHAYTOR, Q.C.:

Q. Well, were you concerned that that happened, that the patients be told that--perhaps phone calls could start to be made within the next hours or day and a half that patients could be, at least a significant portion of them

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could be contacted?

DR. LAING:

A. I don't recall having had any conversations regarding that at that time, no.

CHAYTOR, Q.C.:

Q. Do you know if there was even a plan in place which would have enabled that to happen in an expedited manner, that there may have been a list of patients names and numbers ready to go?

DR. LAING:

A. Not that I was aware of at all.

CHAYTOR, Q.C.:

Q. Okay. And so Doctor, did you ultimately then read the article when you returned to the province?

DR. LAING:

A. I did.

CHAYTOR, Q.C.:

Q. And what did you think of the article?

DR. LAING:

A. I thought that there was items that were placed in the article as direct quotes from me that I didn't recall as having said. To me, a direct quote should be something that is

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verbatim from the person that you're interviewing and other than that, you know, say Dr. Laing said that there was a process underway, but there were things that were put in quotation marks in that article that were not things that I had recalled saying to this reporter. I did subscribe to The Independent and continued to do so until recently, and so it was in my mail box, and it's funny the things that you remember, but I remember my Mom calling me and saying that she heard that there was a story about me in the paper, and I told her to sit down, and because this was a different situation than previously.

CHAYTOR, Q.C.:

Q. And in fact, Doctor, you gave a--you participated in an article with this same reporter on this issue at a later date?

DR. LAING:

A. I did, yeah.

CHAYTOR, Q.C.:

Q. Doctor, did you have any discussions with Susan Bonnell before you participated in the interview with Clare-Marie Gosse?

DR. LAING:

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A. On that day in October?
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. No, I didn't.
CHAYTOR, Q.C.:
Q. And I think the day was actually September 30th, wasn't it? September 30th?
DR. LAING:
A. Yes, sorry, because the Friday would be September 30th. So the Saturday would be the--I'm sorry, yes. No, no, I hadn't spoken to any -
CHAYTOR, Q.C.:
Q. Just Dr. Williams?
DR. LAING:
A. Yeah. Now prior to this issue, I had met Susan Bonnell. This was in 2005, so in the--you know, as we were still the NCTRF, she wasn't someone who I had had a lot of dealings with, in terms of media prior because the NCTRF had its own separate media relations people that were different than Eastern Health's. So I had--although I had met her, and subsequently came to know her quite well

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through this process, she wasn't someone that I had dealt with on media issues before. Before when we did press releases and different things, yes, we would have had some media contact and some pre-planned idea of what people would say. But again, most of those were around things like, you know, positive stories, in terms of new initiatives within the program or, you know, announcements of funding and various things like that. So, but no, prior to that day, to talking to the reporter, the only person that I had talked to was -
CHAYTOR, Q.C.:
Q. And so the only person you had talked to was Dr. Williams?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and I take it there was no media person--was there still a media relations person with the Cancer Centre at this point in time?
DR. LAING:
A. I'm not sure. That was somebody that we had on a contractual basis, so whether or not we had now sort of switched over to using Eastern Health's media personnel, I'm not certain.
CHAYTOR, Q.C.:
Q. You never consulted any media relation person at any point in time on the issue other than Ms. Bonnell and her team?
DR. LAING:
A. Prior to this interview?
CHAYTOR, Q.C.:
Q. At any point, yes.
DR. LAING:
A. Or at any point regarding -
CHAYTOR, Q.C.:
Q. Any point?
DR. LAING:
A. No, no, no. So no, I didn't -
CHAYTOR, Q.C.:
Q. So the media relations people that were on -
DR. LAING:
A. Always -
CHAYTOR, Q.C.:
Q. - contract for the Cancer Centre, to your knowledge, were not involved in this issue?
DR. LAING:
A. No, were never involved with ER/PR, that's

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correct.
CHAYTOR, Q.C.:
Q. Okay. If we could please have P-0086? And this is a copy of the article that ran on October 2nd in The Independent, and it's called "Questionable results: Breast cancer treatments in St. John's impacted by inaccurate lab tests," Clare-Marie Gosse. I'm just going to take you through parts of this, Doctor, and ask you to comment, and if you have any issue with what's being said and perhaps along the way, you can point out the places that you take exception to where you're quoted.
DR. LAING:
A. Okay.
CHAYTOR, Q.C.:
Q. And--I didn't do that, right? Okay, that's better. Thank you.
DR. LAING:
A. I don't have my mouse because if it would be easier if I went through it?
CHAYTOR, Q.C.:
Q. You don't have a mouse now at all?
DR. LAING:

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A. I don't know what happened to it.
CHAYTOR, Q.C.:
Q. Okay. I'll scroll down.
DR. LAING:
A. That's okay.
CHAYTOR, Q.C.:
Q. I think we're having -
THE COMMISSIONER:
Q. The mice are not working, are they?
CHAYTOR, Q.C.:
Q. - problem with that.
DR. LAING:
A. Oh, okay.
THE REGISTRAR:
Q. They're still working on this.
DR. LAING:
A. Okay, fair enough, all right.
CHAYTOR, Q.C.:
Q. So I'll take you down, but if there's anything I skip over, by all means tell me.
DR. LAING:
A. Okay.
CHAYTOR, Q.C.:
Q. Tell me to stop. It says here that "Kara Laing, Director of Medical Oncology with the

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Health Care Corporation of St. John's says patients have been contacted recently on an individual basis as test results become available." So the idea that "patients have been contacted on an individual basis as test results become available," is that an accurate statement of what you would have told her?
DR. LAING:
A. Yes. The only thing that's not accurate in there is that it wasn't the Health Care Corporation of St. John's, but that's understandable.
CHAYTOR, Q.C.:
Q. Okay. Go back to the paragraph before. "The test samples are being reassessed at the Health Sciences Centre, as well as the Mount Sinai Hospital in Ontario. The results are only now returning since the retesting began in May of this year." So let's go with "the test samples are being reassessed at the Health Science Centre, as well as Mount Sinai." Were the test samples being reassessed at both the Health Sciences and Mount Sinai?
DR. LAING:

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A. No. I mean, I think this is speaking to what we had already known, that the first retesting was done on the Ventana system, and then a decision was made to send the test results to Mount Sinai Hospital.
CHAYTOR, Q.C.:
Q. Would you have told that to Clare-Marie Gosse?
DR. LAING:
A. No, I think that was something that she would have already known.
CHAYTOR, Q.C.:
Q. She would have gotten that from somewhere else?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And the fact that the test--not meaning that the test samples are being reassessed at both, both places are doing the same testing on the same samples, there was no discussion along those lines with the reporter?
DR. LAING:
A. Oh no, no, no, not at all.
CHAYTOR, Q.C.:
Q. "The results are only now returning since the

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retesting began in May this year." Doctor, did you have any results back on October 2nd, 2005 from Mount Sinai?
DR. LAING:
A. Not that I know of, no.
CHAYTOR, Q.C.:
Q. Did you tell this to the reporter?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Do you know whether or not anyone at Eastern Health told her that?
DR. LAING:
A. No, I don't know. I don't know where that information came from.
CHAYTOR, Q.C.:
Q. And "since the retesting began in May this year," did you tell the reporter when the retesting began?
DR. LAING:
A. Not that I recall, because I think if I had have said that, I probably would have said April, just thinking back to the index case, but -
CHAYTOR, Q.C.:

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Q. So you would have said April, if she was referring to the index case?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And you don't know where the May would have come from?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And in terms of the test samples being reassessed at Mount Sinai, the index case never went to Mount Sinai, and "the results only coming back since the retesting began in May," the idea that someone could read that and understand that the retests to Mount Sinai began in May, do you know where that information would have come from?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Did you have any discussion with her as to how long the retesting to Mount Sinai had begun, when that had actually initiated?
DR. LAING:

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A. Not that I can recall, and if I had have told her then I would have said that the decision was made to retest at Mount Sinai in August of 2005.
CHAYTOR, Q.C.:
Q. Okay. "Kara Laing, Director of Medical Oncology with the Health Care Corporation St. John's, says patients have been contacted recently on an individual basis as test results become available." And the only issue you had with that was that the Health Care Corporation should in fact be Eastern Health. What patients had recently been contacted on an individual basis as the test results became available?
DR. LAING:
A. So I was talking about the people that we had already disclosed to.
CHAYTOR, Q.C.:
Q. The people that you had disclosed to when?
DR. LAING:
A. Through the index case, the people that we had retested, the metastatic patients.
CHAYTOR, Q.C.:
Q. So the index patient who was told in April?

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DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And this is October.
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. The metastatic, the first few people?
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And the people retested in June?
DR. LAING:
A. And anybody else who we had done--because remember we talked then about that there were still some patients who, up until we stopped--so really it would have been maybe through to even July, would have been, you know, the patient from August whose result went to Mount Sinai through that sort of convoluted way, by the HER2 testing. So I would have been talking about -
CHAYTOR, Q.C.:
Q. There was one patient.
DR. LAING:

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A. Yeah, I would have been talking about that group of patients.
CHAYTOR, Q.C.:
Q. That was August, the one--the patient who -
DR. LAING:
A. Yeah, so I would have been talking -
CHAYTOR, Q.C.:
Q. - was inadvertently tested at Mount Sinai in August?
DR. LAING:
A. Yeah, so I would have been talking about the patients that we have already discussed who were the ones that had the early disclosure.
THE COMMISSIONER:
Q. All of whom had been, except for the one that was retested -
DR. LAING:
A. Yeah, who had been retested in -
THE COMMISSIONER:
Q. - with the HER2/neu, all of whom would have been retested under the Ventana system in house?
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:

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Q. So none of them were part of the retests at Mount Sinai?
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. And in terms of recently, that would--the most recent of those would have been the one in August?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. "The Corporation has refrained from making a public statement to avoid raising concern. 'The reason why we haven't gone public with this is we don't have all the answers,' Laing tells The Independent." Do you take any issue with that portion of the quote?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. "The last thing that you want to do or we want to do is make people afraid" and then she has "... is to cause some sort of mass hysteria." Do you have any problem with that portion of the quote?

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DR. LAING:
A. The portion of that quote that I had problems with was "mass hysteria."
CHAYTOR, Q.C.:
Q. And what issue do you take with that?
DR. LAING:
A. I don't believe that that was the term that I had used.
CHAYTOR, Q.C.:
Q. And what do you think you said?
DR. LAING:
A. I'm not certain, but it's--you know, when you sort of think about things that you would say or terms that you would use to describe situations, mass hysteria is not something that would be a phrase that I would use. I would have said to her, and I do recall saying to her is that I had concerns about causing the patients anxiety, about making them concerned, but I didn't talk about starting some sort of mass hysteria or anything like that, and I remembered when I read this for the first time, I thought "I didn't say that. I didn't say mass hysteria" and I was struck by the fact that it actually is in quotation marks as if this was something that I had said directly.

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CHAYTOR, Q.C.:
Q. And "Susan Bonnell, spokeswoman for the Health Care Corp, says a new more accurate piece of equipment was installed in the laboratory last year, providing clearer results, and current hormone receptor tests are also being double checked as part of the quality review. She adds the retesting is not impacting patients waiting for other laboratory results." When you read this, read the article and Ms. Bonnell's quoted as saying that "a new, more accurate piece of equipment was installed in the last year, providing clearer results, and current hormone receptor tests are also being double checked as part of the quality review," did that cause you any concern?
DR. LAING:
A. Well, I mean, I think this speaks to the whole issue about what exactly the Ventana was as opposed to the old DAKO System, and the discussions about is it really a new--certainly not a new technology, it's still immunohistochemistry. Was it a new piece of equipment; yes, because it was semi-automated. Was it more accurate; you know, I think that that really remained to be seen. So, you know, that wasn't anything that I talked about. This was clearly a statement that Susan had made.

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CHAYTOR, Q.C.:
Q. Yes, and I realize you didn't.
DR. LAING:
A. But --
CHAYTOR, Q.C.:
Q. And I take it, you didn't know whether or not that was going to be referenced in the article?
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. But at the time you read it, did it cause you any concern that that was being stated?
DR. LAING:
A. Other than the discussions that we've already had to say that, you know, I didn't feel that that was--that we had enough information to say at this point that that was the reason why we had a change in test results, until we had

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

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

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to positive, it was the course of their treatment, they were still being treated for breast cancer, would just affect on how we would be treated--oh, sorry, how they would be treated.
CHAYTOR, Q.C.:
Q. That's fine.
DR. LAING:
A. So that was all okay.
CHAYTOR, Q.C.:
Q. And then I think the next quote attributed to you is this paragraph, "We're talking about the care of individual patients", says Laing, "so I can't really give you sort of a global statement other than to tell you, one; estrogen and progesterone receptors are very important piece of information, but they go with other things".
DR. LAING:
A. Sure.
CHAYTOR, Q.C.:
Q. "And number two is that this is very individualized".
DR. LAING:
A. Yes.

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

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is in quotes, "there were one or two patients that had had retesting done for another reason where we noticed sort of a difference ... we noticed some discrepancies and there was a thought that maybe there was something going on".

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. What is the other reason? "The one or two patients that had had retesting done for another reason", what other reason were you referring to?

DR. LAING:

A. I think what that came from was first of all when I was referring to--although not specifically about the index case in any detail or about the lobular histology, was that that was the first reason that we had done the retest, and then the second one was for the patients who had had metastatic disease, so these were the people that would have been the ductals that we had checked. So, you know, I had sort of started to say to her we had gone to ask for retesting on some

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people, and then for other reasons, we checked on other people and this would have been the ductal cancer patients who had had the metastatic disease, and that we noticed there was differences in those, and then that's when we started to put our heads together and say this doesn't seem to be just lobular, this doesn't seem to--there's some ductal patients. Then, of course, as time went on and we did the first full 25, and then so on and so on.

CHAYTOR, Q.C.:

Q. So what was the reason for the retesting of any of those patients?

DR. LAING:

A. Well, it all started with the index case, and the retesting was because of Dr. Hudis saying that in their experience at Memorial Sloan-Kettering was that when they retested the lobulars, they were all 100 percent, that was what had started it, but that there were patients that were retested because of that, but that the other reasons were the patients who had metastatic disease that we were looking for to see if there might be a new treatment and those were some of the very

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early patients, one, two, three, four and five.

CHAYTOR, Q.C.:

Q. But why were they retested? Yes, they had metastatic disease, but why in May of 2005 were those people retested? They weren't retested in March of 2005 or any time prior to that.

DR. LAING:

A. Because of what had happened with the index case.

CHAYTOR, Q.C.:

Q. Okay, "Laing says any patients or past patients found to have inaccurate readings will be able to immediately discuss with their physician any necessary change to their treatment procedures. She adds there's no way to judge at this point in time whether any incorrect tests would have impacted recovery". The idea that patients will immediately be able to discuss with their physicians any necessary change to their treatment, Doctor, at this point in time had it been contemplated that the retest results would first go through a panelling process?

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DR. LAING:

A. Yes, I believe at that time we had had some preliminary discussions about a panelling process. She uses words like "immediately". I guess what I had tried to say to her was that if there were patients who are identified as having changes, that that would be discussed, and if they required a change in their treatment or their care, that that would be discussed with them by their physician. She said, well, do you know now if any of these changes have had an impact on patients, and I said, well, it was too early, we couldn't tell at this point, you know, what difference that would have made, and I really didn't get into a detailed discussion with them--with her, sorry, about that.

CHAYTOR, Q.C.:

Q. Doctor, over here it says, "Because results are still incoming, Laing says it's impossible to predict how many patients may be affected, although she suggests that the number will be relatively small. Of the ones that have been coming back, I looked at maybe, I don't know, 40 or 50 the other day, and there were five or

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six people that were there that it may have had an impact, so it's not a huge thing". What about--that's attributed as being a direct quote, the second paragraph.

DR. LAING:

A. That's right, and so, you know, I think this whole idea about the results still incoming, we were--you know, we were just--this was prior to before we sat down and looked at any of the Mount Sinai tests, and to that, I meant that we did not have the test results back yet, and --

CHAYTOR, Q.C.:

Q. So Doctor --

DR. LAING:

A. So that's--no, I think that's referring, though, to the--because 40 or 50, to me, is not a number that I would have thought back to the first 16 out of 25. So whether or not this was the first Mount Sinai results, I'm not entirely clearly.

CHAYTOR, Q.C.:

Q. Doctor, this is October 2nd, 2005.

DR. LAING:

A. Yes, I know that.

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CHAYTOR, Q.C.:

Q. Had the first results been received from Mount Sinai at this point in time?

DR. LAING:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. So what batch of patients could this be referring to?

DR. LAING:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. Do you recall there ever being 40 or 50 patients that you reviewed where only five or six people may have had an impact?

DR. LAING:

A. I'm actually thinking that this was perhaps the first results back from Mount Sinai because those numbers don't correlate from my recognition about the numbers that we would have looked at already through the first, second, and third batches.

CHAYTOR, Q.C.:

Q. So there may have been the first batch back from Mount Sinai?

DR. LAING:

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A. May have been the first batch back from Mount Sinai, and I know that when they did come back, that I did look at those with Dr. Cook.

CHAYTOR, Q.C.:

Q. And your initial reaction was that there weren't a lot of people in that batch that came back that would be impacted?

DR. LAING:

A. Yeah, I do recall that the initial results that we had back from Mount Sinai were not similar to the numbers that we had seen previously from our own review, and I can tell you that I probably did use the word "huge" because that is my word.

CHAYTOR, Q.C.:

Q. So it's not a "huge" thing, probably was your word?

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. And the idea that "she suggests the number will be relatively small", is that something you would have suggested?

DR. LAING:

A. I don't think I told her that I thought that

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the number was definitely going to be small. I think probably what I told her was that we really didn't have any idea about how big this was going to be, and that we hoped that it wouldn't be as many--you know, that it wouldn't be a lot of people affected, but, you know, I suspect I was basing that--some sort of statement to say that we hope that this is not going to be something that impacts a lot of patients, which, you know, certainly would be a fair statement to have made, but, you know, I guess that was the optimist in me coming through at that point.

CHAYTOR, Q.C.:

Q. And you did mention earlier when you gave a summary of what you had said to her, that you thought you mentioned the 16 out of 25 that was done in-house?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Do you recall that you did tell her that?

DR. LAING:

A. I --

CHAYTOR, Q.C.:

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Q. I don't see that quoted here.
DR. LAING:
A. No, she doesn't quote that.
CHAYTOR, Q.C.:
Q. Or referred to here at all.
DR. LAING:
A. I thought I did, but--because that to me was always the number that--you know, that first batch was always the number that sort of stuck in my mind as the initial patients that there was --
CHAYTOR, Q.C.:
Q. And that would have indicated something other than it was a relatively small number of patients if you were talking 16 out of 25.
DR. LAING:
A. Absolutely not.
CHAYTOR, Q.C.:
Q. That's not referred to. What's referred to here is a review of some patients that indicated to you --
DR. LAING:
A. That that was the --
CHAYTOR, Q.C.:
Q. It wasn't going to be a huge thing.

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DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And you think--when did you go to Toronto? September 30th you're in Toronto. When did you go to Toronto; how long had you been in Toronto up to this point?
DR. LAING:
A. Oh, just a couple of days.
CHAYTOR, Q.C.:
Q. And you --
DR. LAING:
A. When I looked at my calendar those two days--so the Thursday and Friday were blocked off, so I probably flew up Thursday for the Friday meeting.
CHAYTOR, Q.C.:
Q. And do you recall then if results had come back late in September that you would have reviewed them before you went to Toronto?
DR. LAING:
A. Yes, because I do remember that when the first set of results came back from Mount Sinai, that I did speak to Dr. Cook about that.
CHAYTOR, Q.C.:

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Q. And that you reviewed the results?
DR. LAING:
A. That we looked to see what--you know, that was sort of the first list of patients, looking at what the results were, and how they had changed, yeah.
CHAYTOR, Q.C.:
Q. I take it you didn't review any charts or anything --
DR. LAING:
A. No, no, no.
CHAYTOR, Q.C.:
Q. To see if you would need a change in treatment?
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. You would have been relying strictly on who had had a conversion according to the numbers?
DR. LAING:
A. That's exactly right, yes.
CHAYTOR, Q.C.:
Q. And then it goes on to say, "We're dealing with this as quickly as possible. I mean, you're dealing with people who are already in

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a stressful situation who are going through cancer treatment, or who have recovered from cancer treatment. Laing stresses there is no need for breast cancer patients or any other cancer patients to get frightened because the results are a matter of patient care as opposed to cure".
DR. LAING:
A. No, I took--I had problems with the last part of that statement. I don't believe she understood what I was trying to convey. Certainly the first paragraph, "We are dealing with the situation", I would agree with that, acknowledging that having a breast cancer diagnosis and going through treatment was already stressful enough for patients, that this was patients who were currently on treatment and acknowledging that it was even patients who had already had their treatment, and that I really was concerned about this whole idea of patients being frightened or anxious because of this, and I think that she completely misunderstood because I think that this result--that this is a matter certainly of patient care--in the adjuvant setting, we

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had a long discussion yesterday about how, in fact, it is important for risk reduction recurrence and improvement in survival, so care as opposed to cure would not be something that I would have said at all.

CHAYTOR, Q.C.:

Q. And the last quote she has from you is, "We're not trying to cover up anything here. We're trying to take care of patients and we're doing that and continue to do that. I don't think a statement that this is something that has negatively impacted on breast cancer patients as a whole group can be said at all. I think that's false". What about that last quote that's attributed to you, Doctor?

DR. LAING:

A. Yeah. I know that during this interview that she certainly accused--I guess that might be a strong word, but suggested that there was--you know, that we hadn't gone public because we were trying to hide something, and I guess I was trying to say to her, no, that wasn't the reason for that decision, from my point of view, that--you know, I would certainly say something like we're trying to take care of

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patients, we're continuing to do that, and, you know, I--I would have said something that --I think that she had an idea that this meant that all of the breast cancer pathology was incorrect, that all of the ER/PR testing results were wrong, and I was saying that this is something that didn't apply to the whole group. I would say that definitely this something that at the end of the day certainly did negatively impact on all breast cancer patients, on all cancer patients, regardless of whether their test results changed or not. Obviously, this did, but what I was trying to get across by that was that she was saying, well, you know, all breast cancer patients got the wrong results, all breast cancer patients have gotten the wrong treatment, and I was telling her that it was not all of them, and that we really didn't have an idea yet of what percentage that was going to end up being.

CHAYTOR, Q.C.:

Q. Okay, thank you, Doctor. Is there anything else then about the article, and the reason I took you through that in some detail is that this is the first--this is the first thing

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that's told to the public and to many breast cancer patients through this mechanism.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. So I thought it's important that --

DR. LAING:

A. Yes, certainly.

CHAYTOR, Q.C.:

Q. That we go through it and clarify what you may or may not have said.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. Because this was the first--this was the first publication on the issue.

DR. LAING:

A. Right, and as time goes on, you alluded to earlier that I did have another interview with The Independent, but I think it was a different reporter at that time. I think it was Stephanie Porter for the second one.

CHAYTOR, Q.C.:

Q. You did do one with her too, I think.

DR. LAING:

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A. Okay.

CHAYTOR, Q.C.:

Q. But I could be--I could be wrong. Maybe you didn't do another one with Clare Marie.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. But I had thought along the way I had seen that.

DR. LAING:

A. Because it --

CHAYTOR, Q.C.:

Q. We've read a lot of material. I could be mistaken.

DR. LAING:

A. I know that I did look at the second interview, and I'm sure we'll talk about it, and that was better.

CHAYTOR, Q.C.:

Q. Yes, yes, okay.

THE COMMISSIONER:

Q. Ms. Chaytor, it's after five. I suggest we adjourn for the day.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner.

THE COMMISSIONER:
Q. 9:30 in the morning.
COFFEY, Q.C.:
Q. If I could, Commissioner --
THE COMMISSIONER:
Q. Mr. Coffey is on his feet.
COFFEY, Q.C.:
Q. If I could, Commissioner, tomorrow morning we plan to start at 9:30 with Dr. Denic. I think everybody in the room--I think counsel is aware of it, but we should let people know.
THE COMMISSIONER:
Q. All right, so we're switching off to Dr. Denic for tomorrow and Friday.
COFFEY, Q.C.:
Q. Yes.
THE COMMISSIONER:
Q. All right, thank you, 9:30.

CERTIFICATE

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