COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 18, 2008

Appearances:

Bernard Coffey, Q.C. . . . . Commission Co-counsel
Sandra Chaytor, Q.C. . . . . Commission Co-counsel

Rolf Pritchard/Jackie Brazil . . . . Her Majesty in Right of NL

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

Daniel Simmons . . . . . Eastern Regional Integrated
. . . . . Health Authority

Laura Brocklehurst. . . . . Members of the Breast Cancer
. . . . . Testing Class Action

Mark Pike . . . . . NL Medical Association
Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)
Blair Pritchett. . . . . Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

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Certificate

THE COMMISSIONER:
Q. Ms. Chaytor.
DR. KARA LAING, EXAMINATION BY SANDRA CHAYTOR, Q.C. (CONTINUED)
CHAYTOR, Q.C.:
Q. Good morning, Commissioner. Good morning, Dr. Laing.
DR. LAING:
A. Good morning.
CHAYTOR, Q.C.:
Q. If we could have, please, P-0634? Doctor, this is a memo to Dr. Carter back on October 12th, 2005. You'll recall that's the day before the first Panel meeting, from Dr. Robert Williams. And this seems to involve Dr. Carter coming on to the Panel. "Dr. Cook has just informed me that you have agreed to sit on this Panel. Don will be on it in an ex-officio capacity to ensure that all the information is available from the laboratory medicine program. You'll be there as an expert in the area of breast pathology and help with the deliberations of the Panel." And he thanks her for her help and suggestions to deal with the difficult situation. Doctor,

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were you provided with a copy of this memo?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay, and did you understand that there would be any difference in the role that Dr. Cook would play as opposed to Dr. Carter?
DR. LAING:
A. Not a huge difference, no.
CHAYTOR, Q.C.:
Q. Well, any difference at all, and, if so, what difference?
DR. LAING:
A. No, I hadn't considered them to be there in any--I mean, they were both there as pathologists, they were both able to provide information in that respect. Dr. Cook did have the results from Mount Sinai and we certainly used Dr. Carter's expertise, as I said, in reviewing issues related to pathology. For example, if there was some uncertainty of the size of the tumour or if it had to be reviewed as to lymphatic or vascular lesion and those sorts of things, she would do that for us.

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CHAYTOR, Q.C.:
Q. Did Doctor--we understand the deliberations of the Panel would be to recommend any treatment changes that may be required. Did Dr. Carter participate in those discussions?
DR. LAING:
A. No. I would interpret this to be the deliberations of the Panel with respect to assigning prognosis of the patient. So if the information wasn't readily evident from the initial pathology of the patient, for example, if it wasn't clear if there was lymphatic and vascular invasion, because that would have been something that became important as a prognostic factor into '99 and 2000, we may have had to ask her to review that. But as to deciding if someone should or shouldn't receive hormonal therapy at this point, then Dr. Carter didn't contribute in those discussions.
CHAYTOR, Q.C.:
Q. And we saw yesterday that Dr. Carter eventually resigned from the Panel.
DR. LAING:
A. Yes.

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CHAYTOR, Q.C.:
Q. And we also saw that other pathologists were involved after that, including Dr. Elms. What role did he play, did he play more the role of Dr. Cook or did he take over from Dr. Carter?
DR. LAING:
A. When Dr. Elms was there?
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. More on the role of Dr. Carter.
CHAYTOR, Q.C.:
Q. If we could have, please, P-2568? And these are draft notes of another Panel meeting on September 7th, 2006. And we discussed yesterday how there were informal minutes taken after February, '06.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. But these are draft notes.
DR. LAING:
A. Okay.
CHAYTOR, Q.C.:
Q. So it appears that there was at least draft

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notes for this particular meeting. And it indicates that you're in attendance, Dr. Denic, Dr. Zulfiqar, Ms. Predham and Ms. Parsons. And again, is there any particular reason why draft notes would be kept but no formal signed off minutes?
DR. LAING:
A. No, not that I know of.
CHAYTOR, Q.C.:
Q. Okay. And it indicates here that it's reviewed by Dr. Laing, "See enclosed." And there's an issue attached in terms of a letter. Doctor, in this particular meeting the first patient, the recommendation was a disclosure meeting to be organized. "Lab confirmed patient DCIS only. No change in treatment and no letter to be written." And then you'll see down the fourth patient on the list, "Disclosure meeting to be organized. Patient treated with Tamoxifen for DCIS." And this is the first reference that I came across in terms of any notes from the Panel to a disclosure meeting as opposed to follow-up with the patient and having the appropriate physician do so.

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. What was meant by disclosure meeting and how is that differentiated from meeting with the patients to disclose the changes in results or any potential changes in treatment and when was it deemed appropriate to have such a meeting, a disclosure meeting?
DR. LAING:
A. These were the patients who upon review had a change in their actual diagnosis so that these were the patients that when the pathological specimens were sent to Mount Sinai Hospital, the initial result back from Mount Sinai was that it was ductal carcinoma in-situ. Further blocks were sent and it was still ductal carcinoma in-situ. And then the pathology was reviewed by Dr. Carter and Dr. Cook, Dr. Denic and it was determined that these were, in fact, cases of ductal carcinoma in-situ. These were not invasive breast cancer. So there was an actual change in the diagnosis. And so we felt that that would need to be communicated to the patients as the other

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situations. The other situations, mostly what we had been dealing with was a change in the results of the estrogen and progesterone receptor, which didn't change the diagnosis, these patients still had breast cancer. But this was a different matter and we felt that in dealing with that, that it would be appropriate if there was somebody from pathology there to speak to the difference in diagnosis, to try and help the patients understand how ductal carcinoma in-situ is different from invasive disease, and that's why these meetings were set up.
CHAYTOR, Q.C.:
Q. So in those meetings, the difference being that the other patients, the ones who had a change in their hormone receptor status were either--well, they were dealt with by a physician?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. But those who had a change in their diagnosis had a more formal disclosure meeting. And who would have attended those meetings?

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DR. LAING:
A. So I would have attended as an oncologist who could speak to the issue of how this person's treatment would have changed. Dr. Denic participated from the point of view of a pathologist to try and help explain. And Nancy Parsons came to the meetings, as well, to be someone there for the patient, as well. She had had a lot of contact with these people and we felt that it would be appropriate to have somebody else there with the patient to help, you know, support them when we disclosed this information.
CHAYTOR, Q.C.:
Q. And did the originating or the original treating physician attend or was that person not available?
DR. LAING:
A. That person was not available in any of these instances.
CHAYTOR, Q.C.:
Q. Okay, and I take it if they had been available, they would have been the person as opposed to yourself to be there?
DR. LAING:

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A. Yes. When we ever had such situations such as this and subsequently when we did have meetings with, for example, the patient--the families of the patients who were deceased, if at possible if the oncologist involved in their care was still present, then we would ask them to come to those meetings, but if not, it was usually me that would go and meet with patients or their families.
CHAYTOR, Q.C.:
Q. Was there any particular policy followed in the disclosure meetings in terms of what, in fact, was disclosed to the patients and what they were--and what they were told and how they were told it?
DR. LAING:
A. We would have started the meeting by explaining why they were brought there, explaining the change in the diagnosis, explaining what it meant in terms of their treatment, took questions from the patients and their family members if they were present. So we disclosed, you know, fully to them what had--you know, what the difference was and what impact it had on aspects of their care.

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CHAYTOR, Q.C.:
Q. Did any of the patients ever ask what happened or how this could have happened?
DR. LAING:
A. Yes, they would have said, you know, why--you know, how did you find this change. And we would have explained that, you know that their pathology sample was reviewed as part of the retesting and that when it was looked at by the physicians initially at Mount Sinai Hospital, that they had called it ductal carcinoma in-situ and then, you know, this was confirmed by being reviewed by the physicians at Eastern Health. And so that we wanted to assure the patients, Dr. Denic from the pathology side, to assure the patients that this had been reviewed carefully and that this was indeed, you know, the new diagnosis. The patients certainly had questions about, you know, what it meant in terms of their treatment, and so addressed those. There certainly were some questions from the patients about what it meant in terms of their treatment right from their surgical treatment, whether or not they would have still required

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the surgery they had, whether or not they would have still required the radiation, whether or not they still would have required chemotherapy if this patient, for example, had been treated with chemotherapy, and all these various issues were discussed.
CHAYTOR, Q.C.:
Q. Yes, and my question wasn't so much how the problem was detected, but did the patients ask how it could be that their original diagnosis was incorrect?
DR. LAING:
A. I'm not certain if that would have been the exact words that the patients -
CHAYTOR, Q.C.:
Q. No, but you know what I'm trying to ask. I mean, the patients are being told that your original diagnosis wasn't correct.
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. Didn't they ask, well, how could that be, why not, why was it not correct?
DR. LAING:
A. So Dr. Denic would have explained that the

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pathologist who had looked at their pathology specimen initially had, in their opinion, felt that it was an invasive cancer, but upon review that that had changed, and tried to explain, you know, the difference between ductal carcinoma in-situ being changes within the ducts of the breast tissue, not having spread, you know, through what we call the basement membrane and then into the surrounding tissues, thus making it invasive. So, you know, Dr. Denic drew diagrams to try and help the patients understand the difference.
CHAYTOR, Q.C.:
Q. Were there any follow-up meetings with those patients?
DR. LAING:
A. I subsequently spoke to one of those patients again. And I'm not certain if the other ones had any follow-up meetings with physicians.
CHAYTOR, Q.C.:
Q. Were they offered that?
DR. LAING:
A. Yes, they certainly were. They were given both my name and telephone number, Dr. Denic's

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name and telephone number and were told that if they had any further questions, they could certainly contact either of us. And Nancy Parsons certainly did the same.
CHAYTOR, Q.C.:
Q. Okay, and were they offered an apology?
DR. LAING:
A. They certainly were.
CHAYTOR, Q.C.:
Q. And how many of those patients were there that you met with?
DR. LAING:
A. I know that there was initially three. There's subsequently been a fourth one, for sure. That's how many I can remember. There may have been another, but I can remember four.
CHAYTOR, Q.C.:
Q. Okay. And the people meeting with them were always yourself, Dr. Denic and Nancy Parsons?
DR. LAING:
A. In the first instance that was, and then I think with the most--the last one, I believe that Ms. Smith was present from the Cancer Program.

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CHAYTOR, Q.C.:
Q. Along with -
DR. LAING:
A. That was later on.
CHAYTOR, Q.C.:
Q. So four people and she joined the group or she substituted for somebody?
DR. LAING:
A. I think she substituted for Nancy Parsons, but I can't remember exactly.
CHAYTOR, Q.C.:
Q. Okay. And if I could have, please, 2633?
THE COMMISSIONER:
Q. Just before you leave that I just want to make sure I'm clear. Dr. Laing, your description of what Dr. Denic would say and the circumstances about how this had occurred, is it a fair interpretation to say that his explanation for the occurrence was that it was an interpretation issue with a pathologist?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. Okay, thank you.
CHAYTOR, Q.C.:

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Q. Doctor, this is the Physician Panel meeting of June 5th, 2008 that I brought you to yesterday.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And on page 3, the last two patients dealt with, we had some discussion about this. You didn't have adequate information to make any recommendation on their treatment?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And it indicates here the recommendation would be that a letter will be sent to Ms. Pilgrim telling her that. And if we could have, please, P-2614? This is a letter written by yourself June 12th, 2008 to Ms. Pilgrim.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Where you write, "I recently had several inquiries from your office regarding two patients who had estrogen and progesterone receptor retesting done. These patients have

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been placed on a list to be reviewed at the Physician Review Panel. However, we do not have any medical information on these patients. The only information we had was their estrogen and progesterone results. We are not able to find any charts from the," and I can tell you that it was the Carbonear area on those patients. And then the patient, of course, identification has been redacted. And it goes on to say that, "Certainly if you are able to find out further medical information on these patients, I would be happy to review them and either of the two family physicians can certainly contact me if they have some questions related to the care of these patients. However, I unfortunately am unable to give any recommendations on their treatment" given your lack of information. Did you--and this again is June 12th, 2008. Did you receive any response to this correspondence?
DR. LAING:
A. Not written, but I did speak with Ms. Pilgrim about this and she said that they would send the results along to the family physicians of

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these patients and indicate that if there were any questions, that the family physicians could contact me.
CHAYTOR, Q.C.:
Q. Okay. And do you know whether or not that, in fact, has happened?
DR. LAING:
A. I have not received any questions about these patients.
CHAYTOR, Q.C.:
Q. So you haven't received any questions and they haven't been reviewed by you or any other members of the Review Panel?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Since, right, okay. And these were two patients that had a strong conversion, 90 percent ER on retesting?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And whether or not Ms. Pilgrim, in fact, has forwarded the information on to the physicians, the treating family physicians,

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you don't have any other information on that?
DR. LAING:
A. My understanding is she did, but I don't--I can't confirm that 100 percent.
CHAYTOR, Q.C.:
Q. Okay. Doctor, did the Panel review all patients with changes in their hormone receptor status or was it just the patients who had a change in their ER status?
DR. LAING:
A. I'm just trying to think now what the difference would be between the two groups.
CHAYTOR, Q.C.:
Q. I'm trying to think about the people who may have had no change in their ER status, but their PR status may have changed. So, for example, you told us over the course of your evidence about there were a number of people, I think you said, saved by the PRs because their PRs had been positive -
DR. LAING:
A. Oh, yes, so certainly, if someone had been ER negative, PR negative and came back as ER negative, PR positive, yes, we would have reviewed those patients.

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CHAYTOR, Q.C.:
Q. Well, and also those who may have been ER negative, PR positive but came back as ER negative still -
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. - confirmed ER negative, but all of a sudden the PR is now negative, as well?
DR. LAING:
A. Yes, we would have reviewed those patients, as well.
CHAYTOR, Q.C.:
Q. So they were all reviewed?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And were there any patients as a result of that who had been on Tamoxifen or an equivalent treatment because of their PR status who had a change in treatment, needed to come off the Tamoxifen, were there such patients?
DR. LAING:
A. There certainly were.

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CHAYTOR, Q.C.:
Q. Okay, and do you recall how many of those patients there were?
DR. LAING:
A. It was a very small number. I can think of two off the top of my head.
CHAYTOR, Q.C.:
Q. And were there others who had received Tamoxifen or an equivalent treatment and had run the course?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Their PRs had now changed?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So they didn't need a change in treatment, but nonetheless it was determined that they should not have Tamoxifen in the first place?
DR. LAING:
A. The two patients that I can recall in that situation who had some expression of either, I think in both instances that I can recall it was the PR that they were treated based upon

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that when we reviewed them. One patient has recently been started on therapy and so that patient had the therapy discontinued. The other patient had completed the course of Tamoxifen and so it was disclosed to that patient that she finished the treatment but for that primary tumour there wouldn't have been any benefit to that patient, but there would have been, you know, the potential small benefit in terms of reduction of risk of contralateral breast cancer and positive benefits on bone and lipids, but that would have been disclosed to that patient.
CHAYTOR, Q.C.:
Q. Okay, and if we could have then, please, P-2642, Registrar? This is an e-mail which contained a list, and it's called a retro list.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And it's from Heather Predham to Dr. Denic. And she says, "Here is the list. I'll be in touch when I track Kara down." And then I wonder could we have this reformatted? Thank

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you. And a little bigger? Thank you. Okay, and there are a number of patients here, Doctor, for example, the first patient was originally one to five ER, 30 to 35 PR and ended up being zero, zero. And it says, "Panelled. No recommendation. Considered negative," I think. So I take it that meant the person had been considered negative from the beginning?

DR. LAING:

A. Right from the very beginning when we looked through the chart, yes.

CHAYTOR, Q.C.:

Q. Okay. And if we come a little further down, there's a patient here from Carbonear. And originally negative for ER, 50 to 60 for her PR?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. But on retesting is zero and two?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And she was indicated for review. And again,

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the next patient was indicated for review. And the third patient, as well. All three of those from Carbonear with positive PRs that came back five or under were for review. And there's also a patient here from Western, but that patient is indicated to be deceased. So those who had a strong or what was considered a positive PR that ended up being something considered a negative PR, those, in fact, were reviewed by the Panel, as well?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And if we could have then, please, P-1373, and it says, "Kara and I reviewed the retro list". This is an e-mail from Ms. Predham, May 18th, 2006, to Dr. Williams, Dr. Cook and Ms. Parsons. "Kara and I reviewed the retro list and here is the final list that will need to be reviewed", and the name of the patient, "will be panelled next Thursday, given the new results from Mount Sinai", and attached to this list then there's, I think, seven patients--arguably eight, but I think this might be the same, I'm not sure, but anyhow--

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and out of those you have original PRs, certainly one, two, three --

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. Or five of them which were positive and ended up being negative by Newfoundland's definition. So those--how did you go about - obviously the list has been shortened down to these people. So how did you go about that these are the people who need further consideration or review, what did you do? The first list I showed you had a lot more people on it, and I'm just wondering how you end up with this number of people, and eventually you get it down to only two people?

DR. LAING:

A. I'd have to go back and look at the original list and see who came out. I'm not sure if some of them were because I was able to determine on review of their chart that they had been treated as negative from the beginning. I'm not sure.

CHAYTOR, Q.C.:

Q. Even if they were treated as negative from the

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beginning, then they wouldn't need any treatment change obviously or to be told that they'd had incorrect treatment, but they would be told that their results had changed, in any event?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. So if that's the case then, there would be a number of people in that category. For example, here we would have it seems to be three people who are negative ERs, positive PRs, and end up negative in both.

DR. LAING:

A. I'm not certain, though, if these patients had been treated with hormonal therapy or not initially, and perhaps we didn't have that information on the patients that were from the Gander and Carbonear regions.

CHAYTOR, Q.C.:

Q. So were all people--all patients disclosed their results regardless if it had any impact on treatment?

DR. LAING:

A. My understanding is yes.

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CHAYTOR, Q.C.:
Q. And you would have met with two of them?
DR. LAING:
A. No, I wouldn't have met with two of them personally.
CHAYTOR, Q.C.:
Q. You didn't meet with them.
DR. LAING:
A. I know one of them wasn't my patient and the other person I would have--I know of one that I did disclose to who is a lady who, as I mentioned, had completed the five years of Tamoxifen. If there were others--there may have been, I just--my recollection is that I can remember are those patients, and the other reason, of course, is that we wanted this new information to be available on these patient's charts should down the road they develop a recurrence, then we would need this accurate information which would base a decision for their --
CHAYTOR, Q.C.:
Q. Future treatments?
DR. LAING:
A. Further treatment, yeah.

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CHAYTOR, Q.C.:
Q. So it's your understanding they all would have been told. Anybody with any change in results or anybody without a change in results, everybody should have been told whether there was a change, what the change was, and if there was no change, that was also communicated?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. If we could have, please, P-2274. Doctor, this is a letter from Dr. Paul Neil to yourself, and I notice in this time period and a bit beyond Dr. Neil would write to you seeking advice on different patients, and some of that correspondence has already been gone through here with Dr. Neil, and on this particular case, August 7th, 2006, he writes, "Dear Dr. Lang, I received your phone message today on my return from vacation regarding the enclosed patient who was seen in clinic and who has, according to our hospital records, been taking Tamoxifen. As you know, her ER was reported as negative in our review of

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cases retesting. She was not sent since she was seen at", and it's taken out, but I think this is the Cleveland Clinic, if I'm not mistaken, I think it's Cleveland. "It was my understanding at that time that she was retested there. However, as I said in my previous letter, she was not, in fact, retested there. As per your instructions, therefore, I will send her tissue for retesting to Mount Sinai even though our hospital records indicate that she has had Tamoxifen". So, Doctor, this patient had already had Tamoxifen, but her results--I'm sorry, "Even though our hospital records indicate she has had Tamoxifen". So although she had been treated, your instructions were to send her for retesting, in any event?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. If we could have, please, P-2568. I'm sorry, we already did that one. It's 2569, and this is an e-mail exchange between Ms. Predham and Ms. Elliott and Ms. Pilgrim, September 21st, 2006, "I have to tell you both

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about an incident that is unfolding as we speak. Joy McCarthy called me lunch time about a lady who was admitted today with metastases after being diagnosed with breast cancer in 2000. I believe Jonathan Greenland is looking after her. He noticed she was ER/PR negative, but thought she was missed in our review. He called Joy to check on the process and Joy called me. She was retested and the results came back in October of 2005 that she was positive. She was panelled and a letter went to Kara Laing, November 4th, as her attending, to inform her of this. Kara was not chairing the panel that week. It was Joy that signed off the letter. It appears that Kara did not see her and we are checking to see if Kara got the letter. Kara is on a plane right now, so we are unable to check with her. Joy has followed up with her secretary". Doctor, it goes on to say, "We have been contacting physicians to ensure follow-up, but we were leaving the Cancer Clinic to last". Do you recall the circumstances of this patient and was she or he, in fact - I guess it's a she. Was she, in

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fact, missed and if so, how did she fall through the cracks?

DR. LAING:

A. She was missed. The letter was sent, and when I discovered this and went back, from what I could piece together, the letter was sent to me, but this lady had been discharged from the Cancer Clinic. She was no longer being followed up because she had finished her adjuvant therapy and as per our usual guidelines, she had been discharged. I could only look back and think that when I saw her name and saw the letter, I had been thinking that it would going to be acted upon by her family doctor because patients who were discharged, the letters were usually sent to the family doctor. That's the only thing that I can see that that happened at the time. I did go and speak to this patient immediately upon my return after having sorted that out. I sat down with her and her family, went through how I could piece how this was missed by me, and the other physicians that were copied on the letter didn't act upon it either. I apologized to this lady. She had

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at that time developed metastatic disease and based on the new information, she's been treated with hormonal therapy, which she remains on and she still continues to be under my care and is doing well on those treatments.

CHAYTOR, Q.C.:

Q. So, Doctor, your normal practice upon receiving one of the panel letters --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Would be to act on it?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And in cases where the patient had already been discharged, as the case of this patient, what was your practice with those patients?

DR. LAING:

A. I would wait to hear if the family doctor needed any other assistance or guidance.

CHAYTOR, Q.C.:

Q. Even if the--was the letter addressed to you or to the family doctor?

DR. LAING:

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A. This letter was addressed to me.

CHAYTOR, Q.C.:

Q. Yes. So even if he letter is addressed to you?

DR. LAING:

A. I didn't recognize that the letter had been addressed to me. I looked at it and said, oh, this is this lady, she's discharged, signed it and it went on the chart. When I look back, that's the only explanation that I can come up with as to why I didn't call her and ask her to come in at that time.

THE COMMISSIONER:

Q. I'm sorry, Dr. Laing, I just want to make sure about one fact. Are you saying that when the letter came to you, it was cc'd to her family doctor?

DR. LAING:

A. No, if the patient was discharged from the Cancer Centre, the letters were to be written to the family doctor, and then they would be copied to whoever their treating oncologists were, medical oncologists, radiation oncologists, surgeon, whoever else would get a copy of that letter. If I got a letter that

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was copied to me, but it was written to the family doctor to act upon it, I would--you know, in some instances family doctors called me and asked if I would see those patients to do that because the family doctor wasn't comfortable. In other instances, the family doctor would have started the patient on Tamoxifen as per our recommendation. Up to this point, we hadn't sat down and gone through and ensured that everybody had been contacted, and that every person who had had any letter written, that that had been followed up upon.

CHAYTOR, Q.C.:

Q. Tell is then what has happened since then to ensure that there aren't others that could have possibly been missed? What checking process--you said you've since sat down. So what exactly has happened?

DR. LAING:

A. So after this, we were--we had a list of all the patients and all the physicians, their charts have been reviewed. This work has been done most recently by Ms. Pilgrim and her office to ensure that, you know, every person

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who was panelled, every person that has a test, to confirm that they have been spoken to. I know that Ms. Pilgrim has reviewed the Cancer Centre charts because on occasion I've gotten calls to ensure that if it wasn't clear from the notes that the patient was indeed informed, even if it was a confirmed negative result.

CHAYTOR, Q.C.:

Q. And when did that happen, when did that checking take place?

DR. LAING:

A. Oh, it's a while ago now.

CHAYTOR, Q.C.:

Q. Not this calendar year, not 2008?

DR. LAING:

A. Oh, there's--I think there's still --

CHAYTOR, Q.C.:

Q. Still checking happening?

DR. LAING:

A. There's still checking and rechecking, and there's still people who have been--there's even people, as you know, that have come forth this calendar year and those are the people that, for example, we may have panelled late.

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There were one or two patients when Ms. Jones sent out the letter, you know, they had not been found prior to that and somehow the letter found them.

CHAYTOR, Q.C.:

Q. So they received the apology letter, but had never been retested?

DR. LAING:

A. No, no, had been retested.

CHAYTOR, Q.C.:

Q. But had never been contacted about their retest?

DR. LAING:

A. But had never been contacted because they had moved away, and there was instances where somehow a family member ended up receiving this letter and those patients were identified and brought forth.

CHAYTOR, Q.C.:

Q. Were you ever provided a list of your patients and asked to double check and sign off that you, in fact, can ensure that your own patients have been contacted or any patients that you were given responsibility for?

DR. LAING:

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A. Eventually I did, yes.

CHAYTOR, Q.C.:

Q. So when did that happen?

DR. LAING:

A. I can't recall exactly. I think it was some time after this event, but I can't tell you the exact date.

CHAYTOR, Q.C.:

Q. So some time after--this event is September 21st, 2006. So some time in the past two years?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Who provide you with the list of patients, or did you have to come up with your own list?

DR. LAING:

A. No, I believe someone provided that to me.

CHAYTOR, Q.C.:

Q. And do you know who that was?

DR. LAING:

A. I believe it was Ms. Pilgrim.

CHAYTOR, Q.C.:

Q. If we could have, please, 2570. This is an e-mail exchange between your assistant and Ms.

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Parsons, the same date, and she's forwarding an address on a patient. This was last updated when the patient contacted them for release of authorization, and then, "I'm enclosing this lady's original letter as Dr. Laing may want to change the dates in the letter", and the letter is attached here. "The patient had left the province in 2001, no forwarding address, March 6th, 2006", and this was a patient who obviously had been reviewed on March 4th, 2006, and it was determined by the panel that she should be offered Tamoxifen. Do you recall what this is about, what circumstances in September '06 is this letter being brought to your attention again for this patient, and it appears the letter would have originated back shortly, I would think, after the panel meeting? Oh, here it is, March 6th, 2006.

DR. LAING:

A. I'm not sure if this was someone who had left the province and it was only now that they were able to track down her to find someone to send the letter to.

CHAYTOR, Q.C.:

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Q. Okay, and do you recall what letter or what dates--it says, "Dr. Laing may want to change the dates in the letter". What dates would you--would they think you would want to change in the letter?
DR. LAING:
A. I would think the date at the top. You know, usually when you write a letter, you would change the date.
CHAYTOR, Q.C.:
Q. The date of the letter?
DR. LAING:
A. Not the date of her diagnosis, not the date she was discussed at the panel.
CHAYTOR, Q.C.:
Q. Right, the date of the letter?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Do you know whether or not this letter actually was sent and received and that this patient actually received her information?
DR. LAING:
A. I'm not certain, without knowing who the patient is.

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CHAYTOR, Q.C.:
Q. Well, are you aware of any of your patients who have not been contacted?
DR. LAING:
A. At this point, no, I'm not.
CHAYTOR, Q.C.:
Q. So she must have been contacted?
DR. LAING:
A. Yes. I'm not sure that this lady was initially my patient.
CHAYTOR, Q.C.:
Q. Well, it's somebody who, I guess, you've been given responsibility for, in any event?
DR. LAING:
A. Somebody who was panelled.
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and P-2571, please, and this e-mail starts with from Heather Predham to yourself and Dr. Denic, October 4th, 2006, copied to Ms Smith, Sharon Smith, and Nancy Parsons. "A lady called Nancy on Monday asking if she had

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been retested. Apparently she had called in the fall asking if there was retesting and would she be involved. She was told yes and that someone would be in touch. She called in on Monday asking if there has been any word on her retesting as she hadn't heard anything. She was diagnosed with cancer in 1999. Her original ER/PR from May of 1999 showed faint positivity in less than 20 percent of the cells. There's an addendum on her pathology report dated November 4th, 2005, with Mount Sinai results of ER 90, PR 40. I've gone through every scrap of paper related to ER/PR that I have, and I cannot find her name anywhere. We certainly didn't panel her. Can we quickly review her via phone or something and then query, get the letter to her GP, would that be appropriate. She was seeing somebody at the Cancer Clinic. I appreciate your advice", and then it says, "I think Kara should look in the chart and see what had been done in terms of the treatment received and we shall take an action if necessary". That's Dr. Denic's response on October 5th, 2006. So this appears to be a patient who, in fact, was

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retested November 4th, 2005, and some 11 months later she's making further contact and it appears she hadn't been panelled and her results hadn't been communicated to her. Do you recall the circumstances of this patient?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And were you contacted, were you asked by anybody to review the chart to see what would need to be done in terms of treatment?
DR. LAING:
A. I would think that if they had said they were going to contact me, I would have looked at it and we would have discussed her. I'm not sure if she perhaps was discussed at a later panel, or--I'm not certain.
CHAYTOR, Q.C.:
Q. And in terms of why she would have been overlooked, you don't recall anything about this?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Doctor, coming in then to November, 2006, I

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understand that you took part in a presentation for people within Eastern Health?

DR. LAING:

A. Yes, I did.

CHAYTOR, Q.C.:

Q. On this issue.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. You, along with others who were involved, and if we could have, please, P-1425. What was the purpose of the presentation from your point of view, what was your component?

DR. LAING:

A. So there had been a decision that a public information would be given through a media release and interview with the media and we were planning that for early December of 2006. So prior to this, it was felt by Dr. Howell at that time that it would be worthwhile if we could have a meeting of the physicians involved throughout the province. So this was held in one of the auditoriums in the medical school, but we had linked to several other sites across the province, so pathologist, and

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lab people, and various people from all the different aspects--all the different areas in the province could attend, so that we could give an update first, I guess, internally as to where things were, what had been done, and my role was to speak to again how this information is used in the clinic to determine how patients are to be treated.

CHAYTOR, Q.C.:

Q. Okay, and I won't take you through it because most of this presentation is what we started your evidence with.

DR. LAING:

A. We've already done.

CHAYTOR, Q.C.:

Q. If we could go to page 117, please, and this is a--I don't think this was part of your presentation. I think it was more of--may have been Dr. Denic's portion, or I'm not sure who did this portion, but it was what was the problem in the testing.

DR. LAING:

A. It wasn't me.

CHAYTOR, Q.C.:

Q. And on page 117, and it refers to different

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issues, and that's been canvassed with another witness, but one of the things indicated is the large turnover of pathologists?

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And then also the large turnover of oncologists?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Difficult to monitor, correlate, and clinically validate ER results. So if you could just speak to that, please, and explain to the Commissioner how the large turnover of oncologists could have been a contributing factor to what happened with the ER/PR changes in results?

DR. LAING:

A. So this wasn't part of my presentation, but I think we recognized that from the time period in the mid 1990s and, in fact, through until 2002, there were over 20 medical oncologists and radiation oncologists who had come and gone as working within the NCTRF at that time,

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and that we felt that one of the factors that limited the ability to see trends or to recognize that there may have been an issue was the fact that you had so many different people looking at the results over that time period. I think that was one of the main points. Then, of course, the other is that when you are working in a situation where you have two or three people to do the job that you need seven people to do, then there really isn't that time to do the ongoing continuous quality improvement that is part of your day to day work where you notice, um, there might be something going on, we seem to be having a lot more side effects from a particular drug, we seem to be having, you know, something else that you might sort of look to, and I think that that--I think that did have a role. There was also not a lot of subspecializations. It would have been in the last couple of years that we've been able to limit, you know, two or three people, three or four people, depending on the volume within a particular tumour site, so that you have that -you develop more of an expertise, if you

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will, in treating a certain area. When I first came, I saw just about every tumour site that there was. I wasn't just doing breast cancer. So, you know, I think that that definitely played a role in this issue.

CHAYTOR, Q.C.:

Q. And, Doctor, I know very early on in your evidence, you spoke about the need for a database and a means by which certain information, crucial information, could be tracked?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And when you're faced with a situation with a large turnover of oncologists such that your corporate memory is walking out the door, in other spheres we would refer to it as that, so I would take it that the need for documentation is all the more crucial, the need to have a database, the need to have documents in place because the person who may very well have the crucial information may nt be there next year or next month?

DR. LAING:

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A. Yes.

CHAYTOR, Q.C.:

Q. So during this whole phase of the turnover of oncologists, before you reached your phase that you're at now in terms of a fairly stable professional resource base, it would have been even more crucial to have such documentation in place?

DR. LAING:

A. I think it's still very crucial at this point to have such a database, not just for breast cancer, but for all of the malignancies.

CHAYTOR, Q.C.:

Q. Yes.

DR. LAING:

A. And I think that, you know, we had talked way back in the very beginning about the B.C. Cancer Agency's experience with database, and that sort of information, I believe, is just invaluable in terms of many things, in terms of doing outcomes analysis. Because really, at the end of the day, you need to be doing that to be able to know if your programs are effective. It can look for trends, for sure, and it can be invaluable in helping for

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planning. If I think about, you know, having to plan for the budget, just in terms of the fact that we've been able--you know, we have sort of six-year data now of our provincial systemic therapy budget and we can sort of say "look, you know, we've seen 10 to 12 percent growth over the last five years, irrespective of, you know, new expensive drugs that are coming." Then that information is invaluable for things like planning as well. You know -

CHAYTOR, Q.C.:

Q. And that's--sorry.

DR. LAING:

A. - we do have more oncologists now, and we do have stability, but we still don't have enough. You know, if you look at the number, and both the Canadian Association of Medical Oncologists, and the Canadian Association of Radiation Oncologists, look at the number of new patients as a measure of the number of physicians that you should have and if you look at that, we could very easily make a case for nine to ten medical oncologists right now, and you know, we've been working within Eastern Health. We've put forth a human

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resources plan several times now to government and are hoping--I told you we've got a couple of people in the works that have trained to come back, but you know, recruitment and retention is always a concern, not only for physicians, but for all of our health care professionals within the Cancer Care program.

CHAYTOR, Q.C.:

Q. And in terms of developing a database or keeping track now of outcomes and the other information, that remains still on your wish list?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. It's not anything that has been realized to this point?

DR. LAING:

A. No, except for when we had the discussions with Mr. Miller and the group most recently that they were going to do some preliminary discussions with the advice of myself and Dr. Trudeau to look to see, you know--you know, you need to start somewhere. I don't think all of a sudden tomorrow we're going to be

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able to have an instantaneous database, but I think if we started with something like breast cancer and started to build that database. But of course, in order to do that, you need resources, including human resources, but also information technology.

CHAYTOR, Q.C.:

Q. Okay, and that's the state of affairs, to your knowledge, to this point in time?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Doctor, I believe the other meeting that you would have attended in November 2006 was a meeting of November 23rd with Minister Ottenheimer and other officials from his department.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. I'm sorry, Osborne. Osborne, by then it was Minister Osborne.

DR. LAING:

A. Sorry, the O's.

CHAYTOR, Q.C.:

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Q. That's right. It's happened a few times here, and I apologize. So what do you recall about that meeting? And I believe I had taken you to a document with some numbers.

DR. LAING:

A. Right, so that was the--you had showed me yesterday the briefing notes, I believe it was referred to as.

CHAYTOR, Q.C.:

Q. Yes, and we could bring that up again. It's P-0314, page ten, and I guess, first of all, why were you invited along this time? I understood the first meeting you had with the Minister, Minister Ottenheimer on this issue, was about patient disclosure, and why would you be included in this particular meeting with the Minister in November of 2006?

DR. LAING:

A. Well, this is a meeting that we would have had with the Department of Health prior to the media, which was planned for the following week or two, in early December.

CHAYTOR, Q.C.:

Q. Okay, and so why would you be included? Is it because you were going to take part in the

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media briefing?

DR. LAING:

A. Yes, it was.

CHAYTOR, Q.C.:

Q. Okay, and what role did you play in this meeting with the briefing of the Minister?

DR. LAING:

A. So I went with a team from Eastern Health and we met in the main Confederation Building. The House was in session, so I remember it because it was the first time I ever went to a meeting in that part of Confederation Building, and we went in and we were in the conference room, I guess you would call it, next to the House, and Dr. Howell would have been here by this time, and I can't recall who was--if there was someone there from pathology, and there was some discussion about, you know, these numbers and communication, and there was a lot of discussion at this time again, around this issue of a conversion rate, and so I would have been asked certain questions and would have had some discussion, you know, if people had asked for my opinion.

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CHAYTOR, Q.C.:

Q. And who was asking questions about the conversion rate? And what was said in response to that?

DR. LAING:

A. I don't remember who exactly within the Government -

CHAYTOR, Q.C.:

Q. So people from the Government?

DR. LAING:

A. Right. So there was -

CHAYTOR, Q.C.:

Q. The Minister, his officials?

DR. LAING:

A. Yes, yeah. So there was--well, I mean, there was also, at that time too, a lot of interest from the media as to, you know, could we come up with a number, say was it 30 percent, was it 20 percent, was it 70 percent, and of course, there was a lot of discussion about what you would include as the numerator and denominator. Would you include people who -

CHAYTOR, Q.C.:

Q. Yes. But I'm just wondering, did that discussion take place with the Minister? Is

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that something that was discussed with the Minister?

DR. LAING:

A. My recollection is that it was, yes.

CHAYTOR, Q.C.:

Q. Okay, and what was the response from Eastern Health in terms of its position on that issue?

DR. LAING:

A. I think that they felt that we should break down and present it as numbers. So the number of people who required a treatment change, the number of people who -

CHAYTOR, Q.C.:

Q. They being Eastern Health?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Eastern Health, okay, sorry.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay. So Eastern Health thought that numbers should be broken down, as we see here?

DR. LAING:

A. Yes.

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CHAYTOR, Q.C.:

Q. No change in results and subsequently no change in treatment, and then no change in results requires change in treatment as definition of negative changed.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. So this was Eastern Health, and they brought this along. So I guess this was Eastern Health putting this forward. But what, in terms of when the Minister or the Minister's people is asking "well, what does it tell me, in terms of what's your conversion rate? How many people changed?" what was the response given by Eastern Health?

DR. LAING:

A. My recollection that it was that it was--it would depend on what you considered to be the numerator and what you considered to be the denominator and that, you know, if you would look--simply look at people who just had a different number, you know, someone could have been 10 and 60 and come back as, you know, 10 and 65, I mean that would be a different

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number. Did that count as a conversion? And you know, because there was different time periods where different cut offs were used, that it was felt that this information would be better communicated by looking at the numbers of people that were impacted in different ways, i.e., you know, people that simply had no change in the results, people that had a change but had already been given hormonal therapy, for whatever reason, or people that, you know, for example, this group that were low risk from the very beginning and didn't require any therapy. So to try and break it down and explain it that way.

CHAYTOR, Q.C.:

Q. And before you went over to see the Minister and have the briefing, was there any strategy meeting or any get together amongst the Eastern Health people in preparation for the meeting?

DR. LAING:

A. Not that I can recall. We had had these discussions about, you know, from--people had sought my input as a clinician as to what kind of numbers that I would consider important,

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and they, to me, would have been the people whose care would have had been changed as a result of this new information.

CHAYTOR, Q.C.:

Q. Yes, and -

DR. LAING:

A. And I guess I was thinking that because there were some patients who I knew had different results, but because I knew that they had received hormonal therapy already, I would--in my mind, I was thinking of them as being different than the patients who, you know, had negative results and missed out on hormonal therapy, whether it was, you know, for adjuvant treatment or treatment of their metastatic disease.

CHAYTOR, Q.C.:

Q. And how much notice did you have before you went to this meeting?

DR. LAING:

A. Oh, I'm not sure.

CHAYTOR, Q.C.:

Q. Was it the type of thing where you were called and you had to be there that afternoon?

DR. LAING:

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A. I don't know. There was so much of that that happens in my life that -

CHAYTOR, Q.C.:

Q. So you don't know if you actually--well, meeting with Ministers, at least up to this point in time, wasn't a real common occurrence for you, and had you met with Minister Osborne before this?

DR. LAING:

A. I don't know. He had come to the opening of our Cancer Centre. So if you could tell me if that was before or after that.

CHAYTOR, Q.C.:

Q. And so, it doesn't stick out in your mind though whether or not you had a chance to sit down with people and say, "well, what's the meeting about and what are we going to discuss with the Minister?"

DR. LAING:

A. No, my recollection was that it was a meeting that we were having prior to the media briefing.

CHAYTOR, Q.C.:

Q. Doctor, it's indicated here, and these are Minister Osborne's notes, "media briefing next

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week. Canadian Cancer Society to get pre-briefing." Do you recall being part of any discussion around that, about the Cancer Society or Mr. Dawe to get a pre-briefing?

DR. LAING:

A. I know that I had met with Mr. Dawe at one point, but again, you know, I see him often, so it's difficult for me to know if this was prior to the media or not.

CHAYTOR, Q.C.:

Q. We understand that the pre-briefing, in fact, did not occur. That Mr. Dawe wasn't given an advanced briefing.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. Do you recall any discussion around that?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay, and were you part of any decision not to give Peter Dawe a pre-briefing?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

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Q. And if Ms. Bonnell has said otherwise, she's mistaken?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. There's also written here "how many deceased would have had a change in treatment?" and then "don't know." And then there's a line drawn here. What do you recall being discussed about the patients who were deceased?

DR. LAING:

A. So, I recall that we did have some discussions about the fact that we would get questions, and up to this point, you know, had been getting questions about the patients who had died, either as a result of their breast cancer or from other reasons, who were part of the retesting. Up until this time, we had, to a certain degree, had set those patients aside, as we've talked about, in the panelling process and then subsequently had some discussions about, you know, how we would deal with this issue.

At that time, the full retesting of all

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the deceased patients hadn't been completed, and I recall that there were some questions about "well, how do you know how many of the people who have died would have been impacted?" and I explained that that was a very difficult question to answer, because of course, within the patients who had died, you had to look at people who died of breast cancer. You had to look at people who died without recurrence of breast cancer. If you were to take patients who died of their disease, who were hormone receptor--thought to be hormone receptor negative and didn't get hormonal therapy, either in the adjuvant setting or ultimately when they developed their metastatic disease and died from it, you have to go back and look at, you know, the probability that hormonal therapy may have helped them, and you know, you and I have discussed that a lot over the last couple of days, and the most difficult thing is that you can never say certainly one way or the other if it would have prevented somebody's recurrence and if it would have prevented somebody's death.

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That is conversations that, you know, we've ultimately had and I've been involved with with families of these deceased patients, and that's very difficult. You know, the what if questions are always so hard, and it's--you know, when you're looking back at somebody who was diagnosed in a different time period when the therapeutic approach was different, the resources that--you know, how you would have treated people was different, and I was trying to explain that to the group and, you know, there was some discussion back and forth about whether or not we should have had all that information done and ready as part of this media briefing, and also, you know, the whole idea that you could never really be certain what impact it would have had on patients.

CHAYTOR, Q.C.:

Q. And do you recall a fairly heated exchange between yourself and Mr. Hynes around the deceased patients' results?

DR. LAING:

A. No. I mean, I know what you're making reference to, that there was shouting or that sort of thing.

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CHAYTOR, Q.C.:

Q. I don't know if there was shouting or voices raised. Perhaps that was said, but--and it's written here, the concern with the living and there's a circle brought around it, and again, this is the Minister's notes. Any issue with Mr. Hynes expressing displeasure with you saying things like "well, we're concerned with the living, not the dead," phrases like that, and that you--any issue taken with your stand at that point?

DR. LAING:

A. Not that I recall.

CHAYTOR, Q.C.:

Q. So you have no recollection that this -

DR. LAING:

A. Even looking back and thinking back to this meeting, it wasn't something that I had left feeling that I had had even, you know, an argument or a disagreement or a heated conversation with anybody about any issue.

CHAYTOR, Q.C.:

Q. So no confrontation at all?

DR. LAING:

A. No.

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CHAYTOR, Q.C.:

Q. Okay, and I take it you're aware of that because you've heard reference to Mr. Hynes' evidence on the issue?

DR. LAING:

A. I haven't--I read Minister Osborne's testimony related to that issue.

CHAYTOR, Q.C.:

Q. Okay, and I think Mr. Hynes said something like "you need to come up with a better explanation than that for the media in December." You don't recall any exchange like that?

DR. LAING:

A. I recall that, you know, when I had sat down and explained it to them, just as I've explained it to you, that you know, the difference in terms of looking back and how difficult that was, I didn't get a sense that Mr. Hynes was dissatisfied with that response at all.

CHAYTOR, Q.C.:

Q. Okay, and you told it to him like you're telling it to the Commissioner?

DR. LAING:

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A. Yes.

CHAYTOR, Q.C.:

Q. Doctor, you indicated that the conversion rate was the subject of discussion, and written here, and crossed off, is 3.3 to 4 percent, and then "within rate of error." Do you recall any discussion about the results being within the--and I think it should be perhaps margin of error. Do you recall anybody asserting that the outcome here was an acceptable outcome and within a margin of error, within an acceptable margin of error, anything like that?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And do you recall any discussion of a three percent?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. And if we could look at, please, P-1628? And these are notes, we understand, that Mr. Hynes took, and he's written here, "109 changes, recommendations on what to do. Three percent,

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2800 cases within margin of error." So if that was said in the meeting, you don't recall it?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. What was the Minister told in terms of what was to happen in the upcoming media briefing, in terms of information that may not be given out? Was the Minister told that--if we could just go back, please, to 0314, page ten? Was the Minister told that Eastern Health would not be giving out all these numbers to the public?

DR. LAING:

A. Not that I recall, no.

CHAYTOR, Q.C.:

Q. Okay, and why not? If it wasn't the intention to give the numbers out, why not tell the Minister?

DR. LAING:

A. I don't know.

CHAYTOR, Q.C.:

Q. So the information was given to the Minister and the Minister was told that you would be

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having a briefing.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. But the Minister wasn't told "some of this information, Minister, will not be disclosed"?

DR. LAING:

A. Not that I have any recollection of. I wouldn't have said those things to him.

CHAYTOR, Q.C.:

Q. And Dr. Laing, you agreed with the position to only release what at that time was said to be 117 patients with a change in treatment. What was the problem with just giving all of these numbers? These were the numbers to the best of Eastern Health's ability at the time, of what they had put together, and were able to determine with the resources that they used.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. That these were the numbers. What was the problem with giving out all the numbers?

DR. LAING:

A. I didn't think that there was a problem with

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giving out all the numbers.

CHAYTOR, Q.C.:

Q. Okay. So you would--while you concentrated on the 117 -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - as being what you saw as being the most important number, you advocated for all of the numbers being given out?

DR. LAING:

A. I don't recall at that time having a conversation that said, you know, "we're only going to give this number. We're only going to give that number." My recollection was that, you know, again, I come back to being a clinician, that the number that I felt was important was the number of people who needed a treatment change as a result of this, so that we could separate that from the number of people who had already gotten the appropriate treatment. That was sort of my thinking. It was--I would have never, and I would to this day say I would never have had any problem with people saying that 178 people had already

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gotten the right treatment, 60 people didn't need it. You know, that wasn't anything that we--that I or the clinicians that, you know, would have been involved in this discussion had any problem with. What always--you know, that I remember so vividly about this time was this want for this one single number, this conversion rate. That somehow, you know, we should come up with a number that said, you know, 40 percent of the tests were inaccurate. And I guess, you know, if you wanted to look at exactly how many had a change in one of those numbers, you know, maybe--and I've never done the math, so I don't know whatever it would be, but it was this idea that it would be better explained by this sort of a breakdown, but I don't recall any discussions, nor was I part of any discussions that said we should only give this number, we shouldn't give that number. I felt that we needed to explain it, as opposed to giving this overall conversion rate.

CHAYTOR, Q.C.:

Q. Well, Doctor, I just want to be clear on that. We have heard from others that there was a

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meeting of Eastern Health representatives leading up to the media briefing.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Dr. Howell certainly attended the meeting. Dan Boone was in attendance at the meeting. Were you in attendance at that meeting?

DR. LAING:

A. I'm not sure what meeting that would have been.

CHAYTOR, Q.C.:

Q. So it would have been leading up to the media technical briefing, and the discussion, one of the issues discussed would be what would be disclosed at the upcoming media briefing.

DR. LAING:

A. I know that prior to when we did the media briefing, that we did go to the Waterford site and had a meeting with the media relations people, and I think there was a series of potential questions and answers and things that we went over, but I don't recall having a specific discussion that said, you know, we're going to tell this number, but not that

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number.

CHAYTOR, Q.C.:

Q. So you went into the media technical briefing understanding that whatever numbers were requested from the media, we could disclose whatever numbers they asked for?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. If we could look at P-0110, please? No, it's not 0110. I'm looking for the questions and answers related to the media briefing and the media briefing itself. Anybody know that number? I think it's 0101. Try 0101. Maybe I mixed up my numbers. Actually, let's try 0184. Sorry, Registrar. Thank you, Mr. Coffey.

THE COMMISSIONER:

Q. This what you're looking for?

CHAYTOR, Q.C.:

Q. I think so, or at least one document that will help us out, and this is from Ms. Bonnell, December 9th, 2006, so two days before your media technical briefing, and it's to Dr. Howell, Heather Predham, yourself, Dr. Denic,

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Janie Bussey at Stewart McKelvey, Dan Boone at Stewart McKelvey, George Tilley and Leona Barrington, and it's regarding the technical briefing agenda, and draft press release.

"Hello again everyone. Following conversations with Nash, Heather, Dan and Oscar, I have revised the original drafts in anticipation for our meeting at one p.m. tomorrow. We can make further revisions at that point, and I will bring copies with me. Please note I've added speaking notes for everyone, less so for Kara and Nash. I guess the most significant change you will note from the original material is the lack of reference to a rate of error. We can anticipate that this will be a major pressing point with the media, but they approach we will be taking here is that I can't--we can't indicate that an error has actually occurred, and B. the whole process wasn't about identifying a rate of error anyways, it was about identifying patients whose treatment would change as a result of the review and the panelling. Hence, the number of individuals impacted has changed from 104 to 117." And she explains why that

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is.

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And then "re: the dead, we must also be prepared." And then if you--okay, and Doctor, so first of all, this is being sent to you, amongst the others, and do you recall then around this time period that there would have been a meeting to discuss those issues, as to preparation? You said that you attended one at the -

DR. LAING:

A. Yeah, at the Waterford site, yeah.

CHAYTOR, Q.C.:

Q. Okay, and the Q and A's were reviewed, the Q and A's for the media technical briefing. So it would be a document, I take it--this is the document we've been provided anyhow.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. So would it have been something like this?

DR. LAING:

A. Something like that, yeah.

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CHAYTOR, Q.C.:
Q. Yes, okay, and so this would have been passed out to the group in attendance and asked for any input, I take it?
DR. LAING:
A. I don't remember it being passed out, but I do remember that we would have gone through some of the potential questions that would be asked.
CHAYTOR, Q.C.:
Q. Okay, and so this question here--sorry, there's a couple of different ones here. "How many patients have been impacted by this?" and the answer "in the vast majority of cases tested and treated between 1997 and 2005, the patient's treatment was confirmed appropriate. From 1997 to 2005, 2,760 individuals had ER/PR tests in our laboratory. 939 of these patients originally received negative results. 117 of these patients have had recommended changes in their treatment plans as a result of review by a panel of experts." So in terms of these being--well, first of all, let me ask you about "in the vast majority of cases tested and treated, the patient's treatment

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was confirmed appropriate." Doctor, other than the 939 or thereabouts who were part of the retest, and of course, these numbers are according to this point in time, as was known by Eastern Health at this point in time, were any one else other than the 939, was the care of the other patients even reviewed or the treatment of those other people? "The patient's treatment was confirmed appropriate in the vast majority of cases tested."
DR. LAING:
A. Not by me or the panel.
CHAYTOR, Q.C.:
Q. Or the panel.
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And to your knowledge, did anyone in Eastern Health review the treatment of those people?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. And I would take it you would be expected--had that happened, you would expect you would have been involved?

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DR. LAING:
A. Sorry, I would have expected?
CHAYTOR, Q.C.:
Q. You would have expected to be involved, being the -
DR. LAING:
A. Oh, if someone wanted to go back and do an audit to see if people had received appropriate care, then they would have to, you know, look to somebody -
CHAYTOR, Q.C.:
Q. The other 1800 or whatever, yes. If someone were to review those, you would expect that you would have been involved or at least known of the process?
DR. LAING:
A. Looking at this now, I can only think that they were speaking to the patients who were hormone receptor positive.
CHAYTOR, Q.C.:
Q. Yes, okay. Question nine then says "what is the rate of error? How many people converted?" I'm sorry, Doctor, can you just say that again, that last answer?
DR. LAING:

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A. No, I said I was--looking at that now, I'm wondering are they just saying that of the 2760 people who had ER/PR testing done, 939 had ER negative results.
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. And then the other, whatever the math is, would have been positive. So I'm just assuming that they're thinking that if they were positive and they were tested positive, then they would have received the appropriate hormonal therapy, just as a general assumption. But you're correct, without having gone back and reviewed those records.
CHAYTOR, Q.C.:
Q. Yes. "What is the rate of error? How many people converted? Up to this point, our focus has been on making treatment changes where appropriate, and 117 individuals have experienced treatment changes. Some of these changes are because of conversion in their ER/PR test result from negative to positive. Some because the definition of negative has changed. Some because of where patients are

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today with their disease. There are multiple factors involved. Now that legal proceedings have been initiated, we will allow the legal process to determine if in fact error has occurred. The numbers of individual conversions are not relevant and turn the process into a numbers game. For example, some people had minor conversions that did not impact upon whether they will be considered suitable for hormone therapies, and some individuals converted, but upon review of their treatment plan, it was discovered that for other clinical reasons, they were already receiving Tamoxifen. So what is relevant is the number of people whose care may change as a result of the process, and that was 117."

So this idea of the number of individual conversions are not relevant, so that particular number of the other people who were found to have had changes in their results, the answer that was being proposed to be put forward was that that number is not relevant and the relevant number is the 117. So were you aware, going into the media technical briefing, that that was the position of

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Eastern Health?

DR. LAING:

A. No, I would have interpreted that to be that what's not relevant is the number. What's relevant is what it meant to the patient.

CHAYTOR, Q.C.:

Q. So how is the number of people who had a change in their result, how is that number not relevant?

DR. LAING:

A. No, no, not that that--I would interpret that to be that it's not the actual number. So if someone was ER 10 to 20 percent and then they were reviewed and came back as, you know, ER 30 percent, that it wasn't the number. To me that number, I would think of it was being the actual numbers. What was important was how that impacted on that particular patient's care. So I would interpret that to be that not to think about it as, you know, this is-- you know, if you, again as I said, if you wanted to take every number that had changed, what would be important to me would be to think about them as in groups. So people that didn't get treatment and should have. People

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that got treatment, because of whatever, and then people who didn't need treatment in the beginning, and still didn't need treatment now. So I don't think that those numbers are irrelevant. I didn't then and I don't now.

CHAYTOR, Q.C.:

Q. Okay. So similar to the breakdown that in fact was given to the Minister -

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. - you thought all the information on the page to the Minister was relevant information.

DR. LAING:

A. So it could have said, for example, some patients have had minor conversions that did not impact on whether they would be considered for hormonal therapy. There were 60 of these. Some individuals converted, but upon review of their treatment plan, it was discovered that for other clinical reasons, they were already receiving Tamoxifen or other hormonal therapies. There were 148 of these.

CHAYTOR, Q.C.:

Q. Yes.

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DR. LAING:

A. Those would be the numbers that I think belong next to those two statements, if I think back to that document.

CHAYTOR, Q.C.:

Q. Yes, and do you recall any discussion then or did you speak up to say "well, why don't we just give out all the numbers?"

DR. LAING:

A. I didn't even think that they weren't going to be there. It wasn't something that I had thought about at the time.

CHAYTOR, Q.C.:

Q. And Doctor, you did say that you expressed some concern about the issue of coming up with a rate of conversions.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And the numerator and denominator, and you've said that. Did you have any concern over the use of the term "rate of error" or an error rate?

DR. LAING:

A. No.

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CHAYTOR, Q.C.:
Q. So other than what I've already asked you about, in terms of the total numbers, and I just want to be clear, because what I'm hearing you say is that you don't--you didn't take part in any discussion that involved not giving out certain numbers? You weren't present when it was discussed that certain numbers would not be given out, and that only the 117, the 2,760 and the 939 would be referred to? You weren't part of any such discussion?
DR. LAING:
A. No, other than my--you know, that I thought that the 117 was a very important number. I still do. But not to say that I didn't think that the 148 or the 60 or any other numbers shouldn't have been disclosed.
CHAYTOR, Q.C.:
Q. Okay, and you weren't aware--if that were to be the case, you weren't aware? That you, for example, if a reporter asked you, at the briefing, "but how many people had changes in results?" you would have freely offered up the number?

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DR. LAING:
A. Yes, but they didn't ask how--they didn't ask about the number of people who had already gotten the appropriate treatment. The only questions that we got asked about was "well, what was the overall conversion rate? What was the overall conversion rate?" That was the number that we were asked, and then we tried to explain that there were, you know, certain people that fell into this category, certain people that fell into that category, and I think people were focusing on the 117.
CHAYTOR, Q.C.:
Q. And which people were that? Who focused on the 117?
DR. LAING:
A. No, I think that was--you know, that that was the number that was felt to be important. I still think it's an important number.
CHAYTOR, Q.C.:
Q. Yes. Doctor, so what you're saying is that reporters asked for a conversion rate?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:

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Q. But nobody asked how many people overall had changes in results or how many of the results actually changed? That question, in any form, wasn't posed?
DR. LAING:
A. Not to me, that I can recall.
CHAYTOR, Q.C.:
Q. And not within your ear shot?
DR. LAING:
A. Not that I remember. What I can remember is time and time again being asked about a conversion rate. I don't remember words like rate of error, but I remember conversion rate.
CHAYTOR, Q.C.:
Q. But the overall number of changed results was not asked?
DR. LAING:
A. No, not to me.
CHAYTOR, Q.C.:
Q. So Doctor, the 117 number, and of course, we're all aware today that that number has changed. This was as of November 2006.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.:

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Q. And there have been other people since who have been--who've come forward or been otherwise identified.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. In terms of using the 117 number, you understood that was anyone who had had a change in their treatment as a result of the review?
DR. LAING:
A. As a result of the new information provided by the review at Mount Sinai Hospital, yes.
CHAYTOR, Q.C.:
Q. Did it include the people who had a misdiagnosis?
DR. LAING:
A. The ductal carcinoma in situ patients?
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. I would say no.
CHAYTOR, Q.C.:
Q. Okay.
DR. LAING:

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A. That would be my understanding.
CHAYTOR, Q.C.:
Q. And you certainly told me yesterday, or perhaps it was before that, that you would have expected it to include the people who had a change, regardless if that change was recommended by the panel or -
DR. LAING:
A. Right, so those -
CHAYTOR, Q.C.:
Q. - recommended by the treating oncologist?
DR. LAING:
A. Right, so those group of people that we identified that had already been dealt with.
CHAYTOR, Q.C.:
Q. What did you do to assure yourself, before speaking publicly as to the 117 number, what did you do to assure yourself that that number, as of November or December 2006, was in fact the accurate number?
DR. LAING:
A. I was told that that was the number of people who required a treatment change, and that that was based on the review of the panel work.
CHAYTOR, Q.C.:

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Q. And did you ask what they had done to come up with those individuals?
DR. LAING:
A. No, I just assumed that they had looked at the letters and come up with that number.
CHAYTOR, Q.C.:
Q. And it didn't dawn on you at the time, while looking at the letters, if they come across a letter that says "no recommendation to change -
DR. LAING:
A. That they wouldn't count that one.
CHAYTOR, Q.C.:
Q. - that they wouldn't count that person?
DR. LAING:
A. That didn't dawn on me at all.
CHAYTOR, Q.C.:
Q. Okay, and -
THE COMMISSIONER:
Q. Excuse me, Dr. Laing, when you say you were told, could you tell me who told you and who do you understand was doing this work?
DR. LAING:
A. I would have been told by Dr. Howell and it was my understanding that he or Ms. Predham or

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someone had gone back through and had tallied up these numbers, because they had this running list, if you will, of the patients.
THE COMMISSIONER:
Q. Okay. So you don't really know actually who did the work?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. But you believe that--but the information about the work having been done was conveyed to you by Dr. Howell?
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. Thank you.
CHAYTOR, Q.C.:
Q. So Dr. Laing, Rosalind Jardine is a patient of yours, I understand.
DR. LAING:
A. Yes, she is.
CHAYTOR, Q.C.:
Q. Okay, and she's been here and given evidence, so we can use her name, and she was a person who, I understand, had a change in treatment

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as a result of the review.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay, and you would have expected her name then to be on the list of 117?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And certainly, her change was known back in-- one of the earlier ones, back in -
DR. LAING:
A. Yes, it was.
CHAYTOR, Q.C.:
Q. - I believe, late October 2005.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. She was informed of her results, so there would be no reason, in November 2006, for her name not to appear on the list of 117.
DR. LAING:
A. Yes, but I never did know--I didn't ever see a list and look down through that and read the names of the patients, no.

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CHAYTOR, Q.C.:
Q. So if her name is not on the list, and I'll suggest to you the list that we've been provided, her name is not there, she should be added?
DR. LAING:
A. Yes, she should.
CHAYTOR, Q.C.:
Q. Okay. Daphne Coffin, she was told her results and put on a change of treatment in September 2006. Should her name be on the list?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. So she should be added to the 117 as well?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And there are a number of others who I can't name because -
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. - they haven't been here. Doctor, how did the

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briefing go? We understand it was divided into -
DR. LAING:
A. Two.
CHAYTOR, Q.C.:
Q. - two separate briefings.
DR. LAING:
A. Two sessions.
CHAYTOR, Q.C.:
Q. So tell the Commissioner about that.
DR. LAING:
A. So the first group that we met with was the reporters from CBC, and then the second group were reporters from, I think everybody else. So NTV, The Telegram, The Independent, VOCM, you know, whatever other groups. And the discussion after the presentation--and I'm just--I believe that they did a walkabout in the lab, but I didn't go with that part of the media briefing, but they had asked us questions about this conversion rate, and they were very adamant that, you know, that there must be this number, and we tried to explain that, you know, we looked at the groups of patients, just as I've explained to you here

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this morning.
And it was a very disconcerting meeting. They were quite openly upset, angry, cross. I felt that they behaved unprofessionally. When we would answer the questions, they rolled their eyes and smirked, and to me, it was a very upsetting interaction. It was as if they didn't believe what we were saying and, you know, it was upsetting to me, as a person.
The second media briefing was much, much better. We had very good questions and dialogue from the other reporters, and that was it.
CHAYTOR, Q.C.:
Q. And the group that you found to be less than professional, which group was that?
DR. LAING:
A. The CBC reporters.
CHAYTOR, Q.C.:
Q. And Doctor, did you--the issue of not giving out other numbers, you're saying that they asked for a conversion rate?
DR. LAING:
A. They kept saying "well, what was the conversion rate? What was the conversion

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rate? You must have a rate. Why aren't you telling us this rate?" and that's what I remember.
CHAYTOR, Q.C.:
Q. Doctor, were you concerned too that if you gave all of the numbers, they might come up with their own conversion rate?
DR. LAING:
A. I hadn't really thought about it, but sure, I mean, they could have--you know, you could add and, you know, you could put all that on top and that could be your numerator and your denominator could be the 276. It could be all the testing done, you know, this was the issue of, you know, trying to decide which you would use for the numerator. Would you include the 117, the 117 plus the other 148, the 60? Would the bottom be those tests? Would you include all the tests that were done? But you know, I think that sort of thing can happen anyway. You know, whenever you give numbers out, people can interpret them in whatever way they want to, and there's not really a whole lot that you can do to change that.
And I remember getting a feeling from

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them that we had done some sort of statistical analysis, and we had come up with our own conversion number, which wasn't done, and somehow we were not telling that number to them.

THE COMMISSIONER:

Q. Them being the first group or the second group or both groups?

DR. LAING:

A. The first group.

CHAYTOR, Q.C.:

Q. Doctor, I just want to be clear, because you said there was discussion amongst your own group before the briefing as to, well, what numerator would you use, what denominator would you use, there was that discussion?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, so in having that discussion you're saying that there was no discussion about, well, if we give them the 300 and whatever number, they're going to come up with their own conversion rate?

DR. LAING:

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A. Not that I can recall.

CHAYTOR, Q.C.:

Q. So what numerators and denominators were being discussed by your group beforehand?

DR. LAING:

A. Oh, you could use--so the denominator that you could use would be the people, the 2000 some odd retestings or you could look at the whole group, you could look at all of the tests that were done and assume that the ones that were not retested--you know, so it would depend on which denominator that you would decide to use. In terms of the numerator, then you could use pretty much anybody that had any change in test. You could even use people that were confirmed negative but might have had one percent staining. So there's various different combinations and permeations that you could do with these numbers. But my recollection of it wasn't that those numbers were given to prevent that from happening, that's not my recollection.

CHAYTOR, Q.C.:

Q. Okay. Doctor, and what you also said here a few minutes ago is that when I asked you,

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well, were you afraid by giving the overall number of change results, they might come up with their own conversion rate, you answered, "Well, yes, I guess so," but you hadn't really thought about it?

DR. LAING:

A. I hadn't really thought about it, but certainly that's possible.

CHAYTOR, Q.C.:

Q. So if you told that to us in your interview, you thought about it then, that at the time there was concern to give out the 340 number because they might divide that, 340/90 and get a 30 percent error rate?

DR. LAING:

A. 340 over?

CHAYTOR, Q.C.:

Q. 900, sorry, do you recall -

DR. LAING:

A. Or 340/2760.

CHAYTOR, Q.C.:

Q. Do you recall telling that to me and Mr. Coffey?

DR. LAING:

A. Well, if I did, then that would be what I

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would have said, yes.

CHAYTOR, Q.C.:

Q. So, Doctor, was there concern to give out the overall number because the media might come up with their own conversion rate?

DR. LAING:

A. Did I think that that was a main factor in what was eventually presented, no. Is that a concern? Whenever you give numbers out to the media that involve this sort of thing, absolutely.

CHAYTOR, Q.C.:

Q. Okay. If we could have P-0428, please? Doctor, this is an interview, it's actually at page 3. CBC interview on the day of the media coverage, December 11th, 2006. And this is done with Chris O'Neil Yates. Actually, it may not be page 3. It's page 7 I need. Here we go. This one is CBC TV, December 12th, sorry, 2006, so the day after. Chris O'Neil Yates, Oscar Howell, Mrs. Myrtle Lewis, and then yourself?

DR. LAING:

A. Um-hm.

CHAYTOR, Q.C.:

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Q. So you remember taking part in this interview?
DR. LAING:
A. Yes, we were in Dr. Howell's office, from what I can remember, and she had asked us questions.
CHAYTOR, Q.C.:
Q. Okay, "And in 117 people we made some sort of recommendation to have the treatment changed."
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And then you're also interviewed, and I believe this must be the same day, by NTV, and it's Carolyn Stokes, Peter Dawe is also interviewed, Dr. Howell and yourself. And then the portion I wanted to bring you to here is, "Because of the complicated nature of the ER/PR test, Eastern Health doesn't know exactly what went wrong, but they're conducting an external quality review to ensure accuracy is increased in the future. This was something that was taken very seriously by Eastern Health and by all of us. And I could look at them and say, 'You know, this has happened and we don't really know

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why, but we made this decision to retest everybody because we thought if we could help you in some way, that we should do that. And I think that the good that will come out of this is that our lab will be and I think it's on its way to being one of the best labs in the country to do this test.'" Doctor, was there any discussion by the group beforehand as to not disclosing any issues that had been identified that may have potentially contributed to the changed results?
DR. LAING:
A. Issues that were identified in the peer review process, are you referring to, within the laboratory?
CHAYTOR, Q.C.:
Q. Yes, or otherwise, any issues that had been identified through that process or otherwise that may help explain why there were changed results?
DR. LAING:
A. Were those discussions about what to put in from the point of view of pathology in the laboratory wouldn't have been had with me.
CHAYTOR, Q.C.:

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Q. I'm sorry?
DR. LAING:
A. I wouldn't have been part of those discussions about what you could or could not disclose because I'm not sure at this time was that still considered to be protected by peer review.
CHAYTOR, Q.C.:
Q. And, Doctor, I'm just wondering, though, in leading up to the technical briefing if you were part of the discussion as to what could or could not be said regarding any potential causes?
DR. LAING:
A. If it was discussed at those meetings leading up to it and I was there, then I would have heard it. But I don't think people would have been asking me questions about, you know, what had gone on in the lab itself or those sorts of issues.
CHAYTOR, Q.C.:
Q. Okay. Doctor, you had sat in on Trish Wegrynowski's review?
DR. LAING:
A. I did, yes, that's correct.

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CHAYTOR, Q.C.:
Q. Okay, or her exit interview, I should say, following her review. And so you knew what she had found in terms of some quality assurance issues that she had identified and issues with the technical process?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Okay. And you say here you don't really know why it happened. You know this has happened, "We don't really know why." And then you go on to say that, "I think what good will come out of it, the lab will be and I think it's on its way to being one of the best labs in the country to do the test." So as of November, or sorry, mid December, 2006 what information did you have as to the current status of the lab?
DR. LAING:
A. So I knew that they had been setting up a quality assurance program within the lab, that they were going to look at having participating in the external proficiency testing and all those discussions were

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happening. I'm not exactly sure where they were at this time, but, you know, I did know that the lab was working to improve, to improve the results. And then, of course, you know, this issue had raised concerns and questions not only for our province but really across the country in terms of the, you know, the accuracy and reliability of these tests.

CHAYTOR, Q.C.:

Q. Doctor, having sat in on Ms. Wegrynowski's exit interview, do you think you had some idea of some of the things that may have went wrong?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And, Doctor, at this point in time, mid December, 2006, were you in agreement that the lab was getting to the point where it could commence ER/PR testing again?

DR. LAING:

A. I'm not sure when we made that decision. I thought it was after this.

CHAYTOR, Q.C.:

Q. Okay.

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DR. LAING:

A. And that wasn't a decision that I would have made other than I would have had, you know, discussions with Dr. Denic, then the clinical chief, he would have told myself, Oscar Howell, you know, what had been put in place and how the monitoring was going to be. And at the end of the day I was satisfied that we could restart testing.

CHAYTOR, Q.C.:

Q. And I -

DR. LAING:

A. But I can't remember exactly where it was in relation to this.

CHAYTOR, Q.C.:

Q. Okay. You were consulted, I take it, by Dr. Denic at the time?

DR. LAING:

A. Prior to reinstituting the testing, yes.

CHAYTOR, Q.C.:

Q. Yes, and how did you reassure yourself at that point in time, which we understand it was started again in February of 2007, what did you do to reassure yourself or what information were you given to reassure

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yourself that this would now be okay for your patients to have their testing done in St. John's?

DR. LAING:

A. You know, at that time they had talked about setting up the subspecialty group, that was reassuring. That the actual interpretation was going to be done by a small group of people, that was reassuring. That they were participating in the proficiency testing, so the slides were going out, that the slides that were made in our lab were going out to be reviewed and then our lab was being asked to review slides made somewhere else as part of this kind of UK proficiency testing and that people would be monitoring trends and all those sorts of things. And we had started to have these discussions up until this point in December and it wasn't, as you say, until, my recollection was it was into the next year before things were reinstated. And that was also part of the discussion that we had when you referenced that November meeting with the pathologists from across the province. You know, Dr. Elms was placed as the, I guess,

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director, would be the word, of the immunohistochemistry lab at the time. And so, you know, a lot of the recommendations that had been made had been followed through upon.

CHAYTOR, Q.C.:

Q. Yes. And Dr. Denic's presentation or ever who gave the presentation as to what, in fact, had gone wrong, you would have sat through that and had knowledge of whatever was included in that presentation?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. If we could have P-1204, please? And it's page 3 of this document, Registrar. And, Doctor, I stand -

DR. LAING:

A. Still true.

CHAYTOR, Q.C.:

Q. I bet. I stand corrected.

DR. LAING:

A. Yeah. I knew it was someone different.

CHAYTOR, Q.C.:

Q. It was Stephanie Porter that you gave the interview to and not Clare-Marie Gosse. And

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this is an interview that you gave with The Independent. And I think this one took place December 15th, according to my notes. And you're quoted on the bottom here a couple of times. And refers to you being part of the eight person Tumour Board Panel. And then over her you say "Laing maintains there is no big secret being protected from the public's always critical and often cynical eyes. 'We have made the lab better,' she says, 'we have a core group of people doing things in the lab. You now have stability in the oncology in the oncology workforce, you now have people who are paying attention, not just to this but to all things that are happening, so if things start to appear out of sync, you can look at it now.'" Doctor, I'm just wondering what it is that you're referring to there, what is it that is being--how is it different as of December, 2006, who was paying attention to what and what would appear out of sync that would alert you to any problem?

DR. LAING:

A. Oh, I just meant that now that, you know, when we get our test results back, we're looking at

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them, we're making sure that we don't see any trends, you know, looking, make sure that the--if we see a lobular that's negative, automatically retest it. If we notice that someone is ER negative, PR positive, ask to have that reviewed. Just those sorts of issues -

CHAYTOR, Q.C.:

Q. Well, at this point in time you wouldn't be doing--there was no ER/PR testing happening, though, in St. John's?

DR. LAING:

A. No. I was saying that, you know, as -

CHAYTOR, Q.C.:

Q. In general?

DR. LAING:

A. - thinking about this is going to start up again within the next month or two. And also that, you know, with the stability in the oncology workforce, that again that sort of day-to-day continuous quality improvement that you do by looking at what's going on around you and trying to notice trends, be it in any aspect of the care that we provide.

CHAYTOR, Q.C.:

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Q. Okay. And, Doctor, it did start up again in February, 2007. And throughout up until it shut down again due to other reasons this year, do you--were there trends being tracked, do you know were the positivity rates being kept, were there any trends being monitored from an oncology point of view?

DR. LAING:

A. Not from our point of view, no.

CHAYTOR, Q.C.:

Q. And do you know whether or not the lab was tracking any information?

DR. LAING:

A. It's my understanding that the lab was looking at positivity rates and, yeah. When we get our database, that will go in it.

CHAYTOR, Q.C.:

Q. "It really was a systems problem" you're quoted as saying.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. "And we've done everything we can to fix the problem and we hope other labs learn from this." And, Doctor, we've heard that a bit

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here, the systems problem. What did you mean when you said it was a, and I'm assuming that's an accurate quote, is it?

DR. LAING:

A. Yes, that this wasn't, you know, one particular mistaken that happened, this was due to a number of factors all coming together. And that's what I meant by that.

CHAYTOR, Q.C.:

Q. And if we could have, please, 1658?

REGISTRAR:

Q. 1658, Ms. Chaytor?

CHAYTOR, Q.C.:

Q. Yes.

REGISTRAR:

Q. (Inaudible).

CHAYTOR, Q.C.:

Q. It's a Telegram article that the doctor also did in December, 2006. I probably have my numbers wrong. Let's try, please, 0187? Might be that one. That's it.

UNKNOWN SPEAKER:

Q. (Inaudible). Is this it?

CHAYTOR, Q.C.:

Q. Yes, this is it. Telegram, December 13th.

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And, Doctor, this is an article by Deanna Stokes Sullivan. And you're quoted. Do you recall participating in this interview, as well?

DR. LAING:

A. No, but.

CHAYTOR, Q.C.:

Q. No.

DR. LAING:

A. That's okay.

CHAYTOR, Q.C.:

Q. Okay. She quotes you. If there's anything not correct, I'm sure you'll tell us. One thing I wanted to point out to you on this one was that "Laing said while the retesting has resulted in recommended treatment changes for 117 patients, some of these women might have already been taking the commonly prescribed Tamoxifen."

DR. LAING:

A. That wouldn't be true -

CHAYTOR, Q.C.:

Q. So that's not correct?

DR. LAING:

A. - for that 117, no, no.

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CHAYTOR, Q.C.:

Q. No, okay. So that's not correct?

DR. LAING:

A. No, no. I think what I would have said is that it resulted as a change for the 117 but there was another group of women who would have already been taking the Tamoxifen, referring to that, whatever that other number was, 138.

CHAYTOR, Q.C.:

Q. And then the next part they put in quotation marks, "'But,'" quotation marks, "'if seven years had gone by, we wouldn't recommend a treatment change,' she added." And, Doctor, is that accurate, did you, you're quoted -

DR. LAING:

A. No, because there were people who were beyond seven years that we would have recommended. So I don't know if I had been used a specific example. Maybe I said, for example, if someone hadn't had lymph nodes involved or something like that.

CHAYTOR, Q.C.:

Q. Okay, I just wanted to clarify that because we did actually look at a couple of patients

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yesterday -

DR. LAING:

A. Yes, and there certainly were people -

CHAYTOR, Q.C.:

Q. - which went beyond the seven years?

DR. LAING:

A. - that, yeah, yeah.

CHAYTOR, Q.C.:

Q. Okay. If I could have, please--and, Doctor, that's all the questions I really had for you around that time period and the media coverage, unless there's anything else that you can think of that--that's it, okay. And if we could look at, then, P-0166? And, Doctor, this is an e-mail that doesn't--it's not between you, you're not a recipient or a sender.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.:

Q. But you are mentioned.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. And it's actually between Mr. Tilley and

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Minister Osborne, copied to Dr. Howell, and it's January 17th, and I believe this is 2007.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.:

Q. And it involves an adjustment in compensation for the administrative work of three oncologists, including yourself, Dr. Ganguly and Dr. Siddiqui. And I just want to bring you to this paragraph, "Back in November with issues around ER/PR about to be dealt with in the media I asked Dr. Howell," and again, this is Mr. Tilley writing, "I asked Dr. Howell to resolve the compensation issue for Kara Laing as it was different from the others (retroactivity) and we needed her full support when we move forward on the ER/PR discussions." And then that left the division chiefs outstanding in terms, I think he's referring to their compensation issue. Had the issue of your compensation with respect to your administrative duties as clinical chief, had the issue of your compensation been discussed at the time it was resolved, had anyone indicated anything to you that it had

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anything to do with needing your support as they move forward on the ER/PR issues?

DR. LAING:

A. Absolutely not.

CHAYTOR, Q.C.:

Q. Okay, and, Doctor, had that issue not been resolved, would that at all have impacted your level of cooperation with respect to the ER/PR issue?

DR. LAING:

A. Absolutely not.

CHAYTOR, Q.C.:

Q. Okay. And I just wanted to give you the chance to speak to that.

DR. LAING:

A. Thank you.

CHAYTOR, Q.C.:

Q. Okay. And 1207, please? This is an e-mail from Heather Predham to Leona Barrington, Oscar Howell, Pat Pilgrim, Pam Elliott and it's January 25th, 2007. And this appears to be regarding another patient who was missed. "This lady called Nancy last week saying that we had called her and told her that we were going to retest her, but she had not heard

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anything since. On checking into this, this lady was retested and was shown to have a changed ER/PR result. She was panelled in February, 2006 and a letter was written by Kara Laing as chair of the Panel to Kara, the most responsible physician. In September we contacted all physicians who received a letter from the Panel to confirm that the patients had been notified. This included all physicians at the Cancer Clinic. After an incident with another patient the entire list was reviewed with the leadership in the Cancer Care Program. This lady was on Dr. Laing's list. Unfortunately, Kara was not available now to meet with this lady and explain why she was missed. An appointment was arranged with Dr. Zulfiqar to meet with her. She called Nancy a few days later very upset. She did make the comment that she had attempted to call Nancy several months ago but there was no message and no evidence of her calling. Unfortunately, I don't know what else from an Eastern Health perspective we could have done." Doctor, do you recall the incident around this particular patient?

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DR. LAING:

A. I do, yes.

CHAYTOR, Q.C.:

Q. Okay. And what's your recollection of what happened here, what transpired?

DR. LAING:

A. So this was a patient who was retested and her results had changed. And her--when I had--when we had had the other incident, and then when I had looked down through, this lady was actually, I thought that she had been dealt with by her family physician. When we looked back, this lady was, indeed, on a hormonal treatment for a different reason and had, in fact, been given it and had completed almost five years of it when I saw her. I was off on sick leave in January and February of 2007, I required rather urgent surgery, so I was off, that's why I wasn't available that day. When I returned, I met with this lady and we figured out what had happened, that she had been on a medication called Relaxofene which is like a cousin of Tamoxifen and I have thought that she had been placed on Tamoxifen. When we realized what had gone on and this

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mis-communication and she had been finishing this drug, I then switched her to extended treatment with Femara and she remains on that and is doing well.

CHAYTOR, Q.C.:

Q. Yes, okay. And I'm just thinking, though, in terms of the contact. It appears at this point in time there had been a review?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Heather Predham says that in September?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. All physicians were contacted, including the physicians at the Cancer Clinic?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And so in going through your list to confirm that she along with the others had been contacted, why did you assume the family physician had been her contact, what did you do to confirm that had happened? Because it

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says the letter was written to you, by you, so why did you think the family physician made the contact?

DR. LAING:

A. Because she had been discharged from the clinic. And we realized after that I had made contact with the family physician and had understood that she was taking medication. And then we realized that it was actually the Relaxofene that she had been taking for a different reason. And then once, you know, once we sorted it all out and realized what had gone on, I met with this lady and I still follow her and she's well.

CHAYTOR, Q.C.:

Q. Okay, thank you.

DR. LAING:

A. And I think this really just speaks back to the issue of having a one central person responsible.

CHAYTOR, Q.C.:

Q. Yes. If we could have, please, P-1418?

THE COMMISSIONER:

Q. Ms. Chaytor, wherever you can find a convenient space we'll take the morning break.

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CHAYTOR, Q.C.:

Q. Okay, thank you. I'm almost done. 1418 is an e-mail from Ms. Predham to a number of people. And you're copied on this, and it's June 20th, 2007. And actually, I think this actually begins further down, the part on the bottom of the first page. Ms. Predham has received interrogatories that she has to answer in the class action. "As you can see when you read the attachment, I am going to need some assistance in answering these interrogatories. There is a ten day time frame to respond. How should we proceed?" And then Dr. Howell suggests a conference call or meeting with Nash, Don, Terry and Kara to consistently answer the questions. "This will be a priority for all to meet the ten day deadline." And, Doctor, I'm wondering did you, in fact, take part in any discussions around the answers to those interrogatories?

DR. LAING:

A. I'm not sure. Not that I recall.

CHAYTOR, Q.C.:

Q. And, Doctor, is that something you think you would likely recall? I mean, how often are you called upon to discuss a document which, you know, is part of a court process?

DR. LAING:

A. I would think I would recall it, yes.

CHAYTOR, Q.C.:

Q. So you have no recollection of actually taking part in that?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay. Perhaps then we could break there, and I shouldn't be long after the break, Commissioner.

THE COMMISSIONER:

Q. All right, we'll take fifteen minutes.

(BREAK)

THE COMMISSIONER:

Q. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Registrar, if I could have, please, P-2575. Doctor, this is an e-mail to yourself and Dr. Denic from Marian Crawley, August 9th, 2007, and the subject is ER/PR order, high importance, and she says, "Hi, re; ER/PR patients, I've

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attached an order that requires Eastern Health to send a registered letter to all patients who converted or changed from clinically negative to clinically positive. They have to receive this letter by August 20th. I'm needing your help to identify these people. Do we have a list? Thanks, Marian". Doctor, we understand this was involving the class action?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And there was an order that they receive a letter. Did you reply to Ms. Marian Crawley on this issue?

DR. LAING:

A. No, I was on holidays at the time.

CHAYTOR, Q.C.:

Q. So in terms of helping her or assisting her in putting together a list, you weren't involved?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Do you know whether or not any other oncologist was?

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DR. LAING:
A. No, not that I know of.
CHAYTOR, Q.C.:
Q. And if we could have, please, 2576, and this is a letter dated August 16th, 2007, to the patients of Eastern Health, and the patients family members. "On July 20th, 2007, the Supreme Court of Newfoundland and Labrador ordered that Eastern Health contact you with the attached notice of certification. Eastern Health is required by the court order to send the notice to those individuals whose breast cancer screening tests results converted from clinically negative to clinically positive, and who are identifiable from Eastern Health's records", and please find enclosed the notice of certification. Doctor, did this letter come to your attention?
DR. LAING:
A. Only after it had been received by one of my patients.
CHAYTOR, Q.C.:
Q. And how did it come--it came to your attention then through a patient?
DR. LAING:

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A. Yes.
CHAYTOR, Q.C.:
Q. And did you actually then see the letter?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And did you have any concerns about the letter?
DR. LAING:
A. Yes, I then asked--the particular patient who was in my clinic that day mentioned that they had gotten a letter, and they were confused by the letter because it referred to a screening test, and so I called over and asked for a copy of the letter, and when I read the letter I was concerned because of the fact that I thought that the sentence should have read those individuals whose hormone receptor testing results as opposed to their breast cancer screening test results.
CHAYTOR, Q.C.:
Q. Okay, and other than the first patient who brought this to your attention, did you have similar inquiries from other patients?
DR. LAING:

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A. Yes, I did.
CHAYTOR, Q.C.:
Q. So this was the subject of some confusion amongst the patients?
DR. LAING:
A. It was.
CHAYTOR, Q.C.:
Q. And then did you and other oncologists write a letter to Ms. Crawley regarding this issue?
DR. LAING:
A. Yes, we did.
CHAYTOR, Q.C.:
Q. And if we could have, please, P-0730, and this is a letter dated September 19th, 2007, written to Ms. Marian Crawley who's identified as being the quality and risk information coordinator at Eastern Health, and it's signed by a number--I'm sorry, it's signed by a number of people.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And copied to a number of other people.
DR. LAING:
A. Yes.

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CHAYTOR, Q.C.:
Q. And included in this is your signature?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And these other people are Dr. Kwan, Dr. Zulfiqar, Dr. Ganguly, Dr. McCarthy, and who's this person?
DR. LAING:
A. That's me.
CHAYTOR, Q.C.:
Q. Oh, this one is you?
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. And then K. Laing underneath, okay.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And over here this is Dr. Ganguly, okay. So you write to Ms. Crawley.
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Prior to writing this letter--first of all,

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did you draft this letter, or if not, who did?
DR. LAING:
A. We had a meeting. Once I had gotten a copy of the letter, we--Dr. McCarthy, Dr. Ganguly, Dr. Kwan, and I had a meeting to discuss this issue. We all happened to be together in the clinic and I brought the letter to their attention. So we all sort of drafted the letter together. I think maybe it was even Dr. McCarthy who initially typed it, but we all certainly had input into the letter, and we felt that what made us a group, other than being, you know, people who care for patients with breast cancer, was that we had been involved with the issues, many of us had been members of the panel, and that we were concerned because many patients called in and thought this was something completely different. They thought that there was a new issue going on and it caused concern for the patients. So we outlined that this was not a screening test, and that it was sent to patients who didn't have a change--of course, all patients regardless of whether or not their results changed, could become members of

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the class action lawsuit, and so, of course, there as confusion at that level as well, some people saying, well, my understanding was that if my initial test was ER/PR negative and my repeat test was ER/PR negative, why is this letter being sent to me, and--so we could answer the questions for the patients in terms of our understanding, but we said that if they had concerns about the letter, that we felt that they should talk to the person who the letter originated from as well. So we wanted to let her know that we had done that.
CHAYTOR, Q.C.:
Q. You write, "Therefore, we will not be responsible for dealing with the anxiety generated and patient queries resulting from the letter. All patients will be referred back to you and we will not answer any questions related to this letter". Doctor, did you and the other physicians, in fact, do that, did you tell patients you'll have to speak to Ms. Crawley.
DR. LAING:
A. As to why the letter was sent to them, and why it contained that information, we directed

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them to that because we couldn't tell them why it said screening test, we couldn't answer as to why people whose results had not changed at all had been sent the letter. So that we said that, you know, you're going to have to talk to the people in the quality office to address this issue, but we can tell you that this is the same issue. We certainly told patients that this was the ER/PR issue. We would have certainly clarified for them, you know, what we had already told them regarding this issue. So that part of it we dealt with. It was the whole issue--we up to that point had no idea why, in fact, this letter had contained that statement.
CHAYTOR, Q.C.:
Q. And do you since know, has anyone shed any light on that for you?
DR. LAING:
A. Our understanding--my understanding after this was that this was how it was said--this statement was put in the letter because the lawyers involved with saying that this letter had to go out as part of the class action lawsuit, it was my understanding that Eastern

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Health could not give the lawyers involved in the class action suit a list of all the patients, but could on behalf of the class action lawsuit a list of all the patients, but could on behalf of the class action lawsuit send a letter to patients to identify that they could become involved and that that was the reason that the letter was sent, but that this was the wording that was indicated that had to go in the letter.
CHAYTOR, Q.C.:
Q. Who told you that?
DR. LAING:
A. Marian Crawley.
CHAYTOR, Q.C.:
Q. Prior to writing this letter to Ms. Crawley and it's somewhat of a pointed letter, it certainly shows the --
DR. LAING:
A. Frustration.
CHAYTOR, Q.C.:
Q. Frustration and displeasure of the oncologists of the treating physicians. Did you call Ms. Crawley and ask her what was all this about and how could this happen?

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DR. LAING:
A. I know that we subsequently talked to her. I wasn't sure if--I think when we first told her, she basically said I was told to send this letter, and, you know, she did send an e-mail but we didn't--I was away and didn't get it, and we felt that if a physician had read the letter before it had gone out, that we could have clarified that sentence, and if indeed it was the situation in which that was said that that had to be part of that, then I would have asked to be able to speak to whoever had made that decision, as a physician, to say I don't think that that's a correct statement. I guess the irony of this was that, if you recall way back in the very beginning, there had been a reference to a problem with a mammography machine a couple of times when this story first came out, there was pictures on the news of mammograms, so we really had to spend some time in the early days assuring people that this was not a problem with screening, and the fact that this came out in this letter, you know, raised our concerns that people would again think that

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this had something to do with breast cancer screening, which is why you'll see at the end we decided that we would send a copy of the letter to Mr. Gregory Doyle, who is the Director of the Breast Cancer Screening Program.
CHAYTOR, Q.C.:
Q. Okay. Doctor, you were away on August 9th when Ms. Crawley had e-mailed you and Dr. Denic?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. About this letter. The letter went out on August 17th--or August 16th, it's dated.
DR. LAING:
A. Yeah.
CHAYTOR, Q.C.:
Q. Were you still on holidays then?
DR. LAING:
A. I came back just a few days before that, but didn't see the e-mail and had no idea that this letter was happening.
CHAYTOR, Q.C.:
Q. Doctor, you copied this--the letter is copied

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to a number of people, including Louise Jones, Heather Predham, Dr. Howell, and Ms. Pilgrim.
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. Did anyone--any of the people that you copied on the letter contact you or any other of the oncologists about this issue?
DR. LAING:
A. Subsequent to the letter, yes, there were discussions had and people explained to us the reason why the letter was sent, and that during that time there were other people from the quality office who were on holidays and it was left to Ms. Crawley to send the letter, and that, you know, there hadn't been any physician had come forward before the letter had gone out to say that they were concerned about the content of the letter, but nor did they have a sign off, if you will, on the letter from a physician.
CHAYTOR, Q.C.:
Q. In terms of the reference to it being a screening for breast cancer as opposed to saying hormone receptor testing --

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. Where do you understand who drafted the letter, including that phrase?
DR. LAING:
A. It was my understanding that it was given to them, that --
CHAYTOR, Q.C.:
Q. I'm sorry, given to who?
DR. LAING:
A. So that the lawyers gave it to Eastern Health, and that's what was written there.
CHAYTOR, Q.C.:
Q. And whose lawyers?
DR. LAING:
A. The class action --
CHAYTOR, Q.C.:
Q. Lawyers for defending Eastern Health in the class action?
DR. LAING:
A. I don't know. I'm not sure that I thought about which lawyers it were--it was. We were just told that this what we were directed to send out and that's why the letter went out

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containing that information.
CHAYTOR, Q.C.:
Q. So who actually drafted the letter with the erroneous information, you don't know?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. If we could have, please, P-2579. This is an e-mail from Ms. Pilgrim, Heather Predham, Dr. Howell, Louise Jones, Pam Elliott, Nancy Parsons, November 22nd, 2007. She writes, "Hi there, I had a meeting with Kara Laing today. We got confirmation that our own oncologists will panel the results of any living patient. We just have to get the charts and she will get the panel. We did not resolve the issue of notification of the deceased. Oscar and I will further discuss this. We will have to go to an outside person. Pat". Doctor, so this is now late into 2007.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And I take it in terms of putting a panel together for the living patients, those are

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with respect to the patients who had been identified late and retested late in the process?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So you and the others--we saw some panel meeting minutes.
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. So you continued to assist in that regard?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. What was the issue with respect to notification of the deceased?
DR. LAING:
A. So one of the questions put forth to me by Ms. Pilgrim and by Dr. Howell was would the panel look at patients who had been deceased, to go back and say what might have happened if the patients had received treatment or not, and I tried to explain to them that I felt that that was very different than dealing with someone

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who you could sit down and talk to, or that a physician could then go forth with the recommendations about--you could see where that person was in terms of their health, and if they had other problems, and that really when looking back at patients who were deceased, that that was a very different process, and that perhaps they would consider looking to see if an outside oncologist would be willing to do that sort of work. They did make some inquiries, is my understanding, and that there wasn't, in fact, any other oncologist who--outside of our province who were interested in doing that. There had been through many long discussions and ethics consult and all that, a decision that direct contact would not be made with the patient's - the families of the patients who were deceased, but certainly if those families came forward and requested disclosure of the retesting results, that that information would be provided to them. We felt that families would have questions. Up to this point, I had been involved with disclosures to my own patient's families, and I had been involved

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with disclosures at the request of people to meet with families of patients whose results had been found to change up to this point when the family members had called in. So I had been involved with meetings where I sat down with families and said, you know--and really went through right from the very beginning of their family member's diagnosis through to what would have been offered during that time period, what impact it potentially may have had on that patient and provided as much information as I could and answered the questions the best of my ability. So I had had some experience in doing that. That was certainly a process that was difficult to do just from an emotional and that sort of way, time consuming, and I thought that perhaps they would consider looking to an outside source to do that, but when it was evident that that wasn't possible, then we said, yes, you know, please if there are these families, if they wish to meet with and speak to an oncologist, we'll be happy to do that. What we've done in those situations is if the attending oncologist who is involved with that

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patient's care is still there practising in this province, that that person would meet with the family and answer the questions, and if it wasn't, then I would do it, or on occasion Dr. McCarthy would be the one to sit down with the family and try and go through those issues. Of course, we would bring along other people that we may think would be important in that disclosure process. If we thought that pathology needed to be there, we could ask them to come. The later meetings that we've had, Ms. Smith from the Cancer Care Program has attended with us.

CHAYTOR, Q.C.:

Q. Okay, and, Doctor, originally and we saw the early minutes yesterday of your panel --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. And there were some deceased patients who were brought forward.

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And there were notes that indicated and, in

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fact, written into your minutes, that the deceased patients would be dealt with later. So I take it this issue wasn't about the review of their results --

DR. LAING:

A. No, this was about dealing with --

CHAYTOR, Q.C.:

Q. This was about how to deal with the results itself?

DR. LAING:

A. No, this was when the family members came forward and they were --

CHAYTOR, Q.C.:

Q. To speak to the family, okay.

DR. LAING:

A. Right. So if, for example, a family member came forward and said my mother was diagnosed with breast cancer and you just gave them results, I'm not sure that they would know how to interpret that, what that would have meant. So it was that particular part of it.

CHAYTOR, Q.C.:

Q. Yeah, I just wanted to be clear on that, that you did, in fact, take part and the panel did continue on and ultimately review all of the

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deceased results?

DR. LAING:

A. No, we didn't do it as part of the panel.

CHAYTOR, Q.C.:

Q. So that hasn't happened?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. They're only done on an ad hoc basis if somebody comes forward?

DR. LAING:

A. If the family members request that a meeting be held to discuss that.

CHAYTOR, Q.C.:

Q. Except for the 100 and whatever that had-- that's right, there's been over 100 certainly retested.

DR. LAING:

A. We didn't discuss --

CHAYTOR, Q.C.:

Q. But there was only a few reviewed. So the original intention to set the deceased results to one side and do it later, that hasn't happened, it hasn't come back around so that all of the deceased results have been reviewed

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by the panel?

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Okay. So do you have any idea how many results of the deceased patients are yet to be reviewed?

DR. LAING:

A. Reviewed in what way?

CHAYTOR, Q.C.:

Q. In terms of--by the panel, or some equivalent, to say whether or not this is a change and whether or not the change would have involved a change in treatment at the time?

DR. LAING:

A. We've only done that if requested by the families to do that.

CHAYTOR, Q.C.:

Q. Okay, so most of those--most of the results of the deceased have not, in fact, been reviewed?

DR. LAING:

A. I'm not sure what percentage of those, but I would think not because I can, you know, think of the number of families that I've met with so far, and it's certainly not a large number.

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CHAYTOR, Q.C.:
Q. So why was there a change in the original thinking as noted in your minutes that they would be dealt with after all the living had been dealt with?
DR. LAING:
A. It wasn't to be dealt with in the sense that the panel would have reviewed them. It was to be dealt with in the sense of what were we going to do because one of the big questions related to the deceased patients was should this information be given to the families or should we wait until the families asked for that information, and that's the question that involved the ethical review.
CHAYTOR, Q.C.:
Q. If we could go back, please, to 2552. This is the minutes of October 20th, 2005, deceased patients, "Patients who are deceased will be addressed following the review of all the patients who are currently alive".
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. "At that time a decision will have to be made

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whether to notify the patients' physician and family of the change in result".
DR. LAING:
A. That's right.
CHAYTOR, Q.C.:
Q. So you're saying that this didn't mean that the results would be reviewed?
DR. LAING:
A. No, it just meant that how was that information going to be communicated to the families of the deceased patients.
CHAYTOR, Q.C.:
Q. Yes, that's right, and that's how I read it, that the only issue that would be left outstanding, they would be reviewed, I interpreted this--correct me if I'm wrong, I interpreted this to be that once all the living patient's results had been reviewed, then the deceased patients would be reviewed, and the only issue then outstanding would be a decision to be made as to how--and I guess, if, but how whether--yes how and if to notify the patients, physician or patient's family about the issue?
DR. LAING:

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A. No, that's not correct.
CHAYTOR, Q.C.:
Q. So tell me what it's supposed to mean?
DR. LAING:
A. That we would decide how we were going to deal with the deceased patients overall once the living patients had been reviewed.
CHAYTOR, Q.C.:
Q. And you said when Ms. Pilgrim asked you to look at the deceased issue, and you had some reluctance in doing that, a question she said was what might have happened if they had received treatment or not, the question of what might have happened, but would it--I've understood from what you've said with respect to living patients --
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. There's even some reluctance to speculate on what would have happened?
DR. LAING:
A. In that sort of sense, it's not necessarily different. It's just that when you sit down and look at the patients who were deceased,

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then really you're going back and looking through the information and giving an opinion as to, you know, this patient was diagnosed in 1997, they were pre-menopausal, their hormone receptors were said to be negative, and even if they were positive then, they wouldn't have gotten Tamoxifen, they subsequently developed metastatic disease, it was very aggressive metastatic disease, they required chemotherapy, and unfortunately died of their disease a short period of time later, so you may--your opinion may be that hormonal therapy is likely not to have helped that patient, but we did not sit down and go through each of the deceased people and do that work. We weren't asked to do that. We were asked to consider the deceased in the context of meeting with the families and giving that sort of an opinion about, you know, what we think that impact may or may not have been. In some instances, it meant, you know, sitting down with a family and saying, yes, you know, if your loved ones ER/PR results had have been known to be positive, based on the fact of when they were diagnosed and their prognosis,

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my opinion would be that that person would have been offered hormonal therapy, and that if they had gotten hormonal therapy, that it would have reduced the risk of their cancer recurring by a certain percentage. So that's the kind of discussions that we had with the families, but this has not been done on the deceased patients unless it has been requested to be done because of the families.

THE COMMISSIONER:

Q. Dr. Laing, the description of the kind of discussion you have where there is a request and --

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. And you're using the term "we", does that mean there is a panel process before that meeting or is that your assessment in the case where you are doing the --

DR. LAING:

A. It's my assessment in that case, yeah.

THE COMMISSIONER:

Q. So really for the deceased, what happens is the oncologist who meets with the family

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member --

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. Makes an assessment of the chart.

DR. LAING:

A. Yeah.

THE COMMISSIONER:

Q. And the information available, and therefore, gives his or her opinion to the family?

DR. LAING:

A. Yes. Now on some occasions, I've been--the oncologist involved has asked if I would come along to those family meetings, and I have done that, but we've not gone as a panel to discuss this the families.

CHAYTOR, Q.C.:

Q. Doctor, were you involved in the decision to ultimately retest all of the deceased samples?

DR. LAING:

A. Yes, I felt that it was important that if we were to see, you know, how many results changed, that the patients who were deceased be retested as well.

CHAYTOR, Q.C.:

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Q. So they've all been retested, but in terms of anyone sitting down and figuring out if it's a change that would have resulted likely at the time had the patient still been alive and a change of treatment, that's only done according to when contact is made by a family member --

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. Requesting that information?

DR. LAING:

A. That's correct.

CHAYTOR, Q.C.:

Q. When did you and Dr. McCarthy ultimately agree to participate in such family meetings?

DR. LAING:

A. We had been doing it all along up to that point.

CHAYTOR, Q.C.:

Q. But for other than your own patients?

DR. LAING:

A. It would have been not too long after that e-mail from Ms. Pilgrim because it didn't take very long for us to realize that there wasn't

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anybody else who would be able to do that work, so we had said yes, and at this time we had the phone number available for family members to contact us for this, you know, to happen, so we were getting--we were getting calls to deal with this, and, you know, we certainly would continue to do that at any request that we would receive from the families.

CHAYTOR, Q.C.:

Q. And, Doctor, how do you record the fact that patient's families have been met with? Is anybody keeping track of that?

DR. LAING:

A. I actually dictate a note and I put it on the patient's medical record.

CHAYTOR, Q.C.:

Q. Okay, and does that then--the fact that you've now met with this patient's family and the information that was relayed, does that get passed along to anyone else, anyone, for example, in Quality Initiatives?

DR. LAING:

A. I'm not certain. I know that they--any time we have any contact with patients or their

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families, we fill out a form that indicates, you know, the date of the contact, who you spoke to, and sort of a brief summary of that. When I do those forms, I also dictate a corresponding note to go into the patient's file, whether the patient is living or deceased, and after my initial family meeting, I had dictated a note the same as I would dictate a letter in my office, so on a dictaphone, and then I thought, well, after it had been typed up, I thought, well, this probably should be on the patient's file, so subsequently I do them the same way I would do a clinic note, and then they would go on that patient's chart. The reason it's put there is two-fold. One is that, you know, should the patient's family member call back again and need any clarification, then it would be outlined what exactly we discussed, and so that, you know--and then if the family member wanted a copy of that summary of the discussion, they certainly could have that.

CHAYTOR, Q.C.:

Q. Doctor, this form that you referred to that you fill out --

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DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. That's whenever you meet with a patient's family or a patient --

DR. LAING:

A. When we got calls on the 1-800 number.

CHAYTOR, Q.C.:

Q. Okay, and how long was that in place?

DR. LAING:

A. I think from whenever we started that--taking calls on that line.

CHAYTOR, Q.C.:

Q. Okay, so that was a form that was used specifically for the ER/PR issue?

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay, and did you say you would fill out those forms as well when you would meet with patients or patients' families?

DR. LAING:

A. No, when we would call people.

CHAYTOR, Q.C.:

Q. When you would call them?

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DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Okay. So that would be a record of that call?

DR. LAING:

A. Yes, yes.

CHAYTOR, Q.C.:

Q. And there's no equivalent form then for keeping track of patient contact other than through phone calls? There's no equivalent form, for example, that you could fill out and pass along to Quality Initiatives, or whoever is keeping track, when you met with a patient or a patient's family to say, okay, this patient has been contacted, told on such and such a date?

DR. LAING:

A. Oh, no, they would be aware of those as well.

CHAYTOR, Q.C.:

Q. But at the time as things are going along --

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. So you think back the fall of '05 and '06 --

DR. LAING:

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A. Oh, no, no --

CHAYTOR, Q.C.:

Q. And you're meeting patients in your --

DR. LAING:

A. No, no, this has been a new thing, this has been a new way so that we can document every encounter with a patient.

CHAYTOR, Q.C.:

Q. So at the time when you were going through and advising people in your clinic or --

DR. LAING:

A. No, it would only be what would be in the clinic charts.

CHAYTOR, Q.C.:

Q. Okay. Doctor, I'd like to just ask a little bit about the aftermath of all of this and where you are today in terms of your oncology service. Has there been any improvement in the lines of communication between oncologists and pathologists in the aftermath of this issue?

DR. LAING:

A. Yes, there certainly has.

CHAYTOR, Q.C.:

Q. And perhaps you could tell us a bit about

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that?
DR. LAING:
A. You know, one of the things that this has highlighted is the importance of dialogue between pathology and oncology, particularly because we rely so much in oncology on the pathology results, mostly in terms of looking at the prognosis of our patients, but in the example of ER/PR as a predictive test, and that's going to blossom and just increase so significantly in the next few years that, you know, it's going to continue to become more important and more critical as time goes on for that dialogue to occur. I think one of the things through all of this is that it's really strengthened the relationship between oncology and pathology, and I feel that we have a very good relationship with our pathology colleagues. We, for example, through the Breast Disease Site Group, have a place where we can interact and we can talk to a very wide array of people who are involved in breast cancer care, including our pathologists, and a forum really for issues to come up outside a regular tumour board round.

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You know, tumour board may be where something gets sparked, but because we're there to discuss specific patient issues, we feel that this other forum is quite good for us to bring issues to discuss. I think that there's very much an openness, a willingness to pick up the phone and call each other whenever there's a concern. I think that that whole sense of that relationship has improved. We're kept up to date with what's going on, in terms of, you know, if there's a change in the lab, Dr. Denic and I, as clinical chiefs together, through our reporting process, through things like the Medical Advisory Committee, and through our reports and just through informal communications with each other. So I think, yes, I think that it has improved. I think that that needs to happen now in other disease sites. There are other tumour boards that occur outside our usual Wednesday. There's a separate one for lymphoma. There's a separate one for urology. So I think that, you know, as we go forward, we really would like to have, with each disease site, a core of people that are very much involved and that will be

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some work to do as we go forward.
I also think that, you know, even beyond just us here in this province, I think, you know, nationally and internationally, that this whole issue of the importance of pathology to oncology is something that's being considered, and I think back to some of the comments that Dr. Banerjee made. You know, now in oncology, if we look at new drugs that are being developed, they're all these targeted therapies. So let's find the mistake and let's fix it, and that's very rationale thinking, and that's how the drug companies have developed new medications. But what's essential is, well, how are we going to find the mistake? How are we going to determine that that mistake, be it, you know, an over expression of the HER2, which causes increased growth, like how are we going to find these things? Because in order for a drug to be effective in the clinic, you really need to be giving it to the appropriate people. We know that from ER/PR and hormones, but now we need to look at it for things like the epidermal growth factor receptor in colon cancer. So I

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think there's a lot of work to do, but I think that this issue is something that's been acknowledged nationally and internationally and I hope that, you know, as people move forward that there is better dialogue between national and international associations between oncologists and pathologists.
CHAYTOR, Q.C.:
Q. And thinking in that wider context then, has there been any movement amongst oncologists, either locally or across Canada, to seek standardization of how diagnostic or laboratory tests are reported to you, as an oncologist?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And perhaps you could tell us about that.
DR. LAING:
A. We certainly have had some preliminary discussions at various forums. There's a National Cancer Institute of Canada which has a clinical trials group, and I'm just thinking right now of a particular protocol that we're doing that has necessitated a certain mutation

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to be present in patient's cancer. So this has been a reason, if you will, to really look at bridging the Canadian Association of Pathologists with the Canadian Association of Medical Oncologists. I now sit on the executive of the Canadian Association of Medical Oncology and you know, this is something that we're going to discuss at our fall conference call, to sort of see where we need to be, in terms of this liaison between pathologists and oncologists with respect to targeted therapies.

We have done some work nationally, that I have been involved with, through the Canadian Partnership Against Cancer and that's doing a lot of good work, and one of those initiatives has been a synoptic reporting--synoptic reporting refers to how information is given back between surgeons, oncologists and pathologists, and what a synoptic report allows you to do is to have a template which you then just fill in all the important information. So it makes sure that things like the number of lymph nodes involved are put into the pathology report. What the liver

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looked like at the time of the colorectal cancer surgery is in there. So we've been working nationally. We, being some pathologists, surgeons and myself at this level, have been working to improve and develop synoptic reporting templates for across the country, and that's been endorsed by CAMO and many other people, because really what a synoptic reporting tool is going to do is improve that communication between all of the physicians involved with the care of an oncology patient. So that work is happening.

CHAYTOR, Q.C.:

Q. And in terms of standardization of how ER and PR tests are reported to the treating physicians, is that an issue too that's being addressed?

DR. LAING:

A. Yes. You know, I think that there really needs to be some consideration given to looking at how these reports come out from all different areas within the country, and you know, this hasn't been done yet, but certainly, you know, to pick a way of reporting that people can agree upon so that

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that information can be interpreted the same way in the clinic by the people dealing with the care of those patients.

CHAYTOR, Q.C.:

Q. And who is it that's looking into that, seeking that standardization, and how far along in the process is that?

DR. LAING:

A. I'm not sure how far along in the process that is. Certainly, Dr. Denic and I have had some preliminary discussions about looking to see what's happening. The people that are doing the synoptic reporting work, most of that work to date has been done in colorectal cancer, but I know that as we--as the group that looks at breast cancer, we'll be looking at that. But I'm not sure where exactly that is.

CHAYTOR, Q.C.:

Q. Okay, and I asked you about the increase in the communication between the pathologists and the oncologists in the aftermath of this, and you've given us some examples of that, including you now have the breast disease site group, which I understand got up and running in about June of 2006 or some time thereafter.

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Is that about right?

DR. LAING:

A. Yeah, somewhere around there.

CHAYTOR, Q.C.:

Q. And Dr. McCarthy will be able to speak better to that, I understand.

DR. LAING:

A. Yes, yeah.

CHAYTOR, Q.C.:

Q. Okay. Doctor, do you do mortality rounds?

DR. LAING:

A. So we, within the Cancer Care Program, the radiation group has done the equivalent of what we call morbidity and mortality rounds. We've not, to date, had a formal mechanism for that within the medical oncology side. We, however, this has been addressed by Eastern Health and there's been some work, preliminary work done to have a sort of standard format for morbidity and mortality rounds. So that's certainly something that we're planning to start officially within the next few months.

CHAYTOR, Q.C.:

Q. So you think that's something that would be beneficial?

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DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And perhaps you could just educate us a bit on what exactly morbidity and mortality rounds are?
DR. LAING:
A. Right.
CHAYTOR, Q.C.:
Q. And how you think that would be helpful, particularly in the context of the ER/PR issue?
DR. LAING:
A. So what morbidity and mortality rounds are, are a forum where cases can be discussed and these may be cases where an occurrence has happened, whether it's an adverse event, whether it's what we call a near miss, whether it's somebody who just, for example, brings forth a case in which there has been unexpected toxicities from some form of the treatment. So the people sit down and go back through it and see if they can identify if-- you know, can put their finger on something that may have led to this. Was there

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something about this particular patient that may have explained, for example, if there was undue toxicity to a drug, and then that information would be then relayed back to the group as a whole to exercise caution when using that drug in patients with similar events. When those sorts of events happen, we have a responsibility, as physicians, to notify the necessary pharmaceutical company who makes that drug and right now, we do share that information within our pharmacy and therapeutics group.

We have something within the Cancer Care program that we call our medication huddles with our pharmacist, where after our ward rounds, on about a monthly basis, and with the chemotherapy nurses, it's an opportunity for people to discuss any issues that might have come up in the care of a patient. For example, if we noticed that there was a number of reactions to a particular drug, we might have to sort of stop and say, "well, I wonder is there some problem with that lot of the drug? Is there some problem with the rate that the drug is going in?" So that we have a

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way to monitor these sorts of things.

Morbidity and mortality rounds then are a place where you may, you know, come up with some reason why certain things may have happened and then you can go and address those, and it's supposed to be a forum in which people are comfortable with speaking very freely and--you know, because when you're looking back at things, you want it to be such that people are--you know, feel that they can say "look, I think something wrong happened here" and how do we go forth and do that? I think -
THE COMMISSIONER:
Q. Dr. Laing, does a morbidity and mortality round deal strictly with actions taken that have unexpected results or does it deal also with failure to take action?
DR. LAING:
A. Both.
THE COMMISSIONER:
Q. Both?
DR. LAING:
A. Yes.
THE COMMISSIONER:

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Q. So I'm still not sure how you get to be in a morbidity or mortality round, as opposed to another kind of round.
DR. LAING:
A. Well, you can be identified--usually it's -
THE COMMISSIONER:
Q. What distinguishes it from other kinds of rounds that are held within the hospital already?
DR. LAING:
A. So there are groups that do mortality rounds that will select a group of people who have died. They'll just randomly pick patients who have been deceased and go back and look to see if there was anything leading up to their death for any reason. There are groups that will pick unexpected deaths, and so I guess it depends on the context.
THE COMMISSIONER:
Q. So is it limited to deaths?
DR. LAING:
A. No. So that's mortality.
THE COMMISSIONER:
Q. That was my understanding, it wasn't.
DR. LAING:

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A. No, no. So morbidity is -
THE COMMISSIONER:
Q. Okay.
DR. LAING:
A. - something that we use to describe toxicities, side effects, even things like near misses could go into a morbidity round. You know, there might be someone who ends up getting the right dose of drug, but only because of a series of fortunate events that, you know, people manage to pick up on something that could have potentially been an error.
CHAYTOR, Q.C.:
Q. Or if somebody didn't get the required treatment -
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. - because a test was erroneous?
DR. LAING:
A. Right. So, for example, if we found that, you know, there was a patient who ended up not getting treated with Herceptin, then we would go back and say "well, how did this happen?"

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You know, those sorts of things, or if somebody had gotten chemotherapy and, you know, got an undue toxicity, we would look back and see was there something about that patient, was there something about the drug.
THE COMMISSIONER:
Q. So is the difference a retrospective look as opposed to looking forward?
DR. LAING:
A. Right. So it's a retrospective look at what might--what happened, what might--what have went on in the past. It's hard to say. As opposed to a tumour board round where you're bringing a question "how am I going to deal with this patient on a go-forward basis?" So that would be the difference.
CHAYTOR, Q.C.:
Q. Okay, and Doctor, so if such morbidity and mortality rounds had been happening over the years, issues such as an oncologist having a patient that had an ER/PR test and then two, three days later or a year later, the ER/PR test is repeated and a changed result occurs, that kind of an issue could have found itself within a case that would be discussed in

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mortality or morbidity rounds?
DR. LAING:
A. It could have.
CHAYTOR, Q.C.:
Q. And those types of rounds, are they common in other cancer centres across the country?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. Okay. Do you know whether or not B.C. Cancer Agency had one when you were there?
DR. LAING:
A. No, we didn't.
CHAYTOR, Q.C.:
Q. And whether or not they currently do and how long it's been in place, you're not certain?
DR. LAING:
A. I'm not certain.
CHAYTOR, Q.C.:
Q. And you said that the radiations have had--or radiation oncologists have had such rounds. How long have they had their rounds in place?
DR. LAING:
A. For quite some time now. They have a weekly--what they call a review. So they would bring

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forth people that have had unexpected toxicity and that sort of situation.
CHAYTOR, Q.C.:
Q. And what I'm hearing from you is that you recognize that this would be a beneficial thing. There's no concrete plan in place yet though to get this up and running for medical oncologists?
DR. LAING:
A. What had happened within Eastern Health was this was an issue that was discussed by the clinical chiefs some time ago. And there is a group now that's headed by Dr. Kevin Hogan who has looked at this issue again and is going to make some recommendations to all of the programs within Eastern Health for a recommendation of, you know, how these should occur and be minuted and where the information would go and that sort of thing. So that's certainly something that's being addressed.
CHAYTOR, Q.C.:
Q. And do you know why such rounds would not have been taking place for medical oncologists in previous years in St. John's?
DR. LAING:

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A. That we just simply didn't have the time to do this sort of a formal round. And it's really only been in this last--you know, when it was brought forth by Eastern Health as an issue and I think, you know, in light of this type of event that people are saying, you know, who's doing morbidity and mortality rounds within their program. I know cardiology, the cardiac care program does them because I remember participating in them when I was a resident here, but I'm not certain as to what other programs currently have official morbidity and mortality round. Do we discuss cases, yes. You know, there's lots of informal ways that this sort of thing happens, but what you want is to have a more formal process and that's what we're moving towards.

CHAYTOR, Q.C.:

Q. Okay. And, Doctor, what improvements, if any, have taken place amongst the communications in your own team, amongst oncologists, the oncology service in the aftermath of this issue?

DR. LAING:

A. You know, I think as a rule we've tended to be

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a group that, you know, I can only speak to the last few years when we've been this sort of core group, that we certainly have had very good communication with each other. I mentioned that we round together once a week so we see all the inpatients together, and after that we sit down and have discussions. We have departmental meetings. And that, you know, one of things that we've started to do is to be careful that we capture all of our encounters with patients. There's lots of times that you do things that someone may not be seeing you in the clinic that you don't record, so we tend to record all that information now in the chart so that, you know, sort of the time lines of things can be followed carefully. We have--I think this whole issue has, you know, made us think that, you know, in the future should people be concerned or should--you know, that really talking amongst a group about how we do continuous quality improvement and, you know, where these issues should be brought forth, and a recognition, as well, of, you know, other areas that may need room for improvement

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and increased resources and how you go about getting those, and the persistence, if you will, that may be needed for things that we need to run our program.

CHAYTOR, Q.C.:

Q. Doctor, does the oncology service have a quality assurance program?

DR. LAING:

A. We do quality assurance as part of our day-to-day activities. And Ms. Smith, who's the program director, has a background in quality, so that's helpful to our program. And, you know, we certainly identify in our regular meetings of the senior team issues related to quality. I report on it to clinical chiefs if there are areas that we're looking at. So the answer would be yes.

CHAYTOR, Q.C.:

Q. So what we've seen as of late for the laboratory medicine program is quite extensive policies and procedures.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. Would there be an equivalent for the oncology

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service?

DR. LAING:

A. Probably not as extensive as what they've done so far. We recognize -

CHAYTOR, Q.C.:

Q. Do you have any policies, written policies and procedures?

DR. LAING:

A. We have--oh, yes, within the Cancer Care Program we do, yeah.

CHAYTOR, Q.C.:

Q. And I'm sorry, I cut you off.

DR. LAING:

A. No, we have--but we recognize that there are many not only policies and procedures, but guidelines that need to be written. One of our biggest challenges is we simply do not have the resources to be able to do that work. We've only recently had a nurse who's been working with us in terms of developing guidelines related to breast cancer. But, you know, getting those put together, reviewed by the physicians, generated, put into a form where they can be disseminated--one of the biggest concerns about guidelines is that they

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really need to be kept current and up to date.
CHAYTOR, Q.C.:
Q. Yes.
DR. LAING:
A. And when I think of the other cancer programs that have a guideline group, I think about the BC Cancer Agency. They have a dedicated fulltime staff who does that sort of thing. The Cancer Care Ontario's guideline development process probably employs at least 40 or more people. And so, you know, really to be able to do this, you need to have the necessary resources.
CHAYTOR, Q.C.:
Q. Doctor, is there any such thing as external proficiency testing for oncologists?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. Okay. And I take it that's, no, it doesn't exist across the country, that's not something oncologists take part in?
DR. LAING:
A. No. The only thing that we have taken part in is that there's a review process that I

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believe is an Atlantic Canada peer review process and we've been identified, some of us oncologists have been identified for review as part of that process. But it's not, it's not only oncologists, it could be any physicians.
CHAYTOR, Q.C.:
Q. Okay, and in terms of then internally, is there any internal review, for example, chart audits, anything like that that takes place?
DR. LAING:
A. Not currently, no. The only review we have would be a performance evaluation that's done annually.
CHAYTOR, Q.C.:
Q. Okay, and who carries out the performance evaluations of the medical and radiation oncologists?
DR. LAING:
A. The respective divisional chiefs.
CHAYTOR, Q.C.:
Q. Okay, so not the clinical chief, the respective divisional chiefs, yes.
DR. LAING:
A. That's right. And I would do theirs.
CHAYTOR, Q.C.:

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Q. So it would be Dr. Siddiqui for medical oncologists and you would do Dr. Siddiqui's?
DR. LAING:
A. That's right, yeah.
CHAYTOR, Q.C.:
Q. Okay. And those are carried out on a regular consistent basis?
DR. LAING:
A. Yes.
CHAYTOR, Q.C.:
Q. And have been since you've been at Eastern Health or its predecessor?
DR. LAING:
A. No.
CHAYTOR, Q.C.:
Q. When did they start being carried out regularly and -
DR. LAING:
A. So in terms of Eastern Health, this is a fairly new initiative and Dr. John Guy is heading it. In terms of in the old NCTRF organization it did happen, and in those days when I was director of medical oncology, I would have done an annual review of the physicians and--but in the last couple of

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years that we've been transitioning there is now a new review process, there's a new form and that work is ongoing now.
CHAYTOR, Q.C.:
Q. So it's not something that had been happening over the years?
DR. LAING:
A. It did in the NCTRF structure, yeah.
CHAYTOR, Q.C.:
Q. But not since two thousand and, well, 2005, I guess, Eastern Health took over, thereabouts, somewhat later -
DR. LAING:
A. Probably would have done it in 2005. But since we've been in Eastern Health we now have a new process to follow, which we've started to do.
CHAYTOR, Q.C.:
Q. Okay. Doctor, one other question. Something that we noticed in looking through various charts for different patients, there's multiple people seeing patients when they come to the Cancer Clinic. And obviously it's understandable that they see a radiation oncologist, it's a different service and

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medical oncologist. But even amongst those disciplines and the person may come in and be seen by you one given visit and then they're seen by Dr. McCarthy or Dr. Siddiqui or whoever or Dr. Farrell, who is the clinical associate. Is there any policy or procedure in place or being contemplated to--aimed at consistency of care and caregiver?

DR. LAING:

A. Oh, yes, so now when a new patient is seen, they're assigned to a medical oncologist and it's that medical oncologist who follows through on their care, unless that person is absent. When you look back through a lot of the charts, and we found this when we looked through the charts of these patients, the reason why they were seen by so many different people was that there was such a change and such a turnover, so there are patients who through the course of their treatment have had multiple different oncologists. But currently, once a patient is assigned to a medical oncologist unless there's a request by the patient to change physicians, then that oncologist would continue to do their care.

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Dr. McCarthy and I shared patients a few times because between the two of use we've had five children over the last couple of years, fortunately one after the other, so that often, you know, when I was away, she would cover my practice and vice versa. This last couple of weeks if I've not been in clinic, somebody would be seeing my patients, but they would be chemo patients. Nobody would be seeing new patients for me and nobody would be seeing follow-up patients for me unless there was some sort of urgent issue. So no, as a rule people are seen by the same oncologist. We've recently adopted a policy that if somebody is going to leave, if we're going to have a resignation, we usually would stop that person seeing new patients about two months or so prior to that resignation because it's difficult for a cancer patient to come and see someone and then find out that, you know, that person is leaving. But, no, our policy -

CHAYTOR, Q.C.:

Q. So that's a written policy, if you're going to be--is it also written policy in terms of once you're assigned a patient, that's your patient

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unless the patient requests otherwise, is that a written policy?

DR. LAING:

A. I'm not sure if it's a written policy, but it's certainly the way we operate.

CHAYTOR, Q.C.:

Q. How does that work for peripheral clinic patients?

DR. LAING:

A. The peripheral clinic patients are seen by whichever physician happens to be doing the peripheral clinic. And they're also seen by the physicians that we have in the regions that help us to provide the care. When we go to the peripheral clinic, we do so on a rotational basis. And there are a group of us that do Gander and Grand Falls and there's four of us and then the rest of the physicians do the Corner Brook clinic. So we try as much as we can to have consistency in terms of follow-up. So I'll often re-book the patients to come and see me when I know I'm going to be there next time. Many of the patients, though, in the peripheral clinic that are being followed have metastatic disease and so

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they may not always be able to wait that sort of four months, three or four months before that same person is back again, so those people we care for as a group. If there are questions or concerns, though, we know that we can talk to each other. We try to make it clear in the note as to what the plan will be in terms of if I initiate chemotherapy, I'll say that I plan to give it for eight cycles, ten cycles, or whatever that will be and we certainly have communication with each other. Many of the patients in the peripheral clinic we present at tumour board. Sometimes I do that whilst I'm still there, I'll, you know, connect into, if there's something that I need to sort of sort out. Often there's a radiation oncologist and a medical oncologist attending the peripheral clinic at the same time, so if I feel someone needs to be seen and vice versa, that can happen.

CHAYTOR, Q.C.:

Q. Okay. Thank you. Thank you, Doctor, those are my question.

DR. LAING:

A. Okay, thanks.

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THE COMMISSIONER:

Q. It's so close to the lunch hour, I suggest we break before we start cross examination. So we'll meet again at two. There is light at the end of your tunnel, Doctor. Two o'clock.

(LUNCH BREAK)

THE COMMISSIONER:

Q. Mr. Pritchard?

MR. PRITCHARD:

Q. Madam Commissioner, I don't have any questions for this witness.

THE COMMISSIONER:

Q. Thank you. Mr. Simmons?

DR. KARA LAING, EXAMINATION BY MR. DANIEL SIMMONS

MR. SIMMONS:

Q. Good afternoon, Dr. Laing. Just a couple of points I wanted to ask you about.

DR. LAING:

A. Sure.

MR. SIMMONS:

Q. And the first concerns, I'm wondering if you could maybe give us some comments on, in your view, the relative importance of the clinical judgment that's brought to bear by a treating physician when decisions are being made with a

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patient about issues such as whether to use hormone therapy or not? We know that the ER/PR test itself provides information which is taken into account when those decisions are made.

DR. LAING:

A. Yes.

MR. SIMMONS:

Q. In that kind of context how important is the actual individual judgment of the physician who's the primary person treating the patient?

DR. LAING:

A. Right. I think that the decision whether or not a patient is going to decide to take hormonal therapy depends very much on that interaction between the patient and the physician. The test result is simply an indication of whether or not that therapy should be considered. Because somebody is hormone receptor positive, that doesn't automatically equate that that patient is definitely going to receive hormonal therapy. Once that's determined to be positive or in a range that you decide that you're going to offer that person hormonal therapy, there's a

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lot of discussion that goes on by the treating oncologist with the patient. But first of all, as with anything that we do in medicine, talks about the potential benefits so that the patient has a good understanding of why this treatment is being offered, why the hormone therapy is being offered, in the adjuvant setting, what's the expected benefit to the patient in taking that. And then there's the discussion about the potential risks or the potential side effects of that therapy. And although we know of the general side effects, there are some patients that may be more or less predisposed to those side effects, either because of other health concerns, and so that plays a role. So somebody may have what we call an absolute contraindication to a hormonal therapy. I would think of someone with a personal history of a blood clot and a consideration of a drug like Tamoxifen. And then, of course, there's patient preference. And you know, if you list all the factors that go into decision making, patient preference does have a bearing on that, as well.

MR. SIMMONS:

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Q. And those factors are taken into account in the interaction between the treating physician and the patient in the consultation room, are they?

DR. LAING:

A. Yes.

MR. SIMMONS:

Q. When that treating physician seeks a advice or consults with their colleagues, as I understand you will do from time to time with your colleagues in the Cancer Centre, how does that affect, if at all, the decision making that takes place once that physician goes and meets with their patient and discusses whether to being hormone therapy?

DR. LAING:

A. So if a discussion was had, for example, at tumour board rounds, then that context of that discussion and what was talked about is conveyed to that patient by that treating oncologist. So they may say, for example, you know, "You have a low expression of estrogen receptor. This is an area that there's still some debate as to what's the benefit going to be in this situation. I have presented your

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case at tumour board rounds." I usually explain that that's when the doctors get together once a week and review various aspects, "and the recommendation of that group was the following." And so it's another piece of information.

MR. SIMMONS:

Q. Right.

DR. LAING:

A. Again, it's, you know, the patient may then say, "Okay, but, you know, I don't wish to take this," or they may say, "Okay, if that's what the group of physicians felt and you're in agreement with that, then", then you go ahead and make the decision based on those factors.

MR. SIMMONS:

Q. So is it fair to say that just as the result of the ER/PR test is a piece of information that's taken into account when the physician meets the patient to make the decision, the consultation on the tumour board rounds is similarly another piece of information that goes into that?

DR. LAING:

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A. Right, yeah.

MR. SIMMONS:

Q. When the Panel met and reviewed cases and sent letters to physicians, I understand that the object was to try and get those letters to the physician who'd be primarily responsible at that time for the treatment of the patient?

DR. LAING:

A. Yes.

MR. SIMMONS:

Q. Right. Those letters were worded, I think, as making recommendations whether to institute Tamoxifen or not?

DR. LAING:

A. That's correct.

MR. SIMMONS:

Q. Should the treating physicians have treated those letters, in your view, as being binding on them in any way or were they another piece of information to take into account similar to consultations on the rounds that you've just described?

DR. LAING:

A. They would be taken as a recommendation.

MR. SIMMONS:

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Q. Right.

DR. LAING:

A. And that, then that treating physician who is sitting in front of that patient would have to use that just as we use the other information. And for example, we may not have known that perhaps the patient has subsequently developed a health issue that may be a contraindication to hormonal therapy. And then, of course, the patient's personal preference would come in. If this task was left to a physician outside the Cancer Centre, then there was always that option for the patients to be referred back, and that happened on some occasions. Some occasions we had correspondence from the family physician indicating that, indeed, they had received the letter and what the patient had decided. So it was exactly that, a recommendation.

MR. SIMMONS:

Q. Right. So some, there were cases where patients were referred back for further consultation at the Cancer Centre?

DR. LAING:

A. There certainly was.

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MR. SIMMONS:

Q. Now this is a speculative question I'm going to ask you.

DR. LAING:

A. Okay.

MR. SIMMONS:

Q. But, and if you're not comfortable answering it, that's fine. Had there been no panelling and had it just been a letter to the responsible physician with the result, what would your expectation have been about how many referrals there would have had to have been made then back to the Cancer Clinic before treatment could be initiated?

DR. LAING:

A. I would speculate that there would have been many, many more.

MR. SIMMONS:

Q. And in those cases patients would have had to have been scheduled and seen at the clinic in order for a decision to be made as to whether or not hormonal treatment would be initiated?

DR. LAING:

A. Yes.

MR. SIMMONS:

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Q. Okay. The other thing I wanted to ask you about concerned meeting with individual patients. You've told us that there were meetings arranged with those patients who had been determined to have had an incorrect original diagnosis?

DR. LAING:

A. Yes.

MR. SIMMONS:

Q. And there were a number of those meetings attended by an oncologist, pathologist, and Ms. Parsons, the ones you were at. Had it been decided to hold meetings like that with everyone for whom there was a recommended treatment change as a result of panelling, would there have been any capacity within the system for the professionals involved to have been able to do that?

DR. LAING:

A. I think it would have taken a lot longer for that to happen.

MR. SIMMONS:

Q. Um-hm.

DR. LAING:

A. And, you know, those meetings that we had for

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those individuals would have taken place outside usual clinic times for the physicians involved.

MR. SIMMONS:

Q. Yes.

DR. LAING:

A. And when I think back to the duration of those meetings, they were lengthy. When the information was given to the patients in the clinic, it was often given by a physician that was very familiar with that patient, not in all cases, but in several of those cases, and, of course, when it's given in that context, there's ongoing follow-up. So even to date when patients come to see me, they may ask me can you please just go over once again what it meant for me, and that would be in any aspect of patient care. As you know, I deal a lot with patients with breast cancer, and the amount of information that they're given at their first visit with me is sometimes overwhelming and they'll often come back and say, "Could you just tell me again how many lymph nodes I had" or some piece of information like that. So there's a

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continuous exchange of information between the patients and the physician at their visits.

MR. SIMMONS:

Q. Okay, good.

THE COMMISSIONER:

Q. Mr. Simmons, I just want to make sure I understood the premise of that question. We're talking here about the 104, are we?

MR. SIMMONS:

Q. Yes, Commissioner, that's correct.

THE COMMISSIONER:

Q. Okay. So just as a follow-up to that, Dr. Laing, do you know how many of the 104 the letters would have been sent to the Cancer Clinic as opposed to outside?

DR. LAING:

A. I don't know that right down for sure.

THE COMMISSIONER:

Q. All right. Thank you.

MR. SIMMONS:

Q. Okay. Thank you, Dr. Laing, I don't have anything further.

THE COMMISSIONER:

Q. Thank you, Mr. Simmons. Mr. Pritchett?

MR. PRITCHETT:

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Q. No questions, Commissioner. Thank you, Dr. Laing.

THE COMMISSIONER:

Q. Ms. Newbury?

DR. KARA LAING, EXAMINATION BY MS. JENNIFER NEWBURY

MS. NEWBURY:

Q. Good afternoon, Dr. Laing. We've met before. Jennifer Newbury for the Canadian Cancer Society, Newfoundland and Labrador Division.

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. I have a few questions for you this morning. And perhaps we'll start with the Physician Review Panel.

DR. LAING:

A. Okay.

MS. NEWBURY:

Q. And I would like to bring up Exhibit 2457, please? This is the first Panel meeting dated October 13th, 2005, which sets out the mandate of the Panel. I just wanted to bring that up in case you wanted to refer to that for any reason. And I'm going to ask you about the comment here in the second paragraph under

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"Mandate of the Panel." "All agree that the referring physician should be notified and that that primary cancer treating physician would be responsible for follow-up of the recommendations from the Panel."

DR. LAING:

A. Um-hm.

MS. NEWBURY:

Q. Now, as I understand from your evidence, a number of recipients of the Panel letters would ultimately not have been either a medical oncologist or a radiation oncologist or a surgeon involved in the treatment of cancer?

DR. LAING:

A. They may have been the patient's family physician, that's correct.

MS. NEWBURY:

Q. Okay, and do you have any idea what proportion would have been sent to the family physician?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Is that something that you've tracked at all or looked into?

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DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay, and just looking over the minutes of the meetings that we do have, and I understand that there are some minutes or some meetings for which there were no minutes prepared, so I'm not sure that we have access to information about all of the people who were at the meetings over the couple of years since you've been holding them. But I understand that not all oncologists, whether they're medical or radiation oncologists, would have had any direct involvement with the Panel. I know that from time to time oncologists would come and go and take over the role of someone else who was no longer attending the review meetings. But would you agree that some oncologists who work at the Cancer Clinic never attended any meeting at all of the Physician Review Panel?

DR. LAING:

A. That's correct.

MS. NEWBURY:

Q. Okay. I'm wondering if an explanatory letter

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was sent to physician, whether they're oncologists or whether they're family physicians, to explain the purpose of the Physician Review Panel and exactly what the Panel would be doing and what the protocol was for the Panel and then the obligations of the recipients of the letters?

DR. LAING:

A. There was that letter that we looked at that Dr. Gardiner had drafted.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. And somebody asked me was I certain if that was sent or not, and I -

MS. NEWBURY:

Q. And you're not sure?

DR. LAING:

A. I'm not sure.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. The physicians within the Cancer Clinic and certainly, you know, the surgeons that were involved would have been aware of the Panel

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and its mandate and that information.

MS. NEWBURY:

Q. They were aware generally of the mandate of the Panel. Would you have had a, you know, a sit down, a formal sit down meeting just to go through precisely what the Panel was going to be doing and -

DR. LAING:

A. That would have happened at departmental meetings, yes.

MS. NEWBURY:

Q. Okay. And was there any reason for you to believe that there might have been some confusion about what the Panel was going to do, what the rights and responsibilities of the Panel would be and what the rights and responsibilities of the physician would be who received the Panel letter?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Did you at any point in time have any reason to believe that there was confusion about that whole process?

DR. LAING:

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A. No.
MS. NEWBURY:
Q. Okay. I understand that you had spoken to a number of your own patients about the appropriateness of other aspects of their treatment. And this is, you know, whether or not the ER/PR result and the change in result affected chemotherapy or radiation or any other aspect of their treatment?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. I think that was your evidence the other day, okay. And was that something that was initiated by the patients or did you make a practice to bring that up with each of your patients?
DR. LAING:
A. That would have been something that I would have done irregardless of whether the patients had asked that question. But many of the patients would have said did this mean I needed a different operation, did this mean I needed radiation or didn't, did this influence whether or not I needed chemotherapy and those

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sorts of questions. So that would have been addressed in -
DR. LAING:
A. As a matter of course, with you?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Okay, and do you know if your colleagues at the Cancer Clinic, so other oncologists, whether they're medical oncologists or radiation oncologists or perhaps even surgeons if they were involved in follow-up with these patients, do you know if they had a practice as a routine practice when dealing with these Panel letters and patients who had a change in their PR/ER results, did they do that in each and every case, explain to their patients, you know, their treatment in its entirety and whether or not it was all appropriate or whether there would have been any differences?
DR. LAING:
A. I would think so, but I wouldn't be able to tell you 100 percent that every person did.
MS. NEWBURY:
Q. Okay. Was it -

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DR. LAING:
A. There were occasions where physician who didn't feel comfortable in asking that question might have said "Maybe you should ask, you know, Dr. Laing that when you see her next." For example, if the question about the appropriateness of chemotherapy was asked to a radiation oncologist, then they may have said, you know, "Maybe you should ask that to Dr. Laing or I can ask her to address that for you," that sort of thing.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. The ER/PR results really doesn't influence surgery, it doesn't influence radiation. And it very occasionally would influence chemotherapy in that if the person was deemed to be negative and not a candidate for hormonal therapy, then the decision to give chemotherapy may have been made because of that and if someone had of been known to be hormone receptor positive, then perhaps in some instances chemotherapy may have been averted.

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MS. NEWBURY:
Q. Um-hm.
DR. LAING:
A. But in many, many cases patients who have hormone receptor positive disease still require chemotherapy because of the risk of recurrence.
MS. NEWBURY:
Q. Right, and you've explained that, I think, in some detail.
DR. LAING:
A. Okay.
MS. NEWBURY:
Q. The family physicians who would ultimately meet with their patients to discuss the recommendations from the Panel letter, would they have been able to answer those questions? I guess it seems straightforward to you that a change in ER/PR results wouldn't change the radiation or surgery and only in some limited circumstances might impact whether or not they have chemo?
DR. LAING:
A. Yes.
MS. NEWBURY:

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Q. Would the family physicians have been able to address that?
DR. LAING:
A. They may have been, and if they did not, then they often--that was a reason why they would have asked, you know, the patients would have asked to come back. Family physicians do a lot of follow-up care of cancer and many of the patients when they finish their course of active treatment within our cancer program are discharged back to the care of their family physicians, so they're very familiar with the hormonal therapies. We, for a number of years, give the family physicians a guideline for them to follow that sort of outlines various things to monitor and that for people that are on hormonal therapy.
MS. NEWBURY:
Q. That was given to family physicians?
DR. LAING:
A. And the patients, yeah.
MS. NEWBURY:
Q. And the patients?
DR. LAING:
A. Yeah.

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MS. NEWBURY:
Q. Okay.
DR. LAING:
A. And the other thing is is that there are actually some trials and some very good evidence that outcomes in cancer patients being followed by either their family physician or an oncologist or surgeon are equal, that there is actually an equal outcome to people that are followed by either their family physician or an oncologist after their adjuvant therapies are completed. And we have done some work in terms of helping to educate family physicians in this province. And then a few years ago I did a course called "Follow-Up Cancer Care" which was actually run through the MDCME program at Memorial that covered follow-up of more than just breast cancer but--and family physicians often write to us and call us about various aspects of their patients' care.
MS. NEWBURY:
Q. How about when you have something a little bit unusual, you yourself had indicated that it was only after the ER/PR problem arose that it came to your attention that there was research out there about the benefits of delayed adjuvant hormonal therapy. Would family physicians have been aware of that and been able to field some of the perhaps more unique questions that might arise out of a situation such as this one as opposed to more routine follow-up care following treatment of cancer?
DR. LAING:
A. No, I would expect that most family physicians would have not been aware of that article. And in fact, you know, I became aware of it, as you say, because of this issue and went looking for some guidance.
MS. NEWBURY:
Q. Do you know how many family physicians took advantage of the opportunity to refer patients on to the Cancer Clinic to meet with an oncologist to further discuss the recommendations that had been made by the Panel?
DR. LAING:
A. I don't have those numbers, no.
MS. NEWBURY:
Q. Okay.

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DR. LAING:
A. But I know there was, you know, there certainly were a number of those.
MS. NEWBURY:
Q. And do you know if anyone at Eastern Health has kept track of those records?
DR. LAING:
A. I don't know, but I would imagine that they--you know, with some looking, they could be found, but I don't know if somebody else has been tracking it, no.
MS. NEWBURY:
Q. Okay. Were the patients whose cases were reviewed by the panel, I just want to make sure I'm clear on this, were they advised, even of the raw data, the results of the retesting from Mount Sinai, before their case was referred to the Physician Review Panel?
DR. LAING:
A. Not necessarily.
MS. NEWBURY:
Q. Okay. So in some cases, they may have been advised of their results?
DR. LAING:
A. Yes, if they were coming to the clinic or, you

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know, had called in or something like that, but -

MS. NEWBURY:

Q. But as a general rule, they would not have had their results?

DR. LAING:

A. As a general rule, yeah.

MS. NEWBURY:

Q. And were the primary treating physicians, I guess you've called them the primary cancer treating physicians, were they provided with the results of the retest from Mount Sinai before the case was referred on to the Physician Review Panel?

DR. LAING:

A. No, not in all--not necessarily, no.

MS. NEWBURY:

Q. Okay. So they may or may not have -

DR. LAING:

A. That's right.

MS. NEWBURY:

Q. - received those results. Was any consideration given to immediately advising the patient or his or her responsible physician of the results without first

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awaiting for the panel to meet and review and make recommendations?

DR. LAING:

A. You know, there were some discussions, that we've gone through in detail, regarding a letter initially and then the decision not to do that was tied to the time line of having the results back and available within about four to six weeks. There were some early discussions about phoning patients and then I think that, you know, everybody's attention then switched to dealing with the information coming back from Mount Sinai and the start of the panel and so on.

MS. NEWBURY:

Q. Okay. The first decision, I guess, or discussion that you had, that was whether or not to inform patients that they would be retested and it was decided, at the time, in light of the understanding, that it would take four to six weeks to get the results back, that you would postpone that decision until later. My question is focused on what you decided to do when the results were received from Mount Sinai. So they were coming in, a

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lot of them came in in October up and through--October 2005, up through January 2006. Did you consider having a side-by-side process where the primary cancer treating physician would receive a copy of the Mount Sinai test results and at the same time, the case would be considered by the panel?

DR. LAING:

A. No. In some instances, I think if those results were back, then they may have been received by the physician prior to the panelling process. But I think in a lot of instances, the patients were, you know, put through the panel and then the contact was made.

MS. NEWBURY:

Q. Okay.

THE COMMISSIONER:

Q. Those latter type would only be those who were, in fact, being seen by the Cancer Clinic presumably?

DR. LAING:

A. Yes, or perhaps maybe if a patient had called in and asked and the physician went and looked and saw that the result was available. But

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there wasn't a conscious effort to go finding those results and calling patients before they were put before the panelling process.

MS. NEWBURY:

Q. In a normal course of events, upon receipt of results, you know, whether you've had a referral to the Mayo Clinic, which I understand happens from time to time, or other institutions like that, upon receipt of those results, is it your understanding that normally the results would be entered into the system and then forwarded to the treating physician for that physician to deal with appropriately?

DR. LAING:

A. Are you talking specifically about pathology results?

MS. NEWBURY:

Q. Yes

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. I guess pathology or perhaps other diagnostic. I don't know if there would be a difference, but I'm focused on pathology results.

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DR. LAING:
A. They would be sent to the physician, yeah, who ordered them.
MS. NEWBURY:
Q. So was there any consideration to allowing that process to proceed as it would normally, but then allowing--either allowing the physician or the patient to opt in to the panel process or perhaps having a side-by-side process where the physician review panel proceeds and considers those particular cases, but at the same time, giving the treating physician an opportunity to meet with the patient to review the file and to make his or her own decisions about whether anything else should be done with the patient?
DR. LAING:
A. No, I don't--we didn't consider that.
MS. NEWBURY:
Q. And why was that not considered?
DR. LAING:
A. I guess at the time, you know, the decision had been made that, you know, this was an usual clinical situation to try and decide what to do with information that was coming

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late that was outside the normal sort of course of making decisions about adjuvant therapy and, you know, a decision was made that perhaps the best way to deal with it would be for a group of people who were knowledgeable in the care of breast cancer patients to review this information and to make a recommendation, and that's really the way that it played out.
MS. NEWBURY:
Q. So the assumption was that for each and every case for which there was a change of treatment, the panel would be necessary?
DR. LAING:
A. That there should be some--yeah, that there would be a discussion about what would be the best course of action, because we didn't have a lot of experience in this. You know, this was not something that you could draw upon your own clinical practice to have dealt with before. This was not something that there was a lot of literature out there to go and refer to. So really, you know, at the time, it was felt that--you know, that the panelling process would be the way to consider these

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changed results for the patients.
MS. NEWBURY:
Q. Did any of the oncologists who would be ultimately meeting with the patients express their willingness to attempt to handle the case on their own and perhaps bring the case to the tumour board, the normal weekly tumour boards that are held if he or she felt that was necessary? I'm just wondering if anybody said "listen, we really need to do this. I think it would be dangerous to go ahead and treat the patient without first referring them to a panel."
DR. LAING:
A. I don't recall any of those sorts of discussions, no.
MS. NEWBURY:
Q. And looking over the minutes of the meetings and based on some of the evidence that you'd given in the last couple of days, it seemed that once, you know, a number of cases had been reviewed by the panel, the procedure became a little more easy to deal with because you'd sort of started to see the same situations and were a bit more comfortable

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with making decisions about patients in a particular case. Is that fair to say? I think ultimately you would be the -
DR. LAING:
A. I think in some situations, yes, yeah, and certainly if there was an instance where, you know, the panel, even if it was one person, two people, if there was four people there who could make a decision, you know, unless a consensus could be agreed upon and unless people felt that they had all the necessary information to make that decision, then that may have been deferred, and you can see that sometimes there were decisions that were deferred until more information was made available, for sure.
MS. NEWBURY:
Q. And ultimately, I believe, there was more than one meeting where only one oncologist was present.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. And that would be the only person to make--who's actually involved in making a decision

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for the particular patient?
DR. LAING:
A. That's correct.
MS. NEWBURY:
Q. So that would seem to suggest that the decision making got a little bit more routine or easier to deal with for most -
DR. LAING:
A. It did, because we could--you know, you could sort of have an idea about what criteria we had used before and, you know, so if I was doing the panel by myself and, you know, I think we looked yesterday at a couple of examples, somebody who had metastatic disease, you know, that was something that would be--you could very easily say "yes, this person should be considered." The ultimate decision whether to do that or not, of course, would be made in the clinic looking at all the other issues about where the disease was and what sort of chemotherapy the patient was currently receiving and all those sorts of issues. For people that were already on therapy or, you know, had already been dealt with, then those were shorter to review and--but you know, if I

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was doing a panel and looked at a patient and sort of thought "well, I'm not really sure which way this would go," then I would certainly defer it until such time as there was somebody else there. And in fact, if you look at the recent panels that we've had, we've been conscious of the fact of having two people there to have a discussion back and forth about.
MS. NEWBURY:
Q. Were you aware that the panel process itself might have introduced some delay in information being relayed to the patient about his or her treatment, whether any treatment change was necessary, and perhaps the anxiety that that patient might be experiencing waiting for that information?
DR. LAING:
A. Yes, we considered that, for sure.
MS. NEWBURY:
Q. You were aware of that, were you?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Were you keeping track of that throughout the

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time? Did you ever stop the panel and say "let's look at what we've done to date" say in January of 2006, you know, "are we delaying this? What are the risks and benefits of having this particular panel? We've met a number of times. We can have a meeting with our fellow oncologists, explain what the criteria are, and perhaps deal with these decisions for the patients more quickly than having to put everything through the panel."
DR. LAING:
A. No, we didn't do that.
MS. NEWBURY:
Q. Okay, and is there any reason why you wouldn't have thought to stop and evaluate the usefulness of the panel?
DR. LAING:
A. No, because we were just working away and really trying to do our best to--as the results were coming back in, to deal with it, to review it, and you know, while you're going through something like that, you know, your focus is really on that, plus continuing on other clinical work.
MS. NEWBURY:

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Q. Okay. Dr. Siddiqui testified that upon receipt of panel letters, if the panel did not recommend a change of treatment, he would typically await for the next scheduled appointment to review the recommendation, review the patient file, with a view to, I guess, confirming the appropriateness or his agreement with the panel's recommendation.
DR. LAING:
A. Um-hm.
MS. NEWBURY:
Q. Were you aware of that? I don't know if there were any other instances, but certainly that was Dr. Siddiqui's evidence, as I understood it.
DR. LAING:
A. Certainly if the person was coming for a visit in the next little while, I think that would be appropriate.
MS. NEWBURY:
Q. Sometimes he'd indicated that it may be five or six months. If the appointment was that far away, he wouldn't just say well, if they happen to be coming in in a week's time, "I'll just wait until then." He would simply just

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wait--if there was no recommendation change, he would just simply wait until the next appointment, whenever that may be.

DR. LAING:

A. Um-hm.

MS. NEWBURY:

Q. And I understood from him that that could have been as long as six months down the road.

DR. LAING:

A. Okay.

MS. NEWBURY:

Q. You weren't aware of that, I take it?

DR. LAING:

A. I wouldn't--not sure that I would have, you know, thought to see how long it would be before somebody was coming in after that panel letter had gone out. I didn't have any idea of what the delay has been, and for what I know, I don't think that information has been looked at. You've heard me speak about sort of looking at what's happened with the individual patients and the database that has been put together by NLCHI, and one of the things that's, if you want, kind of a follow up to that that I think would be worthwhile to

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do is to see, you know, of the recommendations that were made, how many patients decided to go on therapy late and how many didn't, and if at some point we could even, you know, look at it from the point of view of seeing what these patients outcomes were. Albeit it's, you know, not a randomized trial and it's not a large sample size, but I think that there could be some important -

MS. NEWBURY:

Q. Valuable information.

DR. LAING:

A. - information that I think, you know, really needs to be looked at. Because it may be helpful down the road to other patients in other situations.

MS. NEWBURY:

Q. Yes, I agree, and I'll ask you a little bit about that later, but for now, I guess my focus is on whether you, as the chair of the panel, were aware that some of your colleagues, well, Dr. Siddiqui is one example, would not necessarily immediately contact the patient to advise of the change of the result and whether or not there was a recommended

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change of treatment and also, to make sure that he agreed with the recommendation for that particular patient. So he wouldn't--it's not that he would just take the recommendation from the panel, review the file, make sure he agreed and then wait until three or four or two months down the road to meet with a patient. He would not review the file until immediately before the next regularly scheduled appointment. So if the panel's information was not up to date and if, for some reason, due to new information, the recommendation of Dr. Siddiqui would differ from that of the panel, that would not have been addressed for some months down the road. I'm just wondering if you were aware that that was a potential outcome?

DR. LAING:

A. No.

MS. NEWBURY:

Q. And I take it there was no mechanism in place to make sure that the patients were immediately contacted by the recipients of the letter?

DR. LAING:

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A. No.

MS. NEWBURY:

Q. Did anyone advise the recipients of the letter, of the panel letter, whether they were family physicians or oncologists in the Cancer Clinic, that this was the one and only means, in many cases, for that patient to learn the results of their retesting?

DR. LAING:

A. That wasn't included in those letters, no.

MS. NEWBURY:

Q. Okay, and I had the impression from Dr. Siddiqui that he didn't necessarily know that without him calling the patient and telling the patient that, you know, "there has been a change in your test result, but don't worry, there's not going to be a change in treatment," they would be sitting and perhaps waiting another five or six months until the next visit to learn that information, and that's not something you were aware of?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay, and during those meetings, or you've

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mentioned a meeting, I think it was the staff meeting at the Cancer Clinic when you discussed the mandate of the panel, was it ever made clear to your colleagues that, you know, "we're depending upon you to contact the patient. We don't have the Quality office contacting all of the patients who are going to be referred to the panel"? Was that made clear to those physicians?

DR. LAING:

A. No, I think what we told them was, you know, would have been similar to what's here. I mean, that would have been in the early days of setting up the panel and how it was going to work and that, you know, the letters would go to the physicians and the physicians would contact the patients. But it wasn't sort of laid out, you know, what that time line would be or those sorts of things were not discussed at that time. There were, of course, patients who were calling the quality office. There were patients who were calling our offices.

MS. NEWBURY:

Q. Sure.

DR. LAING:

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A. So there was a whole bunch of back and forth communication between patients and various people that--you know, and again, you know, I think we've mentioned already that there certainly would have been a benefit to having a central contact or central person responsible for the patient contacts. I think what was happening is that all sorts of people were doing all sorts of things, but not--but you know, to a certain degree separately.

MS. NEWBURY:

Q. But would you agree that in addition to having someone there to, you know, keep a very close eye on what's happening here, that from the outset, if there had been more of a clear statement to the various physicians who would be receiving panel letters as to what the panel's responsibility was and what the recipient physician's responsibility was, that could have avoided some of these problems, and just to make it clear to them that "listen, they're not otherwise going to know their retest results." Could that also have helped to eliminate some of the problems?

DR. LAING:

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A. It may have.

MS. NEWBURY:

Q. If I could bring up Exhibit 2585, please? This is panel meeting number two, and you were shown this yesterday, and there's an indication here that Dr. Felix brought a DCIS case to the panel.

DR. LAING:

A. Um-hm.

MS. NEWBURY:

Q. And I understand that typically, the panel was not hearing or not dealing with cases that had been DCIS?

DR. LAING:

A. And that was because ductal carcinoma in situ doesn't routinely have ER/PR testing.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. So they wouldn't have been part of this review.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. Yes.

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MS. NEWBURY:

Q. So Dr. Felix, he was actually involved in the panel meetings, as I understand it?

DR. LAING:

A. He did attend panel meetings, that's correct.

MS. NEWBURY:

Q. Yes, and so he would perhaps be expected to be a bit more familiar with what the panel was doing and what it wasn't doing than other physicians, such as a family physician in Gander or an oncologist in the Cancer Clinic who didn't go to any panel meetings. Would you agree that he might--he would have a better appreciation as to what the panel is and is not doing? I know that this is just a second meeting.

DR. LAING:

A. He may.

MS. NEWBURY:

Q. Yes, okay. I'm just wondering if once he brought this particular case to the panel, did you have any cause for concern that perhaps it wasn't clear, even to the physicians on the panel, what the mandate of the panel was, and perhaps to try and make sure that everyone

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understood?
DR. LAING:
A. No, I believe that Dr. Felix brought this patient to the panel because the patient was asking him a question. This was a patient who was already known to have ductal carcinoma in situ.
MS. NEWBURY:
Q. Right.
DR. LAING:
A. And her question to Dr. Felix was "should I be concerned? Does this ER/PR testing apply to me?" And so Dr. Felix, if you will, used the panel as a resource to address that question.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. I mean, I don't think at that time anybody would have said "I'm sorry, Dr. Felix. We can't talk about this patient because she has ductal carcinoma in situ and that's not the mandate of this panel." I think we, you know, took a few minutes to sit down and say okay, no, you know, we don't do ER/PR testing on DCIS. You can reassure this patient that

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they're not involved.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. So that's how that happened. This was before we dealt with the other issues related to ductal carcinoma in situ, which I would consider a separate issue.
MS. NEWBURY:
Q. Sure, yes, that was in a separate category.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. I appreciate that. So in your view, Dr. Felix brought this case to the panel because he didn't know how to answer the questions of the patient?
DR. LAING:
A. Dr. Felix added her because she was asking a lot of questions, and I -
MS. NEWBURY:
Q. And I would presume that he couldn't answer them without bringing it to the panel?
DR. LAING:
A. That's right, yeah.

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MS. NEWBURY:
Q. Okay. Given that Dr. Felix was unable to answer those questions, did you consider whether there might be other DCIS patients throughout Newfoundland who might also have questions, who would not otherwise be referred to the panel, and it might be useful to provide similar information that was given to Dr. Felix to all of those other physicians?
DR. LAING:
A. I would have--you know, there'd be lots of different possible patients who may not--who may have questions, and we certainly did see that. You know, we saw it amongst patients who had DCIS. We saw it amongst patients who had lobular carcinoma in situ. We saw it amongst patients who had a different cancer diagnosis, and as always, you know, we're there as a resource. There's not very many days or weeks that go by that I don't get a call from somebody asking for some help or clarify an answer or a patient's been concerned. Sometimes it's people who, you know, have a family history of a cancer. So you know, yes, I'm certain that there were

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other patients with ductal carcinoma in situ who may have had questions, but I would think that they would direct those to their physician and if their attending physician that they were directing it to couldn't answer that question, that they would go look for a resource to answer that question.
MS. NEWBURY:
Q. So just to facilitate the process for the family physicians, and recognizing that you're answering perhaps unusual questions--I mean, you haven't really been in a situation like this before, as I understand it, that you've got a change in results and you may have a bunch of questions that have never been asked of these family physicians, or surgeons, or radiation, or medical oncologists, in the past. Did you think that it might be useful to have communication, not just to a physician who happens to call the Cancer Clinic, but generally to keep the family physicians in the province up to date on these are the types of questions we're getting, you know, here are the proposed responses?
DR. LAING:

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A. No.
MS. NEWBURY:
Q. Or how about having just general meetings, teleconference type meetings to have a general discussion with those --
DR. LAING:
A. No
MS. NEWBURY:
Q. Are there any forums where that type of thing might be discussed among physicians, different associations or --
DR. LAING:
A. No. I mean, the only things that I can think about are, you know, times that we might be asked by the university or by the family practice to do ongoing medical education events. As this issue has gone along, and over the last couple of years, we've been asked on different occasions to give updates on hormonal therapy, and in our educational endeavours with--you know, wherever they may be, we've certainly discussed these issues, but, no, at that time nobody was thinking about having those sorts of information sharing events.

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MS. NEWBURY:
Q. Looking back on it now, do you think that might have been useful?
DR. LAING:
A. Oh, yes.
MS. NEWBURY:
Q. Okay, and you were shown a couple of exhibits this morning and I won't bring them up unless you want to see them, where there had been two of your own patients who had been overlooked, and I think in both cases the patient had already been discharged from the Cancer Clinic and you had assumed that the family physician would have followed up with the patient. When that happened, the first time was, I believe, in September of 2006 that was discovered, did that cause you to take any steps to make sure that everyone knew the protocol and had followed that protocol, aside from tracking who had been contacted, but to send out a bulletin to all physicians to say if you've received a panel letter, here is what the protocol is?
DR. LAING:
A. No, we didn't do that at that time.

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MS. NEWBURY:
Q. Okay, and is there any reason why you didn't do it then?
DR. LAING:
A. Not that I can think of, no.
MS. NEWBURY:
Q. Did you do it subsequently in that manner? I know someone embarked upon an effort to try to follow up.
DR. LAING:
A. No, but I think, you know, we did call and ensure that--eventually phone calls were made to ensure that everybody had been contacted.
MS. NEWBURY:
Q. And were the calls made to the patients or to the physicians, or to both?
DR. LAING:
A. I think eventually to the patients.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. But I know in my own practice I did call some of the family doctors that I had sent those letters to. That wasn't my practice initially, but when this--when these incidents

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happened, then, yes. If a patient's letter had gone to their family doctor, I would have called and confirmed. In sone instances, the family doctors wrote back or called back to me so that I knew.
MS. NEWBURY:
Q. You would have already had a record.
DR. LAING:
A. And that sort of correspondence does happen, you know, from outside physicians to us, you know--if I discharge somebody and make a recommendation that they have, for example, a bone density done, it's not uncommon for the family doctor to send me along a little note just so that I have that information. It might just say on it this is just information for your file. So it's not unusual for us to get correspondence from family physicians.
MS. NEWBURY:
Q. But you didn't expect it in every case, and if you didn't get such a letter --
DR. LAING:
A. We didn't assume that --
MS. NEWBURY:
Q. You didn't assume that it hadn't been done,

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okay.
DR. LAING:
A. No.
MS. NEWBURY:
Q. Have you ever thought about requesting on the letter that a signed copy of the letter, acknowledgement that it had been done?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay. In retrospect, I think that might have been useful?
DR. LAING:
A. Oh, yes, there's lots of thing in retrospect that --
MS. NEWBURY:
Q. This type of a physician review panel, and based on the evidence that I've heard about the panel itself, and based on the evidence I've heard generally about the tumour board rounds, it would seem to me that they differ in several respects, and I just want to ask your thoughts on that. The physician review panel did not arise out of the primary cancer treating physician referring the patient to

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the panel. That was a decision made collectively--it may or may not have involved that particular physician. It certainly didn't involve any of the family physicians.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. And that contracts with the tumour board rounds because the tumour board round, the primary treating physician has a difficult case or an interesting case or something a little unusual, and decides to bring that particular case to the next tumour board round, is that a correct assessment of it?
DR. LAING:
A. You would bring a patient to tumour board for a number of different reasons.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. But --
MS. NEWBURY:
Q. But it's initiated by the physician that's actually treating that patient at the time?
DR. LAING:

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A. It's initiated by a physician who's involved with that patient's care.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. So it may not--there may be other physicians involved in that patient's care.
MS. NEWBURY:
Q. Right. In the case of cancer patients, there could be the medical oncologist or the radiation oncologist.
DR. LAING:
A. Exactly, radiation, surgeon.
MS. NEWBURY:
Q. And perhaps even pathologists?
DR. LAING:
A. That's right.
MS. NEWBURY:
Q. But it will be someone who is involved in the care of that patient who initiates it?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Okay, and is it also correct to conclude that with the normal tumour board rounds, your

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regular tumour board rounds, the primary cancer treating physician would first receive all pertinent information that's available for that particular patient, you know, whether it's diagnostic, and pathology test results or an up to date health questionnaire for the patient, you know, weighing, and all those types of things, whether their weight is the same, and whether there's any health problems since the last visit, those types of things.
So would you agree that typically the primary cancer treating physician would have all of that information before referring the case to the tumour board round?
DR. LAING:
A. The tumour board round may be to address one of those pieces of information.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. So it may be to review the pathology.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. It may be to review the diagnostic imaging.

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It may be to ask another treating modality.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. So I may bring someone to say do you think this person should have radiation, I may bring someone to say do you think now that I've given this chemotherapy, that this person can now go on and have surgery if it's a neo-adjuvant setting.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. Or I may be presenting a case that I'm asking for the opinion about what drug treatment to give from the medical oncologists that are present. So there's various different --
MS. NEWBURY:
Q. Various types of opinions that are sought?
DR. LAING:
A. That's right.
MS. NEWBURY:
Q. Would you agree that for each type of opinion that may be sought at a given tumour board round, that all information available and

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pertinent to that particular opinion would have been collected by the referring physician before being brought to the tumour board round?
DR. LAING:
A. If it was available, but as I said, sometimes --
MS. NEWBURY:
Q. Sometimes it's not available, but --
DR. LAING:
A. That's what you're there for.
MS. NEWBURY:
Q. Right.
DR. LAING:
A. Right. So what happens is that--you know, we may be there to discuss, you know, a pathology, but we may decide whilst we're there to bring up the radiology films and look at it, and so there's often more than one piece of that persons information that is being presented, but, yes, whoever is presenting usually has seen the patient recently and would know most things. Sometimes, you know, a recommendation would come back to say, well, let's do this test and

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if it looks like it can be operated on, well, operate on it, and if it doesn't, we'll get radiation. So, you know, there's sometimes something that comes out of tumour board that leads you to do another investigation.
MS. NEWBURY:
Q. Right.
DR. LAING:
A. You know, there's just so many possibilities of things that could go on.
MS. NEWBURY:
Q. And sometimes it might actually be the tumour board round that tweaks it in someone's mind that you should get an additional piece of information?
DR. LAING:
A. Sure.
MS. NEWBURY:
Q. And that might actually be the result of it, but I'm wondering, you know, many cases for treatment of cancer whether or not to give hormone therapy, there's certain types of information that you might expect to know about the patient and whether or not she has had her uterus removed for some other reason.

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I understand that that would be a factor in a decision whether or not to offer Tamoxifen to a particular patient. If there is a concern about a risk of uterine cancer, and if for some reason there is no uterus any more, then that would presumably not be a risk factor.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. So that would be something that a physician would probably know from the outset that, well, let's try to get all of our up to date information here. Would anything like weight be an issue for the patient, history of blood clots, or anything like that?
DR. LAING:
A. Weight in terms of deciding whether or not to put them on hormonal therapy?
MS. NEWBURY:
Q. Yeah, just in terms of any of the other risk factors, is there anything about the patient that you would have to take into account to ascertain whether there is a risk of blood clots, as an example?
DR. LAING:

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A. Oh, yes, there would be things like family history of blood clots.
MS. NEWBURY:
Q. Right.
DR. LAING:
A. If the person has a history of hypertension, hypercholesterolemia, or other things. If there is a family history, do we know if that's been determined to be because of a known inherited hypercoagulable state, sedentary life style. Occasionally we have people that, for example, might be in a wheelchair. Age is an important factor. We know that the risk of thrombotic disease related to Tamoxifen is higher with increasing age.
MS. NEWBURY:
Q. Uh-hm. So would you agree that those types of information would be readily available to the primary treating physician through a meeting with the patient?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. It's not difficult to get this information?

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DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay, and so would you agree then that the physician review panel differs from your normal tumour board rounds in the sense that the panel did not have all of the readily available health information for the patient before reviewing the particular cases?
DR. LAING:
A. It would depend on which patient. Some patients we--who had been recently seen in the Cancer Centre who were still having active follow-up, we would have had that information.
MS. NEWBURY:
Q. So you might have had your own patient there who you saw the day before?
DR. LAING:
A. Or another physician's patient where we could extract that information from the chart.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. I mentioned that on the chart are something that we call first assessment summaries. So

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some of the information would have been there. Clearly if someone had been seen in 1997, and we're in 2005, that's why you would need that up to date information, but--you know, and that's why these were put forth as a recommendation because ultimately, you know, you'd have to sort of decide--if, you know, the patient had a contraindication to Tamoxifen, for example, then you may decide not to give that patient Tamoxifen. You know, those sorts of issues may come up.
MS. NEWBURY:
Q. Do you think that the work of the panel for those particular patients who had not been seen recently by anyone might have been more valuable a process if there was information that was up to date at that time, either through having the physician meet with the patient beforehand and provide that information by way of an update medical note to the panel, or perhaps request that the physician meet with the patient beforehand and then attend a physician panel review meeting?
DR. LAING:
A. It may have, but that's--you know, that's not

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the process which it went about. You know, I can think of some instances where we tried to get--I mean, not through direct contact with the patient, but through contact with other health boards where it did take some time for that information to be found and to be sent in to us. So I think that in the ideal setting, yes, you know, obviously if we had all--you know, the patient in front of us and had all that information --
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. Then it would have been an easier process, but, you know, that wasn't always the case.
MS. NEWBURY:
Q. But was it possible? Did you explore the possibility of simply contacting the treating physician and say please meet with your patient, please update the medical history, provide a medical note to us, or you're welcome to join us if you would desire to do so:?
DR. LAING:
A. No.

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MS. NEWBURY:
Q. Okay, and why not?
DR. LAING:
A. It just wasn't something that we thought about.
MS. NEWBURY:
Q. Okay, and given that the tumour board round would typically take place when you have current information that's available, why would you not consider doing it in the same manner as that tumour board round, to more closely resemble a tumour board round?
DR. LAING:
A. I just think that logistically we hadn't sort of thought about it in that process, that we were looking at making a recommendation based on--you know, we had the information in terms of prognosis.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. That information wasn't going to change. The only information that really would have changed would be if there was something about that patient's health history in the

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intervening year or two years, whatever it was, that would influence whether or not they would, you know, be a candidate for these medications from the point of view of potential side effects. You know, ultimately the decision of whether or not to go on medications, you know, was made by the patient in conjunction with the physician that was discussing that information.
MS. NEWBURY:
Q. Sure.
DR. LAING:
A. Yeah.
MS. NEWBURY:
Q. And that was based on a recommendation of the panel?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. And that recommendation may or may not have been up to date based on the information there. I'm just wondering what the value of the panel is if you did not have that up to date information?
DR. LAING:

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A. Because we would have still known what that patient's initial diagnosis was, we'd still know what that patient's prognosis was, that wouldn't change, and we would, you know, know where the person was in relation to the time of their diagnosis, and we did discuss a little bit about the fact that, you know, although there were recommendations made for patients who were beyond five years and even up to ten years, and even, I think, eleven years we found in one case. Then certainly the benefit to late treatment seems to be--just as an earlier treatment seems to be greater, the higher the risk of recurrence was. So that sort of prognostic information wouldn't have changed. What would have changed would have been, you know, if some other health problem had happened to that patient that we would not have been aware of by looking at their chart, and--you know, but that's--you know, that could be true for other situations where you may decide to do something and then when you go see a patient, something has changed that makes you then change your mind because of something else

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that has come up in the interim.
MS. NEWBURY:
Q. And you were confident that all of the recipients of the letter would know exactly what to take into account in making those final decisions with the patient?
DR. LAING:
A. And if they didn't, then they would refer the patient back to us.
MS. NEWBURY:
Q. And how would the recipient of the letter know what exactly the panel took into account, how would they know how much information you had about the particular patient?
DR. LAING:
A. Well, they would know that we had that patient's cancer chart.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. And know that that included, you know, their initial notes and consultation and what happened to them, and what treatment they had been on over the years for their cancer, that the pathologists were there and could review

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the pathology and the prognostic information related to the pathology, the original results, the new results, how that person was treated initially, you know, so there was --

MS. NEWBURY:

Q. And the physicians who received the letters had no reason to believe that the panel had any communication with the patient, is that your understanding? I'm just wondering if there was any room for confusion there about how much--how reliable or how much weight should be put on the recommendation of the panel. Dr. Siddiqui, it seems, you know, was quite comfortable to put his letter from the panel back in the file and await for five or six months perhaps, maybe two weeks, or six weeks until the next regularly scheduled visit before reviewing the file. I'm just wondering whether that particular oncologist or other physicians receiving letters may not have had a true appreciation of the extent of information that the panel had about the patient?

DR. LAING:

A. I would have imagined that they would know

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what information would be available to us.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. They would know that we would have the patient's cancer clinic chart.

MS. NEWBURY:

Q. Uh-hm.

DR. LAING:

A. I'm thinking about the case of a family physician, you know, he correspondence from the Cancer Clinic in terms of the first assessment summary and all the progress notes would go to the family physician, so they would know that we would have all that. Family physicians often in a patient's file have copies of their pathology reports and those sorts of things, have copies of the notes from the surgeons at the time of initial diagnosis. So the family physician in their own chart would have a lot of patient information and I'm not sure that they would have reason to believe that we would have less within the Cancer Clinic.

MS. NEWBURY:

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Q. Right, but maybe they thought that you had more information than the panel actually had and assumed that there was no need for them to update the patient history and to verify that the recommendation is a valid recommendation, given the patient's current circumstances?

DR. LAING:

A. No, I think if they were concerned about what was recommended, that they would have contacted us, and that certainly happened.

MS. NEWBURY:

Q. Did you consider perhaps writing a--just a bit of a warning on some of those patients who had not been seen by a physician for several years, as an example, to say, you know, this is based on the information that we have in the file which is dated up until whatever, 2002, when she was last seen in the Cancer Clinic, we suggest that you meet with your patient, update the information, make sure there are no risk factors that would otherwise suggest another type of treatment other than what the panel is currently recommending?

DR. LAING:

A. No, we wouldn't have spelled that out. We

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wouldn't have indicated when the last contact was by the Cancer Centre, but the latter part of it would usually be what a physician would do when dealing with a patient.

MS. NEWBURY:

Q. So they would--you would expect them to know this without necessarily going through the file and making sure, well, do I know what the panel knew when they made this recommendation?

DR. LAING:

A. No, I think you're--I think that's two separate things. The panel would have had the prognostic information.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. The panel may not have had up to date information to know if there was a contraindication to these medications, which is why it said, you know, if Tamoxifen was contraindicated, that aromatase inhibitors could be used instead.

MS. NEWBURY:

Q. Okay.

DR. LAING:

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A. And certainly family physicians would be familiar with those drugs, they would have followed many cancer patients who were taking both Tamoxifen and the aromatase inhibitors, would be aware of the potential side effects, contraindications, and if they were not, or if simply the family doctor called and said I've met with the patient, the patient has a lot of questions, would you mind seeing them, then that patient would be scheduled and we would have seen them.

MS. NEWBURY:

Q. Did you understand or believe that the panel had any responsibility to ensure that patients were contacted with the retest results in a timely manner?

DR. LAING:

A. I think the panel felt that the responsibility was to review the patients, make recommendations, and then send the letters to the physician. In terms of following up on that and ensuring that patients were contacted in a timely manner, as I've said to you already, in retrospect, yes, that would have --that's something that could have been

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improved upon, but at that time we were working through this issue, dealing with the patients that were coming before the panel, dealing with the patients that were coming in the clinic, and it wasn't something that we were necessarily following up on, I think, as well as we could have been, and I acknowledge that.

MS. NEWBURY:

Q. And did you understand or believe that the panel had any responsibility to ensure that its recommendation was based on complete up to date information about the patient, not only about the prognosis, but also current patient health information?

DR. LAING:

A. The only way that we would have been able to have the current health information would be if we had done it the way that you had alluded to earlier. So, no, I mean, again I stress that the prognosis wouldn't change and that we really relied on the person who received the information at the other end to process that, and to come back to the oncologist if there was a concern about the recommendation or if

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there was something about that patient's health, or even if it was just a matter that the patient had wanted to come--some of the family physicians, you know, said they were happy to start the patient on the therapy, but it was at the patient's request that they wanted to go back to the Cancer Centre. So there was all sorts of different reasons why people would have been referred back to the Cancer Centre.

MS. NEWBURY:

Q. And do you know where the--whether or not there was any authority for the panel to, I guess, withhold or to divert the retest results from the patient and the treating physician, primary treating physician, for the purpose of the panel looking at those results and making recommendations?

DR. LAING:

A. I'm not certain as to what you mean.

MS. NEWBURY:

Q. I'm just wondering--it seems that the panel had some limited responsibilities to the patient. It did not include responsibility, or your understanding was that it didn't

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include the responsibility to ensure that the patients were contacted. So there's no direct communication, no follow-up with the family physician to make sure the patient was contacted by the family physician, and you didn't feel that was the mandate of the panel, as I understand it?

DR. LAING:

A. No, I'm saying to you that at the end of the day, you know, we got--we started this work, it was going on, and, you know, when it was evident that there were instances where the follow up hadn't gone through, then, yes, not necessarily the panel, but all the people involved in this process did ensure that people were contacted and so on, but at no time did the panel operate in a way to withhold information from patients, or to do anything that--you know, felt that would harm patients in any way. That was not something that we had ever intended to do as part of this panel.

MS. NEWBURY:

Q. I'm not suggesting that that's the case.

DR. LAING:

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A. Okay.
MS. NEWBURY:
Q. But, I guess, my concern is that the retest results were diverted for the purposes of the panel.
DR. LAING:
A. I'm not sure what you mean.
MS. NEWBURY:
Q. They did not immediately go to the patient or the patient's primary treating physician, as I understand it, they were held onto, I guess, for longer for the purposes of the panel?
DR. LAING:
A. I'm not sure how to answer that. I mean, when the results came back from Mount Sinai, the pathologist would have reviewed them, and I'm trying to think of when they would have dictated that addendum. Whether that happened before or after the panelling process, I wouldn't be able to tell you. Do you know what I mean?
MS. NEWBURY:
Q. I might have misunderstood your earlier question. I was wondering whether or not patients had received the raw data from their

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retest results or their primary treating physicians received the raw data from the Mount Sinai retest results prior to the panelling process, and I had understood from you and perhaps I didn't quite understand your answer, that the panel in many cases received those retest results and it did not get relayed on to the primary treating physician until after the panel had finished its process?
DR. LAING:
A. No, I think those results were coming back from Mount Sinai.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. They were being, you know, looked at and reviewed by the pathologist, and then eventually it was the pathologist who dictated the addendum. Often as the results came back, the patients were panelled in the order of when the results came back, so often they were similar in time to--you know, because the decision to panel the patients was mostly made because they were the people who had the test

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results back.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. So I'm--you know what, I'm not certain as how that--you know, it wasn't that nobody's test results could go out until the panel had met and discussed them. We were just dealing with the information as it came back from Mount Sinai, but the actual addendums to the patient's initial pathology report were ultimately put in and dictated by the pathologist and I'm not certain as to --
THE COMMISSIONER:
Q. I'm confused now because I guess I was thinking something similar to what Ms. Newbury is saying in the sense of--are you saying they were two separate processes completely, the question of adding the addendum to the file, and the panel process?
DR. LAING:
A. Well, the--I think that the pathologist would have to answer that because they would have been the ones who added the addendum to the file, and I'm not certain, Commissioner, if

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they did that before or after the panelling process.
THE COMMISSIONER:
Q. Because somewhere along the way I had gotten the impression from you that the reason for the panel was in part because it was felt that that was the more effective way of dealing with it because if the information got out without having gone through the panel process, you effectively would have had all these calls, anyway, and this was a better more organized way of dealing with what you knew would come down the -
DR. LAING:
A. Right, that was a decision to review the information of the ER/PR tests, but I'm not certain as to when those addendums were done by the pathologists and when those results were sent out or signed out, released, or sent to the physicians. I'm just trying to think that, you know, eventually as time went on there must have been results that went out before the patients were panelled, right. So I - I don't think it was that the addendums weren't sent until the panelling process was

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done. What I think was happening was that as those test results were coming back from Mount Sinai, we were being asked to panel those patients based on when their test results were coming back. At the same time, you know, the pathologists were there so that they could make sure we had the right results. So they would have had those results. Now whether they were--I mean, some of them were gone out because I can remember seeing them on the screen in the room, but as to how parallel that process was, or those sorts of issues, I can't answer.

THE COMMISSIONER:

Q. Okay.

MS. NEWBURY:

Q. So is it fair to say then that your assumption was that the panel process did not in any way delay the preparation of the addendum to the pathology report and the transmission of that revised pathology report to the treating physician?

DR. LAING:

A. I'm saying that you'd have to clarify that with the pathologists.

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MS. NEWBURY:

Q. Yeah. No, I want to know what your understanding was. Maybe you didn't think about it.

DR. LAING:

A. No, I didn't think about it. It's not until we're having this conversation now that I'm trying to remember exactly how it worked, but --you know, because I think that maybe there were some instances where results may have come back before somebody was--and somebody would have known that before the patient was panelled. Now whether that was because the patient called in and somebody from Quality went and found the results, whether they were something that were readily available on the patient's medical record, or whether that's how it happened, I can't say for sure which way it was.

MS. NEWBURY:

Q. Okay, and if, in fact, it turns out that some patients or group of patients results were not sent on the pathology--revised pathology report, wasn't sent on to the treating physician because someone thought that it had

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to be panelled first, if that was the assumption of anyone there, and I obviously don't know the answer, would you expect it to have been told that or be aware of that?

DR. LAING:

A. If that was the assumption of?

MS. NEWBURY:

Q. If anyone was withholding any pathology reports from Mount Sinai, the updated information, because of the panelling process, would you expect to have known about that?

DR. LAING:

A. Sure.

MS. NEWBURY:

Q. Okay.

MR. BROWNE:

Q. Is this a hypothetical question?

MS. NEWBURY:

Q. Yes, it is. Generally speaking in terms of dealing with patients, would you agree that generally a patient is entitled to know about any testing procedures involving that particular patient?

DR. LAING:

A. In terms of if you're going to send a patient

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for a test or --

MS. NEWBURY:

Q. Yes.

DR. LAING:

A. To do a test on a patient.'

MS. NEWBURY:

Q. Uh-hm.

DR. LAING:

A. Usually it would be that there would be a discussion about that, yes.

MS. NEWBURY:

Q. Usually by the very nature of the fact that the patient has been sent for an x-ray, they would know about it.

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. But in other circumstances where something is being retested for some reason, would the patient normally be entitled to know that that's happening?

DR. LAING:

A. I guess it would depend on the context in which that retesting was happening.

MS. NEWBURY:

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Q. Okay, and are there any circumstances when a patient wouldn't be entitled to know?
DR. LAING:
A. I'm not sure if you do something like that as part of a quality review, is the patient notified that this is happening, or, you know, if somebody goes back and reviews mammograms, and just picks them randomly, I don't think in those situations a patient would be notified.
MS. NEWBURY:
Q. So that's a possible exception in your mind?
DR. LAING:
A. Yeah.
MS. NEWBURY:
Q. And how about if the reason for the test procedure has something to do with the treatment of the patient or confirming that the treatment for that particular patient was appropriate? As a general rule, would you think they should know about that?
DR. LAING:
A. Oh, yes.
MS. NEWBURY:
Q. Okay, and would you agree that regardless of the motivation for withholding information,

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that that would be a significant encroachment on their rights as a patient?
DR. LAING:
A. Are you referring to our decision to decide to send patients results for retesting?
MS. NEWBURY:
Q. I guess, generally, and I'm not sure if you can perhaps put it in the context of other involvement with the patient, but generally-- you know, obviously we're focusing on what information was relayed to the patients in this particular case, and I'm wondering is this an exception or is this something that's done routinely?
DR. LAING:
A. I don't know because I've never had this sort of experience before, so it's difficult for me to say.
MS. NEWBURY:
Q. So you've never had to make that decision before?
DR. LAING:
A. No. I mean, when I think about, you know, dealing with patients, it's always been on a, you know, individual patient basis. You know,

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if I'm going to say to a patient I'm going to, you know, have somebody look at something again about your pathology, you know if--and sometimes that happens. You know, sometimes I see patients for the first time and I say, you know, in this instance, you know--take example, maybe of someone with colorectal cancer. There's now good evidence that the number of lymph nodes involved is very important in determining whether or not somebody should have treatment. If someone comes and they have a specimen with six lymph nodes and I say, "Look, I can't make a decision. I'm going to ask the pathologist to go back and have another look and see if we can find any more nodes. If they do, then we may decide that you don't need this treatment. If they don't, then we may decide that you do." So in those sorts of situations or, you know, you've had CAT scan done, there's something that shows up in your liver, it's probably a haemangioma but they recommended an MRI. I'm going to send you for it." Like, that's how--I mean, that's my life, right, that's my day-to-day thinking, this whole idea

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of doing a retest on a large sample of patients was never anything that I had ever had thought about. The only other situation that I can think of is when we're looking at clinical trials.
MS. NEWBURY:
Q. Um-hm.
DR. LAING:
A. And in those situations if there's a thought to keep that patient's pathology material to do something with down the road, then in the context now of a clinical trial, particularly in the last few years with, you know, all the changes that have been made with those sorts of things, that the patients actually have to sign a consent form and that consent form can say, you may do whatever you want with my tissue.
MS. NEWBURY:
Q. Right.
DR. LAING:
A. That consent form may say I don't want you to ever use my tissue for anything else, and that consent form may be very specific to say, yes, you may use my tissue but I would only let you

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do A, B and C with it. And that's more what we see now in clinical trials. And then in that case if somebody wanted to do something outside that realm, then consent would have to be asked again. But -

MS. NEWBURY:

Q. Given that you were dealing with this situation which was novel to you, were there any resources available to you within Eastern Health or perhaps outside Eastern Health to, I guess, help you form your own opinion as to whether or not the patient should be told?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay. And I believe it was your evidence the other day that you subsequently had patients that told you that, "Well, I'm glad I didn't know about it, you know, I would have just worried about it if I'd known." Any idea how many patients fell into that category?

DR. LAING:

A. No, because I never did a survey or tallied them up. I think as I mentioned before, it's like many things in medicine, you know, there

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are some people who want to know everything and some people who don't want to know great details. And that's why, you know, we're certainly there, we offer as much information as we can to patients, but that we always get an idea from the patient how much information that you want to give. You know, it would not be very good if you went in and said to somebody, you know, "I think you have two days to live" and the person, you know, never, ever wanted to know that sort of information. So, you know, usually if we're discussing prognosis, times, percentages, any of these sorts of information, we get an idea by sitting down with the patients before to say, "You know, how much information do you want to know." And that's very individual.

MS. NEWBURY:

Q. Sure.

DR. LAING:

A. You know, as you can appreciate.

MS. NEWBURY:

Q. And given your experience that there is a range of levels of information that patients would want, would you have known in the summer

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of 2005 that there are patient that definitely want to know that I'm going to have my specimen retested, I want to know that this is going on?

DR. LAING:

A. Looking back, I can say yes. But at that time, you know, my thinking was focused around, you know, having all the information available to give the patients an answer. Because as a clinician, that's--in the day-to-day clinic, that's usually how my thought processes go. And certainly afterwards, you know, I had patients who said exactly that, you know, I would have wanted to know right from the beginning. Then I had other patients, as I've alluded to, that--but just as much as there's so much variability in people, you know, there'd be that much variability in what patients had said, I'm sure.

MS. NEWBURY:

Q. Yeah, and back in the summer of 2005 you weren't focused on those patients or perhaps even came to mind those patients who would definitely want to know?

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DR. LAING:

A. No.

MS. NEWBURY:

Q. Your focus was on possible anxiety to patients?

DR. LAING:

A. My focus was on trying to get an answer, trying to get a test result back so that I could determine what needed to be done for the patients.

MS. NEWBURY:

Q. Yeah, before letting them know so that they-- as I understood it, it was -

DR. LAING:

A. So it would be a -

MS. NEWBURY:

Q. The order in which you did that was based on -

DR. LAING:

A. A package deal, you know.

MS. NEWBURY:

Q. Yeah, your concern about the anxiety of the patients. Did you consider that there might be a group of patients who might derive a possible therapeutic benefit simply by knowing that the retesting was taking place because

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their results were now called into question, that they may not be reliable?
DR. LAING:
A. A therapeutic, that would be -
MS. NEWBURY:
Q. That that information in and of itself might be enough to allow the patient to have some therapeutic benefit even before their retest results were back? And perhaps I can give you an example. And this is the patient No. 4 that if you can think back to last week when you were testifying, patient No. 4 whose cancer had metastasized and you decided to give that treatment or give -
DR. LAING:
A. Hormonal therapy to the patient, yes, yes.
MS. NEWBURY:
Q. Yeah, even though you didn't have the test results back. Did you consider that there might be other patients, whether they were your patient or a patient of someone else, might actually derive some benefit if they fell into a similar category as that particular patient?
DR. LAING:

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A. At that time? No.
MS. NEWBURY:
Q. Okay. If I could bring up Exhibit C-0229, please? This is a list of Panel letters that had been sent to you. This one actually is signed by you, as well, January 27th, 2006. And this is a patient whose cancer had already metastasized before the Panel met. And the original ER/PR results were negative for both and the repeat report from Mount Sinai showed that the tumour was estrogen receptor positive at 80 percent and PR positive at 30 percent. And it doesn't show here when that particular patient developed metastatic disease, but perhaps it might have been discovered in October of 2005 or perhaps it was known in July of 2005. Either way, did you consider that a patient who had already metastasized might derive some immediate benefit from being advised that his or her, in this case I think it's a her, results for ER/PR were unreliable?
DR. LAING:
A. So patients who had metastatic disease could have had their--we could request for retesting to be done.

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MS. NEWBURY:
Q. Okay.
DR. LAING:
A. And the attending physician who was treating that patient with metastatic disease could have requested that at any time during this review process, and certainly that did happen.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. For some patients with metastatic disease the option of having hormonal therapy, first of all, depends on if they're hormone receptor positive.
MS. NEWBURY:
Q. Sure.
DR. LAING:
A. But it also depends on a lot of other factors. And there are patients who have hormone receptor positive disease who never get hormonal therapy for their metastatic disease and often that has to do with the extent of disease, the symptoms that are involved and where that might be. So if there was a patient, for example, who had quite

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significant symptomatic metastatic disease who is receiving a course of chemotherapy and who is having a very good response to that, with symptomatic improvement, you know, we do a lot of CAT scans and look for, you know, shrinkage of the tumour, etcetera, then the oncologist might have said to themselves, well, I know that this, you know, that this person is going to have retesting, you know, I'll wait and see those results. But if it was a period of time where you needed to make a therapeutic decision either because, you know, that patient had finished the chemotherapy and then you were thinking, well, can I put them on a hormone now, if they are going to be in this group who had changed. Or in some instances, you know, we found out this information after people who had metastatic disease for quite some time. So certainly if there was, if you were at a crossroad in terms of making a treatment decision, then we would have gone and sought this information. And that was well known by all the oncologists and that did happen.
MS. NEWBURY:

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Q. Okay. And with this -
DR. LAING:
A. And we saw some examples of that, yeah.
MS. NEWBURY:
Q. And with this particular case here, and I know that you had requested consults for some patients, this particular case here, it doesn't appear that a consult had requested and her patient situation wasn't reviewed until the Panel met.
DR. LAING:
A. Right.
MS. NEWBURY:
Q. And ultimately, according to this letter, hormone therapy was recommended.
DR. LAING:
A. To be considered.
MS. NEWBURY:
Q. To be considered, right. Now, you're the physician there, so presumably you would have--this letter went to you.
DR. LAING:
A. That doesn't necessarily mean that that person ultimately went on hormonal therapy.
MS. NEWBURY:

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Q. Okay. But it was something that was certainly contemplated as a recommendation?
DR. LAING:
A. That if you're hormone receptor positive with metastatic disease, you can be considered for hormonal therapy.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. But it doesn't mean that you would automatically get that.
MS. NEWBURY:
Q. Right. Now, this was a letter written from you to you. Did you have any more insight into this particular patient?
DR. LAING:
A. I don't know who this patient is, so I don't -
MS. NEWBURY:
Q. You have no recollection?
DR. LAING:
A. No.
MS. NEWBURY:
Q. And perhaps this was a patient that you'd never seen before who wasn't being followed by some other physician?

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DR. LAING:
A. No, I -
MS. NEWBURY:
Q. Is that -
DR. LAING:
A. No. There's two possibilities. One is is that this patient was very recently found to have metastatic disease. The second possibility is is that this is a patient who was receiving chemotherapy and having a response and so I was, you know, just waiting for the results to come back and thinking, you know, once I see what that is, I'll decide whether to go to hormonal therapy. We often interchange between chemotherapy and hormonal therapy, so there may be people that start out with chemotherapy and then between their chemotherapies may go on hormonal therapy for awhile to try and extend the period of time to progression.
MS. NEWBURY:
Q. Okay. And in this particular case you don't--you can't tell from this particular letter what type of cancer she had, whether it was a lobular or ductal?

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DR. LAING:
A. No.
MS. NEWBURY:
Q. No, okay. And you have no recollection of this particular patient?
DR. LAING:
A. No.
MS. NEWBURY:
Q. And in this case here, of course, you're the physician who receives the letter ultimately. Do you know if all other physicians who were following patients were aware that they could consult or send a case for a consultation?
DR. LAING:
A. Oh, yes.
MS. NEWBURY:
Q. Okay. So that they could pull a case out of order and -
DR. LAING:
A. Oh, yes, yes.
MS. NEWBURY:
Q. Yeah. And did you check to see when you were reviewing the files whether any of the patients who were not panelled until the routine results came back, so they weren't a

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consult, they were just a normal retesting case, whether any of those patients were lobular carcinoma or any of the other types of cancers that were anticipated to be ER positive and whether those patients could have possibly been treated with hormonal therapy even before the test results came back?

DR. LAING:

A. No, we didn't look at that.

MS. NEWBURY:

Q. Okay. And can you say that that's not possible?

DR. LAING:

A. Can I say that that's not possible? No, I can't say that's not possible.

MS. NEWBURY:

Q. And can you say that that's not even possible for this particular situation? Is it possible this particular patient was a lobular carcinoma who perhaps could have benefitted from knowing that she was being retested because her results were unreliable back in the summer of 2005?

DR. LAING:

A. The only lobular cancers that I could recall,

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you know, without a database to go and look for for that have been identified.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. The index case.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. Patient No. 2 and patient No. 4. And so when I first dealt with Peggy Deane, the index case, subsequent to that any of my patients who identified with lobular disease, so those were my other two. As time went on, you know, could there have been someone else that was mine that was lobular that I didn't see or didn't pick up or that we didn't know about until the panelling process happened? Yes. Did we have a way to readily go and identify who these lobular patients were? No.

MS. NEWBURY:

Q. Okay. And how about other physicians, do you know if they took as much time to make sure that they had identified all of the patients that they had treated who were lobular?

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DR. LAING:

A. That, you know, when we had the discussions about who could go, you know, who to check on, then, you know, certainly there were people asking on their lobular patients, there were people asking on their metastatic patients and that sort of situation, yeah.

MS. NEWBURY:

Q. And do you know if they actually followed up on that, I guess is my question?

DR. LAING:

A. I don't know, no.

MS. NEWBURY:

Q. And how about other categories of ER/PR patients, maybe they're not as clear to be expected to be ER/PR positive, such as lobular, but there might be other types of cancers that are more likely to be ER/PR positive, was there an effort to find any of these other categories of patients?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay. And why not?

DR. LAING:

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A. I guess just simply that that wasn't something we thought about at the time. But even in retrospect, it would have been difficult to do without a, you know, a way to go and pull those people out.

MS. NEWBURY:

Q. And in light of that difficulty would it not have been valuable to immediately tell all physicians and patients that they were being retested because of their unreliable results and perhaps then the patients or physicians could identify themselves if they might fall into that category and have a better chance of picking up all of those patients before awaiting that six month or eight month period of time that it would take for them to get the retest results back and panelled?

DR. LAING:

A. Sure.

THE COMMISSIONER:

Q. Ms. Newbury, it's about time for the afternoon break, so wherever you can find a convenient spot, we'll take the break.

MS. NEWBURY:

Q. This is a good place.

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THE COMMISSIONER:
Q. It is?
DR. LAING:
A. This is a good place.
THE COMMISSIONER:
Q. All right. We'll take the afternoon break, then.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Ms. Newbury.
MS. NEWBURY:
Q. Thank you. I wonder if I could bring up Exhibit C-0229 again, please? Dr. Laing, while that exhibit is coming up, can you tell if, or do you know when the patient specimens were identified for retesting, would it necessarily have been known what type of cancer each of those patients had been diagnosed with initially?
DR. LAING:
A. Yes, because it would have been on the--if they'd gone to look at the pathology report.
MS. NEWBURY:
Q. Okay.
DR. LAING:

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A. I'm not certain as to how they identified--I believe they looked to see if there had been a requisition in the computer for an ER/PR test. So if they just looked for that, then they may not necessarily have known just by looking at that.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. But that would have been on the original pathology report, whether it was ductal or lobular or whatever.
MS. NEWBURY:
Q. Okay, and whether anyone checked the original pathology report, you don't know?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay, and Exhibit 0229, page 23. This is another case where the patient's cancer had already metastasized before the panel met. This was on March 6th, 2006, that the panel letter was written, and the panel meeting was actually on the 4th of March. Can you recall, given that this letter is written to you and

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it's likely your patient, the circumstances of this particular patient? What type of cancer she might have had, for example?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay. Ms. Coffin, Daphne Coffin, has testified here and as I understand it, she had originally been determined to have a 23 percent ER figure, and that was subsequently increased significantly, and she had initially declined Tamoxifen, I believe because of some risk factors that were pertinent to her, in light of her own medical information. Does that sound familiar to you?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Okay, and you'd indicated that you were aware that in around 2004, the American Society of Clinical Oncology had recommended aromatase inhibitors as part of the adjuvant hormonal therapy for post-menopausal patients. Did I understand that correctly?
DR. LAING:

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A. Yes.
MS. NEWBURY:
Q. Okay. So that would be a different type of medication than what Ms. Coffin had previously been recommended back in, I think, around 2001. So it was Tamoxifen, I think, that she declined because of her risk factors, as opposed to aromatase inhibitors.
DR. LAING:
A. Right, because we weren't using aromatase inhibitors in that -
MS. NEWBURY:
Q. At the time, right, and that information didn't become available, I guess, until around 2004, as I understood it.
DR. LAING:
A. I can't recall if it was 2004 or 2005 that they put out the first technical briefing on the use of aromatase inhibitors in post-menopausal patients.
MS. NEWBURY:
Q. Okay, and again, in 2005, you've testified that through your discussions with Dr. Pritchard and arising out of the issues with the ER/PR testing, you had learned that there

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could be some benefit to delayed hormonal adjuvant therapy?
DR. LAING:
A. Based on a Tamoxifen paper.
MS. NEWBURY:
Q. Okay, and did that also apply to the aromatase inhibitors?
DR. LAING:
A. No, that particular study that had late therapy was done prior to the aromatase inhibitor era.
MS. NEWBURY:
Q. Okay, and were there any conclusions drawn that late--other types of late hormonal therapy might also be beneficial?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Okay, and is that a conclusion that you reached in conjunction with other oncologists, either at Eastern Health or discussions with other oncologists in -
DR. LAING:
A. Yes.
MS. NEWBURY:

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Q. Okay. So you interpreted that more broadly, I guess, than just for Tamoxifen?
DR. LAING:
A. No, no, that was based on other data.
MS. NEWBURY:
Q. Oh, okay.
DR. LAING:
A. The aromatase inhibitor was based on the MA17 trial.
MS. NEWBURY:
Q. Right. Was there a paper that also confirmed that there was likely benefit to delayed aromatase inhibitors being given patients?
DR. LAING:
A. No. No, if I could just take--for a moment, explain that to you.
MS. NEWBURY:
Q. Yes.
DR. LAING:
A. MA17 was a trial that looked at patients who had completed five years of adjuvant Tamoxifen, and it's one of the settings in which aromatase inhibitors have been explored. So you finish five years of Tamoxifen. You randomize to an aromatase inhibitor. In this

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particular study, it was a drug Letrosol or Femara. What had happened was at the very first interim analysis of that, when most people had been getting the treatment for about two and a half years, the results were so positive that the Data Safety and Monitoring Committee suggested that the trial be stopped, that the patients be unblinded and that patients who were on the aromatase inhibitors should be continued on, if that was a decision the patients were agreeable with that. Patients who had been on the placebo arm, okay, so they had five years of Tamoxifen, they had anywhere from, you know, one, two, three years where they hadn't gotten anything, had the option, again upon the investigator discussing it with the patient, of going on late Letrosol. So Tamoxifen for five years, nothing for a few years, and then an aromatase inhibitor.

In December of 2006, so not in the beginning of this process, but as time went on, those patients were analyzed. You know, the patients who had been unblinded, and they compared the patients who went on the Letrosol

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at the unblinding versus those that didn't, and they noticed that the people that decided to go on had a better outcome. This sort of data is what we call--you know, it's obviously bias because people may have decided--they weren't randomly assigned to go on the treatment or not, but all those things taken into consideration, it was another, you know, indication that even with a delay, albeit a very different situation than this.
MS. NEWBURY:
Q. Sure.
DR. LAING:
A. But even prior to that knowledge, the fact that we knew that MA17 was a positive trial and we knew that in 2004, that we knew that there was a benefit to treating people in the five to ten year period. So that helped us in making decisions about that particular time frame.
MS. NEWBURY:
Q. Sure, okay.
DR. LAING:
A. And if you look at aromatase inhibitors versus Tamoxifen upfront, then the studies to date

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have shown equivalents, in terms of overall survival, but a slight advantage in terms of disease free survival for the aromatase inhibitors. But we're waiting for the follow up data.

MS. NEWBURY:

Q. Okay. So is it fair to say then that by the summer of 2005, you had a variety of information that might have been helpful in Ms. Coffin's case in particular, and number one, you had ER positive results of 23 percent and those results were now called into question and if anything, you would have expected that the result would be perhaps lower than it ought to have been? Is that fair to say?

DR. LAING:

A. Lower than it had have ought to be?

MS. NEWBURY:

Q. Yes. Would you have expected her results to go up or down?

DR. LAING:

A. I wouldn't know until she was retested, but I knew that there was a possibility that they could go up, just by virtue of what, you know,

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I had seen during the -

MS. NEWBURY:

Q. Yes. So the concern that you had was not that results were going to go down. The focus was results that were too low, lower than what they should have been? That's why the retesting focused on the ER negatives.

DR. LAING:

A. So were there people in the review who were 30 percent and then came down to 20 percent, yes, so not everybody went up, but -

MS. NEWBURY:

Q. No, my focus is on you've got a patient here, she was 23 percent ER negative--or ER positive, and she was included ultimately in the group that would be retested.

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. Not immediately, but in the summer of 2005, she was someone whose results might have been thought to be unreliable, or did you not consider her to have potentially unreliable results at that time?

DR. LAING:

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A. I don't think I would have considered it at that time, no.

MS. NEWBURY:

Q. Okay. If you had met with Ms. Coffin in 2005, if she happened to come in your office for some reason, would you have considered that there was new treatment available to her, given that aromatase inhibitors were now available for her, being post-menopausal, and that the risk factors that she had, that concerned her with Tamoxifen, may not necessarily apply to the aromatase inhibitors?

DR. LAING:

A. No, we never went back and looked at people who didn't take Tamoxifen because of potential toxicity and offer them aromatase inhibitors.

MS. NEWBURY:

Q. Okay, but given that you're now calling into question a group of patients who had ER/PR testing done over the years, would you have possibly considered that, had she come into the office, if she had learned about the ER/PR testing and if she had said to you, you know, "I declined at the time because of my concern about Tamoxifen, but I want to find out if my

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results are going to be higher," would you have considered any of these factors at the time when meeting with her?

DR. LAING:

A. If she had asked me about them, perhaps, but in 2005, I can't say that I would have for sure, no.

MS. NEWBURY:

Q. So until such time that she came forward and triggered a retesting of her results, there would be no consideration given to her?

DR. LAING:

A. No, because I didn't think about it until I saw her in 2006.

MS. NEWBURY:

Q. Okay, and in the circumstance where you have someone who has declined treatment because of a particular risk factor and in that case, she had a concern, I believe it was about blood clots might have been her concern.

DR. LAING:

A. Um-hm.

MS. NEWBURY:

Q. And new information becomes available and that combined with a concern about reliability of

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the ER/PR results initially, which had been the basis of her, you know, the decision about whether or not to take hormonal therapy, would it have been valuable to have met with her earlier on and to review her results and to review her treatment to date, back in the summer of 2005?

DR. LAING:

A. At that time, we weren't--you know, that was when this had just started. We weren't, at that time, calling back patients. You know, it was later on when we started to do the review process and that sort of thing. So I don't think, in the summer of 2005, my thinking would have been there, as it was, you know, subsequent to starting the panelling and that sort of thing.

MS. NEWBURY:

Q. So there was no effort to look back at patients whose treatment may have been possibly different than what it would have been if their true ER results were known?

DR. LAING:

A. No, I mean, that's why the retesting was undertaken, was to look at patients, but you

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know, when we looked back through, we found patients who didn't take Tamoxifen or couldn't tolerate Tamoxifen. You know, in medicine, it's not usual to go back and, you know, look at people who have been treated in the past and make new treatment recommendations based on the new information that you have. That's not something that we would routinely do. We did it in this situation, and you know, as we both acknowledge, this was a unique situation. But no, I mean, we weren't thinking at that time, and if we had patients who didn't take Tamoxifen or couldn't tolerate it, and two or three years have gone by and we now knew about the aromatase inhibitors in the adjuvant setting, we didn't go back and find those people and then give them aromatase inhibitors. That wasn't our practice.

MS. NEWBURY:

Q. And I guess Ms. Coffin's own history shows that there are many different, you know, varieties of factors that are considered in treating a patient.

DR. LAING:

A. Yes.

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MS. NEWBURY:

Q. And I'm just wondering whether--and again, there was a period of time here, between 1997 and 2005, that there were a number of changes taking place. There were new therapies coming available. There were therapies that were expanded to include different groups, so the aromatase inhibitors were now being applied to post-menopausal patients and they hadn't prior to that.

DR. LAING:

A. Um-hm.

MS. NEWBURY:

Q. And you also have information about the benefits of delayed hormonal therapy. Given that there are so many factors involved and given that there are so many different patients out there who--some who might have been close to the cut off point, such that it is, for hormonal therapy, do you think it might have been beneficial to patients to have a broader retesting program, just to try to capture patients such as Ms. Coffin who was not, I believe, initially captured for the retesting? Perhaps to look at patients who

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were at the lower end of positive and who declined treatment because "well, I'm concerned about Tamoxifen. I'm 40 percent, not 95 percent" and in the interim, of course, you've got new therapies that are now available.

DR. LAING:

A. I mean, I think there's two points to that. I think the first of all is that when we think about adjuvant therapy, we're talking about starting that therapy at the time of the initial diagnosis. So if in 2008, a paper comes out that shows a benefit to a drug in--I'll take lung cancer, for example. You know, it's only really been in the last year, two years, that adjuvant therapy has been shown to be beneficial to lung cancer. We didn't go back and find all the lung cancer people that had surgery and find them and give them adjuvant therapy at this point. That's not something that's done in medicine. We did it in this situation, but it was unusual.

The paper that looked at the delayed Tamoxifen was done because of a change in practice, where pre-menopausal patients were

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not given Tamoxifen prior to the late 1990s, 2000. So that wasn't an uncommon situation and not something that you would do today. There's not going to be any studies done today of delayed adjuvant therapy, because adjuvant therapy, by definition, is given around the time of the original surgery. So no, I mean, that wasn't something that we did. That's not something that we do in medicine. That's not something that would be any--you know, would be a routine practice. I can't come up with an area where you would do it. We did it in this situation because it was a unique situation. If we had an idea, for example, if we knew that if you had breast cancer and if you didn't recur by five years, you'd never recur, we would never have looked at anybody beyond five years. So what we did here was very dependent on the nature of this disease.

As to, you know, the criteria for retesting, I mean, we've talked about that, and you know, we've never had any concerns about the positive results. These ID of people that may have made a decision based on how positive they were, whether you want to

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call them weakly positives or whatever, you know, that is something that has been discussed, as I indicated.

MS. NEWBURY:

Q. There have been no decisions on that though, are there, to date?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay, and I guess the point is not just that the cut off, the clinical cut off that may or may not be applied over the years, the 10 percent or 30 percent, that's not the only factor that the patient relies upon in making the decision in conjunction with the physician?

DR. LAING:

A. No, no.

MS. NEWBURY:

Q. And there may be other people like Ms. Coffin who might have been slightly above the actual cut off that was typically used at a given time?

DR. LAING:

A. Sure.

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MS. NEWBURY:

Q. Who might have made a decision based on that result?

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. Okay, and not only that, but there's also new information out there. So you've got a combination of factors over that period of time. You've got unreliable ER/PR test results. You've got new information about benefits of delayed therapy and new types of therapies that could be applied to patients that maybe a couple of years ago wouldn't have been. So you know, really it does call into treating patients individually, wouldn't you say, and not just to cut off the patients below a certain line, but to look at a broader category of patients?

DR. LAING:

A. Should we look at the weakly positives, that sort of situation, yes.

MS. NEWBURY:

Q. Dr. Laing, the decision, as I understand it, to not advise patients about the fact that

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retesting was taking place until after the results were back, and that was based on an understanding that the results would be back in four to six weeks, but again, it was motivated, I believe, by a concern about anxiety that the patients would experience, awaiting those results, once they know retesting is going on, "I really would like to know my results and I'm going to be anxious in the meantime waiting for it." Had I captured that correctly?

DR. LAING:

A. That was part of the reason, yes.

MS. NEWBURY:

Q. Was it the primary reason? Were there any other significant factors?

DR. LAING:

A. I think there was just--not even just in terms of anxiety, but just in terms of being able to go to the patients with a complete decision about what would need to be done, because that's how we like to do things in medicine. We like to go to our patients and say "this is the information that we have" and you know, "this is what we think needs to be done about

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it." You know, that was when we thought this was going to be a short process.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. And as I said before, nobody, going into this, thought that this was going to be something that would involve so many patients. We had no idea at that point, you know, that the--things were just getting ready to go off to Mount Sinai during that time. Nobody had any idea what number of patients this was going to be. The sample size that has been retested so far is bias because we know there's lobular patients in it and people with metastatic disease and people from a time period or whatever else you want to look at it. So you know, I've explained that my opinion, I wasn't the one who made the final decision, but my opinion was that understanding that we were going to have information back in a four to six-week period, let's get this done, let's sit down and look at it, let's get the patients in, and let's give them the answers to what this means to them.

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MS. NEWBURY:

Q. Okay, and your desire or your preference to go to the patient only once, once you had all of the relevant information, so not only the fact that retesting has taken place, but the actual results of the retesting and your thoughts on what it might mean for that particular patients treatment, was that motivated by concern about the patient's anxiety if you can't give them the complete picture from the beginning, for the first communication, or were you concerned about the financial or the human resources of having the time to do that?

DR. LAING:

A. No, my primary concern always would be that of the patients.

MS. NEWBURY:

Q. Okay, so it was the concern about the patients getting only part of the information at the beginning and not a complete picture?

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. And you were concerned that that would cause anxiety for the patients?

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DR. LAING:

A. Yes.

MS. NEWBURY:

Q. Okay, and there were no other significant factors that would have caused you to wait until you had the retest results back or that was the plan?

DR. LAING:

A. No.

MS. NEWBURY:

Q. Okay, and I guess I'm wondering if the concern about anxiety of the patients was significant enough, you know, in that early period of time, summer of 2005, that it was decided, based in part on your opinion, that it's better to wait until you have the results back. Compare that to the period of time that, after October 2005, this becomes a public issue. Patients are finding out either immediately or overtime that their results are being retested, and I'm wondering, you know, what were the thoughts of you and your colleagues in terms of the anxiety of the patients at that point in time when they're awaiting the results?

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DR. LAING:

A. We would have had concerns then as well.

MS. NEWBURY:

Q. Okay, and would you think it be important to have some mechanism set up so that you could immediately let patients know what is happening for those particular patients by perhaps sending a letter to each of the patients or sending a letter to each of the physicians, just to let them know, even if you don't have the retest results back, just the fact that they've been retested or not. So may not -

DR. LAING:

A. There were discussions about phone calls and that at that time.

MS. NEWBURY:

Q. Okay, and was that something that you considered yourself to be involved in?

DR. LAING:

A. No, by that time, I was--you know, my focus was on the panel and -

MS. NEWBURY:

Q. Okay, and who would have been primarily responsible, in your--I guess, from your

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understanding with making that communication to the patients, you know, with a view to avoiding any unnecessary anxiety?

DR. LAING:

A. Well, at that time, you know, the patients were calling and Nancy Parsons was a resource.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. The Quality office was dealing with patients as well. We were dealing with patients on a day-to-day basis at the Cancer Centre, so there were a number of different -

MS. NEWBURY:

Q. I know that there were mechanisms in place there.

DR. LAING:

A. Sure.

MS. NEWBURY:

Q. And it might depend on if a patient knew who to call or whether they had a treating oncologist at the time, but I'm wondering who was the decision maker in terms of how can we go about doing this? Is this the best mechanism for communicating with the patients,

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who we anticipate will be very anxious? I mean that was the whole -

DR. LAING:

A. Sure.

MS. NEWBURY:

Q. - reason for not telling the retest results from the beginning. So you've got a group of people who you anticipate will be anxious. Who was responsible, from your understanding, with deciding how to communicate with those patients, in a manner that will, I guess, most quickly alleviate any anxiety that they may be suffering?

DR. LAING:

A. I'm not sure if there was one person who was solely responsible for that, but that was certainly something that was discussed, you know, amongst people, Ms. Pilgrim, Dr. Williams, you know, all the people that had been involved at that time.

MS. NEWBURY:

Q. And were you among that group?

DR. LAING:

A. To make a final decision about what to do? No.

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MS. NEWBURY:

Q. Would you have weighed in with your opinion, your thoughts about "listen, we need to communicate with these people immediately, whether it's a letter or a group session or appointments available at the clinic or family physicians?

DR. LAING:

A. Well, I mean, we certainly had appointments available at the clinic. We were certainly available to talk to the patients, but you know, that would have been my input into it.

MS. NEWBURY:

Q. But that would not have been made known to all of the patients whose results were being retested.

DR. LAING:

A. No, because they--are you suggesting that they would have known that only if someone had called them and told them that that was available?

MS. NEWBURY:

Q. Yes.

DR. LAING:

A. Sure, I mean for everybody to know, yes.

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MS. NEWBURY:

Q. A number of people would not even know if they are in the group of people who are among those being retested.

DR. LAING:

A. Yes, yeah.

MS. NEWBURY:

Q. Okay, and I'm just wondering if you had weighed in on how to communicate or not with the patients, the mechanism or whether it should be done and, you know, who should be contacted?

DR. LAING:

A. Not so much more after that time period, no.

MS. NEWBURY:

Q. Dr. Laing, you've emphasized, and I think even today that the number of conversions of ER/PR results that led to treatment changes is still an important number. You're not saying it's the only number, but you're saying it's still an important number to consider.

DR. LAING:

A. Oh yes.

MS. NEWBURY:

Q. Okay, and now albeit that number might have to

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be suggested because some patients may not have been included who you might have expected to be included from the beginning, Rosalind Jardine, I believe, was an example. But the number that we're talking about is the 117 number, and that might have to be adjusted upwards if Rosalind Jardine had not been included.

DR. LAING:

A. I think as I mentioned yesterday, there's two reasons why that number may have to be adjusted. One is because there may have been people not included, and the second is because you have to decide where you're going to take that cut off, that snapshot in time.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. So if you wanted to look and see what it was on September, whatever today is, 2008 -

MS. NEWBURY:

Q. Sure.

DR. LAING:

A. - that would be a different number than six months ago, which would have been a different

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number from two years ago. Part of that would be because you're now going to include people that may not have been included.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. And part of that would be because during the course of the natural history of breast cancer, there will have been further patients who have had a recurrence.

MS. NEWBURY:

Q. Right, okay, and on that note, perhaps an example would be a patient who had a change in the ER/PR results that was significant enough that the patient was referred to the panel, and there are a number of patients, I understood, that by the time they were referred to the panel and because of the date they were initially diagnosed, they might have been eight or nine years out from diagnosis and they were considered to have a good prognosis and they were not recommended for hormonal therapy at that point in time?

DR. LAING:

A. Yes.

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MS. NEWBURY:

Q. Okay, and that's despite the fact that they do have a conversion of significance in their ER/PR test results?

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. And is it possible that some of those patients, notwithstanding their good prognosis, may have a recurrence of cancer next year or next month or in five years time?

DR. LAING:

A. Sure. If you belong to a category in which there's a 99 percent chance you're cured, there's always a one percent chance that you're going to recur. So yes, there always will be people who recur even with very, very, very good prognosis.

MS. NEWBURY:

Q. Okay, and were some of--I mean, were all of the patients who you decided not to recommend hormonal therapy because of their good prognosis and the date from diagnosis, would they all have been in a category of 99 percent chance that they've been cured or were there

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some in a lower category?

DR. LAING:

A. It would depend on their prognostic factors, but certainly there would have been people in the, you know, 90 percent chance of being cured, and again, it goes back to the--when we look at benefit, we look at what the risk is. So the risk of recurrence multiplied by the relative risk gives you your absolute benefit. That's true and then we use that when we see people initially and that same sort of information is true as time goes on. We know, of course, too that your risk of recurrence gets less as time goes on, but it doesn't go to zero.

MS. NEWBURY:

Q. But it doesn't go away entirely. So in light of the fact that some of these patients, some of this group of patients might ultimately have a change in treatment even though it hasn't occurred, so if that patient has a recurrence of ER/PR--sorry, of their cancer, they might come in and because they were ER/PR positive, they might be now given some sort of hormonal therapy?

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DR. LAING:
A. That's correct.
MS. NEWBURY:
Q. Okay, and in light of that type of example and perhaps there might be a group of patients there, wouldn't that make that number more important, the number of actual significant conversions of the lab results, as opposed to just the number of conversions that have led to a treatment change, as of the date of the panel, for example?
DR. LAING:
A. Oh, I think that--I've said this yesterday. I think all of these are important, you know, and there have been attempts by various people to categorize people into, you know, if somebody--you know, how affected they were, and as I said yesterday, I think that it depends on a lot of different factors, and it depends on how you want to group people, but it's very individualized. So the fact that somebody's test results changed, significant? Absolutely. Important to the patient? Absolutely. The fact that somebody's test results didn't change, is that important to a

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patient? Absolutely.
MS. NEWBURY:
Q. Yes.
DR. LAING:
A. So you know, it's very difficult to assign degrees or grades of importance or non-importance. I think all of these are important.
MS. NEWBURY:
Q. And would you agree that the public would have a right to know about not just the conversions that lead to treatment changes, but the conversions that were significant? I'm not talking about a ten ten going to a ten nine, for example, but a larger difference, those that you panelled as an example.
DR. LAING:
A. Do I think that the public has the right to know?
MS. NEWBURY:
Q. Yes.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. And is this something that you have felt all

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along or is it a new realization on your part?
DR. LAING:
A. I think that whenever you deal with a situation where you have, you know, something like this where there are a number of people involved, I think that the most important people to disclose to first are the patients, absolutely, and you know, that's an opinion that we've heard here and, you know, I've attended since seminars regarding this issue in oncology at our meeting just this last May, and you know, it's felt that when there is a situation where there are multiple patients to be disclosed to, that the most important people to disclose to first is the patients, and then subsequently to the public. But public needing to know about these things is important as well, yes.
MS. NEWBURY:
Q. If I could have Exhibit 2642, please? This is an exhibit that you were shown this morning, Dr. Laing. How familiar are you with this particular document, this particular list? It's actually page two has the list itself. Just wondering how familiar you are with this

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particular list.
DR. LAING:
A. I saw it this morning.
MS. NEWBURY:
Q. Is that the first time you saw this list?
DR. LAING:
A. No, I would have seen it before.
MS. NEWBURY:
Q. Okay. Would you have seen it back--the e-mail sending the list from Heather Predham to Dr. Denic is dated May 17th, 2006. Would you have been familiar with this list around that time, not necessarily on that day, but either before or after?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Yes, okay. I'm just wondering if it's a document--because you're not a recipient or the sender of that e-mail, so I just want to make sure you'd been familiar with it back in 2006.
DR. LAING:
A. Yes, we did look at this list.
MS. NEWBURY:

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Q. When you say "we looked at the list," who's included in the we?
DR. LAING:
A. Ms. Predham and Dr. Denic and I.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. I'm not sure who else. I can only know that from -
MS. NEWBURY:
Q. Did you help prepare the list?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Who prepared it, do you know?
DR. LAING:
A. No.
MS. NEWBURY:
Q. And what do you understand this list to be?
DR. LAING:
A. The list of patients whose results went from being positive to negative.
MS. NEWBURY:
Q. Okay, and does it include all of those results from positive to negative, up until, I guess,

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the date of the list, which is May 2006?
DR. LAING:
A. My understanding is that it did.
MS. NEWBURY:
Q. And it doesn't depend on whether or not they had a treatment change?
DR. LAING:
A. Not that--no, I don't think so.
MS. NEWBURY:
Q. And when you say from positive to negative, can you be more precise as to, given that there have been different thresholds over time, and do you know what the precise criteria would be for what's considered a positive to a negative?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay, and who would know that?
DR. LAING:
A. Well, if you look at the list, where the positivity is is in the progesterone receptors.
MS. NEWBURY:
Q. Okay.

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DR. LAING:
A. Okay, so these are people that were retested because their estrogen receptor was less than 30 or less than ten. But we didn't look at progesterone receptor to determine whether or not patients should be retested.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. We know that through the panelling process, and we've discussed this, that there were people that were ER negative PR positive, many of whom were given hormonal therapy based on their PR positivity, right, and you know, we've looked at documents that suggest that that number, not just for that reason, but other reasons, may be as high as 138 or whatever it was that people were already treated. So this would have been people whose progesterone receptor was greater than 30 percent or greater than 10 percent.
MS. NEWBURY:
Q. For what periods of time? The same as the ERs?
DR. LAING:

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A. Yes.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. And that when the results came back from Mount Sinai, these patients' progesterone receptor results remained in the less than ten percent range. Their estrogen receptor results remained negative. None of these were people--because we did see an instance--we did see examples where people were ER negative PR positive and came back as ER positive PR negative. And so, we dubbed these patients the retroconverters and one of the things that we wanted to do was, number one, see had people been treated based on their PR results and if they had, now that we knew that they were negative, then we should check that out and see, and the other--so that was, you know, the reason, and then the other -
MS. NEWBURY:
Q. So just for clarification, before you go on, this was intended to be a list of conversions from positive to negative for PR only. It's not meant to include any conversions from

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positive to negative for ER results?
DR. LAING:
A. No, because if people were ER positive, they weren't retested.
MS. NEWBURY:
Q. Okay. Now we have come across some that were, I guess, inadvertently--they were retested. They were treated, I understand, as positive and subsequently were determined to be negative. Are you familiar with any such list?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Okay, and I note down here that there is, if you look at the entry, the sixth one from the bottom, it has an original ER of ten and an original PR of negative.
DR. LAING:
A. Right, so that could have been someone who -
MS. NEWBURY:
Q. Okay, so that's obviously not a PR conversion, retro conversion? I mean, the PR went from negative to zero, so that's fine.
DR. LAING:

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A. Yes.
MS. NEWBURY:
Q. So if there's any conversion, retro conversion here, it's because of the ER results, but notwithstanding that, you're not understanding this to be a list of retro conversions of ER results?
MR. SIMMONS:
Q. Excuse me, I think that that one and the one above are the two samples from the same person.
THE COMMISSIONER:
Q. Same person.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. Yeah.
MS. NEWBURY:
Q. Okay.
MR. BROWNE:
Q. This is the final list?
DR. LAING:
A. Well, there's another list, right, that I was asked about this morning, and from what I can recall, it was we took those patients off

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because we determined that they were not treated as positive.
MS. NEWBURY:
Q. That was a small list.
DR. LAING:
A. That's right.
MS. NEWBURY:
Q. And are you aware of any more comprehensive lists than this?
DR. LAING:
A. No.
MS. NEWBURY:
Q. I wonder if I could bring up exhibit--I'm going to refer to this one again, but Exhibit 720, please. Actually, if I can just go back to 2642 for a second. There are two different categories that I wanted to bring to your attention for now. The first one is the fifth entry. So that's a patient whose original ER was 10 and original PR was 10, and on retesting at Mount Sinai, it went from zero to zero.
DR. LAING:
A. Uh-hm.
MS. NEWBURY:

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Q. And then if you go over to the right, it says "panelled"?
DR. LAING:
A. Right.
MS. NEWBURY:
Q. Okay, now if we bring up Exhibit 720, there are several possible entries that could relate to that entry I just showed you, the 10/10 zero/zero. I'll just go to--is if you'll look at line 132, there's an entry of 10 ER original, 10 original PR, goes to zero/zero.
DR. LAING:
A. Uh-hm.
MS. NEWBURY:
Q. And page 23--line 239, sorry, there is another entry of 10/10 going to zero/zero, and if you look at line 413, there's another entry of 10/10 and that goes to less than 1, and to zero, and line 804, this is another entry 10/10 going to zero/zero. Now if we bring up Exhibit 2642 again, looking down through that particular exhibit, I can only see one entry that has 10/10 and then going to zero/zero, and I'm just wondering if you can explain why the other--there are four entries there that

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could potentially match, and I know one of them was less than 1 and zero, but certainly three are identical to those numbers 10/10 zero/zero, but there's only one on this particular list.

DR. LAING:

A. I have no idea.

MS. NEWBURY:

Q. Okay, and perhaps that was--picked up the 720 list about a year later, and perhaps they were picked up after the fact.

DR. LAING:

A. And I never saw that list before, so I don't know.

MS. NEWBURY:

Q. Okay, you don't know.

DR. LAING:

A. No.

MS. NEWBURY:

Q. And if you could go back to 2642, and--okay, 2642, please, and entry #11 just there by Gander, there's less than 10 originally ER, less than 10 original PR, and then there's a zero and a zero, and if you go over to the right, it says, "Panelled, confirmed

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negative", and now if we can bring up Exhibit 720 again, please. Now there are a number of entries and I think could relate to less than 10, less than 10, converting to zero/zero, starting off with line 69. So it says less than 10, less than 10, and then zero/zero, and right next to it, line 70, there's actually two entries for line 70, I don't know if that's a typographical error, but they both say less than 10 ER/PR and then going to zero/zero, and then if we turn over to line 473, less than 10, less than 10, zero/zero, line 519, less than 10, less than 10, zero/zero, line 533, the same thing, less than 10, less than 10, zero/zero, and 697 is the same, less than 10 for both and zero for both, and 705 the same thing, and then again line 761--so there are eight different examples of that, but only one entry on Exhibit P-2642 with those results, and I'm wondering were you aware that there were that many instances where you had an original ER/PR of less than 10, less than 10, and then converting to zero/zero?

DR. LAING:

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A. No.

MS. NEWBURY:

Q. Okay, and was it ever discussed with you about whether or not these results should be panelled? Did anyone bring to your attention, listen, you know, we've got these results here, which ones should we panel?

DR. LAING:

A. No, because if somebody came across the panel that was less than 10, less than 10, and zero/zero, they would be a confirmed negative.

MS. NEWBURY:

Q. Okay, but in this particular case here, looking at Exhibit 2642, assuming that this information is accurate, it says that that particular case was sent to a panel before it was confirmed to be negative?

DR. LAING:

A. But there were sometimes patients that were on the panel list that--you know, we saw that in some of the earlier minutes as time went on that some of them would come there, and then when we looked at the results, they would be zero/zero, and we would just say, oh, confirmed negative and we would move on. So

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that happened. I mean, we did have people at the panel that were confirmed negatives. They would show up on the list. I don't know how, but that certain happened.

MS. NEWBURY:

Q. What about the 10/10, results of 10 and 10, was that something that you would have expected to see, all similar results at the panel?

DR. LAING:

A. So that--it would depend on when the person was diagnosed and when the cutoff was. I can tell by looking at that line--I don't know who this person is, I'm just making assumptions that that person was diagnosed in 2005.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. Because they have an '05 surgical number. So they would have been retested because of the 10 and they came back as being zero/zero, and they would have been reviewed because there was a possibility that that person may have been treated, but I don't know who this is, so I can only --

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MS. NEWBURY:
Q. Were the cases selected for retesting chosen based upon whether or not the result was within the threshold at that given time?
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. I mean, would you expect to have many instances where a case had been retested, even though at the time everyone understood that that was above--below the cutoff for ER positivity?
DR. LAING:
A. Yes, so I don't know why that patient was there. Perhaps the oncologist had asked for it to be done.
MS. NEWBURY:
Q. Okay.
DR. LAING:
A. I can't tell by just looking at this list.
MS. NEWBURY:
Q. So you can't explain then why there would be a number of other--a number of cases where some might be panelled, and others with the exact same figures would not be panelled?

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DR. LAING:
A. No.
MS. NEWBURY:
Q. And who would the decision maker be as to which ones make it to the panel?
DR. LAING:
A. So if the--the ones that had a change in results, we would have panelled.
MS. NEWBURY:
Q. Yes, but who decides what's significant enough to be a change?
DR. LAING:
A. So if they were negative/negative and then zero/zero, they'd be confirmed. If somebody wasn't sure, then they would have sent them along to the panelling process. So maybe that's why these people were there, but I don't know.
MS. NEWBURY:
Q. And you can't explain why they would not be all treated identically?
DR. LAING:
A. No.
MS. NEWBURY:
Q. If the results were the same, looking at just the raw numbers, you don't know why some would make it to the panel and others with the exact same numbers would not make it to the panel?
DR. LAING:
A. No.
MS. NEWBURY:
Q. And who would you expect would know that information?
DR. LAING:
A. I don't know.
MS. NEWBURY:
Q. There are also some what I understand to be PR conversions that I can't see on that list, 2642, and perhaps if I can bring up 720, please. So line 20, there are two entries for that, I'm not sure if that's significant, but one of the entries is a negative ER, 75 PR, and then the results at Mount Sinai are 2 and zero. Line 61, again in that case there are three entries for that, but the third entry for 61 says zero and a 50/60, and then on repeat it's zero/zero, and line 142, there's a result of less than 5, less than 25, and then on retesting, it goes to zero/zero. Line 436, less than 10, and 60, goes to zero/zero.

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There's just a couple more. I'll bring them through just for completeness. Line 717, there's a negative and a greater than 60, and that converts to zero/zero, and line 767, there are two entries again for that, that might be significant, the second one is a negative and then a 40/50 for the PR, and that converts to zero/zero, and then line 827, there's a negative ER result, 60/70 for PR, and that converts to zero/zero. Now I stand to be corrected, but I've checked the list at 2642, and I couldn't see any of those what seemed to be PR retro-conversions on that list. Would you have expected those to be on that list, and perhaps they were discovered after May, 2006?
DR. LAING:
A. Perhaps they were. I don't--I don't know.
MS. NEWBURY:
Q. But based on your understanding of the list and what would get addressed through a panel, would you expect for those to have been considered to be retro-conversions for PR that would need to be considered by the panel?
DR. LAING:

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A. I would say they were people that certainly had a change.
MS. NEWBURY:
Q. Uh-hm.
DR. LAING:
A. That would be a false positive in terms of the PR, i.e. the retro-converters, and as I said, what we did with those patients was first all of to determine how the initial treating oncologist viewed that result.
MS. NEWBURY:
Q. Sure.
DR. LAING:
A. In some instances, the initial treating oncologist, particularly if this was back in the 1990s, may have viewed that to be negative. We saw instances where patients may not be as much benefit if you're ER negative, PR positive, so they might not have been treated at that time. They might have been patients who were not offered therapy because of their good prognosis. They may have been patients who were not given treatment at the time because they were pre-menopausal.
MS. NEWBURY:

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Q. Right.
DR. LAING:
A. So there's all sorts of reasons why.
MS. NEWBURY:
Q. There may not have been a change in treatment for those particular patients who had a conversion of the PR result --
DR. LAING:
A. Sure.
MS. NEWBURY:
Q. But did you understand that those types of patients, had they been identified by May of 2006 when this list was prepared, ought to have been on this particular list, which I understood to include all of the PR retro-conversions?
DR. LAING:
A. Well, if that list was supposed to contain them all, then I don't know why those weren't on that.
MS. NEWBURY:
Q. And maybe they were identified after. I don't know that.
DR. LAING:
A. I don't know either.

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MS. NEWBURY:
Q. And you're not aware of any subsequent more up to date list of retro PR conversions after this particular one?
DR. LAING:
A. No.
MS. NEWBURY:
Q. Do you know who would be expected to have such a list?
DR. LAING:
A. Where did this list come from?
MS. NEWBURY:
Q. Well, I guess it was Heather and Dr. Denic were the two people who had it here, but given your familiarity with the panelling process and the people involved --
DR. LAING:
A. No, I mean, I've not been asked recently to panel any patients who were retro-converters. When we did look at those, as I said, I could recall two, I think someone had asked me earlier, people who had changed, and I spoke to that, and also to the fact that when these slides were reviewed by the pathologist, there was some indication that they would not have

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called these patients positive to begin with.
MS. NEWBURY:
Q. Can you recall were you reviewing the PR retro-conversions at about this time, May of 2006? Was that the purpose for this list being generated?
DR. LAING:
A. The shorter list?
MS. NEWBURY:
Q. Yes.
DR. LAING:
A. Yes.
MS. NEWBURY:
Q. Okay, and can you recall at any time subsequent to then doing any additional panelling for PR --
DR. LAING:
A. No, no.
MS. NEWBURY:
Q. Retro-conversions.
DR. LAING:
A. No.
MS. NEWBURY:
Q. Dr. Laing, you mentioned a couple of times in your evidence that you thought it would be

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advisable and very useful to monitor the patients who are involved in the retesting. Could you elaborate on what you meant by that and whether there are any plans to do that, to look at how the progress, you know, follow up and see --

DR. LAING:

A. Oh, yes, we've had some preliminary discussions about how that would work.

MS. NEWBURY:

Q. And when you say "we", who do you mean by that?

DR. LAING:

A. It's myself, Wayne Miller--Mr. Miller is involved with research.

MS. NEWBURY:

Q. Is he with NLCHI?

DR. LAING:

A. No, he's with Eastern Health.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. With Ms. Pilgrim, and just really--you know, there is a start of some--a good database that has a lot of information, and I felt that it

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would be worthwhile to add some of the outcome information to that.

MS. NEWBURY:

Q. Sure.

DR. LAING:

A. Which would be derived from the Cancer Clinic chart, for many reasons, you know, seeing what happened to these patients, and as I alluded to before, to try and help others learn from this experience for sure.

MS. NEWBURY:

Q. And when did that process start?

DR. LAING:

A. What process is that?

MS. NEWBURY:

Q. I guess you're getting together and deciding that it would be a good idea to monitor this group, and, I guess, doing whatever preliminary --

DR. LAING:

A. Oh, that was earlier this year.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. April kind of time period, and it really came

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out of us viewing the NLCHI database and the clinicians in the room saying, you know, maybe this would be good if we could put in what the panel recommendation was, what the people decided to do, and what the outcomes of the patients were.

MS. NEWBURY:

Q. And what is Mr. Miller's background again? He's not a statistician, is he, or --

DR. LAING:

A. I don't know.

MS. NEWBURY:

Q. Do you know if there's any plans to bring in an epidemiologist or a statistician to look at the data just for analysis?

DR. LAING:

A. The Centre for Health Information people, they would be statisticians and epidemiologists and that's what they do.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. Sorry, the Newfoundland and Labrador Centre for Health Information. They are all those types of people.

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MS. NEWBURY:

Q. So you would expect that they would be involved in not just producing the numbers, but actually analysing?

DR. LAING:

A. Oh, no, they were at this meeting that we had to discuss how to look at this.

MS. NEWBURY:

Q. Yeah.

DR. LAING:

A. Yeah, yeah, for sure.

MS. NEWBURY:

Q. And you'd mentioned that there is some effort, I guess, to look at the Cancer Registry and to make improvements to that, perhaps starting with breast cancer, but to expand it to other malignancies as well?

DR. LAING:

A. You mean the registry that we already have or a separate registry?

DR. LAING:

A. Well, whatever it is that you plan to do. Just tell me a bit about the plans or the hopes, I guess, that you have?

DR. LAING:

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A. Oh, my hope would be that we would have a separate breast cancer registry that would include information such as--that would link to our registry just to capture incidents. So you're going to find out who to put into your registry, but then to populate it with much more information than just what would be in a standard cancer registry.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. So things like--so what would be in a standard cancer registry would be age at diagnosis, date of diagnosis, and the collaborative staging information that we gather which now does include ER/PR and we put in an actual number, and it includes HER2 and we put in the actual results.

MS. NEWBURY:

Q. So that's actually added to the cancer registry proper, the ER/PR?

DR. LAING:

A. Yes.

MS. NEWBURY:

Q. And when was that done?

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DR. LAING:

A. It was probably a couple of years ago that it was first there, but now we actually write in the number.

MS. NEWBURY:

Q. Okay.

DR. LAING:

A. So we don't put positive or negative, or whatever, we just put in the percentage, and we've actually just recently within the past two months expanded on how we're capturing the HER2 data, so that that will be something that we could look at, but even beyond that, if I look to what the BC group does, they put in history, where the--what treatment the patient got, all sorts of different factors, the location of the tumour, whether or not there was lympathic and vascular invasion, all sorts of information that you could then use to do outcomes research.

MS. NEWBURY:

Q. And how far as you along on that goal to get your own breast cancer registry, have there been any steps taken?

DR. LAING:

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A. When we had the initial discussions with that group, they were going to look to BC, and I don't know what's been done up to date with that. The first thing that we're going to need is resources.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. Yeah.

MS. NEWBURY:

Q. And so basically there's three separate things that you're looking at. Number one is to improve the existing cancer registry by providing more information to the cancer registry which deals not just with breast cancer, but with all cancers?

DR. LAING:

A. No, that registry now has a certain amount of information that's shared nationally.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. So we look to our national counterparts, and we look to the Canadian Council of Cancer Registries to look at the types of information

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that they wish for us to include, okay.

MS. NEWBURY:

Q. Right, and --

DR. LAING:

A. So a lot of that is basic information.

MS. NEWBURY:

Q. But they've been looking for that for some time, they were looking for information about deaths of cancer patients in Newfoundland. So even though they had the facility to --

DR. LAING:

A. So what's happening now, as you know, is death clearance is done nationally based on our local information that the national group derives from--so our death clearance is not done locally. There is plans, however, to have that happen within the next few months. So what just happened is that the cancer program has bought software to enable us to do that, that is in the process of happening, and that very soon we will, in fact, do our death clearance locally. The advantage of that, of course, is that by looking at death certificate data, we may capture incidents cases that are not captured now because how we

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capture incidents now is based on pathology. So there are people who are diagnosed with cancer who'd never have a biopsy, but, you know, someone comes in very unwell, found to have a metastatic bowel cancer, not well enough for a biopsy, dies, and that's captured on the death certificate, but we wouldn't be capturing that in terms of incidents now. So I think it will improve our incidents data, and I think it will improve our mortality data, and really the work to do that has been done in this last couple of years since the registry has become part of Eastern Health, and we work very closely with our counterparts in Canada, but also this has really been an initiative of the Atlantic region and we've had a lot of help. In fact, some of the--we don't have our own statistician within the Cancer Care Program, and Cancer Care Nova Scotia was kind enough to give us some assistance from their statisticians.

MS. NEWBURY:

Q. So that would be for the cancer registry for all cancers?

DR. LAING:

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A. That's right.

MS. NEWBURY:

Q. But what you're looking at--what you're hoping to do is to also have, I guess your own cancer registry for breast cancer for your own purposes?

DR. LAING:

A. Yes, and, you know, you could argue to make a case to have that for any disease site, but as I said earlier, I think if we started with breast cancer, then that would be certainly very, very worthwhile.

MS. NEWBURY:

Q. Dr. Fontaine had mentioned that--I think he may have a separate cytopathology registry dealing with cervical cancer. Is it something like a subset of cancer registry that you're thinking about for breast cancer, is it something along those lines?

DR. LAING:

A. So they would link to each other.

MS. NEWBURY:

Q. Yes, okay.

DR. LAING:

A. Because what you would do is you would

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populate your breast cancer specific database with the information you had from your overall cancer database, and then you would add in the extra fields.

MS. NEWBURY:

Q. Okay. So for you to accomplish the goal of having a breast cancer registry, you would certainly need to make sure that it can be integrated with the cancer registry?

DR. LAING:

A. Oh, absolutely, because that's how you would populate it.

MS. NEWBURY:

Q. And you would need to make sure that the cancer registry for Newfoundland is complete. It has--I think Dr. Dankwa wasn't sending his diagnosis to the cancer registry.

DR. LAING:

A. Right.

MS. NEWBURY:

Q. So you would want all of Newfoundland to have everything registered there?

DR. LAING:

A. That's right, yeah.

MS. NEWBURY:

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Q. Okay.

DR. LAING:

A. And if you were collecting it that way, what would happen is if you were seeing a breast cancer case, and you wanted to go--somebody would be inputting that data into the registry, then what would happen is they would sit down, go to put that in the registry, and if they found that that person wasn't, then that might be a way that you would find out another way that people were being missed.

MS. NEWBURY:

Q. And the monitoring of the group of patients that were involved in retesting, that would be yet a separate, I guess, subset of patients?

DR. LAING:

A. Well, my argument was would that be a great place to start.

MS. NEWBURY:

Q. Right.

DR. LAING:

A. And then build on that.

MS. NEWBURY:

Q. Okay.

DR. LAING:

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A. You know, so that a database would serve more than one.
MS. NEWBURY:
Q. Would you include all of the patients tested in that time period, 1997 to 2005, not just the ones that had been involved in retesting because there's quite a large group over that time, or would you focus on those that were being retested?
DR. LAING:
A. Ideally I'd want everybody put in.
MS. NEWBURY:
Q. Thank you, Dr. Laing. Those are all the questions I have for you.
DR. LAING:
A. You're more than welcome.
THE COMMISSIONER:
Q. Ms. Brocklehurst?
MS. BROCKLEHURST:
Q. No questions, Commissioner. Thank you.
THE COMMISSIONER:
Q. Mr. Pike.
MR. PIKE:
Q. No questions, Commissioner. Thank you.
THE COMMISSIONER:

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Q. Mr. Browne.
MR. BROWNE:
Q. Thank you, Commissioner.
DR. KARA LAING - EXAMINATION BY MR. PETER BROWNE
MR. BROWNE:
Q. Are you still seeing that light?
DR. LAING:
A. It's glowing now, Mr. Browne.
MR. BROWNE:
Q. Okay, thank you. I don't want to cause any dismay to you, Dr. Laing, but I do want to go back to an exhibit that you were shown probably on the first day or second day, Registrar, P-0505.
THE COMMISSIONER:
Q. Sorry, I didn't hear that number.
MR. BROWNE:
Q. 505, Commissioner, I'm sorry. These were the typewritten--handwritten and typewritten notes of Dr. Williams of a meeting on July 14th, which you were present, and you were asked some questions by Ms. Chaytor surrounding--we'll just go to the typed version first, which is attached, and it's in relation to the second bullet, "Sloan-Kettering went from 75

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to 100 percent positive".
DR. LAING:
A. Uh-hm.
MR. BROWNE:
Q. First of all, Doctor, just to go back and we've had a look at this--it is unclear from looking at this whether, in fact--obviously we don't have Dr. Williams here to assist us, but is that potentially a 7 or 9?
DR. LAING:
A. It could be either.
MR. BROWNE:
Q. Okay. I'm going -
THE COMMISSIONER:
Q. Is that the one that was (inaudible) to us?
MR. BROWNE:
A. I don't know if we --
THE COMMISSIONER:
Q. That's my recollection. Mr. Simmons or --
MR. SIMMONS:
Q. We don't have a typed transcription of those, no, and I can't recall what Dr. Williams said when he was on the stand.
THE COMMISSIONER:
Q. Somehow my memory tells me that Dr. Williams

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assisted us in doing it.
MR. BROWNE:
Q. And I don't -
THE COMMISSIONER:
Q. I'll go back to the record.
MR. BROWNE:
Q. In any event, I going to pose two possible hypotheticals to you.
THE COMMISSIONER:
Q. Okay.
MR. BROWNE:
Q. Is it possible that the figure that may be 95 to 100 as a possibility or, Doctor, during your discussion do you recall mentioning about the percentage of breast cancers that are hormone receptor positive and what would that figure be, if you discussed that?
DR. LAING:
A. 75 percent.
MR. BROWNE:
Q. And the information that you advised the Commission that you got from Dr. Hudis was that it was 100 percent, on their review it was 100 percent of their lobulars?
DR. LAING:

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A. But that was only the lobular histology.
MR. BROWNE:
Q. Correct. So is it possible that this may be mixing two statements, that you, in fact, referred to the 75 percent figure that's there is your comment in relation to the incidence of hormone receptor positivity in breast cancer and then a second comment, independent of that, about the information from Dr. Hudis?
DR. LAING:
A. That's very possible.
MR. BROWNE:
Q. Okay.
THE COMMISSIONER:
Q. While we're on this subject, Mr. Browne, I have this vague recollection, it's early in your testimony, so it's vague by now -
DR. LAING:
A. There's a follow-up to this, Commissioner.
THE COMMISSIONER:
Q. Yes, this--would you -
DR. LAING:
A. And I have done that.
THE COMMISSIONER:
Q. Oh, good.

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MR. BROWNE:
Q. Oh, yes.
DR. LAING:
A. Are you going to ask me that, because I'm waiting for somebody -
THE COMMISSIONER:
Q. Well, if Mr. Browne doesn't -
MR. BROWNE:
Q. No, I mean, that's fine -
THE COMMISSIONER:
Q. Mr. Browne, carry on.
MR. BROWNE:
Q. - while we're on that topic -
DR. LAING:
A. So when I was first asked to look at this, it was my, what I had testified to and my understanding was that I did meet with Dr. Hudis again sometime in the fall of 2005. When I was first shown this, I was thinking, oh, my goodness, does this mean that I had spoke to him, but I didn't think so. So I did two things: I went back and looked through my calendar for that year and there was no where that I went prior to the end of October of 2005 that I would have had any chance to see

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Dr. Hudis. There was no meeting or no place that I went that I would have seen him. So I actually do believe it was either at the Echo meeting in late October of 2005 or in San Antonio that I subsequently had the follow-up discussion with Dr. Hudis. And second of all, he never, ever told me a number. He never, ever said to me that there was a conversion. He simply said to me on our review of our pathology on the lobulars in our tumour bank, 100 percent of them were positive. So I can't think of how I would have had a number. Like, he didn't say to me initially they were 95 and then went to 100, initially they were 75, went to 100. We've never had that sort of discussion, which makes me wonder is this 75 percent the overall number and the 100 percent referring to the lobulars at Memorial Sloan Kettering.
MR. BROWNE:
Q. Thank you, Doctor. You have provided, and I think referred to on a number of occasions during you evidence various studies. Registrar, if we could enter at this point several exhibits? P-2611, P-2612 and P-2613?

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THE COMMISSIONER:
Q. 2611 to?
MR. BROWNE:
Q. 2613.
REGISTRAR:
Q. 2612 and 2613 are already entered.
MR. BROWNE:
Q. Oh, thank you. And then the only one is 2611.
THE COMMISSIONER:
Q. 2611 I have on my list.
MR. BROWNE:
Q. Oh, thank you.
THE COMMISSIONER:
Q. All right, entered.
EXHIBIT ENTERED AND MARKED P-2611.
MR. BROWNE:
Q. Perhaps, Doctor, we could deal with P-2611 in terms of the order of chronology here? Doctor, this is an article entitled "Meeting Highlights, International Expert Consensus on the Primary Therapy of Early Breast Cancer, 2005." This body, and it refers to The Ninth St. Gallen, Switzerland Expert Consensus Meeting." Could you explain to the Commissioner the St. Gallen's Consensus

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Meetings?
DR. LAING:
A. So it's a meeting that's held every two years. They've had now ten. This is from the ninth, which was in 2005 and another one will be planned for March of 2009. And it's a group that meets to discuss the--and make recommendations about treatment of early stage breast cancer. So they look at treatment modalities, including hormonal therapy, chemotherapy, herceptin, transition AB (phonetic) therapy and they also look at risk categories, so they divide people into low, intermediate and high risk. This is something that certainly people in the breast cancer community look to, make reference to. And it's a European lead meeting, but there are people that attend from all over the world, including Canada and the United States.
MR. BROWNE:
Q. Doctor, are there particular passages in this paper and by these authors that you may feel would be of some assistance to the Commission?
DR. LAING:
A. This is the paper that I referred to when I

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talked about this notion of the categories of endocrine responsiveness. This was the first time, in 2005, that the panel identified a notion that, you know, there were people that were endocrine responsive and those were--and this is it here, patients who tumours expressed hormone receptors, and that it was felt that this was a group that endocrine therapy would be effective for. And then there were the endocrine negative or non-responsive and those would be the people with no staining and this first notion that this idea of uncertainty would fall in the category of one to ten percent.
MR. BROWNE:
Q. In fact, Doctor -
DR. LAING:
A. And it refers to it -
MR. BROWNE:
Q. - is that cited there in this paragraph, "Features indicative of uncertainty"?
DR. LAING:
A. Right. So they talk about receptor status being less than ten percent. But they also allude to the lack of progesterone receptors.

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And we've talked about that a little bit here as to, you know, how valid that is yet as a predictive marker, the whole idea of interaction between the HER2 receptor and the ER/PR receptor and other things such as markers of proliferation. So it just lends to the fact that there is still some uncertainty about this group of patients and how endocrine responsive they are or not.
MR. BROWNE:
Q. And, Doctor, again, throughout your evidence you spoke of the differentiation between pre-menopausal and postmenopausal. Was there some discussion about adjuvant therapy for these groups, as well, at this meeting?
DR. LAING:
A. Right, so they would look at pre-menopausal versus postmenopausal in terms of endocrine therapy, recognizing that the optimal therapy for pre-menopausal women remains Tamoxifen. Although, our European colleagues are a little more advanced than us in terms of using ovarian oblation, but this is still the subject of three international large randomized trials which are alluded to here,

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which is a SOFT trial which we are participating in as a centre here in St. John's, the TEXT trial and a trial called the PERCHE trial. But again, these are trials that are looking at combinations of ovarian oblation and aromatase inhibitors in pre-menopausal women to see if that strategy which has been proven beneficial in postmenopausal women can be done if you turn a pre-menopausal woman into a postmenopausal woman by turning off the ovarian function.
MR. BROWNE:
Q. Is there anything else in respect of this article that you wish to draw to the Commissioner's attention?
DR. LAING:
A. No. We have the 2007 update, as well.
MR. BROWNE:
Q. Okay.
DR. LAING:
A. But I think that was all in that.
MR. BROWNE:
Q. Registrar, could we have P-2612? This is the second, the 2007 conference. Doctor, is there again information -

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DR. LAING:
A. When I--if you could just please -
MR. BROWNE:
Q. Scroll down?
DR. LAING:
A. No, that's right, sorry -
MR. BROWNE:
Q. If you want to use the mouse, please.
DR. LAING:
A. I'm allowed to use the mouse.
MR. BROWNE:
Q. Please go ahead.
DR. LAING:
A. This is a summary of the recommendations and discussions that came out from the 2007 meeting. And again, there was discussion about the idea of endocrine responsiveness and still this uncertain area. But it does address the need for very good pathology and, in fact, it very clearly says "A broader agenda of improving pathology including HER 2 and ER/PR testing as well as the role of emerging molecular assays is needed." And emerging molecular assays is the new luminal As and Bs and all this stuff that people are

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trying to do now to further characterize breast cancer. But I think, you know, one year ago this 4000 breast cancer experts from all over the world recognized that, you know, guys, if we're going to be using this information to make treatment, that it's important that this information is correct. And all this, even refer to lymphatic and vascular invasion grade and all that is information that we rely on from pathology.
MR. BROWNE:
Q. Doctor, you mentioned, I think, in answer to some questions, about compliance. Have there been studies about compliance rates among patients who take drugs such as Tamoxifen?
DR. LAING:
A. There haven't been a lot. I alluded to a trial that's called the MA12 study, and this was a National Cancer Institute of Canada trial that was done in the 1990s that looked at randomizing pre-menopausal patients who had chemotherapy for breast cancer in the adjuvant setting to Tamoxifen or not. And in that trial, and that final report is still pending and I expect that it will be published at some

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time this year because I do know the primary author, Dr. Vivian Bramwell, who is a medical oncologist and a colleague of mine now practising in Calgary. But in 2006 or 2007 at the San Antonio Breast Cancer Conference they had a poster that looked at compliance rate and they found that one third of patients were non-compliant with taking the Tamoxifen, and most of those patients who were non-compliant stopped it within the first two years of therapy, and we know that that's when the highest risk of recurrence is. Interestingly, in our own clinical practice we've had to rely quite heavily on compassionate access drugs for our patients for the aromatase inhibitors I mentioned that they're not readily funded by the drug prescription program, so that many patients, we supply them with the aromatase inhibitors and they're given three month blocks. So our pharmacist very diligently will call the patients and say, "I'm getting ready to send out your next supply of drugs" and the patient might say, "Oh, I still have a whole package left." And so the pharmacist then do some education around compliance. In

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the study that I mentioned and in trials that we do that look at pills, when the patients come back for their follow-up visits, they need to bring those pill containers back with them. So either they've taken all the medication and so there's a pill count done and if there's pills left over, then the reason for, you know, the patients not having taken them is reviewed. We don't do that as readily in the clinical situation. And our pharmacists have expressed an interest in, in fact, doing studies regarding compliance. And we've discussed this issue, you know, nationally amongst oncologists and I think it would be a very interesting trial or study, I should say, to look at patient compliance. And you could look at that by actually doing similar to a trial when you're seeing people in three month follow-up, doing pill counts or even just looking at pharmacy data, because you can tell when people went to pick up their medications. Because I think compliance is very important. These drugs have a lot of unfavourable side effects for patients and often patients will tell me with other things,

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"Well, it made me a little bit nauseated, so I took it every second day" or, you know, those sorts of things. So I think whenever you're dealing with a therapy that you expect someone to take for a long duration of time and that you send them home to take, that compliance is certainly something that needs to be considered.

MR. BROWNE:

Q. Now, at the tumour, at the Physician Panel, would you notice any issues in relation to compliance there, as well?

DR. LAING:

A. Yes, there were--when we looked back through charts, we would see that, you know, patients had decided not to take Tamoxifen. They had tried it--or even with the aromatase inhibitors, there are people that go on and come off. Sometimes it would be an issue of compliance, but must often in those cases it would be because of side effects that were bothersome, and you know, hot flashes or vaginal dryness, those sorts of things that would make people less likely to want to continue on the medication.

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MR. BROWNE:

Q. Doctor, this afternoon you were asked by Ms. Newbury about several questions about disclosure and I think you indicated in answer to one of those questions that you recently attended a conference where that topic was discussed. Did you speak to any individuals there about the circumstances here in Newfoundland and if so, could you explain the situation to the Commissioner?

DR. LAING:

A. This year at the American Society of Clinical Oncology I was looking to try and decide what sessions that I was going to attend and they have very informative sessions, which are called "Meet the Professor" which are very small group sessions, there would probably be as many people as in this room, you'd get a chance to sit down and have some, you know, very good presentations, chance for some dialogue with experts in the field. I elected to go to one called "Medical Error in Oncology" and listened to the presentation and then got up and asked questions about disclosure to large groups of people and the

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experience and didn't know it at the time, but one of the speakers on the panel was Dr. Gallagher who came up to me afterwards and said, "Oh yeah, you're from Newfoundland. I was there." And he had been the gentleman that came and spoke here, so I think that, you know there is--and that's the first time I've ever seen and in fact, I believe they acknowledged at that session that that was the first time that there had been that kind of information or educational session available for physicians and oncologists and this would be a meeting attended by surgical, medical, radiation, all different types of oncologists, but this issue is something that's being addressed by the society. And it's often because the "Meet the Professor" sessions are often chosen because of comment that we could give back, like what sorts of topics would you like to see covered in this forum and that's certainly one that has been recognized by ASCO as being important.

MR. BROWNE:

Q. As well, there was a topic came up, I think both by Ms. Chaytor and I think inferentially

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from Ms. Newbury, I believe, the notion of second reviews of cancer diagnosis and I think you talked to this to a certain extent, is there a protocol or practice now to have second reviews, second pathology reviews of newly diagnosed cancers?

DR. LAING:

A. No.

MR. BROWNE:

Q. What's your view in respect of that, having something like that in place?

DR. LAING:

A. I think there should be and we had had some preliminary discussions about setting that up just before Dr. Carter left.

MR. BROWNE:

Q. Now I want to, you were questioned quite extensively on the tumour panel and your role in the tumour panel. I want to ask you, Doctor, at any time you participated in that process and we saw many exhibits, occasions where you in fact had patients of your own who were before the panel and you participated in the panel discussion. At any time did you feel you were in a potential conflict or

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perceived conflict for those patients?
DR. LAING:
A. No, I didn't.
MR. BROWNE:
Q. And why not?
DR. LAING:
A. Because I viewed it similar to the work that I would do regularly in my practice where I would bring patients to be discussed at our tumour board rounds, that I would provide the information and I would communicate that back to the patient.
MR. BROWNE:
Q. Doctor, your views on discussion and again, you were asked by Ms. Chaytor questions extensively and again this afternoon by Ms. Newbury. If you're--I'll give you the opportunity, if it was suggested your views were such of a paternalistic nature, in terms of your approach to disclosing results to the patient, how would you respond to that and this is your opportunity to respond to it.
DR. LAING:
A. I don't consider myself to be paternalistic as a physician. My practice has always been to

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try to provide as much information to my patients when I see them. As I mentioned, one of the first things that I always do is find out what information people already know and what information they would like to know, and then I try and provide them with all the information that they need to make a decision. If I feel that a patient is unable and sometimes when I see a person at a first assessment, that first clinic visit, they're often overwhelmed and don't feel as if they can make a decision. I try and help them by giving them written information. We have diagrams and things in the clinic that we rely upon, visual aids to help patients in making decisions. If people feel that they need time, you know, we let them go away for a week or so and the come back. So we really try and provide patients with as much information as they want to be able to make decisions. That's true at the initial visit, but it's also true as time goes on, in terms of dealing with patients and trying to decide what they may or may not want to do and to try to give them as much information about what's going on

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with their disease process at a time. I've never been known to be someone who finishes my clinic ahead of time. I don't--even if I've got people sitting out in the waiting room for over an hour, I take all the time that I think that a patient needs during that encounter to ensure that all their questions have been answered and that they feel that, you know, I always say to patients "this is a team and you're the boss, not me. I'm here to help you, help you make decisions, to help guide your therapy" and that's how I feel about how I practise.
MR. BROWNE:
Q. So, Doctor, the notion of informed choice, in your view having the retest results in hand, would that be essential to having a patient make an informed choice?
DR. LAING:
A. Yes.
MR. BROWNE:
Q. You were asked about the clinical judgment, I think this was by Mr. Simmons this afternoon, of individual physicians, vis-a-vis the tumour panel recommendations. I just wanted to show

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you an exhibit and quickly have you comment on that. And, Registrar, Exhibit P-2619 please?
REGISTRAR:
Q. 2611?
MR. BROWNE:
Q. Sorry, 2619, my apology. Now this was an article that was entered in through Dr. Dabbs, Dr. Laing. I think I have the section highlighted here. This was shown to you earlier and I had Dr. Dabbs comment on this and it relates to the notion of one percent positivity and again, relates back to some of the articles we just spoke to a minute ago, and things you talked about in terms of clinical judgment. Does this capture the notion of, the considerations that you, as an oncologist, just take a moment, need to look at in making a particular treatment choice for a particular patient?
DR. LAING:
A. Right. So this looks at--the very first sentence talks about the clinical situation, extremely important. It talks about are we talking about the adjuvant setting, are we talking about metastatic disease? Extremely

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important, that's part of the teaching that we do with the medical students when they come to the clinic. You know, and then it's, even if somebody is positive, you don't know that they're going to respond. We know that from the metastatic disease, 60 percent of people who are ER positive of metastatic disease respond and that means 40 percent don't. And then, of course, all the other factors are important, so what is the prognosis of size, nodal involvement, grade, these are all things that come into consideration and, you know, these low risk patients is identified there as a node negative person with a small person. And, you know, someone asked me yesterday if somebody was a hundred percent and a hundred percent, but they had a well differentiated small tumour, would you treat them with hormonal therapy and the answer is no, because you really have to look at at what their prognosis is. So, you know, it's complex, there's a lot of factors that are involved and those are certainly--you know, this paragraph does capture, even back to 1998, the things that are still today extremely important in

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the clinic.

MR. BROWNE:

Q. Just one last question, Doctor, and that is the media briefing in 2006, were you aware of what materials the media may have been given or not given in advance that session?

DR. LAING:

A. Sorry, in -

MR. BROWNE:

Q. In November of 2006.

DR. LAING:

A. In the fall of 2006, no.

MR. BROWNE:

Q. Doctor, it is customary at this point when I finish my question just to offer, you will be glad to note, the witness the opportunity to make any observations, comments or recommendations to the Commissioner. This is now your opportunity.

DR. LAING:

A. Okay, so I've actually written this down so that I will be sure that I don't leave anything out. So first and foremost I'd like to consider the patients. I certainly recognize that this has been very difficult

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for a number of patients and their families and I want them to know that I certainly empathize with them for what's gone on and I am sorry that this has happened. I would like to thank my own patients for their ongoing trust in me, for the support that they have shown to me over this entire time. The continued confidence that they have showed to me in their care has been very important. I think about each clinic and each time the patients have come in and asked how I was, each hug, each kind word, each time they said, you know, we're thinking about you, you're in our thoughts and in our prayers, all that really has meant so much during this process. And in fact, someone once said to me during difficult times in medicine, it is the strength that we draw from you, our patients, that keeps us going. And I think this has been a prime example of that and I want to reassure them that I am not going anywhere, I am going to be around and continue to care for them and continue to do everything that I can on a go-forward basis as a medical oncologist, as clinical chief, to continue to improve

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cancer care for all of the patients of this province.

You know, if I look back since the Spring of 2005 when this was all started, it's been a long road, but it's certainly been very worthwhile. First of all, you know, we've helped a lot of individual patients. I think we've improved the care of breast cancer patients and perhaps even improved the care of many other patients. The dialogue between oncologists and pathologists, we talked a lot about and I firmly believe that that has improved. And as we enter an era now where we are going to be doing more and more targeted therapy, then that becomes extremely important and extremely critical as we move on.

I'd also like to thank the Commissioner and the co-counsel for really the opportunity to speak over these last few days, this week and even last week and I hope that somehow my testimony has helped you to put some more pieces into this very complex puzzle. I think the role and challenge now is to make recommendations that will be heard and acted upon and I think that that has the ability to

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improve the health care of the people of this province, but also beyond. I hope that you recommend a comprehensive database, not only for breast cancer but for other cancers, and we've certainly talked a lot about that, particularly today. There are so many aspects of information technology in health care that need to be improved and you know, when we look back through this, we can see a lot of that. There needs to be a way that health information of the people of this province is accessible to whatever physicians are caring for them throughout this province, so that they can have the best individual patient care that they can have. We need to develop a lot more guidelines, policies, all that is extremely important, but in order to do that, we need to have the resources and we need to have the protected time as physicians. It has to be recognized that's something that is important for us to do so that we have time during our busy clinical practices set aside and acknowledged to allow that work to happen.

I can think of many things that we still need within the Cancer Care Program and, you

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know, I have a short wish list always and a long one. I think about MRI resources, how much more MRI resources we need right now, accessibility to a PET scanner. I know it's in the works, but PET scanning is now being used and MRI is being used routinely in staging and follow-up of many cancers. We need to have a secondary pathology review and we've talked about that. We need an increase in our nursing resources, that's not only an issue for cancer, but you know, nursing is a very important component to the care that we provide. We need more pharmacy resources. We currently have two fulltime clinical pharmacists for the Cancer Care Program for this entire province, two. And we need at least six if you look at Eastern Health and probably seven or eight if you look at the entire province. And this is very important, particularly when you think about patient safety. The synoptic reporting work, I believe that that's a very important tool to improve communication between physicians and we'll certainly continue to work on that. So, you know, there's a lot of things that still

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need to be done and I hope that as time goes on that people will recognize the importance of staying up to date and continuing to adequately resource health care, so that patients can get the best care possible.

And the last thing I want to do is just to thank all of the staff at the cancer clinic for the tremendous work that they do, but also the support, my colleagues within the Cancer Care Program and in fact, all of my colleagues for the support, all the usual people you rely on, your family, your friends for the support and I mentioned yesterday to Mr. Coffey and to Mr. Browne that I felt that the attention and the kindness of all of the people involved in the Commission of Inquiry was very much appreciated during this difficult few days. And that's it. Thank you.

MR. BROWNE:

Q. Unfortunately, I'm not the last person that may have a question for you. So Ms. Chaytor will -

THE COMMISSIONER:

Q. Ms. Chaytor, do you have anything?

CHAYTOR, Q.C.:

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Q. Am I allowed to say yes?

THE COMMISSIONER:

Q. I'm sure Dr. Laing would prefer to leave today, rather than come back, so ask your questions.

DR. KARA LAING, RE-EXAMINATION BY MS. SANDRA CHAYTOR, Q.C.:

CHAYTOR, Q.C.:

Q. P-0505 please? Page 3. And actually this is, I just want to be clear, Commissioner, because this was provided to the Commission by Eastern Health, these exhibits, and the handwritten notes, we were told, are Dr. Williams' handwriting and Dr. Williams, himself, arranged the transcripts, this wasn't done by the Commission, this transcription was done by Dr. Williams, or so we've been told. Dr. Laing, this meeting took place July 14th, 2005.

DR. LAING:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And Mr. Browne brought you back to this and attributed to you under these bullets were "new information, lobular CAs should all be PR

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positive" and then the second bullet at Sloan-Kettering went from, and "I hear the issue being raised, is it 75 percent or 95 percent to 100 percent positive". But those comments are attributed to you by Dr. Williams in this meeting of July 14th, 2005. And you just said in answering to your questions of the Commissioner and Mr. Browne that you didn't have your meeting with Dr. Hudis until sometime after October, 2005.

DR. LAING:

A. Yes.

CHAYTOR, Q.C.:

Q. That's the next time you spoke--the only time that you spoke with him, there was the e-mail communication in April and then you spoke to him sometime after October. Are you able to say when? Where were you and when? You checked your calendar on that, so when did you speak to -

DR. LAING:

A. To the two possibilities where the would have been in attendance because I saw him at a meeting, I knew that and it was -

CHAYTOR, Q.C.:

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Q. A face to face, you are confident on that.

DR. LAING:

A. A face to face, that's right, yes. And so I attended the European meeting and that was from October 30th to early November of that year and then the San Antonio breast cancer conference which would have been around the 7th of December and it's usually for about four or five days. So when you had asked me that the other day, I thought, you know, does this mean that this could happen before and that's why I went back and I did not travel anywhere -

CHAYTOR, Q.C.:

Q. So it couldn't have happened before.

DR. LAING:

A. No.

CHAYTOR, Q.C.:

Q. Because you only saw him either late October, early November or December 7th, around then.

DR. LAING:

A. Right, so it was either at one of those two venues and also because, as I said, Dr. Hudis never talked to me about a conversion or I don't remember any numbers, just that right

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now when they had retest them, they were all positive.

CHAYTOR, Q.C.:

Q. And they were all positive. So this appears to be in keeping with what you would have learned from him in October, November, December of 2005 -

DR. LAING:

A. No, because I wouldn't have learned from him that it went from 75 to 100, I would have learned from him that they were all 100 percent.

CHAYTOR, Q.C.:

Q. But the new information lobular CAs should all be ER/PR positive at Sloan-Kettering went from, whatever, they are all going to be positive, you only learned that from him after this is actually--the meeting actually takes place?

DR. LAING:

A. No, what I had learned from him during my e-mail correspondence about the index case was that, you know, that they said that they were positive, right. He said I've never seen a negative.

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CHAYTOR, Q.C.:

Q. He said it's very rare.

DR. LAING:

A. And then he says, "I have never seen one."

CHAYTOR, Q.C.:

Q. And that he had never seen one.

DR. LAING:

A. Right.

CHAYTOR, Q.C.:

Q. Right, so what could this be referring to? What could this--can you explain what this could be referring to?

DR. LAING:

A. All I can think of is that Dr. Williams heard me talk about the fact that 75 percent of all breast cancers are positive, verses the fact that Dr. Hudis had never seen a negative lobular case.

CHAYTOR, Q.C.:

Q. And why would that be attributed to anything about Sloan-Kettering?

DR. LAING:

A. Because he knew that Dr. Hudis was a physician at Memorial Sloan-Kettering Hospital.

CHAYTOR, Q.C.:

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Q. Okay. Ms. Newbury asked you about, and I won't bring up the exhibit, but Dr. Felix had brought the DCIS patient to the panel.
DR. LAING:
A. That's correct.
CHAYTOR, Q.C.:
Q. And you indicated the DCIS was not part of the review.
DR. LAING:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. The review showed that there were, I think in the range of 60, if not more, DCIS patients who originally had ER testing done and then they weren't retested by Mount Sinai because they weren't testing. Why would those patients have originally had ER/PR testing done?
DR. LAING:
A. I don't know, it wouldn't have been requested by an oncologist because we don't use those results in deciding whether or not patients with DCIS should be offered Tamoxifen or not.
CHAYTOR, Q.C.:
Q. So as part of the analysis or review into this

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matter, did you look into that to see well, who was ordering it and you've satisfied yourself that it wasn't done by any oncologist?
DR. LAING:
A. I didn't look to see who had ordered it. I don't know if anybody else did, but with ductal carcinoma in situ the reason why you give Tamoxifen is to prevent further DCIS and further invasive disease. And there is not enough information that suggests that the ER/PR on the DCIS is helpful for knowing who's going to benefit from Tamoxifen because you're not preventing a recurrence of that DCIS. You're preventing new DCIS or new invasive disease from happening somewhere else in the breast. So, it's a different treatment paradigm.
CHAYTOR, Q.C.
Q. So, obviously, though pathologists were doing the tests on DCIS or a number of those patients and I'm just wondering, was there ever any communication to pathologists that you don't need to be doing that test?
DR. LAING:

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A. Yes, we've actually--that's one of the things we've addressed in the breast disease site group.
CHAYTOR, Q.C.
Q. So, that's something that has come up since the breast disease -
DR. LAING:
A. Yes, and what we did is we've actually, we've done a review. We talked to our colleagues across the country and we've looked at many of the guidelines including ASCO, NCCN. And to date most bodies say that there's just not enough evidence yet to use ER/PR status to make a decision of whether or not to offer Tamoxifen to patients with DCIS. So, we don't routinely request it. Our policy is that it won't be done unless somebody requests for it to be done.
CHAYTOR, Q.C.
Q. But over the years when that was happening and ER/PR tests were being carried out on DCIS patients, over the years, that never came up for discussion amongst the oncologists and pathologists, for example, in your tumour boards rounds to say, there's no need to be

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doing those tests.
DR. LAING:
A. No.
CHAYTOR, Q.C.
Q. Okay. Ms. Newbury also had a question about what information would have been before the panel and the idea of the panel not having up-to-date information on all patients, if they weren't current patient of the cancer care clinic. And I'm just wondering--and I think in answering that, you stated, well, they would know that we had the cancer care chart or the cancer clinic chart.
DR. LAING:
A. Um-hm.
CHAYTOR, Q.C.
Q. And I'm just wondering would it have been a good idea to have stated in the panel letter the most recent information, the date of the most recent information that you had on those patients.
DR. LAING:
A. So, to say something like, your patient was reviewed in the panel on such and such a day and we reviewed the cancer clinic chart up to

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and including such and such a date, and the Meditech up to and including such and such date.

CHAYTOR, Q.C.

Q. That's right. So, then they would know that that's how much you knew -

DR. LAING:

A. Than the last contact -

CHAYTOR, Q.C.

Q. - that point in time and you didn't know whatever had happened with the patient after that point in time.

DR. LAING:

A. Yeah.

CHAYTOR, Q.C.

Q. Is there any consideration given to that?

DR. LAING:

A. No, there wasn't.

CHAYTOR, Q.C.

Q. Okay. And then hindsight, would that have been a good idea?

DR. LAING:

A. Yes, because it would have made it clear, you know, in terms of, again stressing that the prognostic information wouldn't have changed,

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but the recommendation regarding--if--then they would have known how much information we would have had about potential side effects and that up to a certain date.

CHAYTOR, Q.C.

Q. Okay. And if I could just quickly bring up, C-0229, page 17. Is the other part in answering that, you said that they would know we had the chart. And I'm just wondering how would they even know who the "we" is? How would a GP receiving a letter know who the physician review panel--how would they even know who you are and what information you might have? For example, in this particular letter and I realize it's addressed to you, but if it were to be addressed to a general practitioner out somewhere within the Province, it goes on Eastern Health letterhead and this one, in fact, is copied to a number of doctors and it's signed by Dr. Beverley Carter, anatomic pathologist, breast pathologist, acting chair physician review panel. So, how would they even know, well, who's on this panel; what information they had and what access they would have had to the

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patients' records?

DR. LAING:

A. Well, we were just considering that this information was coming from oncologists, so that we practice within the cancer centre and that's where were would the information that would be in a cancer centre chart. If these physicians were receiving correspondence on their patients in the past, then they would have been familiar with--they would have had copies of that information, but we didn't, sort of, stop and think that people might not know where the information came from. But again if there was something -

CHAYTOR, Q.C.

Q. Or who the panel even was.

DR. LAING:

A. - if there was something that they weren't sure about and they received a letter. Then we didn't have anybody call up and say, who is this panel or where were you from or who were these people and what information that you had. Many of these physicians in the community would know exactly who the cancer clinic doctors are. We deal with them on a

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regular basis and through the care of mutual patients and we never did have any queries about the panel or the process or that sort of thin.

CHAYTOR, Q.C.

Q. So, nobody ever phoned up to ask you those questions.

DR. LAING:

A. No. The only question that we would have got would have been from physicians who said, you know, called up and said, hello Dr. Laing or whoever. I got your letter and would you mind, could I sent this lady to see you or the correspondence that we got that said, I got your letter and I've done this.

CHAYTOR, Q.C.

Q. Um-hm. And in this particular case though, the letters are signed by Dr. Carter, it's not even any--there's no affiliation here with the cancer care program.

DR. LAING:

A. It would have been copied to an oncologist, in all cases.

CHAYTOR, Q.C.

Q. Okay. And just one last question, and this

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came up again, I believe it was Ms. Newbury asking the question and you indicated that there were only two lobulars that you were aware of in the retest. Was that your own patients you're referring to?

DR. LAING:

A. Oh, that I could remember off the top of my head. I might have had other lobulars, probably were lots more lobulars. Somebody asked, I think you might have asked earlier, did we ever go back and look and see what the final breakdown was between lobular and ductal and I don't know those numbers. They may be in that data base, but I don't remember looking at that ever.

CHAYTOR, Q.C.

Q. Okay. And if we could just pull up, please, P-1811. I just want to clarify that, that the two lobulars you're referring to was not in relation to your work on the tumour board panel having reviewed all the cases.

DR. LAING:

A. Oh no, not at all, no, no.

CHAYTOR, Q.C.

Q. Those were only in relation to your own

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particular patients that you were aware of.

DR. LAING:

A. Yeah, yeah, yeah. And when I was asked to remember who those initial people were, I could not recall looking back and identifying, I think, Ms. Newbury was referring to a process by which people may have been identified or should we have gone back and pulled all the lobulars and done those patients first.

CHAYTOR, Q.C.

Q. First, yes, in trying to identify that, yes, that was her point on that.

DR. LAING:

A. Yeah, yes, yeah.

CHAYTOR, Q.C.

Q. And so in terms of being the clinic chief or being the chair of the panel at the time, there wasn't nay review of how many lobulars were there, where they may have--whose patients were they and try and do any kind of assessment of the numbers around that.

DR. LAING:

A. No.

CHAYTOR, Q.C.

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Q. There hasn't been that -

DR. LAING:

A. No, there hasn't been that.

CHAYTOR, Q.C.

Q. Okay. And this is from Dr. Mullen to Dr. Cook and it's January 20th, 2006 and I'll just quickly, without going through all of it, but you'll see that there's--over here--and if you go through all of this, Doctor, the L's being lobulars, all through. I won't take you through the whole document, there's 22 pages of it. But when you go through it, there's approximately 40 or a little over 40 lobulars altogether.

DR. LAING:

A. Out of how many?

CHAYTOR, Q.C.

Q. Well, that's up to--well, at this point, ever how many are back in January, January 20, 2006. So, most of your sample would have been back at that point in time.

DR. LAING:

A. Okay.

CHAYTOR, Q.C.

Q. And that's it. Thank you, Commissioner.

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DR. KARA LAING, EXAMINATION BY THE COMMISSIONER

THE COMMISSIONER:

Q. I have a--I know everybody wants to go through the door, but I think you can answer these things very quickly, but I just wanted to be crystal clear on them. You said earlier today that, I wasn't he one who made the final decision to wait until the results were back, although you had a physician on it, in terms of the communications with the patients.

DR. LAING:

A. Yes.

THE COMMISSIONER:

Q. Who was the one who made the final decision?

DR. LAING:

A. I would think that it would have been either--because the initial discussions were had between Dr. Williams and the Department of Health. So, one of those two people.

THE COMMISSIONER:

Q. So, you think the final decision would have been made either by Dr. Williams or the Department of Health. All right. And you said also, earlier today, that you were among those who wanted the deceased people to be

Page 405

retested. Did I understand you correctly.
DR. LAING:
A. Not initially, but, you know, in -
THE COMMISSIONER:
Q. Not initially, but -
DR. LAING:
A. In the long term.
THE COMMISSIONER:
Q. And that the reason for going so was because you felt it was important to know what changes there were.
DR. LAING:
A. Yes.
THE COMMISSIONER:
Q. Is that--because it seems to me to be a little inconsistent with your view that, in respect of the earlier discussion the change itself wasn't an adequate number to be dealing with because the mere fact that someone had changed wasn't going to give you really meaningful information as I understood it, someone could have changed by going from 60 to 65 and that might not have been considered significant to anybody in the piece at all. So, what was it you were looking for out of the information on

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the deceased patients that would distinguish them from that kind of -
DR. LAING:
A. I think if you are going to do a review like this in any situation, if you are going to exclude patients who have died, you very, right away, have a biased sample. In terms of what was done then with looking at those deceased patients, you could certainly look at people whose results changed. What we didn't do at the end of the day was to look at those patients in terms of what may have happened unless we were requested to do so by the families.
THE COMMISSIONER:
Q. Um-hm.
DR. LAING:
A. So, I guess if you were going to be completely complete at the end of the day, then you would have looked back at those deceased patients and at least tried to say if you thought that they had an impact, potentially could have had an impact on their care and that's not something that we had done.
THE COMMISSIONER:

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Q. Yes, okay. So, that's really, I suppose--was your interest in the deceased patients, aside from the fact that some of their family members might come along, was it because in the future further research might be done in respect of not only those people, but the others who you've already dealt with?
DR. LAING:
A. Yes, that if you're going to look at, you know, the histology -
THE COMMISSIONER:
Q. So, that was your with your science cap, as it were.
DR. LAING:
A. Yeah, yes. If you're going to look at how many lobulars there were, if you're going to look at any information about this, not to exclude a population and particularly not to exclude a population who you know, by virtue of the fact many of those patients would have died as a result of their breast cancer, had a different outcome. Do you know what I mean? So, you're going to weed out the people that potentially had the worse prognosis if you take out the people that are deceased. Does

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that make sense?
THE COMMISSIONER:
Q. Yes, I think I'm following you -
DR. LAING:
A. So, you're going to have a biased sample. So, when you think about doing research or making conclusions about things, it's better to be all inclusive. If you take out a certain population of patients and you take out people that have relapsed and died, then you've just taken out the people that had the worse clinical outcome. So, that might have--that might be more likely to be people that are poorly differentiated, who had lymph nodes involved, who were not lobular. So, you could bias your sample by doing that.
THE COMMISSIONER:
Q. All right. Thank you.
DR. LAING:
A. Okay.
THE COMMISSIONER:
Q. Like your tasks, mine involve gathering together a whole bunch of information from different sources and I appreciate -
DR. LAING:

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A. You're more than welcomes.
THE COMMISSIONER:
Q. - very much your coming along to give me the little piece of evidence that you have, so that I can put it all together at some point at the end of the day.
DR. LAING:
A. And if there's something else that I can help you with or you need or these articles, let me know.
THE COMMISSIONER:
Q. We'll be in touch if there is. Thank you.
DR. LAING:
A. I'm going to clinic tomorrow and I can't wait.
THE COMMISSIONER:
Q. It looks so good now, doesn't it.
Upon conclusion.

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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 18th 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 18th day of September, A.D., 2008
Judy Moss

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