

<p>COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p>BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p>September 29, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. . . . . Commission Co-counsel Sandra Chaytor, Q.C. . . . . Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil . . . . Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury . . . . . Doctors Kara Laing et al</p> <p>Daniel Simmons . . . . . Eastern Regional Integrated . . . . . Health Authority</p> <p>Laura Brocklehurst. . . . . Members of the Breast Cancer . . . . . Testing Class Action</p> <p>Mark Pike . . . . . NL Medical Association</p> <p>Jennifer Newbury . . . . . Canadian Cancer Society (NL Division)</p> <p>Blair Pritchett. . . . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p>LIST OF EXHIBITS</p> <p>EXHIBIT P-3085 . . . . . Pg. 4</p> <p>EXHIBIT C-0266 . . . . . Pg. 4</p> <p>EXHIBIT C-0267 . . . . . Pg. 4</p> <p>EXHIBIT P-2729 AND 2730 . . . . . Pg. 289</p> <p>EXHIBIT P-2827 THROUGH P-2830 . . . . . Pg. 289</p> <p>EXHIBIT P-2884 . . . . . Pg. 289</p> <p>EXHIBIT P-3082 THROUGH P-3084 . . . . . Pg. 289</p> <p>EXHIBIT P-3087 THROUGH P-3089 . . . . . Pg. 289</p> <p>EXHIBIT C-268 THROUGH C-272 . . . . . Pg. 289</p>
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1 background and professional background to the  
2 Commissioner?  
3 DR. KWAN:  
4 A. Professionally I'm a surgeon. And I guess I  
5 graduated from McGill Medical School. I did  
6 my surgical residency -  
7 COFFEY, Q.C.:  
8 Q. When would that have been, Doctor?  
9 DR. KWAN:  
10 A. That would have been 1968 when I graduated.  
11 THE COMMISSIONER:  
12 Q. It was a good year.  
13 COFFEY, Q.C.:  
14 Q. Somebody else obviously graduated the same  
15 year.  
16 DR. KWAN:  
17 A. And I did my surgical training from 1968 to  
18 1973 at the Montreal General Hospital at  
19 McGill system. Having finished in '73 I did a  
20 surgical oncology fellowship at the Sloan-  
21 Kettering Memorial Hospital in New York City,  
22 I completed in 1975. And ever since 1975 to  
23 today I've be here in this Province of  
24 Newfoundland.  
25 COFFEY, Q.C.:

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1 Q. And, Doctor, in Newfoundland where have you  
2 worked?  
3 DR. KWAN:  
4 A. I started work with the old General Hospital  
5 back on Forest Road and we moved up to the  
6 Health Science Complex as it now stands and  
7 been here ever since. And since 1972 I also  
8 work out of St. Clare's Hospital.  
9 COFFEY, Q.C.:  
10 Q. I'm sorry, since?  
11 DR. KWAN:  
12 A. Since 1972, '73. I'm sorry, '92.  
13 COFFEY, Q.C.:  
14 Q. '92 or '93?  
15 DR. KWAN:  
16 A. '92, yes.  
17 COFFEY, Q.C.:  
18 Q. So you were at the General from about--well,  
19 you've been at the General from '75 to this  
20 day?  
21 DR. KWAN:  
22 A. Correct.  
23 COFFEY, Q.C.:  
24 Q. And beginning in 1992, '93 you started to also  
25 do surgery at St. Clare's?

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1 DR. KWAN:  
2 A. Correct.  
3 COFFEY, Q.C.:  
4 Q. Doctor, I appreciate you're a surgeon. Do you  
5 also hold any position at Memorial  
6 University's medical school?  
7 DR. KWAN:  
8 A. I was appointed assistant professor and over  
9 the years now I'm a full professor of surgery  
10 at Memorial University.  
11 COFFEY, Q.C.:  
12 Q. And, Doctor, within the, well it would have  
13 been at one point the General Hospital as a  
14 stand alone institution, did you hold any  
15 administrative positions within surgery?  
16 DR. KWAN:  
17 A. I was the divisional chief in general surgery.  
18 I can't remember exactly when I started, it  
19 was probably '95 or it was '93, until  
20 recently, two years ago.  
21 COFFEY, Q.C.:  
22 Q. Okay, so that would be '93 would be the old  
23 General Hospital, '95, around that time, '95,  
24 '96 with the Health Care Corporation of St.  
25 John's. And up until then 2006 -

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1 DR. KWAN:  
2 A. Yes, I was -  
3 COFFEY, Q.C.:  
4 Q. - because it became Eastern Health, I'm sorry,  
5 you were what, you were?  
6 DR. KWAN:  
7 A. I was the divisional chief of general surgery  
8 at the Health Science, not at St. Clare's.  
9 Those days it's still two divisions.  
10 COFFEY, Q.C.:  
11 Q. And what does that mean in practice, Doctor?  
12 DR. KWAN:  
13 A. That means I just have the responsible for the  
14 operation of the division of general surgery.  
15 COFFEY, Q.C.:  
16 Q. Now, Doctor, you've told the Commissioner that  
17 having completed your residency in Montreal  
18 you went to Sloan Kettering for a period of  
19 time doing surgical?  
20 DR. KWAN:  
21 A. Oncology.  
22 COFFEY, Q.C.:  
23 Q. Oncology?  
24 DR. KWAN:  
25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. Could you tell the Commissioner, please, what

3 that involved?

4 DR. KWAN:

5 A. That was a subspecialty in surgery related to

6 cancer surgery that I was trained in differ

7 aspects of cancer surgeries related to--

8 surgery related to cancer. It was within the

9 confines of general surgery. That means I

10 don't do neurosurgery or urology or of that

11 nature.

12 COFFEY, Q.C.:

13 Q. And when you came to Newfoundland in the mid

14 1970s, you've been here for over 30 years now,

15 what types--are there any particular type of

16 surgery that your practice is focused on?

17 DR. KWAN:

18 A. I do most--I do oncology.

19 COFFEY, Q.C.:

20 Q. Oncology.

21 DR. KWAN:

22 A. And at the same time I have to do general

23 surgery because there isn't--you know, that's

24 part and part of my training. I do call for

25 trauma surgeries.

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1 COFFEY, Q.C.:

2 Q. But in the main it is surgery related to

3 oncology or cancer?

4 DR. KWAN:

5 A. That's correct.

6 COFFEY, Q.C.:

7 Q. Doctor, you'd be aware, of course, that this

8 Inquiry is focused on breast cancer, in

9 particular, ER and PR. Doctor, when you first

10 started as a surgeon in Newfoundland in the

11 mid '70s, could you tell the Commissioner

12 then, kind of take us up through time as to

13 what, if any, involvement as a surgeon you

14 would have had in the ER/PR and how was that

15 reported to you at the time, was it reported

16 to you, first of all, in the mid '70s, into

17 the '80s, how was it reported and what, if

18 anything, did it have to do with your

19 treatment of the patients?

20 DR. KWAN:

21 A. Well, I think you have to go back to the '70s

22 when -

23 COFFEY, Q.C.:

24 Q. '70s, that's what I'm -

25 DR. KWAN:

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1 A. When estrogen and progesterone receptors was

2 really basically research tools and a lot of

3 clinical trials, I used them basically on

4 that. And when I first came up here from

5 Sloan-Kettering, within the first two years I

6 started recognizing that is progressively

7 important and I started doing estrogen

8 receptor in my own research lab. And those

9 days that is a pure research tool. I had

10 graduate students who we send down to Toronto

11 for training, do the techniques and we do

12 those as a research tools. After several

13 years of doing this as a research tools I

14 passed this responsibility to, at that time,

15 the General Hospital to continue to do that

16 either in the research lab or in the

17 biochemical lab. I think there is a small gap

18 in between. They were done in one of the

19 research labs and then it was filed along to

20 the chemistry lab, I think.

21 COFFEY, Q.C.:

22 Q. Yes. And then as a surgeon then, as time went

23 on?

24 DR. KWAN:

25 A. After that that will be my few responsibility

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1 as that because you remember those days we do

2 not have the number of medical oncologists

3 that we have today. All the cancer treatments

4 are primarily treated by the radiation

5 oncologists at the, those days, I guess, the

6 Cancer Clinic, which is a branch of the

7 General Hospital. We have--in those days that

8 come in, we have to make our own

9 interpretations and treat it.

10 COFFEY, Q.C.:

11 Q. And when you say make your own interpretations

12 and treat it, your own interpretations of

13 what?

14 DR. KWAN:

15 A. Oh, everything, I think. I'm not particularly

16 restricted to estrogen receptors at that time.

17 COFFEY, Q.C.:

18 Q. Okay. And so you would be deciding--as the

19 surgeon you would do the surgery?

20 DR. KWAN:

21 A. Well, yes.

22 COFFEY, Q.C.:

23 Q. For cancer. How about after the surgery,

24 like, I'm thinking back in the 1980s, how was

25 -

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1 DR. KWAN:  
 2 A. In the '80s, in the early '80s we will be  
 3 looking t the pathology reports and  
 4 determining on the need for adjuvant  
 5 treatment.  
 6 COFFEY, Q.C.:  
 7 Q. Yes.  
 8 DR. KWAN:  
 9 A. Which, and then those days, I think, we  
 10 started before, I think that was even before,  
 11 early '80s would be before Tamoxifen. I can't  
 12 be sure of the date of that. We had to use  
 13 hormone receptor--hormone treatments even  
 14 before the day of hormone receptors being  
 15 widespread use.  
 16 COFFEY, Q.C.:  
 17 Q. And then as certainly as the 1980s went on,  
 18 Tamoxifen became available or was certainly  
 19 used?  
 20 DR. KWAN:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. So who would be prescribing Tamoxifen at that  
 24 point, what sorts--would you be involved in  
 25 prescribing it?

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1 DR. KWAN:  
 2 A. Let me think now. Yes, I would be in certain  
 3 situations because we only had one medical  
 4 oncologist at that time for the entire  
 5 province, so we don't have the resources. We  
 6 used to discuss it and we may well have to  
 7 prescribe it.  
 8 COFFEY, Q.C.:  
 9 Q. And in making a decision as to whether or not  
 10 to prescribe it, you would be using the  
 11 results from whom?  
 12 DR. KWAN:  
 13 A. I'm not remember that we do have that many  
 14 estrogen receptor available for every patients  
 15 that we have. We do have some when the  
 16 estrogen receptor data comes in, we certainly  
 17 based on the estrogen receptors. If not, you  
 18 have to base it on your clinical situations  
 19 where we were--there are certain clinical  
 20 situations patients are likely to respond to  
 21 hormone, there are clinical situations that  
 22 patients are unlikely be response to hormone,  
 23 so we base it on those other clinical  
 24 informations.  
 25 COFFEY, Q.C.:

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1 Q. And if the--some test result for ER/PR was  
 2 available, you would utilize that, as well?  
 3 DR. KWAN:  
 4 A. It would base--yes, correct.  
 5 COFFEY, Q.C.:  
 6 Q. Doctor, in the first, then, test results that  
 7 you used as a treating physician, would they  
 8 be biochemical results?  
 9 DR. KWAN:  
 10 A. Those days would be biochemical, yes.  
 11 COFFEY, Q.C.:  
 12 Q. And the biochemical tests, do you recall where  
 13 that was done, was that done here in St.  
 14 John's?  
 15 DR. KWAN:  
 16 A. They were done, yes. I think they were done  
 17 at the General Hospital laboratory. Those  
 18 reports that I did in my laboratories are  
 19 purely research tools at that time.  
 20 COFFEY, Q.C.:  
 21 Q. I appreciate you weren't doing it for  
 22 treatment purposes, it was a research tool?  
 23 DR. KWAN:  
 24 A. Well, research tool and reference back to the  
 25 patient's -

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1 COFFEY, Q.C.:  
 2 Q. Yes.  
 3 DR. KWAN:  
 4 A. - we need those informations.  
 5 COFFEY, Q.C.:  
 6 Q. But then as time went on the biochemistry  
 7 department somehow connected with the General  
 8 Hospital was doing the ER/PR test and  
 9 providing you with results?  
 10 DR. KWAN:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. Yourself and whomever else was -  
 14 DR. KWAN:  
 15 A. That's what I can remember.  
 16 COFFEY, Q.C.:  
 17 Q. - was treating patients. Doctor, the  
 18 Commissioner had heard and Dr. Khalifa  
 19 testified here. Did you know Dr. Khalifa?  
 20 DR. KWAN:  
 21 A. I knew him very well.  
 22 COFFEY, Q.C.:  
 23 Q. And he has told the Commissioner that, you  
 24 know, after he arrived in the mid 1990s,  
 25 around 1997 or so he started to look into

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1 utilizing immunohistochemistry, in particular,  
 2 using paraffin embedded tissue to conduct  
 3 ER/PR tests. Do you recall that coming on  
 4 line, as it were, here in St. John's?  
 5 DR. KWAN:  
 6 A. I'm sure that Khalifa and I had discussions.  
 7 To say exact date when it come on, I don't  
 8 know, I can't remember that because certainly  
 9 he save a lot of preparation of tissues in the  
 10 operating room and lot of procedures in us to  
 11 get the tissue for a biochemical determination  
 12 and is coming on stream and in the national  
 13 and coming on stream as technologies.  
 14 COFFEY, Q.C.:  
 15 Q. And, Doctor, during the days when biochemical  
 16 assay was being utilized here in St. John's,  
 17 could you tell the Commissioner then as a  
 18 surgeon how you would provide or what was  
 19 expected of you in terms of providing tissue  
 20 for the biochemical assay?  
 21 DR. KWAN:  
 22 A. Well, from the biochemical assays we would  
 23 have to take this tumour specimen out in the  
 24 operating room, get approximately what you  
 25 estimate a gram of tissue which is purely

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1 cancer tissue rather than a fat and all the  
 2 other stuff, fix it and freeze it in the  
 3 operating was just within minutes that it come  
 4 off the patients in the liquid nitrogens as  
 5 provided.  
 6 COFFEY, Q.C.:  
 7 Q. So you say fix it, I take it that that -  
 8 DR. KWAN:  
 9 A. No, freeze it.  
 10 COFFEY, Q.C.:  
 11 Q. Freeze it, yeah.  
 12 DR. KWAN:  
 13 A. Freeze it in the liquid nitrogens and then  
 14 transport to the lab to be frozen in minus 70  
 15 degree refrigerators. And then they'll be  
 16 determined by the laboratory at the time.  
 17 COFFEY, Q.C.:  
 18 Q. And the biochemical test, when that was being  
 19 utilized here, you understood as a surgeon  
 20 this is what's expected of me?  
 21 DR. KWAN:  
 22 A. Well, that's the procedure.  
 23 COFFEY, Q.C.:  
 24 Q. Procedure, yes.  
 25 DR. KWAN:

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1 A. We were told to do all this procedure that I  
 2 had been influence in establishing at that  
 3 time because that was part of the research  
 4 thing that we did.  
 5 COFFEY, Q.C.:  
 6 Q. Doctor, during the days that biochemical assay  
 7 testing for ER/PR was done here in St. John's,  
 8 it would have been, I gather, for--because it  
 9 didn't end until the beginning of 1998, so it  
 10 went on for a period of time, quite a number  
 11 of years. Doctor, do you ever recall  
 12 encountering or being told about any test, any  
 13 questions about the validity of the results?  
 14 I'm not suggesting there were, I'm just -  
 15 DR. KWAN:  
 16 A. No, sir, I have not heard any test problems.  
 17 COFFEY, Q.C.:  
 18 Q. And then Dr. Khalifa introduced the IHC based  
 19 test. As a surgeon in terms of providing  
 20 material for that test, what if anything  
 21 changed?  
 22 DR. KWAN:  
 23 A. We don't have to put in liquid nitrogen any  
 24 more.  
 25 COFFEY, Q.C.:

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1 Q. Okay, so what -  
 2 DR. KWAN:  
 3 A. Because you send the specimen to the  
 4 laboratory as per usual and was done on fixed  
 5 tissues.  
 6 COFFEY, Q.C.:  
 7 Q. Doctor, as a surgeon, I take it, when you  
 8 first did your residency and then continued in  
 9 your career, from the time you first started  
 10 as a surgeon in the OR what, if anything, was  
 11 your understanding of what was expected of you  
 12 as a surgeon in terms of preserving tissue,  
 13 like tumour tissue? Leaving aside the liquid  
 14 nitrogen.  
 15 DR. KWAN:  
 16 A. We'll take it out. I mean, there's procedure  
 17 established in the operating room. We take  
 18 the specimen out, we hand in to the nurse.  
 19 The nurse will pass on, will then ask us  
 20 whether we would like to fix it in formalin or  
 21 we want to send it for or at that time  
 22 commonly called frozen section, quick sections  
 23 or then is part of it want quick sections on  
 24 or have the pathologist look at it, one or the  
 25 other. If we say no, we just want it to be

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<p>1 fixed, it goes directly to formalin.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And what does that involve? It may be second</p> <p>4 nature to you, but a nurse asks you and you</p> <p>5 say, no, I want it fixed?</p> <p>6 DR. KWAN:</p> <p>7 A. I say, no, I want it--no, the assay fine, I</p> <p>8 don't need a frozen sections and then they</p> <p>9 would put it into a formalin. Then I don't</p> <p>10 hear anything about it, I carry on my</p> <p>11 operation, which is, as you're probably aware,</p> <p>12 at that time is by no means complete.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Yes, I appreciate that. So you would excise</p> <p>15 with a scalpel the tissue, be asked by the</p> <p>16 nurses as to what do I do with this, Doctor?</p> <p>17 DR. KWAN:</p> <p>18 A. Well, we just hand it to the nurses, went back</p> <p>19 to then, and then when there is a free moment,</p> <p>20 sometimes we have to do a few things.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Sure.</p> <p>23 DR. KWAN:</p> <p>24 A. Write the specimen out and then you--at the</p> <p>25 free moment ask you can I fix the specimen or</p>	<p>1 look at it when I finished.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Now, Doctor, within the operating room</p> <p>4 structure there, your understanding then, I</p> <p>5 take it, as the surgeon at the time would be</p> <p>6 that the nurse would take it over and have it</p> <p>7 placed in formalin? Okay, again, I'm correct</p> <p>8 in that, am I?</p> <p>9 DR. KWAN:</p> <p>10 A. Well, the nurse, when I say I don't need it</p> <p>11 any more, they will take it in there and put</p> <p>12 it in the--have a bucket which I used to see</p> <p>13 them around and pour formalin in it.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Did you have any understanding of then what</p> <p>16 happened with the tissue samples?</p> <p>17 DR. KWAN:</p> <p>18 A. That would go down to the laboratory, if I</p> <p>19 understood, you know.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Did you have any understanding as to when it</p> <p>22 would go down to the lab?</p> <p>23 DR. KWAN:</p> <p>24 A. It usually go outside after the case with the</p> <p>25 patients outside when the patients are</p>
<p>Page 22</p> <p>1 do you want anything done and you will say,</p> <p>2 no, yes, or whatever instruction you give</p> <p>3 them.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Yes.</p> <p>6 DR. KWAN:</p> <p>7 A. And she will take the specimen out to the</p> <p>8 circulating nurse who will put it in the</p> <p>9 formalin.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. And would this occur actually in the operating</p> <p>12 room itself?</p> <p>13 DR. KWAN:</p> <p>14 A. Correct.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Okay. So the last--from your perspective the</p> <p>17 last you would see of the tissue would be</p> <p>18 somebody would be walking away with it?</p> <p>19 DR. KWAN:</p> <p>20 A. I would, last time I see it is when I hand</p> <p>21 over to the nurse or if I want, specifically</p> <p>22 say I want to take a look at the specimen</p> <p>23 after I complete the operations then, yes, I</p> <p>24 would then keep it on the operating table, I</p> <p>25 mean, around the operating table and then I</p>	<p>Page 24</p> <p>1 wheeling out the operating room, they put it</p> <p>2 outside, put it into an area out, just on the</p> <p>3 outside of the operating room where they will</p> <p>4 be, I understand now, I never seen it, that</p> <p>5 will be the procedure that they would be</p> <p>6 signed into the book, with the specimens out</p> <p>7 and name, patient, identifying informations on</p> <p>8 the book and the type of specimens there and</p> <p>9 this will be then taken down to the--at the</p> <p>10 end of the day or somewhere during the daytime</p> <p>11 to the laboratory and they will be signed to</p> <p>12 be received.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. And if you tell the Commissioner in terms of</p> <p>15 yourself, you wouldn't be actually outside</p> <p>16 supervising that?</p> <p>17 DR. KWAN:</p> <p>18 A. No.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. You understood this was going on?</p> <p>21 DR. KWAN:</p> <p>22 A. That is what I understood that's happening. I</p> <p>23 really don't see them afterwards.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. Doctor, who was responsible for overseeing</p>

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1 that aspect of the matter?

2 DR. KWAN:

3 A. I would say the nursing department or the

4 manager of the operating room.

5 COFFEY, Q.C.:

6 Q. And that would be, in this context, is that

7 the perioperative?

8 DR. KWAN:

9 A. That would be the perioperative program,

10 correct.

11 COFFEY, Q.C.:

12 Q. Perioperative program, whoever is in charge of

13 the perioperative program?

14 DR. KWAN:

15 A. Well -

16 COFFEY, Q.C.:

17 Q. In particular, whoever is in charge of it that

18 day at that place?

19 DR. KWAN:

20 A. It would be the nurse in charge of the

21 operating room for that suite who would be

22 responsible or the nurse in charge of that

23 particular case who will be responsible for

24 taking the specimen out, filling in the form.

25 And the procedure will then be carried on and

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1 the procedure book, whether that would be,

2 procedure would be established by the

3 responsible of the operating room or the nurse

4 in charge -

5 COFFEY, Q.C.:

6 Q. The nurse.

7 DR. KWAN:

8 A. - or manager in charge of the operating room.

9 COFFEY, Q.C.:

10 Q. Of the perioperative program and in particular

11 that room?

12 DR. KWAN:

13 A. Correct.

14 COFFEY, Q.C.:

15 Q. The actual procedure, whatever it was?

16 DR. KWAN:

17 A. The actual procedure, yes, I would think.

18 COFFEY, Q.C.:

19 Q. Doctor, did you have any understanding as to

20 how often tissue samples were supposed to be

21 brought down to the lab, how often per day?

22 DR. KWAN:

23 A. I don't know.

24 COFFEY, Q.C.:

25 Q. Okay. Doctor, you've spoken to the

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1 Commissioner about or mentioned frozen

2 sections or quick sections?

3 DR. KWAN:

4 A. Uh-hm.

5 COFFEY, Q.C.:

6 Q. They're called.

7 DR. KWAN:

8 A. Uh-hm.

9 COFFEY, Q.C.:

10 Q. What do they involve?

11 DR. KWAN:

12 A. Well, if I need some information to direct

13 what type of procedure I want to do or how the

14 operation could be carried on, or what margins

15 are clear or not, I take a sample of the area

16 that I'm concerned about or I need information

17 on it and ask the pathologist come and examine

18 the specimen, freeze it in some sort of gel

19 and freeze they have and cut it into slice,

20 and have a look at the examination under

21 microscope right then and there, and within,

22 say, usually 15/20 minutes, let me know what

23 the answers are.

24 COFFEY, Q.C.:

25 Q. And that was because you need the answer from

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1 the pathologist right then and there in order

2 to proceed with the operation?

3 DR. KWAN:

4 A. Yes, I have to--sometimes, you know, you're

5 doing some form of surgery like

6 (unintelligible) surgery where I have

7 (unintelligible) or not.

8 COFFEY, Q.C.:

9 Q. Yes. Doctor, in relation to that, I take it

10 sometimes the samples, the tissue sample that

11 you have taken from the patient, would be

12 utilized fully for the quick section,

13 sometimes it would be broken down, some quick

14 section and some of it will go out into the

15 formalin?

16 DR. KWAN:

17 A. That's correct.

18 COFFEY, Q.C.:

19 Q. You were referring to the idea that the nurse

20 would ask can I fix all of it or -

21 DR. KWAN:

22 A. Well, I take the specimen out and should I

23 have to--it's fixed or it goes fresh.

24 COFFEY, Q.C.:

25 Q. And the material that didn't go to the fresh

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<p>1 or frozen section, you would expect to be</p> <p>2 fixed and the rest -</p> <p>3 DR. KWAN:</p> <p>4 A. It would be handled by the pathologist then.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Yes.</p> <p>7 DR. KWAN:</p> <p>8 A. The pathologist would already have the</p> <p>9 specimen.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. The -</p> <p>12 DR. KWAN:</p> <p>13 A. The quick section.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. The quick section.</p> <p>16 DR. KWAN:</p> <p>17 A. Yes.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. But the material that was not going to be -</p> <p>20 DR. KWAN:</p> <p>21 A. That's correct.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Quick sectioned, would end up in the formalin</p> <p>24 route?</p> <p>25 DR. KWAN:</p>	<p>1 anything about it.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And in terms of when you say through the</p> <p>4 grapevine, are you talking about the ER/PR</p> <p>5 matter?</p> <p>6 DR. KWAN:</p> <p>7 A. Yes.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Okay, you're talking about this.</p> <p>10 DR. KWAN:</p> <p>11 A. Yes.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. I'm talking--leaving aside the ER/PR, we'll</p> <p>14 get to that in a moment, over the years</p> <p>15 through the 80s, the 90s, up until 2005, were</p> <p>16 there ever any complaints came to your</p> <p>17 attention directly or indirectly about tissue</p> <p>18 not being properly fixed?</p> <p>19 DR. KWAN:</p> <p>20 A. No, sir.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. If there were concerns about that within the</p> <p>23 pathology lab, who would you have expected,</p> <p>24 what sorts of individuals would you have</p> <p>25 expected -</p>
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<p>1 A. Correct.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Doctor, did you--I take it you would have</p> <p>4 understood or understand that the purpose of</p> <p>5 putting tissue into formalin is to preserve</p> <p>6 it?</p> <p>7 DR. KWAN:</p> <p>8 A. That's correct.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Did you ever have any complaints or concerns</p> <p>11 expressed to you over the years about tissue</p> <p>12 specimens that were not properly fixed?</p> <p>13 DR. KWAN:</p> <p>14 A. No concern.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. In terms of downstairs, the pathologist or the</p> <p>17 pathology lab saying -</p> <p>18 DR. KWAN:</p> <p>19 A. Not directly to me.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. How about indirectly?</p> <p>22 DR. KWAN:</p> <p>23 A. I mean, the thing is as these things came up,</p> <p>24 I mean, you heard about through the grapevines</p> <p>25 but nothing was said to me. I have not heard</p>	<p>1 DR. KWAN:</p> <p>2 A. Well, the only person that would know there is</p> <p>3 a problem are the pathologists and the</p> <p>4 laboratory people that would know that there</p> <p>5 is a problem. I wouldn't know that.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Yes.</p> <p>8 DR. KWAN:</p> <p>9 A. And they would have to communicate back to us,</p> <p>10 yes, there is a problem, fix it, but we don't</p> <p>11 --have never heard of it in my days I was</p> <p>12 there.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Doctor, and you're the--for many years the</p> <p>15 site--well, from the mid 90s until really the</p> <p>16 mid 2000's, the site chief for surgery at the</p> <p>17 General?</p> <p>18 DR. KWAN:</p> <p>19 A. 1999 to 2006.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Sorry, '99 to 2006.</p> <p>22 DR. KWAN:</p> <p>23 A. Correct.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And then--I take it then if there were</p>



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1 concerns in the lab, and I'll deal with the  
2 2005 in a moment.

3 DR. KWAN:  
4 A. Right.

5 COFFEY, Q.C.:  
6 Q. Before 2005, if there were concerns in the lab  
7 between '99 and 2005 about the OR not handling  
8 tissue properly, if there were--I'm not saying  
9 there were. If there were, you would have  
10 expected them to be expressed to you as the  
11 chief of surgery, to be brought to your  
12 attention, anyway?

13 DR. KWAN:  
14 A. Yes, I would think they would brought to my  
15 attention or brought to somebody within the  
16 operating room.

17 COFFEY, Q.C.:  
18 Q. The peri-operative program?

19 DR. KWAN:  
20 A. The peri-operative program, yes, not  
21 necessarily myself, but the peri-operative  
22 program.

23 COFFEY, Q.C.:  
24 Q. And if it was brought to the per-operative  
25 program, would you expect that the manager

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1 would bring it to your attention?

2 DR. KWAN:  
3 A. I would--you know, I would think so, but I  
4 don't necessarily get all information from  
5 there.

6 COFFEY, Q.C.:  
7 Q. Yes. Doctor, you've told the Commissioner  
8 that as a surgeon, you certainly earlier in  
9 your career were involving in treating people  
10 based upon their ER/PR status after surgery.  
11 At times you were called upon to do that.  
12 What were you taught about that in terms of  
13 your approach to hormonal therapy or anti-  
14 hormonal therapy?

15 DR. KWAN:  
16 A. I think we had to do what you need to do for  
17 the patient care. I don't have a medical  
18 oncologist--I have one medical oncologist, if  
19 I can remember, over many, many years.  
20 Extensive recruitment has been done and we  
21 don't have any medical oncologists, and a  
22 significant number of people around who needed  
23 treatment. So the radiation oncologist, which  
24 is--who are there at that time, and ourselves,  
25 have to make some decisions in treatment. Now

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1 having said that, you know, they've been  
2 treating with hormone in breast cancer well  
3 before Tamoxifen had become available.

4 COFFEY, Q.C.:  
5 Q. And when Tamoxifen became available then,  
6 Doctor, what was the approach?

7 DR. KWAN:  
8 A. The approach would be--before Tamoxifen  
9 available, we are treating with estrogen, we  
10 are treating with male hormones, steroids,  
11 that kind approach, but when Tamoxifen, that  
12 becomes a drug of choice and that seems to be  
13 the one that we'll be using with the patient  
14 that we thought was suitable for hormone  
15 treatments.

16 COFFEY, Q.C.:  
17 Q. Doctor, could you tell the Commissioner,  
18 please, because I take it that you do do and  
19 have over the years done a significant amount  
20 of breast surgery, breast cancer surgery?

21 DR. KWAN:  
22 A. That's correct.

23 COFFEY, Q.C.:  
24 Q. Within St. John's, and, Doctor, for example,  
25 beginning from the time you first started at

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1 St. Clare's in the early 90s -

2 DR. KWAN:  
3 A. Yeah, I was at St. Clare's in early 90s,  
4 correct.

5 COFFEY, Q.C.:  
6 Q. Early '90s. Doctor, at that point in time in  
7 terms of the breast surgery that was done in  
8 St. John's, approximately how much would you  
9 do a year?

10 DR. KWAN:  
11 A. Probably do about 50, somewhere around there.

12 COFFEY, Q.C.:  
13 Q. And I take it then--do you recall how many  
14 breast cancer patients would be operated on in  
15 St. John's that time of year?

16 DR. KWAN:  
17 A. The tumour registry would probably say  
18 somewhere between 250--200 to 300, 250, 300, I  
19 don't know the exact number. That is the  
20 province.

21 COFFEY, Q.C.:  
22 Q. And who else do you recall in terms of the  
23 surgeons was doing breast cancer surgery  
24 throughout the 90s? It was yourself and--in  
25 the main, the other doctors.

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1 DR. KWAN:  
 2 A. Dr. Felix.  
 3 COFFEY, Q.C.:  
 4 Q. Dr. Felix.  
 5 DR. KWAN:  
 6 A. Dr. Thavanathan, Dr. Wells, and a number of  
 7 others who do the lesser numbers. These are  
 8 the ones I know that do the major number.  
 9 COFFEY, Q.C.:  
 10 Q. Yeah, and we've seen their names on some of  
 11 the material.  
 12 DR. KWAN:  
 13 A. Sure.  
 14 COFFEY, Q.C.:  
 15 Q. The surgeons you referred to, and within St.  
 16 John's itself over the years, proportionately,  
 17 because you worked at both the General and St.  
 18 Clare's, where was most of the breast surgery  
 19 done?  
 20 DR. KWAN:  
 21 A. I do most of the breast surgery in St.  
 22 Clare's.  
 23 COFFEY, Q.C.:  
 24 Q. Was there any particular reason for that?  
 25 DR. KWAN:

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1 A. A couple of reasons. One is the mammogram is  
 2 at St. Clare's. When you need a localization  
 3 technique, in other word if I can't feel the  
 4 tumour, I need to put a wire on the  
 5 mammographic guidance and ultrasound guidance,  
 6 the expertise are in St. Clare's. They put a  
 7 wire so I can sample. And secondly--secondly  
 8 is breast cancer surgery from a surgical  
 9 procedure standpoint is the simplest surgery  
 10 than all the other major abdominal surgery  
 11 that I do. It's little more convenient to do  
 12 smaller surgery in the area that I don't  
 13 attend 24 hours a day, whereas I do a bigger  
 14 operation at the Health Science where I there  
 15 24 hours a day, or something of that nature.  
 16 COFFEY, Q.C.:  
 17 Q. Doctor, I'm going to ask you then to outline  
 18 for the Commissioner because it hasn't--she  
 19 hasn't heard this yet, okay. Now from a  
 20 surgeon's perspective, your approach as a  
 21 surgeon if there is such a thing to a typical  
 22 breast cancer case in terms of when a person  
 23 would first come to you in your capacity as a  
 24 surgeon, and how you approach up to and  
 25 including the point where you're taking the

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1 tumour?  
 2 DR. KWAN:  
 3 A. Usually the patient comes to us in the first  
 4 visit are referred in by their family  
 5 physician, if that's what you mean.  
 6 COFFEY, Q.C.:  
 7 Q. Yes.  
 8 DR. KWAN:  
 9 A. It's usually either they have a lump, they  
 10 have pain, they have discomfort, they have  
 11 some concern about their breast, and the first  
 12 issue is diagnosis. Do we have a malignancy  
 13 or do we have a benign disease? So then our  
 14 radiological colleagues and our clinical  
 15 examination come to play. If we establish  
 16 that this particular situation is of concern,  
 17 either mammographically or clinically, then we  
 18 try to establish the tissue diagnosis.  
 19 COFFEY, Q.C.:  
 20 Q. Uh-hm.  
 21 DR. KWAN:  
 22 A. Meaning tissue diagnosis can be established a  
 23 number of ways. It can be done by a core  
 24 biopsy, which means putting a needle in there  
 25 and getting a sample core, or by radiology

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1 getting a core biopsy because sometimes you  
 2 can't feel the lump. They will be a core  
 3 (unintelligible) and x-ray guidance. If it's  
 4 a lump that's palpable and core biopsy is not  
 5 suitable, there are situations it is not, then  
 6 we have to do an open biopsy which means we  
 7 take the patient to the operating room and  
 8 take a piece out of it, sometimes under  
 9 general anesthetics, other times local  
 10 anesthetics. Once we establish the diagnosis  
 11 of breast cancer, then we discuss with the  
 12 patient the treatment. The first and foremost  
 13 treatment of breast cancer is surgery.  
 14 Surgery is the first one to do. So what we do  
 15 is that we will complete the surgical  
 16 procedure, the are a number of surgical  
 17 options that are available. One is what we  
 18 call, if the patients are suitable, is a  
 19 partial removal of the breast; in other words,  
 20 a generous removal of the breast, depending on  
 21 the pathology report, and do the axilla  
 22 determination whether the axilla is involved  
 23 or not. And it's a basically staged procedure  
 24 properly, and after we have done the surgical  
 25 aspect or completed, satisfactory completed

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<p>1 the surgical aspect of it, then we--when all</p> <p>2 the pathology is back, refer the patient in</p> <p>3 general to the Cancer Clinic or to the medical</p> <p>4 oncologist or to the radiation oncologist to</p> <p>5 consider what we call either adjuvant</p> <p>6 radiation therapy or adjuvant chemotherapy.</p> <p>7 The treatment of the axillary portion of it</p> <p>8 now has become another field that has been</p> <p>9 developing, so called sensitive node</p> <p>10 (phonetic) and other stuff like that, which is</p> <p>11 another thing that surgeons now have to be</p> <p>12 participating in and determining that.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Doctor, the processes you've just described,</p> <p>15 and I have asked you about the actual surgery</p> <p>16 in the OR per se, for example, when you might</p> <p>17 be taking--removing a patient's entire breast</p> <p>18 or a portion of it, and you've described how</p> <p>19 the tissue would be fresh sectioned or</p> <p>20 preserved in formalin. I want to ask you</p> <p>21 about the core biopsies and the open biopsy</p> <p>22 process because you referred to both of them.</p> <p>23 How is the tissue that is extracted there</p> <p>24 preserved?</p> <p>25 DR. KWAN:</p>	<p>1 COFFEY, Q.C.:</p> <p>2 Q. Doctor, how has that changed over the years?</p> <p>3 I mean, compared to the mid 90s to now, how</p> <p>4 has that changed?</p> <p>5 DR. KWAN:</p> <p>6 A. At the mid 90s, we started changing.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. Okay, perhaps you could tell us.</p> <p>9 DR. KWAN:</p> <p>10 A. And mid 90s, I think we were able to get a few</p> <p>11 more medical oncologists and a few more</p> <p>12 radiation oncologists. Some them come and go,</p> <p>13 so there have been significant changes over</p> <p>14 the time. I don't know what exact number we</p> <p>15 have now. I think if I remember right, we</p> <p>16 have seven medical oncologists, and five to</p> <p>17 six radiation oncologists, I don't know the</p> <p>18 exact number, but compared to what's then.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. And how, if anything, has that changed your</p> <p>21 practice in terms of having to follow patients</p> <p>22 after?</p> <p>23 DR. KWAN:</p> <p>24 A. I don't any more. I send all my patients to</p> <p>25 the medical oncologists if they wish to go.</p>
<p>Page 42</p> <p>1 A. It is the same thing. We take it out, give it</p> <p>2 to the nurse, put it in formalin. Often on</p> <p>3 the core biopsies, directly into the formalin.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And then it would be handled then by the</p> <p>6 nursing staff in the way you've described it?</p> <p>7 DR. KWAN:</p> <p>8 A. Correct.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. They would go on with it and do whatever they</p> <p>11 had to get it down to the lab?</p> <p>12 DR. KWAN:</p> <p>13 A. To pathology, yes.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Doctor, in terms of the structure of the--</p> <p>16 I'll come back to the actual administrative</p> <p>17 structure within operating room in a moment,</p> <p>18 but in the early days you've indicated that</p> <p>19 there was, at best, one medical oncologist in</p> <p>20 the province, and at times there were a</p> <p>21 certain number of radiation oncologists who</p> <p>22 would be involved in post-operative treatment</p> <p>23 and surgeons, people like yourself?</p> <p>24 DR. KWAN:</p> <p>25 A. Right.</p>	<p>Page 44</p> <p>1 You know, there are patients who say I don't</p> <p>2 want to enter the door of the Cancer Clinic,</p> <p>3 but that's a very rare unusual situation.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And for those who don't want to go to the</p> <p>6 Cancer Clinic, I take it you would continue</p> <p>7 treatment?</p> <p>8 DR. KWAN:</p> <p>9 A. I will--I have a clinic in the Cancer Clinic</p> <p>10 myself. I follow--do some follow-up in the</p> <p>11 Cancer Clinic. I don't do any active</p> <p>12 treatment there any more. So I don't do</p> <p>13 chemotherapies, or anything of that nature now</p> <p>14 any more.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Doctor, you were the site chief at the General</p> <p>17 Hospital for general surgery beginning in</p> <p>18 1999, do I understand that?</p> <p>19 DR. KWAN:</p> <p>20 A. Correct, yes.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. How about before that?</p> <p>23 DR. KWAN:</p> <p>24 A. Before that, I think in mid 90s, I was the--I</p> <p>25 begin to be the chief of surgery, General</p>

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<p>1 Surgery Division at the Health Science, and 2 1985 to 1992, I was Director of the Cancer 3 Clinic. 4 COFFEY, Q.C.: 5 Q. So '85 to '92, you were Director of the Cancer 6 Clinic, which I take it was then a separate - 7 DR. KWAN: 8 A. Under the Newfoundland Cancer Treatment 9 Research Foundation. 10 COFFEY, Q.C.: 11 Q. And so from '92 then--if you just take the 12 Commissioner then your administrative 13 positions from '92 up to now? 14 DR. KWAN: 15 A. '02 up to now, I was--I was divisional chief 16 from '95 onwards to couple of years ago, a 17 year ago maybe, and I was the site chief of 18 surgery from 1999 to 2006. 19 COFFEY, Q.C.: 20 Q. What's the difference between a divisional 21 chief and a site chief? 22 DR. KWAN: 23 A. Divisional chief is that I just look after - I 24 have the responsibility of the general 25 surgeons at the Health Science. Co-clinical</p>	<p>1 DR. KWAN: 2 A. I don't know. I can't remember when it 3 changed to Eastern Health. 4 COFFEY, Q.C.: 5 Q. And so beginning in 1999, I'm sorry, you were 6 the clinical chief - sorry, co-clinical chief 7 for the peri-operative program? 8 DR. KWAN: 9 A. Correct. 10 COFFEY, Q.C.: 11 Q. Who was the other clinical chief? 12 DR. KWAN: 13 A. That is Dr. Frank King, who is 14 anesthesiologist because operating room is 15 primarily two group of physicians; anesthesia 16 and surgeons. 17 COFFEY, Q.C.: 18 Q. Yes. 19 DR. KWAN: 20 A. And so we have one group - one individual who 21 would deal with the issues arising from 22 anesthesia and surgeons who would deal with 23 issues arising from surgeries. 24 COFFEY, Q.C.: 25 Q. And I take it then in terms of the peri-</p>
<p>1 Chief of the Peri-operative Program, I have 2 the responsibility of dealing with the day to 3 day operations of the - related to the 4 surgeons only at the - and the surgical floor 5 at the Health Science. 6 COFFEY, Q.C.: 7 Q. So what - if I could ask you then, you're, I'm 8 sorry, Clinical Chief of Peri-operative 9 Program? 10 DR. KWAN: 11 A. Co-clinical Chief. 12 COFFEY, Q.C.: 13 Q. Co-clinical Chief of the Peri-operative 14 Program? 15 DR. KWAN: 16 A. That's correct. 17 COFFEY, Q.C.: 18 Q. For the Health Care Corporation or for the 19 General Hospital? 20 DR. KWAN: 21 A. Since '99. I don't remember who - 22 COFFEY, Q.C.: 23 Q. Okay, '99, it would be - the Health Care 24 Corporation existed the beginning of '95/'96, 25 okay, that's -</p>	<p>1 operative program, you as co-chief, co- 2 clinical chief, are responsible for the 3 surgeons? 4 DR. KWAN: 5 A. Uh-hm. 6 COFFEY, Q.C.: 7 Q. And your colleague was responsible for the 8 anesthetists. Were there any other managers 9 of the peri-operative program? 10 DR. KWAN: 11 A. Yes. 12 COFFEY, Q.C.: 13 Q. What sorts of individual - who are they, and 14 what - 15 DR. KWAN: 16 A. They had a program director who actually have 17 the responsibility overseeing the program. 18 COFFEY, Q.C.: 19 Q. Yes. 20 DR. KWAN: 21 A. And individual operating room, they have the 22 managers, and then the head nurse in each 23 operating room. 24 COFFEY, Q.C.: 25 Q. Yes. In terms of the program direction who</p>

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1 was that?

2 DR. KWAN:

3 A. Maria Tracey.

4 COFFEY, Q.C.:

5 Q. Maria Tracey, going back to 1999, Ms. Tracey

6 was -

7 DR. KWAN:

8 A. So far as I remember that she was there when I

9 started.

10 COFFEY, Q.C.:

11 Q. And what was her role, like, in comparison to

12 yours, what was she responsible for? You were

13 responsible for the surgeons, keeping them in

14 line, dealing with them.

15 DR. KWAN:

16 A. She was responsible for all the facets of the

17 operating room, like, the nurses, the

18 cleaners, all the other procedures in the

19 operating rooms, I would assume.

20 COFFEY, Q.C.:

21 Q. So she would be responsible for the activities

22 of everyone except the doctors?

23 DR. KWAN:

24 A. That too, because we report to Maria Tracey.

25 COFFEY, Q.C.:

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1 Q. Okay, and in relation to that now, I want to

2 ask you about that, what sorts of things would

3 you feel that doctors would have to report to

4 Ms. Tracey for?

5 DR. KWAN:

6 A. They would go through me, I would hope, but -

7 COFFEY, Q.C.:

8 Q. I appreciate that, but in terms of yourself,

9 what sorts of things would you -

10 DR. KWAN:

11 A. Well, we discuss, for example, like, simple

12 things like surgeon doesn't show up on time in

13 the morning.

14 COFFEY, Q.C.:

15 Q. Yes.

16 DR. KWAN:

17 A. Is late, delaying the operating room. If, I'm

18 saying "if" -

19 COFFEY, Q.C.:

20 Q. As an example, yeah.

21 DR. KWAN:

22 A. Yeah, example, or constantly overbook the case

23 and late, creating significant financial

24 issues or problems and manpower issues, etc

25 those, you know, would have to be dealt with

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1 collectively. Individual who may be have to

2 be dealt with individually, I mean, by me, and

3 function between physician and nurses -

4 COFFEY, Q.C.:

5 Q. If there were any problems -

6 DR. KWAN:

7 A. Any problems.

8 COFFEY, Q.C.:

9 Q. Okay, and you would deal with Ms. Tracey in

10 that regard?

11 DR. KWAN:

12 A. I would deal with it. She would come to me,

13 because I don't get those. Usually the

14 surgeons don't complain. It's somebody that

15 does, and I don't--you know, they--I mean, no

16 complaints, but they complain a different way,

17 but they don't--those things come through

18 their administrative role, in terms of the

19 union rules and all the stuff like that, which

20 I haven't got a clue.

21 COFFEY, Q.C.:

22 Q. Now Doctor, in relation to written policies

23 and procedures, were--in the sphere of

24 responsibility that you had as co-clinical

25 chief, the perioperative program, were there

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1 any written policies or procedures that

2 related to the doctors, that you were aware

3 of? Did the perioperative -

4 DR. KWAN:

5 A. How do you dress and gown in the operating

6 room? I'm sure they are all written there

7 somewhere, but it's just been around for so

8 long that I just accept it. I don't think I

9 ever seen one.

10 COFFEY, Q.C.:

11 Q. And any written policies and procedures that

12 might apply to staff other than physicians?

13 DR. KWAN:

14 A. Oh, I'm sure there are.

15 COFFEY, Q.C.:

16 Q. Who was--your understanding, who was

17 responsible for those?

18 DR. KWAN:

19 A. I would say the program is.

20 COFFEY, Q.C.:

21 Q. The program director?

22 DR. KWAN:

23 A. And the nursing department.

24 COFFEY, Q.C.:

25 Q. So if there were to be any written standards

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1 or policies or procedures relating to the  
 2 preservation of tissue samples, okay, whether  
 3 they were written or not written, okay, who  
 4 was responsible for formulating them?  
 5 DR. KWAN:  
 6 A. That would be, I would say, the nursing  
 7 department, administrative department.  
 8 COFFEY, Q.C.:  
 9 Q. And you would have expected them to deal with  
 10 what other agency in the hospital? The lab, I  
 11 take it?  
 12 DR. KWAN:  
 13 A. Laboratory would be the one. Laboratory, the  
 14 one who have identified any issues and  
 15 communicate with them and they would have to  
 16 make issues--to make procedure to correct if  
 17 there was any problems.  
 18 COFFEY, Q.C.:  
 19 Q. Doctor, I want to ask, please, Registrar, to  
 20 look at Exhibit C-0225, C-0225?  
 21 DR. KWAN:  
 22 A. What do I do with this?  
 23 COFFEY, Q.C.:  
 24 Q. No, just it'll come up on the screen there,  
 25 Doctor.

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1 DR. KWAN:  
 2 A. Okay.  
 3 COFFEY, Q.C.:  
 4 Q. There you go, see. Now Doctor, this is a  
 5 pathology report. Portions of it have been  
 6 redacted, blacked out, and here, Doctor, on  
 7 the second page of the exhibit, there's an  
 8 addendum one and addendum two.  
 9 DR. KWAN:  
 10 A. Um-hm.  
 11 COFFEY, Q.C.:  
 12 Q. And these happen to be reports by Dr. Elms,  
 13 and there's nothing unique about this  
 14 particular case. It's just a certain aspect  
 15 of it, I'm going to refer you to and then ask  
 16 you a question. Look at addendum number one.  
 17 You'll notice it says "immunochemical staining  
 18 is negative for progesterone receptors. The  
 19 immunohistochemical staining for estrogen  
 20 receptors has been technically unsatisfactory  
 21 on two occasions. A repeat attempt will be  
 22 made and an addendum issued one this  
 23 investigation has been performed." Signed  
 24 Ford Elms. This is dated, entered on  
 25 September 25th, 2001 and signed off by him the

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1 next day.  
 2 DR. KWAN:  
 3 A. Um-hm.  
 4 COFFEY, Q.C.:  
 5 Q. And then if you look above, you'll see  
 6 addendum number two, entered October 10th,  
 7 2001, signed off the same day, and it reads  
 8 "immunohistochemical stains for estrogen and  
 9 progesterone receptors are negative." Now  
 10 Doctor, back in--this is circa September and  
 11 October 2001. The idea that Dr. Elms  
 12 apparently, as a pathologist, was having  
 13 problems with the--being satisfied with the  
 14 staining for estrogen receptors and repeat  
 15 attempt having been required to be made,  
 16 because there's two attempts here, first of  
 17 all. He's going to make a third one. Back in  
 18 2001 and into 2002, was there any concern that  
 19 you ever became aware of at all, officially or  
 20 unofficially -  
 21 DR. KWAN:  
 22 A. No.  
 23 COFFEY, Q.C.:  
 24 Q. - about estrogen staining, progesterone  
 25 staining, back at that time?

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1 DR. KWAN:  
 2 A. No.  
 3 COFFEY, Q.C.:  
 4 Q. Would you, as a surgeon, when you would get a  
 5 report, pathologist's report, because that's--  
 6 like a pathologist report like the one we're  
 7 looking at there. I'm not suggesting at all  
 8 you ever saw that one, but when you would get  
 9 reports like that, I take it that's the format  
 10 they would be in? Over the years, this is the  
 11 sort of format they would take?  
 12 DR. KWAN:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. Doctor, did you ever have occasion to notice  
 16 that--in any report that you saw, that the  
 17 pathologists apparently were--was reporting  
 18 that he or she had to repeat the test?  
 19 DR. KWAN:  
 20 A. I mean, if he's not certain, I have no idea  
 21 why is he not certain that--the first original  
 22 study, there could be a number of reasons that  
 23 can happen. If you roll this pathology report  
 24 a little higher -  
 25 COFFEY, Q.C.:

<p style="text-align: right;">Page 57</p> <p>1 Q. I'm sorry, Doctor, higher is the first page?</p> <p>2 DR. KWAN:</p> <p>3 A. No, no, where the histology report part of it.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Okay, that's -</p> <p>6 DR. KWAN:</p> <p>7 A. Oh, you just passed it.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Okay, right here, yes.</p> <p>10 DR. KWAN:</p> <p>11 A. And you -</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Pathological interpretation.</p> <p>14 DR. KWAN:</p> <p>15 A. Right, you will notice that it's poorly</p> <p>16 differentiated tumour.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Yes.</p> <p>19 DR. KWAN:</p> <p>20 A. And poorly differentiated tumours, oftentimes</p> <p>21 give difficulties. So I mean, I would read</p> <p>22 it. I mean, I don't know the details of it,</p> <p>23 but you've seen enough and you look at that</p> <p>24 they have difficulty, I would not be able to</p> <p>25 tell what kind of difficulties he may have.</p>	<p style="text-align: right;">Page 59</p> <p>1 otherwise there was something unsatisfactory</p> <p>2 from his perspective or her perspective and</p> <p>3 then you saw that the pathologist did then</p> <p>4 though make an actual report, you'll see this</p> <p>5 one here, this is an assertion that the stains</p> <p>6 for estrogen and progesterone receptors are</p> <p>7 negative, would you ever, as a surgeon go</p> <p>8 behind that? In the sense of, okay, if you</p> <p>9 saw this sort of one, addendum number one,</p> <p>10 there was a problem, technical problem of some</p> <p>11 sort. And now a month--actually not a month,</p> <p>12 two weeks later, there's a report that they're</p> <p>13 negative, both of them are negative, would you</p> <p>14 ever challenge that or go behind it, Doctor?</p> <p>15 DR. KWAN:</p> <p>16 A. It matches a poorly differentiated tumour.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Sure.</p> <p>19 DR. KWAN:</p> <p>20 A. Poorly original--estrogen receptor negatives.</p> <p>21 I mean, if you get those--if it changed around</p> <p>22 to something else, I may question it, but if</p> <p>23 it matches the histological findings that you</p> <p>24 expect from the situation, I see no reason to</p> <p>25 question them.</p>
<p style="text-align: right;">Page 58</p> <p>1 Partial may be the tissue, tumour itself, and</p> <p>2 maybe significant other issues, and I would</p> <p>3 leave it up to resolve those issues himself.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Now I wanted to ask you about that, as a</p> <p>6 surgeon, as a treating physician, in your</p> <p>7 capacity as a surgeon utilizing a pathology</p> <p>8 report. If you saw a report like this, okay,</p> <p>9 and I'm not suggesting at all, I repeat, that</p> <p>10 you saw this one. If you saw a report like</p> <p>11 this where you noticed, well, okay, poorly</p> <p>12 differentiated. You would understand that</p> <p>13 that might be--present some difficulty for the</p> <p>14 pathologist in the interpretation process. Am</p> <p>15 I correct on that?</p> <p>16 DR. KWAN:</p> <p>17 A. I mean -</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. It could?</p> <p>20 DR. KWAN:</p> <p>21 A. - if I was to understand, that could be a</p> <p>22 possibility.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. And then if there was a note in an addendum or</p> <p>25 somewhere in the report that technically or</p>	<p style="text-align: right;">Page 60</p> <p>1 COFFEY, Q.C.:</p> <p>2 Q. Okay, and what about if it--a situation in any</p> <p>3 particular patients, and I appreciate you've</p> <p>4 seen quite a number of patients' pathology</p> <p>5 reports over the years.</p> <p>6 DR. KWAN:</p> <p>7 A. Um-hm.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. If the information the pathologist was giving</p> <p>10 you, from your perspective, didn't match or</p> <p>11 wasn't consistent with the histological</p> <p>12 report, what was your approach then, Doctor?</p> <p>13 DR. KWAN:</p> <p>14 A. That's beyond--that's going--when beyond</p> <p>15 estrogen receptors. Anything that comes</p> <p>16 through that doesn't match, doesn't seem to be</p> <p>17 appropriate what I see of things, then I pick</p> <p>18 up the phone and I talk to them.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. Okay.</p> <p>21 DR. KWAN:</p> <p>22 A. You know, and I say--I will usually go down</p> <p>23 with the report, find the pathologist and say</p> <p>24 "hey, what's happening here?"</p> <p>25 COFFEY, Q.C.:</p>

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1 Q. And he or she would give you an explanation?  
 2 DR. KWAN:  
 3 A. We would discuss an explanation and he/she may  
 4 need some clinical history from me in maybe a  
 5 difficult situation, that we need to share  
 6 some information between me and the  
 7 pathologist and maybe after listen to me, he  
 8 may relook at it or we may decide that  
 9 whatever needs to be done, do more testing, do  
 10 more sectioning.  
 11 COFFEY, Q.C.:  
 12 Q. Now Doctor, do you ever recall doing that in  
 13 relation to the ER/PR results you received?  
 14 DR. KWAN:  
 15 A. No, sir.  
 16 COFFEY, Q.C.:  
 17 Q. Do you ever recall hearing other surgeons talk  
 18 about them having to follow up on ER/PR  
 19 results?  
 20 DR. KWAN:  
 21 A. No, sir.  
 22 COFFEY, Q.C.:  
 23 Q. Look, please, at Exhibit P-1572? Doctor, when  
 24 I just referred--that particular one was a  
 25 2001 pathology report. There are a number of

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1 other ones I could show you from 2002.  
 2 DR. KWAN:  
 3 A. Sure.  
 4 COFFEY, Q.C.:  
 5 Q. And in fact, even into 2003, that do indicate  
 6 that, for whatever reason, the ER/PR was rerun  
 7 and sometimes, in fact, there were changed  
 8 results and you don't ever remember anybody  
 9 talking about that or saying, you know, "guess  
 10 what? I had a patient last week that was  
 11 ER/PR negative and now they're telling me--now  
 12 the pathology is telling me they're positive."  
 13 DR. KWAN:  
 14 A. Most of this, at that time, were probably seen  
 15 by a medical oncologist, patient have gone  
 16 down, referred to the Cancer Clinic, the  
 17 addendum comes back, would have been gone,  
 18 would be referred.  
 19 COFFEY, Q.C.:  
 20 Q. I take it then, amongst the--talk amongst the  
 21 surgeons by the early 2000s, you wouldn't be  
 22 as involved in the follow-up treatment,  
 23 adjuvant treatment?  
 24 DR. KWAN:  
 25 A. Correct, I wouldn't be doing very many of

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1 those patients or of the patient that comes  
 2 back to see me with a cancer diagnosis would  
 3 be automatically referred unless there's some  
 4 particular reasons.  
 5 COFFEY, Q.C.:  
 6 Q. If we could look, please, Doctor, this is the  
 7 minutes of a meeting of April 15th, 2003,  
 8 Surgical Pathology Review Committee meeting.  
 9 Present are a number of individuals. Dr.  
 10 Ejeckam is the chairman. Dr. Battcock, I  
 11 think, was a surgeon?  
 12 DR. KWAN:  
 13 A. No.  
 14 COFFEY, Q.C.:  
 15 Q. I'm sorry.  
 16 DR. KWAN:  
 17 A. That's Steve Battcock.  
 18 COFFEY, Q.C.:  
 19 Q. Steve is?  
 20 DR. KWAN:  
 21 A. Radiologist.  
 22 COFFEY, Q.C.:  
 23 Q. Radiologist, I'm sorry. Dr. Dawson?  
 24 DR. KWAN:  
 25 A. Gynecology oncologist.

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1 COFFEY, Q.C.:  
 2 Q. Parai would be a pathologist?  
 3 DR. KWAN:  
 4 A. Pathologist.  
 5 COFFEY, Q.C.:  
 6 Q. Siddiqui, a medical oncologist.  
 7 DR. KWAN:  
 8 A. That's correct.  
 9 COFFEY, Q.C.:  
 10 Q. Thavanathan?  
 11 DR. KWAN:  
 12 A. That's a surgeon.  
 13 COFFEY, Q.C.:  
 14 Q. And yourself, and in fact, yourself and Dr.  
 15 Thavanathan didn't make the meeting  
 16 apparently.  
 17 DR. KWAN:  
 18 A. Correct.  
 19 COFFEY, Q.C.:  
 20 Q. There are terms of reference set out here. A.  
 21 2.1A is standardized reporting of pathology  
 22 specimens, and Doctor, I'm going to ask you  
 23 about this, I'm not going to take you through  
 24 it at length, but the Commissioner has seen  
 25 this before, and she's heard other evidence on



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<p>1 this, that there was a significant concern 2 about inadequacies in the completion of 3 requisition forms coming to pathology from 4 surgeons. Do you recall - 5 DR. KWAN: 6 A. That's correct. 7 COFFEY, Q.C.: 8 Q. And here, "Dr. Ejeckam asked the members for 9 input for standardized reporting of pathology 10 specimens." I want to ask you about that. As 11 a surgeon, reading pathology reports, did you 12 ever have any concerns about the formatting of 13 them? Because we've looked at a number of 14 them and the information could be anywhere in 15 it, all over the place. 16 DR. KWAN: 17 A. The new format that's now being used since, I 18 guess, mid 90s has been much improved, 19 compared to before in the past. From a 20 surgeon's perspective, what we want to know, 21 number one, the diagnosis correct. Number 22 two, our margins are clear. Number three, are 23 lymph nodes--in breast cancer I'm talking 24 about, are there lymph nodes involved or not. 25 That would be our primary concern, and</p>	<p>1 Q. As did ER/PR status? 2 DR. KWAN: 3 A. That's correct too. 4 COFFEY, Q.C.: 5 Q. Doctor, here, looking at this memo, it says 6 "after much discussion, it was agreed that ER 7 and PR receptors be done automatically on 8 breast surgery cases." See that? 9 DR. KWAN: 10 A. That should be done automatically. 11 COFFEY, Q.C.: 12 Q. Yes. This suggests that at the time, in the 13 middle of April 2003, it wasn't always being 14 done. Now you're shrugging and - 15 DR. KWAN: 16 A. I don't know. I can't answer that. 17 COFFEY, Q.C.: 18 Q. At that time, in early 2003, as a surgeon, 19 would you be ordering ER/PR? 20 DR. KWAN: 21 A. Since the time when it was done 22 immunohistochemistry. 23 COFFEY, Q.C.: 24 Q. In the late 90s that would be. 25 DR. KWAN:</p>
<p>Page 66</p> <p>1 oftentimes ER and PR receptor comes much 2 later, before--after even--that's why it's 3 addendum one, addendum two, you got those come 4 much later before most time we don't even see 5 that by the time the patient has been 6 referred. So we are concerned about if our 7 margins are not clear, if you're dealing with 8 a breast conservation surgery, if a margin is 9 not clear, then it is necessary to do further 10 surgery before we send the patients off, so 11 that number one, it will be our interest in 12 finding from the pathologist whether our 13 margins are free. And secondly, if the 14 patient have a lymph node involvement that 15 they come as stage two, then that will be 16 advise the patient used to come to talk to us, 17 "do I get chemotherapy, do I not?" We can at 18 least give them some inkling as to what's 19 happening, what may happen to them. 20 COFFEY, Q.C.: 21 Q. The lymph node involvement had implications 22 for treatment? 23 DR. KWAN: 24 A. Correct. 25 COFFEY, Q.C.:</p>	<p>Page 68</p> <p>1 A. Late 90s, they were done. We don't have to 2 order that any more. 3 COFFEY, Q.C.: 4 Q. Your recollection is, your understanding - 5 DR. KWAN: 6 A. That's right. 7 COFFEY, Q.C.: 8 Q. - was that some--who was ordering it at that 9 time, in the late 90s? 10 DR. KWAN: 11 A. Well, it come up, specimen 12 immunohistochemistry will be done auto--I 13 don't know why it's not done automatically. I 14 really don't under--don't know. 15 COFFEY, Q.C.: 16 Q. Okay. There's a reference to - 17 DR. KWAN: 18 A. I would assume that it's done automatically. 19 COFFEY, Q.C.: 20 Q. And I take it, if you got a pathology report 21 and you were being called upon to follow the 22 breast cancer patient yourself, if it turned 23 out you were, if there was no ER/PR status 24 there - 25 DR. KWAN:</p>

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<p>1 A. I'll ask for it.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. - you'd ask for it. Then there's a reference</p> <p>4 to this clinical information. He has</p> <p>5 circulate a form listing ten requirements a</p> <p>6 properly collected specimen requisition form</p> <p>7 should include. Now Doctor, we will come to</p> <p>8 this shortly, but could you tell the</p> <p>9 Commissioner, please, within a year of this,</p> <p>10 about a year later, you're still having to</p> <p>11 write a memo to surgeons to tell them to</p> <p>12 comply with this. Why is that? Explain that</p> <p>13 to the Commissioner, why.</p> <p>14 DR. KWAN:</p> <p>15 A. I don't know how people behave. I mean,</p> <p>16 because oftentimes that you don't sign the</p> <p>17 pathology report until you're finished the</p> <p>18 case. When you finish the case, you left, I</p> <p>19 would say, and now, I mean, and to the point</p> <p>20 that we have, say, the specimen ain't going</p> <p>21 out of the operating room until you fill out</p> <p>22 that form, and partially too, I remember I</p> <p>23 have some discussion with the pathologist that</p> <p>24 the form that was previously used, previous at</p> <p>25 that time, had only a small little bracket</p>	<p>1 A. They don't leave the operating rooms suite</p> <p>2 until that pathology report is filled out.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. The requisition form filled out?</p> <p>5 DR. KWAN:</p> <p>6 A. Correct, the requisition form is filled out.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And that requires, at least, a satisfactory</p> <p>9 clinical history to be provided?</p> <p>10 DR. KWAN:</p> <p>11 A. Sometimes if very simple.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Sure.</p> <p>14 DR. KWAN:</p> <p>15 A. If you do a gallbladder, just gallbladder with</p> <p>16 gallstones, you know. Other times it's more</p> <p>17 complicated.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Here, Doctor, under new business, 3.1, ER and</p> <p>20 PR receptors. It says "Dr. Ejeckam stated</p> <p>21 that ER and PR receptors are not being</p> <p>22 performed for the next six weeks due to a</p> <p>23 technical problem. If a solution cannot be</p> <p>24 found, these tests will be sent outside St.</p> <p>25 John's. He stated it is being considered to</p>
<p>1 about this much room for you to write</p> <p>2 anything, you know. So I advised them to</p> <p>3 redesign the form and now we had a little</p> <p>4 broader piece of space to write things. At</p> <p>5 that time, it was just tiny little corner.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. And I take it you're telling the Commissioner,</p> <p>8 for whatever reason, some surgeons, it was</p> <p>9 difficult to get them to comply?</p> <p>10 DR. KWAN:</p> <p>11 A. I don't know what to tell you.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. To the point where--and we'll see this there,</p> <p>14 at one point it developed where there was</p> <p>15 going to be the approach that the specimen</p> <p>16 would stay in the OR.</p> <p>17 DR. KWAN:</p> <p>18 A. It would just now.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. Yes.</p> <p>21 DR. KWAN:</p> <p>22 A. Which is current policy.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Which is current policy, yes.</p> <p>25 DR. KWAN:</p>	<p>1 send one or two technologists to Halifax or</p> <p>2 Toronto for training." Now Doctor, do you</p> <p>3 recall--what, if anything, do you recall about</p> <p>4 this?</p> <p>5 DR. KWAN:</p> <p>6 A. I wasn't at the meeting, and I must say, I</p> <p>7 don't know that actually happened.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Well, the idea that they were not being</p> <p>10 performed for a period of time, were you aware</p> <p>11 in 2003?</p> <p>12 DR. KWAN:</p> <p>13 A. No, sir.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. You were not at the time?</p> <p>16 DR. KWAN:</p> <p>17 A. No, sir.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Now these minutes, look down through this,</p> <p>20 they're signed by Dr. Ejeckam. If we look</p> <p>21 back up, here, they're actually stamped as</p> <p>22 having been received by the Vice-President</p> <p>23 Medical Services, that would be Dr. Williams'</p> <p>24 office, as of August 11th 2003, suggesting</p> <p>25 that it was some period of time between April</p>

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1 15th and August before they were produced. Do  
 2 you ever recall seeing these minutes yourself?  
 3 DR. KWAN:  
 4 A. No, sir, and you look at the date and the  
 5 time, the time of the meeting is 2:10 p.m. in  
 6 the afternoon on a Tuesday.  
 7 COFFEY, Q.C.:  
 8 Q. Yes.  
 9 DR. KWAN:  
 10 A. And Tuesday, at that time, and I remember, is  
 11 my operating day or my meeting with the  
 12 clinical chiefs. So it was every Tuesday at  
 13 that time, I'm occupied and I think I remember  
 14 telling them that I would not be able to make  
 15 that meeting at any time, if you don't change  
 16 it.  
 17 COFFEY, Q.C.:  
 18 Q. In fact, Dr. Thavanathan is not there either.  
 19 He's a surgeon. So you're not surprised to  
 20 find that the minutes note that you and he are  
 21 not there at that time of day. If we could  
 22 look, please, at Exhibit P-0113? Doctor,  
 23 these are what I'll refer to as the Ejeckam  
 24 2003 memos. The first page of this is dated  
 25 April 4th, 2003. It's to all pathologists,

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1 Health Sciences Centre, St. Clare's and out of  
 2 town of hospitals from him. This is a memo.  
 3 Subject is immunohistochemical stains. It  
 4 reads "please note that the  
 5 immunohistochemical stains for the following  
 6 antibodies" and he lists eight of them, ER/PR  
 7 are the last two, "have remained unreliable,  
 8 erratic and therefore unhelpful for diagnostic  
 9 purposes. Consequent on the above, staining  
 10 with these antibodies will stop forthwith  
 11 until we can solve the reliability,  
 12 sensitivity and specificity problems. Efforts  
 13 are under way and hopefully a solution will be  
 14 found within the next four to six weeks."  
 15 Doctor, did you see this memo back in 2003?  
 16 DR. KWAN:  
 17 A. No, sir.  
 18 COFFEY, Q.C.:  
 19 Q. Did you hear anybody speak of the subject  
 20 matter of it?  
 21 DR. KWAN:  
 22 A. No, sir.  
 23 COFFEY, Q.C.:  
 24 Q. Doctor, if you look then, please, at page two,  
 25 which is Dr. Ejeckam's May 2nd, 2003 memo, and

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1 again it's to pathologists and the Health  
 2 Sciences Centre, St. Clare's and out of town  
 3 hospitals from Dr. Ejeckam. The subject is  
 4 ER/PR immunohistochemical stains, and he  
 5 writes "I am glad to inform you we have  
 6 rectified the difficulties related to the  
 7 immunostain of ER/PR. Therefore, we can now  
 8 resume regular requests for these antibody  
 9 stains. I will however, like to bring the  
 10 following information to your attention."  
 11 Doctor, he then goes on, in paragraph one,  
 12 "results of the immunostains may be affected  
 13 by delayed fixation, over fixation, under  
 14 fixation, uneven fixation, inadequate tissue  
 15 dehydration and tissue reprocessing." I  
 16 appreciate E and F would occur in the lab, and  
 17 perhaps A to D might occur or be related to  
 18 the lab. But A to D, particularly A, delayed  
 19 fixation here, might relate to the operating  
 20 room or the perioperative program. In 2003,  
 21 did you ever hear any concerns expressed about  
 22 what was going on in the OR?  
 23 DR. KWAN:  
 24 A. No, sir.  
 25 COFFEY, Q.C.:

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1 Q. Or the OR's practices in terms of not getting  
 2 the tissue down to the pathology?  
 3 DR. KWAN:  
 4 A. I have never been informed or aware of this.  
 5 COFFEY, Q.C.:  
 6 Q. And this particular document, Doctor, and I  
 7 appreciate it's not directed at yourself.  
 8 It's directed at pathologists and it goes on  
 9 at some length. Dr. Ejeckam goes on at some  
 10 length about ER/PR aspects of dealing with  
 11 breast cancer, and it's copied to the site  
 12 chief at the Health Sciences Centre in St.  
 13 Clare's and Mr. Dyer and all technical staff  
 14 on immunohistochemistry. Doctor, the April  
 15 4th and May 2nd, 2003 memos, as the co-  
 16 clinical chief of the perioperative program at  
 17 the time, in '03, would you have thought or  
 18 expected at least you'd be told something  
 19 about this?  
 20 DR. KWAN:  
 21 A. I interpret this as the laboratory problems  
 22 themselves and that they should be--if there  
 23 is a fixation issue, then the operating--at  
 24 least the perioperative program or the chief  
 25 would be saying that we think this is part of

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1 your area, we should be informed. Yes, I  
 2 would think they at least--I would think the  
 3 perioperative program somehow would be  
 4 informed. If you think there's a fixation or  
 5 inadequate fixation, whatever issues they  
 6 think is related to the operating room.  
 7 COFFEY, Q.C.:  
 8 Q. Particularly in terms at the beginning of the  
 9 tissue being preserved, if there's a problem,  
 10 there might be problems down the road, further  
 11 down in the process, but there could be a  
 12 problem extending all the way back to the OR?  
 13 DR. KWAN:  
 14 A. If there is--I mean, it would need to be  
 15 examined to find out where the process  
 16 problems are, but you know, but if there's any  
 17 concern about it, I would think they should  
 18 bring it to our attention.  
 19 COFFEY, Q.C.:  
 20 Q. Doctor, how about being told that at least, as  
 21 he's written here, look back at page one, Dr.  
 22 Ejeckam, at that time, asserted in writing,  
 23 April 4th, 2003, that those eight stains, two  
 24 of them are ER/PR and at times, you would be  
 25 relying upon ER/PR results for yourself, you

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1 know, in following your own patients, as well  
 2 whether you were treating the patient, you  
 3 know, following the patient or not, they are  
 4 your patient. You've done the surgery on  
 5 them, even if a medical oncologist is going to  
 6 follow them, would you have been interested--  
 7 you know, at the time, do you think you should  
 8 have been told that a pathologist had  
 9 concluded, in writing, that they have remained  
 10 unreliable, erratic and therefore unhelpful  
 11 for diagnostic purposes?  
 12 DR. KWAN:  
 13 A. I would think a notification to department of  
 14 surgery will be, you know, will be reasonable  
 15 and expected, I guess, I mean, so we know  
 16 about it. Whether we can do anything about  
 17 it, it's a different issue.  
 18 COFFEY, Q.C.:  
 19 Q. And if it involved a change in some practice  
 20 in the OR, I take it then you would have--at  
 21 the time, you'd listen and do what you could  
 22 to make the change.  
 23 DR. KWAN:  
 24 A. Well, that would come up with our operating  
 25 room discussions and find out what needs to be

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1 done and what has to be done and dialogue  
 2 between the pathology department and ourselves  
 3 and find out what the issues are.  
 4 COFFEY, Q.C.:  
 5 Q. Look, please, I want to look at page five of  
 6 this document, Doctor. This is the June 19th,  
 7 2003, Dr. Ejeckam memo to Terry Gulliver, but  
 8 at page seven of the exhibit, you'll notice he  
 9 has copied this to Dr. Desmond Robb, Dr. Cook,  
 10 Dr. Parai, and Mr. Dyer. At the time, you  
 11 certainly would have known Mr. Dyer and Mr.  
 12 Gulliver. Would you have known them?  
 13 Certainly, Mr. Gulliver?  
 14 DR. KWAN:  
 15 A. I know to see who he is.  
 16 COFFEY, Q.C.:  
 17 Q. Okay.  
 18 DR. KWAN:  
 19 A. But that's about it.  
 20 COFFEY, Q.C.:  
 21 Q. How about Dr. Robb?  
 22 DR. KWAN:  
 23 A. I know Desmond very well.  
 24 COFFEY, Q.C.:  
 25 Q. And Dr. Cook and Dr. Parai?

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1 DR. KWAN:  
 2 A. I know Dr. Cook and I know Dr. Parai.  
 3 COFFEY, Q.C.:  
 4 Q. And Dr. Ejeckam as well?  
 5 DR. KWAN:  
 6 A. Yes, I do.  
 7 COFFEY, Q.C.:  
 8 Q. So looking at this memo, back to it, he opens  
 9 by saying "following persistent erratic  
 10 results of immunostains in our laboratory, I  
 11 accepted to work closely with technical staff  
 12 in order to rectify this problem. Despite the  
 13 fact that the problem seems to have been  
 14 arrested, the state of immunostaining at the  
 15 General Hospital, Department of Laboratory  
 16 Medicine pathology is still unsatisfactory"  
 17 and then he goes on at some length, okay,  
 18 about the physical location and so on and so  
 19 forth. But he concludes, Doctor, in paragraph  
 20 six, the last page, by saying "finally, it is  
 21 pertinent to mention the results of  
 22 immunostains are extremely important in  
 23 histopathologic diagnosis, especially where  
 24 classification of lymphomas and determination  
 25 of benign or malignancy of certain lesions,

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1 for example in the prostate biopsies, depend  
 2 on crisp, reliable and reproducible staining  
 3 results. Diagnosis based on inappropriate  
 4 immunostain will surely jeopardize patient  
 5 care and may even expose the Health Care  
 6 Corporation of St. John's to litigation.  
 7 Therefore, it will be ill-advised to operate  
 8 an unreliable and erratic immunohistochemical  
 9 procedures in our laboratory." Now Doctor,  
 10 were you aware of that sentiment in 2003?  
 11 DR. KWAN:  
 12 A. No, sir.  
 13 COFFEY, Q.C.:  
 14 Q. Doctor, should it have been brought to your  
 15 attention?  
 16 DR. KWAN:  
 17 A. I think it should be brought to the whole  
 18 hospital's attention. I mean, administrative  
 19 attention, you know, I mean, more than me as a  
 20 surgeon, because you're looking at diagnosing  
 21 lymphoma where you don't treat and you look at  
 22 a number of other diagnosis that have broad  
 23 spectrum. If that's a situation, what he  
 24 said, is correct there, then I think the  
 25 Department of Pathologists will have, you

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1 know, look at it in a lot more detail. I  
 2 mean, that's the only thing I can say. I  
 3 don't know how to interpret what he said here,  
 4 in terms of the details information that he  
 5 come to that conclusion.  
 6 COFFEY, Q.C.:  
 7 Q. But if it was a genuinely held view at the  
 8 time, by him, as a pathologist -  
 9 DR. KWAN:  
 10 A. At that time, and if that is confirmed by his  
 11 colleagues, then yes, I think we need to -  
 12 COFFEY, Q.C.:  
 13 Q. Address it.  
 14 DR. KWAN:  
 15 A. - address it, yes.  
 16 COFFEY, Q.C.:  
 17 Q. If we could, Doctor, just looking at this  
 18 exhibit, page eight of this exhibit, P-0113,  
 19 Surgical Pathology Review Committee, this is  
 20 dated minutes of a meeting September 23rd,  
 21 2003, and here, Doctor, of course those  
 22 present are listed here and the apologies from  
 23 others. Your name is not on this.  
 24 DR. KWAN:  
 25 A. I presume when I told him I can never attend

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1 those meetings at the time, either change it  
 2 or drop me out of it.  
 3 COFFEY, Q.C.:  
 4 Q. And the time here of this meeting is 2:05 p.m.  
 5 on September 23rd. That would be problematic  
 6 for some one, a surgeon such as yourself  
 7 attending it. Doctor, in your capacity as a  
 8 surgeon on the staff of the Health Care  
 9 Corporation, would you take part in Medical  
 10 Advisory Committee meetings, MAC meetings?  
 11 DR. KWAN:  
 12 A. Not as a medical staff, as a clinical chief,  
 13 co-clinical chief perioperative room, yes.  
 14 COFFEY, Q.C.:  
 15 Q. Okay, in that context. If we could look,  
 16 please, at Exhibit P-1916? Doctor, this is an  
 17 MAC meeting of June 9th, 2004. You're there,  
 18 top right-hand side. See that? Your name is  
 19 listed there. It begins by saying, "Ms.  
 20 Patricia Pilgrim is welcome as a member of the  
 21 Medical Advisory Committee in her new role of  
 22 Vice-President Quality and Clinical Services,"  
 23 and then one, "presentation, quality and  
 24 systems improvement," see that there? And  
 25 then Ms. Predham and Ms.--"Heather Predham and

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1 Pam King Jesso were in attendance to speak on  
 2 patient safety, piecing it together. The  
 3 following are some of the highlights of their  
 4 presentation." The first bullet is "Health  
 5 Care Corporation of St. John's has identified  
 6 the development of comprehensive patient  
 7 safety program as a major goal, strategic  
 8 plan" and there's a formation of the patient  
 9 safety advisory committee, and shared some  
 10 educational initiatives and measurement  
 11 evaluation and finally the adoption of non-  
 12 punitive reporting structure.  
 13 Now, Doctor, up until this point, June of  
 14 2004, in terms of patient safety, quality  
 15 control, quality initiatives in the lab,  
 16 clinical laboratory, would you have had any  
 17 knowledge of those at all?  
 18 DR. KWAN:  
 19 A. No, sir.  
 20 COFFEY, Q.C.:  
 21 Q. In your own sphere, would you have had any  
 22 knowledge of those in surgery?  
 23 DR. KWAN:  
 24 A. In our own surgery department, our own  
 25 division of surgery, that usually falls in the

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<p>1 role of the divisional chief. We have weekly 2 meetings and go through all the patients that 3 we have in-house and those patients that have 4 significant complications and mortalities are 5 reviewed and discussed by the entire staff, 6 resident staff and nursing staff. Partially, 7 as a day-to-day working and partially as to 8 review trend and understanding. We have 9 several ongoing projects, in terms of 10 antibiotic cares (phonetic) in perioperative 11 situations, anti-coagulations in terms of 12 prevention DVTs. We have several projects 13 like this ongoing as quality assurance issues 14 within our department.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Has there ever been a point, before 2005, 17 okay, where surgeons and pathologists 18 routinely met?</p> <p>19 DR. KWAN:</p> <p>20 A. No, sir.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Okay. In St. John's, in your experience, it 23 just didn't happen?</p> <p>24 DR. KWAN:</p> <p>25 A. No, sir.</p>	<p>1 A. Not that I remember.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Exhibit P-1582? Doctor, this is a memo of 4 June 17th, 2004 that you wrote to all surgeons 5 at the Health Sciences site. It's about 6 dealing with this issue of specimen without 7 clinical history, and you say "enclosed is a 8 memo from Dr. Ejeckam regarding pathology 9 without adequate clinical history. This has 10 been going on for some time with no 11 improvement with friendly persuasions," and 12 you tell your fellow surgeons, "the history is 13 to be completed on the pathology requisition 14 form before the specimen goes out of the 15 operating room. I have also advised the OR 16 nurses to remind all physicians to do this or 17 the specimen will not leave the operating room 18 unless the clinical history has been 19 completed. Thank you for your attention." 20 And you've attached to that, the second page 21 of this exhibit is the memorandum that Dr. 22 Ejeckam had written to you on June 9th, 2004, 23 about, from his perspective, non-compliance by 24 many physicians with regards to completing the 25 surgical pathology request forms.</p>
<p>1 COFFEY, Q.C.:</p> <p>2 Q. And I just use the phrase routinely met, and 3 you've indicated that at times, you would deal 4 with a pathologist one on one.</p> <p>5 DR. KWAN:</p> <p>6 A. Yeah.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. But in terms of other meetings, like kind of 9 non-routine, large scale meetings -</p> <p>10 DR. KWAN:</p> <p>11 A. The only time we ever meet--I ever meet with a 12 pathologist on a formal structure is as a 13 clinical chief and Dr. Cook, who was the 14 clinical chief at that time, present at the 15 clinical chief meetings and bring forth his 16 issues to the clinical chief and explain to 17 us, either for information or for support. 18 That's the only formal route that I can ever 19 remember having a formal meeting with 20 pathologists. Now I mean, there may be other 21 sporadic ones, but nothing scheduled.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Did any concerns about fixation or in 24 particular ER/PR ever come up?</p> <p>25 DR. KWAN:</p>	<p>1 So Doctor, having sent that memo in June 2 of 2004 and adopted the practice that's 3 referred to there, was that practice adopted 4 at the time?</p> <p>5 DR. KWAN:</p> <p>6 A. Well, ever since then, I think that's the 7 current practice right now.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Okay. Have you heard any complaints about it 10 since?</p> <p>11 DR. KWAN:</p> <p>12 A. No. The nurses are very good in getting them 13 doing it.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. And here, Doctor, just looking at Dr.-- 16 actually, both your--I apologize, just go back 17 up a bit. Both your memo of June 17th is sent 18 to Dr. Felix, copied to Dr. Felix, Dorothy 19 Budgell, the manager of OR Health Sciences 20 Centre, and Ms. Shirley Taylor, the manager of 21 the OR at St. Clare's Hospital. It's a 22 direction, I take it, from you to them. Would 23 I be correct in that?</p> <p>24 DR. KWAN:</p> <p>25 A. Correct.</p>

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1 COFFEY, Q.C.:

2 Q. And here though, Dr. Ejeckam, in his memo to

3 yourself of June 9th had copied that to Dr.

4 Williams, Dr. Cook and Dr. Felix, your

5 counterpart. So Doctor, in relation then to

6 June 2004, the idea of sending around a memo

7 or somebody such as Dr. Ejeckam sending a

8 memo, not only to yourself but copying it to

9 the VP Medical, to the clinical chief, Dr.

10 Cook, and to your counterpart, Dr. Felix, that

11 sort of practice certainly existed by '04 and

12 -

13 DR. KWAN:

14 A. If there was any important issue like this,

15 there will--I mean, issues, they send us a

16 note or talk to us.

17 COFFEY, Q.C.:

18 Q. If we could look, please, at Exhibit P-0021,

19 page 15, when it comes up? Doctor, these are

20 the MAC minutes of a meeting of March 16th,

21 2005. You'll see that you're there, right

22 there.

23 DR. KWAN:

24 A. Um-hm.

25 COFFEY, Q.C.:

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1 Q. Want to go to page 21 of the exhibit, and

2 additions to the agenda, policy on disclosure.

3 DR. KWAN:

4 A. Um-hm.

5 COFFEY, Q.C.:

6 Q. And it says "the draft policy on disclosure

7 was distributed and discussed at a clinical

8 chief's meeting on September 28th, 2004.

9 Detailed discussion was held with Dr. Claude

10 Martin, who's in charge of risk management at

11 CMPA, and Mr. Peter Browne, during a

12 presentation to clinical chiefs. We are

13 currently waiting for the Newfoundland Medical

14 Board's draft policy to ensure that the two

15 policies are consistent. Once we have

16 completed the policy for the Health Sciences

17 Centre, then it will be forwarded to members

18 of the medical staff. Clinical chiefs will be

19 charged with ensuring that all physicians in

20 their programs are made aware of the

21 implications."

22 So Doctor, I take it then that as of

23 March 2005, going back into 2004, there was

24 discussion at the MAC level about adopting a

25 disclosure policy concerning adverse events,

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1 and it would involve physicians?

2 DR. KWAN:

3 A. It was a document, yeah.

4 COFFEY, Q.C.:

5 Q. And that had been talked about for some period

6 of time before March -

7 DR. KWAN:

8 A. Well, this is--yeah, this applies to the

9 entire hospital for all the events that can

10 happen.

11 COFFEY, Q.C.:

12 Q. If you'd look--just go ahead, Doctor, to page

13 23 of the same exhibit, P-0021, the minutes of

14 the next meeting, April--or a meeting of April

15 13th, 2005. Again, you're there, right there,

16 where the cursor is. Business arising,

17 patient disclosure policy, and again, there's

18 a fairly detailed discussion, I take it, or at

19 least a summary of what was discussed here at

20 the time, about how they were moving ahead

21 with this, and it concludes, Doctor, by saying

22 "it was felt that the principles are the same

23 in both policies," because they talked about

24 two different policies, the Health Sciences

25 versus the Medical--the Health Care

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1 Corporation's versus the Newfoundland Medical

2 Board's, which is specific to physicians. "It

3 was felt that the principles are the same in

4 both policies and that both policies support

5 the right of the patients to have information

6 supplied on a timely basis." So as of April

7 13th, 2005, Doctor, at the MAC level, was it

8 generally accepted that that was so, what's

9 stated here in that last sentence? Do you

10 think so?

11 DR. KWAN:

12 A. I can't recall any reason why it shouldn't be.

13 I mean, you know, at the time, it's something

14 that came up in discussions and I don't know.

15 COFFEY, Q.C.:

16 Q. Now Doctor, I'm going to ask you then, when

17 you first heard of the ER/PR problem that's

18 brought us here today, when did you first hear

19 of this?

20 DR. KWAN:

21 A. July 2005, I think.

22 COFFEY, Q.C.:

23 Q. And who from and in what context, Doctor?

24 DR. KWAN:

25 A. Dr. Williams kind of informally talked to me

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1 and said that we have, you know, this and he  
 2 was going to call a meeting, would I mind  
 3 coming.  
 4 COFFEY, Q.C.:  
 5 Q. What did he tell you?  
 6 DR. KWAN:  
 7 A. I mean, I didn't know much until when I got to  
 8 the meeting and they tell us that there were a  
 9 sentinel case and there has been a number of--  
 10 that they have the ER and PR has been altered  
 11 or changed, as been repeated elsewhere and  
 12 changed. I can't remember exactly what the  
 13 details were, and at that time, only a small  
 14 group of patients has been--numbers have been  
 15 returned, so there has been an issue and how  
 16 big the issue was, none of us know at that  
 17 time.  
 18 COFFEY, Q.C.:  
 19 Q. Exhibit P-0925?  
 20 DR. KWAN:  
 21 A. P-0925.  
 22 COFFEY, Q.C.:  
 23 Q. Yes, it'll come up in a second, Doctor.  
 24 DR. KWAN:  
 25 A. Oh, I'm sorry.

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1 COFFEY, Q.C.:  
 2 Q. No, no, that's fine, Doctor. I'm just asking  
 3 the Registrar.  
 4 DR. KWAN:  
 5 A. Okay.  
 6 COFFEY, Q.C.:  
 7 Q. Page three, please. Doctor, this is typed  
 8 version of handwritten notes of Dr. Williams.  
 9 He kept notes and he was kind enough to have  
 10 them transcribed into typing for us. July  
 11 14th, 2005 at five p.m. There's a number of  
 12 attendees at this meeting, Doctors McCarthy,  
 13 Laing, Felix, Cook, Gardiner, yourself, Ms.  
 14 Predham, Ms. Bonnell, Ms. Thomas and Dr.  
 15 Williams, and there's a general background  
 16 given by Dr. Williams. Specific overview by  
 17 Dr. Cook. Issue of results specifically in  
 18 2002, change in '97 to immunoperoxidase  
 19 testing, semi-automated, switched to Ventana  
 20 late March, early April, 2004. Started  
 21 January 2004 training, etcetera. And then  
 22 there are a number of remarks attributed to  
 23 Dr. Laing here, whether she made them or not,  
 24 I can't say, but here they attribute to Dr.  
 25 Laing, "new information, lobular carcinomas

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1 should all be ER/PR positive. At Sloan-  
 2 Kettering went from"--well, this says 75 to  
 3 100 percent positive. There's some debate  
 4 about whether it should have been 95 to 100  
 5 percent, but it went from something to 100.  
 6 Everybody has agreed on that. "Dr. Laing  
 7 requested retesting and a strongly positive  
 8 result. As a result, asked to retest some  
 9 patients. Followed up on a lot of patients  
 10 from 2002. 16 out of 25 on retesting are  
 11 positive. Doing another 38 patients in a  
 12 process, farm out testing outside the  
 13 province. Dr. Cook to get info on who to  
 14 follow up."  
 15 Doctor, is that the meeting you're  
 16 talking about, the first meeting?  
 17 DR. KWAN:  
 18 A. That's the--I can't say for sure, but that  
 19 sounds the right time.  
 20 COFFEY, Q.C.:  
 21 Q. Doctor, there's reference to "lobular  
 22 carcinomas should all be ER/PR positive."  
 23 DR. KWAN:  
 24 A. That's new information at that time, because  
 25 prior to that, we were not aware. Literature

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1 had not really covered that in that extent,  
 2 but literature came out that suggested these  
 3 all should be positive.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, ask you to kind of cast your mind  
 6 back, if you can, to the meeting, okay. For  
 7 you, at the time, any such assertion would  
 8 have been new? The assertion that lobular  
 9 carcinomas should all be ER/PR positive, in  
 10 your experience, that would have been new?  
 11 DR. KWAN:  
 12 A. That would have been new to me at that time,  
 13 yes.  
 14 COFFEY, Q.C.:  
 15 Q. Do you recall who said that at the time?  
 16 DR. KWAN:  
 17 A. No, I can't really. It just came out at that  
 18 time, that kind of actually new information  
 19 and I don't know whether this was, at that  
 20 time, whether because there was a change of  
 21 percentage that called it positive and lobular  
 22 fall into the categories become now positive  
 23 or for some unknown reason, lobular cancer  
 24 have changed over the years. I don't really  
 25 have a good grasp on that.



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1 COFFEY, Q.C.:

2 Q. There is a reference here to Sloan-Kettering.

3 DR. KWAN:

4 A. Yeah.

5 COFFEY, Q.C.:

6 Q. And of course, you had trained decades before

7 at Sloan-Kettering.

8 DR. KWAN:

9 A. Um-hm.

10 COFFEY, Q.C.:

11 Q. Do you recall Sloan-Kettering being mentioned

12 at the meeting?

13 DR. KWAN:

14 A. I'm sorry?

15 COFFEY, Q.C.:

16 Q. Do you recall during that meeting Sloan-

17 Kettering -

18 DR. KWAN:

19 A. Yes, I remember Sloan-Kettering because I

20 think, if I remember right, the sentinel case

21 went to Sloan-Kettering.

22 COFFEY, Q.C.:

23 Q. That was your understanding?

24 DR. KWAN:

25 A. That's my understanding at that time.

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1 COFFEY, Q.C.:

2 Q. Do you recall what your understanding was

3 about--what do you mean by the case went to

4 Sloan-Kettering?

5 DR. KWAN:

6 A. I think a second opinion.

7 COFFEY, Q.C.:

8 Q. Okay, somebody had asked Sloan-Kettering for

9 an opinion?

10 DR. KWAN:

11 A. Asked for a second opinion somewhere. I don't

12 know the details of it. A second opinion was

13 requested from Sloan-Kettering.

14 COFFEY, Q.C.:

15 Q. Do you recall anything else being talked about

16 at Sloan-Kettering or about Sloan-Kettering?

17 DR. KWAN:

18 A. The only thing I can vaguely remember is that

19 the 75 or 70 percent had been bat around

20 because after number of percentage of

21 positivity and tried to look at our own

22 laboratory, whether the percentage of our

23 positive, ER/PR positive, is at any sort of

24 gauge of how accurate we are. You know, if

25 other laboratories are in the same ballpark as

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1 we are, maybe we're not too far.

2 COFFEY, Q.C.:

3 Q. That would be positivity rates overall?

4 DR. KWAN:

5 A. Yeah, right. If you take 100 people and their

6 determinations, if everybody gets 70 percent

7 and we get 70 percent, well, okay, well maybe

8 we're not too far off. But on the other hand,

9 we don't know that. That was just some of the

10 very vague things that we're looking at.

11 COFFEY, Q.C.:

12 Q. Doctor, do you know Dr. Bev Carter?

13 DR. KWAN:

14 A. Yes, I do.

15 COFFEY, Q.C.:

16 Q. We have seen a memo that she wrote to Dr.

17 Cook. It's dated July 14th, 2005, okay, and

18 it proposes a large, very large scale review,

19 okay, and I'll just tell you that, okay, of

20 all breast cancers, ER and PR results,

21 positive and negatives, going back to 1997, up

22 until 2004. I mean, that's what she lays out

23 as a suggestion or an approach that she wants

24 to adopt. Do you ever recall that coming up?

25 DR. KWAN:

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1 A. No, sir.

2 COFFEY, Q.C.:

3 Q. Until I just told you now?

4 DR. KWAN:

5 A. Correct, the first time I heard of it.

6 COFFEY, Q.C.:

7 Q. Okay. So Doctor, in terms of what you learned

8 about what the laboratory was doing concerning

9 to investigate this, you learned through these

10 meetings?

11 DR. KWAN:

12 A. Correct.

13 COFFEY, Q.C.:

14 Q. That would be the way you would be kept

15 apprised of it?

16 DR. KWAN:

17 A. Correct.

18 COFFEY, Q.C.:

19 Q. Here, there's a reference to--and we're just

20 looking at it there. It say 16 of 25 on

21 retesting are positive. It's said in the

22 context that they've looked at a lot of follow

23 up and a lot of patients from 2002.

24 DR. KWAN:

25 A. I would interpret that 25 specimens was sent.

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<p>1 They were all ER negative and 16 converted to 2 positive. That's how I would interpret it. 3 COFFEY, Q.C.: 4 Q. Sure, and that's in fact how everyone here has 5 said what it meant. 6 DR. KWAN: 7 A. Okay. 8 COFFEY, Q.C.: 9 Q. And they were doing another 38 at the time. 10 DR. KWAN: 11 A. Correct. 12 COFFEY, Q.C.: 13 Q. Doctor, as a surgeon who'd been treating 14 patients over the years, in fact, going--you 15 would have treated patients in 2002, what was 16 your reaction to that? 17 DR. KWAN: 18 A. Concerned. 19 COFFEY, Q.C.: 20 Q. And for what reason? 21 DR. KWAN: 22 A. Well, I mean, they are--any laboratory, any 23 results wrong, whether some patients should 24 have been treated or should not have been 25 treated. Not all patients that are positive</p>	<p>1 facet, number of issues that could be account 2 for it. 3 COFFEY, Q.C.: 4 Q. And your understanding, did--at the time, were 5 you given any understanding, at that time, as 6 to what might be the cause or causes? 7 DR. KWAN: 8 A. Well, I think, we were--I think in a 9 subsequent meeting more likely to be is 10 bounding around--I thought about whether this 11 is a test itself, whether it is the 12 technologists? Is it switching of the 13 machines? All these things have to be looked 14 at as a preliminary before we come up to 15 anything more details. 16 COFFEY, Q.C.: 17 Q. Doctor, the 25 that had been retested, you 18 understood, as of July 14th, they were 19 retested where? What was your understanding 20 when you first - 21 DR. KWAN: 22 A. I can't remember. I think it was Mount--I 23 don't know, Mount Sinai or not. We had to 24 look for other places to retest those 25 patients--if I remember, on the second</p>
<p>Page 102</p> <p>1 will require treatment, but on the other hand, 2 one's will be concerned those patients should 3 have got treatment and didn't. 4 COFFEY, Q.C.: 5 Q. Doctor, at the time then, leaving the meeting 6 that day--well, first of all, did you 7 contribute anything to the meeting yourself? 8 DR. KWAN: 9 A. Not really. I was there for information and 10 try to absorb to myself what the problem is 11 and how magnitude the problem. 12 COFFEY, Q.C.: 13 Q. And leaving the meeting, you understood whose 14 responsibility was it to address the problem, 15 investigate it further? 16 DR. KWAN: 17 A. I really can't remember, but on the other 18 hand, we thought that the laboratory would be 19 responsible sending more specimens out to try 20 to delineate how long a period of time that we 21 have and what is the scope of the problems 22 that we are facing, and try to find out, at 23 that very early stage of the game, what is 24 the--where can we find out quickly what the 25 problems are. That could be a number of</p>	<p>Page 104</p> <p>1 meeting, I think it come up where we have to 2 look for a place to do it. 3 COFFEY, Q.C.: 4 Q. And that comes up in a meeting I'm going to 5 refer you to now, but initially when you first 6 showed up, did you have any understanding 7 where the tests - 8 DR. KWAN: 9 A. No, I can't - it was sent away is all I can 10 remember. 11 COFFEY, Q.C.: 12 Q. Exhibit - same exhibit, Doctor, page eight, 13 925, page eight. Again these are Dr. 14 Williams' typed notes. Your name is there. 15 It's a meeting of July 24th, 2005. This time 16 Mr. Tilley is there, Dr. Gardiner, Dr. Laing, 17 Cook, Gulliver, Ms. Bonnell, yourself, Ms. 18 Predham, Ms. Thomas, Dan Boone, and Dr. 19 Williams. Now, Doctor, you would have 20 understood Mr. Boone is who? 21 DR. KWAN: 22 A. I don't know at that time. I would assume 23 later he was a solicitor of some sort, legal 24 professions. 25 COFFEY, Q.C.:</p>

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<p>1 Q. And he first posed an update on the current 2 status and what we know from other centres, 3 and then testing for patients for 2002, 16 of 4 24, 25 of 32, 22 or 23 to come, which would be 5 the conversions at the time, 16 out of 24, 25 6 out of 32.</p> <p>7 DR. KWAN: 8 A. Uh-hm.</p> <p>9 COFFEY, Q.C.: 10 Q. "There may be a problem with methodology or 11 with the lab" and it goes on, "Dr. Laing not 12 worried about the weakly positives. Dr. Laing 13 wants to be sure the new system is accurate 14 and not overly sensitive. Working with Mount 15 Sinai and quality control. Should we test the 16 repeats against the Ventana System. Dr. Laing 17 is databased to capture various types of 18 breast cancers with ER/PR results. Need to 19 wait until we know that our results are valid. 20 Controls are run every day on ER/PR. 21 Pathologist reporting is an issue. Dr. Kwan 22 will need more info. He feels happier at this 23 meeting that a large percentage due to 24 technological change duplicate positive 25 conversions before we report. Get database of</p>	<p>1 what that--and we need database for all the 2 patients that we have retested.</p> <p>3 COFFEY, Q.C.: 4 Q. So, Doctor, I take it then that the impression 5 you had apparently voiced at the time, or at 6 least Dr. Williams indicates you voiced at the 7 time was - well, first of all, you wanted more 8 information?</p> <p>9 DR. KWAN: 10 A. Yes.</p> <p>11 COFFEY, Q.C.: 12 Q. What sorts of other information would you have 13 wanted?</p> <p>14 DR. KWAN: 15 A. It's hard for me to recall so long ago 16 information. I just wanted to know how good 17 Ventana Systems are compared to Ventana System 18 to other institution that similar size, 19 similar testing, what are the negative and 20 positive results from the other places, and 21 are the other places using the same system to 22 have the same problems. That would be gist of 23 it, if I can vaguely remember.</p> <p>24 COFFEY, Q.C.: 25 Q. Doctor, the idea that "you would feel happier</p>
<p>Page 106</p> <p>1 patients retested. Need to check new Ventana 2 System out. Take some of our conversions and 3 send to Montreal General to confirm our 4 results, and need more information, systematic 5 information". The comment attributed to you 6 is right here. What do you recall then, 7 Doctor, about this, about the meeting over all 8 and what's attributed to you?</p> <p>9 DR. KWAN: 10 A. Well, I mean, I can vaguely remember, such a 11 long time ago now, that we are thinking that 12 we have a problem, and I thought that somebody 13 in the meeting said, well, this is probably 14 due to technology changes we have at that 15 time, and if you happy with technology 16 changing, correct that, but if it's something 17 more complex, it will be more difficult to 18 correct, and that's probably what I'm 19 referring to. At least I was at that time 20 given the impression that it may be 21 technological change that we have within the 22 laboratory, but I may be wrong. That was the 23 impression at that time. I don't know what 24 duplicate positive conversion means from Dr. 25 Williams' writing. So I really don't know</p>	<p>Page 108</p> <p>1 at this meeting that a large percentage due to 2 technological change", does that relate to the 3 idea that, well, look, sometimes newer 4 equipment is just better at doing it?</p> <p>5 DR. KWAN: 6 A. Well, it may be, and I think that change in 7 technology - you have new equipment doing 8 things different, and now you get better 9 results than we had before. Maybe Mount Sinai 10 have much better equipment than we have, those 11 I don't know. I mean, and it seems to me that 12 was some sort of topic of that, and if that's 13 so, that is easy to correct.</p> <p>14 COFFEY, Q.C.: 15 Q. Doctor, in the scenario, did anyone tell you 16 that Mount Sinai was using a DAKO machine like 17 the General Hospital used to use back between 18 '97 and '02?</p> <p>19 DR. KWAN: 20 A. That had been mentioned somewhere along the 21 line. That's why we were somewhat concerned 22 about whether Ventana - obvious technical, 23 which I know very little about, but get 24 people's - you know, try to lead me through 25 that. That would be the reason why I thought,</p>

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1 okay, if it is a technological change and not  
 2 issue related to how we do business, maybe it  
 3 is easy to correct.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, the next page of the exhibit is page  
 6 nine. This is a conference call, July 27th,  
 7 2005, 5 p.m. and a number of attendees, a  
 8 longer list, I believe, this time. You're  
 9 there as a participant, and then there's an  
 10 "overview of our data, average 73 percent.  
 11 Dr. Cook gave results of discussion with Dr.  
 12 Walters in Montreal. They will stain, but  
 13 send back here for interpretation. Halifax,  
 14 no info on tested ER/PR. Sloan-Kettering, no  
 15 information. Mayo Clinic don't know their  
 16 rates, no gold standard, worried re: this  
 17 issue, and then a decision to share new  
 18 information as soon as possible when it  
 19 becomes available, meet on a regular basis".  
 20 Doctor, do you recall this meeting?  
 21 DR. KWAN:  
 22 A. This is a telephone call. It's even worse to  
 23 remember a telephone call than you remember  
 24 meetings. The only thing I can tell you is  
 25 that it goes back to what I say, you're

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1 looking at a percentage of 73 percent positive  
 2 rate. We estimated at that time our rate was  
 3 around 70 percent. Then they gave us this  
 4 number of 73 percent of tests were positive.  
 5 Dr. Cook is try to get other hospitals  
 6 percentage of positive, and get some relative  
 7 information as to compare us to, and I think  
 8 that is what he's reporting, we don't have any  
 9 information on those areas.  
 10 COFFEY, Q.C.:  
 11 Q. If we could look, please, at Exhibit P-548.  
 12 Doctor, page two of this--these are George  
 13 Tilley's handwritten notes, and they're dated  
 14 August 1, 2005, for a meeting of Donald Cook,  
 15 Terry Gulliver, Barry Dyer, Bev Carter, Kara  
 16 Laing, Bob Williams, Susan Bonnell, George  
 17 Tilley, Pat Pilgrim, Heather Predham, Joy  
 18 McCarthy and Alan Kwan. Do you recall  
 19 attending a meeting on August 1st, 2005?  
 20 DR. KWAN:  
 21 A. No, sir.  
 22 COFFEY, Q.C.:  
 23 Q. This would be a meeting where the Commissioner  
 24 has heard evidence, okay, of--in fact, Dr.  
 25 Carter has told the Commissioner that there

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1 was a verbal exchange between her, a very  
 2 sharp verbal exchange between her and Mr.  
 3 Gulliver, and if you were there -  
 4 DR. KWAN:  
 5 A. If I was there, I would remember that, but I  
 6 don't remember having a meeting - I don't even  
 7 know what it - the only meeting that I've been  
 8 in to are usually the administration at the  
 9 Health Science and I don't think I've been to  
 10 any other meetings.  
 11 COFFEY, Q.C.:  
 12 Q. So listing your name here doesn't necessarily,  
 13 of course, mean that you were there, but you  
 14 don't recall the -  
 15 DR. KWAN:  
 16 A. I really seriously don't remember that I was  
 17 at a meeting where there is sharp exchanges  
 18 between Bev Carter - I don't even remember  
 19 being present at a meeting between Bev Carter  
 20 and administrative meetings. I remember  
 21 having meeting with at the panel, but not  
 22 there.  
 23 COFFEY, Q.C.:  
 24 Q. Doctor, I'm going to ask you then, Doctor, up  
 25 to this point - up to that point which is the

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1 meeting that we had just looked at - go back  
 2 to - I'm going to go back in a moment to P-  
 3 925, but in the meantime, if I could look,  
 4 please, at Exhibit P-3085. Doctor, this is a  
 5 letter from Dr. Cook to yourself, July 18th,  
 6 2005, The patient's name and information is  
 7 redacted, but he writes, "This patient has  
 8 been previously reported as estrogen receptor  
 9 and progesterone receptor negative. Repeat  
 10 testing on the Ventana Benchmark System  
 11 indicates positive results for both estrogen  
 12 and progesterone receptors", okay. Doctor, do  
 13 you recall receiving this?  
 14 DR. KWAN:  
 15 A. I probably did, but without a name, it's not  
 16 possible for me to verify that. I mean, it's  
 17 addressed to me, and I probably did.  
 18 COFFEY, Q.C.:  
 19 Q. And, Doctor, this is July 18th - if we could  
 20 then bring up 925 again, please. 925, please  
 21 I apologize. Thank you. Go back to page  
 22 three of it, it's July 14th, the first  
 23 meeting, and you're listed as an attendee.  
 24 DR. KWAN:  
 25 A. Right.

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1 COFFEY, Q.C.:

2 Q. So four days later, it's a letter at least

3 dated four days later.

4 DR. KWAN:

5 A. Uh-hm.

6 COFFEY, Q.C.:

7 Q. Referring to a patient whose ER/PR results

8 went from negative to positive, and then on

9 the--look at page eight of the exhibit, by

10 July 24th, again you're at a meeting, a larger

11 meeting with a number of individuals. I took

12 you through that. I apologize, on July 27th,

13 this conference call.

14 DR. KWAN:

15 A. Uh-hm.

16 COFFEY, Q.C.:

17 Q. Which you are indicated to have participated

18 in. Would this then, looking at 3085, would

19 that be the first patient you would have been

20 asked to deal with, 3085, because it's just

21 because of the time frame?

22 DR. KWAN:

23 A. I would assume this was--in this letter he

24 said repeating test on Ventana Benchmark

25 System. Does that mean they would send it out

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1 or was it did ourself?

2 COFFEY, Q.C.:

3 Q. Ventana was being done locally.

4 DR. KWAN:

5 A. Locally. So, I mean, I just assumed that

6 there was a change they did locally - I was

7 looking at this and there was a change. Now,

8 I may have heard back then, as you know, there

9 are problems, so it didn't came as a surprise

10 to me when it come that.

11 COFFEY, Q.C.:

12 Q. As a surgeon at the time in the middle of

13 July, 2005, what, if anything - you had

14 understood, I take it, that this was being

15 sent to you by Dr. Cook because he expected

16 you to do something?

17 DR. KWAN:

18 A. I would suspect he notify me and I would have

19 to take actions if I think it is appropriate.

20 I wouldn't--you know, getting something like

21 that, I would first take out the patient's

22 chart and find out what's happening and what's

23 exactly going on with that particular patient.

24 COFFEY, Q.C.:

25 Q. Doctor, then - up then to the end of July,

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1 2005, you had attended a number of meetings?

2 DR. KWAN:

3 A. Yes.

4 COFFEY, Q.C.:

5 Q. We looked at them.

6 DR. KWAN:

7 A. Right.

8 COFFEY, Q.C.:

9 Q. There were three of them, attended two, and

10 may have been on the phone with one.

11 DR. KWAN:

12 A. That's true.

13 COFFEY, Q.C.:

14 Q. What was your understanding of why you were

15 there at all?

16 DR. KWAN:

17 A. I presume it's my involvement in breast cancer

18 management over the years, my interest in the

19 progesterone and estrogen receptors back in

20 the 70s, good friend of Bob Williams, and have

21 spoken to him in cancer care deliveries in

22 system, being the previous director at the

23 Cancer Clinic, and Dr. Carter was there as the

24 Director of the Cancer Clinic at that time. I

25 don't really know, you'll have to ask Dr.

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1 Williams that, but presumably that's -

2 COFFEY, Q.C.:

3 Q. I appreciate why from his perspective why he

4 asked you. I mean, we can ask him that, but

5 I'm asking about - you were asked to attend,

6 you did attend, and I'm just asking you to, as

7 best you can, tell the Commissioner what your

8 understanding was at the time of the role that

9 you were expected to play, what you were

10 bringing?

11 DR. KWAN:

12 A. My experience as a surgeon and experience in

13 previous treatment of breast cancer, in

14 general. It may not be specifically estrogen

15 receptor or chemotherapy, but certainly in

16 general.

17 COFFEY, Q.C.:

18 Q. Now, Doctor, looking at this Exhibit 3085

19 that's on the screen there, on July 18th, or

20 whatever day after that you would have

21 received this, you've indicated that - well,

22 the first thing you'd do is get out the

23 patient's chart and see what the status of the

24 patient is at that point in time, okay. As

25 the recipient of that letter, would you have

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1 understood that you were expected to notify  
 2 the patient about the change in result?  
 3 DR. KWAN:  
 4 A. I would look at the situation and who's on the  
 5 care of the patient at that time. I may not  
 6 have seen this patient for God knows how long.  
 7 What I would do is find that out, and who is  
 8 looking after the patient, and transfer the  
 9 information to the individual who is looking  
 10 after that patient, or if the patient have  
 11 received appropriate treatment, this thing has  
 12 not become an issue, then would just notify  
 13 them they have no treatment change, or at  
 14 least in my opinion there is no treatment  
 15 change, or - but whatever the local condition  
 16 and situation of the patient and take it from  
 17 there, you know. It's hard to really second  
 18 guess or predict or make plans without not  
 19 knowing more details.  
 20 COFFEY, Q.C.:  
 21 Q. Sure, and I appreciate--what I'm getting at,  
 22 Doctor, is this, as the recipient of this, did  
 23 you understand that you, or someone on your  
 24 behalf, was supposed to let the patient know  
 25 about the change?

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1 DR. KWAN:  
 2 A. Right.  
 3 COFFEY, Q.C.:  
 4 Q. So it was -  
 5 DR. KWAN:  
 6 A. I would find out the situation and talk to  
 7 them.  
 8 COFFEY, Q.C.:  
 9 Q. So the notion of not telling the patient at  
 10 that point -  
 11 DR. KWAN:  
 12 A. No.  
 13 COFFEY, Q.C.:  
 14 Q. Would that have crossed your mind at all?  
 15 DR. KWAN:  
 16 A. No, I would--I mean, sometimes these patients  
 17 I haven't seen for a number of times, so I  
 18 would get whoever to do that.  
 19 COFFEY, Q.C.:  
 20 Q. And I appreciate there might be a problem  
 21 tracking the patient down and getting in  
 22 contact with them and so on. I understand  
 23 that, and the Commissioner would certainly  
 24 understand that too, but from your own  
 25 perspective, receiving such a letter about a

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1 change in status from the clinical chief of  
 2 laboratory medicine -  
 3 DR. KWAN:  
 4 A. Well, the first important thing is to find out  
 5 if the patients need any treatment altered.  
 6 COFFEY, Q.C.:  
 7 Q. Yes, and whether they need it altered or not,  
 8 would you still tell the patient about the  
 9 change?  
 10 DR. KWAN:  
 11 A. Tell the patients the changes, yes.  
 12 COFFEY, Q.C.:  
 13 Q. Okay.  
 14 THE COMMISSIONER:  
 15 Q. Excuse me, Mr. Coffey, but once again it's one  
 16 of those while it's in my head, Dr. Kwan, you  
 17 seem to have become part of a group of  
 18 individuals who met on a greater or lesser  
 19 regular basis. Did you look at yourself as  
 20 being part of a group who were performing a  
 21 role, or how did you view these meetings?  
 22 DR. KWAN:  
 23 A. I personally look at it as a resource person  
 24 at that time.  
 25 THE COMMISSIONER:

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1 Q. Uh-hm.  
 2 DR. KWAN:  
 3 A. You know, I don't look at myself as a  
 4 significant expert in estrogen receptor  
 5 determination, not after 30 years when I  
 6 haven't done it myself, and  
 7 immunohistochemistry straining which I'm no  
 8 longer - I have never been an expert. So I  
 9 look at myself as a resource person in terms  
 10 of breast cancer as cancer management. That  
 11 would be what my assumed role was when I look  
 12 at it then.  
 13 THE COMMISSIONER:  
 14 Q. And did you see yourself as being part of a  
 15 group with perhaps other people with other  
 16 things to contribute or - I just -  
 17 DR. KWAN:  
 18 A. Yeah, everybody -  
 19 THE COMMISSIONER:  
 20 Q. Somebody was calling meetings from time to  
 21 time and there seemed to be people who were  
 22 turning up at just about every meeting, so  
 23 after a while, did you figure that you were  
 24 part of the group that were dealing with the  
 25 ER/PR?

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1 DR. KWAN:  
 2 A. I personally need information. That would be  
 3 my personal - I need variable source that I  
 4 can get information for myself, what's  
 5 happening.  
 6 THE COMMISSIONER:  
 7 Q. Uh-hm.  
 8 DR. KWAN:  
 9 A. And often - and what I think the overall, and  
 10 like any practising physician, like, Dr. Felix  
 11 was there, and Dr. Gardiner, so other people  
 12 offering their resources as the resource  
 13 person.  
 14 THE COMMISSIONER:  
 15 Q. So this was a two way thing from your  
 16 perspective. Am I reading it right?  
 17 DR. KWAN:  
 18 A. Correct.  
 19 THE COMMISSIONER:  
 20 Q. You might be a resource person to Dr. Williams  
 21 and others who might be seeking your  
 22 perspective based on your experience, but by  
 23 the same token, you wanted information?  
 24 DR. KWAN:  
 25 A. Correct, I wanted information as what is

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1 happening.  
 2 THE COMMISSIONER:  
 3 Q. What was happening and to figure out the  
 4 impact presumably on your own patients?  
 5 DR. KWAN:  
 6 A. Correct.  
 7 THE COMMISSIONER:  
 8 Q. Okay. Mr. Coffey, it's getting about break  
 9 time, in any event, so wherever you can find a  
 10 place to break.  
 11 COFFEY, Q.C.:  
 12 Q. While I'm on the point of your role, Doctor,  
 13 if we could bring up Exhibit P-0544. Doctor,  
 14 this is an e-mail from Sharon Hopkins, August  
 15 3rd, 2005, to Dr. Cook and Ms. Predham. The  
 16 subject is notes, meeting with Kwan/Williams,  
 17 and she writes, "Dr. Williams asked that I  
 18 forward these notes for your info", and then  
 19 on page two of the exhibit is a typed account  
 20 of a meeting between yourself and Dr.  
 21 Williams, August 2nd, 2005, and there are 11  
 22 topics here listed. It says, "Send out  
 23 critical test a.s.a.p. when identified. Do  
 24 everything to get our Ventana System up to par  
 25 so we can do the test here reliably; get

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1 standard samples up and running so that we can  
 2 have tests certified as accurate; three,  
 3 extrapolate change over all the patients;  
 4 four, monitor our results continuously with an  
 5 outside lab; five, how do other centres report  
 6 for pathology, do they report on controls;  
 7 six, need to have outside review of the ER/PR  
 8 reception testing - need to look at whole  
 9 immunohistochemistry system; seven, need to  
 10 consult with all the pathologists in the  
 11 organization, Dr. Cook has already done;  
 12 eight, Dr. Kwan feels we should send out  
 13 information to patients whose test results  
 14 change; nine, schedule extra clinics for  
 15 oncologists to see patients; ten, meet with  
 16 oncologists; eleven, breast tumours are multi-  
 17 clonal". Doctor, do you recall this meeting?  
 18 DR. KWAN:  
 19 A. Yes, vaguely. This is a meeting that actually  
 20 come up after I went to see Dr. Williams for  
 21 another different issue, and at the end of the  
 22 meeting which I see him the issue was very  
 23 short, and he sat me down and said, look, you  
 24 know, let's talk about something else, and  
 25 that's what happened, and I didn't realize

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1 take notes.  
 2 COFFEY, Q.C.:  
 3 Q. And here you are today.  
 4 DR. KWAN:  
 5 A. Uh-hm..  
 6 COFFEY, Q.C.:  
 7 Q. Doctor, can you tell the Commissioner, please,  
 8 then looking at this, "Send out critical test  
 9 a.s.a.p. when identified", I take it that's  
 10 the notion of tests that readily apparent,  
 11 that it could have an acute effect on the  
 12 patient?  
 13 DR. KWAN:  
 14 A. Well, that's critical test, I would presume it  
 15 is remember, apply to patients on treatment,  
 16 you know, ongoing treatments, and probably  
 17 should have it tested quickly so that if they  
 18 need to be changed, we--you know, so we can  
 19 have those information back.  
 20 COFFEY, Q.C.:  
 21 Q. And "do everything to get our Ventana test  
 22 up".  
 23 DR. KWAN:  
 24 A. We still had faith at that time.  
 25 COFFEY, Q.C.:

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1 Q. In fact, because - did you understand, Doctor,  
 2 that in the meantime, that Ventana machine was  
 3 being used for all other IHC except ER/PR?  
 4 DR. KWAN:  
 5 A. No.  
 6 COFFEY, Q.C.:  
 7 Q. Did you have any understanding on that?  
 8 DR. KWAN:  
 9 A. No, I didn't.  
 10 COFFEY, Q.C.:  
 11 Q. What did you understand then about the Ventana  
 12 machine?  
 13 DR. KWAN:  
 14 A. I know nothing about it except it's a  
 15 commercial available machine to do all the  
 16 stuff for us.  
 17 COFFEY, Q.C.:  
 18 Q. And "Extrapolate change over all the  
 19 patients", do you know what that's about,  
 20 Doctor?  
 21 DR. KWAN:  
 22 A. I don't know.  
 23 COFFEY, Q.C.:  
 24 Q. "Monitor results continuously with an outside  
 25 lab. How do other centres report for

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1 pathology, do they report on controls?" Did  
 2 that come up?  
 3 DR. KWAN:  
 4 A. I think that's because some discussions in one  
 5 of the meetings that whether you can--you  
 6 probably picked it up in one of the pathology  
 7 or some say they are controls are positive,  
 8 other didn't mention any controls at all.  
 9 COFFEY, Q.C.:  
 10 Q. Yes.  
 11 DR. KWAN:  
 12 A. So that was picked up at the time and I think  
 13 that we should report controls and see what  
 14 other laboratories does report controls or  
 15 not.  
 16 COFFEY, Q.C.:  
 17 Q. So you thought that they should -  
 18 DR. KWAN:  
 19 A. You know, I thought the controls should be  
 20 reported, but then we don't know whether other  
 21 laboratories do that, because I'm not a  
 22 pathologist, I'm not, you know, reporting  
 23 those things, so I needed--I suggested, well,  
 24 we check other laboratories, whether they are  
 25 reporting that or not.

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1 COFFEY, Q.C.:  
 2 Q. Before this arose in July of 2005 had you ever  
 3 noticed that sometimes some pathology reports  
 4 would refer to controls and sometimes they  
 5 wouldn't?  
 6 DR. KWAN:  
 7 A. I didn't pay attention to that.  
 8 COFFEY, Q.C.:  
 9 Q. Pay attention. When it came up in July of  
 10 2005 you decided it should be -  
 11 DR. KWAN:  
 12 A. The subsequently you start paying attention to  
 13 those things, yes.  
 14 COFFEY, Q.C.:  
 15 Q. And "Need to have outside review of ER/PR  
 16 reception testing. Need to look at whole  
 17 immunohistochemistry system." The idea of  
 18 looking at the whole system, was that your -  
 19 DR. KWAN:  
 20 A. No, I think it's Dr. Williams, but he probably  
 21 know more about the immuno system than I do at  
 22 that time or know more of the inside of it  
 23 than I do.  
 24 COFFEY, Q.C.:  
 25 Q. And "Dr. Kwan feels we should send out

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1 information to patients whose test results  
 2 change." So did you express that to him at  
 3 the time?  
 4 DR. KWAN:  
 5 A. I mean, he said it that way, presumably I  
 6 have.  
 7 COFFEY, Q.C.:  
 8 Q. What was your feeling at the time on that,  
 9 Doctor? This is August 2nd, 2005.  
 10 DR. KWAN:  
 11 A. My feeling, an overall feeling of the  
 12 situation is, yes, they should be informed  
 13 like everybody who had--I also have the  
 14 feelings that to tell the patient that your  
 15 test change and not to be able to tell them  
 16 what can be done about those test changes is  
 17 another issue that we had to grapple with and  
 18 to have to understand. If I tell somebody  
 19 that "Your test changed" now and you ask me,  
 20 of course the next question they will ask me  
 21 as a physician is that "How does that affect  
 22 me?" And now answer is "I don't know," which  
 23 is little bit difficult. And "How long do I  
 24 know?" I say, "I don't know" again. "How long  
 25 does it take you to find out?" I say, "I



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<p>1 don't know" again. That would be a little 2 difficult in, to the patients. I'm not saying 3 they should be sent--the information be told, 4 but on the other hand we should make 5 preparation to find out whether we could or 6 could not be able to--what can be changed or 7 can be done from the physician's standpoint, 8 from medical treatment standpoints. 9 COFFEY, Q.C.: 10 Q. "Schedule extra clinics for oncologists to see 11 the patients." 12 DR. KWAN: 13 A. That's comes after because I figure that with 14 that we don't have any regular route of 15 explaining to patients, patient will need to-- 16 will want to see somebody very quickly. 17 COFFEY, Q.C.: 18 Q. Yes. 19 DR. KWAN: 20 A. That would be that's what follows on that. 21 Because at that time we have not make any 22 decision of how to address the issue. It's 23 just a question that I felt that these 24 patients need to be at least to be advised at 25 what medical treatment can remedy the change</p>	<p>1 what it is, you can sort of mentally figure 2 out that should be a significant number. 3 COFFEY, Q.C.: 4 Q. And now the 40 percent, of course, hadn't been 5 arrived at by then, but you had seen 16 to 25? 6 DR. KWAN: 7 A. We seen two batches. 8 COFFEY, Q.C.: 9 Q. And 25 out of 32 are, roughly? 10 DR. KWAN: 11 A. Two batches. 12 COFFEY, Q.C.: 13 Q. So if that was consistent into the future, 14 there were going to be an awful lot of 15 patients? 16 DR. KWAN: 17 A. Correct. That was the concern. 18 COFFEY, Q.C.: 19 Q. And then the reference to "Meet with 20 oncologists"? 21 DR. KWAN: 22 A. That's Dr. Williams. 23 COFFEY, Q.C.: 24 Q. Dr. Williams. And the "breast tumours are 25 multiclone" is that your -</p>
<p>Page 130</p> <p>1 or is there--how that going to impact or 2 affect them. 3 COFFEY, Q.C.: 4 Q. So at that point in time it was thought or the 5 approach would be that the patients would see 6 individual oncologists to be dealt - 7 DR. KWAN: 8 A. That was, well, we just thought that, you 9 know, we thought that if that happen, it will-- 10 they will need more time and we--that they 11 are all tied up doing all kinds of treatment 12 at the moment and that was the thought. 13 COFFEY, Q.C.: 14 Q. The idea of scheduling extra clinics for 15 oncologists? 16 DR. KWAN: 17 A. To see those patients, if necessary. We still 18 have to do that. 19 COFFEY, Q.C.: 20 Q. Now, Doctor, at that point, August 2nd, 2005, 21 did you have any understanding at the time 22 that there would probably be a lot of patients 23 that would have to be re-seen? 24 DR. KWAN: 25 A. From what we know of the 40 conversion rate,</p>	<p>Page 132</p> <p>1 DR. KWAN: 2 A. I think it's trying to explain to Dr. Williams 3 why somebody is negative and why somebody is 4 positive, why the percentages like, it's more, 5 you know, try to explain to how to interpret 6 them. 7 COFFEY, Q.C.: 8 Q. In fact, you had some familiarity with that 9 because you had been involved research going 10 all the way back to the '70s? 11 DR. KWAN: 12 A. That's a long time ago. 13 COFFEY, Q.C.: 14 Q. Yes. But you did have some basic 15 understanding of it more so than perhaps many 16 surgeons would? 17 DR. KWAN: 18 A. Probably. 19 COFFEY, Q.C.: 20 Q. Yeah. Commissioner, thank you. 21 THE COMMISSIONER: 22 Q. We'll take 15 minutes. 23 (RECESS) 24 THE COMMISSIONER: 25 Q. Mr. Coffey?</p>

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Thank you, Commissioner. Registrar, could you</p> <p>3 bring up, please, Exhibit P-1287? Doctor,</p> <p>4 just looking at the second page of this, it's</p> <p>5 a memo of Dr. Khalifa to all Newfoundland</p> <p>6 pathologists, February 16th, 1998. The</p> <p>7 reference is "Reporting of estrogen and</p> <p>8 progesterone receptor immunohistochemical</p> <p>9 results." And this is a memo where Dr.</p> <p>10 Khalifa advises pathologists throughout</p> <p>11 Newfoundland about kind of the history of his</p> <p>12 introduction of IHC, ER/PR, the process that</p> <p>13 he's followed. And he refers to "We will be</p> <p>14 now ready to move into the next two and final</p> <p>15 phases. Phase 2 will be each pathologist will</p> <p>16 be asked to report results of his or her own</p> <p>17 case as indicated by the brown staining of</p> <p>18 nuclei of the invasive neoplastic cells and</p> <p>19 that will start March 1, '98." And he then--</p> <p>20 attached, he continues on with saying,</p> <p>21 "Attached please find a proposal for uniform</p> <p>22 reporting of ER/PR immunohistochemical</p> <p>23 staining. This proposal was discussed with</p> <p>24 many of my colleagues, who mostly agreed with</p> <p>25 its content and accepted it as a policy. As I</p>	<p>1 examples. Now, Doctor, would you have seen</p> <p>2 that memo back in 1998?</p> <p>3 DR. KWAN:</p> <p>4 A. No, sir.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. You wouldn't. This is the point where he's</p> <p>7 moving from, the whole system is moving from</p> <p>8 the biochemical reporting. And you would have</p> <p>9 been familiar with the way the biochemistry</p> <p>10 reported?</p> <p>11 DR. KWAN:</p> <p>12 A. Correct.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Their testing, to IHC testing for ER/PR. As a</p> <p>15 surgeon in St. John's at the time, this being</p> <p>16 early in, well, '97 into 1998, because Dr.</p> <p>17 Khalifa had been in the meantime reporting</p> <p>18 cases himself individually, how did you know</p> <p>19 or how did you approach how you would then</p> <p>20 interpret these new sorts of reports compared</p> <p>21 to the biochemical, which is a different--uses</p> <p>22 a different numbering system entirely?</p> <p>23 DR. KWAN:</p> <p>24 A. This will be things that I interpret from him</p> <p>25 is that they will be interpreting with these</p>
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<p>1 encourage you to adopt the attached proposal</p> <p>2 in your reporting to maintain uniformity, it</p> <p>3 should be clearly stated that this is only a</p> <p>4 proposal." He talks about there are a lot of</p> <p>5 publications available to be consulted. And</p> <p>6 then in the fourth page of the exhibit, third</p> <p>7 page of his memo, "Proposal for uniformed</p> <p>8 reporting of ER/PR immunohistochemical</p> <p>9 assessment. February, 1998." He talks about</p> <p>10 "The report of a hormone receptor status will</p> <p>11 have three components. The first component, a</p> <p>12 statement of whether the stain is positive or</p> <p>13 negative. Positivity is defined by nuclear</p> <p>14 staining detected in any number of malignant</p> <p>15 cells. The second component is a rough</p> <p>16 estimate of the percentage of the immuno</p> <p>17 reactive cells in the section examined. This</p> <p>18 estimate could be a form of a range or a fixed</p> <p>19 number, as listed in parenthesis. And a third</p> <p>20 component is a comment regarding only ER and</p> <p>21 not PR immuno reactivity and is only to be</p> <p>22 included if, in the report of a small</p> <p>23 percentage of neoplastic cells from one to</p> <p>24 thirty percent is positive." And he's got the</p> <p>25 comment there and he's got two different</p>	<p>1 positive, negatives, and report it to us as</p> <p>2 positive or negative. It's not--because I</p> <p>3 don't look at the slides so I would not be</p> <p>4 able to make any judgment as to positive,</p> <p>5 negativities and they will be reporting this</p> <p>6 as positive or negative to us and we will take</p> <p>7 their interpretations.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. And the percentage, what if any significance</p> <p>10 did that have at that time?</p> <p>11 DR. KWAN:</p> <p>12 A. Well, I would think that I would leave it</p> <p>13 that, as I say, they would be either positive,</p> <p>14 they interpret the literature at that time,</p> <p>15 what the pathological--what the pathology</p> <p>16 literature would suggest which is positive or</p> <p>17 negative and they will have to, they would</p> <p>18 interpret that for us. You know, they could,</p> <p>19 at most times it would be 30 percent or ten</p> <p>20 percent or whatever the literature changes and</p> <p>21 depending on the techniques or the staining</p> <p>22 they do. And as I say, I think that they will</p> <p>23 be interpreted that.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. Did the percentage have any significance to</p>

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1 you?

2 DR. KWAN:

3 A. Means very little. If the report is a

4 positive, I will take the, you know, their

5 interpretation for it because they have the

6 better expertise in that than I do.

7 THE COMMISSIONER:

8 Q. Dr. Kwan, I just want to make sure I

9 understood the point you were making. And I

10 take you to be saying that in respect of ER/PR

11 testing, you rely on the pathologist to

12 consult the literature and determine what

13 percentage is positive or negative, given the

14 literature of the moment?

15 DR. KWAN:

16 A. Correct.

17 THE COMMISSIONER:

18 Q. And that as the treating physician during the

19 period of time when you would have been the

20 treating physician, I recognize that now this

21 information probably goes on to a medical

22 oncologist rather than to you?

23 DR. KWAN:

24 A. Probably 1970--1998, at that time I probably

25 won't be treating most of the patients by

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1 then.

2 THE COMMISSIONER:

3 Q. Okay. This transfer of patients into the

4 oncologists would have started prior to -

5 DR. KWAN:

6 A. It started prior to that. As the number of

7 medical oncologists increases, as I--if I

8 remember right, since I leave--since I ceased

9 being the director at the cancer clinic at

10 that time, I don't go back to treat

11 chemotherapy very much more and as number of

12 medical oncology increases and I transfer most

13 of those responsibilities to them.

14 THE COMMISSIONER:

15 Q. Okay. And that the ceasing to be the director

16 of the cancer clinic was again when?

17 DR. KWAN:

18 A. It was 1992.

19 THE COMMISSIONER:

20 Q. '92.

21 DR. KWAN:

22 A. I mean, it's not immediately I ceased to do

23 so, but as it progresses over the next several

24 years.

25 THE COMMISSIONER:

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1 Q. Thank you.

2 COFFEY, Q.C.:

3 Q. Now, Doctor, we have seen, we've seen many

4 pathology reports here, redacted versions, but

5 we've seen many of them. Some of them did

6 have or did adopt the approach that Dr.

7 Khalifa advocated, which is to give a number

8 for ER, percentage number or a range for

9 percentages for ER and for PR and include this

10 comment that's right there. Now, at the time

11 if, say in 1998 or 1999, if you got a report

12 saying 20 percent, for example, here, or use

13 example two, "Estrogen receptors positive, one

14 to five percent of cells. Please see comment.

15 Progesterone receptors, negative, zero percent

16 of cells." and saw that comment, how did you,

17 at the time interpret this as to the status?

18 DR. KWAN:

19 A. If this one I would consider as negative.

20 COFFEY, Q.C.:

21 Q. And why is that?

22 DR. KWAN:

23 A. Because if they state it's 30 percent cells in

24 there, saying that it would be positive only

25 up to 30 percent, any less than 30 percent, if

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1 I interpret it, it would be considered

2 negative at that time. So is the patient's

3 estrogen receptor status at one to five

4 percent, it will fall into the negative

5 category. Now, they basically say the same

6 thing except I have to interpret. If they

7 don't say the 30 percent on the bottom line,

8 I'd say a lot of people wouldn't know how to

9 interpret it.

10 COFFEY, Q.C.:

11 Q. And that's what I wanted to ask you about. If

12 they didn't--if they had the same thing there,

13 it was identical but there was no comment?

14 DR. KWAN:

15 A. I don't know anybody--not too many people

16 would know how to interpret it. I may know

17 but on the other hand, you know, a lot of

18 people may not know how to interpret it.

19 COFFEY, Q.C.:

20 Q. Now, why might you know?

21 DR. KWAN:

22 A. Just because I have communication with the

23 oncologists very often.

24 COFFEY, Q.C.:

25 Q. And in terms of, for example, that, in 1998,

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<p>1 if there was no comment here and a person fell 2 into this category, one to five percent and 3 zero percent, they would have been treated for 4 hormonal therapy as being what? 5 DR. KWAN: 6 A. They wouldn't be treated, we got negative. 7 COFFEY, Q.C.: 8 Q. Negative. They would have been classified as 9 negative? 10 DR. KWAN: 11 A. They were classified negative. If they 12 treated that, they will be on the outlying-- 13 I'm not saying they shouldn't be treated, but 14 it's outlying. 15 COFFEY, Q.C.: 16 Q. Doctor, we've heard references to 30 percent 17 for ER, anything under 30 being considered 18 negative up until the end of 2000, into 2001, 19 even continuing maybe into 2002. What's your 20 recollection of how that worked? I mean, you 21 worked here in St. John's. I appreciate by 22 that point you wouldn't have been being the 23 primary follow-up physician for very many 24 people, but what was your understanding at the 25 time?</p>	<p>1 Q. Okay. 2 DR. KWAN: 3 A. Oh, yes and no. I mean, they did mention 4 there is a change, but I don't think anybody 5 talked about why there is a change. 6 COFFEY, Q.C.: 7 Q. Did anyone in the summer of 2005 or the early 8 fall of 2005 ever ask you for your views as to 9 what the cutoff should be? 10 DR. KWAN: 11 A. No, sir. 12 COFFEY, Q.C.: 13 Q. To determine--you know what I'm talking about 14 here in 2008 - 15 DR. KWAN: 16 A. No, sir. 17 COFFEY, Q.C.: 18 Q. - but at the time no one ever - 19 DR. KWAN: 20 A. The literature would accept that. That's not 21 up to any one of us to determine. 22 COFFEY, Q.C.: 23 Q. Well, Dr. Cook and others did decide as to 24 what cutoffs were or - 25 DR. KWAN:</p>
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<p>1 DR. KWAN: 2 A. I probably won't be following the literature 3 that closely at that time because I won't be 4 doing very many of them. And I interpret it 5 is that the literate is changing in terms of 6 whether the percentage of cell positive is 7 considered positive. That may be due to a 8 number of reasons, and probably due to 9 technological changes, that cells are being 10 recognized or that we are now accepting a 11 lower percentage of response rate as being 12 positive. Like, if you think that 30 percent 13 give you 90 percent chance of responding to 14 hormone receptors, maybe now the literature is 15 accepting 70 percent as being a positive 16 response. So I really don't have a clear 17 answer to that, but on the other hand it is 18 universally accepted as a change. 19 COFFEY, Q.C.: 20 Q. Now, did that come up in any of these 21 discussions, group discussions that you 22 participated in in 2005? 23 DR. KWAN: 24 A. No, sir. 25 COFFEY, Q.C.:</p>	<p>1 A. Presumably they base it on what - 2 COFFEY, Q.C.: 3 Q. Yeah. But I'm asking you is, is were you ever 4 asked for your input - 5 DR. KWAN: 6 A. No, sir. 7 COFFEY, Q.C.: 8 Q. - amongst the discussion about like we'll use 9 January 1, 2001 or January 1, 2002 or things 10 like that? 11 DR. KWAN: 12 A. No, sir. 13 COFFEY, Q.C.: 14 Q. Okay. Did you overhear any discussion about 15 what the cutoff should be? 16 DR. KWAN: 17 A. No, sir. 18 COFFEY, Q.C.: 19 Q. And then if we could just go back then to P- 20 3085? Doctor, this is that letter of July 18, 21 2005. So here Dr. Cook is in the middle of 22 July has written to you saying that "This 23 patient previously reported as ER/PR negative. 24 Repeat testing indicates positive for both." 25 For your purposes, I take it, that sufficed in</p>

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<p>1 terms of making--if there was going to be 2 treatment - 3 DR. KWAN: 4 A. That has a change. I mean, this is telling me 5 that whatever mechanism he interpreted, the 6 estrogen receptor status now has changed. 7 COFFEY, Q.C.: 8 Q. Okay. 9 DR. KWAN: 10 A. That's all I can interpret from those two 11 sentences. 12 COFFEY, Q.C.: 13 Q. And but how positive is positive here, like, 14 the percentages? 15 DR. KWAN: 16 A. He would have look at those numbers, concluded 17 that these are positive changes and tell me 18 it's a positive change. 19 COFFEY, Q.C.: 20 Q. And for your purposes in approaching the 21 patient, the difference between if, for 22 example, I'll just use a figure, 20 percent 23 was considered positive, anything greater than 24 10 was positive, so if it was 20 or 90, from 25 your perspective as -</p>	<p>1 A. I would hope--I have nobody told me who 2 addressed it, but I assume administration 3 would be addressing it. 4 COFFEY, Q.C.: 5 Q. Were you ever asked, Doctor, for any--your own 6 views or input into or on the issue of whether 7 patients should be told they were being 8 retested? 9 DR. KWAN: 10 A. After the meeting Dr. Williams and I had, 11 nobody asked me specifically. 12 COFFEY, Q.C.: 13 Q. And whether they asked you at all, 14 specifically? 15 DR. KWAN: 16 A. Nobody asked me at all, no. 17 COFFEY, Q.C.: 18 Q. Were you aware of any decisions that had been 19 made in that regard? 20 DR. KWAN: 21 A. No, sir. 22 COFFEY, Q.C.: 23 Q. So, Doctor, after that meeting of August 2nd 24 with Dr. Williams, the one where he sat you 25 down in his office, kind of lured you in and</p>
<p>Page 146</p> <p>1 DR. KWAN: 2 A. If it's positive, from my perspective as a 3 clinician is that this patient warrants 4 treatment. 5 COFFEY, Q.C.: 6 Q. Consideration for, yes. 7 DR. KWAN: 8 A. Consideration for treatment. If they are 9 positive, they should, negative, it may not 10 be. So that's only basis I use, I can 11 determine on. 12 COFFEY, Q.C.: 13 Q. Exhibit P-0729, please? Doctor, this takes us 14 to the end of September, 2005. In the summer 15 then of 2005 you understood then by the end of 16 the summer what was going on with ER/PR? 17 We'll get--this deals with a letter from Dr. 18 Cook, I'll get to this in a moment. But I'm 19 just asking you then by Labour Day, Doctor, 20 what did you understand was going on? 21 DR. KWAN: 22 A. 2005 is I vaguely remember we got a problem. 23 COFFEY, Q.C.: 24 Q. Okay, and who was addressing it? 25 DR. KWAN:</p>	<p>Page 148</p> <p>1 sat you down and spoke to you, your next 2 involvement, did you have any further 3 involvement with this group that you recall? 4 DR. KWAN: 5 A. Well, after leaving the office, I guess this 6 must be August the 2nd or something of that 7 nature, after leaving the office and 8 summertime maybe I'm on holidays, and I 9 thought about the problems. My concern is 10 still at that time what should we tell, how 11 should be--what is the medical issues in terms 12 of how to correct the problems that has been 13 resulted from the estrogen, progesterone 14 results change, is there any information out 15 there we can base on, what can we offer these 16 patients. I spent a lot of time thinking 17 about it and I don't come up with a good 18 answers as to what we can--should these 19 patients get treatment, should these patients 20 stop treatment? There's so many complex 21 issues related to history of the individual 22 that I cannot--none of us could make a blanket 23 statement. So I thought about it and I think-- 24 I can't remember exactly when, probably into 25 September, I went to talk to Dr. Kara Laing</p>

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1 about this.

2 COFFEY, Q.C.:

3 Q. Go ahead and tell the Commissioner about that?

4 DR. KWAN:

5 A. And thought that I am--what does she think

6 about any particular they offer to them and

7 she quoted some--one of these article I think

8 we came across and I said, "How do we go

9 about", you know, I think the best thing we

10 came up with at that time, I said, "What do

11 you think about having a panel review all

12 these patients?" And so none of us will--I

13 mean, none of us ever had the full

14 understanding of because no precedent to help

15 us as to what to decide what to do, and so I

16 made that proposal.

17 COFFEY, Q.C.:

18 Q. And who did you make that to?

19 DR. KWAN:

20 A. Dr. Williams.

21 COFFEY, Q.C.:

22 Q. And the purpose of the panel, you explained to

23 him, would be what?

24 DR. KWAN:

25 A. Would be to review the history of the

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1 patients, the medical history of the patients

2 there is and the breast cancer and current

3 (phonetic) and comorbidity of the patients as

4 involved and versus the breast cancer issue

5 that was there and see whether there is any

6 treatment can be offered or not offered or not

7 necessary at that time with the--and make a

8 recommendation as to whether the group has to,

9 anything to offer.

10 COFFEY, Q.C.:

11 Q. And recommendations would be made to whom?

12 DR. KWAN:

13 A. The recommendation will made to--regard to the

14 patient and then we at that time have not

15 decided upon how we want to put those

16 informations to anybody. I think that has not

17 been--it's just I think off my head that we

18 may need to--whether we should explore that.

19 COFFEY, Q.C.:

20 Q. Doctor, when you made this, you brought up

21 this idea of a panel with Dr. Williams, do you

22 recall when that was?

23 DR. KWAN:

24 A. Not exact date, sir.

25 COFFEY, Q.C.:

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1 Q. How close was it to the first meeting

2 involving the panel?

3 DR. KWAN:

4 A. Oh, it must be--oh, I would say two weeks

5 before, two, three weeks before.

6 COFFEY, Q.C.:

7 Q. Had the matter then--by the time you brought

8 up the panel idea with Dr. Williams, was this

9 already publicly known?

10 DR. KWAN:

11 A. No, sir.

12 COFFEY, Q.C.:

13 Q. Okay, it was still--it still hadn't -

14 DR. KWAN:

15 A. As far as I know.

16 COFFEY, Q.C.:

17 Q. Yes.

18 DR. KWAN:

19 A. As far as I can aware, I don't think. If I

20 can remember, I don't think it was -

21 COFFEY, Q.C.:

22 Q. It was before it broke in the news publicly in

23 a big way? It started October 2nd, we know

24 that.

25 DR. KWAN:

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1 A. Yeah. It's around that time, but I can't

2 remember. I think it's before that, but I

3 can't exactly pinpoint a time.

4 COFFEY, Q.C.:

5 Q. Then the composition of the panel and what

6 their formal role should be, who was that left

7 to?

8 DR. KWAN:

9 A. Dr. Williams.

10 COFFEY, Q.C.:

11 Q. Did he ask you anything more about that?

12 DR. KWAN:

13 A. Well he asked me who I think may be in there,

14 and I said certainly the medical oncologists.

15 And beyond that I don't think I said anything

16 more.

17 COFFEY, Q.C.:

18 Q. So, Doctor, in terms of this panel, your

19 initial idea was is, look, this is, in effect,

20 was sometimes two heads or three heads are

21 better than one, that in the sense of people

22 could examine problematic cases and make a

23 recommendation?

24 DR. KWAN:

25 A. Something of that nature, yes.

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Did the panel have any investigatory role?</p> <p>3 DR. KWAN:</p> <p>4 A. No, sir.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. At the time?</p> <p>7 DR. KWAN:</p> <p>8 A. Yes and no. We need to find out what the</p> <p>9 patient's histories are.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. Yeah, I appreciate in terms of individual</p> <p>12 patients. But like a larger investigative</p> <p>13 role?</p> <p>14 DR. KWAN:</p> <p>15 A. No, sir.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. At the time. Doctor, just looking at this,</p> <p>18 this is an e-mail of September 29, 2005 from</p> <p>19 Denise Dunn to Ms. Jones, Ms. Tracey and</p> <p>20 Dianne Clements to see "Louise, Maria, can the</p> <p>21 surgery and perioperative program leaders</p> <p>22 review, please," and sending Dr. Felix's and</p> <p>23 Kwan's copies by fax. And what's being sent</p> <p>24 here is this letter of September 26th, 2005,</p> <p>25 it's to Dr. Williams from Dr. Cook, ER and PR</p>	<p>1 distributed to, amongst others, yourself?</p> <p>2 DR. KWAN:</p> <p>3 A. Yeah.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. First of all, did you receive a copy of this,</p> <p>6 Doctor?</p> <p>7 DR. KWAN:</p> <p>8 A. I probably, I'm sure I did.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. And what, if anything, did you do about it?</p> <p>11 DR. KWAN:</p> <p>12 A. I think they went to the OR, operating room</p> <p>13 committee and with the--and to be advised with</p> <p>14 the policy and procedure to be adjusted</p> <p>15 accordingly.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. And who was responsible for making such</p> <p>18 adjustments?</p> <p>19 DR. KWAN:</p> <p>20 A. I would say Maria Tracey.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. And, Doctor, there's a reference here to this</p> <p>23 exist interviews of medical and technical</p> <p>24 consultants. Did you know that there were</p> <p>25 medical and technical consultants that come in</p>
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<p>1 review. And it says, "Following the exit</p> <p>2 interviews of both the medical and technical</p> <p>3 consultants one of the issues identified, the</p> <p>4 immunohistochemical staining of ER/PR concerns</p> <p>5 adequate fixation of the specimen. It appears</p> <p>6 in some cases that mastectomy specimens and</p> <p>7 other breast biopsies could very well be left</p> <p>8 lying overnight or over the weekend in the OR</p> <p>9 without adequate formalin fixation. I would</p> <p>10 strongly recommend that all mastectomies,</p> <p>11 needle localizations and lumpectomies with</p> <p>12 axillary node dissection should be booked</p> <p>13 first thing in the morning in the OR from</p> <p>14 Monday to Friday. Ideally this procedure</p> <p>15 should not performed on Friday afternoons.</p> <p>16 Every effort should be made to ensure these</p> <p>17 cases are forwarded to the lab in a timely</p> <p>18 fashion. I would appreciate if this</p> <p>19 information could be forwarded to those</p> <p>20 individuals responsible for OR bookings."</p> <p>21 Now, apparently this was sent and then was</p> <p>22 distributed to a number of people, including</p> <p>23 yourself and Dr. Felix. In fact, you'll note,</p> <p>24 you'll see here, and it's difficult to read,</p> <p>25 but it's Dr. Williams indicated it should be</p>	<p>1 and looked -</p> <p>2 DR. KWAN:</p> <p>3 A. No, sir.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. So this would be the first time you were</p> <p>6 advised about it?</p> <p>7 DR. KWAN:</p> <p>8 A. Well, we talked about it later.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Yes. But this here would be the first time</p> <p>11 that you were aware that that's so. They've</p> <p>12 identified an issue concerning adequate</p> <p>13 fixation of the specimen, the idea that</p> <p>14 certain tissue could be left over, lying over-</p> <p>15 -left overnight from, perhaps from a Wednesday</p> <p>16 to a Thursday or even over a weekend without</p> <p>17 adequate, according to this, formalin</p> <p>18 fixation. Had you had ever had any inkling</p> <p>19 before this -</p> <p>20 DR. KWAN:</p> <p>21 A. No, sir.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. - that that could be so?</p> <p>24 DR. KWAN:</p> <p>25 A. I didn't have any idea that this being an</p>

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<p>1 issue.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. And did you make any inquiries as to whether</p> <p>4 or not it had happened?</p> <p>5 DR. KWAN:</p> <p>6 A. On the Friday afternoons, no, I didn't make</p> <p>7 any inquiries on that.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Well how about the fact it could be left</p> <p>10 overnight?</p> <p>11 DR. KWAN:</p> <p>12 A. I can't remember whether I asked of them or</p> <p>13 not. We generally do not leave specimens</p> <p>14 overnight in the operating room area.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. But I take it, Doctor, when this was discussed</p> <p>17 in late September, when this came up, this is</p> <p>18 something that had to be addressed, there</p> <p>19 would have been inquiries made about, look,</p> <p>20 well, Cook is saying this could happen, Dr.</p> <p>21 Cook is saying this and there would have been</p> <p>22 discussions amongst the group in the</p> <p>23 perioperative program about, look, has this</p> <p>24 happened?</p> <p>25 DR. KWAN:</p>	<p>1 Q. And in terms of addressing then Dr. Cook's</p> <p>2 expression of concern, that would be the</p> <p>3 director of the perioperative program?</p> <p>4 DR. KWAN:</p> <p>5 A. Correct.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. And in terms of surgery scheduling?</p> <p>8 DR. KWAN:</p> <p>9 A. That would be the perioperative program, as</p> <p>10 well. That would be discussion with the</p> <p>11 surgeons. Now, I don't operate Friday</p> <p>12 afternoons, so there was no breast being done</p> <p>13 at the Health Science Friday afternoons.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. How about in the mornings?</p> <p>16 DR. KWAN:</p> <p>17 A. Friday mornings?</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. No, no, the idea of operating first thing in</p> <p>20 the morning Monday or Friday?</p> <p>21 DR. KWAN:</p> <p>22 A. They are not always feasible.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. I take then that was discussed?</p> <p>25 DR. KWAN:</p>
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<p>1 A. Well, it's usually if I am--I can't remember</p> <p>2 the details what the discussion. I would--and</p> <p>3 I say that we're sure that we don't leave</p> <p>4 specimens in the operating room overnight.</p> <p>5 They all go down to the laboratory at 4:00 or</p> <p>6 whatever it times interesting. The only time</p> <p>7 they overnight is a specimen that came up</p> <p>8 late, the case isn't operated on, say, until</p> <p>9 middle of the night and then they go down the</p> <p>10 next morning.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. Sure. But, so, Doctor, at the time then when</p> <p>13 this was discussed at the end of September,</p> <p>14 2005, no one acknowledged that this could have</p> <p>15 happened?</p> <p>16 DR. KWAN:</p> <p>17 A. I am not aware of it, at least these overnight</p> <p>18 things. Whether is other issues than that, I</p> <p>19 don't know, but that's certainly I was--I'm</p> <p>20 not aware that specimens are left overnight in</p> <p>21 the operating room area, routinely. Now,</p> <p>22 presumably they are sometimes forgotten or</p> <p>23 left there, but routinely that's not that I'm</p> <p>24 aware of.</p> <p>25 COFFEY, Q.C.:</p>	<p>1 A. I don't think that's--I don't remember they</p> <p>2 ever discussed this, but I don't think that's</p> <p>3 really feasible to have first thing Monday</p> <p>4 morning for everybody for breast tumours, for</p> <p>5 all breast tumours, the numbers are too big.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. He says first thing every morning Monday to</p> <p>8 Thursdays is what Dr. Cook is looking for.</p> <p>9 But that, from your perspective that's not--it</p> <p>10 wasn't feasible?</p> <p>11 DR. KWAN:</p> <p>12 A. It's just not technically feasible because</p> <p>13 there are other patients that requires to be</p> <p>14 operated first in the morning, a number of</p> <p>15 them, people with diabetes and people who has</p> <p>16 a latex allergies, all these things require</p> <p>17 8:00 morning operating time.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Doctor, the policy that we looked at dating</p> <p>20 back to 2004 that specimens would stay in the</p> <p>21 OR unless the requisition form was properly</p> <p>22 filled out?</p> <p>23 DR. KWAN:</p> <p>24 A. Yeah.</p> <p>25 COFFEY, Q.C.:</p>



<p style="text-align: right;">Page 161</p> <p>1 Q. Then we looked at that earlier.</p> <p>2 DR. KWAN:</p> <p>3 A. Right.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Was that policy enforced?</p> <p>6 DR. KWAN:</p> <p>7 A. After what we were--the date -</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. In 2004, June -</p> <p>10 DR. KWAN:</p> <p>11 A. No, I think the letter we wrote was when, I</p> <p>12 can't remember what time I signed the letter</p> <p>13 out.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. June 17, 2004.</p> <p>16 DR. KWAN:</p> <p>17 A. Okay, shortly after that, that's pretty well</p> <p>18 the nurses instruct not to leave the specimens</p> <p>19 upon (phonetic - coughing) leaving the OR even</p> <p>20 until the surgeon or his assistants have</p> <p>21 completed the form.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. So the surgeon or if someone didn't complete</p> <p>24 the form -</p> <p>25 DR. KWAN:</p>	<p style="text-align: right;">Page 163</p> <p>1 DR. KWAN:</p> <p>2 A. Yes, I would.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Did you take any issue with Dr. Williams or</p> <p>5 have any concerns about Dr. Williams'</p> <p>6 formulation of what the panel was going to be</p> <p>7 about?</p> <p>8 DR. KWAN:</p> <p>9 A. No. They are very competent individuals.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. Here, Doctor, is a reference to, in the second</p> <p>12 paragraph, "So that a plan can be recommended</p> <p>13 to the physician who is following up on each</p> <p>14 of these patients." The idea is is that get</p> <p>15 together a panel of physicians to redo all</p> <p>16 patients in this category, which would be the</p> <p>17 category would be those who were retested at</p> <p>18 Mount Sinai. And they talk about the best</p> <p>19 time for the meeting. Dr. Laing agreed to</p> <p>20 chair the panel and secretarial support is</p> <p>21 described, then what Dr. Cook's role would be.</p> <p>22 Of course, Dr. Carter ended up being added to</p> <p>23 it. Doctor, was it your understanding that</p> <p>24 every patient who had retest results would be</p> <p>25 dealt with by the panel?</p>
<p style="text-align: right;">Page 162</p> <p>1 A. They were called back to fill it out for the</p> <p>2 patient's specimen. If the specimen doesn't</p> <p>3 leave the OR suite, the next case can't come</p> <p>4 on.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. But if they were the last specimen for the</p> <p>7 day?</p> <p>8 DR. KWAN:</p> <p>9 A. Then the residents come back and sign it. The</p> <p>10 nurses can't go home, either, I would think.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. And, Doctor, look at Exhibit P-0634? Page--</p> <p>13 doctors--well, the first page is a fax cover</p> <p>14 sheet, it's to Dr. Carter from Dr. Williams.</p> <p>15 It refers to Dr. Cook having informed Dr.</p> <p>16 Williams that Dr. Carter agreed to sit on this</p> <p>17 panel. And she will be an expert in the area</p> <p>18 of breast pathology and would help with the</p> <p>19 deliberations of the panel. And then there's</p> <p>20 attached to this exhibit is a memo of October</p> <p>21 12th, 2005, it's from Dr. Williams to Doctors</p> <p>22 Laing, yourself, Felix, McCarthy, Zulfiqar and</p> <p>23 Ganguly, Cook and Ms. Predham. Doctor, you</p> <p>24 would have received a copy of this at the</p> <p>25 time?</p>	<p style="text-align: right;">Page 164</p> <p>1 DR. KWAN:</p> <p>2 A. I understand the only thing they have changed.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. The ones whose results have changed?</p> <p>5 DR. KWAN:</p> <p>6 A. Correct.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And change in this context meant what?</p> <p>9 DR. KWAN:</p> <p>10 A. Change in context means, as I interpret it,</p> <p>11 from ER negative, or actually, I can't</p> <p>12 remember how we do. I think there's change,</p> <p>13 not necessary all ERs are negative to</p> <p>14 positive, just changed, significantly changed</p> <p>15 would be reviewed.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. So if there's--I'm sorry, what kind of a</p> <p>18 change?</p> <p>19 DR. KWAN:</p> <p>20 A. Significant change.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Significant change. And what -</p> <p>23 DR. KWAN:</p> <p>24 A. I think that, a lot of the people there are</p> <p>25 some 50 percent, there's 90 percent for</p>

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1 example, that would be--we would consider as a  
 2 (unintelligible) change. I think some of them  
 3 have looked at them that way.  
 4 COFFEY, Q.C.:  
 5 Q. How about going, for example, from a negative  
 6 to five percent or negative to two percent?  
 7 DR. KWAN:  
 8 A. They remain negative, then we won't--that  
 9 won't be -  
 10 COFFEY, Q.C.:  
 11 Q. No, I'm sorry, going from what was originally  
 12 described as negative.  
 13 DR. KWAN:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. Just negative, period, no percentages.  
 17 DR. KWAN:  
 18 A. Right.  
 19 COFFEY, Q.C.:  
 20 Q. To now, say, I'll just pick a figure, two  
 21 percent?  
 22 DR. KWAN:  
 23 A. That would still remain negative and we  
 24 probably won't review those.  
 25 COFFEY, Q.C.:

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1 Q. And who -  
 2 DR. KWAN:  
 3 A. As a change.  
 4 COFFEY, Q.C.:  
 5 Q. Yeah. Who made that determination?  
 6 DR. KWAN:  
 7 A. I don't know, I really can't tell you the  
 8 determination. Now, whether we--that--if  
 9 there are patients like that we have looked  
 10 at.  
 11 COFFEY, Q.C.:  
 12 Q. Yes.  
 13 DR. KWAN:  
 14 A. You know, which is zero to two, we just looked  
 15 at, yeah, it was zero to two is not changed  
 16 and that's it, you know, next case.  
 17 COFFEY, Q.C.:  
 18 Q. So who, Doctor -  
 19 DR. KWAN:  
 20 A. I think, actually, all the patients were  
 21 presented, have been retested were presented  
 22 and then were just as a real -  
 23 COFFEY, Q.C.:  
 24 Q. So if, for example -  
 25 DR. KWAN:

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1 A. Can't remember exactly.  
 2 COFFEY, Q.C.:  
 3 Q. - it was negative and if Mount Sinai reported  
 4 zeros?  
 5 DR. KWAN:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. Well, then, there'd just be a long list of  
 9 patients with zeros and you wouldn't be  
 10 dealing with them?  
 11 DR. KWAN:  
 12 A. Right.  
 13 COFFEY, Q.C.:  
 14 Q. That would be -  
 15 DR. KWAN:  
 16 A. And I think this was all the test results come  
 17 back was real (phonetic) through. We have the  
 18 flow that goes through and then those who  
 19 doesn't have to be discussed, we just passed  
 20 them.  
 21 COFFEY, Q.C.:  
 22 Q. You passed on because you could look, it was  
 23 Mount Sinai ER zero or Mount Sinai -  
 24 DR. KWAN:  
 25 A. No change to -

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1 COFFEY, Q.C.:  
 2 Q. - less than one percent, you just pass right  
 3 on?  
 4 DR. KWAN:  
 5 A. We just pass on it.  
 6 COFFEY, Q.C.:  
 7 Q. How about between, like, a patient that fell  
 8 between one and ten, how were they dealt with,  
 9 were they actually looked at?  
 10 DR. KWAN:  
 11 A. I can't remember, but I'm sure there would be  
 12 discussion as in should we look at this one.  
 13 We may look at the history of the patient very  
 14 quickly and see whether we need any  
 15 recommendation or the patient been on  
 16 treatment before, then we don't--I can't  
 17 remember exactly how we dealt with those, but  
 18 I think -  
 19 COFFEY, Q.C.:  
 20 Q. Doctor, who--what was your understanding of  
 21 who was deciding, like, which patients ended  
 22 up before the panel at all?  
 23 DR. KWAN:  
 24 A. I think a list came out and we all--the  
 25 numbers are presented and we all say, yes,

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1 should we discuss this one and the answer say  
 2 no, agree, then that, then we just moved on.  
 3 COFFEY, Q.C.:  
 4 Q. Who provided the list?  
 5 DR. KWAN:  
 6 A. Administration.  
 7 COFFEY, Q.C.:  
 8 Q. Who is the -  
 9 DR. KWAN:  
 10 A. I think Heather is there with the list -  
 11 COFFEY, Q.C.:  
 12 Q. Okay, Ms. Predham is there. So that's what  
 13 I'm trying to get some sense for the  
 14 Commissioner in terms of you're a physician,  
 15 the end of a long day, 5:00, you're showing up  
 16 and it would all be kind of ready for you, I  
 17 take it, in the sense of the lists and -  
 18 DR. KWAN:  
 19 A. Well, she got the list ready and actually in  
 20 beginning we had the list beforehand to see  
 21 any of these are our patients that belongs to  
 22 me to bring information.  
 23 COFFEY, Q.C.:  
 24 Q. Yes.  
 25 DR. KWAN:

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1 A. If this list of my--have any information from  
 2 my own file to bring them.  
 3 COFFEY, Q.C.:  
 4 Q. Because they would be presumably the current?  
 5 DR. KWAN:  
 6 A. Correct.  
 7 COFFEY, Q.C.:  
 8 Q. Yes. Doctor, but in terms of what criteria,  
 9 for example, if Ms. Predham was making the  
 10 determination as to who was to be seen in the  
 11 sense by the panel?  
 12 DR. KWAN:  
 13 A. Well, just the list that was coming back. I  
 14 don't think you'd make any decisions.  
 15 COFFEY, Q.C.:  
 16 Q. Oh, no, I appreciate that. What I'm asking is  
 17 is this, were you ever asked yourself for any  
 18 input into who should end up in front of a  
 19 panel at all?  
 20 DR. KWAN:  
 21 A. No.  
 22 COFFEY, Q.C.:  
 23 Q. Okay.  
 24 THE COMMISSIONER:  
 25 Q. In the answer to an earlier question I got the

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1 impression that you were getting a list of the  
 2 results that were coming back in a summarized  
 3 form?  
 4 DR. KWAN:  
 5 A. I don't get the list.  
 6 THE COMMISSIONER:  
 7 Q. And that--you don't get the list?  
 8 DR. KWAN:  
 9 A. No. I get the list of the patients that are  
 10 coming up for discussions.  
 11 THE COMMISSIONER:  
 12 Q. Okay.  
 13 DR. KWAN:  
 14 A. The day before or the day--in the beginning.  
 15 Later on we didn't, the beginning is to see  
 16 whether there was any patients of mine that I  
 17 bring in any information that I have.  
 18 THE COMMISSIONER:  
 19 Q. Okay.  
 20 DR. KWAN:  
 21 A. To the panel.  
 22 THE COMMISSIONER:  
 23 Q. And that list that contained the names of  
 24 those who were coming up before the panel  
 25 would imply, since the panel didn't seem to

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1 deal with every patient, that some person had  
 2 -  
 3 DR. KWAN:  
 4 A. Well, the list is there. I think we go  
 5 through all of them, if I remember -  
 6 THE COMMISSIONER:  
 7 Q. Yes, that was my point. I was getting the  
 8 impression from you that, in fact, you got the  
 9 results from everybody?  
 10 DR. KWAN:  
 11 A. No. I think the list is presented, those  
 12 changed had presented, so the one that Mr.  
 13 Coffey presented, those number change are--all  
 14 the retesting are there and then when we  
 15 looked at the number change, this one needs to  
 16 be looked at, this one doesn't need to be  
 17 looked at. As I remember -  
 18 THE COMMISSIONER:  
 19 Q. So does that mean there were sort of two  
 20 decision making processes that before the list  
 21 came to you somebody had decided there were a  
 22 group of patients who need not even go on a  
 23 list?  
 24 DR. KWAN:  
 25 A. No, no, no. That's the list that came up is

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1 the list of patients that will come up at the  
 2 time.  
 3 THE COMMISSIONER:  
 4 Q. Yeah.  
 5 DR. KWAN:  
 6 A. The only reason the list came to me is to ask  
 7 for whether any of those are my patients that  
 8 I bring in informations.  
 9 THE COMMISSIONER:  
 10 Q. Yes.  
 11 DR. KWAN:  
 12 A. So that's the only, as I interpret, that is  
 13 the only reason for that list.  
 14 THE COMMISSIONER:  
 15 Q. All right.  
 16 DR. KWAN:  
 17 A. And then when we go to the meeting, Heather  
 18 will be have all these things together and we  
 19 go through these are the patients we're going  
 20 through.  
 21 THE COMMISSIONER:  
 22 Q. Um-hm.  
 23 DR. KWAN:  
 24 A. And the chart will be there.  
 25 THE COMMISSIONER:

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1 Q. Yes.  
 2 DR. KWAN:  
 3 A. And then the collective decision should we  
 4 review the entire case. That's the  
 5 understanding, that is my recollection of  
 6 what's happening.  
 7 THE COMMISSIONER:  
 8 Q. Okay. Now, but if, for example, Mount Sinai  
 9 had sent back the results on 30 patients,  
 10 assuming for the moment that 15 of those had  
 11 negative results which we know they would have  
 12 had negative results before they went to Mount  
 13 Sinai, assuming for the moment that Mount  
 14 Sinai sent back zero, zero on all 15 of them,  
 15 you would never see those names, would you?  
 16 DR. KWAN:  
 17 A. No. that would be if it's identical results,  
 18 there would be not looked, that would just  
 19 pass, say, yeah, zero, zero, and it's gone.  
 20 We don't look at the chart at all.  
 21 THE COMMISSIONER:  
 22 Q. All right. Now, if there is a change which is  
 23 very small, would that get to you definitely -  
 24 DR. KWAN:  
 25 A. That would -

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1 THE COMMISSIONER:  
 2 Q. - or would someone make a decision before it  
 3 got to you?  
 4 DR. KWAN:  
 5 A. We make a look, decision at the time and say  
 6 zero, zero, zero, one.  
 7 THE COMMISSIONER:  
 8 Q. Um-hm.  
 9 DR. KWAN:  
 10 A. So no, we don't look at those at all either.  
 11 COFFEY, Q.C.:  
 12 Q. So what criteria were you utilizing to make  
 13 that determination?  
 14 DR. KWAN:  
 15 A. I think it was anything we considered changed.  
 16 COFFEY, Q.C.:  
 17 Q. Okay, so what number did Brendan Mullen have  
 18 to report before it became changed and causing  
 19 you to look at it?  
 20 DR. KWAN:  
 21 A. If previously we consider a negative, for  
 22 example, now, say--that's why I'm hesitating  
 23 because as you know back in 1997 we had 30  
 24 percent positive, now in 2005 is ten percent  
 25 positive.

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1 COFFEY, Q.C.:  
 2 Q. So what I'm -  
 3 DR. KWAN:  
 4 A. So those are the issues that we have to  
 5 consider now today as being positive and we  
 6 have to look at.  
 7 COFFEY, Q.C.:  
 8 Q. So if it was 10 percent--and the 10 percent  
 9 was retroactively all the way back to 1997 by  
 10 the panel?  
 11 DR. KWAN:  
 12 A. That was the way we did it.  
 13 COFFEY, Q.C.:  
 14 Q. So it was discussed, the idea of what kind of  
 15 approach we should take with the '97, '98, and  
 16 '99?  
 17 DR. KWAN:  
 18 A. That's the way I remember it, that we  
 19 discussed it at the time. I don't know what  
 20 Kara Laing said at the time, but that's what I  
 21 remember.  
 22 COFFEY, Q.C.:  
 23 Q. And so the panel's approach was going to be 10  
 24 percent is positive, 10 percent or more would  
 25 be positive?

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1 DR. KWAN:  
 2 A. Yeah.  
 3 COFFEY, Q.C.:  
 4 Q. If Brendan Mullen reported 10 percent or more,  
 5 we'll consider it positive?  
 6 DR. KWAN:  
 7 A. They would consider a change, although change  
 8 may not be related to the laboratory, a change  
 9 in therapy.  
 10 COFFEY, Q.C.:  
 11 Q. Yes, you would consider the--the person then  
 12 would be considered for a possible change in  
 13 treatment?  
 14 DR. KWAN:  
 15 A. Correct.  
 16 COFFEY, Q.C.:  
 17 Q. If Mount Sinai reported the ER and PR as less  
 18 than 10.  
 19 DR. KWAN:  
 20 A. Yeah.  
 21 COFFEY, Q.C.:  
 22 Q. Then they wouldn't be considered for change?  
 23 DR. KWAN:  
 24 A. They wouldn't be considered, yeah.  
 25 COFFEY, Q.C.:

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1 Q. They were just simply--fell into another  
 2 category, and we won't review them. So they  
 3 would not be reviewed?  
 4 DR. KWAN:  
 5 A. That would be my understanding. If I  
 6 remember, that's what we did.  
 7 COFFEY, Q.C.:  
 8 Q. And if we could, just to address something the  
 9 Commissioner was just asking about, Exhibit P-  
 10 2554, 2554. Doctor, this is a redacted  
 11 version of a document entitled "Charts for  
 12 Panel Review". This one happens to be  
 13 Thursday, October 27th, 2005. You can see the  
 14 patient's names and, of course, the MCP  
 15 numbers are redacted. There are 25 of them  
 16 originally listed. The physician's names are  
 17 listed there.  
 18 DR. KWAN:  
 19 A. Uh-hm.  
 20 COFFEY, Q.C.:  
 21 Q. And the OPIS number, we've redacted those, but  
 22 there's - the word "hold" is written on a  
 23 number of them. As well when we look down  
 24 through it, yours is here, right there I'm  
 25 pointing to, and then as we go down the page

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1 there are actually quite a number of yours;  
 2 here, here, here, here, here, here. See  
 3 those?  
 4 DR. KWAN:  
 5 A. Yes, I presume it has my name as the operating  
 6 surgeon, or the one who is sending the  
 7 specimen.  
 8 COFFEY, Q.C.:  
 9 Q. Yes. So because your name is here doesn't  
 10 necessarily mean that you were the follow -  
 11 DR. KWAN:  
 12 A. No.  
 13 COFFEY, Q.C.:  
 14 Q. Follow-up physician.  
 15 DR. KWAN:  
 16 A. No.  
 17 COFFEY, Q.C.:  
 18 Q. The person actually treating at that point.  
 19 DR. KWAN:  
 20 A. No.  
 21 COFFEY, Q.C.:  
 22 Q. Although some of these when we look here,  
 23 Ganguly, for example, would not be a surgeon,  
 24 McCarthy would not be a surgeon, or Laing.  
 25 DR. KWAN:

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1 A. Presumably - I can only assume now. I mean,  
 2 memory is that these patients are being  
 3 followed by them or being treated by them.  
 4 COFFEY, Q.C.:  
 5 Q. Doctor, is this the sort of sheet you were  
 6 talking about before to identify patients,  
 7 your own patients?  
 8 DR. KWAN:  
 9 A. No, these are other people's patients.  
 10 COFFEY, Q.C.:  
 11 Q. Okay, so you would sometimes get a sheet -  
 12 DR. KWAN:  
 13 A. That's beginning. Later I don't get them any  
 14 more.  
 15 COFFEY, Q.C.:  
 16 Q. So in the beginning you would get a sheet, and  
 17 what would be on the sheet?  
 18 DR. KWAN:  
 19 A. Just these are patients who have been reviewed  
 20 and we will be discussing in the panel, do you  
 21 have any information related to these  
 22 patients, bring it.  
 23 COFFEY, Q.C.:  
 24 Q. And that sheet would come from whom?  
 25 DR. KWAN:

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1 A. I would say Heather Predham. That's the  
 2 beginning of the first few meetings that we  
 3 had.  
 4 COFFEY, Q.C.:  
 5 Q. Exhibit P-0635, please. Doctor, this is a fax  
 6 sheet of October 12th, 2005. It's from Dr.  
 7 Williams to yourself and other individuals,  
 8 people on the panel really. It says, "Please  
 9 see attached letter. Supper will be  
 10 provided", and then it notes here, location,  
 11 and then dates beginning October 20th, 2005,  
 12 27th, November 3rd, November 10th, November  
 13 17th, December 1st, and December 15th, and the  
 14 activity is listed there, room number, and the  
 15 location. Doctor, was this a listing of what  
 16 was planned to be then panel meetings, do you  
 17 know?  
 18 DR. KWAN:  
 19 A. I don't know. I never saw the list. It's a  
 20 list that we sat at meetings. We certainly  
 21 meet often enough, but I don't know whether  
 22 these are schedules for our meetings, no.  
 23 COFFEY, Q.C.:  
 24 Q. Doctor, from time to time then, how would you  
 25 know - I take it you got that first memo

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1 saying show up at a particular place.  
 2 DR. KWAN:  
 3 A. Each meeting - how I got that, either Heather  
 4 Predham will say we don't have the results  
 5 coming back, and they would tell us when the  
 6 next meeting be when these arrive for us to  
 7 sit down and talk about.  
 8 COFFEY, Q.C.:  
 9 Q. So Ms. Predham would organize it, and at the  
 10 end of a meeting if there was one planned for  
 11 the next day or the next week, she'd tell you?  
 12 DR. KWAN:  
 13 A. That's right.  
 14 COFFEY, Q.C.:  
 15 Q. And if you could make it, you would be  
 16 expected to show up?  
 17 DR. KWAN:  
 18 A. Correct.  
 19 COFFEY, Q.C.:  
 20 Q. Exhibit P-1309. Doctor, these are the minutes  
 21 - this particular version is revised, October  
 22 20th, 2005, for it's for the physician panel  
 23 meeting, October 13th, 2005. You're there and  
 24 others, and the second sentence notes that Dr.  
 25 Williams thanked yourself and Dr. Laing for

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1 suggesting the idea of a panel. Here, Doctor,  
 2 the mandate of the panel is spelled out here.  
 3 There's a note here that Dr. Laing also stated  
 4 the discussion of the group will be officially  
 5 minuted and will stay as a record. All in  
 6 attendance agreed. Doctor, did you ever see  
 7 any minutes afterward?  
 8 DR. KWAN:  
 9 A. No, sir.  
 10 COFFEY, Q.C.:  
 11 Q. As time went on, do you know whether there  
 12 were even any minutes kept?  
 13 DR. KWAN:  
 14 A. I never saw any minutes from this meeting,  
 15 sir.  
 16 COFFEY, Q.C.:  
 17 Q. The second paragraph says, "Discussion ensued  
 18 as to who would be notified whose  
 19 responsibility it would be to carry out the  
 20 follow-up of each patient. All agreed the  
 21 referring physician should be notified, the  
 22 primary cancer treating physician would be  
 23 responsible for follow-up. Other  
 24 recommendations from the panel; notification  
 25 would be in writing, mechanism put in place to

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1 confirm follow-up physician has received  
 2 notification. Also include a paragraph to the  
 3 effect the primary care physician if that  
 4 physician is not comfortable carrying out the  
 5 change in treatment, they have the option of  
 6 referring the patient to an oncologist at the  
 7 Cancer Clinic", and then they go on and talk  
 8 about, the memo does, about the research from  
 9 the French National Cancer Centres dealing  
 10 with a study, TAM, T-A-M 02, "and this article  
 11 was circulated to the panel and Dr. Laing  
 12 advised that the recommendations for treatment  
 13 would be based on the findings in this  
 14 article. It was agreed that Heather Predham  
 15 ask an epidemiologist to review this  
 16 research". Now, Doctor, this is research -  
 17 there's a quote here referring to a randomized  
 18 controlled trial from September, 1986, to  
 19 October, 1998.  
 20 DR. KWAN:  
 21 A. '89.  
 22 COFFEY, Q.C.:  
 23 Q. 1989, I apologize, '86 to '89, found in an  
 24 article entitled "Delayed adjuvant Tamoxifen,  
 25 ten year results of a collaborative randomized

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<p>1 controlled trial in early breast cancer".</p> <p>2 Doctor, I wanted to ask you, from your</p> <p>3 perspective sitting there, October 13th, 2005,</p> <p>4 did you have any real information before you</p> <p>5 got this about whether it was useful or not?</p> <p>6 DR. KWAN:</p> <p>7 A. No, sir.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. To engage in -</p> <p>10 DR. KWAN:</p> <p>11 A. I have no - until Dr. Laing brought this</p> <p>12 article, I have no reference articles that</p> <p>13 deal with this issue of delayed Tamoxifen.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Doctor, did you make any further inquiries in</p> <p>16 that regard?</p> <p>17 DR. KWAN:</p> <p>18 A. No, sir.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. A reference here to asking - agree that Ms.</p> <p>21 Predham ask an epidemiologist to review this</p> <p>22 research, which would be presumably that</p> <p>23 paper?</p> <p>24 DR. KWAN:</p> <p>25 A. I presume so, yes.</p>	<p>1 COFFEY, Q.C.:</p> <p>2 Q. So the panel then, once they set out on this</p> <p>3 course, they continued on?</p> <p>4 DR. KWAN:</p> <p>5 A. That's the best information that we got in</p> <p>6 terms of how to deal with this. At least</p> <p>7 there's some scientific basis for how we can</p> <p>8 treat these patients.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. And there's a reference to what form would be</p> <p>11 used to record certain information, and,</p> <p>12 Doctor, here on the second page of this</p> <p>13 exhibit, there's an action plan styled and</p> <p>14 there's patient information that's redacted,</p> <p>15 the original reported ER/PR, the Mount Sinai</p> <p>16 report on ER/PR, and then</p> <p>17 recommendations/follow-up, and then the</p> <p>18 follow-up physician is identified. I take it</p> <p>19 this would be the physician to whom the letter</p> <p>20 is being addressed?</p> <p>21 DR. KWAN:</p> <p>22 A. Correct.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. And there are a number of different</p> <p>25 recommendations. The recommendations, doctor,</p>
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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Did you ever hear anything afterward about any</p> <p>3 such -</p> <p>4 DR. KWAN:</p> <p>5 A. No, sir.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Epidemiologist comment.</p> <p>8 DR. KWAN:</p> <p>9 A. No, sir.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. Did it ever come up afterward?</p> <p>12 DR. KWAN:</p> <p>13 A. No, sir.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. So once this was embarked upon, the panel's</p> <p>16 approach was, as asserted here by Dr. Laing,</p> <p>17 the recommendations for treatment would be</p> <p>18 based on -</p> <p>19 DR. KWAN:</p> <p>20 A. I believe Dr. Laing talked about a number of</p> <p>21 times another informations. There is a vague</p> <p>22 - there is another somewhere. I can't - I</p> <p>23 don't know if I saw that one, dealing with the</p> <p>24 same issue and that's the best information</p> <p>25 that we have.</p>	<p>1 were there ever any disagreements?</p> <p>2 DR. KWAN:</p> <p>3 A. Sometimes.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And how were they resolved?</p> <p>6 DR. KWAN:</p> <p>7 A. Consensus.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. And, in essence, what does consensus in this</p> <p>10 context mean? I take it, somebody would</p> <p>11 change their mind.</p> <p>12 DR. KWAN:</p> <p>13 A. Somebody would have presented enough to</p> <p>14 convince the other people that this is what</p> <p>15 would be reasonable.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. Did it ever have to be decided on the basis of</p> <p>18 kind of a majority vote?</p> <p>19 DR. KWAN:</p> <p>20 A. No, sir, not that I can remember.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. And who would actually participate in this in</p> <p>23 the sense of -</p> <p>24 DR. KWAN:</p> <p>25 A. Mostly it's the medical oncologists, and we</p>

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1 participated at times that we have anything to  
 2 contribute, and the pathologists will  
 3 interpret the pathology reports, and perhaps  
 4 sometimes the estrogen receptor results.  
 5 COFFEY, Q.C.:  
 6 Q. If we could, I'm just going to look at the  
 7 third page. Here, this patient at the top of  
 8 the page here, negative/negative originally,  
 9 and now 80/0 from Mount Sinai.  
 10 Recommendation, Dr [redacted] advised the  
 11 panel that this was her patient and the  
 12 patient has been notified and started on  
 13 Tamoxifen, and follow-up physician would be  
 14 presumably the same doctor. How was this  
 15 handled?  
 16 DR. KWAN:  
 17 A. Patient notified, has agreed upon, and been  
 18 started, and we agreed that Tamoxifen is  
 19 appropriate thing to do, and already been  
 20 started - I'm presuming that patient is same  
 21 letter you showed me from Don Cook, who send a  
 22 letter way out before these things happened,  
 23 and individual probably got a letter from that  
 24 and has dealt with the issue.  
 25 COFFEY, Q.C.:

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1 Q. And, for example -  
 2 DR. KWAN:  
 3 A. And came down to the panel discussion and we  
 4 agreed and that that was it.  
 5 COFFEY, Q.C.:  
 6 Q. Here in the second patient on this page,  
 7 Recommendation, "As patient has already  
 8 received Tamoxifen, she will be informed of  
 9 the change in ER/PR status, originally  
 10 negative/negative and then Mount Sinai 20 and  
 11 50". In terms of that, there's no way of  
 12 telling from this when the patient received  
 13 Tamoxifen, is there?  
 14 DR. KWAN:  
 15 A. There's no way of telling why it was started,  
 16 no way of telling why who have a - who got a  
 17 crystal ball to tell it could be changed, I  
 18 mean, without information like that. I'm just  
 19 going to say back is that there are situations  
 20 that occasionally we do treat them. As you  
 21 know, sometimes negative estrogen receptor of  
 22 patient, no other thing to offer, to offer you  
 23 a 6 to 10 percent chance of response, and  
 24 occasionally we do start them on them in  
 25 situation where you have nothing to offer.

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1 COFFEY, Q.C.:  
 2 Q. Despite the fact that their hormonal status is  
 3 reported to be negative?  
 4 DR. KWAN:  
 5 A. Despite - - because they suggest  
 6 negative/negative, occasionally they do  
 7 respond.  
 8 COFFEY, Q.C.:  
 9 Q. Doctor, in fact, the third patient falls in  
 10 the same category. The patient has already  
 11 received Tamoxifen.  
 12 DR. KWAN:  
 13 A. It may be again - this may be that people get  
 14 - don't forget, this is the first group of  
 15 patients came in here, and the physician may  
 16 have already gotten the letter at that time  
 17 and then started treatment.  
 18 COFFEY, Q.C.:  
 19 Q. Doctor, I'm going to ask you about this, at  
 20 times would you be receiving the pathology  
 21 reports? We understand that Mount Sinai was  
 22 reporting these generally in spreadsheet  
 23 results, Excel Spreadsheet, and Dr. Cook was  
 24 entering them in the Meditech, individual  
 25 patients.

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1 DR. KWAN:  
 2 A. Okay.  
 3 COFFEY, Q.C.:  
 4 Q. Would you get a copy then of - if you were the  
 5 patients' surgeon, would you get a copy of the  
 6 pathology report?  
 7 DR. KWAN:  
 8 A. I would get a copy of the pathology report.  
 9 If I remember, I do get - I can't remember if  
 10 I get every one of them, but I certainly do  
 11 remember receiving some of the addendum  
 12 reports in 2005 of something back in 1996. I  
 13 mean, I just have to look. I said what am I  
 14 supposed to do with this.  
 15 COFFEY, Q.C.:  
 16 Q. Doctor, with respect to that, at times were  
 17 some of those pathology reports ending up in  
 18 your mail slot, as in pathology reports  
 19 relating to the retest results before people  
 20 were being panelled?  
 21 DR. KWAN:  
 22 A. No, I don't think so.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, and now - here, and this is just the  
 25 second page of the exhibit, there's an entry



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1 here, fourth entry, less than 30 percent, less  
 2 than 30 percent is the original results, and  
 3 now 60 and 70 from Mount Sinai.  
 4 Recommendation, this patient should be offered  
 5 Tamoxifen.  
 6 DR. KWAN:  
 7 A. Uh-hm.  
 8 COFFEY, Q.C.:  
 9 Q. I take it, this is somebody the panel would  
 10 have considered, looked at the -  
 11 DR. KWAN:  
 12 A. That's a recommendation for the panel, and  
 13 this patient would have got - physician would  
 14 have got a letter and advised the patient to  
 15 start.  
 16 COFFEY, Q.C.:  
 17 Q. Doctor, the third page - because we just  
 18 looked at the three of them at the top of the  
 19 page there, "Advised this particular patient  
 20 has been notified and started on Tamoxifen",  
 21 would the patient actually review that  
 22 patient?  
 23 DR. KWAN:  
 24 A. Would just make sure that they did, is getting  
 25 Tamoxifen - some of these patients are Cancer

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1 Clinic patients. We do have the full chart on  
 2 these patients. So look at it and say, yes,  
 3 has been started and be happy with it.  
 4 COFFEY, Q.C.:  
 5 Q. And some of these, I'm going to suggest to  
 6 you, in fact would only have been started  
 7 because of the retest that had occurred -  
 8 DR. KWAN:  
 9 A. Probably, yes.  
 10 COFFEY, Q.C.:  
 11 Q. - during the past month or so, but would the  
 12 panel - what I'm asking you is this, if  
 13 someone present in the room, a pathologist  
 14 said, look - an oncologist said that's my  
 15 patient, I have started him or her on hormone  
 16 therapy.  
 17 DR. KWAN:  
 18 A. Uh-hm.  
 19 COFFEY, Q.C.:  
 20 Q. I got the results recently and I've started  
 21 him or her. Would the panel then actually  
 22 review that patient?  
 23 DR. KWAN:  
 24 A. Probably not as detailed as we reviewed the  
 25 others. We would look at it, and we probably

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1 won't go through, sort of, the fine tooth--as  
 2 to--particularly the medical oncologists would  
 3 make their recommendations who have taken the  
 4 role in treating that patient, and she has, or  
 5 he or she become the treating physician since  
 6 we are not in our role to - we may give  
 7 advice, but we won't be going against them  
 8 very quickly.  
 9 COFFEY, Q.C.:  
 10 Q. Do you ever recall any instance where the  
 11 panel was told or learned that a patient had  
 12 been - because of change results, had had  
 13 their treatment changed, and the panel had  
 14 misgivings about it? I'm not suggesting it  
 15 happened.  
 16 DR. KWAN:  
 17 A. No.  
 18 COFFEY, Q.C.:  
 19 Q. I'm just asking you.  
 20 DR. KWAN:  
 21 A. No, not that I can remember. No, nothing i  
 22 can -  
 23 COFFEY, Q.C.:  
 24 Q. Sure. Doctor, here in the end of these  
 25 minutes on page four, [redacted] was the last

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1 patient reviewed at this meeting. The panel  
 2 agreed to proceed through Dr [blank] patients  
 3 at the next meeting, and Dr. Cook requested  
 4 that certain patients be added for discussion  
 5 at the next meeting. Doctor, the meeting was  
 6 adjourned at 6:35. First of all, I'm going to  
 7 ask you the idea that particular doctor's  
 8 patients be looked at at the next meeting, do  
 9 you recall that happening?  
 10 DR. KWAN:  
 11 A. I presume he must have an issue that he wants  
 12 panel discussed, that he wants our opinion as  
 13 to what to do with that particular situation.  
 14 I really can't comment.  
 15 COFFEY, Q.C.:  
 16 Q. This seems to be through--all of that doctor's  
 17 patients? It looked like the doctor was going  
 18 to have whatever patients of his had retest  
 19 results looked at. Do you recall that coming  
 20 up?  
 21 DR. KWAN:  
 22 A. "Agree to proceed through" -  
 23 COFFEY, Q.C.:  
 24 Q. Not "a" patient, it's "through that doctor's  
 25 patients at the next meeting". The idea of

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1 somebody's patients who are jumping the queue.  
 2 DR. KWAN:  
 3 A. I don't remember selecting anybody as jumping  
 4 the queue for whatever reason, but again maybe  
 5 occasionally - I mean, I don't even remember.  
 6 I'm just guessing here where it is convenient  
 7 that you will be here next meeting, bring all  
 8 his charts in, you know, that kind of stuff  
 9 like that.  
 10 COFFEY, Q.C.:  
 11 Q. Sure.  
 12 DR. KWAN:  
 13 A. May occur, but I don't think I ever recall  
 14 saying so and so got to go above so and so.  
 15 COFFEY, Q.C.:  
 16 Q. Doctor, here this meeting was scheduled again  
 17 at 5 o'clock. Look here at - it adjourned at  
 18 6:35, which is an hour and a half. Now,  
 19 Doctor, how long then would be spent per  
 20 patient?  
 21 DR. KWAN:  
 22 A. That all depends. You know, like any chart  
 23 review you do, and how well the charts are  
 24 organized for you, and how much information  
 25 that is easily accessible, and if those

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1 informations are within the computer system or  
 2 not. If it's in the computer system, it's  
 3 much easier, a lot faster. Mostly it's  
 4 information gathering at the same time so that  
 5 we are not missing something in the  
 6 individual. Comorbidity is one of the serious  
 7 issues that we have to know. Making a  
 8 recommendation of patient to take Tamoxifen  
 9 who have an extensive DVT will be a bad thing.  
 10 COFFEY, Q.C.:  
 11 Q. So, Doctor, I mean, just doing the arithmetic,  
 12 there were twelve patients looked at that day.  
 13 DR. KWAN:  
 14 A. Ten minutes.  
 15 COFFEY, Q.C.:  
 16 Q. Ten minutes.  
 17 DR. KWAN:  
 18 A. Fifteen minutes, yeah.  
 19 COFFEY, Q.C.:  
 20 Q. Ten minutes or less.  
 21 DR. KWAN:  
 22 A. I would think that would be -  
 23 COFFEY, Q.C.:  
 24 Q. Well, it would be less than ten for each.  
 25 DR. KWAN:

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1 A. It say it starts at five o'clock, but often  
 2 time we were there 4:30, you know, it can be  
 3 started at such and such a time. You know, I  
 4 mean, I can't remember exactly we started five  
 5 o'clock or early when clinics are finished.  
 6 COFFEY, Q.C.:  
 7 Q. Doctor, let me ask you this. I appreciate if  
 8 patient "A"'s name comes up and the medical  
 9 oncologist there says, well, she's my patient,  
 10 I got the results two weeks ago, a week ago,  
 11 or back in the summer -  
 12 DR. KWAN:  
 13 A. Uh-hm.  
 14 COFFEY, Q.C.:  
 15 Q. And I put her on Tamoxifen for the following  
 16 reason -  
 17 DR. KWAN:  
 18 A. Uh-hm.  
 19 COFFEY, Q.C.:  
 20 Q. The panel then might take 45 seconds actually,  
 21 if they accept -  
 22 DR. KWAN:  
 23 A. Probably document the fact that we looked at  
 24 it and say yes, this is good enough, and off  
 25 we go.

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1 COFFEY, Q.C.:  
 2 Q. And then other cases where they were more  
 3 problematic, you'd spend more time at it?  
 4 DR. KWAN:  
 5 A. Yes, you would look at when the patient--for  
 6 example, a patient who had lymphoma, in that  
 7 chart over there, that patient probably got a  
 8 lot more discussions as to whether we should  
 9 or should not treat it. We didn't come to any  
 10 conclusion at the end of that day.  
 11 COFFEY, Q.C.:  
 12 Q. Yes, that patient, in fact you're looking,  
 13 Doctor, the second one, second last one, in  
 14 fact.  
 15 DR. KWAN:  
 16 A. I just came through when you came up there -  
 17 COFFEY, Q.C.:  
 18 Q. The second last patient, "this patient should  
 19 be brought back to the clinic to check the  
 20 status of her low grade lymphoma."  
 21 DR. KWAN:  
 22 A. I mean, obviously that patient would have gone  
 23 through--consume a lot more time in looking at  
 24 what this is, what kind of lymphoma it is,  
 25 what type it is and whether--how extensive,

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<p>1 you know, what is the status is like. I mean, 2 those are the situation that would have been 3 taken a lot more time. 4 COFFEY, Q.C.: 5 Q. Doctor, here, looking at the third last 6 patient, the original result was the DAKO 7 ER/PR is negative, negative, and then Mount 8 Sinai's is 90 and 20. The recommendation, 9 under follow up, is "as this patient died 10 shortly after diagnosis, the change in ER/PR 11 status had no impact on care and therefore, no 12 action is required." Now Doctor, what is that 13 about? 14 DR. KWAN: 15 A. Well, as the patient died very shortly after, 16 she could have been died--whatever reason she 17 died of, I don't know, okay. She maybe died 18 of something else totally unrelated, you know, 19 so at this time, the patient had deceased, so 20 no opportunity even for hormone receptor to 21 work and hormone treatment is not a rapidly 22 changing thing. Rather hormones effects on 23 breast cancer is over a period of--lengthy 24 period of time before it produces effect. 25 It's not something that change within a week,</p>	<p>1 COFFEY, Q.C.: 2 Q. The validity of the assertion, I'm not asking 3 you about, and I appreciate you can't answer 4 without--why would it be the panel address its 5 mind to it at all? 6 DR. KWAN: 7 A. Well, always the same that there is--because 8 if the patient had been deceased immediately 9 post-op, what the ER and PR percentage of the 10 patient have no impact on care. 11 COFFEY, Q.C.: 12 Q. So the panel then, at least initially, was 13 keeping track of, for the deceased - 14 DR. KWAN: 15 A. We saw the results. 16 COFFEY, Q.C.: 17 Q. Yes. So the panel was keeping track of, 18 initially, if the patient was dead. They were 19 told the patient was dead, and was making an 20 assertion as to whether or not - 21 DR. KWAN: 22 A. It probably came up with the chart. 23 COFFEY, Q.C.: 24 Q. - whether or not the ER/PR change had an 25 impact on care. That's what I'm getting at</p>
<p>1 like you give penicillin for an infection. 2 COFFEY, Q.C.: 3 Q. And Doctor, that is the treatment effect of - 4 DR. KWAN: 5 A. The treatment effect of hormones, it takes 6 time to become effective. 7 COFFEY, Q.C.: 8 Q. Now Doctor, here, why would it be noted or why 9 was it seen fit to note that the change in 10 ER/PR status had no impact on care? 11 DR. KWAN: 12 A. Well, I don't know the details when the 13 patient died, what time the patient--you know, 14 she may--she died post-operatively as a 15 surgical complication, anasthetic 16 complication, therefore there's no 17 opportunity. I don't know that. 18 COFFEY, Q.C.: 19 Q. I appreciate that. What I'm asking is this, 20 why was the panel recording whether or not the 21 change in status had any impact on that 22 patient's care? Why would that be? 23 DR. KWAN: 24 A. I can't really--without the details, really 25 can't comment on it.</p>	<p>1 here. 2 DR. KWAN: 3 A. I realize that. I think that the only 4 information and how we got at this patient had 5 been deceased, probably came up when we 6 reviewed the chart. 7 COFFEY, Q.C.: 8 Q. Sure. 9 DR. KWAN: 10 A. And it came up and if the patient happened, 11 and happened to decease very shortly after the 12 operation or shortly after the diagnosis, then 13 the level of the ER and PR really had no 14 impact on the patient's death. It may impact 15 for the tumour, but no patient impact on the 16 patient's survival. 17 COFFEY, Q.C.: 18 Q. P-1384, please? Doctor, this is the minutes 19 of a physician panel meeting. It's styled 20 number three, October 27th, 2005. I just note 21 you were there, listed as being there. So 22 Doctor, I take it then--I'm not going to take 23 you through each of them in detail--that you 24 tried to make the panel meetings. You made an 25 effort to actually -</p>

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<p>1 DR. KWAN: 2 A. I did try, yes. 3 COFFEY, Q.C.: 4 Q. And you're recorded as--were there some that 5 you were not able to make? 6 DR. KWAN: 7 A. That's correct. 8 COFFEY, Q.C.: 9 Q. If we could, please, I'm just going to ask 10 that perhaps Exhibit 2554. It's page--I'm 11 just going to flip through to page seven. 12 Doctor, this is a physician panel review, 13 ER/PR results sheet. The date patient 14 reviewed is here. Of course, the name, MCP 15 and OPUS numbers are redacted. The date of 16 pathology, the specimen number, this is a 2000 17 case, 00, original report locally was NN, 18 negative, negative, and Mount Sinai zero, 19 zero, and patient did not convert. You're 20 listed as the follow-up physician, Kwan. 21 DR. KWAN: 22 A. That's me, yeah. 23 COFFEY, Q.C.: 24 Q. Yes, and the follow-up physician in this 25 context would be the person who was going to</p>	<p>1 A. I mean, the only concern of retesting is when 2 they have a change. With a change in 3 diagnosis, I would tell the patient. When 4 nothing is changed, I didn't tell the patient. 5 COFFEY, Q.C.: 6 Q. If there was a change, but it didn't result in 7 a change in treatment, would you tell the 8 patient? 9 DR. KWAN: 10 A. That may well be with laboratory changes and 11 errors, I won't tell the patients either. I 12 mean, you're talking about zero to one, one to 13 two, that could well be treated within 14 laboratory errors. 15 COFFEY, Q.C.: 16 Q. So your practice was, when you would receive 17 these panel letters, if they fell under that 18 category, you would - 19 DR. KWAN: 20 A. There's a much more formal letters than that. 21 COFFEY, Q.C.: 22 Q. Sure. But when you were - 23 DR. KWAN: 24 A. This is not what I'll get. 25 COFFEY, Q.C.:</p>
<p>1 do what? 2 DR. KWAN: 3 A. If need to be informed, the patients, that I 4 will get the letter and I will tell the 5 patient anything that need to be done. I 6 would contact the patients. 7 COFFEY, Q.C.: 8 Q. And here, to do what? 9 DR. KWAN: 10 A. Original report is negative, negative. Mount 11 Sinai is zero and zero. There's nothing to be 12 done. 13 COFFEY, Q.C.: 14 Q. So would you have told the patient? 15 DR. KWAN: 16 A. No. 17 COFFEY, Q.C.: 18 Q. You wouldn't have told - 19 DR. KWAN: 20 A. Have no change, no, I wouldn't have contacted 21 the patient, no. 22 COFFEY, Q.C.: 23 Q. About the fact that they had been retested and 24 were zero, zero? 25 DR. KWAN:</p>	<p>1 Q. Yes, but when you would receive the letter, 2 for example, for this patient, you wouldn't 3 pass that on to the patient? 4 DR. KWAN: 5 A. I wouldn't pass it on, no. 6 COFFEY, Q.C.: 7 Q. And if there was a small change from like zero 8 or negative to two - 9 DR. KWAN: 10 A. If it's affecting the treatment, yes, I will. 11 COFFEY, Q.C.: 12 Q. How about a situation, Doctor--and there are a 13 number of patients who whom it was true, that-- 14 -let me see if I can find one here easily. 15 Here, if we could look at 1384? Thank you. 16 Page one, which we're on. This is the same 17 panel meeting, Doctor, October 27th, and we'll 18 look here at the second patient. The date of 19 pathology is July--I'm sorry, January 26th, 20 2001. The original report ER/PR was five to 21 ten percent ER, 30 to 40 percent PR. Now 22 Mount Sinai was reporting it as 40, 20, okay? 23 And patient previously treated with Tamoxifen 24 and no follow-up treatment required. 25 DR. KWAN:</p>

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1 A. Um-hm.  
 2 COFFEY, Q.C.:  
 3 Q. Would you, when you got this panel letter,  
 4 would you inform the patient of that?  
 5 DR. KWAN:  
 6 A. The panel letter which says that there's no  
 7 change in treatment, I wouldn't tell them. I  
 8 mean, I wouldn't make--wouldn't go looking for  
 9 them. I would say that form letter that we  
 10 sent outside (unintelligible) language that  
 11 this disease had numbers and no change of  
 12 treatments, already get adequate treatment, I  
 13 would not. I mean, I wouldn't have to call  
 14 the patients that time.  
 15 COFFEY, Q.C.:  
 16 Q. And here, Doctor, the top of the second page,  
 17 original report ER/PR, it was negative for ER,  
 18 positive for PR, this particular patient, this  
 19 is a 2001 situation, June 13th, 2001. Mount  
 20 Sinai report, 70 ER 80 PR. The  
 21 recommendation: patient previously treated  
 22 with Tamoxifen and no follow-up treatment  
 23 required. You wouldn't have told--if this  
 24 happened to be your patient, you wouldn't have  
 25 told the patient, even to this day?

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1 DR. KWAN:  
 2 A. Has had adequate treatment, yes, I don't--you  
 3 know, the purpose of my interest is to look at  
 4 the patients where the treatments are changed.  
 5 I mean, if the treatments are changed, yes, I  
 6 think these patients need to be informed, you  
 7 know, that in fact treatments have changed.  
 8 That's why we do ER and PRs. Either one of  
 9 them is positive, we don't--we do the  
 10 treatments. Just we didn't do the single  
 11 receptors.  
 12 COFFEY, Q.C.:  
 13 Q. Now, so Doctor, if the panel letter, a panel  
 14 letter said "look, there's no treatment--the  
 15 result has changed -  
 16 DR. KWAN:  
 17 A. I'm sorry?  
 18 COFFEY, Q.C.:  
 19 Q. If the panel letter pointed out negative,  
 20 positive, and now 80, 90, which is two  
 21 positives, but no treatment change required  
 22 because the patient is already on Tamoxifen,  
 23 if the panel letter went on to say that you--  
 24 asked you to inform the patient about the  
 25 changed results -

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1 DR. KWAN:  
 2 A. I would do that.  
 3 COFFEY, Q.C.:  
 4 Q. Would you?  
 5 DR. KWAN:  
 6 A. If it was asked--that's what the panels are  
 7 there for. If they think that I should inform  
 8 them, then, yes, I would, you know.  
 9 Personally, whether it would change, it may  
 10 not change treatments at all, but they would  
 11 be told.  
 12 COFFEY, Q.C.:  
 13 Q. Exhibit P-0684, please? Doctor, this is an e-  
 14 mail of Heather Predham, November 24th, 2005.  
 15 It's to Dr. Williams, copied to a number of  
 16 individuals, Dr. Cook, Ms. Elliott and Ms.  
 17 Pilgrim, not yourself, update on ER/PR. She  
 18 writes "as you requested, here is an update on  
 19 ER/PR. There hasn't been much activity other  
 20 than getting two more converter results back.  
 21 Dr. Kwan made a suggestion at the last panel  
 22 that I should track those we may have  
 23 potentially harmed. We had agreed to classify  
 24 patients as being converted with or without  
 25 recommendations, but Dr. Kwan, and rightly so,

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1 felt it didn't accurately reflect those who  
 2 have been impacted. For example, if a person  
 3 was initially diagnosed with breast cancer in  
 4 the left breast and was ER/PR negative and  
 5 then had metastases to the right breast which  
 6 was ER/PR positive, the patient would be then  
 7 treated with Tamoxifen. So when we panelled  
 8 the person after their first results  
 9 converted, the panel would have no  
 10 recommendations, but there has been a  
 11 potential impact. At the last panel meeting,  
 12 out of the 17 panelled, there were seven  
 13 patients that were potentially negatively  
 14 impacted. I will have to review all the  
 15 patients panelled, but I'll try to have this  
 16 complete information for you next week. As  
 17 always, if you have any questions, please  
 18 call" and the briefing note is right there, is  
 19 attached here as pages two and three, and goes  
 20 on at some length, and it breaks down the  
 21 numbers in a very detailed way.  
 22 Now Doctor, I want to ask you about the  
 23 e-mail. Did you bring up the topic that Ms.  
 24 Predham here says you did?  
 25 DR. KWAN:

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<p>1 A. I'm sure I brought up something, but whether 2 it's accurately represented or not is that I 3 don't know. Somewhere that I couldn't--I 4 looked at this before. As I said, I can't 5 recall and interpret as to what she really 6 meant what I said. I did at always time be 7 looking at the possibility of gaining 8 informations and research informations and 9 information from these people that has been 10 treated or started on Tamoxifen late as to 11 what's happened in order to gain some long- 12 term information from the situation and I 13 always tell them that we should probably keep 14 track with all these patients that has either 15 converted or have partially converted and see 16 what these patients are like in the long term, 17 and that would help us to get some insight 18 information as to what we're doing. I'm not 19 so sure what he's mentioned about right breast 20 and left breast because it would be a terribly 21 unusual situation from a right breast tumour 22 (unintelligible) an opposite breast.</p> <p>23 MR. COFFEY: 24 Q. She's just using that as an example here 25 because she does say, in the third sentence,</p>	<p>1 COFFEY, Q.C.: 2 Q. You never did? 3 DR. KWAN: 4 A. Not that I can recall. 5 COFFEY, Q.C.: 6 Q. Have you ever heard any discussion about it? 7 DR. KWAN: 8 A. No, sir. 9 COFFEY, Q.C.: 10 Q. Have you ever made any inquiries since about 11 it? 12 DR. KWAN: 13 A. No. 14 COFFEY, Q.C.: 15 Q. Doctor, if we could just bring up, please, 16 Exhibit P-0046? Doctor, this is Dr. 17 Banerjee's--well, it's a covering letter, Dr. 18 Banerjee's report of October 17th, 2005 19 concerning his visit to St. John's in 20 September 2005. Were you ever--well, before 21 the Commission of Inquiry got going, were you 22 ever made aware of what Dr. Banerjee's 23 observations had been? 24 DR. KWAN: 25 A. No, sir.</p>
<p>Page 214</p> <p>1 the second paragraph, for example. Doctor, 2 did you ever ask, at the panel meetings, or 3 suggest at the panel meetings that we should-- 4 we, as a group, should be keeping track of who 5 is potentially harmed or negatively impacted 6 here? 7 DR. KWAN: 8 A. I think we should keep track on these people 9 that we have changed there and follow it up as 10 to see what the long term results of this 11 situation is, you know. I think that we had 12 invaluable bit of information that we can get 13 from it. 14 COFFEY, Q.C.: 15 Q. Doctor, did you--Ms. Predham here has said-- 16 now she's not saying this to you, because 17 although she attributes the subject matter as 18 having arisen because you raised it in the 19 group at the panel, did you ever see any such 20 information? She says here "I will have to 21 review all the patients panelled. I'll try to 22 have this complete information for you next 23 week." 24 DR. KWAN: 25 A. No, sir.</p>	<p>Page 216</p> <p>1 COFFEY, Q.C.: 2 Q. Did you ever make any inquiries about what he 3 had found? 4 DR. KWAN: 5 A. I didn't even know he was here. 6 COFFEY, Q.C.: 7 Q. How about Ms. Wegrynowski, she's the lady from 8 - 9 DR. KWAN: 10 A. No, sir. 11 COFFEY, Q.C.: 12 Q. - from Mount Sinai. No? 13 DR. KWAN: 14 A. No. That may have come from the discussion I 15 had with Dr. Williams back on August the 2nd. 16 COFFEY, Q.C.: 17 Q. And have you read the report since? 18 DR. KWAN: 19 A. No, sir. 20 COFFEY, Q.C.: 21 Q. Either of them? 22 DR. KWAN: 23 A. I'm sorry? 24 COFFEY, Q.C.: 25 Q. Either of them, you haven't read either of</p>

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<p>1 them?</p> <p>2 DR. KWAN:</p> <p>3 A. No, sir.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Have you discussed them with anybody?</p> <p>6 DR. KWAN:</p> <p>7 A. No, sir.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Is there any reason why you haven't, Doctor?</p> <p>10 DR. KWAN:</p> <p>11 A. Because I don't know even where to get a copy.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Pardon me?</p> <p>14 DR. KWAN:</p> <p>15 A. I don't know where to get a copy.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. Well, there are -</p> <p>18 DR. KWAN:</p> <p>19 A. I'm sure they are available. I'm sure it's</p> <p>20 available, but -</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. So Doctor, in terms of yourself, I mean, from</p> <p>23 your own curiosity perspective, I mean, you've</p> <p>24 worked here in this city for--in the province</p> <p>25 for over 30 years, and this has involved your</p>	<p>1 DR. KWAN:</p> <p>2 A. Most of my patients, as I said, at that time</p> <p>3 is probably gone to the Cancer Clinic. I only</p> <p>4 have a few patients that I followed.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Have you discussed it with any of them?</p> <p>7 DR. KWAN:</p> <p>8 A. If they had change, yes.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. And have you ever been asked or were you ever</p> <p>11 asked about why did this happen or how did it</p> <p>12 happen?</p> <p>13 DR. KWAN:</p> <p>14 A. I'm sure they have, I just cannot offer them a</p> <p>15 clear answer.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. What would you tell them or what did you tell</p> <p>18 them?</p> <p>19 DR. KWAN:</p> <p>20 A. I just tell them the change, something</p> <p>21 happened in the laboratory. At this time, we</p> <p>22 have been finding out the causes.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Now Doctor, when we looked at those minutes</p> <p>25 back in July, one of them attributes to you,</p>
<p>Page 218</p> <p>1 patients, you've never decided to go and find</p> <p>2 out what it was -</p> <p>3 DR. KWAN:</p> <p>4 A. I just wait for this Commission to--you know,</p> <p>5 probably had a better insight, the whole</p> <p>6 overall problems than the one external report.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. Doctor, we've heard evidence that in the fall</p> <p>9 of 2005, there was a certain amount of--well,</p> <p>10 the great bulk of results didn't come back</p> <p>11 here until January of 2006. Did you ever</p> <p>12 discuss that, the kind of wait time with</p> <p>13 people?</p> <p>14 DR. KWAN:</p> <p>15 A. With the administration?</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. Yes.</p> <p>18 DR. KWAN:</p> <p>19 A. No, because we all get so busy.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Doctor, in terms of your own patients, because</p> <p>22 you would have discussed this at times with</p> <p>23 your own patients, I'm not going to ask you</p> <p>24 about any individual patient, but you would</p> <p>25 have discussed this whole matter at times?</p>	<p>Page 220</p> <p>1 you're comforted or happy to note, or</p> <p>2 comforted to note or at least relieved to note</p> <p>3 that perhaps it was just a change in</p> <p>4 technology, just in the sense of it's a better</p> <p>5 machine. That's the sense of it there. Did</p> <p>6 you, at any time, ever come to any different</p> <p>7 views on that?</p> <p>8 DR. KWAN:</p> <p>9 A. Well, subsequently, they'd obviously proven</p> <p>10 probably not going to be true. As you</p> <p>11 remember, that's a very early meeting at the</p> <p>12 time, and we are still grappling with the</p> <p>13 problem and tried to find out what is the</p> <p>14 problems and I was happier if it's an easier</p> <p>15 problem that I can--that the laboratory can</p> <p>16 correct.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Doctor, when did you first come to the</p> <p>19 realization that it wasn't simply it's a</p> <p>20 better machine?</p> <p>21 DR. KWAN:</p> <p>22 A. Subsequently, I think, not too soon after</p> <p>23 that, I would assume.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. So by the -</p>

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1 DR. KWAN:  
 2 A. I can't remember a particular time, but I  
 3 would say after the first--maybe another  
 4 meeting or another--I don't know, perhaps even  
 5 after my meeting with Dr. Williams, discussion  
 6 with Dr. Williams. I can't remember exactly  
 7 when.  
 8 COFFEY, Q.C.:  
 9 Q. That it was a more complicated problem, a more  
 10 complex problem than simply it's a better  
 11 machine, move on?  
 12 DR. KWAN:  
 13 A. Um-hm.  
 14 THE COMMISSIONER:  
 15 Q. Mr. Coffey, it's getting near the luncheon  
 16 break.  
 17 COFFEY, Q.C.:  
 18 Q. Yes. If we could, please, Exhibit P-0423?  
 19 Doctor, this is an e-mail of November 6th,  
 20 2006. It's notifying people about Dr. Denic  
 21 giving a presentation to a large group,  
 22 November 20th, this would be 2006. It's to  
 23 include a number of people, including surgeons  
 24 who do breast surgery, and you'd fall into  
 25 that category. Do you recall, did you go or

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1 attend this presentation in November of 2006?  
 2 DR. KWAN:  
 3 A. No, sir.  
 4 COFFEY, Q.C.:  
 5 Q. Did you receive any information concerning it  
 6 afterward about -  
 7 DR. KWAN:  
 8 A. No, sir.  
 9 COFFEY, Q.C.:  
 10 Q. Like a copy of the slide deck or the slide  
 11 presentation or anything like that? The  
 12 answer is no?  
 13 DR. KWAN:  
 14 A. No, sir.  
 15 COFFEY, Q.C.:  
 16 Q. When we look at the second page, "surgeons  
 17 that do breast surgery," you're listed,  
 18 yourself and Dr. Felix are at the top there.  
 19 So Doctor, after getting involved in the  
 20 October and into November 2005 with this  
 21 review panel, okay, other than your  
 22 involvement with the review panel, did you  
 23 have any other involvement with the ER/PR  
 24 matter?  
 25 DR. KWAN:

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1 A. No, sir.  
 2 COFFEY, Q.C.:  
 3 Q. And perhaps then if we could come back then  
 4 after lunch, Commissioner, and I'll finish up.  
 5 THE COMMISSIONER:  
 6 Q. All right then. We'll take the luncheon  
 7 break. We'll meet again at 2:15.  
 8 COFFEY, Q.C.:  
 9 Q. Thank you.  
 10 (LUNCH BREAK)  
 11 THE COMMISSIONER:  
 12 Q. Please be seated. Mr. Coffey.  
 13 COFFEY, Q.C.:  
 14 Q. Yes, Doctor, we've heard evidence concerning a  
 15 breast disease site group which there's been  
 16 some evidence, first, well it was contemplated  
 17 and then formed in 2006. Were you involved in  
 18 that at all?  
 19 DR. KWAN:  
 20 A. Not really. I think, if I understand  
 21 correctly, that is within the Cancer Clinic.  
 22 COFFEY, Q.C.:  
 23 Q. Okay, and so it didn't involve yourself.  
 24 Doctor, you've indicated to the Commissioner,  
 25 you know, in terms of the idea of setting up a

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1 panel, a review panel, remember that, that you  
 2 would have medical oncologists, radiation  
 3 oncologists, surgeons, some--a pathologist or  
 4 two and as it turns out, Dr. Carter was there,  
 5 she's a breast pathologist, and some  
 6 administrative support. That was the -  
 7 DR. KWAN:  
 8 A. I think that's Dr. Williams' structure.  
 9 COFFEY, Q.C.:  
 10 Q. Dr. Williams, the way it finally came?  
 11 DR. KWAN:  
 12 A. That we looked at it, yes.  
 13 COFFEY, Q.C.:  
 14 Q. But yourself, your view of it was that we're  
 15 in uncharted territory here because of the  
 16 delayed treatment, which -  
 17 DR. KWAN:  
 18 A. Correct.  
 19 COFFEY, Q.C.:  
 20 Q. - would happen potentially, and it might be  
 21 that you could only have a certain amount of  
 22 expertise around the table to provide advice  
 23 to people such as yourself, for example, who  
 24 are not in a day to day sense involved in  
 25 following cancer patients after surgery any



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1 more.  
 2 DR. KWAN:  
 3 A. Not at the moment, yes.  
 4 COFFEY, Q.C.:  
 5 Q. Yes, and at the time, I mean, by 2005  
 6 certainly, you weren't involved in that, as  
 7 you pointed out to the Commissioner. Those  
 8 patients were few and far between for you by  
 9 that point?  
 10 DR. KWAN:  
 11 A. That's correct.  
 12 COFFEY, Q.C.:  
 13 Q. And I take it, Doctor, that you would have  
 14 thought, at the time, "well, look, there'll be  
 15 myself, there'll be Dr. Felix and perhaps  
 16 other surgeons in the same position." Did you  
 17 understand, at the time, because this had gone  
 18 all the way back to '97, '98, '99, went back  
 19 for years, that some patients would no longer  
 20 be patients of the Cancer Treatment Centre?  
 21 DR. KWAN:  
 22 A. That's correct.  
 23 COFFEY, Q.C.:  
 24 Q. They would be followed for about five years.  
 25 DR. KWAN:

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1 A. Yeah, I mean, it all depends what the follow  
 2 up, how some--some patients would have been  
 3 discharged from the Cancer Clinic. That is  
 4 correct, no longer followed.  
 5 COFFEY, Q.C.:  
 6 Q. And so some of them, there'd be a group of  
 7 patients who would have been discharged,  
 8 having been followed by the Cancer Treatment  
 9 Centre for a period of time, or some, perhaps,  
 10 who had never been followed by the--for  
 11 whatever reason, not followed by the Cancer  
 12 Treatment Centre, and but their particular  
 13 physicians, their--in many cases, their  
 14 surgeon or their general practitioner would  
 15 need to be told -  
 16 DR. KWAN:  
 17 A. Correct.  
 18 COFFEY, Q.C.:  
 19 Q. - if there was a change, the fact that they  
 20 changed had occurred, as well might require  
 21 some advice as to--from people who would  
 22 presumably be in the best position to know,  
 23 expert advice, as to what is appropriate.  
 24 That was your--at the time, your approach?  
 25 DR. KWAN:

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1 A. Correct.  
 2 COFFEY, Q.C.:  
 3 Q. Doctor, was there ever any discussion about  
 4 the fact that for many of these patients, they  
 5 would already be patients of the Cancer  
 6 Treatment Centre, current patients?  
 7 DR. KWAN:  
 8 A. Yes, we do go through--if they found it with  
 9 the Cancer Treatment follow up program care,  
 10 we would identify the oncologist who's looking  
 11 after it and send him a letter.  
 12 COFFEY, Q.C.:  
 13 Q. Send him or her?  
 14 DR. KWAN:  
 15 A. Him or her, yeah.  
 16 COFFEY, Q.C.:  
 17 Q. In the main, Doctor, if the treating  
 18 oncologist, currently treating oncologist, was  
 19 a medical oncologist, for example, Dr.  
 20 Siddiqui, Dr. McCarthy, Dr. Laing, and  
 21 there'll be others, was there actually any  
 22 need to have the panel look at those patients?  
 23 Because the medical oncologist who's sitting  
 24 next to you on the panel, Dr. Laing or Dr.  
 25 McCarthy, would actually be making the

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1 decision anyway.  
 2 DR. KWAN:  
 3 A. Probably not, you know, in that sense, but we  
 4 don't isolate and identify patients on that,  
 5 and I think this is generally the panel is  
 6 making as a recommendation. For anybody who  
 7 has expertise in that matter, they can either  
 8 accept our recommendation or not accept our  
 9 recommendation.  
 10 COFFEY, Q.C.:  
 11 Q. Sure. Doctor, by the time the panel first  
 12 sat, which is around October 13th, 14th, the  
 13 first meeting, and then October 20th, 27th,  
 14 and there are meetings thereafter at times, by  
 15 the time the panel first sat, you would have  
 16 understood that there were, I don't know, 700-  
 17 800 patients or more that were going to be  
 18 retested? Would you have understood that at  
 19 the time?  
 20 DR. KWAN:  
 21 A. No, I didn't.  
 22 COFFEY, Q.C.:  
 23 Q. Okay, just -  
 24 DR. KWAN:  
 25 A. We didn't know how many numbers was there.

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1 COFFEY, Q.C.:

2 Q. Okay, and I just want to kind of canvas some

3 of that with you. When did you realize, like

4 what turned out to be the actual numbers, not

5 the precise number, but the kind of sheer

6 magnitude?

7 DR. KWAN:

8 A. As it goes along, it seems to be never ends.

9 Then we start getting the feeling that there's

10 a lot more number than, than at least I

11 anticipated. I don't know about the others,

12 at least I anticipated it.

13 COFFEY, Q.C.:

14 Q. Doctor, if you had known two things, if you

15 had known the sheer number involved, okay, of

16 patients that were going to be retested, and

17 for the sake of argument here, we'll assume

18 for the moment that, say 40 percent had a

19 change in result, if you had known that, and

20 I'll just pick a figure, 500 patients being

21 retested, 40 percent of that, 200 patients

22 that would have to go through your panel, and

23 in fact, on 1,000 patients, it would be 400

24 patients would have to go through your panel,

25 if you'd known the sheer size of the numbers

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1 and realized how many of those patients were

2 already patients, current patients of the

3 Cancer Centre, already had a medical

4 oncologist, would you have given any

5 consideration to only having the panel look at

6 the non-cancer -

7 DR. KWAN:

8 A. Certainly if we know that it would take a

9 horrendous amount of effort to go through the

10 sheer magnitude of the number, it may well be

11 a reasonable approach to screen those out and

12 say, yes, if they got a problem, then have

13 those patients referred back to the tumour

14 board, which is totally different entity, to

15 discuss their management of that group. That

16 will be certainly a consideration, but that

17 wasn't -

18 COFFEY, Q.C.:

19 Q. It just didn't happen, it didn't come up?

20 DR. KWAN:

21 A. It just didn't happen, no.

22 COFFEY, Q.C.:

23 Q. It was never--once the panel itself, in the

24 middle of October, kind of embarked on the

25 process, there was no actual kind of--that you

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1 can recall at any time at which there was a

2 reevaluation of the position we're in here?

3 DR. KWAN:

4 A. No. I think we were trying to do as much as

5 we can as the report comes back, to try to

6 deal with it as quick and as soon as we can.

7 So we may have occasionally lost track of the

8 sheer numbers that has to come through

9 eventually.

10 COFFEY, Q.C.:

11 Q. And if we could, please, Doctor, if we could

12 please, Registrar, Exhibit P-1420? Doctor,

13 this is a letter of September 19th, 2007.

14 It's addressed to Marian Crowley, the quality

15 and risk information coordinator at Eastern

16 Health. It's about a letter sent to patients

17 and families of August 17th, 2007 regarding ER

18 and PR retesting. It's "respectfully yours,"

19 that would be your signature, I believe, right

20 there?

21 DR. KWAN:

22 A. Yeah.

23 COFFEY, Q.C.:

24 Q. And it's copied to a number of people within

25 Eastern Health, including people on the

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1 executive, and Doctor, how is it that you came

2 to sign this letter?

3 DR. KWAN:

4 A. Well, it was brought to my attention, by both

5 the medical oncologists and the radiation

6 oncologists, some inaccuracy in that letter.

7 I think it's the letter applied screening,

8 which really wasn't a test that we were

9 concerned about screening. So we thought that

10 we should mention it to them and they asked,

11 mentioned to us, to them that this letter,

12 this process, there's some error in their

13 letter, and it added further confusions to

14 already confused situation. We thought that

15 they should know and we thought that

16 collectively we should put our signatures on

17 it.

18 COFFEY, Q.C.:

19 Q. Do you recall who drafted the letter?

20 DR. KWAN:

21 A. No, I don't. The letter was brought to me

22 through McCarthy and Laing and Ganguly and, I

23 think that's what the -

24 COFFEY, Q.C.:

25 Q. And you read it and then signed it?

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1 DR. KWAN:  
 2 A. And I read it and then signed it, yes.  
 3 COFFEY, Q.C.:  
 4 Q. Doctor, at the time, do you know or did you  
 5 inquire about or make any inquiries or be told  
 6 about how it was that the letter had come to  
 7 be sent at all?  
 8 DR. KWAN:  
 9 A. I don't know. I saw the original letter that  
 10 was sent out, a copy of a letter that  
 11 actually, if I remember correctly, now I have  
 12 not--because I don't receive a copy of that  
 13 letter, it's brought to the attention to one  
 14 of the medical oncologists through his  
 15 patients, his or her patient, I don't even  
 16 know who it was, and I read it and it was, in  
 17 fact, using breast screening tests was what's  
 18 the word used, and we thought that that was an  
 19 incorrect description was the problems were.  
 20 We thought that they needed to be made aware  
 21 of that.  
 22 COFFEY, Q.C.:  
 23 Q. Did you make any inquiries about whether or  
 24 not anybody ran this past us, as a group,  
 25 before it was sent out?

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1 DR. KWAN:  
 2 A. Yes. We talked about--we talked within  
 3 ourselves has anybody seen this letter before  
 4 it goes out, the answer is no, none of us have  
 5 seen this letter before it went out.  
 6 COFFEY, Q.C.:  
 7 Q. Have you made any inquiries since?  
 8 DR. KWAN:  
 9 A. No, sir.  
 10 COFFEY, Q.C.:  
 11 Q. If we could, Exhibit P-0731? 0731, please.  
 12 Doctor, this is a letter of October 11th,  
 13 2007. It's addressed to a number of  
 14 individuals. Here's a third name there. It's  
 15 from Ms. Crowley. It's copied to the people  
 16 that were copied on that letter that we just  
 17 looked at, and it's re: a court order, a  
 18 letter sent to patients and families, August  
 19 17th, 2007, regarding estrogen and  
 20 progesterone retesting, and she acknowledges  
 21 receipt of your letter, yours and others, and  
 22 she says "in an effort to clarify our  
 23 involvement, I will highlight key points  
 24 related to the circumstances around the letter  
 25 for those of you who may not be familiar."

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1 And the second bullet says "professionals  
 2 involved in this matter were sent a copy of  
 3 the court order, but were unable to provide a  
 4 list of the patients involved," and then talks  
 5 about the days spent trying to identify  
 6 patients who met the criteria stated in the  
 7 court order, and in the third bullet, it says  
 8 "staff of the Quality and Risk Management  
 9 department coordinated the logistics of  
 10 getting the letter out, including consulting  
 11 with physicians and others to confirm which  
 12 patients should be included and getting MCP  
 13 numbers, addresses and labels. We eventually  
 14 determined that the patients who were panelled  
 15 by the ER/PR physician review panelling group  
 16 met the legal definition of patients who  
 17 converted from clinically negative to  
 18 clinically positive."  
 19 And then "on August 16th, 2007, Eastern  
 20 Health received a copy of a cover letter to  
 21 accompany the class action notice from the  
 22 lawyers and the registered letters had to be  
 23 in the mail by August 17th." She says "we  
 24 understood from our lawyers we could not  
 25 change the wording which included the

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1 inaccurate reference to screening."  
 2 So Doctor, I'm going to ask you here, in  
 3 terms of this third bullet, were you ever,  
 4 because you had been involved in the physician  
 5 review panelling group, ever approached  
 6 concerning who should get the letter?  
 7 DR. KWAN:  
 8 A. No, sir, not me personally.  
 9 COFFEY, Q.C.:  
 10 Q. Doctor, was there ever any concern amongst the  
 11 panel members about the amount of time it was  
 12 taking to get through them?  
 13 DR. KWAN:  
 14 A. Sometimes we had to wait for the list of  
 15 patients to come through, you know. I don't  
 16 know--I guess we just meet and meet and  
 17 sometimes we just lost track of how long we  
 18 took.  
 19 COFFEY, Q.C.:  
 20 Q. Did you ever encounter yourself any difficulty  
 21 in contacting patients to let them know about  
 22 the review letters?  
 23 DR. KWAN:  
 24 A. Sometimes it takes a few phone calls, yes, to  
 25 track the patients down, and, you know.

1 COFFEY, Q.C.:

2 Q. Were there any patients of your own that you

3 were not able to contact?

4 DR. KWAN:

5 A. No, sir.

6 COFFEY, Q.C.:

7 Q. And did anyone from Eastern Health ever follow

8 up with you to question or to ask of you

9 whether you had contacted all your patients?

10 DR. KWAN:

11 A. I think somebody did. They did call and say

12 have you contacted; yes. I don't know who,

13 though, but I remember somebody called the

14 office.

15 COFFEY, Q.C.:

16 Q. Doctor, you'll recall earlier this morning I

17 referred you to minutes, in particular, MAC

18 minutes referring to adverse events, policies,

19 that sort of thing. Doctor, in relation to

20 your involvement then in ER/PR, did anyone, to

21 your knowledge, within your earshot, or

22 involving you, yourself, ever discuss with

23 anybody the idea of following that policy or

24 policies in dealing with your patients

25 concerning ER/PR, actually getting out that

1 Thank you. Thank you, Doctor.

2 THE COMMISSIONER:

3 Q. Ms. Brazil.

4 MS. BRAZIL:

5 Q. No questions of this witness, Commissioner.

6 THE COMMISSIONER:

7 Q. Mr. Simmons.

8 DR. ALAN KWAN - EXAMINATION BY MR. DAN SIMMONS

9 MR. SIMMONS:

10 Q. Good afternoon, Dr. Kwan. Dan Simmons, I'm

11 the lawyer here for Eastern Health. I just

12 had one thing I wanted to ask you about

13 concerning the contact that you would make

14 with your patients after receiving a panel

15 letter after they'd been panelled, and the

16 letter went out. I'm going to show you just

17 some samples of some of the letters first and

18 that's at C-229, please. This was a selection

19 of letters that we looked at with a witness

20 earlier. I'm just going to show you the first

21 couple because they are examples of the form

22 that a lot of the letter take. In this

23 particular one which comes from October 20th,

24 2005, the second paragraph there says, "The

25 patient as discussed at the physician review

1 policy -

2 DR. KWAN:

3 A. I'm thinking now whether anybody talked to me

4 about ER/PR. No, I don't believe so.

5 COFFEY, Q.C.:

6 Q. The idea of - okay, we're into this, we do

7 have a policy concerning adverse events,

8 because you had been looking at it in the MAC

9 just before this all happened.

10 DR. KWAN:

11 A. I don't - I don't think everybody took that

12 and applied the ER/PR right away. Now may

13 have done it -

14 COFFEY, Q.C.:

15 Q. Afterwards.

16 DR. KWAN:

17 A. After, but that moment, I don't think anybody

18 spoken to me and said we need to do it. They

19 may have done, but I don't know.

20 COFFEY, Q.C.:

21 Q. And if they have, you have never been told?

22 DR. KWAN:

23 A. No.

24 COFFEY, Q.C.:

25 Q. Commissioner, that's all the questions I have.

1 panel, October 13th, 2005, and a review of the

2 patient's chart revealed that she had been

3 notified of the change in results and started

4 on Tamoxifen", and it says the panel had no

5 further recommendations at this time, and the

6 next page is an example of another form of

7 letter that appears frequently, and the second

8 paragraph there is similar, but it starts in a

9 similar way, "This patient was discussed at

10 the physician review panel on October 20th,

11 2005. The recommendation of the panel is that

12 there be no change in treatment as the patient

13 has been previously treated with Tamoxifen",

14 and it continues, "We would ask that you

15 communicate the change in results to your

16 patient as soon as possible". Do you

17 recognize the format of these letters as being

18 the format that would have been used for those

19 panel letters that you received?

20 DR. KWAN:

21 A. Yes.

22 MR. SIMMONS:

23 Q. When you received a letter like this one on

24 page two which asks that you communicate the

25 change in results to your patient, even though

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<p>1 there's no recommended change of treatment, 2 what would you have done upon receiving a 3 letter like that? 4 DR. KWAN: 5 A. Followed the instructions. 6 MR. SIMMONS: 7 Q. And - 8 DR. KWAN: 9 A. At least make an attempt to. Now having said 10 that, all total I probably received maybe half 11 a dozen of letters from the panel that I'm 12 still remained the contact physician, although 13 most of my patients have either been 14 transferred or discharged. 15 MR. SIMMONS: 16 Q. Right. 17 DR. KWAN: 18 A. And no longer the contact physician. 19 MR. SIMMONS: 20 Q. So in any cases where if you received any 21 letters like this which asked you to ensure 22 that the communication took place, do you know 23 if you followed up on that, or if there was - 24 DR. KWAN: 25 A. If I remember, I've contacted every one of</p>	<p>1 found it necessary to do so. We have 2 situations where - particularly in patients, 3 for example, in central Newfoundland and 4 things of that nature, we need to ask 5 permission to get those history before we can 6 make any decisions, and sometimes have to be 7 delayed the next panel visit discussion before 8 we can form any answers, yes, we did. 9 MS. NEWBURY: 10 Q. And so the mechanism in place for patients 11 outside of the St. John's area was different 12 from those within - 13 DR. KWAN: 14 A. No, no, applied to every - I'm just using that 15 as an example. It's exactly the same 16 anywhere. 17 MS. NEWBURY: 18 Q. Okay, and in your view, as the panel meetings 19 proceeded, the ones that you attended, I guess 20 you can speak to specifically, was it your 21 understanding that current medical history was 22 available before the panel made 23 recommendations to the attending physician? 24 DR. KWAN: 25 A. Certainly as close as we can get.</p>
<p>1 them that I was - in that category that I can 2 remember. 3 MR. SIMMONS: 4 Q. Good. Fine, thank you, Dr. Kwan. 5 THE COMMISSIONER: 6 Q. Mr. Pritchett. 7 MR. PRITCHETT: 8 Q. No questions, Commissioner. Thank you, Dr. 9 Kwan. 10 THE COMMISSIONER: 11 Q. Ms. Newbury. 12 DR. ALAN KWAN - EXAMINATION BY MS. JENNIFER NEWBURY 13 MS. NEWBURY: 14 Q. Good afternoon, Dr. Kwan. My name is Jennifer 15 Newbury, and I represent the Canadian Cancer 16 Society. I want to ask you a couple of 17 questions about the physician review panel as 18 well. When you were initially suggested the 19 physician review panel as an idea back in 20 probably the summer of 2005, somewhere around 21 that time, did you expect that the patient's 22 current medical history would be made known to 23 the panel? 24 DR. KWAN: 25 A. We would have to update the history if we</p>	<p>1 MS. NEWBURY: 2 Q. Okay. 3 DR. KWAN: 4 A. You know, I mean, sometimes you get patient's 5 last visit. That's all the information that 6 we have, particularly related to tumours, and 7 there's no particular indications up to that 8 point that we can - felt that we can make the 9 recommendation, we would. 10 MS. NEWBURY: 11 Q. And you're not aware of any consideration of 12 allowing the attending physicians to 13 participate, either by telephone, or perhaps 14 attending the meeting or providing any other 15 sort of written recommendations to the panel 16 before it met? 17 DR. KWAN: 18 A. Oh, I don't think we ever considered that, no. 19 The issue will be a significant hurdle. We 20 did offer, as you know, if they have any 21 questions, please refer the patient back to 22 us. That was included in the letter going out 23 to them. 24 MS. NEWBURY: 25 Q. Okay. So as far as you know, you did have, I</p>
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<p>1 guess, best possible up to date information</p> <p>2 for the patients before the panel made</p> <p>3 recommendations?</p> <p>4 DR. KWAN:</p> <p>5 A. As much as we can make a decision on.</p> <p>6 MS. NEWBURY:</p> <p>7 Q. Okay.</p> <p>8 DR. KWAN:</p> <p>9 A. I mean, we don't go farther into details and</p> <p>10 details of which that we don't think is</p> <p>11 necessary for our information.</p> <p>12 MS. NEWBURY:</p> <p>13 Q. And do you know whether the panel ever left it</p> <p>14 to the attending physician to meet with the</p> <p>15 patient to update the medical history after</p> <p>16 the panel had met and made its</p> <p>17 recommendations?</p> <p>18 DR. KWAN:</p> <p>19 A. All these things is a recommendation. The</p> <p>20 panels can only make recommendations. The</p> <p>21 panel cannot make absolute decisions or</p> <p>22 treatment. If the individual physicians take</p> <p>23 this recommendation and say that, look,</p> <p>24 there's something wrong in the history, I</p> <p>25 can't cope - I can't apply this</p>	<p>1 think that there's a contraindication to</p> <p>2 treatment.</p> <p>3 MS. NEWBURY:</p> <p>4 Q. Uh-hm.</p> <p>5 DR. KWAN:</p> <p>6 A. Then he or she contact back to the oncologist</p> <p>7 and refer the patient back for discussion.</p> <p>8 MS. NEWBURY:</p> <p>9 Q. And if the treating physician, the primary</p> <p>10 recipient of the panel letter, haven't met</p> <p>11 with his or her patient within, say, the last</p> <p>12 eighteen months or two years, was there an</p> <p>13 expectation by the panel that the physician</p> <p>14 meet with the patient, get an update of the</p> <p>15 medical history, and then verify the panel's</p> <p>16 recommendation?</p> <p>17 DR. KWAN:</p> <p>18 A. I think the - I think there would be</p> <p>19 expectation of the physicians to discuss the</p> <p>20 patient's treatment, the change and that, and</p> <p>21 treatment recommendation that had been altered</p> <p>22 with the patients, and explain to him or her</p> <p>23 what the issues are so they can understand the</p> <p>24 issue and then if things are not clear enough,</p> <p>25 then refer back, and if the physician have any</p>
<p>1 recommendation, then we're available for them</p> <p>2 to refer the patient back, discuss the issue,</p> <p>3 and maybe we were - the information is</p> <p>4 missing. I think that's why the decision is</p> <p>5 not sent to the patients, but the physicians.</p> <p>6 MS. NEWBURY:</p> <p>7 Q. Okay, and in terms of communication then with</p> <p>8 the physician who ultimately will meet with</p> <p>9 the patient and make the decision, how would</p> <p>10 those physicians know the information that was</p> <p>11 available to the panel when it made its</p> <p>12 recommendation, if there as no other direct</p> <p>13 communication with the treating physicians?</p> <p>14 DR. KWAN:</p> <p>15 A. When they think there's a contraindication for</p> <p>16 treatment, for example, if the patient, we</p> <p>17 recommend Tamoxifen, and within the last month</p> <p>18 they develop huge deep vein thrombosis and a</p> <p>19 stroke, for example -</p> <p>20 DR. KWAN:</p> <p>21 A. Sure.</p> <p>22 MS. NEWBURY:</p> <p>23 Q. Then he would then recognize there is a</p> <p>24 contraindication here now, which happened</p> <p>25 within last month or two, whatever, and may</p>	<p>1 question about that, to refer the patient</p> <p>2 back. That is the expectation.</p> <p>3 MS. NEWBURY:</p> <p>4 Q. And would there be any concerns that perhaps</p> <p>5 the treating physician might make assumptions</p> <p>6 about the availability or access to</p> <p>7 information that the panel had? Perhaps the</p> <p>8 physician who receives a panel letter might</p> <p>9 assume that the panel had more up to date</p> <p>10 information if - you know, if maybe the</p> <p>11 patient was seen at the cancer clinic more</p> <p>12 recently, that that decision -</p> <p>13 DR. KWAN:</p> <p>14 A. If at the Cancer Clinic more recently, we will</p> <p>15 have that information in our computers to tell</p> <p>16 us that the patients have been there and those</p> <p>17 who were there.</p> <p>18 MS. NEWBURY:</p> <p>19 Q. But the recipient of the letter, though, may</p> <p>20 not necessarily know what information the</p> <p>21 panel did or did not have?</p> <p>22 DR. KWAN:</p> <p>23 A. They may not know, but the communication has</p> <p>24 to occur. I mean, it's difficult for us to</p> <p>25 cover every aspect of it.</p>

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<p>1 MS. NEWBURY:</p> <p>2 Q. Sure, and you're not aware of any sort of</p> <p>3 general direction to the recipients of these</p> <p>4 letters in terms of how to proceed upon</p> <p>5 receipt of the panel letters, how to</p> <p>6 incorporate them in terms of their own</p> <p>7 treatment of the patient?</p> <p>8 DR. KWAN:</p> <p>9 A. No. I mean, we didn't have any communication</p> <p>10 to tell them what exactly to do, but always</p> <p>11 hope that they are physicians and they should</p> <p>12 be able to handle some of those issues.</p> <p>13 MS. NEWBURY:</p> <p>14 Q. Sure. Now these circumstances, though, are</p> <p>15 perhaps a little different than what a</p> <p>16 physician might normally refer for a</p> <p>17 consultation, more contemporaneously with</p> <p>18 treating a particular patient?</p> <p>19 DR. KWAN:</p> <p>20 A. Sure. They would be available for</p> <p>21 consultations and they refer backwards.</p> <p>22 MS. NEWBURY:</p> <p>23 Q. And you had indicated that the current medical</p> <p>24 history is certainly a significant issue -</p> <p>25 DR. KWAN:</p>	<p>1 MS. NEWBURY:</p> <p>2 Q. Dr. Kwan, you mentioned at some of the panel</p> <p>3 meetings where a patient of your own was</p> <p>4 listed to be panelled, you would bring along</p> <p>5 information to the panel meeting?</p> <p>6 DR. KWAN:</p> <p>7 A. Yeah, just in event it was not covered. I</p> <p>8 mean, I had my own office chart which is</p> <p>9 basically - my office charts are duplication</p> <p>10 from the computer of the hospitals. In the</p> <p>11 event sometimes the computer glitch, you then</p> <p>12 have the information, you save time from</p> <p>13 digging it out and have it in my file.</p> <p>14 MS. NEWBURY:</p> <p>15 Q. Okay. So then you would your own chart, but</p> <p>16 you expect it should be a duplicate of the -</p> <p>17 DR. KWAN:</p> <p>18 A. Yes, my chart is all duplicate from what's in</p> <p>19 the computer.</p> <p>20 MS. NEWBURY:</p> <p>21 Q. And you'd mentioned that when you arrived at</p> <p>22 the meeting, the charts would be there. So</p> <p>23 even our own patient chart would still be</p> <p>24 there at the meeting.</p> <p>25 DR. KWAN:</p>
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<p>1 A. Yes, some -</p> <p>2 MS. NEWBURY:</p> <p>3 Q. Comorbidity would be -</p> <p>4 DR. KWAN:</p> <p>5 A. Most definitely.</p> <p>6 THE COMMISSIONER:</p> <p>7 Q. Dr. Kwan, just in answer to that last</p> <p>8 question, were you assuming that the letter</p> <p>9 from the panel was the only information that a</p> <p>10 general practitioner who might have been the</p> <p>11 recipient would have received in the sense of</p> <p>12 official communication from -</p> <p>13 DR. KWAN:</p> <p>14 A. I wouldn't know if they have received anything</p> <p>15 else from anybody else at Eastern Health</p> <p>16 directly. I don't know that.</p> <p>17 THE COMMISSIONER:</p> <p>18 Q. So you don't know whether or not they might</p> <p>19 have received other information -</p> <p>20 DR. KWAN:</p> <p>21 A. Correct.</p> <p>22 THE COMMISSIONER:</p> <p>23 Q. Of a general nature about the issue.</p> <p>24 DR. KWAN:</p> <p>25 A. Correct.</p>	<p>1 A. All the Cancer Clinic charts would be there.</p> <p>2 MS. NEWBURY:</p> <p>3 Q. Okay.</p> <p>4 DR. KWAN:</p> <p>5 A. Don't usually have the hospital chart, but</p> <p>6 hospitals are in computer, Meditech.</p> <p>7 MS. NEWBURY:</p> <p>8 Q. Okay.</p> <p>9 DR. KWAN:</p> <p>10 A. But Cancer Clinic chart which is in a</p> <p>11 different system, and we oftentimes don't have</p> <p>12 access to it.</p> <p>13 MS. NEWBURY:</p> <p>14 Q. Okay. Dr. Kwan, you were shown a letter that</p> <p>15 was forwarded to you from Dr. Cook, July 18th,</p> <p>16 2005. That was early on in the retesting.</p> <p>17 DR. KWAN:</p> <p>18 A. Uh-hm.</p> <p>19 MS. NEWBURY:</p> <p>20 Q. And did you receive any other similar letters</p> <p>21 early on?</p> <p>22 DR. KWAN:</p> <p>23 A. I think there's one more, if I remember, I</p> <p>24 mean, just because I went through it. I</p> <p>25 wouldn't remember it, but there was - I was</p>

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1 brought to attention there's one more.  
 2 MS. NEWBURY:  
 3 Q. Okay, and were you able to handle those two  
 4 letters without the benefit of a review panel,  
 5 and if so, how did you make a decision about  
 6 what to -  
 7 DR. KWAN:  
 8 A. I think they both reviewed.  
 9 MS. NEWBURY:  
 10 Q. Okay, they were both -  
 11 DR. KWAN:  
 12 A. They were - if I remember, they were all  
 13 subsequently reviewed, but those patients were  
 14 contacted as soon as I got the letter.  
 15 MS. NEWBURY:  
 16 Q. Okay, and were any recommendations made to the  
 17 patients in the interim, or did you suggest  
 18 awaiting the outcome of the review panel?  
 19 DR. KWAN:  
 20 A. No, both of them did not require any -  
 21 MS. NEWBURY:  
 22 Q. So it was just an information -  
 23 DR. KWAN:  
 24 A. Just happened to not require any change in  
 25 treatment.

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1 MS. NEWBURY:  
 2 Q. Okay, and if, for example, and this is a  
 3 hypothetical, of course, if there had been a  
 4 change recommended, would you have been able,  
 5 as a surgeon, to have made recommendations  
 6 without the benefit of a panel?  
 7 DR. KWAN:  
 8 A. I would be on very thin grounds.  
 9 MS. NEWBURY:  
 10 Q. Yes.  
 11 DR. KWAN:  
 12 A. Let's put it this way. I certainly would like  
 13 to tell the patient then and wait until these  
 14 things have been given answer. We are  
 15 panelling patients that are well, you know,  
 16 not--and they are panelling patients that  
 17 their treatments at that time, 2005, maybe  
 18 even they're panelling 2002 patients, so there  
 19 really don't have that immediate treatment in  
 20 a week or two that we have to get an answer  
 21 from. If the situation does arrive, we would  
 22 suggest then to go to the tumour board and  
 23 refer it back to the medical oncologist.  
 24 MS. NEWBURY:  
 25 Q. And if either you didn't have the benefit of

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1 the review panel that was in place at this  
 2 time or if you wanted to make a more urgent  
 3 decision before the panel was put in place,  
 4 what other options would have been available  
 5 to you to help make a decision as to -  
 6 DR. KWAN:  
 7 A. That's what I was just mentioning, that we  
 8 will refer the patient to the medical  
 9 oncologist directly.  
 10 MS. NEWBURY:  
 11 Q. Okay.  
 12 DR. KWAN:  
 13 A. Or bring the--I have the advantage of of  
 14 bringing the patient to the tumour board,  
 15 which is totally different than the panel.  
 16 MS. NEWBURY:  
 17 Q. Right.  
 18 DR. KWAN:  
 19 A. And have them to send it in that situation and  
 20 get some answers.  
 21 MS. NEWBURY:  
 22 Q. Okay. Dr. Kwan, you mentioned that you only  
 23 received about a half dozen letters from the  
 24 physician review panel?  
 25 DR. KWAN:

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1 A. About that. I don't know, I don't remember  
 2 the exact number, but it's not a huge amount.  
 3 MS. NEWBURY:  
 4 Q. Just certainly not a huge amount?  
 5 DR. KWAN:  
 6 A. No.  
 7 MS. NEWBURY:  
 8 Q. And those were letters that you were the  
 9 primary recipient as opposed to being copied  
 10 on the letter?  
 11 DR. KWAN:  
 12 A. Correct.  
 13 MS. NEWBURY:  
 14 Q. And how quickly were you able to make your  
 15 calls to those patients to advise of the  
 16 results?  
 17 DR. KWAN:  
 18 A. Most of those patients, those patients were  
 19 patients because I'd been primary physician  
 20 they are followed, I have regular clinic visit  
 21 from them.  
 22 MS. NEWBURY:  
 23 Q. Okay.  
 24 DR. KWAN:  
 25 A. They come visit. So it wasn't that difficult



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1 for me to pick up the phone and say I'll see  
 2 you next week or in two weeks down the road,  
 3 whatever the conveniences are and deal with  
 4 it.  
 5 MS. NEWBURY:  
 6 Q. Okay. In either of those cases would you have  
 7 just simply put the letter in the file and  
 8 await the next regularly scheduled  
 9 appointment, you know, several months down the  
 10 road or would you -  
 11 DR. KWAN:  
 12 A. No, no, those are patients I'd call them.  
 13 MS. NEWBURY:  
 14 Q. Okay.  
 15 DR. KWAN:  
 16 A. Or bring them in clinic earlier.  
 17 MS. NEWBURY:  
 18 Q. And were you given any, aside from what might  
 19 have been stated in the letter itself, were  
 20 you given any direction in terms of the timing  
 21 of communication with patients, the fact that  
 22 they may or may not be awaiting results and  
 23 that the only person who might communicate  
 24 this, the results of the retesting was you?  
 25 DR. KWAN:

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1 A. The two group of paper, letters I get now.  
 2 MS. NEWBURY:  
 3 Q. Sure.  
 4 DR. KWAN:  
 5 A. The first group is coming from Don Cook's  
 6 group, which is have no recommendation or  
 7 treatment.  
 8 MS. NEWBURY:  
 9 Q. Um-hm.  
 10 DR. KWAN:  
 11 A. And that were the patients that unfortunately  
 12 in that particular situation both my patients  
 13 does not require any change or any treatments.  
 14 The second group of letters I get were those  
 15 where the panel with recommendations about  
 16 what to do, those are the patients which I  
 17 have brought back to my clinic a lot earlier  
 18 and informed them of that issues and change.  
 19 And, in fact, many of them, I would say with  
 20 the exception of one patient, have all been  
 21 referred back to the medical oncologist for  
 22 their opinion and discussion.  
 23 MS. NEWBURY:  
 24 Q. Okay. So you communicated with them but -  
 25 DR. KWAN:

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1 A. Correct.  
 2 MS. NEWBURY:  
 3 Q. - referred them on for -  
 4 DR. KWAN:  
 5 A. Yes, I told them that what the changes and  
 6 referred them to what the options of  
 7 treatments and referred them back to a medical  
 8 oncologist to get their opinion as to say, so  
 9 that they get opportunity to discuss it with  
 10 the medical oncologist.  
 11 MS. NEWBURY:  
 12 Q. Okay. And was it your understanding that if  
 13 you had not communicated those results to the  
 14 patients, that there would be no one else  
 15 communicating those results to the patients,  
 16 necessarily?  
 17 DR. KWAN:  
 18 A. With the letter addressed to me to ask me to  
 19 do the job, I thought that since I'm on a  
 20 panel, there's no way I can get away with not  
 21 doing it -  
 22 MS. NEWBURY:  
 23 Q. Sure, okay.  
 24 DR. KWAN:  
 25 A. - I will do it.

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1 MS. NEWBURY:  
 2 Q. So you didn't think that there was some other  
 3 parallel process going on -  
 4 DR. KWAN:  
 5 A. Let's put it this way, I didn't expect anybody  
 6 to be able to do that for me.  
 7 MS. NEWBURY:  
 8 Q. Okay. Dr. Kwan, during the various panel  
 9 meetings that you attended and we do have some  
 10 minutes for some meetings but not for all, as  
 11 I understand it, I'm wondering if you ever  
 12 dealt with a situation where patients were  
 13 initially PR positive and ER negative, but  
 14 upon retesting were both ER and PR negative?  
 15 DR. KWAN:  
 16 A. That is difficult to remember any of that  
 17 because with ER and PR positive you would be  
 18 treated with Tamoxifen.  
 19 MS. NEWBURY:  
 20 Q. Okay. So in your view, as a surgeon, you  
 21 would have treated -  
 22 DR. KWAN:  
 23 A. Yeah, I would assume we would be treating  
 24 either ER, both ER or PR positive, even one of  
 25 them will be treated.

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<p>1 MS. NEWBURY: 2 Q. Okay. 3 DR. KWAN: 4 A. Given Tamoxifen as considered positive for 5 treatment if the situation fits, the required 6 Tamoxifen would have been prescribed, so that 7 would be very few of them. And if compared to 8 be negative, I don't think I ever come across 9 one that become negative. 10 MS. NEWBURY: 11 Q. Okay. 12 DR. KWAN: 13 A. In the situation to suggest--I can see where 14 you're asking because it would be on negative 15 you may go to retesting and you come back both 16 negative, I can see where you're asking, 17 asking the question, but I don't believe we 18 ever come across one of those situations. 19 MS. NEWBURY: 20 Q. Okay. 21 DR. KWAN: 22 A. And if they do come out, they will be admin 23 Tamoxifen, unfortunately they will be treated 24 by Tamoxifen unnecessary or because becoming 25 PR positive.</p>	<p>1 zero, zero. So that's the closest thing I 2 could see to that situation and that case it 3 wasn't dealt with because the patient was 4 deceased. 5 DR. KWAN: 6 A. Deceased, yes. 7 MS. NEWBURY: 8 Q. Looks like from that. During this meeting can 9 you recall any other discussion about 10 retroconversions, either retroconversions from 11 ER and PR positive to ER/PR negative or the PR 12 positive alone to ER, just sort of any general 13 discussions about that type of situation? 14 DR. KWAN: 15 A. I don't recall any particular discussion in 16 that situation. If the situation arrives, 17 then all we--we will be reviewing and 18 discussing whether it is appropriate to stop 19 therapy or whether it's appropriate to 20 continue therapy. I think that will be one of 21 the issues that will have to be discussed. 22 MS. NEWBURY: 23 Q. Okay. And you'd mentioned, I think, earlier 24 this morning that on some occasions lists were 25 available to the panels, you thought all</p>
<p>Page 262</p> <p>1 MS. NEWBURY: 2 Q. Right. So based on the fact that they are PR 3 positive, they would - 4 DR. KWAN: 5 A. They would have been started on Tamoxifen - 6 MS. NEWBURY: 7 Q. - obviously - 8 DR. KWAN: 9 A. - and they become negative, I'm don't--I'm not 10 so sure - 11 MS. NEWBURY: 12 Q. So that doesn't ring a bell to you? 13 DR. KWAN: 14 A. No, it doesn't ring a bell anybody came across 15 like that would be an issue, but didn't came 16 across it. 17 MS. NEWBURY: 18 Q. Just for your information, the only minutes 19 that I saw that you attended where there's 20 anything close to that was P-2632. And I'll 21 just bring that up for the record. And this 22 is the panel, just a fairly recent one, 23 January 28th, 2008, and you're listed there. 24 And on the second page this is actually ER and 25 PR, five to ten, and then it converted to</p>	<p>Page 264</p> <p>1 patients were presented to the panels, even 2 though their charts may not be available to 3 the review panel. Am I correct in that? 4 DR. KWAN: 5 A. Yeah, well they may not be available. There 6 were--I think the list is made up as the 7 reports comes back. 8 MS. NEWBURY: 9 Q. Um-hm. 10 DR. KWAN: 11 A. And we don't--like, I'm pretty sure that all 12 the reports come back and the chart, patient 13 were assumed to be a cancer clinic patient, so 14 the chart would be available. By the time it 15 comes in there, they weren't the cancer clinic 16 patients and the chart wasn't available and 17 have to be sorted somewhere else or the chart 18 will have went over to, say, central 19 Newfoundland on a peripheral clinic, the chart 20 went out there and has not come back and those 21 have been delayed and but retrieved. 22 MS. NEWBURY: 23 Q. But were there some patients for whom the 24 results were there and available on a list but 25 because there wasn't considered to be a</p>

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<p>1 change, their chart wasn't reviewed?</p> <p>2 DR. KWAN:</p> <p>3 A. I don't recall that. I don't think we make</p> <p>4 any decisions, if I remember right, make a</p> <p>5 decisions without the charts. I don't think</p> <p>6 so.</p> <p>7 MS. NEWBURY:</p> <p>8 Q. I guess these would be cases where it was felt</p> <p>9 that a decision wasn't necessary, you're</p> <p>10 deciding who should or should not be panelled?</p> <p>11 DR. KWAN:</p> <p>12 A. You mean those patients that are ER and--I'm</p> <p>13 trying to think of scenario. But patients who</p> <p>14 are ER and PR positive then that was on</p> <p>15 treatment, they usually don't get retested in</p> <p>16 the first place.</p> <p>17 MS. NEWBURY:</p> <p>18 Q. Okay.</p> <p>19 DR. KWAN:</p> <p>20 A. And those patients who are negative and retest</p> <p>21 is positive, that need to be reviewed.</p> <p>22 DR. KWAN:</p> <p>23 A. Or ER negative and PR positive and then</p> <p>24 converted to -</p> <p>25 DR. KWAN:</p>	<p>1 A. I can't recall because that must be very few</p> <p>2 and far between and I can't remember anyone</p> <p>3 that we really hassle a lot through that.</p> <p>4 MS. NEWBURY:</p> <p>5 Q. And in your view it would be appropriate to</p> <p>6 panel those cases because a change of</p> <p>7 treatment might be required?</p> <p>8 DR. KWAN:</p> <p>9 A. I'm sorry?</p> <p>10 MS. NEWBURY:</p> <p>11 Q. And in your view it would be appropriate for</p> <p>12 the panel to have reviewed those cases -</p> <p>13 DR. KWAN:</p> <p>14 A. Yes, they would have -</p> <p>15 MS. NEWBURY:</p> <p>16 Q. - because the change of treatment -</p> <p>17 DR. KWAN:</p> <p>18 A. - change of treatment may be required.</p> <p>19 MS. NEWBURY:</p> <p>20 Q. - might be required? Thank you. Dr. Kwan,</p> <p>21 you'd mentioned earlier this morning that it</p> <p>22 was your suggestion that patients be tracked</p> <p>23 long term, the group of patients that were</p> <p>24 involved in the retesting here. Can you</p> <p>25 recall when you first suggested that?</p>
<p>Page 266</p> <p>1 A. That will be reviewed. I mean, if you are on</p> <p>2 treatment, that would still be looked at.</p> <p>3 MS. NEWBURY:</p> <p>4 Q. Okay.</p> <p>5 DR. KWAN:</p> <p>6 A. But I don't remember -</p> <p>7 MS. NEWBURY:</p> <p>8 Q. So if they were ER negative and PR positive</p> <p>9 and converted to negative ER -</p> <p>10 DR. KWAN:</p> <p>11 A. Negative, negative.</p> <p>12 MS. NEWBURY:</p> <p>13 Q. - and negative PR?</p> <p>14 DR. KWAN:</p> <p>15 A. Yes.</p> <p>16 MS. NEWBURY:</p> <p>17 Q. You believe that they would have been</p> <p>18 reviewed?</p> <p>19 DR. KWAN:</p> <p>20 A. I believe those would have been changed.</p> <p>21 Anything altered significantly, that would be</p> <p>22 looked at.</p> <p>23 DR. KWAN:</p> <p>24 A. Okay. But you had no recollection -</p> <p>25 DR. KWAN:</p>	<p>Page 268</p> <p>1 DR. KWAN:</p> <p>2 A. I think I talked about it July meetings, I</p> <p>3 think. I can't remember about the dates -</p> <p>4 MS. NEWBURY:</p> <p>5 Q. July of 2005?</p> <p>6 DR. KWAN:</p> <p>7 A. Yeah, I think that was somewhat--because I,</p> <p>8 being academic -</p> <p>9 MS. NEWBURY:</p> <p>10 Q. Right.</p> <p>11 DR. KWAN:</p> <p>12 A. And it came out as an opportunity to look at</p> <p>13 this as to what we do with this group of</p> <p>14 patients that we did late treating with</p> <p>15 Tamoxifen, do these patients all uniformly</p> <p>16 have no recurrence of tumours, say, ten years</p> <p>17 down the road or we have a higher than average</p> <p>18 recurrence of the tumours. I think those are</p> <p>19 very valuable information which, as I said to</p> <p>20 you, there is very little guidance in</p> <p>21 literature.</p> <p>22 MS. NEWBURY:</p> <p>23 Q. Sure.</p> <p>24 DR. KWAN:</p> <p>25 A. And we have an opportunity to do, make some</p>

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1 contributions.

2 MS. NEWBURY:

3 Q. Okay. And do you think that there would be

4 value in doing so even for the very group of

5 patients involved?

6 DR. KWAN:

7 A. I'm sorry?

8 MS. NEWBURY:

9 Q. Would there be value not just for general

10 research purposes, but for the particular

11 patients involved?

12 DR. KWAN:

13 A. Probably, yes. I think, you know, as I say,

14 my suggestion in mentioning that is that we

15 need to look at this and follow it.

16 MS. NEWBURY:

17 Q. And what categories of patients would you have

18 included in this long-term tracking?

19 DR. KWAN:

20 A. Anybody that has a changed.

21 MS. NEWBURY:

22 Q. Okay. And do you know, are you aware whether

23 or not any efforts have been started to follow

24 your suggestion?

25 DR. KWAN:

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1 A. I'm not aware of any organized way of doing

2 it. I'm sure the cancer clinic as to see the

3 patients and to treating the patients, that

4 will be followed.

5 MS. NEWBURY:

6 Q. Um-hm.

7 DR. KWAN:

8 A. But I'm not aware of any organized ways. I

9 think this would probably, this what I really

10 meant is these patients should be flagged and

11 in the long run, say, five years down the road

12 we should then take this group of patients who

13 have--and looked at again how they do.

14 MS. NEWBURY:

15 Q. And do an analysis based on -

16 DR. KWAN:

17 A. An analysis based on the status that's

18 available to us.

19 MS. NEWBURY:

20 Q. Okay. And how long would you suggest

21 following those?

22 DR. KWAN:

23 A. I would say five, ten years, as breast cancers

24 are long-term results before we know anything.

25 MS. NEWBURY:

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1 Q. Okay.

2 DR. KWAN:

3 A. Difference.

4 MS. NEWBURY:

5 Q. Thank you, Dr. Kwan, those are all the

6 questions. Thank you.

7 THE COMMISSIONER:

8 Q. Ms. Brocklehurst?

9 MS. BROCKLEHURST:

10 Q. No questions, Commissioner, thank you.

11 THE COMMISSIONER:

12 Q. Mr. Pike?

13 MR. PIKE:

14 Q. No questions.

15 THE COMMISSIONER:

16 Q. Mr. Browne?

17 MR. BROWNE:

18 Q. No questions, Commissioner, but I do believe

19 Dr. Kwan has a statement he wishes to read

20 out.

21 THE COMMISSIONER:

22 Q. Please do.

23 DR. KWAN:

24 Q. I just want to read this out to people, maybe

25 personally I wouldn't add any more than that--

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1 I just say that over the last several years

2 many of us here have been trying to understand

3 and trying to elucidate the reason for the

4 errors of the estrogen receptors and

5 progesterone receptor determinations. I do

6 believe and I believe that this problem is not

7 unique to our laboratories. I would like to

8 credit those who brought those issues to our

9 attentions and encourage us all here and those

10 who are not here to find out the cause and

11 recommend a solution. And I express my regret

12 to those who are adversely impacted. I

13 continue to believe that we have an excellent

14 group of individuals who these includes

15 surgeons, medical oncologists, radiation

16 oncologists, pathologists, laboratory

17 technicians, nurses and managers who are

18 dedicated to produce a high standard of health

19 care system in our province. I also have

20 utmost faith in pathologist colleagues who

21 have over the last 35 years have provided me

22 with excellent service and I trust will

23 continue to provide an accurate diagnosis for

24 all my patients in the future. Estrogen and

25 progesterone receptors is only a part of the

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1 much important information needed for the  
 2 diagnosis and management of breast cancer. It  
 3 should be clear that the error of estrogen  
 4 receptor and progesterone receptor  
 5 determination do not in any way affect the  
 6 histological diagnosis of breast cancer. We  
 7 in health care are painfully aware of the  
 8 consequence of errors and are constantly  
 9 vigilant of the possibility. Unfortunately,  
 10 error do occurs, particularly in a complex  
 11 health care system. I feel we need to improve  
 12 our dialogue and communication with our  
 13 colleagues, understand our mutual problems and  
 14 provide mutual support to our endeavour to  
 15 achieve excellence in health care. Finally, I  
 16 do believe that given the appropriate  
 17 resources our immunohistochemistry laboratory  
 18 will recover and once again become the  
 19 laboratory that we will be worthy of our  
 20 trust. Thank you.

21 THE COMMISSIONER:  
 22 Q. Mr. Coffey, is there anything arising?  
 23 COFFEY, Q.C.:  
 24 Q. No, Commissioner, thank you.  
 25 THE COMMISSIONER:

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1 Q. All right. Thank you, very much, Dr. Kwan,  
 2 for coming and providing us with your  
 3 insights.

4 DR. KWAN:  
 5 A. Thank you.

6 THE COMMISSIONER:  
 7 Q. I do appreciate it. Mr. Coffey, do you want  
 8 to take the afternoon break before we continue  
 9 with the next witness or -

10 COFFEY, Q.C.:  
 11 Q. Yes, Commissioner.

12 THE COMMISSIONER:  
 13 Q. All right, we'll do that.

14 (BREAK)

15 THE COMMISSIONER:  
 16 Q. Please be seated. Mr. Coffey?

17 COFFEY, Q.C.:  
 18 Q. Commissioner, the next witness is Maria  
 19 Tracey.

20 MS. MARIA TRACEY (SWORN) EXAMINATION-IN-CHIEF BY BERNARD  
 21 COFFEY, Q.C.  
 22 REGISTRAR:  
 23 Q. Would you please state and spell your full  
 24 name for the record?  
 25 MS. TRACEY:

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1 A. My name is Maria Tracey, M-A-R-I-A, T-R-A-C-E-  
 2 Y.

3 COFFEY, Q.C.:  
 4 Q. Ms. Tracey, would you please outline for the  
 5 Commissioner your educational and professional  
 6 background?  
 7 MS. TRACEY:  
 8 A. I'm the perioperative program director. I  
 9 graduated with a diploma in nursing in 1997  
 10 (sic.) from the Mater Misericordiae Hospital  
 11 in Dublin, Ireland. I did a post-grad course  
 12 in midwifery, which I graduated from in 1979.

13 COFFEY, Q.C.:  
 14 Q. Okay, I'm sorry, the first one was in 19 -  
 15 MS. TRACEY:  
 16 A. '77.

17 COFFEY, Q.C.:  
 18 Q. '77, okay. I thought you said '97, I thought  
 19 -

20 MS. TRACEY:  
 21 A. I could have.

22 COFFEY, Q.C.:  
 23 Q. You wish. That's '77, I'm sorry, go ahead.  
 24 MS. TRACEY:

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1 A. '77.

2 COFFEY, Q.C.:  
 3 Q. Go ahead.

4 MS. TRACEY:  
 5 A. I moved to live in Newfoundland in 1979 and I  
 6 obtained a job of staff nurse on an orthopedic  
 7 unit, 6 West, at St. Clare's Hospital. And in  
 8 1984 I became the nursing supervisor of that  
 9 unit, actually, and I remained in that  
 10 position for ten years. And then in 1994 I  
 11 moved to a temporary position as the  
 12 administrative supervisor of the operating  
 13 room at St. Clare's and I remained in that  
 14 position until 1996. In 1996 I became the  
 15 program, perioperative program director and  
 16 I'm in that position today. That was for the  
 17 health care corporation when the hospitals  
 18 became aligned -

19 COFFEY, Q.C.:  
 20 Q. Amalgamated.  
 21 MS. TRACEY:  
 22 A. - in the city, yeah.

23 COFFEY, Q.C.:  
 24 Q. By administration. And with the formation of  
 25 the Health Care Corporation you became -

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<p>1 MS. TRACEY: 2 A. That's right. 3 COFFEY, Q.C.: 4 Q. - the director of the perioperative program 5 for the Health Care Corporation of St. John's? 6 MS. TRACEY: 7 A. Yes, which was the two adult sites. 8 COFFEY, Q.C.: 9 Q. Initially, well, initially it would have been 10 the General Hospital? 11 MS. TRACEY: 12 A. It would have been the General, St. Clare's 13 and the Grace. 14 COFFEY, Q.C.: 15 Q. And the Grace. 16 MS. TRACEY: 17 A. Until 2000. 18 COFFEY, Q.C.: 19 Q. And the Grace then closed in 2000 and so you 20 would have continued on? 21 MS. TRACEY: 22 A. The services at the Grace were divided between 23 St. Clare's and the General site. 24 COFFEY, Q.C.: 25 Q. Yes.</p>	<p>1 Care Corporation was in place, I reported to 2 the position was the vice-president of patient 3 care services who was Louise Jones. When 4 Eastern Health came into place, I reported 5 still to Louise Jones but her title changed to 6 chief operating officer for adult acute care. 7 COFFEY, Q.C.: 8 Q. Okay, and the institutions then that you're 9 responsible for even today are the General 10 Hospital here in St. John's and St. Clare's? 11 MS. TRACEY: 12 A. Correct. 13 COFFEY, Q.C.: 14 Q. Here in St. John's. 15 MS. TRACEY: 16 A. The operating rooms. 17 COFFEY, Q.C.: 18 Q. Operating rooms, yes. When I say the 19 institutions, I meant the perioperative 20 programs in them. 21 MS. TRACEY: 22 A. Yes. 23 COFFEY, Q.C.: 24 Q. The other hospitals, for example, within 25 Eastern Health, I'll just name Carbonear,</p>
<p>Page 278</p> <p>1 MS. TRACEY: 2 A. In 2000. 3 COFFEY, Q.C.: 4 Q. And what about the Janeway? 5 MS. TRACEY: 6 A. I don't have any responsibility for the 7 Janeway. 8 COFFEY, Q.C.: 9 Q. Even to this day? 10 MS. TRACEY: 11 A. Even to this day. That's under the Women's 12 Health Program. 13 COFFEY, Q.C.: 14 Q. Now, Eastern Health was formed in April of 15 2005. Do you have a position with Eastern 16 Health? 17 MS. TRACEY: 18 A. Yes, I do. 19 COFFEY, Q.C.: 20 Q. And what's your position? 21 MS. TRACEY: 22 A. My title remains the same and my 23 responsibilities remain the same. My 24 reporting structure, the executive realigned 25 so I actually still reported when the Health</p>	<p>Page 280</p> <p>1 Clarendville and any other facility, do you 2 have any responsibility for perioperative and 3 anything else? 4 MS. TRACEY: 5 A. No. 6 COFFEY, Q.C.: 7 Q. Who does that fall under, the other locations? 8 MS. TRACEY: 9 A. Actually, they all fall under different chief 10 operating officers in the regions. 11 COFFEY, Q.C.: 12 Q. Okay, and the director of perioperative 13 programs in the different hospitals would - 14 MS. TRACEY: 15 A. I don't believe they're structured the same 16 as--because the hospitals--the operating rooms 17 are a smaller number. 18 COFFEY, Q.C.: 19 Q. Yes. 20 MS. TRACEY: 21 A. So I would--I'm not quite sure about the 22 structure, it wouldn't be the same. 23 COFFEY, Q.C.: 24 Q. So, for example, and I'll be asking you in a 25 moment about what a director of perioperative</p>

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1 program does.  
 2 MS. TRACEY:  
 3 A. Um-hm.  
 4 COFFEY, Q.C.:  
 5 Q. But if I was to ask you, for example, what  
 6 that person or the equivalent did or does in  
 7 Carbonear, say, as an example, you would have  
 8 to find out the title of the person who  
 9 actually does it and refer me or the  
 10 Commissioner to that person?  
 11 MS. TRACEY:  
 12 A. That's correct.  
 13 COFFEY, Q.C.:  
 14 Q. And the same thing would be true in  
 15 Clarenville?  
 16 MS. TRACEY:  
 17 A. That's correct.  
 18 COFFEY, Q.C.:  
 19 Q. In terms of breast surgery, which is really in  
 20 the main what we're here about, other than  
 21 Clarenville and Carbonear, the only other two  
 22 places in which breast surgery occurs are the  
 23 Grace and--I'm sorry, St. Clare's and the  
 24 General? St. Clare's and the General. Do you  
 25 know if breast surgery occurs anywhere other

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1 than Carbonear?  
 2 MS. TRACEY:  
 3 A. I couldn't say.  
 4 COFFEY, Q.C.:  
 5 Q. You don't know?  
 6 MS. TRACEY:  
 7 A. No.  
 8 COFFEY, Q.C.:  
 9 Q. Okay. Now then, what--so beginning in 1995,  
 10 '96, if it's changed over the years, you could  
 11 let the Commissioner know. Beginning in '95,  
 12 '96 when you took over as the director of the  
 13 perioperative program for the Health Care  
 14 Corporation what were your responsibilities?  
 15 You reported to Ms. Jones?  
 16 MS. TRACEY:  
 17 A. Correct. I -  
 18 COFFEY, Q.C.:  
 19 Q. Who reported to you and what were your  
 20 responsibilities?  
 21 MS. TRACEY:  
 22 A. I had, at that time there were four managers  
 23 reporting to me, because the Grace was still  
 24 open. Today there's three managers who report  
 25 to me. My position involved strategic

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1 planning for the perioperative program to make  
 2 sure that our programs and goals were in  
 3 alignment with what would have been the Health  
 4 Care Corporation at that time. I am  
 5 responsible for the financial management,  
 6 human resource management and quality  
 7 assurance within the program.  
 8 COFFEY, Q.C.:  
 9 Q. And you said there were initially four  
 10 managers reported to you?  
 11 MS. TRACEY:  
 12 A. That's correct.  
 13 COFFEY, Q.C.:  
 14 Q. They were located where?  
 15 MS. TRACEY:  
 16 A. The Grace operating room and that person had  
 17 responsibility for the recovery room, OR and  
 18 the surgical daycare in that department. The  
 19 St. Clare's operating room, and that person  
 20 had responsibility for recovery room and  
 21 surgical daycare at the Grace--at St. Clare's,  
 22 sorry.  
 23 COFFEY, Q.C.:  
 24 Q. How about outpatients?  
 25 MS. TRACEY:

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1 A. The outpatients does not come under my  
 2 program.  
 3 COFFEY, Q.C.:  
 4 Q. Okay. Wait now, I'm sorry, outpatients. Day  
 5 surgery, I'm sorry, because you referred to  
 6 the--you listed in the Grace, you listed three  
 7 different ones.  
 8 MS. TRACEY:  
 9 A. Okay.  
 10 COFFEY, Q.C.:  
 11 Q. You said OR, recovery and, at the Grace?  
 12 MS. TRACEY:  
 13 A. Surgical daycare.  
 14 COFFEY, Q.C.:  
 15 Q. Surgical daycare.  
 16 MS. TRACEY:  
 17 A. And the same at St. Clare's.  
 18 COFFEY, Q.C.:  
 19 Q. Oh, St. Clare's is the same thing?  
 20 MS. TRACEY:  
 21 A. Yeah, surgical daycare.  
 22 COFFEY, Q.C.:  
 23 Q. The manager over there took care of those  
 24 three things at St. Clare's?  
 25 MS. TRACEY:

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1 A. That's correct.  
 2 COFFEY, Q.C.:  
 3 Q. I'm sorry.  
 4 MS. TRACEY:  
 5 A. Then at the Health Science site the manager is  
 6 in charge of the operating room and the  
 7 recovery room. There's a different manager  
 8 for the surgical daycare department, it's a  
 9 much bigger division at that site, and that  
 10 person also is in charge of the pre-admission  
 11 clinics at St. Clare's and the General.  
 12 COFFEY, Q.C.:  
 13 Q. And that person reported to you?  
 14 MS. TRACEY:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And still does?  
 18 MS. TRACEY:  
 19 A. Yes. Originally the pre-admission clinics  
 20 were not part of the perioperative program,  
 21 they were part of the ambulatory care program  
 22 but they were realigned within perioperative  
 23 because they were a better fit there.  
 24 COFFEY, Q.C.:  
 25 Q. Do you recall when that occurred?

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1 MS. TRACEY:  
 2 A. Late 1990s, I'm not exactly sure when. It was  
 3 probably '98, '99.  
 4 COFFEY, Q.C.:  
 5 Q. Now, could you tell the Commissioner, because  
 6 we've heard the word "perioperative" a number  
 7 of times here, what is, what does  
 8 perioperative mean in the context of these  
 9 institutions?  
 10 MS. TRACEY:  
 11 A. It involves the pre, intra and postoperative  
 12 care, the immediate pre, intra and  
 13 postoperative care of patients. So we prepare  
 14 the patients in the pre-admission clinic for  
 15 their surgery. In surgical daycare the  
 16 morning of surgery they are actually given the  
 17 final preparation and they are brought to the  
 18 OR for their surgical experience, recovered in  
 19 recovery room and either admitted or  
 20 discharged from--they're either admitted to  
 21 the hospital, which is the inpatients units,  
 22 from recovery or else recovery room discharges  
 23 the patients to the surgical daycare  
 24 department because those patients are going  
 25 home the same day.

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1 COFFEY, Q.C.:  
 2 Q. And so in terms of the perioperative, as the  
 3 director of perioperative care, of the  
 4 perioperative division, you're responsible  
 5 for, I gather, the pre-operation stage?  
 6 MS. TRACEY:  
 7 A. The education of patients -  
 8 COFFEY, Q.C.:  
 9 Q. Inter, inter--and this would be during the  
 10 operation itself, what's going on in the OR?  
 11 MS. TRACEY:  
 12 A. Uh-hm.  
 13 COFFEY, Q.C.:  
 14 Q. And then in the recovery room.  
 15 MS. TRACEY:  
 16 A. Phase 1 and 2 of recovery, yes.  
 17 COFFEY, Q.C.:  
 18 Q. The immediate aftermath of that.  
 19 MS. TRACEY:  
 20 A. That's correct.  
 21 THE COMMISSIONER:  
 22 Q. Should I ask what the difference is between a  
 23 Phase 1 and a Phase 2?  
 24 MS. TRACEY:  
 25 A. It's immediate post-operative phase and bring

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1 a patient - it has - they scored where it's  
 2 appropriate to be discharged from recovery  
 3 room. They are discharged either to in-  
 4 patient units or to surgical day care, which  
 5 is Phase 2, which means they are recovering  
 6 from their anesthetic in an appropriate  
 7 manner, and they're ready for discharge. So  
 8 it's the staging of the discharge after an  
 9 anesthetic.  
 10 THE COMMISSIONER:  
 11 Q. Okay. You were just saying you won't take  
 12 them directly from the recovery room to out  
 13 the door. There's a -  
 14 MS. TRACEY:  
 15 A. There's an interim stage, yes.  
 16 COFFEY, Q.C.:  
 17 Q. Or they end up on the ward being in the  
 18 hospital.  
 19 MS. TRACEY:  
 20 A. Correct.  
 21 COFFEY, Q.C.:  
 22 Q. At which point whomever is up on the ward,  
 23 it's their responsibility to care for the  
 24 patient?  
 25 MS. TRACEY:



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1 A. That's correct.  
 2 COFFEY, Q.C.:  
 3 Q. They pass from you.  
 4 MS. TRACEY:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Commissioner, there are a number of exhibits.  
 8 If I could please have them entered.  
 9 THE COMMISSIONER:  
 10 Q. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. They are the following; P-2729, 2730, and then  
 13 there's 2827, 2828, 2829, 2830, and then,  
 14 Commissioner, P-2884, P-3082, P-3083, 3084,  
 15 3087, 3088, and 3089, as well as C-268, 269,  
 16 270, 271 and 272.  
 17 THE COMMISSIONER:  
 18 Q. Entered.  
 19 EXHIBIT P-2729 AND 2730 MARKED AND ENTERED  
 20 EXHIBIT P-2827 THROUGH P-2830 MARKED AND ENTERED  
 21 EXHIBIT P-2884 MARKED AND ENTERED  
 22 EXHIBIT P-3082 THROUGH P-3084 MARKED AND ENTERED  
 23 EXHIBIT P-3087 THROUGH P-3089 MARKED AND ENTERED  
 24 EXHIBIT C-268 THROUGH C-272 MARKED AND ENTERED  
 25 COFFEY, Q.C.:

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1 Q. Thank you. Now as Director then, Ms. Tracey,  
 2 of Peri-Operative Program, what is the  
 3 division of responsibility between you and the  
 4 physicians, for example, Dr. Kwan's role?  
 5 MS. TRACEY:  
 6 A. There are two co-clinical chiefs in a  
 7 leadership team with me, and what Dr. Kwan was  
 8 from 1999 onwards, the co-clinical chief for  
 9 surgery for surgery until 2006, there is a co-  
 10 clinical chief for anesthesia, Dr. Frank King.  
 11 COFFEY, Q.C.:  
 12 Q. And -  
 13 MS. TRACEY:  
 14 A. So the physicians look after the physicians  
 15 within the program.  
 16 COFFEY, Q.C.:  
 17 Q. And you looked after everyone who was not an  
 18 MD, in effect?  
 19 MS. TRACEY:  
 20 A. Essentially, yes, and some - it was, I guess -  
 21 we worked as a team, so physician issues would  
 22 come to my attention perhaps, but I would  
 23 defer to Dr. Kwan or Dr. King as appropriate,  
 24 or currently--there's one clinical chief  
 25 because Dr. Rockwood, who replaced Dr. Kwan,

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1 has resigned.  
 2 COFFEY, Q.C.:  
 3 Q. And so right now there is co-clinical chief of  
 4 anesthesia?  
 5 MS. TRACEY:  
 6 A. Anesthesia.  
 7 COFFEY, Q.C.:  
 8 Q. And the surgery position is vacant?  
 9 MS. TRACEY:  
 10 A. Is vacant.  
 11 COFFEY, Q.C.:  
 12 Q. How long has that been vacant?  
 13 MS. TRACEY:  
 14 A. July 1st, I believe it was around then, July  
 15 1st or 2nd.  
 16 COFFEY, Q.C.:  
 17 Q. Of this year?  
 18 MS. TRACEY:  
 19 A. Uh-hm.  
 20 COFFEY, Q.C.:  
 21 Q. Dr. Rockwood had replaced Dr. Kwan, and he  
 22 resigned effective sometime in July?  
 23 MS. TRACEY:  
 24 A. Uh-hm.  
 25 COFFEY, Q.C.:

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1 Q. Dr. Kwan was just here and he told the  
 2 Commissioner, for example, that Ms. Tracey  
 3 might come to me if a surgeon is supposed to  
 4 start at 7 o'clock and doesn't arrive, doesn't  
 5 show up -  
 6 MS. TRACEY:  
 7 A. That's correct.  
 8 COFFEY, Q.C.:  
 9 Q. She might bring it to my attention.  
 10 MS. TRACEY:  
 11 A. Uh-hm.  
 12 COFFEY, Q.C.:  
 13 Q. He just used that as one example of sort of an  
 14 administrative thing.  
 15 MS. TRACEY:  
 16 A. Sure, that would be true, yes. If there is a  
 17 complaint about an issue or an occurrence  
 18 within the OR, I would defer to Dr. Kwan. We  
 19 would probably discuss it and he would discuss  
 20 it with the physician and follow up  
 21 appropriately.  
 22 COFFEY, Q.C.:  
 23 Q. Now you report in that position to Louise  
 24 Jones until Ms. Jones, I take it, became the  
 25 interim CEO?

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<p>1 MS. TRACEY:  2 A. That's correct.  3 COFFEY, Q.C.:  4 Q. And she was replaced -  5 MS. TRACEY:  6 A. Norma Baker.  7 COFFEY, Q.C.:  8 Q. Norma Baker, and you report to her currently?  9 MS. TRACEY:  10 A. Yes.  11 COFFEY, Q.C.:  12 Q. Who do Dr. Kwan or Dr. Rockwood, the co-  13 clinical chiefs -  14 MS. TRACEY:  15 A. They report to Dr. Oscar Howell.  16 COFFEY, Q.C.:  17 Q. Okay, so they go off in the medical route.  18 COFFEY, Q.C.:  19 Q. As the director of perioperative program, it's  20 one thing to say you're responsible for a  21 particular thing. What, in practice, other  22 than budgets and administrative things would  23 you be involved in?  24 MS. TRACEY:  25 A. The majority of the day to day issues would be</p>	<p>1 policies and procedures?  2 MS. TRACEY:  3 A. I sign off on the policies and procedures for  4 the program.  5 COFFEY, Q.C.:  6 Q. And that goes back - dates back to the time  7 you became director?  8 MS. TRACEY:  9 A. That's correct.  10 COFFEY, Q.C.:  11 Q. And you're responsible then for ensuring, for  12 example, that policies and procedures even  13 exist?  14 MS. TRACEY:  15 A. That's correct.  16 COFFEY, Q.C.:  17 Q. And if so, having them changed for time to  18 time and so on?  19 MS. TRACEY:  20 A. I might not initiate the change, but I will  21 sign off on the final policy.  22 COFFEY, Q.C.:  23 Q. Who might initiate any change?  24 MS. TRACEY:  25 A. Change in practice usually is what initiates</p>
<p>1 looked after by the managers.  2 COFFEY, Q.C.:  3 Q. Those four managers you referred to?  4 MS. TRACEY:  5 A. Yes.  6 COFFEY, Q.C.:  7 Q. Go ahead.  8 MS. TRACEY:  9 A. If there was complex issues or serious  10 incidents occurs, they would be immediately  11 brought to my attention by the managers. I'm  12 also responsible for policy development,  13 standards of care within the program, and  14 oversees the audit process and accreditation,  15 those kind of things.  16 COFFEY, Q.C.:  17 Q. And your office is located where?  18 MS. TRACEY:  19 A. At the General site in administration.  20 COFFEY, Q.C.:  21 Q. That's been so since you became the director?  22 MS. TRACEY:  23 A. That's right.  24 COFFEY, Q.C.:  25 Q. Perioperative program. How about things like</p>	<p>1 the change, or change in current literature  2 that our practice was no longer appropriate,  3 those kind of things usually initiate a change  4 in policy, and the standards we follow  5 closely, the Operating Room Nurses Association  6 of Canada Standards, and changes in those  7 standards would cause us to review our polices  8 and change our appropriately. Now the  9 frontline policy development takes place  10 through an OR Practice Committee which is  11 chaired by the clinical educators within my  12 program, and it consists of frontline staff,  13 nurses.  14 COFFEY, Q.C.:  15 Q. What, if any--when you first started in 1995,  16 1996 -  17 MS. TRACEY:  18 A. 1996.  19 COFFEY, Q.C.:  20 Q. When you first started in 1996 as the  21 director, what if any interaction would you  22 have with the clinical laboratory or people  23 from the clinical laboratory?  24 MS. TRACEY:  25 A. Not a lot of direct interaction. The</p>

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1 specimens were retrieved in the operating room  
 2 and in surgical day care departments and they  
 3 were to be sent to the laboratory. I would  
 4 guess if there was major issues, it would be  
 5 brought to my attention, but I would not have  
 6 had a lot of interaction with the laboratory.  
 7 COFFEY, Q.C.:  
 8 Q. Now if there was a concern from the  
 9 perspective of - from the clinical  
 10 laboratory's perspective, concerning, for  
 11 example, mislabelling a specimen, would that  
 12 be brought to your attention?  
 13 MS. TRACEY:  
 14 A. One specimen, no, it would not. It would be -  
 15 actually, as soon as the specimen is brought  
 16 to the laboratory and there's an issue, the  
 17 manager of the OR is contacted immediately by  
 18 the person in the lab. So that person would  
 19 follow up with it. I would expect if there  
 20 was a lot of issues, then it would be brought  
 21 to my attention.  
 22 COFFEY, Q.C.:  
 23 Q. So a pattern of problems you would expect to  
 24 be brought to your attention by whom?  
 25 MS. TRACEY:

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1 A. By either a manager or director within the  
 2 laboratory program, or one of the physicians,  
 3 and the laboratory has always had a close  
 4 association frontline with the operating rooms  
 5 in that the pathologists do the frozen  
 6 sections actually in the pathology lab within  
 7 each OR.  
 8 COFFEY, Q.C.:  
 9 Q. They actually come up?  
 10 MS. TRACEY:  
 11 A. They could come up to the operating room, yes.  
 12 COFFEY, Q.C.:  
 13 Q. And do the frozen section work right there?  
 14 MS. TRACEY:  
 15 A. Yes, right there in the operating room, so  
 16 that the operating managers know them well and  
 17 the operating staff.  
 18 COFFEY, Q.C.:  
 19 Q. I just want you, if you could, just explain  
 20 that a bit to the Commissioner in terms of the  
 21 OR is a room and there's a series of side -  
 22 MS. TRACEY:  
 23 A. There's a lot of rooms, yes.  
 24 COFFEY, Q.C.:  
 25 Q. There's a lot of rooms, exactly, the operating

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1 room theatre overall, so an operating room,  
 2 for example, where breast surgery was being  
 3 done, where would the pathologist come to do a  
 4 frozen section if he or she was asked to?  
 5 MS. TRACEY:  
 6 A. There's a pathology lab at the back of the  
 7 operating room at the General site, so the  
 8 pathologist would come in the back door to the  
 9 OR. At St. Clare's, they would come in the  
 10 front door because the pathology lab was in  
 11 the front.  
 12 COFFEY, Q.C.:  
 13 Q. Whether they came in front or back, I take it  
 14 it wouldn't at all be unusual to have a  
 15 pathologist -  
 16 MS. TRACEY:  
 17 A. No, it's a frequent occurrence, daily  
 18 occurrence.  
 19 COFFEY, Q.C.:  
 20 Q. And whether for breast surgery or for some  
 21 other type of surgery, to do a frozen section  
 22 is quite a common thing?  
 23 MS. TRACEY:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And so - and these would be actual  
 2 pathologists, Dr. whomever, would show up to  
 3 do the frozen section?  
 4 MS. TRACEY:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. This was not an assistant, this would be the -  
 8 MS. TRACEY:  
 9 A. No, this is the actual pathologist and an  
 10 assistant would often come with him.  
 11 COFFEY, Q.C.:  
 12 Q. Sure.  
 13 MS. TRACEY:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. And so that would involve a certain amount of  
 17 interaction then between the OR staff, the  
 18 nurses, for example, who would provide the  
 19 specimen -  
 20 MS. TRACEY:  
 21 A. Uh-hm.  
 22 COFFEY, Q.C.:  
 23 Q. In its raw state to the pathologist, and from  
 24 your perspective then, there would be a fair  
 25 amount of contact?

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<p>1 MS. TRACEY: 2 A. Yes, frontline. 3 COFFEY, Q.C.: 4 Q. Frontline contact? 5 MS. TRACEY: 6 A. Yes, it would. 7 COFFEY, Q.C.: 8 Q. So if there - in terms of, for example, a 9 problem involving preservation of tissue, 10 fixation, for example, fixation in formalin, 11 is not the only way, I gather, to preserve 12 tissue, but it's one of them - 13 MS. TRACEY: 14 A. Uh-hm. 15 COFFEY, Q.C.: 16 Q. If there was a concern in the clinical 17 laboratory, either at the Grace, say, at one 18 time did have their own clinical lab - 19 MS. TRACEY: 20 A. That's correct, they had a lab in their OR too 21 as well. 22 COFFEY, Q.C.: 23 Q. Or a concern in the clinical laboratory at St. 24 Clare's or the General Hospital about 25 fixation, at one or more of those sites, who</p>	<p>1 similar to that. 2 COFFEY, Q.C.: 3 Q. Now that's the next question I had. That's a 4 single one. If there was a pattern, say in a 5 period of time - 6 MS. TRACEY: 7 A. I would expect that we would review--that the 8 OR manager would actually use--there's in- 9 service time every Tuesday morning for all the 10 operating room staff at every site between 11 eight and nine, so the managers take those 12 opportunities to remind staff of policies and 13 to review policies with them and to bring 14 occurrences that are repetitive to their 15 attention, or even one occurrence that's 16 significant to the attention of the staff. 17 COFFEY, Q.C.: 18 Q. Now until 2005, prior to August of 2005, or 19 perhaps I'll ask, prior to July 2005 first - 20 MS. TRACEY: 21 A. Okay. 22 COFFEY, Q.C.: 23 Q. - do you recall it ever coming to your 24 attention that there was ever any expression 25 of concern by any of the clinical labs about</p>
<p style="text-align: right;">Page 302</p> <p>1 would you have expected to bring that to whose 2 attention? An example of one specimen that 3 was poorly fixed, what would you have 4 anticipated would happen? 5 MS. TRACEY: 6 A. I would expect that the pathology manager or 7 the pathologist would call the OR manager. 8 COFFEY, Q.C.: 9 Q. And - 10 MS. TRACEY: 11 A. And discuss it with them, and then she would 12 follow up with the staff who were actually the 13 scrub and circulating nurses for that case. 14 COFFEY, Q.C.: 15 Q. And to discuss how - 16 MS. TRACEY: 17 A. That's right. 18 COFFEY, Q.C.: 19 Q. If there was a problem, how it happened. 20 MS. TRACEY: 21 A. That's right. 22 COFFEY, Q.C.: 23 Q. And how we address it? 24 MS. TRACEY: 25 A. Yes, and monitor any pattern of occurrences</p>	<p style="text-align: right;">Page 304</p> <p>1 poor fixation? 2 MS. TRACEY: 3 A. I do not recall a pattern of concern being 4 brought to my attention, no. I would expect a 5 single situation that needed to be addressed 6 would have been brought to the managers, but 7 the managers weren't giving me feedback either 8 that they were getting recurrent issues with 9 specimens. 10 COFFEY, Q.C.: 11 Q. And so, looking back on it, you certainly have 12 no record that you were ever so advised? 13 MS. TRACEY: 14 A. No. 15 COFFEY, Q.C.: 16 Q. And no memory of being so advised? 17 MS. TRACEY: 18 A. No. 19 COFFEY, Q.C.: 20 Q. The managers at that time, like in the time 21 period '97, '98, '99, 2000 at the Grace, same 22 period of time but continuing up until 2005 at 23 St. Clare's and the General, have those 24 managers remained the same? 25 MS. TRACEY:</p>

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. They have, over the years. Have you discussed  
 4 with them, to this day, whether there were  
 5 fixation problems back then, back in '96, '97,  
 6 '98, '99? Have you ever had that discussion  
 7 with them?  
 8 MS. TRACEY:  
 9 A. There was not a--they were not aware of a  
 10 pattern of issues with fixation.  
 11 COFFEY, Q.C.:  
 12 Q. And you've discussed that with them?  
 13 MS. TRACEY:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. More recently, you've discussed that with  
 17 them?  
 18 MS. TRACEY:  
 19 A. In the last few years.  
 20 COFFEY, Q.C.:  
 21 Q. Yes, that's what I'm saying, since this all  
 22 became -  
 23 MS. TRACEY:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. - certainly within Eastern Health, a problem,  
 2 a recognized problem, you've discussed with  
 3 them, canvassed with them, "look, did you ever  
 4 know anything about--or hear anything about  
 5 this?"  
 6 MS. TRACEY:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. And you've been told?  
 10 MS. TRACEY:  
 11 A. There was no pattern.  
 12 COFFEY, Q.C.:  
 13 Q. Any individual problems that you've been told  
 14 of? Not the particular patient's name, but  
 15 things that when you would discuss this more  
 16 recently, somebody would say "well, actually,  
 17 there was no pattern, but once in a while, a -  
 18 MS. TRACEY:  
 19 A. Once in a while, things were brought to their  
 20 attention, occasionally, but that could--it  
 21 could be any number of reasons why there was  
 22 issues with a specimen. It could be  
 23 labelling. It could be, you know, wrong site  
 24 marked, something like that. So there's  
 25 numerous issues why--you know, there are

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1 ongoing issues with specimens. We would treat  
 2 thousands of specimens in a year.  
 3 COFFEY, Q.C.:  
 4 Q. Oh yes. How about problems with fixation?  
 5 Like poorly -  
 6 MS. TRACEY:  
 7 A. I don't recall them, you know, identifying a  
 8 lot of issues with fixation, no.  
 9 COFFEY, Q.C.:  
 10 Q. How about any?  
 11 MS. TRACEY:  
 12 A. I would--I don't feel comfortable in saying  
 13 there was never any, but it was a very limited  
 14 amount.  
 15 COFFEY, Q.C.:  
 16 Q. And did any of--do you know, like looking back  
 17 on it, did any of them relate to perhaps a  
 18 specimen having been left in the OR in  
 19 formalin overnight or left in the OR over the  
 20 weekend?  
 21 MS. TRACEY:  
 22 A. I'm sorry, I'm not sure?  
 23 COFFEY, Q.C.:  
 24 Q. Did any of these--do you ever recall, until--  
 25 prior to 2005, because we'll get to that in a

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1 moment, prior to 2005, was there ever any  
 2 concern raised, to your knowledge, about look,  
 3 somebody left a specimen, a tissue specimen,  
 4 in formalin in the OR over the weekend?  
 5 MS. TRACEY:  
 6 A. I'm not aware of issues with it, of complaints  
 7 about it. It was a practice at that time.  
 8 COFFEY, Q.C.:  
 9 Q. I'm sorry, it was?  
 10 MS. TRACEY:  
 11 A. I'm not aware of -  
 12 COFFEY, Q.C.:  
 13 Q. Of complaints?  
 14 MS. TRACEY:  
 15 A. - complaints about it.  
 16 COFFEY, Q.C.:  
 17 Q. But it was?  
 18 MS. TRACEY:  
 19 A. At times, specimens could have been left.  
 20 COFFEY, Q.C.:  
 21 Q. So I'm going to ask you then about that.  
 22 Could you tell then, the Commissioner, prior  
 23 to 2005, and we'll get to then what, if  
 24 anything, has changed since, prior to July,  
 25 August, September 2005, what the practice was

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<p>1 in terms of--in the OR, in terms of handling 2 of specimens, tissue specimens that were going 3 into formalin? How would it work? 4 MS. TRACEY: 5 A. Tissue specimen, how it was handed off by the 6 surgeon? 7 COFFEY, Q.C.: 8 Q. Yes. 9 MS. TRACEY: 10 A. The surgeon hands the specimen to the scrub 11 nurse. The scrub nurse then gets permission 12 from the surgeon to hand it off the set up. 13 She passes the specimen to the circulating 14 nurse. She places it in a container. The 15 circulating nurse and the scrub nurse check 16 the labelling of the specimen that the correct 17 site and the correct name, correct patient, 18 are all indicated correctly on the specimen. 19 Then the specimen is kept in the operating 20 room and was always--our practice is the 21 specimens are kept in the operating room 22 unless they're for frozen section. If they're 23 for frozen section, they immediately go to the 24 pathology lab to the pathologist. When the 25 patient -</p>	<p>1 collected back then. Now they're collected in 2 the morning and the afternoon. 3 COFFEY, Q.C.: 4 Q. So prior to the summer of 2005, because we'll 5 get to what's happened since, your 6 understanding was that they were to be 7 collected by porters - 8 MS. TRACEY: 9 A. Um-hm. 10 COFFEY, Q.C.: 11 Q. - at some point in the day and brought down to 12 the clinical laboratory? 13 MS. TRACEY: 14 A. Yes. 15 COFFEY, Q.C.: 16 Q. I take it then, there was no set pattern as to 17 like you're supposed to do it at 10 and 12 and 18 2? 19 MS. TRACEY: 20 A. I couldn't--I don't recall what the times were 21 for the specimen collection. There would have 22 been pattern--there would have been actually 23 designated times for it. 24 COFFEY, Q.C.: 25 Q. Who was responsible for designating the times?</p>
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<p>1 COFFEY, Q.C.: 2 Q. Which is right at the back of the current lab? 3 MS. TRACEY: 4 A. That's right, yes. 5 COFFEY, Q.C.: 6 Q. Okay. But if it's not going for a frozen 7 section or the portion is not going for a 8 frozen section, what was done with that? 9 MS. TRACEY: 10 A. Once it was placed in formalin, the specimen 11 remained in the operating room with the 12 patient, until the patient exited the 13 operating room and then the specimens were 14 brought out. 15 COFFEY, Q.C.: 16 Q. And then what would happen? 17 MS. TRACEY: 18 A. Then the specimens were collected by a porter 19 and brought to the laboratory a few times 20 during the day. 21 COFFEY, Q.C.: 22 Q. And was there any particular times of the day? 23 MS. TRACEY: 24 A. I wouldn't feel comfortable in telling you 25 accurately what time of the day they were</p>	<p>1 MS. TRACEY: 2 A. The laboratory would have coordinated that 3 with the portering pool. The porters were not 4 OR porters. 5 COFFEY, Q.C.: 6 Q. Okay. Whose porters were they? 7 MS. TRACEY: 8 A. They actually report to diagnostic imaging. 9 It's just the relationship within the program. 10 COFFEY, Q.C.: 11 Q. Okay. 12 MS. TRACEY: 13 A. There's a manager who they report to. 14 COFFEY, Q.C.: 15 Q. And that manager worked in diagnostic imaging? 16 MS. TRACEY: 17 A. Yes. Part of the responsibility designated to 18 porters would have been collection of 19 specimens from the operating room and bringing 20 them to the pathology lab or whatever lab. 21 COFFEY, Q.C.: 22 Q. And how often that happened a day you can't 23 say? 24 MS. TRACEY: 25 A. I can't say, no.</p>

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<p>1 COFFEY, Q.C.:</p> <p>2 Q. Or what times of the day?</p> <p>3 MS. TRACEY:</p> <p>4 A. No.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. What about in terms of how late in the day</p> <p>7 would it happen?</p> <p>8 MS. TRACEY:</p> <p>9 A. 3:00 in the afternoon is--it happens now and</p> <p>10 I'm presuming the last collection would have</p> <p>11 been around that time too.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Back in '98, '99, 2000?</p> <p>14 MS. TRACEY:</p> <p>15 A. I'm not comfortable in commenting ten years</p> <p>16 back because I don't recall.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Well, how about 2002, 2003?</p> <p>19 MS. TRACEY:</p> <p>20 A. I would expect to be in the afternoon</p> <p>21 sometime.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Sometime mid afternoon?</p> <p>24 MS. TRACEY:</p> <p>25 A. Yes.</p>	<p>1 in the morning, presumably?</p> <p>2 MS. TRACEY:</p> <p>3 A. Yes.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. In the meantime then, I take it then the</p> <p>6 specimen would be in formalin just as the</p> <p>7 specimen was excised?</p> <p>8 MS. TRACEY:</p> <p>9 A. Correct.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. And then if there was a large specimen, a</p> <p>12 relatively large piece of tissue, it wouldn't</p> <p>13 have been bread loafed or scored in any way?</p> <p>14 MS. TRACEY:</p> <p>15 A. No.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. So it would just be there overnight?</p> <p>18 MS. TRACEY:</p> <p>19 A. It would have remained in the container it was</p> <p>20 placed in in the operating room until it was</p> <p>21 retrieved.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Was any concern about that kind of a practice</p> <p>24 ever brought to your attention?</p> <p>25 MS. TRACEY:</p>
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<p>1 COFFEY, Q.C.:</p> <p>2 Q. What then would happen with a specimen that</p> <p>3 didn't make it out of the operating room</p> <p>4 proper until after the last pick up? How was</p> <p>5 that handled? Like if the patient, along with</p> <p>6 the specimen, didn't leave the OR until 4:30?</p> <p>7 MS. TRACEY:</p> <p>8 A. The specimen--if the surgeon didn't request</p> <p>9 the specimen to be sent immediately to the</p> <p>10 pathology lab, the specimen would have</p> <p>11 remained overnight in the operating room.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. And when you say in the operating room, you</p> <p>14 mean in the whole -</p> <p>15 MS. TRACEY:</p> <p>16 A. There's a designated holding area for</p> <p>17 specimens.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Okay, and so it would have been--the specimen</p> <p>20 would be sitting in a container in formalin</p> <p>21 overnight?</p> <p>22 MS. TRACEY:</p> <p>23 A. Correct.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And would be taken with the first porter run</p>	<p>1 A. No.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Did you have any knowledge of, for example,</p> <p>4 ideas like formalin penetration rates?</p> <p>5 MS. TRACEY:</p> <p>6 A. Not specific knowledge, no.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. About like how long it would actually take</p> <p>9 formalin to seep into a tissue or anything</p> <p>10 like that?</p> <p>11 MS. TRACEY:</p> <p>12 A. No. That would have come under the purview of</p> <p>13 the laboratory. It wouldn't be my expertise.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. And when I say, referring to tissue specimens</p> <p>16 here, I mean, that could include breast</p> <p>17 tissue. It could include kidney, any type of</p> <p>18 tissue, I take it. There's nothing -</p> <p>19 MS. TRACEY:</p> <p>20 A. Correct.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Would all follow this pattern, that frozen</p> <p>23 section, that portion of it, the pathologist</p> <p>24 would get right away when he or she came.</p> <p>25 Other than that, it would go into formalin in</p>

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1 the OR in the manner in which it was taken -  
 2 MS. TRACEY:  
 3 A. The surgeon decided if the specimen--today,  
 4 which is still the practice, the surgeon  
 5 decides if the specimen is to go downstairs  
 6 fresh and immediately it would be transported.  
 7 COFFEY, Q.C.:  
 8 Q. Okay.  
 9 MS. TRACEY:  
 10 A. Or if it went site in formalin, it would stay  
 11 in the operating room.  
 12 COFFEY, Q.C.:  
 13 Q. And it would stay there until the patient went  
 14 out. It would accompany the patient out to  
 15 the holding area for tissue?  
 16 MS. TRACEY:  
 17 A. That's correct.  
 18 COFFEY, Q.C.:  
 19 Q. And remain there in a container in formalin -  
 20 MS. TRACEY:  
 21 A. It remained in the pathology--actually, the  
 22 specimens were--there's a designated area in  
 23 each OR where the specimens were collected.  
 24 COFFEY, Q.C.:  
 25 Q. And it would remain there in the form it came

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1 off or out of that person's body -  
 2 MS. TRACEY:  
 3 A. In the container it was put in in the  
 4 operating room.  
 5 COFFEY, Q.C.:  
 6 Q. Until the porter picked it up, whether it was  
 7 late--an hour, whether it was five minutes  
 8 later or the next morning?  
 9 MS. TRACEY:  
 10 A. That's correct.  
 11 THE COMMISSIONER:  
 12 Q. Excuse me. Ms. Tracey, it's just that fresh  
 13 has been used in different ways. When you say  
 14 the surgeon decides if it goes to the lab  
 15 fresh, do you mean just in timing or are you -  
 16 MS. TRACEY:  
 17 A. I mean that it's not fixed in any formalin.  
 18 THE COMMISSIONER:  
 19 Q. Not fixed at all?  
 20 MS. TRACEY:  
 21 A. No.  
 22 THE COMMISSIONER:  
 23 Q. Yes, okay, thank you.  
 24 COFFEY, Q.C.:  
 25 Q. Now and that practice that you've described,

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1 work flow pattern, was that true at the Grace,  
 2 St. Clare's and the General for breast  
 3 surgery?  
 4 MS. TRACEY:  
 5 A. I don't remember what our practice was at the  
 6 Grace, to be quite honest with you.  
 7 COFFEY, Q.C.:  
 8 Q. In terms of the--and I'm talking about like  
 9 within the OR.  
 10 MS. TRACEY:  
 11 A. Whether the specimens were actually brought by  
 12 the OR porter or whether they were actually  
 13 collected by central portering, I'm not sure  
 14 if there was a central portering process in  
 15 the Grace. I don't think there was, so I  
 16 would think it would be the OR porter which  
 17 would have brought those to the lab, but I am  
 18 not positive about that.  
 19 COFFEY, Q.C.:  
 20 Q. And now this portering system, did they have  
 21 any written policies or procedures that you  
 22 are aware of?  
 23 MS. TRACEY:  
 24 A. I'm not aware of that. I'm not familiar with  
 25 whether they do or they don't.

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1 COFFEY, Q.C.:  
 2 Q. What about even today?  
 3 MS. TRACEY:  
 4 A. I'm not sure what their policies and  
 5 procedures are.  
 6 COFFEY, Q.C.:  
 7 Q. Even as we sit--we're here now.  
 8 MS. TRACEY:  
 9 A. Correct.  
 10 COFFEY, Q.C.:  
 11 Q. For example, at the General Hospital, is the  
 12 portering still done by central portering?  
 13 MS. TRACEY:  
 14 A. Yes, it is.  
 15 COFFEY, Q.C.:  
 16 Q. And it's run out of diagnostic imaging?  
 17 MS. TRACEY:  
 18 A. That's correct.  
 19 COFFEY, Q.C.:  
 20 Q. And whatever policies and procedures they  
 21 might have -  
 22 MS. TRACEY:  
 23 A. Would be under the diagnostic imaging  
 24 department.  
 25 COFFEY, Q.C.:



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<p>1 Q. - you don't know whether they're written or -</p> <p>2 MS. TRACEY:</p> <p>3 A. No.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. - just understood, and what time -</p> <p>6 MS. TRACEY:</p> <p>7 A. I would imagine there must be something</p> <p>8 written because obviously people have</p> <p>9 designated jobs.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. But I'm thinking about, for example,</p> <p>12 particular times.</p> <p>13 MS. TRACEY:</p> <p>14 A. That's correct.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. For the day, you don't know -</p> <p>17 MS. TRACEY:</p> <p>18 A. I don't know what the -</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. Who would you ask, if I was to ask you to find</p> <p>21 out overnight who that is, who would you have</p> <p>22 to ask?</p> <p>23 MS. TRACEY:</p> <p>24 A. I would ask, I guess, program director, Sean</p> <p>25 Thomas.</p>	<p>1 MS. TRACEY:</p> <p>2 A. Yes.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. And it's noted in passing that you're in</p> <p>5 attendance, as are a number of others. These</p> <p>6 would be, well there's Dr. Felix, Dr. Peddle</p> <p>7 and Dr. Williams, they would be -</p> <p>8 MS. TRACEY:</p> <p>9 A. Dr. Felix was the clinical chief for surgery</p> <p>10 at that time. He was the divisional chief for</p> <p>11 general surgery. Dr. Peddle was the chief for</p> <p>12 orthopedics; John Williams was the chief of</p> <p>13 anesthesia at St. Clare's site. Diane</p> <p>14 Sullivan was the manager of pre-admission</p> <p>15 clinic. Margie Burke was the patient care co-</p> <p>16 ordinator in the recovery room. Sylvia Carter</p> <p>17 was an operating room technician in the</p> <p>18 operating room. Linda Ezekiel is the patient</p> <p>19 care co-ordinator in the operating room.</p> <p>20 Glenda Tapp is the clinical educator in the</p> <p>21 operating room. Val Tilley is an OR nurse at</p> <p>22 St. Clare's site and Cheryl Abbott is my</p> <p>23 secretary and she recorded the minutes.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. So a representative, pretty well, from all of</p>
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<p>1 COFFEY, Q.C.:</p> <p>2 Q. In diagnostic imaging?</p> <p>3 MS. TRACEY:</p> <p>4 A. Diagnostic imaging.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. How about at St. Clare's, what's the situation</p> <p>7 there?</p> <p>8 MS. TRACEY:</p> <p>9 A. They would be--they are still under the</p> <p>10 diagnostic imaging department.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. And it's the same individual?</p> <p>13 MS. TRACEY:</p> <p>14 A. That's correct.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Now, if we could look please at exhibit P-</p> <p>17 2828? Now this is, well it's entitled "St.</p> <p>18 Clare's Site Perioperative Committee Minutes,</p> <p>19 Wednesday, February 18th, 1988." And Ms.</p> <p>20 Taylor, Shirley Taylor is the chair.</p> <p>21 MS. TRACEY:</p> <p>22 A. She's the manager at that site.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Yes, she's chairing the committee and she is</p> <p>25 the manager of that site.</p>	<p>1 the interested groups.</p> <p>2 MS. TRACEY:</p> <p>3 A. Uh-hm. There are actually more physician</p> <p>4 members, but sometimes they can't make the</p> <p>5 meetings.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Here under paragraph 3.01 and there's a</p> <p>8 reference to handling of specimens. There's a</p> <p>9 record book for all specimens being sent to</p> <p>10 the lab was introduced on February 2nd, 1998</p> <p>11 and this method of tracking seems to be</p> <p>12 working well. The new lab is now required to</p> <p>13 tick off and sign for the specimens they have</p> <p>14 taken, as well needle localization specimens</p> <p>15 are being signed for in the pathology lab when</p> <p>16 they are delivered. So I take it this was</p> <p>17 related to keeping track of them.</p> <p>18 MS. TRACEY:</p> <p>19 A. The Grace had a process of tracking specimens</p> <p>20 an St. Clare's did not have a similar log, so</p> <p>21 a record book was introduced to St. Clare's.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. And this is the record of the introduction?</p> <p>24 MS. TRACEY:</p> <p>25 A. That's correct.</p>

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1 COFFEY, Q.C.:

2 Q. If I could, please, could you bring up,

3 please, exhibit P-3089? Which is a record

4 that was received from yourself, and here,

5 these are entitled "The General Hospital

6 Health Sciences Centre, Departmental

7 Procedure" and you will notice here, Ms.

8 Tracey, that's page one of four and it goes

9 on, two of four, three of four and four of

10 four. And they're all for--the department is

11 the operating room, issued by the director of

12 nursing and critical care -

13 MS. TRACEY:

14 A. Which was Norma Baker at the time.

15 COFFEY, Q.C.:

16 Q. Norma Baker at the time. And then the

17 numbering system is roman numeral IIV-5,

18 there's a date, 1986-01, would be January,

19 1986 revised, September 1991 and, revised

20 again, I take it, RV?

21 MS. TRACEY:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. August, 1994 and the section is called

25 "Specimens", there's a procedure, sub-section

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1 which involves, I take it, the page numbers

2 and the pathology specimens, care and

3 handling. And now when you took over then as

4 the director of the perioperative program,

5 what was the situation in terms of the Health

6 Care Corporation in terms of these sorts of

7 policies and procedures?

8 MS. TRACEY:

9 A. Our practice was that the operating rooms

10 followed the existing policies until the

11 policies were realigned. When we took over

12 within--when we took over and became the

13 Health Care Corporation, it was a time of a

14 lot of turmoil, it was a time of a lot of

15 anxiety and there were three new managers

16 within--at least four new managers at that

17 time within my program. All of them had

18 responsibilities that were new to them and

19 three of them were at different sites than

20 they had previously managed.

21 COFFEY, Q.C.:

22 Q. I'm sorry, three of them?

23 MS. TRACEY:

24 A. Were at different sites.

25 COFFEY, Q.C.:

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1 Q. Okay.

2 MS. TRACEY:

3 A. So we put in place a committee, I guess, of

4 frontline staff to begin the process of

5 standardizing policies and at first it was a

6 very onerous task. Staff from the three

7 operating rooms did not know each other and

8 the other part of it was, the Grace was going

9 to close, so that was also a lot of anxiety

10 attached to that. And staff did not always

11 get to choose where they were going to have a

12 new position, even were they going to have a

13 position, so it was a lot of turmoil within

14 the whole system at that time.

15 COFFEY, Q.C.:

16 Q. And that would be beginning with the Health

17 Care Corporation being -

18 MS. TRACEY:

19 A. That's correct.

20 COFFEY, Q.C.:

21 Q. - up and running. Go ahead, I'm sorry.

22 MS. TRACEY:

23 A. We began by standardizing policies that were

24 very simple to try and get the process in

25 place on how this was going to work. And

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1 policies, the first policies were developed in

2 1998 and we simply did the scrubbing technique

3 and we did the dress code for the operating

4 rooms. Also have to remember the staff were

5 using different records. The papers they were

6 writing on were different.

7 COFFEY, Q.C.:

8 Q. Different forms?

9 MS. TRACEY:

10 A. Different forms and they all had to be

11 standardized, absolutely everything in the

12 practice had to be standardized. So we tried

13 to start very simple and it was a long and

14 difficult process at first, but it became

15 easier and better as the time evolved.

16 COFFEY, Q.C.:

17 Q. Now here, in the meantime I take it at any one

18 site, what continued to -

19 MS. TRACEY:

20 A. The policies in place governed the practice at

21 that site.

22 COFFEY, Q.C.:

23 Q. So historically whatever was written, the

24 policy and procedure as it existed at the time

25 the Health Care Corporation came into being,

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<p>1 in particular, for example, this is the 2 General Hospital - 3 MS. TRACEY: 4 A. That's correct. 5 COFFEY, Q.C.: 6 Q. This would have continued to apply then in 7 '95, '96, '97 and '98 at the General? 8 MS. TRACEY: 9 A. Yes. 10 COFFEY, Q.C.: 11 Q. And do you know if each site had its own 12 policies and procedures? 13 MS. TRACEY: 14 A. St. Clare's site did. I'm not familiar with 15 the policies that were at the Grace, exactly 16 what they were. 17 COFFEY, Q.C.: 18 Q. And the General, obviously, at least had this 19 one that we're looking at here. 20 MS. TRACEY: 21 A. Uh-hm. 22 COFFEY, Q.C.: 23 Q. Just to look at this particular one, it says 24 "Pathology/histology specimens care in 25 handling, procedure obtain separate specimen</p>	<p>1 here, the second last one, "Ask surgeon if he 2 wants the specimen put in formalin"--which 3 you've just referred to, the nurse actually 4 asks - 5 MS. TRACEY: 6 A. That's the practice to this day, yes. 7 COFFEY, Q.C.: 8 Q. This day. And the note is, the point of 9 emphasis is the surgeon may want to examine it 10 fresh after the operation, but before it goes 11 into the formalin. 12 MS. TRACEY: 13 A. At times the surgeon asks for the specimen to 14 be left on the set up. 15 COFFEY, Q.C.: 16 Q. And Dr. Kwan was just in here telling us about 17 that, at times he would want to see it, when 18 he could get back to it. 19 MS. TRACEY: 20 A. That's right. So the nurse isolates it on her 21 set up and marks what the specimen is, so that 22 there can be no mistake with that. 23 COFFEY, Q.C.: 24 Q. And I take it after he or his fellow surgeon 25 had done whatever examination -</p>
<p>1 container for each specimen" and points of 2 emphasis, "use larger enough container to 3 allow fixative of one to ten"--which would be 4 a volume of ten to one, I take it, ten times 5 the amount of volume of fixative to the size 6 of the specimen. 7 MS. TRACEY: 8 A. Specimen. 9 COFFEY, Q.C.: 10 Q. And here, this actually then in a fairly 11 systematic fashion talks about labelling, 12 what's supposed to go in the labelling, "tear 13 the backing off the label and affix to the 14 specimen container before accepting the 15 specimen, label the container and not the lid. 16 Hold the empty label container with a gloved 17 hand for scrub nurse to place specimen inside. 18 A filled container may splash, use gloves. 19 Check the label with scrub nurse." And I can 20 take you on down through it, this is fairly 21 detailed, almost a step by step literally - 22 MS. TRACEY: 23 A. Uh-hm. 24 COFFEY, Q.C.: 25 Q. As to how this is supposed to be done. And</p>	<p>1 MS. TRACEY: 2 A. If the surgeon is asking for it, he wants to 3 see it himself. 4 COFFEY, Q.C.: 5 Q. Sure, and then they might then say, well now 6 you can put it in the formalin after I've-- 7 he's finished with it. 8 MS. TRACEY: 9 A. Yes. 10 COFFEY, Q.C.: 11 Q. Here it goes on to say, "Upon request, open up 12 bowel, uterus or other hollow organs, except 13 bladder. (Tie off openings with silk, except 14 one, fill with formalin, tie off)." 15 MS. TRACEY: 16 A. That's no longer a practice. 17 COFFEY, Q.C.: 18 Q. Yeah, I appreciate that, but here on the other 19 side it says, in terms of points of emphasis 20 related to that, is "to allow the formalin to 21 penetrate the specimen or to contact all 22 surfaces." 23 MS. TRACEY: 24 A. Uh-hm. 25 COFFEY, Q.C.:</p>

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1 Q. So at the time your understanding in the late  
 2 1990's was what, in terms of what was required  
 3 to fix a specimen?  
 4 MS. TRACEY:  
 5 A. That the specimen would be saturated in  
 6 formalin. The specimen actually or as graphs  
 7 describe it, it would float in formalin, so  
 8 that all surfaces were surrounded, well  
 9 surrounded with formalin.  
 10 COFFEY, Q.C.:  
 11 Q. Float, meaning, I take it, float to the  
 12 surface?  
 13 MS. TRACEY:  
 14 A. Well that it's absolutely, totally covered in  
 15 formalin.  
 16 COFFEY, Q.C.:  
 17 Q. So much sufficient that if it would float, the  
 18 type of tissue -  
 19 MS. TRACEY:  
 20 A. The formalin would penetrate the specimen is  
 21 the object.  
 22 COFFEY, Q.C.:  
 23 Q. Now that's what I wanted to ask you about.  
 24 Did you--because it says "to penetrate the  
 25 specimen or to contact all surfaces." What

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1 was your understanding of that in terms of,  
 2 was your understanding, look, if it's in  
 3 formalin and it's completely emersed, then  
 4 that's sufficient?  
 5 MS. TRACEY:  
 6 A. Sufficient for what?  
 7 COFFEY, Q.C.:  
 8 Q. To preserve the tissue.  
 9 MS. TRACEY:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. That was your understanding at the time.  
 13 MS. TRACEY:  
 14 A. Yes. I would not have had knowledge about the  
 15 -  
 16 COFFEY, Q.C.:  
 17 Q. Yeah, and that's what I'm asking, in terms of  
 18 that too and for the Commissioner to have some  
 19 sense of what you would have understood at the  
 20 time.  
 21 MS. TRACEY:  
 22 A. And that's what the OR staff would have  
 23 believed that if the specimen was in formalin,  
 24 there wasn't really--I was not aware there was  
 25 a length of time that it was optimum for the

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1 specimen to be in formalin, yes.  
 2 COFFEY, Q.C.:  
 3 Q. Or the idea, for example, that the specimen  
 4 should be cut relatively thinly to allow and  
 5 would -  
 6 MS. TRACEY:  
 7 A. I would not have had that knowledge, no.  
 8 COFFEY, Q.C.:  
 9 Q. From your perspective, the specimen, no matter  
 10 how large it was or small, or large it was, as  
 11 long as it was completely emersed in formalin  
 12 -  
 13 MS. TRACEY:  
 14 A. That was adequate.  
 15 COFFEY, Q.C.:  
 16 Q. That would preserve it, adequate fixation.  
 17 MS. TRACEY:  
 18 A. That's right.  
 19 COFFEY, Q.C.:  
 20 Q. Have you ever learned any different?  
 21 MS. TRACEY:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. Since all this has arisen, okay. And here at  
 25 3 of the exhibit, page 2 of the actual

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1 departmental procedure, it says under  
 2 procedure "Pour formalin as soon as possible  
 3 in the container. Add ten times the amount of  
 4 formalin compared to tissue, then put a lid on  
 5 the container." And points of emphasis,  
 6 "Tissue has to be completely covered.  
 7 Formalin may splash when being poured on the  
 8 specimen." I take it that was to warn you  
 9 that you should be careful of -  
 10 MS. TRACEY:  
 11 A. Formalin is toxic.  
 12 COFFEY, Q.C.:  
 13 Q. Is toxic, yes. And it says here, "After the  
 14 operation, place the specimen and requisition  
 15 on the bottom shelf of the patient stretcher,  
 16 bring it to the main desk and place it in the  
 17 specimen carrier." Which is what you--the  
 18 particular place in the OR where they were  
 19 stored?  
 20 MS. TRACEY:  
 21 A. That's correct.  
 22 COFFEY, Q.C.:  
 23 Q. Here on page 4 of the departmental procedure,  
 24 it says, "Biopsy of breast for estrogen  
 25 receptor", do you see that? And this is a

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1 revised version as of August, 1994. It says,  
 2 this is 1994 now, "Have a container of liquid  
 3 nitrogen available." And I take it this is  
 4 back in the days of biochemical assays, so  
 5 this is--if there was a biopsy that required  
 6 liquid nitrogen to be used, this is the  
 7 procedure to be followed?  
 8 MS. TRACEY:  
 9 A. I don't actually remember when we used to do  
 10 that, my staff didn't remember it either, but  
 11 apparently--a long time ago, many years ago,  
 12 yes.  
 13 COFFEY, Q.C.:  
 14 Q. And here it notes here, "Take the specimen  
 15 container to the main desk for porter to bring  
 16 to the chemistry lab immediately." Do you see  
 17 that?  
 18 MS. TRACEY:  
 19 A. Uh-hm.  
 20 COFFEY, Q.C.:  
 21 Q. So that would be on down to biochemistry. And  
 22 what I'm looking at is that that, in terms of  
 23 the usage of liquid nitrogen to preserve,  
 24 cold, bring it down immediately, while the  
 25 policy we just look at before, the formalin

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1 one -  
 2 MS. TRACEY:  
 3 A. There's no indication of a time -  
 4 COFFEY, Q.C.:  
 5 Q. The timeframe.  
 6 MS. TRACEY:  
 7 A. Uh-hm.  
 8 COFFEY, Q.C.:  
 9 Q. So I take it and I'm going to ask you about  
 10 this, was there any sense at the time, from  
 11 your perspective, of urgency in getting  
 12 formalin, you know, preserved tissue down  
 13 stairs?  
 14 MS. TRACEY:  
 15 A. No.  
 16 COFFEY, Q.C.:  
 17 Q. I say downstairs generally in the hospital,  
 18 it's not always the case it's downstairs.  
 19 Here, page six of the exhibit, there's  
 20 actually a--there's a procedure for frozen  
 21 sections, care and handling. And here it's  
 22 noted that the pathologist comes to the  
 23 theatre to pick up the specimen and the  
 24 requisition and enables the pathologist to  
 25 converse with the surgeon concerning the

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1 specimen, so there was a different procedure  
 2 or process set out here for frozen sections  
 3 than for formalin fixed. You've indicated,  
 4 Ms. Tracey, that with the formation of the  
 5 Health Care Corporation initially and people  
 6 reapplying for positions and the prospect of  
 7 the Grace closing there was a certain amount  
 8 of tension and turmoil.  
 9 MS. TRACEY:  
 10 A. Yes, it was.  
 11 COFFEY, Q.C.:  
 12 Q. You've indicated, I believe, that you kind of  
 13 started simply with developing a uniform  
 14 policy, procedure process and it evolved from  
 15 there. Can you tell the Commissioner about  
 16 that, like when did it really get going and  
 17 how did it evolve?  
 18 MS. TRACEY:  
 19 A. The process gradually developed as we became  
 20 more comfortable--as the staff became more  
 21 comfortable working with each other. The  
 22 practices were subtly different at each site  
 23 and everybody believed their practice was the  
 24 best. The outcomes to the patients were  
 25 different, but the practices within the

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1 departments were different and it took a lot  
 2 of education and time for people to realize  
 3 that one practice had to be adopted and that  
 4 meant that two different hospitals had to  
 5 change their practice. So it did take time.  
 6 We were guided by current literature, by the  
 7 (Unintelligible) Standards and by Best  
 8 Practice Guidelines, and by practices within  
 9 other national hospitals.  
 10 COFFEY, Q.C.:  
 11 Q. Do you know who, in the late 1990's then, was  
 12 responsible for this? I mean, ultimately I  
 13 take it it would be you, but in a day to day -  
 14 MS. TRACEY:  
 15 A. In the actual initial drafting of the  
 16 policies?  
 17 COFFEY, Q.C.:  
 18 Q. Yes.  
 19 MS. TRACEY:  
 20 A. The clinical educators at the St. Clare's site  
 21 and at the General site; the Grace site did  
 22 not have a clinical educator.  
 23 COFFEY, Q.C.:  
 24 Q. So the clinical educators were supposed to get  
 25 together -

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1 MS. TRACEY:  
 2 A. They chaired a committee of frontline staff,  
 3 which was the nurses from each site. And they  
 4 would have done the research and probably  
 5 drafted something because, otherwise, it's  
 6 very hard to get the discussion going on  
 7 what's actually going to be the outcome, so  
 8 they would have come with a draft policy and  
 9 then they would iron out what was appropriate  
 10 and get input from the departments, like  
 11 pathology, if that was appropriate.  
 12 COFFEY, Q.C.:  
 13 Q. Now we just looked at the General Hospital  
 14 departmental procedure--it's still there on  
 15 the screen, one of them, from their revised  
 16 version, August 1994. Have you been able to  
 17 locate any for St. Clare's dating back to that  
 18 timeframe?  
 19 MS. TRACEY:  
 20 A. No, I haven't.  
 21 COFFEY, Q.C.:  
 22 Q. You've looked and -  
 23 MS. TRACEY:  
 24 A. I've looked. They were destroyed.  
 25 COFFEY, Q.C.:

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1 Q. And they did exist at one time.  
 2 MS. TRACEY:  
 3 A. They did, yes.  
 4 COFFEY, Q.C.:  
 5 Q. And whatever the written policy or procedure  
 6 at St. Clare's or the Grace, for that matter,  
 7 said at the time, I take it formalin fixed  
 8 tissues, there was no indication that they  
 9 were supposed to get to the lab right away.  
 10 MS. TRACEY:  
 11 A. No.  
 12 COFFEY, Q.C.:  
 13 Q. Exhibit P-2830. This is records of an OR  
 14 practice meeting in November 29th, 2001,  
 15 certain individuals present. Here there's  
 16 "business arising, draft policies circulated  
 17 for review, a) orientation development and  
 18 ongoing education policy, minor changes were  
 19 made as policy is currently under review by  
 20 the perioperative management team." So I take  
 21 it that this is a time period in which  
 22 policies and procedures were being developed.  
 23 MS. TRACEY:  
 24 A. They were being developed right from, probably  
 25 1997 onwards, it's an ongoing process, the

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1 frontline or practice committee develops the  
 2 policy. When they feel that they have the  
 3 policy finished, they forward it on. Once a  
 4 month my managers and I meet with the clinical  
 5 educators, we review the policies and if  
 6 they're acceptable, make minor changes if  
 7 necessary. If they're acceptable, I sign off  
 8 on them.  
 9 COFFEY, Q.C.:  
 10 Q. Now if we can look, please, at exhibit P-2729?  
 11 Thank you. This is an OR practice meeting  
 12 minutes of January 29th, 2003.  
 13 MS. TRACEY:  
 14 A. Uh-hm.  
 15 COFFEY, Q.C.:  
 16 Q. There are a number of individuals present,  
 17 you're not listed as one of them, but I take  
 18 it this is kind of a sub-group?  
 19 MS. TRACEY:  
 20 A. I'm not a member of this team.  
 21 COFFEY, Q.C.:  
 22 Q. No, you wouldn't be.  
 23 MS. TRACEY:  
 24 A. They are the frontline staff.  
 25 COFFEY, Q.C.:

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1 Q. Frontline staff. And here, after welcoming a  
 2 particular individual, they say "Business  
 3 arising, one, the new OR manuals having  
 4 delivered to the OR's, only a Table of  
 5 Contents is included to date. We have not  
 6 received any signed policies." I take it that  
 7 as of January--the end of January, 2003, that  
 8 was the situation?  
 9 MS. TRACEY:  
 10 A. Actually there were some policies in place  
 11 since 1998. The first thing we developed was  
 12 the Table of Contents and then obviously the  
 13 policy development followed on from that. My  
 14 secretary would have sent out the new manuals  
 15 and I guess what they meant was, because once  
 16 we developed new policies, they replaced the  
 17 existing policies in the existing manuals,  
 18 this was a perioperative manual which was  
 19 going to replace all the site manuals.  
 20 COFFEY, Q.C.:  
 21 Q. And they were just noting the manual is here,  
 22 the Table of Contents is here and the  
 23 policies, as soon as we get them, will follow?  
 24 MS. TRACEY:  
 25 A. Policies will follow, yes.

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1 COFFEY, Q.C.:

2 Q. Number two here, it says, "During the

3 physician job action this past fall, both

4 sites"--and that would be the General and St.

5 Clare's, in this context, I take it both

6 sites, "spent time drafting/reviewing

7 policies. These policies were submitted.

8 Some of these policies need to be typed. The

9 policies drafted will be compiled by Wendy and

10 Glenda prior to the next meeting." So I take

11 it there was a physician job action the fall

12 of 2002?

13 MS. TRACEY:

14 A. Uh-hm.

15 COFFEY, Q.C.:

16 Q. And the staff didn't waste any time, they went

17 on drafting policies.

18 MS. TRACEY:

19 A. Yeah, they were formed into teams, if I

20 remember correctly, to review policies.

21 COFFEY, Q.C.:

22 Q. To review them and then redraft them as

23 necessary.

24 MS. TRACEY:

25 A. That's correct.

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1 COFFEY, Q.C.:

2 Q. Now on that point, this is what I want to ask

3 you about because by that point it would have

4 been four or five years since this process had

5 started back in '97. I take it that if the--

6 when there was a physician job action going

7 on, there was no operating going on -

8 MS. TRACEY:

9 A. It was emergency surgery only.

10 COFFEY, Q.C.:

11 Q. Emergency, but generally there was no -

12 MS. TRACEY:

13 A. That would be one team of nurses that would--

14 the remaining staff would not be working in

15 the operating room.

16 COFFEY, Q.C.:

17 Q. So was this, looking back on it, was this the

18 first real opportunity the staff had to

19 actually sit and go through and do what they

20 did at this point in time in terms of

21 reviewing policies?

22 MS. TRACEY:

23 A. It was the first--if I remember correctly, the

24 clinical educators co-ordinated this whole

25 big--used it as an opportunity to actually

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1 involve all of the staff, as opposed to a

2 representative group which had been to that

3 date, and they were given copies of the

4 policies from sites to look at redrafting

5 them.

6 COFFEY, Q.C.:

7 Q. As a practical matter prior to this, if it

8 wasn't going to be left to just one or two

9 people to review and draft the policies, to

10 revise them -

11 MS. TRACEY:

12 A. It's actually the committee named here where

13 the -

14 COFFEY, Q.C.:

15 Q. I appreciate that, but how much time did

16 people actually have available to them in

17 their workday to do that?

18 MS. TRACEY:

19 A. They met regularly, it was scheduled meetings,

20 but it was once a month as opposed to, you

21 know. Actually, the clinical educators would

22 usually meet and draft a policy that they

23 would bring to this group to look at.

24 COFFEY, Q.C.:

25 Q. And number three here, is policy review and it

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1 says, "The three specimen policies have been

2 redrafted based on feedback from committee

3 members, head nurses, pathology department and

4 quality initiatives, QI. QI also contacted

5 the RNC for input in the legal specimen

6 policy" and the RNC is?

7 MS. TRACEY:

8 A. Royal Newfoundland Constabulary.

9 COFFEY, Q.C.:

10 Q. "And the following policies were again

11 reviewed, legal specimens, specimen care,

12 guidelines for the management of specimens.

13 Revisions were made, the committee agreed to

14 have these policies with revisions be sent to

15 the managers for review/signing." I take it

16 that -

17 MS. TRACEY:

18 A. The policies were in final draft, so then they

19 would come to the management group to be

20 reviewed. And for discussion, the clinical

21 educators were the people who actually drafted

22 the policies would be there to discuss it with

23 us.

24 COFFEY, Q.C.:

25 Q. Exhibit P-2730? These are the minutes of the

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1 perioperative program, clinical educators'  
 2 meeting of January 30th, 2003. In attendance  
 3 are yourself and four others, Ms. Taylor--and  
 4 who is the one from the general -  
 5 MS. TRACEY:  
 6 A. Wendy Walsh is the clinical educator from the  
 7 General; Glenda Tapp is the clinical educator  
 8 from St. Clare's; Dianne Sullivan was the  
 9 manager--she's since retired, she was the  
 10 manager of surgical daycare at the General  
 11 site; and Shirley is the manager of St.  
 12 Clare's O.R.  
 13 COFFEY, Q.C.:  
 14 Q. And here under "Business arising, policies,  
 15 O.R. Practice Group. It's noted 12 policies  
 16 were drafted during the physician job action  
 17 and are to be reviewed. The specimen policy  
 18 was reviewed yesterday and will be ready  
 19 shortly for review by managers. Some issues  
 20 still require clarification. Example,  
 21 responsibility for writing specimens in log  
 22 book, practice for checking specimens is  
 23 different at both sites and needs to be  
 24 reviewed. What role the scrub nurse plays in  
 25 confirming the identity of the patient also

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1 needs to be looked at. Time for a meeting of  
 2 the O.R. practice group is difficult to co-  
 3 ordinate as both O.R.'s are short of staff.  
 4 There are numerous policies to be drafted."  
 5 MS. TRACEY:  
 6 A. Uh-hm.  
 7 COFFEY, Q.C.:  
 8 Q. Does that fairly describe the situation at the  
 9 time?  
 10 MS. TRACEY:  
 11 A. Yes, it does. If the O.R. was short staff  
 12 that day, the staff went to the O.R., as  
 13 opposed to drafting policies.  
 14 COFFEY, Q.C.:  
 15 Q. Now here, if we could look, please, at Exhibit  
 16 P-3087? This is a nine-page document, it's a  
 17 Health Care Corporation of St. John's  
 18 Perioperative Program Operating Room Policy  
 19 Manual. And the number is IX J11, it's May,  
 20 2003. I take it this would be one of those  
 21 guidelines?  
 22 MS. TRACEY:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. And guidelines for the management of specimens

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1 and specimens for pathology. And here it  
 2 notes, one, "Routine pathology specimens are  
 3 brought to a) the designated area in day  
 4 surgery, b) the front desk part of the general  
 5 main O.R., c) the frozen section room at St.  
 6 Clare's O.R. where they are transported to the  
 7 pathology department throughout the day." And  
 8 there's no note here as to when throughout the  
 9 day or--so it was entirely conceivable and at  
 10 times would happen, it would remain overnight.  
 11 If it missed the last -  
 12 MS. TRACEY:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. Kind of round -  
 16 MS. TRACEY:  
 17 A. Last run from the porters.  
 18 COFFEY, Q.C.:  
 19 Q. Last round of porters, it would stay overnight  
 20 and the porter would be expected to pick it up  
 21 the next morning.  
 22 MS. TRACEY:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. And the same thing would happen on a Friday.

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1 MS. TRACEY:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. It would be over the weekend.  
 5 MS. TRACEY:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. There's a reference to frozen sections as to  
 9 how they are to be handled and the recording  
 10 of pathology specimens in the log book, which  
 11 is taking track of them, I take it. Here  
 12 under specimens for--I'm just going to show  
 13 you, cytology, bacteriology, chemistry,  
 14 hematology, etcetera, it says, "These  
 15 specimens are brought to the O.R. front desk  
 16 with a requisition and delivered to the  
 17 appropriate department by the PCA or porter as  
 18 soon as possible. After hours or weekends,  
 19 these specimens are transported to the lab  
 20 department by porter, PCA or nursing staff as  
 21 soon as possible, exception is the General  
 22 site, bacteriology specimens other than an  
 23 aerobic are placed in a refrigerator and the  
 24 PWA to be transported the following morning."  
 25 So, what sorts of specimens were these



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1 compared to, the specimens for pathology  
 2 above?  
 3 MS. TRACEY:  
 4 A. They would have been retrieved in the same  
 5 way, but for, following surgeon's direction,  
 6 they would have wanted the specimens to go to  
 7 these designated areas within the lab.  
 8 COFFEY, Q.C.:  
 9 Q. See here, under this heading, "Specimens for  
 10 Cytology, Bacteriology, Chemistry, Hematology"  
 11 et cetera, and I take it that's in  
 12 contradistinction to specimens for pathology?  
 13 MS. TRACEY:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. So these other ones down here, cytology, et  
 17 cetera, they are to be brought as soon as  
 18 possible, it's actually noted and number two,  
 19 "after hours or on weekends, go as soon as  
 20 possible, with one exception." So there was a  
 21 sense, I take it, of urgency where cytology,  
 22 bacteriology, chemistry, hematology -  
 23 MS. TRACEY:  
 24 A. Yes, these were time sensitive.  
 25 COFFEY, Q.C.:

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1 Q. And they were understood generally to be time  
 2 sensitive?  
 3 MS. TRACEY:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. In the way that at the time it was not  
 7 understood the pathology -  
 8 MS. TRACEY:  
 9 A. The pathology specimens were.  
 10 COFFEY, Q.C.:  
 11 Q. As long as they were in formalin, sufficient  
 12 formalin -  
 13 MS. TRACEY:  
 14 A. They were felt to be fixed adequately. And  
 15 that would be from, that would not be the  
 16 O.R.'s direction, that would be input from  
 17 pathology.  
 18 COFFEY, Q.C.:  
 19 Q. Well on that, because this is the one, I take  
 20 it, the guideline for the management of  
 21 specimens that remained in place, we're going  
 22 to look at another one because it was revised  
 23 briefly--not briefly, moderately in -  
 24 MS. TRACEY:  
 25 A. 2005.

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1 COFFEY, Q.C.:  
 2 Q. Actually it was revised initially in March of  
 3 '04, but in drafting these guidelines for the  
 4 management of specimens in '02, '03 and '04,  
 5 was the clinical laboratory consulted, do you  
 6 know?  
 7 MS. TRACEY:  
 8 A. Yes, it is, and I think there's some minutes  
 9 to reflect that, that input was obtained from  
 10 Dr. Ford Elms.  
 11 COFFEY, Q.C.:  
 12 Q. Okay, and your recollection is that they were  
 13 asked about it and there certainly is--I  
 14 don't--yes, bring up, please, Exhibit P-2830?  
 15 Here, this is this OR practice meeting of  
 16 November 29th, 2001 I showed you earlier,  
 17 which is under A there. We've looked at that  
 18 already. When we go down, policy development  
 19 issues, middle of the page under B, it says  
 20 "Glenda requested site forms for specimen  
 21 policy." So I take it Glenda was kind of  
 22 gathering up all the different forms that  
 23 existed for procedures here from different  
 24 sites.  
 25 MS. TRACEY:

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1 A. Um-hm.  
 2 COFFEY, Q.C.:  
 3 Q. And "Ford Elms, pathologist at St. Clare's, is  
 4 currently reviewing the lab manual to verify  
 5 if the content is still accurate. Glenda will  
 6 follow up with Dr. Elms." And then there's  
 7 Catherine Parnell.  
 8 MS. TRACEY:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Phone number, ongoing.  
 12 MS. TRACEY:  
 13 A. Yes, she's the staff--she was a staff member  
 14 of the lab. Glenda was--that's Glenda's  
 15 writing, I pretty well feel sure.  
 16 COFFEY, Q.C.:  
 17 Q. That's Glenda's here, yes.  
 18 MS. TRACEY:  
 19 A. Yes, that's her writing.  
 20 COFFEY, Q.C.:  
 21 Q. So your understanding at the time was what was  
 22 going on with this then? This is back in '01  
 23 and I take it -  
 24 MS. TRACEY:  
 25 A. I am understanding that Glenda gave the policy

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<p>1 in draft format to Dr. Elms to ask him if it</p> <p>2 was relevant and current and accurate.</p> <p>3 THE COMMISSIONER:</p> <p>4 Q. What does a site form mean?</p> <p>5 MS. TRACEY:</p> <p>6 A. Each hospital would have had it's own forms,</p> <p>7 each site.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. It's own specimen policy, I take it?</p> <p>10 MS. TRACEY:</p> <p>11 A. Yeah.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. So site forms mean -</p> <p>14 MS. TRACEY:</p> <p>15 A. And the forms used for pathology.</p> <p>16 COFFEY, Q.C.:</p> <p>17 Q. The actual forms themselves?</p> <p>18 MS. TRACEY:</p> <p>19 A. Yes. They were eventually consolidated, but</p> <p>20 they weren't initially. There would have been</p> <p>21 different forms the physicians would have</p> <p>22 filled out to request analysis of the</p> <p>23 specimen.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. So was Dr. Elms reviewing the site forms, the</p>	<p>1 we just looked at, for some sorts of</p> <p>2 specimens, it's specified "as soon as</p> <p>3 possible" and pathology, there's no reference</p> <p>4 to "as soon as possible."</p> <p>5 MS. TRACEY:</p> <p>6 A. No.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And your understanding is that Dr. Elms had</p> <p>9 reviewed it?</p> <p>10 MS. TRACEY:</p> <p>11 A. Yes, and I discussed that with Glenda and</p> <p>12 that's her recollection of it.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. You've discussed it with her since?</p> <p>15 MS. TRACEY:</p> <p>16 A. Yes.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. Since 2005, and I take it if there were some</p> <p>19 concern expressed by the clinical lab that</p> <p>20 they wanted it down as soon as possible -</p> <p>21 MS. TRACEY:</p> <p>22 A. We would have incorporated it into the policy.</p> <p>23 COFFEY, Q.C.:</p> <p>24 Q. Like you did the other one?</p> <p>25 MS. TRACEY:</p>
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<p>1 site requisition forms?</p> <p>2 MS. TRACEY:</p> <p>3 A. No, Dr. Elms is actually reviewing the lab</p> <p>4 manual to verify the content is still</p> <p>5 accurate. So he was reviewing -</p> <p>6 THE COMMISSIONER:</p> <p>7 Q. The content of what?</p> <p>8 MS. TRACEY:</p> <p>9 A. The content of the policy they were</p> <p>10 developing.</p> <p>11 THE COMMISSIONER:</p> <p>12 Q. Which is the site form for specimen -</p> <p>13 MS. TRACEY:</p> <p>14 A. No, the site form was--that's separate.</p> <p>15 THE COMMISSIONER:</p> <p>16 Q. Okay. So you read this as saying that Dr.</p> <p>17 Elms was looking at the whole of this policy?</p> <p>18 MS. TRACEY:</p> <p>19 A. The policy we were drafting, for input.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. And it's your understanding that by the time</p> <p>22 it got issued in May of 2003, that's the one</p> <p>23 we just saw, by that point in time, the</p> <p>24 clinical laboratory, in the person of Dr.</p> <p>25 Elms, was satisfied with it? That's your--and</p>	<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Like you did the specimen for cytology, for</p> <p>4 example.</p> <p>5 MS. TRACEY:</p> <p>6 A. Our object is to get the specimen in the best</p> <p>7 quality to the pathology lab or whatever lab</p> <p>8 it is going to.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. If we could look at--go back to Exhibit P-</p> <p>11 3087, please? Here, on page two, because the</p> <p>12 actual--you'll see that basic specimen care,</p> <p>13 and then tissue for routine pathology and it</p> <p>14 refers to particular body parts, but then it</p> <p>15 says "fixative ten percent formalin." So I</p> <p>16 take it that was what was to be used?</p> <p>17 MS. TRACEY:</p> <p>18 A. Um-hm.</p> <p>19 COFFEY, Q.C.:</p> <p>20 Q. And then "place in specimen container with 20</p> <p>21 to one formalin to specimen. Identify</p> <p>22 specimens on pathology requisition. Physician</p> <p>23 will complete and sign the requisition." That</p> <p>24 will be the surgeon, I take it?</p> <p>25 MS. TRACEY:</p>

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Now this idea of using 20 to one, the older  
 4 one from the '90s we looked at was ten to one.  
 5 MS. TRACEY:  
 6 A. Um-hm.  
 7 COFFEY, Q.C.:  
 8 Q. Do you recall where the 20 to one came from?  
 9 MS. TRACEY:  
 10 A. I actually discussed it with Glenda. She does  
 11 not exactly recall. It was some documents or  
 12 at least some literature she reviewed she  
 13 feels she had obtained that from. She did  
 14 discuss it with Dr. Elms and he supported  
 15 this.  
 16 COFFEY, Q.C.:  
 17 Q. Now 20 to one as a volume -  
 18 MS. TRACEY:  
 19 A. Is very large.  
 20 COFFEY, Q.C.:  
 21 Q. - is very large, isn't it? If you have a  
 22 specimen of any size at all -  
 23 MS. TRACEY:  
 24 A. That's right.  
 25 COFFEY, Q.C.:

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1 Q. - the container would have to be -  
 2 MS. TRACEY:  
 3 A. Well, our specimen containers range from a  
 4 tiny test tube to beef bucket size.  
 5 COFFEY, Q.C.:  
 6 Q. And five gallon?  
 7 MS. TRACEY:  
 8 A. Big, yes.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. But to get it 20 to one -  
 11 MS. TRACEY:  
 12 A. It's very large.  
 13 COFFEY, Q.C.:  
 14 Q. - volume, you would have to have a very large  
 15 container, if the specimen is of any size at  
 16 all.  
 17 MS. TRACEY:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Now in practice, from your perspective, again  
 21 looking back at it, what sort of ratios were  
 22 actually being utilized?  
 23 MS. TRACEY:  
 24 A. I would think, in practice, that the specimen  
 25 was very well saturated, as I described. The

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1 nurses felt that the specimen should be well  
 2 floating in the formalin.  
 3 COFFEY, Q.C.:  
 4 Q. So enough formalin to float the specimen off  
 5 the bottom of the container?  
 6 MS. TRACEY:  
 7 A. Really well, and surround it.  
 8 COFFEY, Q.C.:  
 9 Q. Surround it.  
 10 MS. TRACEY:  
 11 A. Um-hm.  
 12 COFFEY, Q.C.:  
 13 Q. But if--and whether that took four to one or  
 14 15 to one?  
 15 MS. TRACEY:  
 16 A. I guess there's no accurate measurement. It's  
 17 a perception of the person fixing the  
 18 specimen.  
 19 COFFEY, Q.C.:  
 20 Q. In fact, to this day, there's no real accurate  
 21 way of doing that, is there?  
 22 MS. TRACEY:  
 23 A. No. There's a lot more education around it has  
 24 occurred.  
 25 COFFEY, Q.C.:

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1 Q. Yes. Here, we go to the next page, it's for  
 2 general surgery specifics, and when we look  
 3 down through it, needle localization, breast  
 4 biopsy, St. Clare's OR, fixative nil, and it  
 5 says "special care. Place the specimen in a  
 6 blue grid container. Avoid excessive  
 7 compression. Label porter transports,  
 8 specimen mammogram to mammography, then  
 9 specimen and film to radiologist and finally  
 10 specimen to pathology with requisition." And  
 11 I take it this would be -  
 12 MS. TRACEY:  
 13 A. This is procedure carried out at St. Clare's  
 14 site only.  
 15 COFFEY, Q.C.:  
 16 Q. Yes, and this would be in relation to what was  
 17 perceived to be or potentially breast cancer?  
 18 MS. TRACEY:  
 19 A. Yes, usually a lump that was very small would  
 20 be difficult for the surgeon to locate,  
 21 probably couldn't palpate it, it was that  
 22 small. So prior to the patient coming to the  
 23 OR, they would have a needle placed in it.  
 24 COFFEY, Q.C.:  
 25 Q. And here, there's no fixative utilized here

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1 for this.  
 2 MS. TRACEY:  
 3 A. No.  
 4 COFFEY, Q.C.:  
 5 Q. And how long--did you ever make any inquiry or  
 6 have you made any inquiries about how long it  
 7 might take the specimen to finally get down to  
 8 pathology?  
 9 MS. TRACEY:  
 10 A. No.  
 11 COFFEY, Q.C.:  
 12 Q. What's a blue grid container?  
 13 MS. TRACEY:  
 14 A. It's a special container that was--well, it  
 15 literally had a grid in it for this purpose.  
 16 So it was to map--it was, you know, was the  
 17 specimen retrieved correctly.  
 18 COFFEY, Q.C.:  
 19 Q. Was there any sense of urgency associated with  
 20 this particular procedure, in terms of this  
 21 part of it?  
 22 MS. TRACEY:  
 23 A. Not at that time.  
 24 COFFEY, Q.C.:  
 25 Q. Not then. How about now?

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1 MS. TRACEY:  
 2 A. There is a different sense of urgency about  
 3 all breast specimens now.  
 4 COFFEY, Q.C.:  
 5 Q. If we could look, please, at--there are a  
 6 number of others. I'm not going to take the  
 7 Commissioner through them, really germane.  
 8 Look at 2827, please? This is that same  
 9 guidelines for management of specimens, except  
 10 here you'll see it's revised.  
 11 MS. TRACEY:  
 12 A. Um-hm.  
 13 COFFEY, Q.C.:  
 14 Q. March of '04. The formatting here in  
 15 specimens for pathology has changed slightly  
 16 in the way it's written, but again, it refers  
 17 to the specimens being brought to particular  
 18 locations and then transported throughout the  
 19 day, there's no sense of urgency specified  
 20 here, and the second page, the tissue for  
 21 routine pathology, and ten percent of  
 22 formalin. This would cover ordinary breast  
 23 tissue?  
 24 MS. TRACEY:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. So that's the same as it was before, and here,  
 3 under the needle localization, breast biopsy  
 4 at St. Clare's OR, again that appears to be,  
 5 does it not, the same?  
 6 MS. TRACEY:  
 7 A. Yes, it is.  
 8 COFFEY, Q.C.:  
 9 Q. As the one we just looked at. Now here, as  
 10 well, noticed on these, see here issuing  
 11 authority here is yourself, your signature?  
 12 MS. TRACEY:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. So by this point certainly, in this particular  
 16 copy anyway, we have--you were seen as and  
 17 perceived to be the issuing authority?  
 18 MS. TRACEY:  
 19 A. Um-hm.  
 20 COFFEY, Q.C.:  
 21 Q. These would be circulated where, these sorts  
 22 of policies?  
 23 MS. TRACEY:  
 24 A. Circulation in each OR and in surgical day  
 25 care at the General site, because procedures

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1 are done there, not at St. Clare's.  
 2 COFFEY, Q.C.:  
 3 Q. Do you know if pathology was consulted about  
 4 the revisions in 2004?  
 5 MS. TRACEY:  
 6 A. I'm presuming that the revisions took place  
 7 because of some feedback.  
 8 COFFEY, Q.C.:  
 9 Q. Okay. Would there be any record of whether  
 10 they were consulted?  
 11 MS. TRACEY:  
 12 A. I haven't got a record of that and I looked  
 13 for it. The change in 2004 was pretty small.  
 14 Oftentimes, the changes occur out of changes  
 15 in practice as well.  
 16 COFFEY, Q.C.:  
 17 Q. Now Ms. Tracey, are there any other policies  
 18 and procedures, written ones, that, you know,  
 19 again relating to breast operations that  
 20 you're aware of that we haven't looked at,  
 21 before we get to '05, because we'll get there  
 22 now?  
 23 MS. TRACEY:  
 24 A. Before this, no, these are the policies that  
 25 we had in place.

<p style="text-align: right;">Page 369</p> <p>1 COFFEY, Q.C.:</p> <p>2 Q. Yes, this is it. If we could look, please, at</p> <p>3 Exhibit P-1939? And this is a memorandum from</p> <p>4 Dr. Cook of August 23rd, 2005 to yourself</p> <p>5 involving mastectomy specimens. Before I look</p> <p>6 through this though, Ms. Tracey, can you tell</p> <p>7 me when you first heard of this ER/PR as kind</p> <p>8 of a topic?</p> <p>9 MS. TRACEY:</p> <p>10 A. I'm not exactly sure when. It was the summer</p> <p>11 of 2005. I can't pinpoint exactly when.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. And the context?</p> <p>14 MS. TRACEY:</p> <p>15 A. I'm not totally sure. It was pretty well</p> <p>16 from, I think, one of my peers I heard it and</p> <p>17 then I did speak to Dr. Kwan about it, to gain</p> <p>18 a better understanding of what was happening</p> <p>19 at that time.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. So one of your colleagues, nursing colleagues</p> <p>22 -</p> <p>23 MS. TRACEY:</p> <p>24 A. One of my program director colleagues.</p> <p>25 COFFEY, Q.C.:</p>	<p style="text-align: right;">Page 371</p> <p>1 very much about ER/PR, I have to say, until</p> <p>2 that. It was the first time I became aware of</p> <p>3 it.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. And in terms of the--when he spoke of the</p> <p>6 issues or potential issues, was it in the</p> <p>7 context of fixation being a potential problem?</p> <p>8 MS. TRACEY:</p> <p>9 A. I don't recall. It was very brief. I really</p> <p>10 did not understand the, I guess, significance</p> <p>11 of all that was going on at that time. It was</p> <p>12 just starting to become knowledge of--all our</p> <p>13 knowledge, you know, was increasing about the</p> <p>14 issue at that time.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. Did it occur to you at that time that this</p> <p>17 might involve my program and require changes</p> <p>18 of our program at that point?</p> <p>19 MS. TRACEY:</p> <p>20 A. I guess the first time I heard of it, probably</p> <p>21 not, but quickly it became -</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Okay, we'll get to that now. Would this be</p> <p>24 the first real sign to you?</p> <p>25 MS. TRACEY:</p>
<p style="text-align: right;">Page 370</p> <p>1 Q. Program directors, had said something to you</p> <p>2 about there's something going on with -</p> <p>3 MS. TRACEY:</p> <p>4 A. That's right.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. - ER/PR breast tissue specimens?</p> <p>7 MS. TRACEY:</p> <p>8 A. Um-hm, so it was late summer 2005, I believe.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. You spoke to Dr. Kwan to make inquiries of</p> <p>11 him.</p> <p>12 MS. TRACEY:</p> <p>13 A. To ask him a little bit more about it.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. What did he tell you at the time, do you</p> <p>16 recall?</p> <p>17 MS. TRACEY:</p> <p>18 A. Well, issues with the specimens, yes. Not an</p> <p>19 in-depth conversation, just a brief "there are</p> <p>20 issues."</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Did he tell you the nature of what the issues</p> <p>23 were?</p> <p>24 MS. TRACEY:</p> <p>25 A. Not that I recall. I actually did not know</p>	<p style="text-align: right;">Page 372</p> <p>1 A. I believe it was, yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. That -</p> <p>4 MS. TRACEY:</p> <p>5 A. It's the first time I actually recall, it was</p> <p>6 the first time I received something in writing</p> <p>7 about it.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. And here, this is from Dr. Cook. It's dated</p> <p>10 July 23rd, 2005. He signed it. Here it says</p> <p>11 "September -</p> <p>12 MS. TRACEY:</p> <p>13 A. 12th.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. - 12th, '05, copy Dianne, Dorothy and Shirley.</p> <p>16 MS. TRACEY:</p> <p>17 A. They're my three managers.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. And this is your handwriting?</p> <p>20 MS. TRACEY:</p> <p>21 A. Yes, it is.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. So you would have sent--after you got this</p> <p>24 from Dr. Cook -</p> <p>25 MS. TRACEY:</p>

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<p>1 A. I was, I believe, on holidays at that time.  2 So by the time I came back from holidays, I  3 sent it out.  4 COFFEY, Q.C.:  5 Q. And it says--it's addressed to yourself as the  6 program director and to Dr. Dan Fontaine, the  7 site chief at the General, and Dr. Cook was  8 already the clinical chief and at St. Clare's  9 presumably he was aware of what he was  10 sending.  11 MS. TRACEY:  12 A. Yes.  13 COFFEY, Q.C.:  14 Q. So he's letting you, as the program director  15 for surgical, the surgical perioperative  16 program -  17 MS. TRACEY:  18 A. Yes, which I'm not the surgical program  19 director.  20 COFFEY, Q.C.:  21 Q. Yes, I appreciate that. It should have been -  22 MS. TRACEY:  23 A. Perioperative.  24 COFFEY, Q.C.:  25 Q. - perioperative program.</p>	<p>1 Q. Then he says "immediately forward to the  2 pathology lab." That would be a change?  3 MS. TRACEY:  4 A. Yes.  5 COFFEY, Q.C.:  6 Q. "Where the breast tumour is appropriately  7 sectioned to allow for even penetration and  8 fixation by formalin." Was that news to you?  9 MS. TRACEY:  10 A. Yes, that was a change for us.  11 COFFEY, Q.C.:  12 Q. Now I take it, it wouldn't actually--other  13 than sending it down immediately, you  14 wouldn't--your people wouldn't be involved in  15 the sectioning?  16 MS. TRACEY:  17 A. No.  18 COFFEY, Q.C.:  19 Q. But the fact that it--did this suggest to you  20 though that breast -  21 MS. TRACEY:  22 A. It suggested that cases were not to be--  23 specimens were not to be left lying around.  24 COFFEY, Q.C.:  25 Q. And they should be sectioned and immersed--</p>
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<p>1 MS. TRACEY:  2 A. Yes.  3 COFFEY, Q.C.:  4 Q. Dan Fontaine, the site chief at the General,  5 know the following. He says "I am requesting  6 that all mastectomy specimens be placed in a  7 large container and completely immersed in ten  8 percent formalin. Specimens should be  9 immediately forwarded to the pathology lab  10 where the breast tumour is appropriately  11 sectioned to allow for even penetration and  12 fixation by formalin." Okay, I'm going to  13 stop there, okay, for a moment. The first  14 sentence, "all mastectomy specimens be placed  15 in a large container and completely immersed  16 in ten percent formalin." Well, you would  17 have understood that back certainly in the mid  18 1990s and probably before.  19 MS. TRACEY:  20 A. That's correct.  21 COFFEY, Q.C.:  22 Q. So that really didn't change.  23 MS. TRACEY:  24 A. No.  25 COFFEY, Q.C.:</p>	<p>1 immersed in formalin, sectioned and presumably  2 put back into formalin.  3 MS. TRACEY:  4 A. I would have seen our role in that as getting  5 the specimen faster to the lab.  6 COFFEY, Q.C.:  7 Q. He does say then "cases should not be left  8 overnight or over the weekend unsectioned as  9 this may interfere with proper fixation of  10 tissue." So up to that point in time, there  11 had been--as you pointed out to the  12 Commissioner, no attempt to avoid this, to  13 avoid things being left overnight or the  14 weekend?  15 MS. TRACEY:  16 A. No, that's correct.  17 COFFEY, Q.C.:  18 Q. And then "for cases that occur after normal  19 working hours, the pathologist on call should  20 be notified." Now that would be new, wouldn't  21 it?  22 MS. TRACEY:  23 A. Yes.  24 COFFEY, Q.C.:  25 Q. Was that then done?</p>

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1 MS. TRACEY:  
 2 A. Yes. I sent it to the managers and my  
 3 expectation would be that anything like this,  
 4 it would be implemented.  
 5 COFFEY, Q.C.:  
 6 Q. Did you receive any feedback from them saying  
 7 that they couldn't do it?  
 8 MS. TRACEY:  
 9 A. No.  
 10 COFFEY, Q.C.:  
 11 Q. And he also -  
 12 MS. TRACEY:  
 13 A. We were already sending some specimens  
 14 immediately to the lab.  
 15 COFFEY, Q.C.:  
 16 Q. Such as?  
 17 MS. TRACEY:  
 18 A. The bacteriology, cytology specimens.  
 19 COFFEY, Q.C.:  
 20 Q. Yes, okay, all those other ones that we looked  
 21 at.  
 22 MS. TRACEY:  
 23 A. So this was just a change in practice for one  
 24 type of specimen.  
 25 COFFEY, Q.C.:

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1 Q. Which is all the pathology ones.  
 2 MS. TRACEY:  
 3 A. Yeah.  
 4 COFFEY, Q.C.:  
 5 Q. Yes. "Please make every attempt to ensure -  
 6 MS. TRACEY:  
 7 A. No, it's only mastectomy specimens.  
 8 COFFEY, Q.C.:  
 9 Q. Mastectomy, I appreciate. This is mastectomy  
 10 and I'm going to ask you about that in a  
 11 moment, okay. "Please make every attempt to  
 12 ensure these cases are done early in the day  
 13 and submitted to the lab before four p.m."  
 14 Now was that a practical suggestion, from your  
 15 perspective?  
 16 MS. TRACEY:  
 17 A. No, it wasn't.  
 18 COFFEY, Q.C.:  
 19 Q. And why is that?  
 20 MS. TRACEY:  
 21 A. Later, I did discuss that with Dr. Cook. The  
 22 operating room does the more complex cases  
 23 first thing in the morning. The sicker  
 24 patients that need the most resources, that  
 25 need surgeons and anasteseologists and nursing

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1 staff fresh, longer cases and the more complex  
 2 cases. Mastectomy patients are usually well,  
 3 but they do have cancer, but the procedure is  
 4 a short procedure. It's not resource  
 5 intensive.  
 6 COFFEY, Q.C.:  
 7 Q. From an OR -  
 8 MS. TRACEY:  
 9 A. From the OR perspective, yes. So these cases  
 10 are often fitted around the bigger cases  
 11 because it helps the flow of the operating  
 12 room. A big case goes first, maybe a smaller  
 13 case next, and then maybe another big case.  
 14 So practically, that was not a solution for  
 15 the operating room. As well as that, it  
 16 depended on the surgeon's operating time.  
 17 Some surgeons only have afternoon slots on  
 18 certain days of the week. So ultimately,  
 19 doing cases earlier in the day was not always  
 20 a solution.  
 21 COFFEY, Q.C.:  
 22 Q. And you discussed that with Dr. Cook?  
 23 MS. TRACEY:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And so what was the result of that, your  
 2 discussion?  
 3 MS. TRACEY:  
 4 A. My discussion was that pathology would have to  
 5 be more available to us.  
 6 COFFEY, Q.C.:  
 7 Q. And his response?  
 8 MS. TRACEY:  
 9 A. He took it under advisement and actually did  
 10 improve the service, the availability of  
 11 pathology to us. The other part of it is,  
 12 mastectomy and breast biopsy specimen, or at  
 13 least surgeries are elective surgeries. So  
 14 they are usually completed by about 4:00 in  
 15 the day. The elective surgery slots are  
 16 usually eight to four. So I wouldn't be  
 17 expecting that there'd be a lot of after hours  
 18 cases or any actually. Very rarely would  
 19 there be any breast specimens after hours.  
 20 COFFEY, Q.C.:  
 21 Q. Now the idea that they would be--should be  
 22 immediately forwarded to the pathology lab, in  
 23 the beginning, right here, and certainly if it  
 24 could be done before four, but whatever time  
 25 it got done, immediately go down to the lab,

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1 what arrangements were made in that way?  
 2 MS. TRACEY:  
 3 A. Our porters bring the specimens down to the  
 4 lab.  
 5 COFFEY, Q.C.:  
 6 Q. I appreciate that, but they'd always--did you  
 7 always have OR porters?  
 8 MS. TRACEY:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Okay. So they're different than the central  
 12 portering service?  
 13 MS. TRACEY:  
 14 A. Yes.  
 15 COFFEY, Q.C.:  
 16 Q. And there have always--in your time, there  
 17 have always been OR porters?  
 18 MS. TRACEY:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. So prior to this, late August 2005, the OR  
 22 porters had existed, they just hadn't been  
 23 utilized to bring down the -  
 24 MS. TRACEY:  
 25 A. They weren't bringing the mastectomy

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1 specimens. They were bringing -  
 2 COFFEY, Q.C.:  
 3 Q. Other specimens?  
 4 MS. TRACEY:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. We've seen a list of some of them.  
 8 MS. TRACEY:  
 9 A. Yes, and all the urgent specimens, we run--our  
 10 porters take them immediately. We don't wait  
 11 for somebody.  
 12 COFFEY, Q.C.:  
 13 Q. And then Ms. Tracey, then in relation to -  
 14 MS. TRACEY:  
 15 A. At times, central portering can also be called  
 16 to do these.  
 17 COFFEY, Q.C.:  
 18 Q. Yes, I appreciate that. So for example, for  
 19 some reason you didn't have a porter  
 20 immediately available in your own service, you  
 21 would get central portering?  
 22 MS. TRACEY:  
 23 A. Yes, but there can be a delay, so this  
 24 wouldn't be really appropriate.  
 25 THE COMMISSIONER:

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1 Q. When you say "our porters bring the mastectomy  
 2 specimens down to the lab," would that be all  
 3 of them or the ones that come up after the  
 4 3:00 run?  
 5 MS. TRACEY:  
 6 A. The ones that--no, all of them now, yes,  
 7 because those specimens are not left at all.  
 8 THE COMMISSIONER:  
 9 Q. Okay.  
 10 COFFEY, Q.C.:  
 11 Q. And that started in August, September 2005,  
 12 that time period, kind of, okay, mastectomy,  
 13 we'll get it down there -  
 14 THE COMMISSIONER:  
 15 Q. We're just talking about mastectomy specimens?  
 16 COFFEY, Q.C.:  
 17 Q. Yes.  
 18 MS. TRACEY:  
 19 A. Yes. Mastectomy and breast specimens, I  
 20 guess, would be more specific.  
 21 COFFEY, Q.C.:  
 22 Q. Ms. Tracey, the--and that was so and even if  
 23 it was after four, if for some reason a breast  
 24 operation went until 5:00?  
 25 MS. TRACEY:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. Still there'd be somebody -  
 4 MS. TRACEY:  
 5 A. And if the--I'm sure we will be looking at  
 6 other memos that state if the pathologist  
 7 isn't available, that he must be called.  
 8 COFFEY, Q.C.:  
 9 Q. Called. Page him and get him in here?  
 10 MS. TRACEY:  
 11 A. Um-hm.  
 12 COFFEY, Q.C.:  
 13 Q. Other specimens, any non, like, non-breast  
 14 specimens, did any of that, the way they were  
 15 handled in terms of being taken down to the OR  
 16 pathology, non-breast specimens, did that  
 17 change in August of '05?  
 18 MS. TRACEY:  
 19 A. No.  
 20 COFFEY, Q.C.:  
 21 Q. So whatever the practice you described earlier  
 22 had been, existed for years, continued on,  
 23 some specimens, non-breast specimens,  
 24 pathology specimens could remain in formalin -  
 25 MS. TRACEY:



Page 385	Page 387
<p>1 A. Overnight.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. - overnight?</p> <p>4 MS. TRACEY:</p> <p>5 A. Um-hm.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Or over the weekend?</p> <p>8 MS. TRACEY:</p> <p>9 A. Um-hm.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. In the OR?</p> <p>12 MS. TRACEY:</p> <p>13 A. Yes.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Is that still true?</p> <p>16 MS. TRACEY:</p> <p>17 A. The time line now is 48 hours, 48 hours for</p> <p>18 specimens fixed in formalin. Ideally they</p> <p>19 should be brought to the OR within 24, but</p> <p>20 they can be left in the OR up to 48 hours.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Okay. That's for non-breast?</p> <p>23 MS. TRACEY:</p> <p>24 A. Yes.</p> <p>25 COFFEY, Q.C.:</p>	<p>1 COFFEY, Q.C.:</p> <p>2 Q. Okay. And, in fact, if we looking under</p> <p>3 "scrub nurse" here there's five steps. In</p> <p>4 fact, it tells here exactly what to do.</p> <p>5 MS. TRACEY:</p> <p>6 A. That's correct.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And the circulating nurse, the same thing, in</p> <p>9 effect. But then number three was "follow the</p> <p>10 specimen chart in the guidelines for the</p> <p>11 management of specimens." Which is the one</p> <p>12 we, the larger one -</p> <p>13 MS. TRACEY:</p> <p>14 A. We just looked at.</p> <p>15 COFFEY, Q.C.:</p> <p>16 Q. - we looked at?</p> <p>17 MS. TRACEY:</p> <p>18 A. Yes. Because that's the specific fixation for</p> <p>19 the specimen.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. And so this, as you point out, in specimen</p> <p>22 care, particularly in the OR, very rigid and</p> <p>23 very detailed rules. Then you got a bit more</p> <p>24 general when you looked at--and perhaps not as</p> <p>25 rigid in the sense of as detailed when you got</p>
<p>Page 386</p> <p>1 Q. If we could look, please, at Exhibit, while</p> <p>2 I'm at it, P-3082? This is another one of</p> <p>3 those documents. And before I pass on</p> <p>4 completely to 2005 and '06, Ms. Tracey, this</p> <p>5 is a Health Care Corporation of St. John's</p> <p>6 perioperative program, operating room policy</p> <p>7 manual, the issuing authority is yourself.</p> <p>8 This would be May, 2003, specimen care. And</p> <p>9 here under, well, it says, "Specimens in the</p> <p>10 OR may include soft tissue and other types of</p> <p>11 tissues." Policy, amongst other things,</p> <p>12 number five, "specimens for routine pathology</p> <p>13 are placed in a container of 20 to one</p> <p>14 formalin with specimen." And then there's a</p> <p>15 description of the procedure which I take it</p> <p>16 is the procedure in terms of these specimens</p> <p>17 that occurs within the OR?</p> <p>18 MS. TRACEY:</p> <p>19 A. That's correct.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. And -</p> <p>22 MS. TRACEY:</p> <p>23 A. Everything within the OR while the surgery is</p> <p>24 in progress is very rigid. There's policies</p> <p>25 and practices for all of it.</p>	<p>Page 388</p> <p>1 out to the guidelines?</p> <p>2 MS. TRACEY:</p> <p>3 A. Well, there's two parts to the policy.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. Yes.</p> <p>6 MS. TRACEY:</p> <p>7 A. You have to follow both of it. The first part</p> <p>8 is how the specimen is actually handed off.</p> <p>9 COFFEY, Q.C.:</p> <p>10 Q. Yes.</p> <p>11 MS. TRACEY:</p> <p>12 A. And the second part just the fixation.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. Fixation?</p> <p>15 MS. TRACEY:</p> <p>16 A. Um-hm. And the treatment of or the care of</p> <p>17 the specimen.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Here under "Circulating nurse," number two, it</p> <p>20 says, "Receive specimen in appropriate</p> <p>21 container based on size/destination following</p> <p>22 confine and contain principles and then follow</p> <p>23 the specimen chart," which is the ones we</p> <p>24 looked at earlier?</p> <p>25 MS. TRACEY:</p>

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<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Look, please, at Exhibit P-3083? These are,</p> <p>4 it's an e-mail, it's a letter, first of all,</p> <p>5 September 26th, 2005 from Dr. Cook to Dr.</p> <p>6 Williams, "ER and PR review." And then back</p> <p>7 to an e-mail from Denise Dunn to, amongst</p> <p>8 other people, on September 29th, amongst other</p> <p>9 people, yourself, Maria, "Louise and Maria,</p> <p>10 can the surgery and perioperative programs</p> <p>11 leaders review, please." And the first page</p> <p>12 of this is also a fax from Dr. Williams'</p> <p>13 office to yourself sending along that letter,</p> <p>14 yourself and others, including Ms. Jones, Dr.</p> <p>15 Felix and Dr. Kwan. She says the same thing</p> <p>16 except it's Bob Williams saying it there.</p> <p>17 Now, what I wanted to ask you about is is</p> <p>18 this, when yourself and Dr. Cook spoke--I</p> <p>19 should ask about his letter of August 23rd.</p> <p>20 You distributed--you came back from vacation</p> <p>21 in September, distributed it. You would have</p> <p>22 spoken to Dr. Cook?</p> <p>23 MS. TRACEY:</p> <p>24 A. Dr. Cook popped his head in around my door,</p> <p>25 actually, that he was going to meet with Dr.</p>	<p>1 that the OR couldn't function in that way,</p> <p>2 that really it was not practical to even</p> <p>3 consider this, and for the reasons I've</p> <p>4 already explained to you.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Um-hm.</p> <p>7 MS. TRACEY:</p> <p>8 A. And that what we needed was pathology to be</p> <p>9 more available to us so that the limitations</p> <p>10 were not put on the OR because we couldn't</p> <p>11 survive with those kind of limitations.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. Yes. And his response?</p> <p>14 MS. TRACEY:</p> <p>15 A. And his response was that he would go speak to</p> <p>16 his colleagues, which he did. And we were</p> <p>17 occasionally having issues with the, you know,</p> <p>18 with locating pathologists, so there was</p> <p>19 another letter subsequently outlining how to</p> <p>20 actually contact pathologists. And Dr. Cook</p> <p>21 realized that, you know, the OR couldn't</p> <p>22 change its practice how these surgeries were</p> <p>23 scheduled, that indeed, you know, they were</p> <p>24 not large surgeries for the OR and that</p> <p>25 pathology actually had to change its practice</p>
<p>1 Williams, wanted to talk to me about this.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. So is it this letter or the one before, the</p> <p>4 August 23rd?</p> <p>5 MS. TRACEY:</p> <p>6 A. I'm not--I can't exactly recall the date</p> <p>7 because it was in this time frame.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. Okay.</p> <p>10 MS. TRACEY:</p> <p>11 A. And it wasn't something I have a record of. I</p> <p>12 have a recollection of it, but I don't have a</p> <p>13 record of it.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Okay, go ahead and tell us then what you</p> <p>16 recall about it?</p> <p>17 MS. TRACEY:</p> <p>18 A. Dr. Cook asked about the scheduling of breast</p> <p>19 surgical patients.</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Um-hm.</p> <p>22 MS. TRACEY:</p> <p>23 A. Could they--he was asking if we could avoid</p> <p>24 doing mastectomies and breast surgery on</p> <p>25 Friday afternoons. And I explained to him</p>	<p>1 and he agreed. So the pathologists--and there</p> <p>2 was a letter too later on outlining how to</p> <p>3 actually contact pathology if there was any</p> <p>4 issues.</p> <p>5 COFFEY, Q.C.:</p> <p>6 Q. Actually working out the nitty, setting out</p> <p>7 the nitty gritty of -</p> <p>8 MS. TRACEY:</p> <p>9 A. Yes.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. - how to deal with -</p> <p>12 MS. TRACEY:</p> <p>13 A. Because at times the OR was waiting to get--</p> <p>14 for extended periods before pathologists</p> <p>15 answered pages and things, so I brought that</p> <p>16 to Dr. Cook's attention. And one on one these</p> <p>17 situations would have been brought to the</p> <p>18 attention of Dr. Cook by the OR managers if</p> <p>19 their staff had difficulty contacting</p> <p>20 pathologists.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Why were you having difficulty contacting</p> <p>23 pathologists, do you know?</p> <p>24 MS. TRACEY:</p> <p>25 A. I can't actually say. It was just at times</p>

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1 they were--they'd be slow responding to the  
2 operating room.  
3 COFFEY, Q.C.:  
4 Q. Did that change?  
5 MS. TRACEY:  
6 A. Yes, it did.  
7 COFFEY, Q.C.:  
8 Q. After, around this time, the fall of 2005 it  
9 changed?  
10 MS. TRACEY:  
11 A. Yes, it did, yes.  
12 COFFEY, Q.C.:  
13 Q. Had it been going on, had that been a problem  
14 for some period of time before that?  
15 MS. TRACEY:  
16 A. It was a problem at St. Clare's more than at  
17 the General site, I recall. Not a huge  
18 problem, just occasionally frustration.  
19 COFFEY, Q.C.:  
20 Q. But in any case, beginning in the fall of 2005  
21 it became less of a problem?  
22 MS. TRACEY:  
23 A. Corrected, yes. The problem is addressed in  
24 one of the later memos.  
25 COFFEY, Q.C.:

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1 Q. Here, looking at this, he makes the assertion  
2 in the second sentence, third line, "Appears  
3 in some cases the mastectomy specimens and  
4 other breast biopsies could very well be left  
5 lying overnight or over the weekend in the OR  
6 without adequate formalin fixation."  
7 MS. TRACEY:  
8 A. Um-hm.  
9 COFFEY, Q.C.:  
10 Q. Which is the same assertion as in the August  
11 23rd letter?  
12 MS. TRACEY:  
13 A. That's correct, um-hm.  
14 COFFEY, Q.C.:  
15 Q. He then goes on to talk about strongly  
16 recommending that these types of surgical  
17 procedures be booked first thing in the  
18 morning, Monday to Friday, and not, in any  
19 case, not be done Friday afternoon.  
20 MS. TRACEY:  
21 A. Afternoon. And I explained to Dr. Cook the OR  
22 is working Friday afternoon same as any other  
23 day of the week, so that wasn't a choice. And  
24 also, surgeons' times, there are surgeons who  
25 have time at St. Clare's only on Friday

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1 afternoons, so he understood that and he  
2 appreciated that.  
3 COFFEY, Q.C.:  
4 Q. Here -  
5 MS. TRACEY:  
6 A. I guess when you're on the outside it's hard  
7 to understand the functioning of an operating  
8 room, but he was open to the discussion.  
9 COFFEY, Q.C.:  
10 Q. Here it says, "Every effort should be made to  
11 ensure that these cases are forwarded to the  
12 lab in a timely fashion." Here, I'll bring  
13 you back to 1938, please, P-1939? That August  
14 23rd memo, the second sentence says,  
15 "Specimens should be immediately forwarded to  
16 the pathology lab where the breast tumour is  
17 appropriately sectioned to allow for even  
18 permeation and fixation by formalin." So back  
19 in August 23rd in the memo you circulated to  
20 your managers on September 12th said  
21 immediate, immediately, I'm sorry, forwarded.  
22 If we could go back then to P-3083, at  
23 September 26th, 2005 letter it says, it's  
24 framed instead in the context of "Every effort  
25 should be made to ensure that these cases are

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1 forwarded to the lab in a timely fashion."  
2 which is not necessarily the same thing as  
3 "immediately." Did you, at the time, what was  
4 your understanding by the time you'd received  
5 this?  
6 MS. TRACEY:  
7 A. I would presume that the letter of August -  
8 COFFEY, Q.C.:  
9 Q. 23rd.  
10 MS. TRACEY:  
11 A. - the third was the one that actually  
12 designated what the practice should be.  
13 COFFEY, Q.C.:  
14 Q. Yes. There's a reference here to "Following  
15 the exit interviews of both the medical and  
16 technical consultants, one of the issues  
17 identified in immunohistochemical staining of  
18 estrogen and progesterone receptors concerns  
19 adequate fixation of the specimen." Was this  
20 the first that you'd heard of this? First of  
21 all, did you know about these external  
22 consultants?  
23 MS. TRACEY:  
24 A. No.  
25 COFFEY, Q.C.:

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<p>1 Q. So it would be the first you heard of them?</p> <p>2 MS. TRACEY:</p> <p>3 A. Yes.</p> <p>4 COFFEY, Q.C.:</p> <p>5 Q. This being them having identified--one of the</p> <p>6 issues being identified in IHC staining of</p> <p>7 ER/PR was adequate fixation of the specimen.</p> <p>8 Is that the first time that was brought to</p> <p>9 your attention?</p> <p>10 MS. TRACEY:</p> <p>11 A. Yes. Well, the August letter was the first</p> <p>12 time.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. In terms of what should get done?</p> <p>15 MS. TRACEY:</p> <p>16 A. Yes.</p> <p>17 COFFEY, Q.C.:</p> <p>18 Q. But I'm thinking of it in terms of external</p> <p>19 consultants.</p> <p>20 MS. TRACEY:</p> <p>21 A. Yes.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. Relating it to fixation. This is the first</p> <p>24 time you would have heard of that?</p> <p>25 MS. TRACEY:</p>	<p>1 MS. TRACEY:</p> <p>2 A. Yes, this would be--yes.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. Is this sort of minutes of the in-service</p> <p>5 meeting?</p> <p>6 MS. TRACEY:</p> <p>7 A. Yes.</p> <p>8 COFFEY, Q.C.:</p> <p>9 Q. I won't say minutes, but it's -</p> <p>10 MS. TRACEY:</p> <p>11 A. Yeah.</p> <p>12 COFFEY, Q.C.:</p> <p>13 Q. - it's a summary?</p> <p>14 MS. TRACEY:</p> <p>15 A. It's a summary. In-service time is often, you</p> <p>16 know, designated to demonstrate new techniques</p> <p>17 or new instruments or new practices, but there</p> <p>18 is also some time set aside to discuss changes</p> <p>19 in practice or anything new the staff need to</p> <p>20 know in the operating room.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Here on the second page of this is a heading</p> <p>23 "Specimens." "Have to be covered completely</p> <p>24 with formalin. Make sure we use lots of</p> <p>25 formalin to cover specimens. Place specimens</p>
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<p>1 A. Yes.</p> <p>2 COFFEY, Q.C.:</p> <p>3 Q. Did you ever have any discussion with anybody</p> <p>4 about that, the fact that these people had</p> <p>5 come in from outside and had noted that there</p> <p>6 was potentially a problem with our practice in</p> <p>7 terms of fixation?</p> <p>8 MS. TRACEY:</p> <p>9 A. I was aware around this time that there was</p> <p>10 issues and concerns about the ER/PR testing</p> <p>11 and that I guess my knowledge of what was</p> <p>12 actually happening and--was evolving as the</p> <p>13 situation became more into focus, I guess.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. Exhibit P-3084? 3084. Now, this is a</p> <p>16 document, "OR information session, October</p> <p>17 4th, 2005."</p> <p>18 MS. TRACEY:</p> <p>19 A. Okay. This is Tuesday in-service -</p> <p>20 COFFEY, Q.C.:</p> <p>21 Q. Yes.</p> <p>22 MS. TRACEY:</p> <p>23 A. Yes.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. And I was going to ask you about that.</p>	<p>1 in larger containers. Mastectomies, large</p> <p>2 container. Cover completely with lots of</p> <p>3 formalin and send directly to"--I'm sorry,</p> <p>4 "Send direct to pathology. Breast reduction</p> <p>5 specimens are treated the same. Small</p> <p>6 specimen container is used for very small</p> <p>7 specimens only." So I take it that this -</p> <p>8 MS. TRACEY:</p> <p>9 A. This is staff being educated.</p> <p>10 COFFEY, Q.C.:</p> <p>11 Q. About this?</p> <p>12 MS. TRACEY:</p> <p>13 A. Um-hm.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. About the two memos?</p> <p>16 MS. TRACEY:</p> <p>17 A. Um-hm.</p> <p>18 COFFEY, Q.C.:</p> <p>19 Q. Particularly the first memo?</p> <p>20 MS. TRACEY:</p> <p>21 A. Yes.</p> <p>22 COFFEY, Q.C.:</p> <p>23 Q. And the change in practice here is make sure</p> <p>24 the container is large enough, it's got enough</p> <p>25 formalin in it and -</p>

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1 MS. TRACEY:  
 2 A. It's a reminder of actually what the policy is  
 3 already saying, but - you know, and outlining  
 4 that there were issues.  
 5 COFFEY, Q.C.:  
 6 Q. And it was a change for the staff in that this  
 7 idea of sending it direct and now?  
 8 MS. TRACEY:  
 9 A. Yes, that's a change of practice.  
 10 COFFEY, Q.C.:  
 11 Q. That was a practice. Were the staff able to  
 12 accomplish that?  
 13 MS. TRACEY:  
 14 A. Yes, they were already doing that for the  
 15 other specimens.  
 16 COFFEY, Q.C.:  
 17 Q. A whole list of non-pathology specimens. If  
 18 we could look, please, at Exhibit P-2884. Now  
 19 here this is again a staff meeting of November  
 20 22nd, 2005. It's from Shirley Taylor. Remind  
 21 us again she is -  
 22 MS. TRACEY:  
 23 A. Manager St. Clare's OR.  
 24 COFFEY, Q.C.:  
 25 Q. St. Clare's.

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1 MS. TRACEY:  
 2 A. The majority of the specimens are done there.  
 3 COFFEY, Q.C.:  
 4 Q. The majority of the breast specimens are  
 5 nowadays and in '05 from St. Clare's?  
 6 MS. TRACEY:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. So this would be sent to all the staff, I take  
 10 it?  
 11 MS. TRACEY:  
 12 A. Yeah. The staff were present during this  
 13 period.  
 14 COFFEY, Q.C.:  
 15 Q. Oh, yes.  
 16 MS. TRACEY:  
 17 A. This is a record afterwards of what was  
 18 discussed.  
 19 COFFEY, Q.C.:  
 20 Q. And here -  
 21 MS. TRACEY:  
 22 A. So the staff who weren't present could read  
 23 it.  
 24 COFFEY, Q.C.:  
 25 Q. There are a number of different entries here,

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1 but number nine is, "Any mastectomy specimens  
 2 coming out for the OR after hours needs to be  
 3 written in the path book and taken up to the  
 4 lab. If there is no one there to receive it,  
 5 we need to page the pathologists and let them  
 6 know it is there". I take it this was the -  
 7 MS. TRACEY:  
 8 A. Yes, that's the practice.  
 9 COFFEY, Q.C.:  
 10 Q. November 22nd.  
 11 MS. TRACEY:  
 12 A. Uh-hm.  
 13 COFFEY, Q.C.:  
 14 Q. It had changed, the overall practice?  
 15 MS. TRACEY:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. Now we understand that certainly there are a  
 19 number of written policies and procedures now  
 20 in place and the Commissioner has seen one in  
 21 particular involving the clinical laboratory  
 22 that's more than 300 pages long, okay. In  
 23 terms of the ER/PR matter as time went on  
 24 then, and we've looked at what happened in  
 25 September of 2005, Dr. Cook spoke to you and

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1 then you dealt with - yourself and Ms. Jones  
 2 would have talked about his letter about  
 3 scheduling.  
 4 MS. TRACEY:  
 5 A. Uh-hm.  
 6 COFFEY, Q.C.:  
 7 Q. What then happened in terms of your own  
 8 involvement with ER/PR? Did you have any  
 9 involvement at all?  
 10 MS. TRACEY:  
 11 A. Not really, no. No, just to follow through on  
 12 the policies and change our practice to meet  
 13 the policies needed for the laboratory.  
 14 COFFEY, Q.C.:  
 15 Q. Now there is one - I apologize, Commissioner,  
 16 there is one - look at, please, 3088. This is  
 17 a specimen care policy for the perioperative  
 18 program. The issuing authority is yourself.  
 19 The original one is May of 2003, the revised  
 20 in March of 2007.  
 21 MS. TRACEY:  
 22 A. Uh-hm.  
 23 COFFEY, Q.C.:  
 24 Q. And do you know if there was a similar  
 25 revision around that time relating to the

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<p>1 guidelines for the management of specimens?  2 MS. TRACEY:  3 A. I'm not sure.  4 COFFEY, Q.C.:  5 Q. Now you were telling the Commissioner that  6 generally there have been - you've been  7 involved in changing policies and procedures  8 and we just took you through some of the  9 practical end of that.  10 MS. TRACEY:  11 A. Uh-hm.  12 COFFEY, Q.C.:  13 Q. How about more formal written policies and  14 procedures involving fixation and the OR?  15 MS. TRACEY:  16 A. The formal policies from the lab? Are you  17 talking about those?  18 COFFEY, Q.C.:  19 Q. That would affect the OR's practices. I mean,  20 what is, for example, the current policy?  21 MS. TRACEY:  22 A. The policy now that we - we implemented the  23 laboratory policies. They superseded the  24 policies that we have in place, and so we're  25 following those, but even since then, there</p>	<p>1 Q. So it's relatively recent?  2 MS. TRACEY:  3 A. Yes.  4 COFFEY, Q.C.:  5 Q. And after -  6 MS. TRACEY:  7 A. Oftentimes our practice changes and the  8 policies come behind it.  9 COFFEY, Q.C.:  10 Q. And -  11 MS. TRACEY:  12 A. Because if there's something that's affecting  13 the specimen, we're anxious to get it sorted  14 out immediately. Policies are a slow process.  15 COFFEY, Q.C.:  16 Q. Now -  17 MS. TRACEY:  18 A. So actually Bev Rowe called us, called my  19 clinical educators about that to inform us.  20 COFFEY, Q.C.:  21 Q. Just looking at this particular one, 3088,  22 page one, for specimen care, is this one still  23 in place?  24 MS. TRACEY:  25 A. Yes, but - actually that's in the process of</p>
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<p>1 has been a change in practice because we were  2 placing specimens in formalin in the  3 refrigerator up until two weeks ago, and now  4 we are no longer doing that because the cold  5 atmosphere in the fridge was affecting the  6 formalin's ability to penetrate the specimens.  7 COFFEY, Q.C.:  8 Q. That changed -  9 MS. TRACEY:  10 A. That changed two weeks ago after Dr. Dabb was  11 here.  12 COFFEY, Q.C.:  13 Q. And that had begun when - that had begun back  14 when?  15 MS. TRACEY:  16 A. When did we start placing the formalin -  17 COFFEY, Q.C.:  18 Q. Yes.  19 MS. TRACEY:  20 A. The summer, this summer.  21 COFFEY, Q.C.:  22 Q. Summer of '08?  23 MS. TRACEY:  24 A. Yes.  25 COFFEY, Q.C.:</p>	<p>1 being revised now to - that one is the general  2 specimen policy.  3 COFFEY, Q.C.:  4 Q. Yes.  5 MS. TRACEY:  6 A. Actually the one that has the - we're going to  7 change this to align it to actually designate  8 that you follow the lab policies.  9 COFFEY, Q.C.:  10 Q. Okay, in relation to specimen care.  11 MS. TRACEY:  12 A. Yes, and I suppose down at the bottom it says  13 that you follow the other policy.  14 COFFEY, Q.C.:  15 Q. That guideline -  16 MS. TRACEY:  17 A. That one, guidelines for the management of  18 specimens, it will now say follow the lab  19 policy, and the lab policy is actually  20 immediately following that in our manual.  21 COFFEY, Q.C.:  22 Q. So what would happen is that, well, within the  23 OR, we'll have our own, you've got it spelled  24 out here -  25 MS. TRACEY:</p>

1 A. Yes, because this is -  
 2 COFFEY, Q.C.:  
 3 Q. Or however you might change it.  
 4 MS. TRACEY:  
 5 A. Our practice in that won't change.  
 6 COFFEY, Q.C.:  
 7 Q. And the hand off one down here?  
 8 MS. TRACEY:  
 9 A. That will change.  
 10 COFFEY, Q.C.:  
 11 Q. That will change and follow the -  
 12 MS. TRACEY:  
 13 A. But that is - that policies from the lab cover  
 14 pathology specimens. We don't have specific  
 15 specimens for cytology, bacteriology, so we  
 16 have got to conform - revise our policy to  
 17 reflect that. In the meantime, I understand  
 18 there will be policies coming from them  
 19 shortly as well.  
 20 COFFEY, Q.C.:  
 21 Q. For the cytology, bacteriology and so on?  
 22 MS. TRACEY:  
 23 A. Bacteriology, but in the meantime, we have to  
 24 have something in place so our staff will know  
 25 what to do. So my educators are actually

1 CERTIFICATE  
 2 I, Judy Moss, hereby certify that the foregoing is  
 3 a true and correct transcript in the matter of the  
 4 Commission of Inquiry on Hormone Receptor Testing,  
 5 heard on the 29th day of September, A.D., 2008  
 6 before the Honourable Justice Margaret A. Cameron,  
 7 Commissioner, at the Commission of Inquiry, St.  
 8 John's, Newfoundland and Labrador and was  
 9 transcribed by me to the best of my ability by  
 10 means of a sound apparatus.  
 11 Dated at St. John's, Newfoundland and Labrador  
 12 this 29th day of September, A.D., 2008  
 13 Judy Moss

1 working on that now.  
 2 THE COMMISSIONER:  
 3 Q. Mr. Coffey, it is -  
 4 COFFEY, Q.C.:  
 5 Q. What I'm going to ask then, Commissioner,  
 6 because it is late, it's 5 o'clock, I  
 7 anticipate I may - I'd just like to think  
 8 about it overnight. I'm probably done, but if  
 9 I could come back in the morning.  
 10 THE COMMISSIONER:  
 11 Q. 9:30.  
 12 Upon conclusion.

Inquiry on Hormone Receptor Testing

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**Inquiry on Hormone Receptor Testing**

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