COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

APRIL 15, 2008

Appearances:

Bernard Coffey, Q.C. . . . . Commission Co-counsel
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Mandy Woodland . . . . . Commission Co-counsel

Rolf Pritchard/Jenny Chai . . . . . Her Majesty in Right of NL

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

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

Pamela Taylor/Chesley Crosbie. . . Members of the Breast Cancer
. . . . . Testing Class Action

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

LIST OF EXHIBITS

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THE COMMISSIONER:
Q. Please be seated. Mr. Simmons, I think you're up.
MR. SIMMONS:
Q. Thank you, Commissioner, I've finished my questions. I don't have any other questions for Mr. Wiseman.
MR. BROWNE:
Q. I was still (inaudible).
THE COMMISSIONER:
Q. That's it, Mr.--we just have to be like the Boy Scouts, prepared.

MR. ROSS WISEMAN, EXAMINATION BY MR. PETER BROWNE

MR. BROWNE:
Q. Good morning, Mr. Wiseman.
MR. WISEMAN:
A. Good morning.
MR. BROWNE:
Q. I just have two areas of questioning I want to pursue with you today. And I do appreciate you have spent a lot of time here today and I'll try to be as expedient as possible in canvassing these areas. The first area--and just so I introduce myself. My name is Peter Browne, I'm representing a number of

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physicians who may or will be called before the Inquiry. And in respect of that I want to go and deal with an area that you mentioned, I think, early in the first days of your evidence and that is a comment to Ms. Chaytor from a line of questioning of Ms. Chaytor that you disagreed with the approach, and I want, if you could, please, I'm giving you an opportunity to clarify this for me, it may be confusion on my part, but in the early days you disagreed with the approach of the previous minister, Minister Ottenheimer and you would have, if you were in that capacity, disclosed to the public earlier. Is that-did I understand you correctly in that regard or did I get that confused?

MR. WISEMAN:

A. What I had indicated I wasn't taking exception to Mr. Ottenheimer's decision, but I had indicated that in my view the information should have been disclosed. I have indicated, you know, Mr. Ottenheimer was there, had a discussion with officials from Eastern Health, I wasn't in the room, I don't know the flavour for the discussion, I don't know what may have

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influenced his decision at that time, I didn't hear the comments made by the people providing the advice and so I, in the absence of being there I wouldn't comment on, you know, his actions. But in terms of the notion that we would, you know, not provide an early disclosure is what I said I had a different opinion and believe that it should have been disclosed at that time.

MR. BROWNE:

Q. Have you formulated when that should have been, at what point in time, looking back, or have you sort of done that sort of retrospective analysis?

MR. WISEMAN:

A. In my view, when we became aware of the fact that there was a large number of people who were impacted, had their tests deemed to be redone. It wasn't a--it was a circumstance where we had a large number of people who were going to be, have their tests redone. Some of those tests were done between 1997 and 2005, so some of it would have been, you know, maybe two, three, four years prior to this point in time in 2005, and given the significance of

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that, what that delay may have meant on their health, then it would have been appropriate to let those people know at that time so they could be a part of that decision making about what course of treatment they would take.

MR. BROWNE:

Q. Okay. Let me just follow that logic a bit further now. You had mentioned in your answer just now and I think earlier on that part of the, I guess, decision making was influenced by advice received from clinicians, is that right?

MR. WISEMAN:

A. Yes.

MR. BROWNE:

Q. That's your understanding?

MR. WISEMAN:

A. What I understand, yes.

MR. BROWNE:

Q. Okay. And I want to pursue that. Well, let me ask you, have you had the opportunity of hearing Mr. Ottenheimer's evidence in that respect?

MR. WISEMAN:

A. I've had a clip of it that was being

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televised, but I haven't had a personal conversation with Mr. Ottenheimer to explore his reasoning or logic at that time.

MR. BROWNE:

Q. Okay. Well, let me just sort of go over some of the issues that were at play. I think the discussion that Mr. Ottenheimer had with clinicians occurred on August 15th, I believe, in 2005. And during his testimony, in fact, during cross-examination by me he was shown a document. Now, I'm going to show you the same document. It's now an exhibit, it's Exhibit 0161. Registrar, if we could find that, please? It'll come up on the screen, Mr. Wiseman, in one second. Mr. Wiseman, this is a document that has been prepared and just recently sanctioned by a body known as the Canadian Patient Safety Institute. Are you familiar with this document?

MR. WISEMAN:

A. I've heard--there was--not the document itself but the commentary that may have been made in it. I read a, it was a summary of issues that are arising across the country that comes across my desk as a part of reading material

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and it would have come by very recently. And there was a reference to a recent decision or position taken by the Canadian Patient Institute around disclosure.

MR. BROWNE:

Q. Yes, and as I understand, I think as recently as February of this year this body adopted this document which is entitled, "Canadian Disclosure Guidelines." Now, I just want to just take you through some parts of this, if I could, please, and begin with page 2. You'll see that, in fact, this body is funded by your national counterpart, Health Canada. Now, there is a disclaimer there that it doesn't necessarily reflect the views of Health Canada. But if you turn to page 3, this is sort of a preamble to the document. And if you look at the first paragraph there, I just want to point out to you some comments and just see your views on them. The first paragraph, the first sentence, "The principles of openness and transparency are becoming increasingly important to the Canadian public." You agree with that?

MR. WISEMAN:

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A. I would agree, yeah.

MR. BROWNE:

Q. And as a matter of fact we've heard evidence this week about the applicability of the transparency legislation to hospitals and so on, so I mean, that's consistent with the government's approach to this issue?

MR. WISEMAN:

A. It is.

MR. BROWNE:

Q. And it goes on to say, "This is especially evident in health care as it relates to information and enables us to make the right choices about our health care and treatment we receive." Again, you support those sentiments?

MR. WISEMAN:

A. It does, yes.

MR. BROWNE:

Q. Now, if you drop down, if you could, please, to the third paragraph, last sentence, "We acknowledge that respect, compassion, honesty and patience will be needed in this process as time will be required to gather all of the necessary facts and information." Do you

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agree with that?

MR. WISEMAN:

A. I'd need to read it in the context of the rest of that sentence. In and of, by itself obviously it follows something else. But, you know, as a stand-alone statement it doesn't appear to make any contradictory comments.

MR. BROWNE:

Q. But the concept of "Time is required to gather all the necessary facts and information." that's my focus here, Minister.

MR. WISEMAN:

A. Before disclosure?

MR. BROWNE:

Q. Yes.

MR. WISEMAN:

A. You would need to, yes, understand what it is you're disclosing, yes.

MR. BROWNE:

Q. Okay. Great, thank you. Now, if you turn to the next page, page 4, you'll see that these are a number of participants and these, I think, these participants are stakeholders, I would suggest, throughout the health care system. And I would suggest, as well, just to

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sort of put this in a bit more context, this document, I would suggest, reflects a consensus across the country and there have been participants, I think, from all provinces to bring this document together. And I just want to point out to you the name Pierre Deschamps. You'll see that one, two, three, four, five, six, seven names down. And I just want to point that out that it seems to me, at least the inference drawn here is that Mr. Deschamps may have some ethics background and that there's emphasis on this body. Now, I know there's been some discussion and there was some confusion, you may recall, about the ethics committee and so on. But I just want to point out to you that in this document there has been some ethical contributions, as well. The particular page, Mr. Wiseman, I want to ask you to comment on is at page 25. Now, I had your colleague, Mr. Ottenheimer, read that and I'd ask you to do the same, please. Take your time.

MR. WISEMAN:

A. Which heading the -

THE COMMISSIONER:

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Q. The whole page or -
MR. BROWNE:
Q. Sorry, "Multi-Patient Disclosure." My apologies.
MR. WISEMAN:
A. "In some situations there may be a need to disclose to more than one patient about the same adverse events. Privacy and confidentiality remain important. Disclosure discussion should be with only one patient at a time, in person, if possible. If disclosure cannot be in person, it should be done by registered mail and/or telephone with opportunities for follow-up made available. In addition, disclosure should be timed, if possible, to occur with all patients involved at approximately the same time, and, if possible, prior to any informing process, especially media coverage being considered."
MR. BROWNE:
Q. Okay. Now, Mr. Ottenheimer was shown this passage, as well, and he was asked the question by me whether or not this was consistent with the advice he received from the clinicians back in August 15th, 2005. He

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said, yes. Do you disagree with any of the sentiments expressed in this paragraph?
MR. WISEMAN:
A. In and of itself and when you--the challenge I have is I don't disagree with the statements being made here. But if you take a document such as this one and if I was to pass judgment or comment on it, I'd want to make sure I understood the full document in the context of which this would have been balanced with something else. But in isolation I wouldn't challenge any of the statements -
MR. BROWNE:
Q. Okay. And I guess the best person to ask whether that advice was consistent with this would be Mr. Ottenheimer who heard that advice?
MR. WISEMAN:
A. Yes, exactly.
MR. BROWNE:
Q. Okay. Thank you. And last evening I was looking at some literature, and unfortunately I could not find the article that I'm just going to mention to you now, and it had to do with a series of questions Ms. Chaytor asked

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you yesterday in regard to lessons learned from this experience and with the view to providing the Commissioner with some recommendations for the future. And there was a reference I found by an author, Jeffrey Rubin which spoke--and the article is entitled "Recurring Pitfalls in Hospital Preparedness and Response." Now, unfortunately, Mr. Wiseman, I could not find the actual article. But, the sentiment that was expressed by this author was that most hospitals at all times are operating at near or full capacity and that there may be occasions where there is an incident which causes a surge on their preparedness, okay, and it's called the surge capacity, that hospitals, when big patients--where there's an issue involving multiple patients does not have the capacity to deal with that surge to its system. And the question I have there for you is is there--and there's some analogies, I would suggest, to what has occurred here. As you talked about a moment ago, the number of patients involved here and we saw e-mails back when Mr. Ottenheimer testified of the numbers being 12

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to 15 hundred. For a role in government to deal, to come in, to step in and help out a hospital or hospitals when they have this surge in their capacity, and I know this is sort of a, maybe a curve ball for you, but that concept generally, do you view that there is a role for government to come in and help out a hospital or hospitals when there is a surge on their capacity in an instance such as this?
MR. WISEMAN:
A. If any hospital or any health authority felt itself in dealing with a major issue that it was facing, whether it was a disaster they were trying to deal with or that they had a spike in activity level, then it wouldn't be unreasonable for the, you know, that particular authority to make contact with the department to see if we could help them facilitate providing some additional resources or to help with that volume. It may include the support from one of the other authorities, it may include support from the department itself to assist with a process. That wouldn't, I wouldn't be--you know, if that

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happened, I'd recognize that as being a, you know, prudent management response.

MR. BROWNE:

Q. Okay. But if I could just come back in terms of the questions. Whose responsibility, I guess, is it to identify the surge and then whose responsibility is it to deal with the surge?

MR. WISEMAN:

A. I mean, the issue of the identifying the surge, I would expect the organization itself, the CEO and the rest of the management team to identify when that surge would be. And my expectation would be that they would explore options to be able to respond to that surge. If they didn't have the capacity within their organization themselves through a realignment of some resources, if it's a temporary issue or to explore opportunities they may have with colleagues and sister authorities within the province, then they would engage discussion with the Department of Health as to how they may get the available resources and supports to be able to do that. But on a day-to-day operational level, most of our authorities, I

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suspect, would deal with--the magnitude may not be as large as what we're talking about here in terms of the numbers, but in any given day I suspect that each of our authorities are dealing with spikes in activity, whether it's an extremely busy emergency department or pressures on the beds that they have or in the community sector a large request for, you know, home support services and these are peeks and valleys that occur, it's the nature of the--of what it is they do within our authorities.

MR. BROWNE:

Q. Right. But I think this author was focusing on special sort of significant events such as this. I think other examples that may come to mind, like SARS or bio-terrorism where large numbers of patients are involved. And that volume has to be dealt with in just the capacity within the system itself needs to be recognized and all the players need to come together.

MR. WISEMAN:

A. I would, my expectation would be that the CEO of an organization, or the leadership of any

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organization, if they found themselves in that set of circumstance, that they would identify clearly what the issue is, clearly what the magnitude would be, and identify the resources they would need to be able to deal with it at that moment. If they didn't have that ability to realign their own operation to be able to accommodate that, it would be reasonable for them to have a discussion either with ourselves as the department or have a discussion with maybe one of the other regional health authorities to see if they could get some temporary support, but collectively, although we'd need to work through to be able to assist that authority.

MR. BROWNE:

Q. Thank you. Thank you, Commissioner.

THE COMMISSIONER:

Q. Thank you, Mr. Browne. I think Mr. Eaton indicated yesterday he had no questions for the witness. That's correct Ms. O'Dea?

MR. ROSS WISEMAN, EXAMINATION BY MR. JENNIFER NEWBURY

MS. NEWBURY:

Q. Good morning, Mr. Wiseman.

MR. WISEMAN:

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A. Good morning.

MS. NEWBURY:

Q. Jennifer Newbury for the Canadian Cancer Society, Newfoundland and Labrador Division. I have a few questions for you this morning. I just wanted to talk to you generally about briefing notes and records in the Department of Health, just some general questions on that topic. First of all, how would a Minister of Health ascertain what the position of his predecessors has been on a particular issue within the department?

MR. WISEMAN:

A. If it was--it might be direct communication with that person and it might flow from, you know, information from officials within the department, but it could come from either one of those sources.

MS. NEWBURY:

Q. Okay. Are there any official records kept of Ministers or the department's official position over a period of time?

MR. WISEMAN:

A. In terms of a policy position or -

MS. NEWBURY:

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Q. Yes, generally any position, you know, the stance taken by a department or any conclusions reached by a department in the past. I think you've indicated, I guess from the totality of your evidence, that the briefing notes would not have represented in the past, certainly, a Minister's position, because a lot of times it's just some suggested answers but not necessarily what the Minister believes to be the department's position or his or her own position?

MR. WISEMAN:

A. I'm not certain if that's been recorded somewhere, if as the Minister today I make a position or take a position on something and make a statement to that effect, I'm not certain if that's recorded in some kind of a log, I'm not aware of that. It would be, there'd be a reliance on the officials in the department and that institutional knowledge that might exist within the organization to be able to share that at some future point. If it's been made in the House of Assembly, the comment would be recorded in Hansard. If it was a position taken by the department because

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there was a, you know, a Cabinet paper put forward on it as in looking for approval from the Cabinet, it might exist in that kind of form. But if it's an opinion expressed by the Minister of the day as being the department's view of that day, I'm not certain that it's documented in any kind of a log of some kind. If it forms a policy that would, you know, influence how our authorities would deliver programs and services or influence a, you know, a direction provided to the authorities, then that would be covered off in some kind of correspondence that would have gone out to the authorities that indicated that the, you know, the position of the department today or the position of the Minister today is this and therefore we'd like you to act accordingly, that might be covered off in correspondence. But in terms of any cataloguing, I'm not certain.

MS. NEWBURY:

Q. Okay. So basically you would have to rely upon, I guess, verbal information relayed from officials in the department or perhaps if it was mentioned in the House of Assembly, you'd

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look to Hansard or perhaps you'd look to letters, but no sort of comprehensive catalogue of information?

MR. WISEMAN:

A. No, not that I'm aware of. I've not see it.

MS. NEWBURY:

Q. And with regard to questions in the House of Assembly, now that we're on that topic, do you typically get feedback from officials in your department about information that you relay while you're in the House of Assembly answering questions or making statements?

MR. WISEMAN:

A. It can happen. In the instance here, for example, you know, I remember last year when I made a comment in the House about the fact that the ER/PR area of the lab had now opened and the, implying that the entire province was now using it, that got corrected by officials when I got back to the department. But if I, you know, if I make a statement in the House that, you know, that I'd expect, you know, officials if they would hear that, that they would bring it to my attention if I had in some way not provided totally accurate

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information or that I had shared something that, you know, may not, you know, provide the clarity that it was necessary or something like that. But I remember that instance in particular because I had said that the lab was open and everybody was using it.

MS. NEWBURY:

Q. And in the period of time when you first focused on this issue, from about May 15th and forward, you were speaking quite frequently in the House of Assembly on these issues, were there any other instances that you can recall when you were corrected by officials in your department?

MR. WISEMAN:

A. That's about the only time I can recall.

MS. NEWBURY:

Q. And is there any requirement that, you know, a designated person on a given day listen to what you are relaying in the House of Assembly or is it just--sorry.

MR. WISEMAN:

A. Generally--it's not a designation, well, it may be but I'm not aware that it is, but it just happens. Each day during the House of

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Assembly the director of communications for the department will generally be present in the House of Assembly itself, in the gallery, or somewhere in the precincts of the House of Assembly, you know, with a view of, you know, supporting the Minister in the event that some issues necessary, but as a part of that process would be listening to question period and listening to the comments that the Minister would have made or if sometimes I may, and as I've done recently, indicated that I didn't have the answer to a particular question, but I undertook to provide the information later when I gathered it and that person would, you know, initiate that kind of information gathering.

MS. NEWBURY:

Q. Okay. And during that period of time, from May 15th and the week or so following that when you were being asked frequent questions about ER/PR, was anyone from your department in the House of Assembly at that time?

MR. WISEMAN:

A. Would have been normal practice for the director of communications to have been there.

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MS. NEWBURY:

Q. Okay. Now, there was a term that you were questioned about, "clinical team members," and I'm not sure if I understood clearly what you understand that term to mean. And I guess I'll ask the question this way, and you made reference to both clinicians and physicians. Do you consider physicians to be a sub-category of clinicians or vice versa?

MR. WISEMAN:

A. When I make a reference to clinicians, I would have been referencing anybody who would have been involved in making a clinical decision around the care and treatment of a patient.

MS. NEWBURY:

Q. Okay. So that could include physicians?

MR. WISEMAN:

A. Could include physicians, might be -

MS. NEWBURY:

Q. And nurse or therapists -

MR. WISEMAN:

A. - psychologists, might be nurses, could be a variety of people.

MS. NEWBURY:

Q. Okay. So physicians then would be a sub-category, obviously, of clinicians?

MR. WISEMAN:

A. Exactly.

MS. NEWBURY:

Q. You were also asked about the term, "Centre of Excellence" and what that meant to you. And just now thinking about those two terms that you've been questioned about, clinical team members and Centre of Excellence, I was wondering whether there's any requirement that in communications, you know, within the Department of Health or between the Department of Health and Eastern Health, as an example, is there any requirement that terms that may not have an obvious meaning be defined either by reference to an existing statute or that if there is no such ready definition that a definition be provided within the document or some other format?

MR. WISEMAN:

A. Not that I'm aware of.

MS. NEWBURY:

Q. Okay.

MR. WISEMAN:

A. What you're--if you're asking whether or not I'm aware if there's some glossary of terms or some understanding that once we introduce new terms, that we in some way formally acknowledge the definition of that term, I'm not aware of the existence of that kind of a policy or that kind of glossary.

MS. NEWBURY:

Q. Okay. And that hasn't been addressed, I know that there was a recent--the briefing notes, there's a new set of guidelines developed in January of 2008 and that hasn't been addressed in that new set of guidelines, has it?

MR. WISEMAN:

A. I don't know the--I've seen the guidelines or a recent set of guidelines, whether it's the one you're referencing or not, and that's not something that would have been ordinarily addressed in that kind of document. I think that was a--if you're referring to the same one, I think that's a document used within government to provide some direction to all departments as to how they may structure briefing notes and their intended use. And so it's an education tool to assist people in drafting briefing notes, if it's the same

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document I'm thinking about.
MS. NEWBURY:
Q. Do you have any concerns about the use of terms that may not have a clear meaning in your own view or perhaps other people in your department might not all be on the same page as to what those terms mean?
MR. WISEMAN:
A. I think it's important in communication that you not use ambiguous terms. And obviously if you're using them, using them in the context that people understand them becomes an important point.
MS. NEWBURY:
Q. Okay. I'm going to ask you some questions now about Peter Dawe and his advocacy on behalf of the Canadian Cancer Society. And I believe it was your evidence that you couldn't recall specifically expressing concerns to Peter Dawe about his comments to the media, but you wouldn't be able to rule out such a conversation taking place because it's consistent with discussions you've had with various advocacy groups. Have you understood your evidence correctly?

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MR. WISEMAN:
A. No, the way you framed the question, I said I couldn't recall having an conversation with Peter Dawe about ER/PR.
MS. NEWBURY:
Q. Okay.
MR. WISEMAN:
A. Was my comment.
MS. NEWBURY:
Q. Okay.
MR. WISEMAN:
A. And but at the same time I had indicated in my evidence that over the course of the--my discussion around this issue in the last eight or ten months and that I have had, you know, numerous discussions around the issue of ER/PR and, you know, those of us who make public commentary about it, you know, wanting to ensure that we create context for it. And because I expressed the view, the concern that in a continuous negative discussion around what's happened here, it has the potential to, you know, undermine or to bring concerns around other aspects of our health care that may not be necessary or question other very

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quality work that's being done. And so in a very general way I indicated that I've had that conversation with any--numerous people in the last while and therefore, you know, if I had the conversation with Peter, it would be consistent with some of the conversations I've had with many, many others.
MS. NEWBURY:
Q. Okay. And did you ever have a particular example of anything that Peter Dawe has done that has caused you concern?
MR. WISEMAN:
A. Not that I can recall.
MS. NEWBURY:
Q. Okay. And I take it you were not familiar with the interview between Peter Dawe and Jeff Gilhooly that you were shown yesterday?
MR. WISEMAN:
A. I saw the e-mail that was sent to me and forwarded to me, but I have no recollection of it.
MS. NEWBURY:
Q. Okay. So you didn't actually read that document?
MR. WISEMAN:

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A. I have no recollection of it.
MS. NEWBURY:
Q. Okay. And do you have any recollection whether anyone in your department highlighted any concerns with anything that was said in that particular -
MR. WISEMAN:
A. I have no--I mean, the issue, the subject matter in the e-mail, in the e-mail itself, I don't have a recollection of.
MS. NEWBURY:
Q. Your predecessor, Mr. Osborne, thought that advocacy groups such as the Canadian Cancer Society speaking to the media on health issues such as ER/PR were playing a necessary role and that this helped to contribute to healthy public policy. Do you share these views?
MR. WISEMAN:
A. I would agree with that.
MS. NEWBURY:
Q. Okay. So your concerns that you've just alluded to earlier about speaking to various advocacy groups, that relates to the manner in which there is a communication with the media?
MR. WISEMAN:

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A. No, my comment earlier in terms of advocacy groups, or any of us who speak on public issues, need to be very cognizant of the context we create around our comments. So if we're talking about ER/PR, or if we're talking about surgical program, or if we're talking about a very specific issue, then it's that very specific issue, and so if we're not careful sometimes, we can cast that net much wider and if we're being critical of an issue or being critical of a broader issue, we may want to focus our comments on.

MS. NEWBURY:

Q. But in the course of your dealing with the ER/PR issue, there has been nothing that has been said by the Canadian Cancer Society that has caused you any concern?

MR. WISEMAN:

A. Not that I'm aware of, no.

MS. NEWBURY:

Q. I'd like to refer you to Exhibit 0219, please. That's a letter to the editor that you wrote in response to an article of Andre Picard.

MR. WISEMAN:

A. Yes.

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MS. NEWBURY:

Q. And paragraph five of the letter, I'm not sure which page that's on -- so right down at the bottom of the page, if you look at the second sentence there, "There was full disclosure with patients and their families once test results became available beginning in October, 2005". I'm just wondering if that statement to you at the time that you wrote this letter or signed the letter, if that applied to both living and deceased patients?

MR. WISEMAN:

A. There's no distinction made in this letter here, and I did become aware some time last year and I don't know if it predates this letter, but I did become aware that not all patients of the -- there had been a distinction made between family members of those that were deceased, and I don't remember what date I became aware of that distinction, but this letter here doesn't make that distinction.

MS. NEWBURY:

Q. Okay, and you hadn't focused on the issue at all at this point in time?

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MR. WISEMAN:

A. I didn't make the distinction in this letter. I can't reflect on my -- think about my thought process at the time, but this letter clearly doesn't make the distinction that's your point. The other one is I did become aware some time during last year that the issue around those that were deceased and that contact had not been made with all of the families.

MS. NEWBURY:

Q. Okay. Were there any other groups of categories of patients for whom notification was deferred?

MR. WISEMAN:

A. No. As I -- at this particular moment in time here as this letter was being written, not that I was aware of.

MS. NEWBURY:

Q. Okay.

MR. WISEMAN:

A. The information I was getting at the time was that all patients had been contacted.

MS. NEWBURY:

Q. But subsequently did you learn of any other

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groups of patients or categories?

MR. WISEMAN:

A. I now understand as of today, and I shared this yesterday in terms of updated information that's been done by the task force on adverse health events is they've looked at reconstructing the database. I now understand that there are other individuals who weren't contacted up until very recently.

MS. NEWBURY:

Q. Some of those, it would appear, might have been through oversight and others might have been an actual decision to postpone?

MR. WISEMAN:

A. I'm not aware of that.

MS. NEWBURY:

Q. Okay. I'm going to ask you some questions now about retesting of deceased patient's samples. First of all, when you first learned of an issue involving retesting of samples of the deceased patients, did you understand at that moment in time that there was actually no existing plan to retest the remaining, I think at that time, 73 samples of deceased patients except if there was a specific request from a

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family member?
MR. WISEMAN:
A. If I remember, there was something to that -- whether the numbers are -- I don't recall any numbers, but I remember at the time wanting to ensure that everyone was redone, including the deceased. I don't recall definitively whether there was a definite decision made to not do, or there was an expression that we may not do, I'm not sure which.
MS. NEWBURY:
Q. Okay.
MR. WISEMAN:
A. But there was -- you know, clearly my desire at that time when I became aware of it, to ensure that they all got done.
MS. NEWBURY:
Q. Okay. So whether the issue was that it was just deferred to a later date or if it was suspended entirely, did you understand that whichever of those situations applied, it was due to some concern about available resources?
MR. WISEMAN:
A. I'm not -- I can't recall the reason and I probably wouldn't have been preoccupied with

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the reason. If it was my desire to have it done, then I would have expressed that view.
MS. NEWBURY:
Q. Okay. Did you have expressed to you by anyone in your Department or anyone at Eastern Health that there were any issues regarding lack of resources?
MR. WISEMAN:
A. To do the retesting?
MS. NEWBURY:
Q. Yes.
MR. WISEMAN:
A. I don't recall that. The issue of resource here was -- they were being done in Mount Sinai, so there was some work in preparation to get them sent out, but the retesting process was being handled at another hospital.
MS. NEWBURY:
Q. And I think it was your evidence the other day that you had understood that the reason for suspending the retesting of the deceased patients was a desire to focus on existing living patients, particularly those who may require a change of treatment?
MR. WISEMAN:

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A. That's what I understood, yes.
MS. NEWBURY:
Q. Okay, and I guess from my own perspective, looking at what might be involved in terms of focusing on the living patients as opposed to those who are deceased and obviously couldn't be helped by a change of treatment, I guess -- to me there's three types of categories of resources that might be required, and I'm just going to ask you a little bit about those. You may agree or disagree, and one you've just highlighted is the retesting of the samples themselves, and you've indicated that the retesting -- the bulk of the retesting was done at Mount Sinai.
MR. WISEMAN:
A. Uh-hm.
MS. NEWBURY:
Q. And were you aware that there were any concerns expressed by Mount Sinai that they didn't have the capacity to do any further retesting or that they were -- or that there were no funds available to do retesting at Mount Sinai?
MR. WISEMAN:

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A. There was a point I understood that at some -- when the exercise started, there was a belief that they'd be able to do them in a certain period of time.
MS. NEWBURY:
Q. Uh-hm.
MR. WISEMAN:
A. And I think that volume of work being sent from St. John's to Mount Sinai, together with their own activity at that hospital, there was some recognition at some point that it was coming slower than they had thought because of the volume. I remember hearing that in a conversation. I don't recall having much of any discussion around challenges with resources and that was a problem here in getting these redone.
MS. NEWBURY:
Q. It was my understanding that most of the retesting of those that were retested had been completed in early 2006, and the decision was not made until later in 2006 to either suspend or postpone the retesting of deceased samples, so obviously that period of time that Mount Sinai was having some capacity issues, in my

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view would not have affected retesting of the deceased samples later on, that particular incident, and you're not aware of any other incidents?

MR. WISEMAN:

A. Not that I'm aware of.

MS. NEWBURY:

Q. Okay, and you're not aware that Eastern Health ran out of money to pay Mount Sinai for this retesting?

MR. WISEMAN:

A. That would have been the first time I would have heard any reference to money in this discussion.

MS. NEWBURY:

Q. And I guess the other possible involvement of resources, either human or financial resources, would be reviewing the information from Mount Sinai. Would you agree that that's another area where some resources might have to be spent?

MR. WISEMAN:

A. Yes.

MS. NEWBURY:

Q. And it was your -- your predecessor, Mr.

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Osborne, indicated that there was a concern that if oncologists and physicians had to devote the same kind of time and effort to review the cases of the patients who are now deceased as they had to do for the living, that it risked making it difficult for them to carry out their regular workload, and he'd also indicated that the people who would be involved in the exercise of identifying and processing the deceased patient's tests was those who sat on the tumor panel which consisted of oncologists, pathologists, and surgeons. Was it your understanding as well that the tumor panel would be involved in the review of the samples of deceased patients?

MR. WISEMAN:

A. I don't recall that conversation, and, you know, the issue -- just so that you understand the length of the discussion or the nature of the discussion I would have had, you know, the time when I would have had that discussion there wouldn't have been a -- I don't recall any lengthy discussion around the issue. It was more a matter of it came to my attention that they weren't done and it was my desire to

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get it done, I would have said so, and that would have been the end of the discussion. So I never did have any --

MS. NEWBURY:

Q. There was no big debate with you?

MR. WISEMAN:

A. There was no big debate with me about this issue.

MS. NEWBURY:

Q. You just said this has to get done.

MR. WISEMAN:

A. It had to be done and move on and get it done.

MS. NEWBURY:

Q. And I think within a week a decision had been clearly made that they were going to proceed with retesting?

MR. WISEMAN:

A. Yes, so I wouldn't have had a great debate or discussion. No one decided to have that debate with me.

MS. NEWBURY:

Q. So you can't either confirm or deny what Mr. Osborne understood to be the case?

MR. WISEMAN:

A. No.

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MS. NEWBURY:

Q. And nothing was ever expressed to you directly about that issue, and a third area, I think, from my perspective that resources, either financial or human might be required regarding the test of the deceased, would be communicating with family members, communicating the results with family members. Had anyone at the Department of Health or Eastern Health ever expressed any concern to you that they lacked the capacity or resources to do that?

MR. WISEMAN:

A. Not to me. Whether they had with officials in the Department, I don't know.

MS. NEWBURY:

Q. And after you made the decision, or directed, or strongly suggested that they proceed with the retesting of the deceased, were you approached to request any sort of special funds or anything else to assist them in terms of a resource?

MR. WISEMAN:

A. No.

MS. NEWBURY:

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Q. And did you hear any problems encountered by Eastern Health, anyone at Eastern Health was involved in this process about accomplishing this task?

MR. WISEMAN:

A. Not to my knowledge, no. In conversations, there were many comments about how taxing this was and how this was consuming a lot of the energy, time, and human resources within the organization focusing on it, but it was said as a comment in terms of the intensity of the work. No one ever came to me and said we can't do this because we don't have enough or we need more money to do this. I never did get those kinds of comments.

MS. NEWBURY:

Q. And you never ever learned one way or the other whether the tumor panel was involved in reviewing --

MR. WISEMAN:

A. I wouldn't have had that discussion, or didn't have the discussion.

MS. NEWBURY:

Q. I'd like to ask you a few questions now regarding contacting patients, and I believe

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you indicated that when you first focused on the ER/PR issue in May, 2007, that there were conflicting stories between what you were hearing from individuals who said that they had not been contacted by Eastern Health, and that included some calls, I believe, to the Department of Health, as well as what you would have heard in the media?

MR. WISEMAN:

A. Yes.

MS. NEWBURY:

Q. And that contrasted with repeated adamant assurances from Eastern Health that all patients had been contacted. I'm just wondering at that point in time, did you explore with Eastern Health, anyone at Eastern Health or anyone within your Department who might have the information, the method of contact used in communicating information to the individuals?

MR. WISEMAN:

A. At some point in time, I learned there was two methods. One, direct contact by the Health Authority itself, and the second was using physicians.

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MS. NEWBURY:

Q. And to go a little bit further, would that direct contact be a telephone call or face to face meeting?

MR. WISEMAN:

A. I don't recall how that broke down, the reference to direct contact by the Authority.

MS. NEWBURY:

Q. Okay. So there was no sort of delving into -- I'm just wondering if you delved into this; okay, we've got one position from Eastern Health, and we've got, you know, apparently more than one patient saying that they hadn't been contacted, did you look further into --

MR. WISEMAN:

A. Some of those inquiries, for example, when we heard those statements, we made contact with Eastern Health, you know, we've heard this story about this particular lady, or that we had a call from this particular lady. There was a couple of instances where we had calls and we were able to identify the individual, and upon exploring it, if I recall, there were a couple of examples where there had been some initial contact, but there hadn't been the

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follow up contact done, so that was taken care of.

MS. NEWBURY:

Q. Okay.

MR. WISEMAN:

A. But beyond that, I mean, there was always - they were pretty clear that they made contact with everybody.

MS. NEWBURY:

Q. So at that time you were able to resolve the calls that had been made to the Department of Health?

MR. WISEMAN:

A. There was a couple that I recall that got resolved, they had been dealt with.

MS. NEWBURY:

Q. Were there any that weren't resolved?

MR. WISEMAN:

A. Not to my knowledge. The ones that got resolved, the ones that contact had been made, and I don't know if there was a communication -- I wouldn't use that phrase "communication", but there was an issue that clearly Eastern Health confirmed that they had, in fact, made contact.

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MS. NEWBURY:
Q. Okay.
MR. WISEMAN:
A. But the issue around the method of contact, I didn't -- I don't recall trying to clarify that in terms of the methodology used.
MS. NEWBURY:
Q. Okay. Now in terms of those two couple of cases that you managed to resolve, you had indicated that they had been initially contacted, but had not -- does that mean that they were told about the retesting, but they did not receive the results?
MR. WISEMAN:
A. And there was no change in the results, so they --
MS. NEWBURY:
Q. Okay, but would you agree that that contact was not complete with the patients, that really that sort of supports the opposite of what Eastern Health was stating that they'd all been contacted? Would you agree that that's the case?
MR. WISEMAN:
A. That would seem to be, yes.

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MS. NEWBURY:
Q. And did that cause you any concerns about, you know, the broad adamant statement of Eastern Health?
MR. WISEMAN:
A. I mean, as I've given already in evidence, as time progressed and particularly as we got into the first part of June when Eastern Health had a meeting with Robert Thompson, in particular, started to put some qualifiers on their statements, and that's when we started to drill down a little further, that's when we started to do the audit and verification process.
MS. NEWBURY:
Q. So this is actually -- I guess, the resolution of those issues from those couple of patients, that's what helped you come to the conclusion that you had to delve into this further?
MR. WISEMAN:
A. We needed to move further and start to --
MS. NEWBURY:
Q. Can you recall approximately when you verified what had happened with those couple of patients?

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MR. WISEMAN:
A. No, I can't. It would have been -- you know, I suspect well into May month because there was a lot of public discussion around it for the weeks that followed the middle of May.
MS. NEWBURY:
Q. Were you ever advised of any incidents, whether or not there were any incident that Eastern Health experienced in problems in their efforts to contact patients with the results of retesting, and in particular whether there were any patients who had the results back and they were -- there wasn't an effort to contact the patient, but for some reason it did not happen as it should have? Were you aware of any of those incidents?
MR. WISEMAN:
A. I've since become aware of it because of the work that's been done by the Centre for Health Information, and I think yesterday we disclosed that there was 19 like that who, because of contact information being different than -- they just haven't been able to contact them for a variety of reasons in terms of either phone numbers or a change of address or

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some other reason.
MS. NEWBURY:
Q. Now this information is probably new to Eastern Health, this is something that actually was learned as a result of the NLCHI project, is that --
MR. WISEMAN:
A. I couldn't say. I don't know.
MS. NEWBURY:
Q. So before you got into doing the NLCHI database, so any time prior to June, 2007, as an example, were you told whether or not Eastern Health knew at that time that there had been previous experiences, that they actually knew -- had confirmed incidents that some patients had not been contacted in a timely fashion with their results?
MR. WISEMAN:
A. Not contact at all or contact timely? I mean -- because the information I had at that particular point is -- your question as I understand it, correct me, is that you want to know if they were expressing a concern about contacting them in a timely way or contacting them at all?

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MS. NEWBURY:
Q. The question is focusing on whether there were any known incidents where someone really ought to have had a decision rather quickly, but didn't have it in a timely fashion?
MR. WISEMAN:
A. The timeliness of the -- I didn't get into a discussion around the timeliness of any of the calls that were made or any of the contacts that were made. My focus was around have all the calls been made or not. The timeliness of the calls that they would have gotten, or whether or not they had it early, late, or whether or not it was too late for treatment, I didn't get into that kind of discussion.
MS. NEWBURY:
Q. Okay. Did you have any discussion or did anyone alert you to any problems where a method had been embarked upon to contact a particular patient, but that method had failed, and it was only through, I guess, a follow up visit by the patient that it was discovered that there had been a retesting?
MR. WISEMAN:
A. There was an incident this past week similar

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to that, or last week or so that came to my attention, but back in May of last year, no.
MS. NEWBURY:
Q. Okay. Now in terms of the NLCHI database, is it your understanding that this database is primarily a compilation of raw or basic data regarding patient contact?
MR. WISEMAN:
A. What we intended to do is make sure the people had been -- that's what the exercise started out to do is to make sure that communication had occurred.
MS. NEWBURY:
Q. Okay.
MR. WISEMAN:
A. To help inform that, obviously you needed to identify who the patients were in question, so you build a database from identifying the patients in question, and then from that track the activity around that patient in terms of their test, their retest, and when the reports came back, what communication has occurred. So it started as an exercise to determine whether everybody has been contacted and to help inform that, you needed to identify who

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the patients were. So that was the scope of the work being done as part of the database.
MS. NEWBURY:
Q. Do you know if the project included an analysis of the quality of the contact with the patient, and in particular, the adequacy of the message and the adequacy of the method of communication?
MR. WISEMAN:
A. What I understand is that there's a -- they looked at the method of contact, and that's what -- but the message itself, and the nature of the dialogue that would have occurred, I don't think it looked at that piece, and I'm using that phrase, "I don't think" because it's just come to our attention or the group doing that this recent week that there were some incidents where the method of communication used was through a physician, and we became aware this week or the latter part of last week, I believe, that there was an incident where a -- that was the method recorded, but as a result of contact with a patient, there was a confirmation that that actually hadn't happened. So Eastern Health

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is in the process now, as I understand it, of actually going back through each of those that were categorized like that to verify directly to ensure that contact was made with the patient.
MS. NEWBURY:
Q. Okay. Are they only going back and looking at that category of patients who are to be contacted through their family physician?
MR. WISEMAN:
A. As I understand it, yes.
MS. NEWBURY:
Q. I'd like to refer to an exhibit that I don't think has been entered yet, P-0439. I wonder if I could have that entered. We've had that distributed to us, but not yet entered.
THE COMMISSIONER:
Q. P-0439, which has not yet been entered? Can you tell me what it is?
MS. NEWBURY:
Q. It's an e-mail from Heather Predham to Pam Elliott, Pat Pilgrim, Oscar Howell, Susan Bonnell, and George Tilley.
THE COMMISSIONER:
Q. We can enter it now, P-0439 entered.

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DOCUMENT P-0439 MARKED AND ENTERED
MS. NEWBURY:
Q. So this is an e-mail, as I've just indicated. It's dated May 16th, 2007, and you're not either the author of this or a recipient of the e-mail, and I'm not going to ask you anything about that in detail. I wanted to bring your attention to item number four in the e-mail that says that, "A lady called and said that she had been called and told she was going to be retested, but she had heard nothing else. She was confirmed negative and she was noted to have been contacted". Heather Predham is writing this letter. She says, "This highlights the fact that all this was done verbally and maybe we should have written follow-up letters to all the confirmed negative". I would suggest that this indicates that there might still be confusion even among those patients that Eastern Health had believed had been contacted, and Heather's concern, I guess, is maybe that the verbal communication was not enough and perhaps follow up letters would have been a good idea. I'm wondering if you have or will give any

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thought when you do the audit, for example, of verifying the contact via family physicians, whether there's any thought given to directly communicating with the patients to make sure that they have received and clearly understood -- you would agree that these are complex issues.
MR. WISEMAN:
A. Actually, the interesting -- you're raising a question here with me today, and I do appreciate your doing that. As I understand from conversation I've had with Robert Thompson, the Cancer Society, I think, has already made the suggestion to Robert, actually, and him and I had a chat about it yesterday because it's a good suggestion and one that has a lot of merit.
MS. NEWBURY:
Q. Okay, thank you. Mr. Wiseman, are you aware whether or not the Cancer Registry was used at any time during the ER/PR review process as a source of information for identifying patients and their status?
MR. WISEMAN:
A. I wouldn't know.

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MS. NEWBURY:
Q. And have you ever been alerted to any issues or by anyone in your Department or anyone at Eastern Health regarding the Cancer Registry?
MR. WISEMAN:
A. No, I haven't, no.
MS. NEWBURY:
Q. I'd like to refer to Exhibit P-0126 please, page 19 of the exhibit. Page 19 is a briefing note, one of two for May 16th, 2007 and if you look at the second page of that, the first bullet on that page says, "An expert panel comprised on oncologists, pathologists and surgeons in St. John's recommended that the focus of retesting should be on patients who are living." And there's a similar reference in the other briefing note for that date to an expert panel. Do you understand what made this panel an expert panel?
MR. WISEMAN:
A. The disciplines that you're--the specialty areas of oncology and pathology and the surgeons involved would have been those, obviously been involved in the treatment of cancer, involved in the surgical procedure in

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the first place and then the pathologist and the diagnosis and examination of the tissue. And so, you know, the expertise that they would bring to evaluating test results would be obviously very varied and so it's because of their expertise that they would bring.
MS. NEWBURY:
Q. Okay, so because the panel contained members who were specialists, that's, in your view, what made it an expert panel.
MR. WISEMAN:
A. Yes.
MS. NEWBURY:
Q. So it wasn't a situation that you had expert oncologists?
MR. WISEMAN:
A. No, I haven't heard as individuals by name referred to as experts. I think my understanding was the expert panel was because of the composition of the panel and the various specialty areas represented on that panel.
MS. NEWBURY:
Q. Were you ever made aware of the individuals who sat on this particular panel?

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MR. WISEMAN:
A. The only reference that I've ever heard made to a name was Dr. Laing, I think, was a reference that I had heard in the context of this panel. I can't recall other names of -
MS. NEWBURY:
Q. And do you know if any of the other individuals, even if you didn't know them by name, did you know if any of those other individuals have been involved in the initial treatment or initial testing of the patients between 1997 and 2005?
MR. WISEMAN:
A. I don't know.
MS. NEWBURY:
Q. There was some discussion yesterday regarding rules of engagement and I believe it was your evidence yesterday morning that both the Board and the department were more actively involved in the ER/PR matter than they would have been historically, did I understand your evidence correctly in that regard?
MR. WISEMAN:
A. I think the--after we started having discussions around this issue in May of 2007,

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I can speak to that period of time, you know, there was a, the period that followed in the preceding week or following weeks and then since the involvement with the Centre for Health Information, you know, that continuous dialogue that would have occurred as to how things were unfolding and discussing what, you know, normally the operations of the health authority is left to the authorities and we wouldn't have people in the department, you know, engaged in a file on a day-to-day basis working through it ordinarily and--but that's happened in this particular case here.
MS. NEWBURY:
Q. Okay, and was the Board also more actively involved in these matters than they would historically have been?
MR. WISEMAN:
A. The Board meaning the Board of Trustees?
MS. NEWBURY:
Q. Yes, that's what I understood you to mean yesterday.
MR. WISEMAN:
A. And I apologize for any confusion that I may have created as a result of my reference to a

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board, you know, verses, you know, the Board of Trustees meaning the trustees themselves, and so my reference to the Board, I may have used it interchangeably to refer the Regional Health Authority and I apologize for that.
MS. NEWBURY:
Q. Okay, so it wasn't your evidence then that the Board of Trustees had been more involved?
MR. WISEMAN:
A. No, no, and I apologize for that.
MS. NEWBURY:
Q. Thank you, those are all the questions I have, thank you, Mr. Wiseman.
THE COMMISSIONER:
Q. Thank you. Ms. Taylor?
MR. ROSS WISEMAN, EXAMINATION BY MS. PAMELA TAYLOR
MS. TAYLOR:
Q. Good morning, Minister Wiseman.
MR. WISEMAN:
A. Good morning.
MS. TAYLOR:
Q. My name is Pam Taylor. I'm here on behalf of the breast cancer testing class action group. I just have a couple of questions for you. Now I want to go back to information that you

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provided yesterday and Ms. Newbury was just asking you some questions on it. The audit that's being done, the contact that was made to patients through physicians and now an audit is being done to determine whether or not patients actually received contact from physicians, so whether they actually received information on their test results. Who initiated this audit process?
MR. WISEMAN:
A. It came about as a result of a--the work that the Centre for Health Information was doing and when they start, they identified the method of contact which was my comment a moment ago, and then a lot of it, a number of them, I think the number was around 400, had been contacted by providing information to the family physician or treating physician and they, in turn, would pass on the results to the patient. It was either the first part of this week or the last part of last week, a circumstance arose where we became aware that a patient, upon visiting their physician, became aware that the results hadn't been earlier communicated and that came to our

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attention. So that prompted then a further discussion around that method of communicating in the beginning. And that conversation included, you know, a comfort level, exploring a comfort level that would exist if it happened to one, you know, could there have been others? And the fact that it happened once and it's now become, we become aware of it, came to our attention, there was a quick recognition that we now need to confirm with the other, whatever the number is, that this in fact did occur and communication did actually happen. Because prior to that, there was a reliance on that method.

MS. TAYLOR:

Q. So is that something that came from your department or Robert Thompson or is that something that Eastern Health initiated? I'm just trying to understand?

MR. WISEMAN:

A. It came, you know, I think it came about as a result of--it was found and came about as a result of the work done by the centre and the decision to move forward with the reverification came about as a result of a

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discussion between Robert Thompson and Eastern Health.

MS. TAYLOR:

Q. So there isn't a comfort level that in fact everyone received contact through their physicians at that time, in terms of their test results?

MR. WISEMAN:

A. Well now we understand that there was one and the concern is there may be another and we need to better understand that. So we now need to reverify more directly with the patients involved to ensure that that did happen.

MS. TAYLOR:

Q. Now I've heard reported in the media that that number is approximately 420. Does that sound right to you or do you have any information on that?

MR. WISEMAN:

A. Yeah, I said four something, if I'm not mistaken it was around that number.

MS. TAYLOR:

Q. Okay, if I can ask the Registrar to pull up 0231, Exhibit 0231. Now this has already been

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reviewed with you by Ms. Chaytor. This is an e-mail, it's a series of e-mails actually at the top. It's an e-mail from Tansy Mundon to Robert Thompson and yourself, June 6th, 2007 and at that time it seems that what precipitated it was a question, a question period where an MHA was asking you about whether or not Eastern Health was misleading the public with respect to a full page ad that, at that time, said that they had informed all patients and their doctors of their individual test results. Now, it looks like Tansy Mundon, who we know was the Communications Director in your department.

MR. WISEMAN:

A. That's true.

MS. TAYLOR:

Q. Had contacted Susan Bonnell, the Communications Director in Eastern Health and according to the response, it was confirmed at that time that once a letter was sent to physicians regarding patients, that they follow it up with individual physicians to ensure that patients were contacted. So obviously that's now being questioned.

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MR. WISEMAN:

A. Yes.

MS. TAYLOR:

Q. So what data is available to show that patients, that that follow up actually occurred at that time? Is there any data?

MR. WISEMAN:

A. In June of '06?

MS. TAYLOR:

Q. June of '07.

MR. WISEMAN:

A. I'm sorry, June of '07. I couldn't answer that question, the people who have been working on the database may be able to confirm for you the documentation that they may have used, but you know, from where I sit today, you know, you're pointing out something that happened here in 2006 that says that Eastern Health or a representative of Eastern Health was confirming that they, in fact, had followed through to confirm that the physician did make contact and I guess, which I'm saying here today that we now know that there was at least one that that didn't happen to. And I'm expressing the view that if it happened to

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one, it may have happened to others and as a result of that and because of that, that now that verification is taking place and will start now.

MS. TAYLOR:

Q. And you had said a moment ago 2006, but we know it's 2007, just a correction.

MR. WISEMAN:

A. I'm sorry, yes.

MS. TAYLOR:

Q. We've also heard from patients, the Commission has heard from patients and I believe at least one has testified that she wasn't aware that there was a letter in her file. Are you aware of that? That's Ms. Beverly Green?

MR. WISEMAN:

A. I'm not aware of that testimony.

MS. TAYLOR:

Q. So that would be another person. She has testified to that effect that she didn't find out until later that that information was there. So that's at least another person.

MR. WISEMAN:

A. Yes.

MS. TAYLOR:

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Q. So at that point, obviously that information wasn't correct?

MR. WISEMAN:

A. The point in time of this e-mail?

MS. TAYLOR:

Q. In June of '07.

MR. WISEMAN:

A. Yes, it would appear now that that was not correct.

MS. TAYLOR:

Q. It was inaccurate.

MR. WISEMAN:

A. Inaccurate, yes.

MS. TAYLOR:

Q. Now something else that you had given evidence on was back in the first part of June, '07, that's at the point I think Ms. Chaytor was asking you at what point did you start to lose confidence in the information that you had been provided and you had a conversation with Robert Thompson. Around that time, people from the department had been sent in to do an overview of the data and I think that you've elaborated on that this morning, but everything wasn't in one database, there was

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no way to do a reconciliation. So my question is, looking at that, how and I'm wondering if you've asked yourself this question, how could Eastern Health have had confidence previously if when your own people go in and look at that data, and they can't reconcile it, they can't figure out what's happened, how could Eastern Health have been confident that in fact everybody had been informed when they were giving those assertions to the public and to your department?

MR. WISEMAN:

A. That's a good question, I've asked myself that many times.

MS. TAYLOR:

Q. Have you come up with any answers?

MR. WISEMAN:

A. No, because there is no answer.

MS. TAYLOR:

Q. Well, I'll just go back to a question on Exhibit P-0231. Now the question that was being asked at that time that precipitated that series of e-mails was an MHA asking whether or not Eastern Health had mislead the public in its ad at that time and we have gone

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through that ad and I believe that you've answered to that ad, at that time there was a reference to all patients having been contacted. It was an ad in June and you had said that that was inaccurate, you now know that information to be inaccurate. So was Eastern Health misleading the public at that period of time with the information that they had in their full page ad? And I can pull it up if you need to see it again. Were they misleading the public?

MR. WISEMAN:

A. I've indicated that the information, as of today I now know that the information is incorrect. I know it because we've had a team of people who have actually completed a review and have been able to confirm for us that--and they have identified the individuals in question who have not been notified and they're in that pool. So the information that was supplied in that ad and the information that was communicated to me, during the course of the period of last year, particularly from the middle of May up to the first part of June, was clearly that they all had been. I

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now know that they weren't and so the information supplied to me last year was inaccurate.

MS. TAYLOR:

Q. So wouldn't you say then that that information was misleading?

MR. WISEMAN:

A. I can say the information was inaccurate. Misleading implies that they intentionally did something and I wouldn't want to--I'm speculating what their motivation might have been.

MS. TAYLOR:

Q. Okay. Now you've said that as Minister of the Department of Health and Community Services, you are the spokesperson within the government, but you're also the spokesperson for government to the people of Newfoundland and Labrador, is that correct?

MR. WISEMAN:

A. On health related issues, yes.

MS. TAYLOR:

Q. On health related issues. So you've, on a number of occasions in press conferences, media scrums, questions in the House, a letter

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that was written to the Global Mail, in various instances you have reiterated the statements that all patients were contacted.

MR. WISEMAN:

A. Yes.

MS. TAYLOR:

Q. And you now know that to be incorrect?

MR. WISEMAN:

A. Uh-hm.

MS. TAYLOR:

Q. Have you given any thoughts, have you gotten angry, have you wondered, you know, you're providing that information, you now know it to be incorrect, have you questioned people about why were you given that information and how could they give it to you at the time?

MR. WISEMAN:

A. If you're inquiring about the range of my emotions on this issue since I've been seized with it last year, they've gone from anger to disbelief to shock and a variety of others. And each and every time that I have questioned why or how come, you know, it's a source of great frustration that, you know, the people who have been impacted here, the people of the

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province find themselves in this very difficult circumstance and there's been many people impacted here, many families have been impacted and so, you know, because there was some errors made. Compounding those errors, then you have the piece around the communication and that's been a tremendous source of frustration for me. The anger is because I've, you know, was being provided information that I was repeating continuously for a period of time and I've since found it's inaccurate and I now wonder, as I now--with the insight I now have and the manner in which the information was gathered, I now recognize that there was no way that they could have told me that. The e-mail you showed me a minute ago that I hadn't seen before, the one that you entered into the evidence and I forget the number of the exhibit, with the comment by Heather Predham, that's information I wasn't privy to last year. And when I read that here this morning, knowing that that was a view shared at that time, and hadn't been clearly shared with me, it further adds to that frustration and anger that I have.

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MS. TAYLOR:

Q. You said a moment ago that you now know that they couldn't have shared that information with you, what do you mean by that?

MR. WISEMAN:

A. Now that I know the manner in which the records were kept, now that I know the challenges that existed in trying to reconcile the information that the Centre for Health Information had, as the officials who went into the department last year in June, came out and said, you know, we can't reconcile this. This information is all over the place. You know, I now recognize it when someone said to me last year definitively that they've all been contacted, I now wonder how any of them could ever tell me that because they, themselves, didn't have it all in front of them.

MS. TAYLOR:

Q. Right.

MR. WISEMAN:

A. And so that's what I meant by that comment.

MS. TAYLOR:

Q. They didn't have the information available to

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be able to make those statements to your or your department?

MR. WISEMAN:

A. It appears now that they didn't.

MS. TAYLOR:

Q. Okay, thank you, Minister Wiseman, that's all the questions I have.

THE COMMISSIONER:

Q. Thank you. Mr. Pike?

MR. ROSS WISEMAN, EXAMINATION BY MR. MARK PIKE

MR. PIKE:

Q. Good morning, Mr. Wiseman, my name is Mark Pike and I represent the Newfoundland and Labrador Medical Association, which, as you know, is a group of over one thousand physicians and students across this province. The subject has come up before and was raised by my learned friend, counsel for the Commission, as well as counsel for the Canadian Cancer Society about your views as to the proper role of advocacy groups, such as the NLMA in this province and the health care system. What are your views on that?

MR. WISEMAN:

A. They play a very important function as they

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represent, as you said, the interests of the membership, but they also too provide a major input into the health system itself, they have expert opinion, they had advice, you know, they have a body of knowledge that only helps us as a system, helps us as a government, helps the authorities to make improvements in our health system, so I always welcome their comment and their input. And so it's a very valuable role they play.

MR. PIKE:

Q. So do you agree then that the NLMA and other groups that I've mentioned and you've referred to in your answer play an important role in pointing out shortcomings in the health care system?

MR. WISEMAN:

A. Absolutely, I mean the issue of any organization, whether it's the Medical Association or the Cancer Society or many others out there who do similar type of activity and, you know, I value as a Minister, as a government we value the comment, both with the counsel they provide in conversation in private meetings we may have, and in

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comments that they may make to the public. The fact that they engage in a very public way to discuss issues relative to our health system or relative to the interest that they represent, I think it's important to inform that kind of public dialogue that we always need to have in our health system. You know, I made some comments yesterday around, you know, I think I may have expressed it or it may have been interpreted as some caution I may make about how we express things sometimes and I said I would have had a conversation with Mr. Ritter of your association, as I have had with others, and so when we engage in that kind of comment, my comment wasn't to suggest at all that I didn't value that advice or that comment or didn't welcome or suggest that public criticism should not occur. My comment would have been that, you know, there will be times when the Medical Association or other organizations may make public comment about an issue that, you know, I may have a different view on and I may share that. If there's a view that, it's like any discussion or debate that might happen, you know, we have varying

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perspectives on that and frequently in some of the meetings I have had with the Medical Association, for example, you know, we've talked about issues where there's, that there is a particular perspective that the association might have, government may have a different perspective and we'll have an exchange of ideas and thoughts. If they happen in a public meeting or happen in a public forum, I think it's still healthy, a public debate, and I would never say anything or try to discourage that kind of public criticism of government or public commentary and input into the public debate around health services, so I welcome it. My comment yesterday was in the context of any reference I would have made to ER/PR and when we talk about ER/PR, you know, it's one piece of a health system and as we talk about it, it's let's not cast the net to be highly critical of an entire health system. So my reference the other day or yesterday would have been in that context, rather than in the broader context of suggesting that any association or any group or any individual, for that matter,

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shouldn't be more than welcome to express in a very public way their comments, concerns, criticisms, compliments, any other comments they may have about the future of our health system.

MR. PIKE:

Q. So you'd have no problem in the NLMA pointing out or commenting publicly on issues such as gaps in service or the needs of a particular community or particular area or discipline or problems or inadequacies with the system, including strengths sometimes?

MR. WISEMAN:

A. Not at all, in fact just the opposite of that actually, I welcome it. I think it's healthy, it's healthy for us as a government and it's healthy for public information.

MR. PIKE:

Q. So any kind of a discouragement or admonishment directed towards any of these groups would not be something that you would find desirable?

MR. WISEMAN:

A. No, not at all. I mean, there may be on occasion where there is a particular comment,

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as I said a moment ago, that might get made sometimes in making public comment that I, as a Minister may have a, or as a government, we may have a different view on and I may want to have a discussion with that association about that particular view, but I think that's healthy.

MR. PIKE:

Q. Even if it's critical of you or critical of the government or embarrassing to you or your department?

MR. WISEMAN:

A. They shouldn't be restricted by the fact that it might embarrass me, personally, or embarrass government, you know, they have a critical role to play and a contribution to make to informing the public and helping inform government, helping inform me, as a Minister. So I don't discourage that at all and I value the input that they provide.

MR. PIKE:

Q. So a healthy system would benefit from this type of encouragement and criticism, no matter--as long as it's done in a constructive way, that's the point that you're making.

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MR. WISEMAN:

A. Yes, and in doing it in a public way, I mean, I think it's important if we work collectively together because I think all of us have the same objective here. At the end of the day we want to make improvements in our health system. We want to make sure that we provide quality service, quality health care, quality programs are being provided to the people of Newfoundland and Labrador; I think we all collectively share that view and I welcome any and all contribution to that end.

MR. PIKE:

Q. Thank you very much. Commissioner, those are my questions.

THE COMMISSIONER:

Q. Thank you, Mr. Pike. Mr. Pritchard?

MR. ROSS WISEMAN, EXAMINATION BY MR. ROLF PRITCHARD

MR. PRITCHARD:

Q. Commissioner, just before I commence my questions, I'd like to seek your leave to enter documents P-0291 through P-0295.

THE COMMISSIONER:

Q. P-0291 to P-0295, those are the correct numbers?

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MR. PRITCHARD:

Q. Yes.

THE COMMISSIONER:

Q. Entered.

EXHIBITS P-0291 THROUGH TO P-0295 ARE ENTERED

MR. PRITCHARD:

Q. Thank you. Minister, I'd like to start by taking you through a few statutory materials that have just been entered and the first one I'd like to ask to be put up, please, is P-0294 which I understand are the Department of Health and Community Service Regulations under the Executive Council Act. You have that in front of you there. And, Minister, I think you were asked some questions about this the other day, so I'd like to take you back to that briefly and I believe the section that was highlighted for you the other day was Section 4, which talks about the duties and powers of the minister. And what your attention was drawn to, the first part of Section 4, "The powers, duties and functions of the minister include the supervision, control and direction of all matters related to" and then there's a list and what I'd like

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to take you to is the end of that section which states, I'll read it in its entirety. It says, "The powers, duties and functions of the minister include the supervision, control and direction of all matters related to"--then it goes through the list and then it says-- "which are not or in so far as they are not the responsibility of another minister, agency, body, corporation, board, organization or person." I'd like to ask what your understanding of that section collectively is?

MR. WISEMAN:

A. As you read it altogether, then obviously it would appear to lay out my responsibilities as a minister, the caveat that's included here in this last section that you just read now, would deal with and would have envisaged the creation of such things as our Regional Health Authorities and then the Regional Health Authorities have been created as another body or corporation and would have its own, in this case, would have its own regulatory structure and legislation that would then define then more clearly how that actually--how the minister's role is divested to that body for

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delivery of certain services.

MR. PRITCHARD:

Q. Okay, so that contemplates a delegation of some of the minister's power to some other body, a corporation or -

MR. WISEMAN:

A. It would appear, yes.

MR. PRITCHARD:

Q. Okay. Minister, I'd like now to take you to the Regional Health Authorities Act, which I believe is document P-0295. Minister, I think you said in your evidence that this has recently come into force on April 1st and I think there was some commentary that it was your understanding that the Regional Health Authorities have acted very much as though this has been in power prior to April 1st, 2007. And what I'd like to do is to take you to a few sections within this Act and then to invite your comment. I think the part that you were previously shown in here was Section 5 which talks about ministerial directions, "The minister may give directions to an authority, including direction for the purposes that are enumerated" and then it says

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"an authority to which the minister gives direction under Section 1 shall comply with the directions." That's the part you were taken to previously. I want to take you now beyond that and to invite your comment on a few sections. I'm going to take you now to Section 7 which says, "An authority is a corporation without share capital for the purposes of the Corporation's Act" and Minister, what's your understanding, what are the authorities' corporations?

MR. WISEMAN:

A. That would be a separate autonomous body, separate legal entity.

MR. PRITCHARD:

Q. And just moving down now to Section 8, "The Board of Directors: The management and affairs and authority shall be directed by a Board of Trustees appointed by the minister in accordance with the regulations." So obviously we can glean from that that you appoint the Board, but could you speak generally to that section please?

MR. WISEMAN:

A. The minister appoints that Board and the Board

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then has, you know, obviously becomes the directors of that corporation and they then would then be responsible to bring around them their management team to run the day-to-day affairs of the health authority itself, and the Board would take a role with respect to policy governance verses an operational role.

MR. PRITCHARD:

Q. All right and now let me just take you now to Section 16, "The Responsibility of the Authority: The authority is responsible for the delivery and administration of health and community services in its health region in accordance with this Act and the regulations." Minister, what's your understanding of that section?

MR. WISEMAN:

A. Well they, basically the authorities then have, because of the legislative power that they've been given and as a government we provide them with the budgetary resources to be able to provide a range of services that are approved and acknowledged by the department, so by way of illustration, if an authority has a responsibility to provide a

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range of tertiary level services and they are identified, then the authority is provided the resources in which to do that. How they go about delivering those services and programs, in terms of, you know, the human resources they would need, the capital resources they would need, the equipment and you know, the day-to-day activities of delivering that program or associated with delivering that program, and providing that service to the people of the province, that would rest with the authority.

MR. PRITCHARD:

Q. Okay, and just on that point about you mentioned the budgetary tools, I'm going to take you now to Section 21 -

THE COMMISSIONER:

Q. Before you leave that point, I understood from the comments made, I believe by Ms. Dawe and maybe by others, that--but the question of whether or not a new service gets to be provided is yours, is it not?

MR. WISEMAN:

A. In a--depending on the--there's some enhancements that could be made to existing

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programs. We define broadly that there will be a surgical program and internal medicine will be provided, obstetrical program will be provided, but if the authority wanted to enhance some of those programs in some fashion, then they have that authority to do that, so it's a--it would be, in broad terms, the range of services to be provided by each authority would be defined by the department.

THE COMMISSIONER:

Q. Okay, so for example, you could say to an authority that in hospital "X" you could have a surgery department and if there is a surgery department which provides general surgery and things like that, can they, for example, decide we're going to add neurosurgery or would the department say, no, neurosurgery for this province will be done in a particular institution?

MR. WISEMAN:

A. The latter, we would define that neurosurgery would be done somewhere else, so they would provide it in those facilities, as defined by government.

THE COMMISSIONER:

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Q. Okay, but could they decide, for example, we're going to add an extra theatre or whatever they now currently call operating rooms?

MR. WISEMAN:

A. They could make that--that would be an operational decision.

THE COMMISSIONER:

Q. All right, thank you.

MR. PRITCHARD:

Q. Minister, I'm going to follow up on that question and just seek some clarification because Mr. Ottenheimer was testifying, I asked him, you know, I think it was clear that there was a budgeting process and I think both you and your predecessors have spoken to the fact that at the end of the day, it's the department that approves the budget and may specify that there should be an operating theatre, somewhere along those lines, but what I asked him was this, I said once that money is decided upon and it gets voted on and is part of the budget and then if the money is turned over to the Health Authority, that's probably a good way to put it, what happens

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then? Do they do what they like with the money or do they have to follow certain constraints? How rigid is that process?

MR. WISEMAN:

A. The budgetary process is a--two terminologies in terms of one is a line-by-line budget process; the other is a global budget process. We don't define, for example, that the Regional Health Authority will have a surgical program and that you will have five nurses and four surgeons and you will have other supports that will be there and here's a salary for each of them, and if they retire or leave, then that salary is gone. What we provide them with is a block of money that they say we want a surgical program and the cost of that surgical program will be this much to operate, so that would be, I use the word "notionally" so we'll add that to the list and they'll identify a range of other programs that they will want and will add that to the list. At the end of the day, we will give them, you know "X" number hundreds of millions of dollars and they will then, you know, provide that range of service. But in the normal

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operations they might say, well, today we can use, you know, we need four nurses in the OR, so we had initially allocated a budget for having six, we're going to take that money for the other two nurses and going to use that in some other program area. The support services that they provide, you know, they'll decide whether we need, you know, "X" number--five people in the dietary service and six people in materials management and they will make those decisions themselves in how they flow that money back and forth. You know, they have a range of institutional programs, together with community programs, so if they, to provide the acute care services, they need the flexibility of being able to discharge patients out of an acute-care hospital back into the community, so therefore, they might decide that they're going to add some money to their community service budget to provide supports for people upon discharge that will allow them to actually free up some of the beds that they have in the institution to give better, you know, utilization of that bed. So they may make operational decisions of flowing

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money back and forth like that. But fundamentally the mandate is to provide a surgical program and to provide community services. And how they actually do that effectively, that's the management decisions and role that they play as to how they move that money around. And so there is a flexibility within the organization to deal with resources and so they have a challenge in one area today, they have the flexibility to be able to move some money from one area to another. They don't have the right, though, or the authority to say in order to do that, we have to actually cut a program. If they make a decision to cut a program in order to free up the money to move to another program, that would require departmental approval. But if they maintain the program, they have the flexibility to move the money around within their organization to respond to operational demands and changes in programs and services.

MR. PRITCHARD:

Q. Minister, I want to take you now to the Transparency and Accountability Act, which is document P-0292. You were asked some

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questions about this the other day, in particular I believe Section 4. And Section 4 states that "The lieutenant governor in council shall establish criteria for the categorization of government entities as either category one, two, or three government entities." And if you move on into the Act, it talks about the categories in Section 5, 6 and 7 and it appears that Section 5 requires a strategic plan every three years and then Section 2 and 3 require a less onerous plan. Minister, you were asked the other day what your understanding was of what level of accountability the Regional Health Authorities had and I believe you had an opportunity to look at that issue?

MR. WISEMAN:

A. Yes, they report at that highest level.

THE COMMISSIONER:

Q. Mr. Pritchard, I'll ask this question to you rather than the witness, really, but if you scroll back up there, if you wouldn't mind, where it says I think the lieutenant governor in council maybe, the lieutenant governor in council shall establish criteria for the

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categorization of government entities as either category one, two or three. I'm assuming that would be done by regulation?

MR. PRITCHARD:

Q. I think that's a reasonable assumption.

THE COMMISSIONER:

Q. Do we know if there are any regulations?

MR. PRITCHARD:

Q. Minister, do you know if there are any regulations?

MR. WISEMAN:

A. I couldn't answer that, no, I don't.

MR. PRITCHARD:

Q. We'll have to -

THE COMMISSIONER:

Q. Well could you perhaps just advise us at some point, because I think we've kind of looked and couldn't find them.

MR. PRITCHARD:

Q. I will check on that, Commissioner.

THE COMMISSIONER:

Q. Either we're not looking in the right place or perhaps they haven't been published.

MR. PRITCHARD:

Q. I've made note, thank you.

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THE COMMISSIONER:
Q. Thank you.
MR. PRITCHARD:
Q. Minister, I want to take you now, the other day you were asked some questions about annual performance reports and I'd like to show you now, document P-0293? And, Minister, can you tell us what this document is?
MR. WISEMAN:
A. This would appear to be the annual report, page from an annual report of Eastern Health.
MR. PRITCHARD:
Q. And, Minister, you were asked the other day if this report and I believe there's actually two pages excerpted from this report that are here, made any reference to the ER/PR issue and I take it that you shared this document with us because there is a reference to the ER/PR issue?
MR. WISEMAN:
A. There is, in the second last paragraph there is a reference here in '06, '07 "that the estrogen progesterone testing was at the forefront of media attention and caused great concern for the public."

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MR. PRITCHARD:
Q. All right, and I'll just show you the second page. I think in the second column, forth paragraph, there's also a reference?
MR. WISEMAN:
A. There is, yes. This page is headed "Opportunities and Challenges" and it says here "Eastern Health has been under increasing public scrutiny due to the internal report, the ER/PR judicial inquiry and class action lawsuit and the Burin Peninsula radiology review. These issues have undoubtedly shaken the confidence of the general public in our health care system."
MR. PRITCHARD:
Q. Thank you, Minister. Minister, I want to take you back now to the start of your ministry which was in January of 2007 and you were asked some questions about your briefing book and whether or not you had read it and so my question to you, just for clarification now, did you have occasion in those first months when you were Minister of Health and Community Services to read your book or look at it or what, if anything, did you do with your

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briefing book?
MR. WISEMAN:
A. The briefing book, as I indicated, is a document prepared by officials in the department to provide information to the minister. They reflect a long list of topics and issues that the department has either been dealing with today or has dealt with or anticipates that will be issues to be dealt with in the immediate future. That document is used, obviously to provide information to a minister and to assist him and establishing priorities and direction and getting a general understanding what are the issues in the department. I did have an opportunity to go through that book, but I had indicated that I hadn't read it from cover to cover, I had gone through it with a view of highlighting those things that needed some immediate attention and those that needed immediate attention, I dealt with accordingly and gave it my immediate attention. Those that didn't need any immediate action and then I would not have delved into those as much. One of the issues, as a minister, obviously you're dealing with

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multiple issues coming across your desk and prioritization becomes an important issue and being able to identify those things that you need to deal with today, verses tomorrow and what requires your attention right now because there's immediate action required. And so that's how I used that briefing book at that point is to inform that process. But I did review it, but I only dealt with those things that needed some immediate action.
MR. PRITCHARD:
Q. And, Minister, in terms of those items that required immediate action or from time to time thereafter items that would require immediate action, how would you become aware of that?
MR. WISEMAN:
A. Officials in the department, particularly the deputy minister or the assistant deputy minister, in, you know, the assistant deputy minister for Board Services which creates a lot of the activity, but we also have an assistant deputy minister for, you know, three other areas that if something was happening in their area of responsibility, you know, they would bring that to my attention and we would

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have--and deal with it appropriately at that time. But the process of bringing to the minister's attention of something, you know, a briefing note becomes one method and as I've already given evidence, you know, back at that time, briefing notes could enter a briefing book without coming to the attention of the minister, so issues that required immediate attention tend to come to the minister's attention via the deputy or one of the ADMs, rather by way of a briefing note that comes across their desks as here is something that you need to turn your attention to day. It tends to come more informally by one of the ADMS or a DM.

MR. PRITCHARD:

Q. One of those issues, I take it, that arose or had been around for sometime was the issue of the pathologists' compensation and we have seen in evidence a letter that came about on May 16th, 2007, which is Exhibit P-0199 please? Now I'm looking at a document in my book that has P-0199 on it, but it's a different document.

THE COMMISSIONER:

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Q. Well, maybe we can resolve that, this is one of ten pages, could this be -

MR. PRITCHARD:

Q. I'm sorry, you're quite right, Commissioner, I'm looking at page 7, thank you.

THE COMMISSIONER:

Q. Page 7.

MR. PRITCHARD:

Q. Yes, there we go, we live in an age or miracles. Thank you. Minister, you've already spoken about this particular issue and how it was ongoing through that time, so I don't want to take you back through all of that. We've seen Mr. Abbott's name on a lot of the documentation around this particular issue, Minister, what, if any, involvement, direct involvement did you have in this particular matter?

MR. WISEMAN:

A. When there was a report that was commissioned, associated with this issue, there was a report that had been commissioned by government to help them form the amount of the stipend or what kind of compensation would be paid to pathologists and that came into our office

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sometime around the end of January. You know, this was an issue that I had had some discussion with, with the deputy on because it was an issue that was being discussed between ourselves and the Department of Health and Community Services and Treasury Board, who are the arm of government that would deal with compensation related issues and any changes that would have been needed to be made, if any, to the agreement between government and the Medical Association on physician compensation. So there had been some discussion between myself and the deputy on this particular issue with respect to the compensation for pathologists.

MR. PRITCHARD:

Q. Okay, and what was your understanding of how that issue was moving along through, you know, January, February, March, April?

MR. WISEMAN:

A. The report itself was, the position, as I understood the process, the department had made representation or put together a position and moved forward to engage Treasury Board in discussion earlier prior to the January report

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coming out, and through that discussion, there was a decision that, you know, this needed to be examined a little further, some expert opinion needed to be brought into bear and that resulted in the request for that review. And that review was now to help inform what might be an appropriate stipend to be paid or what might be an appropriate compensation, so there was dialogue that occurred between the Department of Health and Community Services and Treasury Board on that issue from the period the report came in, until we actually got action.

MR. PRITCHARD:

Q. Okay. Now this particular letter is dated May 16th, 2007. This is the notification to Mr. Abbott from the Treasury Board that this proposal has been approved.

MR. WISEMAN:

A. Yes.

MR. PRITCHARD:

Q. I think we've seen in evidence earlier a letter of May 18th, which is the notification from the department to Dr. O'Grady approving this.

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MR. WISEMAN:
A. Yes.
MR. PRITCHARD:
Q. Now, just to add one more element to that picture, we also know that the news reporting about the disclosure issues around December 11th, came out on May 15th, which is the day before this letter, May 16th.
MR. WISEMAN:
A. Yes.
MR. PRITCHARD:
Q. Now, was there any impetus to this matter being resolved or at least the notification to the department from Treasury Board on May 16th, as the results of the events of May 15th? Is there any connection with that at all?
MR. WISEMAN:
A. It's coincidental, I mean the letter happens to be on the 16th. As I just laid out, there was a process that had started back well before the, I don't know the exact date, I wasn't around, but the report that came into my office from the outside consultant was sometime the end of January and so you can

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appreciate that there had been a discussion that preceded that date, obviously, and then the report came in and there was a dialogue taken place between the end of January and the middle of May between Treasury Board and the Department of Health as to what that should be and what might be a reasonable conclusion to the issue, so dialogue just didn't prop up between May 15th and then overnight, you know, come to a conclusion and resolve the issue. Given the fact that it had been on the go for a long time, it was just timely to have it resolved in any event.
MR. PRITCHARD:
Q. Okay, Minister you were asked some questions about, we've used the term the reopening of the lab, although I suppose that's not technically correct, in February and what your level of awareness was around that, and you know, whether or not you had put to your Dr. Banerjee's report and the table of what had been done in the lab and what hadn't. But just in the context of that, first of all, your understanding now, it's not the lab that opened or closed, what specifically are they

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talking about?
MR. WISEMAN:
A. Well the lab itself, the laboratory services at Eastern Health didn't close down, what happened was, as I understand it, there is an area of testing that was discontinued and the testing for ER/PR was what was discontinued. The laboratory itself, there was still a lab service within Eastern Health.
MR. PRITCHARD:
Q. Okay, and we've heard in evidence that that service, particular service I believe was shut down in August of 2005. And Minister, what's your understanding of who shut that service down in August of 2005?
MR. WISEMAN:
A. That would have been Eastern Health's decision, as I understand it. They would have been in a position, you know, they had the expertise to make that judgment call that it wasn't safe and they shut it down.
MR. PRITCHARD:
Q. And whose decision was it to reopen that service?
MR. WISEMAN:

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A. It would have been Eastern Health.
MR. PRITCHARD:
Q. And issues such as quality control in particular labs, quality assurance, are those matters of which the department would normally be concerned?
MR. WISEMAN:
A. These are matters that, the word "concerned" obviously we would want to make sure that there's quality programs out there and there's a quality assurance program, so there is a concern, but in terms of having a responsibility to maintain quality control programs and to do the monitoring and to make the corrective action when trends are identified as being problematic, then that would be an operational issue that the authorities would deal with.
MR. PRITCHARD:
Q. Now, Minister, just on that issue of the ER/PR service in the lab, I think you indicated in your evidence that you had a meeting on May 15th. You had a meeting on May 15th, but before you went to the House, you had another meeting and some of your officials and Mr.

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Tilley were present and you sort of were briefed on this issue as it was unfolding at that time, is that correct?

MR. WISEMAN:

A. I was, that's true.

MR. PRITCHARD:

Q. And I think it was your evidence that you had spoken about a number of things and one of them was that you were given to understand by Mr. Tilley at that time that all of the recommendations in respect of the lab had been implemented.

MR. WISEMAN:

A. That was the impression I had.

MR. PRITCHARD:

Q. Okay, now when you were taken through the chart the other day, Dr. Banerjee's chart and we saw some of the things had been implemented, some of them were in the process, some of them weren't agreed with. Did you have that kind of a discussion about it with Mr. Tilley? Did he indicate, you know, there were some shades to this, that some things had been done, some things had not been done, some things were in the works or was it more of

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just a blanket statement, do you recall?

MR. WISEMAN:

A. Blanket statement. The grid that I was shown the other day wasn't something that I had in my office until sometime around the end of May that that profile had been submitted, at least to me.

MR. PRITCHARD:

Q. Now, in terms of your officials, for example, your deputy minister was Mr. John Abbott, did you ever ask or have occasion to ask Mr. Abbott when he became aware of the fact that there was a discrepancy between what the department had been told on November 23rd, 2006 would be disclosed and what was actually disclosed on December 11th, 2006? Did you ask him when he became aware of that discrepancy?

MR. WISEMAN:

A. I don't recall ever asking that question directly like that.

MR. PRITCHARD:

Q. Did you make that inquiry of any other officials in your department?

MR. WISEMAN:

A. No, I did not.

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MR. PRITCHARD:

Q. Okay and one of the things you said, you didn't spend a lot of time at that meeting on the 15th taking about what had happened back in 2005 because, you know, that had happened and there was nothing you could do about it at that point. You've been asked some questions by my colleagues, however, about the decision that was made by Mr. Ottenheimer and I want to ask you, Mr. Ottenheimer made a statement when he was here and he said that one of the things that he had been told in that period of time, July and August of 2005, one of the factors that had come up at the meetings, was on the one hand there was his agitation to disclose, but on the other hand, people were saying, well, you know, we don't have all the information, we don't have all the facts at this point in time; therefore, we need to wait. And he made this statement when he was sitting there, that in his view, it would have been preferable to disclose earlier, even if all the information were not available. Is that your view, Minister?

MR. WISEMAN:

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A. I think I've been pretty clear on my view of the events of the fall of 2005 or the summer of 2005, that there should have been a full disclosure at that time.

MR. PRITCHARD:

Q. I wonder if the Minister could be shown document P-0291?

THE COMMISSIONER:

Q. Mr. Pritchard, we've kind of gone past the time for normal break.

MR. PRITCHARD:

Q. Yes, we have.

THE COMMISSIONER:

Q. Would you prefer to have the break now or do you want to finish your questioning before we do that? I'll leave that to your judgment.

MR. PRITCHARD:

Q. I have a few more questions, so perhaps this is a suitable time to take a break.

THE COMMISSIONER:

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

(RECESS)

THE COMMISSIONER:

Q. Please be seated. Mr. Pritchard.

MR. PRITCHARD:

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Q. Thank you, Commissioner. Minister, just before I asked you about the documents on the screen, just going back now, one last question about the meeting that you had with your officials and Mr. Tilley on the 15th, you indicated in your evidence that at some point you had come to understand from Mr. Abbott that the external reviews that had been done were reviews that were protected under the Evidence Act and I wasn't clear, was it your evidence that that was an issue that was discussed at the May 15th meeting or was that another occasion that Mr. Abbott had told you that?

MR. WISEMAN:

A. That would have come up at some other occasion. I don't recall that being the topic of conversation at--on the 15th.

MR. PRITCHARD:

Q. Would that have been before the 15th or after?

MR. WISEMAN:

A. Oh, after the 15th, yes.

MR. PRITCHARD:

Q. Okay, and Minister on the screen now is a document P-0291. It's an attachment, actually

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that I want to take you through but this e-mail, in any event, is from Robert Thompson to a series of individuals. You are not one of them, so I don't expect that you have seen this e-mail. It's really the subject matter of the e-mail I want to ask you about and this is a discussion about the different types of inquiries or investigations that could be conducted and this is a draft document, it says "Options to Conduct a Review". I'd just ask you to have a look at that for a moment. And you can, I can scroll that down for you, it goes on for a couple of pages about different options.

THE COMMISSIONER:

Q. Minister, you have your own mouse there if you wish to control it.

MR. PRITCHARD:

Q. Or I can -

MR. WISEMAN:

A. You can bring my attention to it.

MR. PRITCHARD:

Q. All right, so it talks about there are four options for consideration, two legislated, two non-legislated. It talks about legislated and

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it gives the Commission of Inquiry or a part-two inquiry and then further down it talks about non-legislative reviews and independent review and a consultant review. Now again, you were not a party to this particular e-mail, but Minister, was that a discussion of those sort of options? Were you aware of that type of discussion taking place?

MR. WISEMAN:

A. There was that discussion, yes, I don't recall seeing the document you're showing me, but that discussion, because I had indicated earlier that we had contemplated a review and we were exploring options, I think I made that reference that that surfaced probably as early as the 17th or so of May of last year, that that kind of a discussion evolved.

MR. PRITCHARD:

Q. All right and Minister, at the end of the day, obviously the decision was made to go with one of those particular options, a Commission of Inquiry.

MR. WISEMAN:

A. Yes.

MR. PRITCHARD:

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Q. What is your understanding about why that particular option was picked in contradistinction to these other options?

MR. WISEMAN:

A. It was decided that this kind of an inquiry that we're having here today would provide a greater insight, it would provide a greater power to the Commissioner to be able to, you know, subpoena the evidence, subpoena individuals to provide evidence, to provide documentation, to do a much more a thorough review on a broader range of issues and that's why we chose what we did.

MR. PRITCHARD:

Q. Okay, and that was Cabinet that made that decision, is that correct?

MR. WISEMAN:

A. Yes.

MR. PRITCHARD:

Q. And, Minister, you've been asked on several occasions now and at some length about the statements that you made about your understanding that all patients had been contacted, you were shown several briefing notes which indicate that all patients had

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been contacted and you were shown public statements that you had made that all patients had been contacted and you spoke about that. And, Minister, your belief that all patients had been contacted emanates from where?

MR. WISEMAN:

A. From Eastern Health, they were, you know, very clear through that period that they had made contact with all patients and I was--my public comments were base on that reassurance from Eastern Health. As I said before, you know, that was very--I was emphatic each time it was, in fact we had an exhibit shown this morning where in fact the communications' director was even suggesting that the--the physicians who were supposed to have made contact, that was even confirmed, so that level of reassurance kept coming to suggest that that contact had already been--always been made. So with that in mind, I made my comments.

MR. PRITCHARD:

Q. And, Minister, yesterday you were asked questions by one of my colleagues, Mr. Simmons, about your understanding about some

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of the difficulties that Eastern Health had in terms of the records coming from different hospitals and collected on different systems over different times and how far back some of those records dated. When you were told, and the word you used was "emphatic" that all patients had been contacted, were you made aware of those qualifications?

MR. WISEMAN:

A. There were no qualifications at all to those kinds of statements. The qualifications started to surface, and I just forget the date now, but it was shown to me yesterday, an e-mail that was around the first week or so of June where there was, Robert Thompson was, you know, indicating that they're now starting to qualify or provide some qualifiers to the document, the information that they were supplying, but prior to that there was no qualifier to the statements at all, they were pretty emphatic that everybody had been contacted.

MR. PRITCHARD:

Q. Now, earlier this morning, Minister, I think you said that you didn't like the use of the

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word "mislead" because of the motive that that imputed. Can you explain what you mean by that, please?

MR. WISEMAN:

A. Well, I mean, obviously I can--I'd make--I can acknowledge statements of fact if I knew something or didn't know something or information that was shared with me as being--and I repeated what was shared with me. The basis for why they shared that information with me or the--why they didn't share something else or why they didn't qualify the information they gave me, just I would have to speculate as to why that would be. And if that, one of the speculations is to speculate about whether or not someone mislead me or not, I'm not in a position to--that's caused me to speculate and I--but I can only speak to the facts as I understand them.

MR. PRITCHARD:

Q. Okay. So fair enough then, you don't--you're not suggesting you were mislead by Eastern Health. But whether it was inadvertence or whatever the reason, do you have an understanding now of why the information that

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you were given was not factually correct?

MR. WISEMAN:

A. I mean, I now have an understanding of the challenges that the Centre for Health Information is having on trying to reconcile the numbers and so I can understand now the challenges that they would have had in pulling together the information. But I can't understand why someone would tell me emphatically that something was, in fact, the case, without providing me with some qualifier if they, in fact, understood that there was some qualifiers needed to be provided to put the information in some kind of context.

MR. PRITCHARD:

Q. Okay. So once--I think you mentioned earlier there's an e-mail exchange and some discussion with Robert Thompson and there's an expression of uncertainty about the numbers that you're getting and the response to that uncertainty is to do what?

MR. WISEMAN:

A. Well, what we did was we, just so we could get a sense of, you know, how--where this information was coming from and how they were

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recording it, we had two officials from the Department of Health and Community Services visit Eastern Health to start looking at some of the documentation that was actually being used to supply information to the department. And as a result of those two officials going in and spending a little bit of time there looking at what was in place and what information had been documented and how it had been documented, they came out and said, you know, we don't have the ability to start to reconcile this and the information that we saw is too incomplete and the information that we saw would not give us the ability to be able to reconcile these numbers in any fashion, so it requires a much different, a much larger task. These individuals weren't people who were--you know, they have some, you know, sense of background in the department and in managing files and bring a certain expertise to play, but they're not experts in data management and they would have just reviewed documentation to see if it would have gleaned any--would have provided them with any kind of insight and gleaned some information from it.

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MR. PRITCHARD:

Q. Minister, we know that we've heard in evidence that, you know, these events are the genesis of the Newfoundland Centre for Health Information being tasked to produce this database and we heard from Mr. Simmons about Eastern Health's interest in that project, as well and we have now had the opportunity to view the fruits of some of that work. But as time has evolved and you have become aware of the difficulties that have lead to the necessity for this database what have you done, what, if anything, have you done or the department done to try and address those problems to see that this situation doesn't arise again?

MR. WISEMAN:

A. Well, one of the--the couple of things we've, back in February we made some announcements about some investments we want to make in information management, Eastern Health $2.1 million. We've also, from a policy perspective, insured that in future events such as this there's a very different process put in place, and I think I read in the record

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yesterday, you know, what was in that release that went out in February 22nd which talked about the, you know, designating a person to be--the point person to be responsible for it, putting data management people in place to insure that we had good data collection and an ability to be able to verify and audit the information that would come out of this kind of a process. I also went on to elaborate some of the other pieces that we've added to that since then in terms of the feedback loop back into the Department of Health and Community Services and issues around coordination if there's more than one authority involved. So in terms of an approach to managing an event like this, should it arise, we've started to address some of those issues through that process. On the broader issue and some of the issues around ER/PR, you know, the mandatory accreditation of laboratory services I think will help strengthen the, some of the quality control pieces that we've planned in our labs. And there's some other issues that we talked about with respect to, you know, looking at across

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our four authorities some of the things we're doing with respect to quality assurance and quality programs through a quality network that we'll put in place now to start doing a profile of what a current--is best practice from a quality perspective in our authorities.

MR. PRITCHARD:

Q. Okay. And could we have a look now at document P-0128, page 60, please, page 61, please? Minister, this is the announcement, I think, that you're referring to. And -

MR. WISEMAN:

A. Yes.

MR. PRITCHARD:

Q. At the bottom of the page, this page 2--sorry, just go back a page there. Here we go, this is the announcement here. And then we have the backgrounder?

MR. WISEMAN:

A. Um-hm.

MR. PRITCHARD:

Q. There's a couple of items in the backgrounder, so the first item is the 1.3 million. Can you--well, it says, "The Provincial Government is investing 2.7 million." Can you just explain

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what that is all about?
MR. WISEMAN:
A. That's the total investment that we've made in response to the issue to what we've learned from the ER/PR issue that we've been dealing with in the last, well, since May of last year. And it itemizes a variety of initiatives which is 1.3 for Eastern Health to consolidate clinical information systems. There's $500,000 to the other regional health authorities to conduct an information management capacity assessment. There's a $270,000 allocation for new data management personnel. It goes on to talk about the policy that I just talked about with respect to the, you know, how we handle adverse events such as this in the future. It goes on to talk about $175,000 investment for Eastern Health to implement a training and quality assurance--training and education in quality assurance activities in the IHC area of the lab. And this funding will be allowed to--or provided, rather, for pathologists and technologists to participate in relevant training programs each year. And it'll also

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allow for external reviewers to visit Eastern Health to review this laboratory, this area of the laboratory. And it also talks about a $100,000 investment that will be used to help start a process to get the mandatory accreditation started for the diagnostic services.
MR. PRITCHARD:
Q. Okay.
MR. WISEMAN:
A. So that's the kind of, the details surrounding that dollar figure that you just pointed out.
MR. PRITCHARD:
Q. Okay. Minister, I'd like now to show you an e-mail that is document P-0226. Minister, this is an e-mail that we saw the other day. I'll just go to the bottom to sort of take you up through it to give you some context here. First of all, the department's communications person, Tansy, she's forwarding on a note it says, "Please see attached ad developed by Eastern Health which they plan to put in Saturday's Telegram along with community newspapers next week. Their purpose is to advise the public that patients were informed

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of ER/PR testing throughout this process." And then one of the recipients of that e-mail, I believe, is Elizabeth Matthews. And she makes some editorial comments about the middle of the page, she says, "My only comment would be in the second paragraph," she has some editorial suggestions. And then that's forwarded on and someone else apparently agrees with Elizabeth Matthews' comments. Minister, is this normal for the Premier's office and Department of Health and Community Services to be so involved in editing an Eastern Health advertisement or news release?
MR. WISEMAN:
A. No, this would be, in fact, the department itself wouldn't normally be involved in editing any of that kind of stuff that would have come out of Eastern Health, so definitely the Premier's office would not normally be involved in this kind of editing process.
MR. PRITCHARD:
Q. Okay. So what reason would there be for this level of involvement in this particular instance?
MR. WISEMAN:

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A. I think the, you know, this speaks to the concern that government has around the, you know, what information was being communicated to the public at this time and making sure that, you know, whatever, you know, we've--what we're saying reflects what was known at that particular time. And so this, the ad that we've got here that's been in question is a reflection of what government understood to be the position of both Eastern Health at that particular point.
MR. PRITCHARD:
Q. Okay. Now, I want to ask a few questions about conversations that you may or may not have had with some people. Let me start by asking, since this matter, I guess, became emerged in the news for yourself on May 15th, have you had occasion to discuss it with the Premier and what would be the nature of those discussions?
MR. WISEMAN:
A. I mean, since last year, I mean, there's been, this has been an issue that's been very much in the public domain, an issue that we've talked about intensely within our Cabinet.

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And it's a conversation that I've with the Premier on any number of occasions in terms of, you know, the detail that we went through last year in May, since that time in terms of commentary about, you know, the progress we're making with the database that Robert is doing or some issues around communication that might be occurring and comments that I may be making with respect to the process. You know, there's been, we've had some conversations around some public comments that have been made around government's involvement with this. For example, very recently there was a, couple of weeks ago, week or so ago I had occasion where I was, you know, I had called a press conference to correct some statements that had been made with respect to, you know, the Premier's own knowledge and actions, you know, so him and I would have had a conversation about that very recently where we had to, you know, the leader of the opposition party was making statements that, you know, accused the Premier of withholding information that he personally had, those sort of statements. So him and I would have had a

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conversation around that, and therefore, you know, that followed, was followed by my, you know, making that kind of corrective statement in public. So we would have had, you know, a range of kind of conversations both from an information, you know, providing information as was the case last year in May to since that time periodic comments that we would have as a part of other discussions to give him some comment around, you know, what was happening with the work being done or any kind of public comments that were being made about the issue and what government might be doing or not doing about it.

MR. PRITCHARD:

Q. Okay. Minister, you were also questioned at some length yesterday about conversations that you might have had with Mr. Dawe in connection with the Canadian Cancer Society. And I just want to be clear on that point. You don't have any distinction recollection of having had a particular conversation or indeed not having had any particular conversation, you just don't remember?

MR. WISEMAN:

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A. No, my point is I just don't recall.

MR. PRITCHARD:

Q. You just don't recall, okay. And I think that you were shown a particular e-mail that you were sent by Darrell Hynes during the time that you were the parliamentary secretary for the Minister of Health and Community Services. And what I really wanted to ask you about was your experience as parliamentary secretary. Are you in a position to off any comment to how your experience a parliamentary secretary would compare with others, were you treated as the parliamentary secretary different than other parliamentary secretaries or was it typical?

MR. WISEMAN:

A. As I've said at the very beginning, the role of parliamentary secretary is not one that's necessary well defined in a position description where every single person who becomes a parliamentary secretary hears exactly what you do. You know, the role that you have is in support to the Minister and in support in his role as the Minister of the department, and so upon, you know, being

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appointed to that kind of position or working with the Minister one of the things you will do is, you know, develop a working relationship with that Minister, you come to an understanding of what support you might be able to provide, what your role might be. Sometimes as it was in my case was to take a lead role on behalf of government, pardon me, on a particular file and that would, you know, be your primary focus and then additional supports you might provide would be, you know, as a result of that relationship you would have with that Minister. So it's, you might find that some other parliamentary secretary might describe a different role and that will vary and as my role with each of the Ministers, there were slight variations in the three Ministers that I worked with during that period, as well, so that that would vary.

MR. PRITCHARD:

Q. And I think you mentioned yesterday, just moving along a bit now, that Robert Thompson in his capacity, he reports to Executive Council?

MR. WISEMAN:

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A. Yes, he's secretary to Cabinet.
MR. PRITCHARD:
Q. He doesn't report to the Department of Health and Community Services. And there was a question yesterday about if you had ever asked for copies of the external reviews and if Mr. Thompson had asked for external reviews. He never share that with you, did he, that he -
MR. WISEMAN:
A. He may very well have.
MR. PRITCHARD:
Q. Minister, one of the things you were asked about yesterday was the breadth of the Department of Health and Community Services. And I didn't get a clear understanding. Has the ambit of that department, its responsibilities and the areas that it covers, has that changed greatly over the years, can you offer comment on sort of how that has evolved, if indeed it has evolved?
MR. WISEMAN:
A. It's probably not been a whole lot of change. I mean, I speak to my own experience in the health system going back to 1985. Back at that point the Department of Health and

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Community Services was still responsible for the acute care sector of the province and acute care boards. It had a responsibility for the long-term care homes. There would have been the community support services would have been still the responsibility of the department, but they were, those services and programs were delivered directly by the department, they weren't delegated out to a regional health authority. So fundamentally, you know, within the regional health authorities their structures have change significantly and there's been consolidations, two or three versions of that. But fundamentally acute care services, long-term care services and community-based programmings have been a part of the Department of Health and Community Services, although it may be operationalized by different board structures, but fundamentally it's been the role of the department since my memory, going back to '85. Back 10 or 12 years ago there was some additional things that came a part of the department, which is Child Youth and Family Services and Early Learning and Child Care,

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that would have become a part of the department's responsibility 10 or 12 years ago. But fundamentally the level of activity may have increased, but the scope of the service and scope of the department hasn't changed for many, many years.
MR. PRITCHARD:
Q. Okay. I'm getting down to my last few questions, Minister. Just sort of looking back now over the last year since May 15th of '07, it's not a year yet, since that period of time and over the course of the year you have had occasion, I guess there have been three occasions, four including yesterday, where you have reported to the public on developments. And my question is why have you chosen to disclose in that manner as opposed to waiting and, you know, maybe giving a big report. In April--you've come out several times, made disclosures, you sometimes haven't had a complete picture but you've presented what you had. Why have you chosen that method of disclosure?
MR. WISEMAN:
A. Well, if we go back to comments I would have

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made last year in May and onward in terms of the need for, you know, full disclosure, and this is an issue that impacted a lot of people themselves, it's an issue of major interest and concern to the people of Newfoundland and Labrador and I believed it was important as we were doing some work--I'd indicated we'd launched the task force last year and as we moved forward with some of the work of that task force in trying to gain an understanding of, you know, who's been impacted here and trying to find out who had the information communicated to them. As I became aware of information, I believed it was important and the people of the province, the message I received loud and clear was that there was a desire to have that kind of information when I was aware of it. So what I've tried to do throughout that process, both in November, February and again in March and the other day to, as we became aware of information, to share it. There's a balance sometimes here because one of the things that each time we've come out with information, there's been subsequent questions that have followed and,

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you know, what other information might we get or there's some questions that are still unanswered, but it's an evolving process. So it was a judgment call to provide it in that fashion versus wait until at the end of it, maybe we could be here today summarizing everything we've gleaned since last year in July. But there was a judgment call to share that as we knew it and advise it as a piece of work in progress and if new information became available, we'd share it at that time. So it may look like it came out in bits and pieces, but by virtue of how the work was progressing and that's how we provided the updates.

MR. PRITCHARD:

Q. Minister, you've been good enough to answer my questions and many other questions over the last few days. Now I'd like to ask if there's anything that you would like to say?

MR. WISEMAN:

A. The last, I mean, hopefully over the last two and a half days or so, you know, some of my comments have been able to, you know, shed some light on at least what I've been involved with with this file since last year, May, and

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some of the involvement that, on behalf of government, and government has done in trying to, you know, respond to the issues in and around ER/PR. And but as we--and the Commission will go on for some time yet and there'll be lots of discussions around briefing notes, lots of discussions around numbers and phone calls and those sorts of things. I'll repeat something that I said some time ago in, it was probably back in February month, you know, behind all of these statistics and all of these numbers and all of this discussion around the flow of information, the people who gave testimony here in the first few days of this Inquiry are the important people here and their lives and their families and unfortunately those that are not with us because of their untimely death. And one of the things that as we've gone through this process, as I've gone through this process in the last eight or ten months, that's never been lost on me in as much as this is a, in some respects, a clinical review of a process, but one of the things that I've never lost sight of, this is

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about people. And we know that there's 1013 in particular, but there's many more than that because there are many families who have been impacted by this issue. And for the entire province today it's important that they understand what happened here and the lessons we learn from this exercise and that's why this Inquiry is a very important process. And it's critical that we have, you know, as we talk about this issue, glean from it as much as we possibly can so that we can improve on what we now do today. Because we have the, you know, the--I made some comments about confidence in our health system, but at the same time more importantly we've got, you know, the quality of life, the quality of health services that are provided to the residents of this province, you know, is something that's uppermost in our minds here. And anything that we can glean from this process to help inform us as a government, help inform our authorities to make that improvement, I think it's important and critical. And hopefully any comments I may have made might have in some small way

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contributed to that.

The issue of--the other point I want to-- and you asked me a question about it a moment ago and I want to repeat it again, because a question was posed of me and, in fact, Ms. Chaytor posed a question a couple of days ago and I answered it here but she gave me reason to reflect for quite some time after and I hadn't forgotten the question, when she talked about my public comments last year and what I might have said around the fact that everybody had been tested and whether or not that would have had an impact on someone inquiring about their current status. Anything that I shared in the public domain last year or I share in the public domain today or ever in my role as a Minister is based on the information that's made available to me. And there's a heavy reliance, as I've said in the past, for the information that comes to me. But at the same time the information that I shared last year and as much I said here the other day and I'm acknowledging again today, that the information that I did share last year that everybody else, everybody had been contacted,

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I now know today and knew recently, confirmed recently that that was not, in fact, the case. As I shared it last year, I shared it based on the best information that I had, based on information that had been provided to me in a very reassuring way. And I would never, ever, ever in my role as a Minister, in my role as a parliamentarian ever share information in the public domain that would have--would be misleading or inaccurate and to do it intentionally. And if, you know, the--in areas where it has a profound impact on the health of an individual or the health of a population or an impact on a large number of people, obviously this, you know, it's something that I would take quite seriously, my role as a Minister, and I would never, ever make comment or provide advice or information that would be misleading, that would have a detrimental impact on anybody in this province. So it was an important question she posed. It's prompted me to reflect since there. It was a powerful question. But I can say with honesty and sincerity that anything that I shared in the public domain last year,

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comments I made on behalf of government, based on information that was shared with me has been factual and I shared it as it was shared with me and I took on its face as being factual information because I had a trust and faith in its source. That's been shaken. I now know it was inaccurate.

And hopefully this process we're going through here now will make sure that what's been experiences by these 1013 people will never, ever have to be experienced by anyone else in this province ever again. This process can only lead to strengthen what it is we now do. I think all of us can take some valuable lessons from what we'll learn from this process. And as a government we've made some announcements thus far. In fact, I've added some things to my comments to Ms. Chaytor yesterday that I've learned, what I've learned from this process here as we've been talking, what I learned from her questions to me back in March. And if over the course of the follow coming weeks that new information surfaces that we can learn from and requires some action by government, then my commitment

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is to take that immediate action and to implement the changes that will be necessary to improve. And that's what this is, a learning process. If we can walk away from--and participate in this process and walk away from it as an exercise to open our eyes, to enlighten us, to give us some new insights that'll improve the health system, then I think the people of Newfoundland and Labrador will be better for that, and that's the intent of the Inquiry.

MR. PRITCHARD:

Q. Thank you, Minister. I don't have any further questions for you.

THE COMMISSIONER:

Q. Thank you, Mr. Pritchard. Ms. Chaytor, do you have anything arising?

CHAYTOR, Q.C.:

Q. I do have a few questions.

THE COMMISSIONER:

Q. Okay.

MR. ROSS WISEMAN, EXAMINATION BY SANDRA CHAYTOR, Q.C.:

CHAYTOR, Q.C.:

Q. Minister, we'll try and get you out of here as quickly as possible.

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MR. WISEMAN:

A. That's quite okay.

CHAYTOR, Q.C.:

Q. I'll start at the back and work forward. So the most recently question that I'd like to clarify with you concerns P-0128, page 62. This was the news release that Mr. Pritchard brought to your attention concerning the new investment in the information management.

MR. WISEMAN:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And my first question on this is the $270,000.00 will be allocated for new data management personnel.

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. Who are they, what data management personnel or what new personnel have been identified that weren't in place originally?

MR. WISEMAN:

A. I wouldn't be able to answer that question for you specifically because it's about a very specific question. I wouldn't be able to

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answer that.
CHAYTOR, Q.C.:
Q. So this is --
MR. WISEMAN:
A. We would allocate the funding and the authority would then pull together the skillsets that they would need to enhance what they already have in place. I wouldn't be able to tell you exactly what that would be.
CHAYTOR, Q.C.:
Q. So this would be Eastern Health would have indicated to government personnel that were required?
MR. WISEMAN:
A. Yeah.
CHAYTOR, Q.C.:
Q. Okay. If you come down under quality assurance and monitoring, "The provincial government has approved $175,000.00 per year for Eastern Health to implement education, training, quality assurance activities in IHC. In particular, this funding will allow for pathologists and technologists to participate in relevant training programs". I'm sorry, I think I missed the bullet. It's the one with

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the external reviewers. I'm sorry, yes, participate in relevant training programs each year and allow for external reviewers to visit the Eastern Health IHC laboratory to assess current practise against best practises elsewhere.
MR. WISEMAN:
A. Yes.
CHAYTOR, Q.C.:
Q. So this is an additional $175,000.00 per annum.
MR. WISEMAN:
A. Yes.
CHAYTOR, Q.C.:
Q. For Eastern Health to do this, and it involves education and quality assurance activities in IHC, and also to allow for external reviewers to visit.
MR. WISEMAN:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. To assess current practise against best practise elsewhere. Is there idea of external reviewers coming to visit the IHC laboratory, is that intended that that would go on each

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year or is that intended to be a one time allotment?
MR. WISEMAN:
A. This would -- this $175,000.00 is not a one time investment. This will be an annual investment that will be added to Eastern Health's current existing budget, and it would be intended that this would be an ongoing process.
CHAYTOR, Q.C.:
Q. So the external reviewers would come in each year?
MR. WISEMAN:
A. Well, the issue of the mechanics of how this would work -- because obviously you have a -- tied to this, there's the other piece around the accreditation process, which is the process that's currently being worked through in terms of identifying how that might be structured. So it was envisaged, though, that this would provide some resources to allow people to come in from outside to periodically look at the operation of Eastern Health, that area of the lab. I don't know if we zeroed on it close enough to say this will happen on an

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annual basis, or if it would be every six months. You know, that level of detail, I'm not sure we worked through that piece.
CHAYTOR, Q.C.:
Q. But it was certainly intended that it be more than just --
MR. WISEMAN:
A. One time thing.
CHAYTOR, Q.C.:
Q. 2007/2008.
MR. WISEMAN:
A. You're absolutely right, yes.
CHAYTOR, Q.C.:
Q. So it would be an ongoing periodic review?
MR. WISEMAN:
A. Yes.
CHAYTOR, Q.C.:
Q. And the external reviewers, who will determine who they will be? Will the government have any input into that?
MR. WISEMAN:
A. That would be part of the quality control piece that Eastern Health would do as part of their operations. I mean, right now as I understand it, they take some of their test

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results and send them out to different laboratories outside as part of their quality measure. That's a piece of their own quality initiative. This would be something that they would identify, someone who's able to come in to do a review for them. It's not something that we had envisaged having an approval mechanism by government to sign off on who might do that.

CHAYTOR, Q.C.:

Q. And currently does the government have anything in mind in terms of who might come in to do any kind of review of the laboratory? For example, has the government turned its mind to whether or not to have either or both of the external reviewers who were here originally to come back? Has that been considered?

MR. WISEMAN:

A. I think you might have heard yesterday in my testimony that I had had a recent discussion with my Deputy with respect to the notion of having -- I think the way I phrased it yesterday was I expressed an interest to my Deputy in having a discussion with Eastern

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Health around having someone come back and have a look at the success of the implementation of the recommendations made in the two external reviews previous, while at the same time looking at the progress made towards the implementation of the recommendations made in the quality review that was done, and I referenced a December, 2007, evaluation.

CHAYTOR, Q.C.:

Q. Yes, QMP-LS.

MR. WISEMAN:

A. And I expressed that interest just in recent days to my Deputy, and I think I answered that in evidence yesterday.

CHAYTOR, Q.C.:

Q. Yes.

MR. WISEMAN:

A. We have envisaged -- at least, I have envisaged that, and my Deputy and I have had that discussion. In all fairness, I don't think he's had time to have that discussion with Eastern Health.

CHAYTOR, Q.C.:

Q. Fair enough, but it is something that has been

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a subject of discussion?

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. And I'd just like to clarify something in Mr. Simmons questioning yesterday that came up regarding the recommendations and my line of questioning to you regarding the implementation of the recommendations.

MR. WISEMAN:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And if we could have, please, P-0277 at page six. Of course, this is the spreadsheet which is dated April 26th, 2007, and the one that was actually faxed to your Department the end of May, 2007, was almost a year earlier.

MR. WISEMAN:

A. Yeah, '06, yeah.

CHAYTOR, Q.C.:

Q. I think it was a June '06 document, yes. In asking questions of you yesterday, Mr. Simmons indicated that I had gone through with you and identified each recommendation that was indicated as being something other than

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completed, and then he said he would take you -- he wouldn't take you through them all, but he would point out a couple.

MR. WISEMAN:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. I just want to be clear. What I did in my line of questioning, and I was careful to do this, I did not take you to all the ones that were indicated to be ongoing because clearly some of them should be ongoing, including the two that Mr. Simmons pointed out to you; number five and number six, involving ongoing educational efforts. I did not, in fact, direct your attention to those. The recommendations that I brought your attention to were, in fact, recommendations that were not complete or were in some stage of progressing, but not yet complete, and they weren't ones that commonsense would dictate should be ongoing, so I just wanted to make sure in terms of your answering on that line of questioning that the ones that were, in fact, directed to your attention were not the ones of a nature you would expect to be

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ongoing, and in any event, I understood you to answer, for example, in number six, "Pathologist assistants hired to standardize grossing procedures", training that started, that you indicated some concern that the amount of time that would be taking to have it completed if, in fact, the person was hired two years before. Is that a fair --

MR. WISEMAN:

A. Well, I think the -- I forget the exact question, but something to the effect that training would be something that was ongoing, and I had indicated that if someone was hired a couple of years ago and they're still trying to be trained into the position, I'd be a little bit concerned if it's still ongoing.

CHAYTOR, Q.C.:

Q. Yes, okay. In fairness, when the document of '06 was brought to your attention at the end of May, 2007, seeing in a document dated '06 that there were still items not completed, I take it that wasn't -- didn't raise any alarm bells to you. Even though you've been told all the recommendations were implemented, you're looking at a document that was almost a

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year old.

MR. WISEMAN:

A. That's right, and the focus -- I think I might have said this to you as well, the focus of discussion when I got that document was the nature of the recommendations because -- you're right, this was a year old, so any status report that would have been included as part of that would have been a year old.

CHAYTOR, Q.C.:

Q. Mr. Wiseman, if this document, in fact, had been provided to you, would this have caused you any concern in terms of the status of the implementation of the recommendations?

MR. WISEMAN:

A. I mean, obviously anything that wasn't incomplete, I would have had a -- you know, this is dated April 26th, and I would have having this discussion in May, a month later, so if something was incomplete, then obviously it would have prompted a different kind of discussion.

CHAYTOR, Q.C.:

Q. I would like to clarify what exactly you understood from Mr. Abbott regarding his

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knowledge level of the information that was released in December, 2006, by Eastern Health. I understood in my questioning that you said that you learned at some point in time that Mr. Abbott was aware that all the information had not been disclosed, and did I understand you today to say that, however, when Mr. Abbott became aware of that, you're uncertain because you didn't ask the question?

MR. WISEMAN:

A. I think what I -- I've said that I didn't ask Mr. Abbott the question. I think what I said to you -- I understood what I said to you was that your question was when I spoke to Mr. Abbott about it, he appeared to have some knowledge of it.

CHAYTOR, Q.C.:

Q. Yes, he didn't seem surprised.

MR. WISEMAN:

A. But at the same time, having knowledge of it was my answer to you. So when he got it, how he got it, I didn't ask him when he became aware of it, which was a separate question.

CHAYTOR, Q.C.:

Q. Yes, so why -- why didn't you ask Mr. Abbott

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how long have we realized this?

MR. WISEMAN:

A. I don't recall. I mean, I don't know why I didn't ask him. I just don't recall asking him.

CHAYTOR, Q.C.:

Q. Because when we think about the context in which you would have been having that discussion with Mr. Abbott, the whole point being that you're none too pleased that you've learned this information didn't come out, but you didn't think to say, well, were you aware of that, when did we become aware of that?

MR. WISEMAN:

A. I didn't ask the question.

CHAYTOR, Q.C.:

Q. You didn't ask him that, and you can't tell us why?

MR. WISEMAN:

A. No.

CHAYTOR, Q.C.:

Q. And when you spoke publicly of Eastern Health's failure or your perceived failure for them to have disclosed the information, and you were somewhat critical of Eastern Health

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on that, you did not know the state of your own department's knowledge on that issue, or when your own department may have had the information and could have also released it?

MR. WISEMAN:

A. Yeah, my -- I suppose, the -- it's a fair question you're posing. My comment publicly was -- whether the department knew or didn't know, my observation at that particular point and my comment about what should have been released in December wouldn't have changed because the information should have been released in December.

CHAYTOR, Q.C.:

Q. Okay. If I can ask then about the issue of quality assurance. In answering Mr. Pritchard's questions this morning, you differentiated between what you saw to be the department's responsibility, quality assurance within the Regional Health Authorities, and that of the authorities themselves. Could you just explain what, what is it that you understand to be the role of the Minister and the department in setting quality assurance and standards of practise?

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MR. WISEMAN:

A. Quality assurance programs are the implementation of quality assurance programs and the standards of practise, you know, for the particular service or particular clinical service is the role and responsibility of the Regional Health Authority. As a department, we would want to ensure that quality assurance programs are in place. The nature of the individual standards and the writing of those standards, and the monitoring process associated with that quality control program, that will be the responsibility of the Regional Health Authority.

CHAYTOR, Q.C.:

Q. So the department would have an overseeing role to ensure that, in fact, the quality assurance is in place?

MR. WISEMAN:

A. That's -- they wouldn't carry out an inspection or any kind of an audit to ensure that it was in place for each aspect of the operation. You know, we -- the role of the Regional Health Authorities in the delivering of the programs is to build in the quality

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control processes that are necessary to ensure quality exists, and to make improvements where necessary. The monitoring of that is an internal process within Eastern Health, and, you know, we as a department wouldn't get progress reports on their quality assurance program, we wouldn't get monthly, quarterly, or annual reports about the evaluations that have been done in any one service area, that as a department, we would want to ensure that quality assurance programs are in place, and one of the things -- one of the tools that we would use -- I'll give you some sense of level, our four Regional Health Authorities are approved by the Canadian Council on Health Service accreditation. In order for them to have that accreditation standard, one of the critical pieces that -- my experience and my knowledge of that council, one of the critical things that they're looking for is the quality control programs in an organization. So if an organization didn't have quality control programs in existence, then they would not become accredited. So the fact that each of our authorities have gone through an

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accreditation review and are now accredited, you know, would tell me that there is quality control programs in place. It doesn't tell me what has come out of each of the reports that have been done, but it does tell me that an independent body has come in and determined that there is a quality control program in existence in Eastern Health and in the other three authorities. So it's that kind of level that as a Minister you have an understanding that quality assurance programs are in place. Drilling down to a greater level of detail around what might come out of the monthly audits or quarterly audits is not something that I necessarily would have. For example, in the House of Assembly the other day, there was a question from the NDP Party wondering about the reports associated and the results associated with the quality controls that have been implemented in the ER/PR area, these tests that have been sent out to other laboratories for validation. She inquired about that. I understood it existed, but I wasn't in a position to give her an answer. I gave her an undertaking that I would provide

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it to her, that Eastern Health would provide it to the department and we will in turn provide it. So ordinarily I wouldn't have that in my possession, nor would the department have it in their possession.

CHAYTOR, Q.C.:

Q. Okay. I asked you yesterday about the Medical Consultant position which has recently been advertised for the department, and that's Dr. Hunt's position.

MR. WISEMAN:

A. Yeah.

CHAYTOR, Q.C.:

Q. So that's a position that was already within the department?

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. And in the ad for that position, it indicates that "The professional position will require working collaboratively with other government departments, the regional health authorities. The successful candidate will be expected to advise the department and work with the regional health authorities on medical issues

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related to quality assurance, risk management, clinical practise guidelines, best practise, and safety". So that's Dr. Hunt's position?

MR. WISEMAN:

A. That's right.

CHAYTOR, Q.C.:

Q. And that has been his position for some time?

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. So what role does he play in terms of liaison with the regional health authorities on the issue of quality assurance, best practise, patient safety?

MR. WISEMAN:

A. It wouldn't be a hands-on day to day working arrangement. It would be -- his relationship would be to ensure that -- his relationship would be such that he would ensure that those programs are in place. In terms of the construct of them, the content of them, and the reports coming out of those programs, he wouldn't necessarily get.

CHAYTOR, Q.C.:

Q. But he would liaise with the appropriate

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personnel within the authorities to determine what, in fact, they have in place and --

MR. WISEMAN:

A. His liaison would be with the -- his contact would be with the Vice President of Medical Services.

CHAYTOR, Q.C.:

Q. Okay. So in terms of any issues of quality assurance, risk management, best practises and patient safety that would have been ongoing over the past few years with the regional health authorities, you would expect that Dr. Hunt would be apprised or familiar with any of those issues?

MR. WISEMAN:

A. Well, my expectation would be he would be aware that they existed and that they had them in place. I wouldn't have expected Dr. Hunt to have detail of the quality reports that would have been coming out of them. I would have expected him to have some understanding that each of the authorities did have quality control programs in place, they were dealing with issues such as risk management, infection control type of -- although infection control

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is not his area, but as a department, we'd have that kind of knowledge that those programs were in existence and that they were well developed by the authorities and that they had been functioning and actively reporting up through their Board structure.

CHAYTOR, Q.C.:

Q. Okay, thank you. I just want to clarify on the briefing notes -- your briefing book, and when you reviewed your briefing book in coming into the Department because I understand what you're saying today is that you would have reviewed it to determine basically critical issues or issues that were ongoing and needed your attention in a timely manner. Is that fair?

MR. WISEMAN:

A. I would have had a cursory review of it and pulled out those things that needed some immediate action, yeah.

CHAYTOR, Q.C.:

Q. And when did you give your briefing book that review, how soon after becoming Minister on January 19th, 2007?

MR. WISEMAN:

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A. It would have been -- it wasn't within a matter of days, but within a short period of time after.

CHAYTOR, Q.C.:

Q. So was it within the first couple of weeks, the first month?

MR. WISEMAN:

A. Yeah, within that first two or three weeks for sure.

CHAYTOR, Q.C.:

Q. Okay. So according to what we have, the documentation that we have, the briefing note on ER/PR that you would have reviewed during your cursory review in the first couple of weeks, would have been dated December 12th, 2006, because there's no further briefing note until March 9th, 2007. So you would have done your review before March 9th, 2007?

MR. WISEMAN:

A. I wouldn't have necessarily read the briefing note, but I would have reviewed the briefing book to look at the issues that were there. I wouldn't have read -- I think I've indicated very clearly I didn't read the book from cover to cover.

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CHAYTOR, Q.C.:

Q. I understand.

MR. WISEMAN:

A. I indicated I would have reviewed the book to see what was in the book to determine those issues that required some immediate action. There's a table of content in the front of the book that would outline the nature of the issues that are being dealt with in the book at that time. So, my review of the book would have been to ensure that if there's current issues that we need to deal with, we dealt with them. But I wouldn't have read--and I think I indicated that you--that I wouldn't have read the briefing book from cover to cover.

CHAYTOR, Q.C.:

Q. That's fine. I understood you to say that last day and that's why I wanted some clarity around this issue now today. And I'm not going to take you, in detail, through this particular briefing note as I have with, so not to worry. But my question being, and if this--well, let me think first--if there's a table of contents, does the table of contents

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give you any kind of status? Does it indicate the status on the issue?

MR. WISEMAN:

A. Would have just been the issue, would have been probably ER/PR--I don't know what the description would have been, but it might be as brief as that. It might have been short, you know, would have been, you know, probably four or five words or something. It might have been issues of wait times in diagnostic services. It might be, you know, Child, Youth and Family Services social workers. It might--so there might be some brief description that would give me some indication of what the issue was.

CHAYTOR, Q.C.:

Q. Okay.

MR. WISEMAN:

A. And so that way it would give me some sense of whether or not it was something we needed to deal with now or something that was, you know, that had--that I needed to turn my attention to fairly quickly and a cursory scan of some of the notes and that would have been the extent of which that happened.

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CHAYTOR, Q.C.:

Q. Okay. And if just look at--even if at giving a cursory scan, the issue identified on the note is "a mistake in testing may have led to incorrect treatment for 117 women in this province suffering from breast cancer. Not receiving proper treatment could mean a life an death issue for women going through cancer". Then the anticipated questions followed right after that and asked first, as the Minister of Health and Community Services, have you lost confidence in the physicians and managers at Eastern Health? Secondly, why does it take more than a year for Eastern Health to go public and release the results? Third, what is the rate of error? And fourth, when will breast cancer screening test resume at the laboratory in St. John's? And under "key messages" it indicates that Eastern Health expects to begin testing of new patients in St. John's in the new year.

So, even in giving it a cursory review, what is it that led you to believe that the issue had been dealt with?

MR. WISEMAN:

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A. I didn't read the note.
CHAYTOR, Q.C.:
Q. You didn't read it.
MR. WISEMAN:
A. I had said that--the ER/PR, because I think what I had said to you earlier is that I had reviewed my briefing note to those things that were topical, something that needed immediate action, those things that had been already, in my view, you know, wasn't something that was immediate, something that I had been aware had been dealt with previously and I didn't need to have an immediate decision on. I would have moved on and dealt with other issues.
CHAYTOR, Q.C.:
Q. And I guess that's my question then.
MR. WISEMAN:
A. I think I indicated to you the first time that I had turned my head to this issue was in the middle of May.
CHAYTOR, Q.C.:
Q. Yes, and that's what I had understood, but then today I understood in questioning from Mr. Pritchard that somehow you had reviewed -
MR. WISEMAN:

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A. No, no -
CHAYTOR, Q.C.:
Q. How did you form the impression it had been previously dealt with? Who told you that?
MR. WISEMAN:
A. I mean the issue--because I had said to you in the past, you asked me my knowledge of it before becoming minister and I said it was an issue that had been in the public domain. So, the notion around the public release of information by Eastern Health, they released--the information that became public in the fall of 2005, you know, I had indicated to you before that this is information that was in the public domain and that was the extent of my knowledge. There was nothing that my officials brought to my attention that needed some immediate action. I looked at the note, this is the ER/PR issue that's been dealt with by, you know, that surfaced in the last year or two, my previous colleagues had been dealing with it, nothing that my officials had said that we needed immediate action on and so I moved onto the next issue and dealt with them as they needed action.

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CHAYTOR, Q.C.:
Q. So, your understanding that it was an issue that had been dealt with was based on the fact that there was nothing in the public domain at this point on it and your officials didn't bring the issue to your attention.
MR. WISEMAN:
A. The issue, when I say the issue resolved, been dealt with, I wasn't implying that there was nothing further to ever be done on the file. But what I'm saying is in the context of requiring my immediate attention, you know. And I think I had indicated to you that at that particular point in time there were two or three other issues that there, two in particular, that required some immediate action and that's what I turned my head to. This one didn't require any immediate response by me at that particular point, and so I moved onto the issues that need immediate attention.
CHAYTOR, Q.C.:
Q. Yes, and the fact that the ER/PR testing would resume in early new year, that wasn't brought to your attention?
MR. WISEMAN:

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A. No, I wasn't aware of that.
CHAYTOR, Q.C.:
Q. Okay. If I could have 0293, please. This was the excerpt from the annual report of Eastern Health that was referred to by Mr. Pritchard. And my only question for you on this is this is what would be provided to the department pursuant to the transparency and accountability legislation. This is the annual report.
MR. WISEMAN:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. So, it's the same documentation that is given to the public? It's not a separate document?
MR. WISEMAN:
A. No, no, this would be the public -
CHAYTOR, Q.C.:
Q. This is the public document?
MR. WISEMAN:
A. Yes.
CHAYTOR, Q.C.:
Q. So, the department doesn't get anything more or less than what is given to the public?
MR. WISEMAN:

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A. This is the annual report, yes.
CHAYTOR, Q.C.:
Q. This is it? Okay.
MR. WISEMAN:
A. The department gets it--I think there's a document outlines its action plan or the strategy for the coming three year period. I think there's a three year period that ran from '05 to about now. And this other one being developed now runs from '08 to '11 or something.
CHAYTOR, Q.C.:
Q. Okay, 0294, I believe. These are the new exhibits this morning. Yes, this is the regulation which I brought to your attention the last couple of days and Mr. Pritchard reviewed with you this morning, the regulation pursuant to the Executive Council legislation.
MR. WISEMAN:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And in asking my questions of you, under four, the powers and duties, and I pointed out A,B and C. Do you recall I also did bring to your attention what has been referred today as a

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caveat. I did bring to your attention the final sentence, "which are not, or insofar as they are not the responsibility of another minister, agency, body corporation, board, organization or person". And I asked you whether or not you understood what that might mean or whether you had taken any advice on that issue. I take it since I asked you the question, you have had an opportunity to turn your mind to it?
MR. WISEMAN:
A. You raised this piece of legislation the other day because, like, you asked me about my--it was a general question around what I understood my role and responsibility and how that was defined. Because I think I had indicated I hadn't seen this -
CHAYTOR, Q.C.:
Q. You hadn't seen it, yes.
MR. WISEMAN:
A. - legislations before. So, it's obviously when I--when you asked me, I hadn't seen it and so I needed to find out it.
CHAYTOR, Q.C.:
Q. Yes, okay, all right. And so now what you're

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telling us--your understanding is that insofar as anything with respect to the preservation and promotion of health, the prevention and control of disease, the administration of hospitals, insofar as any of that has been delegated to the Regional Health Authorities, it is not longer within the powers and functions of the minister?
MR. WISEMAN:
A. I don't know if I'd describe it that extreme. I think what's happened here is, what I understand here is that government now has, through the Regional Health Authorities legislation, you know, provided a response or created four Regional Health Authorities to give them the responsibility to deliver the services to respond to those issues within our province. So, the delivery of the programs and services that deals with the adoption of children, the programs and services that deal with child care services; the authority to deliver those programs rests with the Regional Health Authorities and how they deliver those programs and the human resources and the people are that are use to actually provide

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the direct service are the responsibility of the health authorities.
As a minister, ultimately, on behalf of government, you're still ultimately responsible. But the day-to-day operational and the running of those services and the level of detail that the Minister gets involved with is very different than if the Minister was the CEO running it.
CHAYTOR, Q.C.:
Q. Okay. So, ultimately the responsibility rests with the minister, but day-to-day implementation or operationalization of those--I just made up a word--of those duties is done by bodies to whom you have delegated that -
MR. WISEMAN:
A. That's right.
CHAYTOR, Q.C.:
Q. Okay. If I can have 0295, please? And this is the other legislation that both myself and Mr. Pritchard just referred to again. And the section that Mr.--or one of the sections that Mr. Pritchard brought your attention is Section 7. "An authority is a corporation

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without share capital for the purpose of Part 21 of the Corporations Act". And in answering, I believe, Mr. Pritchard's question on that, you indicated that makes the authorities separate, legal entities and that's the purpose of incorporation. Is that also for purposes of liability?

MR. WISEMAN:

A. I don't know what the--the issue around liability--I'm not sure what the connection is between the authorities and government; that's a legal question I've never asked.

CHAYTOR, Q.C.:

Q. Okay, and if we could have, please, P-0206, page eight, and this -- I only bring this to your attention in that same context about the understanding of the authorities being separate legal entities. This is a series of e-mails between your -- I should go back to the beginning for you, sorry. The first one begins, I believe, here from Tansy Mundon, your Director of Communications, and she sends this to George Tilley, Susan Bonnell, Elizabeth Matthews, Josephine Cheeseman, John Abbott, Moira Hennessey, yourself, Ross

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Wiseman, Sharon Vokey, your EA, and she's sending this on May 18th, 2007, and it's a copy -- the subject is, "Eastern Health apologize for withholding cancer details", and it's an excerpt from CBC News on that date, May 18th, 2007. You will see that there's reference -- there's reference here to Eastern Health -- sorry, right here, "Until now, however, Eastern Health, which operates hospitals and clinics at arms length from the Newfoundland and Labrador Government, had indicated that the test error rate was as low as 10 percent". Then your e-mail back to Tansy, the same date at 6:40 p.m, you write, "Note the reference to arms length", and she responds, "I know", and asks you how both interviews went. Mr. Wiseman, what is this referring to and why are you noting the reference to arms length?

MR. WISEMAN:

A. I don't know why I've referenced it here, but the issue of arms length, Eastern Health, as the other three authorities, are operated -- they're separate corporate entities and they do operate at arms length from government, but

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I had also said to your earlier that government ultimately is responsible. Now by definition, whether that means it's completely at arms length, that's a legal question I don't know the answer to.

CHAYTOR, Q.C.:

Q. And was there any particular reason why in this article out of everything that's written there, that's the point that you were emphasizing or that caught your attention?

MR. WISEMAN:

A. No, nothing that rings a bell with me, no.

CHAYTOR, Q.C.:

Q. My final question out of -- final question out of what has been raised by others, I do have one other question after that that I forgot to ask, so I will be asking the Commissioner if I could also ask that question, but my final question in terms of what's been raised by others concerns P-0439, and this was a document, I believe, Ms. Newbury brought to your attention. This is the e-mail exchange from Heather Predham that was brought to your attention a little while ago, and, of course, this is May 16th, 2007. So this is the same

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date, May 15th, you had been given a briefing by George Tilley and others, and perhaps Heather Predham, there is some indication maybe, but I guess we'll wait and see, but this is certainly the 24 hour period in which you are really delving into this issue and bringing yourself up to speed, and this is where it refers to the fact that a lady had called, and I gather from what you said in response to questioning around this, and again then in answers to questions from Mr. Pritchard, that when you reflect on the date and particularly bullet number four where it's indicating that a lady had called and was told she was going to be retested, but hadn't heard anything following, that Eastern Health was aware at least at that date that there were issues surrounding whether or not all patients had been fully contacted?

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. And knowing what you know now in terms of Eastern Health -- the state of Eastern Health's documentation that has been

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ascertained by people working on the database, for example, and the fact that, I think in your words, Robert indicated to you that it was all over the place --

MR. WISEMAN:

A. Yes.

CHAYTOR, Q.C.:

Q. Wouldn't you expect Eastern Health to have been aware of the state of their documentation and recordkeeping around this issue?

MR. WISEMAN:

A. I would have been expecting that, yes.

CHAYTOR, Q.C.:

Q. Can you reconcile what is in this e-mail of May 16th, 2007, with the adamancy with which Eastern Health told you all patients were contacted?

MR. WISEMAN:

A. I can't reconcile it at all, actually. This is the first time -- as I said earlier, the first time I've seen this e-mail, and as I read it here now today, I had -- I mean, obviously that's a very obvious question, how does this reconcile with the adamant statements that they, in fact, all were

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contacted. Later in questioning this morning as well, you know, there was another exhibit displayed where Eastern Health officials were confirming that, taking it one step further, not only have we made contact, but those people who have been contacted by physicians, we've in fact confirmed that that was done as well. So these statements don't reconcile with what I'm reading here at all.

CHAYTOR, Q.C.:

Q. Actually there are -- if I may, Commissioner, two other questions?

THE COMMISSIONER:

Q. Are they both arising or are they --

CHAYTOR, Q.C.:

Q. No --

THE COMMISSIONER:

Q. Just one of them not arising?

CHAYTOR, Q.C.:

Q. One of them --

THE COMMISSIONER:

Q. Find out what they are.

CHAYTOR, Q.C.:

Q. One of them I had intended to ask yesterday, and both of these are not necessarily arising.

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One is a follow up question to something that I asked yesterday, but I don't know that I explored it further.

THE COMMISSIONER:

Q. Let's find out what you want to ask.

CHAYTOR, Q.C.:

Q. Okay. The first question is whether or not communications within the Department of Health itself, the Department of Health, and communication, whether or not any communication issues that have been identified through this process, whether or not any measures have been taken to try and rectify any communications issues within the department internally have been addressed?

THE COMMISSIONER:

Q. So you're asking the Minister whether or not as a result of this issue, there has been any change --

CHAYTOR, Q.C.:

Q. Within the department in terms of --

THE COMMISSIONER:

Q. Within the department's method of communication?

CHAYTOR, Q.C.:

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Q. Own internal communication processes.

THE COMMISSIONER:

Q. Yes, you can ask that question. Minister.

MR. WISEMAN:

A. Not that I can identify that arise out of the ER/PR issue.

CHAYTOR, Q.C.:

Q. Is there any intention to do that?

MR. WISEMAN:

A. I mean, obviously the, you know, the -- I haven't turned my head to examining the role of the Department of Communications in this piece within the department, and I haven't looked at the internal communications that existed in and around the information that was flowing to me. The haunting question, and you've raised it several times in your discussion around the briefing notes, is our ability to provide or to have a heavy reliance, 100 percent reliance on the accuracy of the data that comes to us that are shared in briefing notes, and how we might be able to reconcile that. It's an interesting question you raise, one that we hadn't turned out heads to at this point, but it's a point that needs

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some consideration so that if we're relying on information that comes in the briefing notes, if I'm going to speak to it, then having some comfort that it comes from a valid source and is verifiable, that's a piece that I -- clearly you've highlighted it in this discussion for me, and that I really need to turn my head to, but up to this particular point I haven't turned my head to an evaluation of the internal communication within the department.

CHAYTOR, Q.C.:

Q. Okay, and even the communication between Ministers as one is leaving or being reassigned and, you know, even at that level, the communication of the continuity of knowledge from one Minister to another.

MR. WISEMAN:

A. Yeah.

CHAYTOR, Q.C.:

Q. Okay, and the other question which I did plan to ask yesterday, and if I may, it concerns mortality rates for breast cancer in this province. If I may ask the Minister his knowledge of that.

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THE COMMISSIONER:

Q. Yes. That's been in the news recently.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Is the mortality rate for breast cancer patients higher in this province than in the other Atlantic provinces or the nation?

MR. WISEMAN:

A. I understand that they're slightly higher, but I can't tell you to what degree.

CHAYTOR, Q.C.:

Q. Has the government sought any expert opinion or arranged any research to determine why that would be the case?

MR. WISEMAN:

A. Not yet.

CHAYTOR, Q.C.:

Q. Is there an intention to do so?

MR. WISEMAN:

A. What would happen with that report as it just recently would release, that would be resting with one of the ADMs right now that would do kind of an analysis, and that would be used then for a briefing with me and with the executive members of the department, with a

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view of looking at, you know, any actions that might be necessary. One of the things that I -- - you know, as a part of that process, there is a piece of work that's ongoing as we speak that involves a variety of stakeholders that involves developing a cancer strategy for the province. In fact, I've had a recent discussion with the ADM who is taking the lead on that in our department about needing to actually start moving and rolling that strategy out, and she's indicated that she wants to -- there's a few things she needs to get concluded first and then we'll be able to move forward with it, but in the ordinary course of events what will happen now is that any information we glean from an analysis of a document like recently released, we would want to make sure that it's reflected in what we will roll out as a strategy to deal with cancer in this province.

CHAYTOR, Q.C.:

Q. Thank you, and those are all my questions.

THE COMMISSIONER:

Q. Mr. Minister, are you able to comment on whether or not this is new news? I had

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thought that that was known before. Do you know whether it was or not, that is that the mortality rate from cancer in this province was higher in respect of breast cancer and maybe certain other kinds?

MR. WISEMAN:

A. Yeah, I think the -- there was a report last year that commented on the incidents of cancer, various forms of cancer in this province relative to other jurisdictions, and there was also a -- it also talked about mortality. So the issue around the mortality rates being higher in this province than in other jurisdictions, that was information that would have been -- this is not the first time that's surfaced, is probably a better way to phrase it. That's been obviously -- not obviously, but it's been announced and released in previous reports such as this. So this report that I understand that was just recently referenced is a more recent -- updated that same kind of profiling. As I understood it, it's part of an ongoing assessment that's being done of cancer in the country. So it's tracking the same

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information over a longer period of time.

THE COMMISSIONER:

Q. Thank you. Mr. Wiseman, as you yourself noted, this is a long process and I'm afraid that we've spent a fair amount of our time with you. I do very much appreciate your coming. It's important that I get perspectives from a number of the persons who have knowledge of this situation, including you. So thank you very much for being here.

MR. WISEMAN:

A. Thank you for the opportunity. Hopefully, something I've shared will be of some benefit to the work that you do, and I look forward to receiving your report when it's concluded. As I've said, government has made a commitment to follow through with your recommendations.

THE COMMISSIONER:

Q. Thank you. Given the hour, it doesn't seem that it's much point in swearing in a new witness now.

COFFEY, Q.C.:

Q. Mr. Tilley will be here this afternoon.

THE COMMISSIONER:

Q. Okay. Well, why don't we adjourn then until

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two o'clock.

(BREAK FOR LUNCH)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Thank you, Commissioner. The next witness is George Tilley. Good afternoon, Mr. Tilley. Registrar, please?

MR. GEORGE TILLEY, SWORN, EXAMINATION-IN-CHIEF BY BERNARD COFFEY, Q.C.

REGISTRAR:

Q. And would you please state and spell your complete name for the Commission?

MR. TILLEY:

A. It's George Tilley, G-E-O-R-G-E, T-I-L-L-E-Y.

REGISTRAR:

Q. Thank you.

COFFEY, Q.C.:

Q. Mr. Tilley, before we begin, Commissioner, before I get beyond having asked you your name, Commissioner, there are certain exhibits that I'm going to ask they be entered. They are the following, okay, and Madam Registrar, if you will.

THE COMMISSIONER:

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Q. When you say following that way, I feel that there's certain gaps, is there?

COFFEY, Q.C.:

Q. Yes.

THE COMMISSIONER:

Q. All right.

COFFEY, Q.C.:

Q. 0315 through 0369 inclusive; 0371 through 0374 inclusive; 0376 to 0393 inclusive; 0395 to 0464 inclusive; 0466 to 0480 inclusive; and 0483; and 0484.

THE COMMISSIONER:

Q. All right. I understand you are seeking to have admitted Exhibits P, they're all P exhibits, correct?

COFFEY, Q.C.:

Q. Yes, they are, Commissioner.

THE COMMISSIONER:

Q. P-0315 to 0369; 0371 to 0374; 0376 to 0393; 0395 to 0464; 0466 to 0480; 0483; and 0484?

COFFEY, Q.C.:

Q. Yes, Commissioner.

THE COMMISSIONER:

Q. Entered.

EXHIBITS P-0315 THROUGH P-0369 ENTERED INTO EVIDENCE.

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EXHIBITS P-0371 THROUGH P-0374 ENTERED INTO EVIDENCE.

EXHIBITS P-0376 THROUGH P-0393 ENTERED INTO EVIDENCE.

EXHIBITS P-0395 THROUGH P-0464 ENTERED INTO EVIDENCE.

EXHIBITS P-0466 THROUGH P-0480 ENTERED INTO EVIDENCE.

EXHIBITS P-0483 THROUGH P-0484 ENTERED INTO EVIDENCE.

COFFEY, Q.C.:

Q. Mr. Tilley, first of all I'm, in effect, going to have you introduce yourself to the Commissioner. I'm going to ask you perhaps if it is of some assistance, your curriculum vitae has been entered as Exhibit 0315, P-0315. And if we could bring that up, please, Registrar. And as well, Mr. Tilley, there is a mouse there and if you want, in terms of that, at times you want to scroll down through the page in terms of your own -

MR. TILLEY:

A. Thank you.

COFFEY, Q.C.:

Q. You're able to do that. And again, I just direct your attention to this is there, I'm going to ask you, please, to tell the Commissioner, give us an overview of your educational and work background?

MR. TILLEY:

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A. Okay. Well, from an educational perspective I have been trained at Memorial University where I received both my baccalaureate degree in business and my master's in business administration. Also, I have attained a national certification as a certified health executive with a body that is involved with the credentialing for health executives and that's the Canadian College of Health Service Executives. And of course, throughout my career I've attended quite a number of relatively short-term course work. From my employment perspective, I started off my career post university graduation with the Provincial Government as a recruitment officer with the Public Service Commission. Within a year or two I made my leap into a related health care organization, and that was the Newfoundland and Labrador Health Boards Association. That position was as a labour relations officer and at that time it was to support the hospitals and nursing homes throughout the province in matters dealing with collective agreements, employee relations issue, so it was as an advisor. Shortly

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thereafter in the early '80s, probably around 1983 I moved directly into one of the facilities in St. John's and that was the Waterford Hospital--sorry, 1982 into the Waterford Hospital where I moved into a position that was first called assistant administrator but it had evolved during the time in terms of changing of the title. And it was predominantly to support that organization in terms of the labour relations issues and some opportunity to get into some other departments that were relatively small but began to give me an appreciation for some of the challenges outside of the direct human resource and labour relations area. Then in the late '80s I made a lateral move to the Janeway Child Health Centre and I took on greater responsibility at that point in time for issues that went beyond the human resource side and actually got into some of the non-clinical areas as a senior manager overseeing those areas. And while I was at the Janeway I moved from assistant executive director to associate executive director and then in the fall of 1992 moved into the executive director

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position. And I remained in that position until a decision was made to restructure the organization of health services in this province and the Janeway was folded into what became known as the Health Care Corporation of St. John's.

COFFEY, Q.C.:

Q. Okay. Just before you advance, if you could, executive director, as a practical matter what did that mean?

MR. TILLEY:

A. There were various terms used in and around that time. Administrator would have been an older term, CEO would be probably a newer term. So in that capacity it would be oversight of the activities of the entire organization and being the person that would report to the board of directors that would be a voluntary group of individuals appointed by the ministry.

COFFEY, Q.C.:

Q. And as executive director you were responsible for what?

MR. TILLEY:

A. Well, I would be responsible for the, all the

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activities of the organization. I would have a senior management team that would be responsible for different segments of the organization. There would have been a medical director, there would have been a director of nursing, there would have been an assistant--sorry, assistant executive director for support services, so the organization was carved up in that fashion. It would probably also be appropriate to mention that health care organizations are unique from the perspective that the medical quality has a mechanism where it has a direct access to the board. Medical staff are a part of organizations within each facility whereby they would have a Medical Advisory Committee that would oversee the activities of physicians and there would be provision for that person who chairs that committee to be present at the board meetings and speak to those issues.

COFFEY, Q.C.:

Q. And you say the MAC has direct access to the board. Did the MAC, I take it, was responsible for medical services within the

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hospital like clinical services, physician services?

MR. TILLEY:

A. Well, they would be responsible for the oversight of the physician component directly, but -

COFFEY, Q.C.:

Q. Would they report to you as the executive director of the Janeway?

MR. TILLEY:

A. The Medical Advisory Committee would not.

COFFEY, Q.C.:

Q. Okay.

MR. TILLEY:

A. But there would be certain members of the Medical Advisory Committee would not, nor the committee itself.

COFFEY, Q.C.:

Q. Okay. They would report through their chair to the -

MR. TILLEY:

A. The board of trustees.

COFFEY, Q.C.:

Q. The board of trustees itself, okay.

MR. TILLEY:

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A. There were other clinical services that were not physicians.

COFFEY, Q.C.:

Q. Yes.

MR. TILLEY:

A. Psychology, social work, respiratory therapy, for example, that would have reported in to one of the senior executive members. So the medical advisory -

COFFEY, Q.C.:

Q. And through that person to you?

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. Okay. And was there any other group within the Janeway, as it then was, that did not report to you, you know, directly or indirectly, other than the physicians?

MR. TILLEY:

A. Perhaps the foundation, the fundraising arm for children's services was the Janeway Children's Hospital Foundation and they would have their own board of directors. There was another body, the Provincial Perinatal Program that reported in to government. I think I'm

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capturing the key ones.

COFFEY, Q.C.:

Q. The nurses would have?

MR. TILLEY:

A. Nurses would.

COFFEY, Q.C.:

Q. Would report -

MR. TILLEY:

A. Through the director of nursing -

COFFEY, Q.C.:

Q. To yourself?

MR. TILLEY:

A. To myself.

COFFEY, Q.C.:

Q. Okay. So you were about to tell us the Janeway--well, the health care system within St. John's was reorganized?

MR. TILLEY:

A. Yes, that's correct.

COFFEY, Q.C.:

Q. Could you tell us, please, about that and how--I mean, like, your career as you went?

MR. TILLEY:

A. Right. Well, there was a restructuring decision made by government to collapse the 60

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plus organizations that functioned relatively independent of one another with their own boards of directors into a much smaller number, and 14 seems to stick in my mind. The decision sort of ranged in terms of combination and size throughout the province, but in St. John's it essentially provided for the acute care hospitals, the acute care adult hospitals, the General, St. Clare's and the Grace, the two children's services, the Janeway and the Children's Rehabilitation Centre and the Waterford Hospital to come under a single entity. And that process was in early 1995. The person that was the initial chief executive officer of that organization was Sister Elizabeth Davis and she recruited her senior management team and I was successful in getting one of the positions that was offered.

COFFEY, Q.C.:

Q. And which one was that?

MR. TILLEY:

A. It was senior vice-president for corporate services. And that gave me a number of responsibilities for various clinical programs

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in the organization and some major projects that were under way at that point in time, namely, the plan to restructure the organizational layout from a discipline based to a program based and secondly, a major initiative to reduce the number of physical sites that existed at that point in time in St. John's.

COFFEY, Q.C.:

Q. So, I'm sorry, from a discipline base to a?

MR. TILLEY:

A. A program-based approach.

COFFEY, Q.C.:

Q. Okay.

MR. TILLEY:

A. And if I might, I can elaborate a little bit on that.

COFFEY, Q.C.:

Q. I'm going to ask you to do so, please?

MR. TILLEY:

A. Thank you. Typically and historically hospitals had been designed around the particular discipline, so all of the nurses reported in to a single department to a director of nursing, all of the psychologists

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reported in to a department for--with a director, all of the respiratory therapists would do likewise, so the organization was very much structured upon occupational lines. The move to a program approach was designed primarily to start shifting thinking away from the various occupational groups to more of a patient focus, so that became the centre for how the organization divided itself up. There were other advantages by moving in that model aside from bringing it around the patient, but it also strived to achieve a greater interdisciplinary approach to the delivery of health services. Up until that point in time with individual departments, then it allowed for potential fragmentation of work environment. So you brought the groups together, you organized them along a particularly defined patient group or population. The other significant issue that comes to my mind that was being promoted as an advantage was to bring the physicians more into the management of health services. Traditionally there would be physician leaders in the organization and they would, in turn,

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be represented on the Medical Advisory Committee but there was really no designed or structured mechanism for the communications with the other disciplines in the organization. So the program-based model provided for a leadership team that would involve a physician leader, a professional manager, director of a particular program and if the physician leader was not a part of the university environment where they were a leader in that capacity, then there would be a third member. And to give you an example, if there was in the child health program an academic leader in Memorial University that would be known as a--this chair of the discipline of paediatrics, that person would be a member of the leadership team for that particular program in addition to the professional manager and in addition to the physician that was chosen to be a part of that leadership team. To help probably a little bit more to give you a flavour, the programs, there was a child health program, there was a cardiac program, there was a surgery program. And then there were others that we can't

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remember exactly how we coined them, but I'm sure they've very significant for this purpose, clinical support programs I think may have been the term we used, and lab and diagnostic imaging, in particular, come to mind where they weren't revolving around any particular patient, but they were a major support to all of the clinical programs.

THE COMMISSIONER:

Q. So are you saying that included within clinical support program would be laboratories and -

MR. TILLEY:

A. And diagnostic imaging, which would be radiology, yes.

THE COMMISSIONER:

Q. Okay. Could we go back, I just want to understand a little more about this organizational business. Are you saying that the old method was that the disciplines would report to somebody in their sphere, so was the disadvantage of that that sort of the people in nursing were not necessarily talking to the people in, well, I don't--radiology or in some other aspect of the service, was that the

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problem? Why did you feel the necessity to change in the way it was done?

MR. TILLEY:

A. It was certainly to increase the interdisciplinary collaboration, to remove some of the barriers that were, seemed to exist. For example, in the child health program in the past you would have a social worker and a nurse reporting up to different managers. In the new structure that person, both of those individuals report to the same manger so what you did was that you provided an opportunity for increased dialogue between them. Now, it's not to suggest that there was no collaboration amongst the disciplines prior to that, but the program approach was an evolving organization process, particularly throughout Canada, and had been seen as an opportunity here to pursue in light of the size that this organization was taking on. And the discussions at the time, some of the discussions at the time were if we left it with the traditional model, that it would be more bureaucratic than would need to be the case, so we ended up decentralizing a lot of

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the services. So it -

THE COMMISSIONER:

Q. So do I conclude from that that if the Waterford had remained the Waterford, a separate group, then maybe there wouldn't be problems with the traditional model, but because it was a smaller operation, or were there inherent in the old model difficulties that one would have to get past?

MR. TILLEY:

A. Well, some of it was perceived obstacles, but just having the fact of having a social worker report up to their manager, and the nurses in the same work area report to a separate manager, and now you reported to one, it allowed for that increased dialogue.

COFFEY, Q.C.:

Q. If i could on that point, the manager might not have any particular expertise in social work or nursing?

MR. TILLEY:

A. Absolutely. That was -- that's a very good point. You chose -- you chose a leader because of their leadership skills as opposed to being from any one background. Madam

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Commissioner, the interdisciplinary approach was seen to be enhanced by this model. Taking this very large organization and dividing it up into smaller components was seen as an opportunity to allow for more local decision making, and then, of course, as I mentioned, the ability for the physicians to become more involved in the management process.THE COMMISSIONER:

THE COMMISSIONER:

Q. And from your perspective, did that work?

MR. TILLEY:

A. Over the first couple of years there were a lot of adjustments for everybody because that concept was very new, and I suspect that when the CEO of the day announced that that was the direction that they were going to use, we all looked to learn more about it. There was limited literature, but where it did exist, it was clearly saying there's opportunities to this being of greater benefit, allowing for more localized decision making and physician input, and overall that was seen as a good thing.

COFFEY, Q.C.:

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Q. So there was limited literature on this at the time?

MR. TILLEY:

A. Well, where we found the bulk of our information was actually going to individual organizations that had chosen this route to learn how they had done it, what programs they had selected and beginning to appreciate some of the rationale for doing it.

COFFEY, Q.C.:

Q. So the move from a disciplined based model to a program based model, I think you told the Commissioner it was coming into vogue into Canada or it was being utilized increasingly in Canada?

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. At the time it was adopted here in the mid 90s, 1995, how widespread was it, do you know, in Canada?

MR. TILLEY:

A. I'm going to give you my best estimate. I'd say it would be about 30 to 40 percent of the organizations were starting to see this.

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Individual stand-alone hospitals, you didn't see it much in. It was in the larger organizations that were coming together and you were looking for some way of flattening the layers.

THE COMMISSIONER:

Q. Forgive me for being simplistic, but going back to the first thing, it seems to me you were creating larger organizations and then finding ways of letting them think they were still back in smaller organizations?

MR. TILLEY:

A. Well, not letting them think as much as saying that we recognize child health as a unique area, and, therefore, needed to be seen as a identifiable entity, and we did the same with mental health. So in many ways the child health program in the new structure was very similar to the combined clinical services of the former Janeway and the former Children's Rehabilitation Centre.

THE COMMISSIONER:

Q. Uh-hm.

MR. TILLEY:

A. All of the non-clinical services would have

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been removed and they would have been reporting into Facilities Management, Finance, or whatever administrative support departments because those were all centralized, but on a clinical basis, a more decentralized model was chosen.

COFFEY, Q.C.:

Q. And I take it, for example, surgery as a program, surgical program, that would have been more widespread, it would include the Janeway as well as --

MR. TILLEY:

A. No, in fact, in the case of the Janeway, it was all inclusive.

COFFEY, Q.C.:

Q. Okay.

MR. TILLEY:

A. Thank you for clarifying that. It got very complicated when we got into the surgical area. We had two very related programs. One was surgery, which predominantly addressed the in-patient population, with some out-patient services for the adult sites. It did not include, however, the operating rooms. That became part of the peri-operative program.

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Now why didn't they all go together; in part, was because of the size, we were creating too large of an entity, and surgery had multiple patients to deal with. So some patients would be for cancer, others might be orthopedic, others might be neurological. So it wasn't -- we couldn't find a perfect model where you built it around a defined group of patients. So there were sometimes that we had to make modifications based upon what was a natural fit and what was a reasonable size.

COFFEY, Q.C.:

Q. And I'm going to -- Commissioner, I'm going to come back at a subsequent time to look at some of this and actually look at organizational charts.

THE COMMISSIONER:

Q. Okay.

COFFEY, Q.C.:

Q. In terms of an overview, you've run a -- the CEO of the day, and who is that?

MR. TILLEY:

A. Sister Elizabeth Davis.

COFFEY, Q.C.:

Q. Was the move to a program based model her

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idea?

MR. TILLEY:

A. Yes. Before the executive team had been recruited, it was known that that was the decision that was going to be pursued.

COFFEY, Q.C.:

Q. In other words, in joining or offering oneself to join that executive team, you knew what you were getting yourself into in the sense of what was expected?

MR. TILLEY:

A. Oh, yes, it's fair to say.

COFFEY, Q.C.:

Q. Do you know was that -- at the time, was that unique to the Health Care Corporation in St. John's within Newfoundland?

MR. TILLEY:

A. Yes. I do remember going to St. Anthony, for example, and speaking to their senior management team because they were interested in pursuing a program based model. I'm not sure whether they did or not.

COFFEY, Q.C.:

Q. So initially when it was introduced in Newfoundland, it was your understanding it

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happened in Health Care Corporation?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. In St. John's. Were there -- you've talked about the perceived advantages. What were the perceived or known disadvantages?
MR. TILLEY:
A. Well, I think a number of the disciplines felt that they were losing some of their identity. I particularly recall that from the allied health group, and they would be the social workers, the psychologists, the dieticians. In the past, they would have had a leader that was of their discipline. So clearly that was a known issue. They would have had, therefore, to meet with and present their issues to a manager other than the one of their profession, and, I guess, try to ensure that they have a good understanding of what their issues are. The issue of -- there was still sort of patient movement in multiple programs, and that would have, I guess, been a problem to have to contend with in either the occupational or disciplined based model as

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well as the program based model because patients are obviously, with the exception of some of those defined by age, crossing through multiple programs. The physicians at the time, there were concerns on their part that they might lose some of their profile. I remember spending some time discussing that issue to say, well, in fact, some of the proponents of this particular approach are speaking to the issue of bringing physicians closer into the decision making. So that became less and less of an issue as they became more familiar with the program.
COFFEY, Q.C.:
Q. Now under the disciplined based model, physicians had reported to physicians and ultimately to the MAC?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. And the MAC to the Board?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. Now in the program based model, you've

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indicated that there would be a leadership team within any one program. There would be a physician, a clinical leader or clinical chief, as it were?
MR. TILLEY:
A. Yes, a medical leader.
COFFEY, Q.C.:
Q. A medical leader, a professional administrative manager, and in some instances a separate medical school discipline chair?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. For that particular program. They would all report to whom? That trio, duo or trio, would report to whom?
MR. TILLEY:
A. Well, in the case of the group as a whole, there would be a designated senior manager that would be responsible for a number of programs, and in addition --
COFFEY, Q.C.:
Q. And that senior manager would report to?
MR. TILLEY:
A. The CEO.

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COFFEY, Q.C.:
Q. Sister Davis, at the time?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. So the one change that has occurred is that physicians are now reporting to a physician clinical leader or clinical chief, who's reporting to a senior manager, who's reporting to the CEO?
MR. TILLEY:
A. It's not as neat as that.
COFFEY, Q.C.:
Q. Okay. Perhaps you could expand on that for me. First of all, is that true in one sense?
MR. TILLEY:
A. Only in terms of really the non-medical issues.
COFFEY, Q.C.:
Q. For example, whether or not you show up today to work, that kind of --
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. Scheduling and --

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MR. TILLEY:

A. I mean, there's no doubt that the clinical chiefs were selected through a process of advertising positions and more often than not, they came about accepting their roles because somebody had suggested that they would take the lead, but they had very little interest in the day to day management of the program, but it gave the professional leader, the professional directors, somebody to go to if there were issues where physicians were -- needed to be involved in a particular decision, but the point I was going to refer to in response to your question, there was still a Medical Advisory Committee, and the Medical Advisory Committee would consist of the clinical chiefs of all of the programs, and because of the organization's responsibility and involvement in the teaching of professions at Memorial University, the Medical Advisory Committee would also include what we know as the Discipline Chairs. So that would be the Chief of Pediatrics or the Chief of Radiology. So the physicians still had that opportunity to go through Medical Advisory and

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then on to the Board. There was a little splinter group known as the Clinical Chiefs Committee which, of course, would have been MAC, less the Discipline Chairs, and that was more of a working committee on any issues that -- just to bring the group together to coordinate various entities that were of importance to them, or to the Vice President of Medical Services, that really wasn't needing to go to the Medical Advisory Committee per se.

COFFEY, Q.C.:

Q. Okay, so with that as a background, and I will be coming back to that particularly in relation to the program that -- well, programs that the Commissioner will end up dealing with in detail. This is the mid 90s, you've signed on for this.

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. You are the Senior Vice President. You were there, I believe -- according to your CV, page two of P-0315, you were there from February '95 to June '99. You can start by telling the

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Commissioner about how did it go as it was implemented, in a general way.

MR. TILLEY:

A. Well, it was a very challenging process. We had not only taken on a much larger organization, that none of us really had had any experience in dealing with an organization that large, five to six thousand staff, and on top of that we were changing the way the organization was structured and putting in new processes. On top of that, we were making decisions with regards to how many physical plants we should have and, of course, that decision was made, and then the planning had to be initiated to implement that. I guess, suffice to say, we were doing that as quickly as one could and in an environment that all health care organizations seem to face, and that is under times of financial restraint. So we worked long hours, very hard. We were doing a number of things simultaneous where you may have preferred to say that we would have the program structure in place and then begin the planning for the new sites, but, in fact, we were doing that as a parallel

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initiative. So it was quite a significant responsibility.

COFFEY, Q.C.:

Q. The site closures and relocations during that period were what?

MR. TILLEY:

A. The decisions were to close the Children's Rehabilitation Centre, the former Janeway, and the Grace General Hospital. I know that the Children's Rehabilitation Centre which is down in Pleasantville, I think, closed first to move into the old Janeway. The Grace Hospital was next, and then the Janeway under the Child Health Program relocated to the new space adjacent to -- at the Health Sciences Complex.

COFFEY, Q.C.:

Q. And do you recall what year the Grace closed?

MR. TILLEY:

A. I don't, off the top of my head.

COFFEY, Q.C.:

Q. Were you involved at all in the -- like, in that closure, and the relocation of the clinical services from that site to St. Clare's and the General?

MR. TILLEY:

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A. I can't visualize myself in the middle of that move, so it's possible that it may have happened when I was away.
COFFEY, Q.C.:
Q. And how about the planing for it in terms of the relocation of the services?
MR. TILLEY:
A. I had a major responsibility to oversee that planning process. We had actually recruited a planning team responsible for consulting with the various programs and supports, and then starting to put guidelines around what the new space needs might be and working with architects and the like to see how that could be achieved.
COFFEY, Q.C.:
Q. In terms of relocating and because the Janeway, generally, from what you've told us, I gather moved more or less as an entity, relocated from the east end of Pleasantville onto the General Hospital site.
MR. TILLEY:
A. Yes, predominantly their clinical services, of course, the support services could have gone anywhere.

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COFFEY, Q.C.:
Q. Sure, but the clinical services, I'm sorry, is what I was referring to and have moved on mass, across St. John's when they did. The Grace, I gather that wasn't so?
MR. TILLEY:
A. No.
COFFEY, Q.C.:
Q. Clinical services ended up being split up?
MR. TILLEY:
A. That's correct.
COFFEY, Q.C.:
Q. Do you recall whether or not there was any concerns raised about who would go where?
MR. TILLEY:
A. I have no doubt that there would have been. I know that staff--there was some comments by staff that they were going to be split up and for them, of course, split up would mean either going to the General Hospital/Health Science Centre site or St. Clare's; so whereas the Janeway group were moving and they would reach a new location pretty much with the same peers, the staff in the operating room at the Grace could have gone to either of the adult

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sites.
COFFEY, Q.C.:
Q. And I take it that also would have been true of the clinical laboratory at the Grace?
MR. TILLEY:
A. I suspect so, though I can't specifically recall.
COFFEY, Q.C.:
Q. Okay. Do you recall whether or not in your position as senior vice-president during the period of '95 to '99 you were ever called upon to address, what I'll refer to as cultural issues in the sense of moving across the city from one hospital to another and any problems with integration of staff? Were you ever asked to get involved in anything like that?
MR. TILLEY:
A. I can't recall, but I -
COFFEY, Q.C.:
Q. I'm not suggesting you could -
MR. TILLEY:
A. No, I don't recall. I mean, I -
COFFEY, Q.C.:
Q. Issues being brought to your attention and you being expected to address them?

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MR. TILLEY:
A. Well I can only recall the fact that there were people who felt that they were losing their team, the team was being fragmented. If there were issues that I felt I might have been able to help resolve, then I certainly was very open to meeting with people.
COFFEY, Q.C.:
Q. Where did you go from there?
MR. TILLEY:
A. I left there and went to the Workplace Health Safety and Compensation Commission in the position as chief executive officer and Workers' Compensation is an organization that is responsible for providing compensation to workers throughout the province who may have experienced a workplace injury.
COFFEY, Q.C.:
Q. And you were there from what period?
MR. TILLEY:
A. From July '99 to October of 2000.
COFFEY, Q.C.:
Q. Was there any particular reason you moved?
MR. TILLEY:
A. Well, yes, I felt at that point in time that I

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needed a change and there was an opportunity. There were a lot of busy years that I had just completed at the Health Care Corporation and at that point in time I was thinking that maybe something other than health care would be something that I would like to pursue.

COFFEY, Q.C.:

Q. You were there until October of 2000?

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. And what happened then?

MR. TILLEY:

A. Well, as time went on when I was with the Workplace Health Safety and Compensation Commission, the CEO had made a decision to step down.

COFFEY, Q.C.:

Q. That's the CEO of the Health Care Corporation?

MR. TILLEY:

A. Yes, sorry, Sister Elizabeth Davis. So there were a number of suggestions that I should seriously consider pursuing that position and what I found as time went on when I was with the Commission, my yearning for health care

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grew and I felt that I wanted to be a part of it again and while it would not be my preference to have such a short stay with an employer, I realized that if I was ever going to go back into health care, that this was the opportunity and if I was to forego it, then it was to forego it indefinitely.

COFFEY, Q.C.:

Q. So what happened?

MR. TILLEY:

A. I applied, I went through the interview process and got selected for that position and as you can see that that occurred in 2000, October.

COFFEY, Q.C.:

Q. Okay, so you're president and chief executive office of the Health Care Corporation of St. John's beginning in the fall of 2000. What did that involve?

MR. TILLEY:

A. Well, being responsible for a very large and diverse organization. I've obviously, by this time, had the benefit of my years of experience as a senior vice-president and I would have reported to a Board of Trustees and

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very similar to the discussions that we had earlier, in terms of there being a senior management/executive team that would be responsible for different components of the organization. There would be a medical advisory committee that would have still existed that would have had their Chair sit on the Board of Trustees. And as I recall it now, in addition to the Chair of Medical Advisory, I think the president of the Medical Staff Organization also sat on the Board and the Medical Staff Organization is sort of the, dare I say the union local of the physician group. You know, it didn't have the issues for quality that the Medical Advisory Committee Chair would have, but that person would have represented the views of the medical staff at large. Of course, in addition to the services, again, that are directly delivered, which were both local and provincial in nature, the issue with regards to the academic responsibilities continued and that was again in relation to our responsibility for medical education, so we would have had a close relationship with

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Memorial. And also, by that time, I was starting to think about the need for the organization to become stronger in its research activities. I remember having a discussion with one of the physicians about creating a learning environment and wanting to be on the leading edge, so we really started looking for opportunities to put research more on our agenda and in fact, there was some major initiatives underway which have culminated recently, I understand, with regards to creating research space. So we had education, we had research and we had this responsibility for services, health services.

COFFEY, Q.C.:

Q. And so you reported to the Board of Trustees of the Health Care Corporation. You provided, I take it that organization or facility provided some services province wide, which I gather are referred to as tertiary care services. How involved were you in that? Who was responsible within the organization for that?

MR. TILLEY:

A. There wouldn't have been any one particular

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individual. Children's health was--the major part of children's health was tertiary in nature; that being, it wouldn't be provided in any other site. There were some surgical services that would be tertiary in nature and they would, of course, report to perhaps another vice-president within the organization. So it wasn't organized along provincial or secondary or primary lines.

COFFEY, Q.C.:

Q. Okay. And then looking at your C.V., your time with the Health Care Corporation ends in December of 2005. In January of 2005, you're the president and CEO of the Eastern Regional--I gather it should be Integrated Health Authority. Could you tell us, please, what you know about how that came about and how you ended up with that position?

MR. TILLEY:

A. Government had made a decision to restructure health services in the province again. This time there was an interest in more integration along the continuum and as you've alluded to with, in comparison to the Health Care Corporation that was more on the delivery of

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services or the treatment aspect, what the Eastern Health did was brought in the other dimensions, such as supportive care, in terms of long-term care or child protection and it would have brought in more involvement in what I call the upstream issues, such as health promotion and illness prevention, so very much and all inclusive type of arrangement. Just recalling that the other three authorities, it was geographic base and they were of varying sizes, but certainly Eastern Health was the largest, perhaps even larger than the other three combined.

COFFEY, Q.C.:

Q. Now just again looking at your C.V. and the rough numbers for the Health Care Corporation, number of staff, approximately 6500 staff and 500 physicians. Looking at page one of P-0315, 12,000 staff and 700 physicians and surgeons, that was the organization approximately doubled in size that you were managing?

MR. TILLEY:

A. That's correct.

COFFEY, Q.C.:

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Q. And geographically, I don't know what the number of times it had increased by, it would be 50, 60 or 100 times, I don't know off the top of my head, but the point is, I want to ask you about is this, you understood the government was going to go this route of collapsing, I think it was six or seven -

MR. TILLEY:

A. Seven, I believe.

COFFEY, Q.C.:

Q. Seven health authorities or boards into one. You didn't choose, I take it, to apply for the position?

MR. TILLEY:

A. Yes, I did. I went through a similar process. Back in the fall of 2004, I believe the chair of the board had been named, I'm not certain that the other members would be -

COFFEY, Q.C.:

Q. Who is that?

MR. TILLEY:

A. That would be Joan Dawe and I recall being interviewed by a panel that included her and some staff from the Department of Health, so that was happening towards the end of 2004 and

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shortly, the four or I think it was over the Christmas season, in fact, that I would have met with Mrs. Dawe and she had offered that position to me.

COFFEY, Q.C.:

Q. And again in relation to that, you understood what it was that you were signing on for, getting yourself into?

MR. TILLEY:

A. I did, sir.

COFFEY, Q.C.:

Q. Okay. And you remained, I take it, with Eastern Health until July of 2007?

MR. TILLEY:

A. That's correct.

COFFEY, Q.C.:

Q. Okay, and I'll be speaking to you about the time period involving the end of your time there later. I'm just going to ask you now about your prior dealings with certain individuals. If I could and I'll just begin with Joan Dawe. In what context had you known Joan Dawe?

MR. TILLEY:

A. I had known Joan for a number of years,

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perhaps going back to certainly my Janeway days, maybe even before that. She was a manager at the St. Clare's Hospital and then I next recall her as the executive director of the St. John's Hospital Council, which was an entity that was established to provide for greater collaboration amongst the city hospitals and also to come up with a master plan for how the future of the cite should be in St. John's. Then I recall that she moved to government and a recollection that she spent some time in the Department of Social Services and maybe some time in the Department of Health.

COFFEY, Q.C.:

Q. Would you have had any dealings with her while she was with the Department of Health, do you know?

MR. TILLEY:

A. Undoubtedly would have been into dealings with her on issues between the, both organizations and government.

COFFEY, Q.C.:

Q. And that would be in your capacity at one point as the senior vice-president of the

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Health Care Corporation?

MR. TILLEY:

A. I'm certain there was contact with government because it was happening at multiple levels, but my recollection is that she was the deputy minister in the Department of Health. So predominantly I suspect her contact would have been with the CEO.

COFFEY, Q.C.:

Q. And depending upon the timeframe, it could have been yourself or Sister Elizabeth?

MR. TILLEY:

A. Yes, and I can't recall if our time overlapped or not.

COFFEY, Q.C.:

Q. But you knew her in that, in either the governmental context or the health care in St. John's context?

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. As well at one point was she, did she represent any organization with respect to the Health Care Corporation of St. John's Board, does she sit on the Board?

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MR. TILLEY:

A. She was actually Chair--she was Chair of the Health and Community Services Board in St. John's, which was one of the entities that subsequently came on to Eastern Health and you're right, she was on the Health Care Corporation of St. John's Board.

COFFEY, Q.C.:

Q. And as the CEO of the Health Care Corporation of St. John's, in fact, as a CEO of Eastern Health, you would have attended Board meetings?

MR. TILLEY:

A. Yes.

COFFEY, Q.C.:

Q. Let's see, John Abbott.

MR. TILLEY:

A. John Abbott, I think my first involvement with John came when he was doing a review for government of the expenses of the Health Care Corporation and if my memory is right, he was with Treasury Board.

COFFEY, Q.C.:

Q. Uh-hm.

MR. TILLEY:

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A. And had been asked to do some review of costs with the aim to see if there were opportunities to reduce costs further. My next recollection is that in the early part of my tenure with the Health Care Corporation of St. John's, a consulting group were brought in to identify potential cost savings and there was a steering committee established that, I believe was chaired by the deputy minister of the day, Mr. Thompson.

COFFEY, Q.C.:

Q. Robert Thompson.

MR. TILLEY:

A. Robert Thompson and I believe John Abbott actually sat on that steering committee.

COFFEY, Q.C.:

Q. And this would be the HayGroup, I take it?

MR. TILLEY:

A. Yes, you're correct.

COFFEY, Q.C.:

Q. Go ahead.

MR. TILLEY:

A. And the next recollection I have is that he was appointed as the Chair of the Health Care Corporation of St. John's Board of Trustees.

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COFFEY, Q.C.:
Q. Do you recall approximately when that was or what you were doing at the time?
MR. TILLEY:
A. I would have been CEO at that time, but I can't tell you the actual date of his appointment.
COFFEY, Q.C.:
Q. So it would have been before 2005 because that was Eastern Health -
MR. TILLEY:
A. That was Eastern Health.
COFFEY, Q.C.:
Q. So sometime during the period October 2000 to December 2004?
MR. TILLEY:
A. I remember it was over the Christmas season, I think there was a change, if I can just try to think through, I could probably get the date for you.
COFFEY, Q.C.:
Q. No, that will be fine, it's just to canvass with you in the context that you did deal with him at one point while you were CEO of the Health Care Corporation, for a period of time

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he was the Chair of the Board of Trustees?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. And you had known him before, you actually reported to him.
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. And the Board.
MR. TILLEY:
A. Reported to the Board. And then, of course, he would have went on to become deputy minister of health, so that's where I would have had a continued involvement with him.
COFFEY, Q.C.:
Q. As he moved from Chair of the Board of Trustees, I don't know about directly, but more or less to become deputy minister of health?
MR. TILLEY:
A. Yes, and of course, the Chair was a voluntary position.
COFFEY, Q.C.:
Q. Yes. I'll pick another one, the person you

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just named, Robert Thompson.
MR. TILLEY:
A. Yes. My first time meeting Robert was when he was appointed the deputy minister of health. And actually that seemed to have coincided with my arrival back in the Health Care Corporation of St. John's.
COFFEY, Q.C.:
Q. Which would be the fall of 2000?
MR. TILLEY:
A. Yes, would have known him in that capacity.
COFFEY, Q.C.:
Q. So it would be at all unusual, as in your capacity as a CEO of the Health Care Corporation or for that matter, Eastern Health, to be direct contact with the deputy minister of the day, whomever he or she was?
MR. TILLEY:
A. That's correct.
COFFEY, Q.C.:
Q. And Robert Thompson was certainly one such DM and John Abbott was another.
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:

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Q. Okay. How about as--we understand and it's a matter of public record that Mr. Thompson was, at one point, clerk of council.
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. Would you have had any dealings with him in his capacity of clerk?
MR. TILLEY:
A. Really, no, other than exchange of a personal note. I just remember when he left to go there, he wrote me a note saying, you know, thanks for the working relationship. And beyond that there would have been, really, no dealings up until late, or spring of last year when we started talking about the Inquiry and the follow-up to it.
COFFEY, Q.C.:
Q. Pick some of the ministers of the day, okay. John Ottenheimer?
MR. TILLEY:
A. Knew him by reputation, but really had no direct contact with him until he became minister.
COFFEY, Q.C.:

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Q. Okay. And I'll be talking to you about your dealings with him as minister. Tom Osborne?
MR. TILLEY:
A. The same.
COFFEY, Q.C.:
Q. Okay. Ross Wiseman?
MR. TILLEY:
A. I knew Mr. Wiseman before. He had actually worked in a senior management capacity with the Peninsulas Health Care Organization which is one of the organizations that came together to become Eastern Health. And he may have actually been a human resource manager when it was just Clarenville before Peninsulas. I can't pull out the details at the moment, and one of the projects that was happening at the time that we were both involved in, was called a Health Information Task Force. And that was an initiative that was trying to put some scope and direction to where the province should go in the information capacity IT area and that was actually chaired by Sister Elizabeth Davis. When I recall she was at St. Clare's, I was invited to become a member of that task force and Mr. Wiseman was also

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there.
COFFEY, Q.C.:
Q. That would be the early 1990s?
MR. TILLEY:
A. Was my Janeway days, so, sorry for having to look, but yeah, it would have been the early 90s, '92, '93, '94, '95.
COFFEY, Q.C.:
Q. Yes. That topic will come up again, Commissioner. So you knew him in that capacity, you met him there and how about afterward?
MR. TILLEY:
A. He chose to run for government and--or as an elected official. There may have been sporadic communique while he was with the Liberal party and I'm just trying to remember the--and then he moved to the Progressive Conservatives. From time to time, he may call on a particular issue, but that would be very limited and then, of course, he went on to become minister. There was a period of time that I know he was working in the Department of Health in some other capacity. I'm not sure if it was parliamentary assistant or

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whatever the term might be, I don't recall a lot of involvement with him at that time.
COFFEY, Q.C.:
Q. And then when he became minister, you would have had contact with him at that point?
MR. TILLEY:
A. That's correct.
COFFEY, Q.C.:
Q. Oscar Howell?
MR. TILLEY:
A. Dr. Howell I had known in a social context for maybe going back eight to ten years ago. We had mutual friends, so that sometimes brought us together. He had worked in a professional capacity for the Health Care Corporation of St. John's dealing with employee health and wellness and he had an interest in some training in occupational medicine, so he was brought in in that capacity, and subsequently, of course, when the vacancy came up for the vice-president of Medical Services, he had expressed, applied for it and was successful in getting that position.
COFFEY, Q.C.:
Q. Bob Williams?

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MR. TILLEY:
A. Bob Williams I would have first met, I suspect, back in my Waterford time. I think he may have been an associate deputy minister perhaps at the time.
COFFEY, Q.C.:
Q. With the Department of Health?
MR. TILLEY:
A. With the Department of Health and subsequently went on to become the deputy minister. So we've certainly had dealings with the department when he was in that position. The position of vice-president of Medical Services became vacant at the Health Care Corporation of St. John's and Dr. Williams was one of the candidates and was subsequently recruited as the vice-president for Medical Services in that organization and certainly I would have had dealings with him in that capacity.
COFFEY, Q.C.:
Q. So when he came to work was the VP medical, I'll refer to it, with the Health Care Corporation, that would have been in the mid nineties, late nineties, do you know? What I'm asking is when you were senior VP there -

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MR. TILLEY:
A. Yes, that's correct, it was not while I was CEO, so it would be more in the mid to late.
COFFEY, Q.C.:
Q. If you were senior vice-president, did he report to you?
MR. TILLEY:
A. No, he didn't. The designation of senior basically meant that when the CEO was away, that I was expected to deal with any matters that might come up.
COFFEY, Q.C.:
Q. But when the CEO was present, you were all kind of -
MR. TILLEY:
A. Right, we were all on the same level.
COFFEY, Q.C.:
Q. Equals. Do you recall who recruited Dr. Williams?
MR. TILLEY:
A. Yes, I sat in on a selection committee. Sister Elizabeth would have been there. There were a couple of other -
COFFEY, Q.C.:
Q. I ask that just because, not so much, you

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know, listen to the job interview, but you used the word "recruited" and that has connotations of actually going and getting somebody, you know, encouraging them to apply, was it that kind of context or was it he just simply applied for the job and -
MR. TILLEY:
A. I'm assuming they applied for the position, that was our typical way of doing these things.
COFFEY, Q.C.:
Q. So recruited doesn't have any particular connotation?
MR. TILLEY:
A. I'm sorry, no.
COFFEY, Q.C.:
Q. Okay, that's fair enough. Let me just see if I could, Commissioner, before we break, Moira Hennessey?
MR. TILLEY:
A. Moira Hennessey, I think I--certainly as long as I've been in health care and as long as she's been in the Department of Health, I've known her, whatever time that might have been. I seem to remember that she had evolved from a

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consultant position to a director of health services position to an assistant deputy minister position.
COFFEY, Q.C.:
Q. So you were in health care at the Janeway or the Health Care Corporation of St. John's, as you went up through the hierarchy there or moved and went up.
MR. TILLEY:
A. Yes, and she was probably doing the same.
COFFEY, Q.C.:
Q. And Ms. Hennessey did the same and you would have been aware and at times had dealings with her?
MR. TILLEY:
A. Yes.
COFFEY, Q.C.:
Q. Commissioner, if we could, if we're going to take an afternoon break.
THE COMMISSIONER:
Q. Yes, we can do it now, we'll take fifteen minutes.
COFFEY, Q.C.:
Q. Thank you, Commissioner.
(RECESS)

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THE COMMISSIONER:
Q. Please be seated. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. Mr. Tilley, I gather you've had a lot of time to think about this while matter.
MR. TILLEY:
A. Yes, I have.
COFFEY, Q.C.:
Q. And it's unfortunate but a couple of times, of course, you were about to come and testify and it got postponed because of other matters, not involving yourself. What I'm going to ask is this, is that it's now just past 3:30, we usually sit to 4:45. Could you tell us please what happened? Start at the beginning and if you can, and it has to go over until tomorrow morning, you know, the Commissioner would understand that, but tell us what happened from your perspective. And when I say "what happened" it's ER/PR and -
MR. TILLEY:
A. Yes, I understand.
COFFEY, Q.C.:
Q. Okay, if you could please?

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MR. TILLEY:

A. Well my recollection brings me back to July of 2005 and that's a date that I had recorded in a log book that I use when I have telephone conversations with people. I can't guarantee that it's one hundred percent accurate because there's times, of course, that I would be taking calls in other locations. I received a call around July 7th, could be the 8th, but July 7th is the earlier date that's recorded from Dr. Williams, who is the vice-president of Medical Services, to raise an issue about the test used to identify receptors, estrogen and progesterone receptors that's used to identify whether a patient can benefit from a drug known as Tamoxifen. My recollection at that time was that over the previous few weeks he had been doing some or a lot of work had been going on with regards to this issue, that they had reached a point where they felt this was more than just an isolated situation and that on retesting, there were some patients whose results had changed from negative to positive. During that conversation, he had referenced, I'm reflecting on the notes that

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I've recently reviewed, he had reflected or I had in my notes a reference to Bonnell and Predham. Susan Bonnell is the director of communications and Heather Predham, I think may have been the acting director of quality initiatives at that point in time. I am working on the basis that he would have identified those two individuals as people that he would need to contact in light of the issue. He went on to say it's important that we talk about this publicly as quickly as possible and I have a note which refers to Dr. Ejeckam and I'm not sure what the reference was at that time because I know there was a reference within a couple of days to a conversation about Dr. Ejeckam. So suffice to say that from that moment on, the impact of that call really hasn't gone far from my mind. The context, this is in July, I'm thinking in May and June, the new executive team for Eastern Health has just come together. So here we are tasked with bringing this massive organization together and this issue has come to the forefront. There is a recollection that there's a lot of work going on that he's

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directly involved with, with the lab. And I recall some reference to Dr. Cook, who would have been the clinical chief of the Laboratory Medicine Program and Mr. Gulliver, Terry Gulliver, who would have been the program director for the lab. And they were doing an investigation in terms of or at least lots of discussions in terms of whether, you know, this is specific to a particular year, trying to anticipate what the potential causes might have been. So I know that he was still working through some of those issues for that week. At a later point, two groups that were important to bring into that discussion; namely the Department of Health and the Board Chair, were apprised of the situation. The Board Chair, through a contact with me, through an e-mail because I think at that time she was away on vacation. And I know there was some opportunity to discuss it with her in more detail later. Government had been apprised of the situation, I can't be sure exactly how, but I know that there was a discussion through some level in the organization. I'm recalling that that

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discussion precipitated a call to me by the Minster of Health and Community Services, Mr. Ottenheimer, and he was obviously equally concerned. We were talking about the implications of this and the importance of getting it resolved and I think there was an echoing of the point about this issue needs to be talked about publicly as soon as possible. The time goes on and the next thing that I can recall is that I actually got involved, maybe in the subsequent week in one of the meetings that Dr. Williams was having with, I'm thinking the lab leadership team, representatives from quality and communications, I think were there, to participate in the discussion. I'm not sure if I'm getting all the sequence of events right, but shortly thereafter a group actually went in to meet with the minister to apprise him of the situation in more detail. And I recall that both Dr. Williams and Dr. Cook would have been there because the issue for me was to make sure that the minister was hearing it directly from people who understood it and could articulate it. I remember at that point

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in time, the 20th or 21st or 22nd, I can't be sure of the dates, of July, simultaneous or just before that meeting some information had been compiled which looked at one of the benchmarks that is known to be looked at when you deal with this type of test and the benchmark has to do with the what could be expected to be on average the level of positivity of this particular test. And that range actually changed and got more fine tuned as time went on, but initially I recall some reference to 50 to 85 percent of patients who are treated with this could be expected to be positive. The information that I was recalling was a spreadsheet which showed the positivity rates for several years going back and the positivity rate for a couple of the years, more recent years was showing to be within range. And then the question has been raised, like, have we had a false start here, did we come across something that was isolated or was it something that was unique to a particular period, so all of a sudden we were presented with maybe this is not the situation that we thought it was. So the meeting with

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the minister went ahead and we talked with him. He had a chance to talk about or talk with the chief, the Clinical Chief for Laboratory Medicine, Dr. Cook, and get an appreciation for this issue. The--I recall the minister being concerned, wanting to be sure that this is acted upon. I recall discussing how we might do that because of the issue of writing patients who were impacted was raised. We also acknowledged the fact that oncologists, who are a major partner in the treatment of breast disease, needed to be included in a discussion and that was going to be arranged. So we left the minister essentially with the intent of having further communications, continuing to delve more into this issue and I believe there might have even been a follow-up meeting set up to come back and report our findings.

The next couple of weeks or week there was continued discussion around how are we going to follow-up on this issue. And I remember getting some input through a memo from the Communications Department actually suggesting that the approach that was

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originally envisaged, because Dr. Williams had talked about this going public very early and even to the point of the Communications Department having drafted up the press releases or samples of press releases. But at that point in time, this is after the meeting with the minister, he had--the communications director had indicated to me that the idea of a common press release was not the solution that she was espousing but rather more individual follow-up with patients on the basis that here was a defined group that we were aware of and should make contact but also referencing the need to consult with the oncologists. So I think that was fairly soon after that meeting.

The meeting with the oncologists and lab that I recall me sitting in on occurred in the early part of August, and there were discussions then around this whole issue. I suspect by then they had obvious awareness to this. I can't recall, by the way--I recall initially that this was focused in on the year 2002. So I'm not sure--I would expect at that point in time that the positivity rates that

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were being talked about would have been shared with them.

I don't have off the top of my head a better familiarity with what was said, though I do have notes that I referenced to that meeting if you wanted me to speak to it in more detail, I could probably suggest that we get that note, otherwise I'll just sort of keep going?

COFFEY, Q.C.:

Q. You can keep going because we'll come back to -

MR. TILLEY:

A. Okay.

COFFEY, Q.C.:

Q. - some of the stuff in detail. I'm just trying to get some sense and have the Commissioner get some sense of your perspective.

MR. TILLEY:

A. Right.

COFFEY, Q.C.:

Q. Of an overview.

MR. TILLEY:

A. Right. In the meantime, while the clinical

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people are sort of working through this issue, the extent of it and the like, I recall being in some discussions with Susan in relation to what the various choices were here. And unfortunately, I can't put all the pieces together because there was a point, and I can't remember if it was in that first meeting that I attended with the oncologists or in a meeting that happened a week or two later where the oncologists were taking a position about individual contact. But I'm suspecting by that time there must have been varying options being put forward to the point that I had asked "Well, can you put together something that I can review in terms of the strengths and weaknesses of various options?" And that, those options were sort of a common press release, personal contact with the patients, and I thought there was one other that seems to have totally eluded me at the moment. So that sort of discussion was going on simultaneous to this.

We do have then this subsequent meeting that I recall participating in and there is undoubtedly others that were going on but I

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wasn't involved in all of them, but this one I particularly remember had pathologists, oncologists, Dr. Cook, for example, I think Dr. Bev Carter, another pathologist, Dr. Laing, an oncologist, Dr. McCarthy, another oncologist, may have been a surgeon there, Dr. Kwan seems to ring a bell, and then Dr. Williams, Heather Predham, who would have been the acting director, Susan Bonnell and Terry Gulliver. I sort of visualize the room here and who's there. During that meeting a lot of discussion around ranges of positivity, discussions around the evolving protocols, for lack of a better word, in terms of when it would be best to offer Tamoxifen to a patient and that was with specific regard to the positivity rate, because at one point in time that rate referred to or was anybody who was 30 percent positive or more would benefit from it and we were hearing, I was hearing the discussion which said you can go down to 10 percent, that was sort of a new standard, and even discussions around going down as low as one percent, which means anything that was positive could have that. So those two

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parameters were being talked about.

I also recall some disagreement as to who owned this issue. I'm not sure if owning is the right word, but there was clearly disagreement. I remember there being some disagreement between Dr. Carter and Mr. Gulliver, I can't tell you specifically what that was. I don't think there was disagreement, per se, between the pathologists and the oncologists. But I do have a recollection of just my overall sense here that here I was a CEO of one of the largest organizations, health organizations in this country, I think we were top 20 or something, just trying to embark on bringing it together and here I was facing a major clinical issue and involved in a situation where, you know, there was discussions going on and saying, "No, that's, you know, something that's in your camp," or "that's something that's in your camp," going back and forth.

It actually occurred to me about four week ago in one of my quiet moments of reflection about that meeting. I remembered saying or having to say, "The patient has got

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to be our focus here, not ourselves." So I said, "Well, that's a great revelation" when I'm there thinking about this. But subsequently was reminded when I got some of the exhibits that you were using of my account of that meeting that on the tail end it said "Patient first." So I realized at that moment that that late night recollection was actually a reality.

I think that was also the meeting that we had some further discussions on how we're going to deal with the follow-up, the notification process. Now, I should sort of, before I get into that issue, one thing was never debated, always assumed, don't recall it ever being different other than the intent was that we had to follow-up with all patients who had been impacted by this.

And I think it was at that meeting that one of the oncologists made a statement that I recall, and that is "A patient can benefit from Tamoxifen even as long as seven or ten years later." And from that thought the focus was if we can make a difference for anyone, then we have to go through this.

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So, having said that, back to the issue I think I was getting to, which is the discussion on how we were going to follow-up on this. The Department of Health had made a recommendation subsequent to Dr. Williams' thought about having a standard release or a public release to use a letter to notify the patients and I'm not sure if I brought it up or somebody else brought it up, but the oncologists in their reflection on that felt that we needed to find out the results of the changes before any individual patient was contacted. And as I understand the discussion, they felt that if there was a contact made to say that "You had this test, we now have a concern with regards to the accuracy of this test, we're going back to retest, we'll be in touch with you when there's a result," that that process was expected to bring a high level of anxiety to the patient and they were speaking against that.

Now, just thinking about the retesting for a moment. Initially there was a thought that the retesting was going to be done in

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house, but that was drawn into question when the positivity rates were presented for that multi-year period and had shown that in the past few years the tests were certainly in range and certainly were on the high end of the range, but a question of being too high. So then that raised the question that maybe the problem here is that the current technology which had been put in a year or two before that was being over sensitive. So even the cases that they had looked at up to that point in time were even being questioned and I seem to recall some suggestion that the oncologists wait until those results are reaffirmed. So that was an extensive discussion, maybe lasted an hour or more, multiple people in the room.

I can't remember the direct follow-up on the clinical side, but I do remember after that having some subsequent conversations with representatives in the Department of Health as they were inquiring about the follow-up because I remember saying to them about the oncologists and their view. And what we decided to do either then or shortly

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thereafter was to actually allow for the oncologists to directly speak with the minister so we could have a discussion about how this was--or could understand the rationale for the position that the oncologists were taking. And it really presented a dilemma. The people who are dealing with patients who are fighting cancer obviously were in a position to be able to know how much it's affected those patients, and, I guess, suffice to say that the Minister and I, and the others, felt that the idea of going out in advance to raise this issue without knowing the impact on any particular patient could have the potential of negatively impacting the patient. So the decision was to continue with a plan to deal with the patient's results when they came back. The next point I recall relates to the issue of the equipment that had been installed the year before, and I don't know if the word "VENTANA" has come up in your previous interviews --

COFFEY, Q.C.:

Q. Oh, yes.

MR. TILLEY:

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A. Okay. That was the piece of equipment I was referring to that was now being raised as being overly sensitive. So that precipitated two things. One is to say if we don't have confidence in that particular piece of equipment, then we shouldn't be using it. So arrangements were made with a facility in Ontario, Mount Sinai, to have them do the tests for this particular issue on a go-forward basis until that piece of technology could be evaluated. I'm thinking it's simultaneous, while our original intent was to retest the past specimens on the new VENTANA system, now a decision was made not to do that in-house, but to send it out to Mount Sinai. The turnaround time was to be six to eight weeks. So this is in early August, and the expectation was that in mid September/late September this information will be back to us in terms of what the results were on their retesting of it. The other issue that was starting to be raised was the uncertainty around this test in the first instance, and I recall receiving information including articles that really presented this test as

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being of less value than I think what I was hearing people were assuming. It was clear from those discussions that in Europe and in the United States, there had been a recognition that this particular test has its limits, and there seemed to be more attention being paid to it either in terms of its limitations or in terms of how do you minimize its limitations. I, at this point in time was trying to -- I confess, probably even to today, trying to understand how much of what was being seen in St. John's was a reflection of the limitations that were being seen in the literature. I recall -- I'm assuming there's some discussions or phone calls or the like going on in September, but I recall that Mount Sinai ran into problems and the wish to -- or our expectation that these results of the retests were going to be back to us by the time originally allotted was slipping away, and Dr. Cook had been in contact with them and I was hearing reports around unexpected delays that they were having. Of course, they were doing this on top of their existing workload. They were doing our new tests on a go-forward

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basis. So I thought that I might be able to bring some influence to that issue and I would call my counterpart at Mount Sinai. I can't remember that discussion specifically, but I know that he either transferred me or referred me to the lab leader in Mount Sinai whose name is Dr. Pritzer or --

COFFEY, Q.C.:

Q. Pritzker.

MR. TILLEY:

A. Pritzker. That conversation with Dr. Pritzker was for me to stress the importance to us to get the results back as quickly as possible. They were endeavouring to do that, but ran into their own problems. The other part of that discussion that was particularly significant for me was that he was saying -- speaking to what I had already picked up through some of the literature with regards to the limitations of this particular test, and the literature was saying in Europe there was 60 percent of the hospital's labs would not be able to accurately give results for some ranges, and there was a 30 percent who couldn't give it for another range, so it was

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pretty startling. In any event, Dr. Pritzker had said that this issue with regards to this particular test had been known to him and others. He was actually giving, I think his words were "credit to Newfoundland" for pursuing this issue. We had chosen Mount Sinai because Dr. Cook and others, I guess, Dr. Carter, had recognized it as one of the sites in Canada who had what was known in their profession as a "gold standard", and I suspect that that was more known in the pathologies and technical area than it would have been known to me. So we knew that here was an individual who understood the limitations of the tests, had a high volume lab, but either had brought sort of the expertise around it to give us enough confidence that their results we could have some confidence in. I remember having a discussion with him as to how come this has been an issue in Europe and in Canada and appears to be talked about in the Canadian context, but, you know, we're still saying that more work needs to be done. There was a whole bunch of things, actually, or contacts

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that I sort of took it upon myself while this was -- the follow up, collecting the names and specimens, and getting them out was happening. I called some individuals more on this issue about whether it's a national problem or not, and one of the individuals I called was the CEO of the Canadian Patient Safety Institute, Phil Hassen. I had neglected to mention this earlier, but the reason I had known Mr. Hassen was because I was on the Board of Directors of the Canadian Patient Safety Institute, and that institute was created by the federal government in response to a recent research project that looked at the prevalence of adverse events in health care organizations, and the research had actually identified something to the effect that on average seven patients out of a hundred can -- will have likely experienced an adverse event in a health care setting during their admission. So I had been involved as a Board member on that organization and had been involved in a lot of the discussions that led to its creation, and some of the initiatives that that organization was pursuing. I can get

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back to some of that later if you wish, but I called Phil Hassen because in one of the documents that led up to the creation of this organization, there was a preamble which talked about the value of sharing information throughout the country so that organizations could learn from one another. In the first couple of paragraphs of that document, it referred to a couple of cases of a drug known as Vincristine that's normally used for children with cancer, and if it's given in the spine as opposed to the vein, it can be lethal, and it referred to a fact as to how one of these -- a case of this had happened, but several years earlier there had been one in Halifax, and referenced the point about if one had known about that, then maybe this particular tragedy wouldn't have occurred. As soon as I read it, a flashback I had was that not only did one occur in Halifax, but one had occurred in the Janeway back in the early 80s, because I remember I had just joined the Janeway when that occurred. So here we are looking at multiple events that had not been shared and the inappropriate application of

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that drug was tragic. So by this time, I'm sort of getting a bit of head of steam built up and saying, look, I'm hearing about this issue from the literature, I'm talking to people about the value of this test, like, who owns this issue because by this time I was hearing there's no standards for the process, there's 40 steps from beginning to end, it can be affected by environmental conditions, humidity, how long it's kept in the OR, how it's transported, what the temperature should be. Anyhow, I called Phil and we talked about the situation we're facing here and we talked about the importance of follow up with the patients. I was looking also for him to say whose desk do I land this issue on, and he recommended I call Bob Bell. Bob Bell was recommended to me because he's a Chief Executive Officer, but he's also an oncologist, and Phil's thought was, George, he'd understand this issue from your perspective, but he'd also understand it from a clinical perspective. Doctor Bell, Bob Bell--the one word that I remember coming away with was his description of this as a grey

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test which I interpret as saying, you know, it's not black, it's not white, it's somewhere in the middle. I also recall, I think, Doctor Bell saying to me that reinforcing the perception of Mt. Sinai as a good place to use this. I had also asked Doctor Cook, while he was in the middle of dealing with this issue, to make representation to the oncologists-- sorry, the Canadian Pathology Association because trying to figure out who, in the country, really needs to take ownership of this issue and I do know that he followed up with them.

So, there was a lot of discussion about what I felt was a responsibility that I had to bring this to the attention of others. And if there was somebody else who could potentially benefit from this, then this issue I had with the drug, Vincristine, would not be replicated. Anyways, that was sort of a thing that was happening along that time.

Back in house again, the issue of the sensitivity of the VENTANA technology was being followed up. And I remember they went through great efforts to get the technical

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representative of the company down to assess the equipment and that happened. I can't remember the specific comments at the moment, but the bottom line was, for the most part, the equipment checked out.

Simultaneous with that or around the same time--first of all, you recall my comment about we weren't sure if this was as big as thought it was. But despite that, the decision was made to go forward and re-test several years because we just didn't know. And one of the decisions we made is to initiate a peer review process. And peer review is a mechanism that is often used in hospitals recognizing the unique positioning of physicians, in particular, and recognizing our interest in having staff contribute openly to an investigation. We asked somebody with expertise with creditability to come in and asses the system that we had in place. And there was a physician from British Columbia and a technologist from Mt. Sinai. I remember that that was happening during September/ October. Their reviews, because they were peer reviews, the circulation of them was

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limited, not sure if there's three or four copies made. I didn't take one personally, but I did go to Doctor Williams' office to read it. And issues that come to mind concerns about fixation. And as I understand fixation, that starts outside the lab, in the OR or wherever the specimen was taken and goes on to be completed in the lab. I recall issues about documentation and concerns that there wasn't adequate documentation to be able to confirm whether the controls that were in place were done or not done. I remember a conversation with Doctor Williams that said we need to get our head around this; trying to put these reports in the context of what I was hearing about both internationally and nationally; to get some appreciation for whether the lack of standards nationally was a part of the situation here; whether there was some specific here. I remember coming away thinking that I'm not able to definitively say with all of the context there, what the definitive issue or attributing factor or factors might be.

COFFEY, Q.C.:

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Q. I'm sorry, the what?

MR. TILLEY:

A. Attributing factors.

COFFEY, Q.C.:

Q. Oh, okay.

MR. TILLEY:

A. So what I had indicated or what I had talked about at that point in time was our focus has got to be on the recommendations. Now, the recommendations were became the predominant focus of the lab leadership team. And I remember Doctor Williams being particularly astute to the importance of getting them followed up on, even to the point of, at a later date, asking the individuals who were involved to come back and re-assess those recommendations to see if they had been acted up. But I had looked at recommendations and there obviously were quite a number. And when I reflect on them, they clearly would put us into a go standard because they were talking about having dedicated medical leads, dedicated technologists. And certainly by having or bringing that level of expertise to any particular service would enhance its

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creditability. But I also remember thinking at the time that these recommendations were being put forward for change, but in the recent couple of years that they would have had, without those recommendations in place, the positivity ratings were on the high side. So, trying to figure out how that impact, you know, was just one more element of this.

But I certainly have a recollection to say our focus is on the follow-up here. At some point--early October there was a media inquiry and that inquiry was in the nature of we're hearing something about Eastern Health having an issue with its mammography, which clearly wasn't the issue, but that resulted in an article in one of the local newspapers, The Independent, about this issue. Dr. Williams subsequently did a number of interviews about that, and it wasn't unanticipated, but it was certainly disappointing that we hadn't been able to get the results back by that point in time. The hope was that we were able to deal with this prior to any information coming out through the media. I think because of that there was

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information provided on the website which people were able to use to get some appreciation for what this issue was all about, and information about if you are one of those patients who had this test, then talking about the fact that if there's to be a change in treatment, that we will be back to you. So this is in early October. As a consequence of that coverage, I recall that there were obviously -- there were calls from individuals inquiring as to what this is all about, does this involve me, and I think in mid October sometime the decision was made to call patients and advise them that this test was going to be retested. So that sort of started the whole process of contacting the patients. Now I know the numbers were changing. Initially the number was in the 400 range. That was with regards to those that actually had been interpreted or read in St. John's, and that number subsequently grew when other health authorities provided their information or specimens, and there may have been some others in St. John's that increased it, but I'm not sure of that. So a team was put in

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place then. I think it was through the Quality Initiatives Department, and the majority, if not all of the staff working in that area, were -- had clinical backgrounds. So they started the process of calling individuals who would be retested. Now in terms of the results coming back, I recall that a decision was made at some point in time that if your result came back and it was confirmed negative, that group would make the call and advise you of that. If the result came back and showed a conversion to a positive level, then that was going to be referred to initially the most responsible physician, but that subsequently evolved into a tumor panel, and that tumor panel had representation from pathology, oncology, surgeons, and these are three physician groups, and a representative from Quality, who was serving more as the coordinator of the process. I recall that -- I don't know who initially came up with the idea, but I recall it in terms of consistency, in terms of interpreting the results that were coming back. In my mind, this was evolving on the

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definition of what would trigger a value of Tamoxifen or not, so -- anyway, the tumor panel took those results and evaluated them. When they had evaluated them, my recollection is the information was then sent to the Cancer Program, Cancer Care Program, which was essentially the former Newfoundland Cancer Treatment and Research Foundation, for those who still had their oncologists working there, or to the most responsible physician, and my recollection is for the other health authorities that that information, I can't recall now if that went directly to their labs or if it went to the physicians. So that process was underway, and that would have took us up to -- my recollection, up until December of 2005. During that fall, there would have been discussions with the other regional health authorities. I made it a point to listen in on those discussions, they were held by teleconference. So they -- I know they had been involved at the pathology of lab level back in the summer or June when there was a request from the lab in St. John's to get them to submit some information. So I know there

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was active discussion going on between the labs, but these particular meetings actually occurred at the CEO and Vice President level. I recall discussions about repeating some of the history about what this test is for, talking about its limitations, talking about what was learned in St. John's, and what the follow-up strategy was, and the CEO's, in particular, were certainly well known to one another. Since the time that the four CEO's were appointed that January, there had been ongoing collaboration. So that was continuing. There also had been a provincial mechanism for the Vice Presidents of Medical Services to come together from time to time as well. So that group wasn't new to itself and discussions were open. I'm drawing a blank now in terms of 2006.

COFFEY, Q.C.:

Q. Okay, we're up to '06. Well, let's see, I might help. All the results, I gather, or most of the results were back by February of '06, the retest results.

MR. TILLEY:

A. So results were coming back.

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COFFEY, Q.C.:

Q. They were back -- I gather most of them were back, according to the documents.

MR. TILLEY:

A. Okay.

COFFEY, Q.C.:

Q. By February of '06. So what's your next kind of recollection of what presumably -- the last comes back, the position of the panel, the review panel, still doing its reviews. What then happened?

MR. TILLEY:

A. What I'm recollecting is the issue that there was lots of discussions going on internally about the results. I do recall somebody bringing to my attention that we had inadvertently sent the same tests to Mount Sinai twice and it came back with two different results, but obviously there's an analysis underway in terms of following up with the patients. I remember a discussion about the need to ensure that the physicians who are receiving this information are following up with the patients because of the new information. There may have been an

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example where it had been identified that one had not. What I had referenced earlier about the two external reviewers, they had come back in to assess the status of the recommendations. So I'm recalling also that there might have been a change in the leadership in the lab around that time. Dr. Cook had completed his term, I can't remember what that term was; three years seems to ring a bell, and Dr. Nash Denic became involved. So I'm aware or recalling that there was a lot of discussion going on at that level with regards to the recommendations and the results of the work that had been coming back. And that the people involved in the contact were analysing their work. Sorry, I'm drawing a black here at the moment.

COFFEY, Q.C.:

Q. We're into '06, I'll just--something that's very publicly known. There was a press conference in late '06.

MR. TILLEY:

A. Okay.

COFFEY, Q.C.:

Q. I'm not suggesting that was necessarily the

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next thing, but that's certainly publicly know.

MR. TILLEY:

A. Okay. Working from there, a little bit back, meetings had gone on with Mr. Ottenheimer and Mr. Ottenheimer was unquestionably concerned about the patients and wanting this followed up and certainly there was absolutely no disagreement with that. But somewhere in and around the time, there was a change at the ministerial level. And I do recall contact with the new minister, Mr. Orsborne, Orsborne?

COFFEY, Q.C.:

Q. Osborne.

MR. TILLEY:

A. Osborne, sorry. And we had a meeting with him shortly or in the latter part of the fall, might have been in November some time. And I'm thinking that whatever information that was had at the time was shared. And I remember that meeting now because it was in a room adjacent to the House of Assembly and I'd never been in there before. So, the House was in session and the minister came out of the house. And then the issue about the press

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conference in December. So, that press conference--all throughout this period there was ongoing inquiries from the media with regards to what was happening, what's the update? And by this time the information is being pulled together. I'm starting to tweak some other thoughts now.

There were some internal presentations even before we met with the minister. I think Doctor Denic had undertaken a presentation at the Health Sciences Centre site for people who were interested, and I recall him and a couple of others doing a similar presentation certainly for the executive team, which would have been me and the Vice Presidents and the Chief Operating Officers, and I seem to recall others in the room, but I really can't pull out of my head who they were. So they were referring to this issue, what they've learned in the literature, what the recommendations were for follow-up, what the status of those were. One of the things I remember, and I think it was repeated during that presentation was a reference to the probalistic nature of this test, and I remember a slide going up

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which showed -- I assume what showed what one would -- what a pathologist would see when they've looked through the microscope, and how one of the things that the pathologist had to do was to identify what the rate of positivity was, which is the extent to which the cells were taking up the stain. So I began to appreciate the challenges that go with that type of position. Anyway, it wasn't something that I fully understood, but there were presentations about that, and after having that discussion in-house, excuse me, I also remember discussions about whether the VENTANA System that had been shut down in the summer of 2005 was, in fact, still not being used for that purpose. There was discussion about "are we ready", and I think the general consensus was, yeah, there's no reason we shouldn't. I remember saying to Dr. Howell that when you are at a point of feeling that we're ready to go, then I've got to rely upon you and your team to make that decision. So that was all precursor to the eventual technical briefing that was given in December.

COFFEY, Q.C.:

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Q. Commissioner, if we could take that up in the Morning.

THE COMMISSIONER:

COFFEY, Q.C.:

Q. All right, 9:30 tomorrow morning. Thank you.

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 15th day of April, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 15th day of April, A.D., 2008

Judy Moss

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