

COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

June 4, 2008

Appearances:

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

- Rolf Pritchard/Stephen Mills Her Majesty in Right of NL

- Peter Browne/Jane Hennebury Doctors Kara Laing et al

- Daniel Simmons Eastern Regional Integrated
. Health Authority

- Chesley Crosbie, Q.C. Members of the Breast Cancer
. Testing Class Action
- Mark Pike NL Medical Association
- Jennifer Newbury Canadian Cancer Society (NL Division)
- Blair Pritchett\
- Stacey O’Dea. Central, Western and Labrador-Grenfell
Regional Integrated Health Authorities

THIS PAGE ONLY REVISED NOVEMBER 18, 2008

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Certificate

1 THE COMMISSIONER:
2 Q. Please be seated. Mr. Coffey.
3 DR. GERSHON EJECKAM, EXAMINATION BY BERNARD COFFEY, Q.C.
4 (CONT'D)
5 COFFEY, Q.C.:
6 Q. Thank you, Commissioner. Good morning,
7 Doctor. If we could, Registrar, please,
8 Exhibit P-0113, page five, please? Now
9 Doctor, this is the June 19th 2003 memorandum
10 that you had written to Mr. Gulliver. Doctor,
11 why did you write this to Mr. Gulliver,
12 address it to him?
13 DR. EJECKAM:
14 A. Madame Commissioner, my understanding then was
15 that Mr. Gulliver, he was the program director
16 and also controlled the staff and the budget
17 of the Department, therefore if there was any
18 need for any change which requires some
19 investment that he would be the one to do it
20 or, you know, he would be the one to address
21 that to. So I addressed this concern to him,
22 basically to one of the potential risk. There
23 was no problem at that point actually, but
24 just had the potential, that we haven’t gotten
25 to the optimal level that we needed to be.

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1 COFFEY, Q.C.:

2 Q. You had not gotten to the optimum level?

3 DR. EJECKAM:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. Yes.

7 DR. EJECKAM:

8 A. But work was going on, and there was no danger

9 to anybody at that point.

10 COFFEY, Q.C.:

11 Q. And I take it though that in writing the memo,

12 I take it, from your perspective, if certain

13 things were not done in the future, that there

14 could be a risk?

15 DR. EJECKAM:

16 A. Yeah, the possibility of it.

17 COFFEY, Q.C.:

18 Q. Review of it. Doctor, if I could, Registrar,

19 please, page seven? Now this is the end of

20 the memo. Why did you copy it to Dr. Robb?

21 DR. EJECKAM:

22 A. Robb was the chairman of the department and

23 then Don Cook was the clinical chief.

24 COFFEY, Q.C.:

25 Q. So why would you copy it to--and to Dr. Parai,

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1 the site chief, why would you copy it to the

2 three physicians?

3 DR. EJECKAM:

4 A. My understanding, the line of authority then

5 that these other people could also have

6 influence in achieving what we're looking at.

7 COFFEY, Q.C.:

8 Q. And what you were suggesting in fact?

9 DR. EJECKAM:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. Okay. In terms of the contents of the memo,

13 the actual contents itself, some of the

14 subject matter in it, had you discussed these

15 matters with Dr. Robb, Dr. Cook or Dr. Parai

16 before you wrote it?

17 DR. EJECKAM:

18 A. No.

19 COFFEY, Q.C.:

20 Q. If I could, page five, please? Thank you.

21 Doctor, you do write, as you point out in the

22 first paragraph, middle sentence, "despite the

23 fact that the problem seems to have been

24 arrested, the state of immunostain at the

25 General Hospital, Department of Laboratory

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1 Medicine and Pathology, is still

2 unsatisfactory," and then you go and list the

3 reasons, from your perspective, as to what is

4 unsatisfactory.

5 The first is "the physical location of

6 this facility is unsatisfactory" and you

7 wanted it put into a separate room with proper

8 humidity control. I take it, Doctor, that in

9 the absence of proper humidity control, that

10 can create problems for IHC stains?

11 DR. EJECKAM:

12 A. It's a possibility to do that. It doesn't

13 have to happen, but it's a possibility.

14 COFFEY, Q.C.:

15 Q. It's possible. What can be the effect of

16 improper humidity?

17 DR. EJECKAM:

18 A. Well, we are doing tests that looking at

19 antigen antibody reaction and if you're going

20 to have proper temperature environment, that

21 may affect the result one way or the other.

22 COFFEY, Q.C.:

23 Q. Okay, the effectiveness of the actual

24 procedure -

25 DR. EJECKAM:

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. - may be impaired?

4 DR. EJECKAM:

5 A. Yeah.

6 COFFEY, Q.C.:

7 Q. You point out "immunohistochemical stain is

8 not just another special stain." This is

9 paragraph two. "It's affected by far more

10 numerous factors than may apply in other

11 special stains. It is an extremely sensitive

12 procedure. Therefore a haphazard and laisser

13 faire approach to it is not the way to go."

14 What you saw there at the time, what were you

15 referring to as a haphazard and laisser faire

16 approach? What were you -

17 DR. EJECKAM:

18 A. I was thinking of the way the technologists

19 were deployed. They had other duties. They

20 will do grossing and then go back to doing

21 immunohistochemistry and they were quite busy.

22 So I thought that with that dedicated staff to

23 be on that job without doing other things,

24 their attention may be taken away from that

25 and at that time, I think we were doing partly

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1 manual, partly automated and you might start
 2 off something and then you're called off
 3 somewhere for some other duties somewhere.
 4 Time you come back at it, timing may have
 5 elapsed or something may have happened. So
 6 these were the things I was looking at, I was
 7 thinking about in that paragraph.
 8 COFFEY, Q.C.:
 9 Q. And as you say, I take it at the time, the
 10 equipment was semi-automated, that's the DAKO
 11 system?
 12 DR. EJECKAM:
 13 A. Yeah, yeah.
 14 COFFEY, Q.C.:
 15 Q. Doctor, on that point, the DAKO equipment at
 16 the time it was there, did you have any
 17 concerns about the actual machine or equipment
 18 itself?
 19 DR. EJECKAM:
 20 A. No.
 21 COFFEY, Q.C.:
 22 Q. Okay. You were satisfied. Had you had any
 23 familiarity with that machine before?
 24 DR. EJECKAM:
 25 A. We used the DAKO in Doha, even though I wasn't

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1 working on it myself, and I was satisfied that
 2 the technology knew what to do with it. So I
 3 wasn't worried about the machine itself. DAKO
 4 was probably the first leader in this area in
 5 diagnostic pathology.
 6 COFFEY, Q.C.:
 7 Q. And paragraph three, you refer to "the staff
 8 arrangement as it stands now is grossly
 9 inadequate and unacceptable for problem free
 10 or minimal problem operations," and you then
 11 stipulate, "there has to be a dedicated staff
 12 to take over this special procedure," and you
 13 go on to say--and that's what you're referring
 14 to, I take it, that the staff were not
 15 dedicated solely to this?
 16 DR. EJECKAM:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. And it was a concern of yours?
 20 DR. EJECKAM:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. You go on to say, "the staff is expected to
 24 read wide on the subject and to understand the
 25 theory and practical aspects of

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1 immunohistochemistry." When you arrived in
 2 2002 and then we're into now halfway through
 3 2003, was there any reading material there for
 4 the staff related to immunohistochemistry?
 5 DR. EJECKAM:
 6 A. I don't recall any textbook that was there. I
 7 think they borrowed mine if they wanted to
 8 look at something, but we eventually bought--I
 9 think we ordered books for them.
 10 COFFEY, Q.C.:
 11 Q. When was that?
 12 DR. EJECKAM:
 13 A. Much, much later.
 14 COFFEY, Q.C.:
 15 Q. Much later?
 16 DR. EJECKAM:
 17 A. Yeah.
 18 COFFEY, Q.C.:
 19 Q. This is in 2005 or '06. This is when -
 20 DR. EJECKAM:
 21 A. Yeah, 2004/05, I don't remember the exact
 22 time, but we ordered books.
 23 COFFEY, Q.C.:
 24 Q. And the staff, when you first arrived, how
 25 much did they--in your interaction with them,

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1 how much did you feel that they knew about the
 2 theory of immunohistochemistry?
 3 DR. EJECKAM:
 4 A. I didn't go into that aspect, but they were
 5 doing their practical work reasonably okay, so
 6 I wasn't--I didn't discuss the theory of the
 7 subject with them, but like I said, if one is
 8 doing these on a daily basis, there'd be need
 9 for slightly wider reading to get more
 10 information about what's going on.
 11 COFFEY, Q.C.:
 12 Q. Because when you go on to speak about that in
 13 this memo, this point, you say "the staff" and
 14 you go on to the next page, "should be a
 15 problem shooter and that can only materialize
 16 through thorough understanding of the
 17 subject." You were saying that it would be
 18 helpful or more beneficial for them to have
 19 much greater appreciation of the theory of it?
 20 DR. EJECKAM:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And "besides the designated staff, there
 24 should be a need for standby staff in case of
 25 holidays or illness of the designated staff."

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1 You wanted staff who were even going to
 2 substitute to be trained?
 3 DR. EJECKAM:
 4 A. Yeah, well, I mean, here even I should have
 5 said number of people. I mean, if you have
 6 one person doing it dedicated, that's great,
 7 but if he doesn't come to work, what happens?
 8 So you needed somebody else, minimum of two
 9 or--well, three people usually, so that at all
 10 times there's someone who is familiar with
 11 what is going on.
 12 COFFEY, Q.C.:
 13 Q. And you go on to say then, "the dedicated
 14 staff, if there were such dedicated staff,
 15 should cut and stain all cases while the
 16 assistant/standby staff does that twice a
 17 week," which I take it would be in
 18 substitution?
 19 DR. EJECKAM:
 20 A. Yeah, I was just making a suggestion, you
 21 know.
 22 COFFEY, Q.C.:
 23 Q. Sure. So what you've described here then is a
 24 suggested kind of work arrangement?
 25 DR. EJECKAM:

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1 A. Yes, whoever is going to standby will have
 2 handle of what's going on. He don't have to
 3 wait until the other guy goes and he comes in
 4 and he's new to the process. So he has to
 5 take part in the process periodically so that,
 6 you know, he knows what's going on.
 7 COFFEY, Q.C.:
 8 Q. And you go on to say "the designated staff
 9 uses this valuable time for housekeeping jobs
 10 in immuno. This will include dealing with
 11 ordering and titrating new antibodies."
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. "This ensures that the standby staff is in
 16 tune with the procedure and can produce
 17 acceptable results when the need arises." And
 18 so this was a plan, as it were, a suggestion
 19 by yourself as to how it might be accomplished
 20 with dedicated staff?
 21 DR. EJECKAM:
 22 A. Yeah, that's one way, in my mind, a suggestion
 23 I was making. There could be other ways.
 24 COFFEY, Q.C.:
 25 Q. Sure. And you conclude by saying "to do less

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1 will simply become a gamble where you may win
 2 or lose. This obviously will spell disaster."
 3 So Doctor, those two sentences, what were you
 4 intending to do with those or by using those?
 5 DR. EJECKAM:
 6 A. I just want to drive home the need for the
 7 point I was making, that if you don't have
 8 dedicated staff and you don't have a
 9 substitute staff, then you are dealing with
 10 the situation where, you know, the results may
 11 not be what you expect, because you needed
 12 somebody to be dedicated to the job and you
 13 needed somebody to standby in case the
 14 dedicated staff is not there, unless you're
 15 willing to shut down the system when somebody
 16 goes on holidays or is ill or is taken away
 17 for personal other reasons.
 18 COFFEY, Q.C.:
 19 Q. Now Doctor, on this point, just as a general
 20 proposition, if, from your perspective, and
 21 you have I gather a significant amount of
 22 experience with IHC, if a facility is to be
 23 involved in IHC work, significantly engaged in
 24 it, okay, providing a service -
 25 DR. EJECKAM:

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1 A. Yeah.
 2 COFFEY, Q.C.:
 3 Q. - if a facility is not prepared to actually do
 4 what's required to ensure there is a quality
 5 product being done consistently, should they
 6 be involved in it at all, from your
 7 perspective?
 8 DR. EJECKAM:
 9 A. Most laboratories start small. Not everything
 10 will be there before you start, so you get
 11 everyone to offer the service, what you had
 12 there was good enough to start and then--
 13 because if you don't start, you don't know
 14 what to check on. So I think from that
 15 standpoint, you don't have to wait until every
 16 bit of thing is there. What was at the
 17 hospital at that time, even though the
 18 location wasn't optimal, was good enough to
 19 start doing that and then correct what may be
 20 wrong.
 21 COFFEY, Q.C.:
 22 Q. And I gather though here, in light of the tone
 23 of this memorandum, you were--I gather what
 24 you're telling the Commissioner is at the time
 25 you felt like it's acceptable what's being

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1 turned out right now, with you there to
 2 assist, and with the changes you'd
 3 implemented, but on a go-forward basis, if
 4 they were continuing--if they were going to
 5 continue to do this and involve new antibodies
 6 and so on, get more and more involved, did you
 7 feel--how did you feel about whether or not
 8 they should continue to be involved and
 9 expand, if they didn't address your concerns?
 10 DR. EJECKAM:
 11 A. Well, I feel that if we continued doing the
 12 job without addressing some of this, we may
 13 run into some difficulty down the road. We
 14 may or may not, but there's a potential for
 15 it.
 16 COFFEY, Q.C.:
 17 Q. Now paragraph four, Doctor, you've pointed
 18 out--you go on to say "the volume of
 19 immunohistochemical procedures continues to
 20 increase. Every day more diagnostic
 21 antibodies are added to the armamentarium of
 22 immunohistochemistry. Each new antibody poses
 23 its own special problem that needs to be
 24 mastered and solved before reliable,
 25 reproducible and consistent results can be

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1 obtained. Since this is the only centre in
 2 the province that performs this test, there is
 3 enough case to be made for identifying this
 4 activity as special and unique, therefore
 5 requires financing and staff."
 6 Well, Doctor, I take it the last point is
 7 you need more--to do it properly, perhaps more
 8 money and more dedicated people?
 9 DR. EJECKAM:
 10 A. Yeah, I mean, if they're going to hire more
 11 staff, create more positions, there would be
 12 some budget for it, and like I said, being the
 13 only centre for Newfoundland, I thought we
 14 could make a case to the authorities that
 15 funding should be provided to expand the
 16 services, in terms of more antibodies and
 17 staff positions.
 18 COFFEY, Q.C.:
 19 Q. Doctor, in this paragraph, you do, in the
 20 third sentence, say "each new antibody poses
 21 its own special problem that needs to be
 22 mastered and solved before reliable,
 23 reproducible and consistent results can be
 24 obtained." Can you explain briefly to the
 25 Commissioner what is involved in bringing in a

Page 19

1 new antibody? What are you talking about
 2 there?
 3 DR. EJECKAM:
 4 A. Madame Commissioner, what you do that when we
 5 buy a new antibody or something that we never
 6 used before, the commercial--the maker will
 7 give you some data, but it's advisable not
 8 just to take the data and start doing clinical
 9 work right away. You need to find suitable
 10 control in your laboratory. You need to run
 11 the tests with your own tissue in the
 12 laboratory and ascertain the positivity and
 13 negativity or specificity or sensitivity of
 14 that particular antibody, and you need to do
 15 this not just once. You need to do it on a
 16 series of material and then satisfy yourself
 17 that that antibody that is new is now ready to
 18 go into for diagnostic work. We don't get it
 19 from the makers and then put it--unless, if
 20 you used it before and you buy another one,
 21 the same batch number, then the same batch
 22 number, you have no problem. But even when
 23 you have used that antibody and you purchase
 24 another one that's a different batch number,
 25 you need to again make sure that it's doing

Page 20

1 what it's supposed to be doing before you put
 2 it into use, and this can be time consuming.
 3 COFFEY, Q.C.:
 4 Q. And was that being done when you arrived, that
 5 approach? Was that -
 6 DR. EJECKAM:
 7 A. I believe they were doing that. I believe
 8 that the techs were doing that. I cannot
 9 testify that I saw them doing it, but I
 10 believe they were doing this, because they had
 11 that procedure.
 12 THE COMMISSIONER:
 13 Q. Is there a set procedure, to your knowledge,
 14 in the lab, I mean in the sense of a manual
 15 that says when we get a new batch or a new
 16 antibody, these are the things that have to be
 17 done with it before we use it for the testing
 18 purposes or for diagnostic purposes?
 19 DR. EJECKAM:
 20 A. I don't recall any written manual that these
 21 are information that they have.
 22 THE COMMISSIONER:
 23 Q. Okay.
 24 DR. EJECKAM:
 25 A. And then, of course, later on, we started

Page 21

1 organizing to write a laboratory manual for
 2 immunohistochemistry and I believe that would
 3 have been included in the manual that was
 4 being prepared.
 5 THE COMMISSIONER:
 6 Q. Okay.
 7 COFFEY, Q.C.:
 8 Q. I take it then that when you arrived, there
 9 was no such manual?
 10 DR. EJECKAM:
 11 A. I don't recall seeing any.
 12 COFFEY, Q.C.:
 13 Q. Well, if you had--later on, if you had to
 14 start to create one, I take it no one said
 15 "well, we've already got on"?
 16 DR. EJECKAM:
 17 A. Yeah, yeah.
 18 COFFEY, Q.C.:
 19 Q. Doctor, paragraph five, you do say that "the
 20 present staff performing this procedure are
 21 doing the best they can, but with the myriad
 22 of other duties that take them away from the
 23 immunostain fairly regularly, it is virtually
 24 impossible for them to devote the time
 25 required to master the intricacies of this

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1 procedure." So that's what you're talking
 2 about, I take it, that because they were being
 3 required to do different things -
 4 DR. EJECKAM:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. - didn't have the sufficient time and
 8 concentration time to be able to, from your
 9 perspective, master it?
 10 DR. EJECKAM:
 11 A. Yes, they had other duties to do and they will
 12 start the immuno and they will then halfway
 13 probably go to their other duties, depending
 14 on when they're required to do the other
 15 things. They were doing grossing. They were
 16 probably doing other things. So that was what
 17 I was referring to here.
 18 COFFEY, Q.C.:
 19 Q. You go on to say, Doctor, that "The fairly
 20 good stain we have now," this was in June, mid
 21 June of 2003, "is a credit to them, but they
 22 do not have enough time to spare. It's my
 23 understanding, too, that some of them have
 24 less than two or three years in the
 25 establishment and their exit will create a

Page 23

1 vacuum and another period of uncertainty for
 2 immunohistochemistry." What were you
 3 referring to there?
 4 DR. EJECKAM:
 5 A. They were trying to build a code (phonetic)
 6 and they were producing results that we could
 7 use. The station wasn't optimal. That's one.
 8 Two, I understand that one or two of them were
 9 getting ready to their retirement age or when
 10 they want to leave the service, and unless you
 11 have younger people come in while they were
 12 there, to understudy them, then if they
 13 retire, then you have to bring in new person
 14 and you have to start all over again. But to
 15 have a nice--my suggestion here that they
 16 bring new people while the older ones were
 17 there so that they can understudy what they
 18 are doing before they retire.
 19 COFFEY, Q.C.:
 20 Q. And paragraph 6 you go on to say, "Finally, it
 21 is pertinent to mention the results of
 22 immunostains are extremely important in
 23 histopathologic diagnosis, especially where
 24 classification of lymphomas and determination
 25 of benign or malignancy of certain lesions,

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1 for example, in the prostate biopsies depend
 2 on crisp, reliable and reproducible staining
 3 results. Diagnosis based on inappropriate
 4 immunostain will surely jeopardize patient
 5 care and may even expose the Health Care
 6 Corporation of St. John's to litigation.
 7 Therefore it will be ill advised to operate an
 8 unreliable and erratic immunohistochemical
 9 procedures in our laboratory." And you
 10 conclude by saying, "I, therefore, advise that
 11 you kindly take a hard look at the above and
 12 then commit the necessary resources, human and
 13 financial, to this special, all important and
 14 only service in the Province of Newfoundland."
 15 And you signed your name to it. Doctor, the
 16 last paragraph, paragraph 6, the numbered
 17 paragraph, paragraph 6 you refer to, in
 18 particular, prostate biopsies and lymphomas?
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. You recall that in your April 4th memo you had
 23 referred to four lymphoma stains and one
 24 prostate stain?
 25 DR. EJECKAM:

Page 25

1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Was there anything, was that why you referred
 4 to those here, that you had encountered the
 5 problem with these other five stains and you
 6 were just -
 7 DR. EJECKAM:
 8 A. No, just an example of what could happen, it
 9 could have been another, I could you have used
 10 another antibody in this paragraph, it's an
 11 example.
 12 COFFEY, Q.C.:
 13 Q. And your statement that "Diagnosis based on
 14 inappropriate immunostain will surely
 15 jeopardize patient care and even expose the
 16 Health Care Corporation to litigation." At
 17 that time did you have any reason to believe
 18 then that there was any state of affairs that
 19 would then expose the Health Care Corporation
 20 to litigation?
 21 DR. EJECKAM:
 22 A. There was no incident, there was no problem at
 23 that time, but with my concerns it's possible
 24 that I was thinking ahead and if we don't have
 25 what we consider optimal stains that

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1 interpretation may be a problem and that may
 2 expose both the staff and the hospital to some
 3 difficulties.
 4 COFFEY, Q.C.:
 5 Q. Now, just so--you then go on to say, "It would
 6 be ill advised to operate an unreliable and
 7 erratic immunohistochemical procedures in our
 8 laboratory." Doctor, at that point, on June
 9 19th, 2003, did you believe that the
 10 laboratory then was operating an unreliable
 11 and erratic immunohistochemical procedure at
 12 that point?
 13 DR. EJECKAM:
 14 A. No, no.
 15 COFFEY, Q.C.:
 16 Q. Okay. And you do use the verb "will" which is
 17 the future tense, it will be advised. So I
 18 take then that in writing this, you weren't
 19 saying to Mr. Gulliver and the other--and the
 20 doctors that I am--"we are operating an
 21 unreliable, erratic" -
 22 DR. EJECKAM:
 23 A. No, I didn't mean that. I was just wondering
 24 about the future possibilities.
 25 COFFEY, Q.C.:

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1 Q. Sure. Now, Doctor, you wrote it. Doctor, had
 2 you ever written anything like this before?
 3 Like this, I mean, this is a fairly, I'm going
 4 to suggest to you, for a physician, you know,
 5 of your experience, okay, it's a fairly
 6 emphatic statement, is it not?
 7 DR. EJECKAM:
 8 A. Well, that was my concern and I put it down
 9 the best way I could.
 10 COFFEY, Q.C.:
 11 Q. Yeah. And you've indicated to the
 12 Commissioner yesterday you did this, no one
 13 asked you to do this, this wasn't kind of a
 14 set up, you know, for someone -
 15 DR. EJECKAM:
 16 A. No, no.
 17 COFFEY, Q.C.:
 18 Q. - down the road to use as a tool to get
 19 something. You were stating your own views?
 20 DR. EJECKAM:
 21 A. I wasn't asked to do this.
 22 COFFEY, Q.C.:
 23 Q. You've indicated to the Commissioner afterward
 24 you did speak to Dr. Robb. First you heard
 25 nothing and then at one point you did speak to

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1 Dr. Robb?
 2 DR. EJECKAM:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. And he told you what you've told the
 6 Commissioner yesterday and then he was ill and
 7 -
 8 DR. EJECKAM:
 9 A. I saw him in the corridor, because his office
 10 next door to mine, opposite mine, and he said,
 11 "Yes, I've got the letter and I will arrange
 12 for a meeting for all the stakeholders to
 13 discuss it." Unfortunately, he didn't get
 14 around to doing that. And also I did say that
 15 I did ask Terry about it, too, in the corridor
 16 near the laboratory, I saw him then, he said,
 17 "I will reply to you," that was the response
 18 he gave me at that time.
 19 COFFEY, Q.C.:
 20 Q. And there never was--you told the Commissioner
 21 there never was a reply?
 22 DR. EJECKAM:
 23 A. Yeah, there was no response.
 24 COFFEY, Q.C.:
 25 Q. Doctor, when you didn't receive a response,

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1 why didn't you ever take it up with them
 2 again?
 3 DR. EJECKAM:
 4 A. I had already written a memo indicating my
 5 concerns and when I didn't hear anything from
 6 them, I followed it up by asking did you get
 7 the memo and they said, yes. I didn't think
 8 it was any more necessary for me to pursue
 9 this matter knowing that a number of people
 10 were copied with it and I think that I had
 11 done my own bit at that point.
 12 COFFEY, Q.C.:
 13 Q. Okay. And so you don't recall any meetings
 14 arising out your memo itself?
 15 DR. EJECKAM:
 16 A. No, I don't recall any meeting, someone to
 17 discuss this issue.
 18 COFFEY, Q.C.:
 19 Q. Now, in relation to what it is you suggest
 20 here, which is really dedicated staff and a
 21 particular dedicated location, did the
 22 dedicated location occur at that point?
 23 DR. EJECKAM:
 24 A. Later on there was a move to--the
 25 immunohistochemistry was moved out of the

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1 where it was and moved into a different
 2 location, dedicated location. So, you know,
 3 that was--that took place after the letter.
 4 COFFEY, Q.C.:
 5 Q. Yeah. Sometime after it was moved to the back
 6 of -
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. The lab larger area?
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. Was it walled off?
 15 DR. EJECKAM:
 16 A. It was walled off. Just as I say
 17 (unintelligible) the location was okay.
 18 COFFEY, Q.C.:
 19 Q. Okay. It was moved after. And do you know if
 20 there was humidity control for it?
 21 DR. EJECKAM:
 22 A. It was okay because it was not much going on
 23 in the lab and it was good for air condition,
 24 so that was acceptable as far as I could tell.
 25 COFFEY, Q.C.:

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1 Q. And what about your suggestion about the
 2 dedicated staff, did that occur?
 3 DR. EJECKAM:
 4 A. I don't remember the work process there, but I
 5 know that later on had three of the techs,
 6 senior techs doing immunohistochemistry. I
 7 would suspect two of them were doing that as
 8 their main job or doing the job but maybe one
 9 of them probably helped do other things.
 10 That's kind of, that--it wasn't my position to
 11 know what the details or what they were doing
 12 actually.
 13 COFFEY, Q.C.:
 14 Q. Okay. If we could, please, Exhibit, let me
 15 just see, P-1572? Now these are the minutes
 16 of the first meeting of the surgical pathology
 17 review committee of April 15th, 2003, and we
 18 looked at that briefly yesterday. Doctor, so
 19 this is the first meeting, I take it?
 20 DR. EJECKAM:
 21 A. Yeah.
 22 COFFEY, Q.C.:
 23 Q. We looked at the agenda, and this is your
 24 first meeting. Doctor, your memo of April
 25 4th, 2003 predates this first meeting?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Your initiative in relation to the IHC stains,
 5 those eight stains, and IHC generally, but in
 6 particular those eight stains on April 4th,
 7 that initial initiative, did that have
 8 anything actually to do with the surgical
 9 pathology review committee?
 10 DR. EJECKAM:
 11 A. No.
 12 COFFEY, Q.C.:
 13 Q. That was your--and you described to the
 14 Commissioner yesterday, that arose out of your
 15 meetings with the local pathologists within
 16 the General Hospital and the St. Clare's
 17 people when they would come over?
 18 DR. EJECKAM:
 19 A. No, the surgical pathology committee was set
 20 up Don Cook, the clinical chief.
 21 COFFEY, Q.C.:
 22 Q. For a different -
 23 DR. EJECKAM:
 24 A. As a quality assurance process. It had
 25 nothing to do with the memo or

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1 immunohistochemistry.
 2 COFFEY, Q.C.:
 3 Q. But now in this at page 2, please, of the
 4 memo, at paragraph 3.1 there is a reference to
 5 the ER and PR receptors? You see that?
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. So why was this being talked about then, the
 10 ER/PR matter in the surgical pathology review
 11 committee meetings when, as you pointed out,
 12 they didn't really have a whole lot, if
 13 anything to do with each other because they
 14 were separate activities?
 15 DR. EJECKAM:
 16 A. No, what I was said was the setting up of
 17 surgical pathology review committee had
 18 nothing to do with immunohistochemistry, but
 19 part of the duty of that committee was to
 20 review the surgical reports that have come in
 21 on it and also review what had come into the
 22 laboratory. Therefore, when we stop this
 23 stain and membership to that committee, the
 24 oncologists were there, other users of that
 25 result were there, so I thought it was

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1 necessary to let the committee know that this
 2 test is not being done for a period of time.
 3 COFFEY, Q.C.:
 4 Q. Okay. So your initiative in relation to the
 5 IHC stains, you took up on your own with the
 6 concurrence of your fellow pathologists?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And you've described that. And when the
 11 committee itself was set up by Dr. Cook under
 12 your chairmanship.
 13 DR. EJECKAM:
 14 A. Yeah.
 15 COFFEY, Q.C.:
 16 Q. It had a, the surgical pathology review
 17 committee was a quality assurance issue?
 18 DR. EJECKAM:
 19 A. That's what it was supposed to be.
 20 COFFEY, Q.C.:
 21 Q. And just in the course of its proceedings, you
 22 thought it prudent to let them know this is
 23 going on?
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. Okay. Did the surgical pathology review
 3 committee ever actually oversee your work in
 4 relation to the IHC?
 5 DR. EJECKAM:
 6 A. They are not supposed to.
 7 COFFEY, Q.C.:
 8 Q. If we could, please, and I just--Exhibit P-
 9 1573? Doctor, this is a memo written by
 10 yourself, I'll show you, it's, yes, chair of
 11 that committee to all pathologists in the
 12 Health Sciences Centre and St. Clare's, April
 13 21st, 2003. And I take it this is to inform
 14 everybody that the surgical review committee
 15 was up and running?
 16 DR. EJECKAM:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. And what they would be involved with. And you
 20 point out in the second sentence, "This will
 21 require the pathologists flag cases suitable
 22 for discussion in the committee." And "From
 23 our standpoint incomplete surgical pathology
 24 request forms meet the criteria for review.
 25 In particular cases that have (1) No or

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1 relevant clinical history. No site of tissue.
 2 Absence of working clinical diagnosis
 3 especially for major surgical specimens." And
 4 "(4) All cases where the clinical diagnosis
 5 vary very significantly from the pathologic
 6 diagnosis." And I take it this was to alert
 7 the pathologists to your initiative, we're
 8 going to try to fix this problem with
 9 requisition forms?
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.:
 13 Q. Okay. If we could, please, Exhibit P-1575?
 14 Doctor, this is again minutes of a meeting of
 15 the surgical pathology review committee,
 16 September 23rd, 2003. You're chairing, see
 17 there. And Dr. Siddiqui, Parai, Tennent are
 18 present. Ms. Connors is there as secretary.
 19 And a call to order by yourself. The minutes
 20 of the previous--you asked if there were any
 21 changes needed to the previous minutes. Dr.
 22 Siddiqui moved to accept them and Dr. Parai
 23 seconded it. And I gather they were probably
 24 accepted. The earlier meeting, is that the
 25 April 15th one, would this be the second

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1 meeting of your committee?
 2 DR. EJECKAM:
 3 A. That may be the second or third one, I'm not
 4 sure now.
 5 COFFEY, Q.C.:
 6 Q. Can't recall. This one you do say here in the
 7 business arising at paragraph 2.1 "Estrogen
 8 and Progesterone Status. Dr. Ejeckam stated
 9 that the technical problem with staining for
 10 ER and PR stains has been solved." So that
 11 was -
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. Satisfied. And I take it that reflected what
 16 you said in your May 2nd memo to all
 17 pathologists?
 18 DR. EJECKAM:
 19 A. Yeah, yeah.
 20 COFFEY, Q.C.:
 21 Q. And here you go on to say, "Dr. Siddiqui" here
 22 it goes on to say, "Dr. Siddiqui asked what
 23 were the standards for performing Her2/neu.
 24 Some discussion took place with regards to
 25 this. It was decided that ER and PR will be

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1 done at the time of diagnosis and Her2/neu
 2 will be done by request. Dr. Siddiqui asked
 3 what about turn around time for Her2/neu. Dr.
 4 Ejeckam explained that Her2/neu will have to
 5 be done in batched because of cost associated
 6 with the test. It is usually performed once a
 7 week." Doctor, what was this about, this
 8 aspect of the matter?
 9 DR. EJECKAM:
 10 A. Now, do the test you do for breast cancer,
 11 ER/PR and Her2/neu, they were doing
 12 immunohistochemistry for those tests. Now,
 13 what we're saying here, that when we received
 14 a tissue that is malignant breast cancer, we
 15 should immediately request for estrogen and
 16 progesterone receptors to be done. Now,
 17 Her2/neu is another marker for aggressive
 18 tumors and they were just coming on board, and
 19 then we--the confirmation of that test
 20 required some more complicated tests that we
 21 were not doing at that time, what we are doing
 22 immunohistochemistry on it. And then some--if
 23 we needed, actually, those were sent out to
 24 other--Toronto or somewhere else. And for us
 25 to do it, if you open the vial and use just

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1 that for one, I don't know the cost exactly,
 2 but so cost that you needed to collect enough
 3 specimens so that if you open up a vial, then
 4 you would justify using it up. So it's not a
 5 test you do every day. You could do that for
 6 the ER/PR, but not with Her2/neu.
 7 COFFEY, Q.C.:
 8 Q. Okay. And this is to address that problem?
 9 DR. EJECKAM:
 10 A. For breast cancer, for breast cancer.
 11 COFFEY, Q.C.:
 12 Q. Okay.
 13 DR. EJECKAM:
 14 A. Cancers that are very malignant, poorly
 15 differentiated, most of them would be positive
 16 for Her2/neu. Neither advance for estrogen
 17 receptors. Estrogen receptors, progesterone
 18 receptors tend to be positive for low-grade
 19 tumors. They could be positive for low-grade
 20 tumors and negative for Her2/neu. The reverse
 21 is true for highly malignant tumors.
 22 COFFEY, Q.C.:
 23 Q. Doctor, here in the second page of this, of
 24 these minutes under "business arising",
 25 there's a discussion about, again the issue of

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1 no clinical history, proper clinical history
 2 being given and you had flagged cases
 3 involving hysterectomies, in particular here.
 4 And you said, "Again, no clinical history was
 5 being given or had been given for about 24
 6 percent of the cases flagged." And you go in
 7 the bottom paragraph here to say, the minutes
 8 say, "How do we solve this problem? Some
 9 discussion took place with regards to this.
 10 It was suggested that Dr. Ejeckam to ask Dr.
 11 Williams, vice-president of Medical Services
 12 to address this problem in a memo sent to all
 13 physicians indicating the problem and asking
 14 that they co-operate in filling out the
 15 requisitions properly."
 16 DR. EJECKAM:
 17 A. Yes.
 18 COFFEY, Q.C.:
 19 Q. So in relation to this, what was the
 20 relationship between you, as chair of this
 21 committee and Dr. Williams?
 22 DR. EJECKAM:
 23 A. This committee when it was set up, was
 24 supposed to send reports directly to the vice-
 25 president of Medical and that's what we did.

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1 After each meeting, we sent minutes, copies of
 2 our minutes to Dr. Williams and a copy to Dr.
 3 Cook.
 4 COFFEY, Q.C.:
 5 Q. Would you, having sent the minutes, would you
 6 speak to Dr. Williams too about the -
 7 DR. EJECKAM:
 8 A. No, I didn't go discussing that with him, you
 9 know, I just send the minutes up to him.
 10 THE COMMISSIONER:
 11 Q. Just a point you made earlier, a small point I
 12 think in respect of clarification, when you
 13 said that it was decided that ER/PR will be
 14 done at the time of diagnosis and Her2/neu
 15 would be done on request?
 16 DR. EJECKAM:
 17 A. Yes.
 18 THE COMMISSIONER:
 19 Q. Do I take it then that from the perspective of
 20 the pathologist, whether it was on the request
 21 or not, you would automatically do the ER/PR
 22 or is that a decision for a pathologist in any
 23 event?
 24 DR. EJECKAM:
 25 A. That is a pathologist's decision to make, any

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1 breast cancer that the pathologist sees and
 2 after diagnosing it's malignant on H--on
 3 hematoxylin eosin stain, you will fill out the
 4 request form to the immunohistochemistry lab
 5 for estrogen and progesterone assay.
 6 THE COMMISSIONER:
 7 Q. Okay, so that's a pathologist decision in any
 8 event?
 9 DR. EJECKAM:
 10 A. Yes.
 11 THE COMMISSIONER:
 12 Q. And what about Her2/neu, is that a pathologist
 13 decision?
 14 DR. EJECKAM:
 15 A. Not really, Her2/neu is reserved to people who
 16 have metastasis or would have recurrent
 17 disease and the pathologist have no way of
 18 knowing this, this request would have to come
 19 from (unintelligible) surgeon or the
 20 oncologist.
 21 THE COMMISSIONER:
 22 Q. Okay, thank you.
 23 COFFEY, Q.C.:
 24 Q. Further down on the same page, Doctor, under
 25 "New Business" there's a reference to

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1 guidelines needed for request for second
 2 opinion and it's written here, "Some
 3 discussion took place with regards to this.
 4 It was decided that a review request form is
 5 to be drafted by Doctor Ejeckam, it should
 6 state reason for review, external or internal
 7 consult sought or specify if they want another
 8 pathologist in the department to review the
 9 case. Then the site chiefs to look after this
 10 once it is received in the department. Also
 11 it needs to be clarified who pays when a
 12 physician requests to have a case sent to
 13 another site for a second opinion, even when
 14 the Health Care Corporation of St. John's'
 15 pathologists do not consider the consultation
 16 necessary." And you initial these minutes.
 17 Doctor, what was this about, the idea of, like
 18 a second opinion and how did that work when
 19 you arrived?
 20 DR. EJECKAM:
 21 A. A second opinion is done if a surgeon receives
 22 a pathologic report and he needs, he is not
 23 happy with it or he needs some clarification,
 24 he will have the right to request that someone
 25 else look at that tissue. And rather than do

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1 it haphazardly, we, in Doha, devised that you
 2 fill out a form indicating why you want it to
 3 be done, why you want it done in-house, that
 4 is one pathologist in that department to look
 5 at it or you want it sent out to a different
 6 centre, so you know, the idea that the
 7 surgeon, or whoever sends, will have the
 8 freedom to request for a second opinion. Now
 9 what we want to avoid is while you are doing
 10 your work, somebody phones you, one that you
 11 have sent away, one that you have sent to Dr.
 12 A or Dr. B, that would not be the way to go,
 13 so if somebody wants a second opinion and he
 14 has a right to ask for that and then he should
 15 come down and complete this request form and
 16 the procedure will take off.
 17 COFFEY, Q.C.:
 18 Q. Okay. And this, I take it, this aspect of the
 19 matter here, at this point in time, September
 20 of 2003, was to kind of formalize in the way
 21 of have some documents and a procedure set out
 22 that if you're looking for a second opinion,
 23 this is the way it should be done?
 24 DR. EJECKAM:
 25 A. In a way, yes.

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1 COFFEY, Q.C.:

2 Q. Doctor, in relation to that, you've referred

3 to surgeon, okay, the pathologist's reports in

4 respect of breast cancer, in particular ER and

5 PR results, because by then the diagnosis was

6 done and you're reporting on ER and PR

7 statuses. Those reports would also go to

8 oncologists, I take it?

9 DR. EJECKAM:

10 A. I don't know, I know our business is to send

11 the report to whoever made the request. If

12 the surgeon gets it, he then may refer to

13 oncologist, but we are not involved in

14 referring the case outside of the person who

15 made the request to the laboratory.

16 COFFEY, Q.C.:

17 Q. Doctor, what was the procedure to be if for

18 example you reported, not you, but a

19 pathologist reported a particular ER result

20 and PR result and the person to whom it was

21 reported, the surgeon or the oncologist or

22 both, for that matter, wanted it done again,

23 they had some question about the result, how

24 was that to be handled?

25 DR. EJECKAM:

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1 A. He should come in and talk to the pathologist

2 who reported it and ask that you would like it

3 repeated and he would state his reason, he

4 would discuss it with the pathologist and

5 there's usually no problem in asking the

6 technologist to repeat it.

7 COFFEY, Q.C.:

8 Q. And here's an example in respect of breast

9 cancer, you had pointed out in your memo of

10 May 2nd, 2003, that there are certain types of

11 breast cancers that are generally positive or

12 more often or almost always positive,

13 depending upon which type you're talking

14 about. So if an oncologist, for example, got

15 such a report, I'll just pick lobular cancer -

16 DR. EJECKAM:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. And it was negative and if they wanted to have

20 it redone because they didn't--there was some

21 question about the validity of the result.

22 DR. EJECKAM:

23 A. Yes.

24 COFFEY, Q.C.:

25 Q. It was your view at the time and the practice

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1 was, I take it, that they should approach the

2 reporting pathologist.

3 DR. EJECKAM:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. And just simply ask that it be done again?

7 DR. EJECKAM:

8 A. Yes.

9 COFFEY, Q.C.:

10 Q. Did that ever happen, do you know, in your own

11 experience?

12 DR. EJECKAM:

13 A. I don't recall that happening and nobody

14 approached me to repeat that and I don't know

15 what happened with my colleague's practice, so

16 if anybody made such a request, I wouldn't

17 know.

18 COFFEY, Q.C.:

19 Q. If there were such requests made, they weren't

20 made to you.

21 DR. EJECKAM:

22 A. No.

23 COFFEY, Q.C.:

24 Q. And they weren't reported to you, if they were

25 going on, the people weren't tell you that

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1 this is -

2 DR. EJECKAM:

3 A. No, and the way it went on, they probably

4 wouldn't have reported to me because to me,

5 it's not a second opinion issue, it's a

6 question of repeating a test and the surgeons

7 who request, fill out that form and the

8 technologist will go ahead and repeat it.

9 THE COMMISSIONER:

10 Q. Did I understand you yesterday to say that

11 there were occasions when a pathologist

12 himself or herself would decide to repeat a

13 test in those kinds of circumstances?

14 DR. EJECKAM:

15 A. Yes, because the tests are done and sent to

16 him and he looks at it and if he's not happy

17 with it, he will not make a report, he will

18 ask for repeats.

19 THE COMMISSIONER:

20 Q. Okay, and could that happen in the same kind

21 of situation that Mr. Coffey is now describing

22 one where you saw, assuming that you knew what

23 the diagnosis was, the type of cancer you were

24 dealing with, that that might be one where the

25 chances of having a negative result on ER/PR,

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1 for example, was very low, and you saw that
 2 there was a negative one, would you sort of
 3 say, "Um", maybe -
 4 DR. EJECKAM:
 5 A. Yeah, that's possible, that's possible.
 6 THE COMMISSIONER:
 7 Q. I guess what I'm asking is that the kind of
 8 information that a pathologist would take when
 9 looking at the test result and say, make a
 10 determination as to whether or not that maybe
 11 it should be run again or not?
 12 DR. EJECKAM:
 13 A. Yes, the pathologist will, looking at the
 14 histology first and when you get a result and
 15 if he thinks a discrepancy, he will then
 16 decide to call on the techs and say please
 17 repeat this, basically what's going on here?
 18 THE COMMISSIONER:
 19 Q. Okay, thank you.
 20 COFFEY, Q.C.:
 21 Q. In respect of in St. John's, with respect to
 22 ER/PR, did you ever, do you recall doing any
 23 retests yourself for that reason?
 24 DR. EJECKAM:
 25 A. Oh yes, but not ER/PR--well yeah, some ER/PR

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1 and some other antibodies, if we received any
 2 stain and weren't happy with it, we requested
 3 a repeat.
 4 COFFEY, Q.C.:
 5 Q. And in circumstances like that when it was
 6 repeated and if you got the second result and
 7 it was acceptable, you know, the slide, would
 8 you make any further inquiries at that time as
 9 to well why the first slide, the first process
 10 didn't work?
 11 DR. EJECKAM:
 12 A. Sometimes yes, sometimes no.
 13 COFFEY, Q.C.:
 14 Q. And do you recall if any of these did involve
 15 ER or PR repeats?
 16 DR. EJECKAM:
 17 A. I don't remember that. I know that in general
 18 practice when you receive a stain that you're
 19 not happy with, you ask the techs to repeat it
 20 and they will do that and if, I mean, this was
 21 the way we arrived at the first instance to
 22 stop some immunos because when they are
 23 repeated and they were not particularly
 24 helpful, well then we stop and solve the
 25 problem. And after that, I don't know, I

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1 mean, I don't remember any major issues
 2 involving retesting at that point, I mean,
 3 repeating the immuno stain.
 4 COFFEY, Q.C.:
 5 Q. Doctor, do you recall whether or not in
 6 dealing with ER and PR you encountered any
 7 failure of, by involving internal controls.
 8 DR. EJECKAM:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. Okay, when was that? When did you -
 12 DR. EJECKAM:
 13 A. I can't put a date to it, but in the process
 14 of evaluating the stain, we found that the--
 15 that was part of the reason why we had to stop
 16 and then work on it.
 17 COFFEY, Q.C.:
 18 Q. Okay, so that's back in late 2002, early 2003?
 19 DR. EJECKAM:
 20 A. Yeah.
 21 COFFEY, Q.C.:
 22 Q. That time period. You had, yourself,
 23 encountered some failures of internal
 24 controls?
 25 DR. EJECKAM:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And that caused you concern why?
 4 DR. EJECKAM:
 5 A. Because they should be positive.
 6 COFFEY, Q.C.:
 7 Q. Yes.
 8 DR. EJECKAM:
 9 A. It should be--it's a critical point for us, so
 10 if that was not staining, question the
 11 internal may be positive, but internal control
 12 if it's not staining, then it becomes a
 13 problem and we need to repeat it and be sure
 14 that something haven't gone wrong.
 15 COFFEY, Q.C.:
 16 Q. Now those particular cases, did you repeat
 17 those?
 18 DR. EJECKAM:
 19 A. Yeah.
 20 COFFEY, Q.C.:
 21 Q. And what happened on the repeat?
 22 DR. EJECKAM:
 23 A. We were happy with what we're getting.
 24 COFFEY, Q.C.:
 25 Q. The internal control did stain then on repeat.

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<p>1 DR. EJECKAM: 2 A. Yes, yes. 3 COFFEY, Q.C. 4 Q. And so I take it that the first time, like, a 5 particular slide in the internal control 6 didn't stain, from what you told the 7 Commissioner yesterday, as a pathologist, 8 that's unreportable, should not be reported. 9 DR. EJECKAM: 10 A. Yeah. 11 COFFEY, Q.C. 12 Q. That was your view. 13 DR. EJECKAM: 14 A. I mean, I'm assuming that the pathologists are 15 aware of this, but as I explained yesterday, 16 this is a stain that hasn't really--it's not 17 like an HNE that was started two or three 18 hundred (phonetic) years ago. So, if a 19 particular pathologist is unaware of internal 20 control and then he sees that the tumor cells 21 are staining one way or the other on negative, 22 then he may be pushed to--he may report that, 23 appreciating the potential of that. 24 COFFEY, Q.C. 25 Q. But in your case, when you came along with</p>	<p>1 ie. failed to stain, do you recall whether or 2 not the tumor itself had stained at the time? 3 DR. EJECKAM: 4 A. Sometimes it would stain; sometimes it would 5 be negative. 6 COFFEY, Q.C. 7 Q. Okay. Now, in these meetings when you were, 8 when this was, as you pointed out, these 9 Tuesday and Wednesday meetings - 10 DR. EJECKAM: 11 A. Yeah. 12 COFFEY, Q.C. 13 Q. - were going on, did you raise this in these 14 meetings, this particular problem with ER/PR 15 internal controls? 16 DR. EJECKAM: 17 A. I didn't need to raise it because other people 18 were having the same problem, not just in 19 internal control problem, with consistency 20 would be ER/PR, that was why the stain was 21 stopped. 22 COFFEY, Q.C. 23 Q. Okay. 24 DR. EJECKAM: 25 A. And we started titrating, we started doing the</p>
<p>1 your experience, when you arrived in St. 2 John's in 2002 you encountered some internal 3 controls for ER/PR that did not stain, you 4 realized from - 5 DR. EJECKAM: 6 A. From my--yeah. 7 COFFEY, Q.C. 8 Q. You realized, this is not right, you know, in 9 your world, based upon your experience is 10 something - 11 DR. EJECKAM: 12 A. Yes. 13 COFFEY, Q.C. 14 Q. - not right here. You made further inquiries 15 and you had the test, in fact, re-run and if 16 the internal controls stained then, you would 17 go ahead then and report the case - 18 DR. EJECKAM: 19 A. Yes. 20 DR. EJECKAM: 21 A. - as you saw, the tumors you saw fit. 22 DR. EJECKAM: 23 A. Yes. 24 COFFEY, Q.C. 25 Q. When the internal control initially failed,</p>	<p>1 timing for the antigen retrieval and the one 2 we were happy that we were getting something 3 to rely on, then we'll put back the stain into 4 the stream. 5 THE COMMISSIONER: 6 Q. So, the impetus for the shutdown in the work 7 that you did at the time was this 8 inconsistency, was it, that you were seeing 9 slides that seemed to have been properly 10 processed and the internal control was 11 stained, et cetera, and may be the next one 12 wouldn't be. Is that the idea because it was 13 being - 14 DR. EJECKAM: 15 A. Yeah, is one of the reasons for shutting down. 16 THE COMMISSIONER: 17 Q. But that's only one of them. 18 DR. EJECKAM: 19 A. Another reason was that who would get a good 20 stain, control, today and tomorrow, the same 21 block that was used as control, that would 22 show up differently. So that wasn't 23 consistent. 24 THE COMMISSIONER: 25 Q. Okay.</p>

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1 DR. EJECKAM:
 2 A. So, these cause us to, cause me to say now,
 3 let's stop this and then look at what the
 4 problem was.
 5 THE COMMISSIONER:
 6 Q. All right, thank you.
 7 COFFEY, Q.C.
 8 Q. So, it's inconsistency in the staining of the
 9 control blocks, external control block slides
 10 from day to day, some time an internal control
 11 wouldn't stain or a patient's internal control
 12 tissue wouldn't stain, you'd rerun and it and
 13 it would stain -
 14 DR. EJECKAM:
 15 A. And sometimes the tumor, the patient sample is
 16 not good. Like if we saw that the patient
 17 sample has no normal breast tissue, then we
 18 have to repeat. You have to look for a block
 19 that has normal breast tissue or the tendency
 20 is not to report that, even if it's positive,
 21 it's all only tumor. It would be a good idea
 22 to look for a section that has normal breast
 23 tissue in it.
 24 COFFEY, Q.C.
 25 Q. And that was certainly your own practice? You

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1 would look for something -
 2 DR. EJECKAM:
 3 A. Yeah, that's what I would do.
 4 COFFEY, Q.C.
 5 Q. And I take it that's why you included it in
 6 your memo of May 2nd, 2003. There is a
 7 paragraph refers to having normal acini in
 8 your -
 9 DR. EJECKAM:
 10 A. Yes. Well, I mean, that's general
 11 information. It wasn't based on what I found
 12 in house, but that's general information to
 13 have--if someone didn't know this, that that's
 14 something to have.
 15 COFFEY, Q.C.
 16 Q. Doctor, that memo, when I think about it,
 17 because you were--you did have teaching
 18 responsibilities yourself as part of the--you
 19 were on the staff of the medical school at the
 20 time?
 21 DR. EJECKAM:
 22 A. Yes.
 23 COFFEY, Q.C.
 24 Q. That May 2nd, 2003 memo, okay, the contents of
 25 it, would that be the sort of lesson, as it

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1 were, or outline of information that you would
 2 give to a resident who was dealing with or
 3 learning--you know, was doing breast pathology
 4 at the time? Is that the sort of thing you'd
 5 give to a resident?
 6 DR. EJECKAM:
 7 A. The information was valid for either resident
 8 or pathologists.
 9 COFFEY, Q.C.
 10 Q. For pathologists as well, I appreciate that.
 11 DR. EJECKAM:
 12 A. Yes, yeah.
 13 COFFEY, Q.C.
 14 Q. It's addressed to all pathologists.
 15 DR. EJECKAM:
 16 A. Yeah.
 17 COFFEY, Q.C.
 18 Q. But is it the sort of thing that you, at the
 19 time, in 2003, there were residents being
 20 trained here in St. John's at the time, I take
 21 it?
 22 DR. EJECKAM:
 23 A. Yeah.
 24 COFFEY, Q.C.
 25 Q. So that's the sort of thing that you would

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1 want to ensure that your own residents, people
 2 working for you -
 3 DR. EJECKAM:
 4 A. Yes.
 5 COFFEY, Q.C.
 6 Q. - would know?
 7 DR. EJECKAM:
 8 A. Yeah.
 9 COFFEY, Q.C.
 10 Q. You'd expect them, when you finished teaching
 11 them, you'd expect them to know that?
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.
 15 Q. If we could, please--after the changes were
 16 made in 2003, you know, that you've described
 17 to the Commissioner, involving those eight
 18 stains, in particular ER/PR, in particular, in
 19 your work afterward, throughout '03 and
 20 through '04 and into '05, 2005, did you ever,
 21 afterward, notice any failure of internal
 22 controls involving ER/PR?
 23 DR. EJECKAM:
 24 A. I don't recall that.
 25 COFFEY, Q.C.

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<p>1 Q. I'm not suggesting you did at all, just saying 2 you can't recall.</p> <p>3 DR. EJECKAM:</p> <p>4 A. No.</p> <p>5 COFFEY, Q.C.</p> <p>6 Q. After you made your changes -</p> <p>7 DR. EJECKAM:</p> <p>8 A. Yes, after the changes, I don't remember any 9 of those again.</p> <p>10 COFFEY, Q.C.</p> <p>11 Q. Any failure of internal controls.</p> <p>12 DR. EJECKAM:</p> <p>13 A. Yeah.</p> <p>14 COFFEY, Q.C.</p> <p>15 Q. Doctor, just on a more general point, if you 16 can assist the Commissioner in this regard, in 17 your experience and you pointed out you worked 18 in Qatar for many years, and after the changes 19 were made here, in '03, that you implemented, 20 if a tissue sample is properly fixated, fixed, 21 and it's the appropriate sort of block to have 22 an ER and PR test done on, it's got a proper 23 mixture of tumor and normal tissue and all the 24 laboratory procedures are being properly run 25 and they're all, every I is being dotted,</p>	<p>1 because already controls are run on a daily 2 basis the same way. So, they ought to come 3 out positive all the time, if it's a positive 4 control or negatives, a negative control.</p> <p>5 COFFEY, Q.C.</p> <p>6 Q. If we could, please--and on this issue of 7 internal controls, after you made your 8 adjustments in 2003, I appreciate you didn't 9 encounter any problem with internal controls 10 for ER/PR afterward, yourself, were there any 11 reported to you afterward? Any other 12 pathologists come along and say -</p> <p>13 DR. EJECKAM:</p> <p>14 A. No, no.</p> <p>15 COFFEY, Q.C.</p> <p>16 Q. - Gershon, you know, it's -</p> <p>17 DR. EJECKAM:</p> <p>18 A. No.</p> <p>19 COFFEY, Q.C.</p> <p>20 Q. Okay. So, after the changes were implemented, 21 there were no more complaints about internal 22 controls?</p> <p>23 DR. EJECKAM:</p> <p>24 A. Nobody complained to me and if they existed 25 and they took care of it, I wouldn't know.</p>
<p>Page 62</p> <p>1 every T being crossed, everything is being 2 done precisely, have you ever had occasion to 3 encounter a situation where a particular slide 4 was run, ER test was done and you got a 5 particular result and you were satisfied that 6 the internal and external controls all worked. 7 Is it possible that if the test was done a 8 second time and all the controls worked, the 9 result could be different?</p> <p>10 DR. EJECKAM:</p> <p>11 A. It's possible. I mean, if it was a second 12 time and the antigen retrieval time had 13 changed or somebody missed out anything, 14 that's a possibility, but if all the 15 procedures are followed that the way you 16 describe it, it should come out okay.</p> <p>17 COFFEY, Q.C.</p> <p>18 Q. Should come out the same the second time -</p> <p>19 DR. EJECKAM:</p> <p>20 A. Yes.</p> <p>21 COFFEY, Q.C.</p> <p>22 Q. - if the procedures are precise and is the 23 same each time.</p> <p>24 DR. EJECKAM:</p> <p>25 A. Yeah, that's what I consider being consistent</p>	<p>Page 64</p> <p>1 COFFEY, Q.C.</p> <p>2 Q. Sure, okay. If, for example, a particular 3 pathologist had a problem with the internal 4 control and had the test re-run, they wouldn't 5 necessarily tell you?</p> <p>6 DR. EJECKAM:</p> <p>7 A. They have access to the technology, you know, 8 they didn't have to go through me to them. 9 So, they would directly ask them to repeat it 10 and if they did it and the partic--laboratory 11 is happy with the result, then he wouldn't 12 report it.</p> <p>13 COFFEY, Q.C.</p> <p>14 Q. Doctor, at the time in 2003, I take it that 15 looking at a slide, if there's a problem with 16 fixation of the tissue, is that apparent to 17 you as a pathologist?</p> <p>18 DR. EJECKAM:</p> <p>19 A. You need some degree of experience when you 20 look at the HNE, not on immunohistochemistry 21 because you have to (unintelligible) the HNE. 22 If there are problems of processing, non- 23 fixation, non-dehydration, whatever, you might 24 be able to--you require some degree of 25 experience to notice on the HNE that it is, to</p>

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1 show it's improperly fixed because if it
 2 wasn't properly fixed, the staining
 3 characteristics in the area that wasn't fixed
 4 would be different from the area that's
 5 properly fixed.
 6 COFFEY, Q.C.
 7 Q. And that's the HNE standard -
 8 DR. EJECKAM:
 9 A. HNE, you know--and then if you have that kind
 10 of vision you probably would not pick that
 11 particular block to send to the techs for
 12 immunohistochemistry.
 13 COFFEY, Q.C.
 14 Q. On an IHC slide, is a problem with fixation, a
 15 person of your experience, is it apparent when
 16 you look at a IHC slide?
 17 DR. EJECKAM:
 18 A. Sometimes you could, blurry and then you have
 19 to wonder what went wrong. It's not always
 20 easy to do that on IHC.
 21 COFFEY, Q.C.
 22 Q. So the identification of fixation problems, if
 23 they exist, in your experience, you would
 24 generally do that at the HNE slide stage?
 25 DR. EJECKAM:

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1 A. It's a lot easier to pick it up at HNE level.
 2 COFFEY, Q.C.
 3 Q. Now, during your time in St. John's, between
 4 2002 and 2006, did you notice problems with
 5 fixation on HNE slides?
 6 DR. EJECKAM:
 7 A. Sometimes. I mean, you process thousands of
 8 sections on a monthly basis or, you know--
 9 there's going to be some slide that may have
 10 problem with them. And two things happen, if
 11 the difficulties on the slide are not
 12 critical, let's say if you can make a
 13 diagnosis, despite non-optimum fixation didn't
 14 go ahead, but if he has rendered the section
 15 un-interpretable, then you send it back to the
 16 techs.
 17 COFFEY, Q.C.
 18 Q. With a view to doing what? If it's un-
 19 interpretable, would you send back -
 20 DR. EJECKAM:
 21 A. They may have to re-process it or if you have
 22 tissue left, you may go back and put that
 23 additional tissue for fresh processing.
 24 COFFEY, Q.C.
 25 Q. Okay. How did the, looking back on it, your

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1 observations about fixation or fixation
 2 problems such, you know, whenever they
 3 existed, how did that compare with your
 4 experience in Qatar, the fixation quality in
 5 Newfoundland and Labrador -
 6 DR. EJECKAM:
 7 A. It's not very different. Fixation problem is
 8 the same problem over the world for HNE
 9 because those who send specimen from the OR to
 10 the laboratory tend to have factually the same
 11 sense in that sometimes you have enough
 12 formalin, sometimes you don't have enough.
 13 So, on average, it's almost the same.
 14 COFFEY, Q.C.
 15 Q. I take it as well, with respect to fixation
 16 because you were telling the Commissioner
 17 yesterday that, I take it, in terms of large--
 18 tissue samples that are big in volume, large
 19 samples, have to sliced, thinly sliced -
 20 DR. EJECKAM:
 21 A. Yes, big solid masses, if you want it to fix
 22 properly, you slice it thin and then put it in
 23 the formalin. Because if--especially if it's
 24 encapsulated, if it's encapsulated and you
 25 dump it in formalin like that, you're going to

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1 get maybe three or four millimetre penetration
 2 of formalin, the centre area will not be
 3 fixed, why the periphery would be fixed.
 4 COFFEY, Q.C.
 5 Q. In the central area in the meantime, starts to
 6 deteriorate.
 7 DR. EJECKAM:
 8 A. Yeah, I mean, you're going to
 9 (unintelligible). So, this is a problem
 10 you're going to get. So, to avoid that, what
 11 we do, one will get the specimen, breast or
 12 lymph nodes or masses in the neck, thyroid,
 13 will slice them and then put them in formalin
 14 to fix and then you process them probably the
 15 next day, allow to fix.
 16 COFFEY, Q.C.
 17 Q. What was the--in terms of that, what was the
 18 practice in St. John's in respect of breast
 19 tissue when you arrived, in terms of slicing
 20 the tissue? What did you -
 21 DR. EJECKAM:
 22 A. Breast tissue, they come in fresh, they are
 23 sliced and fixed.
 24 COFFEY, Q.C.
 25 Q. And who was doing the slicing?

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1 DR. EJECKAM:
 2 A. The pathologist or the resident in the
 3 grossing.
 4 COFFEY, Q.C.
 5 Q. And was there--you pointed in your memo of May
 6 2 that there's an optimum fixation time for
 7 breast tissue.
 8 DR. EJECKAM:
 9 A. For immunohistochemistry.
 10 COFFEY, Q.C.
 11 Q. I apologize, you did say immunohistochemistry,
 12 18 - 24 hours.
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.
 16 Q. Was there--within St. John's, within the
 17 General Hospital, for example, or St. Clare's
 18 for that matter, was there any timer or any
 19 record kept of how long the tissue was being
 20 immersed in formalin?
 21 DR. EJECKAM:
 22 A. No, and that record is not kept in any
 23 laboratory that I know of.
 24 COFFEY, Q.C.
 25 Q. I was trying--in terms of how would you figure

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1 out that it was 18 - 24 hours, that's the -
 2 DR. EJECKAM:
 3 A. I mean, you have an OR, at least you know when
 4 the surger was done, they generally put the
 5 date and the time, or sometimes in the
 6 request, from time the tissue was obtained.
 7 And then on the form, you be able to calculate
 8 when we receive tissue. Sometimes a tissue is
 9 brought in fresh and look at it and it is as
 10 fresh, is now ready to go into the tissue
 11 processor. Then you leave it until the next
 12 day. So, most of them will come within that
 13 period of time.
 14 COFFEY, Q.C.
 15 Q. In your experience though, there was not--
 16 people, on a form, weren't keeping track or in
 17 a computer system, were not keep track of, you
 18 know, the surgery occurred at 4:00 p.m. on a
 19 particular day and you'd be in the pathology
 20 lab at 5:00 and would know by looking at the
 21 form that it's 4:00 and I'm doing the slicing
 22 and the next day at 10:00 in the morning you
 23 could calculate the number of hours that had
 24 gone by. I take it there was no kind of
 25 record like that -

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1 DR. EJECKAM:
 2 A. No, no, I mean, no, I don't know that anybody
 3 keep that kind of record in histopathology
 4 laboratory because, I mean, it's within that
 5 period of time, 18 - 24 hours, somebody has
 6 surgery, like you said, at 4:00, it comes in,
 7 by next day it is fixed to go to be processed.
 8 So, it's not even, it comes within that 18 -
 9 24 hours.
 10 COFFEY, Q.C.
 11 Q. But if it doesn't get, I take it grossed that
 12 evening, if it's just left in the formalin
 13 overnight in a mass, that can create a
 14 problem, if it's not sliced up until the next
 15 morning.
 16 DR. EJECKAM:
 17 A. Yes, but by that wasn't the problem with
 18 breast tissue because you, they remove the
 19 breast, they will call because one will call
 20 for the pathologist or the resident that a
 21 breast mass was coming. I don't recall an any
 22 breast that was removed and dumped in formalin
 23 without anybody seeing it until the next day.
 24 I don't recall any one, like -
 25 COFFEY, Q.C.

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1 Q. I take it, you tell the Commissioner, in terms
 2 of the idea of keeping track of, like,
 3 literally the timing of the surgery, the
 4 timing of the grossing, the length of time the
 5 tissue remained in the formalin, that didn't
 6 go on in Qatar either. The idea of keeping -
 7 DR. EJECKAM:
 8 A. No, we didn't keep log books of the timing,
 9 but you could tell from the time of surgery,
 10 the time it come--sometimes they leave the
 11 specimen in OR maybe during the weekend, you
 12 should be able to now call and tell them that
 13 the--first of all, apart from the timing, this
 14 patient has been delayed for 48 hours in the
 15 OR. Therefore, they shouldn't complain about
 16 the late result, that's part of it and then if
 17 the specimen has deteriorated, they should now
 18 note that as incident report, but we don't
 19 keep, we didn't keep, I don't know if in
 20 laboratory that would keep the time the
 21 specimen had been formalin unless doing a
 22 study.
 23 COFFEY, Q.C.
 24 Q. If we could please, Exhibit P-1576. Now,
 25 Doctor, this is a "Division of Anatomical

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1 Pathology Pathologists Meeting". I take it
 2 these are the minutes of the meeting of
 3 September 24, 2003. This is actually the
 4 agenda and then the minutes are on page two of
 5 the exhibit. Present are a number of doctors
 6 including yourself, Dr. Fernandez, Chittal,
 7 Parai, Pirzada, Carter, Barron, Fontaine and
 8 again, another Dr. Parai. These are all
 9 pathologist?
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.
 13 Q. And Dr. S. Parai would have been the site
 14 chief at the time?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.
 18 Q. And, Doctor, there's a reference here under
 19 "Business Arising" to Cantext. Now, this
 20 particular Cantext matter, I take it, involves
 21 prostate needle core biopsies and GI biopsies
 22 and endometrial biopsies and endocervical
 23 biopsies and others. Cantext, what is
 24 Cantext?
 25 DR. EJECKAM:

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1 A. I don't use that word, but understanding of it
 2 is that you kind of stereotype a brief
 3 description for small samples that doesn't
 4 require pathology, you know, gross
 5 description. So, those small samples could
 6 have one type of description, you know, and
 7 make life a little bit easier and faster for
 8 those who are grossing them.
 9 COFFEY, Q.C.
 10 Q. Well, there's a reference in 3.2 to "Q.A.
 11 Program", quality assurance program, that
 12 would be? Q.A. would be quality assurance
 13 program?
 14 DR. EJECKAM:
 15 A. Yeah.
 16 COFFEY, Q.C.
 17 Q. Okay. "The final Q.A. program will be
 18 completed soon after a final meeting with Dr.
 19 D. Cook and Barry Dyer. However, the present
 20 practice of mentioning the name of the
 21 consulting pathologist in the microscopic
 22 description will continue". Do you recall
 23 what this was about?
 24 DR. EJECKAM:
 25 A. I'm not 100 percent sure here, but my

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1 recollection might be that when we're talking
 2 about Cantext, gross description by techs, who
 3 have to do the gross description, dealing with
 4 small samples that they could describe what
 5 does one type of description for. Now, when
 6 it comes to the microscopy, now we are
 7 discussing whether you also have one type of
 8 description for appendix, for skin or that
 9 kind of thing. And based on what is shown--
 10 say, well, may be difficult to do, then it
 11 going to be the name of the pathologist who
 12 signed that out because if you don't put it,
 13 then the surgeon will not know whom to call or
 14 whom to deal with if there's a problem with
 15 that particular case. That's my recollection
 16 of (unintelligible) sign that.
 17 COFFEY, Q.C.
 18 Q. And why I ask you about it is not so much that
 19 it has anything directly to do with the ER/PR
 20 matter, but the reference to the Q.A. program,
 21 I take it that at this point in time, in 2003,
 22 September 2003, there's some effort being made
 23 to address quality assurance in respect of the
 24 surgical pathology review committee and this
 25 division of anatomical pathology?

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1 DR. EJECKAM:
 2 A. Yeah, the surgical pathology review committee,
 3 even they say quality assurance process is not
 4 responsible for poor tests run in the
 5 laboratory. What was being tried here was to
 6 set up a quality assurance program or manual
 7 for the department, I mean, division of
 8 anatomic pathology, completely separate and
 9 different from such group of regular review
 10 committee.
 11 COFFEY, Q.C.
 12 Q. If we look at paragraph 4.1 of this same
 13 exhibit it says, "laboratory technical
 14 quality" and this is under the heading, "new
 15 business", this was discussed with Barry Dyer,
 16 Terry Gulliver and Dr. D. Cook. The
 17 discussion included the technical quality of
 18 the slides, error labelling, floater and
 19 others. Some of these issues have been
 20 documented. Dr. G. Ejeckam has given a
 21 lecture on quality assurance of the laboratory
 22 which was attended by one senior technologist.
 23 This program is available for all the lab
 24 technical staff at a suitable time, if
 25 interested. A log book is available in the

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1 reporting room to record all problems".

2 Now, what was going on here, Doctor, what

3 was this?

4 DR. EJECKAM:

5 A. What I was request--I mean, I had lecture

6 notes from quality assurance that we had used

7 in Doha and I thought we could give a lecture

8 to our residents and our staff. So, this was

9 made an open thing for the residents and the

10 technical staff to attend. Like was noted

11 here, unfortunately, they were very busy doing

12 something and only one of the techs attended,

13 but this lecture was given to residents,

14 doctors who are training along with the techs.

15 COFFEY, Q.C.

16 Q. So, I take it that this was--was this, from

17 your perspective, a new initiative?

18 DR. EJECKAM:

19 A. Well, one of the initiatives was quality

20 assurance in the laboratory.

21 COFFEY, Q.C.

22 Q. And at the time, coming from Qatar, what was

23 the state of quality assurance protocols or

24 procedures in the lab at that time?

25 DR. EJECKAM:

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1 A. Over the period I spent 13 years there, it

2 wasn't that way before and it wasn't started

3 by me, there are people before me, but over

4 the period who have developed quality

5 assurance manual for each of the divisions,

6 for safety manual for the autopsy rooms,

7 quality assurance for immunohistochemistry.

8 So, these were developed over a period of

9 time. And by the time I left, we had this in

10 place.

11 COFFEY, Q.C.

12 Q. Left?

13 DR. EJECKAM:

14 A. By the time I left Doha -

15 COFFEY, Q.C.

16 Q. Doha, and this was developed during your time

17 -

18 DR. EJECKAM:

19 A. Yes.

20 COFFEY, Q.C.

21 Q. So, when you arrived then in St. John's, how

22 did what you find in St. John's compare to

23 what you had left in Doha?

24 DR. EJECKAM:

25 A. I don't recall finding manuals, quality

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1 assurance manual and that led to discussion to

2 produce one, but they have that procedures

3 anyway in the Cantext, the techs use for their

4 work.

5 COFFEY, Q.C.

6 Q. But it was certainly no manual overall?

7 DR. EJECKAM:

8 A. I don't recall seeing any one of those.

9 COFFEY, Q.C.

10 Q. And the idea of--I take it that your lecture

11 then was about the need to even have manuals.

12 DR. EJECKAM:

13 A. Well, yeah, part of it, yes, what you need to

14 do.

15 COFFEY, Q.C.

16 Q. You brought the manual from Doha with you?

17 DR. EJECKAM:

18 A. Yeah, my copy, yes.

19 COFFEY, Q.C.

20 Q. Did you provide a copy to anybody?

21 DR. EJECKAM:

22 A. Yes, I think I provided a copy of it to the

23 site chief.

24 COFFEY, Q.C.

25 Q. That would be Dr. Parai?

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1 DR. EJECKAM:

2 A. Yeah, and I think that was the--I don't know

3 the exact word, yeah, maybe used as a template

4 or to produce one for the laboratory in St.

5 John's.

6 COFFEY, Q.C.:

7 Q. So I take it that was your purpose in

8 providing it?

9 DR. EJECKAM:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. Do you recall when it was in your time here

13 that you would have provided that copy?

14 DR. EJECKAM:

15 A. I don't remember the time, but I made it

16 available to the site chief.

17 COFFEY, Q.C.:

18 Q. Would it have been in 2003, do you think, when

19 you were involved in this?

20 DR. EJECKAM:

21 A. Possibly, but I can't be sure about the dates.

22 COFFEY, Q.C.:

23 Q. If we could, please, Exhibit P-1577? Now,

24 these are notes of a meeting of the laboratory

25 medicine program, September 26th, 2003. The

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1 attendees are Doctors Cook, Williams and Mr.
 2 Gulliver. In particular, please, Registrar,
 3 page 4? And this, in paragraph 5 on this
 4 page, Doctor, is a reference to the surgical
 5 pathology review committee, Dr. Cook
 6 apparently is reporting to this, to Mr.
 7 Gulliver and Dr. Williams that, he said, "Dr.
 8 Cook indicated that this group chaired by Dr.
 9 Ejeckam will meet twice a year and a copy of
 10 the minutes will come to this group." which is
 11 the laboratory medicine leadership team. So
 12 it was envisaged that your committee, surgical
 13 pathology committee would meet twice a year?
 14 DR. EJECKAM:
 15 A. Yeah.
 16 COFFEY, Q.C.:
 17 Q. If we could, please, Exhibit P-1578? Now,
 18 this is a memo, Doctor, again it's from
 19 September 30th, 2003. The subject is
 20 "Surgical Pathology Review Committee Meeting."
 21 It's from yourself to Dr. Williams. You've
 22 signed it. And you say, "Please find attached
 23 the summary and recommendations of the
 24 surgical pathology review committee meeting.
 25 Some of the problems discussed in the

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1 meeting." And you've copied it to Dr. Cook.
 2 It's got a received by the vice president's
 3 offices, October 3rd, 2003 stamp on it right
 4 there. And, Doctor, if you just look at the
 5 second page of this, it says, in bold print,
 6 "Summary of meeting of the surgical pathology
 7 review committee and recommendation to vice
 8 president medical affairs." And you reference
 9 "In a meeting of the committee held on
 10 September 23rd, 2003 reviews of request forms
 11 for histopathology showed a disturbing trend
 12 of tissues sent to the laboratory for
 13 diagnosis without any relevant clinical
 14 history. Generally it will be safe to say
 15 that over 80 percent of the request forms have
 16 one form of deficiency or the other ranging
 17 from the absence of the name of the requesting
 18 physician, scanty to absolutely no clinical
 19 history." And, Doctor, I'm not going to take
 20 you through this in detail, but I take it then
 21 that this was the, really, from the
 22 committee's perspective in dealing with the
 23 vice president of medical, this was the
 24 opening attempt to have that problem
 25 addressed?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. In a formal way?
 5 DR. EJECKAM:
 6 A. Yes.
 7 COFFEY, Q.C.:
 8 Q. And here on the second page of the memo
 9 there's a heading, "Request for a Second or
 10 Third Opinion on Laboratory Diagnosis." And
 11 this, I take it, was you're formally advising
 12 Dr. Williams, you, the committee, as to the
 13 committee's position in terms of second
 14 opinions?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. And the way they should be handled. If we
 19 could, please, Exhibit P-1579? Doctor, these
 20 are minutes of the medical advisory committee,
 21 the MAC, of December 10th, 2003. Page 3,
 22 please, of the exhibit? And there's, I
 23 gather, a report here by Dr. Cook to the MAC
 24 about the surgical pathology review committee.
 25 You can see that from the first sentence where

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1 it talks about your review, your committee's
 2 review of the requisition forms. Doctor, did
 3 you understand that the surgical pathology
 4 review committee's reports were going to, at
 5 least in some form, end up before the MAC?
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. And as the chair of that committee, how did
 10 you feel about the efforts that followed to
 11 implement your recommendations?
 12 DR. EJECKAM:
 13 A. We were happy that Dr. Cook was taking action,
 14 was sending, discussing the issue with Dr.
 15 Williams and they also moved to the medical
 16 advisory committee where most of the
 17 consultants or those who use the services
 18 were. So that was an effort he was making and
 19 we were satisfied as he has taken the case to
 20 where he should go to.
 21 COFFEY, Q.C.:
 22 Q. So you're satisfied that Dr. Cook, at least,
 23 has taken up the effort?
 24 DR. EJECKAM:
 25 A. Yes, yes.

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1 COFFEY, Q.C.:

2 Q. And if we could look, please, at Exhibit P-

3 1580? And, Doctor, this is--I'm just going to

4 go to--this is the agenda for March 9th, 2004

5 for the surgical pathology review committee.

6 But that would be for that meeting on March

7 9th. But attached to it, the exhibit, is a

8 letter of November 27th, 2003, it's to

9 yourself from Dr. Cook, copied to Dr.

10 Williams. And he writes, that's Dr. Cook

11 writes, "As previously discussed with you, I

12 would like a representative from the Surgical

13 Pathology Review Committee to be involved in a

14 Quality Care Initiatives by the Division of

15 Gastroenterology (Medicine Program)." And

16 further down in that paragraph he says, "More

17 specifically, there is a need to standardize

18 pathology requisitions between the St. Clare's

19 and General Sites to eliminate site

20 differences. There is also a review and

21 assessment of the standardization of language

22 used in pathology reports, as well as a review

23 of the standardization of equipment used, and

24 procedures and techniques of taking biopsies

25 between the two sites. It has been suggested

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1 that once the standardization relating to

2 gastric biopsies is complete, this information

3 needs to be shared with the Surgical Program."

4 I appreciate this does not deal with breast

5 cancer.

6 DR. EJECKAM:

7 A. No.

8 COFFEY, Q.C.:

9 Q. But, Doctor, the idea or the acknowledgement

10 of inconsistency in reporting formats between

11 the two sites was a problem, I take it, or

12 acknowledged to be a potential problem

13 involving gastroenterology?

14 DR. EJECKAM:

15 A. No, I -

16 COFFEY, Q.C.:

17 Q. Was it a -

18 DR. EJECKAM:

19 A. - call it inconsistency. There's a question

20 of different style of reporting.

21 COFFEY, Q.C.:

22 Q. Oh, and I--okay, so and could you--what was

23 the concern, Doctor? I take it there must

24 have been some concern if they're going to

25 make -

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1 DR. EJECKAM:

2 A. My recollection about this that Dr. Cook

3 mentioned that we have conferences with the

4 gastroenterology unit and I took up the matter

5 with Dr. Bussey to find the time so that we

6 can interact. It's a kind of a way of

7 pathology and the clinicians coming together,

8 discuss cases and the thrust is to make sure

9 that to have better patient care services,

10 because if we don't talk to each other,

11 wouldn't know what the problem the other is

12 going through. Unfortunately we couldn't

13 agree on the time to have this conference, you

14 know, in the laboratory, so it was--it didn't

15 take off.

16 COFFEY, Q.C.:

17 Q. Doctor, in respect of ER and PR and breast

18 cancer reporting by pathologists, were you

19 aware of any differences in approaches between

20 the two sites in terms of the reporting

21 formats?

22 DR. EJECKAM:

23 A. I'm not aware of any.

24 COFFEY, Q.C.:

25 Q. Okay.

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1 DR. EJECKAM:

2 A. If they existed, I don't know.

3 COFFEY, Q.C.:

4 Q. Okay. Exhibit, please, P-1582? Now, this is

5 a memo of June 14th, 2004, it's from Dr. Kwan,

6 who is the co-clinical chief of the peri-

7 operative program to all surgeons at the

8 Health Sciences site. "Specimen Without

9 Clinical History." And he writes, "Dear

10 Colleague, Enclosed is a memo from Dr.

11 Ejeckam, Chairperson, Surgical Pathology

12 Review Committee regarding pathology without

13 adequate clinical history. This has been

14 going on for some time with no improvement

15 with friendly persuasions." I see you're

16 smiling, Doctor. "This is to advise you that

17 the history is to be completed with the

18 pathology requisition form before the specimen

19 goes out of the operating room. I have also

20 advised the OR nurses to remind all physicians

21 to do this or the specimen will not leave the

22 operating suite unless the clinical history

23 has been completed. Thank you for your

24 attention in this matter. Enclosed you will

25 find a memo I received from Dr. Ejeckam which

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<p>1 I think is quite a reasonable request. 2 Sincerely, Alan Kwan." And if we could look 3 at the second page, Doctor, this is your memo 4 of June 9th, 2004 to Dr. Kwan, and you sign as 5 chair of the Surgical Pathology Review 6 Committee. And you write, "At the last 7 meeting of the Surgical Pathology Review 8 Committee, members continued to show concern 9 over noncompliance by many physicians with 10 regards to completing the surgical pathology 11 request forms adequately. It was decided to 12 request that the OR committee adopt a policy 13 whereby no specimen leaves the OR for the 14 laboratory without adequate clinical history. 15 I request that you kindly evolve a 'modus 16 operandi' to realize this decision." So I 17 take it, Doctor, that your efforts and Dr. 18 Cook's--your efforts, the committee's efforts 19 to have the forms filled out properly had not 20 met with any success up to this, or had not 21 met with sufficient success up to this point? 22 DR. EJECKAM: 23 A. Yeah, it hasn't come to the level that would 24 give us comfort. 25 COFFEY, Q.C.:</p>	<p>1 Q. And one of the methods you were suggesting 2 here to Dr. Kwan was to tell the surgeons it's 3 not leaving the OR unless you fill out the 4 forms? 5 DR. EJECKAM: 6 A. Yes, yeah. 7 COFFEY, Q.C.: 8 Q. Okay. So that would be, I take it, somewhat 9 of a course of measure? 10 DR. EJECKAM: 11 A. Yes. 12 COFFEY, Q.C.: 13 Q. To try and shape compliance. Doctor, if we 14 could look, please, at Exhibit P-1583? This 15 is a Division of Anatomical Pathology 16 pathologists meeting, General Hospital site, 17 November 2nd, 2004. It's the agenda. Look at 18 page 2 of it, the minutes attached for that 19 meeting, the November 2nd meeting. A number 20 of people present, including yourself, see 21 your name there in the middle of the first 22 line, quite a number of pathologists present. 23 Dr. Parai chaired. And in relation to this I 24 have a couple of questions. On the second 25 page, under paragraph 4 there's a reference to</p>
<p>Page 90</p> <p>1 Q. Doctor, does the failure to fill out such 2 forms properly, could that have implications 3 for patient care? 4 DR. EJECKAM: 5 A. It is possible, that's why I would have 6 requested. But again, more importantly, if 7 you don't have it, that means for the 8 pathologist, if he needs this information, 9 will have then have to call for it. I mean, 10 he wouldn't report at a case that he needed 11 clinical information where it was critical, he 12 will not report on--he will either have to 13 look for the information himself or phone up 14 the physician. We want to avoid this waste of 15 time calling up physician or leaving the gross 16 bench and running to the computer to get 17 information. And most hospitals if you send 18 in material to the laboratory, you got to fill 19 information. But it's not particular to St. 20 John's, surgeons, material from OR are known 21 to really come with scanty information most 22 places. Of course, people there have evolved 23 methods to cure that by all the effort we are 24 making. 25 COFFEY, Q.C.:</p>	<p>Page 92</p> <p>1 new business, "4.1 Pathologist Assistant. 2 Much discussion on this issue. It was agreed 3 by the pathologists that this issue should be 4 brought to the attention of the vice president 5 of medical services. Dr. D. Robb, Chair of 6 the discipline, will write to Dr. R. Williams 7 recommending pathologists assistants as per 8 the Royal College recommendation. It is also 9 pointed out that the Anatomical Pathology 10 division is earning over \$100,000 per year by 11 billing for the technical work. It is 12 expected that some of the money should be 13 given to the pathology budget to hire 14 pathologist assistants." Now, Doctor, what 15 was this about pathologist assistants? This 16 is late in 2004. When had this idea first 17 arisen and who was pushing it? 18 DR. EJECKAM: 19 A. In most laboratories, the mainland and United 20 States now, pathologists do not do grossing of 21 tissue any more because that is, you know, so 22 - 23 COFFEY, Q.C.: 24 Q. If I could just this moment. So you're saying 25 now, Doctor, you mean in 2008 or in 2004? I'm</p>

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1 just trying to -

2 DR. EJECKAM:

3 A. 2004.

4 COFFEY, Q.C.:

5 Q. Okay. I apologize, go ahead.

6 DR. EJECKAM:

7 A. 2004, Commissioner, mainland and some other

8 hospitals elsewhere the laboratory had

9 pathologist assistants, and their job would be

10 to take over some of the mundane duties that a

11 pathologist will do to make it difficult for

12 him to have enough time to devote to his

13 either research or patient diagnostic work.

14 Like we talk about counting the small samples

15 that trained staff, well not--they may have a

16 colleague or some kind of school to train

17 these fellows and they can do good job, they

18 can do good job. They can do grossing, they

19 can even do gross autopsy, then pathologist

20 will come in and look at and interpret the

21 findings. So we thought that if this can

22 happen to us, then that will enable us to have

23 more time to devote to diagnostic work.

24 COFFEY, Q.C.:

25 Q. As opposed to actually having to do the

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1 grossing yourself?

2 DR. EJECKAM:

3 A. Yes.

4 COFFEY, Q.C.:

5 Q. Because -

6 DR. EJECKAM:

7 A. Pathologists still do some, because there's

8 some gross bowel, breast, there's some big

9 specimens that because they are not doctors,

10 they may have difficulty in knowing the

11 anatomy of what they have, so those are not--

12 those are few, so that would limit the time

13 the pathologist spends on grossing bench.

14 COFFEY, Q.C.:

15 Q. And that was thought, I take it, locally here,

16 by yourself and by Dr. Robb, for example, to

17 be a good thing, the idea of having pathology

18 assistants was something that was desirable?

19 DR. EJECKAM:

20 A. Oh, everybody agreed to it, yes.

21 COFFEY, Q.C.:

22 Q. So what--when you arrived in 2002, was the

23 idea of pathology assistants being desirable,

24 was that accepted here at the time?

25 DR. EJECKAM:

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1 A. I'm not sure whether I discussed with them,

2 but it's something that's happening other

3 places.

4 COFFEY, Q.C.:

5 Q. And who do you recall as pushing it, who was

6 the leader of the push for it?

7 DR. EJECKAM:

8 A. I can't put my finger on any particular

9 person.

10 COFFEY, Q.C.:

11 Q. Okay. And well, here, by November, 2004

12 there's a note that Dr. Robb will be writing

13 to Dr. Williams to advocate for it. So

14 certainly Dr. Robb, I gather, was one of the

15 leaders in pushing for this?

16 DR. EJECKAM:

17 A. He was the chairman of department.

18 COFFEY, Q.C.:

19 Q. Chair, okay. And what happened with respect

20 to it? I mean, everybody, I gather your

21 recollection of it is pretty well everybody

22 amongst the pathologists was in favour of it?

23 DR. EJECKAM:

24 A. We didn't have pathology assistant, maybe they

25 have it now, it wasn't there until I left. So

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1 it was being on the discussion, but they

2 didn't get to hire until I left the services,

3 2006.

4 COFFEY, Q.C.:

5 Q. So the pathologists are pushing for it.

6 What's your understanding of why it wasn't

7 done back in 2004?

8 DR. EJECKAM:

9 A. I don't remember, but it looks like maybe

10 budgetary problem.

11 COFFEY, Q.C.:

12 Q. There's a reference here to, it says, "Will

13 write to Dr. Williams recommending pathologist

14 assistants as per the Royal College

15 recommendation." So there was a

16 recommendation by the Royal College -

17 DR. EJECKAM:

18 A. I have not seen the recommendation. There

19 must be, I didn't see it.

20 COFFEY, Q.C.:

21 Q. Okay. You, yourself, at the time, were you in

22 favour of using pathology assistants that were

23 properly trained?

24 DR. EJECKAM:

25 A. Yes, yes.

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1 COFFEY, Q.C.:

2 Q. If you look, please, at the next page under

3 "New Business Cont'd", paragraph 4.7. I

4 shouldn't say the next page, it's page 4,

5 actually, of the exhibit. 4.7 the title is

6 "FISH for Her2/neu. This will be

7 automatically done when the Her2/neu is

8 reported 2 plus. Dr. G. Ejeckam is the head

9 of the immuno lab and consultation with him is

10 suggested for any related issue." Now, sir,

11 the--I take it this related to the usage of

12 FISH test in certain Her2/neu results?

13 DR. EJECKAM:

14 A. Yeah.

15 COFFEY, Q.C.:

16 Q. Okay. And you're described here as the head

17 of the immuno lab and "consultation with him

18 is suggested for any related issue" involving

19 this. First of all, at the time would you

20 have described yourself as the head of the

21 immuno lab, at that time?

22 DR. EJECKAM:

23 A. I was a resource person for immunochemistry

24 lab, resource.

25 COFFEY, Q.C.:

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1 Q. I'm sorry, you were?

2 DR. EJECKAM:

3 A. I was a resource person -

4 COFFEY, Q.C.:

5 Q. Oh, resource, I apologize, yeah. I just--so

6 you were a resource person?

7 DR. EJECKAM:

8 A. Yes.

9 COFFEY, Q.C.:

10 Q. So I take it you would--and you would

11 certainly back then have thought of yourself

12 as a resource person for the immunolab.

13 DR. EJECKAM:

14 A. Yeah, that's what I was. I wouldn't call

15 myself head of immuno.

16 COFFEY, Q.C.:

17 Q. At -

18 DR. EJECKAM:

19 A. But there was no administrative structure

20 created for me to be head.

21 COFFEY, Q.C.:

22 Q. Yeah.

23 DR. EJECKAM:

24 A. I offered to help in the laboratory and that's

25 what I did, but in terms of being head, there

Page 99

1 was no administrative structure to create

2 that.

3 COFFEY, Q.C.:

4 Q. There was no administrative structure that

5 would allow for that at the time?

6 DR. EJECKAM:

7 A. Well, you know, these are a question of use of

8 word, I mean, by the, whoever made the minutes

9 that I'm head. But all I knew I had some

10 responsibilities to it, but not, I wasn't

11 appointed head.

12 COFFEY, Q.C.:

13 Q. What were your responsibilities, do you think,

14 at the time? Like, looking back on it in late

15 2004 up to that point, into the beginning of

16 2005, from your own view at the time?

17 DR. EJECKAM:

18 A. As a resource person when I came involved with

19 the--when I became involved with the

20 technologists, as I said earlier, I got

21 impression from them they were happy, for the

22 first time they have someone they could relate

23 to, they could ask questions about what they

24 were doing. So my response to them was to

25 help them become more efficient, help them

Page 100

1 source proper controls, help them review what

2 they are doing to make sure the results coming

3 out are adequate.

4 COFFEY, Q.C.:

5 Q. Okay. If we could look, please, at Exhibit P-

6 0067? Doctor, this is a memorandum, the

7 Commission has seen this before, it's dated

8 May 24th, 2005 to Dr. Williams. It's from Dr.

9 Cook in his capacity as clinical chief. And

10 this relates to the, what leads--it's the

11 beginning of ER/PR issue in 2005. Doctor,

12 when did you first become aware of the index

13 case in conversion?

14 DR. EJECKAM:

15 A. I don't remember a date, but I heard it

16 through the grapevine. I didn't have an

17 official indication that it was happening.

18 COFFEY, Q.C.:

19 Q. Okay.

20 DR. EJECKAM:

21 A. But general discussion in the laboratory,

22 that's how I learned about it. But it could

23 been either 2005 or six.

24 COFFEY, Q.C.:

25 Q. But this is certainly 2005, the reference

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1 here, and I'll be showing you certain
 2 documents in that year, and you say in kind of
 3 general discussion in the lab is the way you
 4 found out?
 5 DR. EJECKAM:
 6 A. Yes, from the grapevine I will say. There was
 7 no announcement, official document saying this
 8 has happened.
 9 COFFEY, Q.C.:
 10 Q. And do you recall what it was you heard
 11 initially?
 12 DR. EJECKAM:
 13 A. Pardon?
 14 COFFEY, Q.C.:
 15 Q. What was your understanding initially as to
 16 what had happened? Of the grapevine -
 17 DR. EJECKAM:
 18 A. What I had thought was said was that some case
 19 was stained in our laboratory, it looked like
 20 normal and it was negative, and then got
 21 stained elsewhere, it was positive and redone
 22 in our laboratory and became positive.
 23 COFFEY, Q.C.:
 24 Q. Now that -
 25 DR. EJECKAM:

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1 A. That's my understanding of it.
 2 COFFEY, Q.C.:
 3 Q. Yes, via the grapevine as you say.
 4 DR. EJECKAM:
 5 A. Yeah, yeah.
 6 COFFEY, Q.C.:
 7 Q. And this grapevine would have involved, I take
 8 it, words from either a technologist or
 9 perhaps other pathologists?
 10 DR. EJECKAM:
 11 A. Possibly.
 12 COFFEY, Q.C.:
 13 Q. Having heard that at the time, do you recall
 14 whether there was discussion then in the lab
 15 amongst the pathologists about that, the
 16 issue?
 17 DR. EJECKAM:
 18 A. There wasn't great discussion. It wasn't an
 19 agenda for discussion as such. I mean, if
 20 people mentioned it along the corridor
 21 probably, but not--it wasn't an agenda. I
 22 don't recall that being an agenda in a
 23 meeting.
 24 COFFEY, Q.C.:
 25 Q. Did anybody approach you about it at the time?

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1 DR. EJECKAM:
 2 A. No, I don't recall that.
 3 THE COMMISSIONER:
 4 Q. Mr. Coffey, wherever you can find a good time,
 5 we'll take the morning break.
 6 COFFEY, Q.C.:
 7 Q. Thank you, Commissioner. If I could just go
 8 back to page one of this exhibit, Doctor, I'm
 9 just going to--in the course of writing this
 10 letter, and Dr. Cook has written to Dr.
 11 Williams in the second paragraph saying "on
 12 May 17th, 2005, a meeting was held which
 13 included myself," which would be Dr. Cook,
 14 "Dr. Bev Carter, our resource person for
 15 breast pathology, Mr. Barry Dyer, divisional
 16 chief for anatomical pathology, and Doctors
 17 Joy McCarthy and Kara Laing, medical
 18 oncologists." And there's a long discussion
 19 here about what went on during the meeting.
 20 Doctor, you would have been working at
 21 this point in time, in May, in St. John's?
 22 DR. EJECKAM:
 23 A. Yes.
 24 COFFEY, Q.C.:
 25 Q. April and May of 2005?

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Do you recall what time you took your vacation
 5 that year?
 6 DR. EJECKAM:
 7 A. I don't remember now.
 8 COFFEY, Q.C.:
 9 Q. Okay. There is a reference in the summer, and
 10 I will point you to it, okay, in the minutes
 11 of a meeting that in the middle of the summer,
 12 apparently you were away at some point,
 13 yourself and Mr. Dyer. So I'll refer you to
 14 that, but in the spring, I take it, you would
 15 have been here?
 16 DR. EJECKAM:
 17 A. Yeah.
 18 COFFEY, Q.C.:
 19 Q. Doctor, it's apparent from the materials here
 20 that the Commission has seen that you're not
 21 listed as an attendee in any of these early
 22 meetings.
 23 DR. EJECKAM:
 24 A. No.
 25 COFFEY, Q.C.:

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1 Q. In April or May or June?
 2 DR. EJECKAM:
 3 A. No.
 4 COFFEY, Q.C.:
 5 Q. Have you ever asked anyone why you weren't
 6 asked to those meetings?
 7 DR. EJECKAM:
 8 A. No, I didn't ask.
 9 COFFEY, Q.C.:
 10 Q. Okay. Have you ever wondered why?
 11 DR. EJECKAM:
 12 A. I don't want to speculate about that. I would
 13 hear that they have these meetings and I'm the
 14 resource for immunohistochemistry and if they
 15 chose to--I didn't know what the agenda was,
 16 so it probably didn't concern me, so I didn't--
 17 -I wasn't curious in that direction.
 18 COFFEY, Q.C.:
 19 Q. So having heard then about this index case, as
 20 you say via the grapevine, did you go to, for
 21 example, Dr. Cook or the site chief and ask
 22 "what's going on?"
 23 DR. EJECKAM:
 24 A. No, I didn't do that.
 25 COFFEY, Q.C.:

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1 Q. Okay, and why not?
 2 DR. EJECKAM:
 3 A. There was nothing to gain from that. I mean,
 4 if they--I mean, they didn't inform me about
 5 it and I wasn't involved in anything about it,
 6 and I didn't think it was necessary to go
 7 fishing for it.
 8 COFFEY, Q.C.:
 9 Q. I take it that they, from your perspective, if
 10 they wanted to talk to you, they knew where to
 11 find you? That would be the--in terms of
 12 that, they knew where you worked and -
 13 DR. EJECKAM:
 14 A. Yeah, I think so.
 15 COFFEY, Q.C.:
 16 Q. Thank you, Commissioner, if we could.
 17 THE COMMISSIONER:
 18 Q. We'll take 15 minutes.
 19 (BREAK)
 20 THE COMMISSIONER:
 21 Q. Please be seated. Mr. Coffey.
 22 COFFEY, Q.C.:
 23 Q. Thank you, Commissioner. If we could look,
 24 please, at Exhibit P-0920? Now, Doctor, this
 25 is a letter written May 20th--dated May 27th

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1 2005 addressed to Dr. Williams. It's from
 2 yourself as chairperson of the surgical
 3 pathology review committee, copied to Dr.
 4 Cook, clinical chief, and you say "Dr.
 5 Williams, please find attached the
 6 recommendations of the surgical pathology
 7 review committee. These recommendations were
 8 approved in a meeting of the committee held on
 9 Tuesday, May 24th, 2005. We hope that the
 10 HCCSJ will embrace and implement these
 11 recommendations."
 12 So I take it, Doctor, that there was a
 13 meeting held Tuesday, May 24th, 2005, of that
 14 committee?
 15 DR. EJECKAM:
 16 A. I should think so, yes.
 17 COFFEY, Q.C.:
 18 Q. Yes, and do you recall whether or not the ER
 19 and PR matter made it on to the proceedings or
 20 agenda of the pathology review committee,
 21 surgical pathology review committee?
 22 DR. EJECKAM:
 23 A. I don't recall that, and -
 24 COFFEY, Q.C.:
 25 Q. When I say that, I mean in '05 now, not in

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1 '03.
 2 DR. EJECKAM:
 3 A. No, I don't think we discussed that.
 4 COFFEY, Q.C.:
 5 Q. And here, looking at page two of this, of the
 6 exhibit is a document entitled "surgical
 7 review committee - update" and you note "the
 8 surgical review committee was set up as a
 9 quality assurance and control committee. The
 10 mandate includes scrutiny of pathology request
 11 forms and surgical reports. This committee
 12 has met on several occasions and reviewed over
 13 1,000 request forms when one includes the
 14 initial screening of the forms by committee
 15 chairman, Dr. Ejeckam. A number of issues
 16 were raised and recommendations sent to the
 17 vice president, Medical Services, with copies
 18 to the clinical chief, Dr. Donald Cook. It
 19 would appear that despite the reports of the
 20 committee, little change, if any, has occurred
 21 in the way surgical requesting clinicians
 22 complete request forms."
 23 So I take it that you hadn't--you're
 24 reporting here that the committee hasn't had
 25 much success in that effort?

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1 DR. EJECKAM:
 2 A. Yeah, that would be right.
 3 COFFEY, Q.C.:
 4 Q. and you make reference then to small and large
 5 intestine and uteri, concerns about those, in
 6 terms of the requisition forms and lack of
 7 clinical information. Then you say "it is the
 8 view of this committee that to achieve a
 9 meaningful, comprehensive, quality control and
 10 assurance in the practice of the Health Care
 11 Corporation of St. John's, a more elaborate
 12 action will be needed. One, a department of
 13 quality assurance and control should be
 14 established. Two, a director of the quality
 15 assurance and quality control is appointed.
 16 This should be a full-time job, or if part-
 17 time performed by any of the clinicians or
 18 other staff, appropriate remuneration should
 19 apply. Three, this department should have at
 20 least two clerks with knowledge of records
 21 department of the Corporation. Four, the
 22 quality control and quality assurance
 23 department shall encourage, supervise and
 24 coordinate the establishment of departmental
 25 quality assurance and quality control units,

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1 and shall liaise with them to establish Health
 2 Care Corporation of St. John's quality
 3 assurance and quality control meetings. Five,
 4 all cases of quality control and quality
 5 assurance and monthly departmental quality
 6 assurance and quality control reports shall be
 7 lodged with the Health Care Corporation of St.
 8 John's Quality Assurance and Quality Control
 9 department and discussed in the quality
 10 assurance and quality control meetings. Six,
 11 all departments, clinical and non-clinical,
 12 shall be represented in the quality assurance
 13 and quality control meetings."
 14 And then you conclude saying "to continue
 15 to look at pathology request forms and make
 16 recommendations that may not be implemented is
 17 considered a waste of valuable time of the
 18 staff that had agreed to serve on the surgical
 19 review committee. The hospital community has
 20 been sensitized to the problem of inadequate
 21 clinical history on the request forms and as
 22 indicated above, compliance may not be
 23 achieved or improved by repeating the process.
 24 We thank you for the opportunity to serve on
 25 this committee and hope that you will consider

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1 this our last recommendation/suggestion."
 2 So I take it, Doctor, that the committee
 3 had done, from its perspective, what it could
 4 in this regard and this was advising Dr.
 5 Williams accordingly?
 6 DR. EJECKAM:
 7 A. Yes, Commissioner.
 8 COFFEY, Q.C.:
 9 Q. From your perspective, as chair, was there a
 10 certain amount of frustration involved in your
 11 ability to--inability to make headway?
 12 DR. EJECKAM:
 13 A. Well, in a way, yes, but it wasn't necessarily
 14 because--what we found that a number of the
 15 members of the committee were consistently
 16 absent and that the regular members would be
 17 the chairman and the other pathologists and
 18 Dr. Siddiqui and one or two other people, and
 19 of course, we had exhausted this process and
 20 we thought the best thing is to put down our
 21 recommendations and then, and also inform
 22 officials that we are no more going to meet.
 23 They shouldn't expect anything any more from
 24 this committee.
 25 COFFEY, Q.C.:

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1 Q. Now Doctor, here, in the middle of the page,
 2 you write or it was written, "it is the view
 3 of this committee that to achieve a
 4 meaningful, comprehensive quality control and
 5 assurance in the practice of the Health Care
 6 Corporation of St. John's, a more elaborate
 7 action will be needed" and you have six
 8 paragraphs numbered there.
 9 DR. EJECKAM:
 10 A. Yeah.
 11 COFFEY, Q.C.:
 12 Q. Six recommendations. I take it that you were
 13 recommending this because at that point, none
 14 of this existed in a formalized way?
 15 DR. EJECKAM:
 16 A. I wouldn't know. I can't--sincerely, I don't
 17 know whether there was a quality assurance
 18 department. I know it was mentioned quality
 19 assurance initiative, that's the word used, so
 20 I don't know if there was a director or
 21 someone responsible. But it wasn't
 22 recommended because none existed. This is
 23 what we thought was appropriate to put in
 24 place.
 25 COFFEY, Q.C.:

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1 Q. And was this a consensus of the committee?
 2 DR. EJECKAM:
 3 A. Yes, yes.
 4 COFFEY, Q.C.:
 5 Q. Universal consensus of the committee that this
 6 was appropriate?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. So at the time, I take it that if the
 11 committee is recommending this and the
 12 committee has been in existence for then two
 13 years -
 14 DR. EJECKAM:
 15 A. About that.
 16 COFFEY, Q.C.:
 17 Q. - yes, from April of '03, and it's now May of
 18 '05. So that's just over two years, and the
 19 committee is not just dealing with forms here.
 20 You're actually talking about suggesting
 21 setting up a department?
 22 DR. EJECKAM:
 23 A. Yes, yes.
 24 COFFEY, Q.C.:
 25 Q. That's actually what it spells out.

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1 DR. EJECKAM:
 2 A. Yeah.
 3 COFFEY, Q.C.:
 4 Q. So there was perceived by the committee to be
 5 a need for such a department, properly funded
 6 and -
 7 DR. EJECKAM:
 8 A. Yes, there was need for it because what the
 9 surgical review committee was was a quality
 10 assurance initiative and, you know, we thought
 11 that to have it achieve its full aim, there
 12 has to be a bigger body and then some officer
 13 responsible for this kind of activity.
 14 COFFEY, Q.C.:
 15 Q. Now Doctor, that sort of a body or organized,
 16 you know, formally recognized and organized
 17 body within a department, like a tertiary care
 18 hospital such as the General Hospital was and
 19 is, does such a department, to your knowledge,
 20 exist in other facilities, other comparable
 21 facilities?
 22 DR. EJECKAM:
 23 A. Yes, we had this in Doha.
 24 COFFEY, Q.C.:
 25 Q. In Doha, there was?

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1 DR. EJECKAM:
 2 A. Yes, we had director of quality assurance, and
 3 then we have a department of quality
 4 assurance, the committee.
 5 COFFEY, Q.C.:
 6 Q. And was this a department that involved
 7 physicians being involved in it?
 8 DR. EJECKAM:
 9 A. Involved physicians and technologists. In the
 10 laboratory it would be pathologists and
 11 technologists, and clerical staff, because
 12 there's different areas to look at.
 13 COFFEY, Q.C.:
 14 Q. Okay. Doctor, did you ever get any response,
 15 you or the committee get any response to this?
 16 DR. EJECKAM:
 17 A. I think there was a reply from Dr. Williams.
 18 COFFEY, Q.C.:
 19 Q. Okay, and was your recommendation implemented?
 20 DR. EJECKAM:
 21 A. I didn't check whether each one of them was
 22 taken care of, but I think in his reply, he
 23 did acknowledge my letter and I think he did
 24 mention that he would be doing something about
 25 it.

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1 COFFEY, Q.C.:
 2 Q. Doctor, while I'm thinking of it, you
 3 indicated that the laboratory manual that you
 4 had brought out of Doha with you and you'd
 5 passed on to the site chief in St. John's?
 6 DR. EJECKAM:
 7 A. Yeah.
 8 COFFEY, Q.C.:
 9 Q. Who was the site chief that you passed it on
 10 to?
 11 DR. EJECKAM:
 12 A. Who was the site chief? Dr. Parai.
 13 COFFEY, Q.C.:
 14 Q. Which?
 15 DR. EJECKAM:
 16 A. S. Parai, Sushil.
 17 COFFEY, Q.C.:
 18 Q. If we could, please, Exhibit P-0493? Doctor,
 19 this is a letter again to Dr. Williams, June
 20 14th 2005. I'll just show you, Doctor, it's
 21 from Dr. Cook and the subject matter is "re:
 22 preliminary update on false negative results
 23 for estrogen and progesterone receptors" and
 24 he writes that "further to my letter of May
 25 24, 2005, we reviewed reports of the estrogen

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1 and progesterone receptors in 160 breast
 2 cancer patients that originated from the
 3 division of anatomical pathology, Laboratory
 4 Medicine program, at the Health Care
 5 Corporation of St. John's. These 160 cases
 6 are also confined to patients and attending
 7 surgeons within the Health Care Corporation of
 8 St. John's. Of the 160 cases that have
 9 estrogen and progesterone receptors, 50
 10 percent of these are reported as ER/PR
 11 negative. That is following a preliminary
 12 review of the pathology reports."
 13 And he says, "it also seems that most of
 14 the negative ER/PR results started sometime
 15 around June 24th 2002. We are in the process
 16 of retesting all negative ER/PR cases with our
 17 newer, more sensitive Ventana benchmark
 18 immunoperoxidase method for the year 2002."
 19 And he goes on from there.
 20 Doctor, in the middle of June of 2005,
 21 were you aware that such an effort was going
 22 on?
 23 DR. EJECKAM:
 24 A. Yeah.
 25 COFFEY, Q.C.:

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1 Q. Okay, and how were you--why were you aware of
 2 it?
 3 DR. EJECKAM:
 4 A. I think I got information from the
 5 technologists. I wasn't informed that--I
 6 didn't know when this material was being sent
 7 out to be done, but I eventually knew that it
 8 was being done.
 9 COFFEY, Q.C.:
 10 Q. So you, in effect, initially then, in terms of
 11 the actual effort being made to look at the
 12 older cases or cases going back to 2002 and
 13 other years, you found out after the grapevine
 14 comment from the technologists?
 15 DR. EJECKAM:
 16 A. Yes, I think so.
 17 COFFEY, Q.C.:
 18 Q. And that would be Mr. Green?
 19 DR. EJECKAM:
 20 A. Les, Ken, you know.
 21 COFFEY, Q.C.:
 22 Q. Les Simms, yes. Les Simms and Mary Butler,
 23 that group.
 24 DR. EJECKAM:
 25 A. Yeah.

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1 COFFEY, Q.C.:
 2 Q. Okay. Now Doctor, between the spring of '03,
 3 when you got involved in the effort to improve
 4 the quality of the slides and you worked with
 5 the technologists then, I gather, to do that,
 6 and this is the spring into the summer of '05,
 7 how much interaction did you have with the
 8 technologists, as the reference person?
 9 DR. EJECKAM:
 10 A. I interacted with them very closely. I would
 11 go into the laboratory and discuss with them
 12 and after their staining of cases, I would
 13 take them to the multiple head microscope in
 14 the resident's room. We would look at things
 15 together. So we had very close relationship.
 16 COFFEY, Q.C.:
 17 Q. And your under--looking back on it, from your
 18 perspective, if they had a question about
 19 something or a concern, did they--do you think
 20 they felt free to come to you about it?
 21 DR. EJECKAM:
 22 A. They were free to come to me anytime and we
 23 had good time. There was no barrier between
 24 me and they, at that time.
 25 COFFEY, Q.C.:

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1 Q. Doctor, there's a reference in that letter to
 2 the Ventana, so-called Ventana benchmark
 3 immunoperoxidase method. Now you had come to
 4 St. John's, when you arrived in 2002, they
 5 were using the DAKO?
 6 DR. EJECKAM:
 7 A. Yeah.
 8 COFFEY, Q.C.:
 9 Q. And we have reason to believe that the Ventana
 10 probably arrived on the site in December of
 11 '04 and started to be used early in '05.
 12 Trying to get it up and running.
 13 DR. EJECKAM:
 14 A. That's possible, yes.
 15 COFFEY, Q.C.:
 16 Q. Did you--were you ever consulted about the
 17 obtaining of--'04, yeah, December '04, and
 18 they started--I'm sorry, December of '03, I
 19 apologize, and it was early '04, they started
 20 to use it, okay, and I apologize. She just
 21 corrected me on the date.
 22 DR. EJECKAM:
 23 A. I don't remember the dates myself.
 24 THE COMMISSIONER:
 25 Q. Why don't we start all over again.

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1 COFFEY, Q.C.:

2 Q. Thank you. Doctor, first of all, were you

3 asked about the advisability of switching from

4 the DAKO to the Ventana?

5 DR. EJECKAM:

6 A. No.

7 COFFEY, Q.C.:

8 Q. When did you first learn that it was going to

9 occur?

10 DR. EJECKAM:

11 A. When I learned that -

12 COFFEY, Q.C.:

13 Q. That the Ventana was--there was going to be a-

14 -the DAKO was going and the Ventana was

15 coming.

16 DR. EJECKAM:

17 A. No, no, I saw the Ventana machine in the

18 laboratory.

19 COFFEY, Q.C.:

20 Q. Okay.

21 DR. EJECKAM:

22 A. And when I saw it, then of course, we started

23 looking at the cases with it. I started

24 looking at the cases with the test, when they

25 started doing stains on it, and compared it

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1 with the stains from the other machine.

2 COFFEY, Q.C.:

3 Q. The DAKO?

4 DR. EJECKAM:

5 A. Yeah.

6 COFFEY, Q.C.:

7 Q. Which you were still then using for reporting

8 initially?

9 DR. EJECKAM:

10 A. Yeah.

11 COFFEY, Q.C.:

12 Q. Okay. So you were involved in the process of

13 calibrating the Ventana or getting it up and

14 running?

15 DR. EJECKAM:

16 A. Well, I would say in a way I was because what

17 happened then, if I recollect properly, that

18 they would do para staining in Ventana and

19 also DAKO and then we would look at them and

20 evaluate the positivity or negativity or

21 crispness of the stains.

22 COFFEY, Q.C.:

23 Q. And who was doing the evaluating?

24 DR. EJECKAM:

25 A. I would do that.

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1 COFFEY, Q.C.:

2 Q. Okay, you were doing it.

3 DR. EJECKAM:

4 A. Yeah, they showed me the--yeah, I would

5 evaluate whether it's good or bad or whatever.

6 COFFEY, Q.C.:

7 Q. So, and I gather--there will be evidence,

8 Commissioner, that the--I understand that the

9 DAKO showed up in--I'm sorry, the Ventana, I

10 apologize, the Ventana showed up in December

11 of '03 and in early '04, January, February and

12 March of '04, this comparison was going on

13 that you refer to.

14 DR. EJECKAM:

15 A. Yeah.

16 COFFEY, Q.C.:

17 Q. And from a pathologist's perspective, I take

18 it you were the person who was overseeing this

19 comparison?

20 DR. EJECKAM:

21 A. Yes.

22 COFFEY, Q.C.:

23 Q. And then the usage of the DAKO was finally

24 discontinued?

25 DR. EJECKAM:

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1 A. Yes.

2 COFFEY, Q.C.:

3 Q. Were you satisfied then to take up and use the

4 Ventana yourself, in the sense of to have the

5 lab go ahead and use the Ventana?

6 DR. EJECKAM:

7 A. Yeah, the machine was okay. I have no problem

8 with the product that we're getting.

9 THE COMMISSIONER:

10 Q. Did the Ventana arrive in the sense of already

11 having been acquired or did it arrive for you

12 to do the assessment as to whether or not you

13 would switch to it?

14 DR. EJECKAM:

15 A. No, everything just had--it had been acquired.

16 It just arrived as part of our equipment.

17 THE COMMISSIONER:

18 Q. Okay.

19 COFFEY, Q.C.:

20 Q. If we could, please, Exhibit P-0069, please?

21 Now Doctor, this is a letter dated July 14th

22 2005. It's to Dr. Donald Cook. It's from Dr.

23 Beverley Carter. It's copied to Dr. Williams.

24 In this letter, Dr. Carter says "as per our

25 many recent discussions, I agree with you that

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1 our estrogen receptor status reports prior to
 2 2003 require immediate investigation." And
 3 she talks about "our recent examples of 16
 4 patients converting from estrogen receptor
 5 negative to estrogen receptor positive status
 6 is quite concerning. The factors identified
 7 on those slides clearly show problems with the
 8 technique of estrogen receptor testing and the
 9 interpretation of same." And she makes
 10 reference to the paperwork, her inability to
 11 yet review it.
 12 And she continues "I am therefore eager
 13 to review the estrogen receptor status of all
 14 patients seen in our laboratory from May 1997
 15 when the immunohistochemical staining for
 16 estrogen receptor status first became
 17 available up until March 2004 when analysis
 18 and readjustment of the estrogen receptor
 19 status protocol was carried out by Dr. G.
 20 Ejeckam. I think that it is vital that we
 21 expediently review these cases and let
 22 patients know as quickly as possible of any
 23 change in their estrogen receptor status."
 24 Now Doctor, I take it you hadn't seen
 25 this letter in '05?

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1 DR. EJECKAM:
 2 A. No.
 3 COFFEY, Q.C.:
 4 Q. One thing I wanted to ask you about was this,
 5 there's a reference to up until March, 2004,
 6 when analysis and readjustment of the estrogen
 7 and receptor status protocol was carried out
 8 by Dr. G. Ejeckam, now I take it that that's
 9 not accurate, is it, the date's not accurate,
 10 your readjustment of the estrogen receptor
 11 status protocol was carried out in 2003? Would
 12 that be -
 13 DR. EJECKAM:
 14 A. I don't know, I think I suppose what's she
 15 referring to is when the Ventana came in and
 16 we are trying to validate that by doing stains
 17 on it and also on DAKO. I suspect that is
 18 what she is referring to here.
 19 COFFEY, Q.C.:
 20 Q. As opposed to the 2003.
 21 DR. EJECKAM:
 22 A. As opposed to when we stopped the stains and--
 23 because we worked with DAKO at that time, not
 24 with Ventana.
 25 COFFEY, Q.C.:

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1 Q. Okay. Now in the second, in the next
 2 paragraph, in the middle of it, she says, "All
 3 of the slides from the cases"--it begins right
 4 here, Doctor, with the cursor--"including the
 5 estrogen receptor slides need to be pulled and
 6 organized. All these slides then need to be
 7 reviewed by me, both estrogen receptor
 8 negative and estrogen receptor positive
 9 patients." And she goes on from there, okay,
 10 with a plan of action, as it were. Were you
 11 made aware that this effort was planned? That
 12 this was the sort of effort that was going to
 13 be undertaken?
 14 DR. EJECKAM:
 15 A. No.
 16 COFFEY, Q.C.:
 17 Q. If we could please, bring up Exhibit P-1586,
 18 now, Doctor, this is a draft of--well it's an
 19 e-mail and then a draft of a briefing note.
 20 If we could look at page 4, please, you will
 21 notice it's dated July 20th, that e-mail, and
 22 under additional notes, it's been written here
 23 that "Dr. Williams has also asked that an
 24 investigation be conducted into the five-week
 25 stoppage of immunoperoxidase staining for

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1 ER/PR receptors in 2003 by Dr. Ejeckam." And
 2 the author has said "this raises concerns."
 3 As well, if we could, please, bring up Exhibit
 4 P-0075? That, I gather, Doctor, what we just
 5 looked at then is an earlier draft of, if we
 6 can look at page 3 of this, this is the actual
 7 July 20th official briefing note, you'll see
 8 that on the bottom of the page there, date
 9 prepared, July 20th, 2005. And this was
 10 apparently prepared, Doctor, just to let you
 11 know, it was prepared for the Minister of
 12 Health at the time, the Department of Health.
 13 On this page, the second last paragraph reads,
 14 "Eastern Health's Vice-President of Quality
 15 and Diagnostic and Medical Services, Dr.
 16 Robert Williams, has also asked that an
 17 investigation be conducted into the five-week
 18 stoppage of immunoperoxidase staining for
 19 ER/PR receptors in 2003 by Dr. Ejeckam." Now,
 20 Doctor, in July or August or September of
 21 2005, were you ever asked--did anybody ever
 22 inquiry of you as to what had happened in
 23 2003?
 24 DR. EJECKAM:
 25 A. I don't recall any discussion about this. I

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<p>1 don't think anybody asked--I wasn't questioned</p> <p>2 about it.</p> <p>3 COFFEY, Q.C.:</p> <p>4 Q. You weren't questioned about it.</p> <p>5 DR. EJECKAM:</p> <p>6 A. No.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. And did you ever bring it up with anybody?</p> <p>9 DR. EJECKAM:</p> <p>10 A. No, there was no need for it.</p> <p>11 COFFEY, Q.C.:</p> <p>12 Q. And I take it there was no need, well from</p> <p>13 your perspective, why is that?</p> <p>14 DR. EJECKAM:</p> <p>15 A. I didn't see any need for that because, I</p> <p>16 mean, I wasn't aware of what was going on</p> <p>17 anyway, so there was no way of bringing any</p> <p>18 matter up because I wasn't aware that this</p> <p>19 was--all these investigations and meetings</p> <p>20 were going on.</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Yes. And Doctor, I take it that you had</p> <p>23 written the memos to, as you pointed out to</p> <p>24 the Commissioner earlier, to the people</p> <p>25 involved, failures of error, so in 2003 they'd</p>	<p>1 probably dated, I understand March 8th, '06,</p> <p>2 you'll see there on the side, it is difficult</p> <p>3 to pick out.</p> <p>4 DR. EJECKAM:</p> <p>5 A. Yes.</p> <p>6 COFFEY, Q.C.:</p> <p>7 Q. Doctor, did anyone, do you recall in March of</p> <p>8 2006, ask you about the 2003 initiative in</p> <p>9 relation to whether or not it was a quality</p> <p>10 assurance initiative at the time?</p> <p>11 DR. EJECKAM:</p> <p>12 A. No, I don't remember that at all.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. If we could, please, Exhibit P-0527? Now,</p> <p>15 Doctor, this is a memo, it's from Dr. Cook,</p> <p>16 you'll see, clinical chief to all</p> <p>17 pathologists, as well as Mr. Gulliver, Mr.</p> <p>18 Dyer and Dr. Williams. The subject is</p> <p>19 reporting of estrogen and progesterone</p> <p>20 receptors and he writes, "When reporting the</p> <p>21 ER and PR receptors, please use the following</p> <p>22 canned test, this will be issued as an</p> <p>23 addendum report." And there is then a</p> <p>24 particular format or protocol for reporting,</p> <p>25 he's referred to Meditech Canned Text and for</p>
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<p>1 known.</p> <p>2 DR. EJECKAM:</p> <p>3 A. Yeah, I've sent a memo and I believe they</p> <p>4 received it and it was my take that if further</p> <p>5 action was required, they would rather come</p> <p>6 back to me or take it up from there.</p> <p>7 COFFEY, Q.C.:</p> <p>8 Q. If we could, please, while I'm on the topic,</p> <p>9 because you stayed in St. John's working as a</p> <p>10 pathologist until the end of April of 2006.</p> <p>11 DR. EJECKAM:</p> <p>12 A. Yeah.</p> <p>13 COFFEY, Q.C.:</p> <p>14 Q. If we could look at, please, Exhibit P-0394,</p> <p>15 page 15, please? Now, Doctor, this is a</p> <p>16 photocopy of actually the same memo with some</p> <p>17 handwriting on it and it will be difficult, I</p> <p>18 anticipate on the screen for you to read it.</p> <p>19 In March of 2006, Doctor, and this would have</p> <p>20 been just about the month before you left,</p> <p>21 okay?</p> <p>22 DR. EJECKAM:</p> <p>23 A. Yes.</p> <p>24 COFFEY, Q.C.:</p> <p>25 Q. The second last month you were here, it is</p>	<p>1 negative ER/PR and for positive ER/PR and they</p> <p>2 conclude by saying, "The reporting of ER and</p> <p>3 PR receptors should include information on</p> <p>4 whether the nuclear staining is weak, moderate</p> <p>5 or strong and an estimation of the percentage</p> <p>6 of invasive neoplastic cells showing staining</p> <p>7 which can include a range. Controls should be</p> <p>8 described as adequate or absent." And then on</p> <p>9 the second page he's got an example here. Do</p> <p>10 you recall receiving this?</p> <p>11 DR. EJECKAM:</p> <p>12 A. I don't remember, but I may have received it,</p> <p>13 since it was sent to everybody.</p> <p>14 COFFEY, Q.C.:</p> <p>15 Q. In relation to this, Doctor, like the usage of</p> <p>16 this sort of canned text for the reporting of,</p> <p>17 for example ER/PR, had you ever encountered</p> <p>18 that before?</p> <p>19 DR. EJECKAM:</p> <p>20 A. You mean elsewhere?</p> <p>21 COFFEY, Q.C.:</p> <p>22 Q. Yes.</p> <p>23 DR. EJECKAM:</p> <p>24 A. I will say, it's a question of volume and the</p> <p>25 number of people reporting the case. I guess</p>

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1 the problem may be that where the number of
 2 pathologists who are dealing with the cases
 3 here.
 4 COFFEY, Q.C.:
 5 Q. Okay. And I take it the fact that there are a
 6 number involved, I take it that it would be
 7 useful to have a certain standardized approach
 8 to it.
 9 DR. EJECKAM:
 10 A. Yes.
 11 THE COMMISSIONER:
 12 Q. Dr. Ejeckam, what is your view of the
 13 difference of having a number of people
 14 involved in reporting this particular test?
 15 Is there an advantage or disadvantage to
 16 limiting the number of pathologists to deal
 17 with this test in the same way that you would
 18 limit the number of technologists?
 19 DR. EJECKAM:
 20 A. It would be useful to have dedicated
 21 pathologists dealing with major decisions of
 22 clinical service, like breast pathology and
 23 that applies to the other divisions too. So,
 24 if you have two people or maximum three,
 25 depending on the number of staff you have, but

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1 if everyone is looking at it and making a
 2 calling because you may not see enough, have
 3 enough experience to deal with it, so it could
 4 be advantageous to limit to a group of people,
 5 one or two or three, depends on the number of,
 6 what number of staff you have.
 7 COFFEY, Q.C.:
 8 Q. Doctor, were you ever aware, I'll refer to it,
 9 I believe it was probably September of 2004,
 10 it will come up in a document before the
 11 Commission eventually, but certainly 2004, a
 12 request by Dr. Carter to look at all ER and PR
 13 slides? And it would have been raised by--I
 14 gather, by Dr. Fontaine?
 15 DR. EJECKAM:
 16 A. I don't remember that. If that request was
 17 made, I don't remember it.
 18 COFFEY, Q.C.:
 19 Q. Okay.
 20 THE COMMISSIONER:
 21 Q. Can I just add a second to that earlier
 22 question about the advantages of having a
 23 smaller number of people do ER/PR? Is there a
 24 point at which--are there a number of cases
 25 below which you shouldn't be doing any ER/PR

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1 if you're not doing that number? I'm
 2 explaining this badly, but it seems to me that
 3 one might argue that if you are doing tests
 4 that require a skill that needs to be
 5 maintained and you're not getting very many of
 6 those tests per year, for example, then there
 7 may be a difficulty with losing the skill you
 8 have and reading ER/PR tests. Is that a
 9 concern at all?
 10 DR. EJECKAM:
 11 A. Yeah, in a way this can be important in
 12 certain type of--especially with like
 13 Her2/neu, but for ER/PR and for Newfoundland
 14 in particular, you're not going to manufacture
 15 cases, you're going to deal with a number of
 16 cases that you have.
 17 THE COMMISSIONER:
 18 Q. Uh-hm.
 19 DR. EJECKAM:
 20 A. So if this number is below any arbitrary cut-
 21 off number, you still have people to read it,
 22 so the way to go would probably be to limit
 23 the number of people, so those further--
 24 whether that number is below or not this, at
 25 least concentrate on it and then they will be

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1 seeing most of it and they acquire experience
 2 and then have standard that they will have to
 3 follow.
 4 THE COMMISSIONER:
 5 Q. So as a practical matter because they have to
 6 be read -
 7 DR. EJECKAM:
 8 A. Yes.
 9 THE COMMISSIONER:
 10 Q. While it might be best to have an optimum
 11 level, if you don't have that, then the next
 12 best thing is to make sure that there is a
 13 limited number of pathologists actually
 14 reading them?
 15 DR. EJECKAM:
 16 A. Yes, Commissioner.
 17 THE COMMISSIONER:
 18 Q. Thank you.
 19 COFFEY, Q.C.:
 20 Q. And if there was a request by Dr. Carter back
 21 in 2004, not to report the cases but just to
 22 look at them, because she, I gather you
 23 understood she had additional training as a
 24 breast pathologist.
 25 DR. EJECKAM:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. As a pathologist, a working staff pathologist
 4 at the General Hospital, would you have had
 5 any concerns about your slides being seen by
 6 Bev Carter yourself?
 7 DR. EJECKAM:
 8 A. The only way I would have concern if it's
 9 being seen without my knowledge. If I know
 10 that, well there's no problem another
 11 pathologist to review any other patient's
 12 case, but it should not be done
 13 surreptitiously or, you know, if we are told
 14 it is being done, that shouldn't be any
 15 problem then.
 16 COFFEY, Q.C.:
 17 Q. Yes, I appreciate that, Doctor, in terms of--
 18 so if there was a general request by somebody
 19 like Bev Carter, who is a breast pathologist
 20 and who is relatively new here in St. John's
 21 in 2004, relatively speaking, as long as you
 22 knew that look, all of my ER/PR slides at
 23 some--I'll report them, but if Bev wants to
 24 have a look at them -
 25 DR. EJECKAM:

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1 A. Yeah, and couldn't stop her actually.
 2 COFFEY, Q.C.:
 3 Q. So from your perspective it was as long as--it
 4 was just a professional courtesy that you'd
 5 know.
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. Okay. And in fact I just mentioned Dr.
 10 Carter, if some other pathologist who had a
 11 particular interest in a particular aspect of
 12 pathology wanted to look at all your slides, I
 13 don't know, all of your gastrointestinal
 14 slides or your lung slides -
 15 DR. EJECKAM:
 16 A. Oh yeah, people do studies, people pull out
 17 cases of, let's say prostrate to look at, it's
 18 not only yours they are going to look at,
 19 they're going to look at other people's cases.
 20 They are telling the site chief who would know
 21 that this study is going on, so it's not going
 22 behind--you're not going to be given a new
 23 report, they're not going to be looking at it
 24 and sending a counter report, you want to look
 25 at it and maybe tabulate your result and maybe

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1 present it for any particular reason, but to
 2 be a problem if you pull the cases out and
 3 give a second report without the pathologist
 4 knowing.
 5 COFFEY, Q.C.:
 6 Q. Without the pathologist being told that this
 7 second opinion was going out there because
 8 then it would be out there circulating without
 9 the original pathologist knowing.
 10 DR. EJECKAM:
 11 A. Yeah, if it's a second opinion, a second--and
 12 the first person probably should know that
 13 that's being done and he should have no
 14 difficulty with that.
 15 COFFEY, Q.C.:
 16 Q. If I could, please, exhibit P-0516? Now,
 17 Doctor, these are Dr. Williams' notes and I
 18 don't anticipate you ever saw his handwritten
 19 notes, but we have a typed version of them,
 20 okay. These are July 21st, 2005, the
 21 attendees at that particular meeting were Mr.
 22 Gulliver, Dr. Cook and Dr. Williams, but No. 9
 23 says, "When Barry Dyer and Dr. Ejeckam return,
 24 they will work with Dr. Cook and Dr. Gulliver
 25 to develop Q.A. and proficiency testing

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1 program." Now I reference this simply because
 2 as of July 21, it suggests that yourself and
 3 Mr. Dyer were aware at the time, so that's why
 4 I was asking about your vacation earlier. So
 5 it is possible, I take it, that you were gone
 6 during a certain point in July.
 7 DR. EJECKAM:
 8 A. Possibly.
 9 COFFEY, Q.C.:
 10 Q. If we could please, exhibit P-0532. Now this
 11 is a handwritten note and I gather it was
 12 obtained from the office of Dr. Williams, but
 13 I gather it was probably Dr. Cook's note.
 14 It's dated July 28th, 2005. It says, "Spoke
 15 to Dan Fontaine to begin negative controls for
 16 ER and PR", do you see that? Were you aware
 17 in late July that there was a discussion about
 18 using negative controls, was that brought to
 19 your attention?
 20 DR. EJECKAM:
 21 A. No.
 22 COFFEY, Q.C.:
 23 Q. The idea of using negative controls for ER/PR,
 24 were you aware -
 25 DR. EJECKAM:

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1 A. It's not a new thing, it depends on the volume
 2 of work you had to do, you either use a
 3 positive control or negative control and in
 4 any event there are also, if you look hard
 5 within the tissue, you might find blood
 6 vessels and things that you could use as
 7 negative control within the tissue. So it's
 8 not a-- something new, but I did not bother
 9 the reason for them to look after it.

10 COFFEY, Q.C.:

11 Q. If we could, please, Exhibit P-0534, now this
 12 is a memo of Health Care Corporation St.
 13 John's' letterhead. It's to all pathologists
 14 in St. John's' hospitals, Eastern Health and
 15 all laboratory directors across Newfoundland,
 16 to Mr. Gulliver, Mr. Dyer and Dr. Williams.
 17 It's from Dr. Cook, July 28th, 2005. It's re
 18 Her2/neu and I'm not going to read the first
 19 part of it, but the last paragraph reads, "As
 20 a reminder when choosing blocks to send for
 21 both hormone receptor testing and Her2/neu
 22 testing, please select a section that contains
 23 both tumor and normal or benign epithelium.
 24 The normal and/or benign epithelium acts as an
 25 internal control for immunohistochemical

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1 staining." So I take it that's the idea of
 2 using an internal control for ER/PR was what
 3 you'd refer to in your May 2nd, 2003 memo.

4 DR. EJECKAM:

5 A. Yes.

6 COFFEY, Q.C.:

7 Q. It's the same. And were you consulted on this
 8 memo, the sending of this memo?

9 DR. EJECKAM:

10 A. No, I wasn't consulted, I may have received it
 11 as one of the pathologists, I wasn't
 12 consulted.

13 COFFEY, Q.C.:

14 Q. If we could, please, Exhibit P-0076. Now this
 15 is a memo again on Health Care Corporation of
 16 St. John's' letterhead to all pathologists and
 17 pathology residents in the Department of
 18 Pathology, St. John's' hospitals, Eastern
 19 Health. It's from Dr. Donald Cook and Dr. Bev
 20 Carter. The date is July 28th, 2005 and is
 21 re: optimal assessment and reporting of
 22 hormone receptor status in infiltrating
 23 carcinoma. And it begins, "When ordering
 24 report ER/PR status on infiltrating carcinoma
 25 of the breast"--and there are actually nine

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1 suggestions, do you see that? And I'll just
 2 go on, there's a space for their signatures.
 3 Do you know if you ever actually received
 4 this?

5 DR. EJECKAM:

6 A. I don't remember if I seen this, but sometime
 7 I could have got it, but I don't remember
 8 seeing that memo signed by both of them, both
 9 Cook, Dr. Cook and Dr. Carter.

10 COFFEY, Q.C.:

11 Q. You don't recall--I'm not suggesting you did,
 12 you actually got one because this doesn't have
 13 any -

14 DR. EJECKAM:

15 A. I may have gotten it, but -

16 COFFEY, Q.C.:

17 Q. Well, Doctor, just to briefly run down through
 18 these, number one, "Select a block that
 19 contains illustrating carcinoma and normal
 20 and/or benign breast epithelium." That was in
 21 your May memo -

22 DR. EJECKAM:

23 A. Yeah, that's okay.

24 COFFEY, Q.C.:

25 Q. May, 2003 memo. "When reporting, always check

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1 internal and external controls." I take it
 2 that that was implicit in your May memo.

3 DR. EJECKAM:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. Three, "The external positive controls should
 7 show some variability of staining throughout
 8 the tissue section."

9 DR. EJECKAM:

10 A. Yes.

11 COFFEY, Q.C.:

12 Q. That's an accurate statement, isn't it?

13 DR. EJECKAM:

14 A. Yes.

15 COFFEY, Q.C.:

16 Q. Four, "The external negative control, if made
 17 available should show no staining."

18 DR. EJECKAM:

19 A. Yes.

20 COFFEY, Q.C.:

21 Q. And you would agree with that. Five, "The
 22 internal negative control, example stroma,
 23 vascular, endothelium should show no
 24 staining." You would agree with that?

25 DR. EJECKAM:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. Six, "Internal breast epithelium should show
 4 some positivity, but not diffuse." That was,
 5 you agree with that?
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. "If the external positive control is negative,
 10 the test is invalid." Would that be correct,
 11 the external positive control doesn't work,
 12 you wouldn't report it?
 13 DR. EJECKAM:
 14 A. Yeah.
 15 COFFEY, Q.C.:
 16 Q. You make inquiries.
 17 DR. EJECKAM:
 18 A. Yes.
 19 COFFEY, Q.C.:
 20 Q. And, "If the external negative control is
 21 positive, the test is invalid." You would
 22 agree with that?
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Finally, Doctor, it says, "If the internal
 2 control shows aberrant staining, the test may
 3 be invalid. Please refer to Dr. Bev Carter."
 4 Now in terms of the internal control for
 5 ER/PR, what was your view on that?
 6 DR. EJECKAM:
 7 A. That was critical to me and as for ductal
 8 epithelium, I needed to see that positive
 9 before I read the slide.
 10 COFFEY, Q.C.:
 11 Q. Read the tumor part of the slide.
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. So from your perspective, if the internal
 16 control didn't stain positive, stain
 17 appropriately positive -
 18 DR. EJECKAM:
 19 A. Yeah.
 20 COFFEY, Q.C.:
 21 Q. Then it was your view that you would not
 22 report?
 23 DR. EJECKAM:
 24 A. Yes, we would have to look at the, after the
 25 period of staining, the procedure.

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1 COFFEY, Q.C.:
 2 Q. Did you ever discuss that aspect of pathology
 3 with Dr. Carter, her views of the internal
 4 control issue verses your own?
 5 DR. EJECKAM:
 6 A. No, I don't remember, no.
 7 COFFEY, Q.C.:
 8 Q. If we could, please, Exhibit P-0938? Now,
 9 Doctor, this is a letter, it's dated July
 10 29th, it should read 2005, there's just an
 11 extra zero in there, it's addressed to
 12 yourself as chairperson of the Surgical
 13 Pathology Review Committee and it's from Dr.
 14 Williams, you will see there, copied to Dr.
 15 Cook and Heather Predham. Now did you know
 16 who Heather Predham was?
 17 DR. EJECKAM:
 18 A. No.
 19 COFFEY, Q.C.:
 20 Q. And here, Doctor, Dr. Williams writes, "It was
 21 a pleasure to meet with you and Dr. Cook on
 22 July 15th, 2004 to discuss the activities of
 23 the surgical pathology review committee." Do
 24 you think that that's--is that 2004, is that--
 25 that should be -

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1 DR. EJECKAM:
 2 A. That should be 2005, perhaps, yeah.
 3 COFFEY, Q.C.:
 4 Q. So this letter was being written about two
 5 weeks after your meeting?
 6 DR. EJECKAM:
 7 A. Yeah.
 8 COFFEY, Q.C.:
 9 Q. And he points outs, "We concur that as a
 10 quality assurance committee, there should be a
 11 linkage between the work of the committee and
 12 the overall quality initiative efforts within
 13 this organization. I'll copy this letter to
 14 Ms. Heather Predham, I will ask her to follow
 15 up with you on the matter to see what reports
 16 the Quality and System's Improvement
 17 Department might give to your activities."
 18 Did you ever hear from Ms. Predham about that?
 19 DR. EJECKAM:
 20 A. No.
 21 COFFEY, Q.C.:
 22 Q. Or anybody from her department?
 23 DR. EJECKAM:
 24 A. No.
 25 COFFEY, Q.C.:

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1 Q. Did you actually receive this letter yourself?
 2 It's addressed to you?
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. Because you, in fact earlier made reference to
 7 the fact that you thought there was a response
 8 to your -
 9 DR. EJECKAM:
 10 A. Yeah, that was a response to a letter and it
 11 somewhere got sent over to Dr. Williams,
 12 that's what I think.
 13 COFFEY, Q.C.:
 14 Q. So I take it then, Doctor, at the bottom of
 15 the first page, Dr. Williams says, "After
 16 further medical leadership follow up, it was
 17 decided to modify the requisition form for
 18 surgical pathology specimens"--and outlined in
 19 bold red letters--"that added medical
 20 information would need to be provided before
 21 the specimens were processed. I understand
 22 this new form has been prepared and gone
 23 forward to the forms committee." So I take it
 24 that that was at least making an effort then
 25 to address your concerns.

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1 DR. EJECKAM:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. In the second page, it says, "In our meeting
 5 Dr. Cook brought up the issue of tissue audit
 6 with respect to the Surgical Pathology Review
 7 Committee now taking on responsibility for
 8 reviewing tissue samples and the medical
 9 history to see if there are problems in terms
 10 of a valid reason for these procedures. We
 11 agree that you felt that this should be under
 12 the auspices of this organization's Quality
 13 Assurance Committee, so that adequate
 14 resources can be available to get the
 15 information together for the committee. I
 16 will ask Heather Predham to follow up with you
 17 on this matter to see if one of her staff
 18 members can be made available to assist in
 19 this worthwhile endeavour. This issue was
 20 captured within the initial Terms of Reference
 21 set up for the Surgical Pathology Review
 22 Committee in reference to the April 15th, 2003
 23 agenda. I trust this is satisfactory and look
 24 forward to a greater improvement in the
 25 quality of information that is received from

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1 physicians." And then it goes on to conclude.
 2 Doctor, I take it then that it was the
 3 committee's view that this whole tissue, audit
 4 issue, should be moved to a wider forum than
 5 the committee itself?
 6 DR. EJECKAM:
 7 A. No, the Tissue Audit Committee or Surgical
 8 Pathology Review Committee is a valid
 9 committee (unintelligible) recommended that
 10 there should be a Quality Assurance Control
 11 Committee for the hospital.
 12 COFFEY, Q.C.:
 13 Q. Yes.
 14 DR. EJECKAM:
 15 A. That should be kind of an umbrella or the
 16 main forum that's controlling all of the
 17 quality assurance initiatives in the hospital.
 18 COFFEY, Q.C.:
 19 Q. And at the time, while you were at Eastern
 20 Health, as it then was by that point in time,
 21 was your view in that regard and the
 22 committee's view in that regard ever accepted,
 23 do you know, that there should be an
 24 institution-wide approach?
 25 DR. EJECKAM:

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1 A. I think looking at Dr. William's letter, it
 2 looks to me that he accepts that that notion
 3 that that should be created.
 4 COFFEY, Q.C.:
 5 Q. Were there any further steps up to the time
 6 you left, that you were aware of that were
 7 taken to do that?
 8 DR. EJECKAM:
 9 A. No, no.
 10 COFFEY, Q.C.:
 11 Q. There weren't. If we could look, please, at
 12 Exhibit P-0538, actually I'll pass on from
 13 that, if we could, Exhibit P-0079 please?
 14 Now, Doctor, this is a letter from Dr. Carter
 15 in fact to Dr.--it's dated August 2nd, 2005,
 16 it's from Dr. Carter and it's copied to Dr.
 17 Williams. It's addressed to Dr. Cook and she
 18 begins by saying, "Regretfully I inform you
 19 that I wish to withdraw from my organizational
 20 role in the investigation of the problems of
 21 ER/PR testing at the Health Care Corporation
 22 of St. John's from '97 to 2004, and a planning
 23 of solutions to the current issues discovered
 24 with the Ventana Automated System". Doctor,
 25 were you aware of this on large scale review

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1 that Dr. Carter had started to undertake -
 2 DR. EJECKAM:
 3 A. I said I wasn't -
 4 COFFEY, Q.C.:
 5 Q. Okay. So, I take it then, did you ever become
 6 aware that she had resigned from it?
 7 DR. EJECKAM:
 8 A. What I heard was she resign her appointment.
 9 I didn't--this is the first time that I'm
 10 seeing her role in the ER/PR thing. But I
 11 heard that she resign her appointment.
 12 COFFEY, Q.C.:
 13 Q. I'm sorry, what?
 14 DR. EJECKAM:
 15 A. I heard that she resigned her appointment.
 16 COFFEY, Q.C.:
 17 Q. Her appointment, oh.
 18 DR. EJECKAM:
 19 A. Not, maybe that's what they meant, but you
 20 know, I didn't get any details.
 21 COFFEY, Q.C.:
 22 Q. Okay. And to get some sense again of what was
 23 going on at this point in time, if we could
 24 look at Exhibit P-0542? Now, Doctor, this is
 25 a memo on Health Care Corporation St. John's'

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1 letterhead, it's to all pathologists in the
 2 Division of Anatomical Pathology, as well as
 3 to Mr. Gulliver and Mr. Dyer. It's from Dr.
 4 Cook, clinical chief, August 2, 2005, re:
 5 resource individual for immunohistochemistry.
 6 And Dr. Cook has written, "Dr. Gershon Ejeckam
 7 is currently our resource person for
 8 immunohistochemistry. All inquiries regarding
 9 immunohistochemistry should be referred to Dr.
 10 Ejeckam. In the event that Dr. Ejeckam is not
 11 available, all inquiries should be referred to
 12 the site chief, General Hospital site, who is
 13 currently Dr. Dan Fontaine." Were you aware
 14 that this was going to be written?
 15 DR. EJECKAM:
 16 A. No, I received it, but I wasn't aware of it.
 17 COFFEY, Q.C.:
 18 Q. And did this actually change anything?
 19 DR. EJECKAM:
 20 A. No.
 21 COFFEY, Q.C.:
 22 Q. I take it, this was written confirmation that
 23 you were the resource person and you
 24 understood that?
 25 DR. EJECKAM:

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1 A. I had function of the resource person and
 2 maybe he decided--maybe you can see why it was
 3 written, Bev says she wasn't getting involved
 4 August 2, he may have decided to write this,
 5 but I don't know.
 6 COFFEY, Q.C.:
 7 Q. And I'll ask Dr. Cook about why he wrote it,
 8 but from your perspective, at the time, you
 9 weren't given a heads up that this is being
 10 written?
 11 DR. EJECKAM:
 12 A. No.
 13 COFFEY, Q.C.:
 14 Q. And having received it, you didn't interpret
 15 anything as being changed?
 16 DR. EJECKAM:
 17 A. No.
 18 COFFEY, Q.C.:
 19 Q. If we could, please, Exhibit P-0545? Now
 20 Doctor, these are Dr. Williams' handwritten
 21 notes, but happily, we have a typed version of
 22 them on page two. It's dated August 3rd, 2005
 23 and it's notes on ER/PR issues, and there's a
 24 reference here to "met with Dr. Don Cook and
 25 Heather Predham, times two. QI, quality

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1 initiatives, follow up and interviews were
 2 held with techs involved in the
 3 immunohistochemistry in the a.m.. Heather
 4 Predham gave me a debriefing on the issue and
 5 the lack of communication between techs and
 6 pathologists. Heather Predham gave Dr. Cook
 7 and general site chief, Dr. Dan Fontaine, a
 8 briefing on her interview in the p.m. Met
 9 with Dr. Cook afterwards and discussed issue
 10 and need for techs to have a pathologist who
 11 they can go to for advice and communication.
 12 Dr. Cook and I will follow up with Dr.
 13 Gulliver and on broad and specific
 14 communications issues identified. Dr. Cook
 15 waiting to hear back from Mount Sinai re:
 16 completing all negative ER/PR testing on a
 17 very expeditious basis."
 18 Now Doctor, in late July or early August
 19 2005, did anyone come to you about any
 20 concerns about lack of communication between
 21 the techs and the pathologists?
 22 DR. EJECKAM:
 23 A. No.
 24 COFFEY, Q.C.:
 25 Q. And you, I take it, were the resource person

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1 for immunohistochemistry?
 2 DR. EJECKAM:
 3 A. Yeah.
 4 COFFEY, Q.C.:
 5 Q. You had been for quite a while.
 6 DR. EJECKAM:
 7 A. Yeah.
 8 COFFEY, Q.C.:
 9 Q. And you had been dealing with the
 10 technologists, if they had a question or
 11 concern, you would try to address it?
 12 DR. EJECKAM:
 13 A. Yeah, I mean, these notes here are surprising
 14 to me because the technologists had easy
 15 access to me all through.
 16 COFFEY, Q.C.:
 17 Q. And what about the pathologists, the other
 18 pathologists, if they had a concern about
 19 technologists, would they come to you and have
 20 you deal with the techs or -
 21 DR. EJECKAM:
 22 A. Oh no, they had access to the techs. There
 23 was no restriction.
 24 COFFEY, Q.C.:
 25 Q. Okay. Did you ever--were you ever made aware

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1 of any concerns expressed by the
 2 technologists, not about their interaction
 3 with you, but about the fact that it was not
 4 only with you? There were others, other
 5 pathologists might come to them not having
 6 gone to you? Did they ever complain to you
 7 about the fact that "look, we want to deal
 8 with you, Dr. Ejeckam, but we have to deal
 9 with Dr. A and B and C"?
 10 DR. EJECKAM:
 11 A. There was no complaint to me and they needed
 12 to deal with everybody. I mean, they didn't
 13 have to deal with me only. They're working
 14 for--their job is doing slides for everybody,
 15 so the other pathologists have right to go
 16 talk to them anytime they chose, and they
 17 didn't have to go through me.
 18 COFFEY, Q.C.:
 19 Q. And if we could, please, Exhibit P-0555?
 20 Doctor, were you ever told by the
 21 technologists that they, perhaps at times,
 22 were getting conflicting opinions from
 23 pathologists on certain matters?
 24 DR. EJECKAM:
 25 A. No, they didn't tell me that. I'm not aware

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1 of--and I don't know the scenario where that
 2 will occur.
 3 COFFEY, Q.C.:
 4 Q. Now were you ever involved in trying to train
 5 the technologists? I mean, I appreciate, and
 6 you've referred to the double-headed
 7 microscope -
 8 DR. EJECKAM:
 9 A. Yes.
 10 COFFEY, Q.C.:
 11 Q. - and so on, but was there ever a formal or
 12 semi-formal arrangement that you were involved
 13 in to train the technologists?
 14 DR. EJECKAM:
 15 A. Well, the way I was training them was the way
 16 to do at that time. They had finished their
 17 training as a technologist, so this is an
 18 additional thing and the only way to train
 19 them was to discuss slides with them
 20 periodically and of course when we made
 21 arrangement to send them out to a bigger
 22 laboratory where specimens were being
 23 processing for them to see what was being
 24 done, because they have learned already the
 25 real methods that, you know, the process.

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1 COFFEY, Q.C.:
 2 Q. Yes, okay, and I'll be getting to them being
 3 sent out in a moment. Looking at this, the
 4 handwritten portion of this says "meeting of
 5 pathologists" and it lists a number of
 6 pathologists, although your name is not
 7 amongst those, and it's dated August 5, 2005,
 8 three p.m., and the typed portion of this says
 9 "this is a list of some concerns that have
 10 emerged during conversations about the current
 11 problem. Included are some of our suggestions
 12 about how to approach this," and the
 13 Commissioner has seen this before, and it
 14 deals with--well, first of all, I'll ask you,
 15 have you ever seen this, this document?
 16 DR. EJECKAM:
 17 A. No.
 18 COFFEY, Q.C.:
 19 Q. Okay. I'll just take you briefly through it.
 20 "Included are some of our suggestions about
 21 how to approach this," and then it says "it is
 22 important that we work together and support
 23 each other as a department. Important
 24 features of the ongoing process should
 25 include: cooperation, transparency,

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1 communication, dissemination of information as
 2 the process evolves, avoidance of finger
 3 pointing to either individuals or a group of
 4 individuals, input into the procedure and
 5 quality control and assurance initiatives
 6 surrounding it. We should ensure that no bias
 7 is introduced into the ongoing study. If the
 8 purpose is to compare methods, then the
 9 following are important features: assume that
 10 the pathologist reported the original test
 11 correctly; then only the report needs to be
 12 compared to the result of the current accepted
 13 method; send an addendum if there is, in fact,
 14 a change in the result. Persons conducting
 15 the study do not need to know which
 16 pathologist signed the report originally.
 17 Anything else is an audit of individual
 18 pathologists, and if that is the aim, this is
 19 not the proper procedure for an audit of
 20 pathologist's performance. We should not be
 21 working in a culture where pathologists feel
 22 they are being criticized for past
 23 performances. Avoid generalized statements
 24 such as 'pathologists don't know how to report
 25 the ER/PR' 'a single pathologist has

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1 repeatedly reported the ER/PR incorrectly' and
 2 'keeping statistics on an individual
 3 pathologist.' These statements, as well as
 4 loud discussions around the issue in corridors
 5 with high public traffic are threatening and
 6 demoralizing. We all assume that we are the
 7 pathologist being referred to however
 8 anonymously. This issue concerns pathologists
 9 outside of the Health Care Corporation and
 10 they also need to be informed and reassured
 11 that the procedure"--I'm sorry, "that the
 12 process is proceeding in a fair and productive
 13 manner."
 14 Now Doctor, the pathologists that are
 15 listed here at the top, Dr. Fontaine, Dr.
 16 Larkin, Dr. M. Parai, Dr. Barron and there's
 17 some others, Dr. Cook and two other names,
 18 difficult to pick out, what site were they on?
 19 Were they on the Health--the General Hospital
 20 or St. Clare's? I appreciate Dr. Cook was at
 21 St. Clare's.
 22 DR. EJECKAM:
 23 A. Yeah, Cook was at St. Clare's.
 24 COFFEY, Q.C.:
 25 Q. The others?

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1 DR. EJECKAM:
 2 A. I think the rest of them were at the Health
 3 Sciences.
 4 COFFEY, Q.C.:
 5 Q. Did the subject--I apologize, Doctor.
 6 DR. EJECKAM:
 7 A. Dan, Lyn, Parai, Pirzada, Barron, they're all
 8 at the Health Sciences.
 9 COFFEY, Q.C.:
 10 Q. Now Doctor, and this is early August, August 5
 11 2005. Were you aware of concerns by the
 12 pathologists at the General Hospital site,
 13 these sorts of concerns?
 14 DR. EJECKAM:
 15 A. I don't know. I wasn't--maybe I was on
 16 holiday. I'm not sure I was in St. John's at
 17 this time. I may have travelled to Nigeria.
 18 But I think when this issue of the index case
 19 broke, there was general discussion about
 20 concerns by pathologists, even at the
 21 conferences or just, you know, just discussing
 22 generally, but I wasn't aware of any meeting
 23 that was called to discuss the issue. So they
 24 may have held this meeting when I wasn't
 25 there, when I left, was on holidays, maybe to

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1 address what may have been--people may have
 2 been talking. From reading through that, it
 3 looks to me like maybe somebody may have gone
 4 out in a different forum, criticize the work
 5 of their fellow pathologists and maybe the
 6 group wanted to have a meeting and then forge
 7 a common front against that kind of behaviour.
 8 That's what I read into this.
 9 COFFEY, Q.C.:
 10 Q. Did you become aware, in the summer of 2005 or
 11 early fall of 2005, that that was the feeling
 12 amongst pathologists, that's reflected here?
 13 DR. EJECKAM:
 14 A. Yeah, I got a feeling that people were unhappy
 15 and concerned that, you know, maybe flippant
 16 statements might be jeopardizing the integrity
 17 of the fellow pathologists.
 18 COFFEY, Q.C.:
 19 Q. Now Doctor, if we could look, please, at
 20 Exhibit P-0560? This is a memo on Health Care
 21 Corporation letterhead to all pathologists in
 22 Eastern Health, St. John's hospitals, Eastern
 23 Health, as well as Mr. Dyer, Gulliver, and Dr.
 24 Williams. It's from Dr. Cook, August 8th
 25 2005. This particular one is re: estrogen

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1 receptors and progesterone receptors on
 2 current cases, and the opening paragraph reads
 3 "There will be a hold on the reporting of ER
 4 and PRs by all pathologists in the division of
 5 anatomical pathology, St. John's Hospitals,
 6 Eastern Health." Then it goes on from there,
 7 okay. I'm not going to--I take it you would
 8 have gotten a copy of this?
 9 DR. EJECKAM:
 10 A. Yeah, I would have gotten it.
 11 COFFEY, Q.C.:
 12 Q. Yes, and the second paragraph says "all ER and
 13 PRs will be forwarded to Mount Sinai Hospital
 14 for immunohistochemical processing and
 15 reporting." Doctor, when did you first become
 16 aware that, at least then for the foreseeable
 17 future, they were going to do current cases at
 18 Mount Sinai? When and how did you become
 19 aware of that?
 20 DR. EJECKAM:
 21 A. I don't remember the time, but it must have
 22 been after all these stories about the index
 23 case became open.
 24 COFFEY, Q.C.:
 25 Q. Do you recall how it was you were first

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1 informed that we're not going to do ER/PR in
 2 St. John's. We're going to do it--have it
 3 done at Mount Sinai? Like who told you that?
 4 DR. EJECKAM:
 5 A. I think it's through this memo.
 6 COFFEY, Q.C.:
 7 Q. This memo?
 8 DR. EJECKAM:
 9 A. Yeah, I think so.
 10 COFFEY, Q.C.:
 11 Q. And in looking at that, those notes of August
 12 5 we just looked at a moment ago, they
 13 suggest, I think in reading them, and would
 14 you agree, that there's a certain unease
 15 amongst the pathologists and a lack of
 16 information that they have about what's going
 17 on?
 18 DR. EJECKAM:
 19 A. I'm not sure whether it was lack of
 20 information or not, but there was some degree
 21 of uneasiness about the entire case. People
 22 were apprehensive.
 23 COFFEY, Q.C.:
 24 Q. So if this memo of August 8th was the first
 25 time that you learned that for current cases

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1 they're going to be done at Mount Sinai,
 2 ER/PR, and you were the resource person for
 3 immunohistochemistry, I take it that you were
 4 not being exactly kept in the loop as it were?
 5 DR. EJECKAM:
 6 A. Not what it looks like.
 7 COFFEY, Q.C.:
 8 Q. If we could look, please, at Exhibit P-0561?
 9 This is again a memo from Dr. Cook to all
 10 pathologists, St. John's Hospitals, Eastern
 11 Health, Dr. Williams, Mr. Dyer and Mr.
 12 Gulliver. It's August 8th 2005, ER and PR on
 13 cases from May 1997 to August 9th, 2005. It
 14 says, it begins by saying "cases from May 1997
 15 to March 31, 2004 that are ER negative, except
 16 those from patients who are deceased, will be
 17 referred to Mount Sinai," and it goes on then
 18 to talk about the procedure for doing the
 19 retesting.
 20 So is this the first--would this memo
 21 have been where you first learned that they
 22 were going to do this mass retesting back to
 23 1997?
 24 DR. EJECKAM:
 25 A. I think so.

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1 COFFEY, Q.C.:
 2 Q. Were you ever consulted about the advisability
 3 of doing it and how they might go about it?
 4 DR. EJECKAM:
 5 A. No. I know that when I got--I think when I
 6 got this memo, item number three, I did tell
 7 Dr. Cook that I didn't agree with that
 8 particular aspect of it, that he should allow
 9 the pathologists who reported the case to sign
 10 in the addendum when the report came back from
 11 Mount Sinai.
 12 COFFEY, Q.C.:
 13 Q. And now just for the benefit of people here,
 14 once the--number three says "once the Mount
 15 Sinai report has been received at the St.
 16 Clare's site, an addendum will be issued by
 17 Dr. Cook or Dr. Carter in the hospital
 18 information system."
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. When you received this, you expressed the view
 23 to Dr. Cook -
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. - that when Mount Sinai does report a retest

3 result, the individual pathologist who did the

4 original report should be the one who enters

5 that information as an addendum?

6 DR. EJECKAM:

7 A. Yes, that was my view.

8 COFFEY, Q.C.:

9 Q. And why is that, Doctor?

10 DR. EJECKAM:

11 A. Well, I think that if a pathologist did the

12 diagnosis and they refer out to another

13 hospital to do ER/PR, there was no

14 justification for someone else to enter that

15 into the system, and it now creates two people

16 signing out a report, and without probably

17 appreciating it, it may, may or may not, may

18 create some kind of confidence difficulties in

19 the mind set of the oncologist that the first

20 pathologist probably didn't know what he was

21 doing, that's why the second person had to

22 sign it in. He don't know how to interpret

23 it. But usually, they should have been better

24 at that the result has come in and has been

25 vetted and then the person who did the first

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1 report in calling the tissue malignant, should

2 then send in the addendum and he's going to

3 say the result came from Mount Sinai anyway.

4 He's not going to claim that he did it or she

5 did it in the centre here.

6 COFFEY, Q.C.:

7 Q. Doctor, what was Dr. Cook's response to that?

8 DR. EJECKAM:

9 A. He told me it was his responsibility to do as

10 clinical chief. And I told him I don't agree

11 with that, but that was his, he was the

12 clinical chief and he had to do what he had to

13 do.

14 COFFEY, Q.C.:

15 Q. Now, looking at--was there any other concern

16 you had with any part of that memo that you

17 expressed?

18 DR. EJECKAM:

19 A. I remember this item that we discussed. I

20 don't think there was any other area that I

21 raised any concerns.

22 COFFEY, Q.C.:

23 Q. Doctor, the idea of doing this retesting at

24 Mount Sinai, did you have any concerns about

25 that when you became aware of it?

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1 DR. EJECKAM:

2 A. No, in the sense that since this issue and

3 Mount Sinai has an accredited laboratory, we

4 could use it to--the only concern I had was

5 that comparing Mount Sinai results with what

6 we had here, I knew that we were using Ventana

7 machine and Mount Sinai was using DAKO, so we

8 got to be careful comparing their results with

9 ours because it's not going to be exactly same

10 thing. They probably use the different clones

11 of antibody and then also had different

12 machine, so we're going to get slightly

13 different percentages of positivity, you know,

14 in those two systems. That was my concern.

15 COFFEY, Q.C.:

16 Q. You anticipated that there would be a slightly

17 different read -

18 DR. EJECKAM:

19 A. Yes, going to be, yeah.

20 COFFEY, Q.C.:

21 Q. - or possibly?

22 DR. EJECKAM:

23 A. It probably didn't matter too much unless

24 somebody puts a lot of weight on the

25 percentage, but I expect that the two machines

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1 should be able to read positive, positive,

2 negative, negative.

3 COFFEY, Q.C.:

4 Q. Okay. And if we could, please, -

5 CROSBIE, Q.C.:

6 Q. What number was that, Mr. -

7 COMMISSIONER:

8 Q. The number of this exhibit?

9 CROSBIE, Q.C.:

10 Q. Yes. 0561?

11 COMMISSIONER:

12 Q. 0561.

13 COFFEY, Q.C.:

14 Q. Yes. And, Doctor, you know, by this point in

15 time, it was August, early August of 2005 you

16 realize now they're going to go back, well, to

17 a period long before, in fact, you had been in

18 St. John's, '97 through 2002. And part of it

19 involved the time period you had been in St.

20 John's. How did you feel about it at the

21 time? Had you ever encountered any such kind

22 of large scale review before in your career?

23 DR. EJECKAM:

24 A. No. But, you know, I don't remember any kind

25 of incident that (unintelligible) to, so.

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1 COFFEY, Q.C.:

2 Q. Yes. And, Doctor, do you recall whether or

3 not you anticipated that there might be large

4 scale, when I say large scale, quite a number

5 of conversions?

6 DR. EJECKAM:

7 A. I have no opinion on that because I really

8 didn't think about--I mean, I didn't know what

9 was going on other than cases were being sent.

10 I didn't know the number that was being sent

11 and being retested, so, you know, I wasn't in

12 a position to start speculating on percentage

13 or whatever.

14 COFFEY, Q.C.:

15 Q. Okay. See, on that point, this is why I asked

16 that, is it that we've heard evidence, well,

17 you heard today or yesterday, but we've heard

18 evidence, for example, in the first wave of

19 people tested on the Ventana, retested on the

20 Ventana, there was 25 people, 16 of them

21 converted, 16 patients' tissue samples

22 converted. And I mean, that works out at a

23 percentage of about 64 percent conversion in

24 that first group. Were you--was that kind of

25 thing being talked about within the pathology

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1 departments at the time? I mean, as a

2 pathologist were you aware that that, in the

3 initial group that there was a conversion of

4 about 60 percent?

5 DR. EJECKAM:

6 A. I wasn't aware of percentage other than I knew

7 that there was a talk about conversions. So,

8 you know, but in terms of number, I had no

9 information to that effect.

10 COFFEY, Q.C.:

11 Q. So that wasn't made generally known within the

12 pathology departments as to what the findings

13 -

14 DR. EJECKAM:

15 A. I don't think so. It may have been, the

16 information the clinical chief and Bev Carter

17 may know about it, but I didn't know what

18 other pathologists know. They could have

19 known, you know, so depends on, you know,

20 where they were at that particular time, they

21 may have known this information. I didn't

22 have that information.

23 COFFEY, Q.C.:

24 Q. And what I'm--from the Commissioner's

25 perspective to know, Doctor, to get some sense

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1 of by the time this retesting effort, major

2 retesting efforts starts in August and things

3 are sent to Mount Sinai and so on, as we come

4 into Labour Day of 2005, early September. As

5 a pathologist working here in St. John's,

6 because you were working here, you continued

7 to work, how much did, from your perspective,

8 were you kept informed about what was going

9 on? I mean, you knew there was a retesting

10 going on?

11 DR. EJECKAM:

12 A. Yes.

13 COFFEY, Q.C.:

14 Q. And you knew all current cases were being done

15 at Mount Sinai?

16 DR. EJECKAM:

17 A. Yes.

18 COFFEY, Q.C.:

19 Q. ER/PR. But other than that, how much were you

20 being kept in the loop, as it were, or being

21 told anything?

22 DR. EJECKAM:

23 A. I think that's all I personally I knew about

24 it.

25 COFFEY, Q.C.:

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1 Q. As a staff pathologist how did you feel about

2 that, did you think, have any feelings about

3 whether or not you should be kept better

4 informed or, from time to time as to what was

5 going on?

6 DR. EJECKAM:

7 A. Well, I personally didn't feel any--I didn't

8 have any opinion one way or the other because

9 it looks like someone is taking care of the

10 situation and, you know, it didn't come into

11 the normal routine of our work, so it didn't

12 really become an issue with me.

13 COFFEY, Q.C.:

14 Q. And if we could, please, Exhibit P-0637? Now,

15 Doctor, this is a letter dated October 13th,

16 2005. And I'll deal with this in a moment.

17 But there has been evidence here that on

18 October 2nd, 2005 this issue hit the media,

19 you know, in the sense of it became publicly

20 known in The Independent newspaper story. Had

21 you been aware or made--were you made aware

22 before it became public that it was about to

23 be made public?

24 DR. EJECKAM:

25 A. I don't remember that. I know that Don used

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1 to drop into the Health Sciences and we have a
 2 chat and he would go so, and it wasn't a
 3 formal meeting with agenda and the minutes, so
 4 if it was discussed, if he said it was
 5 discussed, probably so, but I don't remember
 6 that.
 7 COFFEY, Q.C.:
 8 Q. Do you recall whether or not were you ever
 9 consulted in the summer of 2005 or September,
 10 2005, asked about your views as to whether or
 11 not patients should be told about the fact
 12 that their tissue was being retested?
 13 DR. EJECKAM:
 14 A. No, no, I didn't get an consultation
 15 specifically for that kind of information.
 16 COFFEY, Q.C.:
 17 Q. No one came to you kind of canvassed you,
 18 well, Gershon, what do you think? They didn't
 19 -
 20 DR. EJECKAM:
 21 A. I don't remember that.
 22 COFFEY, Q.C.:
 23 Q. Sure. Looking at this, doctor, this is a
 24 letter of October 13th, 2005, it's addressed
 25 to yourself as a staff pathologist. It's from

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1 Dr. Cook, signed by me and it's copied to Dr.
 2 Dan Fontaine, Terry Gulliver and Dr. Bob
 3 Williams, Robert Williams. And it says, "Dear
 4 Dr. Ejeckam, As discussed, I appreciate your
 5 continuing role in overseeing the
 6 immunoperoxidase service. As you know, we
 7 were in the process of developing a
 8 specialized service with technologists solely
 9 dedicated to immunohistochemical technique.
 10 As agreed, you will oversee all aspects of the
 11 immunoperoxidase operation, have direct
 12 supervision over the technologists involve in
 13 the service. You will also provide direction
 14 to all pathologists involved in the
 15 immunoperoxidase interpretation. In areas
 16 where we hope to develop subspecialized
 17 service, there will obviously be consultation
 18 between you and the appropriate pathologists
 19 on immunoperoxidase staining. If you feel
 20 that there is any deviation from this, you
 21 should report this immediately to both the
 22 clinical chief of the laboratory medicine
 23 program and the vice president of quality,
 24 diagnostic and medical services at Eastern
 25 Health. Once again, I thank you for your

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1 important contribution, guidance and expertise
 2 to our organization in this area. Sincerely
 3 yours, Donald Cook." Now, Doctor, were you
 4 consulted about this appointment before it
 5 occurred?
 6 DR. EJECKAM:
 7 A. I'm not sure. I think what probably prompted
 8 this letter may have been that as a resource
 9 person, quote, unquote, you know, dealing with
 10 the technologists, they were also still, you
 11 know, they had to take their orders from
 12 Barry, the manager, and then probably from
 13 other sources, and that may have created some
 14 problem in terms of work process, and I may
 15 have discussed this with Don saying, look, if
 16 I have to now be a resource person, there may
 17 be difficulty that if you ask, order an
 18 antibody, somebody may say, no, they're not
 19 going to do it or I have to go to beg or to
 20 ask somebody that I need an antibody ordered.
 21 I didn't need to do that if I told the techs
 22 that we needed antibody A, then they have to
 23 follow the process of ordering it to bring it
 24 in. If somebody now stopped them doing it,
 25 then that probably will create a problem. I

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1 wasn't sure whether that was the issue, but I
 2 think we had discussion in that line, that's
 3 why he went ahead to write this letter, maybe
 4 to emphasize that the techs, I'm responsible
 5 for what goes on in that division.
 6 COFFEY, Q.C.:
 7 Q. Because here in the third line and the third
 8 sentence it says, "As agreed," I take it
 9 that's agreed between you and him?
 10 DR. EJECKAM:
 11 A. Yeah, yeah.
 12 COFFEY, Q.C.:
 13 Q. You, that's Dr. Gershon Ejeckam, "will oversee
 14 all aspects of the immunoperoxidase operation
 15 and have direct supervision over the
 16 technologists involved in the service." So I
 17 take it before this that wasn't the case, you
 18 didn't have supervisory responsibility for the
 19 techs?
 20 DR. EJECKAM:
 21 A. Well, it wasn't--I'm saying there was a
 22 dichotomy here, it was they had to report to
 23 Barry and taking orders from, instruction from
 24 different directions. So I think there may
 25 have been discussed and he decided to spell it

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1 out in this memo.
 2 COFFEY, Q.C.:
 3 Q. Yeah. And it goes on to say, as well, "You,"
 4 that's Dr. Ejeckam, "will also provide
 5 direction to all pathologists involved in the
 6 immunoperoxidase interpretation." So before
 7 this had you been providing such direction to
 8 all pathologists?
 9 DR. EJECKAM:
 10 A. If they needed it. If anyone needed help -
 11 COFFEY, Q.C.:
 12 Q. If they needed help, oh, yes.
 13 DR. EJECKAM:
 14 A. Yeah. But, I mean, that direction I will say
 15 was that, because during our informal rounds I
 16 would give my contribution, interpretation of
 17 the immunostain done or during our Tuesday
 18 rounds, I will give my input and
 19 interpretation of any of the
 20 immunohistochemistry done in terms of usage
 21 for diagnosis. So that would be giving
 22 direction or helping my colleagues or with my
 23 opinion, you know. I mean, I wasn't the only
 24 one giving the opinion. The rest of them,
 25 more so. I mean, the other pathologists have

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1 knowledge of immunohistochemistry, so we will
 2 discuss each case together and then come to a
 3 conclusion.
 4 COFFEY, Q.C.:
 5 Q. And he concludes in the first paragraph
 6 saying, "In areas where we hope to develop
 7 subspecialized service, particular areas,
 8 there will obviously be consultation between
 9 you and the appropriate pathologists on
 10 immunoperoxidase staining." So I take it
 11 there was some thought at this point to
 12 developing a subspecialized service?
 13 DR. EJECKAM:
 14 A. Yeah, yeah, it should be a subspecialized unit
 15 of its own, and then if people wanted to
 16 introduce a new antibody, let's say a
 17 pathologist wanted to have a new antibody,
 18 then they will pass that through me, then we
 19 will allow, procure it and then do some
 20 titration before we sign it into--I was
 21 supposed to sign it into system that the
 22 titration has been done and found efficacious
 23 and found good enough.
 24 COFFEY, Q.C.:
 25 Q. Yeah. So that's from this point on?

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1 DR. EJECKAM:
 2 A. Yeah.
 3 COFFEY, Q.C.:
 4 Q. Before this did you have to sign in the -
 5 DR. EJECKAM:
 6 A. No, no, before this I wasn't doing that.
 7 COFFEY, Q.C.:
 8 Q. Okay. So what I'm coming to then in this,
 9 this memo, did this change things, was it
 10 meant to change the structure?
 11 DR. EJECKAM:
 12 A. I looked at this memo as the way to, for
 13 information to the lab manager and tell him
 14 that I have to deal with the technologists
 15 directly. But it hasn't changed very much
 16 because there's no actual structure making me
 17 head of the unit, just work and there's no--
 18 I'm not aware of any appointment. I mean, if
 19 I was, I mean, that isn't an appointment
 20 letter. This is something that gives me some
 21 kind of leeway to deal with the staff, and
 22 that's the way I looked at it, and I wasn't
 23 looking for any big title there. And then I
 24 continued doing the work, anyway, so this
 25 letter didn't change the way I related to the

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1 technologists who we had a good relationship
 2 and we worked together to ensure we got good
 3 result in the laboratory.
 4 COFFEY, Q.C.:
 5 Q. But what it did do, I take it, was was it
 6 informed the technologists supervisors -
 7 DR. EJECKAM:
 8 A. Right.
 9 COFFEY, Q.C.:
 10 Q. - in a formal way, look -
 11 DR. EJECKAM:
 12 A. They should not interfere with my dealing with
 13 the technologists. I think that's the main
 14 thrust of this letter, that they should not
 15 interfere with my dealings with the
 16 technologists.
 17 COFFEY, Q.C.:
 18 Q. And in respect of directed at the other
 19 pathologists, it was where we're going to get
 20 into subspecialization, where we are, you have
 21 to talk to Dr. Ejeckam about the IHC aspect of
 22 that?
 23 DR. EJECKAM:
 24 A. Yes, if they needed to introduce a new
 25 antibody, that's basically there. But the

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1 general discussion on IHC had always been good
 2 enough in our conferences.
 3 COFFEY, Q.C.:
 4 Q. If we could, please, Exhibit P-0531? And in
 5 relation to that letter, I mean, this happens,
 6 this exhibit happens to be dated--I said 0531,
 7 I meant 0351, I apologize. I apologize,
 8 Doctor. 0351. This document is a review of
 9 the immunohistochemistry lab, the General
 10 Hospital site, St. John's, Eastern Health.
 11 It's prepared for Dr. Williams by Mr. Gulliver
 12 and Dr. Cook dated October 13th, 2005. It's
 13 the same date as the letter to yourself.
 14 Doctor, that letter itself, the one we just
 15 looked at, did you, after receiving it,
 16 discuss it, did it come up afterward in
 17 conversation with people, was there any
 18 controversy about it?
 19 DR. EJECKAM:
 20 A. I'm not aware of any controversy.
 21 COFFEY, Q.C.:
 22 Q. And looking here at this, particular aspects
 23 of this memo, were you consulted by Mr.
 24 Gulliver or Dr. Cook, do you recall, about
 25 this review? I believe your name is referred

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1 to a number of places in it I'm going to show
 2 you.
 3 DR. EJECKAM:
 4 A. No.
 5 COFFEY, Q.C.:
 6 Q. Okay. If we could look at page four, please.
 7 I apologize, perhaps we could go back to page
 8 two, I apologize. Under objective, paragraph
 9 1.2, it says "the objective of this proposal
 10 is to identify the requirements needed to
 11 implement a quality--complete quality
 12 assurance program for the immunohistochemistry
 13 lab, ensuring that we provide a standardized
 14 and reliable service, equivalent to the Mount
 15 Sinai reference lab in Toronto."
 16 And scope, 1.3, "the scope of the
 17 proposal includes a review of all components
 18 of the immunohistochemistry service, from
 19 grossing the specimen to pathologists'
 20 interpretation," and 1.4, the methodology, if
 21 I could, says "work processes were reviewed
 22 internally by the lab program including the
 23 pathology manager, technologist, site chief,
 24 clinical chief and program director.
 25 Additionally, suggestions from the QI review

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1 by Heather Predham and the on-site visits by
 2 Dr. B.D. Banerjee from the B.C. Cancer Agency
 3 and Trish Wegrynowski from Mount Sinai are
 4 also incorporated in this proposal."
 5 So I noticed there that your name is not
 6 listed or your position in 1.4. You're not--
 7 you weren't consulted about this?
 8 DR. EJECKAM:
 9 A. No.
 10 COFFEY, Q.C.:
 11 Q. Okay. Now in relation to this, Dr. Banerjee,
 12 did you ever meet Dr. Banerjee?
 13 DR. EJECKAM:
 14 A. Yes, I know him.
 15 COFFEY, Q.C.:
 16 Q. When did you meet him?
 17 DR. EJECKAM:
 18 A. I don't remember the month, but when he
 19 visited to evaluate the laboratory, I met--Don
 20 Cook brought him to my office and I knew him
 21 anyway. We trained together in Ottawa, so -
 22 COFFEY, Q.C.:
 23 Q. Okay.
 24 DR. EJECKAM:
 25 A. - somebody I knew.

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1 COFFEY, Q.C.:
 2 Q. So you had known him back in the 70s then?
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. Okay, back in the 70s, early 80s, okay. So
 7 whenever your CV says you were in Ottawa,
 8 that's the time you would have known Dr.
 9 Banerjee?
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. From decades before. And was it on his first-
 14 -because he was here twice.
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. He was here in September of '05 and April of
 19 '06. Did you meet him both times?
 20 DR. EJECKAM:
 21 A. Yes, I suspect, yes. The first time he came
 22 to my office. I think the second time was a
 23 meeting that, you know, had together with
 24 other people, I don't remember everybody there
 25 now, but I believe I met him on the two

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1 occasions that he arrived.
 2 COFFEY, Q.C.
 3 Q. And the first time that he visited, you say
 4 Dr. Cook brought him to your office.
 5 DR. EJECKAM:
 6 A. Yes.
 7 COFFEY, Q.C.
 8 Q. Do you recall what you discussed?
 9 DR. EJECKAM:
 10 A. General things, family and then we talked
 11 about our immunohistochemistry and, you know,
 12 fleetingly because, you know, he was going to
 13 review cases anyway, so.
 14 COFFEY, Q.C.
 15 Q. Okay. Do you recall if you offered any views
 16 to him or opinions?
 17 DR. EJECKAM:
 18 A. I may have offered my view about
 19 (unintelligible) staff from the--or
 20 appointing, having somebody responsible for,
 21 you know, a particular division. I may have
 22 done that, I'm not sure.
 23 COFFEY, Q.C.
 24 Q. Well, if we could look then at Exhibit, I'm
 25 sorry, page four of the exhibit. Now, this

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1 is, paragraph 2.2, pathologist interpretation,
 2 it says, "currently each pathologist
 3 requesting immunohistochemistry procedures
 4 based upon the type of tissue and possible
 5 type of cancer they are investigating. The
 6 technologist completes the procedures and
 7 returns the slides to the pathologist.
 8 There's a need for sub-specialization of
 9 pathologists particularly in breast cancer
 10 where interpretation of immunoperoxidase
 11 stains and monitoring of trends is crucial.
 12 There's also a need for a single pathologist
 13 to oversee the service and to provide
 14 direction to technical staff and to liaise and
 15 consult with pathologists. It is recommended
 16 that (f) one pathologist be assigned the
 17 responsibility for all aspects of the
 18 immunohistochemistry service". So, I take it,
 19 that's--you recall, you told Dr. Banerjee that
 20 was your view?
 21 DR. EJECKAM:
 22 A. Yeah, well that's what I'm saying, I may have
 23 mentioned this to him, but I believe he knew
 24 that because they have a good lab too.
 25 COFFEY, Q.C.

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1 Q. And (g) says, "while all pathologists will
 2 continue to interpret/report
 3 immunohistochemistry cases, it is recommended
 4 that they be given the opportunity to
 5 subspecialize for certain cases, example, two
 6 to three pathologists would interpret all
 7 breast cancers". From that perspective--now,
 8 I'll ask you, did you ever see this report, do
 9 you know, this October 13 -
 10 DR. EJECKAM:
 11 A. No.
 12 COFFEY, Q.C.
 13 Q. You didn't.
 14 DR. EJECKAM:
 15 A. I didn't, this is the first time I've seen
 16 this.
 17 COFFEY, Q.C.
 18 Q. The idea though expressed here that while all
 19 pathologists will continue to interpret and
 20 report, there should be sub-specialization,
 21 and you thought it was a good idea.
 22 DR. EJECKAM:
 23 A. Yes.
 24 COFFEY, Q.C.
 25 Q. The quality assurance, paragraph 3, says,

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1 third line, "the lab does not participate in
 2 outside proficiency testing for
 3 immunohistochemistry. The lab has never had
 4 the opportunity to participate in either
 5 conferences, tele-conferences or able to
 6 network with other immunoperoxidase labs, IP
 7 labs". First of all, was the lab, at that
 8 point, participating in outside proficiency
 9 testing for IHC, at that point?
 10 DR. EJECKAM:
 11 A. I believe so. I think we had CAP already and
 12 I think, well, College of American
 13 Pathologists, I believe goes on.
 14 COFFEY, Q.C.
 15 Q. And it goes on to say, "it is recommended that
 16 (h) the immunohistochemistry lab enrol in
 17 outside proficiency testing, example CAP and I
 18 take it, you understood they were already
 19 enrolled in that.
 20 DR. EJECKAM:
 21 A. I thought they were, but I wasn't involved
 22 with CAP, I was involved with the UK one.
 23 COFFEY, Q.C.
 24 Q. And paragraph (i), "all recommendations by
 25 Trish Wegrynowski be implemented". And

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1 there's a listing of them here with an et
 2 cetera. And (j) "recommend a separate C.E.
 3 budget be established for books, journals and
 4 conferences". I take it that's something that
 5 you've been recommending for a while.
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.
 9 Q. Doctor, Trish Wegrynowski, did you meet her?
 10 DR. EJECKAM:
 11 A. No, I saw her in the laboratory, but I didn't
 12 sit down to talk to her.
 13 COFFEY, Q.C.
 14 Q. Did you ever speak to her the first or second
 15 time she was here, do you recall?
 16 DR. EJECKAM:
 17 A. No.
 18 COFFEY, Q.C.
 19 Q. Okay. Now, the first time around that Dr.
 20 Banerjee was here, you met him in your office,
 21 did you participate in his exit interview that
 22 time, the first time or was it the second
 23 time?
 24 DR. EJECKAM:
 25 A. I know after discussing with him in my office,

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1 we review some slides together in the multiple
 2 headed microscope and we showed him estrogen
 3 receptors and other, immunohistochemistry and
 4 other antibody, what we were doing, we all sat
 5 together to look at it and he was quite happy
 6 with what we were doing at that--I mean, the
 7 results we're getting at that time.
 8 COFFEY, Q.C.
 9 Q. And when Dr. Banerjee was here in the fall,
 10 September of '05, were you made aware of his
 11 findings at that time?
 12 DR. EJECKAM:
 13 A. No. Well, I shouldn't say no. Dr. Don Cook
 14 read the paper, read the findings in a meeting
 15 of the entire pathologists. After reading it,
 16 were not giving copies, so I just kind of
 17 remember what was said at that time. So, we
 18 didn't have copies of the report, it was read
 19 to us.
 20 COFFEY, Q.C.
 21 Q. Do you recall when that was?
 22 DR. EJECKAM:
 23 A. After he came in, but I'm not too good with
 24 dates now, but it was after, shortly after,
 25 maybe weeks or so after he had come and gone.

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1 COFFEY, Q.C.
 2 Q. And did you recall if Dr. Cook read the whole
 3 of the report?
 4 DR. EJECKAM:
 5 A. Yeah, I think he read the whole report in the
 6 meeting and then said that he wouldn't give
 7 copies, that it was confidential material.
 8 And I said to myself, if I'm in charge of the
 9 immunohistochemistry, why won't I have report
 10 how to improve it. And I think he said if I
 11 wanted to read it again, I could come and read
 12 it, come to his office to read it. I didn't
 13 go.
 14 COFFEY, Q.C.
 15 Q. Okay. And from your perspective, whereby that
 16 point in time, in the fall of 2005, by the
 17 time the report came in and Dr. Cook would
 18 have read it to the group, you were then the
 19 head--October 13 you'd been made responsible
 20 for the IHC part of the lab. You'd agreed to
 21 take it on and you were concerned when you--
 22 you thought you should have a copy of the
 23 report.
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.
 2 Q. Because the report, I take it, was aimed at
 3 the IHC aspect of the lab.
 4 DR. EJECKAM:
 5 A. Yes, yes.
 6 COFFEY, Q.C.
 7 Q. Doctor, was there any discussion among the
 8 pathologists, I mean, you're sitting in a
 9 meeting, Dr. Cook reads the report, do the
 10 pathologists afterward discuss it, do you
 11 know?
 12 DR. EJECKAM:
 13 A. I'm sure some people made comment, but I don't
 14 remember what is said.
 15 COFFEY, Q.C.
 16 Q. Okay.
 17 THE COMMISSIONER:
 18 Q. Wherever you can find a good spot, we'll break
 19 for the luncheon break.
 20 COFFEY, Q.C.
 21 Q. What was--when you were looking at the slides
 22 with Dr. Banerjee, what were you talking
 23 about, do you recall?
 24 DR. EJECKAM:
 25 A. We just showed him a number of sections that

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1 we stained for ER/PR and for other antibodies
 2 and just for him to see the product from our
 3 laboratory and that's what we were talking
 4 about. And not just me, the techs were there
 5 and I think a few of the doctors were looking
 6 through the multiple head microscope.
 7 COFFEY, Q.C.
 8 Q. Would these be current slides at the time?
 9 DR. EJECKAM:
 10 A. Yeah, current -
 11 COFFEY, Q.C.
 12 Q. Current product -
 13 DR. EJECKAM:
 14 A. Current slides.
 15 COFFEY, Q.C.
 16 Q. If he went and looked at historic slides -
 17 DR. EJECKAM:
 18 A. No, no, we're not looking at those cases that
 19 are being retested. We are looking at what
 20 our lab was producing -
 21 COFFEY, Q.C.
 22 Q. Currently producing at that time.
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.

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1 Q. Commissioner, we can break and come back and
 2 take this up and finish off. Thank you.
 3 THE COMMISSIONER:
 4 Q. All right. 2:05.
 5 (LUNCH BREAK)
 6 THE COMMISSIONER:
 7 Q. Please be seated. Mr. Coffey.
 8 COFFEY, Q.C.
 9 Q. Thank you, Mr. Coffey. If I could, there's
 10 one thing I did want to look back at, exhibit
 11 P-0113, page three please. Now Doctor, this
 12 is that May 2 memo, May 2, 2003 memo. In
 13 paragraph five, there's just one point that I
 14 wanted to ask you about. You are here,
 15 reporting of ER/PR several formulae are in the
 16 literature and you spell them out, different
 17 ones. Then what I wanted to point you to,
 18 you've quoted here from Consensus Statement on
 19 Adjuvant Therapy of Breast Cancer, November 1
 20 - 3, 2000, National Institute of Health, "any
 21 positive nuclear ER immunostaining is
 22 considered to be a positive result and should
 23 be a definitive reason for instituting anti-
 24 estrogen therapy for a patient". And you go
 25 on to note then for you fellow pathologist,

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1 "the medical oncologist may require percentage
 2 of tumor positivity". In relation to the
 3 reference to the consensus statement, okay,
 4 where would you have obtained that from?
 5 DR. EJECKAM:
 6 A. From the literature, immunohistochemistry book
 7 by DABBS.
 8 COFFEY, Q.C.
 9 Q. And this National Institute of Health was an
 10 American -
 11 DR. EJECKAM:
 12 A. Yes.
 13 COFFEY, Q.C.
 14 Q. - Institute. Did you have any conversation
 15 with any oncologists about this?
 16 DR. EJECKAM:
 17 A. No.
 18 COFFEY, Q.C.
 19 Q. Did any of the pathologists to whom you sent
 20 the memo speak to you about it?
 21 DR. EJECKAM:
 22 A. No.
 23 COFFEY, Q.C.
 24 Q. Okay. I'm sorry, I just wanted to cover that
 25 off because I had, unfortunately, not done so

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1 when we went through it. If we could look
 2 please, at exhibit P-0351, page five, please.
 3 Now, Doctor, at the top of the page there,
 4 there's a reference to Trish Wegrynowski and
 5 her recommendations. Did you ever see a list
 6 of her recommendations?
 7 DR. EJECKAM:
 8 A. No.
 9 COFFEY, Q.C.
 10 Q. Doctor, I asked you, before lunch, if you
 11 recall having met her, okay. Did you--I'm
 12 just going to--because I had some
 13 understanding of what she, I anticipate, may
 14 say to the Commission, do you recall ever
 15 having an informal conversation with her, just
 16 -
 17 DR. EJECKAM:
 18 A. I don't recall discussing anything with her.
 19 I believe that I may have seen her in the
 20 laboratory.
 21 COFFEY, Q.C.
 22 Q. Okay. Is it -
 23 DR. EJECKAM:
 24 A. But I'm not 100 percent sure. I mean, I'm not
 25 sure whether I discussed with her or not.

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1 COFFEY, Q.C.
 2 Q. Okay. So, if she was to testify that she did
 3 have a discussion with you, an informal
 4 discussion, -
 5 DR. EJECKAM:
 6 A. Well, I'll accept that, if she remembered any
 7 discussion, then that's fine.
 8 COFFEY, Q.C.
 9 Q. Okay, because I understand she certainly does
 10 remember yourself, but I just want to canvas
 11 that.
 12 DR. EJECKAM:
 13 A. Yes.
 14 COFFEY, Q.C.
 15 Q. We look here at paragraph four on this page,
 16 the space, in the second sentence of the
 17 paragraph where it says, upon recommendation
 18 by Dr. Ejeckam, this section moved adjacent to
 19 the main lab in the former hormone assay lab
 20 space. Plans have been in place for several
 21 years to have the pathology lab, as a whole,
 22 renovated incorporating the former hormone
 23 assay lab which had been identified as a new
 24 separate immunohistochemistry lab". So, I
 25 take it this suggests that your recommendation

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1 in '03, at least, was partially implemented.
 2 DR. EJECKAM:
 3 A. Yeah.
 4 COFFEY, Q.C.
 5 Q. Were you aware that there were plans in place
 6 to have the lab redesigned in the sense of the
 7 layout of the lab, which is referred to here.
 8 DR. EJECKAM:
 9 A. Well, I may have had it because the other--
 10 they were renovating the other sections of the
 11 laboratory and I would have had--anatomic
 12 pathology would be there later with--so I
 13 think they were doing hematology and then
 14 maybe they're coming down to -
 15 COFFEY, Q.C.
 16 Q. Okay, doing it in phases?
 17 DR. EJECKAM:
 18 A. Yes.
 19 COFFEY, Q.C.
 20 Q. Steps.
 21 DR. EJECKAM:
 22 A. Yeah.
 23 COFFEY, Q.C.
 24 Q. Okay. Here at paragraph 5(a) "overall impact
 25 analysis, impact/analysis recommendations.

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1 (a) most grossing/dissecting functions to be
 2 formed by trained technologists, pathologists
 3 assistants".
 4 DR. EJECKAM:
 5 A. Yeah.
 6 COFFEY, Q.C.
 7 Q. I take it this is what yourself and Dr. Robb
 8 and company had been looking for in 2004?
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.
 12 Q. And though by the time you left in April of
 13 '06, it still hadn't been arranged.
 14 DR. EJECKAM:
 15 A. No, techs were still--senior techs were still
 16 doing grossing for us. I don't remember any
 17 of them being redesignated pathology
 18 assistants.
 19 COFFEY, Q.C.
 20 Q. Okay.
 21 DR. EJECKAM:
 22 A. But they were already doing the job anyway.
 23 COFFEY, Q.C.
 24 Q. If we could, please, page 6, paragraph--just
 25 get the--yes, this is under the heading

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1 "overall impact/analysis of recommendations",
 2 paragraph (f) says, "one pathologist be
 3 assigned the responsibility for all aspects of
 4 the immunohistochemistry service" and it says,
 5 "completed Dr. Ejeckam has accepted this
 6 responsibility". So, that letter, I take it,
 7 are the same date -
 8 DR. EJECKAM:
 9 A. Yes, yes.
 10 COFFEY, Q.C.
 11 Q. - okay, of October 13. Paragraph (f), just go
 12 down, sorry, "the immunohistochemistry lab
 13 enrol in outside proficiency testing, for
 14 example CAP. Currently enrolled in CAP, cost
 15 per year is \$5,000.00", which is your memory
 16 of it, in fact, that you were already in CAP
 17 when you showed up in 2002.
 18 DR. EJECKAM:
 19 A. Yeah, right.
 20 COFFEY, Q.C.
 21 Q. "And Dr. Ejeckam has requested to enrol in the
 22 UK proficiency testing program and it's going
 23 to cost about \$7,000.00 a year".
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.
 2 Q. That was your request?
 3 DR. EJECKAM:
 4 A. Yes.
 5 COFFEY, Q.C.
 6 Q. Doctor, I take it then you told us that you,
 7 at one point Dr. Cook read yourself and your
 8 fellow pathologists Dr. Banerjee's written
 9 report.
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.
 13 Q. You read it once and you weren't provided with
 14 a copy. Did you ever see a list of his
 15 recommendations, Dr. Banerjee's
 16 recommendations, an actual list?
 17 DR. EJECKAM:
 18 A. No, just it was read out in a meeting, that
 19 was all.
 20 COFFEY, Q.C.
 21 Q. And Trish Wegrynowski's report, we know that
 22 she has a report dated, I think it's November
 23 9th, 2005, but it is November 2005, did you
 24 ever see a copy of her report?
 25 DR. EJECKAM:

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1 A. No.
 2 COFFEY, Q.C.
 3 Q. Was it ever read to you?
 4 DR. EJECKAM:
 5 A. No.
 6 COFFEY, Q.C.
 7 Q. And you never saw a list of her
 8 recommendations either?
 9 DR. EJECKAM:
 10 A. No.
 11 COFFEY, Q.C.
 12 Q. Okay. Doctor, is the person responsible--
 13 well, it says responsible for the IHC, do you
 14 think it was wise or how wise do you think it
 15 was that you weren't provided with a list of
 16 recommendations, at least?
 17 DR. EJECKAM:
 18 A. Well, my answer here would be that whoever was
 19 asked to be responsible for this division of
 20 laboratory work ought to have sent or had
 21 copies of this--because he is going to
 22 implement some of the changes. So, I would
 23 think that it would be necessary for whoever
 24 is going to be responsible for the
 25 implementation to see the reports. Otherwise,

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1 they wouldn't know what to implement or
 2 somebody else would be doing it and, you know,
 3 on your behalf or someone like that.
 4 COFFEY, Q.C.
 5 Q. If we could, please, to take up another thread
 6 in this, Exhibit P-1282, please, and page
 7 three please. Now, this is a note apparently
 8 from Denise who worked, I gather, for Dr.
 9 Williams. It's dated September 6, 2005, "re:
 10 surgical pathology form" and it says, "Dora
 11 Cooper said the form is being printed today.
 12 There was a delay in printing because the
 13 printing machine needed for this particular
 14 service was out of service". And Denise is
 15 nothing that she had informed Dr. Cook about
 16 this. So, I take it, finally, at least the
 17 form was being changed, as you requested?
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.
 21 Q. If we can look please at Exhibit 1283, page
 22 two, please. These are what are entitled,
 23 "Terms of Reference for the External Quality
 24 Review of the Immunohistochemistry Service".
 25 This is what apparently the Terms of Reference

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1 that we are given to understand, Dr. Banerjee
 2 and Trish Wegrynowski were given. Were you
 3 consulted about this at all?
 4 DR. EJECKAM:
 5 A. No.
 6 COFFEY, Q.C.
 7 Q. Okay. If we could look at exhibit P-1302
 8 please. Now Doctor, the first page of this is
 9 a letter dated October 17, 2005 to Dr. Donald
 10 Cook, scroll down through it and you'll see
 11 it's a letter from Dr. Banerjee enclosing his
 12 external quality review of the
 13 immunohistochemistry service. And we look at
 14 the second page of this, this is the report
 15 itself, the cover page, November 17, 2005.
 16 And then the, this is the text of the report.
 17 Doctor, have you ever had the opportunity to
 18 review the report? I mean, I appreciate it
 19 was read to you, you've told us but -
 20 DR. EJECKAM:
 21 A. Yeah, no, I didn't have a chance to read it on
 22 my own.
 23 COFFEY, Q.C.
 24 Q. Pardon me?
 25 DR. EJECKAM:

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1 A. I didn't read it then.
 2 COFFEY, Q.C.
 3 Q. Oh, then. Have you had a chance to read it
 4 since?
 5 DR. EJECKAM:
 6 A. Since I came in, I think, yeah.
 7 COFFEY, Q.C.
 8 Q. In preparation for coming to the Commission of
 9 Inquiry.
 10 DR. EJECKAM:
 11 A. Yes, yes, yes.
 12 COFFEY, Q.C.
 13 Q. Okay. Doctor, I ask you to think back to the
 14 time that Dr. Cook read it to you as a group,
 15 do you recall what your reaction was to what
 16 Dr. Banerjee had apparently said? Were you
 17 surprised by it or not or how did you react to
 18 it?
 19 DR. EJECKAM:
 20 A. At that time--right now--at the time, when I
 21 saw it this time for preparation, I just
 22 didn't remember what he read.
 23 COFFEY, Q.C.
 24 Q. Yes.
 25 DR. EJECKAM:

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1 A. But when I looked at it now, I wasn't
 2 surprised. Most of what he said was exactly
 3 what I would say. So, it does--making the
 4 same recommendation with a few additions to
 5 what I had indicated needed to be done with
 6 the laboratory.
 7 COFFEY, Q.C.
 8 Q. In fact, when you look at, for example, in
 9 the--and you say in preparation here now, to
 10 come here, in reviewing this and looking back
 11 on it, you're not surprised by the
 12 recommendations, for example?
 13 DR. EJECKAM:
 14 A. No.
 15 COFFEY, Q.C.:
 16 Q. The recommendations, I'm just going to, if I
 17 could, begin at the bottom of page five of the
 18 exhibit, and then they continue on, and there
 19 are ten of them, in fact, actually spelled
 20 out. Now the references to--in the report to
 21 "conclusions about the reasons for test
 22 failure" and I appreciate here, Doctor, when
 23 you look back at this, to put this in context,
 24 Dr. Banerjee has reported on the first page
 25 that in the review of cases and in the

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1 paragraph before that, right in here he says
 2 "this led to a review of 50--of their 57 cases
 3 reported in 2002 as negative, which on
 4 retesting on the Ventana benchmark resulted in
 5 a high conversion rate from negative to
 6 positive, 38 over 57, 67 percent."
 7 And then he says "I have a reviewed a
 8 number of cases from their retrospective
 9 testing set with Dr. Donald Cook. All of the
 10 cases that had converted from negative to
 11 positive by switching platforms had one or
 12 more of the following characteristics: poor
 13 fixation, negative internal controls, or
 14 absent internal controls. It is apparent that
 15 too much reliance is being placed on external
 16 positive controls with no attention paid to
 17 internal controls." And that was--I think
 18 you've already communicated to the
 19 Commissioner, your--the significance and the
 20 importance to you of the internal controls in
 21 ER/PR?
 22 DR. EJECKAM:
 23 A. It is very critical.
 24 COFFEY, Q.C.:
 25 Q. Okay. If we could, while we're at it, in the

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1 conclusions about the reasons for test
 2 failure, I'm not going to take you through
 3 them in detail, Doctor, but in effect, in
 4 paragraph one, he says it's not the DAKO
 5 system's fault. That's not a problem. I take
 6 it that while you were there, while the DAKO
 7 was there and you were there, the DAKO system,
 8 as far as you knew, was working?
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. You had no reason to doubt its operational -
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. - utility. The Ventana system too sensitive.
 17 Did you have any reason yourself to believe it
 18 was too sensitive?
 19 DR. EJECKAM:
 20 A. I didn't think so. All I'd seen, the
 21 different machine, the range of positive may
 22 be different. They're not going to be exactly
 23 the same as DAKO because it's a different
 24 machine, it has a different clone of antibody
 25 that was used in these tests.

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1 COFFEY, Q.C.:

2 Q. Okay. So the fact that the positivity

3 percentage might be different wouldn't

4 surprise you?

5 DR. EJECKAM:

6 A. Yeah. No, no.

7 COFFEY, Q.C.:

8 Q. But the fact that it went from, for example,

9 zero/zero to 100/100, that kind of a thing,

10 that would surprise you?

11 DR. EJECKAM:

12 A. Yeah, that would be a problem.

13 COFFEY, Q.C.:

14 Q. That would be a problem, and perhaps if

15 there's a significant change, I take it, that

16 would be a problem?

17 DR. EJECKAM:

18 A. Yeah, if ten percent and 80 percent

19 positivity, that's too wide a range. So one

20 would worry about that.

21 COFFEY, Q.C.:

22 Q. A range from 10 to 15?

23 DR. EJECKAM:

24 A. It's not a big deal, 20 percent.

25 COFFEY, Q.C.:

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1 Q. He says "is there a problem with tissue

2 fixation?" and he then posits that "there

3 appears to be inadequate attention paid by the

4 grossing pathologist to the thickness of

5 tissue slices." Had you been aware of that,

6 the assertion that he makes here that

7 apparently the pathologists are not slicing

8 the tissue thin enough?

9 DR. EJECKAM:

10 A. I'm not aware of that as a problem, and again,

11 I know he mentioned it's possible poor

12 fixation may be due to--like I explained

13 earlier, the tissue may not have been--let's

14 say the tissue wasn't brought down to the

15 laboratory in time, then even if you section

16 it after it lays overnight, fixation will not

17 be adequate. You may fix it a little bit, but

18 because already the damage has been done

19 before the pathologist got to it.

20 COFFEY, Q.C.:

21 Q. And when the damage is done in that regard, it

22 can't be -

23 DR. EJECKAM:

24 A. I mean, you might be able to get at some

25 result, but it's not going to be optimal

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1 because if they had a big mass and it was put

2 in formalin bucket, it wasn't sliced, the

3 central part of that will not fix properly,

4 and if you come in the next day to slice it

5 and then take section, most of the central

6 area may have not been properly fixed and

7 you're going to have the effect when you do

8 the stain. So the problem is not necessarily

9 pathologist not slicing. It's you have to

10 deal with how the sample was brought in, what

11 form it was brought in.

12 COFFEY, Q.C.:

13 Q. It could be either/or or even both for that

14 matter? It could be -

15 DR. EJECKAM:

16 A. I wouldn't put this on the pathologist, for

17 the mere fact that all the pathologists, they

18 were trained and I know that the sections you

19 take can't be thicker than the cassette

20 anyways, and the cassette, if you have a

21 thicker slice, it wouldn't close. So whatever

22 is able to be accommodated in that cassette

23 should fix.

24 COFFEY, Q.C.:

25 Q. Okay. He says, in paragraph four, "inadequate

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1 or no attention is being paid by the reporting

2 pathologist to the status of internal controls

3 with inappropriately exclusive reliance on

4 external positive controls." Doctor, had you

5 been aware or would you have--you know, would

6 you have been aware that a state of affairs

7 existed that would result in this sort of a

8 statement by a person such a Dr. Banerjee?

9 DR. EJECKAM:

10 A. I'm not aware that the pathologists had

11 problem identifying internal control.

12 COFFEY, Q.C.:

13 Q. You weren't aware?

14 DR. EJECKAM:

15 A. Like I said in the beginning, before, one, you

16 need to be aware that those controls are

17 necessary to look at and if anybody didn't

18 have that information, that's, you know,

19 benefitted from my memo.

20 COFFEY, Q.C.:

21 Q. Yes. Anybody who hadn't known about it before

22 your May 2nd memo, certainly if they got that

23 and read it would have been aware of it?

24 DR. EJECKAM:

25 A. Yes.

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1 COFFEY, Q.C.:

2 Q. Or could have been aware of it. The

3 paragraph--well, there's no paragraph five

4 numbered five, but this paragraph numbered

5 six, "inappropriate choice of blocks with no

6 representative normal ductal epithelium." I

7 take it that refers to what? Your

8 understanding they weren't picking blocks with

9 -

10 DR. EJECKAM:

11 A. Yeah, this is a problem. I will say the

12 pathologists, after looking at the HNE, has to

13 pick the block that has normal tissue.

14 Sometimes you have, you know, all just the

15 tumor and if that's all you have, then that's

16 the block you're going to deal with, and this

17 issue--well, I'm not trying to point finger at

18 any particular laboratory, but I noted this

19 maybe more with some of the out of St. John's

20 blocks we received. So that, you know, and

21 you cannot do very much about the quality

22 block they send you to do the stain on .

23 COFFEY, Q.C.:

24 Q. Now, Doctor, well you mentioned the out-of-

25 town pathologists, were you ever contacted in

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1 relation to the ER/PR matter by any out of St.

2 John's pathologists?

3 DR. EJECKAM:

4 A. No, I don't remember anyone of them calling to

5 discuss any issues with this.

6 COFFEY, Q.C.:

7 Q. Nor to discuss either of your -

8 DR. EJECKAM:

9 A. Memos.

10 COFFEY, Q.C.:

11 Q. - memos either?

12 DR. EJECKAM:

13 A. No.

14 COFFEY, Q.C.:

15 Q. Okay. If we could just look at other system

16 flaws briefly, Doctor. "Lack of dedicated

17 immunohistochemistry technologists." Well,

18 you'd been on about that for a while, hadn't

19 you, yourself?

20 DR. EJECKAM:

21 A. Yeah.

22 COFFEY, Q.C.:

23 Q. "Lack of an officially designated pathologist

24 as director of immunohistochemistry service."

25 I take it that actually occurred on October

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1 13th with that letter to you?

2 DR. EJECKAM:

3 A. Yeah, well, it didn't occur in--I mean, when

4 you appoint someone director of anything, you

5 need to have a structure and he knew that a

6 director, I mean, that letter written, I took

7 it that just confirming me as a resource

8 person.

9 COFFEY, Q.C.:

10 Q. Resource person.

11 DR. EJECKAM:

12 A. So that I don't have any interference dealing

13 with the techs, and that is the way I

14 interpreted it.

15 COFFEY, Q.C.:

16 Q. And I appreciate that clarification, Doctor,

17 because I want to be--I'd like the

18 Commissioner to understand what you understood

19 in your own mind as to what it was.

20 DR. EJECKAM:

21 A. Yes.

22 COFFEY, Q.C.:

23 Q. I characterized it just then as appointing you

24 director and you'd say "well, no, Mr. Coffey,

25 that's--I didn't see it as--I wasn't director.

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1 I was -

2 DR. EJECKAM:

3 A. Yeah, because I mean, you see all the meetings

4 that were going on. I would suspect that a

5 properly appointed director should be either

6 driving those meetings or be present at those

7 meetings.

8 COFFEY, Q.C.:

9 Q. Sure.

10 DR. EJECKAM:

11 A. You know, so all I did was to help to make

12 sure the laboratory produced credible good

13 result.

14 COFFEY, Q.C.:

15 Q. Here, number four, Doctor, paragraph four,

16 "lack of subspecialization among pathologists

17 leading to a lack of in-depth knowledge about

18 IHC technical and interpretation details and

19 pitfalls." So I take it you would have been

20 in favour of subspecialization?

21 DR. EJECKAM:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. Certainly, if it was possible to do it.

25 DR. EJECKAM:

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1 A. Yes.
 2 COFFEY, Q.C.:
 3 Q. And there's a reference to the disconnect
 4 between laboratory program director, division
 5 manager, clinical site chief and laboratory
 6 director in decision making, and he then goes
 7 on to talk about the organizational chart,
 8 indicating a complete separation of reporting
 9 structures into technical and clinical streams
 10 with no cross-reporting. Did that reflect
 11 your own thinking, now looking at this now and
 12 looking back on it? Were you concerned about
 13 the division between the clinical staff and
 14 the technical staff?
 15 DR. EJECKAM:
 16 A. Yes, yes. I mean, I had said this before.
 17 COFFEY, Q.C.:
 18 Q. Yes.
 19 DR. EJECKAM:
 20 A. You needed the manager to report to the site
 21 chief and you needed the program manager to
 22 report to the clinical chief. Now that wasn't
 23 the case, so parallel responsibilities, and
 24 the clinical chief and the site chief had no
 25 authority. They didn't control any budget.

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1 They couldn't change anything in the
 2 laboratory, in terms of buying equipment. All
 3 those would be manager and the program manager
 4 who would report then straight to, I think, to
 5 the Vice President of the hospital, leaving
 6 the clinical chief and site chief really just
 7 one of those people in there with no real
 8 authority to make any changes, and I think
 9 that is a little bit absurd.
 10 COFFEY, Q.C.:
 11 Q. Now Doctor, with respect to this, under the--
 12 further on in this paragraph, there's a
 13 reference to the Sakura Express. You see
 14 that?
 15 DR. EJECKAM:
 16 A. Yeah.
 17 COFFEY, Q.C.:
 18 Q. And he says--well, he--this full sentence
 19 reads "the division manager and program
 20 director appear enthusiastic and keen on
 21 modernizing the laboratory, but their efforts
 22 have not been appreciated by the pathologists
 23 and work flow changes have not been mapped out
 24 and implemented, eg. example a Sakura Express
 25 implementation has failed due to lack of

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1 planning of work flow changes." And he goes on
 2 to say "superior outcomes could be achieved by
 3 ensuring better linkages between technical,
 4 managerial and medical leadership." I take it
 5 you would agree with the last sentence
 6 certainly?
 7 DR. EJECKAM:
 8 A. Yes, yes.
 9 COFFEY, Q.C.:
 10 Q. The Sakura Express, what was that about? Do
 11 you recall?
 12 DR. EJECKAM:
 13 A. I think it was a big tissue processor that
 14 could handle larger volumes of tissue, but of
 15 course, it needed to be worked in, in terms of
 16 the size of sample and the type of sample it
 17 could handle.
 18 COFFEY, Q.C.:
 19 Q. Did you have any--was the Sakura Express there
 20 while you were there?
 21 DR. EJECKAM:
 22 A. Yes.
 23 COFFEY, Q.C.:
 24 Q. Was it used at all?
 25 DR. EJECKAM:

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1 A. I think it was used briefly, but after that,
 2 then they stopped using it. We had some
 3 problem. Small samples that got processed
 4 through it, some of them were a little bit--
 5 they didn't come out very well, so I think
 6 they stopped using it, but I can't be sure
 7 which of the--you know, what they did with
 8 that. I think they stopped using it.
 9 COFFEY, Q.C.:
 10 Q. In relation to that, did you have any
 11 involvement in that?
 12 DR. EJECKAM:
 13 A. No.
 14 COFFEY, Q.C.:
 15 Q. The usage or stoppage of it?
 16 DR. EJECKAM:
 17 A. No.
 18 COFFEY, Q.C.:
 19 Q. Okay. You weren't consulted about it?
 20 DR. EJECKAM:
 21 A. I shouldn't be, because that had--it had
 22 nothing to do with me. That's a machine that
 23 does general histopathology work. It has
 24 nothing to do with immunohistochemistry.
 25 COFFEY, Q.C.:

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1 Q. Okay, and paragraph six refers to "attendance
 2 by both medical and technical staff at various
 3 conferences with a focus on new technology
 4 should be encouraged," and you had no problem
 5 with that. You thought people should go to
 6 conferences?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. And training, and finally, "the department
 11 needs dedicated pathology assistants," which
 12 is the same thing yourself and Dr. Robb had
 13 been on about.
 14 DR. EJECKAM:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. So Doctor, with the benefit of having had a
 18 chance to look at this now, in preparation for
 19 coming here to testify, do you take any issue
 20 with what's in Dr. Banerjee's report?
 21 DR. EJECKAM:
 22 A. I agree with what he said.
 23 COFFEY, Q.C.:
 24 Q. Okay. If we could, please, Exhibit P-1587?
 25 Now Dr. Ejeckam, this is a letter of October

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1 18th 2005 to Edward Depestre, Chief of
 2 Pathology Services at Jewish General Hospital
 3 in Montreal, and it opens by saying "we are in
 4 the process of reorganizing our
 5 immunoperoxidase service in the anatomical
 6 pathology. As part of this process, we want
 7 to develop a highly specialized team of
 8 technologists who will be dedicated solely to
 9 immunoperoxidase staining." And he goes on to
 10 talk about the Ventana system they are
 11 currently using.
 12 This is a letter, by the way, Doctor,
 13 from Dr. Cook, you can see, and it's copied to
 14 yourself, amongst others, Dr. Fontaine who
 15 will be the site chief at Mount--I'm sorry, at
 16 the General Hospital at the time, and Dr.
 17 Williams and Mr. Gulliver. In this, in the
 18 middle of the first paragraph, Dr. Cook writes
 19 "it would be greatly appreciated if you can
 20 accommodate one of our technologists for a
 21 four-week period, hopefully in November of
 22 this year," back then?
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. Were you involved in this arrangement?
 2 DR. EJECKAM:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. Okay. Could you tell the Commissioner what
 6 you recall about that?
 7 DR. EJECKAM:
 8 A. My recollection was that after discussion with
 9 Dr. Cook, we agreed that it's necessary to
 10 send one of our technologists to where a
 11 Ventana machine was being used, because there
 12 was a talk of going to Mount Sinai and I
 13 advised that they shouldn't go to Mount Sinai
 14 because Mount Sinai was using DAKO. Even
 15 though they were doing--they did the tests for
 16 us. They should be sent to a hospital where
 17 the same machine that we have here is in
 18 operation, and so I agreed to research and
 19 after looking around was able to locate Jewish
 20 Hospital in Montreal. So I was a part of the
 21 decision, and I think I read the draft of this
 22 letter before it was sent out.
 23 COFFEY, Q.C.:
 24 Q. Okay, and you were in agreement? In fact, it
 25 was your suggestion that's where they send -

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1 DR. EJECKAM:
 2 A. Yes, yes.
 3 COFFEY, Q.C.:
 4 Q. They're using a Ventana at Jewish General.
 5 That's where we should send our tech.
 6 DR. EJECKAM:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. If we could, please, I take it that--do you
 10 recall who was sent?
 11 DR. EJECKAM:
 12 A. Ken Green.
 13 COFFEY, Q.C.:
 14 Q. Ken Green, and how did that work out, do you
 15 know, from your perspective?
 16 DR. EJECKAM:
 17 A. It was beautiful. He was happy to have gone
 18 there. Sometimes you go to new places or
 19 conferences, may not learn a whole lot, but
 20 your confidence get reenforced and you also
 21 see there any housekeeping thing they do that
 22 we are not doing. So I think he was quite
 23 happy when he came back from there.
 24 COFFEY, Q.C.:
 25 Q. Your understanding was is that from--he

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<p>1 communicated it was a positive experience, 2 from his perspective? 3 DR. EJECKAM: 4 A. Pardon? 5 COFFEY, Q.C.: 6 Q. He communicated to you it was a positive 7 experience from his perspective? 8 DR. EJECKAM: 9 A. Yes, my evaluation of, you know, his visit 10 there was that he was happy with it and he 11 also learned something to help improve our own 12 laboratory. 13 COFFEY, Q.C.: 14 Q. If we could, please, Exhibit P-1588? Now 15 Doctor, this is a letter dated November 29th 16 2005. It's from UK NEQAS for 17 immunohistochemistry in London, United 18 Kingdom. It's addressed to yourself and it 19 says "thank you for the application to join UK 20 NEQAS scheme for immunocytochemistry." In 21 fact, I said immunohistochemistry. It is 22 actually titled immunocytochemistry. "I have 23 entered your details on our database so that 24 you will be included on future assessments and 25 confirm that your centre has now joined the</p>	<p>1 happy. The evaluation from London showed that 2 the laboratory was reading good on ER/PR and I 3 think on lymphoma panel that we entered. 4 COFFEY, Q.C.: 5 Q. Now, Doctor, the purpose of picking UKNEQUAS 6 was what, why did you pick them? 7 DR. EJECKAM: 8 A. Looks to me to be about the best standard of 9 quality assurance in immunohistochemistry 10 there is. You know, CAP is there, but the way 11 this is carried out is a lot better. They 12 would send you slides, then you do the stain 13 and send back the slides to them to evaluate. 14 The CAP one, I think, they will send you 15 slides, you do the stain and evaluate it 16 yourself and send them your scores, so you 17 have a chance to cheat if you wanted to do 18 that. But for the UK one, they will recommend 19 this, and four different people evaluate the 20 slide and score that and I thought that was 21 thorough. And UK today, this body, I think, 22 supervises all centres that do immunochemistry 23 for ER/PR and they had the authority to shut 24 down any laboratory that is below par over a 25 period of time.</p>
<p>1 scheme. Your laboratory code, which you 2 should refer to in all correspondence and 3 which ensures your laboratory's anonymity is" 4 that's redacted. 5 COFFEY, Q.C.: 6 Q. The second run is for 1st, April 2005 to the 7 31st, March, 2006 will dispatch sometime in 8 December, 2005. Last, if there's any aspect 9 that you would like to discuss further, please 10 do not hesitate to contact me at the above 11 address." Signed, "Alin Rhodes, Office 12 Manager." So I take it, Doctor, that you had 13 applied to join? 14 DR. EJECKAM: 15 A. Yes. 16 COFFEY, Q.C.: 17 Q. The lab. And did the lab participate? 18 DR. EJECKAM: 19 A. Yes. 20 COFFEY, Q.C.: 21 Q. And did it do so before you finished up in 22 April? 23 DR. EJECKAM: 24 A. Yes. We had, I think, two, I believe we had 25 two runs and it was very good, we were very</p>	<p>1 COFFEY, Q.C.: 2 Q. In the UK? 3 DR. EJECKAM: 4 A. In the UK. 5 COFFEY, Q.C.: 6 Q. Yes. And, Doctor, I believe you had indicated 7 that just at the point where you had left 8 Qatar that your laboratory in Doha had just, 9 was just getting involved in the UK - 10 DR. EJECKAM: 11 A. Yeah, they were just getting involved with 12 this. But we had CAP - 13 COFFEY, Q.C.: 14 Q. Before that? 15 DR. EJECKAM: 16 A. - before that. 17 COFFEY, Q.C.: 18 Q. If we could, please, Exhibit P-1337? Now, 19 Doctor, this is a letter, it's written, it's 20 December 7th, 2005. It's written to Dr. 21 Williams. It's, actually, that version of the 22 letter has only actually got the two pages. 23 If we could bring up, please, Exhibit P-0101? 24 I apologize. That particular exhibit does not 25 have the third page on it, of the letter.</p>
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1 This is the letter, it's the same letter but
 2 it's the one without the letterhead, December
 3 7th, 2005. It's addressed to Dr. Williams,
 4 it's from Dr. Carter, copied to Doctors Cook,
 5 Gulliver and to yourself. Doctor, did you
 6 receive a copy of this letter?
 7 DR. EJECKAM:
 8 A. Yes.
 9 COFFEY, Q.C.:
 10 Q. Okay. And this is the one in which Dr. Carter
 11 advises Dr. Williams that she had been asked
 12 by Dr. Cook to comment on Mr. Dyer's
 13 suggestion that he felt the Ventana testing
 14 for estrogen receptor, progesterone receptor
 15 and Her2/neu could be started at any time and
 16 she says, "I find this comment quite startling
 17 in the face of the two fairly damning reports
 18 by Dr. Banerjee and Trish Wegrynowski." and
 19 goes on from there. Doctor, when you received
 20 that letter, you know, what, if anything, was
 21 your impression or what did you take from it?
 22 DR. EJECKAM:
 23 A. The points Dr. Carter made, Commissioner, were
 24 valid. And what surprised me too that like I
 25 keep saying, the title "Director of

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1 Immunohistochemistry" or "Head of
 2 Immunohistochemistry," there was a meeting
 3 held between, I think, Don Cook and Barry on
 4 this letter where Barry declared that the
 5 immunohistochemistry could now go back to
 6 doing the tests. I wasn't there and the techs
 7 weren't there. So I don't see how that
 8 judgment could have been made. I probably
 9 should have gone up to that, went in to say,
 10 well, okay, or send one of the techs to go.
 11 And I guess that's a part of the reason that
 12 maybe that's--I'm not sure because she didn't
 13 talk to me before she wrote the letter. But I
 14 agree with her observation in the letter that
 15 there are a few things that need to be done.
 16 But in terms of the what we are producing, I
 17 believe we are producing credible results at
 18 that time. And I think we had--we are
 19 producing credible results at that time.
 20 COFFEY, Q.C.:
 21 Q. This is December -
 22 DR. EJECKAM:
 23 A. We have cured the ill that was plaguing the
 24 interpretation or the staining of the ER/PR.
 25 COFFEY, Q.C.:

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1 Q. And -
 2 DR. EJECKAM:
 3 A. I believe the Banerjee's report he did mention
 4 that some of these issues be started
 5 immediately with looking at trying to put in
 6 the other factors in place where there's some
 7 stains could be started right away, because he
 8 looked at what to produce.
 9 COFFEY, Q.C.:
 10 Q. As you indicated, you had shown on the current
 11 slides?
 12 DR. EJECKAM:
 13 A. Yes, yeah, we had shown what we were
 14 producing, yes.
 15 COFFEY, Q.C.:
 16 Q. And certainly--and she lists a number of
 17 things that she thinks or she says should be
 18 done, you know, before retesting of the ER/PR
 19 is re-instituted or testing of ER/PR is re-
 20 instituted. And in, your recollection is in
 21 terms of what she sets out there, you were
 22 in agreement with it?
 23 DR. EJECKAM:
 24 A. Yeah, most of what she said was just repeating
 25 what Banerjee said.

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1 COFFEY, Q.C.:
 2 Q. Yes.
 3 DR. EJECKAM:
 4 A. And these are things that we needed to improve
 5 the overall structure of the tests and
 6 everything else.
 7 COFFEY, Q.C.:
 8 Q. Now, by this point in time, December of '05,
 9 had the report of Dr. Banerjee already been
 10 read to you by Dr. Cook, do you think, by that
 11 time? By the time you saw Dr. Carter saying
 12 these are two fairly damning reports -
 13 DR. EJECKAM:
 14 A. I don't think I've seen--well, I don't
 15 remember the dates now, but I know very well
 16 that I did not see Banerjee's reports before
 17 this -
 18 COFFEY, Q.C.:
 19 Q. Oh, no, no, when I say--been read to you, had
 20 the report been read to you before you got Dr.
 21 Carter's reference to two fairly damning
 22 reports?
 23 DR. EJECKAM:
 24 A. I don't think so.
 25 COFFEY, Q.C.:

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1 Q. It may have been afterward?
 2 DR. EJECKAM:
 3 A. It may be after that, yes.
 4 COFFEY, Q.C.:
 5 Q. Okay. Doctor, were you involved in meetings
 6 in relation to arising out of this letter
 7 involving trying to get the ER/PR up and
 8 running again in St. John's? Were you
 9 involved in any efforts to -
 10 DR. EJECKAM:
 11 A. No, they didn't stop, I didn't stop working
 12 with the techs. But what I didn't do and I
 13 probably wasn't invited, was go into the
 14 meeting for any kind of arrangement. But in
 15 terms of working with the techs, I didn't stop
 16 until I left.
 17 COFFEY, Q.C.:
 18 Q. Okay. And were you involved in any large
 19 efforts involving doctors and others and
 20 technologists to do what was required to
 21 restart the ER/PR?
 22 DR. EJECKAM:
 23 A. Yes, we--the moment we cured the ill, I went
 24 into the mode of making sure first of all,
 25 accumulating controls normal, positive

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1 control, establishing a logbook. And it's not
 2 only ER/PR, the other antibodies. I had a
 3 logbook where I would go in and write in the
 4 surgical number that was found to be good
 5 control. And I also mentioned to my
 6 colleagues that why are signing out cases, if
 7 they found a good control for any particular
 8 antibody, they should please pass it on to the
 9 techs and they would take it and then put it
 10 in the logbook.
 11 COFFEY, Q.C.:
 12 Q. Okay. So there were efforts not only
 13 involving ER/PR, but the larger effort in
 14 terms of IHC services?
 15 DR. EJECKAM:
 16 A. Yes, yes.
 17 COFFEY, Q.C.:
 18 Q. Being made. If I could, and these are
 19 particular items that Mr. Crosbie wishes to
 20 refer to, Commissioner, but if I could have
 21 entered Exhibit P-1604 and P-1605, please?
 22 COMMISSIONER:
 23 Q. P-1604?
 24 COFFEY, Q.C.:
 25 Q. 1604.

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1 COMMISSIONER:
 2 Q. And 1605?
 3 COMMISSIONER:
 4 Q. And 1605, please, Commissioner.
 5 COMMISSIONER:
 6 Q. Entered.
 7 EXHIBIT P-1604 ENTERED INTO EVIDENCE.
 8 EXHIBIT P-1605 ENTERED INTO EVIDENCE.
 9 COFFEY, Q.C.:
 10 Q. Thank you. In relation to, if you could bring
 11 up, please, Exhibit P-1604? This is her
 12 handwritten notes of February 8th, 2006. They
 13 list the attendees of a meeting regarding
 14 update on the implementation of ER and PR and
 15 Doctors Cook, Ejeckam, Carter, Fontaine, Mr.
 16 Gulliver, Mr. Dyer, Mr. Simms, Mr. Green and
 17 Ms. Butler are listed as in attendance. And
 18 I'll leave the body of this to Mr. Crosbie.
 19 But there is a reference here, Doctor, to, in
 20 the middle of the page to a general discussion
 21 followed, including the prospect of bringing
 22 in digital microscopy unit image analyzer.
 23 It's a Ventana visual -
 24 DR. EJECKAM:
 25 A. Yeah.

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1 COFFEY, Q.C.:
 2 Q. - imager. Do you recall what involvement, if
 3 any, the lab had with that, this machine, did
 4 that occur while you were still in St. John's?
 5 DR. EJECKAM:
 6 A. My recollection was that while the Ventana
 7 people brought in the immunohistochemistry
 8 machine, they also brought in VIAS.
 9 COFFEY, Q.C.:
 10 Q. VIAS.
 11 DR. EJECKAM:
 12 A. I think that was the name of it. Which they
 13 think might be the way to go in terms of
 14 evaluating immunohistochemistry digitally and
 15 that may help to eliminate the human error if
 16 it was properly calibrated. The machine for
 17 evaluation. It was demonstrated to us in a
 18 small group and then it was left in the
 19 laboratory and I think that time the agent
 20 said he would leave it for just two weeks and
 21 then we then make an evaluation of that
 22 machine. Of course, two weeks wasn't enough
 23 for anybody to make proper evaluation of that
 24 machine. But their demonstration looked
 25 great, but you needed to work with it and with

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1 our own material to satisfy ourselves that it
 2 was something that was worth looking into. It
 3 wasn't to be purchased, though, it was just
 4 kind of demo that they brought in.
 5 COFFEY, Q.C.:
 6 Q. Okay. Doctor, have you ever--have you had the
 7 opportunity to actually utilize such a machine
 8 yourself?
 9 DR. EJECKAM:
 10 A. Not, I've never seen it before. When it was
 11 brought here, it was the first time I saw it.
 12 And it's a new machine and it's probably
 13 taken--the only similarity to it is what you
 14 have in cytology. Cytology now had digitally
 15 machine that will scan and then identify
 16 abnormal cells. Then the techs still have to
 17 go and look at those abnormal cells to make a
 18 final evaluation. I believe that's what they
 19 are trying to extend that capability. That
 20 particular VIAS machine here was the first
 21 time I saw it. And I think they mentioned
 22 it's a new machine on the market in world.
 23 COFFEY, Q.C.:
 24 Q. Sure. And that there is a reference to it
 25 further -

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1 DR. EJECKAM:
 2 A. Yeah, and it was for evaluation, not for
 3 tests.
 4 COFFEY, Q.C.:
 5 Q. In principle -
 6 COMMISSIONER:
 7 Q. Sorry. I'm just trying to make sure I--are
 8 you saying that in terms of the evaluation,
 9 the period of time which the machine was left
 10 in the lab was not sufficient to even do that?
 11 DR. EJECKAM:
 12 A. Yes, grossly inadequate. Two weeks and we're
 13 all busy. I know I looked at it once or twice
 14 and the other pathologists didn't have time to
 15 even look at it, so. And they wouldn't leave
 16 it more than two weeks, so, you know, or might
 17 have been three weeks, it wasn't enough time
 18 to even decide whether it was good or bad.
 19 COFFEY, Q.C.:
 20 Q. As a pathologist with your experience, because
 21 you have a lot of years experience as a
 22 pathologist and your involvement with IHC, in
 23 principle do you have any--do you take any
 24 issue with the idea of using such a machine,
 25 if it operates properly?

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1 DR. EJECKAM:
 2 A. If it operates properly, I have no quarrel
 3 with that. But you have to convince yourself
 4 you can reproduce the results on it on what
 5 you were using. I mean, like I mentioned now,
 6 when we look at cytology, PAP smears that
 7 women do, it is normally done just by techs or
 8 a pathologist looking at it, but you're
 9 looking at millions of cells. Now, the
 10 device, a digital imaging equipment which
 11 would help you to do the scanning and then
 12 because of the way it had been programmed
 13 identify abnormal cells then that way it do
 14 the job of either not seeing an abnormal cell
 15 or looking at it for too long. So if is a
 16 machine like that and it's well satisfied that
 17 it can do that job, I don't see--I don't have
 18 any quarrel with it. But we couldn't do
 19 anything about it, we couldn't make that
 20 judgment.
 21 COFFEY, Q.C.:
 22 Q. For the reasons you just indicated to the
 23 Commissioner, you didn't have enough time to?
 24 DR. EJECKAM:
 25 A. Pardon?

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1 COFFEY, Q.C.:
 2 Q. You didn't have enough time at the time?
 3 DR. EJECKAM:
 4 A. We never had time with it. And again, at that
 5 time being a new machine, I'm not sure there
 6 was any centre that was already using it that
 7 we could even check about its performance.
 8 COFFEY, Q.C.:
 9 Q. Okay. If we could, please, Exhibit P-0694?
 10 Doctor, this is a letter of December 14th,
 11 2005. It's from Dr. Williams to Dr. Beverley
 12 Carter responding to her December 7th letter.
 13 It's copied to Doctors Cook, Mr. Gulliver and
 14 yourself. And in this Dr. Williams is, after
 15 thanking her for her letter, he says, "I've
 16 asked Dr. Don Cook and Mr. Terry Gulliver to
 17 review all the recommendations made by Dr.
 18 Banerjee and Ms. Wegrynowski and provide me
 19 with a spreadsheet of these recommendations
 20 indicating our progress and status with
 21 respect to implementation. And Dr. Banerjee
 22 has agreed to participate in a conference
 23 call, if required." He goes on to talk from
 24 there about possible timetables. "I
 25 understand that you will be involved in this

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1 process," he concludes, "and look forward to
 2 your input into the decision making process
 3 and the future delivery of reliable and
 4 accurate results in this area." Now, Doctor,
 5 I've asked you whether you ever saw any
 6 recommendations. I take it you didn't see the
 7 spreadsheets if there was such a thing?
 8 DR. EJECKAM:
 9 A. No, no.
 10 COFFEY, Q.C.:
 11 Q. At the time you got this letter, did you think
 12 that you would actually get a copy of the
 13 spreadsheet?
 14 DR. EJECKAM:
 15 A. I wasn't sure because, I mean, I wasn't
 16 involved in the formation of the sheet, so
 17 they probably would have kept it without my
 18 seeing it. So I didn't have an opinion about
 19 it, actually.
 20 COFFEY, Q.C.:
 21 Q. And if we could, please, Exhibit P-1590, page
 22 2, please? Now, Doctor, this is a memo
 23 addressed to Dr. Dan Fontaine, yourself, Mr.
 24 Gulliver and Mr. Dyer, it's from Dr. Cook,
 25 March 6th, 2006 "RE: Implementation of New

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1 Immunohistochemical Antibodies." Dr. Cook
 2 writes, "All new antibodies that are requested
 3 by a pathologist for the immunoperoxidase
 4 service have to be approved by the chief
 5 pathologist overseeing immunohistochemistry.
 6 No new antibodies will enter the system until
 7 there is a sign-off on the protocol form by
 8 the pathologist overseeing the
 9 immunohistochemistry service." So, Doctor,
 10 was this something new at that point?
 11 DR. EJECKAM:
 12 A. Well, it probably wasn't new. I mean, I
 13 believe why this was written was people will
 14 now come up and say they have read about a
 15 particular antibody and that it's going to be
 16 useful in certain type of diagnosis and we
 17 didn't have that in our process. Now rather
 18 than buy the antibodies haphazardly or
 19 whatever anybody thought of, some of these may
 20 be just research material, they may not have
 21 been used clinically. I believe he did that
 22 so that when somebody--I remember getting one
 23 or two requests, they would bring it to me,
 24 then we will ask for one or two amps, ampules
 25 of that, then we'll try it out and then when

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1 we titrate it and it is okay, then we can sign
 2 into the system that now this antibody is now
 3 in the system and people can make requests of
 4 them.
 5 COFFEY, Q.C.:
 6 Q. If we can look, please, at Exhibit P-1112?
 7 Doctor, this is the letter dated March 8th,
 8 2006, it's addressed to yourself and it's from
 9 Dr. Cook, copied to Drs. Williams, Denic--Nash
 10 Denic, and Dan Fontaine and to Mr. Gulliver,
 11 and it says, "Dear Dr. Ejeckam, as discussed
 12 on the morning of March 7th with Terry
 13 Gulliver and myself, I think it is important
 14 that we draw up a detailed job description for
 15 the director of the immunohistochemistry in
 16 the division of anatomic pathology. It would
 17 be most appreciated if you could provide me
 18 with your written response on the duties,
 19 responsibilities and reporting mechanisms
 20 associated with this position. It would be
 21 appreciated if you could address the issue of
 22 pathologists' concerns as they relate to
 23 immunohistochemistry and recommend a mechanism
 24 of how these concerns are investigated and
 25 documented with appropriate follow up.

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1 Sincerely your, Donald Cook." Now, Doctor up
 2 to this point, had you been the director of
 3 immunohistochemistry, from your perspective?
 4 DR. EJECKAM:
 5 A. I would say no, I was a resource person that's
 6 the way I would regard myself.
 7 COFFEY, Q.C.:
 8 Q. Now when you received this, I take it you did
 9 receive it?
 10 DR. EJECKAM:
 11 A. Yes.
 12 COFFEY, Q.C.:
 13 Q. A copy of this. You understood you were being
 14 asked to do what, really?
 15 DR. EJECKAM:
 16 A. My impression that he decided now to appoint
 17 director of immunohistochemistry and that was
 18 looking for a write up of the job descriptions
 19 and duties and whatever that should be
 20 presented to the hospital authority to approve
 21 and then provide funding for it.
 22 COFFEY, Q.C.:
 23 Q. Did you respond to this?
 24 DR. EJECKAM:
 25 A. No, I didn't. I was already, this was 2006.

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1 COFFEY, Q.C.:

2 Q. Yes, I'm about to refer you to an exhibit

3 where you are resigning, retiring.

4 DR. EJECKAM:

5 A. Yeah, I didn't have enough time to get to this

6 and I did mention to him that I just couldn't

7 get it done and when he handed it over to

8 Denic, Denic also mentioned, called me up, had

9 a question, I told him I didn't have time to

10 do it at that time, they can take care of it.

11 COFFEY, Q.C.:

12 Q. That was after Don Cook handed over his

13 clinical chief position to Nash Denic?

14 DR. EJECKAM:

15 A. Yes, yeah.

16 COFFEY, Q.C.:

17 Q. Nash contacted you.

18 DR. EJECKAM:

19 A. Yes, he called me about doing a write up too

20 and my response was I was busy trying to clean

21 up things and I didn't have time to do that.

22 COFFEY, Q.C.:

23 Q. Now this refers to, is discussed on the

24 morning of March 7th, do you see that, with

25 Terry Gulliver and myself--would be Don Cook.

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1 If we could look, please, at Exhibit P-1398?

2 Now, Doctor, these, I understand are notes

3 made by Dr. Cook and it says "Spoke to Dr.

4 Ejeckam, with Terry Gulliver, morning of March

5 7th, 2006 re: the hold on certain stains in

6 2003. I asked him"--that would be Don Cook

7 asked you--"what he meant by erratic? Dr.

8 Ejeckam reported that it meant some stains

9 worked some days and didn't work on others.

10 I"--that would be Done Cook--"asked him if he

11 should have recommended a review of stains at

12 that time. He replied to me that it wasn't

13 his place to initiate or recommend a review."

14 Now did that conversation take place, Doctor?

15 DR. EJECKAM:

16 A. I do not remember this conversation with Terry

17 being there and it's a little bit funny to me,

18 when something that 2006 and being written

19 down as composition here for 2003, that's

20 three years after, that's a little bit, you

21 know, I don't remember this--it could have

22 happened, but I don't remember it.

23 COFFEY, Q.C.:

24 Q. So, just so the Commissioner -

25 DR. EJECKAM:

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1 A. That is interpretation of what I said as

2 erratic is correct, I explained to the

3 Commissioner that erratic, asked me the

4 question before, that it was erratic because

5 it wasn't giving us, you know, consistent

6 result of what it should be and that's what I

7 described as being erratic, one day it's okay,

8 another day the same block, the same tissue

9 stained by the same antibody would give a

10 different result.

11 COFFEY, Q.C.:

12 Q. Yean, and here reports you as saying that, "He

13 meant some stains worked some days and didn't

14 work on others."

15 DR. EJECKAM:

16 A. Yes.

17 COFFEY, Q.C.:

18 Q. And then he goes on to ask you about if you

19 should have recommended--that's presumably

20 back in 2003, a review of the stains at that

21 time, in effect suggesting he talked to you

22 about, in '06, about why in '03 you hadn't

23 recommended going back to '02 and '01, I mean

24 that's what this seemingly refers to.

25 DR. EJECKAM:

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1 A. Yeah.

2 COFFEY, Q.C.:

3 Q. Do you recall that coming up, Doctor Cook

4 saying to you, look, Gershon, why didn't you

5 go back?

6 DR. EJECKAM:

7 A. I don't remember that, but even if he said it,

8 I wouldn't recommend going back to do anything

9 because there was no index case. We were

10 doing--if you are doing experiment in the

11 laboratory, and you've done one year of

12 experimental work and then one year plus one

13 day, you do another one and it doesn't come

14 out okay, that's not a reason to go and repeat

15 what you've done the past year. What you

16 should do is to find out why that one is not

17 good, and that's what we did, to make sure we

18 have good results. Until you have a trigger

19 case that now tells me that all I've done for

20 the past year has been all wrong, there was no

21 reason, there was no danger to the patient at

22 this point in time and I had no reason for me

23 to go back to start reviewing the cases.

24 COFFEY, Q.C.:

25 Q. So in 2003 when you got involved in this

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1 effort that you described in 2003, did it ever
 2 cross your mind at the time, Doctor, that if
 3 the stains are erratic in January and February
 4 and March of 2003, that if they're erratic, I
 5 gather you would have had no reason to believe
 6 they weren't erratic back in December and
 7 November too?
 8 DR. EJECKAM:
 9 A. I had no reason to believe they were erratic
 10 previously. People, like I said, each time
 11 you do scientific experiment, you either get a
 12 result expected or you get something
 13 different, then you should look at why is it
 14 happening that way? Now, there was no way of
 15 now going back to say what was done years ago
 16 was wrong until there was a case showing that
 17 this was done and repeated and then found to
 18 be negative. We are talking about cases that
 19 came to us at the time we were working and we
 20 did it and were not happy, they would have
 21 repeated it and we made sure that it was okay,
 22 and if we couldn't do that, we would send the
 23 cases out to other hospitals, Toronto or
 24 Halifax. So there was no reports sent out
 25 based on inadequate staining.

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1 COFFEY, Q.C.:
 2 Q. That you were aware of?
 3 DR. EJECKAM:
 4 A. Yes, I mean, no such thing.
 5 COFFEY, Q.C.:
 6 Q. And I take it, Doctor, though, in 2003 it
 7 didn't occur to you to go looking for such a
 8 case, to go back to 2002 or 2001, bearing in
 9 mind what you knew in '03, that you were
 10 seeing erratic staining?
 11 DR. EJECKAM:
 12 A. It didn't occur to me and I didn't think it
 13 was a proper way--work to do then.
 14 COFFEY, Q.C.:
 15 Q. Did anyone else suggest it to you--and I'm not
 16 suggesting they did, because you've told the
 17 Commissioner that, look, this arose out of a
 18 bunch of us talking about it, about the
 19 problem, problems we were encountering.
 20 DR. EJECKAM:
 21 A. Yeah.
 22 COFFEY, Q.C.:
 23 Q. A bunch of us being pathologists.
 24 DR. EJECKAM:
 25 A. Yes.

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1 COFFEY, Q.C.:
 2 Q. At these Tuesday and Wednesday meetings.
 3 DR. EJECKAM:
 4 A. Yes.
 5 COFFEY, Q.C.:
 6 Q. So that during these meetings and in
 7 discussing this and after your memos went out,
 8 your April 4th memo and your May 2nd memo, the
 9 topic never came up, no one ever raised the
 10 idea of, look, why don't we go back and see
 11 what was going on six months ago?
 12 DR. EJECKAM:
 13 A. No, no.
 14 COFFEY, Q.C.:
 15 Q. Or a year ago or anything.
 16 DR. EJECKAM:
 17 A. No, nobody raised the issue.
 18 COFFEY, Q.C.:
 19 Q. And on that point, Doctor, I'll just ask you
 20 this, while you were in St. John's at all,
 21 until the spring and summer of 2005, which
 22 we've heard about now about the retests and so
 23 on, had you ever become aware of any
 24 conversion of ER/PR results?
 25 DR. EJECKAM:

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1 A. The one that I knew about was in this -
 2 COFFEY, Q.C.:
 3 Q. Yes.
 4 DR. EJECKAM:
 5 A. Apart from that, I heard about it, there was
 6 no record that anybody brought up.
 7 COFFEY, Q.C.:
 8 Q. Okay. Doctor, in dealing with--just on this
 9 subject matter, in dealing with cases referred
 10 from out of St. John's, for example from
 11 Gander or Grand Falls, okay, for ER/PR
 12 testing. I'm just going to posit a certain
 13 fact scenario to you and just see what you
 14 think. If you were asked by an oncologist in
 15 St. John's, okay, in 2003 to run a Her2/neu on
 16 a 2000 sample out of Gander, okay, and how
 17 would you have gone about getting the block?
 18 DR. EJECKAM:
 19 A. Getting the name of the patient, we'd get a
 20 surgical number of that hospital and we'd make
 21 a request to the pathologist over there
 22 indicating that it's a request from the
 23 oncologist to do this test, and then he would
 24 send down the block.
 25 COFFEY, Q.C.:

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1 Q. He would send the block.
 2 DR. EJECKAM:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. Would he normally send the actual original
 6 reports, do you know?
 7 DR. EJECKAM:
 8 A. Sometimes they'll send the block and the
 9 report.
 10 COFFEY, Q.C.:
 11 Q. And sometimes, I take it, not.
 12 DR. EJECKAM:
 13 A. They just send the block forwarded.
 14 COFFEY, Q.C.:
 15 Q. And I take it then you would use the block to
 16 do whatever the oncologist asked you do,
 17 whatever the test was.
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And the report that you would prepare in 2003,
 22 you would send that to whom? To the
 23 oncologist, I take it -
 24 DR. EJECKAM:
 25 A. Yes, the oncologist who made the request and

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1 the report would go to him or her.
 2 COFFEY, Q.C.:
 3 Q. In St. John's in 2003, did you have any
 4 immediate ability to access, for example, the
 5 Meditech system in Gander?
 6 DR. EJECKAM:
 7 A. No, no, couldn't do that, we were asked for
 8 the physical--either phone up and tell the
 9 secretary to phone up and obtain this, we're
 10 not accessing the -
 11 COFFEY, Q.C.:
 12 Q. Access by a computer, telecommunications
 13 clients.
 14 DR. EJECKAM:
 15 A. No,
 16 COFFEY, Q.C.:
 17 Q. So in 2003, if you did an ER/PR on a surgical
 18 block that the original test had been done in
 19 2000, okay, unless you actually asked for the
 20 2000 ER/PR result on the block, you'd have no
 21 way of knowing it, would you, in 2003?
 22 DR. EJECKAM:
 23 A. Yes and no, the oncologist requesting this
 24 would have known the result.
 25 COFFEY, Q.C.:

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1 Q. Yes.
 2 DR. EJECKAM:
 3 A. And what happened that even when they have a
 4 result diagnosis of a patient, say from Gander
 5 or Corner Brook basically with a malignancy,
 6 not just breast, any malignancy, if they come
 7 in here, the oncologist would request us to
 8 review the slides and then confirm the
 9 diagnosis. So we would do that, we would
 10 request for the slides and look at it and
 11 confirm to them before they treat and that is
 12 the standard practice in most oncologist
 13 centres, you don't treat the patient in centre
 14 A with a diagnosis from centre B, you will
 15 look at a slice, your own pathologist will now
 16 make the same diagnosis, then you have legal
 17 background, standing to start treating that
 18 patient.
 19 THE COMMISSIONER:
 20 Q. So if a patient who normally resided in Corner
 21 Brook came to the cancer clinic in St. John's,
 22 would the pathologist in St. John's then go
 23 back through the information or would they
 24 just take the medical record from Corner Brook
 25 to look at what the diagnosis had been, what

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1 kind of cancer it was, what the status of
 2 ER/PR, for example, was?
 3 DR. EJECKAM:
 4 A. A patient with cancer from Corner Brook would
 5 refer to the oncologists. The oncologist
 6 would send that paper to the laboratory and
 7 then we will ask for the slides of the
 8 original diagnosis. They will write and say
 9 please review, then we would then look at a
 10 slide and reconfirm that diagnosis in our own
 11 report and then we'd send it to the
 12 oncologist.
 13 THE COMMISSIONER:
 14 Q. Okay, so they act on your--if it's you doing
 15 the second look, they would act on your
 16 advice, rather than the advice given from the
 17 original pathologist in Corner Brook, maybe a
 18 year or two before?
 19 DR. EJECKAM:
 20 A. Yes, this has a--well I'm not a lawyer, but it
 21 has a medical, I mean, legal implication. The
 22 patient is being treated here and there's a
 23 legal implication there that the oncologist
 24 must, should have diagnosis of that case in
 25 that place.

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1 THE COMMISSIONER:
 2 Q. In the institution.
 3 DR. EJECKAM:
 4 A. So it may be the same slide, but we're going
 5 to say we borrowed a slide, ten slides, a
 6 hundred slides and after looking at it, this
 7 diagnosis may be the same, but even if there
 8 is a discrepancy, then there may be questions
 9 asked or something.
 10 COFFEY, Q.C.:
 11 Q. Doctor, on that point, in looking at any such
 12 slides, would--I appreciate you're talking
 13 about diagnosis.
 14 DR. EJECKAM:
 15 A. Yes.
 16 COFFEY, Q.C.:
 17 Q. How about calculation or, you know,
 18 consideration of the ER/PR result, would you
 19 be asked to confirm the Corner Brook ER/PR
 20 result?
 21 DR. EJECKAM:
 22 A. The ER/PR result was done here, Corner Brook
 23 wouldn't do it, the only centre is St. John's,
 24 so we would do it and send it to them. Now if
 25 the guy in Corner Brook make an interpretation

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1 and they want us to look at it again, we would
 2 do that and give interpretation to it. So you
 3 have to give a composit--okay, go ahead.
 4 COFFEY, Q.C.:
 5 Q. Just so we're clear then so, for example,
 6 Corner Brook or Gander or Grand Falls, the
 7 tissue would be prepared, taken in surgery, it
 8 would be processed there into a block.
 9 DR. EJECKAM:
 10 A. Yes.
 11 COFFEY, Q.C.:
 12 Q. And the pathologist there would order ER/PR?
 13 DR. EJECKAM:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And that order and the block would come into
 17 St. John's.
 18 DR. EJECKAM:
 19 A. Yes.
 20 COFFEY, Q.C.:
 21 Q. And it would be processed here and the slide
 22 is created.
 23 DR. EJECKAM:
 24 A. Yes.
 25 COFFEY, Q.C.:

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1 Q. And you've described how, certainly in your
 2 time before they got sent, the slides and the
 3 block got sent back to Corner Brook or Gander
 4 or Grand Falls, the technologist used to come
 5 to you to check the controls.
 6 DR. EJECKAM:
 7 A. Well we just look at the technical -
 8 COFFEY, Q.C.:
 9 Q. The technical controls.
 10 DR. EJECKAM:
 11 A. Yeah.
 12 COFFEY, Q.C.:
 13 Q. And then you'd say if they were fine, they'd
 14 go.
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. And the slides would then go back to Corner
 19 Brook, for example.
 20 DR. EJECKAM:
 21 A. Yes.
 22 COFFEY, Q.C.:
 23 Q. And you understood the pathologist there was,
 24 would look at the slides and would decide the
 25 ER/PR result and report it.

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1 DR. EJECKAM:
 2 A. Yes, yes.
 3 COFFEY, Q.C.:
 4 Q. Okay. If that patient was then subsequently
 5 referred to St. John's, to oncologists in St.
 6 John's, okay, would those slides come back
 7 into St. John's for someone like yourself or
 8 another pathologist to look at in relation to
 9 the ER/PR?
 10 DR. EJECKAM:
 11 A. If it's for breast, yes. They would send us
 12 all the material if we request it.
 13 COFFEY, Q.C.:
 14 Q. If they requested it, that's what I think the
 15 Commissioner is--who would have to request it?
 16 DR. EJECKAM:
 17 A. We would request it if we have a request from
 18 an oncologist to review the case.
 19 COFFEY, Q.C.:
 20 Q. Oh, if.
 21 DR. EJECKAM:
 22 A. Because the oncologist will request the
 23 pathology laboratory to review that case
 24 before commencing treatment and we cannot
 25 review the case unless we have the material,

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1 so ask Corner Brook to send us all the slides
 2 involved in this particular case. When they
 3 send it in, it would include the ER/PR done in
 4 our laboratory. So whoever is going to review
 5 that case will look at HME and agree with the
 6 diagnosis and look at the estrogen receptor,
 7 progesterone receptor slides and make a
 8 report.
 9 COFFEY, Q.C.:
 10 Q. Okay. And in any such review of an ER/PR
 11 slide from outside of St. John's, did you ever
 12 have occasion to differ with -
 13 DR. EJECKAM:
 14 A. How do I remember, because it wasn't done by
 15 me, it could have been done by whoever the
 16 pathologist on call for that day, so if there
 17 was any difference, I wouldn't know. But
 18 personally I didn't encounter any.
 19 COFFEY, Q.C.:
 20 Q. If we could, please, and I'll just, Exhibit P-
 21 0022 please? Page 16 please? This is a MAC
 22 meeting for, when we look at the top of the
 23 page here, it's March 8th, 2006 and
 24 resignation listed there is Dr. Gershon
 25 Ejeckam, resignation from the laboratory

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1 medicine program on April 30th, 2006, that's
 2 accurate is it, Doctor?
 3 DR. EJECKAM:
 4 A. Yeah.
 5 COFFEY, Q.C.:
 6 Q. Okay, and if we could, please, same exhibit,
 7 page 40 please? And, Doctor, here under
 8 laboratory medicine program, again it's the
 9 MAC minutes for June 14th, 2006. You're
 10 listed here in the laboratory medicine
 11 program, Dr. Ejeckam, temporary privileges to
 12 perform a locum under the laboratory medicine
 13 program, division of pathology, June 5th to
 14 the 21st, 2006?
 15 DR. EJECKAM:
 16 A. Yes.
 17 COFFEY, Q.C.:
 18 Q. Did you perform the locum here?
 19 DR. EJECKAM:
 20 A. Yes.
 21 COFFEY, Q.C.:
 22 Q. Have you performed any other locums here in
 23 Newfoundland and Labrador since you've
 24 resigned on April 30th?
 25 DR. EJECKAM:

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1 A. Yeah, I had a locum done in Gander.
 2 COFFEY, Q.C.:
 3 Q. In Gander?
 4 DR. EJECKAM:
 5 A. Yeah.
 6 COFFEY, Q.C.:
 7 Q. And when was that, do you recall?
 8 DR. EJECKAM:
 9 A. Last year.
 10 COFFEY, Q.C.:
 11 Q. Okay, in the course of doing this locum in
 12 2006 or the one last year which would be in
 13 '07 in Gander, did you have any involvement in
 14 the ER/PR matter?
 15 DR. EJECKAM:
 16 A. Well this locum was purely to ER/PR--well not
 17 only ER/PR, to hand over the
 18 immunohistochemistry to Dr. Ford Elms.
 19 COFFEY, Q.C.:
 20 Q. Okay, so this one here, the June -
 21 DR. EJECKAM:
 22 A. Yes, had meetings with them and showed him
 23 what I know and then it was he and I think Don
 24 Fontaine were appointed, who took over the
 25 immunohistochemistry. So within that period

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1 for interaction for them to pick up where I
 2 stopped.
 3 COFFEY, Q.C.:
 4 Q. And what did you attempt to do in the course
 5 of that, I take it to pass on what you knew
 6 about the issue and -
 7 DR. EJECKAM:
 8 A. Well we looked at slides together and trying
 9 to show them what, you know, some of the
 10 stains, what they looked like, some of the
 11 directions in terms of quality assurance, in
 12 terms of controls. So these were the things
 13 we discussed.
 14 COFFEY, Q.C.:
 15 Q. I take it in effect, I suppose with a person
 16 with your experience, to do actually some
 17 teaching?
 18 DR. EJECKAM:
 19 A. Well in a way, but I won't call it teaching,
 20 they are my colleagues, they probably know as
 21 much as I do, but I had to, you know, that
 22 have session with them for them to take over
 23 the service.
 24 COFFEY, Q.C.:
 25 Q. And in 2007, you said you had a locum in

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1 Gander, was there any involvement with ER/PR
 2 at the time?
 3 DR. EJECKAM:
 4 A. I think I sent out one then, of course, Gander
 5 wasn't sending anything any more, they were
 6 sending straight to Toronto, so I think I must
 7 have sent one breast to Toronto and it would
 8 be done there and results sent back to them
 9 directly.
 10 COFFEY, Q.C.:
 11 Q. Doctor, until June of 2007, which is when I
 12 gather you were getting contacted about it, is
 13 there anything that you can think of that, you
 14 know, you think the Commissioner should know
 15 in terms of the whole ER/PR matter that
 16 transpired before June of '07 that we haven't
 17 already covered?
 18 DR. EJECKAM:
 19 A. I don't remember anything that's outstanding.
 20 COFFEY, Q.C.:
 21 Q. No, okay, I just -
 22 DR. EJECKAM:
 23 A. Not that I'm aware of and I think we went
 24 through everything, everything that I -
 25 COFFEY, Q.C.:

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1 Q. Sure and that's what I'm really what I'm
 2 asking about because sometimes things are not
 3 written down and people are aware of them and
 4 they just recall them.
 5 THE COMMISSIONER:
 6 Q. Mr. Coffey, it's about time for the afternoon
 7 break.
 8 COFFEY, Q.C.:
 9 Q. Madam Commissioner, those are the questions I
 10 have, Commissioner, so we'll take a break and-
 11 -I want to thank you, Doctor. There will be
 12 other lawyers, I anticipate will have some
 13 questions for you, but I do want to thank you
 14 for your information you provided.
 15 DR. EJECKAM:
 16 A. Thank you.
 17 THE COMMISSIONER:
 18 Q. We'll take fifteen minutes and then proceed
 19 with cross-examination.
 20 (RECESS)
 21 THE COMMISSIONER:
 22 Q. Please be seated. Mr. Pritchard?
 23 MR. PRITCHARD:
 24 Q. Thank you, Commissioner, I don't have any
 25 questions for this witness. Thank you for

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1 your evidence, sir.
 2 DR. EJECKAM:
 3 A. Thank you.
 4 THE COMMISSIONER:
 5 Q. Mr. Simmons?
 6 MR. SIMMONS:
 7 Q. Thank you, Commissioner.
 8 DR. GERSHON CHUKWUEMEKA EJECKAM, EXAMINATION BY MR. DAN
 9 SIMMONS
 10 MR. SIMMONS:
 11 Q. Good afternoon, Dr. Ejeckam, my name is Dan
 12 Simmons and I'm here for Eastern Health. I
 13 just have a few things I want to ask you.
 14 First concerns when you spent your 13 years in
 15 Doha as the head of the immunohistochemistry
 16 laboratory there, I had understood that you
 17 described--you'd given us some of the history
 18 of the development of immunohistochemistry
 19 over that time, that the number of antibodies
 20 increased quite a bit, would it be fair to say
 21 as well that the scientific knowledge about
 22 immunohistochemistry and how to perform the
 23 tests grew over that period of time as well?
 24 DR. EJECKAM:
 25 A. Yes, that would be a proper conclusion.

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1 MR. SIMMONS:
 2 Q. Okay, and you've told us as well that over
 3 time that you developed a manual for use in
 4 your laboratory there in performing these
 5 tests, correct?
 6 DR. EJECKAM:
 7 A. Yes.
 8 MR. SIMMONS:
 9 Q. When you did that, were there any outside
 10 sources that you could go to to find a ready-
 11 made set of procedures or did you have to
 12 develop things on your own?
 13 DR. EJECKAM:
 14 A. No, we combined information from the
 15 literature -
 16 MR. SIMMONS:
 17 Q. Yes.
 18 DR. EJECKAM:
 19 A. - and work we were doing in the laboratory.
 20 MR. SIMMONS:
 21 Q. Yes.
 22 DR. EJECKAM:
 23 A. It wasn't all from our heads, there was some
 24 in the literature already.
 25 MR. SIMMONS:

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<p>1 Q. Yes, so you had to go to the literature to see 2 what studies were there and what other 3 information was available.</p> <p>4 DR. EJECKAM: 5 A. Yes.</p> <p>6 MR. SIMMONS: 7 Q. Was there any single source you could go to, 8 like a standard setting body, such as exists 9 in some areas of health care and medicine 10 where you could just subscribe to a set of 11 policies or procedures to use in your 12 laboratory?</p> <p>13 DR. EJECKAM: 14 A. By the time we did this, I wasn't aware of the 15 textbook, "Immunohistochemistry by DABBS". 16 DABBS is like the Bible of 17 immunohistochemistry, an evaluation, so it 18 wasn't available then, but you could go into 19 the index medicals, that is the library and go 20 to the index in the medical field and then 21 punch in the subject and you will see a lot of 22 articles that will help you to make up a 23 manual that you needed for that job. And then 24 I think CAP, College of American Pathologists, 25 has a booklet on quality assurance in anatomic</p>	<p>1 DR. EJECKAM: 2 A. - particularly ER/PR?</p> <p>3 MR. SIMMONS: 4 Q. Well immunohistochemistry generally? 5 DR. EJECKAM: 6 A. No, immunohistochemistry work has a standard 7 of procedure, it's an antigen/antibody 8 reaction.</p> <p>9 MR. SIMMONS: 10 Q. Yes.</p> <p>11 DR. EJECKAM: 12 A. Now whether you use three steps, four steps to 13 visualize it is what a laboratory has to 14 decide.</p> <p>15 MR. SIMMONS: 16 Q. Right.</p> <p>17 DR. EJECKAM: 18 A. Some people do direct staining where you 19 couple the antibodies to the dye that would 20 show what you did; some people put them 21 separately, but at the end, you are getting to 22 the same result. You either put your primary 23 antibody, secondary antibody, then anti- 24 peroxidase that will cut that antibody, then 25 the DAB to make you visualize it, some other</p>
<p style="text-align: right;">Page 274</p> <p>1 pathology and then we would have that booklet 2 and there are some pertinent information that 3 we would extract from there to put into what 4 we are doing.</p> <p>5 MR. SIMMONS: 6 Q. Right. And we've heard through the course of 7 this inquiry and just generally in the media 8 over the last while, here in Canada, that 9 there isn't any set of national standards that 10 apply to the way this testing are to be done 11 in Canada, are you aware of that?</p> <p>12 DR. EJECKAM: 13 A. Well yeah, I am aware that each laboratory-- 14 there's no national standard, that's not 15 information that I think I'm aware of.</p> <p>16 MR. SIMMONS: 17 Q. Right, and that each laboratory has to 18 determine how they're going to perform this 19 testing, depending on their own circumstances 20 and their own conditions?</p> <p>21 DR. EJECKAM: 22 A. Do you mean doing immunohistochemistry or 23 doing -</p> <p>24 MR. SIMMONS: 25 Q. Yes.</p>	<p style="text-align: right;">Page 276</p> <p>1 people's views already prepared, DAB attaches 2 to the present antibody, but at the end, the 3 procedure is basically the same.</p> <p>4 MR. SIMMONS: 5 Q. So the basic procedure is the same, but there 6 are variations that laboratories can choose as 7 to how they perform the different steps of the 8 procedure, are there?</p> <p>9 DR. EJECKAM: 10 A. Well what you choose is different retirement 11 times.</p> <p>12 MR. SIMMONS: 13 Q. Yes.</p> <p>14 DR. EJECKAM: 15 A. However, when you look at some nuclear 16 antigens may require longer retirement times, 17 so a laboratory may choose to use ten minutes 18 and choose to do 12 minutes.</p> <p>19 MR. SIMMONS: 20 Q. Right.</p> <p>21 DR. EJECKAM: 22 A. Now as long as they are able to convince 23 themselves that those times they have chosen 24 will give them a proper result, then that's 25 it, but it's not a big variation here. It's a</p>

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1 question of the titration and is probably
 2 going to be good from ten to fifteen and some
 3 Americans say, okay, I do it ten, some will
 4 say I do it at twelve, some will say fifteen,
 5 but I don't see a big variation there.
 6 MR. SIMMONS:
 7 Q. Okay, so it's not a big variation in the way
 8 different laboratories will choose to do it,
 9 but is there any single set of standards or
 10 place that we can go to that sets out what the
 11 appropriate range of antigen retrieval times
 12 is, for example, aside from textbooks, is
 13 there anything that's been adopted by the
 14 profession in Canada?
 15 DR. EJECKAM:
 16 A. I'm not aware of any.
 17 MR. SIMMONS:
 18 Q. Okay.
 19 DR. EJECKAM:
 20 A. There may be, I'm not aware of it.
 21 MR. SIMMONS:
 22 Q. Okay, when you were in Doha, were you aware of
 23 anything equivalent to that that was available
 24 to you in Doha?
 25 DR. EJECKAM:

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1 A. No, no.
 2 MR. SIMMONS:
 3 Q. Now I believe you said that when you came here
 4 to St. John's in 2002, although there wasn't a
 5 laboratory manual for immunohistochemistry,
 6 such as you had developed in Doha, I
 7 understood you to say that the technologists
 8 did have their procedures that they followed,
 9 is that correct?
 10 DR. EJECKAM:
 11 A. Yes.
 12 MR. SIMMONS:
 13 Q. And were those in writing?
 14 DR. EJECKAM:
 15 A. I can't recall that.
 16 MR. SIMMONS:
 17 Q. Okay. You were asked some questions about
 18 positivity rates for ER/PR.
 19 DR. EJECKAM:
 20 A. Yes.
 21 MR. SIMMONS:
 22 Q. And what you did when you were in Doha,
 23 because one of the things we've discussed here
 24 at this inquiry is that there is some
 25 literature available that suggests a range of

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1 positivity rates to say that, for example,
 2 maybe 75 percent of the ER tests that are done
 3 in the course of a year should turn out to be
 4 positive and 25 percent should turn out to be
 5 negative. There's different percentages that
 6 show up in the literature at different times.
 7 When you were in Doha, was there any process
 8 in place in your laboratory to track the rate
 9 of positivity of ER tests and PR tests in a
 10 kind of a deliberate way?
 11 DR. EJECKAM:
 12 A. No.
 13 MR. SIMMONS:
 14 Q. In the spring of 2003, you've told us how you
 15 suspended testing for eight antibodies,
 16 including ER and PR in April of 2003 and
 17 you've told us that what you did then with ER
 18 and PR antibodies was to adjust the antigen
 19 retrieval times and to adjust the titration of
 20 the antibodies until you were satisfied that
 21 you were getting the optimum results from the
 22 staining process, have I got that basically
 23 right?
 24 DR. EJECKAM:
 25 A. Yes.

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1 MR. SIMMONS:
 2 Q. Can you tell me a little bit more about what
 3 the antigen retrieval method was that was in
 4 use then when you did that, in the laboratory
 5 here?
 6 DR. EJECKAM:
 7 A. I believe it was DAKO, they were using
 8 pressure cooker or something like that. I
 9 can't be a hundred percent sure about it, but
 10 I didn't do it myself.
 11 MR. SIMMONS:
 12 Q. Right.
 13 DR. EJECKAM:
 14 A. All I did was advise the technologists to try
 15 certain timing and I would look at the slides.
 16 MR. SIMMONS:
 17 Q. The DAKO machine that was in use has been
 18 described to us as semi-automated?
 19 DR. EJECKAM:
 20 A. Yes.
 21 MR. SIMMONS:
 22 Q. And would you have understood that the antigen
 23 retrieval step is not part of the automated
 24 procedure, that was a manual procedure that
 25 still had to be performed by the technologist?

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<p>1 DR. EJECKAM: 2 A. That's my understanding, yes. 3 MR. SIMMONS: 4 Q. And one way or another, it involved boiling 5 the slides in a solution for a period of time? 6 DR. EJECKAM: 7 A. Yes. 8 MR. SIMMONS: 9 Q. Yes, okay, and what you were doing by 10 adjusting that was trying different variations 11 of the length of time during which the slides 12 were boiled in that solution, was it? 13 DR. EJECKAM: 14 A. Yes. 15 MR. SIMMONS: 16 Q. Okay, and when you have referred to adjusting 17 the titration of the antibody, what I 18 understand is that the antibodies come in a 19 bottle, as a liquid, and they're in 20 concentrated form? 21 DR. EJECKAM: 22 A. Yes. 23 MR. SIMMONS: 24 Q. And in order to do the test, that concentrate 25 has to be diluted in another solution and what</p>	<p>1 antibodies are something that can occur 2 because it's something people have to do and 3 they have to try to do time and again the same 4 way each time? 5 DR. EJECKAM: 6 A. Yes, possible. 7 MR. SIMMONS: 8 Q. Okay. Now when the Ventana machine was put in 9 use, am I correct in understanding that the 10 antigen retrieval step now became part of the 11 automated process? 12 DR. EJECKAM: 13 A. That's my understanding of Ventana, yes. 14 MR. SIMMONS: 15 Q. Yes, and that in the Ventana machine, the 16 slide, instead of being immersed in a boiling 17 liquid, actually sits on a metal plate which 18 is heated and the temperature and the length 19 of time at which it's heated is controlled by 20 the machine. Did you understand that? 21 DR. EJECKAM: 22 A. The temperature is controlled, programmed. 23 MR. SIMMONS: 24 Q. Yes. 25 DR. EJECKAM:</p>
<p>Page 282</p> <p>1 you did was tried different variations of 2 dilutions of that antibody in order to 3 optimize the result of the test? 4 DR. EJECKAM: 5 A. Yes, and some of them would come in diluted, 6 so you don't need to dilute them, but those 7 that weren't diluted, you then have to titrate 8 it and determine for yourself which of the 9 dilutions, one in 20, one in 50, one in 100, 10 that would give you the best result. 11 MR. SIMMONS: 12 Q. Yes, okay, and so the dilution of the antibody 13 was another part of the manual process that 14 wasn't in any way automated in the DAKO 15 system? 16 DR. EJECKAM: 17 A. Yeah. 18 MR. SIMMONS: 19 Q. In the DAKO technology. 20 DR. EJECKAM: 21 A. It was manually done. 22 MR. SIMMONS: 23 Q. Right. So if we look at performing the test 24 over a period of time, variations in the 25 antigen retrieval and in the dilution of the</p>	<p>Page 284</p> <p>1 A. Whether it was sitting or left, the position 2 of the slide, I don't know. 3 MR. SIMMONS: 4 Q. Okay. Yes, and I may be wrong on that too, 5 but in any event, with the Ventana machinery, 6 the length of time at which the slide is 7 heated and the temperature at which it's 8 heated is now controlled as part of the 9 automated process? 10 DR. EJECKAM: 11 A. Yes. 12 MR. SIMMONS: 13 Q. So would that have removed an element of the 14 human intervention and removed some risk of 15 variation from the process? 16 DR. EJECKAM: 17 A. Well, I think you have to program--you have to 18 program the time. 19 MR. SIMMONS: 20 Q. Yes. 21 DR. EJECKAM: 22 A. The time in there is not static for every 23 antibody. 24 MR. SIMMONS: 25 Q. Right.</p>

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1 DR. EJECKAM:
 2 A. So I think the antibodies we're purchasing, I
 3 believe, had the antibody--antigen retrieval
 4 time.
 5 MR. SIMMONS:
 6 Q. Yes.
 7 DR. EJECKAM:
 8 A. So you have to cue that in, and you don't
 9 change it for that particular antigen that
 10 you're looking for.
 11 MR. SIMMONS:
 12 Q. Right. So once you set the time though in the
 13 machine, assuming the machine is going to work
 14 properly, every time you run a test, if you
 15 set the time for ten minutes, it should be ten
 16 minutes each time?
 17 DR. EJECKAM:
 18 A. Yes, yes, that's true.
 19 MR. SIMMONS:
 20 Q. Without variation from run to run?
 21 DR. EJECKAM:
 22 A. Yes, that's true.
 23 MR. SIMMONS:
 24 Q. Okay.
 25 DR. EJECKAM:

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1 A. That is for that particular antigen, because
 2 if it's nuclear antigen, the retrieval time is
 3 supposed to be a little bit longer than
 4 cytoplasmic or membranous antigen. So you
 5 have to know what antigen that you're looking
 6 for.
 7 MR. SIMMONS:
 8 Q. Yes.
 9 DR. EJECKAM:
 10 A. ER/PR are both nuclear antigen. It takes a
 11 little bit longer in retrieval than let's say
 12 something like leukocyte common antigen, which
 13 is membrane, not stain.
 14 MR. SIMMONS:
 15 Q. Okay, and with the Ventana system, did you
 16 know whether or not the antibodies now were
 17 going to be provided pre-diluted rather than
 18 in concentrated form?
 19 DR. EJECKAM:
 20 A. My understanding, I remember when I was asking
 21 the techs to dilute, I think the primary
 22 antibody, I was informed, I think, that it
 23 came in diluted. So you couldn't dilute it
 24 any further.
 25 MR. SIMMONS:

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1 Q. Yes.
 2 DR. EJECKAM:
 3 A. You have to use it the way as is.
 4 MR. SIMMONS:
 5 Q. Yes.
 6 DR. EJECKAM:
 7 A. But I believe that the secondary antibody
 8 could be diluted, if I--I may be wrong here,
 9 but this is a technical thing that they did,
 10 you know, and I looked at the slides.
 11 MR. SIMMONS:
 12 Q. So by having a pre-diluted antibody for the
 13 primary antibody, would that also remove some
 14 manual intervention from the process -
 15 DR. EJECKAM:
 16 A. Yes, yes.
 17 MR. SIMMONS:
 18 Q. - in that the technologists no longer had to
 19 precisely dilute the antibody each time there
 20 was a separate run?
 21 DR. EJECKAM:
 22 A. Yes.
 23 MR. SIMMONS:
 24 Q. Okay. One of the things you said earlier
 25 today was that at one point along the way,

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1 there was a decision made to order the ER/PR
 2 tests on all breast cancer cases that came in.
 3 I think you were referred to a document and
 4 told us about that. We've heard some
 5 reference to something we've been calling DCIS
 6 or ductal carcinoma in situ. Would there be
 7 ER/PR tests ordered for those type of cases?
 8 DR. EJECKAM:
 9 A. Some pathologists will argue there's just no
 10 need for it.
 11 MR. SIMMONS:
 12 Q. Yes.
 13 DR. EJECKAM:
 14 A. Others will want to do it. So it's a question
 15 of where you are and what kind of practice
 16 that you--your own school of thought.
 17 MR. SIMMONS:
 18 Q. Okay. The last thing I want to ask you about
 19 is when slides are prepared for the ER test
 20 and the PR test, one of the last steps in the
 21 process is for the pathologist to review the
 22 slide under the microscope and to make a
 23 determination of what the percentage of
 24 positivity is, staining positivity, and
 25 there's obviously a subjective element in

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1 that.

2 DR. EJECKAM:

3 A. Yes.

4 MR. SIMMONS:

5 Q. In this area, is there known to be any interim

6 server variability or any variability among

7 pathologists which is accepted as being a

8 variation that occurs in how different

9 pathologists might read the same slide?

10 DR. EJECKAM:

11 A. Yes. I mean, it is subjective. I could read

12 it to be 50 percent and maybe I would say 55

13 or 60 percent. That's still acceptable. So

14 there's variability there.

15 MR. SIMMONS:

16 Q. Right. So even if you had two slides prepared

17 with exactly the same technical process, if

18 they went to two different pathologists to be

19 read at two different times, you could still

20 have some variation in the results?

21 DR. EJECKAM:

22 A. Yes, yes.

23 MR. SIMMONS:

24 Q. Yes, okay. Thank you very much, Dr. Ejeckam,

25 I don't have anything else for you.

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1 DR. EJECKAM:

2 A. Thank you.

3 THE COMMISSIONER:

4 Q. Thank you, Mr. Simmons. Ms. O'Dea?

5 MS. O'DEA:

6 Q. We have no questions, Commissioner.

7 THE COMMISSIONER:

8 Q. Ms. Newbury?

9 MS. NEWBURY:

10 Q. I don't have any questions.

11 THE COMMISSIONER:

12 Q. Mr. Crosbie?

13 DR. GERSHON EJECKAM, EXAMINATION BY CHESLEY CROSBIE, Q.C.

14 CROSBIE, Q.C.:

15 Q. Thank you, Dr. Ejeckam. I had an opportunity

16 to introduce myself a little earlier when you

17 first took the stand and I represent the

18 members of the Breast Cancer Testing Class

19 Action. So thank you for your long journey

20 here to give evidence.

21 I'd first like you to address something

22 that Mr. Simmons was just asking you about

23 actually a few minutes ago, which is the

24 antigen retrieval stage of the process, and

25 would it be fair to say that this is

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1 identified in the literature as being an area

2 of trouble and possibly an area that can

3 produce erratic results, the antigen retrieval

4 stage?

5 DR. EJECKAM:

6 A. I wouldn't characterize it that way. Antigen

7 retrieval has been described as the one most

8 important procedure in antigen antibody stain,

9 but not an area of problem. If it's properly

10 done, especially if it's computerized--if it's

11 automated, there shouldn't be any problem

12 there.

13 CROSBIE, Q.C.:

14 Q. If it's properly done, which of course would -

15 DR. EJECKAM:

16 A. Unless it is automated. You have an automated

17 machine, and then you time it, then it should

18 be one of the most important, because let me

19 explain a little bit. With fixation problem

20 was a problem initially and a lot of things in

21 the literature about poor fixation, over

22 fixation, that we keep saying. Now it's been

23 shown that if you have proper antigen

24 retrieval, then you override any kind of

25 problem with fixation. So it is the most, one

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1 most important step that needs to be taken

2 before the antigen antibody reaction takes

3 place. But, and that is why, I think, there's

4 improvement in the methodology where instead

5 of doing manual boiling or microwave heating,

6 it moved on to automation. So that you can

7 now decide that you're going to be ten minutes

8 for this antigen and then program it and it

9 will take ten minutes.

10 CROSBIE, Q.C.:

11 Q. Just to take things one step at a time, sir,

12 when you were questioned by Mr. Coffey, I

13 understand you to explain that the formalin

14 fixation binds the estrogen and progesterone

15 receptors together and this therefore masks

16 the receptor sites.

17 DR. EJECKAM:

18 A. Formalin fixation could mask receptor sites.

19 CROSBIE, Q.C.:

20 Q. And these receptor sites are antigens because

21 you are using an antibody to attach to the

22 antigens, right?

23 DR. EJECKAM:

24 A. Yes.

25 CROSBIE, Q.C.:

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1 Q. This is in elementary terms now, and this is
 2 the process that we refer to as antigen
 3 retrieval?
 4 DR. EJECKAM:
 5 A. No.
 6 CROSBIE, Q.C.:
 7 Q. Could you explain that?
 8 DR. EJECKAM:
 9 A. Antigen retrieval is when--well, you know,
 10 fixation will mask the antigens and then you
 11 don't react it with antibody until you've done
 12 antigen retrieval. So what you do is either
 13 we boil it or put it in a microwave so that
 14 the heat effect will now rearrange the
 15 protein. When you fix tissue, the proteins
 16 are sort of bound and then that binding of
 17 proteins in the cell may mask the sites of
 18 antigenic activity. But when you heat it in a
 19 certain solution, it has been shown--used
 20 trial and error before they arrived at this--
 21 that this heating, antigen retrieval heat-
 22 induced will now rearrange the protein in a
 23 way that those sites are now exposed. Then
 24 when you finish that, the next thing then is
 25 to add the antibody which will now go and

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1 attach to those exposed sites.
 2 CROSBIE, Q.C.:
 3 Q. You mentioned, I guess, there are methods,
 4 several different methods that could be used
 5 for accomplishing the unmasking?
 6 DR. EJECKAM:
 7 A. Yes.
 8 CROSBIE, Q.C.:
 9 Q. Trypsin is one that's been used?
 10 DR. EJECKAM:
 11 A. We don't--well, trypsin, yeah, trypsin was
 12 used back sometime ago when we were doing
 13 mainly immunoflourescent and I think Professor
 14 Kwan, who was chairman at Memorial, worked on
 15 this. In fact, he published a lot on this.
 16 You can use trypsin to digest the tissue and
 17 they make more antigens available. But for
 18 immunohistochemistry nowadays, I'm not aware
 19 that we're using trypsin at all.
 20 CROSBIE, Q.C.:
 21 Q. And it was not being used then when you
 22 intervened in 2003?
 23 DR. EJECKAM:
 24 A. No, we were not using trypsin.
 25 CROSBIE, Q.C.:

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1 Q. You can use heat; you can use microwave ovens,
 2 water baths and maybe variations beyond that?
 3 DR. EJECKAM:
 4 A. We used microwave or heating in a pressured
 5 environment. I'm not aware of a water bath
 6 method. I'm not aware that we ever used that.
 7 CROSBIE, Q.C.:
 8 Q. So what exactly were they doing when you
 9 intervened in the lab in 2003? Which of these
 10 methods were they using again?
 11 DR. EJECKAM:
 12 A. I think they were boiling them.
 13 CROSBIE, Q.C.:
 14 Q. And you say this would be--so is that a water
 15 bath method?
 16 DR. EJECKAM:
 17 A. No, not water bath. Well, if you water bath--
 18 what I'm saying, we have water bath in
 19 histopathology, it's a floatation water bath
 20 which is just at 42 degrees. We use it for
 21 when you cut section to lay out the section.
 22 That's different.
 23 CROSBIE, Q.C.:
 24 Q. Yes.
 25 DR. EJECKAM:

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1 A. But when you talk about heating under like
 2 using a pressure cooker is--it's not a water
 3 bath by name, unless that's what they called
 4 it, but we won't call it water bath. You heat
 5 it under pressure, vacuum pressure at times,
 6 or you use microwave to be able to mask the
 7 sites.
 8 CROSBIE, Q.C.:
 9 Q. So the--I think you referred to it as a
 10 boiling method?
 11 DR. EJECKAM:
 12 A. Yeah, well basically.
 13 CROSBIE, Q.C.:
 14 Q. Basically. This is under pressure, is it?
 15 DR. EJECKAM:
 16 A. Yeah.
 17 CROSBIE, Q.C.:
 18 Q. So this is a heat under pressure method?
 19 DR. EJECKAM:
 20 A. Yes.
 21 CROSBIE, Q.C.:
 22 Q. Is that technically how you'd describe it?
 23 DR. EJECKAM:
 24 A. I would describe it as heating under pressure,
 25 you know, pressure cooker. So I mean, we use

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1 pressure cooker to do this and pressure
 2 cooker, my impression that is whatever is
 3 being boiled is under pressure.
 4 CROSBIE, Q.C.:
 5 Q. Did you personally actually observe the method
 6 being used by the techs -
 7 DR. EJECKAM:
 8 A. No.
 9 CROSBIE, Q.C.:
 10 Q. - at the time of your intervention?
 11 DR. EJECKAM:
 12 A. No.
 13 CROSBIE, Q.C.:
 14 Q. So when you'd give us that description of what
 15 they were doing, what's the basis for you to
 16 say that?
 17 DR. EJECKAM:
 18 A. That is a standard and I understand they were
 19 doing, and I did ask them what method. I know
 20 they don't have microwave at that time. They
 21 were--I wasn't aware they were using microwave
 22 in the laboratory.
 23 CROSBIE, Q.C.:
 24 Q. So, I'm sorry, I'm not clear. Did you say you
 25 asked them what they were doing in this

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1 connection?
 2 DR. EJECKAM:
 3 A. I don't remember going to say "what are you
 4 using for heat? What are you using for that?"
 5 What I remember that they would tell me they
 6 were--during this discussion, that they are
 7 doing boil--kind of the retrieval is by
 8 heating, and I know they didn't have microwave
 9 at that time.
 10 CROSBIE, Q.C.:
 11 Q. Okay, you know that much, all right. So you
 12 assumed they--you assumed they were using a
 13 method of pressure heating?
 14 DR. EJECKAM:
 15 A. Yes.
 16 CROSBIE, Q.C.:
 17 Q. And you said boiling?
 18 DR. EJECKAM:
 19 A. Pardon?
 20 CROSBIE, Q.C.:
 21 Q. Pressure heating/boiling, I think you used the
 22 word?
 23 DR. EJECKAM:
 24 A. Yes, yes.
 25 CROSBIE, Q.C.:

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1 Q. So you're constructing what was going on
 2 rather than speaking to your actual
 3 observation of what exactly the techs were
 4 actually doing?
 5 DR. EJECKAM:
 6 A. What the techs did were technical work that I
 7 didn't have anything to do with.
 8 CROSBIE, Q.C.:
 9 Q. Sure.
 10 DR. EJECKAM:
 11 A. And I'm not supposed to actually do it. So
 12 what they did was their job.
 13 CROSBIE, Q.C.:
 14 Q. Yes.
 15 DR. EJECKAM:
 16 A. And produced material for me to evaluate.
 17 CROSBIE, Q.C.:
 18 Q. Okay. Are there potential weaknesses in the
 19 system that you described of applying heat or
 20 that you understood that they were using?
 21 DR. EJECKAM:
 22 A. The potential problem would be if one was to
 23 boil it for ten minutes and boil it for six
 24 minutes or if you're going to boil it for ten
 25 minutes and did it for less, then you are now

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1 not using what you can are the optimum time in
 2 for it. That's what I see as the possible
 3 potential danger there. That's why automation
 4 has removed that manual step.
 5 CROSBIE, Q.C.:
 6 Q. I think you described--again, you have to
 7 forgive me if it's a--you'll no doubt
 8 appreciate that it's somewhat technical for,
 9 well, everyone in the room except yourself, I
 10 guess, or maybe one or two observers, but I
 11 understood you to explain that when you were
 12 doing your troubleshooting--and is that a
 13 reasonable description of what your assignment
 14 was, troubleshooting?
 15 DR. EJECKAM:
 16 A. Yeah, in a way, yes.
 17 CROSBIE, Q.C.:
 18 Q. When you were doing your troubleshooting, you
 19 experimented with various numbers of minutes,
 20 five, ten, I don't know, eight, six, whatever.
 21 DR. EJECKAM:
 22 A. Yes.
 23 CROSBIE, Q.C.:
 24 Q. Trying to refine the length of time that was
 25 optimal for getting the result you wanted in

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1 relation to crisp, getting a crisp staining in
 2 a positive control. Is that -
 3 DR. EJECKAM:
 4 A. Yes.
 5 CROSBIE, Q.C.:
 6 Q. - a fair summary?
 7 DR. EJECKAM:
 8 A. Yes.
 9 CROSBIE, Q.C.:
 10 Q. A control meaning something which is a known
 11 quantity which ought to behave in an expected
 12 manner. You know how it's going to behave if
 13 it's dealt with appropriately.
 14 DR. EJECKAM:
 15 A. Control for me in this situation is a tissue
 16 that possesses the antigen that I'm staining
 17 for, and that if I do the stain, it should be
 18 positive. That's what I call a positive
 19 control.
 20 CROSBIE, Q.C.:
 21 Q. And as we've just seen, in 2003, in the
 22 circumstances at hand, this was a manual
 23 technique?
 24 DR. EJECKAM:
 25 A. Yeah, it was semi-automated.

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1 CROSBIE, Q.C.:
 2 Q. And we've just heard from you that the Ventana
 3 machine has taken the manual human element out
 4 of this and now does that part of the process
 5 automatically?
 6 DR. EJECKAM:
 7 A. The antigen retrieval, I believe, is
 8 incorporated in the new machine, the Ventana
 9 machine. So all they needed to do, I believe-
 10 -I didn't do it myself, but what they needed
 11 to do would be to cue in the number of minutes
 12 they wanted antigen retrieval to take place.
 13 CROSBIE, Q.C.:
 14 Q. Indeed, and that's what I understand. A
 15 manual technique, if not performed properly,
 16 can lead to false negatives, particularly if
 17 the receptors are not plentiful in the tissue?
 18 DR. EJECKAM:
 19 A. Can you say that again, please?
 20 CROSBIE, Q.C.:
 21 Q. A manual technique -
 22 DR. EJECKAM:
 23 A. Yes.
 24 CROSBIE, Q.C.:
 25 Q. - if it's not done in an appropriate manner,

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1 can lead to a false negative, particularly if
 2 you have few receptors in the tissue you're
 3 looking at?
 4 DR. EJECKAM:
 5 A. It's possible. It is possible.
 6 CROSBIE, Q.C.:
 7 Q. And I was going to suggest to you that
 8 literature identifies antigen retrieval as a
 9 common source of false negatives.
 10 DR. EJECKAM:
 11 A. I don't know which literature that is, but as
 12 far as I can tell, antigen retrieval, done
 13 properly, is a good--very important step and
 14 factor in getting appropriate result.
 15 CROSBIE, Q.C.:
 16 Q. I'd like to talk for a moment now about
 17 antibody strengths and concentrations. So if
 18 you don't use the proper concentration of
 19 antibody, this can also lead to false
 20 negatives? Is that correct?
 21 DR. EJECKAM:
 22 A. It is possible.
 23 CROSBIE, Q.C.:
 24 Q. Can you just explain to the Commission how
 25 you--what is the process by which you reach

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1 optimal concentration of antibodies so that
 2 you can achieve good, crisp staining?
 3 DR. EJECKAM:
 4 A. What we did, Commissioner, is that first of
 5 all I will discuss with the technologist what
 6 dilution that they are using. And I don't
 7 remember the figures off head now, but they
 8 would tell me, for instance, primary antibody,
 9 if it is it be diluted, is one in 100 or one
 10 in 50. Then what we will do if we were having
 11 problem with that particular stain is to now
 12 say let us try one in 20, one in 30, one in
 13 50, one in 70 or one in 100. So we'll now
 14 cover, below and above that recommended or
 15 whatever that they were using. Then when we
 16 run this test, we then examine this and see
 17 which of these dilutions with the antigen
 18 retrieval and the whole test completed, that
 19 has given the best stain, what I call the best
 20 stain. Immunohistochemistry we talk about the
 21 noise and signal. The signal here is what we
 22 are looking for the antigen, antibody
 23 reaction. The noise is the background stain,
 24 what has no background as possible. And if
 25 the background is clean and no background

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1 staining and then the antigen we are looking
 2 for is there and stains, then that will then
 3 compare against subjective. Now to say one in
 4 60 is better than one in 70, we'll now say,
 5 okay, that's what we're going to be using as
 6 dilution for that particular antibody.
 7 CROSBIE, Q.C.:
 8 Q. So I guess you described a process of
 9 experimentation against a known positive
 10 control to arrive at the ideal solution?
 11 DR. EJECKAM:
 12 A. Yes, that's what is done in titration of
 13 antibodies, that's what should be done for
 14 even new antibodies purchased before you put
 15 them in the system.
 16 CROSBIE, Q.C.:
 17 Q. Sir, you've told us that you yourself use as a
 18 reference the DABBS textbook, Diagnostic
 19 Immunohistochemistry?
 20 DR. EJECKAM:
 21 A. Yeah, I use that.
 22 CROSBIE, Q.C.:
 23 Q. Yes. Mr. Pike just joked with me a moment ago
 24 that he had a pile of, what is it, Dummies
 25 Guides to Leadership -

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1 MR. PIKE:
 2 Q. (Inaudible).
 3 CROSBIE, Q.C.:
 4 Q. He couldn't find one on diagnostic
 5 immunohistochemistry, so I had to go directly
 6 to the source. So this, of course, you would
 7 recognize?
 8 DR. EJECKAM:
 9 A. Yes.
 10 CROSBIE, Q.C.:
 11 Q. As the DABBS textbook?
 12 DR. EJECKAM:
 13 A. Yeah, yeah.
 14 CROSBIE, Q.C.:
 15 Q. And what I've placed in front of the witness
 16 is the 2002 edition. And there's a copy of
 17 the few pages I was to refer to at Exhibit
 18 1569. Perhaps you could bring that up?
 19 REGISTRAR:
 20 Q. We have a request for it has to be entered.
 21 CROSBIE, Q.C.:
 22 Q. Oh, okay.
 23 REGISTRAR:
 24 Q. That wasn't entered yet, Mr. Crosbie.
 25 CROSBIE, Q.C.:

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1 Q. Yes.
 2 COMMISSIONER:
 3 Q. And what was the number again, please, Mr.
 4 Crosbie?
 5 CROSBIE, Q.C.:
 6 Q. P-1569, it's an excerpt from this textbook.
 7 COMMISSIONER:
 8 Q. 1569, all right. Enter than.
 9 EXHIBIT ENTERED AND MARKED P-1569.
 10 CROSBIE, Q.C.:
 11 Q. And on the second page you can see that it's
 12 copyright 2002? It's toward the bottom of the
 13 page.
 14 DR. EJECKAM:
 15 A. Yeah.
 16 CROSBIE, Q.C.:
 17 Q. It's one of these multiple author textbooks.
 18 And we haven't copied it, but actually if you
 19 look on the inside of the cover,
 20 coincidentally, I think you'll see there's a
 21 date stamp by the library at the medical
 22 school as to when they received that copy.
 23 DR. EJECKAM:
 24 A. 2003.
 25 CROSBIE, Q.C.:

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1 Q. What date exactly?
 2 DR. EJECKAM:
 3 A. "Health Sciences Library, 2003, March 21."
 4 CROSBIE, Q.C.:
 5 Q. March 21. So I guess we could say that this
 6 textbook was actually available in the library
 7 at the time you were intervening and
 8 suspending the processes that were concerned
 9 with IHC in early 2003?
 10 DR. EJECKAM:
 11 A. Well, if that's the date they have there, then
 12 it obviously must have been there.
 13 CROSBIE, Q.C.:
 14 Q. It seems that it was.
 15 DR. EJECKAM:
 16 A. Pardon?
 17 CROSBIE, Q.C.:
 18 Q. It seems that it was there, right?
 19 DR. EJECKAM:
 20 A. Yeah, all I'm saying, if that's the date on
 21 the book.
 22 CROSBIE, Q.C.:
 23 Q. Yes.
 24 DR. EJECKAM:
 25 A. That means they date stamp it, so I assume if

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1 they stamped it, then that must have been
 2 there by 2003, March.
 3 CROSBIE, Q.C.:
 4 Q. It seems pretty logical. Can you turn to or
 5 can we turn to on the screen page 17? And
 6 there's a paragraph there about quality
 7 control, that's the third page in, it's page 3
 8 of the exhibit. As defined by the College of
 9 American Pathologists and they appear, to my
 10 mind, as a lay reader of this, to distinguish
 11 here between quality control and quality
 12 assurance. And it seems the quality assurance
 13 is a larger more inclusive concept and quality
 14 control is somewhat more specific. And I'm
 15 not going to sort of drone through the entire
 16 paragraph, but almost--but the paragraph down
 17 to the final sentence which starts in this
 18 section is basically DABBS and Company's
 19 definition of quality control. And I'm going
 20 to let you take your time and read that.
 21 DR. EJECKAM:
 22 A. The first sentence on quality controls in it.
 23 CROSBIE, Q.C.:
 24 Q. I'm sorry?
 25 DR. EJECKAM:

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1 A. I just want to be sure where you're -
 2 CROSBIE, Q.C.:
 3 Q. It begins, "Quality control as defined by the
 4 College" -
 5 DR. EJECKAM:
 6 A. "As defined by"--yeah, okay, I see that.
 7 CROSBIE, Q.C.:
 8 Q. And then it ends, "Daily records of control
 9 results are maintained and corrective actions
 10 are undertaken and documented when results are
 11 unacceptable."
 12 DR. EJECKAM:
 13 A. I need to see a better way to read it now. I
 14 want to know exactly where you are, sir.
 15 COMMISSIONER:
 16 Q. If you'd prefer to look at the paper copy, if
 17 it's easier to read.
 18 DR. EJECKAM:
 19 A. What page?
 20 CROSBIE, Q.C.:
 21 Q. Page 17, sir.
 22 COMMISSIONER:
 23 Q. Page 17.
 24 DR. EJECKAM:
 25 A. Okay.

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1 COMMISSIONER:
 2 Q. It may be easier that way.
 3 DR. EJECKAM:
 4 A. Okay, I read it.
 5 CROSBIE, Q.C.:
 6 Q. Thank you. As a general statement does it
 7 appear to be a reasonable statement about
 8 quality control in this context?
 9 DR. EJECKAM:
 10 A. I think so.
 11 CROSBIE, Q.C.:
 12 Q. And it says "Specifically, as it pertains to
 13 IHC quality control standards address and
 14 define each step of the total IHC test,
 15 including tissue procurement, fixation,
 16 processing, sectioning, staining and finally
 17 the interpretation and reporting of the
 18 staining results." It goes on, "As part of a
 19 laboratory's quality control program, all
 20 steps of the test are described separately and
 21 parameters of each step are established and
 22 monitored in order to ensure consistency of
 23 performance and reproducibility of results."
 24 Where he's saying there "As part of a
 25 laboratory's quality control program all steps

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1 of the test are described separately," is that
 2 basically the operations manual that we've
 3 heard reference to?
 4 DR. EJECKAM:
 5 A. Yes, all these, these steps would appear in
 6 the operationing manual for the
 7 immunohistochemistry.
 8 CROSBIE, Q.C.:
 9 Q. Did I understand you to suggest a little
 10 earlier this afternoon that a knowledgeable
 11 person could derive from the DABBS textbook
 12 itself enough information to put together,
 13 together with, perhaps, manufacturer's
 14 literature, depending on what machinery
 15 they're using, an operations manual?
 16 DR. EJECKAM:
 17 A. It's not what I said. I said that you'll get
 18 information from the index medicals, there are
 19 several articles published, that and including
 20 information from a textbook like, DABBS, will
 21 enable you and not just anybody, you have to
 22 be a pathologist or a technologist who is
 23 dealing with the immunohistochemistry, will
 24 enable you to write a manual. And I did
 25 mention too that we have manual from College

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1 of American Pathologists dealing with anatomic
 2 pathology and some of the information there
 3 were taken to formulate the manual.
 4 CROSBIE, Q.C.:
 5 Q. Well, thanks for correcting that. So the
 6 DABBS text in front of you, together with
 7 other published sources and sources available
 8 from pathologic organizations?
 9 DR. EJECKAM:
 10 A. Yes.
 11 CROSBIE, Q.C.:
 12 Q. Could be accessed to put together an operating
 13 manual for any given lab for doing IHC?
 14 DR. EJECKAM:
 15 A. Yes, I believe so.
 16 CROSBIE, Q.C.:
 17 Q. And you told us, as well, that you offered or,
 18 in fact, gave a copy, I think, was it, of your
 19 own operating manual from your hospital in the
 20 Middle East to the site chief?
 21 DR. EJECKAM:
 22 A. What I gave was my manual for anatomic
 23 pathology, not for IHC. So you have the
 24 manual for doing anatomic pathology with
 25 ordinary processing; we have manual for IHC.

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1 I didn't give them IHC manual. What I give to
 2 Dr. Parai, the site chief, was manual for
 3 anatomic pathology which the general
 4 processing and producing of slides and
 5 everything that goes with it, that's what I
 6 give him.
 7 CROSBIE, Q.C.:
 8 Q. Would that be of assistance to him and others
 9 in putting together the operations manual for
 10 doing IHC?
 11 DR. EJECKAM:
 12 A. It could be because I have said that
 13 information there, a block is a block, tissue
 14 is tissue, procurement of a tissue before IHC
 15 will be the same procurement for anatomic
 16 pathology. So that might help up to a point,
 17 but they needed to look at
 18 immunohistochemistry material before it could
 19 be completed.
 20 CROSBIE, Q.C.:
 21 Q. Is the operations manual something that you
 22 would expect each lab to do an original work
 23 product for? In other words, I'm trying to
 24 think of this in terms of labs would have
 25 variations in the equipment they use, in the

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1 antibodies they use, in how they optimize
 2 various aspects of the procedure and this
 3 being a sensitive sort of procedure might well
 4 vary from one lab to another, so what you'd
 5 expect the lab to do is to put together its
 6 own original work product of -
 7 DR. EJECKAM:
 8 A. Yes.
 9 CROSBIE, Q.C.:
 10 Q. Long question with a simple answer. So it's
 11 not a matter of just calling Doha and saying
 12 courier over a copy of our own manual, that
 13 would be of limited use, perhaps, to another
 14 lab. They should really do the work
 15 themselves to put together and document their
 16 own processes which are optimal for them, is
 17 that the idea?
 18 DR. EJECKAM:
 19 A. The idea is that you don't want to invent the
 20 wheel. If somebody has a manual that has been
 21 prepared, it could assist you preparing yours.
 22 And no one is suggesting that you just lift
 23 the manual from Lab A and drop it on Lab B and
 24 use that same manual. But if you--a lot of
 25 preambles and preliminaries you have to write

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1 in a manual, you could use a manual that has
 2 already been prepared as a help to you. But
 3 you needed to sit down and do your own because
 4 the machine may be different, the materials
 5 may be different, so you cannot superimpose
 6 one on the other. But if you have already
 7 prepared manual, you can even see the format,
 8 you can see the format, that could help you if
 9 you didn't know what to do from the beginning;
 10 the format would be a help.
 11 CROSBIE, Q.C.:
 12 Q. Is there any question that a lab should have
 13 such a manual?
 14 DR. EJECKAM:
 15 A. A laboratory should have a manual. That's a
 16 standard thing. But a number of laboratories
 17 may not have this, they may have what I call
 18 cardex where the procedure for each test, the
 19 techs will write them on a small cardex and
 20 file them. Now, the problem with that
 21 sometimes may get lost or a new person comes,
 22 he doesn't know where to find them. That's
 23 why laboratories are encouraged to prepare
 24 manual, bind them so a new person comes, you
 25 hand over this manual, the person can go

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1 through it and see what is there and what is
 2 going on.
 3 CROSBIE, Q.C.:
 4 Q. In 2003, to your knowledge, was our lab using
 5 a cardex system?
 6 DR. EJECKAM:
 7 A. I know they have where they do methodology on
 8 a kind of cardex system. I didn't see any
 9 manual when I arrived.
 10 CROSBIE, Q.C.:
 11 Q. Excuse me, I just want to be clear about that.
 12 Were they following a cardex system as you've
 13 just described it?
 14 DR. EJECKAM:
 15 A. They were following a system where they wrote
 16 down their methodologies on paper or cardex or
 17 whatever you call it, they would choose to
 18 call it. But I describe it was a cardex
 19 system where it's not a booklet, it's not a
 20 bound manual, but you have the methods written
 21 out in small cardex and filed, so that if you
 22 want to do Test A, you go there and pick it
 23 and see the method there.
 24 CROSBIE, Q.C.:
 25 Q. I see. So are you telling us as a fact that

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1 that was the system for documentation?
 2 DR. EJECKAM:
 3 A. That's my understanding of the system because
 4 I didn't see any manual when I came, so that
 5 was my understanding. And I would go into the
 6 lab and talk about writing on a piece of
 7 paper, of small paper that, you know, this
 8 may--you know, have to keep them carefully.
 9 But I do know that when you look at their
 10 shelf they have where they file the methods
 11 they are using for their staining.
 12 CROSBIE, Q.C.:
 13 Q. They did have places where they filed away
 14 their methods?
 15 DR. EJECKAM:
 16 A. Yes, yes, I believe that, yes.
 17 CROSBIE, Q.C.:
 18 Q. You believe that, but did you observe that
 19 personally?
 20 DR. EJECKAM:
 21 A. When I--yeah, I saw those.
 22 CROSBIE, Q.C.:
 23 Q. You did?
 24 DR. EJECKAM:
 25 A. Yes.

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1 CROSBIE, Q.C.:
 2 Q. Because I haven't seen any of this. I've
 3 looked through a lot of materials here, and
 4 maybe I missed it, but that's something we're
 5 going to have perhaps have a look for. In any
 6 event, you thought that having a manual was a
 7 superior way to do it?
 8 DR. EJECKAM:
 9 A. Well, it's a better way to keep records.
 10 CROSBIE, Q.C.:
 11 Q. Okay. Can we go to Exhibit P-1604? And I
 12 think Mr. Coffey entered this earlier this
 13 afternoon. And if we look at those present at
 14 this meeting, sir, it's said to be a meeting,
 15 in handwriting here, regarding update on
 16 implementation of ER/PR, February 8th, 2006.
 17 Present, D. Cook and then next is listed
 18 yourself. I believe that's your name, Dr.
 19 Ejeckam?
 20 DR. EJECKAM:
 21 A. Yeah.
 22 CROSBIE, Q.C.:
 23 Q. You agree? And if we look at the first
 24 paragraph, Mr. Coffey looked at other
 25 paragraphs, I am taking from this that the two

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1 persons mentioned, I think, Ken Green and it
 2 may be Mary Young, I'm not sure, but these
 3 would--irrespective of the names, that doesn't
 4 matter so much, they would appear to be
 5 technical people who had been sent away for
 6 training?
 7 DR. EJECKAM:
 8 A. Yeah, Ken went to Montreal.
 9 CROSBIE, Q.C.:
 10 Q. Yeah. It says Montreal Jewish General?
 11 DR. EJECKAM:
 12 A. Yes.
 13 CROSBIE, Q.C.:
 14 Q. Ken, yes, it would seem, and the other person
 15 went to Mount Sinai. And Ken brought back
 16 information for--or from Montreal on types of
 17 antibodies used and problems, is that how
 18 you'd read that?
 19 DR. EJECKAM:
 20 A. I think "protocoled."
 21 CROSBIE, Q.C.:
 22 Q. "And protocoled" sorry. Mary brought back or
 23 brought forth issue on QA. She brought back
 24 document on PAS. What would PA stand for?
 25 DR. EJECKAM:

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1 A. Maybe pathologist assistant.
 2 CROSBIE, Q.C.:
 3 Q. I think it's probably something else, but it
 4 may come to us. "And fixation protocols.
 5 Mary was not allowed to bring back documents
 6 on immunoperoxidase protocols from Mount
 7 Sinai. Both agreed on the need for
 8 documentation of activities in the lab and the
 9 establishment of manuals." And we've just
 10 seen, I think, that you fully endorse that?
 11 DR. EJECKAM:
 12 A. Yeah.
 13 CROSBIE, Q.C.:
 14 Q. But it's also, I guess, of some slight
 15 interest to note that Mount Sinai didn't want
 16 to just give out some of their protocols for
 17 people to bring back to this institution.
 18 DR. EJECKAM:
 19 A. I remember Mary did say they refused to let
 20 her take their manual.
 21 CROSBIE, Q.C.:
 22 Q. And that's what's written here. Sir, if you
 23 go to page 2 of that, if I could ask the
 24 Registrar to go to page 2? This follows on as
 25 part of the same exhibit, although it's not

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1 perhaps totally on topic to what we have just
 2 been talking about, but it's a note of March
 3 6th, 2006. And I make it that this would be
 4 handwriting of Dr. Cook. Are you able to say
 5 whether that's so or not?
 6 DR. EJECKAM:
 7 A. No, I cannot.
 8 CROSBIE, Q.C.:
 9 Q. Well, maybe.
 10 DR. EJECKAM:
 11 A. Maybe, yes.
 12 CROSBIE, Q.C.:
 13 Q. We'll find out in due course. So here it
 14 says, "Spoke to Dr. Nabbibi" (phonetic), is
 15 that the way to pronounce that, Nagihiby?
 16 DR. EJECKAM:
 17 A. Probably.
 18 CROSBIE, Q.C.:
 19 Q. Yes. "B.B. Nagihiby about why Clarenville
 20 discontinued ER/PR slides," I think the words
 21 is. "Dr. Nagihiby replied, 'this was due to
 22 poor quality and to lack of external controls'
 23 plus the fact they were paying for this." I
 24 guess that adds insult to injury. Were you
 25 aware of the situation with Clarenville?

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1 DR. EJECKAM:
 2 A. No.
 3 CROSBIE, Q.C.:
 4 Q. You weren't aware of the situation with
 5 Clarenville in 2003?
 6 DR. EJECKAM:
 7 A. No.
 8 CROSBIE, Q.C.:
 9 Q. Or even in 2006?
 10 DR. EJECKAM:
 11 A. Clarenville in particular, no, I was not--I'm
 12 not aware of any problem that they have, in
 13 particular.
 14 CROSBIE, Q.C.:
 15 Q. Were you aware that there were surgeons who,
 16 from before the year 2000, had insisted that
 17 all of their specimens be sent out of province
 18 for reading, their tumor specimens or
 19 suspected tumor specimens?
 20 DR. EJECKAM:
 21 A. I'm not aware of that. I came in 2002 and I'm
 22 not aware that the surgeons would want the
 23 pathologists to read their cases.
 24 CROSBIE, Q.C.:
 25 Q. When it was discussed, you told us about

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1 yesterday, at a meeting of pathologists, if I
 2 understood this correctly, that basically it
 3 would be a good idea and you either
 4 volunteered or it was thought that you had the
 5 necessary skill, knowledge and background to
 6 be, as Dr. Cook later refers to you, our point
 7 man to go in and tidy a few things up about
 8 IHC. Was that a discussion solely amongst
 9 pathologists or was there any input from, for
 10 example, oncologists?
 11 DR. EJECKAM:
 12 A. No, I didn't see any oncologists on this
 13 issue. They didn't know me and there was no
 14 way for them to contribute to this discussion
 15 unless somebody told them. I'm not aware of
 16 any oncologists on board with the decision.
 17 CROSBIE, Q.C.:
 18 Q. I realize you are here for a relatively number
 19 of years, sir. Did you pick up from
 20 oncologists, during your stay at the Health
 21 Sciences more recently, any sense of
 22 dissatisfaction with the quality of the IHC
 23 service or any other aspect of quality in the
 24 lab?
 25 DR. EJECKAM:

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1 A. I'm not aware of any of the oncologists, they
 2 didn't tell me about any poor quality work
 3 that was coming from the laboratory. I'm not
 4 aware of that. They usually--well, the
 5 laboratory has tumor board, we have the
 6 oncologists and the pathologists and other
 7 clinicians will have meetings and I attended a
 8 couple of times and I didn't hear about poor
 9 job by the lab. We have lymphoma rounds,
 10 sometimes the pathologist--not only lymphoma
 11 hematology rounds where the tumor,
 12 hematological tumor would be discussed and I
 13 didn't hear of anything like that. If they
 14 existed, it didn't come to my notice.
 15 CROSBIE, Q.C.
 16 Q. Registrar, could you bring up P-0554? This
 17 document is dated August 8th, '05 and we've
 18 had it described for us and Mr. Tilley has
 19 been asked about it and identified this -
 20 THE COMMISSIONER:
 21 Q. (Inaudible).
 22 CROSBIE, Q.C.
 23 Q. I'm corrected that it's August 8--or 5.
 24 THE COMMISSIONER:
 25 Q. You said 8.

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1 CROSBIE, Q.C.
 2 Q. Okay. I'll give it to you, Mr. Coffey, I'm
 3 not going to argue over that.
 4 COFFEY, Q.C.
 5 Q. Mr. Crosbie, this is the meeting of August 5
 6 because Ottenheimer, Abbott, Hennessey and
 7 Stephanie were there, I take it Mr. Pritchard
 8 is, in fact, indicating that's his
 9 understanding.
 10 CROSBIE, Q.C.
 11 Q. Okay. I don't want to distort anybody's
 12 chronology, but the date is not of such great
 13 interest to me right at the moment, as if you
 14 go about two-thirds or three quarters of the
 15 way down the page, you'll see the word
 16 "boiling". Can you see that word there?
 17 DR. EJECKAM:
 18 A. Yeah, yes, I see it.
 19 CROSBIE, Q.C.
 20 Q. There it is, the cursor is by the word there
 21 "boiling", so Mr. Tilley's understanding was
 22 that the process involved boiling of tissue
 23 samples. And we could see this in various
 24 places in the documentation, but for example,
 25 if we go to P-1469, page two, these are

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1 briefing notes and it represents what the
 2 Department of Health was being told about the
 3 problems of the time. We go over to page two
 4 under the work "background" first bullet,
 5 "prior to April 2004 DAKO testing technique
 6 was used at Eastern Health's laboratories
 7 which required the manual boiling of tissue
 8 samples" and so there's the reference to
 9 boiling again. And the next exhibit, I
 10 believe Mr. Coffey entered this as 1605.
 11 Perhaps I should explain the providence of the
 12 document to you, Doctor. I mentioned before
 13 that I'm counsel to members of a certain class
 14 action.
 15 DR. EJECKAM:
 16 A. Yes.
 17 CROSBIE, Q.C.
 18 Q. And in the process of that, a bit more than a
 19 year ago we asked one of the witness for
 20 Eastern Health, what's called an interrogatory
 21 which is a question, in a formal sense. And
 22 what we asked for was that she append to her
 23 answers to interrogatories the, I think we
 24 used the term, bench manual. Would you
 25 understand bench manual in this context to be

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1 the same thing as the operation's manual?
 2 DR. EJECKAM:
 3 A. Probably, yeah, depends on what word you use
 4 to describe it.
 5 CROSBIE, Q.C.
 6 Q. Okay. Well, what we got back was the DAKO
 7 manufacturer's literature which you see before
 8 you and if you go to page two of that, you see
 9 it has the DAKO logo there on the top of the
 10 page. And if go down, there's some
 11 handwriting in the left hand margin. And
 12 you'll see there the initials "TG" inside a
 13 circle on the left hand lower side?
 14 DR. EJECKAM:
 15 A. Yeah.
 16 CROSBIE, Q.C.
 17 Q. I'm assuming those initials are those of Terry
 18 Gulliver, but in due course, I suppose we'll
 19 have that confirmed.
 20 DR. EJECKAM:
 21 A. I have no way of knowing that.
 22 CROSBIE, Q.C.
 23 Q. Pardon me?
 24 DR. EJECKAM:
 25 A. I said I have no way of knowing whose initials

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1 those are.
 2 CROSBIE, Q.C.
 3 Q. Okay. Well, we'll proceed on that assumption
 4 for the time being and what it appears he's
 5 marked there is "DAKO antigen retrieval, step
 6 by step". So, I guess he intends us to
 7 understand from that that the procedure he's
 8 outlined there with his marking is the
 9 procedure that this lab was following. That's
 10 what I understand. So, do you have any
 11 comment on that so far?
 12 DR. EJECKAM:
 13 A. No.
 14 CROSBIE, Q.C.
 15 Q. Okay. If we look at, under "recommended
 16 procedure, water bath", number one is "fill
 17 coplin jar or other suitable container with
 18 sufficient quantity of diluted target
 19 retrieval solution, et cetera. Place
 20 container in water bath. Heat water bath to
 21 95 - 99 degrees centigrade (do not boil)".
 22 This is the manufacturers literature as far as
 23 we can tell, is that right?
 24 DR. EJECKAM:
 25 A. I don't know that. I mean, what you showed

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1 me, you have logo of DAKO on top of it, but I
 2 don't know that this is -
 3 CROSBIE, Q.C.
 4 Q. Just scroll up again, please, Registrar. And
 5 an address.
 6 DR. EJECKAM:
 7 A. Okay, fine.
 8 CROSBIE, Q.C.
 9 Q. Someone may correct us, but by appearances and
 10 I guess I can advise you that it was given to
 11 us by Ms. Heather Predham whose name you heard
 12 before -
 13 DR. EJECKAM:
 14 A. Yes.
 15 CROSBIE, Q.C.
 16 Q. - as an attachment to a sworn set of answers
 17 in a court process. This is what was offered
 18 to us as their bench manual. And it appears
 19 to be a manufacturer's document. In any
 20 event, if I'm wrong in all that, I'm sure I'll
 21 be corrected. But what I ask your reaction to
 22 is the manufacturer's instruction there that
 23 we just read, "do not boil".
 24 MR. BROWN:
 25 Q. Excuse me, I'm not sure, this is not a

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1 question for Dr. Ejeckam. Dr. Ejeckam is not,
 2 at least by his evidence in part has not held
 3 himself out to be an expert in this area, it's
 4 purely a technical phase of questioning, now I
 5 mean, obviously it's there, what it is, but if
 6 Mr. Crosbie is attempting to ask what appears
 7 to be opinion evidence on something he's not
 8 qualified on, I caution--I just raise it at
 9 this point.
 10 THE COMMISSIONER:
 11 Q. Mr. Crosbie?
 12 CROSBIE, Q.C.
 13 Q. The witness seems very capable of saying
 14 whether or not he's in a position to offer any
 15 comment on the question.
 16 DR. EJECKAM:
 17 A. You see, what--well, in terms of bench manual,
 18 bench manual should be prepared by the
 19 laboratory, not--shouldn't substitute the
 20 manufacturers manual with it, I mean,
 21 information with it. And that's what we
 22 saying, okay, but in terms of do not boil or
 23 boil somewhere, somebody write boiling, when
 24 you say heat up to 99 degrees, boils at
 25 probably 100, right. So, somebody who is not

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1 a technical person may assume that if you
 2 heat, it's going to boil. So, it is--I don't
 3 know what--I mean, when they said, I mean, say
 4 "do not boil", so I would assume that my
 5 technologists that are doing this, follow the
 6 instruction. Now, if somebody and I
 7 (unintelligible) down wants to describe this
 8 and say boiling, I don't take it that it was
 9 boiling good unless he has an understanding of
 10 what was going on.
 11 CROSBIE, Q.C.
 12 Q. Sir, let me just be clear on this, as someone
 13 with expertise in IHC procedures would you or
 14 would you not see boiling the specimen as
 15 creating a problem?
 16 DR. EJECKAM:
 17 A. If the instruction says do not boil, then we
 18 don't boil it, but you have to raise that
 19 temperature to 99 degrees maximum.
 20 CROSBIE, Q.C.
 21 Q. What happens if you raise it to 100, what's
 22 the risk then?
 23 DR. EJECKAM:
 24 A. For them to boil.
 25 CROSBIE, Q.C.:

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1 Q. And what would that do?
 2 DR. EJECKAM:
 3 A. I don't know because I have not experimented
 4 on that, I don't know what will happen. If
 5 you, a retrieval will cause--I know that
 6 retrieval time will cause what should be
 7 negative to start being positive. We've seen
 8 that when you leave the tissue a longer time
 9 than necessary in the antigen retrieval
 10 solution and heat it for a longer period of
 11 time, then you start to find that some of the
 12 cells that are supposed to be negative, start
 13 showing positivity. Now when you have that,
 14 then of course, you have to ask yourself why I
 15 did like that, and then you now have to check
 16 your time and check what you've done.
 17 CROSBIE, Q.C.:
 18 Q. Well I guess, you know, to put it in layman's
 19 terms, if you take protein and you heat it too
 20 much or for too long, you cook it. So in a
 21 loose way, could you cook the specimens and
 22 render them useless for interpretation?
 23 DR. EJECKAM:
 24 A. It's possible, that's what I'm saying, if you
 25 overheat it or if you leave it for longer

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1 period than necessary, then you'll start
 2 getting spurious results, it may be a result
 3 that you don't want. No more tissues--the
 4 example is this, no more tissue should not be
 5 positive for Her2/neu, but if you heat it, if
 6 you leave it for too long in the antigen
 7 retrieval solution and heat it at high
 8 temperatures, you'll start seeing dots being
 9 positive and that is wrong, but when you see
 10 it, then you tell yourself this is not a
 11 proper result.
 12 THE COMMISSIONER:
 13 Q. Sorry, Mr. Crosbie, two points. Are you
 14 saying that if in fact it was either over
 15 heated or heated too long, there would be
 16 indications of that on the slide?
 17 DR. EJECKAM:
 18 A. Yeah, they may be false positive.
 19 THE COMMISSIONER:
 20 Q. But how do you know it's a false positive?
 21 DR. EJECKAM:
 22 A. Her2/neu, an example, is not supposed to be
 23 seen in normal breast ducts, so when you stain
 24 it and you see normal breast or staining with
 25 Her2/neu, then it's (unintelligible) stain,

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1 there's something wrong, it is not supposed to
 2 happen that way.
 3 CROSBIE, Q.C.:
 4 Q. That's your internal control.
 5 DR. EJECKAM:
 6 A. Yes.
 7 CROSBIE, Q.C.:
 8 Q. Which you say is critical.
 9 DR. EJECKAM:
 10 A. Yes, I say that, yes.
 11 CROSBIE, Q.C.:
 12 Q. But apparently from what we've seen, not
 13 always used here.
 14 DR. EJECKAM:
 15 A. That's an individual problem for individual
 16 pathologists or those who look at it, it is
 17 not a problem of the laboratory. The staining
 18 has been done by the laboratory and someone is
 19 looking at it, so if you send out or an in-
 20 house pathologist looks at it, it's for him or
 21 her to identify this.
 22 CROSBIE, Q.C.:
 23 Q. Just on that same theme about temperature, can
 24 we bring up P-0047 and start with the cover,
 25 it's the Wegrynowski report from the fall of

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1 2005. Doctor, you can see the title of the
 2 document, "Quality Review" and who prepared
 3 it, it's dated November 9th, 2005 and she's a
 4 pathology consultant. Can we go then to page
 5 11, exhibit, page 11. Item 17 says,
 6 "Guarantee pipette and temperature accuracy
 7 and calibration." Then drop down to the third
 8 paragraph from the top, "A standard
 9 thermometric device or referenced thermometer,
 10 NIST certified or guaranteed by manufacturer
 11 to meet NIST standards is to be available to
 12 check thermometers used on all temperature
 13 controlled instruments. Digital temperature
 14 readings do no suffice and thermometer's
 15 readings are to be recorded." So I infer from
 16 the fact that this is listed as a
 17 recommendation that what is said should be
 18 happening was in fact not happening at the
 19 time the investigator or report, Wegrynowski,
 20 did her investigation. Does that seem
 21 reasonable?
 22 DR. EJECKAM:
 23 A. This is the first time I'm seeing this report
 24 and so, talking generally if somebody made a
 25 recommendation, one would assume that a

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1 recommendation was in existence, but this is
 2 the first time I'm seeing it and this is a
 3 technical issue with a technical lab
 4 technologists, I have no, as a pathologist or
 5 even any of my colleagues anything to do with
 6 this aspect of the work.
 7 CROSBIE, Q.C.:
 8 Q. And in fact, it was brought up by somebody
 9 who, I understand, is not a pathologist
 10 herself, but has relevant expertise as a
 11 laboratory specialist who knows about how
 12 this--who knows the technical side of how IHC
 13 should be done, and I believe she works or did
 14 work out of Mount Sinai. So you're saying in
 15 effect that this is not the sort of thing that
 16 would normally be a matter for you attention?
 17 DR. EJECKAM:
 18 A. I wouldn't be involved with this. This is
 19 something for the technologist to take care
 20 of.
 21 CROSBIE, Q.C.:
 22 Q. At page nine, if I could ask that we go to
 23 that? Again, we see here "documentation in
 24 general is deficient. Key areas identified in
 25 IHC" and the first bullet "no test procedure

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1 manual, including standard operating
 2 procedures," and of course, we've been talking
 3 about that, haven't we? And so you and she
 4 would seem to agree on the need for that?
 5 DR. EJECKAM:
 6 A. Yeah, yes.
 7 CROSBIE, Q.C.:
 8 Q. And there's mention at Pipette, four dots
 9 down, and thermometer calibration of accuracy.
 10 That seemed to be an issue. And then we see a
 11 note at the bottom of the page under
 12 recommendations, and it says "the Ventana
 13 Benchmark operator's manual was available at
 14 the workbench. It is an acceptable component
 15 of the overall IHC departmental procedures,
 16 but does not replace a procedure manual," and
 17 I take it you would agree with that?
 18 DR. EJECKAM:
 19 A. Yes.
 20 CROSBIE, Q.C.:
 21 Q. Could I ask the Registrar to now bring up
 22 document 0561, and we're looking for item
 23 four. So this is from August 2005 from Dr.
 24 Cook, and what caught my eye here, and just
 25 ask you about this, is the statement "ER

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1 negative being defined as ten percent or
 2 less." In your memoranda from 2003, we've
 3 seen more than once, you made reference to a
 4 consensus statement from, I think, late 2000.
 5 Do I have that right?
 6 DR. EJECKAM:
 7 A. Yes.
 8 CROSBIE, Q.C.:
 9 Q. In which the consensus was that one percent or
 10 greater should be considered to be positive.
 11 Do I have that right?
 12 DR. EJECKAM:
 13 A. The consensus says one percent or less is a
 14 condition that may warrant treatment of the
 15 patient. A patient may be exposed to anti-
 16 estrogen. Now -
 17 CROSBIE, Q.C.:
 18 Q. Sorry, one percent or greater, would it not
 19 be, presence of positive staining?
 20 DR. EJECKAM:
 21 A. Now if--well, the consensus would say the
 22 positivity of the cells, whether it is one
 23 percent or less, may be a condition where a
 24 patient may be exposed to anti-estrogen. Now
 25 laboratories will set their standard. That's

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1 why when they report it out, they report
 2 percentages. The oncologist will then
 3 determine what he wants to use. Ten percent
 4 that was put in here is not universally used.
 5 When you look at the consensus opinion, a lot
 6 of people may use less percentage.
 7 CROSBIE, Q.C.:
 8 Q. I'm just wondering, and there may well be an
 9 explanation for this, but why, in the face of
 10 a consensus statement of considerable
 11 authority that you yourself quoted several
 12 years before in 2003, is Dr. Cook laying down
 13 ten percent? Can you explain that?
 14 DR. EJECKAM:
 15 A. I think he is the one to explain that. I
 16 cannot explain that, why he--I mean, this--
 17 what I'm just saying that laboratories and
 18 oncology determine their cutoffs. So if this
 19 is the agreed cutoff with the oncologists,
 20 then that's--as clinical chief, that's why he
 21 put this on paper.
 22 CROSBIE, Q.C.:
 23 Q. That's what you got to -
 24 DR. EJECKAM:
 25 A. So that's -

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1 CROSBIE, Q.C.:

2 Q. That's what you have a clinical chief for, I

3 guess.

4 DR. EJECKAM:

5 A. Well, he has to make decisions.

6 MR. SIMMONS:

7 Q. Excuse me, Commissioner, I don't think this is

8 a memo that Dr. Ejeckam was familiar with and

9 may not have taken time to review it

10 carefully, but my understanding of the use of

11 the ten percent here was in selecting samples

12 to be retested. It's not a statement that

13 this is the cutoff. I think that this was the

14 criteria--this is establishing a criteria that

15 was used to select samples to be sent on for

16 retesting.

17 THE COMMISSIONER:

18 Q. Mr. Crosbie.

19 CROSBIE, Q.C.:

20 Q. May I have a moment to read it?

21 THE COMMISSIONER:

22 Q. Yes, of course.

23 CROSBIE, Q.C.:

24 Q. Well, if Mr. Simmons is correct in that

25 statement, why would you select the ten

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1 percent cutoff to assist you in determining

2 which specimens ought to be retested?

3 THE COMMISSIONER:

4 Q. Wait now. Was this witness involved in

5 retesting choices?

6 DR. EJECKAM:

7 A. I was not involved in -

8 CROSBIE, Q.C.:

9 Q. Well, I guess I'm asking, if he can, to

10 explain why--I mean, I'm juxtaposing,

11 Commissioner, obviously the consensus

12 statement from several years before with this

13 use of ten percent, and if you can enlighten

14 us as to why ten percent is pertinent at this

15 point in time, please do. If you can't, we'll

16 have to hear it from Dr. Cook.

17 DR. EJECKAM:

18 A. I can't. I can't make any comment on this

19 issue. I cannot clarify that, why that was

20 put down there.

21 THE COMMISSIONER:

22 Q. Something you said though interests me. Did I

23 take it from what you said that the business

24 of the percentage is the call of the

25 oncologist, in any event?

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1 DR. EJECKAM:

2 A. It is the business agreed between the

3 oncologist and the laboratory if they want to

4 set a percentage.

5 THE COMMISSIONER:

6 Q. Yes.

7 DR. EJECKAM:

8 A. But there should be a meeting to agree what

9 percentage to be decided as positive or

10 negative.

11 THE COMMISSIONER:

12 Q. Okay.

13 DR. EJECKAM:

14 A. But some laboratories will just report the

15 percentage they have and then let the

16 oncologist decide what he decides as what to

17 take as a cutoff to treat his patient. The

18 pathologist has no hand, no input in that,

19 that aspect of it.

20 THE COMMISSIONER:

21 Q. Okay. So the decision as to what percentage

22 would be a cutoff for the purpose of treatment

23 is that of the oncologist?

24 DR. EJECKAM:

25 A. Oncologist, yes.

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1 THE COMMISSIONER:

2 Q. There may be times when of the laboratory or

3 the pathologists, as a group, and the

4 oncologists will say "for the purposes of our

5 organization, this is the percentage which

6 shall be used, and if I say positive, I mean

7 that percentage or greater"?

8 DR. EJECKAM:

9 A. Yes, yes.

10 THE COMMISSIONER:

11 Q. But if they don't do that, then you would

12 expect, would you, that the pathologist would

13 give a percentage so that the oncologist

14 receiving it knows what the percentage is?

15 DR. EJECKAM:

16 A. That's exactly what I mean.

17 THE COMMISSIONER:

18 Q. Okay. Sorry, Mr. Crosbie.

19 CROSBIE, Q.C.:

20 Q. Thank you, Commissioner. Near the beginning

21 of your evidence yesterday, Mr. Coffey asked

22 you, and the discussion appears around page

23 279 of the transcript that's already been

24 prepared, some brief questions about keeping

25 track of ER and PR positivity rates, and you

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1 started by saying "I don't understand the
 2 question," but I was left somewhat unclear on
 3 your attitude toward that, because you ended
 4 up saying that yes, you could get the
 5 statistics on them if you wished and they
 6 could be in the computer. You could get
 7 copies.
 8 What I'm getting at, and I think Mr.
 9 Coffey was getting at, is this: is it a useful
 10 quality assurance device or quality control
 11 device, as the case may be, to periodically
 12 look at your positivity rates in a given lab
 13 to see if they measure up to an expected rate
 14 of positivity, if everything is working
 15 reasonably well?
 16 DR. EJECKAM:
 17 A. I think in the process of quality assurance
 18 that may be something that would be done
 19 periodically, maybe quarterly or yearly or
 20 half yearly, but it's not something you're
 21 going to be doing on a daily basis or routine
 22 basis.
 23 CROSBIE, Q.C.:
 24 Q. In your lab back in the Middle East, in Doha,
 25 is that something that you did periodically,

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1 look at your positivity rates?
 2 DR. EJECKAM:
 3 A. Actually, we didn't do that.
 4 CROSBIE, Q.C.:
 5 Q. You did not do that?
 6 DR. EJECKAM:
 7 A. Yes.
 8 CROSBIE, Q.C.:
 9 Q. Do you think it's a reasonable thing to do?
 10 DR. EJECKAM:
 11 A. I think you could add that to quality
 12 assurance program.
 13 CROSBIE, Q.C.:
 14 Q. Can you tell us, and if you can't then you
 15 can't, but is there an accepted percentage, if
 16 you were to look at positivity versus
 17 negativity rates in a lab, is there a
 18 benchmark rate that you should be measuring
 19 yourself against?
 20 DR. EJECKAM:
 21 A. Well, there are a number of information in the
 22 literature where there's calibrator
 23 comparisons, and there's variation from 70 to
 24 80 percent. Some laboratories will give that.
 25 So it's a question of where you stand with

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1 that kind of field. If that's what you
 2 believe you want to do, then you compare
 3 yourself to such percentages. If you look at
 4 the literature, there's so many articles that
 5 will compare laboratory percentages of
 6 equipment percentages, DAKO against Ventana,
 7 and my understanding that you have a range
 8 sometimes, some going from 60 to 80 percent,
 9 in terms of positivity, but there may be some
 10 variation, laboratory variation that may make
 11 one to be higher and the other to be lower.
 12 CROSBIE, Q.C.:
 13 Q. Can you tell us, sir, if a lab had a rate of
 14 positivity of 65 percent, would that generally
 15 be considered to be sound and acceptable?
 16 DR. EJECKAM:
 17 A. I would think it's on the low side. From 70
 18 up, I would think falls within the generally
 19 accepted, 70-75 to 80-85. It depends on the
 20 laboratory you are evaluating. The British
 21 have evaluated several calibrator laboratory
 22 work and I think most of the evaluation for
 23 calibrator came from either UK or Europe and
 24 they have--there's quite a range between one
 25 laboratory and the other. So I think most

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1 important thing here is if you are able to
 2 satisfy that the work you're doing in your
 3 laboratory is--you're following the proper
 4 methodology, then if you have a low percentage
 5 or high percentage, I'm not sure that is of
 6 critical importance, other than you're looking
 7 at--you know, if you're sure that your
 8 methodology is right. I don't know if I made
 9 myself clear or not.
 10 CROSBIE, Q.C.:
 11 Q. I guess if I under--tell me if I've got this
 12 right or not. It is a quality assurance
 13 measure that a lab might look at. You appear
 14 to feel that it's not obligatory, all the more
 15 so if you're satisfied with your other
 16 measurements and assurances of quality, such
 17 as the presence of the controls that you were
 18 describing earlier?
 19 DR. EJECKAM:
 20 A. Yes.
 21 CROSBIE, Q.C.:
 22 Q. That's a fair statement?
 23 DR. EJECKAM:
 24 A. Yeah.
 25 CROSBIE, Q.C.:

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1 Q. Would the expected or desired positivity rate
 2 vary according to cut point?
 3 DR. EJECKAM:
 4 A. Well, yeah. If you have a cutoff point of ten
 5 percent and someone has a cutoff of 30
 6 percent, then they're going to vary. So
 7 that's one of the things you'd want to compare
 8 and you have to ensure that all the
 9 laboratories you are going to compare have the
 10 same cutoff, about the same range of cutoff,
 11 so that you can have a proper comparison.
 12 CROSBIE, Q.C.:
 13 Q. So what effect would it have to include
 14 clinically negative if you're using a 30
 15 percent cutoff in the positivity rate? What
 16 effect would that have?
 17 DR. EJECKAM:
 18 A. I don't understand the question.
 19 CROSBIE, Q.C.:
 20 Q. Well, let me lead it with--put it to you this
 21 way. You're telling us that the cutoff point
 22 used by the lab will have an effect on how you
 23 do the calculation or will have an effect on
 24 the calculation of positivity rate. Is that
 25 correct?

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1 DR. EJECKAM:
 2 A. Yes.
 3 CROSBIE, Q.C.:
 4 Q. So you have to be aware of the cutoff point in
 5 use at any given period of time when you're
 6 making that calculation?
 7 DR. EJECKAM:
 8 A. Yes.
 9 CROSBIE, Q.C.:
 10 Q. Commissioner, I may have one half hour more of
 11 questioning, and I see that it's now ten to
 12 five.
 13 THE COMMISSIONER:
 14 Q. Okay. We'll break for the day. Let's do the
 15 round, because we have another witness
 16 scheduled for the morning. Mr. Pike?
 17 MR. PIKE:
 18 Q. No questions for me, thank you.
 19 THE COMMISSIONER:
 20 Q. Would you care to estimate, Mr. Browne?
 21 MR. BROWNE:
 22 Q. Currently, I would think 15 minutes, half hour
 23 tops.
 24 THE COMMISSIONER:
 25 Q. Okay. Well, we'll schedule the witness in in

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1 the morning accordingly. Thank you. 9:30,
 2 thank you.

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

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Inquiry on Hormone Receptor Testing

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