

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">MAY 20, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. . . . . Commission Co-counsel Sandra Chaytor, Q.C. . . . . Commission Co-counsel</p> <p>Rolf Pritchard/Megan Collins . . . . Her Majesty in Right of NL</p> <p>Peter Browne . . . . . Doctors Kara Laing et al</p> <p>Daniel Simmons/Sarah Learmonth . . . Eastern Regional Integrated . . . . . Health Authority</p> <p>Pamela Taylor . . . . . Members of the Breast Cancer . . . . . Testing Class Action</p> <p>Mark Pike . . . . . NL Medical Association Jennifer Newbury . . . . Canadian Cancer Society (NL Division) Stacey O’Dea. . . . . Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBIT P-1397 . . . . .Pg. 6 EXHIBIT P-1398 . . . . .Pg. 6 EXHIBITS P-1368 AND P-1384 . . . . .Pg. 159 EXHIBITS P-1307 AND P-1317 . . . . .Pg. 161</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>Discussion . . . . . Pgs. 4 - 5</p> <p>DR. ROBERT WILLIAMS - RESUMES THE STAND</p> <p>Examination by Bernard Coffey, Q.C. . . . . Pgs. 6 - 161 Examination by Peter Browne . . . . . Pgs. 161 - 191 Examination by Jennifer Newbury . . . . . Pgs. 191 - 363 Examination by Pamela Taylor . . . . . Pgs. 363 - 383</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 COMMISSIONER: 2 Q. Please be seated. Mr. Coffey. 3 COFFEY, Q.C.: 4 Q. Yes, Commissioner, before I begin with, I 5 resume with Dr. Williams, I want to let you 6 know that myself and Ms. Chaytor and the other 7 counsel involved here received an e-mail from 8 Jackie Brazil dated Monday, May 19th, 2008 at 9 11:01 p.m., that’s last night. The subject is 10 "Reply of brief." And I’m just going to read 11 it to you, please? 12 COMMISSIONER: 13 Q. Um-hm. 14 COFFEY, Q.C.: 15 Q. It says, "Ladies/Gentlemen, I plan to file a 16 reply brief before 5 p.m. tomorrow. I had 17 hoped to have an electronic copy of the brief 18 for you this evening, but I have run out of 19 time. I trust the Commission counsel will 20 advise the Commissioner accordingly. Yours 21 Truly, Jacqueline Brazil." And, Commissioner, 22 you are so advised. 23 COMMISSIONER: 24 Q. Thank you. What time did you say that was 25 being -</p>

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1 COFFEY, Q.C.:

2 Q. At 11:01 p.m. last night.

3 COMMISSIONER:

4 Q. No, I meant what time does Ms. Brazil intend

5 to file that reply brief?

6 COFFEY, Q.C.:

7 Q. Before 5 p.m. tomorrow, which would be

8 presumably today.

9 COMMISSIONER:

10 Q. Today?

11 COFFEY, Q.C.:

12 Q. Yes.

13 COMMISSIONER:

14 Q. Mr. Pritchard, I regret having to make you a

15 messenger in this, but I have no difficulty

16 with Ms. Brazil filing a reply brief, if

17 indeed she wishes to do so. I just wish to

18 indicate that in light of the timing and our

19 schedule of witnesses, I had indicated that I

20 would make a decision and communicate that to

21 everybody before the next government witness

22 took the stand. And on the timing I'm not

23 confident I can keep that promise but I will

24 endeavour to do so. If I can't, I'll make the

25 decision and communicate it as quickly as I

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1 can, even if the next government witness is in

2 the middle of being examined.

3 MR. PRITCHARD:

4 Q. (Inaudible).

5 COMMISSIONER:

6 Q. Thank you, very much. Now, Mr. Coffey.

7 DR. ROBERT WILLIAMS, EXAMINATION-IN-CHIEF BY BERNARD

8 COFFEY, Q.C.

9 COFFEY, Q.C.:

10 Q. Thank you, Commissioner. Now, Doctor, we had

11 asked in 2006, I--if we could, please, if we

12 could go, please, to Exhibit 1397, please?

13 I'm sorry, oh, I have to enter those,

14 actually. If I could, please, Commissioner,

15 there are two exhibits, I believe, I'd like to

16 move to have entered. 1397 and 1398?

17 COMMISSIONER:

18 Q. Entered.

19 EXHIBIT P-1397 ENTERED INTO EVIDENCE.

20 EXHIBIT P-1398 ENTERED INTO EVIDENCE.

21 COFFEY, Q.C.:

22 Q. And, Doctor, these are--well, this is a, I

23 gather it's a note from Dr. Cook. I want to

24 refer you to its contents and ask you about

25 that. It's dated March 6th, 2006 and Dr. Cook

Page 7

1 has apparently written, "Spoke to Dr. B.B.

2 Nagihily (phonetic)?"

3 DR. WILLIAMS:

4 A. Yes.

5 COFFEY, Q.C.:

6 Q. "About why Clarenville discontinued ER and PR

7 slides. Dr. Nagihily replied this was due to

8 poor quality and lack of external controls,

9 plus the fact they were paying for this. As

10 far as she knows they discontinued without

11 notify people in St. John's." Now, Doctor,

12 did Dr. Cook ever speak to you in March or

13 April of '06 about Clarenville?

14 DR. WILLIAMS:

15 A. Dr. Cook would have spoken earlier than that

16 about Clarenville to me.

17 COFFEY, Q.C.:

18 Q. Okay.

19 DR. WILLIAMS:

20 A. He was going to try to find out why

21 Clarenville wasn't using our lab.

22 COFFEY, Q.C.:

23 Q. Um-hm.

24 DR. WILLIAMS:

25 A. But I've never seen this, you know, before

Page 8

1 this.

2 COFFEY, Q.C.:

3 Q. Oh, I appreciate you've never seen the note.

4 DR. WILLIAMS:

5 A. But I knew he was trying to find out. And at

6 the end trying to remember exactly what he

7 said, but I don't remember him saying he found

8 out for sure, he wasn't really sure, but they

9 did stop using our service.

10 COFFEY, Q.C.:

11 Q. Yeah.

12 DR. WILLIAMS:

13 A. And he was trying to find out. Dr. B.B. was

14 actually working for us at this time.

15 COFFEY, Q.C.:

16 Q. Yeah.

17 DR. WILLIAMS:

18 A. She transferred in from Clarenville.

19 COFFEY, Q.C.:

20 Q. Did he ever report to you what's -

21 COMMISSIONER:

22 Q. This particular doctor was not working in

23 Clarenville at the time?

24 DR. WILLIAMS:

25 A. No, she had transferred in from Clarenville.

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1 COMMISSIONER:  
 2 Q. Oh, okay.  
 3 DR. WILLIAMS:  
 4 A. Was working now for us. And he was trying to  
 5 find out why Clarenville wasn't using our  
 6 service.  
 7 COFFEY, Q.C.:  
 8 Q. In fact, last week you had indicated that at  
 9 one point, yes, you had understood he was  
 10 going off to do that?  
 11 DR. WILLIAMS:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. Does this--with the contents of what I just  
 15 read you, had you ever heard that before?  
 16 DR. WILLIAMS:  
 17 A. I'm not sure, Mr. Coffey, if--I certainly  
 18 haven't seen this before.  
 19 COFFEY, Q.C.:  
 20 Q. Oh, I know. But how about the contents?  
 21 DR. WILLIAMS:  
 22 A. Don, I seem to recall that Don wasn't totally  
 23 sure why, but he had talked to Dr. B.B. about  
 24 it.  
 25 COFFEY, Q.C.:

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1 Q. Did he report what Dr. B.B. had told him to  
 2 you?  
 3 DR. WILLIAMS:  
 4 A. I can't remember that, Mr. Coffey, him  
 5 reporting that, but I knew he was gone off to  
 6 find that out.  
 7 COFFEY, Q.C.:  
 8 Q. If we could, please, Exhibit P-1398? now, and  
 9 I gather this is a note that Dr. Cook had  
 10 written. I want to refer you to its contents  
 11 and then I have a question for you. "Spoke to  
 12 Dr. Ejeckam with Terry Gulliver morning of  
 13 March 7, 2006 re the hold on certain stains in  
 14 2003. I asked him what he meant by erratic.  
 15 Dr. Ejeckam reported that it meant some stains  
 16 worked some days and didn't work on others. I  
 17 asked him if he should have recommended a  
 18 review of stains at that time. He replied to  
 19 me that it wasn't his place to initiate or  
 20 recommend a review." And do you recall if Dr.  
 21 Cook ever reported to you about the fact that  
 22 he had spoken to Dr. Ejeckam and concerning  
 23 the 2003 matter and, if so, what did Dr. Cook  
 24 tell you about what Dr. Ejeckam said?  
 25 DR. WILLIAMS:

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1 A. I subsequently found out after I'd left the  
 2 organization about this particular issue. I  
 3 hadn't seen that note at the time.  
 4 COFFEY, Q.C.:  
 5 Q. Oh.  
 6 DR. WILLIAMS:  
 7 A. But I knew that Dr. Cook had talked to Dr.  
 8 Ejeckam earlier in 2005, actually, at the time  
 9 that he brought the memos to our attention.  
 10 And it was nothing new to report at that time.  
 11 There was some adjustments done to the pH and  
 12 the antibodies and was felt at that time,  
 13 according to Dr. Cook's discussion with Dr.  
 14 Ejeckam, that the situation had been  
 15 rectified.  
 16 COFFEY, Q.C.:  
 17 Q. And this note suggests that Dr. Cook spoke to  
 18 Dr. Ejeckam again in '06?  
 19 DR. WILLIAMS:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. Were you aware that he had done so?  
 23 DR. WILLIAMS:  
 24 A. I'm aware now that he had done so because I  
 25 talked to Dr. Cook, but at the time I was with

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1 the organization, it was some time after I had  
 2 left that I was aware of that.  
 3 COFFEY, Q.C.:  
 4 Q. Yeah. Well, what, since you've left the  
 5 organization what did Dr. Cook tell you about  
 6 that?  
 7 DR. WILLIAMS:  
 8 A. He just told me that he talked to Dr. Ejeckam  
 9 on a number of occasions and his response  
 10 seemed to be a little different than the last  
 11 time he'd talked to him. He felt that he  
 12 didn't have the authority to recommend  
 13 anything on this.  
 14 COFFEY, Q.C.:  
 15 Q. Okay, so and so what Dr. Cook has told you  
 16 since you left Eastern Health accords with -  
 17 DR. WILLIAMS:  
 18 A. Yes, correct.  
 19 COFFEY, Q.C.:  
 20 Q. - this kind of -  
 21 DR. WILLIAMS:  
 22 A. Yes, Mr. Coffey, that's correct.  
 23 DR. WILLIAMS:  
 24 A. - the note itself?  
 25 DR. WILLIAMS:

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1 A. Yes.  
 2 COMMISSIONER:  
 3 Q. Can we go back to the one, 1397 for just a  
 4 moment? A lack of external--"Plus the fact  
 5 that they were paying for this." Does  
 6 Clarenville pay a cost to -  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 COMMISSIONER:  
 10 Q. - the General for doing -  
 11 DR. WILLIAMS:  
 12 A. Other--my understanding is -  
 13 COMMISSIONER:  
 14 Q. - these things or, for that matter, other  
 15 organizations, as well?  
 16 DR. WILLIAMS:  
 17 A. Yes. From my understanding there's certain  
 18 tests that we perform in the lab that we incur  
 19 a cost on that's not funded in our budget that  
 20 we charge other health care organizations in  
 21 the province. There's always some discussion  
 22 about that. At one stage we went to the  
 23 Department of Health to try to get a budget  
 24 adjustment so that we wouldn't have to charge  
 25 these organizations.

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1 COMMISSIONER:  
 2 Q. Um-hm.  
 3 DR. WILLIAMS:  
 4 A. But we weren't successful. It's not about the  
 5 ER and PR, it's about some other charges that  
 6 we made.  
 7 COMMISSIONER:  
 8 Q. Um-hm.  
 9 DR. WILLIAMS:  
 10 A. And we were trying to, in fact, probably in  
 11 the mid 2002, 2003 year looking at sort of  
 12 abolishing that. It was a lot--it was work  
 13 for us to do that and if we got an adjustment  
 14 from the department in our budget, then we  
 15 wouldn't have to charge these other boards.  
 16 COMMISSIONER:  
 17 Q. Well, it would just seem that the mere  
 18 paperwork of going -  
 19 DR. WILLIAMS:  
 20 A. Yes, that's right. We wanted -  
 21 COMMISSIONER:  
 22 Q. - to look for the money might -  
 23 DR. WILLIAMS:  
 24 A. Correct. We wanted to avoid all the  
 25 paperwork. Why do all this paperwork if we

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1 could just have--adjustment to our budget for  
 2 costs?  
 3 COMMISSIONER:  
 4 Q. The source of the payment, presumably comes  
 5 from the same place?  
 6 DR. WILLIAMS:  
 7 A. Yeah, because it's all the same source, that's  
 8 right. That was our concern, it's all the  
 9 same source, it's the Provincial Government  
 10 funding, so why not just get an adjustment to  
 11 our budget and then we wouldn't have to charge  
 12 for those.  
 13 COMMISSIONER:  
 14 Q. Okay.  
 15 DR. WILLIAMS:  
 16 A. But it wasn't related to this, it was related  
 17 to some other tests, as well.  
 18 COMMISSIONER:  
 19 Q. So, are there tests that you actually get  
 20 payment--that you don't get payment for from  
 21 other authorities or -  
 22 DR. WILLIAMS:  
 23 A. Yeah, there's things that historically we've  
 24 never got payment for, but some things, when  
 25 they were set up, they were set up that they

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1 would pay.  
 2 COMMISSIONER:  
 3 Q. Okay.  
 4 DR. WILLIAMS:  
 5 A. And we tried to get that abolished. Make more  
 6 sense to us just to have an adjustment to our  
 7 budget to cover that cost, and then we  
 8 wouldn't have to incur all this paperwork to  
 9 bill.  
 10 COMMISSIONER:  
 11 Q. Okay.  
 12 COFFEY, Q.C.:  
 13 Q. Commissioner, thank you. Exhibit P-0778,  
 14 please? Now, sir, a couple of e-mails, Dr.  
 15 Williams. The first of them at the bottom of  
 16 the page, page 1 of the exhibit is from Rick  
 17 Singleton, Friday, May 19th, 2006, 11:20 a.m.  
 18 to yourself, Louise Jones, Heather Predham,  
 19 Dr. Laing, Nash Denic and D. Pullman. The  
 20 subject is "Ethics consult re disclosure of  
 21 info on deceased patients." And this ethics  
 22 consult re disclosure of info on deceased  
 23 patients, did you have any part to play in  
 24 this?  
 25 DR. WILLIAMS:

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1 A. No, other than to request it. And I requested  
 2 it really probably through Louise Jones, who  
 3 was the vice president who had a lot of  
 4 experience in the whole issue of ethics. She-  
 5 -with the former Health Care Corporation she  
 6 was a lead person on that area, and so when we  
 7 moved into Eastern Health, she was the lead  
 8 person, so I contacted her. That's who I  
 9 actually asked.  
 10 COFFEY, Q.C.:  
 11 Q. And why did you ask for one?  
 12 DR. WILLIAMS:  
 13 A. Well, we had the deceased patients issue here.  
 14 We had some reports come back and that spurred  
 15 me on, Dr. Cook sent me an e-mail and that  
 16 spurred me on to ask for the ethics consult,  
 17 because we would have to deal with that group  
 18 of individuals anyway, Mr. Coffey.  
 19 COFFEY, Q.C.:  
 20 Q. If we could, please, Exhibit P-0780? Now,  
 21 this is an e-mail from Rick Singleton, Friday,  
 22 June 9th, 2006 at 9:47 a.m. It's again to the  
 23 same group of people, but as well, Bandrau?  
 24 DR. WILLIAMS:  
 25 A. Natalie Bandrau, I think.

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1 COFFEY, Q.C.:  
 2 Q. Yes. And McCarthy, Dr. McCarthy?  
 3 DR. WILLIAMS:  
 4 A. Um-hm.  
 5 COFFEY, Q.C.:  
 6 Q. And it says, "Hi, We will have to again  
 7 reschedule our meeting to discuss the  
 8 disclosure of information regarding deceased  
 9 patients. We've had difficulty getting a time  
 10 with the lawyer who has been handling the  
 11 case. He is in court almost every day this  
 12 month. We are now rescheduled to Monday, June  
 13 19th at 5 p.m. Mr. Dan Boone, the lawyer,  
 14 will join us a bit late. The new time is,"  
 15 and they set it out. "We have cancelled the  
 16 meeting previously scheduled for June 19th."  
 17 Now, sir, can you tell us, please, what at the  
 18 time you understood, as you had requested this  
 19 ethics consult, the role of Mr. Boone might  
 20 be?  
 21 DR. WILLIAMS:  
 22 A. I didn't think of what the role of Mr. Boone  
 23 might be, Mr. Coffey. I just asked for the  
 24 ethics consult and to have people who had  
 25 ethics experience review the issues and make a

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1 recommendation.  
 2 COFFEY, Q.C.:  
 3 Q. Exhibit P-0781, please?  
 4 COMMISSIONER:  
 5 Q. Just before we leave that point, did you have  
 6 any input into who was going to be a member of  
 7 the group?  
 8 DR. WILLIAMS:  
 9 A. No, I did not.  
 10 COMMISSIONER:  
 11 Q. Okay.  
 12 DR. WILLIAMS:  
 13 A. I just asked for the ethics consult to be  
 14 done.  
 15 COMMISSIONER:  
 16 Q. You just asked, I presume, you asked, as I  
 17 understood it, Ms. Jones?  
 18 DR. WILLIAMS:  
 19 A. I think I went through Ms. Jones.  
 20 COMMISSIONER:  
 21 Q. To set one up?  
 22 DR. WILLIAMS:  
 23 A. Yes.  
 24 COMMISSIONER:  
 25 Q. And did you have any--and I'm understanding

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1 you to say that the content of the--the nature  
 2 of the expertise of those involved and who was  
 3 to be involved in that consult was outside of  
 4 your control?  
 5 DR. WILLIAMS:  
 6 A. I would leave that to the people who had  
 7 experience in these things.  
 8 COMMISSIONER:  
 9 Q. Okay. Thank you.  
 10 DR. WILLIAMS:  
 11 A. I didn't have a lot of experience in the whole  
 12 issue of ethics consults. Probably the first  
 13 one I'd asked for.  
 14 COMMISSIONER:  
 15 Q. All right. Thank you.  
 16 COFFEY, Q.C.:  
 17 Q. Now, but in asking for it, I take it, you  
 18 would have understood it was coming back to  
 19 you?  
 20 DR. WILLIAMS:  
 21 A. Yes, I would receive a report, yes.  
 22 COFFEY, Q.C.:  
 23 Q. If we could, Exhibit P-0781, it's here on the  
 24 screen. It's from Rick Singleton, Tuesday,  
 25 June 20th, 2006 at 10:20 a.m. It's to

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1 yourself, Doctor, but this one is just to you,  
 2 Dr. Robert Williams. It says, "Hi, Bob,  
 3 yesterday we had the ethics consult on ER/PR.  
 4 Very good discussion and outcome. I will  
 5 forward the summary later. In the meantime,  
 6 an issue can up that I want to give you a  
 7 heads up on. Dr. Denic had a document, a  
 8 report from an external reviewer of the lab  
 9 processes, etcetera, here. He read from it  
 10 and mentioned that he would use the report as  
 11 part of information he was sharing with  
 12 others. It seems the reporter opinion had  
 13 been done for Dan Boone and he did not want  
 14 the information shared as at this time it is  
 15 privileged. Dr. Denic understood from you  
 16 that he was not to copy it, but Dan seemed to  
 17 be a bit concerns that it was being quoted,  
 18 the expert being referred to. Dan's concerns  
 19 seems to be about the privilege status of the  
 20 report which he may need in a proceeding later  
 21 on. Anyway, just thought you might want to  
 22 know there was a bit of fuss about this."  
 23 Signed, "Rick." And sir, and I think you've  
 24 written--I take it, because you use this  
 25 "KIV"?

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1 DR. WILLIAMS:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. June 28th, 2006?  
 5 DR. WILLIAMS:  
 6 A. Um-hm.  
 7 COFFEY, Q.C.:  
 8 Q. So why were you--first of all, what was your  
 9 understanding as to why this was sent to you  
 10 and what you were to do about it and why you  
 11 had it brought forward for June 28th?  
 12 DR. WILLIAMS:  
 13 A. I would have thought that if I KIVED it, it  
 14 might be for a get together I was probably  
 15 having with Dr. Denic around that time and I  
 16 was just going to bring it to his attention  
 17 that that was privileged information and it  
 18 shouldn't be used. That would be the only  
 19 thing I can think of, Mr. Coffey.  
 20 COFFEY, Q.C.:  
 21 Q. Now, is this report one of Banerjee or  
 22 Wegrynowski's reports?  
 23 DR. WILLIAMS:  
 24 A. No, it was not.  
 25 COFFEY, Q.C.:

Page 23

1 Q. Okay. Exhibit, please, P-0783? This is an e-  
 2 mail from Mr. Singleton to yourself and Louise  
 3 Jones, June 22nd, 2006 at 3:04 p.m. The  
 4 subject is "Ethics consult" it says, "Hi, Bob,  
 5 Attached is the report from the ethics consult  
 6 re ER/PR. Thanks."  
 7 DR. WILLIAMS:  
 8 A. Rick.  
 9 COFFEY, Q.C.:  
 10 Q. And we go to--this particular report is dated  
 11 June 23rd, 2006. It's to yourself from Rick  
 12 Singleton and "RE: Ethics consult, ER/PR."  
 13 And this apparently, these documents  
 14 apparently came from your office as VP  
 15 medical.  
 16 DR. WILLIAMS:  
 17 A. Um-hm.  
 18 COFFEY, Q.C.:  
 19 Q. This handwriting, is that yours?  
 20 DR. WILLIAMS:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. Okay. So you've actually spelled Dr. Natalie  
 24 -  
 25 DR. WILLIAMS:

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1 A. Bandrauk, I spelled -  
 2 COFFEY, Q.C.:  
 3 Q. - Bandrauk's name correctly.  
 4 DR. WILLIAMS:  
 5 A. Yes.  
 6 COFFEY, Q.C.:  
 7 Q. Now, sir, looking at this, they've written  
 8 here, "Important" in the third paragraph,  
 9 "Important facts to the history and understand  
 10 of this case include the following: There  
 11 were no mistakes or technical errors at the  
 12 root of this problem. It is impossible to  
 13 know in any specific case if the outcome for  
 14 any individual patient would have been  
 15 different. Intervention for post-menopausal  
 16 women had positive impact by lengthening life  
 17 in 47 percent of patients treated." Now, the  
 18 second like, what I just read to you, "There  
 19 were no mistakes or technical errors at the  
 20 root of this problem."  
 21 DR. WILLIAMS:  
 22 A. Um-hm.  
 23 COFFEY, Q.C.:  
 24 Q. When you received this in June, 2006, did you  
 25 think that that was true or accurate?

Page 25

1 DR. WILLIAMS:  
 2 A. Mr. Coffey, I didn't remember having this  
 3 report until we went back in the files. And -  
 4 COFFEY, Q.C.:  
 5 Q. I'm sorry, you didn't remember?  
 6 DR. WILLIAMS:  
 7 A. Having received this report until we were  
 8 reviewing it here for -  
 9 COFFEY, Q.C.:  
 10 Q. Oh, for the -  
 11 DR. WILLIAMS:  
 12 A. - testimony, yeah. Because I think what  
 13 happened is that I looked at the people who  
 14 were involved there, saw that we had a  
 15 recommendation and probably filed it away for  
 16 future reference, because at that time I was  
 17 still--another issue had come up with the  
 18 DCISs and the retro converters and I was  
 19 trying to work through that and would have  
 20 come back to this report when we were dealing  
 21 with the deceased. So I can't remember, Mr.  
 22 Coffey, really, twigging to that issue. But  
 23 that is an issue that needs to be clarified  
 24 with the author of the report, why that  
 25 statement was there.

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1 COFFEY, Q.C.:  
 2 Q. yes.  
 3 DR. WILLIAMS:  
 4 A. I can see that in retrospect.  
 5 COFFEY, Q.C.:  
 6 Q. Because from your perspective, I take it,  
 7 that's not accurate, is it, based upon what  
 8 you -  
 9 DR. WILLIAMS:  
 10 A. The way it's, the way it's worded there. I'd  
 11 have to see what the context was and how the  
 12 person who authored it explained it, but the  
 13 people around the table would have all the  
 14 information on what particularly happened. We  
 15 had our oncologists and our laboratory  
 16 personnel, they would have the background  
 17 information and Dr. Bandrauk and Mr. Singleton  
 18 would be able to provide the ethical input  
 19 into the decision making process.  
 20 COFFEY, Q.C.:  
 21 Q. Based upon what Dr. Banerjee and Trish  
 22 Wegrynowski had told you in the reports in the  
 23 fall of 2005, though, you would not at the  
 24 time have said, in June of '06, that there  
 25 were no mistakes or technical errors at the

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1 root of this problem?  
 2 DR. WILLIAMS:  
 3 A. No, we didn't get the right results, so there  
 4 had to be something at the root of the  
 5 problem.  
 6 COFFEY, Q.C.:  
 7 Q. Sure.  
 8 DR. WILLIAMS:  
 9 A. But you'd have to ask the author specifically  
 10 what that statement means and what context  
 11 it's said in.  
 12 COFFEY, Q.C.:  
 13 Q. Here Mr. Singleton has couched this in terms  
 14 of "Important facts to the history and  
 15 understanding," I presume he should have  
 16 written the word "understanding" "of this case  
 17 include the following". And the first of them  
 18 is "There are no mistakes or technical  
 19 errors."  
 20 DR. WILLIAMS:  
 21 A. Um-hm.  
 22 COFFEY, Q.C.:  
 23 Q. At the time did it occur to you that that's--  
 24 your understanding at the time would be that  
 25 would not be accurate, based upon what you

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1 knew, that that might effect the outcome, the  
 2 ethical outcome?  
 3 DR. WILLIAMS:  
 4 A. It may now, in retrospect, yeah. Like I say,  
 5 when I reviewed it, I think I just went and  
 6 looked at the people who were there and went  
 7 right to the recommendations, realized that we  
 8 had recommendations to deal with this and  
 9 filed it until we got to the issue, because we  
 10 had a lot of issues that we still had to  
 11 straighten up at the time, that I had to  
 12 follow up in detail.  
 13 COFFEY, Q.C.:  
 14 Q. If we could--so you just took it, looked at  
 15 who was there, changed Dr. Bandrauk's name.  
 16 DR. WILLIAMS:  
 17 A. Yeah.  
 18 COFFEY, Q.C.:  
 19 Q. And filed it away for future reference?  
 20 DR. WILLIAMS:  
 21 A. Yes, so that when we dealt with the issue,  
 22 when we had--we really had a lot of issues  
 23 that arose as a result of this review that  
 24 weren't related to ER and PR, but had a lot of  
 25 issues, had some significance that had to be

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1 worked through and had some serious, potential  
 2 serious impact that I wanted to make sure that  
 3 we dealt with first.  
 4 COFFEY, Q.C.:  
 5 Q. On that point, Exhibit P-0411 please? So  
 6 Doctor, this is a memo dated July 4, 2006.  
 7 The subject is estrogen progesterone receptor  
 8 testing DCIS and retro converters. It's  
 9 addressed to yourself, Mr. Tilley, Ms. Pilgrim  
 10 and Ms. Elliott. It's from Heather Predham  
 11 and she says "I need to bring your attention  
 12 to two situations that have developed during  
 13 our ER/PR review. One is ductal carcinoma in  
 14 situ," and if I could, I'm just going to--and  
 15 two is retro converters, and now sir, I take  
 16 it then that--were you aware of the DCIS and  
 17 retro converter issue before you got this  
 18 memo, July 4th? Would you have been aware of  
 19 that?  
 20 DR. WILLIAMS:  
 21 A. I may have been, yes. I'd have to go back in  
 22 the documents, but I may have been aware of  
 23 that. What's the date on that?  
 24 COFFEY, Q.C.:  
 25 Q. This is July 4th, 2006.

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1 DR. WILLIAMS:  
 2 A. I think I may have been. I think I was aware  
 3 of that before.  
 4 COFFEY, Q.C.:  
 5 Q. And could you tell the Commissioner, you  
 6 indicated this was a new issue that had come  
 7 up.  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. Tell her, from your perspective as VP Medical,  
 12 how the issue presented to you and what you  
 13 did about it.  
 14 DR. WILLIAMS:  
 15 A. Yes. Well, ductal carcinoma in situ really  
 16 means that the tumour cells--the duct is like  
 17 a pipe and outside, on the outside lining of a  
 18 pipe there's a membrane in the ducts of the  
 19 breast. The ductal carcinoma in situ would be  
 20 a tumour that's confined to the duct. It  
 21 doesn't invade through the membrane. And then  
 22 there's ductal carcinoma in situ with minimal  
 23 invasive and then of course, there's invasive  
 24 breast cancer when it goes beyond. There's  
 25 two schools of thought, and I'm not sure if

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1 that's been resolved as yet. Some individuals  
 2 test people with ductal carcinoma in situ and  
 3 other individuals don't test people with  
 4 ductal carcinoma in situ.  
 5 THE COMMISSIONER:  
 6 Q. Test for ER/PR?  
 7 DR. WILLIAMS:  
 8 A. For ER/PR, yes, receptors. I don't know if  
 9 those two schools of thought have been  
 10 resolved as yet in the oncology and pathology  
 11 community. The issue is if somebody had--was  
 12 thought to have ductal carcinoma in situ,  
 13 that's one thing. But if they were sent in  
 14 for ER and PR testing because a pathologist  
 15 had interpreted they weren't ductal carcinoma  
 16 in situ but minimally invasive or invasive  
 17 breast cancer, then that would entail a  
 18 different course of treatment than just ductal  
 19 carcinoma in situ, a more aggressive type of  
 20 treatment with chemotherapy, this type of  
 21 thing.  
 22 THE COMMISSIONER:  
 23 Q. Wait now. Are you suggesting that because you  
 24 did the ER/PR testing with DCIS -  
 25 DR. WILLIAMS:

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1 A. That some of the -  
 2 THE COMMISSIONER:  
 3 Q. - that might result in more invasive--more  
 4 treatment than had traditionally been used for  
 5 DCIS?  
 6 DR. WILLIAMS:  
 7 A. No, I'm sorry, Commissioner. What I meant to  
 8 say is that--what I'm trying to get across is  
 9 that if somebody sent in a case to be tested  
 10 for ER and PR, they may have thought that it  
 11 was an invasive breast cancer, and if it  
 12 turned out to be ductal carcinoma in situ,  
 13 then that person would have got a more  
 14 aggressive treatment than they needed.  
 15 THE COMMISSIONER:  
 16 Q. Yes, yes. Oh, okay.  
 17 DR. WILLIAMS:  
 18 A. So it was important that every case of ductal  
 19 carcinoma in situ be thoroughly reviewed and  
 20 what we did set in place, I think, was Dr.  
 21 Cook and Dr. Carter as a panel of pathologists  
 22 would review each case. Some of these cases  
 23 were from outside our region, so I think if  
 24 you go through the notes that I took at the  
 25 time, I did contact Dr. Alteen and Dr. Jenkins



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1 because some of those cases were from their  
 2 regions and I wanted to make sure that those  
 3 cases were followed up and did they want our  
 4 pathologists to do the panelling or were they  
 5 going to have their pathologists in Corner  
 6 Brook and Grand Falls do the panelling.  
 7 THE COMMISSIONER:  
 8 Q. Okay, just to make sure I know the substance  
 9 of what you're saying. The concern was that  
 10 if you discovered during the retesting that a  
 11 diagnosis which had hitherto thought to be  
 12 applicable to somebody -  
 13 DR. WILLIAMS:  
 14 A. Yes.  
 15 THE COMMISSIONER:  
 16 Q. - and turned out in fact to be DCIS, then the  
 17 question was whether or not these individuals  
 18 would have received treatment which, in the  
 19 normal course of treatment of DCIS, would not  
 20 have been offered?  
 21 DR. WILLIAMS:  
 22 A. Correct.  
 23 THE COMMISSIONER:  
 24 Q. Okay, and you may--as I understand it, you  
 25 wanted all those particular persons to be

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1 reviewed in light of that?  
 2 DR. WILLIAMS:  
 3 A. Yes.  
 4 THE COMMISSIONER:  
 5 Q. Okay.  
 6 COFFEY, Q.C.:  
 7 Q. And Doctor, do you recall how many were  
 8 thought to fall into this category, at least  
 9 initially?  
 10 DR. WILLIAMS:  
 11 A. Oh initially, I think there was around 50, Mr.  
 12 Coffey, something--a fairly large number.  
 13 COFFEY, Q.C.:  
 14 Q. Approximately 50 or so?  
 15 DR. WILLIAMS:  
 16 A. Yes, that's my understanding. I have to go  
 17 back and look through notes, but there was a  
 18 fairly large number which was pretty worrisome  
 19 at the time.  
 20 COFFEY, Q.C.:  
 21 Q. And as time went on then, this was handled by  
 22 having each of those cases looked at?  
 23 DR. WILLIAMS:  
 24 A. Thoroughly reviewed by a panel, you know, Dr.  
 25 Carter who would have the expertise and Dr.

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1 Cook, to give a second opinion, and we also  
 2 contacted--I think my notes show that we  
 3 contacted Dr. Alteen and Dr. Jenkins, the  
 4 medical directors in Western and Central, to  
 5 ask them how they wanted to handle the cases  
 6 from those areas.  
 7 COFFEY, Q.C.:  
 8 Q. To assist you in that regard, and I won't  
 9 forget the retro converters, I'll come back to  
 10 that, Exhibit P-1378 please? It's a couple of  
 11 e-mails of July 11th and 12th 2006, July 10th  
 12 in fact, all the way back actually to July  
 13 9th. There's an e-mail from Heather Predham  
 14 to Lorraine Woolgar and then from Lorraine  
 15 Woolgar to Ken Jenkins on July 10th, 2006,  
 16 10:40 a.m. "Please see attached from Heather  
 17 Predham," and then there's an e-mail from Ken  
 18 Jenkins to Dr. Paul Neil. He says "Hi, Paul.  
 19 Could you please provide your recommendation?  
 20 Thanks, Ken" and then from Paul Neil, July  
 21 11th 2006, 11:26 a.m. to Ken Jenkins. He says  
 22 "Ken, I have no problem with Eastern doing  
 23 this. However, I would like Western to have  
 24 the opportunity to review as well. I am  
 25 unclear as to what the problem really entails.

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1 If Mount Sinai says DCIS, they may only have  
 2 reviewed the slide in block we sent them.  
 3 There may indeed be only DCIS left on the  
 4 slide, but other blocks they did not review  
 5 may show invasive. Only review of the entire  
 6 case would show this. Therefore, I would like  
 7 to have the original pathology reviewed here  
 8 as well. Thanks, Paul."  
 9 So does that kind of fairly summarize, in  
 10 fact, how the 50 cases were gone through?  
 11 DR. WILLIAMS:  
 12 A. Yes, because, you know, he's right there. On  
 13 one section, you might have the tumour  
 14 confined to the duct, but in another section,  
 15 you might have it invasive. So yes, they  
 16 would need to be involved. I can't remember  
 17 this last e-mail. It's not in my package, but  
 18 I'm pretty sure I talked to Dr. Jenkins and  
 19 Dr. Alteen and to make them aware that this  
 20 was an issue and to make sure that they had it  
 21 followed up properly in their regions.  
 22 COFFEY, Q.C.:  
 23 Q. If we could, please, Exhibit P-1380? Now this  
 24 is a letter of July 14th 2006 addressed to  
 25 Doctors Cook and Carter. It's from yourself,

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1 and you say "as a result of the ongoing  
 2 quality review process, could you please  
 3 review the following cases?" and there are a  
 4 number of them.  
 5 DR. WILLIAMS:  
 6 A. Um-hm.  
 7 COFFEY, Q.C.:  
 8 Q. Do you recall what this was about?  
 9 DR. WILLIAMS:  
 10 A. No, I looked at my file and I don't know why I  
 11 would ask Heather that question, and then if  
 12 you look over three or four more days, there's  
 13 a letter signed by me to them saying there's a  
 14 number of patients that needed a review.  
 15 Could you please make sure that that's done,  
 16 and the reports put in their file?  
 17 COFFEY, Q.C.:  
 18 Q. What does your handwriting there say?  
 19 DR. WILLIAMS:  
 20 A. "Heather, any problems with me signing this."  
 21 That's all. I don't know why I would ask her  
 22 that question.  
 23 COFFEY, Q.C.:  
 24 Q. Okay, and -  
 25 DR. WILLIAMS:

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1 A. But when you look farther along, a week or so  
 2 later, or ten days later, there is a letter  
 3 from me to Dr. Cook or Dr. Carter sort of  
 4 encompassing that, and I think that's how I  
 5 handled it, but I can't be sure why I would  
 6 have asked why I should sign it or not sign  
 7 it.  
 8 COFFEY, Q.C.:  
 9 Q. Oh, no, I understand that, Doctor. I'm just -  
 10 DR. WILLIAMS:  
 11 A. I can't remember that.  
 12 COFFEY, Q.C.:  
 13 Q. But do you recall what the subject matter of  
 14 the--like why you were looking for these to be  
 15 looked at at all?  
 16 DR. WILLIAMS:  
 17 A. Because Mount Sinai raised an issue.  
 18 COFFEY, Q.C.:  
 19 Q. Oh, this is--and that's what I'm getting at.  
 20 DR. WILLIAMS:  
 21 A. This is these cases.  
 22 COFFEY, Q.C.:  
 23 Q. Oh, okay, that's what I was asking about,  
 24 Doctor. Okay.  
 25 DR. WILLIAMS:

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1 A. These are to do with the DCIS type of thing.  
 2 COFFEY, Q.C.:  
 3 Q. And these would be, I take it, the local DCIS?  
 4 DR. WILLIAMS:  
 5 A. I would say they were, yes.  
 6 COFFEY, Q.C.:  
 7 Q. And as the e-mail we just looked at, for  
 8 example, Dr. Jenkins is on the west coast of  
 9 Newfoundland?  
 10 DR. WILLIAMS:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. And Dr. Neil, they would have wanted to look  
 14 at DCIS from their area?  
 15 DR. WILLIAMS:  
 16 A. Yes, that was--Paul Neil was chief of  
 17 pathology at Western and Ken Jenkins was my  
 18 counterpart, and in Central Newfoundland, it  
 19 was Dr. Alteen, my counterpart, and Dr.  
 20 Maurice Dalton, who was Dr. Cook's  
 21 counterpart.  
 22 COFFEY, Q.C.:  
 23 Q. And I take it a similar arrangement was made  
 24 with Central Newfoundland as well, in terms of  
 25 the review of the DCIS?

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1 DR. WILLIAMS:  
 2 A. Yes. I phoned Dr. Alteen, and my notes say  
 3 that I did, and I phoned Dr. Jenkins. Now I  
 4 don't have a follow-up e-mail on that. My  
 5 last recollection of this was about an August  
 6 15th note that I had on discussion with Dr.  
 7 Denic. I know that because I was looking at  
 8 it in preparation for the hearings, and  
 9 there's a whole list of individuals there. I  
 10 went down through them one by one, I think,  
 11 with Dr. Denic to make sure that things were  
 12 under control. I wanted to make sure before  
 13 Dr. Howell got there that this issue had been  
 14 dealt with. That's my recollection.  
 15 COFFEY, Q.C.:  
 16 Q. Okay, and this really occupied, I take it,  
 17 when we look at the materials, a fair amount  
 18 of your attention, probably in June when it  
 19 first verbally came to your attention and then  
 20 through July, into August, trying to see -  
 21 DR. WILLIAMS:  
 22 A. Yes.  
 23 COFFEY, Q.C.:  
 24 Q. - how many of this approximately 50 were in  
 25 fact originally truly DCIS?

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1 DR. WILLIAMS:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. And do you recall how many it ended up being  
 5 reduced to?  
 6 DR. WILLIAMS:  
 7 A. I know there was three in Eastern and all  
 8 those three people were notified personally  
 9 with a--a meeting was held, I think, between  
 10 an oncologist, Dr. Denic who was clinical  
 11 chief at the time, and probably Heather  
 12 Predham from quality. There was three people  
 13 met with each patient. That's my  
 14 recollection, and there was three from our  
 15 region and all three were met with. That's my  
 16 understanding.  
 17 COFFEY, Q.C.:  
 18 Q. If we could then, P-0411? No, the next page  
 19 please. The retro converters, because we were  
 20 dealing first of all with the DCIS. Perhaps  
 21 you could tell the Commissioner again what the  
 22 retro converters, from your perspective,  
 23 represented and how it was dealt with?  
 24 DR. WILLIAMS:  
 25 A. These were individuals who would have, to some

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1 level, had some positivity interpreted for ER  
 2 and PR, but when they were retested at Mount  
 3 Sinai, the test came back negative. My  
 4 understanding of these retro converters was  
 5 that these were individuals who, on reading  
 6 the slides, the pathologist read background  
 7 staining and interpreted that as positive.  
 8 That was my understanding.  
 9 COFFEY, Q.C.:  
 10 Q. Okay, you would have gotten that from whom?  
 11 DR. WILLIAMS:  
 12 A. Probably Dr. Denic at the time or Dr. Carter,  
 13 I'm not sure. I know I was at meetings at St.  
 14 Clare's, one meeting to discuss retro  
 15 converters and DCIS with Dr. Carter and Dr.  
 16 Denic, Ms. Predham, Ms. Elliott, myself and  
 17 probably Dr. Cook at the time.  
 18 COFFEY, Q.C.:  
 19 Q. So they explained to you that the original  
 20 readings for these retro--what are now retro  
 21 converters, looking at the original slides -  
 22 DR. WILLIAMS:  
 23 A. That's my understanding of it.  
 24 COFFEY, Q.C.:  
 25 Q. - that they told you it was probably

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1 background staining that was misinterpreted?  
 2 DR. WILLIAMS:  
 3 A. Yes, that's my understanding. I tried to find  
 4 out if there's such a thing as a false  
 5 positive where there's nuclear staining and  
 6 even when the--prior to this when the Ventana  
 7 chief scientific officer--sometime in the  
 8 spring of 2006, Ventana came up with some of  
 9 their senior people from Arizona to present  
 10 the new VIA system to us, which was a  
 11 computerized technique which could scan slides  
 12 for ER and PR, and the computer then would  
 13 interpret what degree of positivity was in  
 14 those slides. It would be another recheck on  
 15 a eyeball view by the pathologist.  
 16 COFFEY, Q.C.:  
 17 Q. It's a visual imager?  
 18 DR. WILLIAMS:  
 19 A. Yes, and I remember asking their chief  
 20 scientific officer, their Ph.D. person, the  
 21 question, you know, and the answer I got was  
 22 pretty well not possible, and I didn't get a  
 23 good explanation how it could ever happen  
 24 really.  
 25 COFFEY, Q.C.:

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1 Q. How a false positive could occur?  
 2 DR. WILLIAMS:  
 3 A. You could get actually nuclear staining.  
 4 COFFEY, Q.C.:  
 5 Q. But in terms of -  
 6 DR. WILLIAMS:  
 7 A. But I stand to be corrected. Somebody else  
 8 might be able to--whose an expert, might be  
 9 able to answer that question.  
 10 COFFEY, Q.C.:  
 11 Q. And I appreciate that. I'm asking you simply  
 12 from the perspective of what you, as VP  
 13 Medical, what occurred to you and what  
 14 inquiries you made, and you're telling us  
 15 that.  
 16 DR. WILLIAMS:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. But in terms of the retro converters referred  
 20 to here in 0411, they were explained to you,  
 21 as you recall, by your local, some of your  
 22 local pathologists as probably  
 23 misinterpretation of background staining?  
 24 DR. WILLIAMS:  
 25 A. That's my understanding. You'd have to ask

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1 those people if that was their explanation to  
 2 me or if I got it wrong.  
 3 COFFEY, Q.C.:  
 4 Q. If we could, please--so what was done with  
 5 them then?  
 6 DR. WILLIAMS:  
 7 A. There was four, my understanding. Two from  
 8 outside our region and two from within our  
 9 region. They would have been notified. One,  
 10 I'm not sure--Heather was having difficulty.  
 11 One patient went back quite a number of years  
 12 and was having difficulty tracking that  
 13 patient down. I can't tell you specifically  
 14 what the other regions did, but I did contact  
 15 the medical directors and asked them to follow  
 16 up on that. One, I know one was contacted and  
 17 one was, when I left, was probably still in  
 18 the process of being contacted. That's my  
 19 understanding, Mr. Coffey.  
 20 COFFEY, Q.C.:  
 21 Q. If we could, please, Exhibit P--while I'm at  
 22 it, and in terms of the contact, it was made  
 23 by, your understanding, by what sorts of  
 24 individuals?  
 25 DR. WILLIAMS:

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1 A. I'm not sure on that.  
 2 COFFEY, Q.C.:  
 3 Q. Okay.  
 4 DR. WILLIAMS:  
 5 A. I know well how the contact was made for the  
 6 DCIS, but I would expect for the retro  
 7 converters, it probably would involve a  
 8 physician contact, because there would need to  
 9 be an explanation.  
 10 COFFEY, Q.C.:  
 11 Q. If we could, please, Exhibit P-0413? This is  
 12 a letter from Dr. Joy McCarthy and Dr.  
 13 Beverley Carter, co-chairs of the Breast  
 14 Disease Site Group. It's carboned to a number  
 15 of people, including Dr. Laing, George Tilley,  
 16 Sharon Smith and Ms. Pilgrim, but it's  
 17 addressed to yourself as VP Medical Services  
 18 and it says "at a recent ad-hoc meeting, great  
 19 enthusiasm is expressed by many specialty  
 20 groups for creating a Breast Disease Site  
 21 Group at Eastern Health. As you recall, the  
 22 impetus for this came from your office as a  
 23 result of multiple meetings concerning ER and  
 24 PR laboratory testing and the care of patients  
 25 with breast cancer in this province. Please

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1 see attached proposal for the development and  
 2 staffing needs for the BDSG. We look forward  
 3 to your prompt reply and are available for a  
 4 meeting at your convenience."  
 5 The doctors' assertion there that the  
 6 impetus came from your office, is that  
 7 correct?  
 8 DR. WILLIAMS:  
 9 A. I certainly supported it.  
 10 COFFEY, Q.C.:  
 11 Q. Okay.  
 12 DR. WILLIAMS:  
 13 A. Now I don't see any paper trail as to what I  
 14 did when I got this, but I certainly would  
 15 have supported it and tried to get resource  
 16 for it. I thought it was actually working or  
 17 had been set up.  
 18 COFFEY, Q.C.:  
 19 Q. To actually implement it?  
 20 DR. WILLIAMS:  
 21 A. Yes, I would have supported implementing it,  
 22 Mr. Coffey, but I can't find, in the  
 23 documentation, what I would have done about  
 24 it, but I certainly would have supported it,  
 25 because it made a lot of sense to get together

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1 people from oncology and pathology around that  
 2 particular diagnosis and disease, develop some  
 3 expertise, exchange information. Hopefully  
 4 that would result in a better quality of care.  
 5 COFFEY, Q.C.:  
 6 Q. And if we could, please, Exhibit P-1377? Now  
 7 this is an e-mail--I'm sorry, a memo to  
 8 yourself from Heather Predham dated July 10th  
 9 '06. It relates to DCIS and retro converters.  
 10 "The following information is a follow-up to  
 11 my briefing note of July 4th 2006," which I  
 12 presume is that one we looked at earlier this  
 13 morning, and it again deals with DCIS and  
 14 retro converters. So here, I gather, Ms.  
 15 Predham is reporting to you on the status of  
 16 the handling of those?  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. And in terms of dealing with the DCIS issue  
 21 and the retro converters issue, from the  
 22 medical end of Eastern Health, were you  
 23 responsible for managing it over all?  
 24 DR. WILLIAMS:  
 25 A. I wanted to make sure it was done. That's why

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1 I spent a lot of time and my notes, again,  
 2 when I signed off on it, I think it's August  
 3 15th or some time around August with Dr.  
 4 Denic, that it was--my understanding was that  
 5 there was one retro converter that they had  
 6 difficulty contacting.  
 7 COFFEY, Q.C.:

8 Q. Sure. Exhibit P-0415 please? Now this is a  
 9 letter of July 19th, 2006 from yourself and  
 10 it's carboned to a number of individuals,  
 11 including Dr. Denic and Mr. Gulliver, Ms.  
 12 Predham, Ms. Elliott. But it's addressed to  
 13 Mr. Tilley and it says, "I am writing  
 14 concerning the national issue we have been  
 15 advocating for concerning setting up a  
 16 reference lab for laboratories that do ER and  
 17 PR testing in the country. I've attached a  
 18 proposal from a group called the Canadian  
 19 Coalition for Quality and Laboratory Medicine  
 20 with a proposal with respect to  
 21 immunohistochemistry. Their proposal deals  
 22 with Class I tests, which does not include the  
 23 important ER & PR component." And you go on  
 24 to say, "Dr. Cook advises that at the weekend  
 25 meeting of the Canadian Association of

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1 Pathologists held in St. John's this matter  
 2 was discussed on their agenda. The Canadian  
 3 Association of Pathologists, through their  
 4 president, Dr. Diponkar Banerjee, will be  
 5 writing the Canadian Coalition for Quality in  
 6 Laboratory Medicine supporting the"--should be  
 7 "thrust", I presume,--"of their initiative,  
 8 but recommending that Class II tests also be  
 9 included in their proposal." And he goes on  
 10 to describe what else Dr. Banerjee was going  
 11 to do, and you conclude by saying, "This is  
 12 good news and, hopefully, this will lead to  
 13 national standardization and assurance that  
 14 labs testing in this area would be part of a  
 15 national quality assurance program." If I  
 16 could, please, this I take it, page two is  
 17 some e-mails from Don Cook to yourself, July  
 18 12, 2006. Subject is "QC for  
 19 Immunoperoxidase" and he's forwarding an e-  
 20 mail from--do you know the doctor's name,  
 21 Laurette Geldenhuys?  
 22 DR. WILLIAMS:  
 23 A. I only would have seen it on the--I don't know  
 24 who she would be.  
 25 COFFEY, Q.C.:

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1 Q. And, but she is described as being an  
 2 anatomical pathologists from QEII Health  
 3 Sciences Centre in Halifax. And she says, "I  
 4 received this documents from Ermina  
 5 Torlakovic. Since we discussed this issue at  
 6 an executive meeting recently, I thought you  
 7 might find these interesting. I attach."  
 8 Now, Doctor, at this point in time, which is  
 9 the summer of '06, what is your involvement at  
 10 this point in this whole area in terms of what  
 11 were you hoping to accomplish?  
 12 DR. WILLIAMS:  
 13 A. Well I guess when you have a problem, a major  
 14 problem like this, you read the literature and  
 15 a lot of issues in Europe had been discussed,  
 16 they seem to be ahead of North America in  
 17 Europe, in terms of standardizing these tests,  
 18 getting some quality assurance--external  
 19 quality assurance programs in place. In the  
 20 U.S. and Canada, that activity didn't seem to  
 21 have taken place, right from, I guess, early  
 22 on in this we were trying to stimulate  
 23 something at a national level to ensure that  
 24 something like this was in place, because we  
 25 really were trying to prevent issues like this

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1 from continuing to happen or happen at all.  
 2 So the reason I wrote Mr. Tilley was I was  
 3 showing him that some, in fact, progress  
 4 seemed to be being made and I also, I think,  
 5 talked to Dr. Dawe at the time about this and  
 6 I probably would have sent him a copy of this,  
 7 I would think I was (sic.) because Mr. Dawe  
 8 was, maybe by this time, through the Canadian  
 9 Cancer Society, was their liaison person that  
 10 was going to be working on this or having some  
 11 input into this as they develop their national  
 12 cancer strategy, if I'm correct on that.  
 13 COFFEY, Q.C.:

14 Q. Okay.  
 15 DR. WILLIAMS:  
 16 A. Now I notice in the weekend paper this whole  
 17 issue in the Globe and Mail on Saturday has  
 18 surfaced again with the same players involved,  
 19 Dr. Torlakovic has been involved in that  
 20 particular article and there's been some  
 21 working going on at British Columbia and in  
 22 Saskatchewan and they've developed a  
 23 computerized, I guess mail-out that people can  
 24 complete and then send back and get their labs  
 25 rated, so I think they've made some progress

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1 in the, almost two years that this has  
 2 happened.  
 3 COFFEY, Q.C.:  
 4 Q. And you say the weekend paper, you mean  
 5 literally like Saturday's paper past?  
 6 DR. WILLIAMS:  
 7 A. Saturday's Globe and Mail, there's a big  
 8 article, full-page article on this.  
 9 COFFEY, Q.C.:  
 10 Q. And Doctor, if I could please, exhibit P-0370?  
 11 Now this is an e-mail of August 7th, 2006,  
 12 it's to a number of--it's from Susan Bonnell,  
 13 11:19 a.m. to Ms. Pilgrim, Ms. Smith, Ms.  
 14 Predham and yourself. Subject is  
 15 "Communication with Family Physicians." And  
 16 she writes, "Just to follow up on our  
 17 conversation this morning, I just spoke with  
 18 Lynn Barter, Communications Director with the  
 19 NLMA. She is going to speak with the head of  
 20 their GPs group, re communicating with family  
 21 physicians. She agrees with me that the  
 22 messages have really gotten mixed in general  
 23 conversation and suspects that many family  
 24 doctors may be hearing from their patients.  
 25 She'll let us know if this is accurate. In

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1 the meantime, they will help us communicate  
 2 with the GPs via letter when we are ready. It  
 3 will be excellent if we were in a position to  
 4 communicate where we are in the review process  
 5 and to clarify what the process was about.  
 6 Some of the results we are finding, generally  
 7 speaking, and to address what we are doing as  
 8 an organization to ensure quality  
 9 control/confidence in the system. If you  
 10 would like to get together in the next couple  
 11 of days to strategize re: ways to reach the  
 12 various groups, let us know. I am very  
 13 nervous about doing any disclosures this week,  
 14 the timing is very bad, especially given that  
 15 we do not have a spokesperson to address this.  
 16 For your information, Mark Quinn has made  
 17 contact with us this morning. Mark is the CBC  
 18 report who we did the Freedom of Information  
 19 on ER/PR for and Leona had discussed with him  
 20 setting up a briefing with our key players. I  
 21 suspect he's looking for this now. We'll let  
 22 you know." Now, Doctor, beginning of August,  
 23 2006, having received that e-mail from Ms.  
 24 Bonnell, what was your view as the VP Medical  
 25 of Eastern Health concerning the apparent

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1 awareness amongst physicians throughout the  
 2 province concerning this matter?  
 3 DR. WILLIAMS:  
 4 A. I really can't remember--I was out of the  
 5 office, I think, the first two weeks of  
 6 August, so I don't remember having any  
 7 discussion about this e-mail. We may well  
 8 have had discussion about it, but I can't  
 9 remember, Mr. Coffey. And I don't remember  
 10 having any discussion with the NLMA around  
 11 that time about a letter, but I may have, it  
 12 doesn't appear in any of my documents.  
 13 COFFEY, Q.C.:  
 14 Q. Now, Doctor, this suggests, if we look at the  
 15 media coverage, really beginning, you know,  
 16 towards Christmas and before Christmas of '05  
 17 and continuing on through '06 of this issue,  
 18 there are a number--the media reported on a  
 19 number of concerns expressed by Mr. Dawe and  
 20 others, concerning a lack of communication by  
 21 Eastern Health on the issue?  
 22 DR. WILLIAMS:  
 23 A. Uh-hm.  
 24 COFFEY, Q.C.:  
 25 Q. And now, August 7th, there's an e-mail

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1 referencing a similar expression of concern by  
 2 the NLMA's communication director.  
 3 DR. WILLIAMS:  
 4 A. Uh-hm.  
 5 COFFEY, Q.C.:  
 6 Q. Now, as the VP Medical going through the  
 7 summer of '06 and into the fall of '06, were  
 8 you concerned at all, I mean, by that state of  
 9 affairs?  
 10 DR. WILLIAMS:  
 11 A. I'm not--Mr. Coffey, to be honest, I can't,  
 12 you know, if I could tell you what discussion  
 13 we had after that, I would, but I can't  
 14 remember what discussion we had. I would have  
 15 gotten back in the office around the middle of  
 16 August, I think, because I was off for a  
 17 couple of weeks and then I would have finished  
 18 up at the end of August, would have taken the  
 19 first week of September off when Dr. Howell  
 20 came on board and then would have come back  
 21 for the last three weeks of September,  
 22 focusing then on really the medical staff  
 23 bylaws and a few other things that I had on  
 24 the agenda.  
 25 COFFEY, Q.C.:

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1 Q. Now, sir, -  
 2 THE COMMISSIONER:  
 3 Q. Dr. Howell came in on the 1st of September?  
 4 DR. WILLIAMS:  
 5 A. Yes, he came the day after Labour Day.  
 6 THE COMMISSIONER:  
 7 Q. Or whatever the day it was. And when he came  
 8 in, I know you were there for a few weeks  
 9 thereafter, but did Dr. Howell sort of take  
 10 over the position immediately and you were  
 11 there if he wanted to call you? Is that the  
 12 arrangement? How did that work?  
 13 DR. WILLIAMS:  
 14 A. Yes, he took over the position the day he came  
 15 in. I stayed out of it for four days, I took  
 16 those four days off after Labour Day, just to  
 17 give him a chance to get, you know, because I  
 18 didn't have an office, to get them to find me  
 19 a space to go and then I was available to him  
 20 for briefing and a couple of other things and  
 21 my main task, pretty well fulltime, was to try  
 22 to develop a set of medical staff bylaws for  
 23 Eastern Health in conformity to what we were  
 24 trying to do at Eastern Health and what we'd--  
 25 plans we made and discussions we had with the

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1 six or seven organizations that made up  
 2 Eastern Health, from a medical perspective,  
 3 and then trying to meld that with the  
 4 requirements from the Department of Health, in  
 5 terms of what they wanted in the medical staff  
 6 bylaws with respect to Saskatchewan and a few  
 7 things like that. All the while this was  
 8 going on, there would be--I had some  
 9 discussions with Dr. Howell I think over the  
 10 summer, he came in a couple of times just to  
 11 get briefed on some things that were going on,  
 12 and then I was available--there was a list of  
 13 major issues that I wanted to brief him on, so  
 14 I was available to brief him on those during  
 15 that timeframe.  
 16 COFFEY, Q.C.:  
 17 Q. Now, Doctor, there are a couple of--if I  
 18 could, again exhibit P-1081? And just to help  
 19 the Commissioner put this in perspective, this  
 20 is an e-mail of Friday, January 20th, '06,  
 21 11:01 from Dr. Cook to yourself, ER/PR cases  
 22 from St. Anthony and he writes, "Hi, Bob. This  
 23 is to let you know that we have received an  
 24 additional 25 cases from St. Anthony intended  
 25 for review at Mount Sinai. This time delay is

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1 completely unacceptable. I will have to  
 2 contact Mount Sinai to see if they can handle  
 3 these cases, after I indicated that we send up  
 4 all cases." Signed Don. Now what was this  
 5 about?  
 6 DR. WILLIAMS:  
 7 A. They come out of a number of other cases when  
 8 they reviewed their files, that's my  
 9 understanding. And we sent them up to Mount  
 10 Sinai and they completed them pretty well  
 11 expeditiously because it was only a small  
 12 number. That's my understanding and they got  
 13 panelled with the patients, other patients  
 14 that got panelled. So in essence, there  
 15 wasn't, I think at the end of the day any  
 16 delay in terms of getting them panelled. They  
 17 would have been put with the panelling that  
 18 was done--that's my understanding anyway, they  
 19 got expedited on an judicious basis because  
 20 there was so many--to help us tidy things up,  
 21 I think that they were done.  
 22 COFFEY, Q.C.:  
 23 Q. Sir, if I could, please, exhibit P-1108? I  
 24 take it these are handwritten notes of yours?  
 25 Just scroll ahead, would that be correct?

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1 DR. WILLIAMS:  
 2 A. That's my writing, yes, I haven't looked at  
 3 this lately.  
 4 COFFEY, Q.C.:  
 5 Q. Okay, and in terms of a date, there's a  
 6 reference here to Dr. Allan Gown, 27th of  
 7 February, so that might help put it in some  
 8 kind of temporal perspective for you.  
 9 DR. WILLIAMS:  
 10 A. That's not my writing--that's my writing on  
 11 top, it's not my writing there.  
 12 COFFEY, Q.C.:  
 13 Q. No, this is not.  
 14 DR. WILLIAMS:  
 15 A. No.  
 16 COFFEY, Q.C.:  
 17 Q. That is, the reference here?  
 18 DR. WILLIAMS:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Okay.  
 22 THE COMMISSIONER:  
 23 Q. I'm sorry, just to make sure I'm clear, are  
 24 you saying the list of regions and results and  
 25 things like that is not your handwriting?

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1 DR. WILLIAMS:  
 2 A. That's not my handwriting, no.  
 3 THE COMMISSIONER:  
 4 Q. What is your writing is just the notation on  
 5 the top of it, with the date.  
 6 DR. WILLIAMS:  
 7 A. Yes, and some stuff on the back -  
 8 THE COMMISSIONER:  
 9 Q. All right, thank you. And the writing on the  
 10 bottom, is that yours?  
 11 DR. WILLIAMS:  
 12 A. Is that comparing names to what we have  
 13 received. See at that stage we were comparing  
 14 names sent out to what we had received taken  
 15 out of lists of results we have already  
 16 received and acted upon.  
 17 COFFEY, Q.C.:  
 18 Q. So is that your handwriting?  
 19 DR. WILLIAMS:  
 20 A. Yes. Three lists, alive and negative, alive  
 21 and need to be panelled, deceased and sent up  
 22 with results and deceased to be tested.  
 23 COFFEY, Q.C.:  
 24 Q. Okay. How about this, is this your  
 25 handwriting too?

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1 DR. WILLIAMS:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. It would be, yes. And the fourth page of the  
 5 exhibit is simply a listing of ER/PR cases for  
 6 retest from October 26th, '05, back in time.  
 7 So, Doctor, in the third--the first bullet,  
 8 well I suppose the third or fourth line down,  
 9 what I read you to say here, "so far,  
 10 approximately 30 percent seems to be  
 11 converting"?  
 12 DR. WILLIAMS:  
 13 A. Uh-hm.  
 14 COFFEY, Q.C.:  
 15 Q. "A positivity rate for PR/ER approximately 74  
 16 percent, over years '97 to 2005 new literature  
 17 says rates 80 - 82 percent positivity rate."  
 18 DR. WILLIAMS:  
 19 A. Uh-hm.  
 20 COFFEY, Q.C.:  
 21 Q. Doctor, why was that, because I gather this  
 22 was probably written in February or March,  
 23 probably February of '06, January/February of  
 24 '06, these notes. Why would that be of  
 25 concern as to whether you were 74 or 82 or--

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1 bearing in mind by that point in time Mount  
 2 Sinai had all the results back or almost all  
 3 them back.  
 4 DR. WILLIAMS:  
 5 A. Just to see if, before, as I said, we were  
 6 looking, based upon our rates of 73 percent, I  
 7 think at the time, and rates of up to 80 or 82  
 8 percent in the literature that we felt that  
 9 overall we'd have a ten percent of tests  
 10 affected, total number of tests, so that would  
 11 be out of 2500, about 250, 260 tests. And I  
 12 don't know if this is a calculation just to,  
 13 at the time, I'd have to spend some time  
 14 looking at it then, Mr. Coffey, but it looks  
 15 to see if that was sort of in keeping with  
 16 that kind of thing and that really, with the  
 17 conversions we had, would that make sense that  
 18 our rates would then be up to around 80 - 82  
 19 percent overall. I think that's what it's  
 20 about, but again, I'm just seeing it now.  
 21 THE COMMISSIONER:  
 22 Q. I'm not sure I follow that, Dr. Williams, I  
 23 think you're going to have to run that past me  
 24 again. You're saying that--let me tell you  
 25 what I took from it and you tell me whether I

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1 got it correct or not. You were looking at  
 2 the numbers of the conversions -  
 3 DR. WILLIAMS:  
 4 A. Yes.  
 5 THE COMMISSIONER:  
 6 Q. Putting them with the percentages of  
 7 positivity that you already had.  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 THE COMMISSIONER:  
 11 Q. And seeing whether if you add the conversions  
 12 to the number of positives that were already  
 13 in your records, the rate of positivity  
 14 overall was in the ballpark?  
 15 DR. WILLIAMS:  
 16 A. Yes, that's what--I'm just looking at it now  
 17 to see if that's what I think I--that's what I  
 18 think I was doing that, if it was done in  
 19 February or So.  
 20 COFFEY, Q.C.:  
 21 Q. If I could, please, exhibit P-1119, now this  
 22 is a fax cover sheet to Don Cook and Nash  
 23 Denic, April 27th, 2006, it's from yourself,  
 24 it says, "Re: letter to Peter Dawe, Don Nash  
 25 for your review and comments. Thanks." Bob.



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1 And we have a draft letter, April 27th, 2006,  
 2 addressed to Mr. Dawe, it's just over, it just  
 3 goes into the second page, and here in the  
 4 second paragraph you say "I've attached a  
 5 dossier of the literature that we've reviewed  
 6 here and Eastern Health respective  
 7 methodologies and outcomes with respect to  
 8 ER/PR marker testing."  
 9 DR. WILLIAMS:  
 10 A. Um-hm.  
 11 COFFEY, Q.C.:  
 12 Q. And you go on then at some length about this.  
 13 If we could, please, Exhibit P-1120. This is  
 14 a fax cover sheet and a letter attached. This  
 15 one, the fax is to Dr. Kara Laing, May 1,  
 16 2006, it's re: a letter to Peter Dawe. And  
 17 Denise, on your behalf is saying "Dr. Williams  
 18 would like you to review this letter before he  
 19 sends". And Exhibit P-1121, please. And this  
 20 is, again, a fax of May 2, 2006 to Pam Elliot  
 21 and Heather Predham, be Denise on your behalf  
 22 again regarding the letter to Peter Dawe.  
 23 "Dr. Williams would like both to review the  
 24 attached letter and provide with comments  
 25 before he sends". Now, Doctor, first of all,

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1 what was the purpose in sending, at that  
 2 point, the letter to Mr. Dawe and the proposal  
 3 to send literature to him?  
 4 DR. WILLIAMS:  
 5 A. Well, I think that at that stage, I might have  
 6 had some discussion with Mr. Dawe, vis-a-vie a  
 7 role that he was going to be playing. He's  
 8 the--he'd be working with the Canadian Cancer  
 9 Society. They were developing--we were  
 10 developing a provincial cancer strategy. I  
 11 think there was a national cancer strategy.  
 12 And with a view to him bringing forward the  
 13 issue of ER/PR as an important component of a  
 14 national cancer strategy and that this is an  
 15 area that needed attention, in terms of  
 16 quality. So, I think that was the reason.  
 17 And give him some background literature on  
 18 what was happening at that time in this  
 19 particular area.  
 20 COFFEY, Q.C.:  
 21 Q. If we could please, P-1123. This is an e-mail  
 22 of May 4, 2006 from Mr. Tilley to Denise Dunn,  
 23 saying, "Bob, the letter you are sending to  
 24 Peter Dawe looks fine to me. Signed, George".  
 25 And if we could, Exhibit P-1126. Now, this is

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1 a letter marked private and confidential and  
 2 it's to Peter Dawe.  
 3 DR. WILLIAMS:  
 4 A. Um-hm.  
 5 COFFEY, Q.C.:  
 6 Q. It's from yourself copied to George Tilley and  
 7 somebody has hand written here "sent May 16,  
 8 '06".  
 9 DR. WILLIAMS:  
 10 A. That's what it looks like, yes.  
 11 COFFEY, Q.C.:  
 12 Q. And copied to Heather -  
 13 DR. WILLIAMS:  
 14 A. Kara Laing, I think.  
 15 COFFEY, Q.C.:  
 16 Q. Kara Laing and Heather Predman, May 16, '06.  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. And I take it this is the letter that came out  
 21 of your draft.  
 22 DR. WILLIAMS:  
 23 A. Yes. I don't know if there was any changes to  
 24 my draft or not; I'm not sure.  
 25 COFFEY, Q.C.:

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1 Q. You certainly are, at the bottom of page  
 2 there, you say "any efforts your national  
 3 association could offer as you move forward  
 4 with the national cancer strategy to encompass  
 5 enhancing quality in this important area  
 6 should be pursued", so, certainly as you've  
 7 pointed out to the Commissioner or trying to  
 8 get his assistance in that regard. You then  
 9 said, "as I advised you, our two consultants  
 10 have revisited the province to review our  
 11 efforts here and once we receive the reports,  
 12 we will making a decision concerning re-  
 13 instituting immunohistochemical testing within  
 14 the laboratory services here in St. John's.  
 15 Before we re-institute testing, we will be  
 16 doing an update and briefing session. I would  
 17 like to extend to you an opportunity to be  
 18 involved in that process".  
 19 DR. WILLIAMS:  
 20 A. Um-hm.  
 21 COFFEY, Q.C.:  
 22 Q. "Again, thank you for your interest. You can  
 23 be assured of Eastern Health's support in any  
 24 further attempts you make in moving hormone  
 25 receptor testing forward in terms of quality

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1 as part of the national cancer strategy for  
 2 our country". And then there is attached  
 3 here, page 3 is an article, "Journal of  
 4 Clinical Oncology, Estrogen and Receptor  
 5 testing of breast cancer in current clinic  
 6 practice, what's the question", it goes on for  
 7 three pages.  
 8 DR. WILLIAMS:  
 9 A. I'm sure there was probably more documents  
 10 attached than that too, Mr. Coffey.  
 11 COFFEY, Q.C.:  
 12 Q. Your recollection of how much you send. Do  
 13 you send him, kind of, a wad of material?  
 14 DR. WILLIAMS:  
 15 A. I do now know; you'd have to ask Mr. Dawe. I  
 16 can't remember. I think there's more than one  
 17 article; I may be wrong on that. And the  
 18 other reason for sending it, of course, was to  
 19 invite him to partake in a debriefing on this  
 20 when it was held.  
 21 COFFEY, Q.C.:  
 22 Q. Now, at that point, it was envisaged that that  
 23 would happen when?  
 24 DR. WILLIAMS:  
 25 A. Well, it would happen at some time before we

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1 re-instituted the testing. And at that time,  
 2 on May 15, we needed to review, I'm not sure  
 3 if both consultants had come back by then, but  
 4 we needed to review their reports, develop a  
 5 strategy as to when we were going to restart  
 6 the testing. And then once people, I guess,  
 7 from the lab primarily, but--or with oncology  
 8 and put, felt that they were in a position to  
 9 recommend that, then some kind of a briefing  
 10 would be held with the CEO, probably that's--  
 11 Mr. Dawe would be invited. That's my  
 12 recollection of it. I don't think I had a  
 13 time in my mind at that time, but when we did  
 14 it.  
 15 COFFEY, Q.C.:  
 16 Q. If we could, please, P-1125. And these are  
 17 your handwritten notes of May 12, 2006.  
 18 DR. WILLIAMS:  
 19 A. Yes,  
 20 COFFEY, Q.C.:  
 21 Q. "Meeting to discuss" -  
 22 DR. WILLIAMS:  
 23 A. Finalizing patient retesting ER and PR.  
 24 COFFEY, Q.C.:  
 25 Q. Yes and Ms. Elliot, Dr. Lain, Dr. Denic, Dr.

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1 Cook, Ms. Predham and yourself.  
 2 DR. WILLIAMS:  
 3 A. Um-hm.  
 4 COFFEY, Q.C.:  
 5 Q. And the topics are retro converters DCIS ER/PR  
 6 and re-instituting testing.  
 7 DR. WILLIAMS:  
 8 A. Re-instituting testing, correct.  
 9 COFFEY, Q.C.:  
 10 Q. I take this was a general -  
 11 DR. WILLIAMS:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. - matter that, internal meeting to discuss,  
 15 kind of, where you were, retro converters are  
 16 number one and it's marked priority number  
 17 one, 17 patients. And then there's, in your  
 18 handwriting, number two is DCIS priority  
 19 number two.  
 20 DR. WILLIAMS:  
 21 A. Um-hm.  
 22 COFFEY, Q.C.:  
 23 Q. And that's in your hand writing, isn't it?  
 24 DR. WILLIAMS:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. If we could, please, number three is ER/PR.  
 3 You say "results not back, 16 out for testing.  
 4 Dr. Cook to get list for Heather Predham.  
 5 Contact Mount Sinai and ask for results", do  
 6 you recall what that was about?  
 7 DR. WILLIAMS:  
 8 A. I don't, but it looks like maybe some late  
 9 tests came in, late requests came in. I'm not  
 10 sure, Mr. Coffey, I'd have to--others at the  
 11 meeting recollect that, but it's not specific  
 12 enough for me to say.  
 13 COFFEY, Q.C.:  
 14 Q. Number four, reports received on deceased -  
 15 ethics consult.  
 16 DR. WILLIAMS:  
 17 A. Refers to getting an ethics consult, yes.  
 18 COFFEY, Q.C.:  
 19 Q. Number five is re-institution testing.  
 20 DR. WILLIAMS:  
 21 A. Need to institute all recommendations for TW,  
 22 await Dr. Banerjee's report, Dr. Makarla and  
 23 Dr. Elms to be in-serviced by Dr. Ejeckam. By  
 24 that stage Dr. Ejeckam had left the  
 25 organization at the end of April, if I'm

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1 correct, he came to see me and said he was  
 2 submitting his resignation. He was going to  
 3 retire, but before he was going to retire, he  
 4 was going to go and do locum in Gander for a  
 5 month. And then we hired him for a week when  
 6 he finished in Gander to in-service Dr.  
 7 Makarla and Dr. Elms in this area because they  
 8 were going to be director and co-director of  
 9 immunohistochemistry. Now subsequently,  
 10 unfortunately, Dr. Makarla submitted his  
 11 resignation and left to go to Calgary, I  
 12 think. So, that delayed the process further  
 13 because, and Dr. Elms had to get up to speed  
 14 and there was nobody else, but Dr. Elms  
 15 involved.  
 16 COFFEY, Q.C.:  
 17 Q. So, why was it necessary to have these two  
 18 pathologists in-serviced by Dr. Ejeckam?  
 19 DR. WILLIAMS:  
 20 A. Because he had had some experience in our area  
 21 and he was going to pass along his experience.  
 22 They were new at this and it was early on in  
 23 their learning curve. Subsequently, as you  
 24 know we did send Dr. Elms, I think he went to  
 25 Seattle with Dr. Allan Gown's lab to spend

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1 some time in the US there. That was  
 2 recognized as probably the premier lab, maybe,  
 3 in North America in this area. That's my  
 4 recollection; I may be wrong on that. Others  
 5 may be able to clarify that.  
 6 COFFEY, Q.C.:  
 7 Q. If we could, please, Exhibit P-1132? I take  
 8 it these are your handwritten notes, May 25th  
 9 '06?  
 10 DR. WILLIAMS:  
 11 A. Yes, "spoke to Heather Predham re: next panel  
 12 meeting and retro converters--retros and  
 13 DCIS's. Follow up with Dr. Denic." That  
 14 would be my note there.  
 15 COFFEY, Q.C.:  
 16 Q. Yes, and then there's May 24th '06 is the  
 17 actual rest of the page.  
 18 DR. WILLIAMS:  
 19 A. Yes, I don't see it there, but -  
 20 COFFEY, Q.C.:  
 21 Q. Well, actually, I'll help you. Right there,  
 22 May 24th '06.  
 23 DR. WILLIAMS:  
 24 A. Okay, yes.  
 25 COFFEY, Q.C.:

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1 Q. And I take it this is a breakdown then of the  
 2 numbers, total patients retested, total  
 3 panelled, confirmed negative, deceased and  
 4 outstanding.  
 5 DR. WILLIAMS:  
 6 A. Um-hm.  
 7 COFFEY, Q.C.:  
 8 Q. This was an update, I take it, on where the  
 9 ER/PR was?  
 10 DR. WILLIAMS:  
 11 A. Yes, and six to be panelled and 36 require  
 12 further review. That was seven retro  
 13 converters and 29 DCIS. I don't know what  
 14 that means "have already been panelled" in  
 15 brackets. I didn't make that note, so I  
 16 don't.  
 17 COFFEY, Q.C.:  
 18 Q. If we could, please, Exhibit P-1133? It's a  
 19 letter of May 25th 2006. It's private and  
 20 confidential to Terry Gulliver from yourself,  
 21 copied to Dr. Denic.  
 22 DR. WILLIAMS:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. You write "I'm writing concerning a number of

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1 issues with respect to quality issues with the  
 2 laboratory medicine program. Now that we have  
 3 an opportunity to review the report from TW, I  
 4 wonder if you would review each of her  
 5 observations and recommendations. I  
 6 especially want to make significant progress  
 7 in the next few weeks on completing the  
 8 policies and procedure manual for the ER/PR  
 9 testing service. We'll need to make a  
 10 decision soon on re-instituting this testing  
 11 and I want to ensure that all issues within  
 12 this area have been dealt with. It would be  
 13 productive to send a copy of the final manual  
 14 to TW when it is completed. I realize from  
 15 reviewing the report that significant progress  
 16 has been made as outlined. However, we now  
 17 need to finalize all issues. The other issue  
 18 we need to pursue is enrolling in the Ontario  
 19 Laboratory Accreditation Program. I  
 20 understand that you have the documentation of  
 21 August 4th, 2005 that was sent to me by the  
 22 managing director, Dr. Harold Richardson. I  
 23 have discussed this matter with Mr. George  
 24 Tilley and he's supportive of us enrolling in  
 25 this program. This will be one other process

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1 to ensure that our lab is on the leading edge  
 2 in terms of quality and peer review. I would  
 3 like to discuss these issues in detail at the  
 4 next laboratory medicine leadership team  
 5 meeting. I trust this is satisfactory."  
 6 Now Doctor, by this point, Ms.  
 7 Wegrynowski and Dr. Banerjee had been back?  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. When they came back the second--in the spring  
 12 of '06, who set out the terms and conditions  
 13 or parameters of what they'd do?  
 14 DR. WILLIAMS:  
 15 A. I guess we just asked them to come back and  
 16 review their previous report and update it and  
 17 make any further comments about our lab before  
 18 we'd consider re-instituting the testing.  
 19 COFFEY, Q.C.:  
 20 Q. Did you speak with Ms. Wegrynowski before she  
 21 started this second review?  
 22 DR. WILLIAMS:  
 23 A. I expect I did, Mr. Coffey, but I don't have  
 24 any documentation that I did.  
 25 COFFEY, Q.C.:

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1 Q. Okay.  
 2 DR. WILLIAMS:  
 3 A. So, I may not have, but I probably did.  
 4 COFFEY, Q.C.:  
 5 Q. Now, with respect to--the first time around in  
 6 September of '05, the report that she sent  
 7 certainly dealt with IHC testing at large,  
 8 didn't it?  
 9 DR. WILLIAMS:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. And not just ER/PR, but IHC testing at large.  
 13 DR. WILLIAMS:  
 14 A. Um-hm.  
 15 COFFEY, Q.C.:  
 16 Q. When she came back the second time, do you  
 17 recall whether or not there was any discussion  
 18 as to whether she should do the whole of the  
 19 IHC again or perhaps concentrate on ER/PR?  
 20 DR. WILLIAMS:  
 21 A. I don't remember telling her just to--I don't  
 22 remember, I guess, is what I'm saying. To try  
 23 to say I did this or I did that, I'm not sure,  
 24 but in retrospect it was just a follow-up and  
 25 what they done previously, see where we were

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1 with the recommendations and what other things  
 2 needed to be attended to before we could  
 3 consider moving forward. That's my  
 4 recollection.  
 5 THE COMMISSIONER:  
 6 Q. Who would be the official contact between her  
 7 and the organization in any event?  
 8 DR. WILLIAMS:  
 9 A. It may have occurred at Mr. Gulliver's level  
 10 the second time. I'm not sure or it may have  
 11 come through my office. I think there's some  
 12 e-mails there suggesting that we were in  
 13 contact about a date. So, I may have talked  
 14 to her on the phone as well. But my  
 15 understanding would have been that she would  
 16 come down and do a follow-up on her first  
 17 report. That would be my understanding.  
 18 COFFEY, Q.C.:  
 19 Q. So, before her and Dr. Banerjee showed up in  
 20 '06, were you given any understanding as to  
 21 how many of the recommendations had actually  
 22 been implemented?  
 23 DR. WILLIAMS:  
 24 A. No, we had this document done up -  
 25 COFFEY, Q.C.:

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1 Q. December 14, '05 spreadsheet.  
 2 DR. WILLIAMS:  
 3 A. Yes, but it was updated on occasion and it was  
 4 updated just before T.W. came and Dr. Banerjee  
 5 came again.  
 6 COFFEY, Q.C.:  
 7 Q. I take it you understood before they arrived  
 8 that there was still a number of  
 9 recommendations -  
 10 DR. WILLIAMS:  
 11 A. I understood that, yes, I understood that some  
 12 other things needed to be done. I wanted to  
 13 get an update on where we were and we would  
 14 use that update to base our decisions on, yes.  
 15 The other thing that was causing us a lot of  
 16 problem at the time and took a lot of time was  
 17 the fact that the pathologist, shortage of  
 18 pathologists got so bad in the fall of 2005  
 19 and early in the spring of 2006 that we were  
 20 sending out \$30,000.00 worth of work to Gamma  
 21 Dynacare in Ottawa to process and that would  
 22 have taken Mr. Dyer and Mr. Gulliver a lot of  
 23 time to make sure that that was done properly.  
 24 You can't be sending specimens out of province  
 25 without proper documentation, making sure that

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1 things don't get lost, all these things that  
 2 had to be--because if you lose a specimen, you  
 3 don't have anything else to test. So, they  
 4 would have been taken off some of the things  
 5 they might have been doing in this respect to  
 6 tend to that, but we had no choice but to do  
 7 that. Otherwise we would have people waiting  
 8 for two or three or four months for pathology  
 9 reports which is far from satisfactory. So,  
 10 we had to send specimens out, a lot of work  
 11 was sent out.  
 12 COFFEY, Q.C.:  
 13 Q. Now, what was your understanding then after  
 14 Ms. Wegrynowski left and her report came in in  
 15 '06., she was here in '06 and left, as to her  
 16 view of the situation at that point? What -  
 17 DR. WILLIAMS:  
 18 A. There was some things that needed to be done.  
 19 She was impressed, according to her report,  
 20 with the quality endeavours that had taken  
 21 place, through Dr. Carter's committee and this  
 22 type of thing in pathology. And that we'd  
 23 enrolled in the external quality assurance  
 24 programs, both in Great Britain and in College  
 25 of American Pathologists in the US.

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1 COFFEY, Q.C.:  
 2 Q. What about in terms of actually getting some  
 3 manuals written?  
 4 DR. WILLIAMS:  
 5 A. Well, I knew her report said that we needed to  
 6 do the manual. And as you see in my letter to  
 7 Mr. Gulliver, I said it would be good if when  
 8 the manual was done that they send it up to  
 9 her, so we could get some feedback from her.  
 10 That was my thought process, yes.  
 11 COFFEY, Q.C.:  
 12 Q. Did that ever get done while you were there?  
 13 DR. WILLIAMS:  
 14 A. I'm not sure if it got done while I was there  
 15 because I wouldn't of had the follow-up  
 16 meeting to talk about the institute and  
 17 retesting, but I'm sure that that was  
 18 something that would have been picked up then.  
 19 COFFEY, Q.C.:  
 20 Q. Do you know, to this day, if it was ever done?  
 21 DR. WILLIAMS:  
 22 A. I would not know.  
 23 COFFEY, Q.C.:  
 24 Q. Okay.  
 25 DR. WILLIAMS:

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1 A. But I wrote and asked it to be done and I  
 2 presume it would be done.  
 3 COFFEY, Q.C.:  
 4 Q. Exhibit P-1135. Now, this is a memorandum to  
 5 yourself from Terry Gulliver, June 7, 2006.  
 6 DR. WILLIAMS:  
 7 A. Yes.  
 8 COFFEY, Q.C.:  
 9 Q. ER/PR rates, it says, "as per your request, in  
 10 light of remarks from Dr. Gown regarding our  
 11 2004/'05 Ventana ER/PR rates, I have rewrote  
 12 each report and I've identified the total  
 13 numbers of positives previously reported and  
 14 also include specimens that were ER/PR  
 15 positive, but were not breast specimens" and  
 16 he's got previous results and new results.  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. And this is copied to Dr. Denic and you've  
 21 written "copy given to Heather Predham on June  
 22 7".  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And under the new results, these are just the  
 2 '04/'05 Ventana rates.  
 3 DR. WILLIAMS:  
 4 A. Yes.  
 5 COFFEY, Q.C.:  
 6 Q. And under "new results" now it comes  
 7 percentage positive 81.2 percent. Okay?  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 COFFEY, Q.C.:  
 11 Q. And that's the total from the--of the Health  
 12 Sciences Centre test and then the total  
 13 positive is 82.6 percent.  
 14 DR. WILLIAMS:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. So, I take it that's the reporting by Mr.  
 18 Gulliver concerning the recalculation -  
 19 DR. WILLIAMS:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. - for the '04/'05 that you refer to before.  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. If we could, please, Exhibit P-11--just a  
 2 moment please--P-1139, please. These are, I  
 3 take it, your handwritten notes of June 30,  
 4 '06.  
 5 DR. WILLIAMS:  
 6 A. Yes.  
 7 COFFEY, Q.C.:  
 8 Q. A meeting re: start up of ER/PR testing.  
 9 DR. WILLIAMS:  
 10 A. Um-hm.  
 11 COFFEY, Q.C.:  
 12 Q. And there's a list of physicians and other  
 13 personnel -  
 14 DR. WILLIAMS:  
 15 A. Um-hm.  
 16 COFFEY, Q.C.:  
 17 Q. - involved. The background decision re ER/PR  
 18 testing and Dr. Denic is quoted as having  
 19 given some input including where they were, I  
 20 take it, with external quality reviews.  
 21 DR. WILLIAMS:  
 22 A. Um-hm.  
 23 COFFEY, Q.C.:  
 24 Q. Continue on with Dr. Denic and there's a  
 25 reference Dr. Elms and Dr. Denic again, Dr.

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1 Cook and then finally decision. Could you  
 2 just read out that, what the decision is,  
 3 numbers one through five.  
 4 DR. WILLIAMS:  
 5 A. Sure. "Probably be ready to start retesting  
 6 early September, 2006. Set meeting for second  
 7 week of September, 2006", I guess to talk  
 8 about it maybe. "Need to set out everything  
 9 that needs to be done and individual assigned  
 10 to do it. Accountability. Decision as to  
 11 validate all our antibodies now, Dr. Makarla  
 12 and Dr. Elms and start work on HER2/neu". I  
 13 think the HER2/new was being sent out of  
 14 province at the time.  
 15 COFFEY, Q.C.:  
 16 Q. Okay. I take it, it was being done at Mount  
 17 Sinai?  
 18 DR. WILLIAMS:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. Now, Doctor, what was the reason for the delay  
 22 in restarting it?  
 23 DR. WILLIAMS:  
 24 A. Well, we--I guess, I was gone at the time  
 25 there was a delay. We had laid out from TW's

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1 report, 30 recommendations. You see my notes  
 2 on that that needed to implemented.  
 3 COFFEY, Q.C.:  
 4 Q. That's the '06 report.  
 5 DR. WILLIAMS:  
 6 A. Yes. Dr. Makarla subsequently resigned and  
 7 left the province. So, that was a delaying  
 8 factor and I don't know what the other  
 9 delaying factors would be because again, I  
 10 knew that Dr. Makarla left before I left.  
 11 Those 30 recommendations needed to be followed  
 12 up and we needed to be sure that they were all  
 13 implemented before we restarted the retesting.  
 14 And I don't know what other factors occurred  
 15 in the fall to delay the retesting, I think,  
 16 until February or so, 2007?  
 17 COFFEY, Q.C.:  
 18 Q. Yes. So, if there's still 30 recommendations  
 19 in TW, as you refer to, second report, did you  
 20 ask anybody, like, how can we still have 30  
 21 outstanding?  
 22 DR. WILLIAMS:  
 23 A. Well, I knew that some of them, because Barry  
 24 and Terry were taking off doing that. A lot  
 25 of it was to do with the--there's a lot of

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1 work in sending out \$30,000.00 worth of  
 2 specimens every month to Gamma DynaCare.  
 3 That's one thing. That would--I would  
 4 consider that was one of the factors. Some of  
 5 those 30 recommendations we were very close to  
 6 implementing at the time if you see the notes,  
 7 the comments that I've made. So, we've made  
 8 progress, but some of them were not, we could  
 9 say, finalized as yet.  
 10 COFFEY, Q.C.:  
 11 Q. Okay. If we could, please, Exhibit P-1145.  
 12 These are your handwritten notes of July 12,  
 13 '06, Doctor.  
 14 DR. WILLIAMS:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. 2:30 p.m., a conversation you had with Dr.  
 18 Cook. This reads to, I take it, the DCIS  
 19 issue.  
 20 DR. WILLIAMS:  
 21 A. Yes.  
 22 COFFEY, Q.C.:  
 23 Q. And information for Dr. Cook concerning again  
 24 DCIS cases.  
 25 DR. WILLIAMS:

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1 A. Um-hm, yes. That's sort of the details on  
 2 each particular situation, I think. I  
 3 haven't--I'd have to scroll down through it  
 4 and see that, but that's what it looks like.  
 5 COFFEY, Q.C.:  
 6 Q. Yes. And can--it refers to the breakdown of  
 7 the 29, at least were, certainly the cases are  
 8 and so on.  
 9 DR. WILLIAMS:  
 10 A. Um-hm.  
 11 COFFEY, Q.C.:  
 12 Q. And the first page refers to, perhaps speaking  
 13 with Dr. Dalton.  
 14 DR. WILLIAMS:  
 15 A. No, I didn't speak to Dr. Dalton. If you see  
 16 there, I spoke to Dr. Larry Alteen.  
 17 COFFEY, Q.C.:  
 18 Q. Larry Alteen, I'm sorry.  
 19 DR. WILLIAMS:  
 20 A. He would be my counterpart.  
 21 COFFEY, Q.C.:  
 22 Q. Yes.  
 23 DR. WILLIAMS:  
 24 A. He will speak to pathologist, Dr. Dalton, re  
 25 these cases. And I presume I would have done

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1 the same with Dr. Jenkins, if there were any  
 2 cases from there.  
 3 COFFEY, Q.C.:  
 4 Q. Okay. If we could, please, Exhibit P-1154.  
 5 It's an e-mail of August 2, '06, 12:02 p.m.  
 6 It's from George Butt to yourself, copied to  
 7 Doris Murphy. The subject is "lawsuit against  
 8 Eastern Health", and it's forwarding a media  
 9 report, CBC media report which is reproduced  
 10 later in the exhibit. But Mr. Butt has  
 11 written, "Dr. Williams, has there been  
 12 discussion with HIROC as to whether these are  
 13 viewed as multiple occurrences or as a single  
 14 occurrence. Insurance impact is significant  
 15 to say the least. Signed, George". Well,  
 16 first of all, who is Mr. Butt?  
 17 DR. WILLIAMS:  
 18 A. Mr. Butt would be the vice-president of  
 19 finance and administration.  
 20 COFFEY, Q.C.:  
 21 Q. Okay. And -  
 22 DR. WILLIAMS:  
 23 A. He formerly sat on the HIROC board for a few  
 24 years, I think. Each of the organizations has  
 25 a seat on the HIROC board, I think that's how

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1 it works.  
 2 COFFEY, Q.C.:  
 3 Q. Now, had you had any involvement with HIROC?  
 4 DR. WILLIAMS:  
 5 A. Not directly, hadn't talked to HIROC directly.  
 6 What we did, we had our legal counsel, Mr.  
 7 Bruce, review the -  
 8 COFFEY, Q.C.:  
 9 Q. I got to be careful on this in terms of--I  
 10 don't want to know anything that might be  
 11 solicitor/client privileged. Mr. Simmons is  
 12 nodding no.  
 13 DR. WILLIAMS:  
 14 A. Okay, sorry, okay.  
 15 COFFEY, Q.C.:  
 16 Q. So, but from your own--without--trying to get  
 17 some sense for the Commissioner your  
 18 involvement without being told, kind of, what  
 19 it was that you were told by the lawyer.  
 20 THE COMMISSIONER:  
 21 Q. We don't need to know what the advice was.  
 22 DR. WILLIAMS:  
 23 A. Okay -  
 24 COFFEY, Q.C.:  
 25 Q. What the advice was.

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1 DR. WILLIAMS:  
 2 A. - was involvement, we looked at the issue and  
 3 we had some legal advice on it. It seemed to  
 4 satisfy our concerns about that and I don't  
 5 know if Mr. Butt was aware of that. That  
 6 happened earlier. My recollection it happened  
 7 earlier.  
 8 COFFEY, Q.C.:  
 9 Q. So you had--within the organization, who was  
 10 responsible for addressing that issue? Was it  
 11 you or Mr. Tilley?  
 12 DR. WILLIAMS:  
 13 A. I would not be able to answer that. There was  
 14 some discussion about it and I know we had our  
 15 lawyer for Eastern Health look at the  
 16 insurance policy for HIROC and make an  
 17 interpretation.  
 18 COFFEY, Q.C.:  
 19 Q. Okay.  
 20 DR. WILLIAMS:  
 21 A. So, as far as we were concerned, we looked at  
 22 it and had dealt with it.  
 23 COFFEY, Q.C.:  
 24 Q. Okay.  
 25 DR. WILLIAMS:

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1 A. Now Mr. Butt may not have been aware of that.  
 2 COFFEY, Q.C.:  
 3 Q. Okay. If we could, please, Exhibit P-1156.  
 4 Now, this is an e-mail from Wayne Miller,  
 5 August 3, '06 4:50 p.m. It's to Ms. Bonnell,  
 6 Mr. Predham, the executive team of Eastern  
 7 Health, re "seriously flawed story on CBC".  
 8 He writes, "I feel that the most appropriate  
 9 way of addressing the issue is to release a  
 10 prepared statement that states the facts in  
 11 the same manner that we would respond to a  
 12 Statement of Claim. Have the lawyers work  
 13 with Dr. Williams to prepared a statement"  
 14 and it's signed by Wayne Miller. Now, he is  
 15 the senior director of corporate strategy and  
 16 research?  
 17 DR. WILLIAMS:  
 18 A. Um-hm.  
 19 COFFEY, Q.C.:  
 20 Q. Did you ever get involved in this, first of  
 21 all?  
 22 DR. WILLIAMS:  
 23 A. No, I was away at the time and when I got back  
 24 I don't remember this issue being bought up,  
 25 bought forward to me.

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1 COFFEY, Q.C.:  
 2 Q. I asked you before about your involvement in  
 3 communications and you'd indicated you hadn't  
 4 had a whole lot. That was Mr. Tilley's -  
 5 DR. WILLIAMS:  
 6 A. Development of communications strategy, I  
 7 didn't think that was my role, but I would be  
 8 a spokesperson for Eastern Health on occasion.  
 9 COFFEY, Q.C.:  
 10 Q. But as to whether or not you should speak -  
 11 DR. WILLIAMS:  
 12 A. Well, I'd take my cue from communications  
 13 people. I understand that some people thought  
 14 I was speaking to much at one stage. But I  
 15 wouldn't have been speaking if communications  
 16 hadn't some and ask me to speak.  
 17 COFFEY, Q.C.:  
 18 Q. Ask you to, yes. If we could, please, Exhibit  
 19 P-1170. Now, this is a letter of August 10,  
 20 '06, it's addressed to Dr. Nash Denic,  
 21 Clinical Chief from Dr. Bev Carter, assigns  
 22 herself, quality management program.  
 23 DR. WILLIAMS:  
 24 A. Um-hm.  
 25 COFFEY, Q.C.:

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1 Q. And she says, "in order to implement a  
 2 fixation policy, enclosed the following  
 3 actions will have to be considered". And  
 4 there's a listing of at least six different  
 5 aspects of the matter. So, were you aware at  
 6 this point in time, in the summer of '06,  
 7 Doctor, that as of yet, as of that point,  
 8 there still was not a fixation policy for  
 9 Eastern Health?  
 10 DR. WILLIAMS:  
 11 A. I hadn't seen this, so I was not--one of the  
 12 things that came out of one of the  
 13 recommendations was Dr. Denic was following up  
 14 on a fixation policy.  
 15 COFFEY, Q.C.:  
 16 Q. Okay. I haven't seen this until today. And  
 17 Dr. Carter, in her role as head of our quality  
 18 program would usually deal with Dr. Denic. It  
 19 there was an issue that they couldn't resolve,  
 20 I suspect she or he would have brought it to  
 21 me.  
 22 COFFEY, Q.C.:  
 23 Q. P-1173, please. This is an e-mail from Denise  
 24 Dunn to Dr. Denic, September 13, '06, the  
 25 subject is ER/PR presentation. "Dr. Denic, I

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1 spoke to Dr. Williams, explained the data  
 2 won't be ready for presentation until and he  
 3 said okay, but he's planning to get out of the  
 4 province for October". So, the data--who is  
 5 in charge, from your perspective, at this  
 6 point, of getting the data ready?  
 7 DR. WILLIAMS:  
 8 A. The data ready on terms of patient notify -  
 9 DR. WILLIAMS:  
 10 A. Well, presentation--well, this is -  
 11 DR. WILLIAMS:  
 12 A. Yeah, I would think that it would be a joint  
 13 effort in terms of lab and in terms of quality  
 14 with respect to patient data. Lab, we well,  
 15 both together. Depending on--well, if the  
 16 thrust was going to be from the lab, then it  
 17 would be primarily lab. I think I would have  
 18 been invited to this presentation as a  
 19 courtesy although I hadn't had responsibility  
 20 anymore, that they were going to invite me a  
 21 courtesy.  
 22 COFFEY, Q.C.:  
 23 Q. And if we could, please, Exhibit P-1174. Now,  
 24 this is a couple of e-mails of September 14,  
 25 '06 from Ms. Bonnell. Well, the first one at



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1 2:51 p.m. to yourself and Dr. Howell, copied  
 2 to a number. She says, "spoken to Pam Elliot  
 3 about this case. She feels we should touch  
 4 base tomorrow when Heather is back in the  
 5 office. She is away in B.C. today. Pam does  
 6 not have access to the database today. We  
 7 should get back to this gentleman by tomorrow  
 8 so he doesn't have the weekend to stew on a  
 9 lack of response. Pam will make contact with  
 10 Dr. Bob tomorrow to discuss". And this  
 11 apparently, if you look at the e-mail below,  
 12 at 12:49 p.m. to Ms. Bonnell, and this is from  
 13 a person who is writing about a previous--"had  
 14 been previously told that my late wife's ER/PR  
 15 receptor was being retested as her diagnosis  
 16 of breast cancer fell into the time period  
 17 when inconsistencies were detected". And he  
 18 goes on to say, "could you please advise who I  
 19 can contact to get an answer. I don't want to  
 20 be put onto a patient relations officer who is  
 21 going to give me the runaround. I have been  
 22 more than patient on this issue, but I know  
 23 require a truthful answer to get on with my  
 24 life". And he identifies his wife by her name  
 25 and date of birth and date of death and

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1 diagnosis. "If I haven't received a reply to  
 2 this e-mail by September 28, '06, I will be  
 3 contacting the media with my problem". Now  
 4 sir, in the middle of September of '06, how  
 5 much involvement did you still have in this?  
 6 DR. WILLIAMS:  
 7 A. I was--I didn't have any responsibility,  
 8 direct responsibility. Heather Predham was  
 9 still keeping me in the loop until the very  
 10 day I left, I think.  
 11 COFFEY, Q.C.:  
 12 Q. Okay.  
 13 DR. WILLIAMS:  
 14 A. If I recollect correctly about this, Heather  
 15 got back and phoned this particular gentleman  
 16 and this issue was resolved. I think Heather  
 17 may have talked to him before.  
 18 COFFEY, Q.C.:  
 19 Q. Yes, there's a reference here to "woman  
 20 retested, negative, negative" something "and  
 21 then HP spoke to man".  
 22 DR. WILLIAMS:  
 23 A. Yes.  
 24 COFFEY, Q.C.:  
 25 Q. Is this your handwriting?

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1 DR. WILLIAMS:  
 2 A. No.  
 3 COFFEY, Q.C.:  
 4 Q. It's not, okay. I take it that this would be  
 5 the period where there was a cross over, you  
 6 were still being copied on material but Dr.  
 7 Howell -  
 8 DR. WILLIAMS:  
 9 A. Yes, I would have left the--the responsibility  
 10 would have rested with Dr. Howell. I had  
 11 really no authority at that time. I wasn't  
 12 the VP Medical, but Heather, where she had, I  
 13 think, been working on this all along with me,  
 14 that she would let me know things.  
 15 COFFEY, Q.C.:  
 16 Q. If we could, please, Exhibit P-1180. Now this  
 17 is--these your notes of October 17th '06?  
 18 DR. WILLIAMS:  
 19 A. That would be '05, I got a feeling. That's  
 20 wrong. October 17th, 2005.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, and so, and this would have been then,  
 23 your notes of a meeting of October 17th '05.  
 24 Back then, Dr. Laing, Ms. Parsons, Ms.  
 25 Predham, Chris?

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1 DR. WILLIAMS:  
 2 A. Power.  
 3 COFFEY, Q.C.:  
 4 Q. Power.  
 5 DR. WILLIAMS:  
 6 A. She was with the Cancer Clinic.  
 7 COFFEY, Q.C.:  
 8 Q. Ms. Bonnell, Ms. Pilgrim, Dr. Cook and  
 9 yourself, and here back then, you had written  
 10 "one, do information for the public, Susan.  
 11 Two, letter to patients." I gather Heather is  
 12 supposed to do that. "Three, notify patients  
 13 with results. -  
 14 DR. WILLIAMS:  
 15 A. Back as negative.  
 16 COFFEY, Q.C.:  
 17 Q. - back as negative, and four, Chris Power to  
 18 get history of all patients -  
 19 DR. WILLIAMS:  
 20 A. Get listing of all patients notified.  
 21 COFFEY, Q.C.:  
 22 Q. I apologize, listing of all patients notified.  
 23 DR. WILLIAMS:  
 24 A. This is around the time a decision was made--  
 25 we talked about it earlier, back in 2005.

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1 COFFEY, Q.C.:

2 Q. And on that point, because we had discussed

3 this before, in the middle of October of what

4 was then '05, the letter, as of this meeting

5 of October 17th '05, the second point, letters

6 to patients, a letter to patient, Heather was

7 being tasked with preparing a letter, I take

8 it, at the time?

9 DR. WILLIAMS:

10 A. Yes, correct. Yes, the meeting occurred on

11 the 18th, as we talked about, I think on

12 Friday.

13 COFFEY, Q.C.:

14 Q. But as of the meeting on the 17th, she was

15 being tasked with doing it?

16 DR. WILLIAMS:

17 A. Yes, correct.

18 COFFEY, Q.C.:

19 Q. If we could, please, Exhibit P-1183. Now

20 these are your handwritten notes?

21 DR. WILLIAMS:

22 A. Yes.

23 COFFEY, Q.C.:

24 Q. Of, this would be October 18th. It's written

25 2006, but I gather it should be '05? Would

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1 that be--you can have a look down through them

2 and just see if you--would that be correct?

3 DR. WILLIAMS:

4 A. That was my notes, yes.

5 COFFEY, Q.C.:

6 Q. Oh yes, it should be -

7 DR. WILLIAMS:

8 A. It should be 2005, I'm sorry, yes.

9 COFFEY, Q.C.:

10 Q. Okay. Kara Laing, George Tilley, Ms. Predham,

11 Ms. Bonnell, Dr. Cook and yourself and Ms.

12 Pilgrim. Dr. Laing, minutes of meeting of

13 panel. Meeting are fine, only a few

14 suggestions to format.

15 DR. WILLIAMS:

16 A. You should have the typed report.

17 COFFEY, Q.C.:

18 Q. Yes. Here it says "two, review media releases

19 and patient letter and suggestions made."

20 DR. WILLIAMS:

21 A. Yeah, the suggestion is that--under 3A, is

22 that we would call all patients.

23 COFFEY, Q.C.:

24 Q. Three, suggestion is that we would call all

25 people. What's that?

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1 DR. WILLIAMS:

2 A. To be retested.

3 COFFEY, Q.C.:

4 Q. To be retested. B. Call all patients who have

5 not converted. Converters will be dealt with

6 by the physicians?

7 DR. WILLIAMS:

8 A. Physicians, yes.

9 COFFEY, Q.C.:

10 Q. And then decision. Could you read out the

11 decision then, please?

12 DR. WILLIAMS:

13 A. "Get information to media in print," that's

14 what we did. "Phone patients who are

15 retested" or to be retested, this type of

16 thing. "Phone patients who have been retested

17 and are not converters. Patients panelled by

18 tumour board to be contacted by physician.

19 Western and Central to phone their patients."

20 MR. SIMMONS:

21 Q. The typewritten version is at P-0927.

22 COFFEY, Q.C.:

23 Q. Sure.

24 MR. SIMMONS:

25 Q. Page 27.

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1 COFFEY, Q.C.:

2 Q. Thank you, Mr. Simmons. But as of the middle

3 of October, I take it then that there was, at

4 a meeting of October 17th, Heather was tasked

5 with preparing a letter to patients and it's

6 your recollection that some time on the 18th,

7 at that meeting, the decision was made not to

8 send the letter?

9 DR. WILLIAMS:

10 A. Yes, according to those notes. If I didn't

11 have the notes, obviously I wouldn't be able

12 to remember back that far, but the notes do

13 say that.

14 COFFEY, Q.C.:

15 Q. Are you able to tell what time of day this

16 meeting occurred, on the 18th? Would you be

17 able to--do you have a calendar that you could

18 reconstruct that from?

19 DR. WILLIAMS:

20 A. I wish I did. My calendar was thrown out, Mr.

21 Coffey. I went looking for it and it was

22 thrown out, so I don't know on what time of

23 the day that would have taken place.

24 COFFEY, Q.C.:

25 Q. Okay. Now sir, in one of the documents we

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1 just looked at, there was a reference to--from  
 2 your perspective, getting this under way,  
 3 these recommendations in '06, implemented.  
 4 Making a listing of them. You referred to  
 5 accountability. In that context, what did it  
 6 mean?  
 7 DR. WILLIAMS:  
 8 A. Well, we were going to have these  
 9 recommendations--I have to look at them, but  
 10 certain people were going to be charged with  
 11 getting them implemented or moving on those.  
 12 COFFEY, Q.C.:  
 13 Q. And what would the point be then of doing  
 14 that? I take it accountable would be if  
 15 they're not done, you'd hold them responsible  
 16 for it?  
 17 DR. WILLIAMS:  
 18 A. Well, yeah, you'd find out why they weren't  
 19 done, this type of thing.  
 20 COFFEY, Q.C.:  
 21 Q. If we could bring up, please, Exhibit P-0326.  
 22 Page, let me see--now sir, these are notes  
 23 from the telephone log of Mr. Tilley. There's  
 24 one there August 2, "follow-up conversation  
 25 Bob, follow-up conversation with Allan Kwan

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1 re: algorithm. Get Ventana now. Meeting with  
 2 oncologists, and then Bob Williams, Ventana,  
 3 being sought Mount Sinai, all go forward, 500  
 4 retests, QI review. Ventana validation, who  
 5 signed off? Bev Carter, letter to Don Cook  
 6 re: "spooked." Do you recall, you know,  
 7 discussing that August 2nd letter of Dr.  
 8 Carter to yourself, the one where she resigns?  
 9 Do you recall discussing that with George  
 10 Tilley?  
 11 DR. WILLIAMS:  
 12 A. I think that related to the August 1st  
 13 meeting.  
 14 COFFEY, Q.C.:  
 15 Q. Yes.  
 16 DR. WILLIAMS:  
 17 A. Yes, I phoned him about the letter.  
 18 COFFEY, Q.C.:  
 19 Q. Did you use the word "spooked"?  
 20 DR. WILLIAMS:  
 21 A. No, I wouldn't. That's not a word I'd use, so  
 22 I don't--I wouldn't have used the word  
 23 "spooked."  
 24 COFFEY, Q.C.:  
 25 Q. What did you tell him, if anything, about why

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1 she was leaving?  
 2 DR. WILLIAMS:  
 3 A. She wasn't going to--at that time, I don't  
 4 think she was going to leave.  
 5 COFFEY, Q.C.:  
 6 Q. Leaving the effort, I'm sorry.  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. I should say. She wasn't leaving the  
 11 organization.  
 12 DR. WILLIAMS:  
 13 A. I started to read the letter out and asked if  
 14 he wanted to see the letter, and he said no,  
 15 he didn't need to see it. My interpretation  
 16 of the letter, after having discussed it with  
 17 Dr. Cook, and that's my interpretation, you'd  
 18 have to ask Dr. Carter directly, my  
 19 understanding is that there was a disagreement  
 20 at one of the meetings that Mr. Gulliver was  
 21 thinking that it was new technology that was  
 22 at the root of this and there was a discussion  
 23 that really we had some problems with how we  
 24 managed the DAKO system, and so although the  
 25 new technology made it easier, it wasn't just

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1 new technology, and that's where there was a  
 2 disagreement between Mr. Gulliver and Dr.  
 3 Carter. That's my recollection. And Mr.  
 4 Tilley was involved in those discussions, and  
 5 Dr. Carter, I think, sensed that Mr. Tilley  
 6 was supporting the manager.  
 7 COFFEY, Q.C.:  
 8 Q. Okay, I'll get -  
 9 DR. WILLIAMS:  
 10 A. That's my understanding.  
 11 COFFEY, Q.C.:  
 12 Q. Mr. Tilley has used the word "spooked" in his  
 13 notes concerning a conversation he had with  
 14 you.  
 15 DR. WILLIAMS:  
 16 A. Yes.  
 17 COFFEY, Q.C.:  
 18 Q. And I was just wondering if you recall -  
 19 DR. WILLIAMS:  
 20 A. I wouldn't have used those--I would have  
 21 probably said something like I just said.  
 22 COFFEY, Q.C.:  
 23 Q. Okay. At the time, in July or August of 2005,  
 24 were you ever made aware of what Dr. Carter  
 25 had found in her review, the review that she

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1 had done?  
 2 DR. WILLIAMS:  
 3 A. Only what was written in anything she did.  
 4 COFFEY, Q.C.:  
 5 Q. So what she may--if she looked at some  
 6 original slides, what she may have noticed in  
 7 terms of those original slides?  
 8 DR. WILLIAMS:  
 9 A. Only what she would have put in writing at the  
 10 time, Mr. Coffey.  
 11 COFFEY, Q.C.:  
 12 Q. And is there any reason why you didn't  
 13 actually speak to her directly about what she  
 14 was finding?  
 15 DR. WILLIAMS:  
 16 A. Again, I would have talked to Dr. Cook. He  
 17 had a good relationship with Dr. Carter. I  
 18 would have met with Dr. Carter and Dr. Cook on  
 19 a number of occasions that summer. I can't  
 20 tell you exactly when, but I was over to their  
 21 office and I remember sitting in the room with  
 22 both of them.  
 23 COFFEY, Q.C.:  
 24 Q. Did you ever see the spreadsheets or working  
 25 papers she created?

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1 DR. WILLIAMS:  
 2 A. No, I don't remember seeing them.  
 3 COFFEY, Q.C.:  
 4 Q. Like ones with patient's names, MCP numbers,  
 5 original ER/PR readings, Ventana retests and  
 6 her observations as to what she'd seen?  
 7 DR. WILLIAMS:  
 8 A. I can't remember seeing those, no.  
 9 COFFEY, Q.C.:  
 10 Q. If we could please, Exhibit P-1347. Now sir--  
 11 thank you, Registrar. This is a performance  
 12 goals and objectives 2004-2005 for Dr. Don  
 13 Cook as clinical chief, Laboratory Medicine  
 14 program, and the headings are  
 15 goals/objectives, December '04 and then  
 16 there's a series of dates across the top.  
 17 DR. WILLIAMS:  
 18 A. Um-hm.  
 19 COFFEY, Q.C.:  
 20 Q. What--could you explain how this works?  
 21 DR. WILLIAMS:  
 22 A. What I would do with Dr. Cook is, starting in  
 23 the fall, because he came on, I think, as  
 24 clinical chief in October of 2002, if I'm  
 25 correct, we would sit down each year and set

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1 out a series of goals and objectives that we  
 2 would work on. He would work on and we'd meet  
 3 on a quarterly basis to pursue.  
 4 COFFEY, Q.C.:  
 5 Q. So those goals and objectives would be like  
 6 here in the left-hand column?  
 7 DR. WILLIAMS:  
 8 A. Yes, right.  
 9 COFFEY, Q.C.:  
 10 Q. And they would be set as of December '04?  
 11 DR. WILLIAMS:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. Goals and objectives would be: one, complete  
 15 an annual review of all pathologists  
 16 credentialed in the laboratory medicine  
 17 program.  
 18 DR. WILLIAMS:  
 19 A. Um-hm.  
 20 COFFEY, Q.C.:  
 21 Q. And then number two, work towards filing -  
 22 DR. WILLIAMS:  
 23 A. Filing.  
 24 COFFEY, Q.C.:  
 25 Q. - filling all pathology positions.

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1 DR. WILLIAMS:  
 2 A. Yes.  
 3 COFFEY, Q.C.:  
 4 Q. Three, work on major quality assurance issues,  
 5 developing a policies and procedures manual in  
 6 the division of anatomical pathology.  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 COFFEY, Q.C.:  
 10 Q. Four, work with the program director for the  
 11 laboratory medicine program to ensure a smooth  
 12 transition to the new Eastern Regional Health  
 13 Authority. And five, continue to support and  
 14 work on implementing recommendations of the  
 15 surgical pathology review committee. And then  
 16 date proposed, December 10th, 2004, and then,  
 17 okay, so there would be those five things, I  
 18 take it, those goals set in December of '04?  
 19 DR. WILLIAMS:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. Okay, tell us then--there are another series  
 23 of dates throughout, April 1/05, July '05,  
 24 October 7th '05 and December 9th '05.  
 25 DR. WILLIAMS:

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1 A. On April 1st, we'd get the first update of how  
 2 far Dr. Cook had advanced that. The normal  
 3 process here is that there's a document that  
 4 each of the pathologists would be asked to  
 5 complete as part of the annual review. So Dr.  
 6 Cook would update me in April that he'd got  
 7 those out, he'd asked the pathologists to  
 8 complete them. There's a fair bit of detail  
 9 there, and he'd received documentation on all  
 10 but five of the physicians.  
 11 COFFEY, Q.C.:  
 12 Q. Okay.  
 13 DR. WILLIAMS:  
 14 A. And he'd be following up on the review process  
 15 when these came in, and of course, then we got  
 16 an update in July.  
 17 COFFEY, Q.C.:  
 18 Q. So you met on July 15th, according to this.  
 19 DR. WILLIAMS:  
 20 A. Yes.  
 21 COFFEY, Q.C.:  
 22 Q. As scheduled, however there were other  
 23 pressing issues that had to be discussed.  
 24 Meeting rescheduled to August 5, but had to be  
 25 cancelled.

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1 DR. WILLIAMS:  
 2 A. Yes, because of the ongoing issues with ER/PR.  
 3 COFFEY, Q.C.:  
 4 Q. And then October 7th '05, due to a major issue  
 5 in the Lab Medicine program, this has been  
 6 delayed.  
 7 DR. WILLIAMS:  
 8 A. Yes, because -  
 9 COFFEY, Q.C.:  
 10 Q. And then finally, no changes noted before. So  
 11 the annual review of all pathologists  
 12 credentialed in the laboratory medicine  
 13 program, in late '04, that was envisaged to be  
 14 done during '05 by Dr. Cook.  
 15 DR. WILLIAMS:  
 16 A. Because it had already been done a couple of  
 17 years earlier, Mr. Coffey, and it was  
 18 envisioned we'd do another cycle at this  
 19 stage, but because of the--Dr. Cook was pretty  
 20 well working full time on ER/PR issues.  
 21 That's the problem.  
 22 COFFEY, Q.C.:  
 23 Q. Thank you. If I could, number two, work  
 24 toward filling all pathologists positions. As  
 25 of April 1/05, five positions interviewed to

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1 date. Four refused the offer of employment.  
 2 Still awaiting the response from the fifth,  
 3 and there's nothing in July of '05. October  
 4 7th '05, new physician, Dr. Makarla.  
 5 DR. WILLIAMS:  
 6 A. Makarla, yes.  
 7 COFFEY, Q.C.:  
 8 Q. Makarla, okay.  
 9 DR. WILLIAMS:  
 10 A. He came and went. He didn't last a year. He  
 11 came and went to Calgary at the end of the  
 12 summer, 2006.  
 13 COFFEY, Q.C.:  
 14 Q. And then December 9th, commitments for two of  
 15 four residents to take up a position and two  
 16 other JI visa applicants being considered.  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 COFFEY, Q.C.:  
 20 Q. Number three, work on a quality, major quality  
 21 assurance issues, developing a policies and  
 22 procedure manual for the division of  
 23 anatomical pathology. On April 1, 2005, it's  
 24 noted "quality assurance committee set up,  
 25 chaired by Dr. Bev Carter." Second bullet,

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1 "policy and procedure manual in progress."  
 2 Third bullet, "check path program, College of  
 3 American Pathologists Performance  
 4 Implementation, evaluation program proficiency  
 5 testing programs in place and records kept of  
 6 how each individual pathologist performed."  
 7 Fourth bullet, "participates in cyto pathology  
 8 evaluation program." Fifth bullet, "these  
 9 programs are all approved by MC -  
 10 DR. WILLIAMS:  
 11 A. MCOMP.  
 12 COFFEY, Q.C.:  
 13 Q. - OMP via Royal College of Physicians and  
 14 Surgeons. Next bullet, "interdepartmental  
 15 consultations documented" and then final  
 16 bullet, "reconcile our reports with those sent  
 17 outside the province." So what was this  
 18 about? I take it this is before ER/PR -  
 19 DR. WILLIAMS:  
 20 A. Yes. This is just -  
 21 COFFEY, Q.C.:  
 22 Q. - became known?  
 23 DR. WILLIAMS:  
 24 A. Yes, this is just ongoing work with respect to  
 25 what's being done in terms of quality

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1 initiatives within Eastern Health and how Dr.  
 2 Cook was moving forward on that agenda,  
 3 nothing to do with ER/PR in a sense, in  
 4 retrospect.  
 5 COFFEY, Q.C.:  
 6 Q. In the sense that the index case had not yet  
 7 occurred.  
 8 DR. WILLIAMS:  
 9 A. Correct.  
 10 COFFEY, Q.C.:  
 11 Q. As of April 1.  
 12 DR. WILLIAMS:  
 13 A. Yes.  
 14 COFFEY, Q.C.:  
 15 Q. Now the external proficiency testing was  
 16 being--what was that about, do you recall?  
 17 DR. WILLIAMS:  
 18 A. Yes, our pathologists were all participating  
 19 in external proficiency testing. It would  
 20 rate the pathologists and also rate the lab.  
 21 My understanding is that each pathologist  
 22 would participate and then there'd be a group  
 23 get together and the lab would--they would  
 24 participate as a group. So I think the lab  
 25 would be rated and the individual pathologist

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1 would be rated. The College of American  
 2 Pathologists has that program which we  
 3 subscribe to for pathologists.  
 4 COFFEY, Q.C.:  
 5 Q. So at the time, early in '05, well in fact,  
 6 going back to late '04, had the idea of--had  
 7 Dr. Cook raised with you any concern that he  
 8 might have had about quality assurance issues  
 9 and getting them documented and getting  
 10 enrolled in having that anatomical pathology -  
 11 DR. WILLIAMS:  
 12 A. Not in anatomical pathology, no. He was just--  
 13 I take this that he was just outlining the  
 14 things that they were doing in that area. I  
 15 didn't see it as an issue that he was raising,  
 16 "we have a problem here." I think he was just  
 17 saying look, here's the things we're doing in  
 18 quality. I wanted to really get some issues  
 19 on the table with respect to quality, what we  
 20 were doing, how we were documenting and these  
 21 type of things.  
 22 COFFEY, Q.C.:  
 23 Q. Now sir, were they doing external proficiency  
 24 testing at the time?  
 25 DR. WILLIAMS:

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1 A. Yes, that was my understanding.  
 2 COFFEY, Q.C.:  
 3 Q. How about for IHC?  
 4 DR. WILLIAMS:  
 5 A. That issue never came up.  
 6 COFFEY, Q.C.:  
 7 Q. Did you--I take it afterward though, you asked  
 8 and -  
 9 DR. WILLIAMS:  
 10 A. Yes.  
 11 COFFEY, Q.C.:  
 12 Q. - when ER/PR did come up and -  
 13 DR. WILLIAMS:  
 14 A. Dr. Cook said in his first memo that they  
 15 weren't doing it. That didn't come up at any  
 16 of these.  
 17 COFFEY, Q.C.:  
 18 Q. Okay. Now sir, if I could please, bring up,  
 19 please, Exhibit P-0467.  
 20 THE COMMISSIONER:  
 21 Q. We'll take the morning break after you're  
 22 through with this exhibit, Mr. Coffey.  
 23 COFFEY, Q.C.:  
 24 Q. Thank you, Commissioner. Page 12, please.  
 25 Now, sir, we have referred before to the 2003

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1 IHC matter. This is Dr. Ejeckam's memo to  
 2 pathologists, St. Clare's--Health Sciences  
 3 Centre, St. Clare's, and out of town  
 4 hospitals. Subject is the immunohistochemical  
 5 stains, April 4th, 2003. And it says "Thank  
 6 you, Dr. G. Ejeckam," copied to Barry Dyer and  
 7 all technical staff on immunohistochemistry.  
 8 So sir, your first recollection of seeing  
 9 this memo was when?  
 10 DR. WILLIAMS:  
 11 A. I don't--I know Dr. Cook gave me memos from  
 12 this issue back in July of 2005.  
 13 COFFEY, Q.C.:  
 14 Q. Okay.  
 15 DR. WILLIAMS:  
 16 A. I remember the two other memos, but I can't  
 17 recollect that. I may have seen it, but it  
 18 wasn't in my package in my binder, so I may  
 19 have lost it. But the memos I was shown or  
 20 what memos I saw were July 2005.  
 21 COFFEY, Q.C.:  
 22 Q. And dated back to '03?  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. So in 2003, you didn't see this memo, that you  
 2 recall?  
 3 DR. WILLIAMS:  
 4 A. No.  
 5 COFFEY, Q.C.:  
 6 Q. How about hear about the subject matter?  
 7 DR. WILLIAMS:  
 8 A. No, I did not.  
 9 COFFEY, Q.C.:  
 10 Q. If we could look, please, at Exhibit P-0904.  
 11 Now this is an agenda of the Surgical  
 12 Pathology Review Committee, April 15th 2003,  
 13 "two p.m. called to order. Business arising.  
 14 Terms of reference. One, the SPRC will review  
 15 standardized reporting of pathology specimens.  
 16 The SPRC will perform tissue audits on  
 17 surgical specimens and will serve as a forum  
 18 for interesting and/or difficult cases that  
 19 would be reviewed on an individual basis or on  
 20 specific request. It would be chaired by a  
 21 pathologist, would meet once every two months.  
 22 Would report directly to the vice-president of  
 23 medical affairs. This committee would make  
 24 recommendations, if necessary," and it's  
 25 copied to yourself and Dr. Cook, the agenda.

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1 Now were you aware that the Surgical Pathology  
 2 Review Committee was being created?  
 3 DR. WILLIAMS:  
 4 A. Yes, it was part of Dr. Cook's performance  
 5 goals and objectives.  
 6 COFFEY, Q.C.:  
 7 Q. And so would you have received this agenda in  
 8 April of '03?  
 9 DR. WILLIAMS:  
 10 A. Probably.  
 11 COFFEY, Q.C.:  
 12 Q. And in the normal course, how would such a  
 13 committee report to you?  
 14 DR. WILLIAMS:  
 15 A. Well, they could send me copies of minutes or  
 16 they could send me a report with  
 17 recommendations to me that my office would  
 18 need to follow up on.  
 19 COFFEY, Q.C.:  
 20 Q. Exhibit P-0467, page 26, please. Now this is-  
 21 -these are minutes of a meeting of April 15th  
 22 2003 for that committee. Present, Dr.  
 23 Ejeckam, Dr. Battcock, Dr. Dawson, Dr. Parai,  
 24 Dr. Siddiqui, Theresa Curtis is the secretary  
 25 and apologies from two physicians. The call

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1 to order, it says "the first meeting of the  
 2 Surgical Pathology Review Committee was called  
 3 to order by Dr. G. Ejeckam, chairman, at two  
 4 p.m. on April 15, 2003, in Room 2864 at Health  
 5 Sciences Centre" and "new business, paragraph  
 6 3.1, ER and PR receptors, Dr. G. Ejeckam  
 7 stated ER and PR receptors are not being  
 8 performed for the next six weeks due to a  
 9 technical problem. If a solution cannot be  
 10 found, these tests will be sent outside St.  
 11 John's. He stated it is being considered to  
 12 send one or two technologists to Halifax or  
 13 Toronto for training."  
 14 So Doctor, I take it then that this was  
 15 never brought to your attention at the time?  
 16 DR. WILLIAMS:  
 17 A. No.  
 18 COFFEY, Q.C.:  
 19 Q. Paragraph 3.1.  
 20 DR. WILLIAMS:  
 21 A. What happened is that I came back to work on  
 22 the day after Labour Day in 2003. I'd been  
 23 off ill for three months.  
 24 COFFEY, Q.C.:  
 25 Q. And so you didn't go off on sick leave until

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1 sometime in June?  
 2 DR. WILLIAMS:  
 3 A. Yes, the 7th or 9th of June, correct.  
 4 COFFEY, Q.C.:  
 5 Q. So if this was all going on in April and May  
 6 of '03, the suspension of testing and the re-  
 7 institution of testing in May that you're  
 8 about to see, can you tell the Commissioner  
 9 how it's possible that you did not see it and  
 10 didn't know about it?  
 11 DR. WILLIAMS:  
 12 A. Well, it wasn't brought to my attention.  
 13 COFFEY, Q.C.:  
 14 Q. Have you ever asked anybody why not?  
 15 DR. WILLIAMS:  
 16 A. Oh yes, yes.  
 17 COFFEY, Q.C.:  
 18 Q. Okay. Well, can you tell the Commissioner  
 19 when you did that and what they told you?  
 20 DR. WILLIAMS:  
 21 A. I did that in 2005 when I got the memos or two  
 22 of the three memos. I might have seen the  
 23 other one.  
 24 COFFEY, Q.C.:  
 25 Q. Who did you ask?

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1 DR. WILLIAMS:  
 2 A. I asked Dr. Cook and I talked to Mr. Gulliver  
 3 as well about the situation. Dr. Cook had  
 4 followed up on the matter in the summer of  
 5 2003. He had the discussion with Dr. Ejeckam  
 6 at the time. He had a discussion with Dr.  
 7 Robb to seek advice, because Dr. Robb was the  
 8 -in charge of the pathology program at the  
 9 medical school, the discipline chair of  
 10 pathology, and he'd followed up with them and  
 11 Mr. Gulliver at the time and also, he'd been  
 12 aware at that time that the surgical pathology  
 13 review committee had looked at the issue and  
 14 felt that the issue had been resolved and  
 15 there was no need to bring anything forward at  
 16 the time. That's my understanding.  
 17 COFFEY, Q.C.:  
 18 Q. Did you ask--I appreciate that they thought--  
 19 you're being told in '05 that they had thought  
 20 in '03 that it was resolved. How about the  
 21 fact that it had occurred at all? Like in the  
 22 period between the original suspension and the  
 23 resolution, did you ask him how the clinical  
 24 laboratory could shut down service for certain  
 25 stains for a period of time and you, as VP

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1 Medical, not be informed, particularly where  
 2 it involved other hospitals outside the city?  
 3 DR. WILLIAMS:  
 4 A. Well, it's a very small part of our lab,  
 5 number one, it's less than two percent of the  
 6 work that we do. Again, he had looked at it,  
 7 reviewed it at the time and felt that the  
 8 situation had been resolved and handled  
 9 properly.  
 10 COFFEY, Q.C.:  
 11 Q. How about your views of it, looking back from  
 12 '05?  
 13 DR. WILLIAMS:  
 14 A. Well, I guess looking at it from 2003 you'd  
 15 have one set of information, looking back at  
 16 it from 2005, you have an entirely different  
 17 set of information, Mr. Coffey.  
 18 COFFEY, Q.C.:  
 19 Q. Um-hm.  
 20 DR. WILLIAMS:  
 21 A. So, I mean, you're looking back in a  
 22 retrospective manner at the time with an  
 23 understanding that certain other issues have  
 24 come forward and there's some problems.  
 25 COFFEY, Q.C.:

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1 Q. So again, when -  
 2 COMMISSIONER:  
 3 Q. Are you saying that you didn't have a problem  
 4 with their decision in light of what they knew  
 5 at the time, is that the bottom line here?  
 6 DR. WILLIAMS:  
 7 A. Well, when Dr. Cook told me he'd had a good  
 8 discussion and follow up with senior people  
 9 and people involved and the surgical pathology  
 10 review committee had reviewed it, on that  
 11 basis he didn't bring it to my attention. I  
 12 was concerned with the memo Dr. Ejeckam wrote  
 13 to Mr. Gulliver and that there was no written  
 14 response to that and I told him such that I  
 15 felt we should have been replied to.  
 16 COFFEY, Q.C.:  
 17 Q. That's the June 19th memo?  
 18 DR. WILLIAMS:  
 19 A. Yes, that's correct.  
 20 COFFEY, Q.C.:  
 21 Q. And -  
 22 COMMISSIONER:  
 23 Q. But I think--I'm sorry, you haven't answered  
 24 Mr. Coffey's question, really, which is even  
 25 in light of what they knew at the time, in

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1 your position as the VP medical, was it your  
 2 view that they should have, in fact, told you  
 3 about it?  
 4 DR. WILLIAMS:  
 5 A. Well, I would have been saying that and it was  
 6 obviously at 2005 -  
 7 COMMISSIONER:  
 8 Q. No, no, I mean -  
 9 DR. WILLIAMS:  
 10 A. Yeah. It's hard to -  
 11 COMMISSIONER:  
 12 Q. Just put yourself back in 2003, without  
 13 knowing what's happening afterwards and judge  
 14 it on that basis, if you will, make your  
 15 assessment on the basis of not knowing about  
 16 what's happening with ER/PR, would it have  
 17 been your position that that was something  
 18 that should have been brought to the attention  
 19 of VP medical?  
 20 DR. WILLIAMS:  
 21 A. I mean, it's hard for me to answer that.  
 22 Given all the information I had in 2005 the  
 23 easy answer would be yes, I think that would  
 24 have been -  
 25 COMMISSIONER:



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1 Q. Yeah, but that's not the answer I'm looking  
 2 for.  
 3 DR. WILLIAMS:  
 4 A. No, no.  
 5 COMMISSIONER:  
 6 Q. I'm looking for the one that -  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 COMMISSIONER:  
 10 Q. - what as a VP medical--really, I suppose,  
 11 what I'm asking is what as a VP medical should  
 12 be brought to your attention? I'm just  
 13 concerned with how it goes up the line.  
 14 DR. WILLIAMS:  
 15 A. Sure. Major issues -  
 16 COMMISSIONER:  
 17 Q. And whether this made that level?  
 18 DR. WILLIAMS:  
 19 A. I guess major issues that cannot be resolved  
 20 in the lab and that I need to be involved in  
 21 further should come up the line to me.  
 22 COMMISSIONER:  
 23 Q. And this one, did they handle it correctly, in  
 24 your view, in light of what was known at the  
 25 time?

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1 DR. WILLIAMS:  
 2 A. Maybe based upon the discussion that Dr. Cook  
 3 had with the people that were involved at the  
 4 time, I can understand why he would have taken  
 5 that decision. He talked to Dr. Robb, who was  
 6 a senior pathologist, he talked to Dr.  
 7 Ejeckam, talked to Mr. Gulliver and he'd, by  
 8 that time, seen that the surgical pathology  
 9 review committee would have looked at the  
 10 issue and there was oncologists on that  
 11 committee and surgeons on that committee and  
 12 he felt at the time that he'd done due  
 13 diligence to it. Now, for me to sit here in  
 14 2005, it's, the easy thing for me to say is  
 15 that, you know, I think it should have been  
 16 brought forward. How I would have dealt with  
 17 it in 2003, had it been brought forward, I'm  
 18 not, to be honest, sure exactly how I would  
 19 have dealt with it.  
 20 COFFEY, Q.C.:  
 21 Q. If I could, please, Commissioner, 0467  
 22 Exhibit, please, page 12? Now the April 4th,  
 23 2003 memo, which is the first one in the  
 24 chain, from Dr. Ejeckam. I mean, as VP  
 25 medical do you think it's part or would you

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1 see it--when you were VP medical at the Health  
 2 Care Corporation, as it then was, as part of  
 3 your job function to be informed that a  
 4 pathologist who apparently had more than a  
 5 passing familiarity with IHC testing was  
 6 saying that eight stains have remained  
 7 unreliable, erratic and therefore unhelpful  
 8 for diagnostic purposes?  
 9 DR. WILLIAMS:  
 10 A. Well, again, I wouldn't -  
 11 COFFEY, Q.C.:  
 12 Q. I take it that's really what the Commissioner  
 13 is asking you. I mean, is that -  
 14 DR. WILLIAMS:  
 15 A. Yeah. I would expect to know this if there  
 16 was a reason for me to know it and that we  
 17 needed to resolve it and there was ongoing  
 18 problems with it. So on that basis I would  
 19 expect to know of these things.  
 20 COMMISSIONER:  
 21 Q. And who gets to make that determination? You  
 22 see my problem here, Dr. Williams, in the  
 23 sense of I know there's judgment call in  
 24 these things.  
 25 DR. WILLIAMS:

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1 A. Yes, um-hm.  
 2 COMMISSIONER:  
 3 Q. And that's the nature of the business and  
 4 somebody has to make this kind of call.  
 5 DR. WILLIAMS:  
 6 A. Sure.  
 7 COMMISSIONER:  
 8 Q. Sometimes the call is obvious, sometimes it  
 9 might be open to debate.  
 10 DR. WILLIAMS:  
 11 A. Yes.  
 12 COMMISSIONER:  
 13 Q. But from the lay person, looking at what  
 14 Ejeckam has written here, even if it is a  
 15 small percentage of what you do in the lab, it  
 16 looks like what he's saying is potentially  
 17 quite serious for the service that you  
 18 provide, not only to people within your area,  
 19 but outside. And you're not going to provide  
 20 it for a period of time, and there's  
 21 potentially the--you know, he's hoping the  
 22 solution is going to be found within the next  
 23 four to six weeks, but, gee, maybe he won't  
 24 find it.  
 25 DR. WILLIAMS:

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1 A. Um-hm.  
 2 COMMISSIONER:  
 3 Q. So from the person outside the organization it  
 4 looks to me like that would be the kind of  
 5 thing where at least you'd give your VP a  
 6 heads up, listen, we may have to go to tell  
 7 the people from outside our organization that  
 8 we're not going to be able to stand behind the  
 9 reliability of these tests which we're doing  
 10 for them and maybe they got to go elsewhere to  
 11 get them, that kind of stuff.  
 12 DR. WILLIAMS:  
 13 A. Um-hm.  
 14 COMMISSIONER:  
 15 Q. So -  
 16 DR. WILLIAMS:  
 17 A. Well, it could come from a variety of sources.  
 18 The leadership team in laboratory medicine  
 19 program or Dr. Ejeckam himself, really, could  
 20 write.  
 21 COFFEY, Q.C.:  
 22 Q. But the people directly involved, your two  
 23 subordinates, are recipients of these memos?  
 24 DR. WILLIAMS:  
 25 A. Yes.

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1 COFFEY, Q.C.:  
 2 Q. And the memo doesn't get sent to you or it's  
 3 not even addressed to you, neither of them is?  
 4 DR. WILLIAMS:  
 5 A. Correct.  
 6 COFFEY, Q.C.:  
 7 Q. Can you explain why that would be? I mean,  
 8 what if any process was in place to ensure  
 9 that, you know, memos of any significance got  
 10 sent to you, as well?  
 11 DR. WILLIAMS:  
 12 A. I don't think there was any particular  
 13 process, but certainly we have a leadership  
 14 team there in the lab and issues would be  
 15 dealt with at that level and then brought to  
 16 my attention.  
 17 COFFEY, Q.C.:  
 18 Q. So you would have had leadership team meetings  
 19 in probably April, May if not June, certainly  
 20 April and May -  
 21 DR. WILLIAMS:  
 22 A. I didn't have any in June or July or August.  
 23 COFFEY, Q.C.:  
 24 Q. But April and May of 2003?  
 25 DR. WILLIAMS:

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1 A. Yes.  
 2 COFFEY, Q.C.:  
 3 Q. And neither Dr. Cook nor Mr. Gulliver  
 4 mentioned this even in passing, that you can  
 5 recall?  
 6 DR. WILLIAMS:  
 7 A. No. It's not in the minutes.  
 8 COFFEY, Q.C.:  
 9 Q. And if it had been referred to, would it have  
 10 been recorded in the minutes?  
 11 DR. WILLIAMS:  
 12 A. Would have been recorded in the minutes, most-  
 13 -yes, everything is recorded in the minutes.  
 14 COFFEY, Q.C.:  
 15 Q. If we could, please, I'll just finish this, if  
 16 I could, Commissioner, this line of  
 17 questioning and then--Exhibit P-0907, please?  
 18 Sir, this is a memo to yourself from Dr.  
 19 Ejeckam dated September 30th, 2003. Appears  
 20 to be a received stamp in your office October  
 21 2nd, '03?  
 22 DR. WILLIAMS:  
 23 A. Um-hm.  
 24 COFFEY, Q.C.:  
 25 Q. And I think you've written "file", haven't

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1 you?  
 2 DR. WILLIAMS:  
 3 A. Yes.  
 4 COFFEY, Q.C.:  
 5 Q. Surgical pathology review committee meeting.  
 6 And it says, "Please find enclosed a copy of  
 7 the surgical pathology review committee  
 8 meeting minutes." It's signed by Dr. Ejeckam,  
 9 copied to Dr. Cook. And we look, these are  
 10 surgical pathology review committee minutes of  
 11 meeting September 23rd, 2003. Doctors  
 12 Ejeckam, Siddiqui, Parai and Tennent are  
 13 present, Mary Connors is there as secretary.  
 14 Apologies from Doctors Dawson and Battcock.  
 15 It's a call to order, paragraph 1, by Dr.  
 16 Ejeckam. Dr. Ejeckam asked if there was  
 17 anything that needed to be added or changed in  
 18 the previous minutes. Dr. Siddiqui moved to  
 19 accept the minutes, seconded by Dr. Parai.  
 20 And then "Business arising." "2.1 Estrogen  
 21 and progesterone status. Dr. Ejeckam stated  
 22 that the technical problem with staining for  
 23 ER and PR stains has been solved. Dr.  
 24 Siddiqui asked what were the standards for  
 25 performing her2/neu." And some discussion

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1 took place with regards to this. And it goes  
 2 on from there. Now, sir, you would have seen  
 3 this, I take it, in early October of 2003, I'm  
 4 sorry, 3, because you wrote "file" on it?  
 5 DR. WILLIAMS:  
 6 A. Um-hm.  
 7 COFFEY, Q.C.:  
 8 Q. The reference to "Dr. Ejeckam stated that the  
 9 technical problem with staining for ER and PR  
 10 stains has been solved," did you notice that  
 11 at the time or understand it?  
 12 DR. WILLIAMS:  
 13 A. No. As well, coming at the same time, on, I  
 14 think, August, October 3rd, there was a three  
 15 or four-page document with recommendations  
 16 from the surgical pathology review committee.  
 17 So I think I would have concentrated on that  
 18 and would have worked on that series of  
 19 recommendations or one big recommendation that  
 20 we move forward to the clinical chief's agenda  
 21 and to the MAC. So I may not have gone into  
 22 the minutes, other than seeing this  
 23 recommendation, unfortunately.  
 24 COFFEY, Q.C.:  
 25 Q. At the time, Doctor, would you have even

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1 understood what the technical problem with  
 2 staining for ER and PR stains has been solved,  
 3 would you have even understood what a  
 4 technical problem with staining for ER and PR  
 5 stains was?  
 6 DR. WILLIAMS:  
 7 A. No, I wouldn't have understood much unless I  
 8 asked a question about it.  
 9 COFFEY, Q.C.:  
 10 Q. I take it at the time you didn't?  
 11 DR. WILLIAMS:  
 12 A. No, I didn't. And I don't remember if I  
 13 looked through the minutes in detail because  
 14 we had, I think, a three-page document come  
 15 around the same time with what the surgical  
 16 pathology review committee felt was important  
 17 for me to deal with.  
 18 COFFEY, Q.C.:  
 19 Q. If we could, just before we break,  
 20 Commissioner, P-0906, please? Thank you.  
 21 Doctor, this is date stamped received by your  
 22 office October the 3rd, '03. It's from Dr.  
 23 Ejeckam to yourself. And he says, "Please  
 24 find attached the summary and recommendations  
 25 of the surgical pathology review committee

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1 meeting on some of the problems discussed in  
 2 the meeting."  
 3 DR. WILLIAMS:  
 4 A. Um-hm.  
 5 COFFEY, Q.C.:  
 6 Q. And then at the second page is a summary of  
 7 meeting of the surgical pathology review  
 8 committee and recommendations to vice  
 9 president medical services. Referring to the  
 10 meeting held on September 23rd, 2003.  
 11 DR. WILLIAMS:  
 12 A. Yes.  
 13 COFFEY, Q.C.:  
 14 Q. I take it this is the document you were  
 15 referring to just then?  
 16 DR. WILLIAMS:  
 17 A. Yes.  
 18 COFFEY, Q.C.:  
 19 Q. It goes on at some length including the fourth  
 20 page of the exhibit, "Recommendation to the  
 21 vice president of medical services." And this  
 22 had to do with filling out the forms properly?  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And trying to enforce that?  
 2 DR. WILLIAMS:  
 3 A. And that's the issue that was brought forward  
 4 and that's the issue that we took the  
 5 recommendations forward and eventually  
 6 resolved it.  
 7 COFFEY, Q.C.:  
 8 Q. Thank you, Commissioner. Break.  
 9 COMMISSIONER:  
 10 Q. Take 15 minutes.  
 11 (RECESS)  
 12 COMMISSIONER:  
 13 Q. Please be seated. Mr. Coffey.  
 14 COFFEY, Q.C.:  
 15 Q. Thank you, Commissioner. If I could, please,  
 16 actually, there are two questions, actually,  
 17 I--two areas I wanted to cover. One is P-  
 18 0385, please?  
 19 COMMISSIONER:  
 20 Q. I'm sorry, I didn't catch the number?  
 21 COFFEY, Q.C.:  
 22 Q. P-0385, I apologize.  
 23 COMMISSIONER:  
 24 Q. 0385?  
 25 COFFEY, Q.C.:

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1 Q. P-0385. This is some e-mails of October 26th,  
 2 '05?  
 3 DR. WILLIAMS:  
 4 A. Um-hm.  
 5 COFFEY, Q.C.:  
 6 Q. Actually, it's just the one. It's from  
 7 Deborah Pennell to a number of individuals.  
 8 It's, the subject is Out of the Fog interview.  
 9 And Dr., it says, "Dr. Williams is tentatively  
 10 scheduled to do a one-on-one interview with  
 11 Out of the Fog at Dr. William's office at  
 12 12:15ish tomorrow. They will bring the camera  
 13 to him and he will do a similar interview that  
 14 he's already done with NTV and CBC, etcetera.  
 15 Dr. Williams will not be going to the studio  
 16 and sitting down with," it's a patient's name,  
 17 "and Peter Dawe. The producer is going to  
 18 confirm the time with me later tonight or in  
 19 the a.m. but that is 99 percent certain as of  
 20 now. Deborah." Do you recall why it was that  
 21 there was a concern about you going in the Out  
 22 of the Fog and sitting down with Mr. Dawe and  
 23 a patient?  
 24 DR. WILLIAMS:  
 25 A. I didn't get a copy of this e-mail, so that's

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1 the--number one. Number two is I'm not sure  
 2 whether--what the background was to that, Mr.  
 3 Coffey. I'm jus surmising it may be that  
 4 there might be patient care issues come up and  
 5 I wouldn't be conversant with that. I'm not  
 6 sure, Mr. Coffey. You'd have to ask somebody  
 7 else. I can't--I'm just trying to surmise now  
 8 rather than recollect what happened.  
 9 COFFEY, Q.C.:  
 10 Q. Okay. If we could, please, Exhibit P-0784?  
 11 Page 44, please. This is the letter of  
 12 October 17th, 2005 from Dr. Banerjee to Dr.  
 13 Cook as clinical chief forwarding his report.  
 14 External quality review of the  
 15 immunohistochemistry service. And then the  
 16 second--I'm sorry, page 45 of the exhibit is  
 17 another, is a copy of the cover sheet of that  
 18 October 17th report. And there are then four  
 19 pages of text, including more than a page of  
 20 recommendations and footnotes.  
 21 DR. WILLIAMS:  
 22 A. Um-hm.  
 23 COFFEY, Q.C.:  
 24 Q. Now, sir, when you got Dr. Banerjee's report  
 25 in October of 2005, he has written here on

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1 page 3, at the bottom, right here, the report,  
 2 under the heading "Conclusions about the  
 3 reasons for test failure."  
 4 DR. WILLIAMS:  
 5 A. Um-hm.  
 6 COFFEY, Q.C.:  
 7 Q. And then on the next page he has another  
 8 heading, "Other system flaws observed." And  
 9 he's listed seven. See that?  
 10 DR. WILLIAMS:  
 11 A. Yes.  
 12 COFFEY, Q.C.:  
 13 Q. Sir, at the time you read this, what, if  
 14 anything, did you understand as to whether Dr.  
 15 Banerjee was here summarizing his views as to  
 16 why there had been a problem with the ER/PR  
 17 results?  
 18 COMMISSIONER:  
 19 Q. I'm not sure I follow the question, Mr.  
 20 Coffey.  
 21 COFFEY, Q.C.:  
 22 Q. I apologize.  
 23 DR. WILLIAMS:  
 24 A. - the question -  
 25 COFFEY, Q.C.:

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1 Q. Was this a summary, was this a summary on  
 2 these two pages of Dr. Banerjee's views as to  
 3 what had caused the problems?  
 4 DR. WILLIAMS:  
 5 A. Yeah, when Dr. Banerjee did--we did an exit  
 6 discussion with Dr. Banerjee.  
 7 COFFEY, Q.C.:  
 8 Q. Yeah, no, I'm just asking -  
 9 DR. WILLIAMS:  
 10 A. This would be a summary of what he found.  
 11 COFFEY, Q.C.:  
 12 Q. In terms of his conclusions about the reasons  
 13 for test failure?  
 14 DR. WILLIAMS:  
 15 A. Yes.  
 16 COFFEY, Q.C.:  
 17 Q. And other system flaws he'd observed, as well?  
 18 DR. WILLIAMS:  
 19 A. Um-hm.  
 20 COFFEY, Q.C.:  
 21 Q. Subsequently is there anything that you've  
 22 learned since you first saw this report in  
 23 October of '05 that has caused you to have any  
 24 doubt about the validity of what he said here?  
 25 DR. WILLIAMS:

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1 A. Well, from what I've read since, the main  
 2 problems you're going to get in a system in  
 3 immunohistochemistry is the retrieval process,  
 4 the heat treatment to tease off the antigen  
 5 antibody complex so that it can stain  
 6 properly. That would be one that keeps coming  
 7 up in anything I've seen. So that complicated  
 8 stages in that 40-step process.  
 9 COFFEY, Q.C.:  
 10 Q. Yes.  
 11 DR. WILLIAMS:  
 12 A. So that would--his comments are similar to  
 13 that. The other issue he talks about was the  
 14 system of checks and balances in terms of  
 15 controls that's designed to detect any problem  
 16 at the time. I would have to go through all  
 17 of these recommendations, but that would be my  
 18 -  
 19 COFFEY, Q.C.:  
 20 Q. Yes.  
 21 COMMISSIONER:  
 22 Q. Let me make sure I understood the point you're  
 23 making, if you would, Dr. Williams. When you  
 24 talk about the retrieval problems with are  
 25 discussed in literature, then I take it you're

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1 saying that that confirms as a problem some of  
 2 the things that Dr. Banerjee was talking  
 3 about?  
 4 DR. WILLIAMS:  
 5 A. Yes.  
 6 COMMISSIONER:  
 7 Q. Not, you know, because the original question  
 8 was have you learned anything since that would  
 9 cause you to doubt this.  
 10 DR. WILLIAMS:  
 11 A. Yes.  
 12 COMMISSIONER:  
 13 Q. And I was taking your answer to be saying, no,  
 14 but was I correct about that?  
 15 DR. WILLIAMS:  
 16 A. Yes, I haven't--I can't recollect anything  
 17 I've learned since and that would cause me to  
 18 doubt what his approach would suggest. Now,  
 19 there's a lot of water under the bridge since  
 20 he made those recommendations.  
 21 COMMISSIONER:  
 22 Q. Um-hm.  
 23 DR. WILLIAMS:  
 24 A. And had done his analysis.  
 25 COFFEY, Q.C.:

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1 Q. Doctor, just on that point, page 3, paragraph  
 2 1 under "Conclusions" about the reasons for  
 3 test failure, after asking the question "Is  
 4 the DAKO system faulty?" And "This is  
 5 unlikely as there are many laboratories using  
 6 the DAKO system successfully. The reason for  
 7 test failure was most likely due to a lack of  
 8 test optimization, including antigen retrieval  
 9 method and antibody/detection system  
 10 titration." So he does even there refer to  
 11 antigen retrieval methods?  
 12 DR. WILLIAMS:  
 13 A. The only thing, and it jigs my memory, the  
 14 only thing that's come up, and somebody else  
 15 is going to have to explain this a little bit  
 16 more, is that there was some issues with the  
 17 DAKO system in New Brunswick from Dr. Anne  
 18 O'Brien, and some suggestions that in her  
 19 statement that there may have been a pump  
 20 problem with that particular piece of  
 21 equipment. And somebody might suggest that  
 22 that may have happened here, but I haven't got  
 23 any strong evidence of that. Some people,  
 24 some of the pathologists have told me, Dr.  
 25 Denic and Dr. Cook, but you'd have to ask them

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1 in more detail because I don't know how that  
 2 pump works.  
 3 COFFEY, Q.C.:  
 4 Q. Um-hm.  
 5 DR. WILLIAMS:  
 6 A. And how it's supposed to pump the antibody  
 7 into certain areas. So you might want to ask  
 8 them a little bit more about that. That's  
 9 something that's very much related to the  
 10 technology and their comments.  
 11 COFFEY, Q.C.:  
 12 Q. Now, Doctor, on this point, I mean, having  
 13 read Dr. Banerjee's report, were you able to  
 14 draw any inferences or did you draw any  
 15 inferences yourself having read his report as  
 16 to how this had gone on undetected for so  
 17 long?  
 18 DR. WILLIAMS:  
 19 A. Not from his report, per se. But there are  
 20 issues that have come to mind, for instance,  
 21 we had a high turn over of pathologists, so  
 22 probably multiple people reading this. It's a  
 23 subspecialized area. And a high turnover of  
 24 oncologists so that the trends and this type  
 25 of thing, although he didn't mention it, may

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1 not have been recognized.  
 2 COFFEY, Q.C.:  
 3 Q. And you were aware, though, I take it, that a  
 4 number of pathologists had been there for many  
 5 years?  
 6 DR. WILLIAMS:  
 7 A. A number had been there, but a number of  
 8 others had come and gone. Since everybody was  
 9 reading these tests, not any one pathologist  
 10 or any number of pathologists would have a  
 11 high number of tests that they've read and may  
 12 not pick up trends if you're only reading a  
 13 small number of tests. That's some of the  
 14 issues that were discussed.  
 15 COFFEY, Q.C.:  
 16 Q. Now, where -  
 17 DR. WILLIAMS:  
 18 A. Not with Dr. Banerjee. The other thing that  
 19 Dr. Banerjee did say when he came from our  
 20 lab, and I remember this at his exit  
 21 interview, because he did spend some time  
 22 talking about it, was that he came out and  
 23 said, "You do have a problem." I didn't take  
 24 any notes on it, unfortunately, exit  
 25 interview, because he said he'd have a short

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1 report that would be very succinct and we'd  
 2 have it in short order but that he had  
 3 reviewed a number of other labs in various  
 4 jurisdictions and he felt that our lab was  
 5 performing in the middle of the pack, that's  
 6 what he said. Some labs are better and some  
 7 labs are worse. He went on to give us then  
 8 some information on some labs that he had  
 9 seen. He didn't name them by lab, but some of  
 10 the issues that had arisen in this particular  
 11 area.  
 12 COFFEY, Q.C.:  
 13 Q. Sir, did you, having read this report, ever  
 14 ask anyone in your organization how there  
 15 could be or could have been inadequate  
 16 attention paid by the grossing pathologist to  
 17 the thickness of tissue slices, quality and  
 18 adequacy of fixation?  
 19 DR. WILLIAMS:  
 20 A. No, I don't remember having a discussion about  
 21 that.  
 22 COFFEY, Q.C.:  
 23 Q. Did you ever ask anyone within your  
 24 organization as to how there could be that  
 25 there was no standardized fixation protocol

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1 that everyone adhered to?  
 2 DR. WILLIAMS:  
 3 A. I don't remember having a discussion about  
 4 that.  
 5 COFFEY, Q.C.:  
 6 Q. Did you ever ask anyone within your  
 7 organization, that's within Eastern Health or  
 8 the Health Care Corporation, as to how it  
 9 could be that there was inadequate or no  
 10 attention being paid by the reporting  
 11 pathologists to the status of internal  
 12 controls?  
 13 DR. WILLIAMS:  
 14 A. I did have some discussion about that, yes.  
 15 COFFEY, Q.C.:  
 16 Q. And what were you told?  
 17 DR. WILLIAMS:  
 18 A. I was told that -  
 19 COFFEY, Q.C.:  
 20 Q. Well, first of all, who did you have it with  
 21 and -  
 22 DR. WILLIAMS:  
 23 A. Well Dr. Cook and maybe subsequently with Dr.  
 24 Denic, I'm not sure. And that the issue of  
 25 internal controls only became an issue around

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1 the mid 2000, 2002, 2003 area, as a--around  
 2 2002, 2003, the issue of internal controls  
 3 were becoming an issue that needed to be paid  
 4 attention to, that's what I was told.  
 5 COFFEY, Q.C.:  
 6 Q. So when you spoke with Dr. Cook in '05 or Dr.  
 7 Denic, perhaps in '06, you were assured by one  
 8 or both of them that the usage of internal  
 9 controls in these sorts of tests -  
 10 DR. WILLIAMS:  
 11 A. Are becoming more of a factor written up in  
 12 the literature in about 2002, 2003 and this is  
 13 why you see Dr. Ejeckam in his memo paying  
 14 pretty careful attention to that issue.  
 15 COFFEY, Q.C.:  
 16 Q. Did Dr. Banerjee ever say that to you, that  
 17 this -  
 18 DR. WILLIAMS:  
 19 A. No, he didn't say that.  
 20 COFFEY, Q.C.:  
 21 Q. Did you ever ask Dr. Banerjee if that was--if  
 22 that's accurate?  
 23 DR. WILLIAMS:  
 24 A. No, I didn't ask Dr. Banerjee if that was  
 25 accurate.

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1 THE COMMISSIONER:  
 2 Q. And just to make sure that I have it straight,  
 3 as a result of your conversations with Drs.  
 4 Cook and Denic, you were given to understand  
 5 that prior to 2002, 2003, one would not be  
 6 using internal controls?  
 7 DR. WILLIAMS:  
 8 A. No, that the issue had been becoming more of a  
 9 factor by that time, it wasn't--that's what my  
 10 understanding from Dr. Cook was, but I'm not  
 11 sure if it was Dr. Denic -  
 12 THE COMMISSIONER:  
 13 Q. But how did you interpret that in the sense of  
 14 was Dr. Cook saying to you, look, you couldn't  
 15 expect us to have internal controls before  
 16 2002, 2003? Was that the message?  
 17 DR. WILLIAMS:  
 18 A. No the issue of the importance of internal  
 19 controls, people paying a lot of, you know,  
 20 hanging their hat a lot on internal controls  
 21 had become a factor as time went on with this  
 22 particular testing, and of course, there's no  
 23 absolutes in these internal controls.  
 24 Sometimes I've been advised that the internal  
 25 controls can be negative; nor breast tissue

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1 may not, I've been told, always take up stain-  
 2 -they've seen some cases since Dr. Cook and  
 3 Dr. Carter have been doing it and it's a small  
 4 group basis and sort of trying to  
 5 subspecialize, that they've seen some cases  
 6 where the controls were negative, yet the  
 7 tests were positive.  
 8 COFFEY, Q.C.:  
 9 Q. Dr. Banerjee, I take it, was telling you in  
 10 October of 2005 in this report that in his  
 11 view, looking at the top of page 4, paragraph  
 12 4, "And in the event, the poor fixation  
 13 resulted in an internal control failure in all  
 14 available blocks. This should have been noted  
 15 in the reports as an uninterpretable cases due  
 16 to failure or absence of internal controls."  
 17 So was it your understanding at the time that  
 18 Dr. Banerjee, if I could just look back here,  
 19 first page of this report, review of cases,  
 20 would have understood that--as he writes here  
 21 under the incident problem case, the third  
 22 paragraph says, "Four other patients  
 23 previously tested as negative in 2002 were  
 24 also retested and all tested positive with the  
 25 Ventana system. This lead to a review of

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1 other 57 cases reported in 2002 as negative,  
 2 which on retesting on the Ventana benchmark  
 3 resulted in a high conversion rate from  
 4 negative to positive, 38 or 57, 67 percent."  
 5 So was it your understanding in October of  
 6 2005 that Dr. Banerjee in writing this report  
 7 knew he was dealing with 2002 cases. That  
 8 says, doesn't it -  
 9 DR. WILLIAMS:  
 10 A. Yes, that's what it says.  
 11 COFFEY, Q.C.:  
 12 Q. Did you ever ask Dr. Cook or Dr. Denic why is  
 13 it that Dr. Banerjee said that this should  
 14 have been picked up in 2002 and would have,  
 15 perhaps, if internal controls had been used?  
 16 DR. WILLIAMS:  
 17 A. Well again, I think Dr. Banerjee's -  
 18 COFFEY, Q.C.:  
 19 Q. If it wasn't yet known. Did you ever take  
 20 that up with him?  
 21 DR. WILLIAMS:  
 22 A. No, I didn't take that up with him. What I  
 23 took up with him is that really what Dr.  
 24 Banerjee is basically saying is that your  
 25 pathologists need to subspecialize if you're

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1 getting into a very detailed area, such as  
 2 this, and that's what I took as his main  
 3 recommendation to deal with these issues--  
 4 along with some other issues. We had Trish  
 5 looking at the technical aspect of it, but his  
 6 main recommendation, one of his main  
 7 recommendations and key ones was your  
 8 pathologists should subspecialize in this  
 9 area.  
 10 THE COMMISSIONER:  
 11 Q. When you say "in this area" do you mean IHC or  
 12 do you mean ER/PR?  
 13 DR. WILLIAMS:  
 14 A. No, ER/PR that you should have--whether all  
 15 pathologists reading ER/PR, you should get  
 16 together a group of pathologists to develop  
 17 expertise and subspecialization around this  
 18 area, so all pathologists wouldn't be reading  
 19 it, that was one of his key recommendations.  
 20 COFFEY, Q.C.:  
 21 Q. Do you recall if in his report, October 17th,  
 22 2005, Dr. Banerjee said anything about the  
 23 issue of certain types of cancer should have  
 24 been perhaps recognized as likely to be ER or  
 25 PR positive?

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1 DR. WILLIAMS:  
 2 A. Well I think he references it in here, Mr.  
 3 Coffey. Another thing he references in here  
 4 and I guess we'll have to do some follow up on  
 5 that, is utilizing different antibodies that  
 6 have been used over time and recommending we  
 7 take a look at the rabbit monoclonal antibody  
 8 as another issue that needs to be dealt with.  
 9 Now I'm not sure when the instituted the  
 10 testing if we used the rabbit monoclonal  
 11 antibody or not, but we indicated that has a  
 12 five to ten percent higher positivity rate,  
 13 then that's another issue for labs that are  
 14 doing testing.  
 15 COFFEY, Q.C.:  
 16 Q. Now under the incident problem case, which is  
 17 page two of his report, he numbers his cover  
 18 page, page number one, he says under the  
 19 incident problem case, second paragraph, "It  
 20 should be noted that invasive lobular  
 21 carcinomas are frequently ER positive, 92  
 22 percent."  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 COFFEY, Q.C.:

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1 Q. And he footnotes it with a citation, "Thus the  
 2 initial negative results should have been  
 3 questioned." Did you ever ask anybody about  
 4 that, either an oncologist or a pathologist  
 5 within Eastern Health or the Health Care  
 6 Corporation as to--take it up with them, Dr.  
 7 Banerjee's assertion that the initial negative  
 8 results should have been questioned?  
 9 DR. WILLIAMS:  
 10 A. Well that was discussed, I can't say with who  
 11 and at what particular time, but we did have  
 12 some discussion and the issue was that, well  
 13 just one case by itself may not cause it to be  
 14 questioned, so if you had different  
 15 pathologists reading and different oncologists  
 16 looking at different cases, you wouldn't get  
 17 any trends established, that's, as I mentioned  
 18 earlier, that was part of that discussion and  
 19 follow up.  
 20 COFFEY, Q.C.:  
 21 Q. Thank you, Commissioner. Thank you.  
 22 DR. WILLIAMS:  
 23 A. Thank you, Mr. Coffey.  
 24 THE COMMISSIONER:  
 25 Q. Mr. Pritchard?

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1 COFFEY, Q.C.:  
 2 Q. Before you do, well I have been asked to enter  
 3 two exhibits, please. I apologize.  
 4 THE COMMISSIONER:  
 5 Q. What two are they?  
 6 COFFEY, Q.C.:  
 7 Q. It's by other counsel. Exhibit P-1368 and P-  
 8 1384, Commissioner?  
 9 THE COMMISSIONER:  
 10 Q. 1368 and 1384?  
 11 COFFEY, Q.C.:  
 12 Q. Yes, ma'am  
 13 THE COMMISSIONER:  
 14 Q. Entered.  
 15 EXHIBITS ENTERED AND MARKED P-1368 AND P-1384.  
 16 THE COMMISSIONER:  
 17 Q. Now, Mr. Pritchard.  
 18 MR. PRITCHARD:  
 19 Q. Thank you, Commissioner, I don't have any  
 20 questions for this witness, thank you.  
 21 THE COMMISSIONER:  
 22 Q. Mr. Browne?  
 23 MR. BROWNE:  
 24 Q. Just a couple of questions, Commissioner.  
 25 THE COMMISSIONER:

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1 Q. Mr. Browne, did you--are those the exhibits  
 2 being put in now at your behest, as it were?  
 3 MR. BROWNE:  
 4 Q. Yes.  
 5 THE COMMISSIONER:  
 6 Q. Oh, all right. I know we had a couple of  
 7 requests, I just want to make sure that your  
 8 particular ones were here, Mr. Browne. I  
 9 think there are two more coming.  
 10 COFFEY, Q.C.  
 11 Q. There are two more, Mr. Browne, I have the  
 12 actual numbers, Commissioner, it's P-1307.  
 13 THE COMMISSIONER:  
 14 Q. 1307.  
 15 COFFEY, Q.C.:  
 16 Q. And P-1317.  
 17 THE COMMISSIONER:  
 18 Q. 1317.  
 19 COFFEY, Q.C.:  
 20 Q. Yeah, it was during the break that Mr. Browne  
 21 asked that these be entered, so that's just  
 22 two more -  
 23 THE COMMISSIONER:  
 24 Q. Yeah, I understood that we were entering two  
 25 different groups at the request of two



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1 different counsel.  
 2 COFFEY, Q.C.:  
 3 Q. Yes, two different lawyers.  
 4 THE COMMISSIONER:  
 5 Q. So Mr. Browne should know that the ones that  
 6 he asked for are 1307 and 1317?  
 7 REGISTRAR:  
 8 Q. He said 1303.  
 9 THE COMMISSIONER:  
 10 Q. O3, all right, dyslexia again, and 1317, okay.  
 11 EXHIBITS ENTERED AND MARKED P-1307 AND P-1317  
 12 DR. ROBERT WILLIAMS, EXAMINATION BY MR. PETER BROWNE  
 13 MR. BROWNE:  
 14 Q. Thank you, Commissioner. Good morning, Dr.  
 15 Williams.  
 16 DR. WILLIAMS:  
 17 A. Good morning. Registrar, are those available  
 18 on the screen now?  
 19 THE COMMISSIONER:  
 20 Q. They can be, whenever you want.  
 21 MR. BROWNE:  
 22 Q. Why don't we, since those have been mentioned,  
 23 deal with those right now, enter them all and  
 24 I'll have some questions on those.  
 25 THE COMMISSIONER:

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1 Q. They're entered.  
 2 REGISTRAR:  
 3 Q. Which one would you like, Mr. Browne?  
 4 MR. BROWNE:  
 5 Q. Can we begin with 1317 please?  
 6 THE COMMISSIONER:  
 7 Q. 1317, all right.  
 8 MR. BROWNE:  
 9 Q. Dr. Williams, this is an article that I found  
 10 and it refers to you, you were speaking to the  
 11 Commissioner about the notion of bimodal  
 12 frequency in ER/PR, you see this is an article  
 13 with regard to that. And if we can--I think  
 14 you have a mouse in front of you, you can  
 15 scroll down, you can look at the abstract  
 16 there.  
 17 DR. WILLIAMS:  
 18 A. I'll let you scroll because I'll interfere  
 19 with you.  
 20 MR. BROWNE:  
 21 Q. Okay, fine. This seems to be--I don't want to  
 22 get into a great degree of analysis here, but  
 23 are you familiar with the classification of  
 24 studies in the literature, like Class I  
 25 studies, Class II studies in terms of degree

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1 of reliability of a particular article or  
 2 journal, presentation. We have med analysis  
 3 that gives it a higher classification, I don't  
 4 want to get into that unless you're -  
 5 DR. WILLIAMS:  
 6 A. I'm aware of the literature that a lot of  
 7 stuff gets published in the literature, when  
 8 you challenge it from an epidemiological  
 9 perspective, I did a couple of courses on  
 10 terms of looking at, reviewing the literature,  
 11 I used to know how to do it back in the early  
 12 1980s, but a lot of things get published in  
 13 the literature may not stand up to some of  
 14 those tests of scrutiny.  
 15 MR. BROWNE:  
 16 Q. Right.  
 17 DR. WILLIAMS:  
 18 A. So they may now, you're probably talking about  
 19 different--I understand the classical  
 20 epidemiology, but I don't understand what  
 21 you're saying about Class I and Class II and  
 22 what -  
 23 MR. BROWNE:  
 24 Q. And as I understand it, there are certain  
 25 categories which are more reliable because

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1 what they do and we think we've heard about  
 2 the term med analysis -  
 3 DR. WILLIAMS:  
 4 A. Yes, med analysis tends to bring together all  
 5 the studies that have been done.  
 6 MR. BROWNE:  
 7 Q. On a particular subject matter.  
 8 DR. WILLIAMS:  
 9 A. Yes, one study in itself may give you a  
 10 certain trend or some studies, but then when  
 11 you--say you look at 15 studies, you might  
 12 think this is the result, but when you look at  
 13 all the hundred studies, you might get a  
 14 different view.  
 15 MR. BROWNE:  
 16 Q. Right, and that's the important--med analysis  
 17 is something that just recently developed, I  
 18 think, over the past -  
 19 DR. WILLIAMS:  
 20 A. Past five or six years, maybe, yes.  
 21 MR. BROWNE:  
 22 Q. Now this particular article, as I understand  
 23 it, is one particular lab's experience with  
 24 and a review of their own ER/PR tumors. And  
 25 if you can see there in the abstract, just

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1 take a moment and read that and tell me if it  
 2 concords with what you understood in telling  
 3 the Commissioner about this information that  
 4 you received in, I think, 2005/2006 regarding  
 5 the bimodal frequency? Do you see that last  
 6 sentence there--last two sentences -  
 7 DR. WILLIAMS:  
 8 A. Yes, that's correct.  
 9 MR. BROWNE:  
 10 Q. "Thus the immunohistochemical method used in  
 11 our lab, ER staining is essentially bimodal,  
 12 the overwhelming majority of breast cancers  
 13 are either completely ER negative or  
 14 unambiguously ER positive and cases with weak  
 15 ER immunostaining are rare." And this  
 16 article, as I understand it, was published in  
 17 2005, so again, is this the literature you  
 18 were referring to earlier in your evidence  
 19 about -  
 20 DR. WILLIAMS:  
 21 A. Yes, it's a different article that came out in  
 22 2006, I think that I sent to Mr. Dawe as part  
 23 of the package I sent to him.  
 24 MR. BROWNE:  
 25 Q. Right.

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1 DR. WILLIAMS:  
 2 A. And the understanding that people had sometime  
 3 before that, especially when they were doing  
 4 the biochemistry staining, was that there was  
 5 a spectrum that's almost a normal distribution  
 6 curve that you'd have some samples were one  
 7 percent, two percent, 10 percent, 20 percent,  
 8 and right up to 100 percent. And based upon  
 9 the new detection systems and this type of  
 10 thing that were coming into the forefront,  
 11 probably around 2003, 2004, as we moved along  
 12 with this, that concept was thrown out the  
 13 window and there is now a bimodal curve that  
 14 90 percent of the patients are either totally  
 15 negative or pretty well completely positive  
 16 and that there is very little in the, what we  
 17 thought was, you know, there's a small number  
 18 at the bottom end of the spectrum that are  
 19 probably difficult to detect, but they are  
 20 there and so that's a bimodal curve, rather  
 21 than a normal distribution curve, you now have  
 22 a bimodal curve. That was the change of  
 23 thought process.  
 24 MR. BROWNE:  
 25 Q. Right, and I guess the point you were trying

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1 to make to the Commissioner, and you can give  
 2 me an answer, was as all this was unfolding,  
 3 this new information was coming in in 2005,  
 4 2006 which affected some of the analysis as  
 5 well?  
 6 DR. WILLIAMS:  
 7 A. Yes, that would be--I know that when the  
 8 Ventana system came into place, there were  
 9 some concerns expressed because there was a  
 10 lot of very high percentage of cells, staining  
 11 positive, unlike what they'd seen before or  
 12 unlike what they expected.  
 13 MR. BROWNE:  
 14 Q. Now, the next article Dr. Williams I would  
 15 like to refer you to, is P-1303? Thank you,  
 16 Registrar. Now this is an article, Doctor,  
 17 that has actually nothing to do with ER/PR or  
 18 immunohistochemistry, in fact, an article  
 19 dealing with hospital responses and an article  
 20 out of the United States, hospital responses  
 21 to fairly severe events, bioterrorism,  
 22 pandemic flus and so on.  
 23 DR. WILLIAMS:  
 24 A. Uh-hm.  
 25 MR. BROWNE:

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1 Q. But I want to focus on, if I could, please, if  
 2 we could go to page, I think it's three of  
 3 this particular--yes, thank you. And it  
 4 follows in a comment that you made about  
 5 having sort of lessons learned and looking  
 6 back on sort of your experiences here. If you  
 7 can look at the paragraph, "Despite  
 8 requirements, standards and best intentions"--  
 9 and just read that for a minute.  
 10 DR. WILLIAMS:  
 11 A. I don't know what the word is in the second  
 12 paragraph.  
 13 MR. BROWNE:  
 14 Q. I think it's lack of--it should be surge  
 15 capacity and I'll explain what I understand  
 16 the article talks about that.  
 17 DR. WILLIAMS:  
 18 A. Okay.  
 19 MR. BROWNE:  
 20 Q. Surge capacity, as I understand then this sort  
 21 of dealt with somewhere in this article as  
 22 well, is that when a major incident, such as  
 23 bioterrorism or a pandemic happens and you  
 24 have, as this paragraph reflects,  
 25 contemporaneously with that, an infrastructure

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1 change, all these demands come upon the  
 2 hospital and it identifies their short comings  
 3 and inability to deal with a problem.  
 4 DR. WILLIAMS:  
 5 A. Uh-hm.  
 6 MR. BROWNE:  
 7 Q. And is that something that you sort of,  
 8 looking back and reflecting on the situation  
 9 here, feel may have some relevance to what  
 10 happened?  
 11 DR. WILLIAMS:  
 12 A. Well certainly in terms of getting a timely  
 13 response from Mount Sinai it had a problem  
 14 because they didn't have, in retrospect, any  
 15 capacity to increase their testing beyond a  
 16 certain amount and we only got dealt with when  
 17 they brought in our tests over Christmas and  
 18 dealt with them, major things like that. Also  
 19 really at the time, as I've said before, we  
 20 were in the midst of a major reorganization  
 21 that was much bigger, I think, than the  
 22 organization that took place in the mid 1990s  
 23 and when you're trying to do that and trying  
 24 to do a lot of other things, your capacity to  
 25 handle it in terms of how much are you

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1 expected to do and how much are you able to  
 2 do, when all these things are happening around  
 3 you. And by the way, this wasn't an isolated  
 4 event, we were having a lot of other issues  
 5 going on within St. John's and within Eastern  
 6 Health. I remember at the time when I look  
 7 back at my notes, we were trying to maintain a  
 8 medical oncology service for the province so  
 9 that people, a hematological oncology service,  
 10 so that people with leukemias, lymphomas and  
 11 that would continue to be treated. We had  
 12 five people in the program, one was doing the  
 13 transplant medicine for us, transplants for  
 14 us, left the province. We were left with  
 15 four. One of those four was a person who was  
 16 semi-retired and the other one was on  
 17 sabbatical leave, so we went down really to  
 18 two fulltime and one part-time person, where  
 19 we are five, four fulltime and one part-time  
 20 person, and then we had to, you know, struggle  
 21 to see how we were going to maintain that  
 22 service and provide coverage for  
 23 hematology/oncology in the province. If we  
 24 had of lost that service, that would have been  
 25 just as much as a problem as the ER/PR issue.

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1 We also, in the summer of 2006, when we were  
 2 trying to deal with some of these things, had  
 3 a major shortage of pharmacists. Pharmacists  
 4 do a lot of work within hospitals and a lot of  
 5 it relates to quality. We were back so that  
 6 we lost, I think 30 percent of our pharmacists  
 7 because we have a big private market out there  
 8 which includes other provinces who pay a bit  
 9 more, the same as the pathology issue, and the  
 10 private sector, like Shoppers Drug Mart and  
 11 these types of thing, were paying 20, 25,000  
 12 more per year than we could in the hospital  
 13 system for a pharmacist. So we had about a  
 14 year working with the Department of Health and  
 15 Treasury Board and Government trying to  
 16 resolve that issue. And I remember in the  
 17 summer of 2006 having to deal with the media  
 18 in July and August about trying to tell the  
 19 public if we had a safe system in the hospital  
 20 with respect to drugs and this type of thing.  
 21 So all these things are going on at the same  
 22 time as you're trying to bring together a  
 23 very, very diverse organization in a diverse  
 24 geographic area. So our ability to sort of  
 25 just focus on this -

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1 MR. BROWNE:  
 2 Q. To deal with this surge in your capacity.  
 3 DR. WILLIAMS:  
 4 A. Yes, but retrospectively, you know, I'll have  
 5 some comments to make later about some of  
 6 these lessons learned here.  
 7 MR. BROWNE:  
 8 Q. Now, if we could just moving into the lab  
 9 medicine program set up and focusing for a  
 10 minute on the proficiency testing. Putting  
 11 aside for a minute the division under Dr. Cook  
 12 and Mr. Gulliver, other divisions in, I guess  
 13 the laboratory medicine program -  
 14 DR. WILLIAMS:  
 15 A. Yes.  
 16 MR. BROWNE:  
 17 Q. Were any of those divisions involved in  
 18 proficiency testing that you were aware of?  
 19 DR. WILLIAMS:  
 20 A. Yes, my understanding is that biochemistry,  
 21 hematology, bacteriology and pathology were  
 22 all involved in proficiency testing,  
 23 standardized proficiency testing that the lab  
 24 would normally participate in.  
 25 MR. BROWNE:

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1 Q. Okay, and were those external proficiency  
 2 testing programs, were they under the auspices  
 3 of the program managers for those divisions?  
 4 DR. WILLIAMS:  
 5 A. Yes, they were, that's my recollection.  
 6 MR. BROWNE:  
 7 Q. And in the lab medicine program, who was  
 8 responsible for the technical aspect?  
 9 DR. WILLIAMS:  
 10 A. There was two--we had two streams and we  
 11 talked about those two streams as part of the  
 12 report and what we've done about them. There  
 13 was a technology stream and the pathology  
 14 stream.  
 15 MR. BROWNE:  
 16 Q. Correct.  
 17 DR. WILLIAMS:  
 18 A. And I would say the managers of the different  
 19 sections, like biochemistry and hematology  
 20 would be dealing with the proficiency testing  
 21 there and the pathology would be done with Dr.  
 22 Cook. That's--now you can clarify that with  
 23 some other people who are closer to it than  
 24 me, but that's my understanding.  
 25 MR. BROWNE:

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1 Q. Sure. And I think you talked about that in  
 2 reference to Dr. Cook's goals in terms of the  
 3 2003, 2004 years.  
 4 DR. WILLIAMS:  
 5 A. Yes.  
 6 MR. BROWNE:  
 7 Q. And he mentioned, I think in there, some  
 8 proficiency testing with the -  
 9 DR. WILLIAMS:  
 10 A. Oh in detail.  
 11 MR. BROWNE:  
 12 Q. In terms of for pathologists individually -  
 13 DR. WILLIAMS:  
 14 A. Pathologists individually and collectively,  
 15 what we did was that pathologists were rated,  
 16 my understanding--Dr. Cook had explained it  
 17 further, College of American Pathologists was  
 18 the group that subscribed to--I'm not sure if  
 19 it's a different group in the U.S. on the St.  
 20 Clare's site, but then pathologists were rated  
 21 individually and then what Dr. Cook would do,  
 22 is bring the pathologists together as a group  
 23 and interpret some of the slides, so then the  
 24 group would be rated too. But individually  
 25 they would be rated and there was a record

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1 kept of those.  
 2 MR. BROWNE:  
 3 Q. But my point there being is that Dr. Cook was  
 4 not responsible for proficiency testing of the  
 5 technical side of that, it was only  
 6 interpretation and so on of slides.  
 7 DR. WILLIAMS:  
 8 A. Yes, he was looking at the pathology side.  
 9 MR. BROWNE:  
 10 Q. Pathology side, okay. Prior to, I guess this  
 11 incident, 2005, were there individuals in  
 12 place for dedicated quality assurance for the  
 13 lab medicine program?  
 14 DR. WILLIAMS:  
 15 A. No, there was not, of course there are now,  
 16 but not arising out of this issue, but as you  
 17 know that when we came together in 2005 as  
 18 Eastern Health and we, we got a mandate for  
 19 quality, that there was a commitment that we'd  
 20 put, you know, try to put more emphasis and  
 21 more resources on quality and we visited  
 22 Calgary which we were told by Dr. Robson who  
 23 came from Winnipeg, don't come to Winnipeg,  
 24 we're just starting the process ourselves, but  
 25 go to Calgary because they had a major problem

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1 with adverse events, an adverse event and two  
 2 or three people died suddenly in Calgary in  
 3 2003 or 2004 and they had a quality audit and  
 4 based upon that quality audit, they did a  
 5 total reorganization of their quality program.  
 6 So Pam Elliott and myself visited Calgary in  
 7 early 2006, January 2006. We made contact  
 8 after Ms. Elliott was appointed in the fall of  
 9 2006--wait now, I'm just trying to recollect  
 10 this, 2005, yes, we made contact in the fall  
 11 of 2005 with Calgary and asked if we could  
 12 visit them. Contacted their vice-president  
 13 responsible for quality and a site visit was  
 14 arranged in early January, 2006, but we did  
 15 sit in on one of their regional quality  
 16 meetings that they had on a once monthly, so  
 17 we did see their senior quality meeting. We  
 18 met all the key players, we spent two or three  
 19 days there and came back and modelled our  
 20 quality program after the Calgary model, which  
 21 would see attached to each of, at least the  
 22 VP's portfolios, at least a minimum of one  
 23 person who would be totally focused on quality  
 24 within that portfolio. No other job, no other  
 25 focus, just quality. So for the diagnostic

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1 area we were able--well it happened after I  
 2 had left but it was in progress before I left,  
 3 that we had one person totally dedicated to  
 4 quality in that particular area of diagnostic  
 5 imaging, pharmacy and laboratory medicine, the  
 6 portfolio of the vice-president responsible  
 7 for the areas.  
 8 MR. BROWNE:  
 9 Q. But nevertheless, was this sort of heading in  
 10 this direction, did that pre-date all of what  
 11 happened in terms of April and May of 2005 in  
 12 terms of -  
 13 DR. WILLIAMS:  
 14 A. Well before Eastern Health came together,  
 15 there was a commitment that we were going to  
 16 do that, it pre-dated the ER and PR, just that  
 17 ER/PR happened contemporaneously with the  
 18 decision that was already made to go in this  
 19 direction.  
 20 MR. BROWNE:  
 21 Q. That was my point. Now the Commissioner asked  
 22 you, I think, as well this morning about the  
 23 test, we saw Dr. Cook's note from Dr. Abidi  
 24 about Clarendville the issues with Clarendville,  
 25 one of the issues there was the fact they were

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1 paying for tests. Besides ER/PR, were there  
 2 other tests that were being paid for by  
 3 hospitals?  
 4 DR. WILLIAMS:  
 5 A. There are other tests that are being paid for  
 6 or were being paid for, I don't know if  
 7 they've changed that since, that required  
 8 Health Care Corporation to bill other health  
 9 boards and what we were trying to do in the  
 10 budget process is get that money put in our  
 11 budget so we wouldn't have to bill these other  
 12 boards. It made a lot of sense to do it that  
 13 way because there's only one payor in the  
 14 province.  
 15 MR. BROWNE:  
 16 Q. But prior to that, the money that was  
 17 generated for these tests, did it go back to  
 18 the lab medicine program?  
 19 DR. WILLIAMS:  
 20 A. No, it did not, it went into general revenue.  
 21 We tried on occasion to get that money just to  
 22 go to the lab, because we wanted to do other  
 23 things in the lab from time to time.  
 24 MR. BROWNE:  
 25 Q. Sure, but it nevertheless went back to general

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1 revenue.  
 2 DR. WILLIAMS:  
 3 A. Yes, it did.  
 4 THE COMMISSIONER:  
 5 Q. General revenue of the province.  
 6 DR. WILLIAMS:  
 7 A. General revenue for the Health Care  
 8 Corporation.  
 9 THE COMMISSIONER:  
 10 Q. For health care.  
 11 DR. WILLIAMS:  
 12 A. Yes. But we weren't able to say well we, that  
 13 money came into the lab, we can use that now  
 14 for some laboratory initiatives. We tried  
 15 that and didn't get very far with that.  
 16 MR. BROWNE:  
 17 Q. Okay, did you try that or did the lab try to  
 18 have that -  
 19 DR. WILLIAMS:  
 20 A. No, we tried, I tried that on occasion, the  
 21 executive team. It may be documented, but we  
 22 tried it.  
 23 MR. BROWNE:  
 24 Q. Now as well you were asked about the  
 25 centralization of lab services, I think this

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1 was raised by Mr. Gulliver in 2003 about doing  
 2 that, now am I correct in understanding that  
 3 his suggestion was centralization of the  
 4 technical side of it, not -  
 5 DR. WILLIAMS:  
 6 A. At that point in time, it was the technical  
 7 side of the operation. They had a--it was  
 8 either this March of 2003 or 2002, they had a  
 9 one-day planning retreat for laboratory  
 10 medicine where all the leadership were there,  
 11 the division managers, the people like Dr.  
 12 Cook, the clinical chief and other people and  
 13 I spoke to them at that time. I had an  
 14 introduction of about a half hour to talk  
 15 about the importance of a planning day and  
 16 that's where the issue of centralizing  
 17 technical processing services came up and then  
 18 we tried to work through that. I think Dr.  
 19 Cook's, one of his notes that was presented to  
 20 me on Friday, 12 point summary after he did  
 21 the reviews of the pathologists, outlined that  
 22 that was one of the issues that we need to be  
 23 pursuing.  
 24 MR. BROWNE:  
 25 Q. Right.

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1 DR. WILLIAMS:  
 2 A. So, you know, it's not that he didn't support  
 3 it, it's that he felt that we needed to, at  
 4 that time he saw it as an issue that we needed  
 5 to deal with.  
 6 MR. BROWNE:  
 7 Q. Flesh it out a bit more.  
 8 DR. WILLIAMS:  
 9 A. Yes, deal with an issue, so at the end of the  
 10 day, he did support it, but some things had to  
 11 be put in place.  
 12 MR. BROWNE:  
 13 Q. And he felt certain things need to be  
 14 addressed before -  
 15 DR. WILLIAMS:  
 16 A. Correct.  
 17 MR. BROWNE:  
 18 Q. And I think it would be fair to say that one  
 19 of the directions that he was moving in was  
 20 wanting to have pathology services  
 21 centralized, along with technical services?  
 22 DR. WILLIAMS:  
 23 A. Probably, I'm not sure certainly after we got  
 24 the technical services centralized and after  
 25 we got these reports, we did have an agreement

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1 in the summer of 2006 to get all the  
 2 pathologists centralized on one site as well,  
 3 but we would have to leave a pathologist at  
 4 the St. Clare's site for frozen sections and  
 5 things that came up on that site.  
 6 MR. BROWNE:  
 7 Q. Right.  
 8 DR. WILLIAMS:  
 9 A. But everybody would be working on the same  
 10 site. That would foster subspecialization  
 11 too, as Dr. Banerjee outlined.  
 12 MR. BROWNE:  
 13 Q. And was there any discussion with regard to  
 14 the site, having a site pathologist at St.  
 15 Clare's and I think possibly a technologist  
 16 about the notion of any telepathology, do you  
 17 recall any discussion -  
 18 DR. WILLIAMS:  
 19 A. We talked about telepathology because we use  
 20 that kind of thing in radiology with the new  
 21 PAX system.  
 22 MR. BROWNE:  
 23 Q. The PAX system, uh-hm.  
 24 DR. WILLIAMS:  
 25 A. My understanding is that they didn't feel that

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1 given that these things were slides under a  
 2 microscope, we were advance enough yet to use  
 3 that. There was some discussion of it, I  
 4 don't think we felt--I think the answer I got  
 5 was that we're not that advanced yet.  
 6 MR. BROWNE:  
 7 Q. Right.  
 8 DR. WILLIAMS:  
 9 A. But it is something that might come in the  
 10 future.  
 11 MR. BROWNE:  
 12 Q. Okay. As well you were asked about the tissue  
 13 auditing system and Dr. Sayid Abidi, his  
 14 initiatives, I think, at the Grace in that  
 15 direction, I think you mentioned that that had  
 16 already been in place.  
 17 DR. WILLIAMS:  
 18 A. Yes, Dr. Abidi was probably at the General  
 19 site, I think. He would have been the first  
 20 chair of the surgical pathology review  
 21 committee. I wouldn't have had any dealings  
 22 with him or received any reports from them at  
 23 that time.  
 24 MR. BROWNE:  
 25 Q. Okay, but I guess -

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1 DR. WILLIAMS:  
 2 A. I'm not sure who they reported to.  
 3 MR. BROWNE:  
 4 Q. Is my understanding correct that tissue  
 5 auditing committee or system melded into the  
 6 surgical pathology review committee?  
 7 DR. WILLIAMS:  
 8 A. Yes, that was part of their mandate, that was  
 9 a big part of their mandate.  
 10 MR. BROWNE:  
 11 Q. And we saw that with one of the exhibits  
 12 earlier this morning.  
 13 DR. WILLIAMS:  
 14 A. Yes, that's one of their big parts of their  
 15 mandate.  
 16 MR. BROWNE:  
 17 Q. Now, can the witness be shown P-0980 please?  
 18 I must have the wrong one, my apologies, I'm  
 19 looking for--Mr. Simmons if you could help me,  
 20 the June 19th, 2003 memo from Dr. Ejeckam to  
 21 Mr. Gulliver. Maybe it's 0984--not that it's  
 22 necessary, Doctor, your reason -  
 23 DR. WILLIAMS:  
 24 A. I'm familiar with -  
 25 REGISTRAR:

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1 Q. P-0111, page 2.  
 2 MR. BROWNE:  
 3 Q. Let's try that. Doctor, just take a moment if  
 4 you need to, to refresh your -  
 5 DR. WILLIAMS:  
 6 A. No, we can go through it.  
 7 MR. BROWNE:  
 8 Q. Okay. you're reasonably familiar with this?  
 9 DR. WILLIAMS:  
 10 A. Yes.  
 11 MR. BROWNE:  
 12 Q. Now the material in this document prepared by  
 13 Dr. Ejeckam, would you agree with me it's  
 14 primarily technical in nature?  
 15 DR. WILLIAMS:  
 16 A. Yes, we need to move down through it, one is  
 17 the location. It's talking about technical  
 18 issues, yes.  
 19 MR. BROWNE:  
 20 Q. Yes, no sort of pathology issues per se?  
 21 DR. WILLIAMS:  
 22 A. He didn't bring them up in this memo, no,  
 23 because he'd be dealing with Mr. Gulliver, not  
 24 -  
 25 MR. BROWNE:

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1 Q. Right. And prior to 2005, and as you've  
 2 pointed out, this was addressed to Mr.  
 3 Gulliver. Did Mr. Gulliver bring this memo to  
 4 your attention?  
 5 DR. WILLIAMS:  
 6 A. No, he did not.  
 7 MR. BROWNE:  
 8 Q. Now Mr. Coffey, I think, asked you on Friday  
 9 as well whether you were aware of Dr. Cook met  
 10 with the pathologist and explained what was  
 11 going on with pathologists at any point.  
 12 DR. WILLIAMS:  
 13 A. I understood that Dr. Cook met with the  
 14 pathologists arising out of Dr. Banerjee's  
 15 report, I don't know the timeframe, but my  
 16 understanding is he did.  
 17 MR. BROWNE:  
 18 Q. Do you know whether or not Dr. Cook also met  
 19 with the technologists and explaining to the  
 20 technologists anything that they knew, whether  
 21 it was pre Dr. Banerjee or post Dr. Banerjee  
 22 about what they understood was going on.  
 23 DR. WILLIAMS:  
 24 A. I'm not sure of that, I would not know. I  
 25 might have been told, but I can't remember. I

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1 don't remember being told that Dr. Cook would  
 2 do that.  
 3 MR. BROWNE:  
 4 Q. Because we saw at, I think it was Exhibit--if  
 5 we could just--maybe this may refresh your  
 6 memory. P-0559? And this is a memo from Dr.  
 7 Cook to the program manager, the--Mr. Dyer,  
 8 Mr. Gulliver and the other individuals, I  
 9 think, are technologists. And that's dated  
 10 August 8th, 2005 and it lists, if you, again,  
 11 a number of things.  
 12 DR. WILLIAMS:  
 13 A. Um-hm.  
 14 MR. BROWNE:  
 15 Q. Again, mostly for the, I guess, retesting of  
 16 the estrogen, progesterone receptors.  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 MR. BROWNE:  
 20 Q. Do you know, does this help you recall whether  
 21 or not there was a meeting around this time,  
 22 probably the following day, between Dr. Cook  
 23 and the technologists as to what was going on?  
 24 DR. WILLIAMS:  
 25 A. I would not know that. Dr. Cook sometimes

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1 reported on meetings to me. Ones that he  
 2 didn't need any direction from me or didn't  
 3 need follow up, he may not. I know Dr. Cook  
 4 was very diligent around this time.  
 5 MR. BROWNE:  
 6 Q. Sure.  
 7 DR. WILLIAMS:  
 8 A. Following up on all these issues.  
 9 MR. BROWNE:  
 10 Q. And lastly, Doctor, if you could look at P-  
 11 0784? Mr. Coffey showed you that this  
 12 morning. And I think it's Dr. Banerjee's  
 13 report, which is enveloped -  
 14 DR. WILLIAMS:  
 15 A. I have it here.  
 16 MR. BROWNE:  
 17 Q. Okay, you have it there. Doctor, Mr. Coffey  
 18 asked you again, it is a reference to the  
 19 fact, I think it's at page 1 in the conclusion  
 20 sections and I can -  
 21 UNKNOWN SPEAKER:  
 22 Q. (Inaudible).  
 23 MR. BROWNE:  
 24 Q. Page 47, thank you. Go back to the first  
 25 page, please? The incident problem case,

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1 Doctor.  
 2 DR. WILLIAMS:  
 3 A. Yes.  
 4 MR. BROWNE:  
 5 Q. You'll see the second paragraph there, "It  
 6 should be noted that invasive lobular  
 7 carcinomas are frequently ER positive." And  
 8 he's got percentage there, 92 percent. "Thus  
 9 the initial negative result should have been  
 10 questioned." And he's referring back to the  
 11 2002 incident.  
 12 DR. WILLIAMS:  
 13 A. Yes.  
 14 MR. BROWNE:  
 15 Q. And if you could look, you'll see there very  
 16 faintly somewhere around--after the 92  
 17 percent, footnote No. 1.  
 18 DR. WILLIAMS:  
 19 A. Yes.  
 20 COFFEY, Q.C.:  
 21 Q. If we go to the end of that and follow that  
 22 footnote, please?  
 23 DR. WILLIAMS:  
 24 A. Um-hm.  
 25 MR. BROWNE:

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1 Q. And tell me what is the date on that article?  
 2 DR. WILLIAMS:  
 3 A. The date of that article is January, 2005.  
 4 MR. BROWNE:  
 5 Q. Right.  
 6 DR. WILLIAMS:  
 7 A. Yes, January, 2005.  
 8 MR. BROWNE:  
 9 Q. So Dr. Banerjee is making a statement in  
 10 relation to the 2002 case using a 2005  
 11 article, is that correct?  
 12 DR. WILLIAMS:  
 13 A. That is a 2005 article, yes.  
 14 MR. BROWNE:  
 15 Q. Thank you. Thank you, Dr. Williams, that's  
 16 all the questions I have.  
 17 DR. WILLIAMS:  
 18 A. Thank you.  
 19 COMMISSIONER:  
 20 Q. Thank you, Mr. Browne. Ms. Newbury. Ms.  
 21 Newbury, we were a bit late having our break  
 22 this morning, so may I suggest you run until  
 23 about 1 and break at a convenient place around  
 24 there and we'll come back then at 2:15.  
 25 DR. ROBERT WILLIAMS, EXAMINATION BY MS. JENNIFER NEWBURY

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1 MS. NEWBURY:  
 2 Q. Sure.  
 3 DR. WILLIAMS:  
 4 A. Good morning.  
 5 MS. NEWBURY:  
 6 Q. Morning, or afternoon now, Dr. Williams.  
 7 Jennifer Newbury for the Canadian Cancer  
 8 Society, Newfoundland and Labrador Division.  
 9 DR. WILLIAMS:  
 10 A. Um-hm.  
 11 MS. NEWBURY:  
 12 Q. I'm going to ask you some questions about the  
 13 media that you were involved with in October  
 14 of 2005. And if I could refer to Exhibit  
 15 0345, please? Now, you were shown this  
 16 particular exhibit the other day.  
 17 DR. WILLIAMS:  
 18 A. Um-hm.  
 19 MS. NEWBURY:  
 20 Q. Now, on page 2 of that exhibit, in the fourth  
 21 column you can see paragraphs 1 and 2 of the  
 22 column No. 4. It says, "We had about 73  
 23 percent of tests that were positive, so we're  
 24 only retesting the 27 percent or so that were  
 25 negative." And "From the early results

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1 Williams said 'It appears only about 10  
 2 percent of the overall tests performed over  
 3 the past seven years show different results.'"  
 4 DR. WILLIAMS:  
 5 A. It should be "will show", I was predicting.  
 6 MS. NEWBURY:  
 7 Q. You were predicting?  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. Right, yeah, I understand that. So that's  
 12 consistent with what you would have relayed at  
 13 the time?  
 14 DR. WILLIAMS:  
 15 A. Yes. But when we, as you know, we tested more  
 16 than just 27 percent because they had a very  
 17 broad definition of what was negative, so we  
 18 would have tested more than 27 percent -  
 19 MS. NEWBURY:  
 20 Q. Okay. And do you have any -  
 21 DR. WILLIAMS:  
 22 A. - in retrospect.  
 23 MS. NEWBURY:  
 24 Q. Do you have any idea what the rough percentage  
 25 of that was?



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1 DR. WILLIAMS:  
 2 A. At the end of the day it looks like we had--  
 3 when I left the organization, it was 900,  
 4 around 900 people.  
 5 MS. NEWBURY:  
 6 Q. Right.  
 7 DR. WILLIAMS:  
 8 A. Out of 2500, so it would have been more than  
 9 that.  
 10 MS. NEWBURY:  
 11 Q. Sure, okay.  
 12 DR. WILLIAMS:  
 13 A. Yes.  
 14 MS. NEWBURY:  
 15 Q. I see your point.  
 16 DR. WILLIAMS:  
 17 A. 35 percent, maybe, something like that.  
 18 MS. NEWBURY:  
 19 Q. Okay. But other than that, other than the  
 20 fact that the percentage turned out to be a  
 21 bit higher, you didn't have any general  
 22 criticisms about how they captured your  
 23 information?  
 24 DR. WILLIAMS:  
 25 A. No. I think we needed to, there was a feeling

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1 that we needed to have a broad definition of  
 2 what, so that we wouldn't miss anything and  
 3 confuse things.  
 4 MS. NEWBURY:  
 5 Q. Okay. Now, there are other similar comments  
 6 attributed to you, and I just want to show you  
 7 a couple of those. It's at the same exhibit,  
 8 page 4. This is an article, CTV.ca for  
 9 October the 6th, the following day, I believe,  
 10 2005. And paragraph 8 of that particular  
 11 article, if you can find it there, it starts  
 12 with "Health care." "Health care officials  
 13 say they can't be precise about the number of  
 14 people affected. Mount Sinai is testing 30  
 15 percent of the hundreds of tissue samples that  
 16 came up negative since 1997. So far 10  
 17 percent of results have changed to positive."  
 18 So that's a similar sentiment?  
 19 DR. WILLIAMS:  
 20 A. Yeah, but it's not, it's not reflected in the  
 21 same way I--it's not a quote.  
 22 MS. NEWBURY:  
 23 Q. Right.  
 24 DR. WILLIAMS:  
 25 A. And it doesn't reflect, it may not reflect

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1 exactly what I would have said. I was looking  
 2 at 10 percent overall.  
 3 MS. NEWBURY:  
 4 Q. Overall, so -  
 5 DR. WILLIAMS:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. So that would be -  
 9 DR. WILLIAMS:  
 10 A. I was trying to keep some semblance of how I  
 11 spoke. We knew that we had around 73 percent  
 12 positive.  
 13 MS. NEWBURY:  
 14 Q. Right.  
 15 DR. WILLIAMS:  
 16 A. And we knew that, you know, up to 82 percent  
 17 could be positive. Looking at that, I guess I  
 18 was predicting at the time that about 10  
 19 percent of the overall tests would probably  
 20 convert or may change.  
 21 MS. NEWBURY:  
 22 Q. Okay. So that would be not just looking at  
 23 the ER negative results, but the ER positive  
 24 results, as well? I mean, that's the overall  
 25 group that you're talking about?

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1 DR. WILLIAMS:  
 2 A. Yeah, we were looking at if 73 percent of our  
 3 tests are positive, and we know that we've had  
 4 some conversions, especially in 2002, because  
 5 that was the year when we had--we got much  
 6 lower percentage of positives than on average.  
 7 MS. NEWBURY:  
 8 Q. Sure.  
 9 DR. WILLIAMS:  
 10 A. But if you look at it over those seven-year  
 11 period, our average positivity rate was 73  
 12 percent.  
 13 MS. NEWBURY:  
 14 Q. Right.  
 15 DR. WILLIAMS:  
 16 A. And the rate might be up to 82 percent. One  
 17 could surmise that probably we'd have it up to  
 18 10 percent overall. So that, you know, it  
 19 doesn't quote me on that, but it's -  
 20 MS. NEWBURY:  
 21 Q. No, it -  
 22 DR. WILLIAMS:  
 23 A. It's not quite in the context I would have  
 24 expressed it in.  
 25 MS. NEWBURY:

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1 Q. Right. Okay, but that's an interpretation of  
 2 it. Is it consistent, though, generally, with  
 3 what you said? It may not be how you phrased  
 4 it, or how you saw it in your own mind, but  
 5 would it still be accurate with the message  
 6 that you were trying to get across?  
 7 DR. WILLIAMS:  
 8 A. Well, I guess the message I was trying to get  
 9 across was we're going to have, you know,  
 10 about 10 percent of overall tests -  
 11 MS. NEWBURY:  
 12 Q. Right.  
 13 DR. WILLIAMS:  
 14 A. - re--coming back, changed.  
 15 MS. NEWBURY:  
 16 Q. So, all of the ER/PR tests between 1997 and  
 17 2005, if you take all of those tests, only 10  
 18 percent would ultimately be changed?  
 19 DR. WILLIAMS:  
 20 A. Yeah, I was, at the time I was predicting  
 21 based upon that, around two hundred and, up to  
 22 250 tests.  
 23 MS. NEWBURY:  
 24 Q. Okay.  
 25 DR. WILLIAMS:

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1 A. Could have changed. That's the best estimate  
 2 I could make at the time based upon the  
 3 figures we had at the time.  
 4 MS. NEWBURY:  
 5 Q. Sure, okay. And just to show you another  
 6 couple, the next page, because this gets  
 7 repeated across several different media  
 8 outlets. This one is CBC News, this is page  
 9 5, October the 6th, 2006, paragraphs 9 through  
 10 11. And it states that, "Most of the tests  
 11 performed in the Newfoundland facility were  
 12 positive. Williams said, 'We are only  
 13 retesting the 27 percent or so that were  
 14 negative.' He said about 10 percent of tests  
 15 done over the last seven years may show  
 16 different results."  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. And one more. Page 10 of the same exhibit, P-  
 21 0345. This is an interview--I'm not sure if  
 22 it's an interview or if it's a recording of a  
 23 statement that you made with CBC Morning Show  
 24 on the 14th of October, 2005, so about a week  
 25 later.

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1 DR. WILLIAMS:  
 2 A. Um-hm.  
 3 MS. NEWBURY:  
 4 Q. I'll go to page 4 of that. So in the exhibit  
 5 it's page 13 but it's page 4 of the transcript  
 6 from the CBC Morning Show. At the very bottom  
 7 paragraph it says, or Quinn says, "Health  
 8 officials say that about 300 people from  
 9 across Newfoundland and Labrador are given  
 10 this test each year. Approximately three  
 11 quarters of them test positive. So hundreds of  
 12 samples are being retested and Dr. Williams  
 13 say they expect that less than 10 percent of  
 14 those will turn out to be false negatives."  
 15 DR. WILLIAMS:  
 16 A. I meant 10 percent of the total.  
 17 MS. NEWBURY:  
 18 Q. Of the total, right. Okay, I understand.  
 19 Now, in terms of the retesting itself from the  
 20 beginning, I understand that the retesting was  
 21 only of those patients who were ER negative?  
 22 DR. WILLIAMS:  
 23 A. ER negative, yes. There were some patients  
 24 who were PR positive, but they were retested.  
 25 We wanted to make sure there was no confusion

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1 and we wouldn't miss anybody.  
 2 MS. NEWBURY:  
 3 Q. So there might have been some unplanned  
 4 testing of ER positive patients?  
 5 DR. WILLIAMS:  
 6 A. No, there was testing of PR positive patients.  
 7 MS. NEWBURY:  
 8 Q. Oh, PR -  
 9 DR. WILLIAMS:  
 10 A. They took a definition -  
 11 MS. NEWBURY:  
 12 Q. Okay. I thought you said ER positive -  
 13 DR. WILLIAMS:  
 14 A. - of negative as they just focused on the ER  
 15 and -  
 16 MS. NEWBURY:  
 17 Q. Right.  
 18 DR. WILLIAMS:  
 19 A. - and you get involved in the PR and ER, then  
 20 you might start missing people so they cast a  
 21 wide net to make sure that we retested a lot  
 22 of people.  
 23 MS. NEWBURY:  
 24 Q. So it's ER negative, regardless of the PR  
 25 status?

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1 DR. WILLIAMS:  
 2 A. Yes.  
 3 MS. NEWBURY:  
 4 Q. Okay. And how about ER positive patients, was  
 5 there a focus on retesting ER positive  
 6 patients?  
 7 DR. WILLIAMS:  
 8 A. No, there was not.  
 9 MS. NEWBURY:  
 10 Q. Okay.  
 11 COMMISSIONER:  
 12 Q. When you say ER negative, you're meaning--  
 13 because we have that -  
 14 DR. WILLIAMS:  
 15 A. Yes, there -  
 16 COMMISSIONER:  
 17 Q. We have that problem of how you define  
 18 negatives.  
 19 DR. WILLIAMS:  
 20 A. Yes, sure. I think it was -  
 21 COMMISSIONER:  
 22 Q. So let's figure out what they are in this  
 23 context.  
 24 DR. WILLIAMS:  
 25 A. Yeah. Less than 30 percent up to December,

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1 2002 and after that, less than 10 percent -  
 2 COMMISSIONER:  
 3 Q. Yeah, but when you had them retested -  
 4 DR. WILLIAMS:  
 5 A. - were considered as negative.  
 6 COMMISSIONER:  
 7 Q. - what you considered positive or negative  
 8 went by what?  
 9 DR. WILLIAMS:  
 10 A. Dr. Cook sent out a memo, it was discussed  
 11 with the oncologists, and basically the  
 12 definition of negative was anything less than  
 13 30 percent up to December, 2002 and anything  
 14 less than 10 percent thereafter because those  
 15 patients even though they had, some of them  
 16 might have 20 percent or 25 percent would not  
 17 have received any treatment at the time.  
 18 MS. NEWBURY:  
 19 Q. Right. So -  
 20 COMMISSIONER:  
 21 Q. So basically would they not be retested?  
 22 Sorry, Ms. Newbury, because this is something  
 23 that I had not quite the way I understood it.  
 24 So when you were determining who you were  
 25 going to send to Mount Sinai, did you go by

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1 way of the definition of positive on the date  
 2 that they were originally tested or did you go  
 3 by a mathematical view of what the percentages  
 4 were and choose a one percent or a zero  
 5 percent and those above are positive and those  
 6 below are negative?  
 7 DR. WILLIAMS:  
 8 A. No, I think it was related to the changing  
 9 therapeutic level cut off. So my  
 10 understanding is that anybody who was less  
 11 than 30 percent up until December, 2002 would  
 12 be retested and after that anybody less than  
 13 10 percent. That was based upon what the  
 14 treatment protocols were at the time and they  
 15 changed at the end of December, 2002.  
 16 COMMISSIONER:  
 17 Q. Yes, I understood that.  
 18 DR. WILLIAMS:  
 19 A. Yes. So that's what it was based on.  
 20 COMMISSIONER:  
 21 Q. About the change, that is. I'm not sure that  
 22 I understood that that was who got chosen, but  
 23 in any event, I'm sure we'll resolve it.  
 24 MS. NEWBURY:  
 25 Q. If I could have Exhibit P-0539, please? Now,

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1 these are notes of your meeting from August  
 2 the 1st, 2005, I understand. And Dr. Cook--I  
 3 think there might be--there's a typed version  
 4 of the notes. So the first bullet there, I  
 5 believe from your earlier evidence, that those  
 6 would be comments attributed to Dr. Cook?  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. Okay. And in the fourth--sorry, in the third  
 11 item listed under Dr. Cook's name under the  
 12 first bullet, it says that "One case, 10  
 13 percent positive, came back negative."  
 14 DR. WILLIAMS:  
 15 A. Um-hm.  
 16 MS. NEWBURY:  
 17 Q. And this was referring to 11 cases sent to  
 18 Mount Sinai negative and variable positives.  
 19 So you were aware, as of that date, August the  
 20 1st, 2005, that there was one case that went  
 21 from positive to negative? Is that, am I  
 22 understanding that properly?  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 MS. NEWBURY:

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1 Q. Okay.  
 2 DR. WILLIAMS:  
 3 A. That's what it looks like. And I'm not sure  
 4 what cases they selected or this type of  
 5 thing.  
 6 MS. NEWBURY:  
 7 Q. Sorry?  
 8 DR. WILLIAMS:  
 9 A. I'm not sure what case they selected, but I'm  
 10 not sure of the details on that, so.  
 11 MS. NEWBURY:  
 12 Q. Okay.  
 13 DR. WILLIAMS:  
 14 A. You'd probably have to ask Dr. Cook about that  
 15 in more detail.  
 16 MS. NEWBURY:  
 17 Q. Sure. But in terms of your understanding, at  
 18 the time you would have understood that this  
 19 one case, for whatever reason, had initially  
 20 been tested as positive?  
 21 DR. WILLIAMS:  
 22 A. Um-hm.  
 23 MS. NEWBURY:  
 24 Q. Ten percent positive and came back negative.  
 25 If I could refer to Exhibit P-1077, please?

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1 Okay. Now, this is a series of, I think a  
 2 couple of e-mails. And I'm going to scroll  
 3 down to the, actually, the original message is  
 4 from Heather Predham. It's dated January the  
 5 11th, 2006, and it's addressed to Sharon  
 6 Smith, Patricia Pilgrim, Pam Elliott and to  
 7 yourself. Now, if you look at the fourth  
 8 paragraph under the original message, there's  
 9 a reference there to a group of samples that  
 10 were done at on our automated Ventana system  
 11 from April, 2004 to August, 2005 that were not  
 12 validated by Mount Sinai. "The decision was  
 13 made in the fall to send these samples up to  
 14 Mount Sinai, as well. We now have a lady  
 15 whose original sample showed a degree of  
 16 positivity under the 10 percent level, so it  
 17 was sent to Mount Sinai but came back  
 18 completely negative. She has been informed  
 19 and she has been taken off Arimedex. We now  
 20 have two more results back with the same  
 21 situation. I guess you can say that they are  
 22 false positives. These two will be panelled  
 23 at this Thursday's meeting." So this e-mail  
 24 then for January, middle of January 2006, does  
 25 that refer to what later became known as retro

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1 converters?  
 2 DR. WILLIAMS:  
 3 A. Probably.  
 4 MS. NEWBURY:  
 5 Q. Okay.  
 6 DR. WILLIAMS:  
 7 A. I can't be sure if these were the same ones.  
 8 MS. NEWBURY:  
 9 Q. Are there any other possible explanations for  
 10 that comment there by Ms. Predham? What else  
 11 could it be referring to?  
 12 DR. WILLIAMS:  
 13 A. Probably that's it, but I'm not sure.  
 14 MS. NEWBURY:  
 15 Q. Okay. So you were aware then certainly by  
 16 August of 2005 that there was a possibility of  
 17 samples converting from positive to negative?  
 18 DR. WILLIAMS:  
 19 A. There's a possibility, yes.  
 20 MS. NEWBURY:  
 21 Q. Okay, and in October of 2005, when you were  
 22 engaged -  
 23 DR. WILLIAMS:  
 24 A. And Dr. Banerjee referenced that because  
 25 that's one of the questions he was asked.

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1 MS. NEWBURY:  
 2 Q. Okay. Now back in October of 2005, you were,  
 3 again, discussing your percentages, your  
 4 expectations in terms of how many conversions  
 5 there would be from negative to positive.  
 6 DR. WILLIAMS:  
 7 A. Um-hm.  
 8 MS. NEWBURY:  
 9 Q. By that time, by October of 2005, had Eastern  
 10 Health taken any steps to attempt to quantify,  
 11 you know, the same way that you're looking at  
 12 the ER negative conversions, were there any  
 13 steps by Eastern Health to attempt to quantify  
 14 whether there would be any conversions from  
 15 positive back to negative?  
 16 DR. WILLIAMS:  
 17 A. Not that I can recollect at the time, no.  
 18 MS. NEWBURY:  
 19 Q. So then in terms of whether or not there could  
 20 possibly be any conversions from positive to  
 21 negative, that would be an unknown quantity?  
 22 DR. WILLIAMS:  
 23 A. Yes, but we asked--Dr. Banerjee sort of tried  
 24 to quantify that. When the people came up  
 25 from Ventana in the spring of 2006, we asked

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1 them that question, and again, we were told  
 2 that it's almost impossible, very highly  
 3 unlikely that that could happen.  
 4 MS. NEWBURY:  
 5 Q. I wonder if I can refer to Exhibit P-0125,  
 6 please, on page 26 of that exhibit. This is  
 7 an e-mail from Marilyn McCormack to Moira  
 8 Hennessey, with a briefing note for the  
 9 Premier on ER/PR receptor tests and it's dated  
 10 August the 18th, 2006, and this is the--  
 11 appears to be the attached briefing note, and  
 12 down below, it has a chart showing a number of  
 13 categories of patients and test results. Are  
 14 you generally familiar with the information in  
 15 that?  
 16 DR. WILLIAMS:  
 17 A. I'm not sure if I've seen that. I might be  
 18 familiar with the information, but I don't  
 19 know that that went through my office, that  
 20 report.  
 21 MS. NEWBURY:  
 22 Q. If you look at page 28 of the exhibit, at the  
 23 top, the very top row, it says "patient test  
 24 results confirmed positive by Newfoundland  
 25 panel" and next to it it has a number of 12.

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1 DR. WILLIAMS:  
 2 A. Um-hm.  
 3 MS. NEWBURY:  
 4 Q. And those were patients, the third column of  
 5 that row, patients whose original test results  
 6 were considered positive by treating physician  
 7 and treated appropriately. There was a slight  
 8 change in ER/PR status but review by  
 9 Newfoundland panel confirmed positive ER/PR  
 10 status.  
 11 DR. WILLIAMS:  
 12 A. Um-hm.  
 13 MS. NEWBURY:  
 14 Q. And looking down at the bottom -  
 15 DR. WILLIAMS:  
 16 A. We wouldn't be surprised with that because  
 17 this is a semi-quantitative test. So it's ten  
 18 percent doesn't mean ten percent, doesn't mean  
 19 ten percent, doesn't mean ten percent.  
 20 MS. NEWBURY:  
 21 Q. Sure. No, I appreciate that.  
 22 DR. WILLIAMS:  
 23 A. If you have 30 percent and then ten percent or  
 24 then five percent, it's semi-quantitative,  
 25 subject to a lot of technical issues.

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1 MS. NEWBURY:  
 2 Q. But I guess, in terms of the retesting of  
 3 these 12 samples, these were considered  
 4 positive and ultimately confirmed positive.  
 5 DR. WILLIAMS:  
 6 A. Positive, that's what I would read it as,  
 7 yeah.  
 8 MS. NEWBURY:  
 9 Q. And down at the last column on that page,  
 10 there's a reference to retro converters, and  
 11 there were four patients listed in that row  
 12 and those are the patients considered positive  
 13 at time of initial ER/PR testing. These  
 14 individuals received hormonal treatment and  
 15 retesting at Mount Sinai confirmed--I'm just  
 16 looking, trying to gauge sort of the scope of  
 17 the problem, because you indicated that the  
 18 Ventana representative had basically indicated  
 19 that there would be--there's very little  
 20 chance of conversions from positive to  
 21 negative.  
 22 DR. WILLIAMS:  
 23 A. Yes, and Dr. Banerjee would have confirmed  
 24 that in his initial report.  
 25 MS. NEWBURY:

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1 Q. Okay. Can you explain then--it would appear  
 2 to me, and again, this is my interpretation of  
 3 this document, but it would appear that there  
 4 were four plus 12 patients who had been  
 5 considered positive that were retested.  
 6 DR. WILLIAMS:  
 7 A. Yes.  
 8 MS. NEWBURY:  
 9 Q. That was a total of 16, and out of those 16,  
 10 four were converted to negative, and I  
 11 understand a low number, four, the number of  
 12 positive patients tested, because that wasn't  
 13 the focus of the retesting by Eastern Health.  
 14 So four out of 16 seems to be a fairly high  
 15 proportion. Did you address that with either  
 16 Dr. Banerjee or the Ventana representative?  
 17 DR. WILLIAMS:  
 18 A. That never came up in our discussion, Ms.  
 19 Newbury.  
 20 MS. NEWBURY:  
 21 Q. Okay.  
 22 DR. WILLIAMS:  
 23 A. Or any discussions we had subsequent to that,  
 24 no.  
 25 MS. NEWBURY:

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1 Q. Okay, so -  
 2 DR. WILLIAMS:  
 3 A. It did come up with the retro converters in  
 4 the sense of what -  
 5 MS. NEWBURY:  
 6 Q. Right, but -  
 7 DR. WILLIAMS:  
 8 A. - there was no recommendation to go back or  
 9 anything, no.  
 10 MS. NEWBURY:  
 11 Q. But there was no effort to try to find out why  
 12 perhaps the percentage or the proportion of  
 13 conversions from positive to negative was not  
 14 consistent with perhaps what the Ventana  
 15 representative or Dr. Banerjee might have  
 16 anticipated?  
 17 DR. WILLIAMS:  
 18 A. No, I don't think, now looking at that, we had  
 19 it in this context either.  
 20 MS. NEWBURY:  
 21 Q. Okay. Now in the media articles that I  
 22 referred you to earlier, you're discussing the  
 23 percentage of tests that show different  
 24 results over the last seven years, and you're  
 25 relating that not to the ER negative test, but

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1 you're relating that to all of the tests done  
 2 between 1997 and 2005, and my suggestion is  
 3 that if you're going to talk about the total  
 4 number of the tests there, that the  
 5 appropriate percentage would be ten plus X  
 6 percent, and X would be the unknown quantity  
 7 of conversions from ER positive to ER  
 8 negative.  
 9 DR. WILLIAMS:  
 10 A. Okay, we were looking at it, at the time, of  
 11 people who were negative and retesting  
 12 positive.  
 13 MS. NEWBURY:  
 14 Q. Right, but when you're talking--when you're  
 15 discussing this with the media, you're  
 16 talking--even though you're talking about  
 17 retesting of ER negative patients, you're  
 18 relating that percentage wise to the entire  
 19 group of retesting. So you're looking at all  
 20 of the ER positive patients and all the ER  
 21 negative patients.  
 22 DR. WILLIAMS:  
 23 A. I guess our focus was on the ER negative  
 24 patients who would convert to positive.  
 25 MS. NEWBURY:

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1 Q. So did you assume that the X, you know, the--  
 2 if there are conversions from positive to  
 3 negative, you don't know what that figure is?  
 4 It's an unknown quantity. You'd never thought  
 5 about it. It wasn't the focus.  
 6 DR. WILLIAMS:  
 7 A. No, it wasn't the focus, I'm sorry.  
 8 MS. NEWBURY:  
 9 Q. Had you assumed that that quantity would be  
 10 zero?  
 11 DR. WILLIAMS:  
 12 A. No, I don't think we could assume that  
 13 quantity would be zero.  
 14 MS. NEWBURY:  
 15 Q. Okay.  
 16 DR. WILLIAMS:  
 17 A. But in a sense, that was what we were thinking  
 18 of at the time. We had four retro converters,  
 19 so it wasn't zero, but we were thinking at the  
 20 time, our problem was really missing people  
 21 who were negative and not picking them up and  
 22 these people were denied treatment.  
 23 MS. NEWBURY:  
 24 Q. Looking back at it now, and recognizing that  
 25 there have been some conversions from positive

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1 to negative, do you think it would have been  
 2 more appropriate when you're talking about  
 3 percentages of different results that there  
 4 should have been some factor taking into  
 5 account by Eastern Health of the conversions  
 6 from positive to negative? Either that or to  
 7 restrict your percentage to the total number  
 8 of ER negative tests that are going to be  
 9 retested?  
 10 DR. WILLIAMS:  
 11 A. I'm not sure of that. I mean, it just wasn't  
 12 a consideration at the time.  
 13 MS. NEWBURY:  
 14 Q. And why is that?  
 15 DR. WILLIAMS:  
 16 A. Because we were--as I say, we were totally  
 17 focused on trying to see who we missed, in  
 18 terms of negative and trying to get people  
 19 panelled, get the tests done as we could,  
 20 panelled and people treated.  
 21 MS. NEWBURY:  
 22 Q. I can understand that your focus -  
 23 DR. WILLIAMS:  
 24 A. It wasn't a conscious, you know, we're not  
 25 going to deal with this, type of thing. I

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1 think just our focus was on the other issue.  
 2 MS. NEWBURY:  
 3 Q. On the ER negative patients.  
 4 DR. WILLIAMS:  
 5 A. Yes.  
 6 MS. NEWBURY:  
 7 Q. And I understand that the focus was to retest  
 8 those, but in terms of your communication on  
 9 the issue, why would you relate the ten  
 10 percent to the overall number of ER tests done  
 11 since 1997 up until 2005?  
 12 DR. WILLIAMS:  
 13 A. Because we -  
 14 MS. NEWBURY:  
 15 Q. When you're not going to test them.  
 16 DR. WILLIAMS:  
 17 A. I guess, again, we were just focused--I can  
 18 only answer it the same way as I've answered.  
 19 It just wasn't a consideration. It's not that  
 20 we'd considered it and didn't do anything with  
 21 it. It's just that we were just looking at  
 22 the negative converting to positive. That's  
 23 all I can say.  
 24 MS. NEWBURY:  
 25 Q. Looking back at it, do you think that there

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1 could be confusion from choosing the  
 2 denominator in calculating your percentage of  
 3 all tests done between '97 and 2005?  
 4 DR. WILLIAMS:  
 5 A. I hope that there wasn't because I tried to  
 6 explain it, but again, I was focused totally  
 7 on negative to positive conversions.  
 8 MS. NEWBURY:  
 9 Q. While you were VP of Medical Services at  
 10 Eastern Health, was there any thought given to  
 11 looking into the issue of retro converters on  
 12 a broader scale, aside from those that were  
 13 tested?  
 14 DR. WILLIAMS:  
 15 A. No, there was not that I can recollect.  
 16 MS. NEWBURY:  
 17 Q. And are you aware of any of the individual  
 18 consequences to a patient of converting from  
 19 positive to negative?  
 20 DR. WILLIAMS:  
 21 A. You'd look at the treatment profile.  
 22 MS. NEWBURY:  
 23 Q. Okay, and there could be a change in  
 24 treatment?  
 25 DR. WILLIAMS:

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1 A. There could be a change in treatment. Now I  
 2 now some people, as we looked at in follow up  
 3 who were negative were already treated with  
 4 Tamoxifen because the physician chose to do  
 5 it, and some people may do that.  
 6 THE COMMISSIONER:  
 7 Q. Time to take the luncheon break now.  
 8 MS. NEWBURY:  
 9 Q. Sure.  
 10 THE COMMISSIONER:  
 11 Q. 20 after 2, thank you.  
 12 (LUNCH BREAK)  
 13 THE COMMISSIONER:  
 14 Q. Please be seated. Ms. Newbury.  
 15 MS. NEWBURY:  
 16 Q. Thank you. Dr. Williams, as of the summer of  
 17 2006, I understand that four retro converters  
 18 were not yet notified. Is that consistent  
 19 with your understanding of their -  
 20 MR. WILLIAMS:  
 21 A. My understanding that one was--my notes say  
 22 one was notified.  
 23 MS. NEWBURY:  
 24 Q. Okay.  
 25 MR. WILLIAMS:

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1 A. The two in the other regions, the other  
 2 regions were following up. I'd have to look  
 3 at my notes. And one, they had difficulty  
 4 contacting and they were still trying to  
 5 follow up when I left the organization.  
 6 MS. NEWBURY:  
 7 Q. When you left, but in the summer of 2006,  
 8 prior to that--perhaps we can pull up Exhibit  
 9 P-0411, please, on page two of this exhibit.  
 10 It talks about retro converters and in the  
 11 third paragraph, it indicates that  
 12 representatives of Eastern Health and the  
 13 clinical chiefs of pathology and Cancer Care  
 14 will meet with them in the next few weeks to  
 15 disclose this information. So it would appear  
 16 from this memo, which is dated--that's to you,  
 17 dated July 4th 2006, that they had not yet, as  
 18 of that date, been notified. Is that -  
 19 MR. WILLIAMS:  
 20 A. Yes, and I would have some more notes, some  
 21 detailed notes that are part of this package  
 22 that where I looked at all the DCIS's. I  
 23 think I phoned Dr. Denic. Now I don't know  
 24 what that note says because I don't have it in  
 25 front of me.

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1 MS. NEWBURY:  
 2 Q. Sure, okay.  
 3 MR. WILLIAMS:  
 4 A. But I would have had the understanding that at  
 5 least three of the four were notified sometime  
 6 over the summer. I knew they had trouble  
 7 contacting the fourth, and I can't answer that  
 8 question. Heather Predham would have to  
 9 answer that. They may not have contacted that  
 10 person by the time I left.  
 11 MS. NEWBURY:  
 12 Q. Okay. I guess the point that I'm making, that  
 13 as of July of 2006, that had not yet been done  
 14 -  
 15 MR. WILLIAMS:  
 16 A. But it was -  
 17 MS. NEWBURY:  
 18 Q. - although some efforts were made in the next  
 19 couple of months before you left to make those  
 20 contacts?  
 21 MR. WILLIAMS:  
 22 A. Yes, and I expect it would have been done, and  
 23 I know that the DCIS's were all notified, as  
 24 far as I can understand, from Eastern Health's  
 25 perspective. Again, I contacted the other

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1 medical directors in the other two regions to  
 2 make sure that there was a process in place,  
 3 and if they wanted us to help, we would help,  
 4 but if they didn't, they could move forward on  
 5 their own.  
 6 MS. NEWBURY:  
 7 Q. Sure, okay. Perhaps we could bring up Exhibit  
 8 P-1077 again, please. This is the e-mail that  
 9 I showed you earlier, and you thought that  
 10 this was probably relating to the retro  
 11 converters, and reading the third paragraph  
 12 there--sorry, the fourth paragraph, under the  
 13 original message, it would appear that three  
 14 of these patients are patients who've  
 15 converted from positive to negative. So if  
 16 these are the same three patients that are in  
 17 the group for the July 2006 memo, do you know  
 18 why it would have taken so long for  
 19 notification to take place?  
 20 MR. WILLIAMS:  
 21 A. No, I don't. I know that when I was notified  
 22 by e-mails that I--over the months of, I  
 23 think, May, June, July and August, except for  
 24 the two weeks when I was away, I was fully  
 25 engaged in making sure the DCIS group and

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1 retro converters were dealt with.  
 2 MS. NEWBURY:  
 3 Q. Okay.  
 4 MR. WILLIAMS:  
 5 A. I'm not sure.  
 6 MS. NEWBURY:  
 7 Q. Now this e-mail here is directed to you, dated  
 8 January the 11th, 2006.  
 9 MR. WILLIAMS:  
 10 A. Sure.  
 11 MS. NEWBURY:  
 12 Q. Had you taken any of those steps as of January  
 13 11th 2006?  
 14 MR. WILLIAMS:  
 15 A. I would have just assumed that people were  
 16 being notified as things moved forward. Then  
 17 I got a specific report sometime about the  
 18 DCIS's and the retro converters and I followed  
 19 up on those.  
 20 MS. NEWBURY:  
 21 Q. Okay. So it wasn't until you saw it in a  
 22 report form that you took -  
 23 MR. WILLIAMS:  
 24 A. Yes.  
 25 MS. NEWBURY:

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1 Q. - your own steps?  
 2 MR. WILLIAMS:  
 3 A. No, as we were going along in the spring, I  
 4 didn't get into hands on in informing  
 5 patients, but at the end of--during the  
 6 summer, I did get focused in on the DCIS's  
 7 because I wanted to get sure they were done  
 8 and the retro converters to make sure--I  
 9 understood by that time that the people had  
 10 been phoned who were being retested and those  
 11 who were negative had been phoned back and  
 12 that those who were panelled, there was  
 13 letters gone out to their physicians. That's  
 14 what I understood at the time.  
 15 MS. NEWBURY:  
 16 Q. Did you ask anyone about the delay from the  
 17 January 11th, 2006 -  
 18 MR. WILLIAMS:  
 19 A. No, I didn't. I didn't--so many e-mails going  
 20 back and forth, to be honest, that I didn't  
 21 link those two. And in fact, I had forgotten  
 22 this e-mail until you just brought it to my  
 23 attention.  
 24 MS. NEWBURY:  
 25 Q. And would the discovery of a conversion from



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1 positive to negative, as indicated in this  
 2 January 11th 2006 e-mail, would that be  
 3 considered an adverse event?  
 4 MR. WILLIAMS:  
 5 A. I think we considered the whole group one big  
 6 adverse event, and anything around it.  
 7 MS. NEWBURY:  
 8 Q. Okay.  
 9 MR. WILLIAMS:  
 10 A. So I don't know a special event file would  
 11 have been filed at that time. I wasn't aware  
 12 of it.  
 13 MS. NEWBURY:  
 14 Q. And you'll note there that one of the patients  
 15 referred to had actually been on a medical,  
 16 Arimedex, and was taken off the medication.  
 17 MR. WILLIAMS:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. So that patient would certainly be considered  
 21 an adverse group and whether it's--or an  
 22 adverse event, whether or not it's a group  
 23 categorization or an individual  
 24 categorization, you don't know.  
 25 MR. WILLIAMS:

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1 A. And that patient had been notified by the  
 2 looks of it, yes.  
 3 MS. NEWBURY:  
 4 Q. Yes, and do you know if any occurrence report  
 5 was ever prepared regarding retro converters,  
 6 either individually or collectively?  
 7 MR. WILLIAMS:  
 8 A. No, I did not see one. You'd have to ask  
 9 people that did a bit more of the hands on  
 10 side.  
 11 MS. NEWBURY:  
 12 Q. Dr. Williams, I'm not sure if you had a chance  
 13 to reflect on the percentages over the lunch  
 14 break, but if so, do you still not have any  
 15 concerns with your choice of denominator,  
 16 which I understand to be in the range of 2500,  
 17 in calculating the percentage of results that  
 18 were anticipated to be different upon  
 19 retesting, even though the vast majority of  
 20 the ER positive results would never be  
 21 retested, according to the plan, and also, in  
 22 light of your recognition that there was a  
 23 possibility that there could be some  
 24 conversions from ER positive to ER negative?  
 25 MR. WILLIAMS:

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1 A. We were totally focused, as I said earlier,  
 2 before lunch, on the negatives that converted  
 3 to positives.  
 4 MS. NEWBURY:  
 5 Q. But having the benefit of hindsight, looking  
 6 back at it now. I realize that you were  
 7 focused on that at the time, but do you still  
 8 not have any concerns with using 2500 or in  
 9 that range as a denominator?  
 10 MR. WILLIAMS:  
 11 A. We're talking about conversions from negative  
 12 to positive. That's the number you probably  
 13 would use because you were looking at that  
 14 number.  
 15 MS. NEWBURY:  
 16 Q. So the denominator should have been the total  
 17 number of negatives, as opposed to the total -  
 18 MR. WILLIAMS:  
 19 A. I would think the denominator, you know, we  
 20 were looking at the number of negatives versus  
 21 the total number of tests.  
 22 MS. NEWBURY:  
 23 Q. Okay, thank you.  
 24 MR. WILLIAMS:  
 25 A. At the time.

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1 MS. NEWBURY:  
 2 Q. And just for clarification, the ten percent  
 3 figure quoted in the media, that wouldn't  
 4 include conversions from positive back to  
 5 negative? You were only focusing then on the  
 6 conversions -  
 7 MR. WILLIAMS:  
 8 A. We really weren't focused at that, because I'm  
 9 not aware of any literature and Dr. Banerjee  
 10 didn't--we asked him about it, and there was  
 11 nothing in the literature that saw that to be  
 12 a problem, in the literature anyway, and from  
 13 Dr. Banerjee's comments. So we were totally  
 14 again focused on the conversions from negative  
 15 to positive, at that time.  
 16 MS. NEWBURY:  
 17 Q. If I could bring up Exhibit P-0411. Just on  
 18 the issue of who was retested, there a note in  
 19 this memo from Heather Predham in the first  
 20 paragraph there, it indicates that as the  
 21 clinical definition of negative changed over  
 22 the years, all patients with an ER of 30  
 23 percent or less were retested. Is that  
 24 consistent with your understanding?  
 25 MR. WILLIAMS:

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1 A. Not totally consistent, no. I thought that it  
 2 was ten--30 percent to a certain date and then  
 3 ten percent after that date.  
 4 MS. NEWBURY:  
 5 Q. Okay. So to this day, you're not sure of  
 6 whether -  
 7 MR. WILLIAMS:  
 8 A. Again, that's my understanding.  
 9 MS. NEWBURY:  
 10 Q. Okay.  
 11 MR. WILLIAMS:  
 12 A. I'd have to go back and look at the memos that  
 13 were sent out by Dr. Cook, but I think that's  
 14 my understanding.  
 15 MS. NEWBURY:  
 16 Q. Okay, thank you. Now Dr. Williams, are you  
 17 familiar with the concept of blameless  
 18 culture?  
 19 MR. WILLIAMS:  
 20 A. Yes, I saw Mr. Tilley talking about that.  
 21 Probably not as familiar as he may be with it,  
 22 yes.  
 23 MS. NEWBURY:  
 24 Q. Yes, he was involved with an organization that  
 25 adopted that.

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1 MR. WILLIAMS:  
 2 A. Yes, so it wouldn't be something that I was  
 3 near as familiar with. I've heard the term,  
 4 terminology and this type of thing, but not in  
 5 any great detail or depth. It was a concept  
 6 that was, I guess, coming on nationally.  
 7 MS. NEWBURY:  
 8 Q. Okay, and was this blameless culture approach,  
 9 in your view, adopted at Eastern Health or the  
 10 Health Care Corporation of St. John's?  
 11 MR. WILLIAMS:  
 12 A. It was in the process of being adopted. I  
 13 can't tell you specifically because at a  
 14 certain stage, I was leaving the organization  
 15 and I don't know exactly when that would come  
 16 into effect.  
 17 MS. NEWBURY:  
 18 Q. Okay.  
 19 MR. WILLIAMS:  
 20 A. I'd have to--if I gave you an answer, I'd be  
 21 guessing, to be honest with you. I'd have to  
 22 go back and look at any notes I had, but I  
 23 didn't see anything in these exhibits that  
 24 talked about that.  
 25 MS. NEWBURY:

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1 Q. And would you expect to see documentation  
 2 generated either by Eastern Health or its  
 3 predecessor about the blameless culture  
 4 approach?  
 5 MR. WILLIAMS:  
 6 A. There should be something, but it may not be  
 7 in these documents. I think you'd have to ask  
 8 somebody who were a little closer to it than  
 9 me.  
 10 MS. NEWBURY:  
 11 Q. Okay.  
 12 MR. WILLIAMS:  
 13 A. To give you an answer, I'd be surmising, to be  
 14 honest.  
 15 MS. NEWBURY:  
 16 Q. And so in say 2005-2006, when you were the VP  
 17 of Medical Services and dealing with the ER/PR  
 18 issue, was the blameless approach factored  
 19 into any of the decision making that you were  
 20 involved in?  
 21 MR. WILLIAMS:  
 22 A. It certainly would be a thought because when  
 23 we were in Calgary, as I said, in 2006, there  
 24 was a lot of discussion, and again, I can't  
 25 really get the details, about how you'd have a

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1 culture that encouraged people to report  
 2 things and whether it was reporting things  
 3 that--adverse events that happened or near  
 4 misses that hadn't caused an adverse event,  
 5 but that would be useful in terms of  
 6 prevention. So I think the whole focus and  
 7 thrust, certainly in Calgary, so we would have  
 8 been aware of it from our discussions there  
 9 and there would have been some discussions I  
 10 know with our executive team when we came back  
 11 from Calgary, as you start to jog my memory.  
 12 MS. NEWBURY:  
 13 Q. Sure.  
 14 MR. WILLIAMS:  
 15 A. Ms. Elliott would be closer to it than me,  
 16 because she's the person who's in charge of  
 17 quality initiatives at that time when that  
 18 system came into place, and Ms. Pilgrim, more  
 19 so than me. But we did have some discussions  
 20 in Calgary. A lot of the discussions in  
 21 Calgary, you know, were about how they were  
 22 handling things there and what we could learn  
 23 from them, but there was the issue of the  
 24 organization's culture and how you'd try to  
 25 move that culture from, you know, maybe hiding

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1 things or not bringing--let's bring it out in  
 2 the open, even if an adverse event hasn't  
 3 occurred, so that something occurred didn't  
 4 cause any harm to anybody, but it was a near  
 5 miss. It could be used then to plan  
 6 strategies to prevent the thing from--prevent  
 7 the next time it might happen, it might cause  
 8 an adverse event. So that discussion was  
 9 under way.  
 10 MS. NEWBURY:  
 11 Q. Okay.  
 12 MR. WILLIAMS:  
 13 A. That's the level of my, I guess -  
 14 MS. NEWBURY:  
 15 Q. Your knowledge.  
 16 MR. WILLIAMS:  
 17 A. - detail and knowledge about time frames,  
 18 you'd have to ask somebody else. I'm sorry, I  
 19 can't answer that. If I can't answer it, I  
 20 just shouldn't try.  
 21 MS. NEWBURY:  
 22 Q. Well, if a blameless culture approach had been  
 23 adopted by Eastern Health, would you expect,  
 24 as VP of Medical Services, to be aware of  
 25 that?

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1 MR. WILLIAMS:  
 2 A. I would be aware of it in the discussion, and  
 3 again, that's what emanated from our  
 4 discussions in Calgary and our approach.  
 5 People in the organization, because I wasn't  
 6 responsible for quality prior to the fall of  
 7 2005, that people may be more knowledgeable  
 8 about that than me, and that may be something  
 9 that was encouraged.  
 10 MS. NEWBURY:  
 11 Q. So in your view then, this would be something  
 12 restricted to the quality. It wouldn't be  
 13 something known throughout the organization?  
 14 MR. WILLIAMS:  
 15 A. Well, it's something that they would be  
 16 working on and try to get that out in the  
 17 organization. We were working--I know, at  
 18 some stage, we were working on changing the  
 19 culture in the organization, yes, towards that  
 20 kind of an approach.  
 21 MS. NEWBURY:  
 22 Q. Okay, and if the quality department or any  
 23 other part of the organization were pursuing  
 24 the blameless culture approach, and if they  
 25 had conducted consultations with stakeholders,

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1 would you expect to be aware of this?  
 2 MR. WILLIAMS:  
 3 A. I would be aware of it, yes.  
 4 MS. NEWBURY:  
 5 Q. Okay, and are you aware that any such  
 6 consultations had taken place with, say, the  
 7 Board of Trustees or other regional health  
 8 authorities, Department of Health, advocacy  
 9 groups?  
 10 MR. WILLIAMS:  
 11 A. Again, to answer the question, I knew we were  
 12 talking about that kind of a culture when we  
 13 visited Calgary, and it wasn't a surprise to  
 14 us that that's the approach we were taking.  
 15 MS. NEWBURY:  
 16 Q. Right.  
 17 MR. WILLIAMS:  
 18 A. Now to tell you the specifics of whether the  
 19 Board was approached and when the Board was  
 20 approached, I'd have to defer you to somebody  
 21 else, because I might mislead you on that.  
 22 MS. NEWBURY:  
 23 Q. Okay, so -  
 24 MR. WILLIAMS:  
 25 A. And I don't want to do that.

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1 MS. NEWBURY:  
 2 Q. - so you don't necessarily know that it was or  
 3 wasn't done?  
 4 MR. WILLIAMS:  
 5 A. No, I don't necessarily know, and I don't want  
 6 to try to answer just in case I may be wrong.  
 7 MS. NEWBURY:  
 8 Q. And Mr. Tilley had indicated and acknowledged  
 9 that the adoption of a blameless culture  
 10 approach by an organization such as Eastern  
 11 Health would be a fundamental shift in the  
 12 philosophy, functioning and culture of the  
 13 organization. Would you agree with that  
 14 statement?  
 15 MR. WILLIAMS:  
 16 A. Well, the past there had been a different  
 17 approach, and the whole issue of the patient  
 18 safety agenda forward was to look at the  
 19 culture and try to change the culture over  
 20 time.  
 21 MS. NEWBURY:  
 22 Q. And you see it as a fundamental shift?  
 23 MR. WILLIAMS:  
 24 A. That's a fundamental shift, and--yes.  
 25 MS. NEWBURY:

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1 Q. And do you know, as VP of Medical Services,  
 2 whether physicians were generally made aware  
 3 of this new approach that was either in the  
 4 works or had already been adopted by Eastern  
 5 Health?  
 6 MR. WILLIAMS:  
 7 A. Well, we had started working on the whole  
 8 issue of adverse events sometime before, but  
 9 we had involved our physicians in the process.  
 10 I think it was in the fall of 2004, September  
 11 2004, we had representatives from the Canadian  
 12 Medical Protective Association come down. Dr.  
 13 Martin, I think Claude Martin was their leader  
 14 in risk manager and Mr. Peter Browne and they  
 15 would have spoken to our clinical chiefs. I  
 16 think the whole clinical chiefs meeting in  
 17 September 2004 was on the whole issue of  
 18 reporting of adverse events and patient  
 19 disclosure, and--or it was--it may have been  
 20 2003. I think it was 2004, or one of those  
 21 years anyway. It may have been--yeah, I think  
 22 it was 2004. 2005, I think we had Dr. Rob  
 23 Robson down to talk about clinical safety. So  
 24 we were talking about clinical safety to our  
 25 clinical chiefs at each annual retreat there

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1 for a few years in a row, but Dr. Robson, I  
 2 think, was 2005 and I think the adverse events  
 3 issue was either 2003, 2004. I stand to be  
 4 corrected on which one it was, but it was in  
 5 the September meeting, and we spent about a  
 6 couple of hours talking about that with  
 7 representatives. Subsequently, I had follow  
 8 up with the Newfoundland--sorry, the Medical  
 9 Board, and had changed themselves to the  
 10 College of Physicians and Surgeons.  
 11 MS. NEWBURY:  
 12 Q. Right.  
 13 MR. WILLIAMS:  
 14 A. They'd done some work on it and we tried to  
 15 meld the adverse event reporting mechanism for  
 16 Eastern Health, which was applying to all  
 17 staff, whether it was physicians or not, with  
 18 what CMPA had recommended and with what the  
 19 Newfoundland--sorry, the College of Physicians  
 20 and Surgeons of Newfoundland and Labrador were  
 21 looking at from other provinces. They had  
 22 some drafts done up. I think that that policy  
 23 was sent out before I signed it off. I heard  
 24 here I signed it off in its final form in  
 25 2005, but I understand that I sent that policy

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1 out to all our physicians before that.  
 2 MS. NEWBURY:  
 3 Q. And that's a disclosure policy on adverse  
 4 events?  
 5 MR. WILLIAMS:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. Was it discussed in the context of a blame  
 9 free culture? Was that also part of your -  
 10 MR. WILLIAMS:  
 11 A. Well, probably in the sense that look, let's  
 12 get this out. We don't--you have to--I think  
 13 if you're going to do that, you probably have  
 14 to discuss it with that background in mind.  
 15 MS. NEWBURY:  
 16 Q. Sure.  
 17 MR. WILLIAMS:  
 18 A. But like I say, to answer the question, I  
 19 don't want to mislead you. I'm sure that it  
 20 was probably discussed in that context. If  
 21 you're going to get stuff out, you're going to  
 22 report near misses, you're going to come right  
 23 upfront with adverse events, I think that  
 24 would probably be the background milieu you  
 25 were talking about.

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1 MS. NEWBURY:  
 2 Q. So the incentive then would be to have the  
 3 disclosure policy, but in the context of a  
 4 blame free culture?  
 5 MR. WILLIAMS:  
 6 A. Well -  
 7 MS. NEWBURY:  
 8 Q. To encourage the reporting.  
 9 MR. WILLIAMS:  
 10 A. - I would think so, but again, to give you the  
 11 specifics, I think you should ask somebody  
 12 else, in terms of that.  
 13 THE COMMISSIONER:  
 14 Q. Would the whole rationale for the policy as  
 15 well as the policy itself be written?  
 16 MR. WILLIAMS:  
 17 A. No, I don't think. I don't recall -  
 18 THE COMMISSIONER:  
 19 Q. There is a policy, is there not?  
 20 MR. WILLIAMS:  
 21 A. Yes, there is a policy on reporting of adverse  
 22 events which we started to do for all our  
 23 staff, nursing staff, employees basically,  
 24 right, of Eastern Health. Well, the Health  
 25 Care Corporation of St. John's.

1 THE COMMISSIONER:  
 2 Q. Right.  
 3 DR. WILLIAMS:  
 4 A. But we also felt that the physicians should be  
 5 part of that strategy of disclosing adverse  
 6 events, and that's why we involved the Medical  
 7 Board and that's why we invited the Canadian  
 8 Medical Protective Association to join us for  
 9 our clinical chiefs retreat in September,  
 10 2004. I may be wrong, it may be 2003 -  
 11 MS. NEWBURY:  
 12 Q. Sure.  
 13 DR. WILLIAMS:  
 14 A. - but it's one of those retreats.  
 15 MS. NEWBURY:  
 16 Q. Now, in terms of you wanted to include the  
 17 physicians, but how about including patients  
 18 in either the consultation or perhaps in an  
 19 education campaign about this approach?  
 20 DR. WILLIAMS:  
 21 A. I never heard that discussed in the strategy,  
 22 to be honest with you. It was the assumption  
 23 that patients would like to know what  
 24 happened, I presume, but I don't remember any  
 25 detailed discussion. Most of my involvement

1 Q. And how would the blame-free culture compare  
 2 with the traditional, the culture that  
 3 preceded the blame-free culture, what would be  
 4 the significant differences?  
 5 DR. WILLIAMS:  
 6 A. Well, I mean, I guess a culture of  
 7 disciplining people for individual issues,  
 8 looking at the individual instead of the  
 9 system as a cause of the errors. And so there  
 10 was some discussion around that, and I've seen  
 11 some literature written on it that problems  
 12 don't occur because of individual, the problem  
 13 occurs because, it maybe occurs because of the  
 14 system. That's some of the discussion that  
 15 would have taken place. But like I say, for  
 16 me to get into time frames and that type of  
 17 thing with you, there's other people who would  
 18 be much more conversant than me.  
 19 MS. NEWBURY:  
 20 Q. Now, if a patient or patients generally or the  
 21 public generally are not involved in the  
 22 consultations or educated about this new  
 23 approach, would you have any concerns that  
 24 perhaps if they were involved in an adverse  
 25 event and then they see nothing being done and

1 would have been at that time was making sure  
 2 that we had the physicians involved in it.  
 3 And so that's why we had our clinical leaders  
 4 involved in probably about a two-hour  
 5 presentation, give an take. There was a  
 6 presentation by CMPA and Mr. Browne here  
 7 locally from the CMPA and a chance for  
 8 physicians, our leaders to get involved in it  
 9 to and fro with questions and this type of  
 10 thing. Then I remember having some--a lot of  
 11 consultation with the Newfoundland, College of  
 12 Physicians and Surgeons of Newfoundland and  
 13 Labrador before--and we sent something, when I  
 14 sent it out, I would have sent out some  
 15 reference to the College of Physicians and  
 16 Surgeons that Labrador had developed a policy  
 17 and if there's a problem with our policy and  
 18 interpreting it along with the policy that  
 19 they'd done for doctors, they could contact my  
 20 office or I might have given them somebody  
 21 else's name to contact just in case they had a  
 22 problem with it. And so I'm pretty sure if  
 23 one looked, that--I would have sent that out.  
 24 But I don't know the exact date.  
 25 MS. NEWBURY:

1 being completely unaware of this new blame-  
 2 free culture and the potential benefits of it,  
 3 might they perceive that as inaction on the  
 4 part of the organization?  
 5 DR. WILLIAMS:  
 6 A. I think, you know, since I've left the  
 7 organization now for almost three years there  
 8 may have been something done on involving  
 9 patients in the consultation process since  
 10 that, I'm not sure.  
 11 MS. NEWBURY:  
 12 Q. But were there any concerns or did that  
 13 perhaps arise out of concerns that patients  
 14 might just see it as inaction rather than  
 15 something that ultimately -  
 16 DR. WILLIAMS:  
 17 A. I can't remember, when I was there, any  
 18 discussion about that, but there may have,  
 19 something happen since that time to have  
 20 involvement of patients in that process. I'm  
 21 not sure if Calgary would have had some kind  
 22 of an input as they went through with their  
 23 cultural change that may have caused us to do  
 24 the same thing as we move through. Because we  
 25 came back from Calgary and made our

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1 presentation and tried to get some resources,  
 2 more resources directed at quality than we've  
 3 ever had in the past.  
 4 MS. NEWBURY:  
 5 Q. Now, in terms of the response by Eastern  
 6 Health to the ER/PR issue, would you see that  
 7 the organization was using the blame-free  
 8 approach in so responding?  
 9 DR. WILLIAMS:  
 10 A. Yeah, that's the approach, I guess, we looked  
 11 at as a systems approach.  
 12 MS. NEWBURY:  
 13 Q. Now, in terms of the cause of the problem,  
 14 would you agree that while you were VP of  
 15 medical services that there was no root cause  
 16 analysis of the problem with the ER/PR  
 17 testing?  
 18 DR. WILLIAMS:  
 19 A. No. We took the approach of having some  
 20 outside consultants come in and look at that.  
 21 MS. NEWBURY:  
 22 Q. Okay. But -  
 23 DR. WILLIAMS:  
 24 A. As our approach we took.  
 25 MS. NEWBURY:

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1 Q. That's to fix the problems?  
 2 DR. WILLIAMS:  
 3 A. To identify what they felt the problems and  
 4 give us a prescription for fixing that so that  
 5 it wouldn't happen again. That's what I  
 6 looked at them for.  
 7 MS. NEWBURY:  
 8 Q. And you wouldn't consider their reports to be  
 9 a root cause analysis?  
 10 DR. WILLIAMS:  
 11 A. I wouldn't consider they'd use that. Now, I  
 12 don't know a lot about root cause analysis and  
 13 the technical issues involved around that.  
 14 But I would have considered their approach as  
 15 a look at our situation and our lab, look at  
 16 what happened and develop a strategy for us  
 17 that if we implement it, it would prevent it  
 18 from happening in the future.  
 19 MS. NEWBURY:  
 20 Q. Okay.  
 21 DR. WILLIAMS:  
 22 A. And prevent probably other things from  
 23 happening in the future. And this is what the  
 24 reports that I got from Trish Wegrynowski and  
 25 Dr. Banerjee, in my view, addressed in that

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1 sense.  
 2 MS. NEWBURY:  
 3 Q. Um-hm. Neither of their reports were directed  
 4 at delving into the origin of the problems?  
 5 DR. WILLIAMS:  
 6 A. Well, Dr. Banerjee did review some slides back  
 7 to 1997 and reviewed that, yes.  
 8 MS. NEWBURY:  
 9 Q. And he identified problems with, for instance,  
 10 the absence of or inadequate attention paid to  
 11 internal controls?  
 12 DR. WILLIAMS:  
 13 A. That's one of the things he identified. He -  
 14 MS. NEWBURY:  
 15 Q. But did he go beyond that and try to find out  
 16 why there was inadequate attention paid to  
 17 internal controls?  
 18 DR. WILLIAMS:  
 19 A. I'm not sure if he--what questions he would  
 20 have asked at the time.  
 21 MS. NEWBURY:  
 22 Q. But did he identify it in his report?  
 23 DR. WILLIAMS:  
 24 A. No, he did not in his report, but he  
 25 identified that we didn't pay attention,

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1 attention wasn't paid, so the approach to that  
 2 would be pay attention to it in the future.  
 3 And also, some of the recommendations, I  
 4 think, like having a subspecializing would  
 5 have dealt with a variety of that issue and  
 6 some other issues that may come up from time  
 7 to time.  
 8 MS. NEWBURY:  
 9 Q. Do you agree that while, certainly while you  
 10 were the VP of medical services that the  
 11 patients and public were not advised by  
 12 Eastern Health as to the cause, the actual  
 13 cause of the problems with the ER/PR testing?  
 14 DR. WILLIAMS:  
 15 A. To a large extent because we had these  
 16 reports, we viewed them as a quality report  
 17 and we--I felt we couldn't share them, based  
 18 upon that. I did say publicly that there was  
 19 a lot of problems in the, you know, the  
 20 boiling the things and that we did have a  
 21 system of checks and balances in place that  
 22 didn't seem to work, I did say that.  
 23 MS. NEWBURY:  
 24 Q. Right.  
 25 DR. WILLIAMS:

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1 A. And that was referring, I guess, to the  
 2 controls, that they didn't work because we--  
 3 that's why we were surprised when basically  
 4 the first one to find out about it, I was told  
 5 there was a system of controls, so I'm  
 6 thinking with a system of controls in place,  
 7 how can this happen. So we found out  
 8 subsequently, you know, that they didn't work  
 9 and I would refer to sort of a checks and  
 10 balances on it, sort of an internal quality  
 11 procedure that you're undertaking.

12 MS. NEWBURY:  
 13 Q. But there was certainly no detail given to  
 14 either the patients or the public as to the  
 15 cause of the problem?

16 DR. WILLIAMS:  
 17 A. No, there was not.

18 MS. NEWBURY:  
 19 Q. Whether it was sort of a more immediate  
 20 general cause of the problems or whether it  
 21 dug down into the origin of all of those  
 22 different issues that Dr. Banerjee or Ms.  
 23 Wegrynowski found?

24 DR. WILLIAMS:  
 25 A. Yes.

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1 MS. NEWBURY:  
 2 Q. Okay.

3 DR. WILLIAMS:  
 4 A. I explained that earlier that that, you know,  
 5 we didn't feel that we could share the detail  
 6 in those because we thought they were--we were  
 7 operating on the basis they were quality  
 8 reports.

9 MS. NEWBURY:  
 10 Q. Can you see that from a patient's perspective  
 11 that it might be troubling for a patient not  
 12 to be told in any detail the cause of the  
 13 problems with ER/PR testing, either on an  
 14 individual basis or perhaps being told as a  
 15 group the types of problems that were  
 16 experienced?

17 DR. WILLIAMS:  
 18 A. And I can see that that's an issue that's been  
 19 certainly identified here in proceedings. And  
 20 that we're going to have to come to grips with  
 21 how, if we have a situation like this in the  
 22 future, that we may be able to deal with that  
 23 so that we can have reports that can be  
 24 disclosed publicly. I may make a few comments  
 25 on that a little later.

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1 MS. NEWBURY:  
 2 Q. Sure, okay. And were there any steps taken  
 3 while you were VP of medical services about  
 4 moving towards having a type of reporting  
 5 system that could address those concerns?

6 DR. WILLIAMS:  
 7 A. No, not when I--not before I left.

8 MS. NEWBURY:  
 9 Q. Okay. But you've become aware of some  
 10 subsequently?

11 DR. WILLIAMS:  
 12 A. I may have become. I don't--I'm not aware of  
 13 any, no.

14 MS. NEWBURY:  
 15 Q. Okay. And can you appreciate that patients  
 16 may be sceptical about the ability of Eastern  
 17 Health to rectify the problem if they don't  
 18 know--if it's never been stated by Eastern  
 19 Health what the cause is or any detail about  
 20 the cause of the problem?

21 DR. WILLIAMS:  
 22 A. Maybe. I guess we said that we had brought in  
 23 people and we did a review of the lab, I know  
 24 we would have said that.

25 MS. NEWBURY:

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1 Q. So you were hoping they would just take  
 2 comfort that there were recommendations made -

3 DR. WILLIAMS:  
 4 A. And we brought in outside people, not people  
 5 inside the lab, because it's difficult for  
 6 people who are working alongside of somebody  
 7 else to work with them on a day-to-day basis  
 8 to have--develop the necessary critique of  
 9 what's being done by one of their colleagues,  
 10 so that's why we went to outside people, yes.

11 MS. NEWBURY:  
 12 Q. Sure. Now, of course, the patients and the  
 13 public and family members of deceased patients  
 14 never did learn, while you were VP of medical  
 15 services, the content of those reports?

16 DR. WILLIAMS:  
 17 A. They did not, no.

18 MS. NEWBURY:  
 19 Q. So they would just be asked to accept that the  
 20 recommendations had been made?

21 DR. WILLIAMS:  
 22 A. Except that we found out what the problems  
 23 were and have acted to make sure that they  
 24 were prevented in the future.

25 MS. NEWBURY:

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1 Q. Do you know if anyone at Eastern Health  
 2 considered the combined effect of number one,  
 3 the patient being unaware of the blameless-  
 4 culture approach and the potential benefits  
 5 and that patient observing that no  
 6 disciplinary action is being taken and perhaps  
 7 interpreting that as no action being taken by  
 8 Eastern Health, and number two, Eastern Health  
 9 not providing an explanation in any detail as  
 10 to the cause of the problem, had any attention  
 11 been paid or consideration given to those  
 12 issues?  
 13 DR. WILLIAMS:  
 14 A. I don't recollect anything being--that  
 15 considered in that framework.  
 16 MS. NEWBURY:  
 17 Q. And would you think that if you're in the  
 18 context of a blameless-culture environment,  
 19 that might be particularly important to be  
 20 able to explain to the patient the cause of  
 21 the problem? I mean, that would be one of the  
 22 benefits, presumably, of the blameless-culture  
 23 approach is that there's a trade off here,  
 24 we're not going to discipline people involved  
 25 but ultimately you'll benefit because we're

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1 going to do all of these steps to improve the  
 2 system. But if they're not aware of that, the  
 3 latter part, certainly not aware of it in any  
 4 detail, do you think that that might be a  
 5 problem for those individuals?  
 6 DR. WILLIAMS:  
 7 A. And I think that you could be right there.  
 8 Certainly our adverse event reporting, which  
 9 was meant to deal with individual cases, one  
 10 of the parts of it is that we tell the person  
 11 how much we knew at the time, because sometime  
 12 when you disclose individually, you may not  
 13 know the full extent of the cause, so you just  
 14 tell them what you knew at the time. Again,  
 15 we were constrained by having these quality  
 16 reports done so that people would--wanted  
 17 everything, all the details done in hard  
 18 hitting reports, and we did. And again, if we  
 19 get into the situation again, maybe one of the  
 20 lessons learned is how we might take a  
 21 different approach.  
 22 MS. NEWBURY:  
 23 Q. On that point, I wonder if I could bring up  
 24 Exhibit P-0161, please? Page 21. Actually, I  
 25 should show you the first page, the cover page

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1 of this document first just so you can  
 2 understand what it is. These are the Canadian  
 3 disclosure guidelines which I understand were  
 4 published in 2008. So I'm not sure if you're  
 5 familiar with that, and I'm not -  
 6 DR. WILLIAMS:  
 7 A. No, I'm not familiar with them.  
 8 MS. NEWBURY:  
 9 Q. I'm not going to quiz you on the document  
 10 itself, but I just want to know if you're  
 11 familiar with some of the concepts that are in  
 12 this document?  
 13 DR. WILLIAMS:  
 14 A. No, I'm not familiar.  
 15 MS. NEWBURY:  
 16 Q. With any?  
 17 DR. WILLIAMS:  
 18 A. No.  
 19 MS. NEWBURY:  
 20 Q. Well, I'll show you the concept and you can  
 21 tell me now if you are aware, not of the  
 22 actual written report, but whether this was a  
 23 theme that you had been aware of before. And  
 24 now if I could turn to page 21, please? Now,  
 25 in the second column, the first paragraph,

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1 this is again a discussion about root cause  
 2 analysis there. But it indicates, "Providers  
 3 and patients should be made aware that there  
 4 are explicit limitations to discussing to  
 5 discussing some of the investigative  
 6 information such as opinions and speculation  
 7 shared as defined in legislation within each  
 8 province or territories quality of care  
 9 protection."  
 10 DR. WILLIAMS:  
 11 A. Where are you reading -  
 12 MS. NEWBURY:  
 13 Q. Sorry.  
 14 DR. WILLIAMS:  
 15 A. Where are you reading from now?  
 16 MS. NEWBURY:  
 17 Q. Sorry. Second column, first paragraph  
 18 starting up, it's the second line.  
 19 DR. WILLIAMS:  
 20 A. Okay.  
 21 MS. NEWBURY:  
 22 Q. Thank you. Now, that's just a general  
 23 statement there. Are you aware of this  
 24 general statement, is this something  
 25 consistent with your understanding of the



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1 quality assurance peer review privilege in  
 2 this province back in 2005, 2006?  
 3 DR. WILLIAMS:  
 4 A. I would not be--you know, I don't even know if  
 5 that was a concept that was discussed at the  
 6 time.  
 7 MS. NEWBURY:  
 8 Q. Okay. So you're not aware -  
 9 DR. WILLIAMS:  
 10 A. These are 2008 guidelines.  
 11 MS. NEWBURY:  
 12 Q. No, no, no, I recognize that. But I think the  
 13 guidelines -  
 14 DR. WILLIAMS:  
 15 A. I'm not sure that was a lot written nationally  
 16 on this or a lot conceived nationally on this.  
 17 Is this to deal with an adverse event with  
 18 respect to a large number of patients or is  
 19 this an individual disclosure issue here?  
 20 MS. NEWBURY:  
 21 Q. I think this is just general information. I  
 22 don't think it's specifically in context -  
 23 DR. WILLIAMS:  
 24 A. But is the -  
 25 MS. NEWBURY:

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1 Q. - to multi-patient disclosure.  
 2 DR. WILLIAMS:  
 3 A. It's not to do with multi-patient disclosure,  
 4 is it?  
 5 MS. NEWBURY:  
 6 Q. No, not -  
 7 DR. WILLIAMS:  
 8 A. It's to do with individual disclosure?  
 9 MS. NEWBURY:  
 10 Q. Yes, that's my understanding.  
 11 DR. WILLIAMS:  
 12 A. Yeah. There's some issues in our adverse  
 13 event policy, and I don't have it in front of  
 14 me, but that talk about some things, about the  
 15 setting and things like that.  
 16 MS. NEWBURY:  
 17 Q. Um-hm. But just in terms of the privilege  
 18 there, was it your view back in 2005 and 2006  
 19 that the privilege part of the peer review or  
 20 quality review would be actually the opinions  
 21 and speculations shared as opposed to,  
 22 perhaps, you know, just straight statement of  
 23 facts?  
 24 DR. WILLIAMS:  
 25 A. No, I wouldn't--I don't know if I've seen that

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1 before in that level of detail back in -  
 2 MS. NEWBURY:  
 3 Q. Okay. So you hadn't thought about that at  
 4 all?  
 5 DR. WILLIAMS:  
 6 A. No. And I don't think there was anything  
 7 written back in 2005 on it that I'm aware of.  
 8 MS. NEWBURY:  
 9 Q. Um-hm. And you, if you heard anything about  
 10 this when you were in Calgary, you wouldn't  
 11 recall it today?  
 12 DR. WILLIAMS:  
 13 A. No, I don't recollect any discussion about  
 14 this issue in Calgary.  
 15 MS. NEWBURY:  
 16 Q. And if we can turn to page 10 of that  
 17 document, please? Now, this is talking about  
 18 the importance of disclosure there is the  
 19 heading in the left-hand column. And at the  
 20 bottom of the column, on the left-hand page  
 21 under the heading, "Patient Perspective" the  
 22 second paragraph there under the bullets, it  
 23 says, "Patients may lose trust or become  
 24 anxious or fearful when they sense that  
 25 information is being withheld. This loss of

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1 trust can negatively affect the therapeutic  
 2 relationship. Patients may be more  
 3 understanding of adverse events when there has  
 4 been open disclosure. Disclosure on adverse  
 5 events--disclosing an adverse event to the  
 6 patient shows respect, involves the patient in  
 7 the clinical decision making process and  
 8 facilitates future safe and appropriate  
 9 clinical care." Is this concept, I know that  
 10 the document was not written until 2008, but  
 11 is the general concept something that you were  
 12 aware of back in 2005, 2006?  
 13 DR. WILLIAMS:  
 14 A. I'm not sure, again, if I--I haven't seen  
 15 anything nationally coming out on that, but in  
 16 our individual adverse events report, we would  
 17 have talked about issues such as those, and  
 18 reporting on an individual basis to an  
 19 individual patient about an event that  
 20 occurred. But I haven't--I don't recollect  
 21 back in 2005, 2006, anything written  
 22 nationally or anything done that would deal  
 23 with something like we had to deal with at the  
 24 time, a major event affecting many people.  
 25 MS. NEWBURY:

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1 Q. But even though there weren't any documents  
 2 such as this at the time that you're aware of,  
 3 you must have had some discussions, enough to  
 4 the point that your response to ER/PR included  
 5 the blameless culture? Would that not be  
 6 something -  
 7 DR. WILLIAMS:  
 8 A. I don't -  
 9 MS. NEWBURY:  
 10 Q. Would that not be something -  
 11 DR. WILLIAMS:  
 12 A. I don't remember having a lot of discussion  
 13 about the blameless culture in terms of the ER  
 14 and PR to be honest with you.  
 15 MS. NEWBURY:  
 16 Q. Okay, so it was more about -  
 17 DR. WILLIAMS:  
 18 A. You know, it was more about, I guess letting--  
 19 well, initially providing some information to  
 20 the public so that we can let the individual  
 21 patients know that there was an issue, in my  
 22 mind at the time.  
 23 MS. NEWBURY:  
 24 Q. But in terms of your response to the ER/PR, I  
 25 mean looking back at it, perhaps you hadn't

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1 focused on it at the time, but would you  
 2 characterize the Eastern Health response to be  
 3 one of a blameless free culture or consistent  
 4 with the blameless free culture? No one was  
 5 disciplined.  
 6 DR. WILLIAMS:  
 7 A. No, and we were looking at it as a system's  
 8 issue and probably in that context, but to be  
 9 specific about a timeframe for that, I can't  
 10 recollect. And I'm not sure and I haven't  
 11 seen anything, is there anything that's come  
 12 out since that talks about the kind of  
 13 situation we were in, in an adverse event that  
 14 affects multiple people and how we would deal  
 15 with it, I'm not sure if there's anything yet  
 16 published on that, that I'm aware of. Anyway,  
 17 there may be, but I'm not aware of it.  
 18 MS. NEWBURY:  
 19 Q. But under a traditional approach, even if you  
 20 have a system's error, would you not have  
 21 contemplated or look into whether or not  
 22 discipline might be appropriate for some of  
 23 the individuals involved?  
 24 DR. WILLIAMS:  
 25 A. I think sometime and even in a blameless

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1 culture if it's wanted disregard for policies  
 2 and procedures and this type of thing, there  
 3 would be some discipline meted out, even in  
 4 those situations, if there was wanted total  
 5 disregard for what happened -  
 6 MS. NEWBURY:  
 7 Q. It would have to be extreme.  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. But how about if it was more ordinary?  
 12 DR. WILLIAMS:  
 13 A. No, that doesn't contemplate that, it  
 14 contemplates trying to correct the system's  
 15 problem, making things better so that things  
 16 don't happen in the future.  
 17 MS. NEWBURY:  
 18 Q. But under the traditional approach, would the  
 19 first reaction be to look and see who might  
 20 need to be disciplined?  
 21 DR. WILLIAMS:  
 22 A. In some people's minds it might be, but other  
 23 people's minds it's let's see what happened  
 24 because there's many facets to problems that  
 25 occur. It's not just one thing goes wrong; a

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1 number of things might have to go wrong.  
 2 MS. NEWBURY:  
 3 Q. But under the traditional approach, would  
 4 there be more of an inclination to look at  
 5 discipline?  
 6 DR. WILLIAMS:  
 7 A. I think it would have been more of an  
 8 inclination, yes.  
 9 MS. NEWBURY:  
 10 Q. And looking back at it now, do you think that  
 11 for the patients involved and the family  
 12 members of deceased patients that there might  
 13 have been some loss of trust as a result of  
 14 patients learning for the first time from the  
 15 media the problems with the ER/PR testing, as  
 16 opposed to hearing about it directly from the  
 17 Eastern Health?  
 18 DR. WILLIAMS:  
 19 A. Yes, I think in retrospect that's an issue  
 20 that--and that's an issue that we had to deal  
 21 with back in the summer in early fall of 2005.  
 22 MS. NEWBURY:  
 23 Q. And do you think that there might also have  
 24 been some loss of trust when Eastern Health  
 25 did not announce the cause of the problems

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1 with ER/PR testing?  
 2 DR. WILLIAMS:  
 3 A. I'm not sure if we did say that we had people  
 4 come in and had identified issues and we were  
 5 going to fix the problem.  
 6 MS. NEWBURY:  
 7 Q. But they weren't told what the cause was?  
 8 DR. WILLIAMS:  
 9 A. No, we did not.  
 10 MS. NEWBURY:  
 11 Q. Nor were they told what the corrections would  
 12 be in any detail?  
 13 DR. WILLIAMS:  
 14 A. No, that's correct.  
 15 MS. NEWBURY:  
 16 Q. So do you think now, looking back at it, that  
 17 maybe there might have been some loss of trust  
 18 in the patients and family members?  
 19 DR. WILLIAMS:  
 20 A. I think if you're going to learn anything from  
 21 this, you'd learn that there's some issues to  
 22 definitely the second time around, yes, of  
 23 course.  
 24 MS. NEWBURY:  
 25 Q. Okay. In terms of the concept of blame, would

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1 you equate finding answers to finding blame?  
 2 DR. WILLIAMS:  
 3 A. Not necessarily, no.  
 4 MS. NEWBURY:  
 5 Q. Okay, would you agree that it depends on what  
 6 you do once you found the answers that would  
 7 determine whether or not an organization is  
 8 engaged in a blaming exercise?  
 9 DR. WILLIAMS:  
 10 A. To a certain extent, yes, depending on what  
 11 you found and--it just depends on what you  
 12 found at the time, right.  
 13 MS. NEWBURY:  
 14 Q. But just because you're looking for answers,  
 15 it doesn't mean that you're engaged in a  
 16 blaming exercise.  
 17 DR. WILLIAMS:  
 18 A. No.  
 19 MS. NEWBURY:  
 20 Q. You may ultimately decide that -  
 21 DR. WILLIAMS:  
 22 A. You're looking for answers to find out what  
 23 happened and what went wrong and usually in  
 24 these cases, a number of things may have went  
 25 wrong.

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1 MS. NEWBURY:  
 2 Q. Sure.  
 3 DR. WILLIAMS:  
 4 A. It's no one person responsible, but it's  
 5 broader than that, yes.  
 6 MS. NEWBURY:  
 7 Q. But even if one of the combination of factors,  
 8 maybe--even if one of those factors involved  
 9 human error to identify that human error in  
 10 the system, would that, in your view, be  
 11 considered a blaming exercise if your purpose  
 12 is to make sure that it doesn't happen again,  
 13 as opposed to penalizing or disciplining that  
 14 individual?  
 15 DR. WILLIAMS:  
 16 A. To find out that there is human error would  
 17 not mean that you are going to discipline and  
 18 in fact the report that was generated, the in-  
 19 home patient safety issue movement, 1999,  
 20 2000, the U.S. was entitled "To Err is Human"  
 21 and that was the first--that was a seminal  
 22 article on patient safety and this type of  
 23 thought process and that was '99, 2000 to Dr.  
 24 Leape in the U.S. started the whole issue of  
 25 patient safety and this type of thing and

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1 things moving forward from there.  
 2 MS. NEWBURY:  
 3 Q. So the exercise would be appropriate in terms  
 4 of the blame free culture and patient safety  
 5 movement?  
 6 DR. WILLIAMS:  
 7 A. The exercise would be appropriate.  
 8 MS. NEWBURY:  
 9 Q. And to identify the human error, would that  
 10 actually be beneficial to the organization to  
 11 do so?  
 12 DR. WILLIAMS:  
 13 A. To identify any cause of error would be  
 14 beneficial to the organization to do so,  
 15 because then once you identify what the causes  
 16 are, you can take measures to prevent them  
 17 from happening again. That would be the  
 18 purpose.  
 19 MS. NEWBURY:  
 20 Q. Did you observe any concern among health care  
 21 workers or administrators or staff at Eastern  
 22 Health that a search for answers, in their  
 23 mind, might have been seen as a search for  
 24 blame?  
 25 DR. WILLIAMS:

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1 A. You always had that issue when we--that's why  
 2 we have peer review rules done up and to have  
 3 peer review that has checks and balances put  
 4 in because there's always that issue when  
 5 they're doing a review, somebody or some  
 6 thing.  
 7 MS. NEWBURY:  
 8 Q. And aside from peer review, are there any  
 9 other tools that Eastern Health can use to  
 10 help address that concern just to, you know,  
 11 let people know that we're looking for  
 12 answers, we need to identify all the factors,  
 13 even if it's human error, not to blame, but to  
 14 correct the problem?  
 15 DR. WILLIAMS:  
 16 A. I think that takes some time in a large  
 17 organization with 12,000 people, such as  
 18 Eastern Health, or 6,000 people such as the  
 19 Health Care Corporation, to work on building  
 20 that culture and people to buy in and that  
 21 takes time and that takes experience and that  
 22 takes examples over time. So that's my own  
 23 view of it, I think I'm not so sure there's  
 24 any set answer, but that is what I would say  
 25 is that that takes time to change an

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1 organizational thought process and culture.  
 2 It's not going to happen overnight because  
 3 somebody says it's like that, that everybody  
 4 says oh fine, I'll report this or I'll report  
 5 that, I think it has to be built over time.  
 6 MS. NEWBURY:  
 7 Q. And do you know if there are any training  
 8 workshops or trained facilitators that can  
 9 assist Eastern Health in -  
 10 DR. WILLIAMS:  
 11 A. I think there's some of that has happened  
 12 since I left, I -  
 13 MS. NEWBURY:  
 14 Q. Within the organization?  
 15 DR. WILLIAMS:  
 16 A. Yes, within the organization and some of it  
 17 may have taken place before I left, actually.  
 18 MS. NEWBURY:  
 19 Q. Okay, and do you think that if people are  
 20 going to buy into the problem, that it might  
 21 be of some benefit to involve other  
 22 stakeholders in the process, just for  
 23 educational purposes or perhaps looking for  
 24 consultation or feedback?  
 25 DR. WILLIAMS:

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1 A. And I think you need to ask people that are  
 2 closer, because some of that might have  
 3 happened by now, I'm not sure.  
 4 MS. NEWBURY:  
 5 Q. Okay, just in terms of -  
 6 DR. WILLIAMS:  
 7 A. I'm out of the organization, so if I was in  
 8 the organization on a daily basis, I'd  
 9 probably have some answers for you, but I'm  
 10 sorry, I can't.  
 11 MS. NEWBURY:  
 12 Q. No, I'm not necessarily asking if you know  
 13 it's happened, but I'm just wondering just now  
 14 with the benefit of your hindsight whether you  
 15 think that might help in terms of promoting  
 16 that type of an approach and to maximize the  
 17 benefit of it.  
 18 DR. WILLIAMS:  
 19 A. Yes, and I think that sort of thought process  
 20 was something that came out in our--I'm just  
 21 trying to think back in our discussions with  
 22 Calgary that they may have done something  
 23 along those lines and I think maybe if you  
 24 looked in the organization now, because we  
 25 didn't get back out of Calgary until 2006,

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1 that that may be moving forward in our  
 2 organization, but I can't be sure of that,  
 3 some people that will come behind me may be  
 4 able to answer that question better than me.  
 5 MS. NEWBURY:  
 6 Q. Okay, thank you. If I could have page 30 of  
 7 this exhibit, P-0161? Now this is a glossary  
 8 of terms and the guidelines, the disclosure  
 9 guidelines that I just referred you to  
 10 earlier, and there's a definition there of  
 11 system failure, "a fault, breakdown or  
 12 dysfunction within an organization's  
 13 operational methods, processes or  
 14 infrastructure." Now, again, this is the 2008  
 15 guidelines, but is this definition consistent  
 16 with your own understanding of a system  
 17 failure?  
 18 DR. WILLIAMS:  
 19 A. I never thought of it, just on a cursory  
 20 review of it, it looks reasonable, but I'd  
 21 have to--if you wanted me to really reflect on  
 22 it, I'd have to reflect on it and think about  
 23 it for some time and I'd have really to look  
 24 at the document and how it was used in that  
 25 perspective in the document.

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1 MS. NEWBURY:  
 2 Q. Okay.  
 3 DR. WILLIAMS:  
 4 A. But, just looking at it, again, I haven't had  
 5 any chance to think about it, so you're asking  
 6 me to look at it, I haven't read the document  
 7 that's embodied, so I really need to--before I  
 8 got into any detailed discussion on it, I'd  
 9 have to do that.  
 10 MS. NEWBURY:  
 11 Q. Sure, so it might depend on the context in  
 12 which -  
 13 DR. WILLIAMS:  
 14 A. It might depend on the context and this type  
 15 of thing, yes.  
 16 MS. NEWBURY:  
 17 Q. Okay. If I could have page 12 of that  
 18 exhibit? And so in the first column there, on  
 19 the left-hand side of the page -  
 20 DR. WILLIAMS:  
 21 A. Uh-hm.  
 22 MS. NEWBURY:  
 23 Q. "This is creating a culture of patient safety"  
 24 is the heading of that section.  
 25 DR. WILLIAMS:

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1 A. Uh-hm.  
 2 MS. NEWBURY:  
 3 Q. And the third paragraphs says that "many  
 4 adverse events in health care are now  
 5 recognized as system failures where safeguards  
 6 to protect patient safety were not in place or  
 7 series of safeguards were not in place which  
 8 resulted in harm to the patient. Adverse  
 9 events often occur after recurrent patterns of  
 10 failures, regardless of the dedication or  
 11 experience of the health care providers  
 12 involved. Systems theory emphasizes that  
 13 focusing on the system, rather than on the  
 14 individual, will prevent more adverse events."  
 15 DR. WILLIAMS:  
 16 A. Uh-hm.  
 17 MS. NEWBURY:  
 18 Q. Now if you want to take a moment to reflect on  
 19 that -  
 20 DR. WILLIAMS:  
 21 A. That's the "swiss cheese" analogy that you're  
 22 talking about there.  
 23 MS. NEWBURY:  
 24 Q. Okay. It does talk about system failure, the  
 25 definition that I just referred you to and the

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1 recognition that "many adverse events in  
 2 health care are now recognized as system  
 3 failures." Is that consistent with your  
 4 understanding?  
 5 DR. WILLIAMS:  
 6 A. Again, looking at it, you're asking me to pick  
 7 out a paragraph in a large document and  
 8 comment on it.  
 9 MS. NEWBURY:  
 10 Q. Not to comment on the document itself, but  
 11 generally, you know -  
 12 DR. WILLIAMS:  
 13 A. No, but it's in the context and this type of  
 14 thing, I mean a system's--it looks reasonable  
 15 to me, but again, if I'm going to be dealing  
 16 with it and questioned on it, it's part of a  
 17 larger document which I haven't read.  
 18 MS. NEWBURY:  
 19 Q. Sure. Well just talking generally then about  
 20 system failure and you alluded to it earlier  
 21 in terms of why an organization may not want  
 22 to discipline individuals because it's  
 23 recognizing that there could be many other  
 24 factors at play, you're looking at the system  
 25 as a whole, as opposed to an individual's

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1 performance.  
 2 DR. WILLIAMS:  
 3 A. Uh-hm.  
 4 MS. NEWBURY:  
 5 Q. Is that, did I capture that correctly?  
 6 DR. WILLIAMS:  
 7 A. Yeah, well I guess we know that people have to  
 8 work in the system and there's obviously a  
 9 system in place, there's more, there's people  
 10 working at different phases and facets of the  
 11 system, so that in order for an adverse event  
 12 to occur, it may occur because of one's  
 13 individual issue, but it often occurs because  
 14 of a number of situations that congeal around  
 15 a certain event and a certain timeframe and a  
 16 certain temporal relationship and you get a  
 17 problem.  
 18 MS. NEWBURY:  
 19 Q. Right.  
 20 DR. WILLIAMS:  
 21 A. That's the theory.  
 22 MS. NEWBURY:  
 23 Q. Now Mr. Osborne testified that he had asked  
 24 Eastern Health on a number of occasions if  
 25 they had pinpointed the problem and he was

1 given the understanding that the problem was a  
 2 system's error and he had interpreted that to  
 3 be an error with the DAKO system and that the  
 4 problem was inherent in the DAKO machine and  
 5 that the new Ventana, which was a more  
 6 sensitive machine, did a better job. And he  
 7 also indicated that he had assurances that it  
 8 was not human error on the part of Eastern  
 9 Health.

10 DR. WILLIAMS:

11 A. Uh-hm.

12 MS. NEWBURY:

13 Q. Now I'm not sure if you're aware of what his  
 14 understanding might have been -

15 DR. WILLIAMS:

16 A. No, I wasn't--I've never met Mr. Osborne and I  
 17 know he came on as minister before I left, but  
 18 I've never been involved with briefing him or  
 19 been involved with him, so I'm not sure -

20 MS. NEWBURY:

21 Q. Where he got that.

22 DR. WILLIAMS:

23 A. Where he got that information.

24 MS. NEWBURY:

25 Q. Do you think there might have been some

1 confusion because of the, on the one hand the  
 2 use, the reference by Eastern Health to the  
 3 system problems, system failure, verses a  
 4 layperson's understanding of what that might  
 5 mean?

6 DR. WILLIAMS:

7 A. I don't know and to be honest with you, I  
 8 don't want to speculate on that.

9 MS. NEWBURY:

10 Q. Okay. Ms. Dawe had also given evidence that  
 11 for a considerable period of time she felt  
 12 that the change in technology was a major  
 13 contributing factor to the circumstance  
 14 surrounding the testing and she had indicated  
 15 she was disappointed not to be made aware of  
 16 the inefficiencies in quality, monitoring and  
 17 documentation and she testified that for a  
 18 considerable period of time she felt that the  
 19 change--sorry, she further stated that the  
 20 minutes and the briefing material that were  
 21 made public, always referenced a change in  
 22 system and she wondered why this would be  
 23 referenced, you know, repeatedly, if it were  
 24 not an issue, and that's, I think, partly the  
 25 context why she assumed that the change in

1 technology was a major contributing factor.  
 2 Are you aware of how she might have arrived at  
 3 that conclusion?

4 DR. WILLIAMS:

5 A. No, I understand that she might have arrived  
 6 at that conclusion, but I'm not aware of--I  
 7 know it was always said that we, when we were  
 8 retested on the new system, we had a new  
 9 system in place, by that time it turned  
 10 positive, that doesn't indicate that it was a  
 11 problem with one system and the other system  
 12 was good and the other system was bad. I  
 13 don't know why--I know we did a very detailed  
 14 briefing after Dr. Banerjee's visit and I know  
 15 it would have mentioned some of the things he  
 16 mentioned in that briefing.

17 MS. NEWBURY:

18 Q. And your briefing was a verbal briefing?

19 DR. WILLIAMS:

20 A. Yes, about a 45 minute briefing.

21 MS. NEWBURY:

22 Q. Did you think about doing a report, a  
 23 document?

24 DR. WILLIAMS:

25 A. No, I didn't do a document, I would have had a

1 book if I--I spent about 35, 45 minutes I'm  
 2 pretty sure in going back on what ER/PR meant,  
 3 how it affected treatment, I would have got  
 4 that from Dr. Laing, what happened in terms of  
 5 sequence and, but the first briefing of the  
 6 Board would have been on the 21st of  
 7 September, I wouldn't have had the debriefing,  
 8 but Trish Wegrynowski at the time, because I  
 9 think that happened after, but I would have  
 10 had Dr. Banerjee's verbal briefing on the  
 11 matter. I'm sure I would have mentioned some  
 12 issues that he brought forward.

13 MS. NEWBURY:

14 Q. Can you say today whether or not you had  
 15 indicated to the Board that there was a  
 16 system's failure or a system's error?

17 DR. WILLIAMS:

18 A. I would have indicated to the Board what we  
 19 knew and as you see some of the things that  
 20 the consultants made many recommendations and  
 21 we were going to be following up on them and  
 22 we have a plan to deal with those.

23 MS. NEWBURY:

24 Q. But can you say whether the term, systems  
 25 error, might have been used or system failure,

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1 something to that -  
 2 DR. WILLIAMS:  
 3 A. I don't recollect what term I used.  
 4 MS. NEWBURY:  
 5 Q. Okay. Do you think that it might have been  
 6 important to have an official report just so  
 7 the board could have something in hand, you  
 8 know, just to aid the communication with the  
 9 board as to the nature of the problems.  
 10 DR. WILLIAMS:  
 11 A. I guess in retrospect, if they feel they  
 12 didn't understand the many briefings that I  
 13 gave pretty well at each board meeting, yes,  
 14 that might have been in retrospect.  
 15 MS. NEWBURY:  
 16 Q. But the point is, if she has taken--she might  
 17 have understood it perfectly in her own mind,  
 18 she might have understood it perfectly to be  
 19 related to a change in technology. If she's  
 20 not--she doesn't have something more official  
 21 there, how can she know that what she took  
 22 away from that meeting is wrong?  
 23 DR. WILLIAMS:  
 24 A. Well, I certainly spent a lot of time and I  
 25 answered a lot of questions and there was a

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1 lot of concern on the faces of all the board  
 2 members and I felt I covered every issue.  
 3 MS. NEWBURY:  
 4 Q. Do you think a report in addition to your  
 5 verbal briefing might have been prudent?  
 6 DR. WILLIAMS:  
 7 A. In retrospect, now you're talking about that,  
 8 yes.  
 9 MS. NEWBURY:  
 10 Q. And how -  
 11 DR. WILLIAMS:  
 12 A. I believe that's in retrospect -  
 13 MS. NEWBURY:  
 14 Q. And even if you were limited by time or other  
 15 circumstances, how about submitting an  
 16 official report subsequent to you meeting with  
 17 the board, just to be sure that they're  
 18 completely aware of all the relevant  
 19 circumstances.  
 20 DR. WILLIAMS:  
 21 A. I felt at the time that I had such a detailed  
 22 briefing, that people were aware, they looked  
 23 very concerned and, of the issues that are  
 24 brought out.  
 25 MS. NEWBURY:

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1 Q. These are fairly complex issues, would you  
 2 agree for people hearing about ER/PR for the  
 3 first time?  
 4 DR. WILLIAMS:  
 5 A. Well, I tried to make it, congeal it as simply  
 6 as I could and in all honestly, I can say that  
 7 I felt I did a good job on it.  
 8 MS. NEWBURY:  
 9 Q. But someone who might be more versed in, you  
 10 know, medical terminology or laboratory  
 11 medicine procedures might take more out of it  
 12 than a member of the board who has not  
 13 familiarity and might want to reflect on -  
 14 DR. WILLIAMS:  
 15 A. I try -  
 16 MS. NEWBURY:  
 17 Q. - said by reading the report a couple of times  
 18 or referring back to it and -  
 19 DR. WILLIAMS:  
 20 A. I try to take the technical pieces out of it  
 21 as best I could.  
 22 MS. NEWBURY:  
 23 Q. Okay. I wonder if I could have Exhibit P-  
 24 0345, please, page nine, please. So, this is  
 25 an article, CBC News, October 14, 2005 and

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1 down at paragraph 10, your attributed with the  
 2 following statement, "Dr. Bob Williams, a  
 3 vice-president with Eastern Health says, 'it  
 4 is possible that some patients with the wrong  
 5 test results may have benefited from the drug.  
 6 An external review of the authorities testing  
 7 equipment will be done', Williams said".  
 8 DR. WILLIAMS:  
 9 A. I don't--that's not in quotes, I would have  
 10 said more than that.  
 11 MS. NEWBURY:  
 12 Q. Okay.  
 13 DR. WILLIAMS:  
 14 A. An external review of everything because we  
 15 weren't just looking at the equipment.  
 16 MS. NEWBURY:  
 17 Q. So, in your view now, looking back at it, you  
 18 would not have led -  
 19 DR. WILLIAMS:  
 20 A. No.  
 21 MS. NEWBURY:  
 22 Q. - the author of this to -  
 23 DR. WILLIAMS:  
 24 A. No, I would have--no, not just--we had these  
 25 people come in and look at--as you'll see from

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1 our Terms of Reference, it wasn't limited to  
 2 equipment.  
 3 MS. NEWBURY:  
 4 Q. I understand that, but just in terms of -  
 5 DR. WILLIAMS:  
 6 A. No, on -  
 7 MS. NEWBURY:  
 8 Q. - the communication with this.  
 9 DR. WILLIAMS:  
 10 A. No.  
 11 MS. NEWBURY:  
 12 Q. Was any contact made with the author of this  
 13 article subsequently?  
 14 DR. WILLIAMS:  
 15 A. No, not that I'm aware of.  
 16 MS. NEWBURY:  
 17 Q. Okay. And does Eastern Health have any  
 18 procedures for monitoring media?  
 19 DR. WILLIAMS:  
 20 A. They do monitor media, but I don't know if  
 21 there's any procedure to correct the media or  
 22 this type of thing.  
 23 MS. NEWBURY:  
 24 Q. And why would this statement here which you  
 25 feel is not accurate, why would that have been

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1 not picked up?  
 2 DR. WILLIAMS:  
 3 A. I'm not sure.  
 4 MS. NEWBURY:  
 5 Q. And whose responsibility would that be to  
 6 notice that?  
 7 DR. WILLIAMS:  
 8 A. Well, if it's--whoever, it may be mine or it  
 9 may be the communications people. I  
 10 certainly, our, certainly review wasn't  
 11 limited to the equipment.  
 12 MS. NEWBURY:  
 13 Q. Just in terms of the handling of the ER/PR  
 14 problem, aside from the communication with the  
 15 board as an example, do you think it might  
 16 have otherwise aided Eastern Health to have  
 17 official reports in place and to update them  
 18 as necessary?  
 19 DR. WILLIAMS:  
 20 A. It would be something that, you know, if were  
 21 doing it again, should be considered, yes.  
 22 There was contact from time to time with the  
 23 media over that time frame.  
 24 MS. NEWBURY:  
 25 Q. Just in terms of communicating with, you've

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1 got patients who are interested advocacy  
 2 groups, the Department of Health -  
 3 DR. WILLIAMS:  
 4 A. Yes, I know what you're saying, yes.  
 5 MS. NEWBURY:  
 6 Q. Okay. And do you think it would be important  
 7 in those reports to include all relevant  
 8 background information and to provide sources  
 9 of the information just to ensure accuracy?  
 10 Do you think that would be something  
 11 important, looking back on it now -  
 12 DR. WILLIAMS:  
 13 A. Well, looking back on it, as I say, having an  
 14 adverse event of this magnitude hitting you  
 15 and then going through it, you'll see after  
 16 you're through it, some things that you could  
 17 have done better -  
 18 MS. NEWBURY:  
 19 Q. Okay.  
 20 DR. WILLIAMS:  
 21 A. - or some suggestions that could be made and I  
 22 presume, hopefully, that some of the things  
 23 that'll come out of this -  
 24 MS. NEWBURY:  
 25 Q. And I guess what I'm looking for, what your

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1 suggestions might be. Would you think that  
 2 putting all relevant information there as well  
 3 as the source of that would have helped?  
 4 DR. WILLIAMS:  
 5 A. Well, I think in retrospect, getting the  
 6 information first of all and making contact,  
 7 thought about making contact, and we actually  
 8 didn't. The important thing, I think, in  
 9 retrospect, was the initial contact with media  
 10 before any of this broke.  
 11 MS. NEWBURY:  
 12 Q. Right, okay, but in terms of -  
 13 DR. WILLIAMS:  
 14 A. But build, I guess, build on it from there.  
 15 MS. NEWBURY:  
 16 Q. Yes. But in terms of just--not just the  
 17 communication with the media, but overall, the  
 18 handling, sort of, the timing of the response  
 19 by Eastern Health to the problem. Could you  
 20 have benefitted by having a comprehensive  
 21 report, not just to communicate with other  
 22 people, but to make decisions about, will we  
 23 test positive people or not or, you know, have  
 24 we contacted all the regional health  
 25 authorities and have we sent out protocols to



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1 other regional health authorities about  
 2 fixation? Just to keep track of where you've  
 3 been and where you're planning to go in your  
 4 response.  
 5 DR. WILLIAMS:  
 6 A. And I think that's one of the things I've  
 7 already said, when I look back at this, is  
 8 having a dedicated task force with no other  
 9 role, senior leadership just to deal with this  
 10 issue because this in itself was a full time  
 11 role.  
 12 MS. NEWBURY:  
 13 Q. I appreciate that. And in the absence of  
 14 having such a task force in place, who would  
 15 be responsible for doing the types of things  
 16 that would be entailed in that job?  
 17 DR. WILLIAMS:  
 18 A. I would have responsibility myself, among  
 19 other people, people who were working with me,  
 20 yes.  
 21 MS. NEWBURY:  
 22 Q. Regarding the decision in around July and  
 23 August, 2005, not to notify the patients until  
 24 the retest results were back, as I understand  
 25 your evidence and correct me if I'm wrong, was

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1 this decision primarily arising from the  
 2 concern of oncologists about the anxiety of  
 3 patients who would have to await the results  
 4 of the retest.  
 5 MS. NEWBURY:  
 6 Q. I guess that was the biggest factor, yes, as  
 7 far as I can recollect and my notes say.  
 8 MS. NEWBURY:  
 9 Q. And you were fairly certain as an organization  
 10 or you personally as VP of medical services  
 11 that certain patients, ER status would, in  
 12 fact, convert upon retesting.  
 13 DR. WILLIAMS:  
 14 A. We'd already had some conversions at the time,  
 15 yes. We would expect some more.  
 16 MS. NEWBURY:  
 17 Q. Yeah. So, it wasn't like a minimal, you know,  
 18 fewer than one percent are expected to  
 19 convert. It was a really significant  
 20 percentage.  
 21 DR. WILLIAMS:  
 22 A. Yeah, we, I guess, looked--by that time we  
 23 looked at our data and looked at what was  
 24 happened in the literature, looked at the  
 25 rates and, you know, knew that we'd have

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1 conversions. That's what we said at the time.  
 2 MS. NEWBURY:  
 3 Q. Sure. So, would you agree, looking back at  
 4 it, that there were competing interests here  
 5 in play between basically those patients who  
 6 would, ultimately, convert and could benefit  
 7 from, perhaps early knowledge about what's  
 8 happening versus those patients who would  
 9 ultimately not convert and might have worried  
 10 needlessly in that interim period.  
 11 DR. WILLIAMS:  
 12 A. There was that issue and the oncologists were  
 13 very concerned that if we went out, as we said  
 14 earlier, we would create a major panic in all  
 15 people and if--you know, to have a heavy  
 16 workload, they'd get a lot of calls, they  
 17 wouldn't know how to deal with it and it maybe  
 18 impact their ability to carry on with the  
 19 care, this type of thing. So, all these  
 20 considerations were considered.  
 21 MS. NEWBURY:  
 22 Q. Was there any specific focus on attempting to  
 23 weigh the risk to the two different groups of  
 24 patients; those that might ultimately convert  
 25 and those who might have worried needlessly?

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1 DR. WILLIAMS:  
 2 A. I don't think there was in the sense, we'll  
 3 weigh the risks there. It was just a feeling  
 4 and a lot of concern by the people who are  
 5 closest to the patients that this was an  
 6 issue.  
 7 MS. NEWBURY:  
 8 Q. Was there any effort to, at least, identify  
 9 those patients who might be expected, because  
 10 of their make up, the factors involving their  
 11 diagnosis of breast cancer, was there any  
 12 effort to identify those patients who were  
 13 more likely to convert from ER negative to ER  
 14 positive?  
 15 DR. WILLIAMS:  
 16 A. That wasn't the thought that came forward from  
 17 anybody.  
 18 MS. NEWBURY:  
 19 Q. Okay.  
 20 DR. WILLIAMS:  
 21 A. The whole focus was let's get, I guess,  
 22 retesting done as soon as we can and get the  
 23 results done. The sooner we get things up--  
 24 and there's a lot of work involved in doing  
 25 that--the sooner we'll have the reports.

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1 MS. NEWBURY:  
 2 Q. So, there's no thought about sending perhaps a  
 3 memo to all of the oncologists to say, listen,  
 4 you might have patients who fall into this  
 5 category and based on their make up,  
 6 statistically speaking, they might be expected  
 7 to convert and perhaps you can disclose the  
 8 information, at least, to those patients.  
 9 DR. WILLIAMS:  
 10 A. There was some discussion, I think, with Dr.  
 11 Carter and Dr. Laing somewhere that, if there  
 12 was any urgent cases that they were concerned  
 13 about, they would contact Dr. Carter. I think  
 14 there's a note there.  
 15 MS. NEWBURY:  
 16 Q. And was that distributed to all oncologists in  
 17 the province?  
 18 DR. WILLIAMS:  
 19 A. Well, I think, I believe that Dr. Laing and  
 20 Dr. McCarthy were there at all the meetings.  
 21 Dr. Ganguly was involved. Dr. Zulfiqar was  
 22 involved from time to time. So, I presume  
 23 that Dr. Laing--they were a small group of  
 24 people that they were conversant with all  
 25 those issues.

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1 MS. NEWBURY:  
 2 Q. And in terms of the decision, the ultimate  
 3 decision to not notify the patients until the  
 4 retest results were back, who ultimately made  
 5 that decision?  
 6 DR. WILLIAMS:  
 7 A. I think it was a consensus decision about,  
 8 well, with the people that were involved.  
 9 MS. NEWBURY:  
 10 Q. Okay. And what meeting was that?  
 11 DR. WILLIAMS:  
 12 A. I'd have to look at my notes to see.  
 13 MS. NEWBURY:  
 14 Q. Yes, sure, if you could, please.  
 15 DR. WILLIAMS:  
 16 A. It looks like it was first raised at August 15  
 17 meeting.  
 18 MS. NEWBURY:  
 19 Q. And you think that the consensus was made at  
 20 that particular meeting?  
 21 DR. WILLIAMS:  
 22 A. No, I think that concern was raised and then  
 23 it was--I think there was a subsequent meeting  
 24 with the minister. I'd have to look at the  
 25 notes to see -

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1 THE COMMISSIONER:  
 2 Q. I'm sorry, subsequent meeting with?  
 3 DR. WILLIAMS:  
 4 A. The minister.  
 5 THE COMMISSIONER:  
 6 Q. Minister.  
 7 MS. NEWBURY:  
 8 Q. And that would be Minister Ottenheimer?  
 9 DR. WILLIAMS:  
 10 A. No, maybe that's--I don't--let me see  
 11 THE COMMISSIONER:  
 12 Q. Would it be helpful if I took the afternoon  
 13 break at this stage. So, that would give Dr.  
 14 Williams a chance to look at the documents  
 15 without the timing pressure.  
 16 MS. NEWBURY:  
 17 Q. Sure.  
 18 THE COMMISSIONER:  
 19 Q. Why don't we do that?  
 20 MS. NEWBURY:  
 21 Q. Thank you.  
 22 (RECESS)  
 23 THE COMMISSIONER:  
 24 Q. Please be seated. Ms. Newbury.

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1 MS. NEWBURY:  
 2 Q. Thank you. Dr. Williams were you able to  
 3 locate the document you were looking for?  
 4 DR. WILLIAMS:  
 5 A. Well, all I can, my notes of August 10 there's  
 6 a fairly lengthy section there on Dr. Laing  
 7 talking about the issue of disclosure and the  
 8 need to wait, this type of thing. Now,  
 9 whether there was some other discussions  
 10 before that because lots of times we had  
 11 discussions on the phone, I may not have taken  
 12 notes of everything that happened.  
 13 MS. NEWBURY:  
 14 Q. Sure, okay.  
 15 DR. WILLIAMS:  
 16 A. But that's the first time--I didn't get a  
 17 chance to look back at all the notes, but -  
 18 MS. NEWBURY:  
 19 Q. Okay, no, that's fine.  
 20 DR. WILLIAMS:  
 21 A. There's a lengthy discussion at that meeting  
 22 on August 10 and then there's a lengthy  
 23 discussion with the Minister on August 15.  
 24 MS. NEWBURY:  
 25 Q. Okay.

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1 DR. WILLIAMS:  
 2 A. They're the two detailed references I have.  
 3 MS. NEWBURY:  
 4 Q. The August 10 meeting, do you have a note  
 5 number at the top of your -  
 6 DR. WILLIAMS:  
 7 A. Note number 17.  
 8 MS. NEWBURY:  
 9 Q. Note number 17. And who was at that meeting?  
 10 DR. WILLIAMS:  
 11 A. Dr. Laing, Mr. Tilley, Ms. Pilgrim, Dr. Cook  
 12 and myself.  
 13 MS. NEWBURY:  
 14 Q. Okay. And the August 15 meeting--did you say  
 15 it was an August 15 meeting?  
 16 DR. WILLIAMS:  
 17 A. August 15 meeting, Note number 19 with the  
 18 minister, the minister was there, Dr. Fleming  
 19 from the department, Ms. Hennessey, Mr.  
 20 Tilley, Dr. Cook, Dr. Laing and myself.  
 21 MS. NEWBURY:  
 22 Q. And those are the two meetings that the  
 23 decision was made not to -  
 24 DR. WILLIAMS:  
 25 A. Well, there was discussion and -

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1 MS. NEWBURY:  
 2 Q. - notify patients until retest -  
 3 DR. WILLIAMS:  
 4 A. - a consensus was reached -  
 5 MS. NEWBURY:  
 6 Q. Okay.  
 7 DR. WILLIAMS:  
 8 A. - and that's my recollection. There may be  
 9 other minutes, meetings, sorry and there may  
 10 be other phone conversations that I wouldn't  
 11 have captured.  
 12 MS. NEWBURY:  
 13 Q. Okay. Would any of them been after the August  
 14 15 meeting?  
 15 DR. WILLIAMS:  
 16 A. I would not know. I guess I didn't take notes  
 17 in preparation for a detailed--I just take  
 18 notes to try to capture the essence of what  
 19 meetings we had and what decisions we might  
 20 have made and where we were going. It was  
 21 just so I could look back and if I had a note  
 22 a week earlier and just try to update myself  
 23 on what was going on.  
 24 MS. NEWBURY:  
 25 Q. In terms of problems that Eastern Health has

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1 had from time to time with shortage of  
 2 pathologists, how would a shortage in that  
 3 area, that speciality compare with other  
 4 specialities?  
 5 DR. WILLIAMS:  
 6 A. It depends on the speciality. Over--in my  
 7 days with the Health Care Corporation of St.  
 8 John's, from time to time we've had shortages  
 9 of specialists in certain disciplines. I  
 10 alluded to the fact that we had a problem with  
 11 hematological oncologists. Over time the  
 12 cancer foundation would have had trouble with  
 13 oncologists. Now, they were associated with  
 14 us, but it would have affected the inpatient  
 15 side of our organization, but not the ongoing  
 16 care of most patients because most patients  
 17 were seen in the cancer clinic. Over time  
 18 we've had, you know, problems in pediatric  
 19 surgery where you got two pediatric general  
 20 surgeons and something happens and you're down  
 21 to one. Early on, I had a problem like that  
 22 and that can be a severe problem because you  
 23 only got two and you lose one, you lose 50  
 24 percent of the people. But the issue with  
 25 pathologists was not unlike some other issues

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1 that we've had from time to time, but it  
 2 causes some problems and it culminated in us  
 3 having to send out specimens to Gama DynaCare,  
 4 late 2005, early 2006, that timeframe. And I  
 5 still think they're sending out, but I'm not  
 6 sure about that.  
 7 MS. NEWBURY:  
 8 Q. And does this ability to out source some of  
 9 the pathologist work, does that help Eastern  
 10 Health deal with a problem -  
 11 DR. WILLIAMS:  
 12 A. Well, that's the first time we've ever done  
 13 it.  
 14 MS. NEWBURY:  
 15 Q. Oh really, okay.  
 16 DR. WILLIAMS:  
 17 A. Before we would send out consultations to  
 18 other labs, like the Canadian Cancer Reference  
 19 Centre in Ottawa from time to time to get a  
 20 second opinion or down to the Mayo clinic or  
 21 some other place to get a second opinion, but  
 22 most of that was related to, not our ability  
 23 to process and examine, but our need to get a  
 24 second opinion.  
 25 MS. NEWBURY:

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1 Q. You might have a complex case -  
 2 DR. WILLIAMS:  
 3 A. An expert opinion because if our pathologists  
 4 coming together weren't sure and you got a big  
 5 grey area, they'd ask some outside  
 6 consultation. That's the first time, to my  
 7 knowledge, that we sent out any large number  
 8 of specimens because we just couldn't continue  
 9 to cope with it. Now, we've had ups and downs  
 10 in pathologists before, and a lot of people  
 11 retire and one person died, people going and  
 12 coming, I really have to trace the numbers by  
 13 month and by year to see if we've had that  
 14 problem, but certainly in the fall of 2005 and  
 15 into 2006, we had enough of a problem that we  
 16 weren't able to produce a timely result for  
 17 patients. So, we had to refer cases out.  
 18 MS. NEWBURY:  
 19 Q. Is it easier, I guess, to deal with the  
 20 shortage of pathologists in the sense that  
 21 it's the samples that you would have to send  
 22 out versus the patients having to go to  
 23 another centre.  
 24 DR. WILLIAMS:  
 25 A. Yes. If we had a shortage of hematologist

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1 oncologists for instance, we'd have to send  
 2 the patient out and all that entails with the  
 3 family and then patients are very, very sick.  
 4 They're in a strange city and all that stuff.  
 5 So, that's worse. At least with the  
 6 pathology, you can send out the specimens and  
 7 it doesn't affect the individuals, as long as  
 8 you can get a good place to do the work and  
 9 get a decent turnaround time, but you got to  
 10 be very careful when you send out a large  
 11 number of specimens. If any of them go  
 12 missing or displaced or disorganized or  
 13 something, and you lose specimens, you have  
 14 not diagnostic tool then to make a diagnosis.  
 15 You might have removed a mole -  
 16 MS. NEWBURY:  
 17 Q. Sure.  
 18 DR. WILLIAMS:  
 19 A. - mole is gone, you don't know if it's a  
 20 melanoma or if it's a normal mole. And you  
 21 can't get a specimen to replace it. So, you  
 22 got a problem. So, it's very important to  
 23 spend a lot of time on the up side of that,  
 24 dealing with it.  
 25 MS. NEWBURY:

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1 Q. And how quickly can arrangements be made if  
 2 there's a sudden departure of a couple of  
 3 pathologists?  
 4 DR. WILLIAMS:  
 5 A. I took us a while to get Gama DynaCare. We  
 6 tried some other hospitals who couldn't do the  
 7 work. I understand now, given issues that we  
 8 predicted back probably about three years ago,  
 9 other centres--because now they're having to  
 10 send out the ER and PR because the people  
 11 involved in it are moving on. We're not able  
 12 to keep that subspecialty service together.  
 13 They're having quite a bit of difficulty  
 14 getting other centres to take up the work load  
 15 because of the problems they're having  
 16 themselves keeping up with the workload.  
 17 MS. NEWBURY:  
 18 Q. Okay.  
 19 MR. WILLIAMS:  
 20 A. And if they can't do their own workload on a  
 21 timely basis, they're not going to take on  
 22 somebody else's workload.  
 23 MS. NEWBURY:  
 24 Q. Sure.  
 25 MR. WILLIAMS:

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1 A. They'll have the surgeons and the other people  
 2 at their own centre, you know, saying "look,  
 3 you can't be taking on this. You can't give  
 4 us a timely turn around of our own work." So  
 5 that's going to be--my prediction, that'll be  
 6 tougher and tougher.  
 7 MS. NEWBURY:  
 8 Q. But so far you haven't had difficulties with  
 9 this one particular lab that you -  
 10 MR. WILLIAMS:  
 11 A. Just this because Gamma Dynacare at the time  
 12 was available and we were able to do that.  
 13 But I'm not sure, in this milieu now, which  
 14 apparently it's gotten worse, whether they'll  
 15 have that ability in the future.  
 16 MS. NEWBURY:  
 17 Q. And do you now have standing arrangements with  
 18 this particular lab to do testing in the  
 19 future, if and when you need it?  
 20 MR. WILLIAMS:  
 21 A. I'm not sure if they got that with Gamma  
 22 Dynacare. I'm not sure. This is a group in  
 23 Ottawa. This is a group of pathologists who  
 24 set up their own business, so to speak.  
 25 MS. NEWBURY:

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1 Q. Okay.

2 MR. WILLIAMS:

3 A. Who do that in after hours and on weekends.

4 They don't do it on the--these are a group

5 from the Ottawa General or Ottawa Civic

6 Hospital. So I don't know if we have a

7 standing--we had a relationship with them

8 then.

9 MS. NEWBURY:

10 Q. At the time.

11 MR. WILLIAMS:

12 A. To do what we needed to do. Whether--because

13 I'm not in the organization any more. We're

14 continuing to send out, but I understand in

15 some conversations I've had that our ability

16 in the future to do those kind of things is

17 going to be much more limited, so we got a

18 problem.

19 MS. NEWBURY:

20 Q. And can you comment on whether there are any

21 advantages or disadvantages to sending out

22 difficult tests or more complicated tests,

23 such as IHC, out to a central specialized lab

24 in some other jurisdiction?

25 MR. WILLIAMS:

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1 A. First of all, you got to get another lab to

2 take on the responsibility for you, in terms

3 of their own workload, and we've seen with

4 Mount Sinai, I doubt if they, you know, would

5 want to take on much more workload. They had

6 quite a bit of difficulty doing our work for

7 us. So that would--that could be a problem.

8 It could be more of a problem now again

9 because things seem to have deteriorated in

10 the last two or three years and workloads are

11 going up, but the pathologists are not going

12 up commensurate with the workload, so I think

13 there's more of a relative shortage of

14 pathologists. So what worries me is that if

15 we can't do the work here, are we going to be

16 able to get somebody else to do the work? I

17 guess we could always try the U.S. situation,

18 but we tried, obviously with the ER/PR. We

19 tried the Mayo Clinic, which we've used

20 before, but they weren't comfortable with the

21 results they were getting, so we didn't use

22 them.

23 MS. NEWBURY:

24 Q. Would there be any economies of scale, for

25 example, if rather than a lot of labs across

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1 the country or across the Atlantic region

2 trying to do--struggle to get their own done,

3 recognizing that there might be some shortage

4 of pathologists, could a group of pathologists

5 do the work more quickly, do you think?

6 MR. WILLIAMS:

7 A. Well, that's an issue that would have to be

8 explored, for some subspecialized work like

9 immunohistochemistry. The other thing that

10 would have to be done if we decided, you know,

11 we meaning Eastern Health, that's not we any

12 more, but Eastern Health decided that they

13 weren't going to do any immunohistochemistry

14 or were going to send out these tests

15 permanently, then there'd have to be some

16 discussions with the medical school because we

17 train pathologists here. We have a residency

18 training program for pathologists and we would

19 probably need to send the residents out of the

20 province to get that training or get that

21 exposure. That came up before when we had a

22 problem with the number of MRI machines here.

23 The residency program in diagnostic imaging

24 said that if we didn't get more MRI machines

25 so the residents could get exposure to MRI, we

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1 might have to send the residents out of the

2 province to fulfil their resident training

3 program. So that might be an issue. It's not

4 an overriding issue, but it's an issue that

5 would have to be explored.

6 MS. NEWBURY:

7 Q. So it's not insurmountable, but it -

8 MR. WILLIAMS:

9 A. No, it's not insurmountable. The

10 insurmountable part might be that if the

11 system can handle that type of an approach,

12 yes.

13 MS. NEWBURY:

14 Q. I wonder if I could have Exhibit P-0493,

15 please. This is a letter that Dr. Cook wrote

16 to you and you were referred to that earlier.

17 I just want to refer you to paragraph two, and

18 it states "on the surface, a negative rate of

19 50 percent, though not the greatest, is not

20 too bad when you compare a 60 percent positive

21 and 40 percent negative rate according to

22 figures provided by Dr. Joy McCarthy. We also

23 need to correlate these figures more with our

24 population. There may very well be a large

25 number of women who have high grade lesions

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1 who would normally be negative for estrogen  
 2 and progesterone receptors."  
 3 Dr. Williams, do you know if this  
 4 correlation exercise was ever carried out?  
 5 MR. WILLIAMS:  
 6 A. No, to my knowledge, it wasn't carried out  
 7 because we got--we made a decision to retest  
 8 everybody and a lot of work was involved in  
 9 that. Really the focus was on getting things  
 10 together and getting the testing done as quick  
 11 as we could, and we thought we were going to  
 12 have that done in a couple of months. So the  
 13 time to do that, we thought it would probably  
 14 be better invested in, you know, getting  
 15 everything together and getting the tests back  
 16 for patients as soon as we could, to be honest  
 17 with you. That's something one could now,  
 18 just to see -  
 19 MS. NEWBURY:  
 20 Q. Sure, for extra reflection.  
 21 MR. WILLIAMS:  
 22 A. But at the time, it would have involved  
 23 people's time who were in short supply and  
 24 given the situation we were in, we thought--  
 25 now I don't think we sat down and said "now,

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1 we won't do this because of this." I think  
 2 just things overtook us and we had to get on  
 3 with it.  
 4 MS. NEWBURY:  
 5 Q. Okay. Do you know if this type of exercise,  
 6 outside of dealing with a problem such as  
 7 ER/PR, do you know if this type of an exercise  
 8 is carried out in any part of Eastern Health  
 9 as an organization, monitoring trends in the  
 10 population to see if, for example, there are a  
 11 large number of women who have high grade  
 12 lesions?  
 13 MR. WILLIAMS:  
 14 A. No, the only trend, the only thing that would  
 15 be done in terms of cancer trends would be  
 16 through the Cancer registry.  
 17 MS. NEWBURY:  
 18 Q. Okay.  
 19 MR. WILLIAMS:  
 20 A. And they now should have good data because our  
 21 lab, back in 2002-2003, and I hope other labs  
 22 agree that we would go online with them so all  
 23 our cancer pathology reports would go directly  
 24 to their registry. There's a linkage, and I'm  
 25 pretty sure--I doubt if other labs would not

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1 do that. I know we did and we had to sign an  
 2 agreement with them.  
 3 MS. NEWBURY:  
 4 Q. So you signed an agreement, that's Eastern  
 5 Health?  
 6 MR. WILLIAMS:  
 7 A. Well, it would be the Health Care Corporation,  
 8 I'm pretty sure.  
 9 MS. NEWBURY:  
 10 Q. It was the Health Care Corporation?  
 11 MR. WILLIAMS:  
 12 A. I'm pretty sure it was when Bertha Paulse was  
 13 there as CEO, and I'm thinking it was 2002-  
 14 2003, but I may be wrong on that, but there  
 15 was a request that we provide, and other labs  
 16 provide, this data online so that the registry  
 17 could be accurate, and I know we did sign up  
 18 and linked to them online. I'd be very  
 19 surprised if that didn't--I'm pretty sure we  
 20 signed up on that and supported them in doing  
 21 that. So they're monitoring, I guess, cancer  
 22 trends in our province. There's a national--  
 23 cancer trends are published yearly, incidence  
 24 rates and mortality rates are published and I  
 25 think our province is part of those, part of

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1 that database.  
 2 MS. NEWBURY:  
 3 Q. And were you ever made aware of any problems  
 4 with the cancer statistics from this province,  
 5 due to lack of information being provided  
 6 about mortality rates?  
 7 MR. WILLIAMS:  
 8 A. I think that's why Bertha Paulse wanted to  
 9 link with our lab, to get the incidence rates,  
 10 but I don't know about mortality rates, how  
 11 they get their information, whether they link  
 12 with Vital Statistics or not, I'm not sure.  
 13 You'd have to ask them that.  
 14 MS. NEWBURY:  
 15 Q. So the types of information that you  
 16 understood would be relayed to the Cancer  
 17 Registry as a result of this agreement, you've  
 18 mentioned incident rates and you're not sure  
 19 about mortality?  
 20 MR. WILLIAMS:  
 21 A. I would think they would get the pathology  
 22 reports.  
 23 MS. NEWBURY:  
 24 Q. Okay.  
 25 MR. WILLIAMS:

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1 A. From our lab directly. We wouldn't have  
 2 mortality rates in our lab.  
 3 MS. NEWBURY:  
 4 Q. Okay.  
 5 MR. WILLIAMS:  
 6 A. Our lab would only be giving them the reports  
 7 of the cancer pathology that they did.  
 8 MS. NEWBURY:  
 9 Q. So they deal with the pathologist as opposed  
 10 to the oncologists?  
 11 MR. WILLIAMS:  
 12 A. Yes, they deal with--that gives them  
 13 information from our lab directly, not the  
 14 pathologists, but just the information.  
 15 There's some kind of an online arrangement we  
 16 signed that when reports on cancer were sent--  
 17 were signed out, that they would get a copy of  
 18 that.  
 19 MS. NEWBURY:  
 20 Q. Okay.  
 21 MR. WILLIAMS:  
 22 A. So they would know.  
 23 MS. NEWBURY:  
 24 Q. So there's no comparable agreement that would  
 25 require that oncologists -

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1 MR. WILLIAMS:  
 2 A. No.  
 3 MS. NEWBURY:  
 4 Q. - provide any information at all?  
 5 MR. WILLIAMS:  
 6 A. No.  
 7 MS. NEWBURY:  
 8 Q. It's solely the lab?  
 9 MR. WILLIAMS:  
 10 A. All mortality data would be housed in the  
 11 Registry of Vital Statistics. Now is there a  
 12 link with the Registry to the Cancer Registry  
 13 linking with the Registry of Vital Statistics,  
 14 you'd have to ask them that. That would be a  
 15 linkage with the Department of Health and  
 16 Community Services. I don't know why--I don't  
 17 see why they wouldn't, if they wanted an up to  
 18 date registry, because their registry needs to  
 19 have information on incidence rates and  
 20 mortality rates.  
 21 MS. NEWBURY:  
 22 Q. So aside from this arrangement with the Cancer  
 23 Registry, are you aware of any other  
 24 additional formal or informal procedures in  
 25 place in Eastern Health for monitoring any

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1 trends, you know, proliferation of breast  
 2 cancer or looking at any, you know, possible  
 3 environmental causes or looking for that type  
 4 of information?  
 5 MR. WILLIAMS:  
 6 A. No, I think that would be a function of the  
 7 Cancer Registry. Now the Cancer Registry is  
 8 now under Eastern Health, because everything  
 9 else seems to be under Eastern Health, it's so  
 10 big, so that's something that you would have  
 11 to ask those responsible for the Cancer Care  
 12 program within Eastern Health. But I'm pretty  
 13 sure that that information exists there.  
 14 MS. NEWBURY:  
 15 Q. Could I have Exhibit P-0785 please? This is  
 16 an e-mail that you're neither the sender or  
 17 the recipient, but I just wanted to show this--  
 18 actually, sorry, you are a recipient of it,  
 19 down below. This is August the 8th, 2005.  
 20 It's an e-mail from Heather Predham to Dr.  
 21 Williams, Dr. Cook, Terry Gulliver and  
 22 Patricia Pilgrim. The heading, first heading  
 23 there is database, and Ms. Predham says "I've  
 24 got the lab database and the NCRTF database  
 25 combined." Would that be the Cancer Registry?

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1 MR. WILLIAMS:  
 2 A. Yes.  
 3 MS. NEWBURY:  
 4 Q. Okay. "But I still have issues to clarify.  
 5 There are data quality issues such as people  
 6 with the same name and address and different  
 7 MCP numbers and people with different names  
 8 and addresses but with the same MCP numbers.  
 9 Also, there are a lot of individuals with  
 10 incomplete MCP numbers. I'll work on that  
 11 today. There are a couple of issues that came  
 12 to light though during this process," and the  
 13 third bullet, "rough numbers from the combined  
 14 database show 4,510 people overall. The  
 15 Cancer registry does not identify almost 2100  
 16 of individuals who had ER/PR testing. Current  
 17 status, living or deceased is only identified  
 18 in 1,245 of those people. It's going to be  
 19 difficult to determine this for the rest of  
 20 the individuals."  
 21 And the next bullet, "ER/PR status is  
 22 indicated in 1,230 people with an overall  
 23 positivity rate of 55 percent" and then she  
 24 goes on to say the overall positivity rate by  
 25 year.

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1 So were you focused, upon receipt of this  
 2 e-mail, were you focused upon the deficiencies  
 3 in the Cancer registry that appear to be -  
 4 MR. WILLIAMS:  
 5 A. Yes, I think Mr. Coffey showed me this e-mail  
 6 in his questioning earlier, and knowing what I  
 7 know about the registry and the issues they  
 8 had of getting adequate information from the  
 9 labs and asking for an online transfer of  
 10 information, I felt that that--they might have  
 11 a deficiency of information there from all  
 12 health boards, in terms of this issue.  
 13 MS. NEWBURY:  
 14 Q. And you had indicated that Eastern Health  
 15 Board, when you were answering Mr. Coffey's  
 16 question, that Eastern Health Board had signed  
 17 up, but you weren't sure if other health  
 18 boards had signed up?  
 19 MR. WILLIAMS:  
 20 A. Yes, and even if they did sign up, it probably  
 21 wasn't anything retroactive to go back for  
 22 previous years. I think it was on a go-  
 23 forward basis. That's my recollection, and  
 24 you really have to go back and find out what  
 25 year that was, but it was when Mrs. Paulse was

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1 the Executive Director, and she left in 2004.  
 2 MS. NEWBURY:  
 3 Q. In 2004, Ms. Paulse left?  
 4 MR. WILLIAMS:  
 5 A. Yes, she left in December 2004, so it was  
 6 sometime before that that they asked for that,  
 7 and there was a formal contract, I think, or  
 8 agreement we had to sign with respect to the  
 9 information and how it would be used and that.  
 10 So I don't know what year that was. So the  
 11 fact that they may not have had as many  
 12 individuals there made me think that perhaps,  
 13 you know, that's why she asked for that to be  
 14 put in place.  
 15 MS. NEWBURY:  
 16 Q. So some of that might have been prior to this  
 17 formal contract coming into play?  
 18 MR. WILLIAMS:  
 19 A. Yes.  
 20 MS. NEWBURY:  
 21 Q. And do you know if Eastern Health, while you  
 22 were still VP of Medical Services, followed  
 23 through on its contract?  
 24 MR. WILLIAMS:  
 25 A. Oh yes, I'm pretty--we had a contract signed

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1 when I was with the Health Care Corporation of  
 2 St. John's and if we didn't follow through  
 3 with what we signed, I'm pretty sure Mrs.  
 4 Paulse would have brought it up.  
 5 MS. NEWBURY:  
 6 Q. So there weren't any health boards that you're  
 7 aware of that were unwilling to participate in  
 8 this?  
 9 MR. WILLIAMS:  
 10 A. I can't answer that question. She would have  
 11 dealt with them individually, rather than she  
 12 would have dealt with us, but we had no  
 13 problem with doing that. We felt it was  
 14 something valuable that should be done. So I  
 15 don't think there was any hesitation on our  
 16 part. That's all I recollected.  
 17 MS. NEWBURY:  
 18 Q. Okay. Were there any issues with, you know,  
 19 the database transferring the information from  
 20 the pathologist to the cancer registry?  
 21 MR. WILLIAMS:  
 22 A. I don't recall--I think probably her people,  
 23 Ms. Paulse's people in the cancer registry may  
 24 have worked with our people to get those  
 25 things clarified. I never heard there was an

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1 issue with it. She never came back to me and  
 2 said you haven't been cooperating or haven't  
 3 been giving us the information. So I just  
 4 presume, on that basis, that we did do what we  
 5 said we would do.  
 6 MS. NEWBURY:  
 7 Q. And the agreement, I take it, didn't provide  
 8 for retroactive reporting of results?  
 9 MR. WILLIAMS:  
 10 A. No, I think it was on a go-forward basis, but  
 11 again, that's my recollection, but I have to--  
 12 there is a signed agreement that should be  
 13 available if somebody wants to -  
 14 MS. NEWBURY:  
 15 Q. And were you the signature on that agreement?  
 16 MR. WILLIAMS:  
 17 A. I may have been a signature on it. I may not  
 18 have been, but I may have been. I would have  
 19 been aware of it because of the lab role.  
 20 MS. NEWBURY:  
 21 Q. And you weren't made aware of any resource  
 22 issues regarding this contract on either the  
 23 cancer registry side or the pathologists?  
 24 MR. WILLIAMS:  
 25 A. I'm pretty sure we signed off on it and did



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1 what we were supposed to do. I think it was  
 2 just linking our computer systems to theirs.  
 3 Now that's not simple to do, but I'm sure  
 4 people know how to do that.  
 5 MS. NEWBURY:  
 6 Q. Sure.  
 7 MR. WILLIAMS:  
 8 A. And get the information. I'd have to go back  
 9 and check really, if you wanted to pursue  
 10 that, but I'm pretty sure that we--our intent  
 11 was to cooperate, put it that way.  
 12 MS. NEWBURY:  
 13 Q. Okay, thanks, and I think other witnesses  
 14 might be along who can elaborate on that. One  
 15 of the recommendations of Dr. Banerjee was for  
 16 pathologists to attend educational and  
 17 scientific conferences.  
 18 MR. WILLIAMS:  
 19 A. Yeah.  
 20 MS. NEWBURY:  
 21 Q. And this was noted to be ongoing in the  
 22 recommendations spreadsheet.  
 23 MR. WILLIAMS:  
 24 A. Yes.  
 25 MS. NEWBURY:

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1 Q. Are these educational and scientific  
 2 conferences mandatory for pathologists?  
 3 MR. WILLIAMS:  
 4 A. Pathologists in our organization have to  
 5 participate in MOCOMP. That's the maintenance  
 6 of competence program run by the Royal College  
 7 of Physicians and Surgeons. It requires them  
 8 to undertake so much CME activity in any given  
 9 time frame, and if they don't, they could lose  
 10 their certification by the Royal College. So  
 11 all our pathologists are supposed to  
 12 participate in that and do participate.  
 13 That's my understanding from Dr. Cook.  
 14 Number two is we've always had money  
 15 available for our salaried physicians to  
 16 attend conferences. Now it may not be enough.  
 17 It's never enough, in a sense, and we tried to  
 18 get more, but every pathologist every year was  
 19 entitled to \$2,000 a year to assist in  
 20 attending a conference of his or her choosing,  
 21 because the conferences would be outside the  
 22 province. We didn't run any CME in the  
 23 province. It would be usually at a larger  
 24 centre, so probably Toronto, Montreal, maybe  
 25 sometimes in Chicago or some places in the

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1 U.S. they went. But we supported them within  
 2 the budget that we had. I don't think I ever  
 3 denied a pathologist that \$2,000. Now I had  
 4 to fight every year, especially in times of  
 5 restraint, the first thing that they'd want to  
 6 cut was CME funding and travel and all that  
 7 stuff.  
 8 MS. NEWBURY:  
 9 Q. So since Dr. Banerjee made the recommendation,  
 10 what changes have there been, in terms of  
 11 pathologists attending CME programs?  
 12 MR. WILLIAMS:  
 13 A. Well, I'm not sure if there's anything in a  
 14 sense, except that we--specifically, we did  
 15 sent Dr. Elms out to Dr. Allan Gown's lab for  
 16 a period of time to gain expertise in  
 17 immunohistochemistry, in particular, and I  
 18 would think that we would have just continued  
 19 to fund our pathologists. I did argue one  
 20 year and got a little bit more money in one  
 21 year, just to make sure that we wouldn't run  
 22 short of money. I had over \$100,000, I think,  
 23 or so to assist people, but I had to deal with  
 24 pathologists, some general practitioners and  
 25 some psychiatrists. Most of our salaried

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1 people were in that category people. The  
 2 university people, what I did with the  
 3 university people was in order to protect the  
 4 money I had for the non-university people, the  
 5 university people have funding that they get  
 6 from Memorial University as part of their  
 7 appointment as a GFT and there's about six or  
 8 seven of those people that I didn't let them  
 9 access our funding, because they could access  
 10 the university funding. So I could protect  
 11 the funding for our own people. They're all  
 12 our people, but -  
 13 MS. NEWBURY:  
 14 Q. Sure.  
 15 MR. WILLIAMS:  
 16 A. Yes, but they had another source of funding.  
 17 MS. NEWBURY:  
 18 Q. Yes, you want to get as much money as  
 19 possible, sure.  
 20 MR. WILLIAMS:  
 21 A. Yes.  
 22 MS. NEWBURY:  
 23 Q. So then in terms of the education and  
 24 scientific conferences that are attended by  
 25 pathologists, is there any--do they attend

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1 them more frequently or are they more  
 2 comprehensive in the types of conferences that  
 3 they attend since Dr. Banerjee made his  
 4 recommendations?  
 5 MR. WILLIAMS:  
 6 A. I'm not sure. You'd have to go back and look  
 7 at--I used to keep a record in a black binder  
 8 every year of how we spent that money, so I  
 9 would know who went off to a conference and  
 10 how much. We usually gave the maximum  
 11 contribution because the cost was always more  
 12 than 2,000, and the clinical chief got 2500.  
 13 MS. NEWBURY:  
 14 Q. Okay, and you indicated that the pathologists  
 15 are required to participate in MOCOMP?  
 16 MR. WILLIAMS:  
 17 A. Yes.  
 18 MS. NEWBURY:  
 19 Q. And how long have they been engaged in that?  
 20 MR. WILLIAMS:  
 21 A. I would think that's been probably under way  
 22 now for four or five, maybe six years. The  
 23 Royal College brought that in. That can be  
 24 done by online conferencing. They can  
 25 participate in some of the things these days

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1 are done online, so they can participate in a  
 2 conference that's probably online, and that  
 3 counts or meetings or maybe tumour board  
 4 rounds and clinical rounds also count.  
 5 MS. NEWBURY:  
 6 Q. Okay.  
 7 MR. WILLIAMS:  
 8 A. So things that they can do internally, in  
 9 terms of maintaining competence also count,  
 10 not just conferences. That's just one form.  
 11 MS. NEWBURY:  
 12 Q. Dr. Williams, you've discussed several times  
 13 about the change in cut-off points and you  
 14 indicated that initially the cut off for  
 15 recommending Tamoxifen was 30 percent and then  
 16 it was reduced to ten percent -  
 17 MR. WILLIAMS:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. - and later down to one percent.  
 21 MR. WILLIAMS:  
 22 A. No, I don't -  
 23 MS. NEWBURY:  
 24 Q. Oh, it hasn't been?  
 25 MR. WILLIAMS:

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1 A. Not so sure it's down to one percent. You'd  
 2 have to ask our oncologists about that. It  
 3 depends--the one percent rule or the one  
 4 percent feature, whatever you want to call it,  
 5 may depend on where you are. I'm not too  
 6 sure, unless it's just happened recently that  
 7 there's a total consensus around the one  
 8 percent right across Canada. That was one of  
 9 the issues that Dr. McCarthy alluded to in one  
 10 of the documents, and maybe that's part of the  
 11 National Cancer Strategy that there should be  
 12 some--I mean, every--I don't--I guess I don't  
 13 understand why there's a cut off here in this  
 14 area and over here, we deal with it in this  
 15 way.  
 16 MS. NEWBURY:  
 17 Q. Right.  
 18 MR. WILLIAMS:  
 19 A. It seems to me that if there's a scientific--  
 20 if there's scientific knowledge, there should  
 21 be scientific knowledge and that's what people  
 22 treat. Now in medicine, unfortunately there's  
 23 no absolutes, but my understanding is some  
 24 oncologists in some areas would treat on the  
 25 basis of one percent. Some would treat on the

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1 basis of ten percent. Up until 2000, the end  
 2 of 2000, it was 30 percent here. And I  
 3 suspect some oncologists would give a trial of  
 4 therapy even if there was no standing in some  
 5 areas, depending on the situation. So that's  
 6 an area that needs resolution, I guess.  
 7 MS. NEWBURY:  
 8 Q. Sure, okay, I appreciate that. Focusing now  
 9 on the, I guess, the point in time where  
 10 Eastern Health decides or someone decides that  
 11 the protocol would change and now rather than  
 12 recommending Tamoxifen or a comparable drug  
 13 when a patient's 30 percent positive, that it  
 14 would now be ten percent positive. Looking at  
 15 the point in time do you know if an oncologist  
 16 typically advised patients of this who might  
 17 have been, say, diagnosed or tested for ER  
 18 positivity in the six months before?  
 19 DR. WILLIAMS:  
 20 A. Yes. As far as I gather, that was not done.  
 21 The cancer clinic, though, was a separate  
 22 organization from the Health Care Corporation  
 23 and Eastern Health at that time.  
 24 MS. NEWBURY:  
 25 Q. Um-hm.

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1 DR. WILLIAMS:  
 2 A. The oncologists were credentialed in Health  
 3 Care Corporation for their inpatient work, but  
 4 the majority of the work was done on an  
 5 outpatient basis. I was not made aware that  
 6 anybody had been contacted when that changed,  
 7 but you would have to ask the oncologists  
 8 that.  
 9 MS. NEWBURY:  
 10 Q. Was that ever an issue discussed -  
 11 DR. WILLIAMS:  
 12 A. Well -  
 13 MS. NEWBURY:  
 14 Q. - in responding to ER/PR?  
 15 DR. WILLIAMS:  
 16 A. I guess it was never an issue discussed,  
 17 because we didn't need to discuss it, we  
 18 retested all those patients.  
 19 MS. NEWBURY:  
 20 Q. Right, okay. But just in terms of dealing,  
 21 you know, looking at the whole situation,  
 22 would that not be information -  
 23 DR. WILLIAMS:  
 24 A. It would be something, I think, if we didn't  
 25 retest and some people would say that, well,

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1 you know, why retest, just go back and if  
 2 they're, you know, have a certain percentage,  
 3 just advise them that there's new protocols  
 4 come into place. But I can't tell you if that  
 5 was done back in 2000.  
 6 MS. NEWBURY:  
 7 Q. Right.  
 8 DR. WILLIAMS:  
 9 A. But because we retested everybody, we didn't  
 10 need to consider that because the test -  
 11 MS. NEWBURY:  
 12 Q. You were picking them up anyway?  
 13 DR. WILLIAMS:  
 14 A. Yes, we were going to pick them up anyway,  
 15 that's right.  
 16 MS. NEWBURY:  
 17 Q. Right. But you don't know now to this day  
 18 whether typically the patients who were tested  
 19 for ER/PR six months before the change in  
 20 protocol from 30 to 10 percent, you don't know  
 21 if the oncologists would advise their patients  
 22 accordingly -  
 23 DR. WILLIAMS:  
 24 A. My understanding -  
 25 MS. NEWBURY:

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1 Q. - and perhaps offer treatment to them?  
 2 DR. WILLIAMS:  
 3 A. - that hadn't changed, but I stand to be  
 4 corrected on that. That was my understanding.  
 5 But again, we didn't need to get into it  
 6 because we were retesting everybody anyway.  
 7 MS. NEWBURY:  
 8 Q. Right. Are you aware of any protocols in  
 9 place for handling that sort of general  
 10 situation where there's a new best practice -  
 11 DR. WILLIAMS:  
 12 A. No.  
 13 MS. NEWBURY:  
 14 Q. - out there?  
 15 DR. WILLIAMS:  
 16 A. No.  
 17 MS. NEWBURY:  
 18 Q. Nothing?  
 19 DR. WILLIAMS:  
 20 A. Not here or in other centres, as far as I  
 21 know.  
 22 MS. NEWBURY:  
 23 Q. So it's left to individual physicians to make  
 24 that decision?  
 25 DR. WILLIAMS:

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1 A. I think so, I think that may be correct.  
 2 Again, you'd have to ask others, but that's my  
 3 understanding.  
 4 MS. NEWBURY:  
 5 Q. Dr. Williams, you were talking on a couple of  
 6 occasions about meta-analysis?  
 7 DR. WILLIAMS:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. And you had requested Dr. Parfrey to see if he  
 11 could locate any meta-analysis on the benefit  
 12 of Tamoxifen?  
 13 DR. WILLIAMS:  
 14 A. Yes.  
 15 MS. NEWBURY:  
 16 Q. In the ER/PR receptor positive patients with  
 17 breast cancer. And you had defined, as I  
 18 understood it, meta-analysis to be a review of  
 19 all of the literature that's been done on an  
 20 issue and put together in one document and  
 21 draws conclusions on all of the studies done.  
 22 Do you know if meta-analysis has, I guess, a  
 23 more detailed quantitative calculation of all  
 24 of these various studies?  
 25 DR. WILLIAMS:

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1 A. Well, yes, it would, because if you look at  
 2 any one study or two studies or three studies,  
 3 you will get a result based on those studies.  
 4 You might find some studies say one thing. In  
 5 epidemiology you might find that an  
 6 association in one study doesn't really exist,  
 7 and in another study it does exist on the same  
 8 thing. So this tends to put together, instead  
 9 of ten studies or of one study, you get the  
 10 impression of one study, you put together all  
 11 the studies that have ever been done in this--  
 12 good studies that have been done in this area  
 13 and it gives you a full picture of, in fact,  
 14 what the issues and what the outcomes are.  
 15 MS. NEWBURY:  
 16 Q. So it's the aggregate of studies. But do you  
 17 know if it's done from a statistical  
 18 perspective -  
 19 DR. WILLIAMS:  
 20 A. Yeah, it's expected to be better than analysis  
 21 of any one study, because you might find that  
 22 100 studies are done showing in 15 percent  
 23 that this is the result and then in the other  
 24 80 percent or 85 percent that it's this  
 25 result. You put them all together and you get

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1 a--you might reach one conclusion on one set  
 2 of studies, but when you put everything  
 3 together, you might reach a different set of  
 4 conclusions. So scientifically it's supposed  
 5 to be an advance over what was in place  
 6 before.  
 7 MS. NEWBURY:  
 8 Q. Okay.  
 9 DR. WILLIAMS:  
 10 A. So that's why we asked Dr. Parfrey if he could  
 11 do it.  
 12 MS. NEWBURY:  
 13 Q. Sure. Now, I understand the concept of  
 14 getting together the different studies, but my  
 15 focus is in on how you pull all of those  
 16 studies together. Are you aware of whether or  
 17 not as a statistical or quantitative analysis-  
 18 -and I'll give you an example. If you've got  
 19 a study that lasted for five years and  
 20 involved 100,000 patients versus a six-month  
 21 study of two patients, would you give more  
 22 weight to one -  
 23 DR. WILLIAMS:  
 24 A. Yes, you'd give more weight to the study that  
 25 did 1000 patients. It's quantitative in that

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1 sense, yes.  
 2 MS. NEWBURY:  
 3 Q. Okay.  
 4 DR. WILLIAMS:  
 5 A. The person really to, person that's most  
 6 knowledgeable in this area would be Dr. Parfrey  
 7 and he's--he didn't do it when I asked him,  
 8 but he subsequently has done it.  
 9 MS. NEWBURY:  
 10 Q. Oh, has he done it in relation to this -  
 11 DR. WILLIAMS:  
 12 A. Yes. And he's--yes, he's done some work on  
 13 this whole area and the last time I saw her  
 14 wrote an article in the paper.  
 15 MS. NEWBURY:  
 16 Q. Okay. But did he -  
 17 DR. WILLIAMS:  
 18 A. Some months ago.  
 19 MS. NEWBURY:  
 20 Q. And it was considered a meta-analysis? Why  
 21 was it -  
 22 DR. WILLIAMS:  
 23 A. I expect that's how he did it. You'd have to  
 24 really ask him to come here and question him  
 25 on it, how he did it. I asked him to do it

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1 because, again, I wanted to see, have an  
 2 overview of what this all meant.  
 3 MS. NEWBURY:  
 4 Q. Okay.  
 5 DR. WILLIAMS:  
 6 A. For what we were doing and how it might affect  
 7 people overall. I was just trying to get a  
 8 feel for it.  
 9 MS. NEWBURY:  
 10 Q. Sure.  
 11 DR. WILLIAMS:  
 12 A. It didn't affect us going and retesting  
 13 because we were going to retest and we were  
 14 going to provide that information to the  
 15 physician and the physician's patient and then  
 16 have that best input go into that. But I  
 17 wanted to see the whole picture.  
 18 MS. NEWBURY:  
 19 Q. Sure.  
 20 DR. WILLIAMS:  
 21 A. And so I think he didn't, he couldn't do it at  
 22 the time because he was busy, and it wasn't  
 23 germane to--we were going to retest anyway,  
 24 but I would have liked to see the whole  
 25 picture. And I think subsequently I think

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1 he's done that and so he'd probably be in a  
 2 good position to provide you with that  
 3 information.  
 4 MS. NEWBURY:  
 5 Q. Did you actually ask Dr. Parfrey to do a meta-  
 6 analysis or were you asking him to see if  
 7 there was one that already existed.  
 8 DR. WILLIAMS:  
 9 A. Well, I asked him to see what was out there,  
 10 basically.  
 11 MS. NEWBURY:  
 12 Q. Okay.  
 13 DR. WILLIAMS:  
 14 A. I don't have the -  
 15 MS. NEWBURY:  
 16 Q. That's what I understood. I can pull up the  
 17 exhibit if you want to see it, because that  
 18 was what I understood.  
 19 DR. WILLIAMS:  
 20 A. Yeah, I sort of asked him if he could help us  
 21 there, is there a meta-analysis or do you know  
 22 of something that can help us there and pull  
 23 this all together. And I don't know if that's  
 24 been done for that, so the best thing would be  
 25 to ask Dr. Parfrey.

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1 MS. NEWBURY:  
 2 Q. Sure, okay. And in terms of looking at the  
 3 literature out there, is there something, I  
 4 guess, less sophisticated or less quantitative  
 5 than a meta-analysis, just a general review of  
 6 the literature without putting it together in  
 7 a -  
 8 DR. WILLIAMS:  
 9 A. I think if we wanted to do something there,  
 10 there's a meta-analysis done or if he could do  
 11 a meta-analysis, I mean, he has people that  
 12 he's training at the master's level in  
 13 epidemiology.  
 14 MS. NEWBURY:  
 15 Q. Sure.  
 16 DR. WILLIAMS:  
 17 A. I've asked him to do things before for me when  
 18 I was at the Health Care Corporation of St.  
 19 John's on different issues that had come up.  
 20 And he used to be able to find a master's  
 21 level student who always wanted a few extra  
 22 dollars to try to get through their master's  
 23 so he'd put them onto the project. So I think  
 24 he's probably have somebody over there who's  
 25 doing a master's level in epidemiology who he

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1 could assign to that and get that information  
 2 brought together. And then obviously he'd  
 3 review it to make sure it was done properly,  
 4 but.  
 5 MS. NEWBURY:  
 6 Q. But I guess I'm wondering if there's something  
 7 perhaps less complicated than a meta-analysis  
 8 -  
 9 DR. WILLIAMS:  
 10 A. There may be -  
 11 MS. NEWBURY:  
 12 Q. - just a systematic review of literature  
 13 without doing weighted studies and -  
 14 DR. WILLIAMS:  
 15 A. Yeah. There may be, but I'm not aware of it.  
 16 MS. NEWBURY:  
 17 Q. You're not aware?  
 18 DR. WILLIAMS:  
 19 A. That's why I asked him.  
 20 MS. NEWBURY:  
 21 Q. Sure, okay. And are you aware of the term  
 22 "evidence-based decision making"?  
 23 DR. WILLIAMS:  
 24 A. Yeah, I'm aware of that.  
 25 MS. NEWBURY:

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1 Q. Okay. What, can you describe what that means?  
 2 DR. WILLIAMS:  
 3 A. Well, you're supposed to make a decision for  
 4 patient care based upon the best evidence  
 5 that's available. So that's evidence-based  
 6 decision making. Let me give you an example  
 7 that everybody can probably understand. And  
 8 evidence would indicate that most sore throats  
 9 are caused by viruses, so people don't need an  
 10 antibiotic, okay. There's some things you can  
 11 do if you suspect they have strep throat  
 12 because that's the only kind of a--that's the  
 13 only person who should get an antibiotic for a  
 14 sore throat is somebody who had a strep  
 15 throat. Now, there's a simple test you can do  
 16 that's called, it's--and you can get the  
 17 results in 24 hours, so. Evidence-based  
 18 decision making would indicate that if you  
 19 think it's a strep throat, you order this  
 20 test, have the result back in 24 hours and  
 21 then you treat the patient.  
 22 MS. NEWBURY:  
 23 Q. Okay.  
 24 DR. WILLIAMS:  
 25 A. If you don't feel it's a bacteria because

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1 there's no exudate on their throat and their  
 2 tonsils are not swollen, you don't have a  
 3 fever and headache and all that stuff you get  
 4 with a sore throat--with a strep throat, then  
 5 you just treat them on the basis that it's a  
 6 viral sore throat and you don't treat them at  
 7 all. But evidence-based decision making is  
 8 not always in place in our systems and  
 9 sometimes we find that a lot of people with a  
 10 sore throat get an antibiotic.

11 MS. NEWBURY:  
 12 Q. Okay.

13 DR. WILLIAMS:  
 14 A. When the majority won't need it. That's what  
 15 I mean by evidence-based decision.

16 MS. NEWBURY:  
 17 Q. Okay.

18 DR. WILLIAMS:  
 19 A. In its simplest explanation.

20 MS. NEWBURY:  
 21 Q. And would a meta-analysis be a tool used in  
 22 evidence-based decision making?

23 DR. WILLIAMS:  
 24 A. Yes.

25 MS. NEWBURY:

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1 Q. Okay. And are there any other examples of  
 2 tools that might be used?

3 DR. WILLIAMS:  
 4 A. Well, studies like that. Study, you might  
 5 have a study that -

6 MS. NEWBURY:  
 7 Q. Okay.

8 DR. WILLIAMS:  
 9 A. - in itself is so good and the epidemiology is  
 10 so good and somebody's reviewed it.

11 MS. NEWBURY:  
 12 Q. Sure.

13 DR. WILLIAMS:  
 14 A. So just because it gets published in the  
 15 literature doesn't mean it's any good, okay.  
 16 That's what we want to make sure.

17 MS. NEWBURY:  
 18 Q. Okay. And -

19 DR. WILLIAMS:  
 20 A. The good, good journals like the New England  
 21 Journal have junk published in them sometimes.

22 MS. NEWBURY:  
 23 Q. Okay. Does Eastern Health incorporate  
 24 evidence-based decision making in its  
 25 decisions?

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1 DR. WILLIAMS:  
 2 A. We've had some clinical practice guidelines  
 3 developed over time and some of the clinical  
 4 chiefs try to do that. Like, you know, x-rays  
 5 for people who have sinusitis, Dr. Collingwood  
 6 did some work there. Some work on the use of  
 7 x-rays in neck problems and things like that.  
 8 I'd have to go back and look, but there are  
 9 examples that our clinical chiefs introduced  
 10 to our organization that we try to propagate  
 11 throughout the organization, but you have to  
 12 work at it. And there's books written on  
 13 evidence-based decision making and how to  
 14 impact clinical decision making based on  
 15 evidence. There's books written on it.

16 MS. NEWBURY:  
 17 Q. Sure.

18 DR. WILLIAMS:  
 19 A. And it's very difficult to change old habits.

20 MS. NEWBURY:  
 21 Q. Right.

22 DR. WILLIAMS:  
 23 A. And that's why I think you really have to work  
 24 at some of these people when they're in  
 25 medical school.

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1 MS. NEWBURY:  
 2 Q. Okay. And aside from in a clinical setting  
 3 are there other types of areas that Eastern  
 4 Health would incorporate evidence, or  
 5 evidence-based decision making, for example,  
 6 policy decisions on resource allocation?

7 DR. WILLIAMS:  
 8 A. There was some work done on that, yes.

9 MS. NEWBURY:  
 10 Q. Okay.

11 DR. WILLIAMS:  
 12 A. Sometime over the past number of years we had  
 13 some work done on that and it went to the  
 14 ethics committee, I think, in the last year or  
 15 two when I was there, and Dr. Pullman was  
 16 involved in that. There should be a document  
 17 on that somewhere, if you want to see it. I  
 18 don't know where it is. But it is in there.  
 19 It proved quite difficult to try to get a  
 20 handle on it.

21 MS. NEWBURY:  
 22 Q. Um-hm.

23 DR. WILLIAMS:  
 24 A. But there was a document. I remember going to  
 25 a meeting or so or a series of meetings. And

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1 you'd have to ask Ms. Jones or something to  
 2 produce that document, but there was something  
 3 done on, you know, how do you allocate  
 4 resources among competing demands in a health  
 5 care system. So you might have a demand over  
 6 here with good strong, you know, support and a  
 7 demand over here with good strong report.  
 8 This requires 50,000, this requires 50,000,  
 9 you only have 50,000, what do you do, that  
 10 kind of stuff.  
 11 MS. NEWBURY:  
 12 Q. And would efficacy of whatever it is you're  
 13 looking at also be an issue?  
 14 DR. WILLIAMS:  
 15 A. Yes, that would be all factors. Somebody  
 16 would have to make the case. So that was done  
 17 for just in the end of the Health Care  
 18 Corporation or early Eastern Health. Louise  
 19 Jones would have probably been involved in  
 20 that. I remember we went to a couple of  
 21 meetings to--with the ethicists there to try  
 22 to get a handle on what factors should we  
 23 consider.  
 24 MS. NEWBURY:  
 25 Q. Are you aware if evidence-based decision

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1 making was ever applied in the context of the  
 2 laboratory medicine program?  
 3 DR. WILLIAMS:  
 4 A. No, I can't remember in terms--what happens in  
 5 the laboratory medicine program is they happen  
 6 to be there, they're a service provider and  
 7 everybody out there, the GPs and physicians in  
 8 our organization request tests. They might be  
 9 a cholesterol test or this type of thing. But  
 10 it's hard for people in the lab to know if  
 11 that test is justified on that patient. You'd  
 12 have to get the patient's history and go into  
 13 it and this type of--the lab is really just in  
 14 a situation where they're responding to  
 15 things, requests from people who are licensed  
 16 to ask for those things to be done.  
 17 MS. NEWBURY:  
 18 Q. So more the oncologists, perhaps, that would  
 19 have to make those decisions?  
 20 DR. WILLIAMS:  
 21 A. No, I think all physicians make decisions and  
 22 the laboratory just is a responder, they  
 23 provide a service. Just like the diagnostic  
 24 imaging is a provider. X-rays are ordered by  
 25 physicians and it's probably in some of the

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1 things if they're a little bit outrageous,  
 2 based upon the history they get on the  
 3 requisition for an x-ray, maybe occasionally a  
 4 radiologist might ask some questions before  
 5 they do the procedure.  
 6 MS. NEWBURY:  
 7 Q. Um-hm.  
 8 DR. WILLIAMS:  
 9 A. But we get thousands and thousands and  
 10 thousands per day of individual tests and  
 11 individual patients. It's very difficult. We  
 12 tried it one time to get a utilization officer  
 13 into the laboratory to see if we impact on  
 14 that, but we didn't have the resources. It  
 15 would mean laying off somebody on the front  
 16 lines. The lab is, requests are going up in  
 17 the lab about six percent a year because new  
 18 tests are coming on and this type of thing,  
 19 and that's, they're a provider that they just  
 20 can't respond.  
 21 MS. NEWBURY:  
 22 Q. And how about the oncologists, would there be  
 23 any role for evidence-based decision making in  
 24 that group?  
 25 DR. WILLIAMS:

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1 A. Yes, there would be. There would be a lot of  
 2 articles on oncology in the literature -  
 3 MS. NEWBURY:  
 4 Q. And is it done collectively or individually by  
 5 physicians?  
 6 DR. WILLIAMS:  
 7 A. I think the physicians would look at the  
 8 latest literature, would read the latest  
 9 literature. And sometimes documents are  
 10 published that they would look at, published  
 11 literature. And maybe a meta-analysis is  
 12 every now and then published about a major  
 13 event, too, but I think most of the  
 14 oncologists would look at what's propagated in  
 15 the literature. Some of the oncologists, not  
 16 all our physicians, some of our physicians  
 17 have training in clinical epidemiology at a  
 18 master's level that we provide in the  
 19 organization, so some of them would be able to  
 20 read the literature with a jaundiced eye,  
 21 which is what it needs to be read with. But a  
 22 lot of our physicians would not.  
 23 MS. NEWBURY:  
 24 Q. So would the oncologists, aside from having  
 25 evidence-based decision making taken into

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1 account for clinical decisions, how about the  
 2 policy, broader policy decisions?  
 3 DR. WILLIAMS:  
 4 A. In what sense?  
 5 MS. NEWBURY:  
 6 Q. Are they involved in that at all, you know,  
 7 resource allocation or -  
 8 DR. WILLIAMS:  
 9 A. Oh, sure, they--one of the issues I had to  
 10 deal with when Ms. Paulse left and before  
 11 Eastern Health came--well, when Eastern Health  
 12 came together, but before they really came  
 13 together, Mr. Tilley asked me to take over as  
 14 CEO of the Cancer Foundation, so one of--  
 15 Cancer Foundation. So one of the things we  
 16 were--they were dealing with there is issues  
 17 relating to resources for colon cancer.  
 18 MS. NEWBURY:  
 19 Q. Um-hm.  
 20 DR. WILLIAMS:  
 21 A. And some new evidence had come out that  
 22 certain drugs offered an advantage over the  
 23 previous drugs, and then we had do battle to  
 24 get some resources in the budget to enable us  
 25 to implement those new regimes. So that's the

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1 kind of things they'd be dealing with on a  
 2 day-to-day basis. So that affects--that's a  
 3 clinical issue that affects policy.  
 4 MS. NEWBURY:  
 5 Q. And in terms of your request to Dr. Parfrey,  
 6 you were looking to see if there are any  
 7 existing studies, meta-analysis of the benefit  
 8 of Tamoxifen. Is that something that Eastern  
 9 Health or its predecessor, the Health Care  
 10 Corporation would have looked at before  
 11 introducing that drug?  
 12 DR. WILLIAMS:  
 13 A. No. No, I don't think that -  
 14 MS. NEWBURY:  
 15 Q. You don't expect that that -  
 16 DR. WILLIAMS:  
 17 A. - that level of detail, no. I'm pretty sure  
 18 every time a drug comes on, they don't do  
 19 that.  
 20 MS. NEWBURY:  
 21 Q. Okay.  
 22 DR. WILLIAMS:  
 23 A. They'd be doing a lot of it if they did, but  
 24 they rely on, I guess, published articles and  
 25 what the consensus is and the generally

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1 accepted approach to it is.  
 2 MS. NEWBURY:  
 3 Q. Right.  
 4 DR. WILLIAMS:  
 5 A. That's my understanding.  
 6 MS. NEWBURY:  
 7 Q. So not as detailed or intricate as a meta-  
 8 analysis but -  
 9 DR. WILLIAMS:  
 10 A. No. Correct.  
 11 MS. NEWBURY:  
 12 Q. - you would think that they would do some sort  
 13 of literature review?  
 14 DR. WILLIAMS:  
 15 A. Yes, the physicians would review the  
 16 literature and be current. They might go to a  
 17 conference and there might be a guest speaker  
 18 come and speak at that conference on some new  
 19 developments in there, so they would get it  
 20 from reviewing the literature or going off to  
 21 conferences and bringing back that information  
 22 back to the organization.  
 23 MS. NEWBURY:  
 24 Q. So those are all, I guess, clinical decisions  
 25 made on evidence that's available, the best

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1 evidence that's available.  
 2 DR. WILLIAMS:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. But there's no sort of separate, well, we'll  
 6 look at the policy of it for the organization,  
 7 in terms of resource allocation, as an  
 8 example, and I'm not sure what the  
 9 implications are. I know it was an issue for  
 10 Herceptin, but I don't know if it was as much  
 11 of an issue with regard to Tamoxifen, in terms  
 12 of the cost -  
 13 DR. WILLIAMS:  
 14 A. No, then Tamoxifen came in, I think that--I  
 15 can't remember because again, the cancer  
 16 clinic was separate from the Health Care  
 17 Corporation of St. John's and those patients  
 18 would be getting that on an out-patient basis,  
 19 so it wouldn't be a relative issue that we  
 20 would have dealt with in the Health Care  
 21 Corporation at the time.  
 22 MS. NEWBURY:  
 23 Q. Okay, and in terms of responding to a crisis  
 24 or a major adverse event or a series of  
 25 adverse events, do you think there would be a



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1 role for evidence based decision-making in so  
 2 responding?  
 3 DR. WILLIAMS:  
 4 A. Yes, if you got the time to go and search it  
 5 out. We already made the decision to retest,  
 6 I just wanted to see when I asked Dr. Parfrey  
 7 after we made the decision, what's the  
 8 evidence here and -  
 9 MS. NEWBURY:  
 10 Q. Sure.  
 11 DR. WILLIAMS:  
 12 A. - what the implications are.  
 13 MS. NEWBURY:  
 14 Q. What about other types of decisions that  
 15 you're making, for example communication with  
 16 patients, disclosure with patients? Would  
 17 there be a role for looking out there to see  
 18 what's the literature on best available  
 19 practices, what's the best evidence on that?  
 20 DR. WILLIAMS:  
 21 A. You know, I think now we'll see a lot more  
 22 literature on that.  
 23 MS. NEWBURY:  
 24 Q. Okay, how about a decision whether or not to  
 25 retest ER positive patients? Would you think

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1 there's a role for evidence based decision-  
 2 making on that, going out to find if there is  
 3 literature, best practices -  
 4 DR. WILLIAMS:  
 5 A. As far as I know, positives, there's very  
 6 little in the literature. There's a lot of  
 7 literature about negatives and problems there.  
 8 I haven't seen any in the literature about  
 9 positives and the problem with the positives,  
 10 that's what--I haven't seen, it's not been  
 11 brought to my attention.  
 12 MS. NEWBURY:  
 13 Q. Well I guess the question is did anyone look  
 14 for that? Was anyone looking for the best  
 15 available evidence on the issue of ER positive  
 16 issues?  
 17 DR. WILLIAMS:  
 18 A. Well yes, we had a lot of information on the  
 19 ER and PR testing and the only thing that was  
 20 in that literature which was, I suspect  
 21 balance literature, was the problem with  
 22 negatives being missed.  
 23 MS. NEWBURY:  
 24 Q. Okay.  
 25 DR. WILLIAMS:

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1 A. I don't remember anything in the literature  
 2 that related to positives being a problem.  
 3 MS. NEWBURY:  
 4 Q. So you understand that your search or the  
 5 search that was conducted by people at Eastern  
 6 Health was broad enough to have picked up any  
 7 issues about ER positive patients?  
 8 DR. WILLIAMS:  
 9 A. I think if you're talking about ER and PR  
 10 testing, they would have picked up that there  
 11 was a problem with the positives and a problem  
 12 with negatives, most of the problem--all of  
 13 them were talking about the negatives.  
 14 MS. NEWBURY:  
 15 Q. I'd like to refer to exhibit P-0503 please?  
 16 These are meeting notes.  
 17 DR. WILLIAMS:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. You were one of the individuals in attendance  
 21 along with Ms. Predham, Dr. Cook and Mr.  
 22 Gulliver and item No. 4, one of the issues  
 23 discussed was to assess current testing  
 24 standards, cross referencing with another  
 25 laboratory, it only speaks of one laboratory

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1 there, is that your recollection of what would  
 2 have been discussed at that meeting?  
 3 DR. WILLIAMS:  
 4 A. No, I think what was subsequently done, Dr.  
 5 Cook did some cross referencing with the  
 6 Montreal Jewish Hospital and I guess  
 7 retesting, all the retesting we did with Mount  
 8 Sinai, you could consider that too, probably  
 9 some cross referencing, but he did have some  
 10 discussions with the Montreal Jewish and he  
 11 did have some discussions with Dr. O'Brien in  
 12 New Brunswick, Dr. Dogan down in the Mayo  
 13 Clinic at some stage along the way.  
 14 MS. NEWBURY:  
 15 Q. Was there a more comprehensive analysis, a  
 16 review of testing standards, for example, all  
 17 across Canada?  
 18 DR. WILLIAMS:  
 19 A. Yes, there was a survey carried out, quality  
 20 carried it out and that should be in your  
 21 package. It didn't give us a lot of, what I  
 22 call information that was, you know, we could  
 23 really use.  
 24 MS. NEWBURY:  
 25 Q. Did that relate to rates of positivity, as

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1 opposed to actual standards for testing?  
 2 DR. WILLIAMS:  
 3 A. Yeah, if they had any problems and what's your  
 4 rate of positivity and do you track that  
 5 thing, this kind of thing, these are the kind  
 6 of questions and they're all there. The  
 7 referencing would have been Dr. Cook talking  
 8 to Montreal Jewish and our ongoing efforts, I  
 9 guess, with the Mount Sinai people.  
 10 MS. NEWBURY:  
 11 Q. But there was no analysis of labs throughout  
 12 the country as to how they do their testing,  
 13 what their testing standards are to identify,  
 14 for example, whether other labs use internal  
 15 controls or not?  
 16 DR. WILLIAMS:  
 17 A. Not to that level of detail, I don't know  
 18 what's in--I'd have to refresh my memory about  
 19 what was in that document, but it would have  
 20 told us what kind of systems they used at the  
 21 time, I'm pretty sure.  
 22 MS. NEWBURY:  
 23 Q. Whether it was DAKO or Ventana -  
 24 DR. WILLIAMS:  
 25 A. Yes.

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1 MS. NEWBURY:  
 2 Q. But not the testing, not all the detail that  
 3 Dr. Banerjee and Ms. Wegrynowski detailed in  
 4 their various reports.  
 5 DR. WILLIAMS:  
 6 A. No. And, of course, Dr. Cook did follow up  
 7 with those organizations at the time and then  
 8 Dr. Banerjee when he came in and debriefed us,  
 9 he would have talked about his knowledge of  
 10 what was going on. And then we had Dr. Gown  
 11 come in, of course, who would be recognized as  
 12 an expert.  
 13 MS. NEWBURY:  
 14 Q. But in addition to having these external  
 15 reviewers come in, do you think it would have  
 16 been helpful for Eastern Health to look for  
 17 the best available evidence across the country  
 18 as to the current testing standards so that  
 19 they could make decisions about quality of  
 20 care and also communication with patients and  
 21 the public?  
 22 DR. WILLIAMS:  
 23 A. I don't think that was, communication with the  
 24 patient and public wouldn't have been an issue  
 25 and Dr. Cook had some discussions, we were

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1 dealing with Mount Sinai, which was the gold  
 2 standard as we understood it, and Dr.  
 3 Banerjee, so I think we would have known, you  
 4 know, we didn't know that certain things were  
 5 possible with a lot of detail going into the  
 6 testing and analysis.  
 7 MS. NEWBURY:  
 8 Q. It was Mr. Tilley's evidence, as I understand  
 9 it, that part of the reluctance or  
 10 reservations that he had about identifying a  
 11 cause of the ER/PR problems was distinguishing  
 12 between what's inherent in Eastern Health  
 13 itself verses what are problems inherent in  
 14 ER/PR testing generally and whether or not  
 15 everyone or a lot of other labs across Canada  
 16 are experiencing the same types of problems.  
 17 And I'm just wondering in terms of  
 18 communication with patients, shouldn't Eastern  
 19 Health have taken steps to identify that so  
 20 they can relay the best information available  
 21 to their patients?  
 22 DR. WILLIAMS:  
 23 A. Well, I think this issue--you mean the other  
 24 labs, we should tell the other people across  
 25 the other -

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1 MS. NEWBURY:  
 2 Q. No, no, whether you should do an analysis or  
 3 survey to find out what are the testing  
 4 standards across the country to find out  
 5 whether this is a problem inherent in Eastern  
 6 Health or whether it's part of a larger  
 7 national problem or some combination, so that  
 8 patients can then be informed.  
 9 DR. WILLIAMS:  
 10 A. Well we know from what work has been done in  
 11 Great Britain and some conversations that we  
 12 had with Dr. Banerjee that--and literature  
 13 coming out of the U.S., although there is not  
 14 much literature in Canada, that there are  
 15 problems with this testing and that other  
 16 countries have seen fit to introduce some  
 17 external quality and proficiency into their  
 18 country so that labs doing this test had to  
 19 meet certain standards. That issue was called  
 20 for in the U.S. in some of the literature, but  
 21 had not--there's nothing put in place as far  
 22 as I know yet, so we knew that these were  
 23 issues that had been in other countries, had  
 24 been in the U.S., nothing had been published  
 25 in Canada. There was no central quality

1 assurance for this, so we would have assumed  
 2 that there's a potential there, we would have-  
 3 -by phoning around we wanted to find out if  
 4 other people had experienced some issues, and  
 5 Dr. O'Brien said that they had some issues in  
 6 New Brunswick. The other ones that reported  
 7 back said they weren't monitoring, but they  
 8 didn't know of any issues at the time.  
 9 MS. NEWBURY:  
 10 Q. But not so much to find out if other people  
 11 are having problems because some people might  
 12 be having it and haven't identified it, but to  
 13 find out what are your testing standards? How  
 14 do you do these tests or how have you been  
 15 doing these tests the past number of years?  
 16 Would that be information that could be of  
 17 some benefit to Eastern Health to perhaps find  
 18 out why did another lab, using the DAKO  
 19 system, why were they able to do this  
 20 successfully and maybe that could be  
 21 informative for Eastern Health in a broader  
 22 sense about IHC testing in general.  
 23 DR. WILLIAMS:  
 24 A. Well, I think you'd look at Mount Sinai as  
 25 sort of a reference lab like you had in Great

1 information useful to Eastern Health to  
 2 ascertain why it took a major event such as  
 3 this to put the proper procedures in place and  
 4 whether other labs were able to put the proper  
 5 procedures in place without needing a large  
 6 adverse event?  
 7 DR. WILLIAMS:  
 8 A. Uh-hm. I guess when we contacted them, we  
 9 didn't get any information to that effect. We  
 10 put out something, went out nationally that  
 11 there was a problem here and I guess that  
 12 would give them a chance to go back and see if  
 13 they had a problem themselves, but we didn't  
 14 get any feedback from--I think there was one  
 15 call came from one lab asking a little bit  
 16 about it.  
 17 MS. NEWBURY:  
 18 Q. Thank you, those are all the questions I have.  
 19 THE COMMISSIONER:  
 20 Q. Thank you. Ms. Taylor?  
 21 DR. ROBERT WILLIAMS, EXAMINATION BY MS. PAMELA TAYLOR  
 22 MS. TAYLOR:  
 23 Q. Commissioner, I don't think that I would  
 24 finish this afternoon, however Ms. Newbury has  
 25 covered a lot of the territory that I would

1 Britain and they were the gold standard and  
 2 they had expertise and they were, I guess,  
 3 dealing with this in a detailed manner and had  
 4 things in place. But I don't recollect, you  
 5 know, other labs saying that--getting into  
 6 that level of detail. We knew we had a  
 7 problem at this time and what we wanted to do  
 8 was get somebody in and identify the problem  
 9 and fix it for us--or help us fix it.  
 10 MS. NEWBURY:  
 11 Q. Sure.  
 12 DR. WILLIAMS:  
 13 A. That's what our focus was at the time.  
 14 MS. NEWBURY:  
 15 Q. I can appreciate that was a priority, but I'm  
 16 wondering -  
 17 DR. WILLIAMS:  
 18 A. And then the other focus was getting  
 19 everything together as quickly as we could and  
 20 get the retesting.  
 21 MS. NEWBURY:  
 22 Q. I appreciate that, but I'm just wondering on  
 23 looking back whether it might have been useful  
 24 for Eastern Health to delve into it a little  
 25 bit further and perhaps that would be

1 want to cover. Perhaps if I could continue  
 2 with Dr. Williams to about 4:45 break, I will  
 3 review my questions and then finish off in the  
 4 morning?  
 5 THE COMMISSIONER:  
 6 Q. All right.  
 7 MS. TAYLOR:  
 8 Q. Good afternoon, Dr. Williams.  
 9 DR. WILLIAMS:  
 10 A. Good afternoon.  
 11 MS. TAYLOR:  
 12 Q. My name is Pam Taylor; I'm here on behalf of  
 13 the breast cancer testing class action group.  
 14 I'm going to ask you a couple of preliminary  
 15 questions on the disclosure aspect of things.  
 16 Now, you've answered a number of questions on  
 17 that and I just want to be clear on a couple  
 18 of points. Your view on disclosure when this  
 19 issue first arose, what I took from your  
 20 evidence was that you were in favour of public  
 21 disclosure, that personal contact with  
 22 patients would be the way to go. I think that  
 23 there was some issue between personal contact  
 24 in the form of a phone call verses a letter,  
 25 those sorts of things, but then we have

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1 discussions with the oncologist where that  
 2 influenced the thinking on disclosure. And I  
 3 understand that with the oncologists and  
 4 particularly Dr. Laing putting forth the  
 5 position on behalf of some other oncologists,  
 6 that to contact patients when the results  
 7 weren't back and not having something to tell  
 8 them might unnecessarily panic them. The  
 9 other issue on disclosure was there was some  
 10 information that was provided in terms of  
 11 public disclosure that legal counsel and risk  
 12 management were advising against disclosure at  
 13 some point early on, particularly before the  
 14 impacted patients have had the opportunity to  
 15 hear about this from us, "us" being Eastern  
 16 Health. So those were some of the dynamics  
 17 entering into the issue of disclosure verses  
 18 do we disclose now or do we wait, is that  
 19 correct?  
 20 DR. WILLIAMS:  
 21 A. Uh-hm.  
 22 MS. TAYLOR:  
 23 Q. Now, around that time, going back to the  
 24 August meeting with the oncologists, you would  
 25 have known at that time that some people had

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1 been informed.  
 2 DR. WILLIAMS:  
 3 A. Yes.  
 4 MS. TAYLOR:  
 5 Q. And I think that I saw a reference to  
 6 approximately ten people having been informed  
 7 -  
 8 DR. WILLIAMS:  
 9 A. Yes.  
 10 MS. TAYLOR:  
 11 Q. At the time of that meeting with the  
 12 oncologists in August.  
 13 DR. WILLIAMS:  
 14 A. Uh-hm.  
 15 MS. TAYLOR:  
 16 Q. So they already knew that there had been a  
 17 problem with the testing and that they had  
 18 test results which had changed. They had been  
 19 informed of that.  
 20 DR. WILLIAMS:  
 21 A. Uh-hm.  
 22 MS. TAYLOR:  
 23 Q. At the time in terms of trying to think about  
 24 well what's going to happen, there's  
 25 information already out there to at least a

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1 certain group of individuals that, you know,  
 2 they're aware that there has been a problem in  
 3 Eastern Health, they're aware of difficulties,  
 4 what was the sense in terms of--what was your  
 5 thoughts on if we wait, what if this gets out  
 6 there publicly before we have a chance to tell  
 7 patients, wouldn't they be negatively impacted  
 8 or stressed by that?  
 9 DR. WILLIAMS:  
 10 A. I think that's probably and I can't remember  
 11 some of the issues we discussed because I just  
 12 didn't have any notes on them and I can't  
 13 remember what I might have said at some of the  
 14 meetings, but I understand I was, from some  
 15 people, laying out some of the pros and cons  
 16 of this, so whether that was an issue we  
 17 discussed, I'm not sure.  
 18 MS. TAYLOR:  
 19 Q. Right.  
 20 DR. WILLIAMS:  
 21 A. But obviously we knew and the results came  
 22 back, we're not going to not tell people  
 23 because we had an obligation to tell people  
 24 and their physicians as soon as possible to  
 25 get on with whatever, anything else that

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1 needed to be done. So I'm sure maybe that was  
 2 something we discussed, but I can't remember  
 3 in detail the thoughts around that, but  
 4 basically my feeling initially was the only  
 5 way we could get to individuals was by  
 6 something public because we didn't know who  
 7 those individuals were. It's not that we go  
 8 public for the sake of going public, it's the  
 9 sense of going public because we need to try  
 10 to inform individuals, we're not going to know  
 11 who they are at the time.  
 12 MS. TAYLOR:  
 13 Q. And in terms of when it did go public, the  
 14 October 2005 news article, Mr. Coffey was  
 15 asking you some questions about whether or not  
 16 there had been any actual concrete planning  
 17 done as to how disclosure was going to be  
 18 handled when the first wave of results came  
 19 back and there's a meeting in early October  
 20 where you sit down with other individuals to  
 21 talk about that.  
 22 DR. WILLIAMS:  
 23 A. Uh-hm.  
 24 MS. TAYLOR:  
 25 Q. You had indicated that although there were a

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1 lot of draft things that had been done, there  
 2 wasn't really--that that meeting was about  
 3 sitting down at that time looking at, okay,  
 4 when we get the test results back, see what  
 5 they are, then we do a strategy about going  
 6 public. So at that point there wasn't a plan  
 7 in place?  
 8 DR. WILLIAMS:  
 9 A. I think we felt that when the reports were  
 10 coming back, we would have a little bit of  
 11 time, we'd see what they were, it takes awhile  
 12 to get them into--and you'd have a few days or  
 13 maybe a week to develop a strategy. I think  
 14 that's what happened, but my notes don't--I'm  
 15 not clear on that.  
 16 MS. TAYLOR:  
 17 Q. Right. But at the same time the clock is  
 18 ticking -  
 19 DR. WILLIAMS:  
 20 A. Yes, I understand.  
 21 MS. TAYLOR:  
 22 Q. That people know and that information could  
 23 get out there, so there was no separate group  
 24 that was working on having a hard and fast  
 25 strategy in place in terms of disclosure and

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1 how we deal with this issue and exactly what  
 2 we're going to say if things come out -  
 3 DR. WILLIAMS:  
 4 A. There were documents developed and things like  
 5 that, but we needed to then sit down and say  
 6 now, which way are we going to go? I think  
 7 that's what the thinking was.  
 8 MS. TAYLOR:  
 9 Q. Right. And I think in terms of a spokesperson  
 10 while Dr. Laing, I think, was put forth for an  
 11 interview around that time, and there had been  
 12 some discussions about whom might be a  
 13 spokesperson, that it doesn't seem like that  
 14 had been completely decided, that in fact she  
 15 would be the spokesperson, that this has  
 16 already been identified because you had to  
 17 find her, actually, in another province?  
 18 DR. WILLIAMS:  
 19 A. Yes, when this happened, she was in another  
 20 province, when this story broke, so we had to  
 21 respond immediately. She was contactable by  
 22 phone on a regular basis, so we reached her  
 23 and talked about it, early on we thought we'd  
 24 have somebody speak from the clinical  
 25 perspective, rather than from the laboratory

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1 perspective, the laboratory perspective would  
 2 come later.  
 3 MS. TAYLOR:  
 4 Q. Right, but from the point of time when people  
 5 are first notified, when that smaller group of  
 6 people become aware that there's a problem  
 7 with their test results, at that point there  
 8 is some information that's out there to some  
 9 members of the public -  
 10 DR. WILLIAMS:  
 11 A. Uh-hm.  
 12 MS. TAYLOR:  
 13 Q. So wouldn't, from that point until October  
 14 when the story actually comes out, each day it  
 15 could have come out.  
 16 DR. WILLIAMS:  
 17 A. Yes.  
 18 MS. TAYLOR:  
 19 Q. So time is of the essence in making sure that  
 20 you have your plan in place as to how you  
 21 would respond to queries from people,  
 22 concerns, the media, patients, so that wasn't  
 23 being worked on at that point?  
 24 DR. WILLIAMS:  
 25 A. I think it was being worked on but we needed

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1 to come together then and see what we had done  
 2 and spend some time, depending on what was  
 3 coming back, how we would deal with it.  
 4 MS. TAYLOR:  
 5 Q. Would you say that the approach at that time,  
 6 looking back on it now, that it was maybe more  
 7 of a reactionary approach, rather than  
 8 proactive?  
 9 DR. WILLIAMS:  
 10 A. When we look back on things, obviously we  
 11 learn from what you've done and what the  
 12 outcomes are, so you hopefully learn something  
 13 and the next time around you might do it  
 14 differently, this type of thing. So that's--  
 15 sometimes you do something and new information  
 16 becomes available, what you've done, I guess  
 17 you try to learn from that and you would take  
 18 a different approach the next time.  
 19 MS. TAYLOR:  
 20 Q. And in terms of the contact that was when it  
 21 was finally decided that contact would be made  
 22 by phone with patients, wasn't one of the  
 23 factors that weighed heavily in that, wasn't  
 24 it the fact that a person had come forward,  
 25 you dealt with an individual, I believe it

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1 came forward through an e-mail from Ross Reid,  
 2 I believe. You met with the individual along  
 3 with Pat Pilgrim -  
 4 DR. WILLIAMS:  
 5 A. Uh-hm, yes.  
 6 MS. TAYLOR:  
 7 Q. And you had provided evidence that, you know,  
 8 she made a number of good points about why  
 9 people should know -  
 10 DR. WILLIAMS:  
 11 A. Yes, sure.  
 12 MS. TAYLOR:  
 13 Q. And that you thought that probably factored  
 14 heavily into making sure we got the  
 15 information out to people and we decided to do  
 16 it by phone. So again, at that point someone  
 17 has come forward, then it's decided we'll  
 18 contact everybody by phone, but wasn't it  
 19 being thought of--it wasn't being thought of  
 20 before then that we need to do this?  
 21 DR. WILLIAMS:  
 22 A. Yes, it was being thought of before then that  
 23 we need to do that, the comments that that  
 24 person made would have some impact on the  
 25 ultimate decision. I know I favoured

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1 personally the individual contact by phone.  
 2 MS. TAYLOR:  
 3 Q. Right.  
 4 DR. WILLIAMS:  
 5 A. That was my own personal view and some other  
 6 people, obviously, would have supported that.  
 7 MS. TAYLOR:  
 8 Q. And when you were talking about your own  
 9 personal view on that, the individual contact,  
 10 that you had said that that was your own  
 11 thoughts and you didn't have any expertise in  
 12 communications in terms of mass  
 13 communications, was there anybody on staff who  
 14 would have had any sort of expertise from a  
 15 disclosure point of view on mass  
 16 communications?  
 17 DR. WILLIAMS:  
 18 A. I guess our communications people would have.  
 19 MS. TAYLOR:  
 20 Q. And mass communications in the sense of  
 21 disclosure of an adverse event of this size?  
 22 DR. WILLIAMS:  
 23 A. I'm not sure if anybody, to the extent that we  
 24 had, would have had a lot of experience with  
 25 that.

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1 MS. TAYLOR:  
 2 Q. Right. Was any inquiry made in that regard,  
 3 do you know?  
 4 DR. WILLIAMS:  
 5 A. No, I don't know.  
 6 MS. TAYLOR:  
 7 Q. It wasn't a thought that had come to your mind  
 8 in terms of do we have somebody who may have  
 9 dealt with an issue like this before?  
 10 DR. WILLIAMS:  
 11 A. No, we have communications people there, we'd  
 12 seen what happened in Labrador when they dealt  
 13 with it and some of the issues that were  
 14 there, but -  
 15 MS. TAYLOR:  
 16 Q. Was there any other--well Labrador was looked  
 17 at, was there any other organizations or any  
 18 other advice sought from outside sources on  
 19 how something of a similar nature may have  
 20 been dealt with previously, in terms of  
 21 disclosure?  
 22 DR. WILLIAMS:  
 23 A. Not to my knowledge, I hadn't seen any and I  
 24 don't know if our communications people might  
 25 have contacted somebody in their line of work,

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1 but I don't--I'm not aware of it.  
 2 MS. TAYLOR:  
 3 Q. And it wasn't something that you considered at  
 4 that time or thought that maybe this would be  
 5 something that might be helpful?  
 6 DR. WILLIAMS:  
 7 A. Well again, there's so much going on and with  
 8 this, it's a lot of things that I, you know,  
 9 it just didn't come out.  
 10 MS. TAYLOR:  
 11 Q. Now if we could turn to P-0067? Now, Dr.  
 12 Williams, this is the memo from Dr. Cook to  
 13 you, dated May 24th, '05.  
 14 DR. WILLIAMS:  
 15 A. Uh-hm.  
 16 MS. TAYLOR:  
 17 Q. We've talked about this a bit already. Now  
 18 you answered previously that in your previous  
 19 background you would have had very little  
 20 knowledge, certainly from a clinical  
 21 perspective of ER/PR testing prior to becoming  
 22 aware of this issue in 2005, is that correct?  
 23 DR. WILLIAMS:  
 24 A. Yes.  
 25 MS. TAYLOR:

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1 Q. Okay, and I think that you had also testified  
 2 that you didn't know about the lab closure  
 3 that had occurred prior to seeing it in this  
 4 letter, when Dr. Ejeckam had shut down the lab  
 5 testing on this issue back in 2003?  
 6 MR. WILLIAMS:  
 7 A. There was some reference in 2003  
 8 correspondence, but I don't remember having  
 9 focused in or been alerted to that in my own  
 10 mind. I wasn't told at the time.  
 11 MS. TAYLOR:  
 12 Q. This was the first time that you would have  
 13 been focused in on it?  
 14 MR. WILLIAMS:  
 15 A. Yes.  
 16 MS. TAYLOR:  
 17 Q. Is that correct?  
 18 MR. WILLIAMS:  
 19 A. Yes.  
 20 MS. TAYLOR:  
 21 Q. Okay. Now, Dr. Cook provides a brief  
 22 explanation as to how the receptor status may  
 23 influence treatment. I'm just going to find  
 24 that, the top paragraph there on page two, and  
 25 according to this, "those patients that are

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1 ER/PR negative will be given chemotherapy with  
 2 its side effects much earlier in the course of  
 3 treatment. It's possible that the patient who  
 4 is ER and PR positive and responds favourably  
 5 to hormone manipulation may not require the  
 6 full chemotherapeutic regime." And the first  
 7 sentence, that "receptor status influences at  
 8 what stage chemotherapy will be given to a  
 9 patient." Now at this point, at least, you  
 10 would have been aware that if there's problems  
 11 with the test and therefore some of the test  
 12 results there could be cancer patients that  
 13 may have either missed out on treatment, i.e.  
 14 the hormone manipulation and/or received  
 15 incorrect or possibly unnecessary treatment.  
 16 Is that correct?  
 17 MR. WILLIAMS:  
 18 A. Yes, we would have.  
 19 MS. TAYLOR:  
 20 Q. Okay. Now in the third paragraph on that  
 21 page, when he's talking about one system, the  
 22 DAKO system, being replaced by the new Ventana  
 23 system, in the last paragraph he's saying "it  
 24 is my understanding that all previously  
 25 reported ER negative patients under the old

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1 manual technique had positive controls."  
 2 MR. WILLIAMS:  
 3 A. Yes.  
 4 MS. TAYLOR:  
 5 Q. Okay, but then in the next paragraph, towards  
 6 the end of the paragraph, he--first of all,  
 7 he's talking a bit about immunoperoxidase  
 8 staining and gives a bit more of an  
 9 explanation of it, but then he says that  
 10 "there are potential pitfalls to  
 11 immunoperoxidase stains. Many of these  
 12 pitfalls can be avoided by scrupulous quality  
 13 control, periodic checking of antibody  
 14 activity and proper use of negative and  
 15 positive controls."  
 16 Now when you read that, did that--did  
 17 your mind twig to any difference there that  
 18 "wait now, it's saying under the old method -  
 19 MR. WILLIAMS:  
 20 A. No, it didn't twig to anything different  
 21 there. I saw controls as controls and didn't  
 22 twig. You know, we're talking -  
 23 MS. TAYLOR:  
 24 Q. A difference between use of positive and  
 25 negative versus the positive.

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1 MR. WILLIAMS:  
 2 A. Yeah, you know, we're talking about it now in  
 3 retrospect obviously, but it didn't twig  
 4 anything in my mind at the time.  
 5 MS. TAYLOR:  
 6 Q. So it wasn't a difference that you questioned  
 7 or you would have asked Dr. Cook about at that  
 8 time?  
 9 MR. WILLIAMS:  
 10 A. No.  
 11 MS. TAYLOR:  
 12 Q. Okay. Now in terms of the recommendations  
 13 themselves there on the last page, the first  
 14 recommendation, the immediate establishment of  
 15 external proficiency testing and monitoring  
 16 program for immunoperoxidase testing, you had  
 17 said that you thought that this was already in  
 18 place, in terms of proficiency testing. You  
 19 would have thought -  
 20 MR. WILLIAMS:  
 21 A. I thought we had proficiency testing  
 22 throughout our organization, yes.  
 23 MS. TAYLOR:  
 24 Q. Right, and in the lab and in this portion of  
 25 the lab, you would have thought that there

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1 would have been proficiency testing?  
 2 MR. WILLIAMS:  
 3 A. I understood that we had proficiency testing  
 4 throughout our organization in the lab.  
 5 MS. TAYLOR:  
 6 Q. Is that an assumption that you are making or  
 7 had somebody told you that previously?  
 8 MR. WILLIAMS:  
 9 A. Oh, I'd been told that before, not with  
 10 respect to immunohistochemistry, but just in a  
 11 general sense.  
 12 MS. TAYLOR:  
 13 Q. A general sense?  
 14 MR. WILLIAMS:  
 15 A. Yes.  
 16 MS. TAYLOR:  
 17 Q. So whether or not it was specific to that -  
 18 MR. WILLIAMS:  
 19 A. No, it wouldn't -  
 20 MS. TAYLOR:  
 21 Q. - that certainly was your understanding?  
 22 MR. WILLIAMS:  
 23 A. That wouldn't have come up, in terms of the  
 24 specific issue.  
 25 MS. TAYLOR:

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1 Q. Now you said when you asked Dr. Cook about it,  
 2 that he described it as an island in the sea?  
 3 MR. WILLIAMS:  
 4 A. Yes.  
 5 MS. TAYLOR:  
 6 Q. Can you explain that reference for me?  
 7 MR. WILLIAMS:  
 8 A. That all around we had proficiency testing and  
 9 this area, there was not any.  
 10 MS. TAYLOR:  
 11 Q. And in terms of with Dr. Ejeckam and the--I  
 12 understand that you asked Dr. Cook to look  
 13 into the issue of why there was a stoppage in  
 14 the lab.  
 15 MR. WILLIAMS:  
 16 A. Yes.  
 17 MS. TAYLOR:  
 18 Q. Did you ask for any sort of written report?  
 19 MR. WILLIAMS:  
 20 A. No, I asked him to look at it. He didn't give  
 21 me a written report, and that's one report  
 22 he's given me, and other correspondence, but  
 23 no, I didn't ask for a written report at the  
 24 time.  
 25 MS. TAYLOR:

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1 Q. What would be your normal practice in terms of  
 2 when you're asking somebody to look into a  
 3 particular issue?  
 4 MR. WILLIAMS:  
 5 A. I would ask him to look into it and brief me  
 6 on what his findings were.  
 7 MS. TAYLOR:  
 8 Q. And you would take an oral briefing over a  
 9 written report?  
 10 MR. WILLIAMS:  
 11 A. I would take a--I took an oral briefing in  
 12 this case, yes.  
 13 MS. TAYLOR:  
 14 Q. Okay. Madame Commissioner, I'm going to get  
 15 into comparing some of this to another  
 16 document, so perhaps that would be a good  
 17 place to break at this time.  
 18 THE COMMISSIONER:  
 19 Q. All right. 9:30 in the morning. 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 20th day of May, 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 20th day of May, A.D., 2008  
 13 Judy Moss



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