

COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MAY 21, 2008

Appearances:

- Bernard Coffey, Q.C. Commission Co-counsel
- Sandra Chaytor, Q.C. Commission Co-counsel
- Rolf Pritchard/Megan Collins Her Majesty in Right of NL
- Peter Browne Doctors Kara Laing et al
- Daniel Simmons Eastern Regional Integrated
. Health Authority
- Pamela Taylor Members of the Breast Cancer
. Testing Class Action
- Mark Pike NL Medical Association
- Jennifer Newbury Canadian Cancer Society (NL Division)
- Stacey O’Dea. Central, Western and Labrador-Grenfell
. Regional Integrated Health Authorities

1 COMMISSIONER:
 2 Q. Please be seated.
 3 MS. TAYLOR:
 4 Q. Good morning, Commissioner.
 5 COMMISSIONER:
 6 Q. Good morning.
 7 DR. ROBERT WILLIAMS, EXAMINATION BY MS. PAMELA TAYLOR
 8 (CONTINUED)
 9 MS. TAYLOR:
 10 Q. Good morning, Mr. Williams.
 11 DR. WILLIAMS:
 12 A. Good morning.
 13 MS. TAYLOR:
 14 Q. Registrar, if we could please pull up Exhibit
 15 P-0113, page 5? Actually, if you could--yeah,
 16 page 5, please? Now, Dr. Williams, this is
 17 the memo to Terry Gulliver from Dr. Ejeckam
 18 dated June 19th, 2003.
 19 DR. WILLIAMS:
 20 A. Um-hm.
 21 MS. TAYLOR:
 22 Q. And you’ve gone through this before.
 23 DR. WILLIAMS:
 24 A. Yes.
 25 MS. TAYLOR:

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1 Q. I do have some questions on it, however.
 2 DR. WILLIAMS:
 3 A. Um-hm.
 4 MS. TAYLOR:
 5 Q. This is a memo that was cc’ed to a group of
 6 people, including, as I can see here on the
 7 last page of this memo, Dr. Cook?
 8 DR. WILLIAMS:
 9 A. Yes.
 10 MS. TAYLOR:
 11 Q. Who would have been the clinical chief, and he
 12 was site chief at St. Clare’s at that time?
 13 DR. WILLIAMS:
 14 A. Correct.
 15 MS. TAYLOR:
 16 Q. Okay. If I can go back to page 1 of that
 17 memo, which is page 5? Now, there are a
 18 number of things in here that Dr. Ejeckam
 19 indicates need to be looked at and that he
 20 thinks are unsatisfactory in terms of the
 21 state of immunostain at the General Hospital
 22 Department of Laboratory Medicine and
 23 Pathology.
 24 DR. WILLIAMS:
 25 A. Um-hm.

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1 MS. TAYLOR:
 2 Q. He talks about the--in bullet 1, "The physical
 3 location of the facility is unsatisfactory."
 4 He talks about it needing to be housed in a
 5 separate room with proper humidity control.
 6 He also talks about staff arrangement being
 7 grossly inadequate and a need in bullet 3 for
 8 dedicated staff to take over this special
 9 procedure, he refers to it as a special
 10 procedure. He refers, as well, to, in
 11 paragraph 5 on page 7 at the top. He's also
 12 referring to the fact that it's his
 13 understanding that some of the technologists
 14 would be retiring within the next two to three
 15 years, which would create a vacuum and another
 16 period of uncertainty in immunohistochemistry.
 17 And then with all of those points and other
 18 points he indicates that "Diagnosis based on
 19 inappropriate immunostain will shortly
 20 jeopardize patient care and may even expose
 21 the Health Care Corporation of St. John's to
 22 litigation." Now, as far as you're aware,
 23 because obviously you didn't see the memo back
 24 in 2003, we've covered that before.
 25 DR. WILLIAMS:

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1 A. Correct.
 2 MS. TAYLOR:
 3 Q. Are you aware of the recommendations that he
 4 outlined were implemented back in 2003?
 5 DR. WILLIAMS:
 6 A. My understanding what was done was the lab was
 7 moved to the place that it was designed to be
 8 moved to, which is the hormone assay section
 9 of our lab. That was done back in the fall of
 10 2003. The workload of the three techs was
 11 lessened in some other aspects, they weren't
 12 dedicated as they are now to performing only
 13 those functions.
 14 MS. TAYLOR:
 15 Q. Right, they weren't dedicated, though, because
 16 I think there's a reference -
 17 DR. WILLIAMS:
 18 A. No, they were not dedicated.
 19 MS. TAYLOR:
 20 Q. Right.
 21 DR. WILLIAMS:
 22 A. At the time their workload in other aspects of
 23 their work was lessened so they were more
 24 dedicated to immunohistochemistry, but not
 25 totally dedicated.

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1 MS. TAYLOR:
 2 Q. Right.
 3 DR. WILLIAMS:
 4 A. So there was some adjustment, I understand, of
 5 their workload. Now, Mr. Gulliver can clarify
 6 that for you when he testifies, but my
 7 understanding is that some of their other
 8 duties were reduced at the time. But they
 9 were still not dedicated when this issue
 10 surfaced in 2005 and we had the external
 11 reviews.
 12 MS. TAYLOR:
 13 Q. Right. And I think that in Trish
 14 Wegrynowski's, Ms. Wegrynowski's review, she
 15 had indicated that at that time the
 16 technologists were still on a rotation basis?
 17 DR. WILLIAMS:
 18 A. Yes. That changed, obviously, once we got the
 19 consultants' report and started the
 20 implementation process.
 21 MS. TAYLOR:
 22 Q. Right. But it hadn't changed back in 2003?
 23 DR. WILLIAMS:
 24 A. No, it had not changed back in 2003, you're
 25 correct.

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1 MS. TAYLOR:
 2 Q. Okay. There's also a reference in bullet 4,
 3 which is on page 2, and it refers to
 4 identifying the test as a special and unique
 5 service requiring financing and staffing.
 6 DR. WILLIAMS:
 7 A. Um-hm.
 8 MS. TAYLOR:
 9 Q. Now, if there were financing issues that were
 10 involved in implementing any of these steps,
 11 and it certainly is something that Dr. Ejeckam
 12 seems to suggest would be involved, is that
 13 something that you would have to be informed
 14 of, would you have to be involved in that
 15 process in order for budgetary decisions to be
 16 made?
 17 DR. WILLIAMS:
 18 A. The normal process is that if something is
 19 needed in the lab, we meet regularly, once a
 20 month. There's a budget process that starts
 21 in the fall of each year and goes into the
 22 spring until we make representation internally
 23 first to our own organization and try to get--
 24 we move things up from the lab budget up to
 25 the executive. And then at the executive

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1 level we try to deal with things because we
 2 know that the requests and demands are always
 3 more than we're going to get, so we have to
 4 try to fine tune those. Even then we make a
 5 lot of requests to government, given the
 6 funding situation, that they often cannot
 7 accede to. So that's the process. So there's
 8 a couple of steps that normally happen if you
 9 want to deal with something budgetary, you
 10 bring it forward in the normal budgetary
 11 process. If it's something that's urgent and
 12 has to be dealt with on an expeditious basis,
 13 then we have month--we'll have monthly
 14 meetings that I could, it could come up and
 15 then I could bring it forward to the executive
 16 if it was an issue.
 17 MS. TAYLOR:
 18 Q. But it would be brought forward to you as VP
 19 of medical services?
 20 DR. WILLIAMS:
 21 A. Yes, funding issues would usually come through
 22 me.
 23 MS. TAYLOR:
 24 Q. Right. And in this memo some of the things
 25 that Dr. Ejeckam is indicating would be

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1 necessary, he's indicating that, in his view,
 2 there would be financing or budgetary issues
 3 that would be involved in that. You would
 4 agree with that?
 5 DR. WILLIAMS:
 6 A. Yes.
 7 MS. TAYLOR:
 8 Q. Okay. So it leads me to a question. You had
 9 said yesterday that when you were asked, you
 10 know, why wouldn't it have been brought to
 11 your attention or would you have expected it
 12 would have been brought to your attention back
 13 in 2003, I think your answer was if it was--if
 14 they, meaning the people who were aware of the
 15 existence of the memo, felt it was necessary.
 16 But if there are budgetary issues in there,
 17 wouldn't it have to be brought to your
 18 attention for it to be considered?
 19 DR. WILLIAMS:
 20 A. To move it forward, yes, totally, forward.
 21 MS. TAYLOR:
 22 Q. Right. So if it was going to be moved forward
 23 at that time -
 24 DR. WILLIAMS:
 25 A. Well, I guess -

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1 MS. TAYLOR:
 2 Q. - you would have to be made aware of it?
 3 DR. WILLIAMS:
 4 A. - the individuals that were there at the time
 5 felt they'd resolved the issue at their level.
 6 That's my understanding.
 7 MS. TAYLOR:
 8 Q. Right.
 9 DR. WILLIAMS:
 10 A. So it wasn't brought forward.
 11 MS. TAYLOR:
 12 Q. Right. But in terms of feeling that it was
 13 resolved at that level, you've just indicated
 14 that the dedicated staffing didn't happen back
 15 in 2003?
 16 DR. WILLIAMS:
 17 A. No, it did not.
 18 MS. TAYLOR:
 19 Q. So there were at least some issues that hadn't
 20 been dealt with back in 2003?
 21 DR. WILLIAMS:
 22 A. Oh, yeah, there was issues that hadn't totally
 23 been dealt with. That's why when the
 24 consultants came in, there was some
 25 adjustments that we had to make.

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1 MS. TAYLOR:
 2 Q. Right.
 3 DR. WILLIAMS:
 4 A. And in October, on October, I think, sometime
 5 in October, 2005 after Dr. Banerjee had
 6 visited here and Trish Wegrynowski had visited
 7 here, there was a proposal put forward. I
 8 asked Dr. Cook and Mr. Gulliver to put forward
 9 a proposal to deal with some of the issues
 10 that had been identified early on so that we
 11 could get moving on them, yes.
 12 MS. TAYLOR:
 13 Q. Sure. And absolutely, it's just when I go
 14 back to the Dr. Ejeckam memo and that
 15 statement that "Diagnosis based on
 16 inappropriate immunostain will surely
 17 jeopardize patient care and may even expose
 18 the Health Care Corporation of St. John's to
 19 litigation." That was the situation, in Dr.
 20 Ejeckam's view, back in 2003?
 21 DR. WILLIAMS:
 22 A. Yes.
 23 MS. TAYLOR:
 24 Q. And those things, not all of them had been
 25 dealt with.

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1 DR. WILLIAMS:
 2 A. No. I can only tell you that what happened at
 3 the time.
 4 MS. TAYLOR:
 5 Q. Sure, right. But you weren't made aware of
 6 them?
 7 DR. WILLIAMS:
 8 A. I was not made aware of them.
 9 MS. TAYLOR:
 10 Q. Now, if we could go back to P-0067 and page 3?
 11 And when I look at the recommendations here,
 12 Dr. Williams, that Dr. Cook was making to you
 13 in 2005 when he informed you of this issue,
 14 No. 2, "The establishment of a separate
 15 immunoperoxidase service with at least three
 16 technologists solely dedicated to
 17 immunoperoxidase testing with separate testing
 18 facilities." That's really not that different
 19 from what Dr. Ejeckam was suggesting two years
 20 previous in the sense of dedicated
 21 technologists?
 22 DR. WILLIAMS:
 23 A. No, the issue was similar and that's the issue
 24 that, one of the themes that came up in the
 25 consultant's report.

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1 MS. TAYLOR:
 2 Q. Right.
 3 DR. WILLIAMS:
 4 A. That's one of the things we dealt with early
 5 on because, you know, you have to make a
 6 decision up front if you're going to deal with
 7 those things, are you going to move forward or
 8 not with the recommendations.
 9 MS. TAYLOR:
 10 Q. Sure. But two years previously it was already
 11 coming up inside of your organization?
 12 DR. WILLIAMS:
 13 A. We've talked about that before.
 14 MS. TAYLOR:
 15 Q. Yeah.
 16 DR. WILLIAMS:
 17 A. There was some issues came up and some of the
 18 issues got dealt with fully and some others
 19 did not get dealt with fully.
 20 MS. TAYLOR:
 21 Q. Right.
 22 DR. WILLIAMS:
 23 A. We finalized them in 2005.
 24 MS. TAYLOR:
 25 Q. There would have been people aware in your

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1 organization, even in 2003, it didn't
 2 necessarily have to be pointed out by an
 3 external reviewer that this was an issue, it
 4 was already seen to be an issue by at least
 5 one person who was referred to by Dr. Cook as
 6 the point man for immunoperoxidase testing in
 7 2003 and was still in that position,
 8 apparently, in 2005?
 9 DR. WILLIAMS:
 10 A. Um-hm.
 11 MS. TAYLOR:
 12 Q. I think he was referred to as the resource
 13 person for immunohistochemistry?
 14 DR. WILLIAMS:
 15 A. Um-hm.
 16 MS. TAYLOR:
 17 Q. Now, on that point, while Dr. Cook talked to
 18 Dr. Ejeckam, you had asked Dr. Cook to follow
 19 up with Dr. Ejeckam, you hadn't spoke to him
 20 yourself?
 21 DR. WILLIAMS:
 22 A. No.
 23 MS. TAYLOR:
 24 Q. When I look through the ongoing, I'm going to
 25 refer to it as an investigation, looking into

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1 the issue of ER/PR internally in terms of
 2 collecting slides, setting up testing, all of
 3 those sorts of things, there's a number of
 4 people that are involved in that, but Dr.
 5 Ejeckam certainly doesn't have a lot of
 6 involvement in that, and that's despite his
 7 2003 involvement and the fact that he was the
 8 point man for this particular type of testing.
 9 Is there any particular reason for that?
 10 DR. WILLIAMS:
 11 A. Well, getting the slides, you mean, sent of
 12 out the province, this type of thing?
 13 MS. TAYLOR:
 14 Q. Well, just even being involved in a discussion
 15 of the issue. He certainly seemed to be
 16 recognized as someone who had a level of
 17 knowledge in the organization on this issue?
 18 DR. WILLIAMS:
 19 A. Yes.
 20 MS. TAYLOR:
 21 Q. I would think that you'd be trying to collect
 22 together the best minds that you have to deal
 23 with an issue that you've referred to as the
 24 biggest issue that Eastern Health had dealt
 25 with and probably will deal with?

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1 DR. WILLIAMS:
 2 A. Um-hm.
 3 MS. TAYLOR:
 4 Q. So you'd want to collect together the best
 5 people that you could?
 6 DR. WILLIAMS:
 7 A. Um-hm.
 8 MS. TAYLOR:
 9 Q. So why wouldn't Dr. Ejeckam have had more of a
 10 role in that process?
 11 DR. WILLIAMS:
 12 A. Well, Dr. Cook did speak to him in some detail
 13 on a number of occasions just after this event
 14 surfaced in 2005. He talked to him in 2003 on
 15 the matter, is my understanding. And he
 16 talked to Dr. Robb, among other people, to get
 17 some other views involved at the time, too.
 18 MS. TAYLOR:
 19 Q. Right.
 20 DR. WILLIAMS:
 21 A. And based upon that there was no
 22 recommendation coming forward to retest, to do
 23 anything other than what was done in 2003.
 24 MS. TAYLOR:
 25 Q. Right. Now, if we could go, please, to P-

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1 0069? I just have a few questions for you on
 2 this, Dr. Williams. This is, again, a letter
 3 that you've already talked about previously,
 4 the July 14th, 2005 letter to Dr. Cook from
 5 Dr. Carter. Now, when I look at this, and you
 6 were asked a question on this previously. In
 7 the first paragraph she indicates "Factors
 8 identified on those slides," this is in
 9 reference, obviously, according to the earlier
 10 sentence, that 16 patients converted from
 11 estrogen receptor negative to estrogen
 12 receptor positive status. "Factors identified
 13 on those slides clearly show problems with the
 14 technique of estrogen receptor testing and the
 15 interpretation of same." Now, I think that
 16 you had indicated that you didn't recall
 17 speaking to Dr. Carter on this. But do you
 18 recall if you raised that issue with Dr. Cook?
 19 DR. WILLIAMS:
 20 A. I can't be sure -
 21 MS. TAYLOR:
 22 Q. Asking him what that means?
 23 DR. WILLIAMS:
 24 A. Yes. I had a number of, I know I had a number
 25 of meetings with Dr. Cook and Dr. Carter on

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1 the St. Clare's site just to, as we moved
 2 forward with this, but I can't--there's
 3 nothing in my notes to indicate what
 4 discussions were always held at the time, so
 5 I'm not sure how much discussion was held on
 6 this particular issue. What we did, this was
 7 a request to get additional resources and to
 8 help her do that, and I had a discussion with
 9 Dr. Cook about that, I know, because he would
 10 have wrote her back, which he did, Dr. Carter,
 11 and support her in moving forward on this.
 12 And subsequently, of course, that changed, but
 13 so I would have had discussion with Dr. Cook
 14 on that because he wouldn't have written the
 15 letter to Dr. Carter, he said, you know, we
 16 couldn't support that because there was some
 17 resources involved, this type of thing.
 18 MS. TAYLOR:
 19 Q. Right. But in terms of specifically whether
 20 or not you asked about this particular issue,
 21 you wouldn't have any recollection of that?
 22 DR. WILLIAMS:
 23 A. No, I didn't, and I don't know, I thought this
 24 was sort of a preliminary review and that she
 25 wanted really to investigate this more

Page 20

1 thoroughly.
 2 MS. TAYLOR:
 3 Q. Right.
 4 DR. WILLIAMS:
 5 A. And the letter was written, I think if you
 6 look thorough it all, it's requesting that,
 7 based upon her preliminary review, she'd like
 8 to do more work on it, and we did support her
 9 on it.
 10 MS. TAYLOR:
 11 Q. What about the next line, the next sentence
 12 that she, "I've been unable to review
 13 paperwork from 1997 to 2003 with regards to
 14 protocols, quality practice and controls."
 15 Did you ask any questions about that?
 16 DR. WILLIAMS:
 17 A. No. I just thought that that was, you know,
 18 some things she'd like to follow up on.
 19 MS. TAYLOR:
 20 Q. Okay.
 21 DR. WILLIAMS:
 22 A. I didn't see it that somebody was refusing her
 23 to do it or it wasn't available. I looked at
 24 her letter, to be honest with you, as a
 25 request for resources to carry out an

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1 investigation and would have talked to Dr.
 2 Cook about it.
 3 MS. TAYLOR:
 4 Q. Yeah.
 5 DR. WILLIAMS:
 6 A. Dr. Cook, subsequently replied and we followed
 7 up, I think, with Mr. Gulliver and maybe Mr.
 8 Dyer to make sure that those resources would
 9 be available.
 10 MS. TAYLOR:
 11 Q. Later, though, as you became more involved in
 12 the process, that's what you were thinking
 13 initially, but did you come to any knowledge
 14 or understanding in terms of the paperwork
 15 that would have been available during that
 16 period of time, 1997 to 2003, on protocols,
 17 quality practice and controls?
 18 DR. WILLIAMS:
 19 A. Well, I came to be aware, as we moved through
 20 the consultants' reports and that, especially
 21 Trish's, that some of the paperwork was not to
 22 the standard that they would have in Ontario.
 23 And there's also some question about the
 24 paperwork, we had a flood at the time, as
 25 well, that we lost a lot of material in.

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1 MS. TAYLOR:
 2 Q. Some of the paperwork wouldn't have been to
 3 the standard, but, for example, on protocols,
 4 was it actually even in existence? I mean,
 5 there were a number of recommendations made by
 6 Ms. Wegrynowski about putting protocols in
 7 place?
 8 DR. WILLIAMS:
 9 A. Yes, um-hm.
 10 MS. TAYLOR:
 11 Q. And the documentation wasn't there.
 12 DR. WILLIAMS:
 13 A. Yeah, the -
 14 MS. TAYLOR:
 15 Q. So did it actually even exist?
 16 DR. WILLIAMS:
 17 A. It didn't seem to be that we recorded
 18 everything in terms of controls and this type
 19 of thing.
 20 MS. TAYLOR:
 21 Q. Right.
 22 DR. WILLIAMS:
 23 A. And we needed to develop, as you can see, a
 24 policy and procedures manual, this type of
 25 thing, was one of the beginnings.

Page 23

1 MS. TAYLOR:
 2 Q. Right. So in terms of protocol, quality
 3 practice and controls, wasn't, it wasn't just
 4 that she couldn't see them, there's a good
 5 chance it didn't exist?
 6 DR. WILLIAMS:
 7 A. Yeah, in this, in this, I guess, letter, I
 8 didn't see it as saying that it did or didn't
 9 exist. It was a request -
 10 MS. TAYLOR:
 11 Q. Sure.
 12 DR. WILLIAMS:
 13 A. I took this letter as a request, let's do some
 14 more work, and can you get--I need resources
 15 to do that.
 16 MS. TAYLOR:
 17 Q. Right. And that's fine in that letter. But
 18 in terms of what you later came to know, you
 19 later came -
 20 DR. WILLIAMS:
 21 A. What we later came to know I think is laid out
 22 in the consultants' reports, basically.
 23 MS. TAYLOR:
 24 Q. Okay. Now, if I can go down a little bit
 25 further, in the second paragraph she's laying

Page 24

1 out what seems to be the plan of what she
 2 thinks needs to happen and what she feels that
 3 would be appropriate to do in this situation
 4 in terms of reviewing receptor status of
 5 patients. And sorry, seven lines down or six
 6 lines down she's saying, "All of the slides
 7 from the cases, including the estrogen
 8 receptor slides, need to be pulled and
 9 organized. All slides then need to be
 10 reviewed by me, both estrogen receptor
 11 negative and estrogen receptor positive
 12 patients. Estrogen receptor negative patients
 13 should be given priority." Looking at that,
 14 it seems to be, in my reading of it, that she
 15 contemplated a review of all patient receptor
 16 status, of all patients' receptor status, not
 17 just those that were negative?
 18 DR. WILLIAMS:
 19 A. It looks that way, yes.
 20 MS. TAYLOR:
 21 Q. Okay. Did you discuss that with Dr. Carter?
 22 DR. WILLIAMS:
 23 A. No, I didn't discuss it. Now, we may have
 24 discussed it, because I met with Dr. Cook and
 25 Dr. Carter on a number of occasions, but I'm

Page 25

1 not so sure I got down into, you know, that
 2 level.
 3 MS. TAYLOR:
 4 Q. Right.
 5 DR. WILLIAMS:
 6 A. What I was, I guess, discussing with Dr. Cook
 7 was he had a letter, he talked to me about it
 8 and the discussion really emanated around Dr.
 9 Carter will be going forward on this.
 10 MS. TAYLOR:
 11 Q. Right.
 12 DR. WILLIAMS:
 13 A. He supported her doing it and we needed to
 14 make sure we got her the resources to do it,
 15 and we started to do that.
 16 MS. TAYLOR:
 17 Q. Right.
 18 DR. WILLIAMS:
 19 A. And then, of course, subsequently she was not
 20 able to continue or she did not choose to
 21 continue.
 22 MS. TAYLOR:
 23 Q. But now in terms of a review that would
 24 involve both estrogen receptor negative and
 25 estrogen receptor positive patients, that's

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1 not what's actually done later?
 2 DR. WILLIAMS:
 3 A. No.
 4 MS. TAYLOR:
 5 Q. It's a focus on estrogen receptor negative
 6 patients?
 7 DR. WILLIAMS:
 8 A. The focus was on people who were negative to
 9 try to ascertain if we had missed false
 10 negatives.
 11 MS. TAYLOR:
 12 Q. Okay. So at that time she thought that that
 13 was important, so what happened in terms of
 14 the change in that respect?
 15 DR. WILLIAMS:
 16 A. Well, we were all involved--I don't know if it
 17 was a change. We were all involved in moving
 18 forward on the, focusing on the negative side.
 19 Nobody raised any flags at the time, we need
 20 to be doing people who are positive at the
 21 time. That's my understanding.
 22 MS. TAYLOR:
 23 Q. Okay.
 24 DR. WILLIAMS:
 25 A. I mean, Dr. Carter was doing--we were doing

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1 the retesting, Dr. Carter was doing maybe more
 2 of an investigation.
 3 MS. TAYLOR:
 4 Q. And that, but that didn't continue?
 5 DR. WILLIAMS:
 6 A. No.
 7 MS. TAYLOR:
 8 Q. Okay. And even though she was no longer
 9 involved in terms of a front person, in that
 10 investigation or in that process, even when
 11 she resigned, nobody else took up that role?
 12 DR. WILLIAMS:
 13 A. Nobody took up the investigation role because
 14 then we got an outside consultant to come in,
 15 two outside consultants to come in to review
 16 what was going on in a broad sense in
 17 immunohistochemistry, look at what the causes
 18 might have been and make some recommendations
 19 for us. In the process Dr. Carter, although
 20 she didn't take on that role, was working
 21 closely with Dr. Cook as an advisor in terms
 22 of what was going on and Dr. Cook relied on
 23 her input and advice on an ongoing basis. And
 24 as we moved through the process we made sure
 25 that Dr. Carter was involved in sort of the

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1 key decision making points.
 2 MS. TAYLOR:
 3 Q. Well, let's talk now about her resignation
 4 letter.
 5 COMMISSIONER:
 6 Q. Sorry, can I just clarify a point?
 7 MS. TAYLOR:
 8 Q. Sure.
 9 COMMISSIONER:
 10 Q. Before you move onto that question. Dr.
 11 Williams, I wasn't sure whether you were
 12 saying that when Dr. Carter choose not to
 13 carry on the quote, unquote, "investigative
 14 role" were you saying that you choose to go
 15 outside because of her decision or did they
 16 have anything to do with each other, were you
 17 going outside anyway?
 18 DR. WILLIAMS:
 19 A. I expect we would have went outside anyway
 20 because when you do an investigation, if you
 21 want to do an investigation of yourself, it's
 22 better to go outside to get somebody who is
 23 outside the organization and if you're working
 24 with people inside the organization and
 25 investigating them, it's hard to get in there

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1 and work with them and this type of thing. So
 2 if you're doing an investigation, be better to
 3 go outside.
 4 MS. TAYLOR:
 5 Q. And one last question then on that point. And
 6 this investigation, the outside investigation,
 7 that didn't contemplate looking at estrogen
 8 receptor negative and estrogen receptor
 9 positive?
 10 DR. WILLIAMS:
 11 A. It just looked at, contemplated, I guess,
 12 looking at the issue of immunohistochemistry
 13 services with particular emphasis on the ER
 14 and PR issue. It didn't say negative or--in
 15 the terms of reference.
 16 MS. TAYLOR:
 17 Q. But in terms of the slides being looked at,
 18 that wasn't something that was being done?
 19 DR. WILLIAMS:
 20 A. Well, the slides we were sending out was for
 21 retesting purposes.
 22 MS. TAYLOR:
 23 Q. Right. The negative ones?
 24 DR. WILLIAMS:
 25 A. Yes. And the literature was saying that the

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1 problem in ER and PR testing was the issue of
 2 false negatives.
 3 MS. TAYLOR:
 4 Q. P-0079, please, Registrar.
 5 MS. TAYLOR:
 6 Q. Now Dr. Cook, this--I'm sorry, Dr. Williams,
 7 this is a letter to Dr. Cook from Dr. Carter
 8 dated August 2nd, 2005, and this is that
 9 resignation letter when she steps back -
 10 DR. WILLIAMS:
 11 A. Yes.
 12 MS. TAYLOR:
 13 Q. - from the role that she's had.
 14 DR. WILLIAMS:
 15 A. Yes.
 16 MS. TAYLOR:
 17 Q. Now if I could just go down through a couple
 18 of things in this. I think that you had
 19 indicated on this, in terms of the receipt of
 20 the letter, that you had asked Dr. Cook
 21 whether or not--you know, did you need to step
 22 in and talk to Dr. Carter or is it something
 23 that he felt he could handle and he, I think

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1 based on the relationship that he had with Dr.
 2 Carter, he thought it was best for him to
 3 speak with her. Is that correct?
 4 DR. WILLIAMS:
 5 A. Well, I'll couch it in a little different
 6 terms.
 7 MS. TAYLOR:
 8 Q. Okay.
 9 DR. WILLIAMS:
 10 A. When I received the letter, I was concerned
 11 about its contents, so I asked Dr. Cook is
 12 there anything I could do. Should I talk--
 13 would it be a value for me to talk to Dr.
 14 Carter to see if she might change her mind and
 15 this type of thing.
 16 MS. TAYLOR:
 17 Q. Right.
 18 DR. WILLIAMS:
 19 A. He had a good working relationship with Dr.
 20 Carter and still does, and he said no, he'd
 21 talk to her and he didn't think--he was pretty
 22 sure it wouldn't be any value for me to talk
 23 to her at the time, but that she was--had
 24 indicated to him that she would continue in
 25 her role with him of helping him deal with

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1 this issue and providing advice as we moved
 2 forward.
 3 MS. TAYLOR:
 4 Q. That's on the issue of her role and whether or
 5 not she's going to be involved, or I guess,
 6 change her mind about being involved. But
 7 let's talk about some of the contents of the
 8 actual letter itself. In the second
 9 paragraph, she's indicating that there was a
 10 meeting with George Tilley on August 1st, 2005
 11 and it showed, in her opinion, that "Mr. Terry
 12 Gulliver and Mr. Barry Dyer do not have a good
 13 understanding of the limitations of automated
 14 immunohistochemistry, rigorous clinical and
 15 technical validation of antibodies" and it
 16 goes on from there. She's questioning the
 17 level of knowledge that Terry Gulliver and Mr.
 18 Barry Dyer have in relation to this process.
 19 DR. WILLIAMS:
 20 A. Um-hm.
 21 MS. TAYLOR:
 22 Q. And that actually is repeated a little bit
 23 further on actually in the last paragraph on
 24 that page. She says that Mr. Terry Gulliver,
 25 "it's his responsibility to provide high

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1 quality service and document the performance
 2 of same with respect to the testing." There's
 3 also a reference, if I can find it for you,
 4 there's a reference as well, Dr. Carter saying
 5 that "the ER/PR status was currently remaining
 6 in the hands of para-professional staff within
 7 the laboratory." When you saw those comments,
 8 did that raise any--did that set off any alarm
 9 bells for you in terms of, you know, Dr.
 10 Carter was a breast--and is a breast
 11 pathologist, so she has a subspecialty in that
 12 area. You would anticipate that she would
 13 have a high level of knowledge about this
 14 test. She's somebody obviously whose opinion
 15 was valued and whose opinion Dr. Cook valued,
 16 and she's expressing--this is her opinion in
 17 terms of the people that are actually in
 18 charge of the lab. Did that raise any alarm
 19 bells for you?
 20 DR. WILLIAMS:
 21 A. Well, there was some issues of concern, sure,
 22 and I discussed them with Mr. Tilley, this
 23 type of thing, but also, in terms of this
 24 issue, some of the consultants brought up the
 25 organization structure and how in

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1 immunohistochemistry, we might look for a
 2 triangular structure to make sure that there
 3 was no confusion on who made the final
 4 decisions, in terms of these issues.
 5 Also, I noted at the meeting there was a
 6 disagreement on the issue of what had caused
 7 the problem. There was some concern, some
 8 statements expressed that it was just due to
 9 new technology, which really some people
 10 thought maybe that was the issue, but Dr.
 11 Carter felt that the issue was not this new
 12 technology, but the fact that with the
 13 technology we had previously, we should have
 14 gotten better results, this type of thing.
 15 MS. TAYLOR:
 16 Q. Who thought it was new technology?
 17 DR. WILLIAMS:
 18 A. Well -
 19 MS. TAYLOR:
 20 Q. Who thought it was an issue?
 21 DR. WILLIAMS:
 22 A. Mr. Gulliver was saying that some of this was
 23 new technology, but you know, Dr. Carter felt
 24 that it wasn't just new technology. It was
 25 the fact that we could have done better with

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1 the testing results that we--with the
 2 equipment that we had and the approach that we
 3 used. So I know we discussed it with Dr. Cook
 4 and Mr. Gulliver, and that, you know, we did
 5 make some changes to the structure in
 6 immunohistochemistry and it's also something
 7 that, on the long term, we've made some
 8 adjustments to how the lab is organized. We
 9 had what we call a program based structure
 10 that had come into place in the Health Care
 11 Corporation in 2005 which had two streams of
 12 management responsibility. On further
 13 reflection and looking at everything that had
 14 happened and the consultants' reports, a
 15 number of changes were made in how that lined
 16 up, and now in terms of immunohistochemistry,
 17 there's a triangular relationship with the
 18 pathologist at the top of the triangle, the
 19 techs here and other pathologists over here.
 20 So that everything has to go through that -
 21 MS. TAYLOR:
 22 Q. To the pathologist.
 23 DR. WILLIAMS:
 24 A. - pathologist who makes the final decisions
 25 there, and that's Dr. Elms right now.

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1 Number two is that the structure was
 2 changed in the lab and that the head person in
 3 the lab now is now your clinical chief who has
 4 full authority in the lab. So the management
 5 structure is changed somewhat to have Mr.
 6 Gulliver reporting to that person, in terms of
 7 quality. That person, the medical person, has
 8 responsibility for all aspects of quality and
 9 all aspects of pathology, physician side of
 10 the lab. Mr. Gulliver, I understand, has
 11 responsibilities for budget, staffing, this
 12 type of thing, but that the final authority
 13 rests in the clinical chief.
 14 MS. TAYLOR:
 15 Q. Mr. Gulliver and Mr. Dyer were fairly involved
 16 in this process, even after this point. Was
 17 there ever a time when you spoke with Dr. Cook
 18 or spoke with Mr. Gulliver about the concerns
 19 that had been expressed in this particular
 20 letter, in terms of whether or not, you know,
 21 to satisfy yourself do they have a good
 22 understanding, do Mr. Dyer and Mr. Gulliver
 23 have a good understanding of this process?
 24 Was there any discussions like that?
 25 DR. WILLIAMS:

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1 A. There were some discussions in follow up to
 2 Dr. Carter's--now I can't--I haven't got the
 3 documentation on them, but you know, we moved
 4 to making sure that the final decision rested
 5 with the pathologist and subsequently, for the
 6 whole lab, the final decision rested with the
 7 medical leadership.

8 MS. TAYLOR:
 9 Q. Now in the last paragraph in that letter, she
 10 says that she "regrets not being able to
 11 participate fully in this process, but am very
 12 uncomfortable placing my professional
 13 licensure in the forefront of this operation
 14 and risking my reputation locally, nationally
 15 and internationally as an expert in breast
 16 pathology." Did that set off any alarm bells
 17 for you?

18 DR. WILLIAMS:
 19 A. Sure, at the time, like I say, we moved to
 20 change the structure in that particular
 21 section of the lab and in the long term, we
 22 changed the structure in the lab completely.
 23 That's a structure we still have in Eastern
 24 Health, program based structure, but that
 25 structure was modified for the lab.

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1 MS. TAYLOR:
 2 Q. So the structure, did the structure change
 3 right after this and then there were more
 4 changes after the external reviews or was it
 5 after -

6 DR. WILLIAMS:
 7 A. No, the structure changed after the external
 8 reviews and after some further thought
 9 process, yes.

10 MS. TAYLOR:
 11 Q. Now if I could, Registrar, if we could go to
 12 P-0411?

13 THE COMMISSIONER:
 14 Q. Just let me interrupt -

15 MS. TAYLOR:
 16 Q. Sure.

17 THE COMMISSIONER:
 18 Q. - once again, just to make sure I understood
 19 this. Dr. Williams, regarding the structure
 20 in the lab, we're dealing with events from
 21 1997 onward.

22 DR. WILLIAMS:
 23 A. Um-hm.

24 THE COMMISSIONER:
 25 Q. Over a decade really, and the structure in the

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1 lab, are we dealing with two different
 2 structures or are we dealing with three
 3 different structures in the lab over that
 4 period of time?

5 DR. WILLIAMS:
 6 A. Basically, the structure now is different than
 7 it was, so it's really two different
 8 structures. The program--prior to the Health
 9 Care Corporation being formed in 1995, each of
 10 the labs in St. John's had different
 11 structures.

12 THE COMMISSIONER:
 13 Q. Okay.

14 DR. WILLIAMS:
 15 A. In 1995, when Sister Elizabeth Davis took
 16 over, there was discussion about how they were
 17 going to provide for management within the
 18 Health Care Corporation of St. John's, and
 19 that program based structure was put in in
 20 1995/96, and that's the structure that was in
 21 place until it was changed. So there was one
 22 structure. Now we have a different structure
 23 in the lab.

24 THE COMMISSIONER:
 25 Q. Okay.

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1 DR. WILLIAMS:
 2 A. The same structures are still in place in
 3 other programs.

4 THE COMMISSIONER:
 5 Q. Yes.

6 DR. WILLIAMS:
 7 A. The lab was changed.

8 THE COMMISSIONER:
 9 Q. Okay, and the lab was changed following your
 10 receipt of the recommendations from the -

11 DR. WILLIAMS:
 12 A. Well, the lab was changed -

13 THE COMMISSIONER:
 14 Q. - external reviewers?

15 DR. WILLIAMS:
 16 A. For immunohistochemistry, it was changed early
 17 on with the triangular type relationship. For
 18 the overall structure, it was changed after I
 19 left. After I left, I was reflecting on this
 20 issue and I did write Dr. Howell that I
 21 thought probably some thought should be given.
 22 I discussed that with Dr. Flynn, who is the--
 23 took over from Dr. Richardson in the quality
 24 management program in Ontario and looked, and
 25 asked him what kind of structures they had in

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1 Ontario with respect to their labs and there
 2 was a variety of structures. There was no one
 3 structure, but based on those discussions and
 4 what had come out over the time frame here, I
 5 felt that the structure in the lab might need-
 6 -should change.
 7 THE COMMISSIONER:
 8 Q. So what we have is a structure that was put in
 9 place when Health Care Corp -
 10 DR. WILLIAMS:
 11 A. Came in.
 12 THE COMMISSIONER:
 13 Q. - was formed?
 14 DR. WILLIAMS:
 15 A. Yes.
 16 THE COMMISSIONER:
 17 Q. And that structure within the lab system
 18 continued on until there was a change in the
 19 structure following your departure from the
 20 organization, with the exception of one area
 21 of the lab.
 22 DR. WILLIAMS:
 23 A. That changed, yes.
 24 THE COMMISSIONER:
 25 Q. The IHC area?

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1 DR. WILLIAMS:
 2 A. Yes.
 3 THE COMMISSIONER:
 4 Q. And that would have--can you be a little more
 5 precise about in what time frame that change
 6 would have been made?
 7 DR. WILLIAMS:
 8 A. That change in the structure was made, I
 9 think, in October of 2005 in
 10 immunohistochemistry. There should be a
 11 letter in the documentation that you have that
 12 went from Dr. Cook to Dr. Ejeckam outlining
 13 that. I think Mr. Coffey already asked me
 14 about that.
 15 THE COMMISSIONER:
 16 Q. Yes, I have vague memory myself of that, but I
 17 just--okay, just wanted for the purpose of
 18 this discussion. All right, thank you.
 19 DR. WILLIAMS:
 20 A. Mr. Coffey, I think, asked me about that
 21 before and we discussed it before. That's my
 22 recollection.
 23 THE COMMISSIONER:
 24 Q. I'm sure he'll find it. Thank you.
 25 MS. TAYLOR:

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1 Q. Registrar, P-0411. Now again, Dr. Williams,
 2 this is another memo that you've been asked
 3 some questions on before. It's a memo that's
 4 directed to you, Mr. Tilley, Ms. Pat Pilgrim,
 5 Ms. Pam Elliott from Heather Predham, and it's
 6 dated July 4th, 2006.
 7 Now it's--one of the issues that's
 8 discussed in here is the significance of
 9 ductal carcinoma in situ, or DCIS.
 10 DR. WILLIAMS:
 11 A. Yes.
 12 MS. TAYLOR:
 13 Q. And this information suggests that there's no
 14 reason, and it says there in the first full
 15 paragraph under bullet one, that there's no
 16 reason to test ER/PR status of individuals
 17 with DCIS.
 18 DR. WILLIAMS:
 19 A. Um-hm.
 20 MS. TAYLOR:
 21 Q. Now Heather Predham is--well, she's part of
 22 the quality department and she's a risk
 23 manager. Is that a fair characterization?
 24 That's what we've understood.
 25 DR. WILLIAMS:

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1 A. Well, she was the leadership at the time and
 2 then leadership changed in 2005 when we had
 3 Eastern Health. So that she was assistant
 4 director for quality and risk management at
 5 the time this was done.
 6 MS. TAYLOR:
 7 Q. Now her background is a nursing background?
 8 DR. WILLIAMS:
 9 A. She has a nursing background and had spent--
 10 first when I met her, she was in this area of
 11 quality and risk management, when I first met
 12 her.
 13 MS. TAYLOR:
 14 Q. Do you know if she had any particular
 15 expertise in DCIS or in cancer in general?
 16 DR. WILLIAMS:
 17 A. No, she would not have. She would read--
 18 obviously reading the literature as they moved
 19 forward here.
 20 MS. TAYLOR:
 21 Q. Would it be unusual--it seems unusual that a
 22 memo would come from a risk management person
 23 instead of from a clinical expert outlining an
 24 issue like this.
 25 DR. WILLIAMS:

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1 A. Well, she was working on this file and
 2 following up on the retesting, so she just
 3 wrote a memo saying that here's some issues
 4 that have come up in the retesting thing and
 5 that we need to follow up on and resolve.
 6 MS. TAYLOR:
 7 Q. But would you--normally though, an explanation
 8 of an issue like this, wouldn't it come from
 9 somebody that would have a specialty or
 10 knowledge, a medical background in that field?
 11 DR. WILLIAMS:
 12 A. Well, it's a comment she made, but she was the
 13 one that was tasked with following up and she
 14 was bringing it to our attention that this
 15 issue had come to light and it was something
 16 that we needed to follow up on. So, you know,
 17 she made a comment. I see it as ductal
 18 carcinoma in situ, there's some issues arising
 19 here. We need to follow up on those.
 20 MS. TAYLOR:
 21 Q. Was there any--I don't see anything attached
 22 to it. Would there have been any supporting
 23 clinical documentation that would have been
 24 attached to that or that would be the extent
 25 of that memo, the two pages?

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1 DR. WILLIAMS:
 2 A. I don't know if there was any patient issues
 3 attached, numbers or not. I'm not sure.
 4 Subsequently, I know what happened. We did
 5 have a number of around 50 that we needed to
 6 follow up on. If you look at the literature,
 7 again, as we're finding so much in this
 8 particular area, there's no 100 percent
 9 consensus on do--some people were sending
 10 patients with known DCIS for retesting.
 11 MS. TAYLOR:
 12 Q. Right, and actually I have a couple questions
 13 on that. First of all, you agreed with the
 14 conclusion that there was no reason to retest
 15 ER/PR status of DCIS patients? Ultimately,
 16 they weren't retested.
 17 DR. WILLIAMS:
 18 A. Yeah, I -
 19 MS. TAYLOR:
 20 Q. They were just put to the side.
 21 DR. WILLIAMS:
 22 A. - I wouldn't be in a position to conclude
 23 whether they should or they shouldn't. The
 24 question we had here was that we wanted to
 25 make sure that, in fact, they were ductal

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1 carcinoma in situ or were not some other
 2 diagnosis that we needed to follow up on or
 3 confirm. So we wanted to--we really needed to
 4 find out what the status of those patients
 5 were.
 6 MS. TAYLOR:
 7 Q. But there were samples sent -
 8 DR. WILLIAMS:
 9 A. Yes.
 10 MS. TAYLOR:
 11 Q. - to Mount Sinai of people who were ER
 12 negative but DCIS cases.
 13 DR. WILLIAMS:
 14 A. Yes.
 15 MS. TAYLOR:
 16 Q. So originally, those individuals had been
 17 tested. Their ER/PR status had been tested.
 18 DR. WILLIAMS:
 19 A. Correct, yes.
 20 MS. TAYLOR:
 21 Q. And presumably a physician orders the test?
 22 DR. WILLIAMS:
 23 A. Yes, that's right.
 24 MS. TAYLOR:
 25 Q. So presumably, the physician ordering the test

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1 felt it was relevant to determine the
 2 appropriate treatment for that particular
 3 patient.
 4 DR. WILLIAMS:
 5 A. Um-hm.
 6 MS. TAYLOR:
 7 Q. Right, and you had said that there's not a
 8 consensus as to whether or not you test -
 9 DR. WILLIAMS:
 10 A. I've been able to see that some people might
 11 differ on that.
 12 MS. TAYLOR:
 13 Q. Right.
 14 DR. WILLIAMS:
 15 A. Whether--you know, and we wanted to make sure
 16 that, in fact, ductal carcinoma was ductal
 17 carcinoma or if it was some other diagnosis
 18 that we wanted to be sure of.
 19 MS. TAYLOR:
 20 Q. But in terms of retesting the ER/PR status, if
 21 the physician ordering the test originally
 22 thought that it was appropriate to test for
 23 ER/PR status, why not just retest them and
 24 send that information back to the physician to
 25 allow them to decide if it had any impact on

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1 treatment versus making a unilateral decision
 2 not to retest?
 3 DR. WILLIAMS:
 4 A. I guess they were retested on that basis.
 5 They'd been previously retested. They'd been
 6 retested again and the results were going
 7 back. It raised the question because people
 8 were wondering if some of those patients were
 9 invasive carcinomas that the diagnosis had
 10 been made by us as invasive, but they were
 11 ductal carcinoma. So we needed to check that.
 12 MS. TAYLOR:
 13 Q. So all of the DCIS cases would have been
 14 retested?
 15 DR. WILLIAMS:
 16 A. Any case that was tested before was sent for
 17 retesting. That's my understanding.
 18 MS. TAYLOR:
 19 Q. And were retested?
 20 MR. WILLIAMS:
 21 A. Retested. That's my understanding, yes.
 22 THE COMMISSIONER:
 23 Q. On the basis of being negative or on the basis
 24 of being DCIS?
 25 MR. WILLIAMS:

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1 A. On the basis of being negative, nothing to do
 2 with the DCIS diagnosis. Anybody who was sent
 3 for ER/PR and came back as negative was sent
 4 up for retesting again. The issue of -
 5 THE COMMISSIONER:
 6 Q. That was my understanding.
 7 MR. WILLIAMS:
 8 A. Yes.
 9 THE COMMISSIONER:
 10 Q. Up until now, but I got confused then.
 11 MR. WILLIAMS:
 12 A. No, that's my understanding too.
 13 THE COMMISSIONER:
 14 Q. So the decision to make it go, to send a block
 15 onward was based on the original finding of ER
 16 positive versus ER negative, leaving aside for
 17 the moment what that ER positive and ER
 18 negative mean, but -
 19 MR. WILLIAMS:
 20 A. Yes.
 21 THE COMMISSIONER:
 22 Q. - on the basis of negativity -
 23 MR. WILLIAMS:
 24 A. Yes.
 25 THE COMMISSIONER:

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1 Q. - that's what sent it on, not on the basis of
 2 any diagnosis of a particular kind of cancer?
 3 MR. WILLIAMS:
 4 A. Correct, and when it came back, then some--you
 5 know, it was not total agreement, as far as we
 6 knew, that DCIS would be tested at all.
 7 MS. TAYLOR:
 8 Q. Because the -
 9 MR. WILLIAMS:
 10 A. So we checked.
 11 MS. TAYLOR:
 12 Q. - the second paragraph says there, "of the
 13 results returned from Mount Sinai, there were
 14 ones that Mount Sinai did not retest as they
 15 diagnosed them as being DCIS."
 16 MR. WILLIAMS:
 17 A. Yeah.
 18 MS. TAYLOR:
 19 Q. So there were some that were sent.
 20 MR. WILLIAMS:
 21 A. Yes, Mount Sinai would not do ductal carcinoma
 22 in situ because it was--treatment wasn't based
 23 on that for ductal carcinoma in situ. That's
 24 my understanding.
 25 MS. TAYLOR:

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1 Q. But if -
 2 MR. WILLIAMS:
 3 A. We didn't go back and say well, this is ductal
 4 carcinoma. We won't send it up for retesting.
 5 MS. TAYLOR:
 6 Q. No.
 7 MR. WILLIAMS:
 8 A. But we did send everything up for retesting.
 9 MS. TAYLOR:
 10 Q. But you didn't--Mount Sinai wasn't contacted
 11 to say well, retest them anyway, because they
 12 were tested in the first place, retest them
 13 anyway. Was the decision from Mount Sinai
 14 that these don't need to be retested?
 15 MR. WILLIAMS:
 16 A. Yes, that would be their decision based on
 17 what they do.
 18 MS. TAYLOR:
 19 Q. And Eastern Health, were there individuals
 20 within Eastern Health who would make decisions
 21 on this agreed with it?
 22 MR. WILLIAMS:
 23 A. Yes, the panel. Looks like the panel reviewed
 24 those.
 25 MS. TAYLOR:

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1 Q. And no further action then. Yes, it says
 2 that. Reviewed the original pathology report.
 3 If that report diagnosed the person as having
 4 DCIS, then there was no further action
 5 required. So there was no further retesting?
 6 MR. SIMMONS:
 7 Q. Commissioner, if I might, I think as we
 8 progress through other witnesses who were more
 9 closely involved, we may find that there was
 10 some degree of communication back and forth
 11 with Mount Sinai on this issue, and I don't
 12 know if Dr. Williams would have been involved
 13 or aware of that.
 14 THE COMMISSIONER:
 15 Q. Well, perhaps we can ask him whether he was.
 16 MR. WILLIAMS:
 17 A. I was not aware of other--I was not aware that
 18 there was any issues involved in this
 19 approach. Nobody brought that to my
 20 attention. The main thing that was brought to
 21 my attention was that there was a problem in
 22 some cases here when we double panelled and
 23 Dr. Carter and Dr. Cook did most of the
 24 reviews just to make sure that there was some
 25 people who were really ductal carcinoma in

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1 situ but had been sent up because the
 2 diagnosis had been invasive cancer, you know,
 3 invasive cancer, and that they would have a
 4 different treatment than they would if it was
 5 ductal carcinoma in situ, and we uncovered a
 6 number of those patients and disclosed to
 7 those patients. That's -
 8 MS. TAYLOR:
 9 Q. Right -
 10 MR. WILLIAMS:
 11 A. - the result of this.
 12 MS. TAYLOR:
 13 Q. - and beyond that, in terms of DCIS cases and
 14 testing or retesting, that's something that
 15 you're saying the panel would have been
 16 involved in, but you wouldn't have?
 17 MR. WILLIAMS:
 18 A. No, I wouldn't have got the level--you know, I
 19 have--these are the people, the oncologists
 20 are the people that are treating people with
 21 breast cancer. They're the ones that are
 22 knowledgeable. I would rely on their advice.
 23 Our concern with DCIS was that there were some
 24 people who were felt to be DCIS who were felt
 25 to be invasive carcinoma in situ, but were

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1 diagnosed here as DCIS and when we double
 2 checked those, there was a number in that
 3 category. Three from Eastern Health's area, I
 4 know that, that were--that we had to disclose
 5 information to.
 6 MS. TAYLOR:
 7 Q. They weren't -
 8 MR. WILLIAMS:
 9 A. Because it affected their -
 10 MS. TAYLOR:
 11 Q. Yeah, they weren't DCIS.
 12 DR. WILLIAMS:
 13 A. No, they were not DCIS, they were invasive, so
 14 that's the issue that arose from that area.
 15 MS. TAYLOR:
 16 Q. Registrar, P-1368? Now, Dr. Williams, this is
 17 a document, well it's the physician panel
 18 meeting, the first one on October 13th, 2005.
 19 And you were asked, I think a general question
 20 about the panel, you had sent out a letter to
 21 people, you felt that it was, I think you said
 22 in the letter "an excellent suggestion" in
 23 terms of having the panel, and thanking, I
 24 think, people for being involved in that?
 25 DR. WILLIAMS:

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1 A. Well the suggestion came from Dr. Kwan and Dr.
 2 Laing and Dr. Kwan is a surgical oncologist
 3 that has been dealing with these issues for at
 4 least 30 years in our organization. Dr. Laing
 5 had a lead role in medical oncology in the
 6 cancer clinic and subsequently with our
 7 organization and based upon their advice and
 8 suggestions in this situation which was
 9 somewhat unique, that I felt that was a good
 10 idea.
 11 MS. TAYLOR:
 12 Q. And you would have been, obviously you're
 13 recorded as one of the people being in
 14 attendance at that meeting.
 15 DR. WILLIAMS:
 16 A. I went to the meeting to thank them,
 17 basically.
 18 MS. TAYLOR:
 19 Q. Right. Did you stay there for the whole
 20 meeting?
 21 DR. WILLIAMS:
 22 A. No, I did not.
 23 MS. TAYLOR:
 24 Q. Okay. I did want to ask you a couple of
 25 questions on it, however, on that first page,

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1 under "Mandate of Panel" in the paragraph
 2 "Discussion ensued as to who would be
 3 notified"--there's discussion there in terms
 4 of who would be notified. "All agreed that
 5 the referring physician should be notified and
 6 that the primary cancer treating physician
 7 will be responsible for follow up of the
 8 recommendations from the panel. Notification
 9 will be in writing and a mechanism will be put
 10 in place to confirm that the follow up
 11 physician has received notification." Now,
 12 whose responsibility would it have been to set
 13 up this mechanism to confirm that the follow
 14 up physician had indeed received notification
 15 in writing from the panel, do you know?
 16 DR. WILLIAMS:
 17 A. I would expect that once the things were sent
 18 out, it would probably be quality to follow
 19 up, that would be my expectation.
 20 MS. TAYLOR:
 21 Q. Now we've since learned from other witnesses
 22 that have testified here that Eastern Health
 23 is in the process of doing a review of letters
 24 that were sent out to the physicians to ensure
 25 that in actual fact patients were contacted,

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1 that the information had been passed along.
 2 That would suggest to me that whatever
 3 mechanism was put in place at the time, didn't
 4 exactly work.
 5 DR. WILLIAMS:
 6 A. My understanding that late in September of--
 7 August of 2006--no, September of 2006 the
 8 organization became aware of a number of areas
 9 where follow up did not, as anticipated, did
 10 not seem to take place and I understand at
 11 that time that there was going to be follow up
 12 in the fall of 2006 with physicians, that was
 13 my understanding when I left the organization.
 14 MS. TAYLOR:
 15 Q. What exactly was the panel going to do? What
 16 sort of documentation would they have and what
 17 would they do?
 18 DR. WILLIAMS:
 19 A. The panel, to my understanding, would have
 20 patient records, be able to review those,
 21 even, I think they got the records sent in
 22 from outside, that's my understanding; would
 23 look at the results, whether the results
 24 changed, number one; number two, if the
 25 results had changed and taking into

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1 consideration everything else because it's an
 2 individual, I understand it, consideration,
 3 that they would make a recommendation to the
 4 physician about what course of action needed
 5 to be undertaken.
 6 MS. TAYLOR:
 7 Q. Would they have these records prior to the
 8 actual meeting, do you know?
 9 DR. WILLIAMS:
 10 A. I understood that you would have to--that's my
 11 understanding, you'd have to ask somebody who
 12 was at the meeting as to, I think they had the
 13 charts there, yes, that's my understanding.
 14 MS. TAYLOR:
 15 Q. At the meeting -
 16 DR. WILLIAMS:
 17 A. Information.
 18 MS. TAYLOR:
 19 Q. Would they have the charts before the meeting?
 20 Would the particular individuals have the
 21 charts before the meetings?
 22 DR. WILLIAMS:
 23 A. You would have to ask, I can't answer that
 24 question specific, I know the charts were
 25 being made available at, I think for sure at

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1 the meeting, I'm not sure before the meeting,
 2 you would have to ask Dr. Laing, probably
 3 would be the person that you would have to ask
 4 her on that when she testifies.
 5 MS. TAYLOR:
 6 Q. And you think that the charts, if there
 7 weren't--because there were patients outside
 8 of the St. John's, area.
 9 DR. WILLIAMS:
 10 A. My understanding is that medical information
 11 would have been made available to the panel,
 12 that's my understanding. You would have to
 13 clarify that again with somebody who was at
 14 the meetings. I only attended the meeting to
 15 start the ball rolling and to thank people for
 16 doing it and assured them of the support of
 17 the organization as they carried out their
 18 work.
 19 MS. TAYLOR:
 20 Q. Now, you thought it was an excellent
 21 suggestion, so obviously you agreed with this
 22 creation of the panel.
 23 DR. WILLIAMS:
 24 A. Yes.
 25 MS. TAYLOR:

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1 Q. Is it a generally accepted model of
 2 physician/patient relationship to treat
 3 patients by recommendation of a panel?
 4 DR. WILLIAMS:
 5 A. This was a unique situation and I'm sure if
 6 you put yourself in the position of a
 7 physician, you had a test that had been done
 8 some years previously coming back and it
 9 changed, that may require a change in the
 10 treatment, that you're probably going to go
 11 and seek other opinions before you do that.
 12 It's just an unique situation that I thought
 13 the people who we were working with and had
 14 quite a bit of experience in this area had
 15 made a suggestion and it seemed to be a
 16 reasonable suggestion. These are the people
 17 that are going to have to deal with the
 18 situation, as individuals for their own
 19 patients, and so, they felt by getting
 20 together an expert panel of people who were
 21 involved in this area, that that would be a
 22 beneficial help to physicians who were
 23 required to follow up.
 24 MS. TAYLOR:
 25 Q. But the panel didn't necessarily include a

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1 member who was clinically involved in treating
 2 the patient actually being reviewed?
 3 DR. WILLIAMS:
 4 A. No, that's correct. The ultimate decision,
 5 obviously, to be left with the treating
 6 physician, but the physician would get the
 7 information with a recommendation from the
 8 panel, that's my understanding.
 9 MS. TAYLOR:
 10 Q. But the recommendation is already made, the
 11 input is not there at that time from the
 12 treating physician.
 13 DR. WILLIAMS:
 14 A. No, the treating physician would take the
 15 recommendation and go and make a phone call
 16 and go back and say, look, I've got this
 17 recommendation from the panel and I need to
 18 talk to you about this, or this type of thing.
 19 They could always choose to do that, it wasn't
 20 mandatory for them to -
 21 MS. TAYLOR:
 22 Q. Well what about a chart review with no
 23 clinical discussion with the actual patient?
 24 It seems a little unusual -
 25 DR. WILLIAMS:

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1 A. Yeah, well I think, obviously, that the
 2 discussion with the patient would take place
 3 between the physician who is responsible for
 4 the patient's care and the patient when they
 5 disclosed to the patient.
 6 MS. TAYLOR:
 7 Q. And what about having a risk manager on a
 8 panel like this? What role does a risk
 9 manager play in terms of deciding patient
 10 care?
 11 DR. WILLIAMS:
 12 A. The risk manager was not to provide any input
 13 into patient care; the risk manager's role was
 14 to get the information, try to get together to
 15 be a support for the panel. We had a
 16 secretarial support and we had Ms. Predham,
 17 who had been involved all along in it, to
 18 bring together the information that was
 19 needed, get the reports that had come back
 20 together, so it was a resource person to the
 21 panel, somebody who had been involved and
 22 somebody who would then be involved in the
 23 follow up would be there in that capacity, not
 24 as a risk manager, but as a resource person.
 25 Like the secretarial person was there as a

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1 resource person to do the minutes and get the
 2 things typed up and this type of thing, so -
 3 MS. TAYLOR:
 4 Q. So the person was there as secretarial
 5 support?
 6 DR. WILLIAMS:
 7 A. We had secretarial support, Heather Predham
 8 was there as a resource person to get together
 9 the documentation and information for the
 10 panel.
 11 MS. TAYLOR:
 12 Q. So she wasn't there as secretarial support?
 13 DR. WILLIAMS:
 14 A. No, she was there as a resource--we had two
 15 people there, the person who took the minutes
 16 -
 17 MS. TAYLOR:
 18 Q. The recording secretary?
 19 DR. WILLIAMS:
 20 A. Yes, that's right.
 21 MS. TAYLOR:
 22 Q. Okay. And there was no question as to why,
 23 you know, because there is a number of doctors
 24 from various specialities on this panel,
 25 there's oncologists, there's surgeons, there's

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1 pathologists and originally it would have been
 2 the patient and the treating oncologist that
 3 would have made the decision together,
 4 obviously the oncologist, but with input from
 5 the patient as to what was the appropriate
 6 treatment after the original ER/PR status was
 7 established.
 8 DR. WILLIAMS:
 9 A. Uh-hm.
 10 MS. TAYLOR:
 11 Q. You didn't question why so many doctors would
 12 be needed to make a treatment recommendation
 13 after retests when, you know, one doctor and
 14 the patient was able to do it in the
 15 beginning?
 16 DR. WILLIAMS:
 17 A. Well, you're into a unique situation where you
 18 get reports that are some years later in
 19 coming back, might be four or five years
 20 later, and you get together an expert panel of
 21 people who had involvement in the care of
 22 cancer patients who had expertise going back
 23 some thirty years in Dr. Kwan's case, who are
 24 up to date, and they would provide a
 25 recommendation so that the physician who was

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1 treating the patient could then discuss that
 2 with the patient and a decision would be made.
 3 It wouldn't interfere with the decision-making
 4 process between the patient and the physician.
 5 It would just provide another level of input
 6 into the physician and the patient making that
 7 decision.
 8 MS. TAYLOR:
 9 Q. Do you have any knowledge of the level of
 10 detail, like what sort of information would be
 11 sent out in this letter to physicians?
 12 DR. WILLIAMS:
 13 A. No, I don't.
 14 MS. TAYLOR:
 15 Q. You haven't seen any -
 16 DR. WILLIAMS:
 17 A. I would leave that to the people who know
 18 best.
 19 MS. TAYLOR:
 20 Q. Okay, and do you know what sort of doctors the
 21 information would be sent out to? Because it
 22 might be sent out to an oncologist, but it
 23 might be sent out to a family physician as
 24 well, did you know that?
 25 DR. WILLIAMS:

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1 A. Most cases I expect it might be sent to a
 2 specialist, but it may go back to a family
 3 physician if the specialist of record had left
 4 or something like this.
 5 MS. TAYLOR:
 6 Q. Right.
 7 DR. WILLIAMS:
 8 A. But again, the person who got it would just
 9 have a recommendation based upon the
 10 considered opinion of a variety of people.
 11 The reason why it had so many on it was that
 12 Dr. Kwan couldn't be there, maybe Dr. Felix
 13 would be there; if Dr. McCarthy couldn't get
 14 there, maybe Dr. Laing--I'd have to look at
 15 the composition of the panel, but obviously at
 16 every meeting, everybody who was on the panel
 17 didn't get there, so you wanted to make sure
 18 you got some expertise. It was just to try to
 19 help the situation, a difficult situation. I
 20 don't--I still, no matter how hard I was
 21 questioned on it, I still would do it again.
 22 MS. TAYLOR:
 23 Q. Do you see any pitfalls with it, though? Did
 24 you see any?
 25 DR. WILLIAMS:

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1 A. I didn't see any pitfalls with it, no.
 2 MS. TAYLOR:
 3 Q. Because we've heard testimony from some of the
 4 cancer patients that were involved in this and
 5 there was one individual who, when they were
 6 originally tested for ER/PR, they were
 7 negative.
 8 DR. WILLIAMS:
 9 A. Uh-hm.
 10 MS. TAYLOR:
 11 Q. And based upon, she testified that based upon,
 12 you know, discussions with her doctor, her own
 13 research into the issue, whether or not it
 14 would actually have any impact for her because
 15 she was to her understanding negative, she
 16 refused Tamoxifen, okay.
 17 DR. WILLIAMS:
 18 A. Uh-hm.
 19 MS. TAYLOR:
 20 Q. When she was panelled, there was no treatment-
 21 -even though she was positive, there was no
 22 treatment recommendation change because it was
 23 noted that she had refused Tamoxifen, but she
 24 refused in on the basis of a particular set of
 25 circumstances, but they wouldn't know that

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1 because there was no contact with the patient.
 2 DR. WILLIAMS:
 3 A. Well, I presume they'd still write her
 4 physician and that choice would be hers and
 5 the physician's. I'm not aware of individual
 6 cases--this is something really you're getting
 7 into a level of detail that I'm not probably
 8 not confident to be commenting upon in terms
 9 of when you get into issues that were required
 10 to go to a panel with expertise, it's
 11 something that you probably should address to
 12 somebody who is on the panel.
 13 THE COMMISSIONER:
 14 Q. The question is not whether or not that should
 15 have been done, the question is whether or not
 16 in retrospect you have seen any weaknesses in
 17 the use of the panel?
 18 DR. WILLIAMS:
 19 A. I haven't seen anything brought to my
 20 attention.
 21 MS. TAYLOR:
 22 Q. Now I have a question on the ethics consult,
 23 that's P-0481. Now I'm not going to refer you
 24 to the specifics of the actual consult, Dr.
 25 Williams. My question has more to do with the

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1 timing of it. You were the person who had
 2 ordered the ethics consult?
 3 DR. WILLIAMS:
 4 A. Yes.
 5 MS. TAYLOR:
 6 Q. And it would have been ordered, I think,
 7 sometime in May of '06?
 8 DR. WILLIAMS:
 9 A. Sometime around then.
 10 MS. TAYLOR:
 11 Q. Was any thought or did you give any thought,
 12 consideration to ordering and obtaining an
 13 ethics consult when this issue first arose?
 14 DR. WILLIAMS:
 15 A. No, I didn't at the time. The issue came up
 16 and we were going to have to deal with this
 17 issue, so let's get an ethics consult, that's
 18 -
 19 MS. TAYLOR:
 20 Q. Right, this is a year later and it would have
 21 been known--and this is in particular dealing
 22 with deceased patients. Now obviously it
 23 would have been known fairly early on because
 24 there were deceased patient samples that were
 25 sent up for retesting and that was known, so

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1 was there any thought of obtaining a consult
 2 at an earlier date in terms of, you know, how
 3 are we going to handle this, what do you think
 4 we need to do?
 5 DR. WILLIAMS:
 6 A. Well we were going to, we knew we were going
 7 to deal with the retesting of the decreased
 8 patients, but we wanted to deal with the other
 9 issues first before we did that, so I guess we
 10 got an ethics consult at the time, we were
 11 going to start to deal with that process. The
 12 issue hadn't come up before that, but we knew
 13 that we had to deal with deceased, so we got
 14 an ethics consult before we moved forward on
 15 that.
 16 MS. TAYLOR:
 17 Q. So your mind didn't turn to that before that
 18 period of time?
 19 DR. WILLIAMS:
 20 A. No, it did not.
 21 MS. TAYLOR:
 22 Q. Okay. Now when Mr. Coffey was asking you some
 23 questions on Friday, he was talking to you
 24 about the external reviews and after the
 25 external reviews were received, you had the

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1 exit meetings I think as well, with both Dr.
 2 Banerjee and Ms. Wegrynowski?
 3 DR. WILLIAMS:
 4 A. Yes, we did. I took notes of Ms.
 5 Wegrynowski's exit meeting, but I don't have
 6 any notes of Dr. Banerjee's exit meeting. I
 7 have some recollections, but not notes.
 8 MS. TAYLOR:
 9 Q. Right, but you had said that after you got
 10 that information that you felt that there was
 11 some work to do, you needed to get on with it.
 12 DR. WILLIAMS:
 13 A. Uh-hm.
 14 MS. TAYLOR:
 15 Q. And you asked Dr. Cook and Dr. (sic.) Gulliver
 16 to prepare a document that would capture the
 17 essence of what was said and would enable us
 18 to move forward.
 19 DR. WILLIAMS:
 20 A. Uh-hm.
 21 MS. TAYLOR:
 22 Q. And you also said you remember talking to Mr.
 23 Tilley and telling him that if we didn't move
 24 forward, we really needed to consider whether
 25 we were going to continue to have an

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1 immunohistochemical lab here.
 2 DR. WILLIAMS:
 3 A. Well, yeah, I said that, you know, if we're
 4 going to provide that service, then we need to
 5 move forward on those issues identified.
 6 MS. TAYLOR:
 7 Q. That would suggest to me that without the
 8 correction of those issues, you were thinking
 9 at the time that either we correct these
 10 things or maybe we shouldn't even have the
 11 service?
 12 DR. WILLIAMS:
 13 A. Well I put it in that terms, I guess, I felt
 14 we should continue to have the service, but I
 15 said, you know, if we're not going to react in
 16 the positive fashion, then we could consider
 17 the alternative. But I didn't go any further
 18 than that in considering the alternative.
 19 MS. TAYLOR:
 20 Q. Right, but I guess my point is without those
 21 corrections at the time, what were you
 22 thinking--your--what you knew by that time, in
 23 terms of the external reviews and having met
 24 with and spoken with Dr. Banerjee and Ms.
 25 Wegrynowski and knowing what you did then

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1 about the state of that service and the lab,
 2 in terms of that service, you know, was it an
 3 either/or, we either fix it or we don't have
 4 it?
 5 DR. WILLIAMS:
 6 A. Well I was feeling that if we were having
 7 consultants come in and do thorough reviews,
 8 that we really needed to move forward on their
 9 recommendations on a timely basis.
 10 MS. TAYLOR:
 11 Q. Now, I do have just maybe one last question
 12 for you. The actual order-in-council that
 13 created this Commission, there's a series of
 14 questions that the Commission will have to
 15 addressed--the Commissioner will have to
 16 address and one of the things that the actual
 17 Commission inquires into is why the estrogen
 18 and progesterone hormone receptor tests done
 19 between 1997 and 2005 in the Newfoundland and
 20 Labrador health system resulted in a high rate
 21 of conversions when retested, that's one of
 22 the questions that's going to have to be
 23 answered. Now do I take from your evidence
 24 that in terms of the cause of the problems as
 25 to why the--there were a high rate of

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1 conversions on retest, that the reasons for
 2 that would be contained within the four
 3 corners of the documents from Dr. Banerjee and
 4 Ms. Wegrynowski, that those things would cover
 5 the cause?
 6 DR. WILLIAMS:
 7 A. They would go a long way to covering the--I
 8 can't tell you the cause in each individual
 9 case going back to 1997.
 10 MS. TAYLOR:
 11 Q. No.
 12 DR. WILLIAMS:
 13 A. Because one would have to, you know, look at
 14 each slide, but they would--I guess Dr.
 15 Banerjee's approach was sort of a broad-brush
 16 approach in terms of here's what he feels is
 17 the cause, but a broad-brush approach in terms
 18 of here's how I think you need to structure
 19 things to ensure that that doesn't happen
 20 again.
 21 MS. TAYLOR:
 22 Q. Right, but I see what you're saying on an
 23 individual case, that you would have to look
 24 at that individual case.
 25 DR. WILLIAMS:

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1 A. Yes, you would.
 2 MS. TAYLOR:
 3 Q. But in terms of looking at, on a given day, a
 4 combination of things which may have lead to
 5 the conversion, in terms of the cause of that,
 6 would it be your evidence that the cause of it
 7 would be contained within those reports in
 8 terms of the problems that they identified?
 9 DR. WILLIAMS:
 10 A. Well I think Dr. Banerjee identified two main
 11 issues. One would be the most difficult issue
 12 in terms of immunohistochemistry, which is the
 13 antigen retrieval, the, I guess heat induced
 14 retrieval that seems to be the most
 15 significant part, it's written in the
 16 literature that's probably one of the main
 17 factors here, in his view. And number two was
 18 the issue of controls that didn't seem totally
 19 to work. And he recommended a broad-brush
 20 approach to deal with that. Whether that's
 21 what happened in each individual case, I can't
 22 be sure because there may be some other
 23 combination of things, but I think his
 24 recommendations and those of Trish Wegrynowski
 25 would cover, if we implemented those measures,

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1 should deal with the problem.
 2 MS. TAYLOR:
 3 Q. So, in terms of anything outside of those
 4 reports, that could contribute or result in a
 5 high rate of conversions on retest for this
 6 particular type of test, is there anything
 7 else that you can indicate to the Commissioner
 8 that might have contributed or caused those
 9 problems?
 10 DR. WILLIAMS:
 11 A. The only thing that's been brought to my
 12 attention and this came up in Saint John, New
 13 Brunswick was, there was some issue with
 14 respect to a pump failure in the DAKO system.
 15 That's what they said. That's the only other
 16 thing that I've heard that may be a
 17 contributing factor. There's no way we can go
 18 back because we didn't have the equipment to
 19 recheck. We had dispersed of it at the time
 20 that this issue surfaced.
 21 MS. TAYLOR:
 22 Q. Other than that, there's nothing that you can
 23 indicate -
 24 DR. WILLIAMS:
 25 A. That I can indicate, some other people who

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1 have more expertise than me may be able to
 2 shed some additional light on the matter.
 3 MS. TAYLOR:
 4 Q. And what about, there's another question
 5 that's going to have to be answered which is
 6 why the problem with the estrogen and
 7 progesterone hormone receptor tests was not
 8 detected until 2005, whether it could have
 9 been detected at an earlier date? Could it
 10 have been detected at an earlier date? If the
 11 Ejeckam memo had been followed up on and it
 12 had been brought to your attention?
 13 DR. WILLIAMS:
 14 A. Well, I guess it wasn't brought to my
 15 attention. If it had to have been brought to
 16 my attention, what action I would have taken,
 17 I'm not sure, at the time, because looking at,
 18 in retrospect--so, but the issue first
 19 surfaced in 2003, I have to agree on that.
 20 The other issue that has come up from time to
 21 time is that there was a turnover of
 22 pathologists and a turnover of oncologists and
 23 may be somebody suggested maybe some trends
 24 might have been seen, but because of the big
 25 turnover that didn't happen.

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1 MS. TAYLOR:
 2 Q. Well, and I think Mr. Coffey had asked you
 3 about this. The word "turnover" with
 4 particular individuals, but they're also
 5 individuals both in the lab -
 6 DR. WILLIAMS:
 7 A. Yes -
 8 MS. TAYLOR:
 9 Q. - as well as people within the structure of
 10 Eastern Health and also pathologists who are
 11 still in place during that period of time.
 12 DR. WILLIAMS:
 13 A. Yes, but no one--in the system we had, no one
 14 pathologist was reading all the slides. We
 15 weren't subspecialized.
 16 MS. TAYLOR:
 17 Q. And what about whether testing protocols
 18 during the period between 1997 and 2005 were
 19 reasonable and appropriate? Were the
 20 protocols reasonable and appropriate during
 21 that period of time?
 22 DR. WILLIAMS:
 23 A. According to our consultants, that was an
 24 issue and we needed to improve in that area.
 25 MS. TAYLOR:

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1 Q. So, they weren't reasonable and appropriate?
 2 DR. WILLIAMS:
 3 A. Well, they weren't, according to the
 4 consultants that reported on--that's why we
 5 asked people to come in to -
 6 MS. TAYLOR:
 7 Q. And you accept the view of the consultants?
 8 DR. WILLIAMS:
 9 A. We accept the review that we needed to improve
 10 in those areas, yes.
 11 MS. TAYLOR:
 12 Q. So, you agree that they weren't reasonable in
 13 -
 14 DR. WILLIAMS:
 15 A. They needed improvement, yes, I will say that.
 16 MS. TAYLOR:
 17 Q. That's all the questions that I have, Dr.
 18 Williams.
 19 DR. WILLIAMS:
 20 A. Thank you.
 21 MS. TAYLOR:
 22 Q. Thank you.
 23 THE COMMISSIONER:
 24 Q. Thank you, Ms. Taylor. Mr. Pike?
 25 DR. ROBERT WILLIAMS, EXAMINATION BY MR. MARK PIKE

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1 MR. PIKE:
 2 Q. Good morning, Dr. Williams.
 3 DR. WILLIAMS:
 4 A. Good morning, Mr. Pike.
 5 MR. PIKE:
 6 Q. Mark Pike is my name. We've met before, of
 7 course, and I'm counsel for the Newfoundland
 8 and Labrador Medical Association. You'd be
 9 happy to know I just have one area left that
 10 I'd like to ask you some questions on.
 11 During your tenure as vice-president of
 12 medical services with either the organization
 13 of Eastern Health or its predecessor
 14 organization, what was your relationship with
 15 the NLMA?
 16 DR. WILLIAMS:
 17 A. I felt we had a good working relationship, a
 18 cordial working relationship. The NLMA's role
 19 is to support the practice of medicine in the
 20 province. You know, they're interested in
 21 quality by having enough physicians of the
 22 right mix and the right backgrounds to get the
 23 job done. We feel we have a synergistic role
 24 with the Newfoundland and Labrador Medical
 25 Association because we wanted to have the same

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1 thing in our organization. We were involved
 2 in recruited and retention of hard to recruit
 3 for areas. We felt we had to advocate on
 4 behalf of our physicians in our organization
 5 to ensure that we had people who were well
 6 trained and highly trained to get the job
 7 done. So, we felt we had a synergistic role
 8 with, one of the main roles of the
 9 Newfoundland and Labrador Medical Association.
 10 So, over the years we worked on a number of
 11 issues to try to impact that in a positive
 12 way. One of which, the last one of which, of
 13 course, was very relevant to this which was
 14 the coming together with the NLMA through the
 15 service coverage committee which was
 16 representatives from the NLMA and
 17 administration in the hospitals and we set up
 18 a working group which I chaired to try to deal
 19 with the issue of pathologists recruitment and
 20 retention because it had been causing some
 21 problems over the previous few years. In a
 22 negotiation process, I don't think that was
 23 able to be addressed and that this committee
 24 came together in 2005 in follow up to a
 25 presentation by the Newfoundland Association

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1 of Pathologists who are an arm of the NLMA.
 2 So, we would work closely with them on those
 3 issues. There's a lot of other issues. We
 4 have a lot of--especially in our pediatric
 5 area, in our organization where it's hard to
 6 recruit specialists and subspecialists in the
 7 pediatric area because the volumes are low
 8 and, of course, payment in a fee-for-service
 9 system is based upon volumes. And you're not
 10 able to give a person a reasonable income with
 11 the volumes they have there and compete with
 12 other jurisdictions.
 13 So, with the co-operation of the NLMA and
 14 ourselves working with the Department of
 15 Health, we were able to offer a number of
 16 alternate payment systems, payment plans, to
 17 impact that in a positive way. So, we felt
 18 that we had a lot of synergies with them. So,
 19 we had a pretty good working relationship over
 20 the years and there would be a lot of contact,
 21 to and fro, with the organization.
 22 MR. PIKE:
 23 Q. So, you'd be in contact, back and forth, with
 24 Mr. Rob Ritter? You know Mr. Ritter is
 25 executive director.

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1 DR. WILLIAMS:
 2 A. And a lot of contact with Stephen Jerrett on
 3 some of these issues I mentioned because he
 4 was their director of economics. So, he was
 5 the person who was dealing with those issues.
 6 Mr. Ritter would be another level, in terms of
 7 -
 8 MR. PIKE:
 9 Q. Sure.
 10 DR. WILLIAMS:
 11 A. - involved in some of these meetings, but most
 12 of the on-the-ground meetings, in terms of
 13 getting these situations in place, although
 14 Mr. Ritter was supporting them, it would be
 15 Mr. Jerrett who would be working with us and
 16 mostly Dr. Bradbury's office that the
 17 Department of Health and Community Services on
 18 those issues.
 19 MR. PIKE:
 20 Q. What about the issue, particularly now that
 21 we're concerned with here, the issue of
 22 disclosure of the events surrounding ER/PR and
 23 the method of contacting patients and
 24 communicating with the public. Would you ever
 25 had occasion or do you have occasion, more

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1 pointedly, to have any discussion with the
 2 NLMA or any of its representatives concerning
 3 those issues?
 4 DR. WILLIAMS:
 5 A. I did not. I know that Mr. Abbott asked Mr.
 6 Ritter to phone me and I've spoken to Mr.
 7 Ritter so often that I can't remember on which
 8 occasions I spoke to him or what we discussed.
 9 But I would say there wouldn't have been, you
 10 know, a long time go by that I would have some
 11 conversation with somebody at the NLMA or Mr.
 12 Ritter.
 13 MR. PIKE:
 14 Q. I was going to ask you about that,
 15 particularly, there's one exhibit that we've
 16 seen time and time again, P-0137, if you have
 17 it there, Madame Registrar. I think that's
 18 the one you're referring to. You've no doubt
 19 seen it.
 20 DR. WILLIAMS:
 21 A. Yes.
 22 MR. PIKE:
 23 Q. It's been presented to you by Commission
 24 counsel July 25, '05. So, I take it you can't
 25 recall and I mean, I have to put this to you

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1 know, because we know Mr. Ritter is going to
 2 come behind you -
 3 DR. WILLIAMS:
 4 A. Sure, yes.
 5 MR. PIKE:
 6 Q. And you have some idea what he's going to say
 7 about this, he can recall the telephone
 8 conversation with you, but you can't recall -
 9 DR. WILLIAMS:
 10 A. No, I can't recall. I'm sure we had the
 11 conversation, Mr. Pike, but I can't recall it,
 12 if I tried to say something, I'd be, you know
 13 -
 14 MR. PIKE:
 15 Q. Yes, well you're only saying you're sure
 16 because I'm telling you Mr. Ritter is going to
 17 say it, that's all.
 18 DR. WILLIAMS:
 19 A. Yeah.
 20 MR. PIKE:
 21 Q. Not because you have any independent
 22 recollection?
 23 DR. WILLIAMS:
 24 A. No, I don't have--but I'm sure that happened.
 25 I would have talked to Mr. Ritter, but I can't

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1 remember the details of our discussion, on any
 2 one discussion because I've talked to him so
 3 much.
 4 MR. PIKE:
 5 Q. Sure. Those are my questions for Dr.
 6 Williams. Thank you very much.
 7 THE COMMISSIONER:
 8 Q. Thank you. Mr. Simmons?
 9 MR. SIMMONS:
 10 Q. Thank you, Commissioner.
 11 DR. ROBERT WILLIAMS, EXAMINATION BY MR. DANIEL SIMMONS
 12 MR. SIMMONS:
 13 Q. Good morning, Dr. Williams.
 14 DR. WILLIAMS:
 15 A. Good morning, sir.
 16 MR. SIMMONS:
 17 Q. I am going to have to go back and ask you a
 18 few more questions about some specific things
 19 that you've been questioned on over the last
 20 number of days, but I'm going to try to narrow
 21 and keep it as specifically as possible.
 22 I have a question for you first about the
 23 external review reports and the terms under
 24 which they were requested.
 25 DR. WILLIAMS:

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1 A. Yes.
 2 MR. SIMMONS:
 3 Q. And I'd like to have you look, please, at
 4 document P-1283. This is an e-mail message
 5 from Heather Predham to Dr. Cook and you on
 6 September 12, 2005 which, I think we've
 7 previously established was prior to either of
 8 the consultants arriving to begin their work
 9 in St. John's.
 10 DR. WILLIAMS:
 11 A. Yes.
 12 MR. SIMMONS:
 13 Q. And attached to it there are Terms of
 14 Reference for external quality review of the
 15 immunohistochemistry service.
 16 DR. WILLIAMS:
 17 A. Yes.
 18 MR. SIMMONS:
 19 Q. And I believe you already told us that these
 20 were prepared by Ms. Predham at your request.
 21 DR. WILLIAMS:
 22 A. Yes.
 23 MR. SIMMONS:
 24 Q. Is that correct?
 25 DR. WILLIAMS:

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1 A. Yes.
 2 MR. SIMMONS:
 3 Q. Okay. And the statement of purpose there is
 4 to review the operation and make
 5 recommendations as to the processes involved
 6 in a service of the laboratory medicine
 7 program. The accountability was that the
 8 consultant would take direction from and make
 9 recommendations to the leadership team of the
 10 laboratory medicine program.
 11 DR. WILLIAMS:
 12 A. Correct.
 13 MR. SIMMONS:
 14 Q. And that leadership team was comprised of who?
 15 DR. WILLIAMS:
 16 A. The program director and the clinical chief.
 17 MR. SIMMONS:
 18 Q. Which would be Mr. Gulliver and Dr. Cook.
 19 DR. WILLIAMS:
 20 A. Correct.
 21 MR. SIMMONS:
 22 Q. The timeframe was to be a report done within
 23 three months and then it sets out five
 24 responsibilities. You can have a look at
 25 those.

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1 DR. WILLIAMS:
 2 A. Yes.
 3 MR. SIMMONS:
 4 Q. My first question is those listed
 5 responsibilities, were they the questions that
 6 were being put to the reviewers for them to
 7 consider when they conducted this review or
 8 the tasks being given to them?
 9 DR. WILLIAMS:
 10 A. Yes, that looks to be what we felt they should
 11 do.
 12 MR. SIMMONS:
 13 Q. The first one is to review current practices
 14 and procedures within the immunohistochemistry
 15 service of the laboratory medicine program.
 16 DR. WILLIAMS:
 17 A. Um-hm.
 18 MR. SIMMONS:
 19 Q. And I notice the emphasis on current
 20 practices. Were they tasked with going back
 21 and looking at practices that had been used
 22 historically from '97 up to 2005?
 23 DR. WILLIAMS:
 24 A. As part of the review, I thought they would
 25 look at that, yes.

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1 MR. SIMMONS:
 2 Q. Okay. The Terms of Reference though direct
 3 them more specifically to look at the current
 4 practices. Would there be any reason why
 5 there would be more emphasis on looking at
 6 current practices than on historically the way
 7 things had been done.
 8 DR. WILLIAMS:
 9 A. Well, we wanted to know what was happening
 10 currently to see where we were going at that
 11 point in time, but we know there was some
 12 issues to be looked at in terms of past issues
 13 as well to try to identify.
 14 MR. SIMMONS:
 15 Q. Okay. And the second one there refers to
 16 interviewing individuals with relevant. The
 17 third one says to identify other issues of
 18 concern using a systems approach which may
 19 have contributed to the situation being
 20 reviewed. Why the emphasis on systems
 21 approach?
 22 DR. WILLIAMS:
 23 A. I would think that we were looking at all the
 24 factors and issues that went into having a
 25 testing--doing testing and then having a

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1 result, right from the first step to the last
 2 step.
 3 MR. SIMMONS:
 4 Q. Um-hm.
 5 DR. WILLIAMS:
 6 A. Because it is a detailed system that gets you
 7 from Point A to Point B. There's a lot of
 8 steps in between.
 9 MR. SIMMONS:
 10 Q. Okay. And the fourth one is a request to
 11 provide recommendations -
 12 DR. WILLIAMS:
 13 A. Yes.
 14 MR. SIMMONS:
 15 Q. - to deal with issues identified. And then
 16 the fifth one, to summarize the findings in a
 17 confidential report.
 18 DR. WILLIAMS:
 19 A. Yes.
 20 MR. SIMMONS:
 21 Q. Now, you were referred a few moments ago to
 22 the Terms of Reference of this Commission.
 23 And one of those, the first one is to try to
 24 answer the question of why there was so many
 25 changes in test results when they were

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1 retested in 2005 compared to earlier. Was
 2 that a question that the external reviewers
 3 were tasked to answer in those Terms?
 4 DR. WILLIAMS:
 5 A. Not if you read them specifically, look like--
 6 but in order to provide recommendations
 7 dealing with any issues in moving onto the
 8 future. We might need to look at what has
 9 happened in the past.
 10 MR. SIMMONS:
 11 Q. So, to the extent necessary to make
 12 recommendations about what should be done now,
 13 you had an expectation that they might have to
 14 look back at what had happened in the past.
 15 DR. WILLIAMS:
 16 A. Yes, and they did, actually.
 17 MR. SIMMONS:
 18 Q. All right. But was there an expectation or a
 19 direction to them to specifically address the
 20 question of answering the question why there
 21 were changes in the retest results compared to
 22 what had happened in the past?
 23 DR. WILLIAMS:
 24 A. No, not in these Terms of Reference, there was
 25 not.

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1 MR. SIMMONS:
 2 Q. And, of course, at that point, the retest
 3 results weren't back. They were there in
 4 September of 2005.
 5 DR. WILLIAMS:
 6 A. That's correct.
 7 MR. SIMMONS:
 8 Q. And the Mount Sinai results had not yet come
 9 back, the retests hadn't happened.
 10 DR. WILLIAMS:
 11 A. No, we had the number of reports that we knew
 12 had changed, enough for us to request that--
 13 enough concern that we felt we needed to
 14 retest.
 15 MR. SIMMONS:
 16 Q. Right. And there were a limited number of
 17 retest results available based on the
 18 retesting that had been done on the Ventana
 19 technology in St. John's.
 20 DR. WILLIAMS:
 21 A. Correct.
 22 MR. SIMMONS:
 23 Q. Which were largely, I think, from 2002 and
 24 maybe a few from outside the 2002 range.
 25 DR. WILLIAMS:

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1 A. Yes, the was, I think, probably five or so
 2 from outside the two thousand--if I'm correct
 3 about the five, four to five, from outside the
 4 2002 -
 5 MR. SIMMONS:
 6 Q. So, at that point would it be correct to say
 7 that the information available about which
 8 tests had changed or were likely to change on
 9 retesting was fairly limited compared to what
 10 became known afterwards when the Mount Sinai
 11 results came back.
 12 DR. WILLIAMS:
 13 A. That's correct. We were just in the early
 14 stages of it.
 15 MR. SIMMONS:
 16 Q. Okay.
 17 DR. WILLIAMS:
 18 A. We really didn't know what we would find, but
 19 we expected to find some issues; that's why we
 20 retested.
 21 MR. SIMMONS:
 22 Q. Okay. Now, I'm not going to be very organized
 23 in flowing through my questions from area to
 24 area.
 25 DR. WILLIAMS:

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1 A. Okay.
 2 MR. SIMMONS:
 3 Q. I just have a number of different ones I want
 4 to address with you. You've been asked quite
 5 a bit about Dr. Ejeckam's memos from 2003.
 6 DR. WILLIAMS:
 7 A. Yes.
 8 MR. SIMMONS:
 9 Q. And you were questioned this morning about the
 10 June memo in which Dr. Ejeckam had made some
 11 recommendations for changes that he would like
 12 to see in the immunohistochemistry laboratory.
 13 DR. WILLIAMS:
 14 A. Yes.
 15 MR. SIMMONS:
 16 Q. After you returned from your illness that
 17 summer, you came back in September of 2003.
 18 DR. WILLIAMS:
 19 A. Yes.
 20 MR. SIMMONS:
 21 Q. Did Dr. Ejeckam continue to chair the surgical
 22 pathology review committee for some time after
 23 that, did he not?
 24 DR. WILLIAMS:
 25 A. He chaired it until he left in 2006, that's my

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1 recollection, April 2006.
 2 MR. SIMMONS:
 3 Q. Right. And I believe you told us that he
 4 actually reported--his reporting was to you
 5 from that committee.
 6 DR. WILLIAMS:
 7 A. Yes.
 8 MR. SIMMONS:
 9 Q. And did you periodically get reports and
 10 committee minutes and so on from him after you
 11 returned in September 2003?
 12 DR. WILLIAMS:
 13 A. Yes.
 14 MR. SIMMONS:
 15 Q. And did he, at any time, did he or the
 16 committee at any time, ever raise with you or
 17 bring to your attention any concern that the
 18 issues raised in his June 2003 memo had not
 19 been addressed to his satisfaction?
 20 MR. WILLIAMS:
 21 A. No, we didn't get any recommendations on
 22 immunohistochemistry from that committee.
 23 MR. SIMMONS:
 24 Q. Okay.
 25 THE COMMISSIONER:

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1 Q. What was the name of the committee again?
 2 MR. WILLIAMS:
 3 A. The Surgical Pathology Review Committee.
 4 THE COMMISSIONER:
 5 Q. Review?
 6 MR. WILLIAMS:
 7 A. Yes.
 8 THE COMMISSIONER:
 9 Q. Okay, I knew I was missing a word. Thank you.
 10 MR. SIMMONS:
 11 Q. You were also asked a number of questions and
 12 explained that the criteria used at different
 13 times by the oncologists for deciding whether
 14 to recommend hormonal treatment for patients
 15 varied, and at one point, if the ER test
 16 showed 30 percent positivity or higher, a
 17 patient was considered a candidate for
 18 Tamoxifen or similar drug, and after a time,
 19 that changed to if the test result was ten
 20 percent -
 21 MR. WILLIAMS:
 22 A. Yes.
 23 MR. SIMMONS:
 24 Q. - or higher, they would be considered a
 25 candidate. Can you tell me whether that

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1 change happened in some discreet formal way,
 2 such as a policy change or a concrete decision
 3 to say "tomorrow we start making this change"
 4 or whether it would have come about in some
 5 other process?
 6 MR. WILLIAMS:
 7 A. Well, at the time that change was made, the
 8 Cancer Clinic was not part of the Health Care
 9 Corporation. The physicians who were
 10 credentialed in the Cancer Clinic were also
 11 credentialed in Eastern Health for in-patient
 12 care, but that decision would have been made
 13 really at the Cancer Clinic and most--you
 14 know, that would be an outpatient treatment
 15 issue. So I'm not sure of what happened at
 16 that time, back in December 2002. I know, I
 17 was told subsequently that there was a
 18 conference. Dr. Laing came back from a
 19 conference and the consensus was, at that
 20 conference, that ten percent would be the
 21 recommended cut-off point for treating people
 22 with--offering people Tamoxifen.
 23 MR. SIMMONS:
 24 Q. Would it be your understanding that in areas
 25 like cancer treatment, that there is constant

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1 evolution and change in the way treatments are
 2 administered and in what's considered the best
 3 thing to try to do at any particular time?
 4 MR. WILLIAMS:
 5 A. Well, I'm aware that there's a constant
 6 evolution everywhere, in terms of therapy for
 7 patients, whether it's in cancer care or other
 8 forms of therapy, and in fact, in something
 9 like--I'll give you an example. High blood
 10 pressure treatment, we've gone full circle and
 11 we're back to the basic drug I used when I
 12 started in practice 30 years ago, which fell
 13 out of disfavour for a while and now that's
 14 the recommended drug of choice to start people
 15 off for hypertension. So there's constant
 16 change. Sometimes it goes full circle.
 17 MR. SIMMONS:
 18 Q. And when changes happen in the way that
 19 patients are treated in cancer care or with
 20 blood pressure, does that happen because an
 21 organization like the Health Authority decrees
 22 or directs that an approach to treatment
 23 change or does it happen as part of the
 24 clinical practice of the practitioners in
 25 their dealings with their patients?

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1 MR. WILLIAMS:
 2 A. It really happens as a result of the
 3 literature that--conferences that our
 4 clinicians go to and bringing back new ideas,
 5 either from the literature or from conferences
 6 and that becomes practice in the organization,
 7 again based upon the expertise that these
 8 people have.
 9 MR. SIMMONS:
 10 Q. So is it fair to say it becomes the practice
 11 of the physicians who practice within the
 12 organization?
 13 MR. WILLIAMS:
 14 A. Yes.
 15 MR. SIMMONS:
 16 Q. To make a change such as that.
 17 MR. WILLIAMS:
 18 A. That's the normal way things happen.
 19 MR. SIMMONS:
 20 Q. Okay.
 21 MR. WILLIAMS:
 22 A. Now we try to develop clinical practice
 23 guidelines in a number of areas over the
 24 years, but normal practice is that, you know,
 25 people review the literature, see what the

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1 best practices are, go to conferences where
 2 experts often talk and that's what usually
 3 happens.
 4 MR. SIMMONS:
 5 Q. Okay. You were asked some questions about the
 6 Cancer Registry.
 7 THE COMMISSIONER:
 8 Q. Sorry, Mr. Simmons, but now that this is in my
 9 mind, and you may not be the correct witness
 10 to ask this to, so if you're not, let me know.
 11 But when you have something of the nature of
 12 the business of a cut off on the ER/PR, the 30
 13 to 10, etcetera, is that a decision made by
 14 each individual treating oncologist?
 15 MR. WILLIAMS:
 16 A. It may vary from oncologist to oncologist. We
 17 may have some people who came from a centre
 18 who just joined our organization and the
 19 practice at that centre might be different
 20 than the practices at this centre. So when
 21 you practice in medicine, sometimes you don't
 22 always reach a consensus.
 23 THE COMMISSIONER:
 24 Q. Well, that's my point.
 25 MR. WILLIAMS:

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1 A. Yes, that's right.
 2 THE COMMISSIONER:
 3 Q. So that's--I'm just asking whether within an
 4 institution, a consensus gets to be arrived at
 5 or whether each individual oncologist looks at
 6 the information -
 7 MR. WILLIAMS:
 8 A. Yes.
 9 THE COMMISSIONER:
 10 Q. - which is available and either attends or
 11 doesn't attend a conference and might come to
 12 the conclusion that "we're moving in the
 13 direction of ten percent, therefore for my
 14 patients, I'll go from using 30 to 10," or
 15 some might say, "well, I'm not ready to go
 16 there yet. So for my patients, I'm sticking
 17 to the 30."
 18 MR. WILLIAMS:
 19 A. Yes, that could happen and it happens in other
 20 jurisdictions like cardiac care, that
 21 physician X sees patient Y, might have a
 22 different approach to patient Y than Dr. S
 23 might have to patient Y. So that's -
 24 THE COMMISSIONER:
 25 Q. Okay.

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1 MR. WILLIAMS:
 2 A. - that's what happens in medicine.
 3 THE COMMISSIONER:
 4 Q. It's just a matter of--it's one of those
 5 things you just park in the professional
 6 judgment.
 7 MR. WILLIAMS:
 8 A. You have to leave it to professional judgment
 9 of each physician for each individual patient.
 10 THE COMMISSIONER:
 11 Q. Okay.
 12 MR. WILLIAMS:
 13 A. Unless it's something off the wall, obviously,
 14 which is not relevant, but you know, it's just
 15 a problem.
 16 THE COMMISSIONER:
 17 Q. Okay, thank you. Sorry, Mr. Simmons.
 18 MR. SIMMONS:
 19 Q. To follow up on that, I'm going to ask you
 20 questions like many others you've been asked.
 21 Now you might not be the right person to
 22 answer this, and if so tell me, but do you
 23 know if when the decision was made about how
 24 to select which patients were to be retested,
 25 if the possibility that different oncologists

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1 adopted the change in cut off at different
 2 times was taken into account in any way?
 3 MR. WILLIAMS:
 4 A. I do not think it was based on individual. I
 5 thought it was based on the 30 and the ten
 6 percent cut off, what seemed to be the
 7 practice at the time.
 8 MR. SIMMONS:
 9 Q. Okay.
 10 MR. WILLIAMS:
 11 A. You could have--you'd have to ask Dr. Laing
 12 and Dr. Cook for more detail, but that's my
 13 understanding.
 14 MR. SIMMONS:
 15 Q. Okay, all right. So we can leave that
 16 question for them. Sometime earlier in your
 17 evidence, you'd mentioned the topic of the
 18 possibility of lab accreditation. I want to
 19 refer you just to a couple documents
 20 concerning that. The first one is Exhibit P-
 21 0029 please, and can we go to page 16 please.
 22 These are corporate quality initiatives
 23 committee minutes from the Health Care
 24 Corporation for October 28th 2004. You sat on
 25 this committee?

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1 MR. WILLIAMS:
 2 A. Yes.
 3 MR. SIMMONS:
 4 Q. And there's a section here on accreditation,
 5 Section 4.2.
 6 MR. WILLIAMS:
 7 A. Sure.
 8 MR. SIMMONS:
 9 Q. It refers to CCHSA, Canadian Council on Health
 10 Services Accreditation.
 11 MR. WILLIAMS:
 12 A. Correct.
 13 MR. SIMMONS:
 14 Q. Survey, and that's the accreditation of the
 15 whole institution?
 16 MR. WILLIAMS:
 17 A. Yes.
 18 MR. SIMMONS:
 19 Q. The survey was held during the week of October
 20 2004, some report on that, and if you go down
 21 to the bottom paragraph, Ms. Smith advised
 22 that a new document has been released by CCHSA
 23 entitled "Planning models for quality." The
 24 document supports where accreditation is
 25 moving in the future and the expectations of

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1 organizations, and it highlights various needs
 2 there in relation to quality, and then it
 3 continues, on the next page, in the first full
 4 paragraph there, to say "on a related note,
 5 the absence of a laboratory accreditation or
 6 inspection program was raised. In some areas
 7 in Canada, accreditation or inspections of
 8 laboratories is mandated by the provinces.
 9 However, this is not the case in this province
 10 and is seen as a major gap. The potential for
 11 a self-assessment or having an external agency
 12 conduct an assessment was suggested. Dr.
 13 Williams will ask the leadership team of the
 14 laboratory program to pursue the options with
 15 Ms. Smith."
 16 And I'm going to refer you now to some
 17 other minutes that address that topic as well.
 18 P-0030, please, page 45. These are corporate
 19 quality initiatives committee minutes now from
 20 June 24th of--ooh, I might be on the wrong
 21 page. Just one moment please. I think this
 22 is one of those documents where we changed
 23 some pages at one point, is it? No.
 24 REGISTRAR:
 25 Q. What was the date, Mr. Simmons?

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1 MR. SIMMONS:
 2 Q. I'm looking for March. I think I'm almost
 3 there. March 24th.
 4 MR. WILLIAMS:
 5 A. There may be something just here.
 6 MR. SIMMONS:
 7 Q. Okay, here we are.
 8 MR. WILLIAMS:
 9 A. Yes, 2.2 I guess.
 10 MR. SIMMONS:
 11 Q. 2.2, these are the March 24th minutes, and the
 12 heading is list of programs, departmental
 13 accreditations.
 14 MR. WILLIAMS:
 15 A. Um-hm.
 16 MR. SIMMONS:
 17 Q. It refers to a list circulated senior
 18 management, and the review has highlighted the
 19 issue with respect to services in the
 20 organization which should pursue accreditation
 21 or meet specific standards. There's a
 22 reference to stem cell transplant program and
 23 work being taken to investigate that, and then
 24 it also says "it was also noted that there's
 25 no laboratory accreditation in this province.

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1 Dr. Whitman reported on laboratory
 2 accreditations in other provinces and noted
 3 that it is a provincial initiative. The
 4 integration of health boards is an opportunity
 5 to lobby our provincial government to pursue a
 6 provincial approach. Dr. Williams will raise
 7 this with the CEO of the new Eastern Health
 8 for a follow up."
 9 So this is all before the ER/PR matter
 10 came up.
 11 MR. WILLIAMS:
 12 A. Yes.
 13 MR. SIMMONS:
 14 Q. And it has come up in the context of
 15 accreditation. Can you tell us something more
 16 about what was being discussed at these
 17 committee meetings and what the initiatives
 18 were that were being considered?
 19 MR. WILLIAMS:
 20 A. I think this came to our attention because
 21 there was a couple of things. We'd just gone
 22 through our accreditation on October 22nd. I
 23 just tried to link--going back and linking
 24 this with something that happened at our
 25 laboratory leadership in a meeting. There was

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1 an article that Mr. Gulliver said that the
 2 people from the Canadian Council of Health
 3 Services Accreditation came over to the lab
 4 and said things were pretty good over there.
 5 But my recollection is also Mr. Gulliver would
 6 have said to me that they didn't really spend
 7 much time there and maybe that's the impetus
 8 for our April--sorry, our earlier discussion
 9 in the fall, in October, October 28th or
 10 whatever it was, and Dr. Whitman would have
 11 been there. So there may have been some
 12 points that she would have wanted to make
 13 because Dr. Whitman was a hemata pathologist
 14 who worked as a physician providing medical
 15 leadership in the lab in the area of
 16 hematology. So there was some--probably would
 17 have been some discussion with her around the
 18 lab as well.
 19 My recollection is that at some point I
 20 remember Mr. Gulliver telling me that, you
 21 know, in the accreditation process, it was
 22 just, you know, a 10-15 minute site tour of
 23 the lab and that was all, which struck me as
 24 an issue because lab, lab services and
 25 diagnostic imaging services are two big

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1 support services that everything else in your
 2 organization depends on those. So maybe that
 3 was the impetus for the discussion and the
 4 follow up. I know at some stage, I--and I
 5 don't, I didn't really remember until I'd seen
 6 this. At some stage, I remember talking to
 7 Mr. Tilley about maybe that would be something
 8 that could be pursued now that we had four
 9 boards for the province, not just the
 10 laboratories under Eastern Health, but it
 11 looked like something that maybe all
 12 laboratories in the province should
 13 participate in.
 14 MR. SIMMONS:
 15 Q. And why did you consider that the formation of
 16 this new board structure would give an
 17 opportunity to pursue this provincial -
 18 MR. WILLIAMS:
 19 A. Well, you know, there was only four
 20 organizations now to deal with it, probably
 21 less organizations and maybe you could sort of
 22 look at getting our labs into--we knew about
 23 the Ontario program at the time, somewhat
 24 about it, because it might have been Dr.
 25 Whitman who told us about it at the meeting.

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1 So, and again, I can't document writing Mr.
 2 Tilley, but I'm pretty sure I talked to him
 3 about it and he was going to--it may have--
 4 they had a meeting of CEOs with the Deputy
 5 Minister of Health, the four regional CEOs,
 6 probably every couple of weeks. That's my
 7 recollection at the time.
 8 MR. SIMMONS:
 9 Q. Okay. So from what you've told us, it sounds
 10 that the concept or the idea that something
 11 more than the CCHSA accreditation was needed
 12 in the lab actually originated from a report
 13 within the lab, from Mr. Gulliver?
 14 MR. WILLIAMS:
 15 A. Well, Mr. Gulliver was saying that they'd been
 16 over there and said our lab was really good,
 17 and when I asked him about it, they really
 18 didn't spend a lot of time there, and it got
 19 me thinking, and I'm sure Dr. Whitman had a
 20 perspective on it too, and other people around
 21 the table at that time.
 22 MR. SIMMONS:
 23 Q. Okay. How far had any initiatives in relation
 24 to working towards some type of lab specific
 25 accreditation gone by the time the ER/PR issue

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1 came to your attention in May of 2005?
 2 MR. WILLIAMS:
 3 A. It would have gone to the level, I think we
 4 might have raised it to be raised in that
 5 forum, provincial forum. So it wouldn't have
 6 had any impact on having done anything then in
 7 the ER/PR issue because that was already in
 8 May, I guess, coming to the forefront a couple
 9 of months later.
 10 MR. SIMMONS:
 11 Q. But it was a direction that you saw the
 12 organization proceeding?
 13 MR. WILLIAMS:
 14 A. It was a direction that I thought was going to
 15 be pursued at the provincial level. Now I
 16 don't have any access to the minutes of the
 17 CEOs and the deputy minister but--and I don't
 18 know how it was raised. It looks like over
 19 the summer I sent Mr. Tilley a copy of the
 20 stuff I got off the website and my discussion
 21 with Dr. Richardson, I don't know was in
 22 follow up to this or just because of the ER
 23 and PR at the time I did it. I can't be--to
 24 be honest with you, I can't tell you why.
 25 MR. SIMMONS:

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1 Q. Okay.
 2 MR. WILLIAMS:
 3 A. But it might have been in follow up to this.
 4 MR. SIMMONS:
 5 Q. Dr. Williams, at this point, I understand that
 6 you may have some remarks that you'd like to
 7 make to the Commissioner or to the Commission
 8 yourself, some comments that you'd prepared to
 9 make at the conclusion of your testimony.
 10 MR. WILLIAMS:
 11 A. Yes, if that's all right, just a few comments.
 12 I've got something, some points written down
 13 here I'll need to refer to.
 14 THE COMMISSIONER:
 15 Q. I'd be pleased to hear them.
 16 MR. WILLIAMS:
 17 A. When one looks back at 2005, and I've talked
 18 about this before, there was a lot of things
 19 occurring at the time. We had a new complex
 20 organization coming together that encompassed
 21 much more than just acute care. Before that,
 22 we had a board at the Health Care Corporation
 23 that their only mandate was to deal with acute
 24 care issues, and that was a--I thought it was
 25 a full mandate. There was a lot of discussion

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1 around medical issues and acute care issues
 2 that you would expect at a tertiary care
 3 academic Health Sciences Centre.
 4 So we had a new board coming into place
 5 with a much broader mandate, bringing seven
 6 diverse organizations together, and then the
 7 hormone receptor issue hit at that same time.
 8 We didn't really have a lot of time to bring
 9 our organizational structure together. Our
 10 medical staff hadn't come together in a sense.
 11 We knew what direction we were heading in, but
 12 you needed to get your bylaws in place and
 13 that takes quite a bit to get there. So there
 14 was not as much medical input into the board
 15 as the previous board have had, and I don't
 16 know, to this day, what the level of medical
 17 input, because I still think they're working
 18 on the bylaws to try to finalize them.
 19 So we had people also dealing with issues
 20 about bringing the organization together and a
 21 changing organization and then the hormone
 22 receptor test hit and it was almost--I think
 23 it created a perfect storm in that kind of an
 24 environment where you had a lot of things
 25 going on, big challenge in itself to bring

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1 that organization together, and then a major
 2 challenge with the hormone receptor issue
 3 coming forward.
 4 A number of other issues occurred as
 5 well. The testing took much longer than we
 6 anticipated at the time, and that was beyond
 7 our control. We lobbied as hard as we could.
 8 We pestered Mount Sinai, but they had some
 9 issues. So we did our best to try to speed up
 10 the testing, but it was longer than we thought
 11 was going to happen at the time.
 12 There's the whole issue of coordination
 13 retesting and disclosure and follow up with
 14 other regional health authorities that took
 15 place, I guess, in the fall and in the spring
 16 of--fall of 2005-2006 when all this was going
 17 on, and I'm trying to sort of put this in the
 18 context of what lessons we've learned, and the
 19 first lesson we've learned, and it's an old
 20 adage in medicine, prevention is better than
 21 cure, and that's the first lesson, I think,
 22 that comes out of this.
 23 And there's a number of themes that I
 24 think arose in the consultants' reports and in
 25 the documentation that Dr. Carter, in the

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1 suggestions that she's made in some of her
 2 letters, and that scrupulous attention to deal
 3 with testing and quality issues in a very
 4 sensitive area. These tests are fraught with
 5 difficulties, as we know now, and they require
 6 scrupulous attention to deal with all aspects
 7 of the testing and the quality that's built
 8 into the testing for to get a good result. I
 9 can see that, and that was stressed by her.
 10 And then there's checks by external quality
 11 initiatives. So I guess we've learned that,
 12 and in work I've done and discussions I've
 13 had, we can get external quality organizations
 14 such as the College of American Pathologists
 15 and a group in Great Britain to do checks on
 16 us every four months, but there's nothing
 17 better than having a rigorous standard in
 18 terms of what's ongoing between those checks
 19 to take place and the quality management
 20 program for laboratory services in Ontario
 21 seems to address both these facets, the need
 22 for detail and scrupulous testing, along with
 23 some external proficiency testing and quality,
 24 and that's why I know it's being pursued and
 25 it's my hope that that somehow we can enrol in

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1 that, all the labs in the province, so that we
 2 can be assured that all aspects of the lab are
 3 going to be at the highest standard on a
 4 continuous basis. So that's an important
 5 issue, and I think it's being pursued and
 6 something like that needs to be pursued
 7 because we want to make sure that this--we
 8 take everything we can do to prevent this from
 9 happening again.
 10 Number two, I think is now we're at an
 11 era in our health care system where things are
 12 very complex and complicated, and there's--
 13 health care is more effective than it used to
 14 be, but it's more complex and prone to errors
 15 and this type of thing. A lot of things can
 16 happen, and things--some of the things we do
 17 are very complex. There's a lot of people
 18 involved and I think there's a need probably
 19 to have a patient safety and quality focus,
 20 and maybe rather than have a vice president
 21 who's response for that and a number of other
 22 things, that that's something, I think, that
 23 each organization needs to consider in your
 24 system, have a vice president who has quality
 25 as the mandate, quality and patient safety

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1 rather than quality patient safety and this,
 2 this, and this and something else. So that's,
 3 I think that's something we might want to
 4 think about and we might have learned from.
 5 We obviously need to develop a plan to
 6 handle situations, major adverse events like
 7 this in the future. And I think in planning
 8 for this we should bring together the
 9 Department of Health and Community Services
 10 because I think they have a role to play along
 11 with the regional health authorities to look
 12 at some process similar to what was done for
 13 pandemic influenza. There was a lot of work
 14 done on developing a strategy for pandemic
 15 influenza in our province if it struck. And I
 16 think there's the same analogy here that maybe
 17 that type of an approach should be taken here
 18 so that we have the thing documented and a
 19 strategy to deal with the next major adverse
 20 event, because I don't think we can say that
 21 it may not happen again. We have to plan on
 22 it happening again and we have to be prepared.
 23 And I think the Department of Health and the
 24 regional health authorities both need to be
 25 involved in that because a major strategic

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1 issue like that, in my view, so, is so far
 2 reaching that there is a role for the
 3 Department of Health to play in this. That
 4 would be my--now, it may be biased based on my
 5 background, but I think there is.
 6 And really, you need to have senior
 7 leadership and staff who are involved and
 8 dedicated to, if the issue is that big, I
 9 think the staff who are involved and are
 10 bringing, try to bring, trying to deal with it
 11 need to be dedicated to that task only.
 12 That's one of the lessons, from my
 13 perspective, I think I've learned out of this.
 14 You can't be--it's very difficult to bring
 15 together, and I want to describe this as sort
 16 of a web of interactions on the issue, because
 17 somebody might have said this over here three
 18 months ago and then did you consider that they
 19 said that three months ago, did you follow up
 20 on that three months ago. It's almost like a
 21 web, in my view, of interactions that take
 22 place as we move forward. And I think
 23 somebody needs to be totally focused if one is
 24 to bring together that web of interactions and
 25 bring it all together to wrap it around the

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1 problem that we're dealing with and deal with
 2 all aspects of it appropriately. And I think
 3 it's very hard to do this when one is moving
 4 from one topic to another. It might be me,
 5 might be Ms. Predham, it might be some other
 6 people that are involved heavily in this but
 7 also doing something else. So I might have,
 8 on one day, four meetings. My average would
 9 be four or five meetings a day. I might deal
 10 with ER and PR issues one minute, then I'm
 11 going out in the next room trying to keep the
 12 medical oncology program together because
 13 we've had a shortage, some people have left,
 14 and we got a major challenge. Some of these
 15 other issues, they didn't come to the
 16 forefront because we were able to deal with
 17 them, but some of these issues in themselves
 18 are major issues and you move around from one
 19 and you just can't get the focus.
 20 And the next thing is the whole issue of
 21 follow-up, which is important, to address
 22 findings and their dissemination out to the
 23 system. And that needs to be part of that
 24 web. So you wrap--you bring all the issues
 25 together in linkages in the web and you see

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1 the total picture and you wrap it around the
 2 issue and make sure everything, all the bases
 3 are covered.
 4 And then there's the whole issue of we've
 5 talked a lot about peer review. There is an
 6 important aspect of peer review, I think,
 7 that's worth protecting, especially on an
 8 individual basis to get issues dealt with and
 9 get all the issues out on the table. But in
 10 something like an adverse event we need to
 11 give some thought to how we might approach
 12 that so that anything we find can be more--can
 13 be shared with the public and we're not
 14 involved in or breaching anything in peer
 15 review. It might be that we just have to, if
 16 things--something happens in the future, we
 17 set it up outside the quality and peer review
 18 process. Hopefully we'll get all the things
 19 out on the table and people will be forthright
 20 in their reports and this type of things. But
 21 that's one of the considerations that if
 22 somebody comes together and talks about this,
 23 how we might get a handle on it. That needs
 24 to be discussed.
 25 The issue of communications came up and

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1 that's always a difficult issue. I brought it
 2 up in the context early on that we would have
 3 to go public rather than a case-by-case basis
 4 because I thought that we didn't know who the
 5 case-by-case basis would be. And sometimes in
 6 going public with communications you're trying
 7 to get at the individuals who will be impacted
 8 rather than just, you're not just trying to
 9 deal with the public, you're trying to deal
 10 with individuals but you can't find, you don't
 11 know who these individuals are yet because
 12 you're not far enough along. It always
 13 strikes me and I had a gut feeling that you're
 14 always--the issue of saying something up
 15 front, if you don't say it up front, you're
 16 probably--somebody brought out you may be
 17 subject to people feeling that you're hiding
 18 something or suspicious and you're behind the
 19 eight ball to start out with. So we, at the
 20 time there was a lot of thought and
 21 consideration gone into that. And we did
 22 consider the concerns of the oncologists, they
 23 were there from day one working through this
 24 with us. They have difficult jobs to do and
 25 very sensitive jobs to do and they're on the

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1 front lines in dealing with patients. And I
 2 look at the oncologists in terms of their
 3 number that we have, in terms of their
 4 workload, I think they're always skating on
 5 thin ice, to be--make that analogy, that
 6 they're able to cope, but it's a difficult
 7 situation on a day-to-day basis. And they
 8 raised the concerns that if this happened
 9 early on, it might affect their ability to
 10 continue to deliver care and they'd have to
 11 deal with a lot of people who would be upset.
 12 So that was a consideration. When you look at
 13 that in retrospect, that's something we
 14 weighed at the time and we made a judgment
 15 call, but that's something that I think the
 16 whole issue of communications is something
 17 that we wound up in this and how we might
 18 approach it based on the lessons we've
 19 learned. Because there's individual
 20 communications that have to be done, there's
 21 probably some public issues. You have to look
 22 at how you approach it and you have to look at
 23 the timing.
 24 There's a number of other points I'd like
 25 to raise, I'll try to be as quick as I can.

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1 COMMISSIONER:
 2 Q. No, take your time.
 3 DR. WILLIAMS:
 4 A. I'd just like to say that from my perspective
 5 this has been a very difficult situation. And
 6 from the perspective of the patients and
 7 families I know it's been an even more, much
 8 more significant and difficult situation.
 9 I've been in health care for 38 years now
 10 trying to help, that's what I got involved in
 11 it for, to try to improve care both at the
 12 individual level, it's been my practice and
 13 ongoing practice and experience in the past
 14 and at the collective level for patients in
 15 our province. And by far this has been the
 16 most difficult situation I have ever had to
 17 deal with. You've got an important test going
 18 back many years, affecting many people. I'll
 19 never be able to get over this. When we made
 20 a decision early on to retest, we knew the
 21 magnitude of the decision at the time, we knew
 22 that this was going to be a major issue at the
 23 time but felt retesting must be pursued.
 24 Since then we've seen many similar issues
 25 surface across the country and some of these

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1 issues have been on the forefront of the media
 2 right across Canada lately, in the papers and
 3 the Globe and Mail you can't go by with a week
 4 you don't have another issue such as this
 5 coming out. We had to make many decisions and
 6 judgments along the way with the focus always
 7 being on retesting of patients as soon as
 8 possible, getting results to patients and
 9 their family--and their physicians with the
 10 best possible advice for follow-up. In this
 11 process decisions were not black and white.
 12 We were not dealing with a perfect science.
 13 And after decisions, often decisions had to be
 14 made by balancing certain considerations as we
 15 moved along. Often things, when you have a
 16 chance to look back at them and reflect on
 17 them in retrospect, they look different on
 18 further consideration.
 19 I want to sincerely apologize, I'm going
 20 to do this on a personal basis, for any of my
 21 shortcomings in this process. I just hope and
 22 I--that the over 100 patients whose treatment,
 23 who had a recommended change in their
 24 treatment will benefit by the retesting and
 25 the recommendations. It's late, but at least

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1 I'm hoping that these people will benefit.
 2 Over the next few months and weeks,
 3 months, you'll be hopefully hearing from many
 4 good and caring people at all levels in our
 5 organization, whether it's people trying to do
 6 a good job within the organizations on a daily
 7 basis and the Inquiry will hear from them,
 8 whether it's people in communications, in
 9 quality, management or the lab techs on the
 10 bench or from our physician leaders in our
 11 organizations. I think they'll have a story
 12 to tell and hopefully it will help the
 13 Commission reach their mandate.
 14 And finally, I'd like to say that the
 15 process of this Commission, because there's
 16 been a lot said about it, has been very
 17 detailed and it's been very pointed and it's
 18 been hard hitting, both in the interview
 19 process and here over the past four or five
 20 days for me. But I appreciate that you have a
 21 job to do and I want to say that from my
 22 perspective I've been fairly treated by the
 23 co-counsels in this whole endeavour, Ms.
 24 Chaytor and Mr. Coffey, and I want to commend
 25 them for that. Thank you, very much.

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1 COMMISSIONER:
 2 Q. Thank you, Mr. Williams. Do you have anything
 3 further, Mr. Simmons?
 4 MR. SIMMONS:
 5 Q. No. Thank you, Commissioner.
 6 COMMISSIONER:
 7 Q. Mr. Coffey, is there anything arising from Dr.
 8 Williams' -
 9 COFFEY, Q.C.:
 10 Q. Yes, just a couple of points.
 11 DR. ROBERT WILLIAMS, RE-EXAMINATION-IN-CHIEF BY BERNARD
 12 COFFEY, Q.C.
 13 COFFEY, Q.C.:
 14 Q. Doctor, just on a point that was raised with
 15 you. If we could just bring up, please,
 16 Exhibit P-0623, page 3? Thank you. This is
 17 this poor quality version of the October 6th,
 18 2005 Evening Telegram or the Telegram
 19 newspaper report, Doctor.
 20 UNKNOWN SPEAKER:
 21 Q. (Inaudible).
 22 COFFEY, Q.C.:
 23 Q. Yeah, there is, but, in fact, it's only to
 24 remind--just to put it in context for you is
 25 the only reason I raise it, Doctor, bring it

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1 up here. And you've already explained to the
 2 Commissioner the, kind of how you arrived at
 3 the ten percent?
 4 DR. WILLIAMS:
 5 A. Yes.
 6 COFFEY, Q.C.:
 7 Q. Early on which is really just subtracting 73
 8 from approximately 82 or so and -
 9 DR. WILLIAMS:
 10 A. Yeah, low 80s, 80.
 11 COFFEY, Q.C.:
 12 Q. Yes. It was a rough figure?
 13 DR. WILLIAMS:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. And just on the point, just to do the
 17 arithmetic, as 27 percent at the time you
 18 thought of the overall original ER tests were
 19 going to be retested?
 20 DR. WILLIAMS:
 21 A. Um-hm.
 22 COFFEY, Q.C.:
 23 Q. You figured 27. So if you actually just do
 24 the arithmetic, you divide 10 by 27, if you
 25 just divide 10 percent over the--27 are going

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1 to be--27 percent are going to be retested, 10
 2 percent will probably change or convert?
 3 DR. WILLIAMS:
 4 A. Ten percent overall.
 5 COFFEY, Q.C.:
 6 Q. Ten percent overall. So it's 10 divided by
 7 27. In fat, you then get a projected
 8 conversion rate of about 37 percent of the
 9 retests? That would be -
 10 DR. WILLIAMS:
 11 A. I was looking at around maybe we'll get 30
 12 percent.
 13 COFFEY, Q.C.:
 14 Q. Yeah.
 15 DR. WILLIAMS:
 16 A. But we were looking at trying to put that into
 17 context of overall people that would be
 18 affected.
 19 COFFEY, Q.C.:
 20 Q. Yeah. And -
 21 DR. WILLIAMS:
 22 A. That was the perspective I took at the time.
 23 COFFEY, Q.C.:
 24 Q. Yes. Doctor, you did, in answer to a question
 25 one of my colleagues asked you, say that from

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1 your perspective the entire ER/PR matter could
 2 be characterized as, I think you said, all one
 3 adverse event?
 4 DR. WILLIAMS:
 5 A. Well -
 6 COFFEY, Q.C.:
 7 Q. Looked at from one perspective.
 8 DR. WILLIAMS:
 9 A. I would look at it as a major adverse event
 10 that occurred in the province.
 11 COFFEY, Q.C.:
 12 Q. Yeah. Affecting many individuals.
 13 DR. WILLIAMS:
 14 A. Many people. Now, you could say, well, there
 15 was, we retested so many people and the people
 16 that were affected, there were so many--these
 17 are individual adverse events. I choose--but
 18 I said it's a major adverse event.
 19 COFFEY, Q.C.:
 20 Q. Doctor, on that point, was there anything--I
 21 mean, what characteristic, kind of now looking
 22 back at it, what characteristic or
 23 characteristics, from your perspective of the
 24 overall circumstances led you to say, well,
 25 looked at now or at least even at the time,

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1 but certainly now it could be seen as one
 2 large or major adverse event, what is it about
 3 it?
 4 DR. WILLIAMS:
 5 A. Well, I look at the magnitude of it, Mr.
 6 Coffey, and the time frames that were
 7 involved. And when I reflect back on it, when
 8 I--in early July I started to realize it was
 9 your worse nightmare, really, that you would
 10 have a large number of patients potentially
 11 affected by an important test that went back
 12 for many years. So that's why I would
 13 classify it as a major adverse event. Now,
 14 within that event there was obviously a
 15 series, but I--there was events within the
 16 event, but I took it collectively when I said
 17 that.
 18 COFFEY, Q.C.:
 19 Q. Doctor, in--would it be fair to say, Doctor,
 20 that you've talked about lessons learned here
 21 from your perspective, that without those two
 22 external reviewers reports being able to be
 23 made public, okay, to this day do you think
 24 that the public would be aware of what the
 25 causes of the problems were?

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1 DR. WILLIAMS:
 2 A. And that's why I reflected on that.
 3 COFFEY, Q.C.:
 4 Q. Yes.
 5 DR. WILLIAMS:
 6 A. You may want to take a different approach, Mr.
 7 Coffey. There is a value in protecting peer
 8 review maybe for an individual basis where you
 9 can talk over the results, because we've had
 10 that happen in our organization. But also we
 11 may need to take a different approach if we
 12 have a similar event in the future. So that's
 13 an issue and I've tried to address it in my
 14 points here.
 15 COFFEY, Q.C.:
 16 Q. Doctor, just on the matter of what you--when
 17 you briefed the board, in particular, in
 18 September, I believe, September 21st, 2005,
 19 now, and I appreciate you didn't keep notes on
 20 it and it certainly wasn't recorded, but do
 21 you think that you conveyed to the board and
 22 the one person from the board we've had here
 23 is Ms. Dawe.
 24 DR. WILLIAMS:
 25 A. Um-hm. Yes.

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1 COFFEY, Q.C.:
 2 Q. That you conveyed to the board the message
 3 that Dr. Banerjee had by then given you, that
 4 it's not the machines, it's the humans?
 5 DR. WILLIAMS:
 6 A. Well, I would have conveyed what I knew at the
 7 time, which was what Dr. Banerjee, the
 8 comments he made. I didn't have his report at
 9 the time and I hadn't been debriefed by Trish
 10 Wegrynowski, because I think her debriefing
 11 took place on the 22nd.
 12 COFFEY, Q.C.:
 13 Q. Yes.
 14 DR. WILLIAMS:
 15 A. That was the 21st. That's my understanding I
 16 was talking about what Dr. Banerjee said. And
 17 I think Mr. Tilley had some notes, I didn't
 18 take notes, he took some notes on what I said,
 19 apparently. That would be my perspective on
 20 it, Mr. Coffey. I can't produce you a set of
 21 notes. I did talk for, I would think it was
 22 upwards to 45 minutes and I think I covered
 23 the basis on what I knew at the time. Other
 24 people were there from the executive and maybe
 25 remember, may remember parts of what I said.

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1 But that's my -
 2 COMMISSIONER:
 3 Q. Sorry to interrupt, did you complete the
 4 thought, I'm sorry?
 5 DR. WILLIAMS:
 6 A. Well, I think I would have.
 7 COMMISSIONER:
 8 Q. Yeah. I'm just wondering how that arose from
 9 the examination of other counsel?
 10 COFFEY, Q.C.:
 11 Q. Well, it's--I had been making a habit of
 12 cross-referencing them, Commissioner, and I
 13 will leave it, okay. I believe it did, but--
 14 it's just that there was this juxtaposition
 15 between your account and -
 16 DR. WILLIAMS:
 17 A. Yes, I understand in retrospect, Mr. Coffey,
 18 and I feel I presented the full picture and I
 19 feel that I made--I brought out comments that
 20 Dr. Banerjee--Mr. Tilley had some notes
 21 talking about, I think, fixation and things
 22 like that. He wouldn't have had those notes,
 23 I don't think, if the word "fixation" and
 24 things like that didn't come up, sir.
 25 COFFEY, Q.C.:

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1 Q. Okay.
 2 DR. WILLIAMS:
 3 A. So I can only say that, and again, this is a
 4 board that had been new at the time, just
 5 coming together, had an awful broad mandate
 6 and a lot of things to get their head around
 7 at that time and subsequently. So if it's not
 8 clear to some people, I apologize for that,
 9 but I thought I covered the bases, sir.
 10 COFFEY, Q.C.:
 11 Q. You thought you had?
 12 DR. WILLIAMS:
 13 A. Yes, I did, sir.
 14 COFFEY, Q.C.:
 15 Q. And that's what I really wanted to ask you
 16 about.
 17 DR. WILLIAMS:
 18 A. That's what I think.
 19 COFFEY, Q.C.:
 20 Q. You did make reference to the day in terms of
 21 you said that they in times of restraint, of
 22 course, always first wanted to cut CME
 23 funding?
 24 DR. WILLIAMS:
 25 A. Any travel, when we get together at, you know

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1 -

2 COFFEY, Q.C.:

3 Q. I was just going to ask you, who is "they"?

4 DR. WILLIAMS:

5 A. - this goes back to my days in Department of

6 Health and things like that. Anything--the

7 first things that go when you're trying to cut

8 a budget is travel.

9 COFFEY, Q.C.:

10 Q. So who is they?

11 DR. WILLIAMS:

12 A. It would be us, around the table having to try

13 to deal with a budget, you try to--and when I

14 was at the department, one of the first things

15 we do is slash the travel budget in your

16 organization because you felt some of that was

17 discretionary and when you're trying to

18 deliver a service to a patient, sometimes you

19 have to make the decisions that anything that

20 affects the service to this individual patient

21 you're going to try to protect, so you slash

22 the other things that you think are

23 discretionary and travel budgets is the key,

24 one of the key ones. Now, that's not just in

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1 Eastern Health, that's when I was at the

2 department.

3 COMMISSIONER:

4 Q. I believe you, if I recall correctly, often

5 the choices are not easy?

6 DR. WILLIAMS:

7 A. The choices are never easy.

8 COMMISSIONER:

9 Q. If you're--if you don't cut travel, then you

10 may have to cut into a program or something

11 like that?

12 DR. WILLIAMS:

13 A. Yes, or may have to deny a service to somebody

14 at the front lines.

15 COFFEY, Q.C.:

16 Q. You also said in response to a question one of

17 my colleagues asked you that you're doing an

18 investigation of yourself, you're well advised

19 to go outside?

20 DR. WILLIAMS:

21 A. I think, yes, I think if you're going to

22 really--if you're sitting around a table with

23 the colleagues you work for every day and you

24 think there might be a problem there, I think

25 to get a real assessment, you're going to have

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1 to work with these people after, to get a real

2 and fair assessment we always go outside our

3 organization for peer reviews, Mr. Coffey.

4 COFFEY, Q.C.:

5 Q. So I take it that's going to be an implicit

6 recognition that there's a conflict of

7 interest potential?

8 DR. WILLIAMS:

9 A. There is a conflict when you're dealing with

10 sitting next to somebody every day and working

11 with them side by side. You're going to--if

12 there's a deficiency there, are you really

13 going to bring it out and then go work with

14 them the next day? So that's why in our peer

15 reviews we always get somebody who's not a

16 colleague within our organization but is

17 somebody at the same level of training and

18 expertise and should be able to do it, of a

19 colleague. Colleague in the sense that

20 they're not working with them, but a colleague

21 in the sense that they do the same kind of job

22 or have the same kind of background.

23 COFFEY, Q.C.:

24 Q. If I could, Commissioner, just one final point

25 of clarification, actually, two. And this,

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1 Commissioner, I will acknowledge it didn't

2 arise from other counsel's questions, but I

3 think it's important because it occurred to me

4 upon reflection to explore it with the doctor.

5 And it's just if we could bring up, please,

6 Exhibit, say, P-0063? Page--I'm sorry, I

7 apologize, 0631, I apologize, P-0631. Page 3,

8 please? Doctor, this is, I gather that, and

9 again, this is one of those tables,

10 spreadsheets, prepared probably in October of

11 '05 when you look at some of the ones that are

12 related to it in the exhibit. And you'll

13 notice here that, I spoke about this earlier,

14 that the--that 11 percent, Ventana, April '04

15 to March, '05, which is total percent negative

16 is 11 percent. It should be, the converse

17 would be 89 percent positive and weak

18 positives combined.

19 DR. WILLIAMS:

20 A. Um-hm.

21 COFFEY, Q.C.:

22 Q. And if we could bring up, please, Exhibit P-

23 1135, page 1? 1135, page 1. Now, this is

24 this June 7th, 2006 memo which you've

25 explained to the Commissioner, you know, got

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1 recalculated based upon or in light of remarks
 2 from Dr. Gown regarding the '04, '05 Ventana
 3 ER/PR?
 4 DR. WILLIAMS:
 5 A. Um-hm.
 6 COFFEY, Q.C.:
 7 Q. And here Mr. Gulliver has said, he said, "We
 8 read each report and identified the total
 9 number of positive previously reported and
 10 also included specimens that were ER/PR
 11 positive but not breast specimens."
 12 DR. WILLIAMS:
 13 A. Yes.
 14 COFFEY, Q.C.:
 15 Q. You understood he was then taking out the non-
 16 breast specimens for the Ventana?
 17 DR. WILLIAMS:
 18 A. That's my understanding at the time.
 19 COFFEY, Q.C.:
 20 Q. Okay. On that point, it just occurred to me
 21 after, if I might be allowed to ask the
 22 question, Commissioner, what about the other
 23 times, what about the other years and those
 24 figures for, like, oh, '89--I'm sorry, '99,
 25 2000, '01, '02, '03, '04?

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1 DR. WILLIAMS:
 2 A. I didn't think there would be breast specimens
 3 in them or otherwise he would have probably
 4 alerted me to that.
 5 COFFEY, Q.C.:
 6 Q. So what I was asking -
 7 DR. WILLIAMS:
 8 A. I thought they were primary breasts.
 9 COFFEY, Q.C.:
 10 Q. Yes.
 11 DR. WILLIAMS:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. And you had originally thought that, when we
 15 look at exhibit, the one we just had up,
 16 Exhibit P-0631. Yes. Page 3. You had back
 17 in the fall of '05 thought that these were
 18 primary breast?
 19 DR. WILLIAMS:
 20 A. Yes, sir.
 21 COFFEY, Q.C.:
 22 Q. Yeah. But as it turns out this particular
 23 column, the last one on the right, by June of
 24 '06 you'd figured out that, in fact, it wasn't
 25 just primary breast, this column included

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1 others?
 2 DR. WILLIAMS:
 3 A. Well, it had come up before Dr. Gown had made
 4 a comment -
 5 COFFEY, Q.C.:
 6 Q. Sure, and I appreciate -
 7 DR. WILLIAMS:
 8 A. - so I asked him to go and review it and he
 9 brought me back a set of figures that were
 10 primary breast.
 11 COFFEY, Q.C.:
 12 Q. Which we just looked at just then?
 13 DR. WILLIAMS:
 14 A. Yes.
 15 COFFEY, Q.C.:
 16 Q. For that. But the figures he brought back
 17 were only for this year? He only brought
 18 back, according to what we just looked at, P-
 19 1135.
 20 DR. WILLIAMS:
 21 A. I didn't, again, I didn't link that back, I
 22 thought that that was done under the Ventana,
 23 I thought that would cover all the new Ventana
 24 tests.
 25 COFFEY, Q.C.:

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1 Q. And I appreciate that.
 2 DR. WILLIAMS:
 3 A. Yes.
 4 COFFEY, Q.C.:
 5 Q. Is what he's telling you here.
 6 DR. WILLIAMS:
 7 A. Yes.
 8 COFFEY, Q.C.:
 9 Q. Like upon recalculation of the Ventana
 10 results.
 11 DR. WILLIAMS:
 12 A. Yes.
 13 COFFEY, Q.C.:
 14 Q. We get down to about 82 and a half percent
 15 total positives?
 16 DR. WILLIAMS:
 17 A. Yes, that was in the range that you could
 18 consider reasonable.
 19 COFFEY, Q.C.:
 20 Q. Because, and we get that because I had earlier
 21 included non-breast ER/PR?
 22 DR. WILLIAMS:
 23 A. Yes, that's correct.
 24 COFFEY, Q.C.:
 25 Q. For that period?

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1 DR. WILLIAMS:
 2 A. Yes.
 3 COFFEY, Q.C.:
 4 Q. Did you ever take up with Mr. Gulliver whether
 5 or not for the 2000, 2001, 2002, 2003 and two
 6 thousand and--well, the pre Ventana days, the
 7 figures we just looked at there, 0631, did
 8 they include -
 9 DR. WILLIAMS:
 10 A. I just assumed we were talk about ER and PR
 11 and primary breast that they -
 12 COFFEY, Q.C.:
 13 Q. Yeah. Did you ever -
 14 COMMISSIONER:
 15 Q. Maybe you should ask -
 16 COFFEY, Q.C.:
 17 Q. Yes, okay, so you never did take it up with
 18 him?
 19 DR. WILLIAMS:
 20 A. No, I didn't take it up with him and I didn't
 21 think I had any reason to take it up with him,
 22 Mr. Coffey.
 23 COFFEY, Q.C.:
 24 Q. And I want to thank you, Doctor. Thank you,
 25 very much, Commissioner.

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1 DR. WILLIAMS:
 2 A. Thank you. Thank you, Mr. Coffey.
 3 COMMISSIONER:
 4 Q. Thank you. I too would like to add my thanks,
 5 Dr. Williams. I've said when other witnesses
 6 have been here, it's critically important that
 7 I get the story about what occurred and the
 8 views of the people who have been involved,
 9 and a lot of those, of course, would come from
 10 Eastern Health. I thank you very much for
 11 your contribution and for your, what I will
 12 call advice about things that should be
 13 considered.
 14 DR. WILLIAMS:
 15 A. Thank you, very much.
 16 COMMISSIONER:
 17 Q. Okay. Thank you. Now, we'll take the morning
 18 break. Counsel, if you have not gotten my
 19 message, I would like a meeting with counsel
 20 in our boardroom. May I suggest you take your
 21 break, get your coffee and meet me in the
 22 boardroom in, say, ten minutes? Thank you.
 23 (RECESS)
 24 COMMISSIONER:
 25 Q. Thank you. Please be seated. We've just had

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1 a meeting of counsel in which we discussed
 2 some organizational issues and at that same
 3 meeting we agreed that we would adjourn at
 4 this point until 9:30 tomorrow morning. The
 5 reason for the adjournment is the arrival of
 6 some additional materials from the next
 7 witness and to give all of the parties with
 8 standing an opportunity to review that
 9 material before the witness takes the stand.
 10 So we'll adjourn then until 9:30 tomorrow
 11 morning. Thank you.
 12 Adjourned at 12:18 p.m.

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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 21st 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 21st day of May, A.D., 2008
 13 Judy Moss

Inquiry on Hormone Receptor Testing

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