COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MAY 21, 2008

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Regional Integrated Health Authorities

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Q. Please be seated.
MS. TAYLOR:
Q. Good morning, Commissioner.
COMMISSIONER:
Q. Good morning.
DR. ROBERT WILLIAMS, EXAMINATION BY MS. PAMELA TAYLOR
(CONTINUED)
MS. TAYLOR:
Q. Good morning, Mr. Williams.
DR. WILLIAMS:
A. Good morning.
MS. TAYLOR:
Q. Registrar, if we could please pull up Exhibit P-0113, page 5? Actually, if you could--yeah, page 5, please? Now, Dr. Williams, this is the memo to Terry Gulliver from Dr. Ejeckam dated June 19th, 2003.
DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. And you've gone through this before.
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:

Q. I do have some questions on it, however.
DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. This is a memo that was cc'ed to a group of people, including, as I can see here on the last page of this memo, Dr. Cook?
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:
Q. Who would have been the clinical chief, and he was site chief at St. Clare's at that time?
DR. WILLIAMS:
A. Correct.
MS. TAYLOR:
Q. Okay. If I can go back to page 1 of that memo, which is page 5? Now, there are a number of things in here that Dr. Ejeckam indicates need to be looked at and that he thinks are unsatisfactory in terms of the state of immunostain at the General Hospital Department of Laboratory Medicine and Pathology.
DR. WILLIAMS:
A. Um-hm.

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

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A. Correct.
MS. TAYLOR:
Q. Are you aware of the recommendations that he outlined were implemented back in 2003?
DR. WILLIAMS:
A. My understanding what was done was the lab was moved to the place that it was designed to be moved to, which is the hormone assay section of our lab. That was done back in the fall of 2003. The workload of the three techs was lessened in some other aspects, they weren't dedicated as they are now to performing only those functions.
MS. TAYLOR:
Q. Right, they weren't dedicated, though, because I think there's a reference -
DR. WILLIAMS:
A. No, they were not dedicated.
MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. At the time their workload in other aspects of their work was lessened so they were more dedicated to immunohistochemistry, but not totally dedicated.

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MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. So there was some adjustment, I understand, of their workload. Now, Mr. Gulliver can clarify that for you when he testifies, but my understanding is that some of their other duties were reduced at the time. But they were still not dedicated when this issue surfaced in 2005 and we had the external reviews.
MS. TAYLOR:
Q. Right. And I think that in Trish Wegrynowski's, Ms. Wegrynowski's review, she had indicated that at that time the technologists were still on a rotation basis?
DR. WILLIAMS:
A. Yes. That changed, obviously, once we got the consultants' report and started the implementation process.
MS. TAYLOR:
Q. Right. But it hadn't changed back in 2003?
DR. WILLIAMS:
A. No, it had not changed back in 2003, you're correct.

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

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level we try to deal with things because we know that the requests and demands are always more than we're going to get, so we have to try to fine tune those. Even then we make a lot of requests to government, given the funding situation, that they often cannot accede to. So that's the process. So there's a couple of steps that normally happen if you want to deal with something budgetary, you bring it forward in the normal budgetary process. If it's something that's urgent and has to be dealt with on an expeditious basis, then we have month--we'll have monthly meetings that I could, it could come up and then I could bring it forward to the executive if it was an issue.

MS. TAYLOR:

Q. But it would be brought forward to you as VP of medical services?

DR. WILLIAMS:

A. Yes, funding issues would usually come through me.

MS. TAYLOR:

Q. Right. And in this memo some of the things that Dr. Ejeckam is indicating would be

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necessary, he's indicating that, in his view, there would be financing or budgetary issues that would be involved in that. You would agree with that?

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

Q. Okay. So it leads me to a question. You had said yesterday that when you were asked, you know, why wouldn't it have been brought to your attention or would you have expected it would have been brought to your attention back in 2003, I think your answer was if it was--if they, meaning the people who were aware of the existence of the memo, felt it was necessary. But if there are budgetary issues in there, wouldn't it have to be brought to your attention for it to be considered?

DR. WILLIAMS:

A. To move it forward, yes, totally, forward.

MS. TAYLOR:

Q. Right. So if it was going to be moved forward at that time -

DR. WILLIAMS:

A. Well, I guess -

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MS. TAYLOR:

Q. - you would have to be made aware of it?

DR. WILLIAMS:

A. - the individuals that were there at the time felt they'd resolved the issue at their level. That's my understanding.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. So it wasn't brought forward.

MS. TAYLOR:

Q. Right. But in terms of feeling that it was resolved at that level, you've just indicated that the dedicated staffing didn't happen back in 2003?

DR. WILLIAMS:

A. No, it did not.

MS. TAYLOR:

Q. So there were at least some issues that hadn't been dealt with back in 2003?

DR. WILLIAMS:

A. Oh, yeah, there was issues that hadn't totally been dealt with. That's why when the consultants came in, there was some adjustments that we had to make.

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MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. And in October, on October, I think, sometime in October, 2005 after Dr. Banerjee had visited here and Trish Wegrynowski had visited here, there was a proposal put forward. I asked Dr. Cook and Mr. Gulliver to put forward a proposal to deal with some of the issues that had been identified early on so that we could get moving on them, yes.

MS. TAYLOR:

Q. Sure. And absolutely, it's just when I go back to the Dr. Ejeckam memo and that statement that "Diagnosis based on inappropriate immunostain will surely jeopardize patient care and may even expose the Health Care Corporation of St. John's to litigation." That was the situation, in Dr. Ejeckam's view, back in 2003?

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

Q. And those things, not all of them had been dealt with.

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

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MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. That's one of the things we dealt with early on because, you know, you have to make a decision up front if you're going to deal with those things, are you going to move forward or not with the recommendations.
MS. TAYLOR:
Q. Sure. But two years previously it was already coming up inside of your organization?
DR. WILLIAMS:
A. We've talked about that before.
MS. TAYLOR:
Q. Yeah.
DR. WILLIAMS:
A. There was some issues came up and some of the issues got dealt with fully and some others did not get dealt with fully.
MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. We finalized them in 2005.
MS. TAYLOR:
Q. There would have been people aware in your organization, even in 2003, it didn't necessarily have to be pointed out by an external reviewer that this was an issue, it was already seen to be an issue by at least one person who was referred to by Dr. Cook as the point man for immunoperoxidase testing in 2003 and was still in that position, apparently, in 2005?

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DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. I think he was referred to as the resource person for immunohistochemistry?
DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. Now, on that point, while Dr. Cook talked to Dr. Ejeckam, you had asked Dr. Cook to follow up with Dr. Ejeckam, you hadn't spoke to him yourself?
DR. WILLIAMS:
A. No.
MS. TAYLOR:
Q. When I look through the ongoing, I'm going to refer to it as an investigation, looking into the issue of ER/PR internally in terms of collecting slides, setting up testing, all of those sorts of things, there's a number of people that are involved in that, but Dr. Ejeckam certainly doesn't have a lot of involvement in that, and that's despite his 2003 involvement and the fact that he was the point man for this particular type of testing. Is there any particular reason for that?

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DR. WILLIAMS:
A. Well, getting the slides, you mean, sent of out the province, this type of thing?
MS. TAYLOR:
Q. Well, just even being involved in a discussion of the issue. He certainly seemed to be recognized as someone who had a level of knowledge in the organization on this issue?
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:
Q. I would think that you'd be trying to collect together the best minds that you have to deal with an issue that you've referred to as the biggest issue that Eastern Health had dealt with and probably will deal with?

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DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. So you'd want to collect together the best people that you could?
DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. So why wouldn't Dr. Ejeckam have had more of a role in that process?
DR. WILLIAMS:
A. Well, Dr. Cook did speak to him in some detail on a number of occasions just after this event surfaced in 2005. He talked to him in 2003 on the matter, is my understanding. And he talked to Dr. Robb, among other people, to get some other views involved at the time, too.
MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. And based upon that there was no recommendation coming forward to retest, to do anything other than what was done in 2003.
MS. TAYLOR:
Q. Right. Now, if we could go, please, to P-

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

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

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thoroughly.
MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. And the letter was written, I think if you look thorough it all, it's requesting that, based upon her preliminary review, she'd like to do more work on it, and we did support her on it.
MS. TAYLOR:
Q. What about the next line, the next sentence that she, "I've been unable to review paperwork from 1997 to 2003 with regards to protocols, quality practice and controls." Did you ask any questions about that?
DR. WILLIAMS:
A. No. I just thought that that was, you know, some things she'd like to follow up on.
MS. TAYLOR:
Q. Okay.
DR. WILLIAMS:
A. I didn't see it that somebody was refusing her to do it or it wasn't available. I looked at her letter, to be honest with you, as a request for resources to carry out an

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investigation and would have talked to Dr. Cook about it.

MS. TAYLOR:

Q. Yeah.

DR. WILLIAMS:

A. Dr. Cook, subsequently replied and we followed up, I think, with Mr. Gulliver and maybe Mr. Dyer to make sure that those resources would be available.

MS. TAYLOR:

Q. Later, though, as you became more involved in the process, that's what you were thinking initially, but did you come to any knowledge or understanding in terms of the paperwork that would have been available during that period of time, 1997 to 2003, on protocols, quality practice and controls?

DR. WILLIAMS:

A. Well, I came to be aware, as we moved through the consultants' reports and that, especially Trish's, that some of the paperwork was not to the standard that they would have in Ontario. And there's also some question about the paperwork, we had a flood at the time, as well, that we lost a lot of material in.

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MS. TAYLOR:

Q. Some of the paperwork wouldn't have been to the standard, but, for example, on protocols, was it actually even in existence? I mean, there were a number of recommendations made by Ms. Wegrynowski about putting protocols in place?

DR. WILLIAMS:

A. Yes, um-hm.

MS. TAYLOR:

Q. And the documentation wasn't there.

DR. WILLIAMS:

A. Yeah, the -

MS. TAYLOR:

Q. So did it actually even exist?

DR. WILLIAMS:

A. It didn't seem to be that we recorded everything in terms of controls and this type of thing.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. And we needed to develop, as you can see, a policy and procedures manual, this type of thing, was one of the beginnings.

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MS. TAYLOR:

Q. Right. So in terms of protocol, quality practice and controls, wasn't, it wasn't just that she couldn't see them, there's a good chance it didn't exist?

DR. WILLIAMS:

A. Yeah, in this, in this, I guess, letter, I didn't see it as saying that it did or didn't exist. It was a request -

MS. TAYLOR:

Q. Sure.

DR. WILLIAMS:

A. I took this letter as a request, let's do some more work, and can you get--I need resources to do that.

MS. TAYLOR:

Q. Right. And that's fine in that letter. But in terms of what you later came to know, you later came -

DR. WILLIAMS:

A. What we later came to know I think is laid out in the consultants' reports, basically.

MS. TAYLOR:

Q. Okay. Now, if I can go down a little bit further, in the second paragraph she's laying

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out what seems to be the plan of what she thinks needs to happen and what she feels that would be appropriate to do in this situation in terms of reviewing receptor status of patients. And sorry, seven lines down or six lines down she's saying, "All of the slides from the cases, including the estrogen receptor slides, need to be pulled and organized. All slides then need to be reviewed by me, both estrogen receptor negative and estrogen receptor positive patients. Estrogen receptor negative patients should be given priority." Looking at that, it seems to be, in my reading of it, that she contemplated a review of all patient receptor status, of all patients' receptor status, not just those that were negative?

DR. WILLIAMS:

A. It looks that way, yes.

MS. TAYLOR:

Q. Okay. Did you discuss that with Dr. Carter?

DR. WILLIAMS:

A. No, I didn't discuss it. Now, we may have discussed it, because I met with Dr. Cook and Dr. Carter on a number of occasions, but I'm

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not so sure I got down into, you know, that level.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. What I was, I guess, discussing with Dr. Cook was he had a letter, he talked to me about it and the discussion really emanated around Dr. Carter will be going forward on this.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. He supported her doing it and we needed to make sure we got her the resources to do it, and we started to do that.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. And then, of course, subsequently she was not able to continue or she did not choose to continue.

MS. TAYLOR:

Q. But now in terms of a review that would involve both estrogen receptor negative and estrogen receptor positive patients, that's

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not what's actually done later?

DR. WILLIAMS:

A. No.

MS. TAYLOR:

Q. It's a focus on estrogen receptor negative patients?

DR. WILLIAMS:

A. The focus was on people who were negative to try to ascertain if we had missed false negatives.

MS. TAYLOR:

Q. Okay. So at that time she thought that that was important, so what happened in terms of the change in that respect?

DR. WILLIAMS:

A. Well, we were all involved--I don't know if it was a change. We were all involved in moving forward on the, focusing on the negative side. Nobody raised any flags at the time, we need to be doing people who are positive at the time. That's my understanding.

MS. TAYLOR:

Q. Okay.

DR. WILLIAMS:

A. I mean, Dr. Carter was doing--we were doing

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the retesting, Dr. Carter was doing maybe more of an investigation.

MS. TAYLOR:

Q. And that, but that didn't continue?

DR. WILLIAMS:

A. No.

MS. TAYLOR:

Q. Okay. And even though she was no longer involved in terms of a front person, in that investigation or in that process, even when she resigned, nobody else took up that role?

DR. WILLIAMS:

A. Nobody took up the investigation role because then we got an outside consultant to come in, two outside consultants to come in to review what was going on in a broad sense in immunohistochemistry, look at what the causes might have been and make some recommendations for us. In the process Dr. Carter, although she didn't take on that role, was working closely with Dr. Cook as an advisor in terms of what was going on and Dr. Cook relied on her input and advice on an ongoing basis. And as we moved through the process we made sure that Dr. Carter was involved in sort of the

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key decision making points.

MS. TAYLOR:

Q. Well, let's talk now about her resignation letter.

COMMISSIONER:

Q. Sorry, can I just clarify a point?

MS. TAYLOR:

Q. Sure.

COMMISSIONER:

Q. Before you move onto that question. Dr. Williams, I wasn't sure whether you were saying that when Dr. Carter choose not to carry on the quote, unquote, "investigative role" were you saying that you choose to go outside because of her decision or did they have anything to do with each other, were you going outside anyway?

DR. WILLIAMS:

A. I expect we would have went outside anyway because when you do an investigation, if you want to do an investigation of yourself, it's better to go outside to get somebody who is outside the organization and if you're working with people inside the organization and investigating them, it's hard to get in there

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and work with them and this type of thing. So if you're doing an investigation, be better to go outside.

MS. TAYLOR:

Q. And one last question then on that point. And this investigation, the outside investigation, that didn't contemplate looking at estrogen receptor negative and estrogen receptor positive?

DR. WILLIAMS:

A. It just looked at, contemplated, I guess, looking at the issue of immunohistochemistry services with particular emphasis on the ER and PR issue. It didn't say negative or--in the terms of reference.

MS. TAYLOR:

Q. But in terms of the slides being looked at, that wasn't something that was being done?

DR. WILLIAMS:

A. Well, the slides we were sending out was for retesting purposes.

MS. TAYLOR:

Q. Right. The negative ones?

DR. WILLIAMS:

A. Yes. And the literature was saying that the

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problem in ER and PR testing was the issue of false negatives.

MS. TAYLOR:

Q. P-0079, please, Registrar.

MS. TAYLOR:

Q. Now Dr. Cook, this--I'm sorry, Dr. Williams, this is a letter to Dr. Cook from Dr. Carter dated August 2nd, 2005, and this is that resignation letter when she steps back -

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

Q. - from the role that she's had.

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

Q. Now if I could just go down through a couple of things in this. I think that you had indicated on this, in terms of the receipt of the letter, that you had asked Dr. Cook whether or not--you know, did you need to step in and talk to Dr. Carter or is it something that he felt he could handle and he, I think

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based on the relationship that he had with Dr. Carter, he thought it was best for him to speak with her. Is that correct?

DR. WILLIAMS:

A. Well, I'll couch it in a little different terms.

MS. TAYLOR:

Q. Okay.

DR. WILLIAMS:

A. When I received the letter, I was concerned about its contents, so I asked Dr. Cook is there anything I could do. Should I talk--would it be a value for me to talk to Dr. Carter to see if she might change her mind and this type of thing.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. He had a good working relationship with Dr. Carter and still does, and he said no, he'd talk to her and he didn't think--he was pretty sure it wouldn't be any value for me to talk to her at the time, but that she was--had indicated to him that she would continue in her role with him of helping him deal with

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this issue and providing advice as we moved forward.

MS. TAYLOR:

Q. That's on the issue of her role and whether or not she's going to be involved, or I guess, change her mind about being involved. But let's talk about some of the contents of the actual letter itself. In the second paragraph, she's indicating that there was a meeting with George Tilley on August 1st, 2005 and it showed, in her opinion, that "Mr. Terry Gulliver and Mr. Barry Dyer do not have a good understanding of the limitations of automated immunohistochemistry, rigorous clinical and technical validation of antibodies" and it goes on from there. She's questioning the level of knowledge that Terry Gulliver and Mr. Barry Dyer have in relation to this process.

DR. WILLIAMS:

A. Um-hm.

MS. TAYLOR:

Q. And that actually is repeated a little bit further on actually in the last paragraph on that page. She says that Mr. Terry Gulliver, "it's his responsibility to provide high

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quality service and document the performance of same with respect to the testing." There's also a reference, if I can find it for you, there's a reference as well, Dr. Carter saying that "the ER/PR status was currently remaining in the hands of para-professional staff within the laboratory." When you saw those comments, did that raise any--did that set off any alarm bells for you in terms of, you know, Dr. Carter was a breast--and is a breast pathologist, so she has a subspecialty in that area. You would anticipate that she would have a high level of knowledge about this test. She's somebody obviously whose opinion was valued and whose opinion Dr. Cook valued, and she's expressing--this is her opinion in terms of the people that are actually in charge of the lab. Did that raise any alarm bells for you?

DR. WILLIAMS:

A. Well, there was some issues of concern, sure, and I discussed them with Mr. Tilley, this type of thing, but also, in terms of this issue, some of the consultants brought up the organization structure and how in

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immunohistochemistry, we might look for a triangular structure to make sure that there was no confusion on who made the final decisions, in terms of these issues.

Also, I noted at the meeting there was a disagreement on the issue of what had caused the problem. There was some concern, some statements expressed that it was just due to new technology, which really some people thought maybe that was the issue, but Dr. Carter felt that the issue was not this new technology, but the fact that with the technology we had previously, we should have gotten better results, this type of thing.

MS. TAYLOR:

Q. Who thought it was new technology?

DR. WILLIAMS:

A. Well -

MS. TAYLOR:

Q. Who thought it was an issue?

DR. WILLIAMS:

A. Mr. Gulliver was saying that some of this was new technology, but you know, Dr. Carter felt that it wasn't just new technology. It was the fact that we could have done better with

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the testing results that we--with the equipment that we had and the approach that we used. So I know we discussed it with Dr. Cook and Mr. Gulliver, and that, you know, we did make some changes to the structure in immunohistochemistry and it's also something that, on the long term, we've made some adjustments to how the lab is organized. We had what we call a program based structure that had come into place in the Health Care Corporation in 2005 which had two streams of management responsibility. On further reflection and looking at everything that had happened and the consultants' reports, a number of changes were made in how that lined up, and now in terms of immunohistochemistry, there's a triangular relationship with the pathologist at the top of the triangle, the techs here and other pathologists over here. So that everything has to go through that -

MS. TAYLOR:

Q. To the pathologist.

DR. WILLIAMS:

A. - pathologist who makes the final decisions there, and that's Dr. Elms right now.

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Number two is that the structure was changed in the lab and that the head person in the lab now is now your clinical chief who has full authority in the lab. So the management structure is changed somewhat to have Mr. Gulliver reporting to that person, in terms of quality. That person, the medical person, has responsibility for all aspects of quality and all aspects of pathology, physician side of the lab. Mr. Gulliver, I understand, has responsibilities for budget, staffing, this type of thing, but that the final authority rests in the clinical chief.

MS. TAYLOR:

Q. Mr. Gulliver and Mr. Dyer were fairly involved in this process, even after this point. Was there ever a time when you spoke with Dr. Cook or spoke with Mr. Gulliver about the concerns that had been expressed in this particular letter, in terms of whether or not, you know, to satisfy yourself do they have a good understanding, do Mr. Dyer and Mr. Gulliver have a good understanding of this process? Was there any discussions like that?

DR. WILLIAMS:

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

MS. TAYLOR:

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

DR. WILLIAMS:

A. Sure, at the time, like I say, we moved to change the structure in that particular section of the lab and in the long term, we changed the structure in the lab completely. That's a structure we still have in Eastern Health, program based structure, but that structure was modified for the lab.

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MS. TAYLOR:

Q. So the structure, did the structure change right after this and then there were more changes after the external reviews or was it after -

DR. WILLIAMS:

A. No, the structure changed after the external reviews and after some further thought process, yes.

MS. TAYLOR:

Q. Now if I could, Registrar, if we could go to P-0411?

THE COMMISSIONER:

Q. Just let me interrupt -

MS. TAYLOR:

Q. Sure.

THE COMMISSIONER:

Q. - once again, just to make sure I understood this. Dr. Williams, regarding the structure in the lab, we're dealing with events from 1997 onward.

DR. WILLIAMS:

A. Um-hm.

THE COMMISSIONER:

Q. Over a decade really, and the structure in the lab, are we dealing with two different structures or are we dealing with three different structures in the lab over that period of time?

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DR. WILLIAMS:

A. Basically, the structure now is different than it was, so it's really two different structures. The program--prior to the Health Care Corporation being formed in 1995, each of the labs in St. John's had different structures.

THE COMMISSIONER:

Q. Okay.

DR. WILLIAMS:

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

THE COMMISSIONER:

Q. Okay.

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DR. WILLIAMS:

A. The same structures are still in place in other programs.

THE COMMISSIONER:

Q. Yes.

DR. WILLIAMS:

A. The lab was changed.

THE COMMISSIONER:

Q. Okay, and the lab was changed following your receipt of the recommendations from the -

DR. WILLIAMS:

A. Well, the lab was changed -

THE COMMISSIONER:

Q. - external reviewers?

DR. WILLIAMS:

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

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Ontario with respect to their labs and there was a variety of structures. There was no one structure, but based on those discussions and what had come out over the time frame here, I felt that the structure in the lab might need--should change.

THE COMMISSIONER:

Q. So what we have is a structure that was put in place when Health Care Corp -

DR. WILLIAMS:

A. Came in.

THE COMMISSIONER:

Q. - was formed?

DR. WILLIAMS:

A. Yes.

THE COMMISSIONER:

Q. And that structure within the lab system continued on until there was a change in the structure following your departure from the organization, with the exception of one area of the lab.

DR. WILLIAMS:

A. That changed, yes.

THE COMMISSIONER:

Q. The IHC area?

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DR. WILLIAMS:

A. Yes.

THE COMMISSIONER:

Q. And that would have--can you be a little more precise about in what time frame that change would have been made?

DR. WILLIAMS:

A. That change in the structure was made, I think, in October of 2005 in immunohistochemistry. There should be a letter in the documentation that you have that went from Dr. Cook to Dr. Ejeckam outlining that. I think Mr. Coffey already asked me about that.

THE COMMISSIONER:

Q. Yes, I have vague memory myself of that, but I just--okay, just wanted for the purpose of this discussion. All right, thank you.

DR. WILLIAMS:

A. Mr. Coffey, I think, asked me about that before and we discussed it before. That's my recollection.

THE COMMISSIONER:

Q. I'm sure he'll find it. Thank you.

MS. TAYLOR:

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Q. Registrar, P-0411. Now again, Dr. Williams, this is another memo that you've been asked some questions on before. It's a memo that's directed to you, Mr. Tilley, Ms. Pat Pilgrim, Ms. Pam Elliott from Heather Predham, and it's dated July 4th, 2006.

Now it's--one of the issues that's discussed in here is the significance of ductal carcinoma in situ, or DCIS.

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

Q. And this information suggests that there's no reason, and it says there in the first full paragraph under bullet one, that there's no reason to test ER/PR status of individuals with DCIS.

DR. WILLIAMS:

A. Um-hm.

MS. TAYLOR:

Q. Now Heather Predham is--well, she's part of the quality department and she's a risk manager. Is that a fair characterization? That's what we've understood.

DR. WILLIAMS:

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A. Well, she was the leadership at the time and then leadership changed in 2005 when we had Eastern Health. So that she was assistant director for quality and risk management at the time this was done.

MS. TAYLOR:

Q. Now her background is a nursing background?

DR. WILLIAMS:

A. She has a nursing background and had spent--first when I met her, she was in this area of quality and risk management, when I first met her.

MS. TAYLOR:

Q. Do you know if she had any particular expertise in DCIS or in cancer in general?

DR. WILLIAMS:

A. No, she would not have. She would read--obviously reading the literature as they moved forward here.

MS. TAYLOR:

Q. Would it be unusual--it seems unusual that a memo would come from a risk management person instead of from a clinical expert outlining an issue like this.

DR. WILLIAMS:

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

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

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carcinoma in situ or were not some other diagnosis that we needed to follow up on or confirm. So we wanted to--we really needed to find out what the status of those patients were.
MS. TAYLOR:
Q. But there were samples sent -
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:
Q. - to Mount Sinai of people who were ER negative but DCIS cases.
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:
Q. So originally, those individuals had been tested. Their ER/PR status had been tested.
DR. WILLIAMS:
A. Correct, yes.
MS. TAYLOR:
Q. And presumably a physician orders the test?
DR. WILLIAMS:
A. Yes, that's right.
MS. TAYLOR:
Q. So presumably, the physician ordering the test

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felt it was relevant to determine the appropriate treatment for that particular patient.
DR. WILLIAMS:
A. Um-hm.
MS. TAYLOR:
Q. Right, and you had said that there's not a consensus as to whether or not you test -
DR. WILLIAMS:
A. I've been able to see that some people might differ on that.
MS. TAYLOR:
Q. Right.
DR. WILLIAMS:
A. Whether--you know, and we wanted to make sure that, in fact, ductal carcinoma was ductal carcinoma or if it was some other diagnosis that we wanted to be sure of.
MS. TAYLOR:
Q. But in terms of retesting the ER/PR status, if the physician ordering the test originally thought that it was appropriate to test for ER/PR status, why not just retest them and send that information back to the physician to allow them to decide if it had any impact on

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treatment versus making a unilateral decision not to retest?

DR. WILLIAMS:

A. I guess they were retested on that basis. They'd been previously retested. They'd been retested again and the results were going back. It raised the question because people were wondering if some of those patients were invasive carcinomas that the diagnosis had been made by us as invasive, but they were ductal carcinoma. So we needed to check that.

MS. TAYLOR:

Q. So all of the DCIS cases would have been retested?

DR. WILLIAMS:

A. Any case that was tested before was sent for retesting. That's my understanding.

MS. TAYLOR:

Q. And were retested?

MR. WILLIAMS:

A. Retested. That's my understanding, yes.

THE COMMISSIONER:

Q. On the basis of being negative or on the basis of being DCIS?

MR. WILLIAMS:

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A. On the basis of being negative, nothing to do with the DCIS diagnosis. Anybody who was sent for ER/PR and came back as negative was sent up for retesting again. The issue of -

THE COMMISSIONER:

Q. That was my understanding.

MR. WILLIAMS:

A. Yes.

THE COMMISSIONER:

Q. Up until now, but I got confused then.

MR. WILLIAMS:

A. No, that's my understanding too.

THE COMMISSIONER:

Q. So the decision to make it go, to send a block onward was based on the original finding of ER positive versus ER negative, leaving aside for the moment what that ER positive and ER negative mean, but -

MR. WILLIAMS:

A. Yes.

THE COMMISSIONER:

Q. - on the basis of negativity -

MR. WILLIAMS:

A. Yes.

THE COMMISSIONER:

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Q. - that's what sent it on, not on the basis of any diagnosis of a particular kind of cancer?

MR. WILLIAMS:

A. Correct, and when it came back, then some--you know, it was not total agreement, as far as we knew, that DCIS would be tested at all.

MS. TAYLOR:

Q. Because the -

MR. WILLIAMS:

A. So we checked.

MS. TAYLOR:

Q. - the second paragraph says there, "of the results returned from Mount Sinai, there were ones that Mount Sinai did not retest as they diagnosed them as being DCIS."

MR. WILLIAMS:

A. Yeah.

MS. TAYLOR:

Q. So there were some that were sent.

MR. WILLIAMS:

A. Yes, Mount Sinai would not do ductal carcinoma in situ because it was--treatment wasn't based on that for ductal carcinoma in situ. That's my understanding.

MS. TAYLOR:

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Q. But if -

MR. WILLIAMS:

A. We didn't go back and say well, this is ductal carcinoma. We won't send it up for retesting.

MS. TAYLOR:

Q. No.

MR. WILLIAMS:

A. But we did send everything up for retesting.

MS. TAYLOR:

Q. But you didn't--Mount Sinai wasn't contacted to say well, retest them anyway, because they were tested in the first place, retest them anyway. Was the decision from Mount Sinai that these don't need to be retested?

MR. WILLIAMS:

A. Yes, that would be their decision based on what they do.

MS. TAYLOR:

Q. And Eastern Health, were there individuals within Eastern Health who would make decisions on this agreed with it?

MR. WILLIAMS:

A. Yes, the panel. Looks like the panel reviewed those.

MS. TAYLOR:

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Q. And no further action then. Yes, it says that. Reviewed the original pathology report. If that report diagnosed the person as having DCIS, then there was no further action required. So there was no further retesting?

MR. SIMMONS:

Q. Commissioner, if I might, I think as we progress through other witnesses who were more closely involved, we may find that there was some degree of communication back and forth with Mount Sinai on this issue, and I don't know if Dr. Williams would have been involved or aware of that.

THE COMMISSIONER:

Q. Well, perhaps we can ask him whether he was.

MR. WILLIAMS:

A. I was not aware of other--I was not aware that there was any issues involved in this approach. Nobody brought that to my attention. The main thing that was brought to my attention was that there was a problem in some cases here when we double panelled and Dr. Carter and Dr. Cook did most of the reviews just to make sure that there was some people who were really ductal carcinoma in

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situ but had been sent up because the diagnosis had been invasive cancer, you know, invasive cancer, and that they would have a different treatment than they would if it was ductal carcinoma in situ, and we uncovered a number of those patients and disclosed to those patients. That's -

MS. TAYLOR:

Q. Right -

MR. WILLIAMS:

A. - the result of this.

MS. TAYLOR:

Q. - and beyond that, in terms of DCIS cases and testing or retesting, that's something that you're saying the panel would have been involved in, but you wouldn't have?

MR. WILLIAMS:

A. No, I wouldn't have got the level--you know, I have--these are the people, the oncologists are the people that are treating people with breast cancer. They're the ones that are knowledgeable. I would rely on their advice. Our concern with DCIS was that there were some people who were felt to be DCIS who were felt to be invasive carcinoma in situ, but were

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diagnosed here as DCIS and when we double checked those, there was a number in that category. Three from Eastern Health's area, I know that, that were--that we had to disclose information to.

MS. TAYLOR:

Q. They weren't -

MR. WILLIAMS:

A. Because it affected their -

MS. TAYLOR:

Q. Yeah, they weren't DCIS.

DR. WILLIAMS:

A. No, they were not DCIS, they were invasive, so that's the issue that arose from that area.

MS. TAYLOR:

Q. Registrar, P-1368? Now, Dr. Williams, this is a document, well it's the physician panel meeting, the first one on October 13th, 2005. And you were asked, I think a general question about the panel, you had sent out a letter to people, you felt that it was, I think you said in the letter "an excellent suggestion" in terms of having the panel, and thanking, I think, people for being involved in that?

DR. WILLIAMS:

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A. Well the suggestion came from Dr. Kwan and Dr. Laing and Dr. Kwan is a surgical oncologist that has been dealing with these issues for at least 30 years in our organization. Dr. Laing had a lead role in medical oncology in the cancer clinic and subsequently with our organization and based upon their advice and suggestions in this situation which was somewhat unique, that I felt that was a good idea.

MS. TAYLOR:

Q. And you would have been, obviously you're recorded as one of the people being in attendance at that meeting.

DR. WILLIAMS:

A. I went to the meeting to thank them, basically.

MS. TAYLOR:

Q. Right. Did you stay there for the whole meeting?

DR. WILLIAMS:

A. No, I did not.

MS. TAYLOR:

Q. Okay. I did want to ask you a couple of questions on it, however, on that first page,

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under "Mandate of Panel" in the paragraph "Discussion ensued as to who would be notified"--there's discussion there in terms of who would be notified. "All agreed that the referring physician should be notified and that the primary cancer treating physician will be responsible for follow up of the recommendations from the panel. Notification will be in writing and a mechanism will be put in place to confirm that the follow up physician has received notification." Now, whose responsibility would it have been to set up this mechanism to confirm that the follow up physician had indeed received notification in writing from the panel, do you know?

DR. WILLIAMS:

A. I would except that once the things were sent out, it would probably be quality to follow up, that would be my expectation.

MS. TAYLOR:

Q. Now we've since learned from other witnesses that have testified here that Eastern Health is in the process of doing a review of letters that were sent out to the physicians to ensure that in actual fact patients were contacted,

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that the information had been passed along. That would suggest to me that whatever mechanism was put in place at the time, didn't exactly work.

DR. WILLIAMS:

A. My understanding that late in September of--August of 2006--no, September of 2006 the organization became aware of a number of areas where follow up did not, as anticipated, did not seem to take place and I understand at that time that there was going to be follow up in the fall of 2006 with physicians, that was my understanding when I left the organization.

MS. TAYLOR:

Q. What exactly was the panel going to do? What sort of documentation would they have and what would they do?

DR. WILLIAMS:

A. The panel, to my understanding, would have patient records, be able to review those, even, I think they got the records sent in from outside, that's my understanding; would look at the results, whether the results changed, number one; number two, if the results had changed and taking into

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consideration everything else because it's an individual, I understand it, consideration, that they would make a recommendation to the physician about what course of action needed to be undertaken.

MS. TAYLOR:

Q. Would they have these records prior to the actual meeting, do you know?

DR. WILLIAMS:

A. I understood that you would have to--that's my understanding, you'd have to ask somebody who was at the meeting as to, I think they had the charts there, yes, that's my understanding.

MS. TAYLOR:

Q. At the meeting -

DR. WILLIAMS:

A. Information.

MS. TAYLOR:

Q. Would they have the charts before the meeting? Would the particular individuals have the charts before the meetings?

DR. WILLIAMS:

A. You would have to ask, I can't answer that question specific, I know the charts were being made available at, I think for sure at

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the meeting, I'm not sure before the meeting, you would have to ask Dr. Laing, probably would be the person that you would have to ask her on that when she testifies.

MS. TAYLOR:

Q. And you think that the charts, if there weren't--because there were patients outside of the St. John's, area.

DR. WILLIAMS:

A. My understanding is that medical information would have been made available to the panel, that's my understanding. You would have to clarify that again with somebody who was at the meetings. I only attended the meeting to start the ball rolling and to thank people for doing it and assured them of the support of the organization as they carried out their work.

MS. TAYLOR:

Q. Now, you thought it was an excellent suggestion, so obviously you agreed with this creation of the panel.

DR. WILLIAMS:

A. Yes.

MS. TAYLOR:

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

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

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A. Yeah, well I think, obviously, that the discussion with the patient would take place between the physician who is responsible for the patient's care and the patient when they disclosed to the patient.
MS. TAYLOR:
Q. And what about having a risk manager on a panel like this? What role does a risk manager play in terms of deciding patient care?
DR. WILLIAMS:
A. The risk manager was not to provide any input into patient care; the risk manager's role was to get the information, try to get together to be a support for the panel. We had a secretarial support and we had Ms. Predham, who had been involved all along in it, to bring together the information that was needed, get the reports that had come back together, so it was a resource person to the panel, somebody who had been involved and somebody who would then be involved in the follow up would be there in that capacity, not as a risk manager, but as a resource person. Like the secretarial person was there as a

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resource person to do the minutes and get the things typed up and this type of thing, so -
MS. TAYLOR:
Q. So the person was there as secretarial support?
DR. WILLIAMS:
A. We had secretarial support, Heather Predham was there as a resource person to get together the documentation and information for the panel.
MS. TAYLOR:
Q. So she wasn't there as secretarial support?
DR. WILLIAMS:
A. No, she was there as a resource--we had two people there, the person who took the minutes -
MS. TAYLOR:
Q. The recording secretary?
DR. WILLIAMS:
A. Yes, that's right.
MS. TAYLOR:
Q. Okay. And there was no question as to why, you know, because there is a number of doctors from various specialities on this panel, there's oncologists, there's surgeons, there's

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pathologists and originally it would have been the patient and the treating oncologist that would have made the decision together, obviously the oncologist, but with input from the patient as to what was the appropriate treatment after the original ER/PR status was established.

DR. WILLIAMS:

A. Uh-hm.

MS. TAYLOR:

Q. You didn't question why so many doctors would be needed to make a treatment recommendation after retests when, you know, one doctor and the patient was able to do it in the beginning?

DR. WILLIAMS:

A. Well, you're into a unique situation where you get reports that are some years later in coming back, might be four or five years later, and you get together an expert panel of people who had involvement in the care of cancer patients who had expertise going back some thirty years in Dr. Kwan's case, who are up to date, and they would provide a recommendation so that the physician who was

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treating the patient could then discuss that with the patient and a decision would be made. It wouldn't interfere with the decision-making process between the patient and the physician. It would just provide another level of input into the physician and the patient making that decision.

MS. TAYLOR:

Q. Do you have any knowledge of the level of detail, like what sort of information would be sent out in this letter to physicians?

DR. WILLIAMS:

A. No, I don't.

MS. TAYLOR:

Q. You haven't seen any -

DR. WILLIAMS:

A. I would leave that to the people who know best.

MS. TAYLOR:

Q. Okay, and do you know what sort of doctors the information would be sent out to? Because it might be sent out to an oncologist, but it might be sent out to a family physician as well, did you know that?

DR. WILLIAMS:

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A. Most cases I expect it might be sent to a specialist, but it may go back to a family physician if the specialist of record had left or something like this.

MS. TAYLOR:

Q. Right.

DR. WILLIAMS:

A. But again, the person who got it would just have a recommendation based upon the considered opinion of a variety of people. The reason why it had so many on it was that Dr. Kwan couldn't be there, maybe Dr. Felix would be there; if Dr. McCarthy couldn't get there, maybe Dr. Laing--I'd have to look at the composition of the panel, but obviously at every meeting, everybody who was on the panel didn't get there, so you wanted to make sure you got some expertise. It was just to try to help the situation, a difficult situation. I don't--I still, no matter how hard I was questioned on it, I still would do it again.

MS. TAYLOR:

Q. Do you see any pitfalls with it, though? Did you see any?

DR. WILLIAMS:

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A. I didn't see any pitfalls with it, no.

MS. TAYLOR:

Q. Because we've heard testimony from some of the cancer patients that were involved in this and there was one individual who, when they were originally tested for ER/PR, they were negative.

DR. WILLIAMS:

A. Uh-hm.

MS. TAYLOR:

Q. And based upon, she testified that based upon, you know, discussions with her doctor, her own research into the issue, whether or not it would actually have any impact for her because she was to her understanding negative, she refused Tamoxifen, okay.

DR. WILLIAMS:

A. Uh-hm.

MS. TAYLOR:

Q. When she was panelled, there was no treatment--even though she was positive, there was no treatment recommendation change because it was noted that she had refused Tamoxifen, but she refused in on the basis of a particular set of circumstances, but they wouldn't know that

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

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timing of it. You were the person who had ordered the ethics consult?
DR. WILLIAMS:
A. Yes.
MS. TAYLOR:
Q. And it would have been ordered, I think, sometime in May of '06?
DR. WILLIAMS:
A. Sometime around then.
MS. TAYLOR:
Q. Was any thought or did you give any thought, consideration to ordering and obtaining an ethics consult when this issue first arose?
DR. WILLIAMS:
A. No, I didn't at the time. The issue came up and we were going to have to deal with this issue, so let's get an ethics consult, that's -
MS. TAYLOR:
Q. Right, this is a year later and it would have been known--and this is in particular dealing with deceased patients. Now obviously it would have been known fairly early on because there were deceased patient samples that were sent up for retesting and that was known, so

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

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exit meetings I think as well, with both Dr. Banergee and Ms. Wegrynowski?
DR. WILLIAMS:
A. Yes, we did. I took notes of Ms. Wegrynowski's exit meeting, but I don't have any notes of Dr. Banerjee's exit meeting. I have some recollections, but not notes.
MS. TAYLOR:
Q. Right, but you had said that after you got that information that you felt that there was some work to do, you needed to get on with it.
DR. WILLIAMS:
A. Uh-hm.
MS. TAYLOR:
Q. And you asked Dr. Cook and Dr. (sic.) Gulliver to prepare a document that would capture the essence of what was said and would enable us to move forward.
DR. WILLIAMS:
A. Uh-hm.
MS. TAYLOR:
Q. And you also said you remember talking to Mr. Tilley and telling him that if we didn't move forward, we really needed to consider whether we were going to continue to have an

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

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

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conversions on retest, that the reasons for that would be contained within the four corners of the documents from Dr. Banerjee and Ms. Wegrynowski, that those things would cover the cause?
DR. WILLIAMS:
A. They would go a long way to covering the--I can't tell you the cause in each individual case going back to 1997.
MS. TAYLOR:
Q. No.
DR. WILLIAMS:
A. Because one would have to, you know, look at each slide, but they would--I guess Dr. Banerjee's approach was sort of a broad-brush approach in terms of here's what he feels is the cause, but a broad-brush approach in terms of here's how I think you need to structure things to ensure that that doesn't happen again.
MS. TAYLOR:
Q. Right, but I see what you're saying on an individual case, that you would have to look at that individual case.
DR. WILLIAMS:

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

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

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

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MS. TAYLOR:
Q. Well, and I think Mr. Coffey had asked you about this. The word "turnover" with particular individuals, but they're also individuals both in the lab -
DR. WILLIAMS:
A. Yes -
MS. TAYLOR:
Q. - as well as people within the structure of Eastern Health and also pathologists who are still in place during that period of time.
DR. WILLIAMS:
A. Yes, but no one--in the system we had, no one pathologist was reading all the slides. We weren't subspecialized.
MS. TAYLOR:
Q. And what about whether testing protocols during the period between 1997 and 2005 were reasonable and appropriate? Were the protocols reasonable and appropriate during that period of time?
DR. WILLIAMS:
A. According to our consultants, that was an issue and we needed to improve in that area.
MS. TAYLOR:

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Q. So, they weren't reasonable and appropriate?
DR. WILLIAMS:
A. Well, they weren't, according to the consultants that reported on--that's why we asked people to come in to -
MS. TAYLOR:
Q. And you accept the view of the consultants?
DR. WILLIAMS:
A. We accept the review that we needed to improve in those areas, yes.
MS. TAYLOR:
Q. So, you agree that they weren't reasonable in -
DR. WILLIAMS:
A. They needed improvement, yes, I will say that.
MS. TAYLOR:
Q. That's all the questions that I have, Dr. Williams.
DR. WILLIAMS:
A. Thank you.
MS. TAYLOR:
Q. Thank you.
THE COMMISSIONER:
Q. Thank you, Ms. Taylor. Mr. Pike?
DR. ROBERT WILLIAMS, EXAMINATION BY MR. MARK PIKE

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

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

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

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

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pointedly, to have any discussion with the NLMA or any of its representatives concerning those issues?

DR. WILLIAMS:

A. I did not. I know that Mr. Abbott asked Mr. Ritter to phone me and I've spoken to Mr. Ritter so often that I can't remember on which occasions I spoke to him or what we discussed. But I would say there wouldn't have been, you know, a long time go by that I would have some conversation with somebody at the NLMA or Mr. Ritter.

MR. PIKE:

Q. I was going to ask you about that, particularly, there's one exhibit that we've seen time and time again, P-0137, if you have it there, Madame Registrar. I think that's the one you're referring to. You've no doubt seen it.

DR. WILLIAMS:

A. Yes.

MR. PIKE:

Q. It's been presented to you by Commission counsel July 25, '05. So, I take it you can't recall and I mean, I have to put this to you

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know, because we know Mr. Ritter is going to come behind you -

DR. WILLIAMS:

A. Sure, yes.

MR. PIKE:

Q. And you have some idea what he's going to say about this, he can recall the telephone conversation with you, but you can't recall -

DR. WILLIAMS:

A. No, I can't recall. I'm sure we had the conversation, Mr. Pike, but I can't recall it, if I tried to say something, I'd be, you know -

MR. PIKE:

Q. Yes, well you're only saying you're sure because I'm telling you Mr. Ritter is going to say it, that's all.

DR. WILLIAMS:

A. Yeah.

MR. PIKE:

Q. Not because you have any independent recollection?

DR. WILLIAMS:

A. No, I don't have--but I'm sure that happened. I would have talked to Mr. Ritter, but I can't

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remember the details of our discussion, on any one discussion because I've talked to him so much.

MR. PIKE:

Q. Sure. Those are my questions for Dr. Williams. Thank you very much.

THE COMMISSIONER:

Q. Thank you. Mr. Simmons?

MR. SIMMONS:

Q. Thank you, Commissioner.

DR. ROBERT WILLIAMS, EXAMINATION BY MR. DANIEL SIMMONS

MR. SIMMONS:

Q. Good morning, Dr. Williams.

DR. WILLIAMS:

A. Good morning, sir.

MR. SIMMONS:

Q. I am going to have to go back and ask you a few more questions about some specific things that you've been questioned on over the last number of days, but I'm going to try to narrow and keep it as specifically as possible.

I have a question for you first about the external review reports and the terms under which they were requested.

DR. WILLIAMS:

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A. Yes.

MR. SIMMONS:

Q. And I'd like to have you look, please, at document P-1283. This is an e-mail message from Heather Predham to Dr. Cook and you on September 12, 2005 which, I think we've previously established was prior to either of the consultants arriving to begin their work in St. John's.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. And attached to it there are Terms of Reference for external quality review of the immunohistochemistry service.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. And I believe you already told us that these were prepared by Ms. Predham at your request.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. Is that correct?

DR. WILLIAMS:

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A. Yes.
MR. SIMMONS:
Q. Okay. And the statement of purpose there is to review the operation and make recommendations as to the processes involved in a service of the laboratory medicine program. The accountability was that the consultant would take direction from and make recommendations to the leadership team of the laboratory medicine program.
DR. WILLIAMS:
A. Correct.
MR. SIMMONS:
Q. And that leadership team was comprised of who?
DR. WILLIAMS:
A. The program director and the clinical chief.
MR. SIMMONS:
Q. Which would be Mr. Gulliver and Dr. Cook.
DR. WILLIAMS:
A. Correct.
MR. SIMMONS:
Q. The timeframe was to be a report done within three months and then it sets out five responsibilities. You can have a look at those.

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DR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. My first question is those listed responsibilities, were they the questions that were being put to the reviewers for them to consider when they conducted this review or the tasks being given to them?
DR. WILLIAMS:
A. Yes, that looks to be what we felt they should do.
MR. SIMMONS:
Q. The first one is to review current practices and procedures within the immunohistochemistry service of the laboratory medicine program.
DR. WILLIAMS:
A. Um-hm.
MR. SIMMONS:
Q. And I notice the emphasis on current practices. Were they tasked with going back and looking at practices that had been used historically from '97 up to 2005?
DR. WILLIAMS:
A. As part of the review, I thought they would look at that, yes.

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

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result, right from the first step to the last step.
MR. SIMMONS:
Q. Um-hm.
DR. WILLIAMS:
A. Because it is a detailed system that gets you from Point A to Point B. There's a lot of steps in between.
MR. SIMMONS:
Q. Okay. And the fourth one is a request to provide recommendations -
DR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. - to deal with issues identified. And then the fifth one, to summarize the findings in a confidential report.
DR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. Now, you were referred a few moments ago to the Terms of Reference of this Commission. And one of those, the first one is to try to answer the question of why there was so many changes in test results when they were

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retested in 2005 compared to earlier. Was that a question that the external reviewers were tasked to answer in those Terms?

DR. WILLIAMS:

A. Not if you read them specifically, look like-- but in order to provide recommendations dealing with any issues in moving onto the future. We might need to look at what has happened in the past.

MR. SIMMONS:

Q. So, to the extent necessary to make recommendations about what should be done now, you had an expectation that they might have to look back at what had happened in the past.

DR. WILLIAMS:

A. Yes, and they did, actually.

MR. SIMMONS:

Q. All right. But was there an expectation or a direction to them to specifically address the question of answering the question why there were changes in the retest results compared to what had happened in the past?

DR. WILLIAMS:

A. No, not in these Terms of Reference, there was not.

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MR. SIMMONS:

Q. And, of course, at that point, the retest results weren't back. They were there in September of 2005.

DR. WILLIAMS:

A. That's correct.

MR. SIMMONS:

Q. And the Mount Sinai results had not yet come back, the retests hadn't happened.

DR. WILLIAMS:

A. No, we had the number of reports that we knew had changed, enough for us to request that-- enough concern that we felt we needed to retest.

MR. SIMMONS:

Q. Right. And there were a limited number of retest results available based on the retesting that had been done on the Ventana technology in St. John's.

DR. WILLIAMS:

A. Correct.

MR. SIMMONS:

Q. Which were largely, I think, from 2002 and maybe a few from outside the 2002 range.

DR. WILLIAMS:

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A. Yes, the was, I think, probably five or so from outside the two thousand--if I'm correct about the five, four to five, from outside the 2002 -

MR. SIMMONS:

Q. So, at that point would it be correct to say that the information available about which tests had changed or were likely to change on retesting was fairly limited compared to what became known afterwards when the Mount Sinai results came back.

DR. WILLIAMS:

A. That's correct. We were just in the early stages of it.

MR. SIMMONS:

Q. Okay.

DR. WILLIAMS:

A. We really didn't know what we would find, but we expected to find some issues; that's why we retested.

MR. SIMMONS:

Q. Okay. Now, I'm not going to be very organized in flowing through my questions from area to area.

DR. WILLIAMS:

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A. Okay.

MR. SIMMONS:

Q. I just have a number of different ones I want to address with you. You've been asked quite a bit about Dr. Ejeckam's memos from 2003.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. And you were questioned this morning about the June memo in which Dr. Ejeckam had made some recommendations for changes that he would like to see in the immunohistochemistry laboratory.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. After you returned from your illness that summer, you came back in September of 2003.

DR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. Did Dr. Ejeckam continue to chair the surgical pathology review committee for some time after that, did he not?

DR. WILLIAMS:

A. He chaired it until he left in 2006, that's my

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recollection, April 2006.
MR. SIMMONS:
Q. Right. And I believe you told us that he actually reported--his reporting was to you from that committee.
DR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. And did you periodically get reports and committee minutes and so on from him after you returned in September 2003?
DR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. And did he, at any time, did he or the committee at any time, ever raise with you or bring to your attention any concern that the issues raised in his June 2003 memo had not been addressed to his satisfaction?
MR. WILLIAMS:
A. No, we didn't get any recommendations on immunohistochemistry from that committee.
MR. SIMMONS:
Q. Okay.
THE COMMISSIONER:

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Q. What was the name of the committee again?
MR. WILLIAMS:
A. The Surgical Pathology Review Committee.
THE COMMISSIONER:
Q. Review?
MR. WILLIAMS:
A. Yes.
THE COMMISSIONER:
Q. Okay, I knew I was missing a word. Thank you.
MR. SIMMONS:
Q. You were also asked a number of questions and explained that the criteria used at different times by the oncologists for deciding whether to recommend hormonal treatment for patients varied, and at one point, if the ER test showed 30 percent positivity or higher, a patient was considered a candidate for Tamoxifen or similar drug, and after a time, that changed to if the test result was ten percent -
MR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. - or higher, they would be considered a candidate. Can you tell me whether that

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

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

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MR. WILLIAMS:
A. It really happens as a result of the literature that--conferences that our clinicians go to and bringing back new ideas, either from the literature or from conferences and that becomes practice in the organization, again based upon the expertise that these people have.
MR. SIMMONS:
Q. So is it fair to say it becomes the practice of the physicians who practice within the organization?
MR. WILLIAMS:
A. Yes.
MR. SIMMONS:
Q. To make a change such as that.
MR. WILLIAMS:
A. That's the normal way things happen.
MR. SIMMONS:
Q. Okay.
MR. WILLIAMS:
A. Now we try to develop clinical practice guidelines in a number of areas over the years, but normal practice is that, you know, people review the literature, see what the

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

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

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MR. WILLIAMS:
A. - that's what happens in medicine.
THE COMMISSIONER:
Q. It's just a matter of--it's one of those things you just park in the professional judgment.
MR. WILLIAMS:
A. You have to leave it to professional judgment of each physician for each individual patient.
THE COMMISSIONER:
Q. Okay.
MR. WILLIAMS:
A. Unless it's something off the wall, obviously, which is not relevant, but you know, it's just a problem.
THE COMMISSIONER:
Q. Okay, thank you. Sorry, Mr. Simmons.
MR. SIMMONS:
Q. To follow up on that, I'm going to ask you questions like many others you've been asked. Now you might not be the right person to answer this, and if so tell me, but do you know if when the decision was made about how to select which patients were to be retested, if the possibility that different oncologists

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adopted the change in cut off at different times was taken into account in any way?

MR. WILLIAMS:

A. I do not think it was based on individual. I thought it was based on the 30 and the ten percent cut off, what seemed to be the practice at the time.

MR. SIMMONS:

Q. Okay.

MR. WILLIAMS:

A. You could have--you'd have to ask Dr. Laing and Dr. Cook for more detail, but that's my understanding.

MR. SIMMONS:

Q. Okay, all right. So we can leave that question for them. Sometime earlier in your evidence, you'd mentioned the topic of the possibility of lab accreditation. I want to refer you just to a couple documents concerning that. The first one is Exhibit P-0029 please, and can we go to page 16 please. These are corporate quality initiatives committee minutes from the Health Care Corporation for October 28th 2004. You sat on this committee?

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MR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. And there's a section here on accreditation, Section 4.2.

MR. WILLIAMS:

A. Sure.

MR. SIMMONS:

Q. It refers to CCHSA, Canadian Council on Health Services Accreditation.

MR. WILLIAMS:

A. Correct.

MR. SIMMONS:

Q. Survey, and that's the accreditation of the whole institution?

MR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. The survey was held during the week of October 2004, some report on that, and if you go down to the bottom paragraph, Ms. Smith advised that a new document has been released by CCHSA entitled "Planning models for quality." The document supports where accreditation is moving in the future and the expectations of

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organizations, and it highlights various needs there in relation to quality, and then it continues, on the next page, in the first full paragraph there, to say "on a related note, the absence of a laboratory accreditation or inspection program was raised. In some areas in Canada, accreditation or inspections of laboratories is mandated by the provinces. However, this is not the case in this province and is seen as a major gap. The potential for a self-assessment or having an external agency conduct an assessment was suggested. Dr. Williams will ask the leadership team of the laboratory program to pursue the options with Ms. Smith."

And I'm going to refer you now to some other minutes that address that topic as well. P-0030, please, page 45. These are corporate quality initiatives committee minutes now from June 24th of--ooh, I might be on the wrong page. Just one moment please. I think this is one of those documents where we changed some pages at one point, is it? No.

REGISTRAR:

Q. What was the date, Mr. Simmons?

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MR. SIMMONS:

Q. I'm looking for March. I think I'm almost there. March 24th.

MR. WILLIAMS:

A. There may be something just here.

MR. SIMMONS:

Q. Okay, here we are.

MR. WILLIAMS:

A. Yes, 2.2 I guess.

MR. SIMMONS:

Q. 2.2, these are the March 24th minutes, and the heading is list of programs, departmental accreditations.

MR. WILLIAMS:

A. Um-hm.

MR. SIMMONS:

Q. It refers to a list circulated senior management, and the review has highlighted the issue with respect to services in the organization which should pursue accreditation or meet specific standards. There's a reference to stem cell transplant program and work being taken to investigate that, and then it also says "it was also noted that there's no laboratory accreditation in this province.

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Dr. Whitman reported on laboratory accreditations in other provinces and noted that it is a provincial initiative. The integration of health boards is an opportunity to lobby our provincial government to pursue a provincial approach. Dr. Williams will raise this with the CEO of the new Eastern Health for a follow up."

So this is all before the ER/PR matter came up.

MR. WILLIAMS:

A. Yes.

MR. SIMMONS:

Q. And it has come up in the context of accreditation. Can you tell us something more about what was being discussed at these committee meetings and what the initiatives were that were being considered?

MR. WILLIAMS:

A. I think this came to our attention because there was a couple of things. We'd just gone through our accreditation on October 22nd. I just tried to link--going back and linking this with something that happened at our laboratory leadership in a meeting. There was

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an article that Mr. Gulliver said that the people from the Canadian Council of Health Services Accreditation came over to the lab and said things were pretty good over there. But my recollection is also Mr. Gulliver would have said to me that they didn't really spend much time there and maybe that's the impetus for our April--sorry, our earlier discussion in the fall, in October, October 28th or whatever it was, and Dr. Whitman would have been there. So there may have been some points that she would have wanted to make because Dr. Whitman was a hemata pathologist who worked as a physician providing medical leadership in the lab in the area of hematology. So there was some--probably would have been some discussion with her around the lab as well.

My recollection is that at some point I remember Mr. Gulliver telling me that, you know, in the accreditation process, it was just, you know, a 10-15 minute site tour of the lab and that was all, which struck me as an issue because lab, lab services and diagnostic imaging services are two big

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support services that everything else in your organization depends on those. So maybe that was the impetus for the discussion and the follow up. I know at some stage, I--and I don't, I didn't really remember until I'd seen this. At some stage, I remember talking to Mr. Tilley about maybe that would be something that could be pursued now that we had four boards for the province, not just the laboratories under Eastern Health, but it looked like something that maybe all laboratories in the province should participate in.

MR. SIMMONS:

Q. And why did you consider that the formation of this new board structure would give an opportunity to pursue this provincial -

MR. WILLIAMS:

A. Well, you know, there was only four organizations now to deal with it, probably less organizations and maybe you could sort of look at getting our labs into--we knew about the Ontario program at the time, somewhat about it, because it might have been Dr. Whitman who told us about it at the meeting.

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So, and again, I can't document writing Mr. Tilley, but I'm pretty sure I talked to him about it and he was going to--it may have--they had a meeting of CEOs with the Deputy Minister of Health, the four regional CEOs, probably every couple of weeks. That's my recollection at the time.

MR. SIMMONS:

Q. Okay. So from what you've told us, it sounds that the concept or the idea that something more than the CCHSA accreditation was needed in the lab actually originated from a report within the lab, from Mr. Gulliver?

MR. WILLIAMS:

A. Well, Mr. Gulliver was saying that they'd been over there and said our lab was really good, and when I asked him about it, they really didn't spend a lot of time there, and it got me thinking, and I'm sure Dr. Whitman had a perspective on it too, and other people around the table at that time.

MR. SIMMONS:

Q. Okay. How far had any initiatives in relation to working towards some type of lab specific accreditation gone by the time the ER/PR issue

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

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

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

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

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

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that, all the labs in the province, so that we can be assured that all aspects of the lab are going to be at the highest standard on a continuous basis. So that's an important issue, and I think it's being pursued and something like that needs to be pursued because we want to make sure that this--we take everything we can do to prevent this from happening again.

Number two, I think is now we're at an era in our health care system where things are very complex and complicated, and there's--health care is more effective than it used to be, but it's more complex and prone to errors and this type of thing. A lot of things can happen, and things--some of the things we do are very complex. There's a lot of people involved and I think there's a need probably to have a patient safety and quality focus, and maybe rather than have a vice president who's response for that and a number of other things, that that's something, I think, that each organization needs to consider in your system, have a vice president who has quality as the mandate, quality and patient safety

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rather than quality patient safety and this, this, and this and something else. So that's, I think that's something we might want to think about and we might have learned from.

We obviously need to develop a plan to handle situations, major adverse events like this in the future. And I think in planning for this we should bring together the Department of Health and Community Services because I think they have a role to play along with the regional health authorities to look at some process similar to what was done for pandemic influenza. There was a lot of work done on developing a strategy for pandemic influenza in our province if it struck. And I think there's the same analogy here that maybe that type of an approach should be taken here so that we have the thing documented and a strategy to deal with the next major adverse event, because I don't think we can say that it may not happen again. We have to plan on it happening again and we have to be prepared. And I think the Department of Health and the regional health authorities both need to be involved in that because a major strategic

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issue like that, in my view, so, is so far reaching that there is a role for the Department of Health to play in this. That would be my--now, it may be biased based on my background, but I think there is.

And really, you need to have senior leadership and staff who are involved and dedicated to, if the issue is that big, I think the staff who are involved and are bringing, try to bring, trying to deal with it need to be dedicated to that task only. That's one of the lessons, from my perspective, I think I've learned out of this. You can't be--it's very difficult to bring together, and I want to describe this as sort of a web of interactions on the issue, because somebody might have said this over here three months ago and then did you consider that they said that three months ago, did you follow up on that three months ago. It's almost like a web, in my view, of interactions that take place as we move forward. And I think somebody needs to be totally focused if one is to bring together that web of interactions and bring it all together to wrap it around the

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problem that we're dealing with and deal with all aspects of it appropriately. And I think it's very hard to do this when one is moving from one topic to another. It might be me, might be Ms. Predham, it might be some other people that are involved heavily in this but also doing something else. So I might have, on one day, four meetings. My average would be four or five meetings a day. I might deal with ER and PR issues one minute, then I'm going out in the next room trying to keep the medical oncology program together because we've had a shortage, some people have left, and we got a major challenge. Some of these other issues, they didn't come to the forefront because we were able to deal with them, but some of these issues in themselves are major issues and you move around from one and you just can't get the focus.

And the next thing is the whole issue of follow-up, which is important, to address findings and their dissemination out to the system. And that needs to be part of that web. So you wrap--you bring all the issues together in linkages in the web and you see

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the total picture and you wrap it around the issue and make sure everything, all the bases are covered.

And then there's the whole issue of we've talked a lot about peer review. There is an important aspect of peer review, I think, that's worth protecting, especially on an individual basis to get issues dealt with and get all the issues out on the table. But in something like an adverse event we need to give some thought to how we might approach that so that anything we find can be more--can be shared with the public and we're not involved in or breaching anything in peer review. It might be that we just have to, if things--something happens in the future, we set it up outside the quality and peer review process. Hopefully we'll get all the things out on the table and people will be forthright in their reports and this type of things. But that's one of the considerations that if somebody comes together and talks about this, how we might get a handle on it. That needs to be discussed.

The issue of communications came up and

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

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front lines in dealing with patients. And I look at the oncologists in terms of their number that we have, in terms of their workload, I think they're always skating on thin ice, to be--make that analogy, that they're able to cope, but it's a difficult situation on a day-to-day basis. And they raised the concerns that if this happened early on, it might affect their ability to continue to deliver care and they'd have to deal with a lot of people who would be upset. So that was a consideration. When you look at that in retrospect, that's something we weighed at the time and we made a judgment call, but that's something that I think the whole issue of communications is something that we wound up in this and how we might approach it based on the lessons we've learned. Because there's individual communications that have to be done, there's probably some public issues. You have to look at how you approach it and you have to look at the timing.

There's a number of other points I'd like to raise, I'll try to be as quick as I can.

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

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issues have been on the forefront of the media right across Canada lately, in the papers and the Globe and Mail you can't go by with a week you don't have another issue such as this coming out. We had to make many decisions and judgments along the way with the focus always being on retesting of patients as soon as possible, getting results to patients and their family--and their physicians with the best possible advice for follow-up. In this process decisions were not black and white. We were not dealing with a perfect science. And after decisions, often decisions had to be made by balancing certain considerations as we moved along. Often things, when you have a chance to look back at them and reflect on them in retrospect, they look different on further consideration.

I want to sincerely apologize, I'm going to do this on a personal basis, for any of my shortcomings in this process. I just hope and I--that the over 100 patients whose treatment, who had a recommended change in their treatment will benefit by the retesting and the recommendations. It's late, but at least

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I'm hoping that these people will benefit.

Over the next few months and weeks, months, you'll be hopefully hearing from many good and caring people at all levels in our organization, whether it's people trying to do a good job within the organizations on a daily basis and the Inquiry will hear from them, whether it's people in communications, in quality, management or the lab techs on the bench or from our physician leaders in our organizations. I think they'll have a story to tell and hopefully it will help the Commission reach their mandate.

And finally, I'd like to say that the process of this Commission, because there's been a lot said about it, has been very detailed and it's been very pointed and it's been hard hitting, both in the interview process and here over the past four or five days for me. But I appreciate that you have a job to do and I want to say that from my perspective I've been fairly treated by the co-counsels in this whole endeavour, Ms. Chaytor and Mr. Coffey, and I want to commend them for that. Thank you, very much.

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

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up here. And you've already explained to the Commissioner the, kind of how you arrived at the ten percent?

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. Early on which is really just subtracting 73 from approximately 82 or so and -

DR. WILLIAMS:

A. Yeah, low 80s, 80.

COFFEY, Q.C.:

Q. Yes. It was a rough figure?

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. And just on the point, just to do the arithmetic, as 27 percent at the time you thought of the overall original ER tests were going to be retested?

DR. WILLIAMS:

A. Um-hm.

COFFEY, Q.C.:

Q. You figured 27. So if you actually just do the arithmetic, you divide 10 by 27, if you just divide 10 percent over the--27 are going

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to be--27 percent are going to be retested, 10 percent will probably change or convert?

DR. WILLIAMS:

A. Ten percent overall.

COFFEY, Q.C.:

Q. Ten percent overall. So it's 10 divided by 27. In fat, you then get a projected conversion rate of about 37 percent of the retests? That would be -

DR. WILLIAMS:

A. I was looking at around maybe we'll get 30 percent.

COFFEY, Q.C.:

Q. Yeah.

DR. WILLIAMS:

A. But we were looking at trying to put that into context of overall people that would be affected.

COFFEY, Q.C.:

Q. Yeah. And -

DR. WILLIAMS:

A. That was the perspective I took at the time.

COFFEY, Q.C.:

Q. Yes. Doctor, you did, in answer to a question one of my colleagues asked you, say that from

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your perspective the entire ER/PR matter could be characterized as, I think you said, all one adverse event?

DR. WILLIAMS:

A. Well -

COFFEY, Q.C.:

Q. Looked at from one perspective.

DR. WILLIAMS:

A. I would look at it as a major adverse event that occurred in the province.

COFFEY, Q.C.:

Q. Yeah. Affecting many individuals.

DR. WILLIAMS:

A. Many people. Now, you could say, well, there was, we retested so many people and the people that were affected, there were so many--these are individual adverse events. I choose--but I said it's a major adverse event.

COFFEY, Q.C.:

Q. Doctor, on that point, was there anything--I mean, what characteristic, kind of now looking back at it, what characteristic or characteristics, from your perspective of the overall circumstances led you to say, well, looked at now or at least even at the time,

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but certainly now it could be seen as one large or major adverse event, what is it about it?

DR. WILLIAMS:

A. Well, I look at the magnitude of it, Mr. Coffey, and the time frames that were involved. And when I reflect back on it, when I--in early July I started to realize it was your worse nightmare, really, that you would have a large number of patients potentially affected by an important test that went back for many years. So that's why I would classify it as a major adverse event. Now, within that event there was obviously a series, but I--there was events within the event, but I took it collectively when I said that.

COFFEY, Q.C.:

Q. Doctor, in--would it be fair to say, Doctor, that you've talked about lessons learned here from your perspective, that without those two external reviewers reports being able to be made public, okay, to this day do you think that the public would be aware of what the causes of the problems were?

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

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

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

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Q. Okay.
DR. WILLIAMS:
A. So I can only say that, and again, this is a board that had been new at the time, just coming together, had an awful broad mandate and a lot of things to get their head around at that time and subsequently. So if it's not clear to some people, I apologize for that, but I thought I covered the bases, sir.
COFFEY, Q.C.:
Q. You thought you had?
DR. WILLIAMS:
A. Yes, I did, sir.
COFFEY, Q.C.:
Q. And that's what I really wanted to ask you about.
DR. WILLIAMS:
A. That's what I think.
COFFEY, Q.C.:
Q. You did make reference to the day in terms of you said that they in times of restraint, of course, always first wanted to cut CME funding?
DR. WILLIAMS:
A. Any travel, when we get together at, you know

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-
COFFEY, Q.C.:
Q. I was just going to ask you, who is "they"?
DR. WILLIAMS:
A. - this goes back to my days in Department of Health and things like that. Anything--the first things that go when you're trying to cut a budget is travel.
COFFEY, Q.C.:
Q. So who is they?
DR. WILLIAMS:
A. It would be us, around the table having to try to deal with a budget, you try to--and when I was at the department, one of the first things we do is slash the travel budget in your organization because you felt some of that was discretionary and when you're trying to deliver a service to a patient, sometimes you have to make the decisions that anything that affects the service to this individual patient you're going to try to protect, so you slash the other things that you think are discretionary and travel budgets is the key, one of the key ones. Now, that's not just in

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Eastern Health, that's when I was at the department.
COMMISSIONER:
Q. I believe you, if I recall correctly, often the choices are not easy?
DR. WILLIAMS:
A. The choices are never easy.
COMMISSIONER:
Q. If you're--if you don't cut travel, then you may have to cut into a program or something like that?
DR. WILLIAMS:
A. Yes, or may have to deny a service to somebody at the front lines.
COFFEY, Q.C.:
Q. You also said in response to a question one of my colleagues asked you that you're doing an investigation of yourself, you're well advised to go outside?
DR. WILLIAMS:
A. I think, yes, I think if you're going to really--if you're sitting around a table with the colleagues you work for every day and you think there might be a problem there, I think to get a real assessment, you're going to have

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to work with these people after, to get a real and fair assessment we always go outside our organization for peer reviews, Mr. Coffey.
COFFEY, Q.C.:
Q. So I take it that's going to be an implicit recognition that there's a conflict of interest potential?
DR. WILLIAMS:
A. There is a conflict when you're dealing with sitting next to somebody every day and working with them side by side. You're going to--if there's a deficiency there, are you really going to bring it out and then go work with them the next day? So that's why in our peer reviews we always get somebody who's not a colleague within our organization but is somebody at the same level of training and expertise and should be able to do it, of a colleague. Colleague in the sense that they're not working with them, but a colleague in the sense that they do the same kind of job or have the same kind of background.
COFFEY, Q.C.:
Q. If I could, Commissioner, just one final point of clarification, actually, two. And this,

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Commissioner, I will acknowledge it didn't arise from other counsel's questions, but I think it's important because it occurred to me upon reflection to explore it with the doctor. And it's just if we could bring up, please, Exhibit, say, P-0063? Page--I'm sorry, I apologize, 0631, I apologize, P-0631. Page 3, please? Doctor, this is, I gather that, and again, this is one of those tables, spreadsheets, prepared probably in October of '05 when you look at some of the ones that are related to it in the exhibit. And you'll notice here that, I spoke about this earlier, that the--that 11 percent, Ventana, April '04 to March, '05, which is total percent negative is 11 percent. It should be, the converse would be 89 percent positive and weak positives combined.
DR. WILLIAMS:
A. Um-hm.
COFFEY, Q.C.:
Q. And if we could bring up, please, Exhibit P-1135, page 1? 1135, page 1. Now, this is this June 7th, 2006 memo which you've explained to the Commissioner, you know, got

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recalculated based upon or in light of remarks from Dr. Gown regarding the '04, '05 Ventana ER/PR?

DR. WILLIAMS:

A. Um-hm.

COFFEY, Q.C.:

Q. And here Mr. Gulliver has said, he said, "We read each report and identified the total number of positive previously reported and also included specimens that were ER/PR positive but not breast specimens."

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. You understood he was then taking out the non-breast specimens for the Ventana?

DR. WILLIAMS:

A. That's my understanding at the time.

COFFEY, Q.C.:

Q. Okay. On that point, it just occurred to me after, if I might be allowed to ask the question, Commissioner, what about the other times, what about the other years and those figures for, like, oh, '89--I'm sorry, '99, 2000, '01, '02, '03, '04?

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DR. WILLIAMS:

A. I didn't think there would be breast specimens in them or otherwise he would have probably alerted me to that.

COFFEY, Q.C.:

Q. So what I was asking -

DR. WILLIAMS:

A. I thought they were primary breasts.

COFFEY, Q.C.:

Q. Yes.

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. And you had originally thought that, when we look at exhibit, the one we just had up, Exhibit P-0631. Yes. Page 3. You had back in the fall of '05 thought that these were primary breast?

DR. WILLIAMS:

A. Yes, sir.

COFFEY, Q.C.:

Q. Yeah. But as it turns out this particular column, the last one on the right, by June of '06 you'd figured out that, in fact, it wasn't just primary breast, this column included

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others?

DR. WILLIAMS:

A. Well, it had come up before Dr. Gown had made a comment -

COFFEY, Q.C.:

Q. Sure, and I appreciate -

DR. WILLIAMS:

A. - so I asked him to go and review it and he brought me back a set of figures that were primary breast.

COFFEY, Q.C.:

Q. Which we just looked at just then?

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. For that. But the figures he brought back were only for this year? He only brought back, according to what we just looked at, P-1135.

DR. WILLIAMS:

A. I didn't, again, I didn't link that back, I thought that that was done under the Ventana, I thought that would cover all the new Ventana tests.

COFFEY, Q.C.:

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Q. And I appreciate that.

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. Is what he's telling you here.

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. Like upon recalculation of the Ventana results.

DR. WILLIAMS:

A. Yes.

COFFEY, Q.C.:

Q. We get down to about 82 and a half percent total positives?

DR. WILLIAMS:

A. Yes, that was in the range that you could consider reasonable.

COFFEY, Q.C.:

Q. Because, and we get that because I had earlier included non-breast ER/PR?

DR. WILLIAMS:

A. Yes, that's correct.

COFFEY, Q.C.:

Q. For that period?

DR. WILLIAMS:
A. Yes.
COFFEY, Q.C.:
Q. Did you ever take up with Mr. Gulliver whether or not for the 2000, 2001, 2002, 2003 and two thousand and--well, the pre Ventana days, the figures we just looked at there, 0631, did they include -
DR. WILLIAMS:
A. I just assumed we were talk about ER and PR and primary breast that they -
COFFEY, Q.C.:
Q. Yeah. Did you ever -
COMMISSIONER:
Q. Maybe you should ask -
COFFEY, Q.C.:
Q. Yes, okay, so you never did take it up with him?
DR. WILLIAMS:
A. No, I didn't take it up with him and I didn't think I had any reason to take it up with him, Mr. Coffey.
COFFEY, Q.C.:
Q. And I want to thank you, Doctor. Thank you, very much, Commissioner.

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

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

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 21st day of May, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.
Dated at St. John's, Newfoundland and Labrador this 21st day of May, A.D., 2008
Judy Moss

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