COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

MAY 22, 2008

Appearances:

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

Rolf Pritchard/Megan Collins . . . . Her Majesty in Right of NL

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

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

Pamela Taylor . . . . . Members of the Breast Cancer
. . . . . Testing Class Action

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

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COMMISSIONER:
Q. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Good morning, Commissioner. Our next witness is Dr. Oscar Howell. Good morning, Dr. Howell.
DR. HOWELL:
A. Good morning.
DR. OSCAR HOWELL (SWORN) EXAMINATION-IN-CHIEF BY SANDRA CHAYTOR, Q.C.
REGISTRAR:
Q. And would you please state and spell your complete name for the Commission?
DR. HOWELL:
A. Oscar James Howell, O-S-C-A-R, J-A-M-E-S, H-O-W-E-L-L.
REGISTRAR:
Q. Thank you.
CHAYTOR, Q.C.:
Q. Thank you. Commissioner, exhibits to be entered this morning include P-1400 through to 1403, inclusive. 1405 through 1410, inclusive. 1412, 1414 through to 1424, inclusive.
COMMISSIONER:

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Q. 1412, is that one--that is included, is it?
CHAYTOR, Q.C.:
Q. 1412 is, yes.
COMMISSIONER:
Q. Yes, all right. And the latter part was 1414 through to 1424?
CHAYTOR, Q.C.:
Q. That's correct.
COMMISSIONER:
Q. All right, thank you. Those exhibits are entered.
EXHIBITS P-1400 THROUGH P-1403, INCLUSIVE, ENTERED INTO EVIDENCE.
EXHIBITS P-1405 THROUGH P-1410, INCLUSIVE, ENTERED INTO EVIDENCE.
EXHIBIT P-1412 ENTERED INTO EVIDENCE.
EXHIBITS P-1414 THROUGH P-1424, INCLUSIVE, ENTERED INTO EVIDENCE.
CHAYTOR, Q.C.:
Q. Thank you.
COMMISSIONER:
Q. Thank you. Good morning, Doctor.
DR. HOWELL:
A. Good morning.
CHAYTOR, Q.C.:

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Q. How are you?
DR. HOWELL:
A. I am very well, thank you.
CHAYTOR, Q.C.:
Q. Perhaps you can begin, please, by telling us your background and both your educational and your professional, just give us a brief summary?
DR. HOWELL:
A. Born in Placentia, grew up in Carbonear, went to Memorial University for both my undergraduate and my medical degree, starting in general practice in St. John's, developed a busy general practice, busy and working in emergency, large obstetrical practice. Got offered a position as a medical officer with Department of National Defence, position I still hold, through there developed an interest in occupational medicine. Started a company which provided medical support services to the oil industry during the exploration years on the Grand Banks. Took a position as the chief occupational medical officer with the Province of Newfoundland. I did that for four or five years. Provided

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some consultant services to the Workers Compensation. Decided to--had other contracts on occupational medicine, decided to go back to school, went to McGill University in Montreal, did a post-graduate degree in occupational medicine. Sat the Canadian Board of Occupational Medicine exams, became a certified occupational health physician. Went into fulltime occupational medicine. Had several large contracts, one of which was as the occupational health physician for the Health Care Corporation of St. John's. And then took a very large contract with a corporate client with offices throughout Atlantic Canada and some international, as a result of that joined their senior leadership team and through that experience gained some knowledge in terms of management.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. Also took a role with the medical school teaching occupational medicine.
CHAYTOR, Q.C.:
Q. Okay. And when did you graduate with your

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medical school degree?
DR. HOWELL:
A. 1975.
CHAYTOR, Q.C.:
Q. And your post-graduate degree from McGill?
DR. HOWELL:
A. Late 1990s.
CHAYTOR, Q.C.:
Q. And when were you employed with the Health Care Corporation as an occupational health physician?
DR. HOWELL:
A. I'm not sure of those dates. It would eight, ten years ago, maybe.
CHAYTOR, Q.C.:
Q. And it was a salaried position?
DR. HOWELL:
A. No, that was a contract position.
CHAYTOR, Q.C.:
Q. Oh, contract, okay. And how long were you in that position or how long was that contract?
DR. HOWELL:
A. Four or five years.
CHAYTOR, Q.C.:
Q. And currently you still do work for National

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Defence?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And what does that involve?
DR. HOWELL:
A. I'm the medical officer there. I would see military members who, for regular medical care and for occupational issues related to being a soldier.
CHAYTOR, Q.C.:
Q. Okay. And is that a part-time position?
DR. HOWELL:
A. That is part-time.
CHAYTOR, Q.C.:
Q. And how many hours would you devote to that per week?
DR. HOWELL:
A. I share that with another physician. It would be from 7:30 in the morning to 9:30, two days one week, three days another week.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. I also still have some other contracts that I

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do outside of my position with Eastern Health.
CHAYTOR, Q.C.:
Q. Yeah.
DR. HOWELL:
A. I am required to be a licensed physician to be in this position, and therefore -
CHAYTOR, Q.C.:
Q. So this is how you carry out -
DR. HOWELL:
A. That is correct.
CHAYTOR, Q.C.:
Q. - your requisite number of hours?
DR. HOWELL:
A. That is correct.
CHAYTOR, Q.C.:
Q. And your current position then with Eastern Health, what is that position?
DR. HOWELL:
A. Vice president of medical services and diagnostics.
CHAYTOR, Q.C.:
Q. And when did you begin?
DR. HOWELL:
A. September 5th, 2006.
CHAYTOR, Q.C.:

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Q. And perhaps you can tell us how that came about?
DR. HOWELL:
A. I received a phone call from Dr. Williams indicating that Mr. Tilley had asked him to contact me to see if I might have an interest in the position as Dr. Williams was wishing to retire. I subsequently met with Dr. Williams. I had a very busy successful occupational health career going and it certainly wasn't something that I had been looking for, but I met with Dr. Williams in any case and I subsequently met with Mr. Tilley and eventually I went through an interview process of four interviews and I was offered the position.
CHAYTOR, Q.C.:
Q. Okay. And what does it mean to be the vice president of medical services and diagnostics?
DR. HOWELL:
A. It means that I have executive responsibility for the areas of medical services, which would be largely physician services for laboratory, for diagnostic imaging and for pharmacy.
CHAYTOR, Q.C.:

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Q. So you took over Dr. Williams' position?
DR. HOWELL:
A. All except the quality portion of that portfolio.
CHAYTOR, Q.C.:
Q. Yes. So the quality portion of the portfolio is now held by whom?
DR. HOWELL:
A. Ms. Pilgrim.
CHAYTOR, Q.C.:
Q. Pat Pilgrim, okay. And do you know what was the thinking behind not having the VP medical also carry the quality portfolio?
DR. HOWELL:
A. I was not party to that decision making, but Mr. Tilley and I had met and he said, "You are going to have a very steep learning curve here" and I suspect it was more of a consideration for the workload that I was going to experience.
CHAYTOR, Q.C.:
Q. Okay. Is there any consideration being given to having that portion of the portfolio put back with the VP medical?
DR. HOWELL:

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A. I have not been party to any discussion of that.
CHAYTOR, Q.C.:
Q. Okay. So it wasn't just a temporary measure until you climbed the steep learning curve is what I'm asking?
DR. HOWELL:
A. Well, as I read back through the--which I think is an exhibit and I read through the minutes of an executive meeting, I think there was initially some thought that that would be a temporary measure, but it hasn't risen since.
CHAYTOR, Q.C.:
Q. What does that mean, though, in practice, are you--or who is responsible for the quality of medical services for Eastern Health?
DR. HOWELL:
A. For medical services?
CHAYTOR, Q.C.:
Q. Medical services.
DR. HOWELL:
A. Meaning physician services?
CHAYTOR, Q.C.:
Q. Yes.

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DR. HOWELL:
A. Well, I think every physician is responsible for that.
CHAYTOR, Q.C.:
Q. But in terms of you not having the quality portion of the portfolio, what, in effect, does that really mean in terms of the areas that you are responsible for?
DR. HOWELL:
A. You know, I guess to my thinking every individual who works in the organization, from those that might deliver the food to sweep the floor to those who are in the operating room have a responsibility for quality.
CHAYTOR, Q.C.:
Q. Yes. So what does it mean, what's the quality portion, then, of the portfolio, what is that, what is it that Ms. Pilgrim now has that she is responsible for overall?
DR. HOWELL:
A. Well, her area would be responsible for the framework and she chairs the regional quality committee that we all feed into.
CHAYTOR, Q.C.:
Q. Okay.

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DR. HOWELL:
A. So I would have and am evolving a quality portfolio committee for those areas that I have responsibility for and we would meet on a monthly basis and have our own initiatives that would then feed into the regional quality committee.
CHAYTOR, Q.C.:
Q. Yes, okay. And my question then in terms of the medical, meaning the physicians, and of course, everyone understands everyone has individual accountability and responsibility, but ultimately in terms of overseeing that, who is responsible for the quality of medical services at Eastern Health?
DR. HOWELL:
A. From a structure point of view it would be the medical advisory committee.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. And the medical advisory committee consists of the discipline chairs and the clinical chiefs, several chief operating officers and some directors.

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CHAYTOR, Q.C.:
Q. Okay. And so I'll get into that in some more detail with you because I do have questions about the medical advisory committee for you.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. If we could look, please, at P-0044? And this is an organizational chart that we've been provided with from Eastern Health. And the date in the corner is difficult to see, but I believe it's November 22nd, 2006. And we see your name down towards the bottom right, "Oscar Howell, Vice President Medical Services and Diagnostics." And it indicates your responsibility for diagnostic imaging, laboratory services, medical director of infection control, medical services and pharmacy. Are those still your portfolios?
DR. HOWELL:
A. Yes, except I would--and we'll hopefully get some understanding of this as we progress. But the medical director of infection control, while he might report to me as the physician

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involved, the actual infection control actually resides within the quality portfolio.

CHAYTOR, Q.C.:

Q. Okay. So -

DR. HOWELL:

A. So I would not have primary responsibility for infection control.

CHAYTOR, Q.C.:

Q. And you are not the medical director of infection control, that's somebody else?

DR. HOWELL:

A. That is somebody else, that's correct.

CHAYTOR, Q.C.:

Q. And that person reports to you, but -

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. - infection control is under Ms. Pilgrim's portfolio?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. What does it mean then to be the person responsible for laboratory services?

DR. HOWELL:

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A. It means that I have the executive responsibility for that and I sit and chair the laboratory services leadership team.

CHAYTOR, Q.C.:

Q. So perhaps it would be helpful to the Commissioner if you could tell the Commissioner on a day-to-day practical basis what does it mean to hold the position that you hold within Eastern Health? And in particular, obviously, with respect to laboratory services and being VP medical in terms of how it interacts with the physicians within the organization?

DR. HOWELL:

A. Um-hm. How best to explain that? If we look at laboratory services specifically, I would not be involved in the day-to-day operations of the laboratory. I wouldn't have the knowledge or the skill set to do that, in any case. I would meet with that group, the clinical chief for laboratory medicine, the program director and now the discipline chair, for some time that position was not filled, and I would meet with those individuals on a monthly basis and review a number of issues

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that are going on within that particular area of the organization. And as you'll see in the minutes of those meetings, many things are discussed that range from financial to staffing issues, to capital equipment, infrastructure issues. It would be the gamut of trying to operate and provide a laboratory service throughout the region. And part of the evolution of this that's a major challenge is it is throughout the region, it's not just St. John's.

CHAYTOR, Q.C.:

Q. Yes, okay. And in terms of your, you mentioned in giving us your background that you do have some background in management. What exactly do you have in terms of medical management and do you have any experience in health administration?

DR. HOWELL:

A. I have no formal business training whatsoever.

CHAYTOR, Q.C.:

Q. And so what is your practical experience?

DR. HOWELL:

A. My practical experience would evolve from managing small medical clinics or being the

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primary person for running those throughout my career, which there have been three or four, to having two companies providing occupational health services and then sitting on the senior leadership of this large corporate client which allowed me to participate in things, training in change management, very involved in the human resource side of operating a large enterprise.

CHAYTOR, Q.C.:

Q. So it's not the first time that people have reported to you?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And how many people report to you at Eastern Health, around how many?

DR. HOWELL:

A. In the lab I think there are about 450 people.

CHAYTOR, Q.C.:

Q. Which would ultimately come up the chain to report to you?

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

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Q. They don't report directly, I take it?
DR. HOWELL:
A. They don't report directly.
CHAYTOR, Q.C.:
Q. Okay. And who reports directly to you within the lab?
DR. HOWELL:
A. Within the lab it would be the program director, Mr. Gulliver, and the clinical chief, Dr. Denic, and now the new position, Ms. Wade, as the quality and safety manager.
CHAYTOR, Q.C.:
Q. That's Lynn Wade?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. And who do you report to?
DR. HOWELL:
A. I report to the CEO.
CHAYTOR, Q.C.:
Q. Which is Louise Jones right now?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And when you began, that was Mr. Tilley?

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DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. In terms of the reporting structure within the lab, perhaps you can tell us when you began, what was the reporting structure and whether or not you have implemented any change to that?
DR. HOWELL:
A. Well, when I arrived there, there were, really it was a program-based structure, which I understand came forward from the Health Care Corporation of St. John's, and that is that there was a dual leadership position with the program director and the clinical chief, and that existed in the laboratory program when I arrived.
CHAYTOR, Q.C.:
Q. And that's currently the situation?
DR. HOWELL:
A. That is not the situation now.
CHAYTOR, Q.C.:
Q. Not the situation, no, sorry. What is--I'm sorry, what is the current situation?
DR. HOWELL:

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A. So now the change that we have implemented is that we have moved away from a program management approach in the laboratory to Dr. Denic now has become the chief of laboratory medicine and has the authority, responsibility and accountability to run the entire laboratory program.
CHAYTOR, Q.C.:
Q. Okay. So but Mr. Gulliver still reports up to you?
DR. HOWELL:
A. The way--this is an evolving process. Remembering I've been in this position 18 or 19 months and so trying to get a feel for this and get advice from various areas and look at other jurisdictions, we're slowly moving into some change here, and Dr. Denic and I have had many discussions as we try to evolve this. And so the way we've currently set it up is that he has, Mr. Gulliver reports to him. And I think about it this way, that ultimately my goals was let's focus on the product that the laboratory delivers. And I need somebody who has the expertise to be the final arbiter of that product. And so Mr. Gulliver now reports

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to him, but I have retained a partial reporting relationship for Mr. Gulliver to me in terms of some of the administrative issues around staffing and budget and those sorts of things. I could not layer that on Dr. Denic at this point in time. And Dr. Denic wishes to retain some clinical work and we need him to retain some clinical work under our current situation, and so that is the agreement that we have at this point.
CHAYTOR, Q.C.:
Q. Okay. So before when Dr. Williams was in the position, it was a program-based structure where both Mr. Gulliver and the clinical chief reported directly on all matters up to Dr. Williams whereas now Mr. Gulliver only reports to you on administrative matters?
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And--okay. And everything else in terms of the services provided within the lab, Mr. Gulliver now reports to Dr. Denic, who in turn reports to you?
DR. HOWELL:

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A. Right. So there was a division, if you like, between the technical side and the physician professional side. And the clinical chief had the physician professional side and the program director had the technical side and the administrative side.

CHAYTOR, Q.C.:

Q. Yes. And I believe that's common for many areas throughout Eastern Health's program-based structure?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. And, for example, you're also responsible for diagnostic imaging. Is there a program-based structure still in place for diagnostic imaging?

DR. HOWELL:

A. There is.

CHAYTOR, Q.C.:

Q. What was the concern then in terms of the laboratory medicine service, why was that changed?

DR. HOWELL:

A. It's difficult for me to answer that clearly.

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I think the--I still struggle a little bit with the whole program management piece and I was not around when those decisions were made and why it was decided to go with that structure. And I think those that were there fundamentally felt that was a strong structure where a more cooperative approach to running the -

CHAYTOR, Q.C.:

Q. And my question is not so much why program-based, it's why has the decision been made to do other than program-based for laboratory medicine?

DR. HOWELL:

A. Because we're going to focus on the product we deliver and part of that is exactly the reason that we're here today, is to look at doing things better and maybe that will make it better.

CHAYTOR, Q.C.:

Q. Okay. So you came to the determination that this would obviously be a better way to manage the laboratory medicine service. And so what are the advantages, what is it you're trying to achieve?

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DR. HOWELL:

A. And I didn't come to that decision just me, as -

CHAYTOR, Q.C.:

Q. No, I understand that it may have been in the works, in fact, before you arrived?

DR. HOWELL:

A. Yes. In fact, Dr. Williams had discussed that with me several times, that perhaps that was something to look at and a direction that we should be going. But intuitively I, conceptually I just felt that one person who had the knowledge and had the authority worked better in my mind. The accountability fit better for me.

CHAYTOR, Q.C.:

Q. Okay. Well, then, just let me explore that a bit with you. What is it about the accountability that didn't fit so well for you under the old structure?

DR. HOWELL:

A. I guess as I--my own thought processes and as I chatted with people and I'm trying to understand how this operation works, people worked within their own camp, like, this is my

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job, I just do my part, and as long as I do my part, that's it. And as I explored the decision as to whether I would take this job, I really felt that there needed to be substantive changes in health care, and part of that drive needed to be a very patient-centric approach, so that whenever we had to make difficult decisions, we should always be drawing that down to why are we here, and it's about patient care so that ultimately if I could get everyone to think as to focus on that end point, which is the product, the thing that we are doing to deliver to the person who ordered that, and I, you know, I'm sure my--up to that point in time my whole career had been really, I think, spent more particularly in the occupational health world in the corporate thinking process. And so, I was focused on that end product which was going to be delivered to the ordering physician for the care of the patient, and I wanted people to focus on that, and so I didn't want them to think about just their little piece. I wanted them to think about what their piece contributed to that end

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point. So in the case of a technologist, that yes, you do your piece that you then are going to give to the pathologist so that they can do the interpretation, and I want you to be a team, and I want you to focus on that end product.

CHAYTOR, Q.C.:

Q. And there was a sense that that wasn't necessarily the focus prior to then?

DR. HOWELL:

A. Well, again, if I looked at the structure, it seemed like a separation that wasn't natural to me, and in discussions with Dr. Williams, he seemed to have the feeling too, and he'd been there a long period of time, and so it seemed like a natural way to go.

CHAYTOR, Q.C.:

Q. Is there any understanding between you and clinical chief as to whether it's an oral understanding or anything in writing as to what matters have to be brought to your attention?

DR. HOWELL:

A. No, there isn't anything in writing. I think they understand that it's their job to operate

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the laboratory medicine program. They meet with me on a monthly basis. We talk about the various issues and my role is if there are barriers or they're running into problems, that they would bring those to me and we would--my job would be to work with them to try to resolve those difficulties?

CHAYTOR, Q.C.:

Q. And what kinds of issues are brought to your attention at those monthly meetings?

DR. HOWELL:

A. The range could be that we are over budget, why is that? It could be that we want to purchase a new piece of equipment. How do we justify, how do we build a business case for that piece of equipment? It could be issues around recruiting and staffing. You know, those would be typical issues in trying to run a large department.

CHAYTOR, Q.C.:

Q. And of course, we've seen some of the minutes from those meetings. Is that something new or were those monthly meetings held during Dr. Williams' time with the organization?

DR. HOWELL:

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A. I can't--I believe those were an ongoing process. I think, as I reflected back in preparation for this, the first meeting I attended was September the 15th, I think, and I'd only been in the job nine days at that point. So I think that was an automatic thing in the calendar on a monthly basis.

CHAYTOR, Q.C.:

Q. And how far back it dates, you're not sure, but it's certainly something you've continued?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And you meet pretty regularly in terms of your monthly meeting?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Do issues such as any difficulties in terms of the provision of the service, do issues of that nature come to your attention in those meetings?

DR. HOWELL:

A. Oh yes, absolutely.

CHAYTOR, Q.C.:

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Q. Okay, and I take it the ER/PR issue has been the subject of discussion?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay, and we know that back in 2003 or we know now, back in 2003, there was an interruption in the IHC service by Dr. Ejeckam for a period of some weeks. Given the types of issues that are discussed in your monthly meetings, would you expect that that kind of issue, should it arise today, would be brought forward through your monthly meeting?

DR. HOWELL:

A. That would be my expectation.

CHAYTOR, Q.C.:

Q. When you began, Dr. Denic, you told us, is currently the clinical chief. Was Dr. Cook still the clinic chief when you began, clinical chief?

DR. HOWELL:

A. No. Dr. Cook had resigned and Dr. Denic had become the interim clinical chief.

CHAYTOR, Q.C.:

Q. Okay, and who is the discipline chief?

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DR. HOWELL:
A. Dr. Avis, and that is a more recent appointment.
CHAYTOR, Q.C.:
Q. And how long has that been?
DR. HOWELL:
A. I'm not sure. It would be within a year.
CHAYTOR, Q.C.:
Q. And does Dr. Avis then also report to you?
DR. HOWELL:
A. He does not.
CHAYTOR, Q.C.:
Q. He does not. Who does he report to?
DR. HOWELL:
A. He would report to the Dean of Medicine. Well, Dr. Avis, I guess, has two roles, as a discipline chair and as the chief coroner.
CHAYTOR, Q.C.:
Q. Okay. If we could look at the--actually, I can just do it, the second page of P-0044, and again this is dated back November 2006, and this shows the organizational structure, management, laboratory medicine program, Eastern Health, and Terry Gulliver, and I don't know if you can read that, Doctor, but

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it then has regional divisional managers listed, and site managers.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Is this still the current structure?
DR. HOWELL:
A. The names have changed and moved around, but this structure is largely still in place, that's correct.
CHAYTOR, Q.C.:
Q. Okay. So this would show that there are different regional managers for the different divisions within the lab, such as biochemistry, hematology, microbiology, pathology, which would be the division that we're mostly focused on here, cytology, and then there's a regional manager for client services.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And that's Lynn Wade?
DR. HOWELL:
A. Not now.

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CHAYTOR, Q.C.:
Q. Not now, no.
DR. HOWELL:
A. There is a new manager there.
CHAYTOR, Q.C.:
Q. She's in a new quality -
DR. HOWELL:
A. And safety.
CHAYTOR, Q.C.:
Q. - portfolio, right. And then a regional manager for immunology and genetics, site manager for the Avalon region, okay, and where would that be? What areas does that encompass?
DR. HOWELL:
A. That would be Carbonear.
CHAYTOR, Q.C.:
Q. Carbonear, and site manager for Clarenville and Bonavista, and site manager as well as infection control for Burin.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And then a provincial coordinator for blood utilization and biochemists, and so all of

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these people report up to Terry Gulliver?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Who now would report to Dr. Denic on those issues?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. So the piece that's missing from this flow chart doesn't show above Terry Gulliver now would go to Dr. Denic, and then on to you?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Depending on what it relates to.
CHAYTOR, Q.C.:
Q. Yes. Yes, if it's administrative issues arising, we understand it would go from Terry Gulliver directly to you?
DR. HOWELL:
A. At this point in time, yes.
CHAYTOR, Q.C.:

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Q. Okay. But anything to do with the provision of services or quality of services within those divisions would go through Dr. Denic before arriving on your desk?

DR. HOWELL:

A. That's correct, for clinical issues.

CHAYTOR, Q.C.:

Q. For clinical issues, okay, and so this is true, this structure is true throughout the entire region? It's not just the St. John's hospitals?

DR. HOWELL:

A. That's correct, although that--you know, that integration of the whole organization is continuing and, you know, many days remains a challenge, but these regional managers for each of these divisions had in fact happened prior to my arriving there. The physician piece of--we have two pathologists in Clarenville and one pathologist in Carbonear. It would be very recently that I talked to them about Dr. Denic assuming that role and having responsibility there and, for example, Dr. Denic and I have been trying to find the opportunity to go out and sit down with those

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individuals to see how we're going to work together and make that work better.

CHAYTOR, Q.C.:

Q. Okay. So if we just look at P-0044, page two, this is your technical staff. So currently, do I understand all the technical staff throughout the region, including Clarenville and Carbonear, all report up through Terry Gulliver?

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. And that's been in place for quite some time?

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. In fact, this is done back in November 2006?

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. Okay. But what you're telling us is that with respect to the pathologists, there still hasn't been full integration across the region?

DR. HOWELL:

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A. No. If you were to go out and speak to the pathologist in Carbonear, for example, Dr. Baker, he is the clinical chief for rural Avalon as well. So most of the clinical chiefs are program based in St. John's, but there are three clinical chiefs who are regionally based. They're more geographic in nature. That would be Dr. Baker in rural Avalon, Dr. Arthur in Burin/Grand Bank, and Dr. Beamont in Clarenville/Bonavista.

CHAYTOR, Q.C.:

Q. Okay. So what I'm wondering then is if I were to go and ask Dr. Baker "who do you report to?" what would he tell me?

DR. HOWELL:

A. Dr. Baker would probably--well, he would probably say he reports to me.

CHAYTOR, Q.C.:

Q. Directly?

DR. HOWELL:

A. That would be his clinical chief role.

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. I think, and I hope now, that he would say

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that he reports to Dr. Denic for his pathology, but that is -

CHAYTOR, Q.C.:

Q. And that's very recent, that's just -

DR. HOWELL:

A. That is very recent.

CHAYTOR, Q.C.:

Q. Yes, and recent since you and I last had a discussion?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. Yes, and that's true, I take it, of Clarenville as well? Would they now also say in terms of their clinical work as a pathologist, we report to Dr. Denic, but in terms of my role as otherwise, clinical chief or otherwise, we report to Dr. Howell?

DR. HOWELL:

A. Well, the two pathologists in Clarenville would likely say that they report to Dr. Beamont, who's the clinical chief there. We would -

CHAYTOR, Q.C.:

Q. So not Dr. Denic?

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DR. HOWELL:
A. Well, they've--I have talked to one of them on the phone. The meeting had to be cancelled due to weather, but we're going to bring those people together.
CHAYTOR, Q.C.:
Q. It hasn't happened yet?
DR. HOWELL:
A. No. It's an evolving process, and I'm sure there's a sensitivity to this in that the whole integration of the organization has been a struggle. I think if you were to move outside St. John's into the regions, they would probably feel they lost more than they gained in the integration, at least, in terms of their own independence and ability to do things. So one has got to build a team one step at a time.
CHAYTOR, Q.C.:
Q. Okay. So right now, the way it is right now, all the pathologists in St. John's would have no difficulty saying that they report to Dr. Denic?
DR. HOWELL:
A. That's correct.

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CHAYTOR, Q.C.:
Q. Dr. Baker, you believe, is now moved to that point?
DR. HOWELL:
A. I think he would understand that.
CHAYTOR, Q.C.:
Q. And the pathologists in Clarenville, there's still a clinical chief in Clarenville and the pathologists report to that clinical chief?
DR. HOWELL:
A. But they have been told that we are changing the structure and that Dr. Denic's role is a regional role. What we have not had the opportunity to do is to sit down and work together as to how best to make that work for all parties.
CHAYTOR, Q.C.:
Q. And Dr. Howell, it's three years into Eastern Health, and I understand there's been struggles along the way. It's happened though for the technical side of laboratory medicine program. What has been the difficulties in reaching that point from the medical staff point of view?
DR. HOWELL:

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A. I don't think that there's been any particular difficulty. I guess each of the--we have not integrated the bylaws piece yet. There isn't one bylaw for -
CHAYTOR, Q.C.:
Q. I was going to come to that.
DR. HOWELL:
A. I knew you would.
CHAYTOR, Q.C.:
Q. So that hasn't happened yet either.
DR. HOWELL:
A. The bylaws have not been brought together. There are--each of the MACs are operating under their existing bylaws. They are a force onto themselves and it's a continued integration. Nothing moves quickly here. It takes time to work through these issues.
CHAYTOR, Q.C.:
Q. So if we think about some of the issues that came out of the hormone receptor test problems and issues such as, for example, standardizing the way even reporting, pathology reports go forward, right now, if Dr. Denic were to have an idea that this is the best way for this to happen so that we can retrieve the information

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efficiently and accurately, does he have any authority to tell Clarenville "this is the way we're going to report"?
DR. HOWELL:
A. He has that authority.
CHAYTOR, Q.C.:
Q. He has that authority?
DR. HOWELL:
A. He does.
CHAYTOR, Q.C.:
Q. And since when did he--did that stage, when was that reached?
DR. HOWELL:
A. Functionally, he assumed that role in December 2007, but from the point of view of an announcement through the organization, that would have been within the last several months.
CHAYTOR, Q.C.:
Q. So what is it that he wouldn't be able to give direction on?
DR. HOWELL:
A. Well, he could, from a clinical matter, he now has the authority to give direction on all matters related to laboratory medicine. But,

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that is not the way in which we would do it. We would--leadership is not about as much command as influence.

CHAYTOR, Q.C.:

Q. Yes, and I wasn't suggesting that. I'm just wondering what it is then that--how he's not perceived to be the clinical chief or the person that's being reported to, what is it that there would be a reluctance to either report to Dr. Denic on or for Dr. Denic to be able to give direction? And when I say direction, I don't--I'm not saying command, I'm saying direction.

DR. HOWELL:

A. Yeah. I'm not sure that there is a reluctance. It's that, you know, Peninsulas was its own entity at one time, and I think if you were to talk to the medical staff out there, they would prefer it remained one entity.

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. But it hasn't, and so that integration takes a period of time and these are professional

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people who have their own views of how the world should operate and we're working our way through getting them together as a team.

CHAYTOR, Q.C.:

Q. So are you telling me that in reality, Dr. Denic is the person who has the ultimate authority, in reality, but obviously everyone is being diplomatic in terms of how he would exert that authority?

DR. HOWELL:

A. That is correct. He is assuming the mantle of leadership. He has many, many things coming at him, and St. John's is where he resides and where most of the work is, and I guess he's really involved in that with me, more than anywhere else, and gradually we're trying to step that out into the region, the rest of the region.

CHAYTOR, Q.C.:

Q. Okay.

THE COMMISSIONER:

Q. Ms. Chaytor, just something crossed my mind, so I'd like to deal with it now, just in terms of the regions. As I understood what you were saying is that the change that has been

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implemented since you arrived at the organization is one that was done on the basis of your view, which is shared by others, that the most effective way of building a team approach and assuring that everybody, from the technology side and the clinical side, keeps the view of the person whom you're serving, essentially the patient, in mind when you're doing your individual little jobs caused you to make this change so that, as I see it, what you're saying is you want to make sure that both groups are seen as the team and that you both have the same objective and that you're very cooperative in the way you go forward. And then you started talking about the outside groups, and I'm wondering whether if somebody in Burin is going to feel that they are part of a team if really the team resides in St. John's, in the sense of if the structure through which they report is in St. John's, how do you build the team in Burin?

DR. HOWELL:

A. Commissioner, that's why I alluded to the fact that if you were--as I talk to people, I get the impression, as I go outside St. John's,

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that they feel like they've lost more than they've gained, and for many years, we've all heard and talked about the overpass syndrome and I think there's always reluctance that St. John's would dictate to the region. So I remember having this discussion with Mr. Tilley in the past and him telling me that it took seven or eight years for the Health Care Corporation of St. John's to finally start to come together as an organization where people felt part of that organization.

THE COMMISSIONER:

Q. Well, I understand that that's a problem, but it--now, perhaps I'm not understanding how your team is going to work and that's why I'm asking this question. Because it seems to me that what--if you're talking about a team, it's the team in the lab, the people who are actually doing what they do every day, to some extent, side by side, perhaps in separate rooms on some occasions, but each of them has a role to play in respect to the end product which goes out to other physicians in terms of either diagnosis or whatever, and what you are describing to me is an effort to build that

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team in a lab in Eastern Health, and I can even see how you might say "well, that'll work across town as well," if your lab in St. Clare's, because there might be that much activity. But unless there's that same kind of team atmosphere in Burin, i.e. we who are technologists are working with you who are pathologists and we're all in this to produce the same quality results for our patients, I'm not sure how the revised structure is going to help the people in Burin, put it that way.

DR. HOWELL:

A. It all -

THE COMMISSIONER:

Q. Should you have a mini team, if you will, is what I'm saying, in Burin?

DR. HOWELL:

A. It all comes from having strong leaders in all those areas and who feel part of the team. So it starts with working with the leaders themselves. As I'm sure we'll get at at some point in this, I've had town hall meetings with the technologists alone, pathologists alone. Then I've brought them together and met with them together. They, the managers,

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including across the region, come together, I think on a monthly basis and they talk about issues and I believe that that group is coming together very well and what I saw happen in preparation for accreditation helped me feel a lot better that that was happening, and the reality is relationships are important. Dr. Denic needs to get out into the regions. I need to get out into the regions, and it's the pressure of time to make all of those things happen, but it's from the leaders this will come.

CHAYTOR, Q.C.:

Q. So the Laboratory Medicine program's leadership team, does that include the clinical chief in Carbonear?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. Who comprises the leadership team?

DR. HOWELL:

A. For laboratory?

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

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A. The discipline chair, the clinical chief or now the chief of laboratory medicine, and the program director and myself.

CHAYTOR, Q.C.:

Q. Okay, and you're all obviously here in St. John's?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. And has there been any consideration to perhaps building that bridge by including others from outside St. John's on the leadership team?

DR. HOWELL:

A. Yes, many things have to come together to make that happen. We need to get the one set of bylaws. We are working towards a regional medical advisory committee so that there will be representation from the region and I think that will help bring us together a little bit more from a medical staff point of view. And the other piece that I put in place was quarterly a meeting between the clinical chiefs in Clarenville, Bonavista, Burin, Grand Bank and rural Avalon and myself, along with

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the directors who have responsibility for the clinical roles in each of those regions and quarterly I would get together with those individuals and the program director for diagnostic imaging, laboratory and pharmacy, so that I could get that interaction going with that group. And see the dynamic and build the relationships between that core group.

CHAYTOR, Q.C.:

Q. Okay. Is there an updated organizational chart for the Laboratory Medicine Program?

DR. HOWELL:

A. It is still a work-in-progress, but there is a document, yes, that's correct.

CHAYTOR, Q.C.:

Q. But it's draft?

DR. HOWELL:

A. It's still, I would consider it a draft document because one of the things I've--when I met with Mr. Gulliver and Dr. Denic and we talked about this change and how that would happen. I think said to them, I want you to go now and look at the rest of the laboratory, look at how other laboratories are organized

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across the country and I want you to look at whether we should make any other changes in the laboratory. It also was the intention and is the intention and Dr. Denic and I are scheduled to do a little travel of some laboratories in Ontario and possibly Alberta in June and that would be to visit some organizations similar to ours to see what their organizational structure looks like, how their quality processes work and hopefully we'll get some learning there that will allow us to mature our organizational structure even further.

CHAYTOR, Q.C.:

Q. Okay, and Lynn Wade's new position, how does that work, where does she fit into the piece?

DR. HOWELL:

A. That was a brand new position with responsibility for quality and safety in my entire portfolio, so it's not just laboratory. And she reports directly to me, she does not report to Dr. Denic or to any director. It is a position that reports directly to me and is an overseer of those two particular areas.

CHAYTOR, Q.C.:

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Q. And that pertains throughout the region outside of St. John's, as well?

DR. HOWELL:

A. That's correct. I think she assumed that position in, around May of 2007. At this point in time, though, I've asked her to really focus mostly on the laboratory and she is a very experienced manager with many years of service in the laboratory; has deep knowledge of that area. And so she's been doing a fantastic job to move us along in that direction.

CHAYTOR, Q.C.:

Q. So you've told us a bit about some of the difficulties in trying to achieve really a fully integrated continuum of care across the geographical region.

DR. HOWELL:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. You also mentioned that you've held town hall meetings for technologists and then pathologists separately, and then brought them together. Do I get from that that there's also this--a sense or there was a sense of

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divide between the two teams in the laboratory, the technical and the clinical side?

DR. HOWELL:

A. I don't know if I could say there was a sense of divide.

CHAYTOR, Q.C.:

Q. Okay, well then tell us about why you held your town hall meetings, what was the purpose of that and the outcome?

DR. HOWELL:

A. The town hall meetings, I guess I am particularly a fan of town hall meetings and it's an opportunity for very informal discussion with people and I, from a leadership point of view, wanted to not be unknown to these people and to not be seen to just sit in my office and never really talk to the people on the frontlines. But more particularly, I mean there was so much going on in the press that was--many issues affecting Eastern Health, that was affecting the staff and I could walk through the corridor and meet people that I knew and I would chat with them and I could see the

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anguish and the pain that many of them were experiencing. And, you know, I was in quite a unique position because as the occupational health physician for the organization previously, I sat with many employees from those that sweep the floor to even at the very senior leadership level and understood many of the issues that they faced, both personally at home and at work, so when I would meet these people and we'd chat, it had even evolved to the point where these people, if someone asked where they worked, they hated to say Eastern Health. And that was very sad to me, considering the volume of work that we do and the quality of the work. So I decided and talked to Mr. Gulliver and he felt that that was a beneficial thing. I think he was very supportive of that and so we had that meeting with the technologists. So my goal in that meeting, that initial meeting with the technologists and I think some did come from outside St. John's to that meeting. It was a large, very well attended meeting.

CHAYTOR, Q.C.:

Q. So it was for everybody across the

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geographical region?
DR. HOWELL:
A. That was my understanding, that he had put the invitation out. Now, you know, you can't empty your lab because the VP says why don't you come and talk to me; we still have to do the work, so not everyone would be there, but a large number were there and it had no agenda, it was very open and free for discussion and my goal was to really introduce myself and to try to build the morale and the spirit of that group as best I could and to talk to them about any issues they had, to encourage them to come forward and speak to their leaders if they felt that there were issues, and the other thing I wanted to offer was to say if they were to do that and they felt that there were still issues, that my door was open and that they were to come and speak to me, personally.
CHAYTOR, Q.C.:
Q. They could approach you directly?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:

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Q. When did you hold those meetings?
DR. HOWELL:
A. I don't know the date. It was quite -
CHAYTOR, Q.C.:
Q. Early in your mandate.
DR. HOWELL:
A. Yes, it wouldn't have been in the first few months, but it was maybe halfway through my mandate so far.
CHAYTOR, Q.C.:
Q. And through that process or otherwise, did you become aware of any discord between the medical and the technical--or the clinical and the technical staff?
DR. HOWELL:
A. No, certainly in that meeting, I mean, these are very strong personalities, particularly on the physician side, so there's always strong opinions voiced and sometimes aggressively so, but I don't think that I had any great, other than people being people, I really, it wasn't something that was sort of, really a major concern of mine at that point in time. I mean, I was just trying to support all parties here.

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CHAYTOR, Q.C.:
Q. So have you ever become aware or been advised of any discord between the technical staff and the clinical staff or any members of the staff?
DR. HOWELL:
A. Well, you know, certainly as time has progressed and as we have gotten into the ER/PR issue and the level of stress and anxiety is increased, one can see the, you know, that those strong opinions come forward and I've heard more about that a technologist might feel that they haven't received enough feedback from a pathologist or that the pathologist haven't been appropriately understanding and those are just general comments. I mean, in terms of anything formal, I haven't had that.
CHAYTOR, Q.C.:
Q. And those issues have come up in the context of the ER/PR issue?
DR. HOWELL:
A. It has heightened with that, it has become more evident that there's tension there.
CHAYTOR, Q.C.:

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Q. Yes. And what's been done to try and address that?
DR. HOWELL:
A. Well, as part of the evolution of having Dr. Denic assume that role and that was done with--and that's why it took long. First of all, I had to get a feel for Dr. Denic myself. I, someone told me in my prior career, if you want to be successful, gather good people around you. So I was trying to sort out the strengths and weaknesses of all the people who were reporting to me and under me and so on. So Dr. Denic and I first needed to get a feel for each other and our comfort level with each other and the skill sets and the strengths and the weaknesses, et cetera. And then I had to get a feel for his relationship with Mr. Gulliver and how were the pathologists--and I wasn't so much worried about that because I saw that there was a natural leadership role in Dr. Denic in his relationship with the pathologists and in fact, Dr. Denic was, when I first met him, he was also the chair of the Newfoundland Pathologists Association, so I knew that they had recognized him as a leader

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and that he had that relationship with those individuals. Then I had to get a feel for how the technologists were going to feel with this happening, so I gently introduced that idea with Mr. Gulliver and saw what the reaction was and I didn't get any, you know, bad vibes or -

CHAYTOR, Q.C.:

Q. So he was receptive to this change in the reporting structure?

DR. HOWELL:

A. He was receptive, but he wanted to understand it more for Dr. Denic, as an individual. And then I remember I decided I would try it on Lynn Wade and I had a discussion with Lynn that I was thinking about making this change and how did she feel that would go over with the technologist side. And I had great respect for Lynn's knowledge of the laboratory and the people and I felt she was well respected within that group. So that I got positive view from her and I thought, okay, this is the way to go and then I had my discussion with Dr. Denic and we talked about the need to build team, and from there, after

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some discussion, not a lot of arm twisting, he assumed the role.

CHAYTOR, Q.C.:

Q. And were the technologists also receptive to the change in structure?

DR. HOWELL:

A. To the best of my knowledge, that's correct.

CHAYTOR, Q.C.:

Q. And who would have discussed that with them?

DR. HOWELL:

A. That got away from me a little bit, in that I had planned to meet with the managers, all the division managers and talk to them about this change. Unfortunately, I think I got called away for some other major issue and Mr. Gulliver ended up meeting with the technologists--with the division managers and advising them of this.

CHAYTOR, Q.C.:

Q. And he reported back to you that they were receptive?

DR. HOWELL:

A. He did.

CHAYTOR, Q.C.:

Q. And that included the divisional managers

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across the region?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Including outside of St. John's?

DR. HOWELL:

A. That's correct, that was my understanding.

CHAYTOR, Q.C.:

Q. And this, then the actual formal change came into effect when?

DR. HOWELL:

A. The, I think functionally Dr. Denic assumed it, I think December 2007 and as I say, he was evolving into that role, but no major announcement went out until, I'm not sure of the date, it might be March, April, it was not that long ago.

CHAYTOR, Q.C.:

Q. Perhaps we could have a copy of the draft new organizational chart that you referred to. I understand that it's in draft, but if we could have a copy of that.

DR. HOWELL:

A. You certainly can, I have it with me.

CHAYTOR, Q.C.:

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Q. Thank you, that would be great. And that, I take it, would be what has been in place then since December of 2007?

DR. HOWELL:

A. Yes, understanding that it is an evolving process.

CHAYTOR, Q.C.:

Q. In terms of -

DR. HOWELL:

A. Like really the only major changes happened is Dr. Denic in that role.

CHAYTOR, Q.C.:

Q. Right.

DR. HOWELL:

A. And Ms. Wade reporting to me, those are the two major pieces here with the charge to Dr. Denic and Mr. Gulliver, that let's look throughout the rest and see if there's changes that should be made. If they don't need to be made, if we're working fine, we'll leave that; if there are changes--and part of that decision will be made with Dr. Denic and myself and perhaps others, visiting some other key laboratories in this country and talking to those people.

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CHAYTOR, Q.C.:
Q. But right now there aren't any other changes on the horizon?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. The monthly meetings that you hold, is that-- is that just the leadership team?
DR. HOWELL:
A. That's the leadership team.
CHAYTOR, Q.C.:
Q. Here in St. John's?
DR. HOWELL:
A. Yes.
CHAYTOR, Q.C.:
Q. Do you also hold any regular meetings with the people outside of St. John's, with Burin, Clarenville, Carbonear?
DR. HOWELL:
A. With the laboratory people you're referring to?
CHAYTOR, Q.C.:
Q. Well, yes, with your clinical chiefs there, like how and when do you interact with them?
DR. HOWELL:

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A. I have a monthly phone call with the clinical chiefs outside of St. John's and I try to visit one of the other MACs at least once a quarter and I would like to make that every second month. I did not have a medical director for a goodly part of this time and so, until I fill that position, time just was at a premium, but as I explained, I do have a quarterly meeting with each of the clinical chiefs. I bring them together as a group with some of the other key clinical leaders and the program directors for pharmacy, diagnostic imaging and laboratory on a quarterly basis to talk about common issues for the region.
CHAYTOR, Q.C.:
Q. And so the current structure then, in terms of reporting up to Dr. Denic as clinical chief and we talked about this early this morning where you're saying that the person who is actually doing the work at the bench, the technologists, understanding at the end of the day the piece that that plays in terms of ultimate, the patient care and so from the accountability point of view, the technologist is reporting up to the pathologist and in

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terms of accountability for the quality of service, then I guess the clinical chief has direction or is able to give direction directly back to the person performing the work, so that they can be more assured that the quality is there that they need to see, is that what you're hoping to achieve?
DR. HOWELL:
A. The person on the bench would report to their manager.
CHAYTOR, Q.C.:
Q. Yes, but they ultimately report up to the clinical chief?
DR. HOWELL:
A. They would now report, at the end of that pyramid would be Dr. Denic, correct.
CHAYTOR, Q.C.:
Q. Yes. And so the purpose being and understanding what you said from the accountability point of view for the technologists to gain or, I don't know if it's gain, but to have more insight and understanding into ultimately the end product that's trying to be achieved and the purpose for that. How does it work the other way?

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What, how does it work from Dr. Denic's point of view in terms of assuring him of his ability to play what his role in the whole triangular piece?
DR. HOWELL:
A. I'm not sure what you're getting at there. I mean -
CHAYTOR, Q.C.:
Q. So in terms of the, ultimately in terms of the quality and the service, it's now coming up to Dr. Denic as clinical chief -
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And he's accountable for the product that's coming out of the lab.
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And that's the way it works now.
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And so how does this work in terms of what advantage is it to Dr. Denic? How would he

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perceive that as being advantageous? And maybe it's self-explanatory?

DR. HOWELL:

A. I mean, he would understand that he has the authority to make change where it needs to be made and as we build the key indicators for the laboratory, that's going to help him understand what's going on in his laboratory and will help build the arguments that we need to continue to develop the laboratory.

CHAYTOR, Q.C.:

Q. Yes, okay; whereas before, if we just do the comparison, before then he would be--he would only sit on the clinical side and the technologists would be reporting up to Mr. Gulliver.

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. And the technologists would not necessarily have to take direction from the pathologists who might want to have the services performed in a different way?

DR. HOWELL:

A. Right, right.

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CHAYTOR, Q.C.:

Q. That's the main aim, I take it?

DR. HOWELL:

A. I'd like to just make one analogy and I may be wasting the Commissioner's time, but I remember when we were--as I start to try to understand the quality framework and things, and I'm trying to see how we're going to shift this culture to and what that culture would look like and be defined, and the simplest way that I could define it for myself was I would love to have a day when I walked up to one of our domestic workers who was sweeping the floor and I asked him what he did or she did, and if they would look at me and say "I look after patients" I would feel we have arrived.

CHAYTOR, Q.C.:

Q. Uh-hm.

DR. HOWELL:

A. So if you take that into the laboratory piece, then I want everybody to focus on the end product that we put out to the physician who is going to treat the patient.

CHAYTOR, Q.C.:

Q. Yes. Perhaps if we could look then at P-0046,

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page 5? Sorry, I'll just go back, please, to page 1, so Dr. Howell can see the document. This is the report of October 17th, 2005 from Dr. Banerjee and I take it you're familiar with this report?

DR. HOWELL:

A. I am.

CHAYTOR, Q.C.:

Q. And if we could look now please then at page 5, when did you first read this report, Doctor?

DR. HOWELL:

A. Probably it would have been late October of 2006.

CHAYTOR, Q.C.:

Q. Okay. So, about a month or so into your position?

DR. HOWELL:

A. Yes, or a couple, yes, a month and a half or two months.

CHAYTOR, Q.C.:

Q. And the part that i just wanted to bring your attention to or discuss this morning is under number five, "these are other system flaws observed" and it talks about this issue of

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communication and accountability. And Dr. Banerjee observed a disconnect, he calls it "between laboratory program director, division manager, clinical site chief and laboratory director in decision making".

DR. HOWELL:

A. Um-hm.

CHAYTOR, Q.C.:

Q. "The organizational charts indicate a complete separation of reporting structures into technical and clinical strains with no matrix cross reporting between technical and medical leadership". Is that, from your perspective, is that accurate from what you encountered when you joined?

DR. HOWELL:

A. Not when I joined, but certainly as it's evolved over time, I have certainly realized that there was that division and there was a tension.

CHAYTOR, Q.C.:

Q. Okay. And it goes on to say, "this leads to frustration and resentment on both sides, lack of communication, lack of accountability and lack of buy in. The division manager and

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program director appear enthusiastic and keen on modernizing changes"--sorry--"modernizing the laboratory, but their efforts have not been appreciated by the pathologists and work flow changes have not been mapped out and implemented". And then he specifically refers to the "Sakura Express implementation as failed due to lack of planning and work flow changes. Superior outcomes could be achieved by ensuring better linkages between technical, managerial medial leadership". So, I take it that's what you're aiming at, trying to rectify through your new reporting structure?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And so other than reading about this in Dr. Banerjee's report in October, had you by then become aware of this disconnect? Had it been pointed out to you by anyone else or had you observed it yourself?

DR. HOWELL:

A. No, not to that degree. As I said, I saw strong personalities with strong opinions, not unusual in the medical field. It really--

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ER/PR was really starting to come under my radar to understand how big this was as I got into late October, I think. And then somewhere along the way I read this report, but that was about one thing in a whole list of things that I was picking up here that needed to be done.

CHAYTOR, Q.C.:

Q. Yes. And in terms of the status of Sakura Express, do you know whether or not that's now been implemented?

DR. HOWELL:

A. It has not, I don't think.

CHAYTOR, Q.C.:

Q. And do you know why not?

DR. HOWELL:

A. I think there still is, I don't think the pathologists have signed onto that machine. I remember at some point along the way doing a walk about in the laboratory and Dr. Williams is said to be now, you know, Mr. Gulliver really is into machines. He's going to be always after you about buying new equipment, new equipment. And so I did the walk about and I was really impressed with the type of

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equipment and how we used it. And we came upon this machine that was in the corridor taking up space and the laboratory looked very crowded to me. I mean, the corridors were full of storage items. Anyway, that was an issue for me, as well. And I asked about this piece of equipment and I was advised that the pathologists were not wanting to use it.

CHAYTOR, Q.C.:

Q. And that was this piece of equipment, the Sakura Express?

DR. HOWELL:

A. I believe that is the piece of equipment. And then as we continued on through I was also shown another piece of equipment in the immunohistochemistry laboratory that was an add on to the Ventana machine, that the -

CHAYTOR, Q.C.:

Q. Is that the visual imaging machine?

DR. HOWELL:

A. Yes, yes. And Mr. Gulliver talked to me about that and it sounded like a good idea to me, but he advised me that the pathologists were not supportive and would not participate.

CHAYTOR, Q.C.:

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Q. And what's the status of that machine? Is that now used? I understand -

DR. HOWELL:

A. That machine was returned.

CHAYTOR, Q.C.:

Q. Returned.

DR. HOWELL:

A. It was on loan as a demo and it was returned.

CHAYTOR, Q.C.:

Q. So, were you sensing in those discussions with Mr. Gulliver, some frustration on his part in terms of wanting to introduce new equipment and that not being received or the pathologists not being receptive to that.

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

Q. And did -

DR. HOWELL:

A. What I wasn't sure in my mind was -

CHAYTOR, Q.C.:

Q. The why.

DR. HOWELL:

A. - is--yes, is that just a program director who loves the new toys.

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CHAYTOR, Q.C.:
Q. So, what did you find out? I'm sure you spoke to the other side to find out what the pathologists thinking would be on that.
DR. HOWELL:
A. Yes, I would have talked to Dr. Denic about that and he said, you know, this is a new piece of equipment. It's not in broad use anywhere and we're not going to be the first to use it with everything else that's going on. And I'm saying, okay, I have no grounds upon which to argue with that thought process.
CHAYTOR, Q.C.:
Q. Okay. And you weren't presented, I take it with any documentation from either Mr. Gulliver or Dr. Denic to show how widely used the machine is, what's the benefits, advantages or disadvantages to the machinery?
DR. HOWELL:
A. I didn't get to that level and I guess the other question, I would say, so, do we have budget for it anyway and I would have heard no.
CHAYTOR, Q.C.:
Q. So the Sakura Express, I take it, is all

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ready?
DR. HOWELL:
A. That was there.
CHAYTOR, Q.C.:
Q. That's already purchased?
DR. HOWELL:
A. Yes, that was purchased and was there.
CHAYTOR, Q.C.:
Q. And so what's the reason behind the Sakura Express? Why isn't the pathologists keen on that machine?
DR. HOWELL:
A. It's been some time since I discussed that with them and it probably would have been within the first couple of weeks of being on the job and I just don't think that they expressed a faith in the machine, but honestly, I think you're better asking Dr. Denic as to why they would have reluctance with that.
CHAYTOR, Q.C.:
Q. Okay. It's not something you've explored, or if you have, you don't remember what reason was given?
DR. HOWELL:

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A. No, it was very, very early in my mandate. I saw it there, asked why weren't we using it and there just was so much going on that I didn't -
CHAYTOR, Q.C.:
Q. And do you know whether or not that was one of the recommendations from the external reviews, in terms of implementing the Sakura Express?
DR. HOWELL:
A. I'd have to go back and look at whether there was specific to a--one of the recommendations referred to the tissue tech machine. I'm not sure if that's the same piece of equipment or not. But if it is, I understand that of all of those recommendations, that one is outstanding.
CHAYTOR, Q.C.:
Q. Yes. So you did understand that it was a recommendation?
DR. HOWELL:
A. Yes.
CHAYTOR, Q.C.:
Q. Yes, and the visual imaging machine, what did you understand that would be able to do?
DR. HOWELL:

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A. My understanding was that it would do a scan of the slide and give a report which then could be married to still having the pathologist do the interpretation and my understanding was that would be a double check.
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. It could add--to my way of thinking, that would have added to the accuracy. Mr. Gulliver advised me that Dr. Carter had refused to even come to the presentation and Dr. Denic was not supportive of it, as it was, as I explained, his statement to me was "look, this is not in broad use. It's new. We're not going to be the first."
CHAYTOR, Q.C.:
Q. And whether or not there's any statistical analysis in terms of how broadly the machine is used, you didn't see anything in writing to support that position or otherwise refute it?
DR. HOWELL:
A. The little that I had was that the pathologists--if the pathologists weren't

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going to support it, I certainly was not going to be pushing it, and certainly at that stage in my mandate.

CHAYTOR, Q.C.:

Q. Okay. This issue of Dr. Carter didn't--refused to even come and see the machine. Did you sense that there was a tension between Mr. Gulliver and Dr. Carter or are you otherwise aware of that?

DR. HOWELL:

A. I don't think I did at that point, but certainly over time, I have felt and become aware that there was a disagreement between the two individuals.

CHAYTOR, Q.C.:

Q. And in terms of the current reporting structure, if Mr. Gulliver wanted to purchase a machine or a piece of equipment, he would now have to go to Dr. Denic and have approval from Dr. Denic first?

DR. HOWELL:

A. That would be my--I would expect that they would jointly come, that he and Dr. Denic would reach some agreement and jointly come -

CHAYTOR, Q.C.:

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Q. That's not something he would report directly to you on? I'm just wondering, so if he wants to, you know, there's something else that he wants to be able--he would first to have to have Dr. Denic in agreement and then he would go to you for the budget implications, is that how that would work?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. So, he would have to have Dr. Denic's approval?

DR. HOWELL:

A. He would, now he would, absolutely.

CHAYTOR, Q.C.:

Q. Whereas perhaps under the old structure, these two pieces of machinery were acquired and I realize one went back, but they were acquired because Dr. Denic did not have to have the approval of the clinical--I'm sorry, because Mr. Gulliver didn't have to have the approval of Dr. Cook at the time.

DR. HOWELL:

A. Mr. Gulliver, I'm sure would have felt able to, for a technological piece of equipment,

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that he could go ahead and have that brought in as a demo and let people have a look at it and so on. And he would hope that he would get the funding for it.

CHAYTOR, Q.C.:

Q. Well, the Sakura was certainly more than a demo because it's still there.

DR. HOWELL:

A. They purchase--and I don't know the history behind how they purchased that piece of equipment.

CHAYTOR, Q.C.:

Q. Well, we'll take that up with them. Okay. If we could look, please, at P-1400.

THE COMMISSIONER:

Q. Dr. Howell, 1400 would also be in the book that's in front of you if you'd prefer to look at a paper copy.

DR. HOWELL:

A. Okay.

CHAYTOR, Q.C.:

Q. Should be right at the beginning of your book, Doctor, or close to the beginning.

DR. HOWELL:

A. Thank you. I have it.

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CHAYTOR, Q.C.:

Q. And this, I realize, is before your time, but it's a letter written from Dr. Carter, February 8, 2006 to Dr. Cook and have you seen this correspondence before?

DR. HOWELL:

A. I have not.

CHAYTOR, Q.C.:

Q. And this letter, Doctor Carter writes, "please accept this as official notice of my resignation" and again this is February 8, 2006. So, it's a few months before you joined. "As you know, over the last eight months I have had many differences of opinion with the team regarding the processes, work assignments and goals for the successful institution of an ER/PR HER2/neu immunohistochemical laboratory at Eastern Health. It is clear to me that we will not be able to resolve our differences. I cannot as a fellowship trained breast pathologist agree with the direction in which this process is proceeding. Therefore, I feel that resigning is the best option for me and for the team". So at this point in time, Doctor, Doctor

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Carter's concerns and the tension between yourself and what she refers to as the team had come to the point where she was going to resign her position and she gives the date and then there's a handwritten note that it was going to be after a three month notice period. Was that ever brought to your attention, that her difference of opinion with members of the team was such that back in the beginning of February or back in the beginning of '06, she was prepared to resign?

DR. HOWELL:

A. I have never seen this piece of correspondence before and I do not recollect being told, no, of her previously saying she was going to resign. I don't recall being told that.

CHAYTOR, Q.C.:

Q. Okay. And during your time period you haven't learned, other than recently, have you learned of any other time period in which Dr. Carter was prepared to resign and had written correspondence that she would be resigning?

DR. HOWELL:

A. There are two areas of resignation that I recall. One is when she was chairing the

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quality assurance process for ER/PR in the lab and I think there was disagreement, maybe with her and Ms. Wade when we were trying to bring the standard operating procedures--and it was the approach, I think, more that was anything, as I recall. And she resigned and one of the other pathologists took up that role. And the only other resignation is the more recent one that I -

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. - that Dr. Denic advised me that she had resigned from her position and would be leaving Eastern Health.

CHAYTOR, Q.C.:

Q. Okay. And are you aware of whether or not that has anything to do with ongoing differences of opinion between herself and members of the team?

DR. HOWELL:

A. I don't know her reasons.

CHAYTOR, Q.C.:

Q. Okay. If we could look at, please, P-1414 and that again should be in your book. And if

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not, it's on the screen in front of you, Doctor.

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

Q. And this is correspondence that does happen during your time with Eastern Health. It's March 21, 2007. It's written to Mr. John Abbott who is Deputy Minister at the time at Department of Health. And it's written by Dr. Denic as Interim Clinical Chief and copied to Ross Wiseman and also copied to yourself. So, you would have received this correspondence.

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. And this correspondence does say, references, "possible loss of a breast pathology specialist. I just wanted to inform you that another pathologist is looking for a job elsewhere. Dr. Beverley Carter is the only pathologist with sub-speciality training in breast pathology in Newfoundland and Labrador. The reasons for applying for a job in BC is clearly stated in her letter submitted to me

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March 19, 2007. Letter enclosed". And unfortunately, we don't have that letter. So this letter though, you would have been aware then that Dr. Carter was looking for a job in BC back March 21, 2007.

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. Would you also have received her letter, that letter enclosed of March 21, 2007, was that provided to you as well?

DR. HOWELL:

A. I don't recall.

CHAYTOR, Q.C.:

Q. Okay. So any reasons that were given for her resignation at that time or her contemplated resignation, you don't recall?

DR. HOWELL:

A. No. I certainly, I think, and around this letter I did have a--recall a conversation with Dr. Denic and I knew that Dr. Carter was not happy and I was honestly not sure why she was so unhappy. It's not unusual for us to have physicians who are exploring other options outside our province. And I knew that

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Dr. Denic was--he may well be wearing the hat also of the Chair of the Provincial Pathology Association and I think he was trying to get the message through to government that we have a continuing problem here with recruitment and retention of pathologists.

CHAYTOR, Q.C.:

Q. Okay. So whether the issue that was certainly been--raised by Dr. Carter during her time with Eastern Health in terms of problems she was having with differences of opinion within the team, whether or not that was every addressed to her satisfaction or not, you don't know?

DR. HOWELL:

A. You would have to ask her.

CHAYTOR, Q.C.:

Q. That's never come to your attention. So, you don't know the current state of that?

DR. HOWELL:

A. Dr. Denic--I've let Dr. Denic work with that. I know that in her most recent--I've been out of the country for a month and I know that in her most recent resignation, that Dr. Guy, the Medical Director of Medical Services or the

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Director of Medical Services did have a meeting with her to explore, you know, what her issues were and where things that we could be doing--but I have not had an opportunity. He's out of town at the moment and I haven't had a chance to talk to him about that.

CHAYTOR, Q.C.:

Q. When would it come to your attention? If the differences, you know, hadn't been resolved, when would--hadn't been resolved to her satisfaction and then ultimately, and I'm just using Dr. Carter at this point because this is who we have these correspondences in relation to, but when then would that get brought up the chain to you? I mean, would it be before the physician actually walks out the door, that you would be brought in to see what you could do?

DR. HOWELL:

A. Dr. Denic might well phone me or e-mail me or at a leadership meeting, it would be very common for me to be saying, trying to get updates on where are we with our numbers now in terms of pathologists. And it would be certainly not unusual for him to phone me or

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e-mail me to say, you know, another pathologist now is looking at leaving or we're going to lose to or something, that would happen--he would inform me, but he would manage that. He would be dealing with that.

CHAYTOR, Q.C.:

Q. Okay. And in terms of then the other--I understand there's a separate structure again in place for reporting within the IHC lab. Can you explain that to us?

DR. HOWELL:

A. Arising from the external reviews that were done, the immunohistochemistry lab has been changed and I think Dr. Williams has given testimony to that. Dr. Ford Elms now is the Medical Director. And there are three technologists who are assigned to that area only and have received additional training in immunohistochemistry. In addition, a senior technician has been put in the role of quality assurance for that particular lab.

CHAYTOR, Q.C.:

Q. And who is that person?

DR. HOWELL:

A. Catherine Parnell. She is retiring at this

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point and a new person is assuming that role.

CHAYTOR, Q.C.:

Q. So, she's new to it, but now she's retiring?

DR. HOWELL:

A. Well, she's been in that role--I don't know for how long she's been in that role, but she is retiring, as I understand it and a new person has assumed the position.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. And then there is a breast group which did have three physicians and is now down to two and will shortly be down to none.

CHAYTOR, Q.C.:

Q. In terms of -

DR. HOWELL:

A. Well, that was Doctor Cook and we lost one of the pathologists, I think left for BC, I think and Dr. Cook is off on sick leave at this point in time and, of course, Dr. Carter has tendered her resignation.

CHAYTOR, Q.C.:

Q. Yes. And Dr. Elms then, he is the person who is in charge of the IHC lab.

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DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. So, the techs within IHC would, if they had any problems or troubleshooting, they would go to Dr. Elms?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And then ultimately Dr. Elms reports to Dr. Denic?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And to whom does Barry Dyer report? Where does he fit into this puzzle?
DR. HOWELL:
A. Barry Dyer would be, at this point in time, would be reporting to Mr. Gulliver.
CHAYTOR, Q.C.:
Q. And you say "at this point in time", is that changed or is it contemplated that that will change?
DR. HOWELL:
A. As we continue to look into the structure,

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obviously one of those areas we will be looking will be how pathology is structured. And I've asked Dr. Denic and Mr. Gulliver to start in that area and have a look first. And part of that will be hopefully, if next month I can get away to look at some other laboratories and meet with Dr. Flynn and with QMP-LS, we'll have a little better look at what some of the possibilities might be for that.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Dr. Howell, I'm not sure I'm understanding. Is IHC division of the laboratory then managed differently than the rest of the laboratory?
DR. HOWELL:
A. It has a medical director.
THE COMMISSIONER:
Q. And that's the--okay so--but the structures that you're giving me this morning in respect of the lab and how it operates, I have to have a little asterisk in my minds view of your structure because IHC doesn't neatly fall in that structure.

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DR. HOWELL:
A. No.
THE COMMISSIONER:
Q. Would that be right?
DR. HOWELL:
A. It is virtually an island to itself and has evolved into its own entity.
THE COMMISSIONER:
Q. Okay. And as I understand it, within that it is unusual because it has a medical director, in this case Dr. Elms. It also has three technologists who are assigned permanently to there. And do I take it that they report to Dr. Elms, not through the regular reporting system?
DR. HOWELL:
A. They would certainly be reporting to Dr. Elms, but they still would--they would report principally to Dr. Elms, but I think they would still feel that they have some reporting relationship to Mr. Dyer and ultimately up to Mr. Gulliver. I think when you examine those individuals, they'll clarify that a little bit further for you.
CHAYTOR, Q.C.:

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Q. Do you think it'll be clear in their minds?
DR. HOWELL:
A. I would hope it would be.
CHAYTOR, Q.C.:
Q. Is there an organization chart for that which has been provided to them?
DR. HOWELL:
A. I don't know the answer.
CHAYTOR, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Okay. So, there is a technologist in the IHC lab and let's take a couple of examples of the kind of a problem a technologist might have. If the technologist has a problem related to something like, oh I don't know, personal benefits, that kind of stuff, who does that person go to?
DR. HOWELL:
A. Personal benefits?
THE COMMISSIONER:
Q. Yes.
DR. HOWELL:
A. I would expect that person would be going to Mr. Dyer who is his division manager.

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THE COMMISSIONER:
Q. Mr. Dyer, okay. If that person has a problem with staining on a batch in any one morning, who does that person go to?
DR. HOWELL:
A. Dr. Elms.
THE COMMISSIONER:
Q. Okay. It seems to me those two examples are pretty clear. You would expect that that would happen.
DR. HOWELL:
A. Correct.
THE COMMISSIONER:
Q. What's on the margins where somebody might be doubting who they go to.
DR. HOWELL:
A. Correct.
THE COMMISSIONER:
Q. What kind of thing--I mean, as with most things in most organizations, there are those nice things that fit very clearly within this place and very clearly within that place, then there's all that grey. Would you expect that there would be grey here and is it still being worked out? And if so, what's an example of

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grey?
DR. HOWELL:
A. You know, I would just, in my mind, have two categories; those things that are more administrative in nature and those things that are clinical in nature. If it's clinical, my expectation would be that they would understand they have a relationship with Dr. Elms.
CHAYTOR, Q.C.:
Q. So, for example, what if a technologist had an issue as to whether or not they should buy a particular kind of stain or a greater quantity of a particular stain. Who would the technologist ask that question of?
DR. HOWELL:
A. I believe that would be a collaborative effort.
CHAYTOR, Q.C.:
Q. So they could go to either.
DR. HOWELL:
A. If they were going to be changing a stain in any way, as the medical director, Dr. Elms would be the person who should be working with them on those decisions.

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CHAYTOR, Q.C.:
Q. And if they're running out of a particular stain, who would they speak to?
DR. HOWELL:
A. If they're running out of a stain, I would suspect that would--that's an excellent way to look at it--that would be Mr. Dyer.
CHAYTOR, Q.C.:
Q. I'm not sure, Commissioner, is that clear now for you?
THE COMMISSIONER:
Q. Probably not, but it's clearer than it was. I'll come back to it if I need to.
CHAYTOR, Q.C.:
Q. Okay. Doctor, before I leave the whole lab structuring and restructuring, is there a plan in place in terms of the consolidation of laboratory services within the St. John's region onto one site.
MR. SIMMONS:
Q. Lab services or pathology?
CHAYTOR, Q.C.:
Q. Well, start with lab.
DR. HOWELL:
A. Well, there is a plan to consolidate all the

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pathologists on one site.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. So, all -
CHAYTOR, Q.C.:
Q. So, this is just in relation to pathology.
DR. HOWELL:
A. Yes, all the pathologists will be moving to the Health Science site in St. John's as quickly as we can get the renovations done to make that happen. We will maintain a presence on the St. Clare's site with a pathologist going down for the purpose of frozen sections and that sort of thing to support the surgery program at St. Clare's.
CHAYTOR, Q.C.:
Q. So, that decision has already been made.
DR. HOWELL:
A. That decision has been made.
CHAYTOR, Q.C.:
Q. All pathology service--so the only pathology lab within St. John's will be within the Health Sciences and there's renovations ongoing to the physical plan to -

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DR. HOWELL:
A. They're not ongoing, but they--I'm trying to make them ongoing.
CHAYTOR, Q.C.:
Q. So, what stage is this at?
DR. HOWELL:
A. There is a diagram and there are many things that have to come together to make that happen. And we have to move some things out of the Health Sciences to St. Clare's in order to facilitate the construction. Before we do that, there are slides stored in corridors, in old labs. All of that has got to be found and put in storage. That storage space has to be found. That's in evolution, and my understanding is there will be--there are renovations occurring at the Miller Centre. We will get space there and we will get new storage for laboratory materials there.
As that happens, we'll be moving some part of the lab in the Health Sciences to St. Clare's to facilitate that construction, and then we will move all the pathologists on one site.
CHAYTOR, Q.C.:

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Q. And what's your estimated time for completion?
DR. HOWELL:
A. My estimated time was yesterday, but -
CHAYTOR, Q.C.:
Q. What's your realistic time period? Is there a plan?
DR. HOWELL:
A. When I left for vacation, I knew there was a diagram and they were working out the stages of how this would evolve. I have not had an opportunity to pressure Facilities to get this done.
CHAYTOR, Q.C.:
Q. Is it happening in 2008?
DR. HOWELL:
A. It will happen in 2008.
CHAYTOR, Q.C.:
Q. And what was the--why the pathology lab? What was the reason behind this move?
DR. HOWELL:
A. The pathologists.
CHAYTOR, Q.C.:
Q. Okay. So tell us about that. They wanted this?
DR. HOWELL:

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A. My understanding is that this had come up before. I did not know that. My goal in bringing the pathologists onto one site was there was--in reading the external reviews that had been done, in looking at the turnover in pathologists, and the continued shortages that we were having, looking at the costs and the amount of work we were sending out of the province, looking at my desire to strengthen team, I felt it made infinite sense to bring all the pathologists on one site. That would allow better collaboration amongst the pathologists and would allow possibly better opportunities for workload distribution, and so I started to press for that direction. I discussed it with Dr. Denic and Mr. Gulliver and I ultimately went to Mr. Tilley. I got a rough estimate of what it might cost to do that, and I went to Mr. Tilley and said I really, really, really think we need to do this, and I got approval to proceed, and we've been probably a year trying to make it happen.
CHAYTOR, Q.C.:
Q. And did you experience any opposition to this move?

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DR. HOWELL:
A. No, I didn't really receive any opposition. I guess my first--I thought I was doing a great thing and my first glimpse that maybe I wasn't going to get 100 percent support was a meeting with--when I had this town hall meeting with the pathologists by themselves and a pathologist, one of the pathologists spoke up and said "don't you think you should have asked us first?" and -
CHAYTOR, Q.C.:
Q. And was that Dr. Carter?
DR. HOWELL:
A. It was, and I reflected on that and I said yes, you are probably quite right, I should have.
CHAYTOR, Q.C.:
Q. So they hadn't been consulted in the decision making?
DR. HOWELL:
A. They had not been consulted.
CHAYTOR, Q.C.:
Q. And she would have been a pathologist at St. Clare's who would be required to move to the Health Sciences?

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DR. HOWELL:
A. That is correct, and subsequent to that, I reflected that I probably had not done the very thing that I was encouraging everyone else to do, the consultative process. So I started to inquire into that a little bit more and found that this was not a new idea. It was an old idea and it had been discussed previously and had been vigorously opposed by, I think, the St. Clare's pathologists.
CHAYTOR, Q.C.:
Q. It had been in the past?
DR. HOWELL:
A. That was what I was advised.
CHAYTOR, Q.C.:
Q. And were the--ultimately then, were the St. Clare's pathologists on board for the move?
DR. HOWELL:
A. I received no--other than that one question, I received no further opposition and I believe Dr. Denic has continued discussions with them and I could be corrected on this, but I do believe he has shown them the blueprint of how we designed the space for their offices and some other changes that we'll take advantage

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of to improve the grossing area and such.
CHAYTOR, Q.C.:
Q. Okay, and just before we take the morning break, Commissioner, I've brought up again P-0044, which shows the organizational chart, and Doctor, I just want to be clear on the IHC lab, and from what I've understood you to say, and through answering the Commissioner's questions, the IHC lab, although we show the pathology, regional manager pathology division being Barry Dyer here, and he reports up to Terry Gulliver, the IHC lab itself would be then a division of the pathology lab, which isn't shown here, and within that, it has its own triangular reporting structure. Is that right?
DR. HOWELL:
A. That is correct.
CHAYTOR, Q.C.:
Q. Okay, and when we say a triangular reporting structure, we have Dr. Elms at the top of the triangle, the technologists, the three dedicated technologists to IHC in one corner, and do we have the pathologists doing IHC in the other corner?

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DR. HOWELL:
A. That would be my understanding.
CHAYTOR, Q.C.:
Q. So those pathologists who are carrying out any work in IHC would report through to Dr. Elms first?
DR. HOWELL:
A. Dr. Elms had a responsibility for the IHC lab. You know, it is my belief that this needs further work.
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. I believe it needs further work, but I need them to work it through and I need to look at other organizations, how they do it, before we really make that change.
CHAYTOR, Q.C.:
Q. Yes, because the importance of clarity in communications and the reporting lines, particularly if we look at a situation like the ER/PR situation and making sure that people are clear on who they go to for direction.
DR. HOWELL:

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A. Absolutely.
CHAYTOR, Q.C.:
Q. So that needs further work.
DR. HOWELL:
A. Absolutely, it very much does.
THE COMMISSIONER:
Q. So the current organization for the IHC really only deals with what happens before the lab--before the slide gets showed to the pathologist who's reading it, is it?
DR. HOWELL:
A. No.
THE COMMISSIONER:
Q. Okay. What I wasn't clear on was the answer to your question regarding--and perhaps it's a presumption I'm making that isn't correct. I understand that Dr. Elms is responsible for the lab, so that--and that now pathologists are not involved with grossing. Is that correct?
DR. HOWELL:
A. There are -
THE COMMISSIONER:
Q. Technologists -
DR. HOWELL:

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A. There have been added expertise brought in for the grossing.
THE COMMISSIONER:
Q. But it's not done by pathologists any more?
DR. HOWELL:
A. Pathologist assistants.
THE COMMISSIONER:
Q. Exactly.
DR. HOWELL:
A. Under the supervision of a pathologist.
THE COMMISSIONER:
Q. Okay. So that for most pathologists, they don't actually get to apply their expertise to the area of IHC until someone hands them a slide? Is that right?
DR. HOWELL:
A. Well, Dr. Elms is a pathologist and would have the -
THE COMMISSIONER:
Q. Yes, but is Dr. Elms reading all IHC slides? Is that work not shared with others?
DR. HOWELL:
A. In terms of the breast, it is purely with two individuals now, Dr. Cook and Dr. Carter.
THE COMMISSIONER:

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Q. Okay.
DR. HOWELL:
A. The depth of the detail, Commissioner, I think you really need to talk to the individuals involved.
THE COMMISSIONER:
Q. Yes, okay. So who do I talk to, Dr. Denic? Would he know that? Or do you have to talk to Dr. Elms to know?
DR. HOWELL:
A. I think both individuals will help clarify that.
THE COMMISSIONER:
Q. All right. Now, you want to take the morning break?
CHAYTOR, Q.C.:
Q. Yes, thank you.
THE COMMISSIONER:
Q. We'll take 15 minutes.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor.
CHAYTOR, Q.C.:
Q. Thank you, Commissioner. Dr. Howell, are there different classifications of physicians

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within Eastern Health?
DR. HOWELL:
A. Different -
CHAYTOR, Q.C.:
Q. In terms of fee-for-service, salaried?
DR. HOWELL:
A. Oh, yes, there are really three categories, if you like, three payment methods. One is fee-for-service. One would be an alternate payment plan, and a third would be salary.
CHAYTOR, Q.C.:
Q. And which category do the pathologists fall within?
DR. HOWELL:
A. Salary.
CHAYTOR, Q.C.:
Q. So they're salaried within Eastern Health, salaried employees of Eastern Health?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And what authority do you have, as the VP Medical, over the medical staff?
DR. HOWELL:
A. I have a responsibility for medical services,

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so that would be from the recruiting of physicians, doing the appropriate credentialling and privileging of those physicians, and then the ongoing evaluation of the work that they do through their programs, etcetera.
CHAYTOR, Q.C.:
Q. And is that true of all classifications, whether they're fee-for-service or salaried physicians or alternate payment?
DR. HOWELL:
A. That is correct. I would have really no control about how they're paid or what they're paid. That is something that they negotiate with government through their association.
CHAYTOR, Q.C.:
Q. But you have responsibility for the credentialling and the evaluation?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay, and how do you measure the quality of a physician's work?
DR. HOWELL:
A. This is largely done through the program, so

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the clinical chief ultimately, in any given program, including the laboratory, would be responsible for the work done by the physicians in that program. Since I've come, we have been attempting to strengthen that process and while there is an expectation that there would be annual evaluations done on all physicians, that certainly hasn't been a consistent process, my understanding is historically, through the organization, and I have been attempting to change that and I've just started doing evaluations on all of the clinical chiefs, with the intention that they will then do evaluations on the division chiefs, who will then ultimately do evaluations on all of the physicians within any given division.

CHAYTOR, Q.C.:

Q. So you would only personally do the clinical chiefs. So in terms of the laboratory medicine program right now, that would be Dr. Denic?

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

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Q. And then it goes on down the chain.

DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. And that had not been happening on a regular basis in Eastern Health?

DR. HOWELL:

A. I'm not certain to what degree it was happening. I guess it really--as I looked at the roles and--my roles and responsibilities, I realized that that was one of them, and then as we look at the accreditation report of May 2007, that was a highlighted area that we needed -

CHAYTOR, Q.C.:

Q. September, September 2007 you mean?

DR. HOWELL:

A. Yes. That we needed to improve in that area. So I think part of the challenge there was there was no medical director--or director of medical services. I think Dr. Williams was really carrying a very, very great load. But we are certainly moving in that direction now.

CHAYTOR, Q.C.:

Q. So what role will the medical director play in

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that?

DR. HOWELL:

A. The medical director will take the lead role for all medical services and that will--and I have specifically asked him to focus on the credentialling, privileging area, bylaws and evaluation.

CHAYTOR, Q.C.:

Q. And there was nobody in that position while Dr. Williams was VP Medical?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. So since assuming your position, have you, in fact, carried out a performance evaluation of Dr. Denic?

DR. HOWELL:

A. I have not. It is scheduled for--I think it was scheduled for today.

CHAYTOR, Q.C.:

Q. You're otherwise occupied, I take it.

DR. HOWELL:

A. I don't think it will be happening.

CHAYTOR, Q.C.:

Q. And would you -

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THE COMMISSIONER:

Q. (Inaudible) service to somebody, you know.

CHAYTOR, Q.C.:

Q. And in terms of Mr. Gulliver now, he would be then evaluated by Dr. Denic? Is that correct?

DR. HOWELL:

A. He will be.

CHAYTOR, Q.C.:

Q. Would he be evaluated by you with respect to certain aspects of his job?

DR. HOWELL:

A. A work in progress.

CHAYTOR, Q.C.:

Q. So you don't know?

DR. HOWELL:

A. It is a work in progress. Ultimately because he's reporting to me for part of the function now, I will be involved in that.

CHAYTOR, Q.C.:

Q. And do you know whether or not to date Dr. Denic has carried out a performance evaluation of Mr. Gulliver?

DR. HOWELL:

A. I don't think he has, but I can't speak with certainty.

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CHAYTOR, Q.C.:
Q. The performance evaluations that are carried out by the pathologists or with respect, sorry, to the pathologists, would those performance evaluations ultimately end up on your desk?
DR. HOWELL:
A. I have not seen any performance evaluations, and I don't know that they have been done.
CHAYTOR, Q.C.:
Q. So there may not have been any carried out since you've taken up your duties in September 2006?
DR. HOWELL:
A. None that I'm aware of or that I have seen.
CHAYTOR, Q.C.:
Q. Okay, and would the--when the process gets--and I understand what you're telling us. You're trying to strengthen that process, and of course, that was brought up in the accreditation, you're right. So when ultimately the performance evaluations are completed, the plan would be, however, that they would go up the chain and you would ultimately see those evaluations?

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DR. HOWELL:
A. Yes. In the plan that we are trying to pull together, there are some areas that we will try to centralize and that is to--remembering that all of our clinical chiefs have large clinical loads and they are trying to do this administrative work around those clinical loads, so while we have a very small office of the vice president, we're going to try to centralize as much as we can there, in terms of sending out the evaluations and collecting them and making sure that there are tick boxes of all the things that needed to be done.
And so that will--what we've done is we've introduced a new evaluation tool. We've shared that with the clinical chiefs. We've made some adjustments in that tool. It is far from perfect, but what we do is there are sections for the individual to fill out. There's sections for us to fill out, and then there are comments made by whoever the person reports to.
So we've brought in that new tool and as I say, we've started and once we're doing the clinical chiefs, so that they get a good feel

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about--from both sides. They've had a chance to look at the tool. They've had a chance to make some adjustments in its content, and we've tried not to make the workload too onerous and but still to gain valuable information, and so we're doing the clinical chiefs and then we're asking them to do their division chiefs and roll it on down. So once we do the clinical chief, Dr. Guy, who's the director of medical services, his assistant will then send out the forms to other physicians, ask them to complete their part and to book a time to meet with their clinical chief or division chief as appropriate, and part of that issue was--and then all of that will come back and reside in the physician's file within the office of the Director of medical services.
Part of that process which created, I gather, while I was out of the country, some concern about a confidentiality agreement. Part of the idea was to ensure that that file is as complete as possible and that one of the documents that we would want in that file would include that the physician had

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understood clearly and had signed a confidentiality agreement with the organization. In addition, within that file, it collects information about positions held or anything that's changed. It asks questions about what continuing medical education activity that they have pursued through the year. So we're looking at the work they did, any changes that happened. We're looking at their continuing education and their competency levels. We are asking them whether there are any outstanding complaints against them. Do they still--have they still maintained their license, have they still maintained their Canadian Medical Protective Insurance, and so -
CHAYTOR, Q.C.:
Q. Was such--sorry, I didn't mean to cut off.
DR. HOWELL:
A. No.
CHAYTOR, Q.C.:
Q. Was such a process in place before or is this something new that's being implemented by you?
DR. HOWELL:
A. I think--my understanding is that different

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programs had different tools they were using and it was inconsistently applied across the programs. But -

CHAYTOR, Q.C.:

Q. And I'm just, of course, focusing on the laboratory medicine program.

DR. HOWELL:

A. Yes, and I honestly do not know what was done in the past in that area.

CHAYTOR, Q.C.:

Q. So whether or not in the past people were ever asked about what continuing education had been pursued and whether--and evaluation of their competency levels, you're not able to speak to that?

DR. HOWELL:

A. No. It has been everything that I can do to handle looking forward. Looking back has been a challenge.

CHAYTOR, Q.C.:

Q. But the fact that you're now bringing this in and standardizing it across, I take it that that hadn't been done before. There had been no standardization of the type of performance evaluation for physicians prior to what's now

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under way?

DR. HOWELL:

A. I'm not certain what was present before.

CHAYTOR, Q.C.:

Q. Well, I guess you wouldn't be reinventing the wheel if it was already there.

DR. HOWELL:

A. I think that's a fair statement.

THE COMMISSIONER:

Q. Can you just remind me what a director of medical services does?

DR. HOWELL:

A. It would be the--if you looked at all the other areas that I have responsibility for, there are directors in place in each of those, Commissioner. There was not for medical services, so now there is for medical services.

CHAYTOR, Q.C.:

Q. You mean as in a director for a particular -

DR. HOWELL:

A. Diagnostic imaging, for example, a director of pharmacy. So for medical services, there wasn't such a position, and this is really the day-to-day operational issues of having a

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medical staff and its function in the organization. So recruitment, retention issues. For example, last Friday, I get a phone call that a physician who is on call, their pager doesn't work. Well, they're on call. We have to have communication. That's an issue, I just do not have time to get down to that level of operational. So the director of medical services would the day-to-day operational issues where the rubber hits the road.

THE COMMISSIONER:

Q. Thank you.

CHAYTOR, Q.C.:

Q. In terms of the pathologists then outside St. John's, who would be responsible for carrying out their performance evaluations?

DR. HOWELL:

A. In the past, it would--in the past -

CHAYTOR, Q.C.:

Q. No, on the go forward basis.

DR. HOWELL:

A. On the go forward, ultimately Dr. Denic would have a responsibility there because he has a regional responsibility.

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CHAYTOR, Q.C.:

Q. Is there any concern about Dr. Denic's knowledge level of the work performed by those pathologists outside the region?

DR. HOWELL:

A. Short answer is yes. And I think Dr. Denic himself, as he and I discussed this new role and new position, I think one of his greatest concerns was that he didn't, you know, his responsibility now for laboratories outside of St. John's and he certainly had no great in depth knowledge of those areas. And so again, it is part of that evolving process in trying to get the appropriate org structure in place and responsibilities.

CHAYTOR, Q.C.:

Q. What about the technologists, have performance evaluations been carried out on the technologists on a regular basis?

DR. HOWELL:

A. I don't know.

CHAYTOR, Q.C.:

Q. And would that ultimately be reported up to you?

DR. HOWELL:

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A. No.
CHAYTOR, Q.C.:
Q. Okay. So who would that be reported to?
DR. HOWELL:
A. That would be reported to Mr. Gulliver.
CHAYTOR, Q.C.:
Q. And it wouldn't go beyond Mr. Gulliver?
DR. HOWELL:
A. Well, ultimately I would expect that his division managers would be doing those evaluations and they would be coming into them. And I honestly don't know how that process works and how he has done those evaluations. I have not seen any of them.
CHAYTOR, Q.C.:
Q. But in terms of the--so the chain of reporting with respect to the pathologists' would be done by the clinical chief and ultimately you would foresee that--you would see that coming to your desk?
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. But not from the technologists to the division manager, to Mr. Gulliver, through Mr. Denic,

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perhaps, and then to you, you wouldn't expect that to happen?
DR. HOWELL:
A. It's all changing and evolving, but from the pathologist's point of view I would expect that Dr. Denic would be doing pathologists' reviews and that they would then come into the director of medical services and be housed in his office as there are fills on all physicians and their current status of their credentialling and their privileging. But they--you know, I would not be reading all of them. I certainly wouldn't be that intimately involved with those reviews.
CHAYTOR, Q.C.:
Q. How often, you said you're responsible for the credentialling of physicians. How often are physicians credentialed at Eastern Health?
DR. HOWELL:
A. At initial appointment and then there are five-year reappointments.
CHAYTOR, Q.C.:
Q. And what exactly is involved in the credentialling? What does it mean? And perhaps you could explain first what does it

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mean to be credentialed and what's involved then in the credentialling at the five-year interval?
DR. HOWELL:
A. Okay. So a physician might apply to Eastern Health. And just as a, by way of explanation, I'm probably going to talk more about how it happens in St. John's and there may be variations, although I don't think that there is very much, between what might happen in Clarenville, Bonavista or Burin, Grand Bank area. That is another part of bringing all the bylaws to one set of bylaws. So a physician would be--would be recruited or might apply for a position. They would send in an application, fill out an application form that would be sent in. It would be received in our office. There is an administrator there who would receive that, start a file. They must provide three letters of reference before it can go to the credentials committee. There are some stipulations. If this is a relatively new graduate, then we would require a reference letter from their program director in their

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training program. If they're a more senior physician who's been out in practice, we would be looking for reference letters and at least one of those letters would be from a, somebody who had supervised them in their previous position. They would then need to provide proof of licensure in the province of Newfoundland and Labrador. They need to indicate that they carry malpractice insurance and they have to give us the appropriate number, you know, their member number for both their licence. There is a fairly close liaison between the administrator in our office and the College of Physicians and Surgeons of Newfoundland and Labrador that double check that this person is--has a licence and has gone through a rather detailed vetting part of being given a licence in the province. And then the clinical chief would be required to endorse this person and put a written letter on the file in support of this person being credentialed in the organization. Now, once you--once we accept that you have the skill set and you have a licence and are recognized to be an orthopedic surgeon, the

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next area is where are we going to give you privileges and what is it that we will allow you to do. So you might be given privileges in one hospital but not another, you might be given privileges to do certain procedures but not others, and again, we rely very heavily on the clinical chief to support that process.

CHAYTOR, Q.C.:

Q. And at the five-year interval is there any reexamination then of those various criterion?

DR. HOWELL:

A. Then there is they must apply again and in their application answer many of the questions which are very similar. We are in the process of reviewing that and, you know, our current discussion is that five years is too long, it probably should be reappointment after three years. And but there would be an annual evaluation. If we can strengthen this annual evaluation and get that working efficiently, then that will feed up very nicely into the time at which reappointment is appropriate.

CHAYTOR, Q.C.:

Q. So perhaps then the five-year interval would be appropriate if you can make sure that the

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annual evaluations are carries out?

DR. HOWELL:

A. That is correct. And as we evolve to a common set of bylaws, hopefully we will again standardize a lot of that process through our region.

CHAYTOR, Q.C.:

Q. Are issues of upgrading of skills or continuing medical education, are those addressed at the credentialling levels, is it done though the credentialling process or is it just done at the performance evaluation?

DR. HOWELL:

A. It's not a strong part of the credentialling process, no.

CHAYTOR, Q.C.:

Q. So and if annual evaluations hadn't been taking place, then it could be quite some time before any questions are asked in terms of a physician, how much upgrading of the skills physicians have had or how much continuing education has taken place?

DR. HOWELL:

A. Except that their own professional bodies, the Royal College of Physicians and Surgeons of

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Canada and the College of Family Practice all have requirements for minimum levels of continuing medical education at a given standard and you must provide evidence of having participated that, so external to the organization there are other demands if you're going to maintain your stature in that organization.

CHAYTOR, Q.C.:

Q. But does that direct in what areas you receive your hours of continuing medical education? For example, if we're dealing with a pathologist who is focused on doing IHC, I take it through that process there wouldn't be any direction given that there has to be certain upgrading of skills directed specifically at IHC?

DR. HOWELL:

A. That is correct, to the best of my knowledge.

CHAYTOR, Q.C.:

Q. So if that were to take place and depending on what procedures the physician has been permitted to do within Eastern Health, if there were to be any direction given of upgrading of skills specifically directed

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towards those procedures, that would have to take place within Eastern Health through the performance evaluation process?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. To your knowledge, was any requirement for the upgrading of skills or continuing medical education deriving from the ER/PR issue ever the subject of discussion with physicians either through the credentialling process or through performance evaluations?

DR. HOWELL:

A. Not to my knowledge.

CHAYTOR, Q.C.:

Q. And do you know why not?

DR. HOWELL:

A. I don't know why not.

CHAYTOR, Q.C.:

Q. Has that ever been the subject of discussion or anything that you have sought an answer to?

DR. HOWELL:

A. As I read the external reviews and that were performed and I'm looking at how we strengthen the laboratory, then the participation and

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continuing medical education and the--there is an allocation of if you're a--as negotiated under the memorandum of understanding between the NLMA and government--and I must say I do not have a strong, in depth knowledge of that. I've been private practice for many years outside of where it's been my own contracts, so. But as I understand it, part of that agreement is that specialists get allocations of $2000 and general practitioners get $1000 which is a contribution towards their continuing medical education. So that would come through to our office to sign off for that payment and what it requires is the signature of the clinical chief supporting it and of the vice president that will change now to the director of medical service.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. So in that part I would be expecting that the clinical chief would be at least in that small sum of money, be looking at what that individual might be going to do and was it supportive of the program. That would be my

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hope and would be discussion that I would have with the clinical chiefs, that -

CHAYTOR, Q.C.:

Q. And whether or not that's happened, do you know?

DR. HOWELL:

A. Whether they--I don't, no, I can't speak to that. It's an evolving process and part of where I want--we must invest much more in that education and we must get much more focused.

CHAYTOR, Q.C.:

Q. And you've read Dr. Banerjee's report?

DR. HOWELL:

A. I did.

CHAYTOR, Q.C.:

Q. And you're aware that he recommended that there be continuing education for both the technologists and the physicians, the pathologists in the area of IHC, in particular?

DR. HOWELL:

A. Um-hm.

CHAYTOR, Q.C.:

Q. Other than Dr. Elms, are you aware of whether or not any other pathologists have had such

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additional training?

DR. HOWELL:

A. No. My understanding is that Dr. Elms did and that the technologists did. The other pathologists, I do not have specific knowledge about what additional CME they've attended.

CHAYTOR, Q.C.:

Q. And whether or not that was directed by Eastern Health or the clinical chief, you don't know?

DR. HOWELL:

A. I don't know.

CHAYTOR, Q.C.:

Q. At the reevaluation of credentials at the five-year mark, you've told me that the issue of upgrading skills would not normally be the subject of discussion. What happens then, what has to happen to be reevaluated and to receive your credentials again at the five-year mark?

DR. HOWELL:

A. Again, there would be a reapplication process. And I haven't looked at that application in some time because now Dr. Guy does, the director of medical services does all the

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credentialling.

CHAYTOR, Q.C.:

Q. So you'd apply all over in the same--is that it?

DR. HOWELL:

A. Yes, you make application again and have to reaffirm that you hold those--you know, you hold all the appropriate degrees. And if you've changed your position or you're serving on new roles, all that would be in that application, that you still have your licence and that they're so on and so forth.

CHAYTOR, Q.C.:

Q. And the clinical chief would have to put a letter again on the application file?

DR. HOWELL:

A. The clinical chief must support the reappointment process.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. That new evaluation process will strengthen that immensely, it is my hope. If we can continue to roll that out and apply it consistently, by the time reappointment comes

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up, you know, if we have physicians who we're not happy with some aspect of their practice, that should have been identified in the evaluation process and attempts at remediation should have taken place.

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. And it will be a challenge for us to--there are some situations where we have very few subspecialists in a given area and so this will be a challenging -

CHAYTOR, Q.C.:

Q. And breast pathology, of course, was one of those?

DR. HOWELL:

A. It would be one of those, that is correct.

CHAYTOR, Q.C.:

Q. If we could see, please, P-0745? Page 95, please? And this is the accreditation report which I understand the report is dated September 23rd to 28th, 2007. And I take it, Dr. Howell, you were actively involved in this process?

DR. HOWELL:

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A. I was.

CHAYTOR, Q.C.:

Q. And on page 95, under "Human Resources" there's a recommendation, "It is recommended that the processes to credential, appoint, reappoint and grant medical staff privileges be standardized and criteria be clearly defined." And under "Potential Adverse," or the organization rating, and we had a witness, I believe it was Ms. Jones, tell us that seven is the ultimate number, the highest number. Organization rated itself a four, the survey rated it a three. "Potential adverse event without standardization, there exists potential for maintain practitioners that may not have the qualifications required for the job. Reason for urgency, there is little consistency in the content of documentation on the physicians' file." Can you speak to that and explain what is being referred to in the accreditation?

DR. HOWELL:

A. Each physician has a file within the medical administrator's office and there--when I first arrived and looked at some of those files, I

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felt that there were--I felt there were things missing from those files.

CHAYTOR, Q.C.:

Q. So you'd agree with this assessment?

DR. HOWELL:

A. I totally agree, I do.

CHAYTOR, Q.C.:

Q. And what did you think was missing from the files?

DR. HOWELL:

A. I'm trying to think of an example. I wanted to see a little bit more organization to the file and sometimes there would be a situation where there was, we had an urgent need for a specialist and that specialist arrived and while we demanded three references, only two were in. There was repeated chasing of third one, it didn't arrive. We needed that person in the position and it happened. And so, you know, I have tried to push the clinical chiefs to say I don't want it even to come to the credentials committee. There wasn't on the front cover a check mark that said, you know, here are all the components that we need to have in the file and what I wanted to see was

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that before that file went to the credentials committee, that there was a tick in every box and if there was not, don't take it to the credentials committee. And so it was really a strengthening of that process to make sure that the process was followed stringently. Now, you know, it's easy to be critical of that and to get very hard nosed about it, but at the same time if you only have two pediatric surgeons and one is gone and you're recruiting another and the other person is worn out and you need somebody now, I can see whereby sometimes you bend the rules to get that person in place. So it's the balance between being consistent and diligent and making sure you provide the service.

CHAYTOR, Q.C.:

Q. And did you discuss this with the surveyors?

DR. HOWELL:

A. I did not.

CHAYTOR, Q.C.:

Q. You didn't discuss this particular issue?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

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Q. So do you understand, is it your understanding that it's more a documentation issue or is there any concern being expressed that, in fact, there may be practitioners that do not have the appropriate qualifications for the job?

DR. HOWELL:

A. No, I understood it was a documentation issue.

CHAYTOR, Q.C.:

Q. And then the second recommendation here also says "It is recommended that the process for credential appointment, reappointment and grading of privileges be documented and applied consistently across the Eastern Health region." And I take it the first one is recommending that standardization and criteria be clearly defined?

DR. HOWELL:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And the second one seems to be specifically aimed at documentation, and there is reference to "Incomplete files may give rise to fragmented and inadequate processes." So I take it the other, the first concern that I

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directed your attention to is the need also for standardization and clearly defining the criteria by which a physician would be credentialed?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. So and I take it you would agree with both of those recommendations?

DR. HOWELL:

A. I strongly agree with both of those recommendations.

CHAYTOR, Q.C.:

Q. Have you, in particular, checked the records regarding the credentialling of pathologists?

DR. HOWELL:

A. I have not.

CHAYTOR, Q.C.:

Q. Do you know if anybody has?

DR. HOWELL:

A. I do not know.

CHAYTOR, Q.C.:

Q. Do you know if the concerns raised by the surveyors pertain to pathologists?

DR. HOWELL:

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A. My understanding was it was of a very general nature, not specific to any particular program or department or whatever.

CHAYTOR, Q.C.:

Q. So you wouldn't expect the record keeping or the lack of standardization to be any different for pathologists than any other physician group?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. If we can have 1401, please? I'd like to ask you a few questions now about the medical bylaws, medical staff bylaws. And it was referenced in an answer you gave earlier. This is a memo that was written to yourself by Dr. Williams, September 29th, 2006. So I take it is Dr. Williams still at Eastern Health in this time period?

DR. HOWELL:

A. There was a transition period when I came on board and he remained in the office for the first month.

CHAYTOR, Q.C.:

Q. So you overlapped by a month?

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DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And you started, you said, the Tuesday after Labour Day, is it?

DR. HOWELL:

A. Right. I think it was September 5th.

CHAYTOR, Q.C.:

Q. So by early October he'd left Eastern Health?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And in this memo it deals with the medical staff bylaws. And he's attached the first draft at that point, blending the draft from the Health Boards Association with previous bylaws of the organizations which now form Eastern Health. And he goes on to say that, "There is some work to do," but he felt the bulk of the work has now been done and most of the rest requires a discussion at the October 18th, 2006 meeting of medical directors. And there's three items that he indicated need to be discussed. So Dr. Williams, certainly at that point in time,

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September 29th, 2006, felt that this was well under way. And I understand from your answer earlier that this has not been achieved to date. Can you tell us what is the current status and any challenges you have encountered along the way?

DR. HOWELL:

A. When I took over this role and there was that little transition period for Dr. Williams and I, I begged him if there was one thing not to leave me to do it was to rewrite the bylaws. He ultimately had the knowledge, was fully involved and thank God that he did agree that he would continue to try to complete that. It did, though, take on a life of its own in as much as I became aware that in the formation of the regional health authorities, the four regional health authorities that government had indicated that it wished for the four regional health authorities to have a very similar set of bylaws, at least along certain core elements such as credentialling and privileging, discipline and I think there were four or five modules that they said this core must be the same in all regional health

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authorities. And the first exposure I had to that was going to a meeting of the, all the other vice presidents of medical services for the other regional health authorities and there had been some work done to--and I think as I came into that, they were into the seventh or eighth draft of what this might look like.

CHAYTOR, Q.C.:

Q. I'm sorry, did you say that the government had directed that they wanted to see the regionalization of the bylaws?

DR. HOWELL:

A. They wished to see a common set of bylaws for some core elements.

CHAYTOR, Q.C.:

Q. So that's the minister of Health and Community Services, I take it?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. So a common set, so across the province it would be basically the same template across the province?

DR. HOWELL:

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A. That's correct. For not maybe the entire set of bylaws in that there may be some structural difference that would wrap around that core, but the core must be the same across the province.

CHAYTOR, Q.C.:

Q. And the authority that the government would be relying on to give that direction would be under the Regional Health Authorities Act?

DR. HOWELL:

A. Correct.

CHAYTOR, Q.C.:

Q. Okay. I'm sorry, continue on then, and you went to a meeting, and what happened?

DR. HOWELL:

A. They were through multiple drafts. And I'm trying to recall this now, I may not be totally accurate, but it was trying to distil down to what this might look like and there was a desire, certainly from the CEOs of all the--of the four regional health authorities to get this done as quickly as possible. We had to move from getting that draft out to a consultative process with the physicians across the province and through the

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Newfoundland and Labrador Medical Association and that process continues up to today. And certainly within Eastern Health the medical advisory committee of the St. John's hospitals asked several of its members to take this on and come back with a report to the medical advisory committee. And it is my understanding that that group is also working with the Newfoundland and Labrador Medical Association to--and have suggested some changes which I have not seen to this point. And I now have asked the director of medical services that that be one of his key functions, that he would be working with those bylaws, and I think he's intimately involved with that, trying to bring it to some conclusion.

CHAYTOR, Q.C.:

Q. What are the stumbling blocks? Are there some issues that are contentious?

DR. HOWELL:

A. I am not certain of those that are contentious. The one that has been brought to my attention as key one is that these new bylaws have the medical staffs accountable to

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the CEO.
CHAYTOR, Q.C.:
Q. To the CEO of the authorities?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Okay. And who is proposing that?
DR. HOWELL:
A. That is proposed through the--through government, through the minister.
CHAYTOR, Q.C.:
Q. Okay. So Department of Health is proposing that?
DR. HOWELL:
A. That's my understanding.
CHAYTOR, Q.C.:
Q. Who currently are they accountable to?
DR. HOWELL:
A. The medical staff have voiced to me that they are accountable to the board and they wish to be accountable to the board, not to the CEO.
CHAYTOR, Q.C.:
Q. So we've heard that the medical advisory committee sits at the board and reports to the board. So right now the structure that the

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physicians--the physicians are in favour of the current structure in continuing to report directly to the board of directors, is that correct?
DR. HOWELL:
A. That is my understanding.
CHAYTOR, Q.C.:
Q. And what's being proposed would require that the physicians would report to the CEO within their health authority?
DR. HOWELL:
A. That's correct. And there are other issues, but I really have not been close to it for some months.
CHAYTOR, Q.C.:
Q. But that's a significant one that has been brought to your attention?
DR. HOWELL:
A. That is correct.
CHAYTOR, Q.C.:
Q. And what's the concern with reporting to the CEO?
DR. HOWELL:
A. You would have to ask them.
CHAYTOR, Q.C.:

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Q. That hasn't been told to you?
DR. HOWELL:
A. You know, I think there is tremendous confusion out there as to who owns the bylaws. I've heard members of the medical staff say the medical staff bylaws belong to the medical staff. I don't believe that to be so. I think that they have always belonged to the board of the organization. But I think I don't have a more clear answer on that than that, but just wanting to get a consistent set of bylaws across the region in place and it is critical in order for us to move forward with the structural changes that we need.
CHAYTOR, Q.C.:
Q. So what bylaws do you current operate under?
DR. HOWELL:
A. The legacy bylaws of the legacy organization.
CHAYTOR, Q.C.:
Q. So in St. John's it would be the Health Care Corporation medical staff bylaws, in Clarenville it would be the bylaws -
DR. HOWELL:
A. Peninsulas.
CHAYTOR, Q.C.:

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Q. Peninsulas. And what's the position of the board on the issue of the change in reporting to the CEO?
DR. HOWELL:
A. I am not aware, I have not heard any position from the board.
CHAYTOR, Q.C.:
Q. And you sit at board meetings?
DR. HOWELL:
A. I do.
CHAYTOR, Q.C.:
Q. And that issue hasn't been addressed?
DR. HOWELL:
A. Not when I have been present.
CHAYTOR, Q.C.:
Q. What then is the position, do you know, of the medical advisory committee within Eastern Health?
DR. HOWELL:
A. Well, there are five medical advisory committees within Eastern Health.
CHAYTOR, Q.C.:
Q. And who are those five?
DR. HOWELL:
A. There is the acute care hospitals in St.

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John's; there is long-term care in St. John's; there, and then there is one for Clarenville, Bonavista area; one for rural Avalon; and one for Burin, Grand Bank.

CHAYTOR, Q.C.:

Q. So not only there's been this issue of trying to come up something that everybody could live with across the province in keeping with what the minister had directed or suggested, there's also Eastern Health itself has not adopted its own regional bylaws?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. That hasn't happened?

DR. HOWELL:

A. There is no Eastern Health bylaws as such.

CHAYTOR, Q.C.:

Q. It's all still within whatever the legacy organization was using?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And so you currently have five MACs?

DR. HOWELL:

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A. Yes.

CHAYTOR, Q.C.:

Q. And all five report to the board?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And do all five have a representative sitting at board meetings?

DR. HOWELL:

A. They do not have a representative sitting there, only by invitation or at their request would they attend.

CHAYTOR, Q.C.:

Q. Okay. And -

DR. HOWELL:

A. They submit minutes, though, our items of concern from the MAC to the board.

CHAYTOR, Q.C.:

Q. So the chair of MAC for acute care, St. John's, is not necessarily representing the areas outside St. John's?

DR. HOWELL:

A. That is definitely so.

CHAYTOR, Q.C.:

Q. Is not representing?

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DR. HOWELL:

A. Is not.

CHAYTOR, Q.C.:

Q. Okay. And do the chairs of the MAC for those regions also attend board meetings?

DR. HOWELL:

A. By invitation or at their request.

CHAYTOR, Q.C.:

Q. And is that also true for the chair of acute care in St. John's?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And does the chair--who is the chair, currently?

DR. HOWELL:

A. In St. John's?

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. Dr. Linda Inkpen.

CHAYTOR, Q.C.:

Q. Okay. And does she normally attend board meetings?

DR. HOWELL:

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A. She does not.

CHAYTOR, Q.C.:

Q. Do you have any liaison with the chairs of MAC, the five chairs?

DR. HOWELL:

A. More so--you know, I have attended MAC meetings across the region. The acute care St. John's, I would attend every MAC meeting there. And I try to get--you know, I would have been at the other MACs at least a couple of times since I've been in the position.

CHAYTOR, Q.C.:

Q. And are the medical advisory committees involved in the credentialling of the physicians?

DR. HOWELL:

A. They are.

CHAYTOR, Q.C.:

Q. Okay. And what is their role?

DR. HOWELL:

A. Well, there is a--there are some standing committees of MAC and one of those is the credentials committee and the credentials committee submits a report to MAC about credentials, which MAC must adopt prior to it

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going to the board for final acceptance.

CHAYTOR, Q.C.:

Q. And where do you fit in that picture?

DR. HOWELL:

A. I, I guess, would be the consistent person at the board meeting and would put forward the reports from the MAC through the CEO and the chair of the board to the board.

CHAYTOR, Q.C.:

Q. Okay. So earlier when we talked about the credentialling of physicians, that's not actually done by yourself, that's done by a committee of whichever MAC is applicable?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. And then that committee reports to the MAC, and MAC currently reports directly to the board?

DR. HOWELL:

A. Yes. But the element of consistency, I guess, in that, is that, you know, in the past the vice president and the bylaws actually specify that the vice president will sit on the credentials committee. Now, as we've evolved

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to a director of medical services and with all the other things I'm dealing with I have delegated that to the director of medical services who sits in the credentials meeting in St. John's only. In the outside regions the clinical chief would be the person who would be the sort of common person sitting on that from an administrative point of view.

CHAYTOR, Q.C.:

Q. And who would sit there for the credentialling and the clinical chief?

DR. HOWELL:

A. That's a very good question. But it is a committee, a group of individuals who are evaluating your credentials and your reappointment. And I must tell you that the-- exactly how that works in each of those other MACs and credentials committee, I do not have a sound a knowledge as I do in St. John's.

CHAYTOR, Q.C.:

Q. Okay. And, Dr. Howell, you've agreed with the recommendations from the accreditation and you feel strongly about the need to have these things standardized. And I'm just thinking, you've got five MACs that you have to work

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with to try and coordinate this, that's currently is the dilemma that you face. Is that of concern to you and how is this going to happen? It's been, you know, three years trying get bylaws in place. How is that you're going to be able to regionalize the credentialling process?

DR. HOWELL:

A. Step 1, well, we've executed this new tool and we're rolling it out through acute care St. John's. And we, hopefully we will see these new bylaws in place in the fall, that would be my fondest wish. That will add some standardization and some consistency. And part of the structure process that will sit around that is there will be--there will continue to be local medical advisory committees--those existing medical advisory committees will not disappear. They will still remain in their geographic areas with their specific areas of responsibility and expertise. But they will report up to a regional medical advisory committee which will have representative from each of those medical advisory committees, local medical advisory

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committees. And that will be how we will hold the discussions and help drive the standardization and the expectations to that group. And I would then see that group being the group that reports to the board.

CHAYTOR, Q.C.:

Q. If we could have, please--or reports to see.

COMMISSIONER:

Q. Could I just ask a sort of, outsiders naive question. It seems you're making things more complicated than less. Is that right?

DR. HOWELL:

A. It's a very much a layered organization, Commissioner.

COMMISSIONER:

Q. And you're adding more layers?

DR. HOWELL:

A. What we're trying to do is to bring the region together and, again, the challenge is that the medical staff in Burin wishes to maintain some autonomy and control over those issues that are relevant to their region.

COMMISSIONER:

Q. Um-hm.

DR. HOWELL:

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A. And in order to do that they need some structure, but we have to have a way that there are certain elements that are standardized in the approach. So again, it's trying to influence and collaborate -

COMMISSIONER:

Q. Okay, you know, I think I get the message in terms of what your many problems are. But just looking at this from a outside perspective, we have had various witnesses who have come along here and said, essentially, that as a matter of policy government decided initially to create Health Care Corp. That took a long period of time, there were growing pains. They eventually felt that they were getting somewhere and then government policy changed and larger organizations were created with perhaps more diversity in the kinds of operations which they were then taking over. There wasn't that commonality of what we're doing that had been there in Health Care, at least that's my perception of what people have been saying.

DR. HOWELL:

A. Um-hm.

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COMMISSIONER:

Q. They also said that in the process one of the theories was that you could make things more streamlined, you could save on administrative costs and hopefully that kind of cost could be put into other things. But it seems to me what you're describing in terms of what's currently being happening, I'm not knocking the nature of the problems you have because of the fact that you are now trying to bring into an organization, that happens to be in a central place, people and organizations that had been accustomed up to now to effectively running their own show.

DR. HOWELL:

A. Um-hm.

COMMISSIONER:

Q. And I can perhaps relate a little to the concerns that maybe St. John's would be so dominant that their view of the world would never get through to anybody.

DR. HOWELL:

A. Um-hm.

COMMISSIONER:

Q. But in this process it seems to me we're

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creating more layers. And I'm wondering if in the end it's going to make life so complicated that you're not going to meet your objective. Am I just being unnecessarily pessimistic or naive about how much is possible with organizational structure properly achieved?

DR. HOWELL:

A. Commissioner, I would share the sentiments that you're expressing. And I wish that this could be done in a--before I took this job I didn't get a lot of support from my friends or family for taking it, and one of the reasons was that I'm not known to be a patient person. When I see a direction to go, I want to go there quickly. I have learned in this organization that you cannot go that quickly, you must work your way through the process and bring people along and, you know, there certainly is a politic of how medicine is practised throughout this province and at least at this point in time, we have not been able to see another direction to go. I really haven't changed, moved the ship a long ways in terms of that process of having a local medical advisory committee and then a

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regional.

THE COMMISSIONER:

Q. Uh-hm.

DR. HOWELL:

A. But I will tell you that every single medical advisory committee that I go to outside of St. John's, I constantly have to reaffirm that they are not going to lose their medical advisory committee. It is very, very important to them.

THE COMMISSIONER:

Q. Uh-hm.

DR. HOWELL:

A. And they view that as their voice into the Board and so at least at this point in time, I see no way to streamline it beyond that. Over time as maybe we build a team and everybody starts to look at things a little different and some of the, maybe the suspicions and the trust and the support amongst us grows, and I have some ideas about how to do that, but until that happens, I think we're stuck with this cumbersome structure.

THE COMMISSIONER:

Q. And just bring this back to labs, which is

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really where we need to sort of focus, are there peculiar problems to the laboratory and pathology end of things that are not operative in respect of other disciplines or -

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. What you have said generally applies equally to that area?

DR. HOWELL:

A. I think the difference would be that in terms of pathologists, there are only three--in Eastern Health, there are only three pathologists outside St. John's, it's a small group; there's one in Carbonear and that individual is very, very familiar with administrative side of things and understand its; and the other two individuals are in Clarenville. As far as a technologist per se, I think they all do similar work and I certainly get an impression that they are a group that get along fairly well. I haven't come across any lack of cohesion or that same degree that I would see with medical staff's, for example.

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THE COMMISSIONER:

Q. No, okay. Sorry, Ms. Chaytor, I've interrupted again.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. If we could have, please, P-1422, page 11? These are your handwritten notes that we managed to get through, thank you, Dr. Howell, yesterday. And this is October 5th, I take it, 2006 and do I take it you're having a meeting on this day with Linda Inkpen?

DR. HOWELL:

A. That is correct.

CHAYTOR, Q.C.:

Q. Or is this a telephone call? Does this mean you're meeting with her?

DR. HOWELL:

A. I think, I can't recall, this was as I was -

CHAYTOR, Q.C.:

Q. Certainly a discussion with her in any event.

DR. HOWELL:

A. Yes, I was working through all the stakeholders and she was one of those.

CHAYTOR, Q.C.:

Q. And this is about a month into your job?

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DR. HOWELL:

A. Right.

CHAYTOR, Q.C.:

Q. And she's the chair of the MAC for acute care in St. John's?

DR. HOWELL:

A. Correct.

CHAYTOR, Q.C.:

Q. And did you have similar meetings or discussions early in your tenure with the other chairs of MAC, outside of St. John's--acute care I'm mostly concerned with.

DR. HOWELL:

A. I did with the clinical chiefs outside of St. John's.

CHAYTOR, Q.C.:

Q. With the clinical chiefs.

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

Q. And one of the issues it appears that you discussed on this date with Ms. Inkpen was the ER/PR issue?

DR. HOWELL:

A. Correct.

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CHAYTOR, Q.C.:

Q. See that listed here.

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

Q. And do you recall what was discussed and why that would be of interest to Dr. Inkpen?

DR. HOWELL:

A. No, this would be, if you look at earlier slides, I was trying to build a template for gathering information and trying to understand who the people were, what roles they played, who were the strong leaders, who were the influencers, and then I was trying to get an idea of what Dr. Inkpen's role was, how MAC worked and this would have been a question--this is me reflecting back, but I think this would have been a question to say, so what are some of the key issues that might be before MAC at this point?

CHAYTOR, Q.C.:

Q. Okay, so this is your list of a key issue that may be before MAC?

DR. HOWELL:

A. This may be things that she said to me these

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are key issues that are of concern to MAC.
CHAYTOR, Q.C.:
Q. Okay, and why would the ER/PR issue be an issue of concern to the MAC?
DR. HOWELL:
A. It must have been discussed at MAC as a major issue.
CHAYTOR, Q.C.:
Q. You don't recall what discussion you had with her around that?
DR. HOWELL:
A. At that point it would have been extremely superficial.
CHAYTOR, Q.C.:
Q. Number two is written here, "relationship, MAC to the Board of Directors, advisory, needs feedback from Board of Directors. What does Board of Directors want? Clinical chiefs duplication." Can you tell us what that means? Are these concerns, by the way, that Dr. Inkpen would have been raising?
DR. HOWELL:
A. I think we were both commiserating on how the Board, how the MAC related to the Board and, you know, I was still trying to understand how

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I related to the Board and what the structure was and relationship between the VP's office and the Board was and I was exploring that with her. I think the, for example, what MAC sends to the Board of Directors at each Board of Directors' meeting, varies somewhat from MAC to MAC. Some send very detailed minutes, some just send their credentialling report, it varied, so we would be chatting about that. The clinical chiefs duplication issue is that the MAC in St. John's has become a very large structure, a very, very large group, which makes it a challenge to manage from a meeting perspective. And also the clinical chiefs meet separate from MAC, so what happens is the clinical chiefs' meetings are operational in nature and so, but what happens was a lot of the issues that the clinical chiefs had discussed in their meeting, were now getting also discussed at MAC. And so there was a duplication of effort and a lot of time lost.
CHAYTOR, Q.C.:
Q. So all the clinical chiefs sit at MAC?
DR. HOWELL:
A. That's correct.

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CHAYTOR, Q.C.:
Q. And is that still the situation then, is this duplication still taking place?
DR. HOWELL:
A. It does, very much so.
CHAYTOR, Q.C.:
Q. And with not an insignificant amount of time for busy physicians to attend both lots of meetings.
DR. HOWELL:
A. There is not a great love of meetings with physicians.
CHAYTOR, Q.C.:
Q. On the bottom of the page, you've written "credentials: evaluations peer review" and I take it that concerns the credentialling of physicians?
DR. HOWELL:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And what's meant here by evaluations and then peer review?
DR. HOWELL:
A. I think it was, again, very general discussion with Dr. Inkpen just talking to me about--

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because she chairs the credentials committee, so it would have been general discussion about some of the, how all that worked and maybe particular issues for her or whatever, but this was a very general help me understand how you and I relate.
CHAYTOR, Q.C.:
Q. Right. And I take it if there were to be a peer review conducted, that's done through MAC?
DR. HOWELL:
A. There is a--certainly in St. John's in acute care there is a very defined policy about how peer review is conducted.
CHAYTOR, Q.C.:
Q. Yes, which we have had occasion to see.
DR. HOWELL:
A. You have.
CHAYTOR, Q.C.:
Q. And that is done then through MAC?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Is there, the clinical chiefs, how are clinical chiefs appointed?

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DR. HOWELL:
A. There is a search process whereby a message would go from my office looking for applications for the position of clinical chief. Physicians would apply for the position and a search committee usually consisting of several physicians from the discipline program and the chief operating officer for the program would sit on that search committee.
CHAYTOR, Q.C.:
Q. Is there a job description for the clinical chief of the laboratory medicine program?
DR. HOWELL:
A. There is a job description for clinical chief -
CHAYTOR, Q.C.:
Q. In general.
DR. HOWELL:
A. - that is generic.
CHAYTOR, Q.C.:
Q. Okay, so it's not specific for a particular area?
DR. HOWELL:
A. It is changing, it is another task to be

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completed.
CHAYTOR, Q.C.:
Q. It's on your list.
DR. HOWELL:
A. It is on the "To Do" list.
CHAYTOR, Q.C.:
Q. And is there also a Medical Staff Association?
DR. HOWELL:
A. There is.
CHAYTOR, Q.C.:
Q. And what is the purpose of that organization?
DR. HOWELL:
A. The Medical Staff Association is all physicians who are members of the medical staff.
CHAYTOR, Q.C.:
Q. Of Eastern Health?
DR. HOWELL:
A. Of--well, each, again just as there is a MAC, there is a Medical Staff Association, although there are not five Medical Staff Associations, but there would be a Medical Staff Association in Burin, there would be one in Clarenville, there would be one in St. John's.
CHAYTOR, Q.C.:

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Q. And what's the purpose of that group? How does that group differ from the MACs?
DR. HOWELL:
A. The MACs are the physician leaders; the Medical Staff Association is totally independent. It is all physicians and it elects its own president and secretary/treasurer.
CHAYTOR, Q.C.:
Q. But what would their mandate be, what do they do?
DR. HOWELL:
A. To discuss issues of importance to the medical staff and bring it forward to administration.
CHAYTOR, Q.C.:
Q. And who do they report to? Who do they bring their questions to?
DR. HOWELL:
A. They would bring issues forward to my office or they might bring it forward directly to the Board if they so chose.
CHAYTOR, Q.C.:
Q. Do they have a representative that sits at the Board?
DR. HOWELL:

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A. They do not.
CHAYTOR, Q.C.:
Q. But they can have direct access to the Board if they so choose?
DR. HOWELL:
A. I'm not sure of the answer to that, I'm sure if they asked to speak to the Board that the Board Chair would have to make a decision, but I would expect that the Board Chair would entertain that. It's--well, I've only been there such a short time, I have not seen it happen.
CHAYTOR, Q.C.:
Q. Have you also had discussions or met with the Chair of the Medical Staff Association?
DR. HOWELL:
A. No, I haven't.
CHAYTOR, Q.C.:
Q. Are you aware of whether or not they have brought forward anything in terms of the ER/PR issue? Has anything come to your office or has anything gone directly to the Board from the Medical Staff Association regarding this issue?
DR. HOWELL:

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A. The president of the Medical Staff has written some communications, but they've had great difficulty with the Medical Staff Association. It typically meets quarterly, but they've had immense difficulty getting quorums to hold a meeting.

CHAYTOR, Q.C.:

Q. Who is the current president?

DR. HOWELL:

A. Dr. Scully. And we're talking about St. John's now, remembering that there are other-- in Eastern Health, there are the others.

CHAYTOR, Q.C.:

Q. But Dr. Scully has written regarding the ER/PR issue?

DR. HOWELL:

A. No, I don't remember any correspondence from her on ER/PR.

CHAYTOR, Q.C.:

Q. Okay, all right. My question was whether or not there had been any proposals or anything put forward by the Medical Staff Association regarding the ER/PR issue?

DR. HOWELL:

A. Not of which I'm aware.

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CHAYTOR, Q.C.:

Q. And that's true of the Medical Staff Associations throughout the Eastern region?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. To your knowledge they haven't put forward anything?

DR. HOWELL:

A. To the best of my knowledge.

THE COMMISSIONER:

Q. Is the Medical Staff Association primarily involved in issues which relate to perhaps compensation benefits, that kind of thing or are there interests wider than that, in the sense of items in relation to patient care, would they get involved with that, as opposed to one of the other methods?

DR. HOWELL:

A. It's far ranging, Commissioner, they can get involved in many--compensation would not be a common thing that they would talk about because that would be done directly between the Newfoundland and Labrador Medical Association and Government, but patient care

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issues certainly would be discussed there. It can run the range of complaints about parking to patient care issues.

THE COMMISSIONER:

Q. Okay.

CHAYTOR, Q.C.:

Q. I'd like to turn then to any involvement you've had regarding recruitment and retention of medical staff and in particular, pathologists. First of all, was that identified as an issue to you when you took your current position?

DR. HOWELL:

A. It certainly--I became aware, yes, very very early, even in the note you just showed me, I think with Dr. Inkpen, virtually the first few days of the job I recognized that we had a problem with hematology/oncology and we were down to, I think only two physicians providing coverage for that important area and it's like every day there's a crisis and that one appeared very early in my tenure.

CHAYTOR, Q.C.:

Q. And how about the issue regarding pathologists?

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DR. HOWELL:

A. That, I became aware of that gradually as I think you'll see in the flow of my notes that that too was an issue.

CHAYTOR, Q.C.:

Q. And that was something that was brought to your attention early, fairly early in this?

DR. HOWELL:

A. Yes, it would be.

CHAYTOR, Q.C.:

Q. If we could look at please, P-0488, page 4? And these are minutes of an executive management committee of January 10th, 2007. So you've been in the job a few, a few months at this point.

DR. HOWELL:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And I just want to look at, show you who is present at the meeting, which does include yourself and then when we look at page 4, under "ER/PR testing to resume January 15th, 2007" and I'll have questions with you regarding that a little later on, but you go on to state here, "Dr. Howell explained that

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the monitoring of one receptor will continue to be carried out by a contract with Gamma-Dynacare Medical Laboratories and the organization have renewed the contract in that respect. And the question was raised that the salary physician budget is a separate budget that cannot be utilized for that purpose. The organization"--this is the part here--"has received another resignation from one of our pathologists. Currently the organization is down 13 pathologists from the normal contingent of 19 and the workload report commissioned by the Department of Health and Community Services is expected to be received by the end of the month." And we understand that's Dr. Raymond Maung's report?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And "Dr. Howell noted that it's critical to get all pathologists on one site within the city and renovations have been slow." And we spoke about that earlier. So I take it that at least as of January 10th, 2007, this is being discussed at executive management while

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you're there?

DR. HOWELL:

A. That should read "currently the organization is down to 13 pathologists" not down 13.

CHAYTOR, Q.C.:

Q. Down to 13, yes, not down 13. So you're down to 13, so you're down six pathologists at that point in time?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And had that changed from when you began in September 2006? Was this new or had it remained stable at 13?

DR. HOWELL:

A. No, I think shortly after I arrived and I'm not totally certain of this, but I think a couple of pathologists left shortly. As I was arriving, I think they were departing.

CHAYTOR, Q.C.:

Q. And if we could look then please at P-0201 and this is a couple of months now after the executive management committee minutes that we just looked at and this is a letter of March 8th, 2007 to Dr. Abbott and it's from Dr.

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Denic and he's writing as the president of the Newfoundland Association of Pathologists and also in his role as interim clinical chief?

DR. HOWELL:

A. Uh-hm.

CHAYTOR, Q.C.:

Q. And he's copied this to a number of people, including the Minister, the Premier, Minister of Health and the Minister of Finance, and to Mr. Ritter. Have you seen this document before, Doctor?

DR. HOWELL:

A. I have.

CHAYTOR, Q.C.:

Q. And you'll see here where he's referring to the "current staffing in St. John's hospital is below the optimum to guarantee proper patient care. We are currently short four pathologists, with the fifth one departing on March 30th, 2007. Dr. Fontaine, director of cytopathology, postponed his resignation until June 22nd pending the outcome of the negotiations of the Pathology Group and Government. This will result in a shortfall of over 30 percent for St. John's hospital.

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The situation outside St. John's is even more serious, with only one pathologist left in Clarenville and one in Gander, and there is a resignation in Corner Brook."

So at this point in time, Dr. Fontaine had submitted his resignation, but had postponed it pending the outcome, and Dr. Denic is indicating they're now short four pathologists with a fifth one departing. So did--it appeared you were down six in January. Had the situation improved in that two or three month period?

DR. HOWELL:

A. I would--I can't recollect back as to what the exact numbers. It seems to be a dynamic situation coming and going and I knew that Dr. Fontaine was looking at leaving and I remember having multiple meetings with him at one time, him and his wife, trying to one, understand some of the issues, and two, try to find was there any way that we could retain him.

CHAYTOR, Q.C.:

Q. Yes, and of course, Dr. Fontaine has recently submitted his resignation again.

DR. HOWELL:

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A. Correct.
CHAYTOR, Q.C.:
Q. And I showed you earlier, around this same time period--well, we can go there, 1414, it's the one where in March of '07, Dr. Carter was also indicating that she was looking for work.
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Okay. So in this time period, certainly the first two or three months into 2007, this was identified to be a fairly significant issue?
DR. HOWELL:
A. Correct.
THE COMMISSIONER:
Q. The first exhibit that we brought up that referred to the 19, which was down to 13 as you rightfully point out, the 19, is that Government funded and approved positions?
DR. HOWELL:
A. They were.
THE COMMISSIONER:
Q. And that is within Eastern Health as a whole of operation, as opposed to within St. John's?
DR. HOWELL:

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A. I think that was St. John's.
THE COMMISSIONER:
Q. Just St. John's?
DR. HOWELL:
A. I think, Commissioner.
THE COMMISSIONER:
Q. So if I start counting, I should find 19 positions within St. Clare's and the Health -
DR. HOWELL:
A. Health Science.
THE COMMISSIONER:
Q. - Health Science?
DR. HOWELL:
A. I think that is correct.
THE COMMISSIONER:
Q. Okay.
CHAYTOR, Q.C.:
Q. So the reference then two months later to there being a shortage of four, "we're currently short of four and with the fifth one departing," whether or not there were a couple of people within that time period--because this clearly is referring to St. John's hospital, Dr. Denic's letter.
DR. HOWELL:

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A. Right.
CHAYTOR, Q.C.:
Q. And there appears to be a discrepancy. Either that or you picked up a couple of people in that two-month period. Can you offer any clarity to that?
DR. HOWELL:
A. I honestly can't give you any clarity on that point. I'm sure Dr. Denic will be able to.
CHAYTOR, Q.C.:
Q. Okay, but you're reporting to the Board in January that you were down six people at that point.
DR. HOWELL:
A. That would be the information that Dr. Denic would have conveyed to me that I would convey to the Board.
CHAYTOR, Q.C.:
Q. Okay. If we could look at 0479 please, and this is a series of communications regarding issues of pathology turnover, clinical chiefs, and if we--I'll just take you to page seven, and I wonder, Registrar, can you make that fit the screen, please? Thank you. And this is a document we've been provided by Eastern

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Health. Have you seen this document before, Doctor?
DR. HOWELL:
A. I have, at some point, that's correct.
CHAYTOR, Q.C.:
Q. All right, and this shows--well, it's called Eastern Health St. John's, so I take it this is just the St. John's physicians.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Pathologist staffing, and it's from 1995 through to 2007, so certainly the time period which is of importance to the Commission, and 1995 down through we'll see to 2007 here, and it appears that the number of approved positions has increased over time, starting in 1995 to be 15 and up to--it changed to 19 in 2000 and continues to be at 19 through to the current.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And then we get the number of positions filled as of January 1, number of terminations,

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number of recruits for vacancies, number filled at the end of the year, December 31st, and then vacancies as of December 31st. If we look through here, we can see that in 1995 through to 1999, there were no vacancies. So all 15 or 16 positions were filled.

DR. HOWELL:

A. Um-hm.

CHAYTOR, Q.C.:

Q. And in the year 2000 when it went to 19, I think there must be--and it went to 19 in 2000, at the end of the year anyhow, all 19 were filled. So there were no vacancies in the year 2000, and then continuing on, 2001, 2002, you're down two and three and then by 2003, you're back up doing pretty good, only one vacancy, and then it's continued on at two or three and then 2004 is shown to be four vacancies. So do you know, are those numbers accurate?

DR. HOWELL:

A. They would have been produced for us probably by somebody in my office who does that sort of work, but I was not present for any of that. I can't speak for the numbers. I would have

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to accept them as they are there.

CHAYTOR, Q.C.:

Q. And it was done at your request?

DR. HOWELL:

A. Yes.

CHAYTOR, Q.C.:

Q. You asked someone in your office to get this information together?

DR. HOWELL:

A. Actually, I think it was done at Mr. Tilley's request, if I remember correctly.

CHAYTOR, Q.C.:

Q. But you're familiar with this document?

DR. HOWELL:

A. I had seen the document, that's correct.

CHAYTOR, Q.C.:

Q. Yes, okay, and so you have no reason to think it would be other than accurate?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. Okay. The contractual relationship with labs outside the province, including Dynacare, that's still in place, I take it?

DR. HOWELL:

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A. It is.

CHAYTOR, Q.C.:

Q. And is that--that's been in place for some period of time. Is that partly due to the shortage of pathologists within the province?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And what type of work is sent outside the province?

DR. HOWELL:

A. In my understanding, in talking to Dr. Denic, it would be tissue that is deemed to be less critical for turnaround time, for example, the removal of a non-suspicious mole or a small skin tag lesion or something that was not requiring an urgent report and direct communication between pathologist and surgeon, and that's my understanding of what we're currently sending to Dynacare.

CHAYTOR, Q.C.:

Q. Okay, and -

DR. HOWELL:

A. Although that obviously will change as we encounter challenges in any area.

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CHAYTOR, Q.C.:

Q. Right, again an evolving process, I take it.

DR. HOWELL:

A. Unfortunately, yes.

CHAYTOR, Q.C.:

Q. And this here, 2007 indicating 19 number of approved positions, as of January 1, there were 16 filled and as of the end of the year, there were only 15 filled, but there's two asterisks and it says "the numbers for 2007 are up to June 1st, 2007 and Dr." is it Hamodat?

DR. HOWELL:

A. Hamodat.

CHAYTOR, Q.C.:

Q. Will be starting on July 1st, 2007 and one new recruit will start in September/October 2007. Did that happen? Were two new pathologists--did two new pathologists join by the end of the year?

DR. HOWELL:

A. I think that that is so, but Dr. Denic should confirm.

CHAYTOR, Q.C.:

Q. Okay. So then going into 2008, you would have

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been down two positions?
DR. HOWELL:
A. I really would have to go to Dr. Denic and clarify those numbers.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. It seems to be always a dynamic situation that's changing and I remember in talking to Dr. Denic and the flux in pathologists, there's so much more to the numbers he would explain to me. For example, you know, two of the individuals there would be--one was a neuropathologist and the other involved in the pediatric side, and so they've been in those positions for long periods of time and are not in that group of general pathologists doing all the other work. They're very, very specialized and do only that area. So that if you had a flux of pathologists occurring, it really--in the pool of work that they would be doing, it would be smaller number than the 19 from a functional perspective. That's how he explained it to me. And the other thing that he has explained to me on a number of

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occasions is it's not just the numbers. It's how senior the pathologist might be. It's--you could have all your numbers, all your posts filled, but if they're predominantly new graduates, then there is a period of time they're not able to operate at the same pace and need more support from senior colleagues and so on. So hard core--as he's explained it to me, the hard core numbers don't tell the whole story, and that's the best way I can explain.
CHAYTOR, Q.C.:
Q. And we'll certainly ask him more about that too, and I take it another relevant factor, of course, would be the area of expertise of the pathologists?
DR. HOWELL:
A. The whole subspecialty piece is critical in all that.
CHAYTOR, Q.C.:
Q. Yes. So in terms of the issue of trying to recruit and trying to retain the pathologists, what ideas have you brought to bear on that issue?
DR. HOWELL:

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A. Well, as I've talked to the pathologists, as I think we all have read the papers and so on, my understanding is there is a shortage of pathologists. This is not just a situation unique to Eastern Health. We're not graduating a lot of pathologists. It's not a really popular specialty for physicians to go into and there is a demand throughout North America for pathologists. So we are, as we are in many of the specialties and certainly subspecialties, competing in a global market now for these individuals.
As it has been explained to me, there--when we go to attract a recruit, we cannot offer a competitive salary, certainly for the large markets like in Ontario and Alberta, and I doubt if we ever will be able to compete at that level. So our discussions have been, I don't have control of the remuneration. I can support the pathologists with government that we desperately need to be able to recruit, and not only recruit, but retain and stabilize that group, so that they can build relationships with the rest of their colleagues. Remuneration appears to be a key

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component of that, and I understand there's activity happening as we speak to make that happen.
The other part then is to look at the other things like continuing education and whatever package ultimately government may choose to offer, I would hope that it will have a large segment of investment in continuing education for that core entity.
In addition, part of my idea was, as we talked about earlier, to bring all the pathologists to one site. That had a number of advantages that I've alluded to. One was to handle workload, distribute workload a little better maybe. Number two, to allow better collaboration. Number three, bring them in very close proximity to the medical school where we've got the library and the discipline of laboratory medicine there.
So from there, the other recruitment things, our best opportunity for recruitment is our own graduates, and that is not just for pathology, that is for all aspects of our medical recruitment. So going after Newfoundlanders and training here or elsewhere

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or people who are married to Newfoundlanders. The pathologists who are here, and have been here for some time, are here because they love this province, and so that's our key market that we would be going after, and that too has become a little bit of a catch 22 situation for us because if--while there is a residency program there now, if this pathology program is severely damaged, if we have a shortage of pathologists and we don't have a combination of some juniors and some seniors and we don't have stability, then I could see that that pathology training program would be in jeopardy and now we don't have residents and that's a strong pool to be negotiating with. So contacting those people early and trying to get them to agree to stay in our province.

THE COMMISSIONER:

Q. Do you want to take the luncheon break now? Is this a convenient spot?

CHAYTOR, Q.C.:

Q. That's fine, yes. Thank you.

THE COMMISSIONER:

Q. All right then. We'll break until 2:15.

(LUNCH BREAK)

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THE COMMISSIONER:

Q. Please be seated. Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Dr. Howell, you've told us that Dr. Williams remained in the position for about a month after you joined, so you overlapped by about a month. I take it then he was a good source or a good resource to you in terms of bringing you up to speed on most issues that you would be facing?

DR. HOWELL:

A. He was.

CHAYTOR, Q.C.:

Q. And did you, in fact, have meetings with Dr. Williams even prior to taking the job?

DR. HOWELL:

A. I did.

CHAYTOR, Q.C.:

Q. If we could look at, please, 1422, page one, and this is the beginning, Doctor, of the notes that you gave us. These are your handwritten notes, I take it?

DR. HOWELL:

A. They are.

CHAYTOR, Q.C.:

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Q. And this page indicates that you met, in fact, with Bob Williams on, is that July 24th?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. 2006. And what was the purpose of your meeting with Dr. Williams on that date? If we look through your notes, we see that there's--I believe that meeting went--you have at least five, six, six pages of notes from your meeting that day.

DR. HOWELL:

A. The first few pages actually were structured before I--well, as you'll note, this occurred before I even assumed the position and -

CHAYTOR, Q.C.:

Q. Sorry, when were you hired for the position? I know you began the beginning of September.

DR. HOWELL:

A. I think the Board might have endorsed this in early July, but I could stand to be corrected. I'm not sure of the exact date. I would have known at this point that I had the position.

CHAYTOR, Q.C.:

Q. Okay.

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DR. HOWELL:

A. I wasn't going to be starting until the 5th of September. I had to give notice to, you know, the largest corporate client I had, but I had already--my brain had already started to work into gear for the new job and I was trying to devise in my mind a 30-60-90 day plan for assuming the position. So I had contacted Dr. Williams and I had asked if he and I could get together and these first few pages, I think, are more--well, first two pages there, I guess, are some structure that I was trying to put around the kinds of information that I might look for from him. In addition to that, I wanted to make sure that I didn't arrive on September the 5th and then it would take two weeks longer before I had a computer and all the paraphernalia I needed to get moving into the job.

CHAYTOR, Q.C.:

Q. Okay, and so the first page then, you talk--you've written about infrastructure, you know, logistics of taking on the job -

DR. HOWELL:

A. That's correct.

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CHAYTOR, Q.C.:
Q. - in terms of actual computer equipment, that kind of thing.
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. Then the office of VP, the roles, functions. So is this your notes to yourself in preparation for meeting with Dr. Williams? Is that it?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And on the second page then, C, you have direct reports, little, none, reporting style, SWAT?
DR. HOWELL:
A. Sorry, that's direct reports.
CHAYTOR, Q.C.:
Q. Title, is it?
DR. HOWELL:
A. Title name, reporting style and strengths, weaknesses, opportunities and threats.
CHAYTOR, Q.C.:
Q. And threats, right, okay, and major issues,

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solutions identified resources, and again, is this before you meet or is this during your meeting?
DR. HOWELL:
A. This is before I met, again.
CHAYTOR, Q.C.:
Q. General situation, strengths and capabilities exist now. Is that what that says?
DR. HOWELL:
A. Strengths and capabilities, what exists now, what are the key priorities, what are lower priorities, what are untouchables.
CHAYTOR, Q.C.:
Q. What does that mean, what are untouchables?
DR. HOWELL:
A. I think I was mostly trying to understand how the political process worked at that point and where were there areas that I should not be going.
CHAYTOR, Q.C.:
Q. And were you given any advice on that by Dr. Williams?
DR. HOWELL:
A. Not that I recall.
CHAYTOR, Q.C.:

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Q. And then the next page then is reference--is this then actual discussion with Dr. Williams, page three?
DR. HOWELL:
A. Yes, now we're into the actual office of the vice president and who are the individuals who sit in that office, what do they do, and well, as indicated, I'm trying to find out a little bit about those individuals.
CHAYTOR, Q.C.:
Q. Yes, okay.
DR. HOWELL:
A. And page four, the top of the page, the position of director medical services, and that's the position you've indicated there is vacant at that time and it's since been filled by Dr. John Guy?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And clinical chiefs report to this position?
DR. HOWELL:
A. Clinical chiefs will, when the position is filled, yes, that they would report there.
CHAYTOR, Q.C.:

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Q. Okay. So is that currently the structure, they report to Dr. Guy directly and not to you?
DR. HOWELL:
A. That is evolving. We have done a new org chart that shows them reporting through that office, but up until now, we've been slowly moving that way, but I really had him focused more on the credentialling issues, the bylaws issues and those sorts of things, but we are moving towards that.
CHAYTOR, Q.C.:
Q. Okay, and that has not been the situation in the past? In the past they reported directly to Dr. Williams?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And that's because the position was vacant, is that right?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And what does the next line say, chair -
DR. HOWELL:

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A. That the director of medical services will then end up chairing the meeting and would be the ad-hoc liaison person to MAC.
CHAYTOR, Q.C.:
Q. Okay, and over on the right, then if we come down a few lines under lab, we see Terry Gulliver's name.
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And there's a couple of points redacted, and then directly underneath that, we see--can you read what's written there, please? It's cut off on our page.
DR. HOWELL:
A. It says "estrogen progesterone" and I can't pick out the--I think receptors. It's R-E-C, I think it means, and then it looks like I wrote "positive 73 percent, quality assurance system in place."
CHAYTOR, Q.C.:
Q. Is that "in place"?
DR. HOWELL:
A. I think that's in--I think, in place.
CHAYTOR, Q.C.:

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Q. And what's the last?
DR. HOWELL:
A. And the last, I can't read it.
CHAYTOR, Q.C.:
Q. Okay. So I take it in this July 24th meeting with Dr. Williams, the ER/PR issue was the subject of discussion?
DR. HOWELL:
A. Well, what I've done is I've looked at all the people who report to me. I've asked him about some of their strengths and their weaknesses. He's given me that, and then under each of those headings, I've tried to look at what are the current hot issues that are going on in those particular areas.
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. And he's outlined that to me.
CHAYTOR, Q.C.:
Q. Okay, and so the ER/PR issue was identified as a hot issue?
DR. HOWELL:
A. It was.
CHAYTOR, Q.C.:

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Q. And then under oncology, can you read what's written there?
DR. HOWELL:
A. The issues there were home chemotherapy. He's suggesting that there had been conflict of some sort within the group, but it had declined of late, and that there were some personality issues.
CHAYTOR, Q.C.:
Q. Okay, and what does "missing reports" to the right, is that in relation -
DR. HOWELL:
A. That falls under diagnostic imaging.
CHAYTOR, Q.C.:
Q. Okay, and underneath oncology then, is check -
DR. HOWELL:
A. This is under -
CHAYTOR, Q.C.:
Q. Looks like tech.
DR. HOWELL:
A. Remember that this category falls all the way down under pharmacy. So even the oncology issue, he was alerting me to that there were issues that related to pharmacy, and check tech check was the--within the first month or

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six weeks of being in the job, I ran into the major issue of inadequate pharmacists. We -
CHAYTOR, Q.C.:
Q. Okay. So that's nothing to do with technologists?
DR. HOWELL:
A. No, no.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. None whatsoever.
CHAYTOR, Q.C.:
Q. Okay. If we look then, turn to the next page, under stakeholders, and you have the CEO, COO and others listed, clinical chiefs, program directors, executive management team, I think that is, directors office, VP staff, and to the right, we have external, is that right?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And Rob Ritter?
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:

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Q. And Rob Ritter, of course, being the executive director of the NLMA?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. So he would be someone that you would be expected to liaise with?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And then John Peddle?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And he's with the Health Board Association?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And Ed Hunt, Cathy Bradbury and Blair Fleming, all physicians with the Department of Health?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And then coming down underneath there, we have "meet" -

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DR. HOWELL:
A. Every two months.
CHAYTOR, Q.C.:
Q. Every two months.
DR. HOWELL:
A. And those would be my confreres in the other regions.
CHAYTOR, Q.C.:
Q. Okay. So those are the VP Medical, Ken Jenkins, Larry Alteen and Michael -
DR. HOWELL:
A. Jeong.
CHAYTOR, Q.C.:
Q. They're VP medicals in the other regions?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And you would meet every two months, and is that in fact what happens? Do you meet -
DR. HOWELL:
A. That is correct.
CHAYTOR, Q.C.:
Q. Via conference call, I take it?
DR. HOWELL:
A. Face to face or conference call.

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CHAYTOR, Q.C.:
Q. And then there's a list of meetings. I take it these are meetings that you would be expected to attend as VP Medical?
DR. HOWELL:
A. That's what I'm trying to sort out with him, what are the meetings that I'll be attending.
CHAYTOR, Q.C.:
Q. And I don't see anything of relevance really on the next page, unless you can tell me otherwise.
DR. HOWELL:
A. No.
CHAYTOR, Q.C.:
Q. No, okay. So in terms of this meeting with Dr. Williams, on page four we see the reference to ER/PR as being what you would describe as a hot issue. Did he give you any other background to that issue at that time?
DR. HOWELL:
A. No, he did not. He showed me a cabinet with several binders in there, and I don't know if he showed me in this meeting or that was subsequently in September, but he showed me a cabinet with binders marked ER/PR.

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CHAYTOR, Q.C.:
Q. And I take it at some later point in time then that he did give you more of a briefing on the issue?
DR. HOWELL:
A. No, I don't recall that he and I ever had a very long detailed discussion about ER/PR.
CHAYTOR, Q.C.:
Q. So how did you become apprised of the issue? Did others fill you in? How did that happen?
DR. HOWELL:
A. As I was saying, I think what happened is I got totally distracted with the pharmacy issue and the shortage of pharmacists and we had ceased clinical pharmacy services and I had complaints from physicians all over the place, and I ended up with multiple meetings with Mr. Tilley and Mr. Dodge, the VP of HR, and we ended up meeting with Department of Health, Treasury Board, and pharmacists walked out at one point, and so it was probably very--I'm thinking late in October before I really ever came back to understand the significance of the ER/PR issue for the organization and for patients.

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CHAYTOR, Q.C.:
Q. Okay. So until you came back to understand the significance. So you had very little discussion on the issue with Dr. Williams, and by late October, as you indicated, Dr. Williams would have left the position.
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And you had--so up to that point in time, when you say come back to the significance of it, had it been brought to your attention by anyone else?
DR. HOWELL:
A. Well, in the--there were references to it in the lab leadership meetings. You'll see in the agendas or the minutes of those meetings that it would be one item that was referenced, amongst many, and really my understanding at that point, and it was a slow evolution with all the other things that were going on, and I understood that quality was working the ER/PR case and eventually, over time, I learned of the external reviews that had been done and I don't recall even the first time that I took

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those out and started to read through them to try to understand it. I think all of that was evolving when we had reached a point where Dr. Denic and the pathologists were going to do a briefing for all the medical stakeholders and the technologists in St. John's.
CHAYTOR, Q.C.:
Q. Yes, and that happens in November, and we'll come to that.
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. So I just want to understand, when you come into the position, you're told very little about ER/PR. You're in that position for about a month, into late October, and I understood from this morning that your recollection is that you would have read the external review reports in October, late October?
DR. HOWELL:
A. I'm not sure when it was, but I'm guessing it would have been then.
CHAYTOR, Q.C.:
Q. Okay, and so that first month that you're

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there, who did you understand had carriage of the issue?
DR. HOWELL:
A. I don't think, in that first month there, that I--it really was--there were so many things, so many people that I was meeting with. I was still trying to understand my role and I was meeting all the COOs and I was meeting all the direct reports I had. ER/PR was really not even on my radar screen in that first month.
CHAYTOR, Q.C.:
Q. Okay. So it wasn't on your radar screen, so who did you understand was managing the issue?
DR. HOWELL:
A. My understanding is that Quality, Ms. Pilgrim, Heather Predham, that they were working--always along this path, my focus has been forward more than it has been backward, and the understanding that the quality folks were working back through that issue.
CHAYTOR, Q.C.:
Q. Well, did you understand--by saying that, did you understand the issue was done at that point, that it was resolved or was there anything ongoing with ER/PR that would require

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a forward focus?
DR. HOWELL:
A. It would have bene somewhere in the month of October that I would have started to really come up to speed and understand that there were actions taking place as a follow up to the external reviews, but exactly what date, I don't know.
CHAYTOR, Q.C.:
Q. And at that point in time, did you become the person in charge of the issue?
DR. HOWELL:
A. No, I always viewed myself as the person who was the go-forward person, to make sure that all the things that had to be enacted as a result of the various reviews and things that were performed.
CHAYTOR, Q.C.:
Q. So when Dr. Williams was here, he understood that he was in charge of managing the issue. You take over from Dr. Williams. At any point in time do you understand that that now becomes an issue that you are, as VP Medical, in charge of managing?
DR. HOWELL:

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A. I understood that my--that the retrospective view was resting with Quality.
CHAYTOR, Q.C.:
Q. So Ms. Pilgrim?
DR. HOWELL:
A. That's correct, and that the prospective view, the go-forward was my responsibility.
CHAYTOR, Q.C.:
Q. Okay, and divide that for us then. What falls under retrospective and what falls under going forward?
DR. HOWELL:
A. Go forward would be looking--well, looking backward would be really the whole analysis of the numbers, the data that was being collected and assessed, the contacting of patients, the contacting of physicians. That entire piece I understood to be resting with Quality.
CHAYTOR, Q.C.:
Q. So that's resting with Ms. Pilgrim?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. So analysis of the numbers, any contacting of patients, any further testing, if necessary,

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of additional patients, that rests with Ms. Pilgrim?
DR. HOWELL:
A. That was my understanding.
CHAYTOR, Q.C.:
Q. And what's your piece?
DR. HOWELL:
A. My piece is looking at the continued functioning of the lab and looking at, from the reviews that had been done, the actions that needed to be taken, that they were in fact taken and that we had the appropriate proficiency testing and things in place.
CHAYTOR, Q.C.:
Q. Okay. So your piece then was to take whatever came out of the external reviews and determine whether or not the recommendations had been fully implemented, and if not, ensuring that that took place?
DR. HOWELL:
A. Take the learnings that have come and work with the leadership team, the lab leadership team, to ensure that we had acted on those things.
CHAYTOR, Q.C.:

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Q. And who divided the tasks in that manner?
DR. HOWELL:
A. I would assume it was the CEO.
CHAYTOR, Q.C.:
Q. Ms. Jones? Or, sorry, Mr. Tilley at that point in time?
DR. HOWELL:
A. Well, would have been Mr. Tilley, that's correct.
CHAYTOR, Q.C.:
Q. Mr. Tilley. So Mr. Tilley told you that this is what he needed you to look after and that Ms. Pilgrim would be looking after the rest?
DR. HOWELL:
A. That was my understanding.
CHAYTOR, Q.C.:
Q. Okay. And that was what Mr. Tilley told you?
DR. HOWELL:
A. I don't recall a conversation where Mr. Tilley said "Here's what Ms. Pilgrim is doing and here's what you're doing." I can't recall that kind of a conversation. But certainly I was on the periphery of many meetings and events where I knew that the people in quality

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were working with these numbers and with contacting patients and so on, I knew that that was going on over there.
CHAYTOR, Q.C.:
Q. And if it required further patients to be tested, that fell within what Ms. Pilgrim was responsible for?
DR. HOWELL:
A. She was still working that, that's correct. Now that would not mean -
CHAYTOR, Q.C.:
Q. And so is that -
DR. HOWELL:
A. - that she would never speak to me about those things and you know, her and I would chat not infrequently and, you know, sometimes if we were talking to Mount Sinai and it was going slow, she might ask me to contact the physician up there. But in most cases she was doing all of that.
CHAYTOR, Q.C.:
Q. And I would take it if it involved having to engage the clinical chief of pathology, that would be done through you?
DR. HOWELL:

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A. Yes, there were meetings that she might have with them that I wouldn't be there, but most times that would be something we both would be involved in.

CHAYTOR, Q.C.:

Q. Do you know, what was the rationale for dividing the tasks in terms of responsibility? I can see the rationale of dividing the actual workload, but what was the rationale of dividing the tasks in terms of accountability or management of the issued?

DR. HOWELL:

A. You know, maybe it was just that there was a recognition that I was new to the organization, I had none of the history. It was going, as Mr. Tilley had said to me, this is going to be a very steep learning curve and certainly it has been. And it was resided in quality, and I think Ms. Predham was very heavily engaged with this and her reporting relationship was through quality. And I think that Dr. Williams had had quality but then that had been taken from my portfolio and put with Ms. Pilgrim.

CHAYTOR, Q.C.:

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Q. Yes, okay. So when you're saying it was October before really, or late October before really the issue hit your radar screen. And how was it brought to your attention at that point in time, who told you and what were you told?

DR. HOWELL:

A. Other than what's in these notes, I think we were moving to this point where, as I said earlier, Dr. Denic and his colleagues were going to do a presentation to all the interested folks within not only the medical staff but technologists, etcetera, on this particular issue, and so I had had conversations with him about that. I think that meeting was on November the 20th.

CHAYTOR, Q.C.:

Q. Okay. Well, perhaps we'll take you through your notes, if that will -

DR. HOWELL:

A. Yeah, I think that's the -

CHAYTOR, Q.C.:

Q. - assist your recollection.

DR. HOWELL:

A. That'll help.

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CHAYTOR, Q.C.:

Q. Okay. The first note that I could find with any additional writing on it would be September 15th, 2006. And that's P-1422, page 10, please? This looks like it may be a meeting of the lab medicine leadership team. Would that be right?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And if we scroll down, the fifth item that you've indicated--these are your notes, I take it, at the meeting, are they, Dr. Howell?

DR. HOWELL:

A. This would be my personal notes in the meeting.

CHAYTOR, Q.C.:

Q. Okay. So it appears then that ER/PR was discussed in the meeting. And you've written, "Internal controls; external controls; QA program; proficiency testing; improving documentation; do we open lab in October?" Is that what that says?

DR. HOWELL:

A. That's what that says.

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CHAYTOR, Q.C.:

Q. Okay. So this was being discussed in this meeting. And what's this list, "internal controls; external controls; QA program; proficiency testing; improving documentation" what did you understand that to be?

DR. HOWELL:

A. That was quite sometime ago. I was in the job ten days. And I really can't recall--those were, in any questions I might have asked, those would just--would have been pertinent points that I would have heard in asking questions or them talking and that I recorded there on the conversation. But beyond that, it was very superficial for me at that point in time.

CHAYTOR, Q.C.:

Q. I can understand that. And knowing what you know now and later, in late October when you read the external reports, the issue of internal controls, external controls, QA program, proficiency testing and improving documentation, would you agree with me those are recommendations or points that came out of the external reviews?

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DR. HOWELL:
A. That's exactly what I think that is.
CHAYTOR, Q.C.:
Q. Okay. So that's what's being told to you?
DR. HOWELL:
A. That's what I think, yes.
CHAYTOR, Q.C.:
Q. In terms of what came out of the reports, perhaps?
DR. HOWELL:
A. That's my guess.
CHAYTOR, Q.C.:
Q. Okay. If we could look at page 14, then, please? And, Doctor, if I've missed any along the way, please bring my attention to it. I tried to review it as best I could last evening. And this looks like October 26th. So now this is late October?
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And this is when you've indicated that perhaps the issue is brought to your attention?
DR. HOWELL:
A. Right.

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CHAYTOR, Q.C.:
Q. In a little more detail?
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And this says, "ER/PR" at the top. Now, does this, is this a meeting? It doesn't really say if it's a meeting or are these your notes summarizing documentation, what--are you able to tell us what this is?
DR. HOWELL:
A. I am not. Most commonly if I was in a meeting, I would record who attended that meeting. I don't have that written there. And so this could be--this might be me at the end of a day collecting ideas and thoughts of things that I don't want to lose. And I think here I'm becoming more aware of individual patient situations and I'm starting to understand a little bit more about the impact of this test.
CHAYTOR, Q.C.:
Q. Okay. So you don't know if this is being told to you or--and if it's not being told to you, is it documentation that you're reviewing and

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making notes on?
DR. HOWELL:
A. No. No, it--I would be almost certain that it was somebody had shared information with me and I was recording it and trying to categorize it in my own way.
CHAYTOR, Q.C.:
Q. Okay. And so the number one you've written here is Dr. Ganguly and then we've redacted, there's redactions done here which mostly, I believe, are patient names?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. "Lab work, you converted. I don't know what this means." So that's a note to yourself, is it?
DR. HOWELL:
A. No, no, no. I think this is that he had had a meeting with a patient.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. Whose results had changed and whoever had talked to me about this had indicated that he

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had said to the patient that he didn't know what this means.
CHAYTOR, Q.C.:
Q. Dr. Ganguly had said?
DR. HOWELL:
A. That's correct. And that the patient was now going to see Mr. Crosbie.
CHAYTOR, Q.C.:
Q. Okay. So you have a recollection of -
DR. HOWELL:
A. I only have what I have written here, that somewhere along the way someone talked to me about that.
CHAYTOR, Q.C.:
Q. Okay. Someone had talked to you about this. And the patient--Dr. Ganguly had said he didn't know what this means about conversion?
DR. HOWELL:
A. That's correct, that's correct.
CHAYTOR, Q.C.:
Q. Okay. And did you make any inquiries as to whether or not that--of Dr. Ganguly as to whether or not that was correct?
DR. HOWELL:
A. I did not.

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CHAYTOR, Q.C.:
Q. Do you know if anybody did?
DR. HOWELL:
A. I don't know.
CHAYTOR, Q.C.:
Q. Okay. And again, all of this is with respect to ER/PR?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And number two, again, I believe it might be a patient being referenced here, my understanding.
DR. HOWELL:
A. I think it was a spouse of a patient.
CHAYTOR, Q.C.:
Q. Okay, spouse of a patient, is it, okay. And "discussed with" did you have a discussion with this person?
DR. HOWELL:
A. No, no. This again is I have been made aware of this from some source and again, it was a patient of Dr. Ganguly's who was in Corner Brook. And I'm assuming that the patient or the patient's spouse had not been communicated

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with and Dr. Ganguly agreed to see the man and talk to him.
CHAYTOR, Q.C.:
Q. Okay. And in quotation marks you have there, "Breakdown in communication." Do you recall who was telling you that and what that refers to?
DR. HOWELL:
A. I don't recall who was telling me that.
CHAYTOR, Q.C.:
Q. And was it a breakdown in communication with the patient or the patient's family?
DR. HOWELL:
A. That is my understanding.
CHAYTOR, Q.C.:
Q. And Dr. Ganguly was agreeing to meet with the relative?
DR. HOWELL:
A. That's what I think that means.
CHAYTOR, Q.C.:
Q. Okay. Number three was "Retro converters."
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. Okay. And did you understand then when you're

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writing this at this point in time what retro converters were?
DR. HOWELL:
A. I probably did not.
CHAYTOR, Q.C.:
Q. Okay. So part of your steep learning curve?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. And then there's numbers written here, "Positive, less than"--or sorry, "before 2001" I take it that means, "greater than or equal to 30 percent," and then after 2001, ten percent?
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. "The National Institute of Health" is that "2004"?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. "One percent."
DR. HOWELL:
A. That's correct.

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CHAYTOR, Q.C.:
Q. And what would be your source of information on that?
DR. HOWELL:
A. It could have come from pathologists, oncologists or technologists. I would have been talking to many people. And again, I'm trying to understand what positive means and understand this percentage component.
CHAYTOR, Q.C.:
Q. Okay. So you're not able to tell us what the source of any of this information would be?
DR. HOWELL:
A. I wish I could, but -
CHAYTOR, Q.C.:
Q. But were there like one or two people who you mainly would have learned about ER/PR from?
DR. HOWELL:
A. The principal people that I would be talking to about this would be Dr. Denic, Mr. Gulliver, Dr. Laing, Ms. Predham, Ms. Pilgrim.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. Those would be the individuals I would be most

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commonly conversing with.
CHAYTOR, Q.C.:
Q. Right, okay. And did Mr. Tilley ever give you any briefing on ER/PR?
DR. HOWELL:
A. Not that I recall.
CHAYTOR, Q.C.:
Q. And from your perception on joining the organization, did it appear to you that Mr. Tilley had much involvement in the issue?
DR. HOWELL:
A. He certainly had, I think, good knowledge of it, but I mean, he would not understand the technical components of that, I don't think, the science -
CHAYTOR, Q.C.:
Q. No, but in terms of the management of the issue?
DR. HOWELL:
A. As far as I understand he knew about it and was well versed in it, yes.
CHAYTOR, Q.C.:
Q. Okay. And who did you--did you understand that he was actually the person who was managing the issue?

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DR. HOWELL:
A. No. I thought that--the rearward looking view and the management of the cases, past cases, the database, the contact was with quality, Ms. Pilgrim and Predham.
CHAYTOR, Q.C.:
Q. And the moving forward was with you?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And I take it you reported then to Mr. Tilley?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. And you've indicated "panel" here, and a list of names. What did you understand that to be?
DR. HOWELL:
A. Those were the individuals who sat on the panel as the results were coming back to review whether the patients needed a change in treatment.
CHAYTOR, Q.C.:
Q. Okay. And did you understand that all of these people would sit at every panel meeting

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or a selection of those people?
DR. HOWELL:
A. I think from an oncologists' point of view, the way I've written this note, that there could be one of three people who might be there from an oncology point of view. But I didn't understand that the others were regular attendees.
CHAYTOR, Q.C.:
Q. Um-hm. And then if we go to the next page, I believe this is then you're attending a seminar, CPSI seminar in Halifax?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And I can't make the date out there, but it appears to be sometime in November, 2006?
DR. HOWELL:
A. Looks like 14th, November, 2006.
CHAYTOR, Q.C.:
Q. And did you find this to be useful in terms of your understanding of the handling of an adverse event, were there any lessons really learned in there that you could apply or bring to the ER/PR issue?

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DR. HOWELL:
A. I think the greatest lesson for me was that I had a long ways to go to understand where we needed to be in terms of patient safety, and it was a lot of concepts here that were new to me that I needed to develop further.
CHAYTOR, Q.C.:
Q. So you were hearing some of this for the first time?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. The concepts at this seminar?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Okay. If we just continue on, you've taken fairly detailed notes, and I would assume you also had material provided to you?
DR. HOWELL:
A. It subsequently was provided, that's correct.
CHAYTOR, Q.C.:
Q. And there's just a couple of points in here on page 20 of the exhibit. You see here, "IHI-QI for doctors, road map." Looks like "pay for

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performance, right thing to do. Privileges reporting, self-evaluation." Do you recall what was being discussed?

DR. HOWELL:

A. I think it's--I think this was a presentation on how to engage physicians in the whole patient safety quality movement.

CHAYTOR, Q.C.:

Q. Looks like the name of the presentation may have been "Leading Physicians Through Change"?

DR. HOWELL:

A. Correct.

CHAYTOR, Q.C.:

Q. Okay. What's IHI stand for?

DR. HOWELL:

A. Not sure.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. Institute for Health Information, maybe, but I'm not positive.

CHAYTOR, Q.C.:

Q. Okay. And the next page--and by the way, if there's anything that you think else that may be of any relevance, you can point it out as

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we go through. But the next I notice is page 21, "Patient/public involvement." And if we--it comes under a heading before that, "Foster a Culture of Safety". "Disclosure Policy." "Is board of directors involved?" Is that what that says?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. "Patients involved in learnings?"

DR. HOWELL:

A. "Learnings".

CHAYTOR, Q.C.:

Q. "Communicate media."

DR. HOWELL:

A. Correct.

CHAYTOR, Q.C.:

Q. And do you recall what was being discussed there and why you saw fit to make note?

DR. HOWELL:

A. Again, I'm taking quick notes while speakers are speaking and I'm sort of trying to put it into my own categories and from there sort of develop themes about areas where I need to cultivate further knowledge. And I guess when

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you ask me would I point anything out, "Lead and support staff" was an -

CHAYTOR, Q.C.:

Q. That same page?

DR. HOWELL:

A. That's on that same page.

CHAYTOR, Q.C.:

Q. Yes, yeah.

DR. HOWELL:

A. And it was, I guess, some of that really resonated well with me and the concept of a just and trusting culture.

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. And I was interested in how you move that thought process forward and then the whole reporting of adverse events and the, how you would get people to come forward freely with information. And there was talk about rather than calling them near misses, call them -

CHAYTOR, Q.C.:

Q. "Close calls" is what you wrote here.

DR. HOWELL:

A. "Good catch" or something.

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CHAYTOR, Q.C.:

Q. Or "good catch." Not even a close call, good catch, okay. And you also wrote under that, you've got, "Reporting adverse events disclosure," and then "knowledge transfer." What did you mean by "knowledge transfer" or what did the speaker mean who you were taking these notes from?

DR. HOWELL:

A. I think it was the whole business of capturing adverse events that may go on or near misses, close calls, whatever you wish to call it and being able to put that in a common data set that you shared with others. A classic example of that would be mortality and morbidity rounds, which I saw as a wonderful tool for learning. The problem with it is that the areas that do do mortality and morbidity rounds did not keep good records of it and certainly did not share it with anyone else and I just thought that that was such a lost opportunity.

CHAYTOR, Q.C.:

Q. And have you taken steps to try and correct that or rectify that?

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DR. HOWELL:
A. We did in last October have a full clinical chief retreat on mortality and morbidity rounds. It ties very much into, though, the whole peer review quality assurance piece and the fear of litigation and so on. And so, I brought in--Capital Health in Halifax has been moving ahead with a similar process and were a little bit ahead of us, so I brought in a physician from there thinking that that might help us move ahead a little more quickly because any mistakes they made or difficulties they had run into. So we did advance it some, but I think with us dealing with this issue, we've slowed down in our proceeding with that, but it is our intention to try to strengthen that.
CHAYTOR, Q.C.:
Q. Okay, and so the knowledge transfer being that you can share, not only within your own organization, but beyond your own organization, learnings from an adverse event or a close call, near miss, so that you can get that knowledge out there so others may learn and prevent a similar occurrence

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elsewhere?
DR. HOWELL:
A. Absolutely critical.
CHAYTOR, Q.C.:
Q. And how you do that, in the context of people being concerned with litigation, is the challenge?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And on page 23 of the exhibit, so if we can just turn over a couple of pages, Doctor, at the top of the page you've numbered nine, here, I believe, "root cause of sentinel event, the highest is poor communication." Do you recall what was being put forward there?
DR. HOWELL:
A. This would have been a presenter and it would have been a statement that they made that very much resinated with me.
CHAYTOR, Q.C.:
Q. And why is that?
DR. HOWELL:
A. Because I guess through my whole career many times we've made mistakes, it's been poor

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communication, it may be physician, the physician--it could be as simple as the handing off of a patient from one physician to another and the poor quality of physician's notes and being able to communicate with another physician at trans--it just resonated very much with me. And certainly, I think, it carries on into the whole ER/PR issue as we will explore.
CHAYTOR, Q.C.:
Q. And do you want to share that insight with us?
DR. HOWELL:
A. In terms of communication in general?
CHAYTOR, Q.C.:
Q. Yes, no how you think that that was pertinent--a pertinent observation to the ER/PR issue?
DR. HOWELL:
A. I'd have to go backward a little bit to talk about communication.
CHAYTOR, Q.C.:
Q. Well if there's a better place along the way that you'd like to bring it up, but I'm just thinking you said that it is something that occurred to you as being relevant to the ER/PR issue, so rather than forget the thought,

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perhaps we could explore it now.
DR. HOWELL:
A. No, the issue for me, which we will get to, is unless you have solid data and you can get it efficiently and effectively, it's very hard to communicate, so that's why I would hesitate that a struggle for me, not only in this, but in the other things I've had to deal with in the short time in this job, is that ability to access data that you can feel confident about and that you can get in an efficient manner.
CHAYTOR, Q.C.:
Q. And so the issue of, for example, the--even the formatting of the pathology report and being able to access the information on that report, through your system and ultimately getting the information that you need out of that, and using it.
DR. HOWELL:
A. Absolutely.
CHAYTOR, Q.C.:
Q. Okay.
DR. HOWELL:
A. And the document management, the place is full of paper and, but yet to find something is

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impossible.
CHAYTOR, Q.C.:
Q. Okay. And then, Doctor, the next page I think it looks like you're probably back in St. John's, November 20th, 2006, and you've got "ER/PR" written at the top of this page.
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And is this notes from a meeting or how are you acquiring this information?
DR. HOWELL:
A. I am sitting in the audience and in the main lecture theatre of the medical school and many of our clinicians and technologists are in the room and the pathologists and others from around the regions are teleconferenced into this room and we are having presentations from many of our pathologists.
CHAYTOR, Q.C.:
Q. Okay. So this is the presentation that was given to the medical and other staff? Your notes of that.
DR. HOWELL:
A. These are my notes as I'm trying to understand

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what this is all about myself.
CHAYTOR, Q.C.:
Q. Okay. So is this really your first time to, in hearing the issue in any detail?
DR. HOWELL:
A. This is the first time where I'm really starting to understand what immunohistochemistry is all about.
CHAYTOR, Q.C.:
Q. Okay. And prior then to attending the presentation on November 20th, had you already read--do you feel confident you had already read the external review reports at that point in time?
DR. HOWELL:
A. I think I had, but--yes, I think I had, but I'm not certain what time I first read those, but I think I had.
CHAYTOR, Q.C.:
Q. And I'll bring you back to those notes, I just want to try to stay in chronological order here and there is another document I'd like to bring to your attention first and that's P-1402 and this is an e-mail exchange of October 26th, 2006 and if we scroll down through, you

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can see that it originates with an e-mail from Ms. Predham and Ms. Predham is e-mailing to yourself and Dr. Denic, Mr. Gulliver, Ms. Elliott, Ms. Pilgrim, Susan Bonnell, Sharon Smith and Kara Laing, and she's also copied Nancy Parsons, Leona Barrington on this. And it's an issue regarding a retro converter, a patient who has--what's been referred to as a retro converter and you will see that if we look at the exchange of e-mails, she's suggesting or there's a suggestion put forward about meeting, I believe Sharon Smith puts that forward. "Heather and I were talking this morning, we felt a meeting would be in order. Who wants to arrange it?" And then you offer to arrange it at 4:30 in the afternoon. So I take it at this point in time you are certainly involved in the issue to the point where you can arrange a meeting or you can suggest to the group -
DR. HOWELL:
A. I was the facilitator of the meeting.
CHAYTOR, Q.C.:
Q. And is that it, you were just the facilitator of the meeting or are you somehow managing

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this aspect of the issue?
DR. HOWELL:
A. Well I'm certainly getting increasingly involved in trying to, again, understand what happened here and feeling my role out, I guess a little bit as well.
CHAYTOR, Q.C.:
Q. Okay. And if we just look down through the e-mail itself, the first paragraph, you'll see it as involving a person who is a retro converter.
DR. HOWELL:
A. Uh-hm.
CHAYTOR, Q.C.:
Q. And she explains that that means she originally stained positive, it was now coming back negative. Then it continues on with "She has been treated with Tamoxifen from 1999 to 2004 and the panel had had much discussion and debate on how best to disclose this information to the client." And the original intent had been a meeting with the clinical chiefs and someone from QRM, the quality and risk management, but a complicated factor at that time was the media coverage after the

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DCIS meetings and then, "Upon further review, the panel identified they had early disclosed another retro converter had been contacted by the most responsible physician and that was the usual process." Then it continues on with Nancy having received a phone call the next day or yesterday afternoon and "I can only assume that Mr. Crosbie will now have another story. I anticipate that he will call for a total retest of all ER/PR results. We didn't discuss that at the panel level, but there is a documented false positive rate with this test and five out of 962 falls well within this range. Of course, we can revisit this decision." And then she concludes with "This entire ER/PR review has been very difficult and drawn out, with constant hard and difficult decisions being made. The only thing making it bearable at all was that we were doing what we had to do to make it right for our patients. We were always "doing the right thing". Personally this, combined with the two situations involving Dr. Ganguly in the past two weeks has left me totally and absolutely disheartened." And I did have a

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few questions for you on this. First of all, did the meeting go ahead to discuss what Ms. Predham has raised?

DR. HOWELL:

A. I don't recall the meeting.

CHAYTOR, Q.C.:

Q. You don't recall any -

DR. HOWELL:

A. I don't recall the meeting. It's interesting that as I read that, I, you know, I recall back my concern in talking to Ms. Predham and seeing the degree of emotional stress and pain that she was feeling and dealing with this issue and that makes me believe that the information that I had gathered about the two patients with Dr. Ganguly likely came from her.

CHAYTOR, Q.C.:

Q. So that may have been that discussion -

DR. HOWELL:

A. That may be the tie in to that particular note being written.

CHAYTOR, Q.C.:

Q. And that's one of the things I wanted to ask you about this, because--about the emotional

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stress because Dr. Williams certainly told the Commission that early in the process, I think he said like September of 2005, he, himself, was feeling pretty overwhelmed with having to deal with the issue and you come into this with a fresh perspective. Did you have concerns about the people who then were trying to continue to deal with this issue a year later and where they were on the issue? Did you have concerns about how well they were coping?

DR. HOWELL:

A. I certainly--yes, I think my answer--my answer is yes. I certainly saw that Ms. Predham was feeling the strain of dealing with this, I think she carried a great deal of the weight. I was quite--in the world that I had come out of, when you would have an event of such magnitude as this and so large, and I'll call it a project, there would have been a person assigned, seconded to a position to deal with that and it would have been their only activity. Here people were dealing with this, continuing to do the rest of their day's work and manage this major significant event on top

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of that day's work. That was--I had great difficulty understanding that particular way of approaching the problem. I will be honest and I, myself, was finding that, I thought I was a pretty good multi-tasker, but this is just coming from every direction.

CHAYTOR, Q.C.:

Q. And Dr. Williams told us on top of that, in having to manage and it was an issue of a magnitude that he certainly had not seen in his lengthy career were of such significance and on top of that, was also the restructuring that was happening within the organization at the time and I believe his terms, in describing that for the Commissioner, he used the term "perfect storm" and he used the term that it was his "worse nightmare". So you come along a year really or a little bit beyond a year into this, and it was certainly no ordinary clinical issue that was being managed, you, unlike everyone else on the team, you're coming at this with a fresh perspective and you certainly haven't had to be entrenched in the issue and the day to day of it, did you express your concern to anyone?

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Did you go to Mr. Tilley and indicate to him that--or anyone else, did you express concern as to the strain that the staff were under in having to deal with this issue and any other concerns you may have had as to their capacity to really continue to manage this issue?

DR. HOWELL:

A. My recollection is that there were conversations held, you know, at the executive level about the level of strain that these folks were under and I'm fairly certain that I had a conversation with Mrs. Pilgrim out of concern for Ms. Predham and I remember making the comment that she was her own worse enemy because she could say no to nobody. And so every time there was an issue, an adverse event or a question mark about care or whatever, she was the person who was being called. And I probably started to become guilty of that myself because she was the person to call and yes, there was quite a great deal of concern, but my other problem was I was still feeling my way out within the executive itself and the style in which meetings were held and the way information was

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transferred and just keeping up with the volume of material that was being sent on a daily basis to read was quite a piece of work.

CHAYTOR, Q.C.:

Q. And you've told us that you had a fairly extensive background in human resources and you did notice this strain certainly at least with respect to Ms. Predham. You spoke to Ms. Pilgrim about it and she indicated that Ms. Predham being her own worse enemy, but beyond that, was there any, you know, at some point any further action taken or in terms of the, you know, the executive team are the people who ultimately Ms. Predham would take her directions from, but I take it nothing further came of that and Ms. Predham continued on in her role and her--certainly a significant role that she played on this group that was put together to manage this issue.

DR. HOWELL:

A. I don't know at what time, but I know that Mrs. Pilgrim did step in and take some things off the table for Ms. Predham in concern for her health and for the volume of work that she was carrying.

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CHAYTOR, Q.C.:

Q. And what about others? Did you notice similar issues with others who had been involved heavily in this issue?

DR. HOWELL:

A. This was affecting the entire organization at this point. I mean I was seeing extreme--as we got into this presentation on November 20 and then subsequent to that and I know we're headed there chronologically, I mean, the stress level in general was mounting all around me, particularly on the laboratory side, but throughout the organization--I mean, I--you know, meeting people in the corridor. The level of, the volume of work--I mean, to put in perspective, we had had the pharmacy issue, then the Turner Report came out, and the executive was having to deal with the repercussions of that. And I think it was at that time that I started to realize that the name Eastern Health was going to be in the news every single day because--and I don't know if this is relevant, so stop me if I'm--but we were truly cradle to grave. So suddenly Mr. Tilley ultimately had the

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responsibility from that baby that was being born through the daycare, through the social services system, if that had to happen and then into long term care and everywhere along that continuum, there were problems. And so there was now way that we were not going to be in the news virtually every day and the majority of that would likely be not happy things. And that was quite a realization to me as to--and then to meet somebody who would say, you know, I hate when someone asks me where I work. I thought that was--that was not what I had signed up for.

CHAYTOR, Q.C.:

Q. And did you offer any advice to people?

DR. HOWELL:

A. I tried to direct--that was, again, part of my town hall approach, was trying to direct people, but you know, what we're hearing is that that piece that didn't go well, but all that stuff we do, that we do so well, that I know is as good as anywhere in the country, that's not as newsworthy.

THE COMMISSIONER:

Q. That isn't new though, is it? I'm just

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trying--while you're talking here, I'm thinking about what you're saying and I understand it, but you are just joining what is probably the largest single organization in the Province. It certainly isn't news to anybody that bad news is much more interesting then good news. And when you look at the role that that organization plays in life, at least on one side of the Island, it seems to me you should have anticipated that.

DR. HOWELL:

A. I probably should have, Commissioner, but I think when things go awry in the past if in the days in which I spent most of my career working in hospitals for over 20 years, if there was an adverse event that happened in the Grace Hospital, the news was about the Grace Hospital. If there was an issue that happened with social service, it was some other name that appeared or, you know, another hospital was named or daycare certainly wouldn't have been in that mix. I certainly was naive to the fact that suddenly, Eastern Health, as a name, as a brand, if you like, now contained all of these elements and that

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was the name that would be talked about. And the people who work in Eastern Health, who really hadn't even had an opportunity to call it home yet, who really hadn't even bought into that concept were suddenly left thinking, you know, I just don't want to say I work there.

THE COMMISSIONER:

Q. Well, and when you think about it, you know, the one--whatever you might think if you worked in a hospital where an adverse event occurred, now you were going to hear the name of your institute when it occurred hundreds of miles away and in a place where you had nothing to do about it, but that was the nature of the organization you were joining.

DR. HOWELL:

A. That's correct, it was and it is.

CHAYTOR, Q.C.:

Q. Thank you, Commissioner. Doctor Howell, this portion of Ms. Predham's e-mail, "I can only assume that Mr. Crosbie will not have another story and I anticipate that he will call for a total retest of all ER/PR results" and there's a comment also from Ms. Bonnell and I believe

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she may be the one instigating the meeting to happen. "I think it is essential that we pull together an emergency meeting of the 'group' to discuss this latest development". Now, would you have considered yourself part of the 'group'?

DR. HOWELL:

A. I would have.

CHAYTOR, Q.C.:

Q. "We need to consider how we can position this before Ches Crosbie does it for us". Did those types of comments--again coming at this from a fresh perspective--those types of comments catch your eye or cause you any concern?

DR. HOWELL:

A. I guess I was in a situation where I was trying to understand a very complex situation and I also--there was a class action lawsuit that was active at this point in time. And I'm trying to understand the Rules of Engagement here and I guess, still feeling my way out as to what part of this that I was having responsibility for and to work through.

CHAYTOR, Q.C.:

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Q. So, I take it it didn't cause you any concern or it didn't raise a red flag to you, those types of comments.

DR. HOWELL:

A. From Ms. Bonnell?

CHAYTOR, Q.C.:

Q. Well, there's one from Ms. Bonnell and there's one from Ms. Predham. "I can only assume that Mr. Crosbie will now have another story". That's Ms. Predham's comment. You've acknowledged or you've noticed that people are under strain, people are under stress and I'm wondering if those types of comments caught your attention, coming at this with a fresh perspective?

DR. HOWELL:

A. You know, I think those comments were reflective of a high level of press activity, the strain of understanding this test and maybe also the realization now it's coming out that all the patients haven't been contacted. There is work yet left to be done, and it truly was a whirlwind trying to understand, and there was tremendous emotion here at this point in time.

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CHAYTOR, Q.C.:
Q. Yes, and I understand and I'm just wondering though, you did have concerns about their capacity to continue on and deal with the issue under the strain in which they were working. Did you also--did it appear to you at times that individuals involved were starting to lack a sense of objectivity or impartiality or even detachment in making decisions regarding the issue?
DR. HOWELL:
A. It certainly didn't at that time. I felt embroiled and swept up in it, and I certainly--to step back now and look at that, I mean, you would see, yes, that people are losing focus maybe on why we're there, but at that time, I was swept up in the whole dealing with the issue and all these things coming in and new revelations and, you know, this would have been maybe one of 80 e-mails in a day and just dealing with all of those things.
CHAYTOR, Q.C.:
Q. The e-mail also indicates that there was a--the panel had much discussion and debate as to how to best disclose the information to the

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client and the original intent is outlined there, as I read before. But a complicating factor at the time was the media coverage after the DCIS meetings. Do you know what that referred to? Why was media coverage a complicating factor in how to disclose to the patient?
DR. HOWELL:
A. I don't know what that means.
CHAYTOR, Q.C.:
Q. And you have no recollection of a meeting after this to discuss this issue?
DR. HOWELL:
A. I don't.
CHAYTOR, Q.C.:
Q. And I take it then, you don't know what decision was ultimately made as to how best to disclose to this particular patient?
DR. HOWELL:
A. No, I don't. It was being dealt with with Quality and I really don't know how they approached that.
CHAYTOR, Q.C.:
Q. And I understand what you're saying to me in terms of you yourself then coming in with your

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safe learning curve and then really just becoming embroiled in the whole situation. So, I take it then, Doctor, at no point in time did you give any advice to the people involved in terms of saying, it's time to step back.
DR. HOWELL:
A. No, I didn't.
CHAYTOR, Q.C.:
Q. This issue that's raised here about all tests, Ms. Predham is indicating that she anticipates that Mr. Crosbie will now look to have all ER/PR results retested and I assume she means also the positives. Is that currently under way? Are all ER/PR tests now being retested?
DR. HOWELL:
A. Positives are not.
CHAYTOR, Q.C.:
Q. Positives are not.
DR. HOWELL:
A. No.
CHAYTOR, Q.C.:
Q. And do you know whether or not they are being done if patients request that they be done?
DR. HOWELL:

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A. It would be better to ask Ms. Pilgrim that, but I am not aware of any patients that have had that done, but that could be the case.
CHAYTOR, Q.C.:
Q. Okay, we'll continue on to the ER/PR presentation then that happens with the medical and technical staff.
THE COMMISSIONER:
Q. Ms. Chaytor, it's a good time for the afternoon break. Would you prefer to do that now, before you start this or afterwards? I'll leave it to you.
CHAYTOR, Q.C.:
Q. Yes, that's fine, well then, perhaps we'll take the break now since it's a new area.
THE COMMISSIONER:
Q. All right.
CHAYTOR, Q.C.:
Q. Thank you.
THE COMMISSIONER:
Q. We'll take 15 minutes.
(RECESS)
THE COMMISSIONER:
Q. Please be seated. Ms. Chaytor?
CHAYTOR, Q.C.:

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Q. Thank you, Commissioner. Now Doctor, leading up to the break, I was about to take you to the ER/PR presentation which was carried out for medical and technical staff. I understand that took place November 20, 2006. And were you involved in actually arranging that presentation?

DR. HOWELL:

A. I think Dr. Denic asked me to arrange it and I had my assistant arrange the room and the teleconference facilities et cetera, as I recall.

CHAYTOR, Q.C.:

Q. Okay. And if we could look, please, at P-0422. And, Doctor, this is an e-mail from Dr. Denic to yourself, November 6, 2006 and he's looking to--he's asking if your office can arrange a presentation. "I think the best venue"--and he indicates where he thinks it should take place. He also indicates "I would like to invite the lab directors from the island because we were all involved". The name and telephone numbers and he goes on from there. And he also wants to invite the cancer clinic professionals and managers, surgeons

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and QI personnel. The title of the presentation is "ER and PR testing, Eastern Health Experience" and he indicates he could be ready the week of November 13 and for you to let him know what you think about it.

Did the lab directors, pathologists across Newfoundland attend?

DR. HOWELL:

A. I think they did.

CHAYTOR, Q.C.:

Q. Okay. So, not just Eastern Health people. The lab directors across the province?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. Okay. And if we look at P-1193, please. And Denise Dunn is your assistant, I take it?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And she's writing here to Dr. Williams and inviting Dr. Williams to attend at your invitation. Do you know if Dr. Williams attended?

DR. HOWELL:

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A. I don't know.

CHAYTOR, Q.C.:

Q. You don't recall that?

DR. HOWELL:

A. I don't recall.

CHAYTOR, Q.C.:

Q. Okay. Had you, up to this point, had any discussions with Dr. Williams about the issue after he had left his employment?

DR. HOWELL:

A. Dr. Williams, to his credit, wished to stayed involved from the quality perspective. And as I was bringing together my quality portfolio group, he sat on that group.

CHAYTOR, Q.C.:

Q. Okay. And I did see his name in one of the minutes of the lab quality group. How long did he or does he still continue to sit on that committee?

DR. HOWELL:

A. Yes, we still view him as a member.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. He hasn't been there in the last several

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meetings, but I think he's been out of the province.

CHAYTOR, Q.C.:

Q. And has he remained involved in terms of providing any advice to you on the ER/PR issue?

DR. HOWELL:

A. We've really not had much contact, no, about ER/PR since that time, other than his involvement and his interest in the whole realm of quality and health care and sitting on that portfolio committee.

CHAYTOR, Q.C.:

Q. Okay.

DR. HOWELL:

A. But specific to ER/PR, no.

CHAYTOR, Q.C.:

Q. Okay. If we could look P-0424, please. And this again, I understand is e-mail exchange in trying to arrange the November 20 presentation. And this time the e-mail comes from Joyce Penney to George Tilley. It's sent November 6--I'm sorry, is that 15th maybe, '06, no, November 6. And she writes, "George on Monday, November 20 November 5:00 p.m. Dr.

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Howell is organizing a presentation by Heather Predham and Dr. Denic among others on the ER/PR with the view to having a presentation to executive then on the 21st. Question to you.....who do you see giving the presentation to executive? Dr. Denic and Heather Predham plus legal counsel. Do you want anyone else to attend? Note that we have John Hylton, CCHSE giving a presentation to executive on the 21st as well. And then they're holding time on November 30 for a potential press conference on ER/PR". And then Mr. Tilley writes back and says the same date "Joyce, talked to Oscar and agreed to legal counsel attending" and then talks about timing. And I take it that was legal counsel to attend the executive management meeting as opposed to the overall presentation. Is that correct?

DR. HOWELL:

A. I'm not certain.

CHAYTOR, Q.C.:

Q. Do you recall your discussion with Mr. Tilley on that point?

DR. HOWELL:

A. I do not.

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CHAYTOR, Q.C.:

Q. Do you know why it was felt necessary to have legal counsel attend either presentation?

DR. HOWELL:

A. Not with any clarity, no. For information would be my thought for them to understand the issue, I would presume.

CHAYTOR, Q.C.:

Q. To understand, I'm sorry, which issue?

DR. HOWELL:

A. To have the same level of detail knowledge that was going to be shared with us from the presenters.

CHAYTOR, Q.C.:

Q. For legal counsel to have that knowledge?

DR. HOWELL:

A. If they wished.

CHAYTOR, Q.C.:

Q. And who did you understand legal counsel to be in this context?

DR. HOWELL:

A. Mr. Boone.

CHAYTOR, Q.C.:

Q. So, he's legal counsel for the defence of the class action?

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DR. HOWELL:

A. Correct, for the insurer.

CHAYTOR, Q.C.:

Q. And so your understanding would be for Mr. Boone to have the benefit of the presentation.

DR. HOWELL:

A. That's again, supposition on my part, but I think that's so.

CHAYTOR, Q.C.:

Q. You have no recollection then either way?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. As to what the purpose would be in Mr. Boone attending?

DR. HOWELL:

A. No.

CHAYTOR, Q.C.:

Q. And it appears from this that you agreed to that. Do you have any reason to take issue with that?

DR. HOWELL:

A. I wouldn't have felt it was my--if the CEO wanted legal counsel there, it wasn't a request of mine, to the best of my knowledge.

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CHAYTOR, Q.C.:

Q. And what was the--if you look at the bigger group picture of November 20th, I believe the one, the presentation to executive management takes place then the next day, the 12st--what was the purpose of the November 20 session?

DR. HOWELL:

A. It was an attempt to engage the other laboratory people in the region plus the health professionals and technologists within Eastern Health around--to help generate better understanding and knowledge around the whole ER/PR issue and it was information sharing.

CHAYTOR, Q.C.:

Q. Okay. And to your knowledge, up to that point in time, had there been any similar session conducted?

DR. HOWELL:

A. Not of which I'm aware of.

CHAYTOR, Q.C.:

Q. Okay. So, this is the first time that the technologists and the medical personnel involved would have had any in-depth presentation on this ER/PR issue?

DR. HOWELL:

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A. To the best of my knowledge.
CHAYTOR, Q.C.:
Q. And if we could look then at P-1190, please. And this is the memo that went out to all surgeons, oncologists, pathologist and laboratory technologists from yourself, November 7, 2006. And it's indicating the time, the date, time and place of the presentation. And again, to your knowledge, the laboratory directors across the province also attended, is that right?
DR. HOWELL:
A. That's correct.
THE COMMISSIONER:
Q. Is this by teleconference?
DR. HOWELL:
A. Well, those in St. John's were in the main lecture theatre at the Medical School, but there was a teleconference link as well over speakers.
CHAYTOR, Q.C.:
Q. And if we look then at the--I understand from looking through, this is the slide presentation that would have been given that day?

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DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And I understand looking through those slides, Dr. Ford Elms spoke on immunohistochemistry, and as well, Doctors Carter, Cook and Laing made presentation?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. Did you make any presentation?
DR. HOWELL:
A. I did not.
CHAYTOR, Q.C.:
Q. If we could have page 19 and 20, please. It's kind of difficult to make out, but this slide in particular here, I'd like to look at, if we--can we make that a little bigger, please, Registrar? And this is part of Dr. Carter's presentation, I understand, and she's writing about how to get a perfect result, and I don't know if you can make that out there, Doctor, but--if you can read that or not, but it's talking, I believe, about the slicing of the specimens at five millimetres, placing in

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certain formula, ten percent buffered formalin, and she also mentions about "while alcoholic fixatives may be used, please don't. Mercury and" something else which I can't read, and then she's got a query, I think, keep blocks--I'm not really sure what it--it's difficult to read, lost over time, and then if we look at the next slide -
MR. BROWNE:
Q. I think it says (inaudible) maybe.
CHAYTOR, Q.C.:
Q. Okay, thank you. Thank you. And then it continues on with the next slide, she talks about "standardized protocol, validated for your centre, never believe the manufacturer's protocol," and she goes on about the antibody, "stringent internal QC program, external proficiency testing (less valuable unless in a Court of law and perform 250 cases a year)" And then the next slide continues with how to get a perfect result, "positive and negative controls used/examined. Select block with internal control. Pick a representative block, not the highest grade leaving edge," I believe is what she writes, and it continues

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on. I won't take you through it all, but just to give you a flavour of what--and you recall her, I take it, making this presentation?
DR. HOWELL:
A. I do.
CHAYTOR, Q.C.:
Q. Okay, and did some of these points sound familiar to you?
DR. HOWELL:
A. Certainly, you know, much of the conversation that each one of those individuals was talking about was beyond my level of expertise or knowledge, that's why I was taking such copious notes and trying to understand it, but certainly, in having read the external reviews, a lot of what she's saying is marrying very well with that.
CHAYTOR, Q.C.:
Q. Yes, Dr. Banerjee's and Trish Wegrynowski's reviews?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And to your knowledge, this is the first time the pathologists in attendance would have been

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told this information?
DR. HOWELL:
A. I don't know the answer to that. Whether-- what conversations Dr. Denic may have had with pathologists within Eastern and across the region, considering his other hat, he would have to speak for himself. I'm not certain.
CHAYTOR, Q.C.:
Q. And it's the first time that this information has been given in a group session such as this, to your knowledge?
DR. HOWELL:
A. To the best of my knowledge.
CHAYTOR, Q.C.:
Q. If we could look then at your notes that you took that day, and I believe it's 1422, page 24. Okay, and you took fairly detailed notes. I believe it goes on for quite a number of pages. It goes on for about five pages, I believe.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And the first part being immunohistochemistry, so I take it that was Dr. Elms' session, and

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he referred to in his session as cutting tissue, and you've got, I think that says "clear" is it?
DR. HOWELL:
A. It does.
CHAYTOR, Q.C.:
Q. Okay, and what--you've written over here "not grand round." What did you mean by that?
DR. HOWELL:
A. I'm not sure. It may have been a note to myself that this was not a standard grand round like we have on Fridays at the Health Sciences. This was an extraordinary event.
CHAYTOR, Q.C.:
Q. The event that you were attending?
DR. HOWELL:
A. That's correct. I think that's what I--why I'd be putting that there, but I'm not certain.
CHAYTOR, Q.C.:
Q. Do you know whether or not the pathologists and oncologists in the time frame, you know, 2000, 2005 up to that time period, say, do you know whether or not they were taking part in any grand rounds?

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DR. HOWELL:
A. I don't know for certain.
CHAYTOR, Q.C.:
Q. And I realize you weren't there.
DR. HOWELL:
A. Yeah.
CHAYTOR, Q.C.:
Q. You have an asterisk by "no standardization across labs. Is standardization within a lab?" Is that what that says?
DR. HOWELL:
A. Yes.
CHAYTOR, Q.C.:
Q. Why do you have an asterisk or a particular note made of that point?
DR. HOWELL:
A. Because it was a point I felt of some significance, the fact that there was no standardization across labs.
CHAYTOR, Q.C.:
Q. No standardization across labs within Eastern Health?
DR. HOWELL:
A. I think I understood that to mean that there wasn't a standardization for

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immunohistochemistry across the country.
CHAYTOR, Q.C.:
Q. And what did you understand at that point in time, in terms of Eastern Health's own standardization in terms of fixation? This is really a lot of what's being discussed here, it appears, by Dr. Elms.
DR. HOWELL:
A. I think, again from the external reviews that were done, that fixation and--well, all of the--let me recollect. If fixation was of concern and that particularly would be important since we were receiving specimens from outside laboratories. It was all the issues that had been raised by the external reviewers and that the test, in general, there wasn't standardization and we were moving to some standardization within the lab and we were needing those other individuals to participate in that standardization, particularly in terms of fixation, if they were sending tissues in to this lab.
CHAYTOR, Q.C.:
Q. And do you recall, was that actually discussed though in the presentation that day?

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DR. HOWELL:
A. I don't recall.
CHAYTOR, Q.C.:
Q. And the next page, you make a note--now you've got a number two, so does that mean this is the second presentation or -
DR. HOWELL:
A. Second page.
CHAYTOR, Q.C.:
Q. Second page, okay, it's just your page numbering, okay. And you're writing a fair number of notes here, so I take it you're trying to comprehend as much of this information as you can yourself?
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. And you're talking about "estrogen bonds to cell" and then you have an arrow "grow, Tamoxifen blocks receptor" and then your second point there being "cut off" is that one percent, pre 1999?
DR. HOWELL:
A. Per 1999.
CHAYTOR, Q.C.:

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Q. Per 1999. Do you recall what that was about?
DR. HOWELL:
A. I don't.
CHAYTOR, Q.C.:
Q. Okay, and you come down towards the bottom, "atmospheric pressure, humidity effects" and "i.e. must standardize within the lab, standardized and validated testing is needed" or is used, sorry.
DR. HOWELL:
A. Right.
CHAYTOR, Q.C.:
Q. And again, these are your notes that you're just taking from -
DR. HOWELL:
A. Other people are speaking and I'm -
CHAYTOR, Q.C.:
Q. Other people are speaking, yes.
DR. HOWELL:
A. - gathering information.
CHAYTOR, Q.C.:
Q. And we could look to the slide presentation for -
DR. HOWELL:
A. It should marry to that, that's correct.

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CHAYTOR, Q.C.:
Q. I just want to highlight in terms of what you yourself made note of that day, for your own-- to figure out where you were, in terms of your knowledge level.
DR. HOWELL:
A. Um-hm.
CHAYTOR, Q.C.:
Q. And you've got Don Cook's--the next page, Don Cook's name in the margin, and then May 11th 2005. So this is now Don Cook's presentation, I take it?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And he's referring to the index patient. Now--or a patient anyhow with lobular cancer, 2002. Is the first time you would have heard about the circumstances surrounding the index patient or how this whole issue came to be?
DR. HOWELL:
A. I don't know if it would have been the first time, but it certainly would have been close to. It was in that late October and through November period that I'm starting to

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understand this, but was this the first time, I can't say for sure.
CHAYTOR, Q.C.:
Q. Well, what do you recall? What were you told how did this whole issue come about?
DR. HOWELL:
A. To me?
CHAYTOR, Q.C.:
Q. Yes, what -
DR. HOWELL:
A. How? When?
CHAYTOR, Q.C.:
Q. What were you told about why they set out on the course of retesting all the ER negatives?
DR. HOWELL:
A. What I was told was that there was a quite ill patient that they were having trouble helping, and were trying to find a treatment option and that the oncologist, I think, who was managing the case called a colleague in another centre and got advice, to get advice from that individual, and through that call, they started to discuss that it was unusual, that that should have been positive, that's as I remember it, and that started them down the

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road.
CHAYTOR, Q.C.:
Q. Okay. You have another asterisk and it says "August '05 accredited, leading breast pathologist, using old semi-automated," is that what that says?
DR. HOWELL:
A. Yes.
CHAYTOR, Q.C.:
Q. And what was--what's this in reference to, accredited August 2005?
DR. HOWELL:
A. I'm darned if I know what that--it was partial statements from somebody that I probably asterisked it because I didn't understand it and thought I should probably get more information about it, but I don't remember what that was about. It would have been from Dr. Cook's presentation.
CHAYTOR, Q.C.:
Q. Did you understand, up to this point in time, that the lab had not been part of the accreditation process, or certainly not the pathology portion?
DR. HOWELL:

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A. I don't think I really had any idea what level of accreditation had been done for the lab.
CHAYTOR, Q.C.:
Q. And then on your fifth page, you have "external reviewer, technical Mount Sinai, professional B.C. Cancer Centre. Implemented recommendations IHC lab," and what does this say, Doctor? Is it separate department?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Consolidated cases one site.
DR. HOWELL:
A. One site.
CHAYTOR, Q.C.:
Q. Okay. So you do understand at this point in time that you have the responsibility for moving forward with the recommendations?
DR. HOWELL:
A. I do.
CHAYTOR, Q.C.:
Q. And putting in place what's needed to improve the lab, and what did you understand in terms of the recommendations, as of November 2006?
DR. HOWELL:

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A. At some point, I don't know in what proximity to this, I was shown a spreadsheet of all the recommendations and I made inquiry as to where we were on completion of those recommendations, and I was shown through that spreadsheet those that were completed and many of which were ongoing.
CHAYTOR, Q.C.:
Q. And up to now, the present time, what stage are the-
DR. HOWELL:
A. At this -
CHAYTOR, Q.C.:
Q. Yes, at what stage is it?
DR. HOWELL:
A. - moment in time?
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. My last conversation with Dr. Denic and Mr. Gulliver, I think all but one of those recommendations had been enacted.
CHAYTOR, Q.C.:
Q. And that's the one regarding the Sakara -
DR. HOWELL:

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A. The tissue tech processor.
CHAYTOR, Q.C.:
Q. Okay, and you haven't followed up to ask why or is that going to be implemented or why?
DR. HOWELL:
A. The tissue tech processor?
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. Yes, I did, I had a discussion with Dr. Denic as to why we weren't proceeding with it and he indicated that they still did not have a comfort level with utilizing that piece of equipment, and I have to accept -
CHAYTOR, Q.C.:
Q. And that's left with him?
DR. HOWELL:
A. I have to leave that to his judgment.
CHAYTOR, Q.C.:
Q. Okay. Yes, I'm sorry, you did indicate that earlier. Is that the end then of your notes from the presentation, and then the next thing is EMC meeting, executive management committee, is that what that is?
DR. HOWELL:

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A. That's correct.
CHAYTOR, Q.C.:
Q. It looks like there had been a post-it and there's a date missing here. Do you have your--you don't have your original there, do you? But this is executive management committee meeting.
DR. HOWELL:
A. It would have been the 21st, the very following day.
CHAYTOR, Q.C.:
Q. Okay. And so then this is the presentation from there?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. Okay, then perhaps we can go there. We also have a copy of the minutes which are at, I believe, P-0487, page 82. And I take it, Doctor, did you find the presentation on the 20th helpful?
DR. HOWELL:
A. I did, indeed.
CHAYTOR, Q.C.:
Q. You did. Okay. Thank you, Doctor. Now, this

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is the minutes that we have of the executive management meeting, November 21st, 2006, and you are in attendance that day. And there are a number of guests for the presentation which include Terry Gulliver, Heather Predham, Doctors Denic, Cook, Elms, Laing and Mr. Boone is in attendance. And there's a number of different points raised during the presentation. And the following points are raised during the presentation. It indicates--sorry. Starts here, "Presentation ER/PR. Dr. Denic focused on the reliability of the testing and Dr. Laing's presentation focused on epidemiology, adjuvant therapy" and it goes on from there. And then the followings points were raised during the presentation and the first is indicated, "The organization cannot speak publicly on the findings and recommendations of the review because there is currently a class action lawsuit ongoing. This information is protected under the Evidence Act. Discussion ensued regarding the need to share the experience with the other pathologists within the province. Dr. Howell and Dan Boone to discuss further prior to

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making any discussion to," I guess that should be "decision" "to discuss the reviewers' report with the provincial pathologists." Now, Doctor, what was that about?
DR. HOWELL:
A. I'm trying to recall now. That would be the recommendations that had come from the external review and it would be could we share that, feeling that there was a need to share that, with colleagues across the province, particularly since we were a referral centre for them. And I guess I'm being directed to discuss that with Mr. Boone prior to allowing any of that to go forward.
CHAYTOR, Q.C.:
Q. Now the findings and recommendations of the review, and as we just saw in the PowerPoint presentation, Dr. Carter had spoke to, without pointing out where those recommendations may have come from, she certainly spoke to a number of the recommendations, including internal controls, including the fixation issue. So do you know were, in fact, pathologists from the other regions in attendance for that?

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DR. HOWELL:
A. There were pathologists on the teleconference, that is for sure.
CHAYTOR, Q.C.:
Q. Okay. And do you recall whether or not those things were actually discussed by Dr. Carter in her presentation?
DR. HOWELL:
A. That was her presentation that you put up on the screen.
CHAYTOR, Q.C.:
Q. Yeah, okay. So what's the concern, then, about the information being shared with the other regions?
DR. HOWELL:
A. Reading this, I honestly do not know and I do not recall ever having that meeting or a conversation with Mr. Boone about it.
CHAYTOR, Q.C.:
Q. So you have no recollection of this being raised or anybody saying, well, they were in attendance yesterday while we discussed all of this?
DR. HOWELL:
A. I think there were two things, there was an

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information exchange that had occurred the evening prior and there had been, as I remember, lots of participation from others around the province in that call. And in addition, you know, I am fairly certain that Dr. Denic, and I don't know at what point Dr. Denic had a conversation--developed a protocol for fixation and some standardization there that he shared with the other pathologists across the province prior to starting ER/PR testing again. And it was to ensure that that fixation was done appropriately and that the specimen that they received was adequate for test.

CHAYTOR, Q.C.:

Q. I'm sorry, when did you understand Dr. Denic had that exchange of information?

DR. HOWELL:

A. I don't know when that -

CHAYTOR, Q.C.:

Q. No, but it's after -

DR. HOWELL:

A. - piece took place.

CHAYTOR, Q.C.:

Q. - Dr. Denic has become clinical chief?

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DR. HOWELL:

A. Well, he was the clinical chief when I went there.

CHAYTOR, Q.C.:

Q. Yes.

DR. HOWELL:

A. He was interim, then he became permanent and now he's the chief of laboratory medicine.

CHAYTOR, Q.C.:

Q. Yes. So that, from what we understand, happened probably in May of '07?

DR. HOWELL:

A. That--you're probably quite right.

CHAYTOR, Q.C.:

Q. Does that seem right to you?

DR. HOWELL:

A. Yes, that sounds like it would be right.

CHAYTOR, Q.C.:

Q. Okay.

COMMISSIONER:

Q. So are we saying that the protocol for fixation was--or was communicated in '07, May?

DR. HOWELL:

A. I'm not certain of the date that Dr. Denic communicated that. I think we'd have to ask him.

CHAYTOR, Q.C.:

Q. and I think that there will be evidence to that effect.

COMMISSIONER:

Q. All, right, thank you.

CHAYTOR, Q.C.:

Q. Doctor, so the organization cannot speak publicly on the findings and recommendations because of the review, because there is currently a class action lawsuit ongoing. Was this something new to you, was this a foreign concept, did you understand what was being told to you here?

DR. HOWELL:

A. Well, I think my understanding of when there was a lawsuit that the exchange of information--that put it in another realm, in another category and the types of things that one would talk about would change once this was going to enter a court of law and that you didn't release the same sorts of information because that was going to come out in the court system eventually. That was my understanding.

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CHAYTOR, Q.C.:

Q. And who was telling you that?

DR. HOWELL:

A. I don't think anyone told me that, I think that was just my understanding.

CHAYTOR, Q.C.:

Q. You had that understanding before you came to Eastern Health?

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. So this whole concept of certain information being protected under the Evidence Act, that wasn't a new concept to you?

DR. HOWELL:

A. No, I wouldn't say I had any in depth knowledge of it. But the whole idea of things protected under the Evidence Act, I had some superficial knowledge of that coming into the job and the whole issue of their being a lawsuit and that that changed the parameters under which one communicated, I think was something I had in the back of my head coming into the job.

CHAYTOR, Q.C.:

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Q. What information was it that needed to be shared with the other pathologists across the province?
DR. HOWELL:
A. To my way of thinking specific to this test, certainly their involvement from the point at which a tissue is removed from a patient there is a protocol for managing that tissue, particularly if it's going to be sent to a lab at Eastern Health for further analysis.
CHAYTOR, Q.C.:
Q. Well, if it's going to be sent anywhere?
DR. HOWELL:
A. Absolutely, anywhere.
CHAYTOR, Q.C.:
Q. It has to be done right -
DR. HOWELL:
A. But thinking about Eastern Health, that there needs to be a protocol for doing that.
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. But I think beyond that it's much like the discussion we had earlier today about mortality and morbidity rounds, it's, there

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needs to be a general sharing of information on a large scale that may increase level of understanding and would spread out to other elements.
CHAYTOR, Q.C.:
Q. Okay. I guess my question then, Doctor, is that you would have seen the importance of sharing any information, whether it's the appropriate manner in which the tissue or specimen is to be fixed, whether it's information about the importance of internal controls, the importance of that information and the learnings from the external reviews being shared with pathologists wherever?
DR. HOWELL:
A. That I would see the importance of that?
CHAYTOR, Q.C.:
Q. Yes, you understood the importance?
DR. HOWELL:
A. I do understand the importance of that.
CHAYTOR, Q.C.:
Q. Right, okay. And this was obviously acknowledged by the group that appears because the need to share the experience with other pathologists within the province is noted

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here. What information had not, up to this point in time now, November, 2006, what had not been shared with the other pathologists that was deemed important to get to them?
DR. HOWELL:
A. Well, just if I could, with your leave, backup just a little bit. There are two, two pieces there that are affecting the decision about knowledge transfer, information, communication, etcetera. One is the issue of that the early thinking was that these external reviews were done under a peer review quality assurance piece, protected under the Evidence Act at this point in time is what I'm understanding. And then in addition to that, that there has been a class action lawsuit initiated and that that has modified the flow of information. Having said that, the presentations that we saw in the earlier documents -
CHAYTOR, Q.C.:
Q. The day before?
DR. HOWELL:
A. The day before were, you know, being widely talked about, as you can see, with the

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professionals that were involved in doing that kind of work.
CHAYTOR, Q.C.:
Q. Right. On November 20th, 2006?
DR. HOWELL:
A. Correct.
CHAYTOR, Q.C.:
Q. And so if there was additional information that the next day was being of concern here in this discussion with the executive management, you don't know what the additional information is?
DR. HOWELL:
A. I don't.
CHAYTOR, Q.C.:
Q. So perhaps, was there an issue raised about the fact that not many pathologists, or perhaps if any, I don't know, I guess we'll have to hear about that, but not many of the pathologists outside Eastern Health had taken part in the presentation and the need to get the information out to everyone?
DR. HOWELL:
A. I would have hoped that the people who took part in that presentation, though, from

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outside, would be sharing that information with their colleagues in their own laboratories.

CHAYTOR, Q.C.:

Q. Yes. But we don't know, I guess, whether we had everyone from all the authorities there. So I'm just trying to figure out is that why there was this discussion about the need to get the information out to everyone and then was there an issue raised about concern about being able to share the information because of the protection it was thought to be afforded the information under the Evidence Act? Does that jog your memory about what's happening here?

DR. HOWELL:

A. It certainly sounds like there was concern about what do you release considering these two other factors, but beyond that I can't for the life of me think of what it was that, even that I was being asked to talk to Mr. Boone about.

CHAYTOR, Q.C.:

Q. And you have no recollection of any follow-up discussion with Mr. Boone on it?

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DR. HOWELL:

A. On that particular item, no.

CHAYTOR, Q.C.:

Q. Now, you're both in the room?

DR. HOWELL:

A. Yeah.

CHAYTOR, Q.C.:

Q. And it appears that in terms of being tasked with this, you're to go away and discuss further before making any decision.

DR. HOWELL:

A. The only other part to this would be that, whether this is referring to the fact that we are looking at that the quality folks have now finished their analysis with whatever data that they have and that we're looking at--and I think that'll come through further down, at putting together a--the technical briefing for the press, for the media. And whether that's referring to what can you use -

CHAYTOR, Q.C.:

Q. Well, it talks about the public is the first sentence.

DR. HOWELL:

A. Yeah.

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CHAYTOR, Q.C.:

Q. In terms of what can be released to the public.

DR. HOWELL:

A. Yeah.

CHAYTOR, Q.C.:

Q. But I think in terms of my line of questioning here perhaps the more important piece is the actual getting the information out into the hands of the pathologists who are doing this work so that they can ensure that they are doing the best work possible, in the best interests of patient care.

DR. HOWELL:

A. And as you rightly point out, it certainly was my understanding that that had been done the evening before.

CHAYTOR, Q.C.:

Q. For those who were in attendance?

DR. HOWELL:

A. And my recollection is it was--I can't say with certainty that every region was represented, but I think that there seemed to be a lot of people on that call.

CHAYTOR, Q.C.:

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Q. So it that happened the day before, there was certainly not that concern the day before, but the next day there's a concern being raised about getting information out and how far that can go. And that's being raised in this executive management meeting. And do you know why or who would have raised that as a concern?

DR. HOWELL:

A. I cannot expand on any more than what is written there.

THE COMMISSIONER:

Q. Dr. Howell, can you just clarify one thing you said a little earlier for me? You were saying that there were two pieces to be considered in the matter of what information was to be released. One was your view that the external reviews had been done as peer reviews; and the second was the existence of the class action suit. Is there, in your view, any difference in the result, whether one or both of those applied? To be perhaps more clear about it, would the fact that it was peer review allow you, as an organization, to reveal more or less information than it would have if you

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were dealing with a class action suit? Is there really any difference in the end from the perspective of your organization? Because as I understood it, the view of Eastern Health was, well what was done under peer review remained a closely guarded secret, if you will, available only to a handful of people, the original reports were revealed, as I understood it, to maybe four--there were four or five copies made, perhaps other people heard about it in different ways, but there were initially at least only a few copies even made of the reports when they came in.

DR. HOWELL:

A. That's correct.

THE COMMISSIONER:

Q. And up to this point I had gotten the impression that Eastern Health's position was that because of the nature of these reports, they were not to go any further. And I'm wondering how could you give out less information than that, because of the existence of a class action suit?

DR. HOWELL:

A. What I had been told, Commissioner, is that

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those that participated in that external review understood that it was done under the protection of the Evidence Act and therefore, the contents would not be released.

THE COMMISSIONER:

Q. Yes.

DR. HOWELL:

A. Beyond a very few people.

THE COMMISSIONER:

Q. Uh-hm.

DR. HOWELL:

A. And remembering that much of this was rather new to me coming into the job, but that I did somewhere along the way have the understanding that recommendations though could be put forward and in terms of where the class action lawsuit fit, I would not profess to have the legal knowledge--I would have to take the advice of others.

THE COMMISSIONER:

Q. So from--your understanding would be had there not been a class action suit, Eastern Health could have been free to discuss openly all recommendations--could have and would have discussed openly all recommendations made by

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the peer review?

DR. HOWELL:

A. My understanding was that the actual contents and the report itself would not be shared, but recommendations could be.

CHAYTOR, Q.C.:

Q. And where did you get that information?

DR. HOWELL:

A. I'm darned if I know, it was information coming from any different sources and that is an understanding that I was--I couldn't tell you how that understanding evolved.

THE COMMISSIONER:

Q. Okay, and is it further--do I take from what you're saying then that further, your understanding would be the existence of a class action suit would prohibit even the sharing of the recommendations?

DR. HOWELL:

A. I don't think I knew or even today understand for sure how that works.

THE COMMISSIONER:

Q. Okay, thank you.

CHAYTOR, Q.C.:

Q. And are you concerned about it?

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DR. HOWELL:

A. I'm concerned when I now am wearing a mantle of responsibility for the laboratory, absolutely.

CHAYTOR, Q.C.:

Q. And what concerns you?

DR. HOWELL:

A. Well, you know, I guess for me it's making sure that and we will get there, that all actions arising out of those external reviews have been taken and that we have the processes in place, including the proficiency testing, that ensures that the quality of the product that we give to the ordering physician is at the highest level.

CHAYTOR, Q.C.:

Q. And in order for that to happen, there would have to be this knowledge transfer.

DR. HOWELL:

A. That's correct.

CHAYTOR, Q.C.:

Q. And before I leave that, Doctor, while Dr. Carter's presentation would have referred to a number of issues certainly raised through the external reviews, could it be that the broader

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information to be shared would be the actual findings in the report, findings for example for a test failure that Dr. Banerjee had found, perhaps the discussion was more to actually let pathologists know what went wrong so that they will indeed pay the appropriate attention to the points that were raised. It's one thing to have a PowerPoint presentation and say here's what you should do and here are, you know, the best ways to get, as she calls it, the perfect test result. But to actually tell people that this is what we didn't do so well the first time round, do you agree that that would be important to put it in that context and actually say that these are the findings of the reviewers?

DR. HOWELL:

A. Yes, but you know, that presentation, to my understanding, was as much designed as a general education for all parties as it was maybe more so than specifically dealing with the recommendations arising out of the--at least that's, as I saw those folks get up there and do their presentations, it was much as I would have anticipated if I went to a

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grand round where that was to be discussed and we had one of the academic physicians talking about a particular health problem or process, it was delivered in that kind of -

CHAYTOR, Q.C.:

Q. Right, and that's my point really, that it was done as a general educational session and not tied to the findings or to the actual outcomes of the peer reviews or external reviews. And what I'm saying to you is that it certainly didn't cover everything, there was, you know, while there's many points raised, it certainly didn't cover anything and if people are being told here's a general educational session, as opposed to we really need to pay attention to this because this is what, in fact, we didn't do so well the first time round, that would have much more impact in terms of getting the message out to others?

DR. HOWELL:

A. But I think that all that participated in that evening event were aware of the ER/PR issue and in general that something major was afoot here, so I think they would have significant interest and be at least linking the two as

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part of knowledge transfer and quality learning.

THE COMMISSIONER:

Q. So the people who met were the surgeons--or who were invited were surgeons, oncologists, pathologists and lab techs?

DR. HOWELL:

A. That's correct.

THE COMMISSIONER:

Q. As I understand it all of whom have a part, some greater, some lesser, to play in the process from the obtaining of a specimen to the eventual decisions about treatment of a patient.

DR. HOWELL:

A. That's correct.

THE COMMISSIONER:

Q. There's certain steps along the way and all of the people who would be involved in those steps were in that room.

DR. HOWELL:

A. That's correct, that was the goal.

THE COMMISSIONER:

Q. So I suppose you would not expect that a surgeon would necessarily have the knowledge

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of all the details that a pathologist does, but wouldn't a surgeon understand that what happened in that room when the specimen was being taken was an important step in making sure that at the end of the day, the advice that was given to the patient was as good as advice as we could possibly arrange for in the circumstance? I mean, everybody had a part to play, the surgeon did, the pathologist did, the lab techs did and the oncologist did and if they all applied their mind and did the best they could do, then that's the best hope that the patient is going to get the best advice.

DR. HOWELL:

A. Correct.

THE COMMISSIONER:

Q. And it seems to me that if you look at the recommendations coming out of the external reports, while they concentrate on the role of a laboratory technologist and the pathologist, they're certainly lessons to be learned by the two groups who are on the external ends of that process, i.e. the surgeons and the oncologists.

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DR. HOWELL:
A. Absolutely.
THE COMMISSIONER:
Q. So I'm not sure why this would be a general education session as opposed to kind of this is what we now know, we really got to pull together and make sure this never happens again?
DR. HOWELL:
A. Commissioner, I think this was obviously a very big event for the patients, for the organization and while I--I don't think the surgeon would be particularly that interested in immunohistochemistry and how it worked, I think it was felt by the pathologist that it was important that the surgeons understood the complexity of this test to some degree. And you know, as I read those external reports and I'm thinking about the issue of from the moment that that tumor is removed, as you have pointed out, it starts with that process in order to end up with the proper finding, most accurate finding at the back end. So how that tissue is managed, i.e. for example with being quickly refrigerated, are pertinent things and

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the more understanding that more people have, the less risk of error.
THE COMMISSIONER:
Q. Really my point, which it seems to me makes it all the more important that the, I suppose as Ms. Chaytor alluded to earlier, it's one thing to say to somebody in order for this test to be done well, you have to do this and this, but it has a lot more impact if you understand why it is that's important, why it is that your role in this very long process can be critical and can make a difference.
DR. HOWELL:
A. Uh-hm.
COMMISSIONER:
Q. So it would seem to me that if you wanted to achieve the best product, as you would call it, for the future, then one step in doing that would be to make sure that all these people who are in these critical positions along that route understood not only that they had to do something, but how they could adversely impact what was going on at the end of the road by failing to do that, and that means educating them on some of the

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intricacies of the work of the pathologists, I would think. I'm not sure that--you know, I'm not suggesting that every surgeon should have a major course in pathology, but certainly if every surgeon realized how--what goes on in the OR can adversely affect the information that gets to the oncologist in the end, then it's only natural, as human beings, that we pay more attention to what it is we're doing? And given the people who are in the room, I'm just sort of hard, find it hard to chuck it up to just sort of general information for people who might have some interest as opposed to some effort to make sure that we're doing it the best way we can?
DR. HOWELL:
A. I -
COMMISSIONER:
Q. But you were in the room, I wasn't. I'm just--just in terms of the--when I looked at the sort of people who were in the room and the nature of the information that was given, I'm here thinking, well, people are trying to get it right.
DR. HOWELL:

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A. Well, I, you know, the only great feedback that I can give you from that meeting was I remember going up to speak to Dr. Denic after and Dr. Felix, who does a lot of breast surgery coming up to Dr. Denic and congratulating him on the presentation and that he felt that it was an excellent learning opportunity for him. And that's about the only feedback of any substantive nature that I heard, but that was heartening to me.
COMMISSIONER:
Q. Okay.
CHAYTOR, Q.C.:
Q. Did you have the impression it was the first time Dr. Felix was hearing those things about, particularly about fixation issue?
DR. HOWELL:
A. No, I really -
CHAYTOR, Q.C.:
Q. But he indicated it was a great learning -
DR. HOWELL:
A. I think he--I don't know if he used the word "learning" but he certainly seemed to be genuinely pleased with the presentation.
CHAYTOR, Q.C.:

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Q. Doctor, before we leave the minutes, the third bullet says, "We have to position ourselves appropriately so the public has confidence in the laboratory and that the people who have been waiting for information have confidence and understanding of the events related to ER and PR testing. A subgroup will be established to identify key messages to be delivered and develop a strategic communication plan" and you in conjunction with Susan Bonnell is to lead that subgroup to develop the communication strategy. Had you had experience with developing key messages?

DR. HOWELL:

A. No, no, that would not--I had had media training in my prior lives, both involved with the Newfoundland and Labrador Medical Association and with the large corporate client I worked for, but certainly key massaging along this line would be a new endeavour for me.

CHAYTOR, Q.C.:

Q. Okay. And did you do that then, did you and Ms. Bonnell lead the subgroup? I take it this is the communication strategy that went

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forward then on December 11th, 2006 in communicating on this issue? This is all part of the ER/PR presentation in the meeting so this was to put together a communication strategy, I take it, for disclosure to the public on December 11th?

DR. HOWELL:

A. This was to do that technical briefing, that's correct.

CHAYTOR, Q.C.:

Q. Yes, okay. And so then you, in conjunction with Susan Bonnell, lead that process?

DR. HOWELL:

A. That was the direction.

CHAYTOR, Q.C.:

Q. Is that what happened?

DR. HOWELL:

A. There--in preparation for my testimony I mean, it's so long ago I had to go back and I had to call Ms. Bonnell and get her to refresh my memory as to how we actually did that and then go back and find my journals which I had forgotten all about, as you know, and -

CHAYTOR, Q.C.:

Q. That's why we got them yesterday.

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DR. HOWELL:

A. And refresh my memory as to so what as this subgroup. And in my notes, as you've seen, there really is only the one note of a meeting that was held with Dr. Denic, Ms. Predham, Mr. Boone -

CHAYTOR, Q.C.:

Q. And yourself?

DR. HOWELL:

A. And myself and Ms. Bonnell.

CHAYTOR, Q.C.:

Q. So that's the subgroup?

DR. HOWELL:

A. But along that way I, while I have no notes, it seems to me there were a number of people that were involved other than that in making contributions, but I can only speak to what I had recorded.

CHAYTOR, Q.C.:

Q. Yes. Well, there are other notes, too, and perhaps when we get to them, you can tell me, but there are certainly other notes. But you're right, there is the one meeting in late November of the individuals that you just noted. So you think that must be the subgroup

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that was formed?

DR. HOWELL:

A. That's what I'm -

CHAYTOR, Q.C.:

Q. To deal with it?

DR. HOWELL:

A. - I'm guessing.

CHAYTOR, Q.C.:

Q. Okay. Did anyone ever suggest to you that they weren't convinced errors had taken place in the hormone receptor testing?

DR. HOWELL:

A. This is why I say I believe there was a lot more involvement in putting the presentation together. Through all of this there--as I was trying to understand the even what ER/PR was all about, let along the technical science behind it, I was also being introduced to the ideas of the Swiss cheese model that I've hear you've all spent some time maybe in the symposium talking about and that there was considerable discussion, whether, in fact, there was an error, per se, that had occurred. And I was shown the picture of the Swiss cheese model and that this, there was great

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discussion as to this being a systems event.
CHAYTOR, Q.C.:
Q. And who was saying this, who was telling you this?
DR. HOWELL:
A. This would be in meetings that I would have had with Mr. Gulliver, Dr. Denic, Dr. Laing, Ms. Predham, those would be the principal and Ms. Bonnell would have been there for those discussions. That would be the group that we would be talking about that.
CHAYTOR, Q.C.:
Q. And so those individuals weren't convinced that, in fact, errors had been made in the testing process?
DR. HOWELL:
A. It was that if one thought about an error, one thought about that is--that thing there, that event there, that person there made a mistake and that fix that and that's where this broke down.
CHAYTOR, Q.C.:
Q. That's not what the Swiss cheese model is saying, is that there are a number of different holes and you line them all up and

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you get through and then there's an error that happens -
DR. HOWELL:
A. That's correct.
CHAYTOR, Q.C.:
Q. - because everything lined up.
DR. HOWELL:
A. So that's when they were talking to me about this being a systems issue, that there were-- it wasn't one thing, that there were many different things.
CHAYTOR, Q.C.:
Q. So nobody was suggesting that an error hadn't taken place, they were suggesting no one individual or no one event can be solely, solely pointed at and attributed to make that error, is that what it is? I mean, it's different to say no error took place as opposed to, well, we can't point to one person or one thing.
DR. HOWELL:
A. Yeah. It was more than that, that they were talking to me about the fact that this was not a great test, that if you looked at the literature, that there was a significant false

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negative rate. That--and as you see in the presentation, Dr. Denic repeatedly brought up the fact that this was, I forget his term now, probalistic as opposed to a definitive result.
CHAYTOR, Q.C.:
Q. The same presentation in which Dr. Carter made her presentation, you're talking about the group presentation?
DR. HOWELL:
A. And in the ultimate technical briefing when we did that he talked about the quotation from the University of Toronto where it was probalistic.
CHAYTOR, Q.C.:
Q. Yes.
DR. HOWELL:
A. And so the information that I was receiving from them was that this was a test that was fraught with problems, that had a significant false negative rate, that it was a very much an evolving science. I heard discussion about the fact that there were, it was a 40-step procedure, that it was very complex, that they were boiling tissue. And that there were changes occurring in antigen retrieval methods

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and the types of antibodies that were being used. And that there was also confusion because the--not only was there many changes occuring with the test itself from the laboratory perspective, but that the whole concept of what was positive, what a positive test was was changing. And I remember trying to understand then why do we use the word positive? Why don't we just give the percentage and then I learned that yes, now, that is what we're doing, but that wasn't always the case. And then I heard conversations about the--there was no standardization of the test worldwide, that even for the diagnosis of what was, or saying something that was positive, that some people were using the number of cells uptake, others were talking about the intensity of the stain. And I will tell you that through that whole conversation about the science, let alone the numbers, there were so many people with so many opinions and so many views that it was a very confusing situation for me.
CHAYTOR, Q.C.:
Q. Okay. I understand that. So, what--I just

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want to ask you now to step back, because that's what you heard from all the people who were entrenched in the issue for over a year through some stressful times as we talked about earlier, and step back with that fresh perspective. You read Dr. Banerjee's report, how did what you were hearing jive with what you read in Dr. Banerjee's report?

DR. HOWELL:

A. I think when I read Dr. Banerjee's report, I really took more of that forward vision as to, okay, what needs to be done here? And I tried to take the report and, you know, my way of remembering things is to try to segment it into categories and I was looking at fixation, optimization of staining, controls, and documentation. So, I was really looking, in all those recommendations, have we done those?

CHAYTOR, Q.C.:

Q. If we could have P-0046 please, page 3. This is Dr. Banerjee's report, Doctor. I bought you to this earlier today. Under his review of cases, "I reviewed a number of cases from the retrospect of testing set with Dr. Donald Cook, all of the cases that had converted from

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negative to positive by switching platforms had one or more of the following characteristics. One, poor fixation; two, negative internal controls, (normal ductal epithelium, when present, was completely negative); three, absent internal controls, (no normal ductal epithelium present to evaluate). It is apparent that too much reliance is being placed on external positive controls with no attention paid to internal controls". And then on page five, I'm sorry, page four, bottom of the page, "conclusions about the reasons for test failure. Number one is the DAKO system faulty, this is unlikely as there are many laboratories using the system successfully. The reason for the test failure was most likely due to a lack of test optimization including antigen retrieval method" and it goes on from there. Two is basically saying the Ventana system seems to be okay. Three, "is there a problem with tissue fixation? There appears to be an adequate attention paid by the grossing pathologist to the thickness of tissue slices. Quality, quality and adequacy of fixation and

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there is no standardized fixation protocol that everyone adheres to. Four, inadequate or not attention paid to the status of internal controls" which we also saw in the first part I bought you to. And then six, which should be five, "inappropriate choice of blocks with no representative normal ductal epithelium" and seven, "better education is required" and then there's a list of other system flaws that he observed.

So my question to you was, coming at this with a fresh perspective, having read Dr. Banerjee's report, hearing the long list of things that people were presenting to you as somewhat of disbelief on their part, that an error actually could have occurred, were you concerned that this did not seem consistent with what Dr. Banerjee had said?

DR. HOWELL:

A. There are significant deficiencies identified here and that my understanding when I arrived on the scene, that all of those deficiencies were being worked.

CHAYTOR, Q.C.:

Q. Yes.

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DR. HOWELL:

A. And I had a forward looking view.

CHAYTOR, Q.C.:

Q. Yes. And that list that you gave me in answering the question, I didn't hear, we weren't paying attention to fixation, there were issues with our fixation, we weren't paying adequate attention to internal controls. Those things weren't in the list that you gave. And I'm just wondering, having read it and coming at this from a fresh perspective, were you concerned that perhaps there was something not connecting with what you read here and what you were being told by those involved?

DR. HOWELL:

A. My approach was to read that and then to look at the list and say, so, where are we on correcting this.

CHAYTOR, Q.C.:

Q. I understand that, but do you understand how that's not my question? My question is what you were told by those involved as to whether or not, in fact, there was errors made and whether or not what you were told in response

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to that--and what I was hearing you say, because my original question was, were there people who weren't convinced that, in fact, any errors had been made, was my original question, and what you were told by those people involved versus what you read in Dr. Banerjee's and did you see a disconnect.

DR. HOWELL:

A. They certainly were not talking to me about, that there were errors made. That is not what they were talking to me about.

CHAYTOR, Q.C.:

Q. And did you, in fact, get the impression that there were people who weren't convince that, in fact, errors had happened?

DR. HOWELL:

A. There was--at not point did anyone say to me, we made a mistake here, we made a mistake there. I had people say to me, you know, we did a lot of things, but we didn't have the documentation to support it. But I wasn't getting from anyone, that's correct, that these are the errors. Nobody has talked to me about there are errors.

CHAYTOR, Q.C.:

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Q. Did anyone ever tell you that Dr. Carter has set out on an investigation in the early days which was abandoned around the beginning of August 2005?

DR. HOWELL:

A. No, I'm unsure when that letter first came to my attention, but it was--somewhere along the way I became aware of the fact that Dr. Carter had expressed concern.

CHAYTOR, Q.C.:

Q. And I take it that was much further along the way?

DR. HOWELL:

A. I don't know what--it certainly wasn't early on in the time that I was there.

CHAYTOR, Q.C.:

Q. And could that have, in fact, been through the process coming on through to 2007 and ultimately into this process?

DR. HOWELL:

A. It could be.

CHAYTOR, Q.C.:

Q. That you became aware that she had even set out on that.

DR. HOWELL:

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A. Yes, it very well could be.

THE COMMISSIONER:

Q. Wherever you can find a convenient place to break, Ms. Chaytor.

CHAYTOR, Q.C.:

Q. Okay, perhaps this would be a good place then.

THE COMMISSIONER:

Q. All right then, 9:30 in the morning.

CHAYTOR, Q.C.:

Q. Thank you.

THE COMMISSIONER:

Q. Thank you.

Upon conclusion at 4:51 p.m

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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 22nd 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 22nd day of May, A.D., 2008

Judy Moss

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