

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">MAY 22, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Megan Collins Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Pamela Taylor Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Stacey O’Dea. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-1400 THROUGH P-1403, INCLUSIVE Pg. 5 EXHIBITS P-1405 THROUGH P-1410, INCLUSIVE Pg. 5 EXHIBIT P-1412 Pg. 5 EXHIBITS P-1414 THROUGH P-1424, INCLUSIVE Pg. 5</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>DR. OSCAR HOWELL - SWORN</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 4 - 331</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 COMMISSIONER: 2 Q. Ms. Chaytor. 3 CHAYTOR, Q.C.: 4 Q. Good morning, Commissioner. Our next witness 5 is Dr. Oscar Howell. Good morning, Dr. 6 Howell. 7 DR. HOWELL: 8 A. Good morning. 9 DR. OSCAR HOWELL (SWORN) EXAMINATION-IN-CHIEF BY SANDRA 10 CHAYTOR, Q.C. 11 REGISTRAR: 12 Q. And would you please state and spell your 13 complete name for the Commission? 14 DR. HOWELL: 15 A. Oscar James Howell, O-S-C-A-R, J-A-M-E-S, H-O- 16 W-E-L-L. 17 REGISTRAR: 18 Q. Thank you. 19 CHAYTOR, Q.C.: 20 Q. Thank you. Commissioner, exhibits to be 21 entered this morning include P-1400 through to 22 1403, inclusive. 1405 through 1410, 23 inclusive. 1412, 1414 through to 1424, 24 inclusive. 25 COMMISSIONER:</p>

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1 Q. 1412, is that one--that is included, is it?
 2 CHAYTOR, Q.C.:
 3 Q. 1412 is, yes.
 4 COMMISSIONER:
 5 Q. Yes, all right. And the latter part was 1414
 6 through to 1424?
 7 CHAYTOR, Q.C.:
 8 Q. That's correct.
 9 COMMISSIONER:
 10 Q. All right, thank you. Those exhibits are
 11 entered.
 12 EXHIBITS P-1400 THROUGH P-1403, INCLUSIVE, ENTERED INTO
 13 EVIDENCE.
 14 EXHIBITS P-1405 THROUGH P-1410, INCLUSIVE, ENTERED INTO
 15 EVIDENCE.
 16 EXHIBIT P-1412 ENTERED INTO EVIDENCE.
 17 EXHIBITS P-1414 THROUGH P-1424, INCLUSIVE, ENTERED INTO
 18 EVIDENCE.
 19 CHAYTOR, Q.C.:
 20 Q. Thank you.
 21 COMMISSIONER:
 22 Q. Thank you. Good morning, Doctor.
 23 DR. HOWELL:
 24 A. Good morning.
 25 CHAYTOR, Q.C.:

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

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

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1 medical school degree?
 2 DR. HOWELL:
 3 A. 1975.
 4 CHAYTOR, Q.C.:
 5 Q. And your post-graduate degree from McGill?
 6 DR. HOWELL:
 7 A. Late 1990s.
 8 CHAYTOR, Q.C.:
 9 Q. And when were you employed with the Health
 10 Care Corporation as an occupational health
 11 physician?
 12 DR. HOWELL:
 13 A. I'm not sure of those dates. It would eight,
 14 ten years ago, maybe.
 15 CHAYTOR, Q.C.:
 16 Q. And it was a salaried position?
 17 DR. HOWELL:
 18 A. No, that was a contract position.
 19 CHAYTOR, Q.C.:
 20 Q. Oh, contract, okay. And how long were you in
 21 that position or how long was that contract?
 22 DR. HOWELL:
 23 A. Four or five years.
 24 CHAYTOR, Q.C.:
 25 Q. And currently you still do work for National

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1 Defence?
 2 DR. HOWELL:
 3 A. That's correct.
 4 CHAYTOR, Q.C.:
 5 Q. And what does that involve?
 6 DR. HOWELL:
 7 A. I'm the medical officer there. I would see
 8 military members who, for regular medical care
 9 and for occupational issues related to being a
 10 soldier.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And is that a part-time position?
 13 DR. HOWELL:
 14 A. That is part-time.
 15 CHAYTOR, Q.C.:
 16 Q. And how many hours would you devote to that
 17 per week?
 18 DR. HOWELL:
 19 A. I share that with another physician. It would
 20 be from 7:30 in the morning to 9:30, two days
 21 one week, three days another week.
 22 CHAYTOR, Q.C.:
 23 Q. Okay.
 24 DR. HOWELL:
 25 A. I also still have some other contracts that I

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1 do outside of my position with Eastern Health.
 2 CHAYTOR, Q.C.:
 3 Q. Yeah.
 4 DR. HOWELL:
 5 A. I am required to be a licensed physician to be
 6 in this position, and therefore -
 7 CHAYTOR, Q.C.:
 8 Q. So this is how you carry out -
 9 DR. HOWELL:
 10 A. That is correct.
 11 CHAYTOR, Q.C.:
 12 Q. - your requisite number of hours?
 13 DR. HOWELL:
 14 A. That is correct.
 15 CHAYTOR, Q.C.:
 16 Q. And your current position then with Eastern
 17 Health, what is that position?
 18 DR. HOWELL:
 19 A. Vice president of medical services and
 20 diagnostics.
 21 CHAYTOR, Q.C.:
 22 Q. And when did you begin?
 23 DR. HOWELL:
 24 A. September 5th, 2006.
 25 CHAYTOR, Q.C.:

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

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1 Q. So you took over Dr. Williams' position?
 2 DR. HOWELL:
 3 A. All except the quality portion of that
 4 portfolio.
 5 CHAYTOR, Q.C.:
 6 Q. Yes. So the quality portion of the portfolio
 7 is now held by whom?
 8 DR. HOWELL:
 9 A. Ms. Pilgrim.
 10 CHAYTOR, Q.C.:
 11 Q. Pat Pilgrim, okay. And do you know what was
 12 the thinking behind not having the VP medical
 13 also carry the quality portfolio?
 14 DR. HOWELL:
 15 A. I was not party to that decision making, but
 16 Mr. Tilley and I had met and he said, "You are
 17 going to have a very steep learning curve
 18 here" and I suspect it was more of a
 19 consideration for the workload that I was
 20 going to experience.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. Is there any consideration being given
 23 to having that portion of the portfolio put
 24 back with the VP medical?
 25 DR. HOWELL:

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1 A. I have not been party to any discussion of
 2 that.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So it wasn't just a temporary measure
 5 until you climbed the steep learning curve is
 6 what I'm asking?
 7 DR. HOWELL:
 8 A. Well, as I read back through the--which I
 9 think is an exhibit and I read through the
 10 minutes of an executive meeting, I think there
 11 was initially some thought that that would be
 12 a temporary measure, but it hasn't risen
 13 since.
 14 CHAYTOR, Q.C.:
 15 Q. What does that mean, though, in practice, are
 16 you--or who is responsible for the quality of
 17 medical services for Eastern Health?
 18 DR. HOWELL:
 19 A. For medical services?
 20 CHAYTOR, Q.C.:
 21 Q. Medical services.
 22 DR. HOWELL:
 23 A. Meaning physician services?
 24 CHAYTOR, Q.C.:
 25 Q. Yes.

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1 DR. HOWELL:
 2 A. Well, I think every physician is responsible
 3 for that.
 4 CHAYTOR, Q.C.:
 5 Q. But in terms of you not having the quality
 6 portion of the portfolio, what, in effect,
 7 does that really mean in terms of the areas
 8 that you are responsible for?
 9 DR. HOWELL:
 10 A. You know, I guess to my thinking every
 11 individual who works in the organization, from
 12 those that might deliver the food to sweep the
 13 floor to those who are in the operating room
 14 have a responsibility for quality.
 15 CHAYTOR, Q.C.:
 16 Q. Yes. So what does it mean, what's the quality
 17 portion, then, of the portfolio, what is that,
 18 what is it that Ms. Pilgrim now has that she
 19 is responsible for overall?
 20 DR. HOWELL:
 21 A. Well, her area would be responsible for the
 22 framework and she chairs the regional quality
 23 committee that we all feed into.
 24 CHAYTOR, Q.C.:
 25 Q. Okay.

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1 DR. HOWELL:
 2 A. So I would have and am evolving a quality
 3 portfolio committee for those areas that I
 4 have responsibility for and we would meet on a
 5 monthly basis and have our own initiatives
 6 that would then feed into the regional quality
 7 committee.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, okay. And my question then in terms of
 10 the medical, meaning the physicians, and of
 11 course, everyone understands everyone has
 12 individual accountability and responsibility,
 13 but ultimately in terms of overseeing that,
 14 who is responsible for the quality of medical
 15 services at Eastern Health?
 16 DR. HOWELL:
 17 A. From a structure point of view it would be the
 18 medical advisory committee.
 19 CHAYTOR, Q.C.:
 20 Q. Okay.
 21 DR. HOWELL:
 22 A. And the medical advisory committee consists of
 23 the discipline chairs and the clinical chiefs,
 24 several chief operating officers and some
 25 directors.

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

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1 involved, the actual infection control
 2 actually resides within the quality portfolio.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So -
 5 DR. HOWELL:
 6 A. So I would not have primary responsibility for
 7 infection control.
 8 CHAYTOR, Q.C.:
 9 Q. And you are not the medical director of
 10 infection control, that's somebody else?
 11 DR. HOWELL:
 12 A. That is somebody else, that's correct.
 13 CHAYTOR, Q.C.:
 14 Q. And that person reports to you, but -
 15 DR. HOWELL:
 16 A. That is correct.
 17 CHAYTOR, Q.C.:
 18 Q. - infection control is under Ms. Pilgrim's
 19 portfolio?
 20 DR. HOWELL:
 21 A. That's correct.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. What does it mean then to be the person
 24 responsible for laboratory services?
 25 DR. HOWELL:

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1 A. It means that I have the executive
 2 responsibility for that and I sit and chair
 3 the laboratory services leadership team.
 4 CHAYTOR, Q.C.:
 5 Q. So perhaps it would be helpful to the
 6 Commissioner if you could tell the
 7 Commissioner on a day-to-day practical basis
 8 what does it mean to hold the position that
 9 you hold within Eastern Health? And in
 10 particular, obviously, with respect to
 11 laboratory services and being VP medical in
 12 terms of how it interacts with the physicians
 13 within the organization?
 14 DR. HOWELL:
 15 A. Um-hm. How best to explain that? If we look
 16 at laboratory services specifically, I would
 17 not be involved in the day-to-day operations
 18 of the laboratory. I wouldn't have the
 19 knowledge or the skill set to do that, in any
 20 case. I would meet with that group, the
 21 clinical chief for laboratory medicine, the
 22 program director and now the discipline chair,
 23 for some time that position was not filled,
 24 and I would meet with those individuals on a
 25 monthly basis and review a number of issues

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1 that are going on within that particular area
 2 of the organization. And as you'll see in the
 3 minutes of those meetings, many things are
 4 discussed that range from financial to
 5 staffing issues, to capital equipment,
 6 infrastructure issues. It would be the gamut
 7 of trying to operate and provide a laboratory
 8 service throughout the region. And part of
 9 the evolution of this that's a major challenge
 10 is it is throughout the region, it's not just
 11 St. John's.
 12 CHAYTOR, Q.C.:
 13 Q. Yes, okay. And in terms of your, you
 14 mentioned in giving us your background that
 15 you do have some background in management.
 16 What exactly do you have in terms of medical
 17 management and do you have any experience in
 18 health administration?
 19 DR. HOWELL:
 20 A. I have no formal business training whatsoever.
 21 CHAYTOR, Q.C.:
 22 Q. And so what is your practical experience?
 23 DR. HOWELL:
 24 A. My practical experience would evolve from
 25 managing small medical clinics or being the

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1 primary person for running those throughout my
 2 career, which there have been three or four,
 3 to having two companies providing occupational
 4 health services and then sitting on the senior
 5 leadership of this large corporate client
 6 which allowed me to participate in things,
 7 training in change management, very involved
 8 in the human resource side of operating a
 9 large enterprise.
 10 CHAYTOR, Q.C.:
 11 Q. So it's not the first time that people have
 12 reported to you?
 13 DR. HOWELL:
 14 A. That's correct.
 15 CHAYTOR, Q.C.:
 16 Q. And how many people report to you at Eastern
 17 Health, around how many?
 18 DR. HOWELL:
 19 A. In the lab I think there are about 450 people.
 20 CHAYTOR, Q.C.:
 21 Q. Which would ultimately come up the chain to
 22 report to you?
 23 DR. HOWELL:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. They don't report directly, I take it?
 2 DR. HOWELL:
 3 A. They don't report directly.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. And who reports directly to you within
 6 the lab?
 7 DR. HOWELL:
 8 A. Within the lab it would be the program
 9 director, Mr. Gulliver, and the clinical
 10 chief, Dr. Denic, and now the new position,
 11 Ms. Wade, as the quality and safety manager.
 12 CHAYTOR, Q.C.:
 13 Q. That's Lynn Wade?
 14 DR. HOWELL:
 15 A. That's correct.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. And who do you report to?
 18 DR. HOWELL:
 19 A. I report to the CEO.
 20 CHAYTOR, Q.C.:
 21 Q. Which is Louise Jones right now?
 22 DR. HOWELL:
 23 A. That's correct.
 24 CHAYTOR, Q.C.:
 25 Q. And when you began, that was Mr. Tilley?

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1 DR. HOWELL:
 2 A. That's correct.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. In terms of the reporting structure
 5 within the lab, perhaps you can tell us when
 6 you began, what was the reporting structure
 7 and whether or not you have implemented any
 8 change to that?
 9 DR. HOWELL:
 10 A. Well, when I arrived there, there were, really
 11 it was a program-based structure, which I
 12 understand came forward from the Health Care
 13 Corporation of St. John's, and that is that
 14 there was a dual leadership position with the
 15 program director and the clinical chief, and
 16 that existed in the laboratory program when I
 17 arrived.
 18 CHAYTOR, Q.C.:
 19 Q. And that's currently the situation?
 20 DR. HOWELL:
 21 A. That is not the situation now.
 22 CHAYTOR, Q.C.:
 23 Q. Not the situation, no, sorry. What is--I'm
 24 sorry, what is the current situation?
 25 DR. HOWELL:

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1 A. So now the change that we have implemented is
 2 that we have moved away from a program
 3 management approach in the laboratory to Dr.
 4 Denic now has become the chief of laboratory
 5 medicine and has the authority, responsibility
 6 and accountability to run the entire
 7 laboratory program.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So but Mr. Gulliver still reports up to
 10 you?
 11 DR. HOWELL:
 12 A. The way--this is an evolving process.
 13 Remembering I've been in this position 18 or
 14 19 months and so trying to get a feel for this
 15 and get advice from various areas and look at
 16 other jurisdictions, we're slowly moving into
 17 some change here, and Dr. Denic and I have had
 18 many discussions as we try to evolve this.
 19 And so the way we've currently set it up is
 20 that he has, Mr. Gulliver reports to him. And
 21 I think about it this way, that ultimately my
 22 goals was let's focus on the product that the
 23 laboratory delivers. And I need somebody who
 24 has the expertise to be the final arbiter of
 25 that product. And so Mr. Gulliver now reports

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1 to him, but I have retained a partial
 2 reporting relationship for Mr. Gulliver to me
 3 in terms of some of the administrative issues
 4 around staffing and budget and those sorts of
 5 things. I could not layer that on Dr. Denic
 6 at this point in time. And Dr. Denic wishes
 7 to retain some clinical work and we need him
 8 to retain some clinical work under our current
 9 situation, and so that is the agreement that
 10 we have at this point.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So before when Dr. Williams was in the
 13 position, it was a program-based structure
 14 where both Mr. Gulliver and the clinical chief
 15 reported directly on all matters up to Dr.
 16 Williams whereas now Mr. Gulliver only reports
 17 to you on administrative matters?
 18 DR. HOWELL:
 19 A. Right.
 20 CHAYTOR, Q.C.:
 21 Q. And--okay. And everything else in terms of
 22 the services provided within the lab, Mr.
 23 Gulliver now reports to Dr. Denic, who in turn
 24 reports to you?
 25 DR. HOWELL:

Page 25

1 A. Right. So there was a division, if you like,
 2 between the technical side and the physician
 3 professional side. And the clinical chief had
 4 the physician professional side and the
 5 program director had the technical side and
 6 the administrative side.
 7 CHAYTOR, Q.C.:
 8 Q. Yes. And I believe that's common for many
 9 areas throughout Eastern Health's program-
 10 based structure?
 11 DR. HOWELL:
 12 A. That is correct.
 13 CHAYTOR, Q.C.:
 14 Q. And, for example, you're also responsible for
 15 diagnostic imaging. Is there a program-based
 16 structure still in place for diagnostic
 17 imaging?
 18 DR. HOWELL:
 19 A. There is.
 20 CHAYTOR, Q.C.:
 21 Q. What was the concern then in terms of the
 22 laboratory medicine service, why was that
 23 changed?
 24 DR. HOWELL:
 25 A. It's difficult for me to answer that clearly.

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1 I think the--I still struggle a little bit
 2 with the whole program management piece and I
 3 was not around when those decisions were made
 4 and why it was decided to go with that
 5 structure. And I think those that were there
 6 fundamentally felt that was a strong structure
 7 where a more cooperative approach to running
 8 the -
 9 CHAYTOR, Q.C.:
 10 Q. And my question is not so much why program-
 11 based, it's why has the decision been made to
 12 do other than program-based for laboratory
 13 medicine?
 14 DR. HOWELL:
 15 A. Because we're going to focus on the product we
 16 deliver and part of that is exactly the reason
 17 that we're here today, is to look at doing
 18 things better and maybe that will make it
 19 better.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. So you came to the determination that
 22 this would obviously be a better way to manage
 23 the laboratory medicine service. And so what
 24 are the advantages, what is it you're trying
 25 to achieve?

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1 DR. HOWELL:
 2 A. And I didn't come to that decision just me, as
 3 -
 4 CHAYTOR, Q.C.:
 5 Q. No, I understand that it may have been in the
 6 works, in fact, before you arrived?
 7 DR. HOWELL:
 8 A. Yes. In fact, Dr. Williams had discussed that
 9 with me several times, that perhaps that was
 10 something to look at and a direction that we
 11 should be going. But intuitively I,
 12 conceptually I just felt that one person who
 13 had the knowledge and had the authority worked
 14 better in my mind. The accountability fit
 15 better for me.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. Well, then, just let me explore that a
 18 bit with you. What is it about the
 19 accountability that didn't fit so well for you
 20 under the old structure?
 21 DR. HOWELL:
 22 A. I guess as I--my own thought processes and as
 23 I chatted with people and I'm trying to
 24 understand how this operation works, people
 25 worked within their own camp, like, this is my

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

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1 point. So in the case of a technologist, that
 2 yes, you do your piece that you then are going
 3 to give to the pathologist so that they can do
 4 the interpretation, and I want you to be a
 5 team, and I want you to focus on that end
 6 product.
 7 CHAYTOR, Q.C.:
 8 Q. And there was a sense that that wasn't
 9 necessarily the focus prior to then?
 10 DR. HOWELL:
 11 A. Well, again, if I looked at the structure, it
 12 seemed like a separation that wasn't natural
 13 to me, and in discussions with Dr. Williams,
 14 he seemed to have the feeling too, and he'd
 15 been there a long period of time, and so it
 16 seemed like a natural way to go.
 17 CHAYTOR, Q.C.:
 18 Q. Is there any understanding between you and
 19 clinical chief as to whether it's an oral
 20 understanding or anything in writing as to
 21 what matters have to be brought to your
 22 attention?
 23 DR. HOWELL:
 24 A. No, there isn't anything in writing. I think
 25 they understand that it's their job to operate

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1 the laboratory medicine program. They meet
 2 with me on a monthly basis. We talk about the
 3 various issues and my role is if there are
 4 barriers or they're running into problems,
 5 that they would bring those to me and we
 6 would--my job would be to work with them to
 7 try to resolve those difficulties?
 8 CHAYTOR, Q.C.:
 9 Q. And what kinds of issues are brought to your
 10 attention at those monthly meetings?
 11 DR. HOWELL:
 12 A. The range could be that we are over budget,
 13 why is that? It could be that we want to
 14 purchase a new piece of equipment. How do we
 15 justify, how do we build a business case for
 16 that piece of equipment? It could be issues
 17 around recruiting and staffing. You know,
 18 those would be typical issues in trying to run
 19 a large department.
 20 CHAYTOR, Q.C.:
 21 Q. And of course, we've seen some of the minutes
 22 from those meetings. Is that something new or
 23 were those monthly meetings held during Dr.
 24 Williams' time with the organization?
 25 DR. HOWELL:

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1 A. I can't--I believe those were an ongoing
 2 process. I think, as I reflected back in
 3 preparation for this, the first meeting I
 4 attended was September the 15th, I think, and
 5 I'd only been in the job nine days at that
 6 point. So I think that was an automatic thing
 7 in the calendar on a monthly basis.
 8 CHAYTOR, Q.C.:
 9 Q. And how far back it dates, you're not sure,
 10 but it's certainly something you've continued?
 11 DR. HOWELL:
 12 A. That's correct.
 13 CHAYTOR, Q.C.:
 14 Q. And you meet pretty regularly in terms of your
 15 monthly meeting?
 16 DR. HOWELL:
 17 A. That's correct.
 18 CHAYTOR, Q.C.:
 19 Q. Do issues such as any difficulties in terms of
 20 the provision of the service, do issues of
 21 that nature come to your attention in those
 22 meetings?
 23 DR. HOWELL:
 24 A. Oh yes, absolutely.
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and I take it the ER/PR issue has been
 2 the subject of discussion?
 3 DR. HOWELL:
 4 A. That's correct.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, and we know that back in 2003 or we know
 7 now, back in 2003, there was an interruption
 8 in the IHC service by Dr. Ejeckam for a period
 9 of some weeks. Given the types of issues that
 10 are discussed in your monthly meetings, would
 11 you expect that that kind of issue, should it
 12 arise today, would be brought forward through
 13 your monthly meeting?
 14 DR. HOWELL:
 15 A. That would be my expectation.
 16 CHAYTOR, Q.C.:
 17 Q. When you began, Dr. Denic, you told us, is
 18 currently the clinical chief. Was Dr. Cook
 19 still the clinic chief when you began,
 20 clinical chief?
 21 DR. HOWELL:
 22 A. No. Dr. Cook had resigned and Dr. Denic had
 23 become the interim clinical chief.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, and who is the discipline chief?

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1 DR. HOWELL:
 2 A. Dr. Avis, and that is a more recent
 3 appointment.
 4 CHAYTOR, Q.C.:
 5 Q. And how long has that been?
 6 DR. HOWELL:
 7 A. I'm not sure. It would be within a year.
 8 CHAYTOR, Q.C.:
 9 Q. And does Dr. Avis then also report to you?
 10 DR. HOWELL:
 11 A. He does not.
 12 CHAYTOR, Q.C.:
 13 Q. He does not. Who does he report to?
 14 DR. HOWELL:
 15 A. He would report to the Dean of Medicine.
 16 Well, Dr. Avis, I guess, has two roles, as a
 17 discipline chair and as the chief coroner.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. If we could look at the--actually, I
 20 can just do it, the second page of P-0044, and
 21 again this is dated back November 2006, and
 22 this shows the organizational structure,
 23 management, laboratory medicine program,
 24 Eastern Health, and Terry Gulliver, and I
 25 don't know if you can read that, Doctor, but

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1 it then has regional divisional managers
 2 listed, and site managers.
 3 DR. HOWELL:
 4 A. Um-hm.
 5 CHAYTOR, Q.C.:
 6 Q. Is this still the current structure?
 7 DR. HOWELL:
 8 A. The names have changed and moved around, but
 9 this structure is largely still in place,
 10 that's correct.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So this would show that there are
 13 different regional managers for the different
 14 divisions within the lab, such as
 15 biochemistry, hematology, microbiology,
 16 pathology, which would be the division that
 17 we're mostly focused on here, cytology, and
 18 then there's a regional manager for client
 19 services.
 20 DR. HOWELL:
 21 A. Um-hm.
 22 CHAYTOR, Q.C.:
 23 Q. And that's Lynn Wade?
 24 DR. HOWELL:
 25 A. Not now.

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1 CHAYTOR, Q.C.:
 2 Q. Not now, no.
 3 DR. HOWELL:
 4 A. There is a new manager there.
 5 CHAYTOR, Q.C.:
 6 Q. She's in a new quality -
 7 DR. HOWELL:
 8 A. And safety.
 9 CHAYTOR, Q.C.:
 10 Q. - portfolio, right. And then a regional
 11 manager for immunology and genetics, site
 12 manager for the Avalon region, okay, and where
 13 would that be? What areas does that
 14 encompass?
 15 DR. HOWELL:
 16 A. That would be Carbonear.
 17 CHAYTOR, Q.C.:
 18 Q. Carbonear, and site manager for Clarendville
 19 and Bonavista, and site manager as well as
 20 infection control for Burin.
 21 DR. HOWELL:
 22 A. Um-hm.
 23 CHAYTOR, Q.C.:
 24 Q. And then a provincial coordinator for blood
 25 utilization and biochemists, and so all of

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1 these people report up to Terry Gulliver?
 2 DR. HOWELL:
 3 A. Correct.
 4 CHAYTOR, Q.C.:
 5 Q. Who now would report to Dr. Denic on those
 6 issues?
 7 DR. HOWELL:
 8 A. Correct.
 9 CHAYTOR, Q.C.:
 10 Q. So the piece that's missing from this flow
 11 chart doesn't show above Terry Gulliver now
 12 would go to Dr. Denic, and then on to you?
 13 DR. HOWELL:
 14 A. Correct.
 15 CHAYTOR, Q.C.:
 16 Q. Okay.
 17 THE COMMISSIONER:
 18 Q. Depending on what it relates to.
 19 CHAYTOR, Q.C.:
 20 Q. Yes. Yes, if it's administrative issues
 21 arising, we understand it would go from Terry
 22 Gulliver directly to you?
 23 DR. HOWELL:
 24 A. At this point in time, yes.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. But anything to do with the provision
 2 of services or quality of services within
 3 those divisions would go through Dr. Denic
 4 before arriving on your desk?
 5 DR. HOWELL:
 6 A. That's correct, for clinical issues.
 7 CHAYTOR, Q.C.:
 8 Q. For clinical issues, okay, and so this is
 9 true, this structure is true throughout the
 10 entire region? It's not just the St. John's
 11 hospitals?
 12 DR. HOWELL:
 13 A. That's correct, although that--you know, that
 14 integration of the whole organization is
 15 continuing and, you know, many days remains a
 16 challenge, but these regional managers for
 17 each of these divisions had in fact happened
 18 prior to my arriving there. The physician
 19 piece of--we have two pathologists in
 20 Clarenville and one pathologist in Carbonear.
 21 It would be very recently that I talked to
 22 them about Dr. Denic assuming that role and
 23 having responsibility there and, for example,
 24 Dr. Denic and I have been trying to find the
 25 opportunity to go out and sit down with those

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1 individuals to see how we're going to work
 2 together and make that work better.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So if we just look at P-0044, page two,
 5 this is your technical staff. So currently,
 6 do I understand all the technical staff
 7 throughout the region, including Clarenville
 8 and Carbonear, all report up through Terry
 9 Gulliver?
 10 DR. HOWELL:
 11 A. Right.
 12 CHAYTOR, Q.C.:
 13 Q. And that's been in place for quite some time?
 14 DR. HOWELL:
 15 A. Right.
 16 CHAYTOR, Q.C.:
 17 Q. In fact, this is done back in November 2006?
 18 DR. HOWELL:
 19 A. Right.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. But what you're telling us is that with
 22 respect to the pathologists, there still
 23 hasn't been full integration across the
 24 region?
 25 DR. HOWELL:

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1 A. No. If you were to go out and speak to the
 2 pathologist in Carbonear, for example, Dr.
 3 Baker, he is the clinical chief for rural
 4 Avalon as well. So most of the clinical
 5 chiefs are program based in St. John's, but
 6 there are three clinical chiefs who are
 7 regionally based. They're more geographic in
 8 nature. That would be Dr. Baker in rural
 9 Avalon, Dr. Arthur in Burin/Grand Bank, and
 10 Dr. Beamont in Clarenville/Bonavista.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So what I'm wondering then is if I were
 13 to go and ask Dr. Baker "who do you report
 14 to?" what would he tell me?
 15 DR. HOWELL:
 16 A. Dr. Baker would probably--well, he would
 17 probably say he reports to me.
 18 CHAYTOR, Q.C.:
 19 Q. Directly?
 20 DR. HOWELL:
 21 A. That would be his clinical chief role.
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 DR. HOWELL:
 25 A. I think, and I hope now, that he would say

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1 that he reports to Dr. Denic for his
 2 pathology, but that is -
 3 CHAYTOR, Q.C.:
 4 Q. And that's very recent, that's just -
 5 DR. HOWELL:
 6 A. That is very recent.
 7 CHAYTOR, Q.C.:
 8 Q. Yes, and recent since you and I last had a
 9 discussion?
 10 DR. HOWELL:
 11 A. That is correct.
 12 CHAYTOR, Q.C.:
 13 Q. Yes, and that's true, I take it, of
 14 Clarenville as well? Would they now also say
 15 in terms of their clinical work as a
 16 pathologist, we report to Dr. Denic, but in
 17 terms of my role as otherwise, clinical chief
 18 or otherwise, we report to Dr. Howell?
 19 DR. HOWELL:
 20 A. Well, the two pathologists in Clarenville
 21 would likely say that they report to Dr.
 22 Beamont, who's the clinical chief there. We
 23 would -
 24 CHAYTOR, Q.C.:
 25 Q. So not Dr. Denic?

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

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1 CHAYTOR, Q.C.:
 2 Q. Dr. Baker, you believe, is now moved to that
 3 point?
 4 DR. HOWELL:
 5 A. I think he would understand that.
 6 CHAYTOR, Q.C.:
 7 Q. And the pathologists in Clarenville, there's
 8 still a clinical chief in Clarenville and the
 9 pathologists report to that clinical chief?
 10 DR. HOWELL:
 11 A. But they have been told that we are changing
 12 the structure and that Dr. Denic's role is a
 13 regional role. What we have not had the
 14 opportunity to do is to sit down and work
 15 together as to how best to make that work for
 16 all parties.
 17 CHAYTOR, Q.C.:
 18 Q. And Dr. Howell, it's three years into Eastern
 19 Health, and I understand there's been
 20 struggles along the way. It's happened though
 21 for the technical side of laboratory medicine
 22 program. What has been the difficulties in
 23 reaching that point from the medical staff
 24 point of view?
 25 DR. HOWELL:

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

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1 efficiently and accurately, does he have any
 2 authority to tell Clarenville "this is the way
 3 we're going to report"?
 4 DR. HOWELL:
 5 A. He has that authority.
 6 CHAYTOR, Q.C.:
 7 Q. He has that authority?
 8 DR. HOWELL:
 9 A. He does.
 10 CHAYTOR, Q.C.:
 11 Q. And since when did he--did that stage, when
 12 was that reached?
 13 DR. HOWELL:
 14 A. Functionally, he assumed that role in December
 15 2007, but from the point of view of an
 16 announcement through the organization, that
 17 would have been within the last several
 18 months.
 19 CHAYTOR, Q.C.:
 20 Q. So what is it that he wouldn't be able to give
 21 direction on?
 22 DR. HOWELL:
 23 A. Well, he could, from a clinical matter, he now
 24 has the authority to give direction on all
 25 matters related to laboratory medicine. But,

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1 that is not the way in which we would do it.
 2 We would--leadership is not about as much
 3 command as influence.
 4 CHAYTOR, Q.C.:
 5 Q. Yes, and I wasn't suggesting that. I'm just
 6 wondering what it is then that--how he's not
 7 perceived to be the clinical chief or the
 8 person that's being reported to, what is it
 9 that there would be a reluctance to either
 10 report to Dr. Denic on or for Dr. Denic to be
 11 able to give direction? And when I say
 12 direction, I don't--I'm not saying command,
 13 I'm saying direction.
 14 DR. HOWELL:
 15 A. Yeah. I'm not sure that there is a
 16 reluctance. It's that, you know, Peninsulas
 17 was its own entity at one time, and I think if
 18 you were to talk to the medical staff out
 19 there, they would prefer it remained one
 20 entity.
 21 CHAYTOR, Q.C.:
 22 Q. Yes.
 23 DR. HOWELL:
 24 A. But it hasn't, and so that integration takes a
 25 period of time and these are professional

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1 people who have their own views of how the
 2 world should operate and we're working our way
 3 through getting them together as a team.
 4 CHAYTOR, Q.C.:
 5 Q. So are you telling me that in reality, Dr.
 6 Denic is the person who has the ultimate
 7 authority, in reality, but obviously everyone
 8 is being diplomatic in terms of how he would
 9 exert that authority?
 10 DR. HOWELL:
 11 A. That is correct. He is assuming the mantle of
 12 leadership. He has many, many things coming
 13 at him, and St. John's is where he resides and
 14 where most of the work is, and I guess he's
 15 really involved in that with me, more than
 16 anywhere else, and gradually we're trying to
 17 step that out into the region, the rest of the
 18 region.
 19 CHAYTOR, Q.C.:
 20 Q. Okay.
 21 THE COMMISSIONER:
 22 Q. Ms. Chaytor, just something crossed my mind,
 23 so I'd like to deal with it now, just in terms
 24 of the regions. As I understood what you were
 25 saying is that the change that has been

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1 implemented since you arrived at the
 2 organization is one that was done on the basis
 3 of your view, which is shared by others, that
 4 the most effective way of building a team
 5 approach and assuring that everybody, from the
 6 technology side and the clinical side, keeps
 7 the view of the person whom you're serving,
 8 essentially the patient, in mind when you're
 9 doing your individual little jobs caused you
 10 to make this change so that, as I see it, what
 11 you're saying is you want to make sure that
 12 both groups are seen as the team and that you
 13 both have the same objective and that you're
 14 very cooperative in the way you go forward.
 15 And then you started talking about the outside
 16 groups, and I'm wondering whether if somebody
 17 in Burin is going to feel that they are part
 18 of a team if really the team resides in St.
 19 John's, in the sense of if the structure
 20 through which they report is in St. John's,
 21 how do you build the team in Burin?
 22 DR. HOWELL:
 23 A. Commissioner, that's why I alluded to the fact
 24 that if you were--as I talk to people, I get
 25 the impression, as I go outside St. John's,

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1 that they feel like they've lost more than
 2 they've gained, and for many years, we've all
 3 heard and talked about the overpass syndrome
 4 and I think there's always reluctance that St.
 5 John's would dictate to the region. So I
 6 remember having this discussion with Mr.
 7 Tilley in the past and him telling me that it
 8 took seven or eight years for the Health Care
 9 Corporation of St. John's to finally start to
 10 come together as an organization where people
 11 felt part of that organization.
 12 THE COMMISSIONER:
 13 Q. Well, I understand that that's a problem, but
 14 it--now, perhaps I'm not understanding how
 15 your team is going to work and that's why I'm
 16 asking this question. Because it seems to me
 17 that what--if you're talking about a team,
 18 it's the team in the lab, the people who are
 19 actually doing what they do every day, to some
 20 extent, side by side, perhaps in separate
 21 rooms on some occasions, but each of them has
 22 a role to play in respect to the end product
 23 which goes out to other physicians in terms of
 24 either diagnosis or whatever, and what you are
 25 describing to me is an effort to build that

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

12 DR. HOWELL:
 13 A. It all -

14 THE COMMISSIONER:
 15 Q. Should you have a mini team, if you will, is
 16 what I'm saying, in Burin?

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

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

13 CHAYTOR, Q.C.:
 14 Q. So the Laboratory Medicine program's
 15 leadership team, does that include the
 16 clinical chief in Carbonear?

17 DR. HOWELL:
 18 A. No.

19 CHAYTOR, Q.C.:
 20 Q. Who comprises the leadership team?

21 DR. HOWELL:
 22 A. For laboratory?

23 CHAYTOR, Q.C.:
 24 Q. Yes.

25 DR. HOWELL:

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

4 CHAYTOR, Q.C.:
 5 Q. Okay, and you're all obviously here in St.
 6 John's?

7 DR. HOWELL:
 8 A. That is correct.

9 CHAYTOR, Q.C.:
 10 Q. And has there been any consideration to
 11 perhaps building that bridge by including
 12 others from outside St. John's on the
 13 leadership team?

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

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

10 CHAYTOR, Q.C.:
 11 Q. Okay. Is there an updated organizational
 12 chart for the Laboratory Medicine Program?

13 DR. HOWELL:
 14 A. It is still a work-in-progress, but there is a
 15 document, yes, that's correct.

16 CHAYTOR, Q.C.:
 17 Q. But it's draft?

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

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

14 CHAYTOR, Q.C.:

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

17 DR. HOWELL:

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

25 CHAYTOR, Q.C.:

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

3 DR. HOWELL:

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

13 CHAYTOR, Q.C.:

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

18 DR. HOWELL:

19 A. Uh-hm.

20 CHAYTOR, Q.C.:

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

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

4 DR. HOWELL:

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

7 CHAYTOR, Q.C.:

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

11 DR. HOWELL:

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

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

24 CHAYTOR, Q.C.:

25 Q. So it was for everybody across the

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

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

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1 CHAYTOR, Q.C.:
 2 Q. So have you ever become aware or been advised
 3 of any discord between the technical staff and
 4 the clinical staff or any members of the
 5 staff?
 6 DR. HOWELL:
 7 A. Well, you know, certainly as time has
 8 progressed and as we have gotten into the
 9 ER/PR issue and the level of stress and
 10 anxiety is increased, one can see the, you
 11 know, that those strong opinions come forward
 12 and I've heard more about that a technologist
 13 might feel that they haven't received enough
 14 feedback from a pathologist or that the
 15 pathologist haven't been appropriately
 16 understanding and those are just general
 17 comments. I mean, in terms of anything
 18 formal, I haven't had that.
 19 CHAYTOR, Q.C.:
 20 Q. And those issues have come up in the context
 21 of the ER/PR issue?
 22 DR. HOWELL:
 23 A. It has heightened with that, it has become
 24 more evident that there's tension there.
 25 CHAYTOR, Q.C.:

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

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1 and that he had that relationship with those
 2 individuals. Then I had to get a feel for how
 3 the technologists were going to feel with this
 4 happening, so I gently introduced that idea
 5 with Mr. Gulliver and saw what the reaction
 6 was and I didn't get any, you know, bad vibes
 7 or -
 8 CHAYTOR, Q.C.:
 9 Q. So he was receptive to this change in the
 10 reporting structure?
 11 DR. HOWELL:
 12 A. He was receptive, but he wanted to understand
 13 it more for Dr. Denic, as an individual. And
 14 then I remember I decided I would try it on
 15 Lynn Wade and I had a discussion with Lynn
 16 that I was thinking about making this change
 17 and how did she feel that would go over with
 18 the technologist side. And I had great
 19 respect for Lynn's knowledge of the laboratory
 20 and the people and I felt she was well
 21 respected within that group. So that I got
 22 positive view from her and I thought, okay,
 23 this is the way to go and then I had my
 24 discussion with Dr. Denic and we talked about
 25 the need to build team, and from there, after

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1 some discussion, not a lot of arm twisting, he
 2 assumed the role.
 3 CHAYTOR, Q.C.:
 4 Q. And were the technologists also receptive to
 5 the change in structure?
 6 DR. HOWELL:
 7 A. To the best of my knowledge, that's correct.
 8 CHAYTOR, Q.C.:
 9 Q. And who would have discussed that with them?
 10 DR. HOWELL:
 11 A. That got away from me a little bit, in that I
 12 had planned to meet with the managers, all the
 13 division managers and talk to them about this
 14 change. Unfortunately, I think I got called
 15 away for some other major issue and Mr.
 16 Gulliver ended up meeting with the
 17 technologists--with the division managers and
 18 advising them of this.
 19 CHAYTOR, Q.C.:
 20 Q. And he reported back to you that they were
 21 receptive?
 22 DR. HOWELL:
 23 A. He did.
 24 CHAYTOR, Q.C.:
 25 Q. And that included the divisional managers

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1 across the region?
 2 DR. HOWELL:
 3 A. That's correct.
 4 CHAYTOR, Q.C.:
 5 Q. Including outside of St. John's?
 6 DR. HOWELL:
 7 A. That's correct, that was my understanding.
 8 CHAYTOR, Q.C.:
 9 Q. And this, then the actual formal change came
 10 into effect when?
 11 DR. HOWELL:
 12 A. The, I think functionally Dr. Denic assumed
 13 it, I think December 2007 and as I say, he was
 14 evolving into that role, but no major
 15 announcement went out until, I'm not sure of
 16 the date, it might be March, April, it was not
 17 that long ago.
 18 CHAYTOR, Q.C.:
 19 Q. Perhaps we could have a copy of the draft new
 20 organizational chart that you referred to. I
 21 understand that it's in draft, but if we could
 22 have a copy of that.
 23 DR. HOWELL:
 24 A. You certainly can, I have it with me.
 25 CHAYTOR, Q.C.:

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1 Q. Thank you, that would be great. And that, I
 2 take it, would be what has been in place then
 3 since December of 2007?
 4 DR. HOWELL:
 5 A. Yes, understanding that it is an evolving
 6 process.
 7 CHAYTOR, Q.C.:
 8 Q. In terms of -
 9 DR. HOWELL:
 10 A. Like really the only major changes happened is
 11 Dr. Denic in that role.
 12 CHAYTOR, Q.C.:
 13 Q. Right.
 14 DR. HOWELL:
 15 A. And Ms. Wade reporting to me, those are the
 16 two major pieces here with the charge to Dr.
 17 Denic and Mr. Gulliver, that let's look
 18 throughout the rest and see if there's changes
 19 that should be made. If they don't need to be
 20 made, if we're working fine, we'll leave that;
 21 if there are changes--and part of that
 22 decision will be made with Dr. Denic and
 23 myself and perhaps others, visiting some other
 24 key laboratories in this country and talking
 25 to those people.

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1 CHAYTOR, Q.C.:

2 Q. But right now there aren't any other changes

3 on the horizon?

4 DR. HOWELL:

5 A. That's correct.

6 CHAYTOR, Q.C.:

7 Q. The monthly meetings that you hold, is that--

8 is that just the leadership team?

9 DR. HOWELL:

10 A. That's the leadership team.

11 CHAYTOR, Q.C.:

12 Q. Here in St. John's?

13 DR. HOWELL:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. Do you also hold any regular meetings with the

17 people outside of St. John's, with Burin,

18 Clarenville, Carbonear?

19 DR. HOWELL:

20 A. With the laboratory people you're referring

21 to?

22 CHAYTOR, Q.C.:

23 Q. Well, yes, with your clinical chiefs there,

24 like how and when do you interact with them?

25 DR. HOWELL:

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1 A. I have a monthly phone call with the clinical

2 chiefs outside of St. John's and I try to

3 visit one of the other MACs at least once a

4 quarter and I would like to make that every

5 second month. I did not have a medical

6 director for a goodly part of this time and

7 so, until I fill that position, time just was

8 at a premium, but as I explained, I do have a

9 quarterly meeting with each of the clinical

10 chiefs. I bring them together as a group with

11 some of the other key clinical leaders and the

12 program directors for pharmacy, diagnostic

13 imaging and laboratory on a quarterly basis to

14 talk about common issues for the region.

15 CHAYTOR, Q.C.:

16 Q. And so the current structure then, in terms of

17 reporting up to Dr. Denic as clinical chief

18 and we talked about this early this morning

19 where you're saying that the person who is

20 actually doing the work at the bench, the

21 technologists, understanding at the end of the

22 day the piece that that plays in terms of

23 ultimate, the patient care and so from the

24 accountability point of view, the technologist

25 is reporting up to the pathologist and in

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1 terms of accountability for the quality of

2 service, then I guess the clinical chief has

3 direction or is able to give direction

4 directly back to the person performing the

5 work, so that they can be more assured that

6 the quality is there that they need to see, is

7 that what you're hoping to achieve?

8 DR. HOWELL:

9 A. The person on the bench would report to their

10 manager.

11 CHAYTOR, Q.C.:

12 Q. Yes, but they ultimately report up to the

13 clinical chief?

14 DR. HOWELL:

15 A. They would now report, at the end of that

16 pyramid would be Dr. Denic, correct.

17 CHAYTOR, Q.C.:

18 Q. Yes. And so the purpose being and

19 understanding what you said from the

20 accountability point of view for the

21 technologists to gain or, I don't know if it's

22 gain, but to have more insight and

23 understanding into ultimately the end product

24 that's trying to be achieved and the purpose

25 for that. How does it work the other way?

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1 What, how does it work from Dr. Denic's point

2 of view in terms of assuring him of his

3 ability to play what his role in the whole

4 triangular piece?

5 DR. HOWELL:

6 A. I'm not sure what you're getting at there. I

7 mean -

8 CHAYTOR, Q.C.:

9 Q. So in terms of the, ultimately in terms of the

10 quality and the service, it's now coming up to

11 Dr. Denic as clinical chief -

12 DR. HOWELL:

13 A. Right.

14 CHAYTOR, Q.C.:

15 Q. And he's accountable for the product that's

16 coming out of the lab.

17 DR. HOWELL:

18 A. Right.

19 CHAYTOR, Q.C.:

20 Q. And that's the way it works now.

21 DR. HOWELL:

22 A. Right.

23 CHAYTOR, Q.C.:

24 Q. And so how does this work in terms of what

25 advantage is it to Dr. Denic? How would he

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1 perceive that as being advantageous? And
 2 maybe it's self-explanatory?
 3 DR. HOWELL:
 4 A. I mean, he would understand that he has the
 5 authority to make change where it needs to be
 6 made and as we build the key indicators for
 7 the laboratory, that's going to help him
 8 understand what's going on in his laboratory
 9 and will help build the arguments that we need
 10 to continue to develop the laboratory.
 11 CHAYTOR, Q.C.:
 12 Q. Yes, okay; whereas before, if we just do the
 13 comparison, before then he would be--he would
 14 only sit on the clinical side and the
 15 technologists would be reporting up to Mr.
 16 Gulliver.
 17 DR. HOWELL:
 18 A. Right.
 19 CHAYTOR, Q.C.:
 20 Q. And the technologists would not necessarily
 21 have to take direction from the pathologists
 22 who might want to have the services performed
 23 in a different way?
 24 DR. HOWELL:
 25 A. Right, right.

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1 CHAYTOR, Q.C.:
 2 Q. That's the main aim, I take it?
 3 DR. HOWELL:
 4 A. I'd like to just make one analogy and I may be
 5 wasting the Commissioner's time, but I
 6 remember when we were--as I start to try to
 7 understand the quality framework and things,
 8 and I'm trying to see how we're going to shift
 9 this culture to and what that culture would
 10 look like and be defined, and the simplest way
 11 that I could define it for myself was I would
 12 love to have a day when I walked up to one of
 13 our domestic workers who was sweeping the
 14 floor and I asked him what he did or she did,
 15 and if they would look at me and say "I look
 16 after patients" I would feel we have arrived.
 17 CHAYTOR, Q.C.:
 18 Q. Uh-hm.
 19 DR. HOWELL:
 20 A. So if you take that into the laboratory piece,
 21 then I want everybody to focus on the end
 22 product that we put out to the physician who
 23 is going to treat the patient.
 24 CHAYTOR, Q.C.:
 25 Q. Yes. Perhaps if we could look then at P-0046,

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1 page 5? Sorry, I'll just go back, please, to
 2 page 1, so Dr. Howell can see the document.
 3 This is the report of October 17th, 2005 from
 4 Dr. Banerjee and I take it you're familiar
 5 with this report?
 6 DR. HOWELL:
 7 A. I am.
 8 CHAYTOR, Q.C.:
 9 Q. And if we could look now please then at page
 10 5, when did you first read this report,
 11 Doctor?
 12 DR. HOWELL:
 13 A. Probably it would have been late October of
 14 2006.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. So, about a month or so into your
 17 position?
 18 DR. HOWELL:
 19 A. Yes, or a couple, yes, a month and a half or
 20 two months.
 21 CHAYTOR, Q.C.:
 22 Q. And the part that I just wanted to bring your
 23 attention to or discuss this morning is under
 24 number five, "these are other system flaws
 25 observed" and it talks about this issue of

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1 communication and accountability. And Dr.
 2 Banerjee observed a disconnect, he calls it
 3 "between laboratory program director, division
 4 manager, clinical site chief and laboratory
 5 director in decision making".
 6 DR. HOWELL:
 7 A. Um-hm.
 8 CHAYTOR, Q.C.:
 9 Q. "The organizational charts indicate a complete
 10 separation of reporting structures into
 11 technical and clinical strains with no matrix
 12 cross reporting between technical and medical
 13 leadership". Is that, from your perspective,
 14 is that accurate from what you encountered
 15 when you joined?
 16 DR. HOWELL:
 17 A. Not when I joined, but certainly as it's
 18 evolved over time, I have certainly realized
 19 that there was that division and there was a
 20 tension.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And it goes on to say, "this leads to
 23 frustration and resentment on both sides, lack
 24 of communication, lack of accountability and
 25 lack of buy in. The division manager and

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1 program director appear enthusiastic and keen
 2 on modernizing changes"--sorry--"modernizing
 3 the laboratory, but their efforts have not
 4 been appreciated by the pathologists and work
 5 flow changes have not been mapped out and
 6 implemented". And then he specifically refers
 7 to the "Sakura Express implementation as
 8 failed due to lack of planning and work flow
 9 changes. Superior outcomes could be achieved
 10 by ensuring better linkages between technical,
 11 managerial medial leadership". So, I take it
 12 that's what you're aiming at, trying to
 13 rectify through your new reporting structure?
 14 DR. HOWELL:
 15 A. That's correct.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. And so other than reading about this in
 18 Dr. Banerjee's report in October, had you by
 19 then become aware of this disconnect? Had it
 20 been pointed out to you by anyone else or had
 21 you observed it yourself?
 22 DR. HOWELL:
 23 A. No, not to that degree. As I said, I saw
 24 strong personalities with strong opinions, not
 25 unusual in the medical field. It really--

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1 ER/PR was really starting to come under my
 2 radar to understand how big this was as I got
 3 into late October, I think. And then
 4 somewhere along the way I read this report,
 5 but that was about one thing in a whole list
 6 of things that I was picking up here that
 7 needed to be done.
 8 CHAYTOR, Q.C.:
 9 Q. Yes. And in terms of the status of Sakura
 10 Express, do you know whether or not that's now
 11 been implemented?
 12 DR. HOWELL:
 13 A. It has not, I don't think.
 14 CHAYTOR, Q.C.:
 15 Q. And do you know why not?
 16 DR. HOWELL:
 17 A. I think there still is, I don't think the
 18 pathologists have signed onto that machine. I
 19 remember at some point along the way doing a
 20 walk about in the laboratory and Dr. Williams
 21 is said to be now, you know, Mr. Gulliver
 22 really is into machines. He's going to be
 23 always after you about buying new equipment,
 24 new equipment. And so I did the walk about
 25 and I was really impressed with the type of

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1 equipment and how we used it. And we came
 2 upon this machine that was in the corridor
 3 taking up space and the laboratory looked very
 4 crowded to me. I mean, the corridors were
 5 full of storage items. Anyway, that was an
 6 issue for me, as well. And I asked about this
 7 piece of equipment and I was advised that the
 8 pathologists were not wanting to use it.
 9 CHAYTOR, Q.C.:
 10 Q. And that was this piece of equipment, the
 11 Sakura Express?
 12 DR. HOWELL:
 13 A. I believe that is the piece of equipment. And
 14 then as we continued on through I was also
 15 shown another piece of equipment in the
 16 immunohistochemistry laboratory that was an
 17 add on to the Ventana machine, that the -
 18 CHAYTOR, Q.C.:
 19 Q. Is that the visual imaging machine?
 20 DR. HOWELL:
 21 A. Yes, yes. And Mr. Gulliver talked to me about
 22 that and it sounded like a good idea to me,
 23 but he advised me that the pathologists were
 24 not supportive and would not participate.
 25 CHAYTOR, Q.C.:

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1 Q. And what's the status of that machine? Is
 2 that now used? I understand -
 3 DR. HOWELL:
 4 A. That machine was returned.
 5 CHAYTOR, Q.C.:
 6 Q. Returned.
 7 DR. HOWELL:
 8 A. It was on loan as a demo and it was returned.
 9 CHAYTOR, Q.C.:
 10 Q. So, were you sensing in those discussions with
 11 Mr. Gulliver, some frustration on his part in
 12 terms of wanting to introduce new equipment
 13 and that not being received or the
 14 pathologists not being receptive to that.
 15 DR. HOWELL:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And did -
 19 DR. HOWELL:
 20 A. What I wasn't sure in my mind was -
 21 CHAYTOR, Q.C.:
 22 Q. The why.
 23 DR. HOWELL:
 24 A. - is--yes, is that just a program director who
 25 loves the new toys.

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1 CHAYTOR, Q.C.:

2 Q. So, what did you find out? I'm sure you spoke

3 to the other side to find out what the

4 pathologists thinking would be on that.

5 DR. HOWELL:

6 A. Yes, I would have talked to Dr. Denic about

7 that and he said, you know, this is a new

8 piece of equipment. It's not in broad use

9 anywhere and we're not going to be the first

10 to use it with everything else that's going

11 on. And I'm saying, okay, I have no grounds

12 upon which to argue with that thought process.

13 CHAYTOR, Q.C.:

14 Q. Okay. And you weren't presented, I take it

15 with any documentation from either Mr.

16 Gulliver or Dr. Denic to show how widely used

17 the machine is, what's the benefits,

18 advantages or disadvantages to the machinery?

19 DR. HOWELL:

20 A. I didn't get to that level and I guess the

21 other question, I would say, so, do we have

22 budget for it anyway and I would have heard

23 no.

24 CHAYTOR, Q.C.:

25 Q. So the Sakura Express, I take it, is all

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1 ready?

2 DR. HOWELL:

3 A. That was there.

4 CHAYTOR, Q.C.:

5 Q. That's already purchased?

6 DR. HOWELL:

7 A. Yes, that was purchased and was there.

8 CHAYTOR, Q.C.:

9 Q. And so what's the reason behind the Sakura

10 Express? Why isn't the pathologists keen on

11 that machine?

12 DR. HOWELL:

13 A. It's been some time since I discussed that

14 with them and it probably would have been

15 within the first couple of weeks of being on

16 the job and I just don't think that they

17 expressed a faith in the machine, but

18 honestly, I think you're better asking Dr.

19 Denic as to why they would have reluctance

20 with that.

21 CHAYTOR, Q.C.:

22 Q. Okay. It's not something you've explored, or

23 if you have, you don't remember what reason

24 was given?

25 DR. HOWELL:

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1 A. No, it was very, very early in my mandate. I

2 saw it there, asked why weren't we using it

3 and there just was so much going on that I

4 didn't -

5 CHAYTOR, Q.C.:

6 Q. And do you know whether or not that was one of

7 the recommendations from the external reviews,

8 in terms of implementing the Sakura Express?

9 DR. HOWELL:

10 A. I'd have to go back and look at whether there

11 was specific to a--one of the recommendations

12 referred to the tissue tech machine. I'm not

13 sure if that's the same piece of equipment or

14 not. But if it is, I understand that of all

15 of those recommendations, that one is

16 outstanding.

17 CHAYTOR, Q.C.:

18 Q. Yes. So you did understand that it was a

19 recommendation?

20 DR. HOWELL:

21 A. Yes.

22 CHAYTOR, Q.C.:

23 Q. Yes, and the visual imaging machine, what did

24 you understand that would be able to do?

25 DR. HOWELL:

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1 A. My understanding was that it would do a scan

2 of the slide and give a report which then

3 could be married to still having the

4 pathologist do the interpretation and my

5 understanding was that would be a double

6 check.

7 CHAYTOR, Q.C.:

8 Q. Yes.

9 DR. HOWELL:

10 A. It could add--to my way of thinking, that

11 would have added to the accuracy. Mr.

12 Gulliver advised me that Dr. Carter had

13 refused to even come to the presentation and

14 Dr. Denic was not supportive of it, as it was,

15 as I explained, his statement to me was "look,

16 this is not in broad use. It's new. We're

17 not going to be the first."

18 CHAYTOR, Q.C.:

19 Q. And whether or not there's any statistical

20 analysis in terms of how broadly the machine

21 is used, you didn't see anything in writing to

22 support that position or otherwise refute it?

23 DR. HOWELL:

24 A. The little that I had was that the

25 pathologists--if the pathologists weren't

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1 going to support it, I certainly was not going
 2 to be pushing it, and certainly at that stage
 3 in my mandate.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. This issue of Dr. Carter didn't--
 6 refused to even come and see the machine. Did
 7 you sense that there was a tension between Mr.
 8 Gulliver and Dr. Carter or are you otherwise
 9 aware of that?
 10 DR. HOWELL:
 11 A. I don't think I did at that point, but
 12 certainly over time, I have felt and become
 13 aware that there was a disagreement between
 14 the two individuals.
 15 CHAYTOR, Q.C.:
 16 Q. And in terms of the current reporting
 17 structure, if Mr. Gulliver wanted to purchase
 18 a machine or a piece of equipment, he would
 19 now have to go to Dr. Denic and have approval
 20 from Dr. Denic first?
 21 DR. HOWELL:
 22 A. That would be my--I would expect that they
 23 would jointly come, that he and Dr. Denic
 24 would reach some agreement and jointly come -
 25 CHAYTOR, Q.C.:

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1 Q. That's not something he would report directly
 2 to you on? I'm just wondering, so if he wants
 3 to, you know, there's something else that he
 4 wants to be able--he would first to have to
 5 have Dr. Denic in agreement and then he would
 6 go to you for the budget implications, is that
 7 how that would work?
 8 DR. HOWELL:
 9 A. That's correct.
 10 CHAYTOR, Q.C.:
 11 Q. So, he would have to have Dr. Denic's
 12 approval?
 13 DR. HOWELL:
 14 A. He would, now he would, absolutely.
 15 CHAYTOR, Q.C.:
 16 Q. Whereas perhaps under the old structure, these
 17 two pieces of machinery were acquired and I
 18 realize one went back, but they were acquired
 19 because Dr. Denic did not have to have the
 20 approval of the clinical--I'm sorry, because
 21 Mr. Gulliver didn't have to have the approval
 22 of Dr. Cook at the time.
 23 DR. HOWELL:
 24 A. Mr. Gulliver, I'm sure would have felt able
 25 to, for a technological piece of equipment,

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1 that he could go ahead and have that brought
 2 in as a demo and let people have a look at it
 3 and so on. And he would hope that he would
 4 get the funding for it.
 5 CHAYTOR, Q.C.:
 6 Q. Well, the Sakura was certainly more than a
 7 demo because it's still there.
 8 DR. HOWELL:
 9 A. They purchase--and I don't know the history
 10 behind how they purchased that piece of
 11 equipment.
 12 CHAYTOR, Q.C.:
 13 Q. Well, we'll take that up with them. Okay. If
 14 we could look, please, at P-1400.
 15 THE COMMISSIONER:
 16 Q. Dr. Howell, 1400 would also be in the book
 17 that's in front of you if you'd prefer to look
 18 at a paper copy.
 19 DR. HOWELL:
 20 A. Okay.
 21 CHAYTOR, Q.C.:
 22 Q. Should be right at the beginning of your book,
 23 Doctor, or close to the beginning.
 24 DR. HOWELL:
 25 A. Thank you. I have it.

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1 CHAYTOR, Q.C.:
 2 Q. And this, I realize, is before your time, but
 3 it's a letter written from Dr. Carter,
 4 February 8, 2006 to Dr. Cook and have you seen
 5 this correspondence before?
 6 DR. HOWELL:
 7 A. I have not.
 8 CHAYTOR, Q.C.:
 9 Q. And this letter, Doctor Carter writes, "please
 10 accept this as official notice of my
 11 resignation" and again this is February 8,
 12 2006. So, it's a few months before you
 13 joined. "As you know, over the last eight
 14 months I have had many differences of opinion
 15 with the team regarding the processes, work
 16 assignments and goals for the successful
 17 institution of an ER/PR HER2/neu
 18 immunohistochemical laboratory at Eastern
 19 Health. It is clear to me that we will not be
 20 able to resolve our differences. I cannot as
 21 a fellowship trained breast pathologist agree
 22 with the direction in which this process is
 23 proceeding. Therefore, I feel that resigning
 24 is the best option for me and for the team".
 25 So at this point in time, Doctor, Doctor

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1 Carter's concerns and the tension between
 2 yourself and what she refers to as the team
 3 had come to the point where she was going to
 4 resign her position and she gives the date and
 5 then there's a handwritten note that it was
 6 going to be after a three month notice period.
 7 Was that ever brought to your attention, that
 8 her difference of opinion with members of the
 9 team was such that back in the beginning of
 10 February or back in the beginning of '06, she
 11 was prepared to resign?
 12 DR. HOWELL:
 13 A. I have never seen this piece of correspondence
 14 before and I do not recollect being told, no,
 15 of her previously saying she was going to
 16 resign. I don't recall being told that.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And during your time period you haven't
 19 learned, other than recently, have you learned
 20 of any other time period in which Dr. Carter
 21 was prepared to resign and had written
 22 correspondence that she would be resigning?
 23 DR. HOWELL:
 24 A. There are two areas of resignation that I
 25 recall. One is when she was chairing the

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1 quality assurance process for ER/PR in the lab
 2 and I think there was disagreement, maybe with
 3 her and Ms. Wade when we were trying to bring
 4 the standard operating procedures--and it was
 5 the approach, I think, more that was anything,
 6 as I recall. And she resigned and one of the
 7 other pathologists took up that role. And the
 8 only other resignation is the more recent one
 9 that I -
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 DR. HOWELL:
 13 A. - that Dr. Denic advised me that she had
 14 resigned from her position and would be
 15 leaving Eastern Health.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. And are you aware of whether or not
 18 that has anything to do with ongoing
 19 differences of opinion between herself and
 20 members of the team?
 21 DR. HOWELL:
 22 A. I don't know her reasons.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. If we could look at, please, P-1414 and
 25 that again should be in your book. And if

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1 not, it's on the screen in front of you,
 2 Doctor.
 3 DR. HOWELL:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And this is correspondence that does happen
 7 during your time with Eastern Health. It's
 8 March 21, 2007. It's written to Mr. John
 9 Abbott who is Deputy Minister at the time at
 10 Department of Health. And it's written by Dr.
 11 Denic as Interim Clinical Chief and copied to
 12 Ross Wiseman and also copied to yourself. So,
 13 you would have received this correspondence.
 14 DR. HOWELL:
 15 A. That is correct.
 16 CHAYTOR, Q.C.:
 17 Q. And this correspondence does say, references,
 18 "possible loss of a breast pathology
 19 specialist. I just wanted to inform you that
 20 another pathologist is looking for a job
 21 elsewhere. Dr. Beverley Carter is the only
 22 pathologist with sub-speciality training in
 23 breast pathology in Newfoundland and Labrador.
 24 The reasons for applying for a job in BC is
 25 clearly stated in her letter submitted to me

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1 March 19, 2007. Letter enclosed". And
 2 unfortunately, we don't have that letter. So
 3 this letter though, you would have been aware
 4 then that Dr. Carter was looking for a job in
 5 BC back March 21, 2007.
 6 DR. HOWELL:
 7 A. That is correct.
 8 CHAYTOR, Q.C.:
 9 Q. Would you also have received her letter, that
 10 letter enclosed of March 21, 2007, was that
 11 provided to you as well?
 12 DR. HOWELL:
 13 A. I don't recall.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. So any reasons that were given for her
 16 resignation at that time or her contemplated
 17 resignation, you don't recall?
 18 DR. HOWELL:
 19 A. No. I certainly, I think, and around this
 20 letter I did have a--recall a conversation
 21 with Dr. Denic and I knew that Dr. Carter was
 22 not happy and I was honestly not sure why she
 23 was so unhappy. It's not unusual for us to
 24 have physicians who are exploring other
 25 options outside our province. And I knew that

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1 Dr. Denic was--he may well be wearing the hat
 2 also of the Chair of the Provincial Pathology
 3 Association and I think he was trying to get
 4 the message through to government that we have
 5 a continuing problem here with recruitment and
 6 retention of pathologists.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. So whether the issue that was certainly
 9 been--raised by Dr. Carter during her time
 10 with Eastern Health in terms of problems she
 11 was having with differences of opinion within
 12 the team, whether or not that was every
 13 addressed to her satisfaction or not, you
 14 don't know?
 15 DR. HOWELL:
 16 A. You would have to ask her.
 17 CHAYTOR, Q.C.:
 18 Q. That's never come to your attention. So, you
 19 don't know the current state of that?
 20 DR. HOWELL:
 21 A. Dr. Denic--I've let Dr. Denic work with that.
 22 I know that in her most recent--I've been out
 23 of the country for a month and I know that in
 24 her most recent resignation, that Dr. Guy, the
 25 Medical Director of Medical Services or the

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1 Director of Medical Services did have a
 2 meeting with her to explore, you know, what
 3 her issues were and where things that we could
 4 be doing--but I have not had an opportunity.
 5 He's out of town at the moment and I haven't
 6 had a chance to talk to him about that.
 7 CHAYTOR, Q.C.:
 8 Q. When would it come to your attention? If the
 9 differences, you know, hadn't been resolved,
 10 when would--hadn't been resolved to her
 11 satisfaction and then ultimately, and I'm just
 12 using Dr. Carter at this point because this is
 13 who we have these correspondences in relation
 14 to, but when then would that get brought up
 15 the chain to you? I mean, would it be before
 16 the physician actually walks out the door,
 17 that you would be brought in to see what you
 18 could do?
 19 DR. HOWELL:
 20 A. Dr. Denic might well phone me or e-mail me or
 21 at a leadership meeting, it would be very
 22 common for me to be saying, trying to get
 23 updates on where are we with our numbers now
 24 in terms of pathologists. And it would be
 25 certainly not unusual for him to phone me or

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1 e-mail me to say, you know, another
 2 pathologist now is looking at leaving or we're
 3 going to lose to or something, that would
 4 happen--he would inform me, but he would
 5 manage that. He would be dealing with that.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. And in terms of then the other--I
 8 understand there's a separate structure again
 9 in place for reporting within the IHC lab.
 10 Can you explain that to us?
 11 DR. HOWELL:
 12 A. Arising from the external reviews that were
 13 done, the immunohistochemistry lab has been
 14 changed and I think Dr. Williams has given
 15 testimony to that. Dr. Ford Elms now is the
 16 Medical Director. And there are three
 17 technologists who are assigned to that area
 18 only and have received additional training in
 19 immunohistochemistry. In addition, a senior
 20 technician has been put in the role of quality
 21 assurance for that particular lab.
 22 CHAYTOR, Q.C.:
 23 Q. And who is that person?
 24 DR. HOWELL:
 25 A. Catherine Parnell. She is retiring at this

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1 point and a new person is assuming that role.
 2 CHAYTOR, Q.C.:
 3 Q. So, she's new to it, but now she's retiring?
 4 DR. HOWELL:
 5 A. Well, she's been in that role--I don't know
 6 for how long she's been in that role, but she
 7 is retiring, as I understand it and a new
 8 person has assumed the position.
 9 CHAYTOR, Q.C.:
 10 Q. Okay.
 11 DR. HOWELL:
 12 A. And then there is a breast group which did
 13 have three physicians and is now down to two
 14 and will shortly be down to none.
 15 CHAYTOR, Q.C.:
 16 Q. In terms of -
 17 DR. HOWELL:
 18 A. Well, that was Doctor Cook and we lost one of
 19 the pathologists, I think left for BC, I think
 20 and Dr. Cook is off on sick leave at this
 21 point in time and, of course, Dr. Carter has
 22 tendered her resignation.
 23 CHAYTOR, Q.C.:
 24 Q. Yes. And Dr. Elms then, he is the person who
 25 is in charge of the IHC lab.

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1 DR. HOWELL:
 2 A. That's correct.
 3 CHAYTOR, Q.C.:
 4 Q. So, the techs within IHC would, if they had
 5 any problems or troubleshooting, they would go
 6 to Dr. Elms?
 7 DR. HOWELL:
 8 A. That's correct.
 9 CHAYTOR, Q.C.:
 10 Q. And then ultimately Dr. Elms reports to Dr.
 11 Denic?
 12 DR. HOWELL:
 13 A. Correct.
 14 CHAYTOR, Q.C.:
 15 Q. And to whom does Barry Dyer report? Where
 16 does he fit into this puzzle?
 17 DR. HOWELL:
 18 A. Barry Dyer would be, at this point in time,
 19 would be reporting to Mr. Gulliver.
 20 CHAYTOR, Q.C.:
 21 Q. And you say "at this point in time", is that
 22 changed or is it contemplated that that will
 23 change?
 24 DR. HOWELL:
 25 A. As we continue to look into the structure,

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

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1 DR. HOWELL:
 2 A. No.
 3 THE COMMISSIONER:
 4 Q. Would that be right?
 5 DR. HOWELL:
 6 A. It is virtually an island to itself and has
 7 evolved into its own entity.
 8 THE COMMISSIONER:
 9 Q. Okay. And as I understand it, within that it
 10 is unusual because it has a medical director,
 11 in this case Dr. Elms. It also has three
 12 technologists who are assigned permanently to
 13 there. And do I take it that they report to
 14 Dr. Elms, not through the regular reporting
 15 system?
 16 DR. HOWELL:
 17 A. They would certainly be reporting to Dr. Elms,
 18 but they still would--they would report
 19 principally to Dr. Elms, but I think they
 20 would still feel that they have some reporting
 21 relationship to Mr. Dyer and ultimately up to
 22 Mr. Gulliver. I think when you examine those
 23 individuals, they'll clarify that a little bit
 24 further for you.
 25 CHAYTOR, Q.C.:

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1 Q. Do you think it'll be clear in their minds?
 2 DR. HOWELL:
 3 A. I would hope it would be.
 4 CHAYTOR, Q.C.:
 5 Q. Is there an organization chart for that which
 6 has been provided to them?
 7 DR. HOWELL:
 8 A. I don't know the answer.
 9 CHAYTOR, Q.C.:
 10 Q. Okay.
 11 THE COMMISSIONER:
 12 Q. Okay. So, there is a technologist in the IHC
 13 lab and let's take a couple of examples of the
 14 kind of a problem a technologist might have.
 15 If the technologist has a problem related to
 16 something like, oh I don't know, personal
 17 benefits, that kind of stuff, who does that
 18 person go to?
 19 DR. HOWELL:
 20 A. Personal benefits?
 21 THE COMMISSIONER:
 22 Q. Yes.
 23 DR. HOWELL:
 24 A. I would expect that person would be going to
 25 Mr. Dyer who is his division manager.

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1 THE COMMISSIONER:
 2 Q. Mr. Dyer, okay. If that person has a problem
 3 with staining on a batch in any one morning,
 4 who does that person go to?
 5 DR. HOWELL:
 6 A. Dr. Elms.
 7 THE COMMISSIONER:
 8 Q. Okay. It seems to me those two examples are
 9 pretty clear. You would expect that that
 10 would happen.
 11 DR. HOWELL:
 12 A. Correct.
 13 THE COMMISSIONER:
 14 Q. What's on the margins where somebody might be
 15 doubting who they go to.
 16 DR. HOWELL:
 17 A. Correct.
 18 THE COMMISSIONER:
 19 Q. What kind of thing--I mean, as with most
 20 things in most organizations, there are those
 21 nice things that fit very clearly within this
 22 place and very clearly within that place, then
 23 there's all that grey. Would you expect that
 24 there would be grey here and is it still being
 25 worked out? And if so, what's an example of

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1 grey?
 2 DR. HOWELL:
 3 A. You know, I would just, in my mind, have two
 4 categories; those things that are more
 5 administrative in nature and those things that
 6 are clinical in nature. If it's clinical, my
 7 expectation would be that they would
 8 understand they have a relationship with Dr.
 9 Elms.
 10 CHAYTOR, Q.C.:
 11 Q. So, for example, what if a technologist had an
 12 issue as to whether or not they should buy a
 13 particular kind of stain or a greater quantity
 14 of a particular stain. Who would the
 15 technologist ask that question of?
 16 DR. HOWELL:
 17 A. I believe that would be a collaborative
 18 effort.
 19 CHAYTOR, Q.C.:
 20 Q. So they could go to either.
 21 DR. HOWELL:
 22 A. If they were going to be changing a stain in
 23 any way, as the medical director, Dr. Elms
 24 would be the person who should be working with
 25 them on those decisions.

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1 CHAYTOR, Q.C.:
 2 Q. And if they're running out of a particular
 3 stain, who would they speak to?
 4 DR. HOWELL:
 5 A. If they're running out of a stain, I would
 6 suspect that would--that's an excellent way to
 7 look at it--that would be Mr. Dyer.
 8 CHAYTOR, Q.C.:
 9 Q. I'm not sure, Commissioner, is that clear now
 10 for you?
 11 THE COMMISSIONER:
 12 Q. Probably not, but it's clearer than it was.
 13 I'll come back to it if I need to.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. Doctor, before I leave the whole lab
 16 structuring and restructuring, is there a plan
 17 in place in terms of the consolidation of
 18 laboratory services within the St. John's
 19 region onto one site.
 20 MR. SIMMONS:
 21 Q. Lab services or pathology?
 22 CHAYTOR, Q.C.:
 23 Q. Well, start with lab.
 24 DR. HOWELL:
 25 A. Well, there is a plan to consolidate all the

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1 pathologists on one site.
 2 CHAYTOR, Q.C.:
 3 Q. Okay.
 4 DR. HOWELL:
 5 A. So, all -
 6 CHAYTOR, Q.C.:
 7 Q. So, this is just in relation to pathology.
 8 DR. HOWELL:
 9 A. Yes, all the pathologists will be moving to
 10 the Health Science site in St. John's as
 11 quickly as we can get the renovations done to
 12 make that happen. We will maintain a presence
 13 on the St. Clare's site with a pathologist
 14 going down for the purpose of frozen sections
 15 and that sort of thing to support the surgery
 16 program at St. Clare's.
 17 CHAYTOR, Q.C.:
 18 Q. So, that decision has already been made.
 19 DR. HOWELL:
 20 A. That decision has been made.
 21 CHAYTOR, Q.C.:
 22 Q. All pathology service--so the only pathology
 23 lab within St. John's will be within the
 24 Health Sciences and there's renovations
 25 ongoing to the physical plan to -

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

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1 Q. And what's your estimated time for completion?
 2 DR. HOWELL:
 3 A. My estimated time was yesterday, but -
 4 CHAYTOR, Q.C.:
 5 Q. What's your realistic time period? Is there a
 6 plan?
 7 DR. HOWELL:
 8 A. When I left for vacation, I knew there was a
 9 diagram and they were working out the stages
 10 of how this would evolve. I have not had an
 11 opportunity to pressure Facilities to get this
 12 done.
 13 CHAYTOR, Q.C.:
 14 Q. Is it happening in 2008?
 15 DR. HOWELL:
 16 A. It will happen in 2008.
 17 CHAYTOR, Q.C.:
 18 Q. And what was the--why the pathology lab? What
 19 was the reason behind this move?
 20 DR. HOWELL:
 21 A. The pathologists.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So tell us about that. They wanted
 24 this?
 25 DR. HOWELL:

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

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1 DR. HOWELL:
 2 A. No, I didn't really receive any opposition. I
 3 guess my first--I thought I was doing a great
 4 thing and my first glimpse that maybe I wasn't
 5 going to get 100 percent support was a meeting
 6 with--when I had this town hall meeting with
 7 the pathologists by themselves and a
 8 pathologist, one of the pathologists spoke up
 9 and said "don't you think you should have
 10 asked us first?" and -
 11 CHAYTOR, Q.C.:
 12 Q. And was that Dr. Carter?
 13 DR. HOWELL:
 14 A. It was, and I reflected on that and I said
 15 yes, you are probably quite right, I should
 16 have.
 17 CHAYTOR, Q.C.:
 18 Q. So they hadn't been consulted in the decision
 19 making?
 20 DR. HOWELL:
 21 A. They had not been consulted.
 22 CHAYTOR, Q.C.:
 23 Q. And she would have been a pathologist at St.
 24 Clare's who would be required to move to the
 25 Health Sciences?

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

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1 of to improve the grossing area and such.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and just before we take the morning
 4 break, Commissioner, I've brought up again P-
 5 0044, which shows the organizational chart,
 6 and Doctor, I just want to be clear on the IHC
 7 lab, and from what I've understood you to say,
 8 and through answering the Commissioner's
 9 questions, the IHC lab, although we show the
 10 pathology, regional manager pathology division
 11 being Barry Dyer here, and he reports up to
 12 Terry Gulliver, the IHC lab itself would be
 13 then a division of the pathology lab, which
 14 isn't shown here, and within that, it has its
 15 own triangular reporting structure. Is that
 16 right?
 17 DR. HOWELL:
 18 A. That is correct.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and when we say a triangular reporting
 21 structure, we have Dr. Elms at the top of the
 22 triangle, the technologists, the three
 23 dedicated technologists to IHC in one corner,
 24 and do we have the pathologists doing IHC in
 25 the other corner?

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1 DR. HOWELL:
 2 A. That would be my understanding.
 3 CHAYTOR, Q.C.:
 4 Q. So those pathologists who are carrying out any
 5 work in IHC would report through to Dr. Elms
 6 first?
 7 DR. HOWELL:
 8 A. Dr. Elms had a responsibility for the IHC lab.
 9 You know, it is my belief that this needs
 10 further work.
 11 CHAYTOR, Q.C.:
 12 Q. Yes.
 13 DR. HOWELL:
 14 A. I believe it needs further work, but I need
 15 them to work it through and I need to look at
 16 other organizations, how they do it, before we
 17 really make that change.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, because the importance of clarity in
 20 communications and the reporting lines,
 21 particularly if we look at a situation like
 22 the ER/PR situation and making sure that
 23 people are clear on who they go to for
 24 direction.
 25 DR. HOWELL:

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1 A. Absolutely.
 2 CHAYTOR, Q.C.:
 3 Q. So that needs further work.
 4 DR. HOWELL:
 5 A. Absolutely, it very much does.
 6 THE COMMISSIONER:
 7 Q. So the current organization for the IHC really
 8 only deals with what happens before the lab--
 9 before the slide gets showed to the
 10 pathologist who's reading it, is it?
 11 DR. HOWELL:
 12 A. No.
 13 THE COMMISSIONER:
 14 Q. Okay. What I wasn't clear on was the answer
 15 to your question regarding--and perhaps it's a
 16 presumption I'm making that isn't correct. I
 17 understand that Dr. Elms is responsible for
 18 the lab, so that--and that now pathologists
 19 are not involved with grossing. Is that
 20 correct?
 21 DR. HOWELL:
 22 A. There are -
 23 THE COMMISSIONER:
 24 Q. Technologists -
 25 DR. HOWELL:

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1 A. There have been added expertise brought in for
 2 the grossing.
 3 THE COMMISSIONER:
 4 Q. But it's not done by pathologists any more?
 5 DR. HOWELL:
 6 A. Pathologist assistants.
 7 THE COMMISSIONER:
 8 Q. Exactly.
 9 DR. HOWELL:
 10 A. Under the supervision of a pathologist.
 11 THE COMMISSIONER:
 12 Q. Okay. So that for most pathologists, they
 13 don't actually get to apply their expertise to
 14 the area of IHC until someone hands them a
 15 slide? Is that right?
 16 DR. HOWELL:
 17 A. Well, Dr. Elms is a pathologist and would have
 18 the -
 19 THE COMMISSIONER:
 20 Q. Yes, but is Dr. Elms reading all IHC slides?
 21 Is that work not shared with others?
 22 DR. HOWELL:
 23 A. In terms of the breast, it is purely with two
 24 individuals now, Dr. Cook and Dr. Carter.
 25 THE COMMISSIONER:

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1 Q. Okay.
 2 DR. HOWELL:
 3 A. The depth of the detail, Commissioner, I think
 4 you really need to talk to the individuals
 5 involved.
 6 THE COMMISSIONER:
 7 Q. Yes, okay. So who do I talk to, Dr. Denic?
 8 Would he know that? Or do you have to talk to
 9 Dr. Elms to know?
 10 DR. HOWELL:
 11 A. I think both individuals will help clarify
 12 that.
 13 THE COMMISSIONER:
 14 Q. All right. Now, you want to take the morning
 15 break?
 16 CHAYTOR, Q.C.:
 17 Q. Yes, thank you.
 18 THE COMMISSIONER:
 19 Q. We'll take 15 minutes.
 20 (RECESS)
 21 THE COMMISSIONER:
 22 Q. Please be seated. Ms. Chaytor.
 23 CHAYTOR, Q.C.:
 24 Q. Thank you, Commissioner. Dr. Howell, are
 25 there different classifications of physicians

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1 within Eastern Health?
 2 DR. HOWELL:
 3 A. Different -
 4 CHAYTOR, Q.C.:
 5 Q. In terms of fee-for-service, salaried?
 6 DR. HOWELL:
 7 A. Oh, yes, there are really three categories, if
 8 you like, three payment methods. One is fee-
 9 for-service. One would be an alternate
 10 payment plan, and a third would be salary.
 11 CHAYTOR, Q.C.:
 12 Q. And which category do the pathologists fall
 13 within?
 14 DR. HOWELL:
 15 A. Salary.
 16 CHAYTOR, Q.C.:
 17 Q. So they're salaried within Eastern Health,
 18 salaried employees of Eastern Health?
 19 DR. HOWELL:
 20 A. Correct.
 21 CHAYTOR, Q.C.:
 22 Q. And what authority do you have, as the VP
 23 Medical, over the medical staff?
 24 DR. HOWELL:
 25 A. I have a responsibility for medical services,

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1 so that would be from the recruiting of
 2 physicians, doing the appropriate
 3 credentialling and privileging of those
 4 physicians, and then the ongoing evaluation of
 5 the work that they do through their programs,
 6 etcetera.
 7 CHAYTOR, Q.C.:
 8 Q. And is that true of all classifications,
 9 whether they're fee-for-service or salaried
 10 physicians or alternate payment?
 11 DR. HOWELL:
 12 A. That is correct. I would have really no
 13 control about how they're paid or what they're
 14 paid. That is something that they negotiate
 15 with government through their association.
 16 CHAYTOR, Q.C.:
 17 Q. But you have responsibility for the
 18 credentialling and the evaluation?
 19 DR. HOWELL:
 20 A. That's correct.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and how do you measure the quality of a
 23 physician's work?
 24 DR. HOWELL:
 25 A. This is largely done through the program, so

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1 the clinical chief ultimately, in any given
 2 program, including the laboratory, would be
 3 responsible for the work done by the
 4 physicians in that program. Since I've come,
 5 we have been attempting to strengthen that
 6 process and while there is an expectation that
 7 there would be annual evaluations done on all
 8 physicians, that certainly hasn't been a
 9 consistent process, my understanding is
 10 historically, through the organization, and I
 11 have been attempting to change that and I've
 12 just started doing evaluations on all of the
 13 clinical chiefs, with the intention that they
 14 will then do evaluations on the division
 15 chiefs, who will then ultimately do
 16 evaluations on all of the physicians within
 17 any given division.
 18 CHAYTOR, Q.C.:
 19 Q. So you would only personally do the clinical
 20 chiefs. So in terms of the laboratory
 21 medicine program right now, that would be Dr.
 22 Denic?
 23 DR. HOWELL:
 24 A. Right.
 25 CHAYTOR, Q.C.:

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1 Q. And then it goes on down the chain.
 2 DR. HOWELL:
 3 A. Right.
 4 CHAYTOR, Q.C.:
 5 Q. And that had not been happening on a regular
 6 basis in Eastern Health?
 7 DR. HOWELL:
 8 A. I'm not certain to what degree it was
 9 happening. I guess it really--as I looked at
 10 the roles and--my roles and responsibilities,
 11 I realized that that was one of them, and then
 12 as we look at the accreditation report of May
 13 2007, that was a highlighted area that we
 14 needed -
 15 CHAYTOR, Q.C.:
 16 Q. September, September 2007 you mean?
 17 DR. HOWELL:
 18 A. Yes. That we needed to improve in that area.
 19 So I think part of the challenge there was
 20 there was no medical director--or director of
 21 medical services. I think Dr. Williams was
 22 really carrying a very, very great load. But
 23 we are certainly moving in that direction now.
 24 CHAYTOR, Q.C.:
 25 Q. So what role will the medical director play in

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1 that?
 2 DR. HOWELL:
 3 A. The medical director will take the lead role
 4 for all medical services and that will--and I
 5 have specifically asked him to focus on the
 6 credentialing, privileging area, bylaws and
 7 evaluation.
 8 CHAYTOR, Q.C.:
 9 Q. And there was nobody in that position while
 10 Dr. Williams was VP Medical?
 11 DR. HOWELL:
 12 A. That's correct.
 13 CHAYTOR, Q.C.:
 14 Q. So since assuming your position, have you, in
 15 fact, carried out a performance evaluation of
 16 Dr. Denic?
 17 DR. HOWELL:
 18 A. I have not. It is scheduled for--I think it
 19 was scheduled for today.
 20 CHAYTOR, Q.C.:
 21 Q. You're otherwise occupied, I take it.
 22 DR. HOWELL:
 23 A. I don't think it will be happening.
 24 CHAYTOR, Q.C.:
 25 Q. And would you -

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1 THE COMMISSIONER:
 2 Q. (Inaudible) service to somebody, you know.
 3 CHAYTOR, Q.C.:
 4 Q. And in terms of Mr. Gulliver now, he would be
 5 then evaluated by Dr. Denic? Is that correct?
 6 DR. HOWELL:
 7 A. He will be.
 8 CHAYTOR, Q.C.:
 9 Q. Would he be evaluated by you with respect to
 10 certain aspects of his job?
 11 DR. HOWELL:
 12 A. A work in progress.
 13 CHAYTOR, Q.C.:
 14 Q. So you don't know?
 15 DR. HOWELL:
 16 A. It is a work in progress. Ultimately because
 17 he's reporting to me for part of the function
 18 now, I will be involved in that.
 19 CHAYTOR, Q.C.:
 20 Q. And do you know whether or not to date Dr.
 21 Denic has carried out a performance evaluation
 22 of Mr. Gulliver?
 23 DR. HOWELL:
 24 A. I don't think he has, but I can't speak with
 25 certainty.

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1 CHAYTOR, Q.C.:

2 Q. The performance evaluations that are carried

3 out by the pathologists or with respect,

4 sorry, to the pathologists, would those

5 performance evaluations ultimately end up on

6 your desk?

7 DR. HOWELL:

8 A. I have not seen any performance evaluations,

9 and I don't know that they have been done.

10 CHAYTOR, Q.C.:

11 Q. So there may not have been any carried out

12 since you've taken up your duties in September

13 2006?

14 DR. HOWELL:

15 A. None that I'm aware of or that I have seen.

16 CHAYTOR, Q.C.:

17 Q. Okay, and would the--when the process gets--

18 and I understand what you're telling us.

19 You're trying to strengthen that process, and

20 of course, that was brought up in the

21 accreditation, you're right. So when

22 ultimately the performance evaluations are

23 completed, the plan would be, however, that

24 they would go up the chain and you would

25 ultimately see those evaluations?

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1 DR. HOWELL:

2 A. Yes. In the plan that we are trying to pull

3 together, there are some areas that we will

4 try to centralize and that is to--remembering

5 that all of our clinical chiefs have large

6 clinical loads and they are trying to do this

7 administrative work around those clinical

8 loads, so while we have a very small office of

9 the vice president, we're going to try to

10 centralize as much as we can there, in terms

11 of sending out the evaluations and collecting

12 them and making sure that there are tick boxes

13 of all the things that needed to be done.

14 And so that will--what we've done is

15 we've introduced a new evaluation tool. We've

16 shared that with the clinical chiefs. We've

17 made some adjustments in that tool. It is far

18 from perfect, but what we do is there are

19 sections for the individual to fill out.

20 There's sections for us to fill out, and then

21 there are comments made by whoever the person

22 reports to.

23 So we've brought in that new tool and as

24 I say, we've started and once we're doing the

25 clinical chiefs, so that they get a good feel

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1 about--from both sides. They've had a chance

2 to look at the tool. They've had a chance to

3 make some adjustments in its content, and

4 we've tried not to make the workload too

5 onerous and but still to gain valuable

6 information, and so we're doing the clinical

7 chiefs and then we're asking them to do their

8 division chiefs and roll it on down. So once

9 we do the clinical chief, Dr. Guy, who's the

10 director of medical services, his assistant

11 will then send out the forms to other

12 physicians, ask them to complete their part

13 and to book a time to meet with their clinical

14 chief or division chief as appropriate, and

15 part of that issue was--and then all of that

16 will come back and reside in the physician's

17 file within the office of the Director of

18 medical services.

19 Part of that process which created, I

20 gather, while I was out of the country, some

21 concern about a confidentiality agreement.

22 Part of the idea was to ensure that that file

23 is as complete as possible and that one of the

24 documents that we would want in that file

25 would include that the physician had

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1 understood clearly and had signed a

2 confidentiality agreement with the

3 organization. In addition, within that file,

4 it collects information about positions held

5 or anything that's changed. It asks questions

6 about what continuing medical education

7 activity that they have pursued through the

8 year. So we're looking at the work they did,

9 any changes that happened. We're looking at

10 their continuing education and their

11 competency levels. We are asking them whether

12 there are any outstanding complaints against

13 them. Do they still--have they still

14 maintained their license, have they still

15 maintained their Canadian Medical Protective

16 Insurance, and so -

17 CHAYTOR, Q.C.:

18 Q. Was such--sorry, I didn't mean to cut off.

19 DR. HOWELL:

20 A. No.

21 CHAYTOR, Q.C.:

22 Q. Was such a process in place before or is this

23 something new that's being implemented by you?

24 DR. HOWELL:

25 A. I think--my understanding is that different

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1 programs had different tools they were using
 2 and it was inconsistently applied across the
 3 programs. But -
 4 CHAYTOR, Q.C.:
 5 Q. And I'm just, of course, focusing on the
 6 laboratory medicine program.
 7 DR. HOWELL:
 8 A. Yes, and I honestly do not know what was done
 9 in the past in that area.
 10 CHAYTOR, Q.C.:
 11 Q. So whether or not in the past people were ever
 12 asked about what continuing education had been
 13 pursued and whether--and evaluation of their
 14 competency levels, you're not able to speak to
 15 that?
 16 DR. HOWELL:
 17 A. No. It has been everything that I can do to
 18 handle looking forward. Looking back has been
 19 a challenge.
 20 CHAYTOR, Q.C.:
 21 Q. But the fact that you're now bringing this in
 22 and standardizing it across, I take it that
 23 that hadn't been done before. There had been
 24 no standardization of the type of performance
 25 evaluation for physicians prior to what's now

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1 under way?
 2 DR. HOWELL:
 3 A. I'm not certain what was present before.
 4 CHAYTOR, Q.C.:
 5 Q. Well, I guess you wouldn't be reinventing the
 6 wheel if it was already there.
 7 DR. HOWELL:
 8 A. I think that's a fair statement.
 9 THE COMMISSIONER:
 10 Q. Can you just remind me what a director of
 11 medical services does?
 12 DR. HOWELL:
 13 A. It would be the--if you looked at all the
 14 other areas that I have responsibility for,
 15 there are directors in place in each of those,
 16 Commissioner. There was not for medical
 17 services, so now there is for medical
 18 services.
 19 CHAYTOR, Q.C.:
 20 Q. You mean as in a director for a particular -
 21 DR. HOWELL:
 22 A. Diagnostic imaging, for example, a director of
 23 pharmacy. So for medical services, there
 24 wasn't such a position, and this is really the
 25 day-to-day operational issues of having a

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1 medical staff and its function in the
 2 organization. So recruitment, retention
 3 issues. For example, last Friday, I get a
 4 phone call that a physician who is on call,
 5 their pager doesn't work. Well, they're on
 6 call. We have to have communication. That's
 7 an issue, I just do not have time to get down
 8 to that level of operational. So the director
 9 of medical services would the day-to-day
 10 operational issues where the rubber hits the
 11 road.
 12 THE COMMISSIONER:
 13 Q. Thank you.
 14 CHAYTOR, Q.C.:
 15 Q. In terms of the pathologists then outside St.
 16 John's, who would be responsible for carrying
 17 out their performance evaluations?
 18 DR. HOWELL:
 19 A. In the past, it would--in the past -
 20 CHAYTOR, Q.C.:
 21 Q. No, on the go forward basis.
 22 DR. HOWELL:
 23 A. On the go forward, ultimately Dr. Denic would
 24 have a responsibility there because he has a
 25 regional responsibility.

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1 CHAYTOR, Q.C.:
 2 Q. Is there any concern about Dr. Denic's
 3 knowledge level of the work performed by those
 4 pathologists outside the region?
 5 DR. HOWELL:
 6 A. Short answer is yes. And I think Dr. Denic
 7 himself, as he and I discussed this new role
 8 and new position, I think one of his greatest
 9 concerns was that he didn't, you know, his
 10 responsibility now for laboratories outside of
 11 St. John's and he certainly had no great in
 12 depth knowledge of those areas. And so again,
 13 it is part of that evolving process in trying
 14 to get the appropriate org structure in place
 15 and responsibilities.
 16 CHAYTOR, Q.C.:
 17 Q. What about the technologists, have performance
 18 evaluations been carried out on the
 19 technologists on a regular basis?
 20 DR. HOWELL:
 21 A. I don't know.
 22 CHAYTOR, Q.C.:
 23 Q. And would that ultimately be reported up to
 24 you?
 25 DR. HOWELL:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. So who would that be reported to?
 4 DR. HOWELL:
 5 A. That would be reported to Mr. Gulliver.
 6 CHAYTOR, Q.C.:
 7 Q. And it wouldn't go beyond Mr. Gulliver?
 8 DR. HOWELL:
 9 A. Well, ultimately I would expect that his
 10 division managers would be doing those
 11 evaluations and they would be coming into
 12 them. And I honestly don't know how that
 13 process works and how he has done those
 14 evaluations. I have not seen any of them.
 15 CHAYTOR, Q.C.:
 16 Q. But in terms of the--so the chain of reporting
 17 with respect to the pathologists' would be
 18 done by the clinical chief and ultimately you
 19 would foresee that--you would see that coming
 20 to your desk?
 21 DR. HOWELL:
 22 A. Right.
 23 CHAYTOR, Q.C.:
 24 Q. But not from the technologists to the division
 25 manager, to Mr. Gulliver, through Mr. Denic,

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

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

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

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1 next area is where are we going to give you
 2 privileges and what is it that we will allow
 3 you to do. So you might be given privileges
 4 in one hospital but not another, you might be
 5 given privileges to do certain procedures but
 6 not others, and again, we rely very heavily on
 7 the clinical chief to support that process.
 8 CHAYTOR, Q.C.:
 9 Q. And at the five-year interval is there any
 10 reexamination then of those various criterion?
 11 DR. HOWELL:
 12 A. Then there is they must apply again and in
 13 their application answer many of the questions
 14 which are very similar. We are in the process
 15 of reviewing that and, you know, our current
 16 discussion is that five years is too long, it
 17 probably should be reappointment after three
 18 years. And but there would be an annual
 19 evaluation. If we can strengthen this annual
 20 evaluation and get that working efficiently,
 21 then that will feed up very nicely into the
 22 time at which reappointment is appropriate.
 23 CHAYTOR, Q.C.:
 24 Q. So perhaps then the five-year interval would
 25 be appropriate if you can make sure that the

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1 annual evaluations are carries out?
 2 DR. HOWELL:
 3 A. That is correct. And as we evolve to a common
 4 set of bylaws, hopefully we will again
 5 standardize a lot of that process through our
 6 region.
 7 CHAYTOR, Q.C.:
 8 Q. Are issues of upgrading of skills or
 9 continuing medical education, are those
 10 addressed at the credentialling levels, is it
 11 done though the credentialling process or is
 12 it just done at the performance evaluation?
 13 DR. HOWELL:
 14 A. It's not a strong part of the credentialling
 15 process, no.
 16 CHAYTOR, Q.C.:
 17 Q. So and if annual evaluations hadn't been
 18 taking place, then it could be quite some time
 19 before any questions are asked in terms of a
 20 physician, how much upgrading of the skills
 21 physicians have had or how much continuing
 22 education has taken place?
 23 DR. HOWELL:
 24 A. Except that their own professional bodies, the
 25 Royal College of Physicians and Surgeons of

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1 Canada and the College of Family Practice all
 2 have requirements for minimum levels of
 3 continuing medical education at a given
 4 standard and you must provide evidence of
 5 having participated that, so external to the
 6 organization there are other demands if you're
 7 going to maintain your stature in that
 8 organization.
 9 CHAYTOR, Q.C.:
 10 Q. But does that direct in what areas you receive
 11 your hours of continuing medical education?
 12 For example, if we're dealing with a
 13 pathologist who is focused on doing IHC, I
 14 take it through that process there wouldn't be
 15 any direction given that there has to be
 16 certain upgrading of skills directed
 17 specifically at IHC?
 18 DR. HOWELL:
 19 A. That is correct, to the best of my knowledge.
 20 CHAYTOR, Q.C.:
 21 Q. So if that were to take place and depending on
 22 what procedures the physician has been
 23 permitted to do within Eastern Health, if
 24 there were to be any direction given of
 25 upgrading of skills specifically directed

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1 towards those procedures, that would have to
 2 take place within Eastern Health through the
 3 performance evaluation process?
 4 DR. HOWELL:
 5 A. That's correct.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. To your knowledge, was any requirement
 8 for the upgrading of skills or continuing
 9 medical education deriving from the ER/PR
 10 issue ever the subject of discussion with
 11 physicians either through the credentialling
 12 process or through performance evaluations?
 13 DR. HOWELL:
 14 A. Not to my knowledge.
 15 CHAYTOR, Q.C.:
 16 Q. And do you know why not?
 17 DR. HOWELL:
 18 A. I don't know why not.
 19 CHAYTOR, Q.C.:
 20 Q. Has that ever been the subject of discussion
 21 or anything that you have sought an answer to?
 22 DR. HOWELL:
 23 A. As I read the external reviews and that were
 24 performed and I'm looking at how we strengthen
 25 the laboratory, then the participation and

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1 continuing medical education and the--there is
 2 an allocation of if you're a--as negotiated
 3 under the memorandum of understanding between
 4 the NLMA and government--and I must say I do
 5 not have a strong, in depth knowledge of that.
 6 I've been private practice for many years
 7 outside of where it's been my own contracts,
 8 so. But as I understand it, part of that
 9 agreement is that specialists get allocations
 10 of \$2000 and general practitioners get \$1000
 11 which is a contribution towards their
 12 continuing medical education. So that would
 13 come through to our office to sign off for
 14 that payment and what it requires is the
 15 signature of the clinical chief supporting it
 16 and of the vice president that will change now
 17 to the director of medical service.
 18 CHAYTOR, Q.C.:
 19 Q. Okay.
 20 DR. HOWELL:
 21 A. So in that part I would be expecting that the
 22 clinical chief would be at least in that small
 23 sum of money, be looking at what that
 24 individual might be going to do and was it
 25 supportive of the program. That would be my

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1 hope and would be discussion that I would have
 2 with the clinical chiefs, that -
 3 CHAYTOR, Q.C.:
 4 Q. And whether or not that's happened, do you
 5 know?
 6 DR. HOWELL:
 7 A. Whether they--I don't, no, I can't speak to
 8 that. It's an evolving process and part of
 9 where I want--we must invest much more in that
 10 education and we must get much more focused.
 11 CHAYTOR, Q.C.:
 12 Q. And you've read Dr. Banerjee's report?
 13 DR. HOWELL:
 14 A. I did.
 15 CHAYTOR, Q.C.:
 16 Q. And you're aware that he recommended that
 17 there be continuing education for both the
 18 technologists and the physicians, the
 19 pathologists in the area of IHC, in
 20 particular?
 21 DR. HOWELL:
 22 A. Um-hm.
 23 CHAYTOR, Q.C.:
 24 Q. Other than Dr. Elms, are you aware of whether
 25 or not any other pathologists have had such

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1 additional training?
 2 DR. HOWELL:
 3 A. No. My understanding is that Dr. Elms did and
 4 that the technologists did. The other
 5 pathologists, I do not have specific knowledge
 6 about what additional CME they've attended.
 7 CHAYTOR, Q.C.:
 8 Q. And whether or not that was directed by
 9 Eastern Health or the clinical chief, you
 10 don't know?
 11 DR. HOWELL:
 12 A. I don't know.
 13 CHAYTOR, Q.C.:
 14 Q. At the reevaluation of credentials at the
 15 five-year mark, you've told me that the issue
 16 of upgrading skills would not normally be the
 17 subject of discussion. What happens then,
 18 what has to happen to be reevaluated and to
 19 receive your credentials again at the five-
 20 year mark?
 21 DR. HOWELL:
 22 A. Again, there would be a reapplication process.
 23 And I haven't looked at that application in
 24 some time because now Dr. Guy does, the
 25 director of medical services does all the

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1 credentialling.
 2 CHAYTOR, Q.C.:
 3 Q. So you'd apply all over in the same--is that
 4 it?
 5 DR. HOWELL:
 6 A. Yes, you make application again and have to
 7 reaffirm that you hold those--you know, you
 8 hold all the appropriate degrees. And if
 9 you've changed your position or you're serving
 10 on new roles, all that would be in that
 11 application, that you still have your licence
 12 and that they're so on and so forth.
 13 CHAYTOR, Q.C.:
 14 Q. And the clinical chief would have to put a
 15 letter again on the application file?
 16 DR. HOWELL:
 17 A. The clinical chief must support the
 18 reappointment process.
 19 CHAYTOR, Q.C.:
 20 Q. Okay.
 21 DR. HOWELL:
 22 A. That new evaluation process will strengthen
 23 that immensely, it is my hope. If we can
 24 continue to roll that out and apply it
 25 consistently, by the time reappointment comes

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1 up, you know, if we have physicians who we're
 2 not happy with some aspect of their practice,
 3 that should have been identified in the
 4 evaluation process and attempts at remediation
 5 should have taken place.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 DR. HOWELL:
 9 A. And it will be a challenge for us to--there
 10 are some situations where we have very few
 11 subspecialists in a given area and so this
 12 will be a challenging -
 13 CHAYTOR, Q.C.:
 14 Q. And breast pathology, of course, was one of
 15 those?
 16 DR. HOWELL:
 17 A. It would be one of those, that is correct.
 18 CHAYTOR, Q.C.:
 19 Q. If we could see, please, P-0745? Page 95,
 20 please? And this is the accreditation report
 21 which I understand the report is dated
 22 September 23rd to 28th, 2007. And I take it,
 23 Dr. Howell, you were actively involved in this
 24 process?
 25 DR. HOWELL:

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1 A. I was.
 2 CHAYTOR, Q.C.:
 3 Q. And on page 95, under "Human Resources"
 4 there's a recommendation, "It is recommended
 5 that the processes to credential, appoint,
 6 reappoint and grant medical staff privileges
 7 be standardized and criteria be clearly
 8 defined." And under "Potential Adverse," or
 9 the organization rating, and we had a witness,
 10 I believe it was Ms. Jones, tell us that seven
 11 is the ultimate number, the highest number.
 12 Organization rated itself a four, the survey
 13 rated it a three. "Potential adverse event
 14 without standardization, there exists
 15 potential for maintain practitioners that may
 16 not have the qualifications required for the
 17 job. Reason for urgency, there is little
 18 consistency in the content of documentation on
 19 the physicians' file." Can you speak to that
 20 and explain what is being referred to in the
 21 accreditation?
 22 DR. HOWELL:
 23 A. Each physician has a file within the medical
 24 administrator's office and there--when I first
 25 arrived and looked at some of those files, I

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1 felt that there were--I felt there were things
 2 missing from those files.
 3 CHAYTOR, Q.C.:
 4 Q. So you'd agree with this assessment?
 5 DR. HOWELL:
 6 A. I totally agree, I do.
 7 CHAYTOR, Q.C.:
 8 Q. And what did you think was missing from the
 9 files?
 10 DR. HOWELL:
 11 A. I'm trying to think of an example. I wanted
 12 to see a little bit more organization to the
 13 file and sometimes there would be a situation
 14 where there was, we had an urgent need for a
 15 specialist and that specialist arrived and
 16 while we demanded three references, only two
 17 were in. There was repeated chasing of third
 18 one, it didn't arrive. We needed that person
 19 in the position and it happened. And so, you
 20 know, I have tried to push the clinical chiefs
 21 to say I don't want it even to come to the
 22 credentials committee. There wasn't on the
 23 front cover a check mark that said, you know,
 24 here are all the components that we need to
 25 have in the file and what I wanted to see was

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1 that before that file went to the credentials
 2 committee, that there was a tick in every box
 3 and if there was not, don't take it to the
 4 credentials committee. And so it was really a
 5 strengthening of that process to make sure
 6 that the process was followed stringently.
 7 Now, you know, it's easy to be critical of
 8 that and to get very hard nosed about it, but
 9 at the same time if you only have two
 10 pediatric surgeons and one is gone and you're
 11 recruiting another and the other person is
 12 worn out and you need somebody now, I can see
 13 whereby sometimes you bend the rules to get
 14 that person in place. So it's the balance
 15 between being consistent and diligent and
 16 making sure you provide the service.
 17 CHAYTOR, Q.C.:
 18 Q. And did you discuss this with the surveyors?
 19 DR. HOWELL:
 20 A. I did not.
 21 CHAYTOR, Q.C.:
 22 Q. You didn't discuss this particular issue?
 23 DR. HOWELL:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. So do you understand, is it your understanding
 2 that it's more a documentation issue or is
 3 there any concern being expressed that, in
 4 fact, there may be practitioners that do not
 5 have the appropriate qualifications for the
 6 job?
 7 DR. HOWELL:
 8 A. No, I understood it was a documentation issue.
 9 CHAYTOR, Q.C.:
 10 Q. And then the second recommendation here also
 11 says "It is recommended that the process for
 12 credential appointment, reappointment and
 13 grading of privileges be documented and
 14 applied consistently across the Eastern Health
 15 region." And I take it the first one is
 16 recommending that standardization and criteria
 17 be clearly defined?
 18 DR. HOWELL:
 19 A. Um-hm.
 20 CHAYTOR, Q.C.:
 21 Q. And the second one seems to be specifically
 22 aimed at documentation, and there is reference
 23 to "Incomplete files may give rise to
 24 fragmented and inadequate processes." So I
 25 take it the other, the first concern that I

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1 directed your attention to is the need also
 2 for standardization and clearly defining the
 3 criteria by which a physician would be
 4 credentialed?
 5 DR. HOWELL:
 6 A. That's correct.
 7 CHAYTOR, Q.C.:
 8 Q. So and I take it you would agree with both of
 9 those recommendations?
 10 DR. HOWELL:
 11 A. I strongly agree with both of those
 12 recommendations.
 13 CHAYTOR, Q.C.:
 14 Q. Have you, in particular, checked the records
 15 regarding the credentialing of pathologists?
 16 DR. HOWELL:
 17 A. I have not.
 18 CHAYTOR, Q.C.:
 19 Q. Do you know if anybody has?
 20 DR. HOWELL:
 21 A. I do not know.
 22 CHAYTOR, Q.C.:
 23 Q. Do you know if the concerns raised by the
 24 surveyors pertain to pathologists?
 25 DR. HOWELL:

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1 A. My understanding was it was of a very general
 2 nature, not specific to any particular program
 3 or department or whatever.
 4 CHAYTOR, Q.C.:
 5 Q. So you wouldn't expect the record keeping or
 6 the lack of standardization to be any
 7 different for pathologists than any other
 8 physician group?
 9 DR. HOWELL:
 10 A. That's correct.
 11 CHAYTOR, Q.C.:
 12 Q. If we can have 1401, please? I'd like to ask
 13 you a few questions now about the medical
 14 bylaws, medical staff bylaws. And it was
 15 referenced in an answer you gave earlier.
 16 This is a memo that was written to yourself by
 17 Dr. Williams, September 29th, 2006. So I take
 18 it is Dr. Williams still at Eastern Health in
 19 this time period?
 20 DR. HOWELL:
 21 A. There was a transition period when I came on
 22 board and he remained in the office for the
 23 first month.
 24 CHAYTOR, Q.C.:
 25 Q. So you overlapped by a month?

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1 DR. HOWELL:
 2 A. That's correct.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And you started, you said, the Tuesday
 5 after Labour Day, is it?
 6 DR. HOWELL:
 7 A. Right. I think it was September 5th.
 8 CHAYTOR, Q.C.:
 9 Q. So by early October he'd left Eastern Health?
 10 DR. HOWELL:
 11 A. That's correct.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. And in this memo it deals with the
 14 medical staff bylaws. And he's attached the
 15 first draft at that point, blending the draft
 16 from the Health Boards Association with
 17 previous bylaws of the organizations which now
 18 form Eastern Health. And he goes on to say
 19 that, "There is some work to do," but he felt
 20 the bulk of the work has now been done and
 21 most of the rest requires a discussion at the
 22 October 18th, 2006 meeting of medical
 23 directors. And there's three items that he
 24 indicated need to be discussed. So Dr.
 25 Williams, certainly at that point in time,

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1 September 29th, 2006, felt that this was well
 2 under way. And I understand from your answer
 3 earlier that this has not been achieved to
 4 date. Can you tell us what is the current
 5 status and any challenges you have encountered
 6 along the way?
 7 DR. HOWELL:
 8 A. When I took over this role and there was that
 9 little transition period for Dr. Williams and
 10 I, I begged him if there was one thing not to
 11 leave me to do it was to rewrite the bylaws.
 12 He ultimately had the knowledge, was fully
 13 involved and thank God that he did agree that
 14 he would continue to try to complete that. It
 15 did, though, take on a life of its own in as
 16 much as I became aware that in the formation
 17 of the regional health authorities, the four
 18 regional health authorities that government
 19 had indicated that it wished for the four
 20 regional health authorities to have a very
 21 similar set of bylaws, at least along certain
 22 core elements such as credentialling and
 23 privileging, discipline and I think there were
 24 four or five modules that they said this core
 25 must be the same in all regional health

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1 authorities. And the first exposure I had to
 2 that was going to a meeting of the, all the
 3 other vice presidents of medical services for
 4 the other regional health authorities and
 5 there had been some work done to--and I think
 6 as I came into that, they were into the
 7 seventh or eighth draft of what this might
 8 look like.
 9 CHAYTOR, Q.C.:
 10 Q. I'm sorry, did you say that the government had
 11 directed that they wanted to see the
 12 regionalization of the bylaws?
 13 DR. HOWELL:
 14 A. They wished to see a common set of bylaws for
 15 some core elements.
 16 CHAYTOR, Q.C.:
 17 Q. So that's the minister of Health and Community
 18 Services, I take it?
 19 DR. HOWELL:
 20 A. That is correct.
 21 CHAYTOR, Q.C.:
 22 Q. So a common set, so across the province it
 23 would be basically the same template across
 24 the province?
 25 DR. HOWELL:

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1 A. That's correct. For not maybe the entire set
 2 of bylaws in that there may be some structural
 3 difference that would wrap around that core,
 4 but the core must be the same across the
 5 province.
 6 CHAYTOR, Q.C.:
 7 Q. And the authority that the government would be
 8 relying on to give that direction would be
 9 under the Regional Health Authorities Act?
 10 DR. HOWELL:
 11 A. Correct.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. I'm sorry, continue on then, and you
 14 went to a meeting, and what happened?
 15 DR. HOWELL:
 16 A. They were through multiple drafts. And I'm
 17 trying to recall this now, I may not be
 18 totally accurate, but it was trying to distil
 19 down to what this might look like and there
 20 was a desire, certainly from the CEOs of all
 21 the--of the four regional health authorities
 22 to get this done as quickly as possible. We
 23 had to move from getting that draft out to a
 24 consultative process with the physicians
 25 across the province and through the

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1 Newfoundland and Labrador Medical Association
 2 and that process continues up to today. And
 3 certainly within Eastern Health the medical
 4 advisory committee of the St. John's hospitals
 5 asked several of its members to take this on
 6 and come back with a report to the medical
 7 advisory committee. And it is my
 8 understanding that that group is also working
 9 with the Newfoundland and Labrador Medical
 10 Association to--and have suggested some
 11 changes which I have not seen to this point.
 12 And I now have asked the director of medical
 13 services that that be one of his key
 14 functions, that he would be working with those
 15 bylaws, and I think he's intimately involved
 16 with that, trying to bring it to some
 17 conclusion.
 18 CHAYTOR, Q.C.:
 19 Q. What are the stumbling blocks? Are there some
 20 issues that are contentious?
 21 DR. HOWELL:
 22 A. I am not certain of those that are
 23 contentious. The one that has been brought to
 24 my attention as key one is that these new
 25 bylaws have the medical staffs accountable to

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1 the CEO.
 2 CHAYTOR, Q.C.:
 3 Q. To the CEO of the authorities?
 4 DR. HOWELL:
 5 A. Correct.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. And who is proposing that?
 8 DR. HOWELL:
 9 A. That is proposed through the--through
 10 government, through the minister.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So Department of Health is proposing
 13 that?
 14 DR. HOWELL:
 15 A. That's my understanding.
 16 CHAYTOR, Q.C.:
 17 Q. Who currently are they accountable to?
 18 DR. HOWELL:
 19 A. The medical staff have voiced to me that they
 20 are accountable to the board and they wish to
 21 be accountable to the board, not to the CEO.
 22 CHAYTOR, Q.C.:
 23 Q. So we've heard that the medical advisory
 24 committee sits at the board and reports to the
 25 board. So right now the structure that the

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1 physicians--the physicians are in favour of
 2 the current structure in continuing to report
 3 directly to the board of directors, is that
 4 correct?
 5 DR. HOWELL:
 6 A. That is my understanding.
 7 CHAYTOR, Q.C.:
 8 Q. And what's being proposed would require that
 9 the physicians would report to the CEO within
 10 their health authority?
 11 DR. HOWELL:
 12 A. That's correct. And there are other issues,
 13 but I really have not been close to it for
 14 some months.
 15 CHAYTOR, Q.C.:
 16 Q. But that's a significant one that has been
 17 brought to your attention?
 18 DR. HOWELL:
 19 A. That is correct.
 20 CHAYTOR, Q.C.:
 21 Q. And what's the concern with reporting to the
 22 CEO?
 23 DR. HOWELL:
 24 A. You would have to ask them.
 25 CHAYTOR, Q.C.:

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1 Q. That hasn't been told to you?
 2 DR. HOWELL:
 3 A. You know, I think there is tremendous
 4 confusion out there as to who owns the bylaws.
 5 I've heard members of the medical staff say
 6 the medical staff bylaws belong to the medical
 7 staff. I don't believe that to be so. I
 8 think that they have always belonged to the
 9 board of the organization. But I think I
 10 don't have a more clear answer on that than
 11 that, but just wanting to get a consistent set
 12 of bylaws across the region in place and it is
 13 critical in order for us to move forward with
 14 the structural changes that we need.
 15 CHAYTOR, Q.C.:
 16 Q. So what bylaws do you current operate under?
 17 DR. HOWELL:
 18 A. The legacy bylaws of the legacy organization.
 19 CHAYTOR, Q.C.:
 20 Q. So in St. John's it would be the Health Care
 21 Corporation medical staff bylaws, in
 22 Clarenville it would be the bylaws -
 23 DR. HOWELL:
 24 A. Peninsulas.
 25 CHAYTOR, Q.C.:

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1 Q. Peninsulas. And what's the position of the
 2 board on the issue of the change in reporting
 3 to the CEO?
 4 DR. HOWELL:
 5 A. I am not aware, I have not heard any position
 6 from the board.
 7 CHAYTOR, Q.C.:
 8 Q. And you sit at board meetings?
 9 DR. HOWELL:
 10 A. I do.
 11 CHAYTOR, Q.C.:
 12 Q. And that issue hasn't been addressed?
 13 DR. HOWELL:
 14 A. Not when I have been present.
 15 CHAYTOR, Q.C.:
 16 Q. What then is the position, do you know, of the
 17 medical advisory committee within Eastern
 18 Health?
 19 DR. HOWELL:
 20 A. Well, there are five medical advisory
 21 committees within Eastern Health.
 22 CHAYTOR, Q.C.:
 23 Q. And who are those five?
 24 DR. HOWELL:
 25 A. There is the acute care hospitals in St.

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1 John's; there is long-term care in St. John's;
 2 there, and then there is one for Clarenville,
 3 Bonavista area; one for rural Avalon; and one
 4 for Burin, Grand Bank.
 5 CHAYTOR, Q.C.:
 6 Q. So not only there's been this issue of trying
 7 to come up something that everybody could live
 8 with across the province in keeping with what
 9 the minister had directed or suggested,
 10 there's also Eastern Health itself has not
 11 adopted its own regional bylaws?
 12 DR. HOWELL:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. That hasn't happened?
 16 DR. HOWELL:
 17 A. There is no Eastern Health bylaws as such.
 18 CHAYTOR, Q.C.:
 19 Q. It's all still within whatever the legacy
 20 organization was using?
 21 DR. HOWELL:
 22 A. That's correct.
 23 CHAYTOR, Q.C.:
 24 Q. And so you currently have five MACs?
 25 DR. HOWELL:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And all five report to the board?
 4 DR. HOWELL:
 5 A. That's correct.
 6 CHAYTOR, Q.C.:
 7 Q. And do all five have a representative sitting
 8 at board meetings?
 9 DR. HOWELL:
 10 A. They do not have a representative sitting
 11 there, only by invitation or at their request
 12 would they attend.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And -
 15 DR. HOWELL:
 16 A. They submit minutes, though, our items of
 17 concern from the MAC to the board.
 18 CHAYTOR, Q.C.:
 19 Q. So the chair of MAC for acute care, St.
 20 John's, is not necessarily representing the
 21 areas outside St. John's?
 22 DR. HOWELL:
 23 A. That is definitely so.
 24 CHAYTOR, Q.C.:
 25 Q. Is not representing?

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1 DR. HOWELL:
 2 A. Is not.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And do the chairs of the MAC for those
 5 regions also attend board meetings?
 6 DR. HOWELL:
 7 A. By invitation or at their request.
 8 CHAYTOR, Q.C.:
 9 Q. And is that also true for the chair of acute
 10 care in St. John's?
 11 DR. HOWELL:
 12 A. That's correct.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And does the chair--who is the chair,
 15 currently?
 16 DR. HOWELL:
 17 A. In St. John's?
 18 CHAYTOR, Q.C.:
 19 Q. Yes.
 20 DR. HOWELL:
 21 A. Dr. Linda Inkpen.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And does she normally attend board
 24 meetings?
 25 DR. HOWELL:

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1 A. She does not.
 2 CHAYTOR, Q.C.:
 3 Q. Do you have any liaison with the chairs of
 4 MAC, the five chairs?
 5 DR. HOWELL:
 6 A. More so--you know, I have attended MAC
 7 meetings across the region. The acute care
 8 St. John's, I would attend every MAC meeting
 9 there. And I try to get--you know, I would
 10 have been at the other MACs at least a couple
 11 of times since I've been in the position.
 12 CHAYTOR, Q.C.:
 13 Q. And are the medical advisory committees
 14 involved in the credentialling of the
 15 physicians?
 16 DR. HOWELL:
 17 A. They are.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. And what is their role?
 20 DR. HOWELL:
 21 A. Well, there is a--there are some standing
 22 committees of MAC and one of those is the
 23 credentials committee and the credentials
 24 committee submits a report to MAC about
 25 credentials, which MAC must adopt prior to it

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1 going to the board for final acceptance.
 2 CHAYTOR, Q.C.:
 3 Q. And where do you fit in that picture?
 4 DR. HOWELL:
 5 A. I, I guess, would be the consistent person at
 6 the board meeting and would put forward the
 7 reports from the MAC through the CEO and the
 8 chair of the board to the board.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. So earlier when we talked about the
 11 credentialling of physicians, that's not
 12 actually done by yourself, that's done by a
 13 committee of whichever MAC is applicable?
 14 DR. HOWELL:
 15 A. That is correct.
 16 CHAYTOR, Q.C.:
 17 Q. And then that committee reports to the MAC,
 18 and MAC currently reports directly to the
 19 board?
 20 DR. HOWELL:
 21 A. Yes. But the element of consistency, I guess,
 22 in that, is that, you know, in the past the
 23 vice president and the bylaws actually specify
 24 that the vice president will sit on the
 25 credentials committee. Now, as we've evolved

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1 to a director of medical services and with all
 2 the other things I'm dealing with I have
 3 delegated that to the director of medical
 4 services who sits in the credentials meeting
 5 in St. John's only. In the outside regions
 6 the clinical chief would be the person who
 7 would be the sort of common person sitting on
 8 that from an administrative point of view.
 9 CHAYTOR, Q.C.:
 10 Q. And who would sit there for the credentialling
 11 and the clinical chief?
 12 DR. HOWELL:
 13 A. That's a very good question. But it is a
 14 committee, a group of individuals who are
 15 evaluating your credentials and your
 16 reappointment. And I must tell you that the--
 17 exactly how that works in each of those other
 18 MACs and credentials committee, I do not have
 19 a sound a knowledge as I do in St. John's.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. And, Dr. Howell, you've agreed with the
 22 recommendations from the accreditation and you
 23 feel strongly about the need to have these
 24 things standardized. And I'm just thinking,
 25 you've got five MACs that you have to work

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1 with to try and coordinate this, that's
 2 currently is the dilemma that you face. Is
 3 that of concern to you and how is this going
 4 to happen? It's been, you know, three years
 5 trying get bylaws in place. How is that
 6 you're going to be able to regionalize the
 7 credentialling process?
 8 DR. HOWELL:
 9 A. Step 1, well, we've executed this new tool and
 10 we're rolling it out through acute care St.
 11 John's. And we, hopefully we will see these
 12 new bylaws in place in the fall, that would be
 13 my fondest wish. That will add some
 14 standardization and some consistency. And
 15 part of the structure process that will sit
 16 around that is there will be--there will
 17 continue to be local medical advisory
 18 committees--those existing medical advisory
 19 committees will not disappear. They will
 20 still remain in their geographic areas with
 21 their specific areas of responsibility and
 22 expertise. But they will report up to a
 23 regional medical advisory committee which will
 24 have representative from each of those medical
 25 advisory committees, local medical advisory

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1 committees. And that will be how we will hold
 2 the discussions and help drive the
 3 standardization and the expectations to that
 4 group. And I would then see that group being
 5 the group that reports to the board.
 6 CHAYTOR, Q.C.:
 7 Q. If we could have, please--or reports to see.
 8 COMMISSIONER:
 9 Q. Could I just ask a sort of, outsiders naive
 10 question. It seems you're making things more
 11 complicated than less. Is that right?
 12 DR. HOWELL:
 13 A. It's a very much a layered organization,
 14 Commissioner.
 15 COMMISSIONER:
 16 Q. And you're adding more layers?
 17 DR. HOWELL:
 18 A. What we're trying to do is to bring the region
 19 together and, again, the challenge is that the
 20 medical staff in Burin wishes to maintain some
 21 autonomy and control over those issues that
 22 are relevant to their region.
 23 COMMISSIONER:
 24 Q. Um-hm.
 25 DR. HOWELL:

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1 A. And in order to do that they need some
 2 structure, but we have to have a way that
 3 there are certain elements that are
 4 standardized in the approach. So again, it's
 5 trying to influence and collaborate -
 6 COMMISSIONER:
 7 Q. Okay, you know, I think I get the message in
 8 terms of what your many problems are. But
 9 just looking at this from a outside
 10 perspective, we have had various witnesses who
 11 have come along here and said, essentially,
 12 that as a matter of policy government decided
 13 initially to create Health Care Corp. That
 14 took a long period of time, there were growing
 15 pains. They eventually felt that they were
 16 getting somewhere and then government policy
 17 changed and larger organizations were created
 18 with perhaps more diversity in the kinds of
 19 operations which they were then taking over.
 20 There wasn't that commonality of what we're
 21 doing that had been there in Health Care, at
 22 least that's my perception of what people have
 23 been saying.
 24 DR. HOWELL:
 25 A. Um-hm.

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1 COMMISSIONER:
 2 Q. They also said that in the process one of the
 3 theories was that you could make things more
 4 streamlined, you could save on administrative
 5 costs and hopefully that kind of cost could be
 6 put into other things. But it seems to me
 7 what you're describing in terms of what's
 8 currently being happening, I'm not knocking
 9 the nature of the problems you have because of
 10 the fact that you are now trying to bring into
 11 an organization, that happens to be in a
 12 central place, people and organizations that
 13 had been accustomed up to now to effectively
 14 running their own show.
 15 DR. HOWELL:
 16 A. Um-hm.
 17 COMMISSIONER:
 18 Q. And I can perhaps relate a little to the
 19 concerns that maybe St. John's would be so
 20 dominant that their view of the world would
 21 never get through to anybody.
 22 DR. HOWELL:
 23 A. Um-hm.
 24 COMMISSIONER:
 25 Q. But in this process it seems to me we're

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1 creating more layers. And I'm wondering if in
 2 the end it's going to make life so complicated
 3 that you're not going to meet your objective.
 4 Am I just being unnecessarily pessimistic or
 5 naive about how much is possible with
 6 organizational structure properly achieved?
 7 DR. HOWELL:
 8 A. Commissioner, I would share the sentiments
 9 that you're expressing. And I wish that this
 10 could be done in a--before I took this job I
 11 didn't get a lot of support from my friends or
 12 family for taking it, and one of the reasons
 13 was that I'm not known to be a patient person.
 14 When I see a direction to go, I want to go
 15 there quickly. I have learned in this
 16 organization that you cannot go that quickly,
 17 you must work your way through the process and
 18 bring people along and, you know, there
 19 certainly is a politic of how medicine is
 20 practised throughout this province and at
 21 least at this point in time, we have not been
 22 able to see another direction to go. I really
 23 haven't changed, moved the ship a long ways in
 24 terms of that process of having a local
 25 medical advisory committee and then a

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1 regional.
 2 THE COMMISSIONER:
 3 Q. Uh-hm.
 4 DR. HOWELL:
 5 A. But I will tell you that every single medical
 6 advisory committee that I go to outside of St.
 7 John's, I constantly have to reaffirm that
 8 they are not going to lose their medical
 9 advisory committee. It is very, very
 10 important to them.
 11 THE COMMISSIONER:
 12 Q. Uh-hm.
 13 DR. HOWELL:
 14 A. And they view that as their voice into the
 15 Board and so at least at this point in time, I
 16 see no way to streamline it beyond that. Over
 17 time as maybe we build a team and everybody
 18 starts to look at things a little different
 19 and some of the, maybe the suspicions and the
 20 trust and the support amongst us grows, and I
 21 have some ideas about how to do that, but
 22 until that happens, I think we're stuck with
 23 this cumbersome structure.
 24 THE COMMISSIONER:
 25 Q. And just bring this back to labs, which is

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1 really where we need to sort of focus, are
 2 there peculiar problems to the laboratory and
 3 pathology end of things that are not operative
 4 in respect of other disciplines or -
 5 DR. HOWELL:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. What you have said generally applies equally
 9 to that area?
 10 DR. HOWELL:
 11 A. I think the difference would be that in terms
 12 of pathologists, there are only three--in
 13 Eastern Health, there are only three
 14 pathologists outside St. John's, it's a small
 15 group; there's one in Carbonear and that
 16 individual is very, very familiar with
 17 administrative side of things and understand
 18 its; and the other two individuals are in
 19 Clarenville. As far as a technologist per se,
 20 I think they all do similar work and I
 21 certainly get an impression that they are a
 22 group that get along fairly well. I haven't
 23 come across any lack of cohesion or that same
 24 degree that I would see with medical staff's,
 25 for example.

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1 THE COMMISSIONER:
 2 Q. No, okay. Sorry, Ms. Chaytor, I've
 3 interrupted again.
 4 CHAYTOR, Q.C.:
 5 Q. Thank you, Commissioner. If we could have,
 6 please, P-1422, page 11? These are your
 7 handwritten notes that we managed to get
 8 through, thank you, Dr. Howell, yesterday.
 9 And this is October 5th, I take it, 2006 and
 10 do I take it you're having a meeting on this
 11 day with Linda Inkpen?
 12 DR. HOWELL:
 13 A. That is correct.
 14 CHAYTOR, Q.C.:
 15 Q. Or is this a telephone call? Does this mean
 16 you're meeting with her?
 17 DR. HOWELL:
 18 A. I think, I can't recall, this was as I was -
 19 CHAYTOR, Q.C.:
 20 Q. Certainly a discussion with her in any event.
 21 DR. HOWELL:
 22 A. Yes, I was working through all the
 23 stakeholders and she was one of those.
 24 CHAYTOR, Q.C.:
 25 Q. And this is about a month into your job?

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1 DR. HOWELL:
 2 A. Right.
 3 CHAYTOR, Q.C.:
 4 Q. And she's the chair of the MAC for acute care
 5 in St. John's?
 6 DR. HOWELL:
 7 A. Correct.
 8 CHAYTOR, Q.C.:
 9 Q. And did you have similar meetings or
 10 discussions early in your tenure with the
 11 other chairs of MAC, outside of St. John's--
 12 acute care I'm mostly concerned with.
 13 DR. HOWELL:
 14 A. I did with the clinical chiefs outside of St.
 15 John's.
 16 CHAYTOR, Q.C.:
 17 Q. With the clinical chiefs.
 18 DR. HOWELL:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. And one of the issues it appears that you
 22 discussed on this date with Ms. Inkpen was the
 23 ER/PR issue?
 24 DR. HOWELL:
 25 A. Correct.

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1 CHAYTOR, Q.C.:
 2 Q. See that listed here.
 3 DR. HOWELL:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And do you recall what was discussed and why
 7 that would be of interest to Dr. Inkpen?
 8 DR. HOWELL:
 9 A. No, this would be, if you look at earlier
 10 slides, I was trying to build a template for
 11 gathering information and trying to understand
 12 who the people were, what roles they played,
 13 who were the strong leaders, who were the
 14 influencers, and then I was trying to get an
 15 idea of what Dr. Inkpen's role was, how MAC
 16 worked and this would have been a question--
 17 this is me reflecting back, but I think this
 18 would have been a question to say, so what are
 19 some of the key issues that might be before
 20 MAC at this point?
 21 CHAYTOR, Q.C.:
 22 Q. Okay, so this is your list of a key issue that
 23 may be before MAC?
 24 DR. HOWELL:
 25 A. This may be things that she said to me these

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

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

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1 CHAYTOR, Q.C.:
 2 Q. And is that still the situation then, is this
 3 duplication still taking place?
 4 DR. HOWELL:
 5 A. It does, very much so.
 6 CHAYTOR, Q.C.:
 7 Q. And with not an insignificant amount of time
 8 for busy physicians to attend both lots of
 9 meetings.
 10 DR. HOWELL:
 11 A. There is not a great love of meetings with
 12 physicians.
 13 CHAYTOR, Q.C.:
 14 Q. On the bottom of the page, you've written
 15 "credentials: evaluations peer review" and I
 16 take it that concerns the credentialling of
 17 physicians?
 18 DR. HOWELL:
 19 A. Uh-hm.
 20 CHAYTOR, Q.C.:
 21 Q. And what's meant here by evaluations and then
 22 peer review?
 23 DR. HOWELL:
 24 A. I think it was, again, very general discussion
 25 with Dr. Inkpen just talking to me about--

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1 because she chairs the credentials committee,
 2 so it would have been general discussion about
 3 some of the, how all that worked and maybe
 4 particular issues for her or whatever, but
 5 this was a very general help me understand how
 6 you and I relate.
 7 CHAYTOR, Q.C.:
 8 Q. Right. And I take it if there were to be a
 9 peer review conducted, that's done through
 10 MAC?
 11 DR. HOWELL:
 12 A. There is a--certainly in St. John's in acute
 13 care there is a very defined policy about how
 14 peer review is conducted.
 15 CHAYTOR, Q.C.:
 16 Q. Yes, which we have had occasion to see.
 17 DR. HOWELL:
 18 A. You have.
 19 CHAYTOR, Q.C.:
 20 Q. And that is done then through MAC?
 21 DR. HOWELL:
 22 A. Correct.
 23 CHAYTOR, Q.C.:
 24 Q. Is there, the clinical chiefs, how are
 25 clinical chiefs appointed?

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1 DR. HOWELL:
 2 A. There is a search process whereby a message
 3 would go from my office looking for
 4 applications for the position of clinical
 5 chief. Physicians would apply for the
 6 position and a search committee usually
 7 consisting of several physicians from the
 8 discipline program and the chief operating
 9 officer for the program would sit on that
 10 search committee.
 11 CHAYTOR, Q.C.:
 12 Q. Is there a job description for the clinical
 13 chief of the laboratory medicine program?
 14 DR. HOWELL:
 15 A. There is a job description for clinical chief
 16 -
 17 CHAYTOR, Q.C.:
 18 Q. In general.
 19 DR. HOWELL:
 20 A. - that is generic.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, so it's not specific for a particular
 23 area?
 24 DR. HOWELL:
 25 A. It is changing, it is another task to be

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1 completed.
 2 CHAYTOR, Q.C.:
 3 Q. It's on your list.
 4 DR. HOWELL:
 5 A. It is on the "To Do" list.
 6 CHAYTOR, Q.C.:
 7 Q. And is there also a Medical Staff Association?
 8 DR. HOWELL:
 9 A. There is.
 10 CHAYTOR, Q.C.:
 11 Q. And what is the purpose of that organization?
 12 DR. HOWELL:
 13 A. The Medical Staff Association is all
 14 physicians who are members of the medical
 15 staff.
 16 CHAYTOR, Q.C.:
 17 Q. Of Eastern Health?
 18 DR. HOWELL:
 19 A. Of--well, each, again just as there is a MAC,
 20 there is a Medical Staff Association, although
 21 there are not five Medical Staff Associations,
 22 but there would be a Medical Staff Association
 23 in Burin, there would be one in Clarendville,
 24 there would be one in St. John's.
 25 CHAYTOR, Q.C.:

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1 Q. And what's the purpose of that group? How
 2 does that group differ from the MACs?
 3 DR. HOWELL:
 4 A. The MACs are the physician leaders; the
 5 Medical Staff Association is totally
 6 independent. It is all physicians and it
 7 elects its own president and
 8 secretary/treasurer.
 9 CHAYTOR, Q.C.:
 10 Q. But what would their mandate be, what do they
 11 do?
 12 DR. HOWELL:
 13 A. To discuss issues of importance to the medical
 14 staff and bring it forward to administration.
 15 CHAYTOR, Q.C.:
 16 Q. And who do they report to? Who do they bring
 17 their questions to?
 18 DR. HOWELL:
 19 A. They would bring issues forward to my office
 20 or they might bring it forward directly to the
 21 Board if they so chose.
 22 CHAYTOR, Q.C.:
 23 Q. Do they have a representative that sits at the
 24 Board?
 25 DR. HOWELL:

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1 A. They do not.
 2 CHAYTOR, Q.C.:
 3 Q. But they can have direct access to the Board
 4 if they so choose?
 5 DR. HOWELL:
 6 A. I'm not sure of the answer to that, I'm sure
 7 if they asked to speak to the Board that the
 8 Board Chair would have to make a decision, but
 9 I would expect that the Board Chair would
 10 entertain that. It's--well, I've only been
 11 there such a short time, I have not seen it
 12 happen.
 13 CHAYTOR, Q.C.:
 14 Q. Have you also had discussions or met with the
 15 Chair of the Medical Staff Association?
 16 DR. HOWELL:
 17 A. No, I haven't.
 18 CHAYTOR, Q.C.:
 19 Q. Are you aware of whether or not they have
 20 brought forward anything in terms of the ER/PR
 21 issue? Has anything come to your office or
 22 has anything gone directly to the Board from
 23 the Medical Staff Association regarding this
 24 issue?
 25 DR. HOWELL:

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1 A. The president of the Medical Staff has written
 2 some communications, but they've had great
 3 difficulty with the Medical Staff Association.
 4 It typically meets quarterly, but they've had
 5 immense difficulty getting quorums to hold a
 6 meeting.
 7 CHAYTOR, Q.C.:
 8 Q. Who is the current president?
 9 DR. HOWELL:
 10 A. Dr. Scully. And we're talking about St.
 11 John's now, remembering that there are other--
 12 in Eastern Health, there are the others.
 13 CHAYTOR, Q.C.:
 14 Q. But Dr. Scully has written regarding the ER/PR
 15 issue?
 16 DR. HOWELL:
 17 A. No, I don't remember any correspondence from
 18 her on ER/PR.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, all right. My question was whether or
 21 not there had been any proposals or anything
 22 put forward by the Medical Staff Association
 23 regarding the ER/PR issue?
 24 DR. HOWELL:
 25 A. Not of which I'm aware.

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1 CHAYTOR, Q.C.:
 2 Q. And that's true of the Medical Staff
 3 Associations throughout the Eastern region?
 4 DR. HOWELL:
 5 A. That's correct.
 6 CHAYTOR, Q.C.:
 7 Q. To your knowledge they haven't put forward
 8 anything?
 9 DR. HOWELL:
 10 A. To the best of my knowledge.
 11 THE COMMISSIONER:
 12 Q. Is the Medical Staff Association primarily
 13 involved in issues which relate to perhaps
 14 compensation benefits, that kind of thing or
 15 are there interests wider than that, in the
 16 sense of items in relation to patient care,
 17 would they get involved with that, as opposed
 18 to one of the other methods?
 19 DR. HOWELL:
 20 A. It's far ranging, Commissioner, they can get
 21 involved in many--compensation would not be a
 22 common thing that they would talk about
 23 because that would be done directly between
 24 the Newfoundland and Labrador Medical
 25 Association and Government, but patient care

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1 issues certainly would be discussed there. It
 2 can run the range of complaints about parking
 3 to patient care issues.
 4 THE COMMISSIONER:
 5 Q. Okay.
 6 CHAYTOR, Q.C.:
 7 Q. I'd like to turn then to any involvement
 8 you've had regarding recruitment and retention
 9 of medical staff and in particular,
 10 pathologists. First of all, was that
 11 identified as an issue to you when you took
 12 your current position?
 13 DR. HOWELL:
 14 A. It certainly--I became aware, yes, very very
 15 early, even in the note you just showed me, I
 16 think with Dr. Inkpen, virtually the first few
 17 days of the job I recognized that we had a
 18 problem with hematology/oncology and we were
 19 down to, I think only two physicians providing
 20 coverage for that important area and it's like
 21 every day there's a crisis and that one
 22 appeared very early in my tenure.
 23 CHAYTOR, Q.C.:
 24 Q. And how about the issue regarding
 25 pathologists?

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1 DR. HOWELL:
 2 A. That, I became aware of that gradually as I
 3 think you'll see in the flow of my notes that
 4 that too was an issue.
 5 CHAYTOR, Q.C.:
 6 Q. And that was something that was brought to
 7 your attention early, fairly early in this?
 8 DR. HOWELL:
 9 A. Yes, it would be.
 10 CHAYTOR, Q.C.:
 11 Q. If we could look at please, P-0488, page 4?
 12 And these are minutes of an executive
 13 management committee of January 10th, 2007.
 14 So you've been in the job a few, a few months
 15 at this point.
 16 DR. HOWELL:
 17 A. Uh-hm.
 18 CHAYTOR, Q.C.:
 19 Q. And I just want to look at, show you who is
 20 present at the meeting, which does include
 21 yourself and then when we look at page 4,
 22 under "ER/PR testing to resume January 15th,
 23 2007" and I'll have questions with you
 24 regarding that a little later on, but you go
 25 on to state here, "Dr. Howell explained that

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1 the monitoring of one receptor will continue
 2 to be carried out by a contract with Gamma-
 3 Dynacare Medical Laboratories and the
 4 organization have renewed the contract in that
 5 respect. And the question was raised that the
 6 salary physician budget is a separate budget
 7 that cannot be utilized for that purpose. The
 8 organization"--this is the part here--"has
 9 received another resignation from one of our
 10 pathologists. Currently the organization is
 11 down 13 pathologists from the normal
 12 contingent of 19 and the workload report
 13 commissioned by the Department of Health and
 14 Community Services is expected to be received
 15 by the end of the month." And we understand
 16 that's Dr. Raymond Maung's report?
 17 DR. HOWELL:
 18 A. That's correct.
 19 CHAYTOR, Q.C.:
 20 Q. And "Dr. Howell noted that it's critical to
 21 get all pathologists on one site within the
 22 city and renovations have been slow." And we
 23 spoke about that earlier. So I take it that
 24 at least as of January 10th, 2007, this is
 25 being discussed at executive management while

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1 you're there?
 2 DR. HOWELL:
 3 A. That should read "currently the organization
 4 is down to 13 pathologists" not down 13.
 5 CHAYTOR, Q.C.:
 6 Q. Down to 13, yes, not down 13. So you're down
 7 to 13, so you're down six pathologists at that
 8 point in time?
 9 DR. HOWELL:
 10 A. That's correct.
 11 CHAYTOR, Q.C.:
 12 Q. And had that changed from when you began in
 13 September 2006? Was this new or had it
 14 remained stable at 13?
 15 DR. HOWELL:
 16 A. No, I think shortly after I arrived and I'm
 17 not totally certain of this, but I think a
 18 couple of pathologists left shortly. As I was
 19 arriving, I think they were departing.
 20 CHAYTOR, Q.C.:
 21 Q. And if we could look then please at P-0201 and
 22 this is a couple of months now after the
 23 executive management committee minutes that we
 24 just looked at and this is a letter of March
 25 8th, 2007 to Dr. Abbott and it's from Dr.

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1 Denic and he's writing as the president of the
 2 Newfoundland Association of Pathologists and
 3 also in his role as interim clinical chief?
 4 DR. HOWELL:
 5 A. Uh-hm.
 6 CHAYTOR, Q.C.:
 7 Q. And he's copied this to a number of people,
 8 including the Minister, the Premier, Minister
 9 of Health and the Minister of Finance, and to
 10 Mr. Ritter. Have you seen this document
 11 before, Doctor?
 12 DR. HOWELL:
 13 A. I have.
 14 CHAYTOR, Q.C.:
 15 Q. And you'll see here where he's referring to
 16 the "current staffing in St. John's hospital
 17 is below the optimum to guarantee proper
 18 patient care. We are currently short four
 19 pathologists, with the fifth one departing on
 20 March 30th, 2007. Dr. Fontaine, director of
 21 cytopathology, postponed his resignation until
 22 June 22nd pending the outcome of the
 23 negotiations of the Pathology Group and
 24 Government. This will result in a shortfall
 25 of over 30 percent for St. John's hospital.

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1 The situation outside St. John's is even more
 2 serious, with only one pathologist left in
 3 Clarenville and one in Gander, and there is a
 4 resignation in Corner Brook."
 5 So at this point in time, Dr. Fontaine
 6 had submitted his resignation, but had
 7 postponed it pending the outcome, and Dr.
 8 Denic is indicating they're now short four
 9 pathologists with a fifth one departing. So
 10 did--it appeared you were down six in January.
 11 Had the situation improved in that two or
 12 three month period?
 13 DR. HOWELL:
 14 A. I would--I can't recollect back as to what the
 15 exact numbers. It seems to be a dynamic
 16 situation coming and going and I knew that Dr.
 17 Fontaine was looking at leaving and I remember
 18 having multiple meetings with him at one time,
 19 him and his wife, trying to one, understand
 20 some of the issues, and two, try to find was
 21 there any way that we could retain him.
 22 CHAYTOR, Q.C.:
 23 Q. Yes, and of course, Dr. Fontaine has recently
 24 submitted his resignation again.
 25 DR. HOWELL:

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

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1 A. I think that was St. John's.
 2 THE COMMISSIONER:
 3 Q. Just St. John's?
 4 DR. HOWELL:
 5 A. I think, Commissioner.
 6 THE COMMISSIONER:
 7 Q. So if I start counting, I should find 19
 8 positions within St. Clare's and the Health -
 9 DR. HOWELL:
 10 A. Health Science.
 11 THE COMMISSIONER:
 12 Q. - Health Science?
 13 DR. HOWELL:
 14 A. I think that is correct.
 15 THE COMMISSIONER:
 16 Q. Okay.
 17 CHAYTOR, Q.C.:
 18 Q. So the reference then two months later to
 19 there being a shortage of four, "we're
 20 currently short of four and with the fifth one
 21 departing," whether or not there were a couple
 22 of people within that time period--because
 23 this clearly is referring to St. John's
 24 hospital, Dr. Denic's letter.
 25 DR. HOWELL:

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

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1 Health. Have you seen this document before,
 2 Doctor?
 3 DR. HOWELL:
 4 A. I have, at some point, that's correct.
 5 CHAYTOR, Q.C.:
 6 Q. All right, and this shows--well, it's called
 7 Eastern Health St. John's, so I take it this
 8 is just the St. John's physicians.
 9 DR. HOWELL:
 10 A. Um-hm.
 11 CHAYTOR, Q.C.:
 12 Q. Pathologist staffing, and it's from 1995
 13 through to 2007, so certainly the time period
 14 which is of importance to the Commission, and
 15 1995 down through we'll see to 2007 here, and
 16 it appears that the number of approved
 17 positions has increased over time, starting in
 18 1995 to be 15 and up to--it changed to 19 in
 19 2000 and continues to be at 19 through to the
 20 current.
 21 DR. HOWELL:
 22 A. Um-hm.
 23 CHAYTOR, Q.C.:
 24 Q. And then we get the number of positions filled
 25 as of January 1, number of terminations,

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1 number of recruits for vacancies, number
 2 filled at the end of the year, December 31st,
 3 and then vacancies as of December 31st. If we
 4 look through here, we can see that in 1995
 5 through to 1999, there were no vacancies. So
 6 all 15 or 16 positions were filled.
 7 DR. HOWELL:
 8 A. Um-hm.
 9 CHAYTOR, Q.C.:
 10 Q. And in the year 2000 when it went to 19, I
 11 think there must be--and it went to 19 in
 12 2000, at the end of the year anyhow, all 19
 13 were filled. So there were no vacancies in
 14 the year 2000, and then continuing on, 2001,
 15 2002, you're down two and three and then by
 16 2003, you're back up doing pretty good, only
 17 one vacancy, and then it's continued on at two
 18 or three and then 2004 is shown to be four
 19 vacancies. So do you know, are those numbers
 20 accurate?
 21 DR. HOWELL:
 22 A. They would have been produced for us probably
 23 by somebody in my office who does that sort of
 24 work, but I was not present for any of that.
 25 I can't speak for the numbers. I would have

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1 to accept them as they are there.
 2 CHAYTOR, Q.C.:
 3 Q. And it was done at your request?
 4 DR. HOWELL:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. You asked someone in your office to get this
 8 information together?
 9 DR. HOWELL:
 10 A. Actually, I think it was done at Mr. Tilley's
 11 request, if I remember correctly.
 12 CHAYTOR, Q.C.:
 13 Q. But you're familiar with this document?
 14 DR. HOWELL:
 15 A. I had seen the document, that's correct.
 16 CHAYTOR, Q.C.:
 17 Q. Yes, okay, and so you have no reason to think
 18 it would be other than accurate?
 19 DR. HOWELL:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. The contractual relationship with labs
 23 outside the province, including Dynacare,
 24 that's still in place, I take it?
 25 DR. HOWELL:

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1 A. It is.
 2 CHAYTOR, Q.C.:
 3 Q. And is that--that's been in place for some
 4 period of time. Is that partly due to the
 5 shortage of pathologists within the province?
 6 DR. HOWELL:
 7 A. That's correct.
 8 CHAYTOR, Q.C.:
 9 Q. And what type of work is sent outside the
 10 province?
 11 DR. HOWELL:
 12 A. In my understanding, in talking to Dr. Denic,
 13 it would be tissue that is deemed to be less
 14 critical for turnaround time, for example, the
 15 removal of a non-suspicious mole or a small
 16 skin tag lesion or something that was not
 17 requiring an urgent report and direct
 18 communication between pathologist and surgeon,
 19 and that's my understanding of what we're
 20 currently sending to Dynacare.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and -
 23 DR. HOWELL:
 24 A. Although that obviously will change as we
 25 encounter challenges in any area.

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1 CHAYTOR, Q.C.:
 2 Q. Right, again an evolving process, I take it.
 3 DR. HOWELL:
 4 A. Unfortunately, yes.
 5 CHAYTOR, Q.C.:
 6 Q. And this here, 2007 indicating 19 number of
 7 approved positions, as of January 1, there
 8 were 16 filled and as of the end of the year,
 9 there were only 15 filled, but there's two
 10 asterisks and it says "the numbers for 2007
 11 are up to June 1st, 2007 and Dr." is it
 12 Hamodat?
 13 DR. HOWELL:
 14 A. Hamodat.
 15 CHAYTOR, Q.C.:
 16 Q. Will be starting on July 1st, 2007 and one new
 17 recruit will start in September/October 2007.
 18 Did that happen? Were two new pathologists--
 19 did two new pathologists join by the end of
 20 the year?
 21 DR. HOWELL:
 22 A. I think that that is so, but Dr. Denic should
 23 confirm.
 24 CHAYTOR, Q.C.:
 25 Q. Okay. So then going into 2008, you would have

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

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

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

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

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1 or people who are married to Newfoundlanders.
 2 The pathologists who are here, and have been
 3 here for some time, are here because they love
 4 this province, and so that's our key market
 5 that we would be going after, and that too has
 6 become a little bit of a catch 22 situation
 7 for us because if--while there is a residency
 8 program there now, if this pathology program
 9 is severely damaged, if we have a shortage of
 10 pathologists and we don't have a combination
 11 of some juniors and some seniors and we don't
 12 have stability, then I could see that that
 13 pathology training program would be in
 14 jeopardy and now we don't have residents and
 15 that's a strong pool to be negotiating with.
 16 So contacting those people early and trying to
 17 get them to agree to stay in our province.
 18 THE COMMISSIONER:
 19 Q. Do you want to take the luncheon break now?
 20 Is this a convenient spot?
 21 CHAYTOR, Q.C.:
 22 Q. That's fine, yes. Thank you.
 23 THE COMMISSIONER:
 24 Q. All right then. We'll break until 2:15.
 25 (LUNCH BREAK)

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1 THE COMMISSIONER:
 2 Q. Please be seated. Ms. Chaytor.
 3 CHAYTOR, Q.C.:
 4 Q. Thank you, Commissioner. Dr. Howell, you've
 5 told us that Dr. Williams remained in the
 6 position for about a month after you joined,
 7 so you overlapped by about a month. I take it
 8 then he was a good source or a good resource
 9 to you in terms of bringing you up to speed on
 10 most issues that you would be facing?
 11 DR. HOWELL:
 12 A. He was.
 13 CHAYTOR, Q.C.:
 14 Q. And did you, in fact, have meetings with Dr.
 15 Williams even prior to taking the job?
 16 DR. HOWELL:
 17 A. I did.
 18 CHAYTOR, Q.C.:
 19 Q. If we could look at, please, 1422, page one,
 20 and this is the beginning, Doctor, of the
 21 notes that you gave us. These are your
 22 handwritten notes, I take it?
 23 DR. HOWELL:
 24 A. They are.
 25 CHAYTOR, Q.C.:

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1 Q. And this page indicates that you met, in fact,
 2 with Bob Williams on, is that July 24th?
 3 DR. HOWELL:
 4 A. That's correct.
 5 CHAYTOR, Q.C.:
 6 Q. 2006. And what was the purpose of your
 7 meeting with Dr. Williams on that date? If we
 8 look through your notes, we see that there's--
 9 I believe that meeting went--you have at least
 10 five, six, six pages of notes from your
 11 meeting that day.
 12 DR. HOWELL:
 13 A. The first few pages actually were structured
 14 before I--well, as you'll note, this occurred
 15 before I even assumed the position and -
 16 CHAYTOR, Q.C.:
 17 Q. Sorry, when were you hired for the position?
 18 I know you began the beginning of September.
 19 DR. HOWELL:
 20 A. I think the Board might have endorsed this in
 21 early July, but I could stand to be corrected.
 22 I'm not sure of the exact date. I would have
 23 known at this point that I had the position.
 24 CHAYTOR, Q.C.:
 25 Q. Okay.

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1 DR. HOWELL:
 2 A. I wasn't going to be starting until the 5th of
 3 September. I had to give notice to, you know,
 4 the largest corporate client I had, but I had
 5 already--my brain had already started to work
 6 into gear for the new job and I was trying to
 7 devise in my mind a 30-60-90 day plan for
 8 assuming the position. So I had contacted Dr.
 9 Williams and I had asked if he and I could get
 10 together and these first few pages, I think,
 11 are more--well, first two pages there, I
 12 guess, are some structure that I was trying to
 13 put around the kinds of information that I
 14 might look for from him. In addition to that,
 15 I wanted to make sure that I didn't arrive on
 16 September the 5th and then it would take two
 17 weeks longer before I had a computer and all
 18 the paraphernalia I needed to get moving into
 19 the job.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and so the first page then, you talk--
 22 you've written about infrastructure, you know,
 23 logistics of taking on the job -
 24 DR. HOWELL:
 25 A. That's correct.

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1 CHAYTOR, Q.C.:

2 Q. - in terms of actual computer equipment, that

3 kind of thing.

4 DR. HOWELL:

5 A. Right.

6 CHAYTOR, Q.C.:

7 Q. Then the office of VP, the roles, functions.

8 So is this your notes to yourself in

9 preparation for meeting with Dr. Williams? Is

10 that it?

11 DR. HOWELL:

12 A. That's correct.

13 CHAYTOR, Q.C.:

14 Q. And on the second page then, C, you have

15 direct reports, little, none, reporting style,

16 SWAT?

17 DR. HOWELL:

18 A. Sorry, that's direct reports.

19 CHAYTOR, Q.C.:

20 Q. Title, is it?

21 DR. HOWELL:

22 A. Title name, reporting style and strengths,

23 weaknesses, opportunities and threats.

24 CHAYTOR, Q.C.:

25 Q. And threats, right, okay, and major issues,

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1 solutions identified resources, and again, is

2 this before you meet or is this during your

3 meeting?

4 DR. HOWELL:

5 A. This is before I met, again.

6 CHAYTOR, Q.C.:

7 Q. General situation, strengths and capabilities

8 exist now. Is that what that says?

9 DR. HOWELL:

10 A. Strengths and capabilities, what exists now,

11 what are the key priorities, what are lower

12 priorities, what are untouchables.

13 CHAYTOR, Q.C.:

14 Q. What does that mean, what are untouchables?

15 DR. HOWELL:

16 A. I think I was mostly trying to understand how

17 the political process worked at that point and

18 where were there areas that I should not be

19 going.

20 CHAYTOR, Q.C.:

21 Q. And were you given any advice on that by Dr.

22 Williams?

23 DR. HOWELL:

24 A. Not that I recall.

25 CHAYTOR, Q.C.:

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1 Q. And then the next page then is reference--is

2 this then actual discussion with Dr. Williams,

3 page three?

4 DR. HOWELL:

5 A. Yes, now we're into the actual office of the

6 vice president and who are the individuals who

7 sit in that office, what do they do, and well,

8 as indicated, I'm trying to find out a little

9 bit about those individuals.

10 CHAYTOR, Q.C.:

11 Q. Yes, okay.

12 DR. HOWELL:

13 A. And page four, the top of the page, the

14 position of director medical services, and

15 that's the position you've indicated there is

16 vacant at that time and it's since been filled

17 by Dr. John Guy?

18 DR. HOWELL:

19 A. That's correct.

20 CHAYTOR, Q.C.:

21 Q. And clinical chiefs report to this position?

22 DR. HOWELL:

23 A. Clinical chiefs will, when the position is

24 filled, yes, that they would report there.

25 CHAYTOR, Q.C.:

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1 Q. Okay. So is that currently the structure,

2 they report to Dr. Guy directly and not to

3 you?

4 DR. HOWELL:

5 A. That is evolving. We have done a new org

6 chart that shows them reporting through that

7 office, but up until now, we've been slowly

8 moving that way, but I really had him focused

9 more on the credentialing issues, the bylaws

10 issues and those sorts of things, but we are

11 moving towards that.

12 CHAYTOR, Q.C.:

13 Q. Okay, and that has not been the situation in

14 the past? In the past they reported directly

15 to Dr. Williams?

16 DR. HOWELL:

17 A. That's correct.

18 CHAYTOR, Q.C.:

19 Q. And that's because the position was vacant, is

20 that right?

21 DR. HOWELL:

22 A. That's correct.

23 CHAYTOR, Q.C.:

24 Q. And what does the next line say, chair -

25 DR. HOWELL:

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1 A. That the director of medical services will
 2 then end up chairing the meeting and would be
 3 the ad-hoc liaison person to MAC.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and over on the right, then if we come
 6 down a few lines under lab, we see Terry
 7 Gulliver's name.
 8 DR. HOWELL:
 9 A. Correct.
 10 CHAYTOR, Q.C.:
 11 Q. And there's a couple of points redacted, and
 12 then directly underneath that, we see--can you
 13 read what's written there, please? It's cut
 14 off on our page.
 15 DR. HOWELL:
 16 A. It says "estrogen progesterone" and I can't
 17 pick out the--I think receptors. It's R-E-C,
 18 I think it means, and then it looks like I
 19 wrote "positive 73 percent, quality assurance
 20 system in place."
 21 CHAYTOR, Q.C.:
 22 Q. Is that "in place"?
 23 DR. HOWELL:
 24 A. I think that's in--I think, in place.
 25 CHAYTOR, Q.C.:

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1 Q. And what's the last?
 2 DR. HOWELL:
 3 A. And the last, I can't read it.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. So I take it in this July 24th meeting
 6 with Dr. Williams, the ER/PR issue was the
 7 subject of discussion?
 8 DR. HOWELL:
 9 A. Well, what I've done is I've looked at all the
 10 people who report to me. I've asked him about
 11 some of their strengths and their weaknesses.
 12 He's given me that, and then under each of
 13 those headings, I've tried to look at what are
 14 the current hot issues that are going on in
 15 those particular areas.
 16 CHAYTOR, Q.C.:
 17 Q. Yes.
 18 DR. HOWELL:
 19 A. And he's outlined that to me.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and so the ER/PR issue was identified as
 22 a hot issue?
 23 DR. HOWELL:
 24 A. It was.
 25 CHAYTOR, Q.C.:

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1 Q. And then under oncology, can you read what's
 2 written there?
 3 DR. HOWELL:
 4 A. The issues there were home chemotherapy. He's
 5 suggesting that there had been conflict of
 6 some sort within the group, but it had
 7 declined of late, and that there were some
 8 personality issues.
 9 CHAYTOR, Q.C.:
 10 Q. Okay, and what does "missing reports" to the
 11 right, is that in relation -
 12 DR. HOWELL:
 13 A. That falls under diagnostic imaging.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, and underneath oncology then, is check -
 16 DR. HOWELL:
 17 A. This is under -
 18 CHAYTOR, Q.C.:
 19 Q. Looks like tech.
 20 DR. HOWELL:
 21 A. Remember that this category falls all the way
 22 down under pharmacy. So even the oncology
 23 issue, he was alerting me to that there were
 24 issues that related to pharmacy, and check
 25 tech check was the--within the first month or

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1 six weeks of being in the job, I ran into the
 2 major issue of inadequate pharmacists. We -
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So that's nothing to do with
 5 technologists?
 6 DR. HOWELL:
 7 A. No, no.
 8 CHAYTOR, Q.C.:
 9 Q. Okay.
 10 DR. HOWELL:
 11 A. None whatsoever.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. If we look then, turn to the next page,
 14 under stakeholders, and you have the CEO, COO
 15 and others listed, clinical chiefs, program
 16 directors, executive management team, I think
 17 that is, directors office, VP staff, and to
 18 the right, we have external, is that right?
 19 DR. HOWELL:
 20 A. That's correct.
 21 CHAYTOR, Q.C.:
 22 Q. And Rob Ritter?
 23 DR. HOWELL:
 24 A. Um-hm.
 25 CHAYTOR, Q.C.:

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1 Q. And Rob Ritter, of course, being the executive
 2 director of the NLMA?
 3 DR. HOWELL:
 4 A. That's correct.
 5 CHAYTOR, Q.C.:
 6 Q. So he would be someone that you would be
 7 expected to liaise with?
 8 DR. HOWELL:
 9 A. Correct.
 10 CHAYTOR, Q.C.:
 11 Q. And then John Peddle?
 12 DR. HOWELL:
 13 A. Correct.
 14 CHAYTOR, Q.C.:
 15 Q. And he's with the Health Board Association?
 16 DR. HOWELL:
 17 A. Correct.
 18 CHAYTOR, Q.C.:
 19 Q. And Ed Hunt, Cathy Bradbury and Blair Fleming,
 20 all physicians with the Department of Health?
 21 DR. HOWELL:
 22 A. That's correct.
 23 CHAYTOR, Q.C.:
 24 Q. And then coming down underneath there, we have
 25 "meet" -

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1 DR. HOWELL:
 2 A. Every two months.
 3 CHAYTOR, Q.C.:
 4 Q. Every two months.
 5 DR. HOWELL:
 6 A. And those would be my confreres in the other
 7 regions.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So those are the VP Medical, Ken
 10 Jenkins, Larry Alteen and Michael -
 11 DR. HOWELL:
 12 A. Jeong.
 13 CHAYTOR, Q.C.:
 14 Q. They're VP medicals in the other regions?
 15 DR. HOWELL:
 16 A. Correct.
 17 CHAYTOR, Q.C.:
 18 Q. And you would meet every two months, and is
 19 that in fact what happens? Do you meet -
 20 DR. HOWELL:
 21 A. That is correct.
 22 CHAYTOR, Q.C.:
 23 Q. Via conference call, I take it?
 24 DR. HOWELL:
 25 A. Face to face or conference call.

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

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

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1 CHAYTOR, Q.C.:

2 Q. Okay. So until you came back to understand

3 the significance. So you had very little

4 discussion on the issue with Dr. Williams, and

5 by late October, as you indicated, Dr.

6 Williams would have left the position.

7 DR. HOWELL:

8 A. That's correct.

9 CHAYTOR, Q.C.:

10 Q. And you had--so up to that point in time, when

11 you say come back to the significance of it,

12 had it been brought to your attention by

13 anyone else?

14 DR. HOWELL:

15 A. Well, in the--there were references to it in

16 the lab leadership meetings. You'll see in

17 the agendas or the minutes of those meetings

18 that it would be one item that was referenced,

19 amongst many, and really my understanding at

20 that point, and it was a slow evolution with

21 all the other things that were going on, and I

22 understood that quality was working the ER/PR

23 case and eventually, over time, I learned of

24 the external reviews that had been done and I

25 don't recall even the first time that I took

Page 214

1 those out and started to read through them to

2 try to understand it. I think all of that was

3 evolving when we had reached a point where Dr.

4 Denic and the pathologists were going to do a

5 briefing for all the medical stakeholders and

6 the technologists in St. John's.

7 CHAYTOR, Q.C.:

8 Q. Yes, and that happens in November, and we'll

9 come to that.

10 DR. HOWELL:

11 A. Correct.

12 CHAYTOR, Q.C.:

13 Q. So I just want to understand, when you come

14 into the position, you're told very little

15 about ER/PR. You're in that position for

16 about a month, into late October, and I

17 understood from this morning that your

18 recollection is that you would have read the

19 external review reports in October, late

20 October?

21 DR. HOWELL:

22 A. I'm not sure when it was, but I'm guessing it

23 would have been then.

24 CHAYTOR, Q.C.:

25 Q. Okay, and so that first month that you're

Page 215

1 there, who did you understand had carriage of

2 the issue?

3 DR. HOWELL:

4 A. I don't think, in that first month there, that

5 I--it really was--there were so many things,

6 so many people that I was meeting with. I was

7 still trying to understand my role and I was

8 meeting all the COOs and I was meeting all the

9 direct reports I had. ER/PR was really not

10 even on my radar screen in that first month.

11 CHAYTOR, Q.C.:

12 Q. Okay. So it wasn't on your radar screen, so

13 who did you understand was managing the issue?

14 DR. HOWELL:

15 A. My understanding is that Quality, Ms. Pilgrim,

16 Heather Predham, that they were working--

17 always along this path, my focus has been

18 forward more than it has been backward, and

19 the understanding that the quality folks were

20 working back through that issue.

21 CHAYTOR, Q.C.:

22 Q. Well, did you understand--by saying that, did

23 you understand the issue was done at that

24 point, that it was resolved or was there

25 anything ongoing with ER/PR that would require

Page 216

1 a forward focus?

2 DR. HOWELL:

3 A. It would have been somewhere in the month of

4 October that I would have started to really

5 come up to speed and understand that there

6 were actions taking place as a follow up to

7 the external reviews, but exactly what date, I

8 don't know.

9 CHAYTOR, Q.C.:

10 Q. And at that point in time, did you become the

11 person in charge of the issue?

12 DR. HOWELL:

13 A. No, I always viewed myself as the person who

14 was the go-forward person, to make sure that

15 all the things that had to be enacted as a

16 result of the various reviews and things that

17 were performed.

18 CHAYTOR, Q.C.:

19 Q. So when Dr. Williams was here, he understood

20 that he was in charge of managing the issue.

21 You take over from Dr. Williams. At any point

22 in time do you understand that that now

23 becomes an issue that you are, as VP Medical,

24 in charge of managing?

25 DR. HOWELL:

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1 A. I understood that my--that the retrospective
 2 view was resting with Quality.
 3 CHAYTOR, Q.C.:
 4 Q. So Ms. Pilgrim?
 5 DR. HOWELL:
 6 A. That's correct, and that the prospective view,
 7 the go-forward was my responsibility.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and divide that for us then. What falls
 10 under retrospective and what falls under going
 11 forward?
 12 DR. HOWELL:
 13 A. Go forward would be looking--well, looking
 14 backward would be really the whole analysis of
 15 the numbers, the data that was being collected
 16 and assessed, the contacting of patients, the
 17 contacting of physicians. That entire piece I
 18 understood to be resting with Quality.
 19 CHAYTOR, Q.C.:
 20 Q. So that's resting with Ms. Pilgrim?
 21 DR. HOWELL:
 22 A. That's correct.
 23 CHAYTOR, Q.C.:
 24 Q. So analysis of the numbers, any contacting of
 25 patients, any further testing, if necessary,

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1 of additional patients, that rests with Ms.
 2 Pilgrim?
 3 DR. HOWELL:
 4 A. That was my understanding.
 5 CHAYTOR, Q.C.:
 6 Q. And what's your piece?
 7 DR. HOWELL:
 8 A. My piece is looking at the continued
 9 functioning of the lab and looking at, from
 10 the reviews that had been done, the actions
 11 that needed to be taken, that they were in
 12 fact taken and that we had the appropriate
 13 proficiency testing and things in place.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. So your piece then was to take whatever
 16 came out of the external reviews and determine
 17 whether or not the recommendations had been
 18 fully implemented, and if not, ensuring that
 19 that took place?
 20 DR. HOWELL:
 21 A. Take the learnings that have come and work
 22 with the leadership team, the lab leadership
 23 team, to ensure that we had acted on those
 24 things.
 25 CHAYTOR, Q.C.:

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1 Q. And who divided the tasks in that manner?
 2 DR. HOWELL:
 3 A. I would assume it was the CEO.
 4 CHAYTOR, Q.C.:
 5 Q. Ms. Jones? Or, sorry, Mr. Tilley at that
 6 point in time?
 7 DR. HOWELL:
 8 A. Well, would have been Mr. Tilley, that's
 9 correct.
 10 CHAYTOR, Q.C.:
 11 Q. Mr. Tilley. So Mr. Tilley told you that this
 12 is what he needed you to look after and that
 13 Ms. Pilgrim would be looking after the rest?
 14 DR. HOWELL:
 15 A. That was my understanding.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. And that was what Mr. Tilley told you?
 18 DR. HOWELL:
 19 A. I don't recall a conversation where Mr. Tilley
 20 said "Here's what Ms. Pilgrim is doing and
 21 here's what you're doing." I can't recall
 22 that kind of a conversation. But certainly I
 23 was on the periphery of many meetings and
 24 events where I knew that the people in quality

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1 were working with these numbers and with
 2 contacting patients and so on, I knew that
 3 that was going on over there.
 4 CHAYTOR, Q.C.:
 5 Q. And if it required further patients to be
 6 tested, that fell within what Ms. Pilgrim was
 7 responsible for?
 8 DR. HOWELL:
 9 A. She was still working that, that's correct.
 10 Now that would not mean -
 11 CHAYTOR, Q.C.:
 12 Q. And so is that -
 13 DR. HOWELL:
 14 A. - that she would never speak to me about those
 15 things and you know, her and I would chat not
 16 infrequently and, you know, sometimes if we
 17 were talking to Mount Sinai and it was going
 18 slow, she might ask me to contact the
 19 physician up there. But in most cases she was
 20 doing all of that.
 21 CHAYTOR, Q.C.:
 22 Q. And I would take it if it involved having to
 23 engage the clinical chief of pathology, that
 24 would be done through you?
 25 DR. HOWELL:

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1 A. Yes, there were meetings that she might have
 2 with them that I wouldn't be there, but most
 3 times that would be something we both would be
 4 involved in.
 5 CHAYTOR, Q.C.:
 6 Q. Do you know, what was the rationale for
 7 dividing the tasks in terms of responsibility?
 8 I can see the rationale of dividing the actual
 9 workload, but what was the rationale of
 10 dividing the tasks in terms of accountability
 11 or management of the issued?
 12 DR. HOWELL:
 13 A. You know, maybe it was just that there was a
 14 recognition that I was new to the
 15 organization, I had none of the history. It
 16 was going, as Mr. Tilley had said to me, this
 17 is going to be a very steep learning curve and
 18 certainly it has been. And it was resided in
 19 quality, and I think Ms. Predham was very
 20 heavily engaged with this and her reporting
 21 relationship was through quality. And I think
 22 that Dr. Williams had had quality but then
 23 that had been taken from my portfolio and put
 24 with Ms. Pilgrim.
 25 CHAYTOR, Q.C.:

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1 Q. Yes, okay. So when you're saying it was
 2 October before really, or late October before
 3 really the issue hit your radar screen. And
 4 how was it brought to your attention at that
 5 point in time, who told you and what were you
 6 told?
 7 DR. HOWELL:
 8 A. Other than what's in these notes, I think we
 9 were moving to this point where, as I said
 10 earlier, Dr. Denic and his colleagues were
 11 going to do a presentation to all the
 12 interested folks within not only the medical
 13 staff but technologists, etcetera, on this
 14 particular issue, and so I had had
 15 conversations with him about that. I think
 16 that meeting was on November the 20th.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. Well, perhaps we'll take you through
 19 your notes, if that will -
 20 DR. HOWELL:
 21 A. Yeah, I think that's the -
 22 CHAYTOR, Q.C.:
 23 Q. - assist your recollection.
 24 DR. HOWELL:
 25 A. That'll help.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. The first note that I could find with
 3 any additional writing on it would be
 4 September 15th, 2006. And that's P-1422, page
 5 10, please? This looks like it may be a
 6 meeting of the lab medicine leadership team.
 7 Would that be right?
 8 DR. HOWELL:
 9 A. That's correct.
 10 CHAYTOR, Q.C.:
 11 Q. And if we scroll down, the fifth item that
 12 you've indicated--these are your notes, I take
 13 it, at the meeting, are they, Dr. Howell?
 14 DR. HOWELL:
 15 A. This would be my personal notes in the
 16 meeting.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. So it appears then that ER/PR was
 19 discussed in the meeting. And you've written,
 20 "Internal controls; external controls; QA
 21 program; proficiency testing; improving
 22 documentation; do we open lab in October?" Is
 23 that what that says?
 24 DR. HOWELL:
 25 A. That's what that says.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. So this was being discussed in this
 3 meeting. And what's this list, "internal
 4 controls; external controls; QA program;
 5 proficiency testing; improving documentation"
 6 what did you understand that to be?
 7 DR. HOWELL:
 8 A. That was quite sometime ago. I was in the job
 9 ten days. And I really can't recall--those
 10 were, in any questions I might have asked,
 11 those would just--would have been pertinent
 12 points that I would have heard in asking
 13 questions or them talking and that I recorded
 14 there on the conversation. But beyond that,
 15 it was very superficial for me at that point
 16 in time.
 17 CHAYTOR, Q.C.:
 18 Q. I can understand that. And knowing what you
 19 know now and later, in late October when you
 20 read the external reports, the issue of
 21 internal controls, external controls, QA
 22 program, proficiency testing and improving
 23 documentation, would you agree with me those
 24 are recommendations or points that came out of
 25 the external reviews?

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1 DR. HOWELL:
 2 A. That's exactly what I think that is.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So that's what's being told to you?
 5 DR. HOWELL:
 6 A. That's what I think, yes.
 7 CHAYTOR, Q.C.:
 8 Q. In terms of what came out of the reports,
 9 perhaps?
 10 DR. HOWELL:
 11 A. That's my guess.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. If we could look at page 14, then,
 14 please? And, Doctor, if I've missed any along
 15 the way, please bring my attention to it. I
 16 tried to review it as best I could last
 17 evening. And this looks like October 26th.
 18 So now this is late October?
 19 DR. HOWELL:
 20 A. Right.
 21 CHAYTOR, Q.C.:
 22 Q. And this is when you've indicated that perhaps
 23 the issue is brought to your attention?
 24 DR. HOWELL:
 25 A. Right.

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

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1 making notes on?
 2 DR. HOWELL:
 3 A. No. No, it--I would be almost certain that it
 4 was somebody had shared information with me
 5 and I was recording it and trying to
 6 categorize it in my own way.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. And so the number one you've written
 9 here is Dr. Ganguly and then we've redacted,
 10 there's redactions done here which mostly, I
 11 believe, are patient names?
 12 DR. HOWELL:
 13 A. That's correct.
 14 CHAYTOR, Q.C.:
 15 Q. "Lab work, you converted. I don't know what
 16 this means." So that's a note to yourself, is
 17 it?
 18 DR. HOWELL:
 19 A. No, no, no. I think this is that he had had a
 20 meeting with a patient.
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 DR. HOWELL:
 24 A. Whose results had changed and whoever had
 25 talked to me about this had indicated that he

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1 had said to the patient that he didn't know
 2 what this means.
 3 CHAYTOR, Q.C.:
 4 Q. Dr. Ganguly had said?
 5 DR. HOWELL:
 6 A. That's correct. And that the patient was now
 7 going to see Mr. Crosbie.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So you have a recollection of -
 10 DR. HOWELL:
 11 A. I only have what I have written here, that
 12 somewhere along the way someone talked to me
 13 about that.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. Someone had talked to you about this.
 16 And the patient--Dr. Ganguly had said he
 17 didn't know what this means about conversion?
 18 DR. HOWELL:
 19 A. That's correct, that's correct.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. And did you make any inquiries as to
 22 whether or not that--of Dr. Ganguly as to
 23 whether or not that was correct?
 24 DR. HOWELL:
 25 A. I did not.

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1 CHAYTOR, Q.C.:

2 Q. Do you know if anybody did?

3 DR. HOWELL:

4 A. I don't know.

5 CHAYTOR, Q.C.:

6 Q. Okay. And again, all of this is with respect

7 to ER/PR?

8 DR. HOWELL:

9 A. That's correct.

10 CHAYTOR, Q.C.:

11 Q. And number two, again, I believe it might be a

12 patient being referenced here, my

13 understanding.

14 DR. HOWELL:

15 A. I think it was a spouse of a patient.

16 CHAYTOR, Q.C.:

17 Q. Okay, spouse of a patient, is it, okay. And

18 "discussed with" did you have a discussion

19 with this person?

20 DR. HOWELL:

21 A. No, no. This again is I have been made aware

22 of this from some source and again, it was a

23 patient of Dr. Ganguly's who was in Corner

24 Brook. And I'm assuming that the patient or

25 the patient's spouse had not been communicated

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1 with and Dr. Ganguly agreed to see the man and

2 talk to him.

3 CHAYTOR, Q.C.:

4 Q. Okay. And in quotation marks you have there,

5 "Breakdown in communication." Do you recall

6 who was telling you that and what that refers

7 to?

8 DR. HOWELL:

9 A. I don't recall who was telling me that.

10 CHAYTOR, Q.C.:

11 Q. And was it a breakdown in communication with

12 the patient or the patient's family?

13 DR. HOWELL:

14 A. That is my understanding.

15 CHAYTOR, Q.C.:

16 Q. And Dr. Ganguly was agreeing to meet with the

17 relative?

18 DR. HOWELL:

19 A. That's what I think that means.

20 CHAYTOR, Q.C.:

21 Q. Okay. Number three was "Retro converters."

22 DR. HOWELL:

23 A. Um-hm.

24 CHAYTOR, Q.C.:

25 Q. Okay. And did you understand then when you're

Page 231

1 writing this at this point in time what retro

2 converters were?

3 DR. HOWELL:

4 A. I probably did not.

5 CHAYTOR, Q.C.:

6 Q. Okay. So part of your steep learning curve?

7 DR. HOWELL:

8 A. That's correct.

9 CHAYTOR, Q.C.:

10 Q. Okay. And then there's numbers written here,

11 "Positive, less than"--or sorry, "before 2001"

12 I take it that means, "greater than or equal

13 to 30 percent," and then after 2001, ten

14 percent?

15 DR. HOWELL:

16 A. Right.

17 CHAYTOR, Q.C.:

18 Q. "The National Institute of Health" is that

19 "2004"?

20 DR. HOWELL:

21 A. That's correct.

22 CHAYTOR, Q.C.:

23 Q. "One percent."

24 DR. HOWELL:

25 A. That's correct.

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1 CHAYTOR, Q.C.:

2 Q. And what would be your source of information

3 on that?

4 DR. HOWELL:

5 A. It could have come from pathologists,

6 oncologists or technologists. I would have

7 been talking to many people. And again, I'm

8 trying to understand what positive means and

9 understand this percentage component.

10 CHAYTOR, Q.C.:

11 Q. Okay. So you're not able to tell us what the

12 source of any of this information would be?

13 DR. HOWELL:

14 A. I wish I could, but -

15 CHAYTOR, Q.C.:

16 Q. But were there like one or two people who you

17 mainly would have learned about ER/PR from?

18 DR. HOWELL:

19 A. The principal people that I would be talking

20 to about this would be Dr. Denic, Mr.

21 Gulliver, Dr. Laing, Ms. Predham, Ms. Pilgrim.

22 CHAYTOR, Q.C.:

23 Q. Okay.

24 DR. HOWELL:

25 A. Those would be the individuals I would be most

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1 commonly conversing with.
 2 CHAYTOR, Q.C.:
 3 Q. Right, okay. And did Mr. Tilley ever give you
 4 any briefing on ER/PR?
 5 DR. HOWELL:
 6 A. Not that I recall.
 7 CHAYTOR, Q.C.:
 8 Q. And from your perception on joining the
 9 organization, did it appear to you that Mr.
 10 Tilley had much involvement in the issue?
 11 DR. HOWELL:
 12 A. He certainly had, I think, good knowledge of
 13 it, but I mean, he would not understand the
 14 technical components of that, I don't think,
 15 the science -
 16 CHAYTOR, Q.C.:
 17 Q. No, but in terms of the management of the
 18 issue?
 19 DR. HOWELL:
 20 A. As far as I understand he knew about it and
 21 was well versed in it, yes.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And who did you--did you understand
 24 that he was actually the person who was
 25 managing the issue?

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1 DR. HOWELL:
 2 A. No. I thought that--the rearward looking view
 3 and the management of the cases, past cases,
 4 the database, the contact was with quality,
 5 Ms. Pilgrim and Predham.
 6 CHAYTOR, Q.C.:
 7 Q. And the moving forward was with you?
 8 DR. HOWELL:
 9 A. That's correct.
 10 CHAYTOR, Q.C.:
 11 Q. And I take it you reported then to Mr. Tilley?
 12 DR. HOWELL:
 13 A. That's correct.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And you've indicated "panel" here, and
 16 a list of names. What did you understand that
 17 to be?
 18 DR. HOWELL:
 19 A. Those were the individuals who sat on the
 20 panel as the results were coming back to
 21 review whether the patients needed a change in
 22 treatment.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And did you understand that all of
 25 these people would sit at every panel meeting

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

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1 DR. HOWELL:
 2 A. I think the greatest lesson for me was that I
 3 had a long ways to go to understand where we
 4 needed to be in terms of patient safety, and
 5 it was a lot of concepts here that were new to
 6 me that I needed to develop further.
 7 CHAYTOR, Q.C.:
 8 Q. So you were hearing some of this for the first
 9 time?
 10 DR. HOWELL:
 11 A. That's correct.
 12 CHAYTOR, Q.C.:
 13 Q. The concepts at this seminar?
 14 DR. HOWELL:
 15 A. That's correct.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. If we just continue on, you've taken
 18 fairly detailed notes, and I would assume you
 19 also had material provided to you?
 20 DR. HOWELL:
 21 A. It subsequently was provided, that's correct.
 22 CHAYTOR, Q.C.:
 23 Q. And there's just a couple of points in here on
 24 page 20 of the exhibit. You see here, "IHI-QI
 25 for doctors, road map." Looks like "pay for

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1 performance, right thing to do. Privileges
 2 reporting, self-evaluation." Do you recall
 3 what was being discussed?
 4 DR. HOWELL:
 5 A. I think it's--I think this was a presentation
 6 on how to engage physicians in the whole
 7 patient safety quality movement.
 8 CHAYTOR, Q.C.:
 9 Q. Looks like the name of the presentation may
 10 have been "Leading Physicians Through Change"?
 11 DR. HOWELL:
 12 A. Correct.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. What's IHI stand for?
 15 DR. HOWELL:
 16 A. Not sure.
 17 CHAYTOR, Q.C.:
 18 Q. Okay.
 19 DR. HOWELL:
 20 A. Institute for Health Information, maybe, but
 21 I'm not positive.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And the next page--and by the way, if
 24 there's anything that you think else that may
 25 be of any relevance, you can point it out as

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1 we go through. But the next I notice is page
 2 21, "Patient/public involvement." And if we--
 3 it comes under a heading before that, "Foster
 4 a Culture of Safety". "Disclosure Policy."
 5 "Is board of directors involved?" Is that
 6 what that says?
 7 DR. HOWELL:
 8 A. That's correct.
 9 CHAYTOR, Q.C.:
 10 Q. "Patients involved in learnings?"
 11 DR. HOWELL:
 12 A. "Learnings".
 13 CHAYTOR, Q.C.:
 14 Q. "Communicate media."
 15 DR. HOWELL:
 16 A. Correct.
 17 CHAYTOR, Q.C.:
 18 Q. And do you recall what was being discussed
 19 there and why you saw fit to make note?
 20 DR. HOWELL:
 21 A. Again, I'm taking quick notes while speakers
 22 are speaking and I'm sort of trying to put it
 23 into my own categories and from there sort of
 24 develop themes about areas where I need to
 25 cultivate further knowledge. And I guess when

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1 you ask me would I point anything out, "Lead
 2 and support staff" was an -
 3 CHAYTOR, Q.C.:
 4 Q. That same page?
 5 DR. HOWELL:
 6 A. That's on that same page.
 7 CHAYTOR, Q.C.:
 8 Q. Yes, yeah.
 9 DR. HOWELL:
 10 A. And it was, I guess, some of that really
 11 resonated well with me and the concept of a
 12 just and trusting culture.
 13 CHAYTOR, Q.C.:
 14 Q. Yes.
 15 DR. HOWELL:
 16 A. And I was interested in how you move that
 17 thought process forward and then the whole
 18 reporting of adverse events and the, how you
 19 would get people to come forward freely with
 20 information. And there was talk about rather
 21 than calling them near misses, call them -
 22 CHAYTOR, Q.C.:
 23 Q. "Close calls" is what you wrote here.
 24 DR. HOWELL:
 25 A. "Good catch" or something.

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1 CHAYTOR, Q.C.:
 2 Q. Or "good catch." Not even a close call, good
 3 catch, okay. And you also wrote under that,
 4 you've got, "Reporting adverse events
 5 disclosure," and then "knowledge transfer."
 6 What did you mean by "knowledge transfer" or
 7 what did the speaker mean who you were taking
 8 these notes from?
 9 DR. HOWELL:
 10 A. I think it was the whole business of capturing
 11 adverse events that may go on or near misses,
 12 close calls, whatever you wish to call it and
 13 being able to put that in a common data set
 14 that you shared with others. A classic
 15 example of that would be mortality and
 16 morbidity rounds, which I saw as a wonderful
 17 tool for learning. The problem with it is
 18 that the areas that do do mortality and
 19 morbidity rounds did not keep good records of
 20 it and certainly did not share it with anyone
 21 else and I just thought that that was such a
 22 lost opportunity.
 23 CHAYTOR, Q.C.:
 24 Q. And have you taken steps to try and correct
 25 that or rectify that?

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

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1 elsewhere?
 2 DR. HOWELL:
 3 A. Absolutely critical.
 4 CHAYTOR, Q.C.:
 5 Q. And how you do that, in the context of people
 6 being concerned with litigation, is the
 7 challenge?
 8 DR. HOWELL:
 9 A. Correct.
 10 CHAYTOR, Q.C.:
 11 Q. And on page 23 of the exhibit, so if we can
 12 just turn over a couple of pages, Doctor, at
 13 the top of the page you've numbered nine,
 14 here, I believe, "root cause of sentinel
 15 event, the highest is poor communication." Do
 16 you recall what was being put forward there?
 17 DR. HOWELL:
 18 A. This would have been a presenter and it would
 19 have been a statement that they made that very
 20 much resonated with me.
 21 CHAYTOR, Q.C.:
 22 Q. And why is that?
 23 DR. HOWELL:
 24 A. Because I guess through my whole career many
 25 times we've made mistakes, it's been poor

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

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1 perhaps we could explore it now.
 2 DR. HOWELL:
 3 A. No, the issue for me, which we will get to, is
 4 unless you have solid data and you can get it
 5 efficiently and effectively, it's very hard to
 6 communicate, so that's why I would hesitate
 7 that a struggle for me, not only in this, but
 8 in the other things I've had to deal with in
 9 the short time in this job, is that ability to
 10 access data that you can feel confident about
 11 and that you can get in an efficient manner.
 12 CHAYTOR, Q.C.:
 13 Q. And so the issue of, for example, the--even
 14 the formatting of the pathology report and
 15 being able to access the information on that
 16 report, through your system and ultimately
 17 getting the information that you need out of
 18 that, and using it.
 19 DR. HOWELL:
 20 A. Absolutely.
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 DR. HOWELL:
 24 A. And the document management, the place is full
 25 of paper and, but yet to find something is

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1 impossible.

2 CHAYTOR, Q.C.:

3 Q. Okay. And then, Doctor, the next page I think

4 it looks like you're probably back in St.

5 John's, November 20th, 2006, and you've got

6 "ER/PR" written at the top of this page.

7 DR. HOWELL:

8 A. That's correct.

9 CHAYTOR, Q.C.:

10 Q. And is this notes from a meeting or how are

11 you acquiring this information?

12 DR. HOWELL:

13 A. I am sitting in the audience and in the main

14 lecture theatre of the medical school and many

15 of our clinicians and technologists are in the

16 room and the pathologists and others from

17 around the regions are teleconferenced into

18 this room and we are having presentations from

19 many of our pathologists.

20 CHAYTOR, Q.C.:

21 Q. Okay. So this is the presentation that was

22 given to the medical and other staff? Your

23 notes of that.

24 DR. HOWELL:

25 A. These are my notes as I'm trying to understand

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1 what this is all about myself.

2 CHAYTOR, Q.C.:

3 Q. Okay. So is this really your first time to,

4 in hearing the issue in any detail?

5 DR. HOWELL:

6 A. This is the first time where I'm really

7 starting to understand what

8 immunohistochemistry is all about.

9 CHAYTOR, Q.C.:

10 Q. Okay. And prior then to attending the

11 presentation on November 20th, had you already

12 read--do you feel confident you had already

13 read the external review reports at that point

14 in time?

15 DR. HOWELL:

16 A. I think I had, but--yes, I think I had, but

17 I'm not certain what time I first read those,

18 but I think I had.

19 CHAYTOR, Q.C.:

20 Q. And I'll bring you back to those notes, I just

21 want to try to stay in chronological order

22 here and there is another document I'd like to

23 bring to your attention first and that's P-

24 1402 and this is an e-mail exchange of October

25 26th, 2006 and if we scroll down through, you

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1 can see that it originates with an e-mail from

2 Ms. Predham and Ms. Predham is e-mailing to

3 yourself and Dr. Denic, Mr. Gulliver, Ms.

4 Elliott, Ms. Pilgrim, Susan Bonnell, Sharon

5 Smith and Kara Laing, and she's also copied

6 Nancy Parsons, Leona Barrington on this. And

7 it's an issue regarding a retro converter, a

8 patient who has--what's been referred to as a

9 retro converter and you will see that if we

10 look at the exchange of e-mails, she's

11 suggesting or there's a suggestion put forward

12 about meeting, I believe Sharon Smith puts

13 that forward. "Heather and I were talking

14 this morning, we felt a meeting would be in

15 order. Who wants to arrange it?" And then

16 you offer to arrange it at 4:30 in the

17 afternoon. So I take it at this point in time

18 you are certainly involved in the issue to the

19 point where you can arrange a meeting or you

20 can suggest to the group -

21 DR. HOWELL:

22 A. I was the facilitator of the meeting.

23 CHAYTOR, Q.C.:

24 Q. And is that it, you were just the facilitator

25 of the meeting or are you somehow managing

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1 this aspect of the issue?

2 DR. HOWELL:

3 A. Well I'm certainly getting increasingly

4 involved in trying to, again, understand what

5 happened here and feeling my role out, I guess

6 a little bit as well.

7 CHAYTOR, Q.C.:

8 Q. Okay. And if we just look down through the e-

9 mail itself, the first paragraph, you'll see

10 it as involving a person who is a retro

11 converter.

12 DR. HOWELL:

13 A. Uh-hm.

14 CHAYTOR, Q.C.:

15 Q. And she explains that that means she

16 originally stained positive, it was now coming

17 back negative. Then it continues on with "She

18 has been treated with Tamoxifen from 1999 to

19 2004 and the panel had had much discussion and

20 debate on how best to disclose this

21 information to the client." And the original

22 intent had been a meeting with the clinical

23 chiefs and someone from QRM, the quality and

24 risk management, but a complicated factor at

25 that time was the media coverage after the

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

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1 few questions for you on this. First of all,
 2 did the meeting go ahead to discuss what Ms.
 3 Predham has raised?
 4 DR. HOWELL:
 5 A. I don't recall the meeting.
 6 CHAYTOR, Q.C.:
 7 Q. You don't recall any -
 8 DR. HOWELL:
 9 A. I don't recall the meeting. It's interesting
 10 that as I read that, I, you know, I recall
 11 back my concern in talking to Ms. Predham and
 12 seeing the degree of emotional stress and pain
 13 that she was feeling and dealing with this
 14 issue and that makes me believe that the
 15 information that I had gathered about the two
 16 patients with Dr. Ganguly likely came from
 17 her.
 18 CHAYTOR, Q.C.:
 19 Q. So that may have been that discussion -
 20 DR. HOWELL:
 21 A. That may be the tie in to that particular note
 22 being written.
 23 CHAYTOR, Q.C.:
 24 Q. And that's one of the things I wanted to ask
 25 you about this, because--about the emotional

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1 stress because Dr. Williams certainly told the
 2 Commission that early in the process, I think
 3 he said like September of 2005, he, himself,
 4 was feeling pretty overwhelmed with having to
 5 deal with the issue and you come into this
 6 with a fresh perspective. Did you have
 7 concerns about the people who then were trying
 8 to continue to deal with this issue a year
 9 later and where they were on the issue? Did
 10 you have concerns about how well they were
 11 coping?
 12 DR. HOWELL:
 13 A. I certainly--yes, I think my answer--my answer
 14 is yes. I certainly saw that Ms. Predham was
 15 feeling the strain of dealing with this, I
 16 think she carried a great deal of the weight.
 17 I was quite--in the world that I had come out
 18 of, when you would have an event of such
 19 magnitude as this and so large, and I'll call
 20 it a project, there would have been a person
 21 assigned, seconded to a position to deal with
 22 that and it would have been their only
 23 activity. Here people were dealing with this,
 24 continuing to do the rest of their day's work
 25 and manage this major significant event on top

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1 of that day's work. That was--I had great
 2 difficulty understanding that particular way
 3 of approaching the problem. I will be honest
 4 and I, myself, was finding that, I thought I
 5 was a pretty good multi-tasker, but this is
 6 just coming from every direction.
 7 CHAYTOR, Q.C.:
 8 Q. And Dr. Williams told us on top of that, in
 9 having to manage and it was an issue of a
 10 magnitude that he certainly had not seen in
 11 his lengthy career were of such significance
 12 and on top of that, was also the restructuring
 13 that was happening within the organization at
 14 the time and I believe his terms, in
 15 describing that for the Commissioner, he used
 16 the term "perfect storm" and he used the term
 17 that it was his "worse nightmare". So you
 18 come along a year really or a little bit
 19 beyond a year into this, and it was certainly
 20 no ordinary clinical issue that was being
 21 managed, you, unlike everyone else on the
 22 team, you're coming at this with a fresh
 23 perspective and you certainly haven't had to
 24 be entrenched in the issue and the day to day
 25 of it, did you express your concern to anyone?

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1 Did you go to Mr. Tilley and indicate to him
 2 that--or anyone else, did you express concern
 3 as to the strain that the staff were under in
 4 having to deal with this issue and any other
 5 concerns you may have had as to their capacity
 6 to really continue to manage this issue?
 7 DR. HOWELL:
 8 A. My recollection is that there were
 9 conversations held, you know, at the executive
 10 level about the level of strain that these
 11 folks were under and I'm fairly certain that I
 12 had a conversation with Mrs. Pilgrim out of
 13 concern for Ms. Predham and I remember making
 14 the comment that she was her own worse enemy
 15 because she could say no to nobody. And so
 16 every time there was an issue, an adverse
 17 event or a question mark about care or
 18 whatever, she was the person who was being
 19 called. And I probably started to become
 20 guilty of that myself because she was the
 21 person to call and yes, there was quite a
 22 great deal of concern, but my other problem
 23 was I was still feeling my way out within the
 24 executive itself and the style in which
 25 meetings were held and the way information was

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1 transferred and just keeping up with the
 2 volume of material that was being sent on a
 3 daily basis to read was quite a piece of work.
 4 CHAYTOR, Q.C.:
 5 Q. And you've told us that you had a fairly
 6 extensive background in human resources and
 7 you did notice this strain certainly at least
 8 with respect to Ms. Predham. You spoke to Ms.
 9 Pilgrim about it and she indicated that Ms.
 10 Predham being her own worse enemy, but beyond
 11 that, was there any, you know, at some point
 12 any further action taken or in terms of the,
 13 you know, the executive team are the people
 14 who ultimately Ms. Predham would take her
 15 directions from, but I take it nothing further
 16 came of that and Ms. Predham continued on in
 17 her role and her--certainly a significant role
 18 that she played on this group that was put
 19 together to manage this issue.
 20 DR. HOWELL:
 21 A. I don't know at what time, but I know that
 22 Mrs. Pilgrim did step in and take some things
 23 off the table for Ms. Predham in concern for
 24 her health and for the volume of work that she
 25 was carrying.

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1 CHAYTOR, Q.C.:
 2 Q. And what about others? Did you notice similar
 3 issues with others who had been involved
 4 heavily in this issue?
 5 DR. HOWELL:
 6 A. This was affecting the entire organization at
 7 this point. I mean I was seeing extreme--as
 8 we got into this presentation on November 20
 9 and then subsequent to that and I know we're
 10 headed there chronologically, I mean, the
 11 stress level in general was mounting all
 12 around me, particularly on the laboratory
 13 side, but throughout the organization--I mean,
 14 I--you know, meeting people in the corridor.
 15 The level of, the volume of work--I mean, to
 16 put in perspective, we had had the pharmacy
 17 issue, then the Turner Report came out, and
 18 the executive was having to deal with the
 19 repercussions of that. And I think it was at
 20 that time that I started to realize that the
 21 name Eastern Health was going to be in the
 22 news every single day because--and I don't
 23 know if this is relevant, so stop me if I'm--
 24 but we were truly cradle to grave. So
 25 suddenly Mr. Tilley ultimately had the

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1 responsibility from that baby that was being
 2 born through the daycare, through the social
 3 services system, if that had to happen and
 4 then into long term care and everywhere along
 5 that continuum, there were problems. And so
 6 there was now way that we were not going to be
 7 in the news virtually every day and the
 8 majority of that would likely be not happy
 9 things. And that was quite a realization to
 10 me as to--and then to meet somebody who would
 11 say, you know, I hate when someone asks me
 12 where I work. I thought that was--that was
 13 not what I had signed up for.
 14 CHAYTOR, Q.C.:
 15 Q. And did you offer any advice to people?
 16 DR. HOWELL:
 17 A. I tried to direct--that was, again, part of my
 18 town hall approach, was trying to direct
 19 people, but you know, what we're hearing is
 20 that that piece that didn't go well, but all
 21 that stuff we do, that we do so well, that I
 22 know is as good as anywhere in the country,
 23 that's not as newsworthy.
 24 THE COMMISSIONER:
 25 Q. That isn't new though, is it? I'm just

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

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

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

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

17 DR. HOWELL:
 18 A. That's correct, it was and it is.

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

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

7 DR. HOWELL:
 8 A. I would have.

9 CHAYTOR, Q.C.:
 10 Q. "We need to consider how we can position this
 11 before Ches Crosbie does it for us". Did
 12 those types of comments--again coming at this
 13 from a fresh perspective--those types of
 14 comments catch your eye or cause you any
 15 concern?

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

25 CHAYTOR, Q.C.:

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

4 DR. HOWELL:
 5 A. From Ms. Bonnell?

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

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

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1 CHAYTOR, Q.C.:

2 Q. Yes, and I understand and I'm just wondering

3 though, you did have concerns about their

4 capacity to continue on and deal with the

5 issue under the strain in which they were

6 working. Did you also--did it appear to you

7 at times that individuals involved were

8 starting to lack a sense of objectivity or

9 impartiality or even detachment in making

10 decisions regarding the issue?

11 DR. HOWELL:

12 A. It certainly didn't at that time. I felt

13 embroiled and swept up in it, and I certainly-

14 -to step back now and look at that, I mean,

15 you would see, yes, that people are losing

16 focus maybe on why we're there, but at that

17 time, I was swept up in the whole dealing with

18 the issue and all these things coming in and

19 new revelations and, you know, this would have

20 been maybe one of 80 e-mails in a day and just

21 dealing with all of those things.

22 CHAYTOR, Q.C.:

23 Q. The e-mail also indicates that there was a--

24 the panel had much discussion and debate as to

25 how to best disclose the information to the

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1 client and the original intent is outlined

2 there, as I read before. But a complicating

3 factor at the time was the media coverage

4 after the DCIS meetings. Do you know what

5 that referred to? Why was media coverage a

6 complicating factor in how to disclose to the

7 patient?

8 DR. HOWELL:

9 A. I don't know what that means.

10 CHAYTOR, Q.C.:

11 Q. And you have no recollection of a meeting

12 after this to discuss this issue?

13 DR. HOWELL:

14 A. I don't.

15 CHAYTOR, Q.C.:

16 Q. And I take it then, you don't know what

17 decision was ultimately made as to how best to

18 disclose to this particular patient?

19 DR. HOWELL:

20 A. No, I don't. It was being dealt with with

21 Quality and I really don't know how they

22 approached that.

23 CHAYTOR, Q.C.:

24 Q. And I understand what you're saying to me in

25 terms of you yourself then coming in with your

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1 safe learning curve and then really just

2 becoming embroiled in the whole situation.

3 So, I take it then, Doctor, at no point in

4 time did you give any advice to the people

5 involved in terms of saying, it's time to step

6 back.

7 DR. HOWELL:

8 A. No, I didn't.

9 CHAYTOR, Q.C.:

10 Q. This issue that's raised here about all tests,

11 Ms. Predham is indicating that she anticipates

12 that Mr. Crosbie will now look to have all

13 ER/PR results retested and I assume she means

14 also the positives. Is that currently under

15 way? Are all ER/PR tests now being retested?

16 DR. HOWELL:

17 A. Positives are not.

18 CHAYTOR, Q.C.:

19 Q. Positives are not.

20 DR. HOWELL:

21 A. No.

22 CHAYTOR, Q.C.:

23 Q. And do you know whether or not they are being

24 done if patients request that they be done?

25 DR. HOWELL:

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1 A. It would be better to ask Ms. Pilgrim that,

2 but I am not aware of any patients that have

3 had that done, but that could be the case.

4 CHAYTOR, Q.C.:

5 Q. Okay, we'll continue on to the ER/PR

6 presentation then that happens with the

7 medical and technical staff.

8 THE COMMISSIONER:

9 Q. Ms. Chaytor, it's a good time for the

10 afternoon break. Would you prefer to do that

11 now, before you start this or afterwards?

12 I'll leave it to you.

13 CHAYTOR, Q.C.:

14 Q. Yes, that's fine, well then, perhaps we'll

15 take the break now since it's a new area.

16 THE COMMISSIONER:

17 Q. All right.

18 CHAYTOR, Q.C.:

19 Q. Thank you.

20 THE COMMISSIONER:

21 Q. We'll take 15 minutes.

22 (RECESS)

23 THE COMMISSIONER:

24 Q. Please be seated. Ms. Chaytor?

25 CHAYTOR, Q.C.:

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1 Q. Thank you, Commissioner. Now Doctor, leading
 2 up to the break, I was about to take you to
 3 the ER/PR presentation which was carried out
 4 for medical and technical staff. I understand
 5 that took place November 20, 2006. And were
 6 you involved in actually arranging that
 7 presentation?
 8 DR. HOWELL:
 9 A. I think Dr. Denic asked me to arrange it and I
 10 had my assistant arrange the room and the
 11 teleconference facilities et cetera, as I
 12 recall.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And if we could look, please, at P-
 15 0422. And, Doctor, this is an e-mail from Dr.
 16 Denic to yourself, November 6, 2006 and he's
 17 looking to--he's asking if your office can
 18 arrange a presentation. "I think the best
 19 venue"--and he indicates where he thinks it
 20 should take place. He also indicates "I would
 21 like to invite the lab directors from the
 22 island because we were all involved". The
 23 name and telephone numbers and he goes on from
 24 there. And he also wants to invite the cancer
 25 clinic professionals and managers, surgeons

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1 and QI personnel. The title of the
 2 presentation is "ER and PR testing, Eastern
 3 Health Experience" and he indicates he could
 4 be ready the week of November 13 and for you
 5 to let him know what you think about it.
 6 Did the lab directors, pathologists
 7 across Newfoundland attend?
 8 DR. HOWELL:
 9 A. I think they did.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. So, not just Eastern Health people.
 12 The lab directors across the province?
 13 DR. HOWELL:
 14 A. That's correct.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. And if we look at P-1193, please. And
 17 Denise Dunn is your assistant, I take it?
 18 DR. HOWELL:
 19 A. That's correct.
 20 CHAYTOR, Q.C.:
 21 Q. And she's writing here to Dr. Williams and
 22 inviting Dr. Williams to attend at your
 23 invitation. Do you know if Dr. Williams
 24 attended?
 25 DR. HOWELL:

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1 A. I don't know.
 2 CHAYTOR, Q.C.:
 3 Q. You don't recall that?
 4 DR. HOWELL:
 5 A. I don't recall.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. Had you, up to this point, had any
 8 discussions with Dr. Williams about the issue
 9 after he had left his employment?
 10 DR. HOWELL:
 11 A. Dr. Williams, to his credit, wished to stayed
 12 involved from the quality perspective. And as
 13 I was bringing together my quality portfolio
 14 group, he sat on that group.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. And I did see his name in one of the
 17 minutes of the lab quality group. How long
 18 did he or does he still continue to sit on
 19 that committee?
 20 DR. HOWELL:
 21 A. Yes, we still view him as a member.
 22 CHAYTOR, Q.C.:
 23 Q. Okay.
 24 DR. HOWELL:
 25 A. He hasn't been there in the last several

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1 meetings, but I think he's been out of the
 2 province.
 3 CHAYTOR, Q.C.:
 4 Q. And has he remained involved in terms of
 5 providing any advice to you on the ER/PR
 6 issue?
 7 DR. HOWELL:
 8 A. We've really not had much contact, no, about
 9 ER/PR since that time, other than his
 10 involvement and his interest in the whole
 11 realm of quality and health care and sitting
 12 on that portfolio committee.
 13 CHAYTOR, Q.C.:
 14 Q. Okay.
 15 DR. HOWELL:
 16 A. But specific to ER/PR, no.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. If we could look P-0424, please. And
 19 this again, I understand is e-mail exchange in
 20 trying to arrange the November 20
 21 presentation. And this time the e-mail comes
 22 from Joyce Penney to George Tilley. It's sent
 23 November 6--I'm sorry, is that 15th maybe,
 24 '06, no, November 6. And she writes, "George
 25 on Monday, November 20 November 5:00 p.m. Dr.

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1 Howell is organizing a presentation by Heather
 2 Predham and Dr. Denic among others on the
 3 ER/PR with the view to having a presentation
 4 to executive then on the 21st. Question to
 5 you.....who do you see giving the presentation
 6 to executive? Dr. Denic and Heather Predham
 7 plus legal counsel. Do you want anyone else
 8 to attend? Note that we have John Hylton,
 9 CCHSE giving a presentation to executive on
 10 the 21st as well. And then they're holding
 11 time on November 30 for a potential press
 12 conference on ER/PR". And then Mr. Tilley
 13 writes back and says the same date "Joyce,
 14 talked to Oscar and agreed to legal counsel
 15 attending" and then talks about timing. And I
 16 take it that was legal counsel to attend the
 17 executive management meeting as opposed to the
 18 overall presentation. Is that correct?
 19 DR. HOWELL:
 20 A. I'm not certain.
 21 CHAYTOR, Q.C.:
 22 Q. Do you recall your discussion with Mr. Tilley
 23 on that point?
 24 DR. HOWELL:
 25 A. I do not.

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1 CHAYTOR, Q.C.:
 2 Q. Do you know why it was felt necessary to have
 3 legal counsel attend either presentation?
 4 DR. HOWELL:
 5 A. Not with any clarity, no. For information
 6 would be my thought for them to understand the
 7 issue, I would presume.
 8 CHAYTOR, Q.C.:
 9 Q. To understand, I'm sorry, which issue?
 10 DR. HOWELL:
 11 A. To have the same level of detail knowledge
 12 that was going to be shared with us from the
 13 presenters.
 14 CHAYTOR, Q.C.:
 15 Q. For legal counsel to have that knowledge?
 16 DR. HOWELL:
 17 A. If they wished.
 18 CHAYTOR, Q.C.:
 19 Q. And who did you understand legal counsel to be
 20 in this context?
 21 DR. HOWELL:
 22 A. Mr. Boone.
 23 CHAYTOR, Q.C.:
 24 Q. So, he's legal counsel for the defence of the
 25 class action?

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1 DR. HOWELL:
 2 A. Correct, for the insurer.
 3 CHAYTOR, Q.C.:
 4 Q. And so your understanding would be for Mr.
 5 Boone to have the benefit of the presentation.
 6 DR. HOWELL:
 7 A. That's again, supposition on my part, but I
 8 think that's so.
 9 CHAYTOR, Q.C.:
 10 Q. You have no recollection then either way?
 11 DR. HOWELL:
 12 A. No.
 13 CHAYTOR, Q.C.:
 14 Q. As to what the purpose would be in Mr. Boone
 15 attending?
 16 DR. HOWELL:
 17 A. No.
 18 CHAYTOR, Q.C.:
 19 Q. And it appears from this that you agreed to
 20 that. Do you have any reason to take issue
 21 with that?
 22 DR. HOWELL:
 23 A. I wouldn't have felt it was my--if the CEO
 24 wanted legal counsel there, it wasn't a
 25 request of mine, to the best of my knowledge.

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1 CHAYTOR, Q.C.:
 2 Q. And what was the--if you look at the bigger
 3 group picture of November 20th, I believe the
 4 one, the presentation to executive management
 5 takes place then the next day, the 12st--what
 6 was the purpose of the November 20 session?
 7 DR. HOWELL:
 8 A. It was an attempt to engage the other
 9 laboratory people in the region plus the
 10 health professionals and technologists within
 11 Eastern Health around--to help generate better
 12 understanding and knowledge around the whole
 13 ER/PR issue and it was information sharing.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And to your knowledge, up to that point
 16 in time, had there been any similar session
 17 conducted?
 18 DR. HOWELL:
 19 A. Not of which I'm aware of.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. So, this is the first time that the
 22 technologists and the medical personnel
 23 involved would have had any in-depth
 24 presentation on this ER/PR issue?
 25 DR. HOWELL:

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

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

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

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1 on. I won't take you through it all, but just
 2 to give you a flavour of what--and you recall
 3 her, I take it, making this presentation?
 4 DR. HOWELL:
 5 A. I do.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and did some of these points sound
 8 familiar to you?
 9 DR. HOWELL:
 10 A. Certainly, you know, much of the conversation
 11 that each one of those individuals was talking
 12 about was beyond my level of expertise or
 13 knowledge, that's why I was taking such
 14 copious notes and trying to understand it, but
 15 certainly, in having read the external
 16 reviews, a lot of what she's saying is
 17 marrying very well with that.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, Dr. Banerjee's and Trish Wegrynowski's
 20 reviews?
 21 DR. HOWELL:
 22 A. Correct.
 23 CHAYTOR, Q.C.:
 24 Q. And to your knowledge, this is the first time
 25 the pathologists in attendance would have been

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1 told this information?

2 DR. HOWELL:

3 A. I don't know the answer to that. Whether--

4 what conversations Dr. Denic may have had with

5 pathologists within Eastern and across the

6 region, considering his other hat, he would

7 have to speak for himself. I'm not certain.

8 CHAYTOR, Q.C.:

9 Q. And it's the first time that this information

10 has been given in a group session such as

11 this, to your knowledge?

12 DR. HOWELL:

13 A. To the best of my knowledge.

14 CHAYTOR, Q.C.:

15 Q. If we could look then at your notes that you

16 took that day, and I believe it's 1422, page

17 24. Okay, and you took fairly detailed notes.

18 I believe it goes on for quite a number of

19 pages. It goes on for about five pages, I

20 believe.

21 DR. HOWELL:

22 A. Um-hm.

23 CHAYTOR, Q.C.:

24 Q. And the first part being immunohistochemistry,

25 so I take it that was Dr. Elms' session, and

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1 he referred to in his session as cutting

2 tissue, and you've got, I think that says

3 "clear" is it?

4 DR. HOWELL:

5 A. It does.

6 CHAYTOR, Q.C.:

7 Q. Okay, and what--you've written over here "not

8 grand round." What did you mean by that?

9 DR. HOWELL:

10 A. I'm not sure. It may have been a note to

11 myself that this was not a standard grand

12 round like we have on Fridays at the Health

13 Sciences. This was an extraordinary event.

14 CHAYTOR, Q.C.:

15 Q. The event that you were attending?

16 DR. HOWELL:

17 A. That's correct. I think that's what I--why

18 I'd be putting that there, but I'm not

19 certain.

20 CHAYTOR, Q.C.:

21 Q. Do you know whether or not the pathologists

22 and oncologists in the time frame, you know,

23 2000, 2005 up to that time period, say, do you

24 know whether or not they were taking part in

25 any grand rounds?

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1 DR. HOWELL:

2 A. I don't know for certain.

3 CHAYTOR, Q.C.:

4 Q. And I realize you weren't there.

5 DR. HOWELL:

6 A. Yeah.

7 CHAYTOR, Q.C.:

8 Q. You have an asterisk by "no standardization

9 across labs. Is standardization within a

10 lab?" Is that what that says?

11 DR. HOWELL:

12 A. Yes.

13 CHAYTOR, Q.C.:

14 Q. Why do you have an asterisk or a particular

15 note made of that point?

16 DR. HOWELL:

17 A. Because it was a point I felt of some

18 significance, the fact that there was no

19 standardization across labs.

20 CHAYTOR, Q.C.:

21 Q. No standardization across labs within Eastern

22 Health?

23 DR. HOWELL:

24 A. I think I understood that to mean that there

25 was n' t a s t a n d a r d i z a t i o n f o r

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1 immunohistochemistry across the country.

2 CHAYTOR, Q.C.:

3 Q. And what did you understand at that point in

4 time, in terms of Eastern Health's own

5 standardization in terms of fixation? This is

6 really a lot of what's being discussed here,

7 it appears, by Dr. Elms.

8 DR. HOWELL:

9 A. I think, again from the external reviews that

10 were done, that fixation and--well, all of

11 the--let me recollect. If fixation was of

12 concern and that particularly would be

13 important since we were receiving specimens

14 from outside laboratories. It was all the

15 issues that had been raised by the external

16 reviewers and that the test, in general, there

17 wasn't standardization and we were moving to

18 some standardization within the lab and we

19 were needing those other individuals to

20 participate in that standardization,

21 particularly in terms of fixation, if they

22 were sending tissues in to this lab.

23 CHAYTOR, Q.C.:

24 Q. And do you recall, was that actually discussed

25 though in the presentation that day?

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1 DR. HOWELL:
 2 A. I don't recall.
 3 CHAYTOR, Q.C.:
 4 Q. And the next page, you make a note--now you've
 5 got a number two, so does that mean this is
 6 the second presentation or -
 7 DR. HOWELL:
 8 A. Second page.
 9 CHAYTOR, Q.C.:
 10 Q. Second page, okay, it's just your page
 11 numbering, okay. And you're writing a fair
 12 number of notes here, so I take it you're
 13 trying to comprehend as much of this
 14 information as you can yourself?
 15 DR. HOWELL:
 16 A. That's correct.
 17 CHAYTOR, Q.C.:
 18 Q. And you're talking about "estrogen binds to
 19 cell" and then you have an arrow "grow,
 20 Tamoxifen blocks receptor" and then your
 21 second point there being "cut off" is that one
 22 percent, pre 1999?
 23 DR. HOWELL:
 24 A. Per 1999.
 25 CHAYTOR, Q.C.:

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1 Q. Per 1999. Do you recall what that was about?
 2 DR. HOWELL:
 3 A. I don't.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and you come down towards the bottom,
 6 "atmospheric pressure, humidity effects" and
 7 "i.e. must standardize within the lab,
 8 standardized and validated testing is needed"
 9 or is used, sorry.
 10 DR. HOWELL:
 11 A. Right.
 12 CHAYTOR, Q.C.:
 13 Q. And again, these are your notes that you're
 14 just taking from -
 15 DR. HOWELL:
 16 A. Other people are speaking and I'm -
 17 CHAYTOR, Q.C.:
 18 Q. Other people are speaking, yes.
 19 DR. HOWELL:
 20 A. - gathering information.
 21 CHAYTOR, Q.C.:
 22 Q. And we could look to the slide presentation
 23 for -
 24 DR. HOWELL:
 25 A. It should marry to that, that's correct.

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1 CHAYTOR, Q.C.:
 2 Q. I just want to highlight in terms of what you
 3 yourself made note of that day, for your own--
 4 to figure out where you were, in terms of your
 5 knowledge level.
 6 DR. HOWELL:
 7 A. Um-hm.
 8 CHAYTOR, Q.C.:
 9 Q. And you've got Don Cook's--the next page, Don
 10 Cook's name in the margin, and then May 11th
 11 2005. So this is now Don Cook's presentation,
 12 I take it?
 13 DR. HOWELL:
 14 A. Correct.
 15 CHAYTOR, Q.C.:
 16 Q. And he's referring to the index patient. Now--
 17 -or a patient anyhow with lobular cancer,
 18 2002. Is the first time you would have heard
 19 about the circumstances surrounding the index
 20 patient or how this whole issue came to be?
 21 DR. HOWELL:
 22 A. I don't know if it would have been the first
 23 time, but it certainly would have been close
 24 to. It was in that late October and through
 25 November period that I'm starting to

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

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1 road.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. You have another asterisk and it says
 4 "August '05 accredited, leading breast
 5 pathologist, using old semi-automated," is
 6 that what that says?
 7 DR. HOWELL:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And what was--what's this in reference to,
 11 accredited August 2005?
 12 DR. HOWELL:
 13 A. I'm darned if I know what that--it was partial
 14 statements from somebody that I probably
 15 asterisked it because I didn't understand it
 16 and thought I should probably get more
 17 information about it, but I don't remember
 18 what that was about. It would have been from
 19 Dr. Cook's presentation.
 20 CHAYTOR, Q.C.:
 21 Q. Did you understand, up to this point in time,
 22 that the lab had not been part of the
 23 accreditation process, or certainly not the
 24 pathology portion?
 25 DR. HOWELL:

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1 A. I don't think I really had any idea what level
 2 of accreditation had been done for the lab.
 3 CHAYTOR, Q.C.:
 4 Q. And then on your fifth page, you have
 5 "external reviewer, technical Mount Sinai,
 6 professional B.C. Cancer Centre. Implemented
 7 recommendations IHC lab," and what does this
 8 say, Doctor? Is it separate department?
 9 DR. HOWELL:
 10 A. Correct.
 11 CHAYTOR, Q.C.:
 12 Q. Consolidated cases one site.
 13 DR. HOWELL:
 14 A. One site.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. So you do understand at this point in
 17 time that you have the responsibility for
 18 moving forward with the recommendations?
 19 DR. HOWELL:
 20 A. I do.
 21 CHAYTOR, Q.C.:
 22 Q. And putting in place what's needed to improve
 23 the lab, and what did you understand in terms
 24 of the recommendations, as of November 2006?
 25 DR. HOWELL:

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1 A. At some point, I don't know in what proximity
 2 to this, I was shown a spreadsheet of all the
 3 recommendations and I made inquiry as to where
 4 we were on completion of those
 5 recommendations, and I was shown through that
 6 spreadsheet those that were completed and many
 7 of which were ongoing.
 8 CHAYTOR, Q.C.:
 9 Q. And up to now, the present time, what stage
 10 are the-
 11 DR. HOWELL:
 12 A. At this -
 13 CHAYTOR, Q.C.:
 14 Q. Yes, at what stage is it?
 15 DR. HOWELL:
 16 A. - moment in time?
 17 CHAYTOR, Q.C.:
 18 Q. Yes.
 19 DR. HOWELL:
 20 A. My last conversation with Dr. Denic and Mr.
 21 Gulliver, I think all but one of those
 22 recommendations had been enacted.
 23 CHAYTOR, Q.C.:
 24 Q. And that's the one regarding the Sakara -
 25 DR. HOWELL:

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1 A. The tissue tech processor.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and you haven't followed up to ask why
 4 or is that going to be implemented or why?
 5 DR. HOWELL:
 6 A. The tissue tech processor?
 7 CHAYTOR, Q.C.:
 8 Q. Yes.
 9 DR. HOWELL:
 10 A. Yes, I did, I had a discussion with Dr. Denic
 11 as to why we weren't proceeding with it and he
 12 indicated that they still did not have a
 13 comfort level with utilizing that piece of
 14 equipment, and I have to accept -
 15 CHAYTOR, Q.C.:
 16 Q. And that's left with him?
 17 DR. HOWELL:
 18 A. I have to leave that to his judgment.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. Yes, I'm sorry, you did indicate that
 21 earlier. Is that the end then of your notes
 22 from the presentation, and then the next thing
 23 is EMC meeting, executive management
 24 committee, is that what that is?
 25 DR. HOWELL:

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1 A. That's correct.
 2 CHAYTOR, Q.C.:
 3 Q. It looks like there had been a post-it and
 4 there's a date missing here. Do you have
 5 your--you don't have your original there, do
 6 you? But this is executive management
 7 committee meeting.
 8 DR. HOWELL:
 9 A. It would have been the 21st, the very
 10 following day.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. And so then this is the presentation
 13 from there?
 14 DR. HOWELL:
 15 A. Correct.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, then perhaps we can go there. We also
 18 have a copy of the minutes which are at, I
 19 believe, P-0487, page 82. And I take it,
 20 Doctor, did you find the presentation on the
 21 20th helpful?
 22 DR. HOWELL:
 23 A. I did, indeed.
 24 CHAYTOR, Q.C.:
 25 Q. You did. Okay. Thank you, Doctor. Now, this

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

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

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1 DR. HOWELL:
 2 A. There were pathologists on the teleconference,
 3 that is for sure.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. And do you recall whether or not those
 6 things were actually discussed by Dr. Carter
 7 in her presentation?
 8 DR. HOWELL:
 9 A. That was her presentation that you put up on
 10 the screen.
 11 CHAYTOR, Q.C.:
 12 Q. Yeah, okay. So what's the concern, then,
 13 about the information being shared with the
 14 other regions?
 15 DR. HOWELL:
 16 A. Reading this, I honestly do not know and I do
 17 not recall ever having that meeting or a
 18 conversation with Mr. Boone about it.
 19 CHAYTOR, Q.C.:
 20 Q. So you have no recollection of this being
 21 raised or anybody saying, well, they were in
 22 attendance yesterday while we discussed all of
 23 this?
 24 DR. HOWELL:
 25 A. I think there were two things, there was an

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1 information exchange that had occurred the
 2 evening prior and there had been, as I
 3 remember, lots of participation from others
 4 around the province in that call. And in
 5 addition, you know, I am fairly certain that
 6 Dr. Denic, and I don't know at what point Dr.
 7 Denic had a conversation--developed a protocol
 8 for fixation and some standardization there
 9 that he shared with the other pathologists
 10 across the province prior to starting ER/PR
 11 testing again. And it was to ensure that that
 12 fixation was done appropriately and that the
 13 specimen that they received was adequate for
 14 test.
 15 CHAYTOR, Q.C.:
 16 Q. I'm sorry, when did you understand Dr. Denic
 17 had that exchange of information?
 18 DR. HOWELL:
 19 A. I don't know when that -
 20 CHAYTOR, Q.C.:
 21 Q. No, but it's after -
 22 DR. HOWELL:
 23 A. - piece took place.
 24 CHAYTOR, Q.C.:
 25 Q. - Dr. Denic has become clinical chief?

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1 DR. HOWELL:
 2 A. Well, he was the clinical chief when I went
 3 there.
 4 CHAYTOR, Q.C.:
 5 Q. Yes.
 6 DR. HOWELL:
 7 A. He was interim, then he became permanent and
 8 now he's the chief of laboratory medicine.
 9 CHAYTOR, Q.C.:
 10 Q. Yes. So that, from what we understand,
 11 happened probably in May of '07?
 12 DR. HOWELL:
 13 A. That--you're probably quite right.
 14 CHAYTOR, Q.C.:
 15 Q. Does that seem right to you?
 16 DR. HOWELL:
 17 A. Yes, that sounds like it would be right.
 18 CHAYTOR, Q.C.:
 19 Q. Okay.
 20 COMMISSIONER:
 21 Q. So are we saying that the protocol for
 22 fixation was--or was communicated in '07, May?
 23 DR. HOWELL:
 24 A. I'm not certain of the date that Dr. Denic
 25 communicated that. I think we'd have to ask

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1 him.
 2 CHAYTOR, Q.C.:
 3 Q. and I think that there will be evidence to
 4 that effect.
 5 COMMISSIONER:
 6 Q. All, right, thank you.
 7 CHAYTOR, Q.C.:
 8 Q. Doctor, so the organization cannot speak
 9 publicly on the findings and recommendations
 10 because of the review, because there is
 11 currently a class action lawsuit ongoing. Was
 12 this something new to you, was this a foreign
 13 concept, did you understand what was being
 14 told to you here?
 15 DR. HOWELL:
 16 A. Well, I think my understanding of when there
 17 was a lawsuit that the exchange of
 18 information--that put it in another realm, in
 19 another category and the types of things that
 20 one would talk about would change once this
 21 was going to enter a court of law and that you
 22 didn't release the same sorts of information
 23 because that was going to come out in the
 24 court system eventually. That was my
 25 understanding.

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1 CHAYTOR, Q.C.:
 2 Q. And who was telling you that?
 3 DR. HOWELL:
 4 A. I don't think anyone told me that, I think
 5 that was just my understanding.
 6 CHAYTOR, Q.C.:
 7 Q. You had that understanding before you came to
 8 Eastern Health?
 9 DR. HOWELL:
 10 A. That's correct.
 11 CHAYTOR, Q.C.:
 12 Q. So this whole concept of certain information
 13 being protected under the Evidence Act, that
 14 wasn't a new concept to you?
 15 DR. HOWELL:
 16 A. No, I wouldn't say I had any in depth
 17 knowledge of it. But the whole idea of things
 18 protected under the Evidence Act, I had some
 19 superficial knowledge of that coming into the
 20 job and the whole issue of their being a
 21 lawsuit and that that changed the parameters
 22 under which one communicated, I think was
 23 something I had in the back of my head coming
 24 into the job.
 25 CHAYTOR, Q.C.:

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1 Q. What information was it that needed to be
 2 shared with the other pathologists across the
 3 province?
 4 DR. HOWELL:
 5 A. To my way of thinking specific to this test,
 6 certainly their involvement from the point at
 7 which a tissue is removed from a patient there
 8 is a protocol for managing that tissue,
 9 particularly if it's going to be sent to a lab
 10 at Eastern Health for further analysis.
 11 CHAYTOR, Q.C.:
 12 Q. Well, if it's going to be sent anywhere?
 13 DR. HOWELL:
 14 A. Absolutely, anywhere.
 15 CHAYTOR, Q.C.:
 16 Q. It has to be done right -
 17 DR. HOWELL:
 18 A. But thinking about Eastern Health, that there
 19 needs to be a protocol for doing that.
 20 CHAYTOR, Q.C.:
 21 Q. Yes.
 22 DR. HOWELL:
 23 A. But I think beyond that it's much like the
 24 discussion we had earlier today about
 25 mortality and morbidity rounds, it's, there

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1 needs to be a general sharing of information
 2 on a large scale that may increase level of
 3 understanding and would spread out to other
 4 elements.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. I guess my question then, Doctor, is
 7 that you would have seen the importance of
 8 sharing any information, whether it's the
 9 appropriate manner in which the tissue or
 10 specimen is to be fixed, whether it's
 11 information about the importance of internal
 12 controls, the importance of that information
 13 and the learnings from the external reviews
 14 being shared with pathologists wherever?
 15 DR. HOWELL:
 16 A. That I would see the importance of that?
 17 CHAYTOR, Q.C.:
 18 Q. Yes, you understood the importance?
 19 DR. HOWELL:
 20 A. I do understand the importance of that.
 21 CHAYTOR, Q.C.:
 22 Q. Right, okay. And this was obviously
 23 acknowledged by the group that appears because
 24 the need to share the experience with other
 25 pathologists within the province is noted

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

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1 professionals that were involved in doing that
 2 kind of work.
 3 CHAYTOR, Q.C.:
 4 Q. Right. On November 20th, 2006?
 5 DR. HOWELL:
 6 A. Correct.
 7 CHAYTOR, Q.C.:
 8 Q. And so if there was additional information
 9 that the next day was being of concern here in
 10 this discussion with the executive management,
 11 you don't know what the additional information
 12 is?
 13 DR. HOWELL:
 14 A. I don't.
 15 CHAYTOR, Q.C.:
 16 Q. So perhaps, was there an issue raised about
 17 the fact that not many pathologists, or
 18 perhaps if any, I don't know, I guess we'll
 19 have to hear about that, but not many of the
 20 pathologists outside Eastern Health had taken
 21 part in the presentation and the need to get
 22 the information out to everyone?
 23 DR. HOWELL:
 24 A. I would have hoped that the people who took
 25 part in that presentation, though, from

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1 outside, would be sharing that information
 2 with their colleagues in their own
 3 laboratories.
 4 CHAYTOR, Q.C.:
 5 Q. Yes. But we don't know, I guess, whether we
 6 had everyone from all the authorities there.
 7 So I'm just trying to figure out is that why
 8 there was this discussion about the need to
 9 get the information out to everyone and then
 10 was there an issue raised about concern about
 11 being able to share the information because of
 12 the protection it was thought to be afforded
 13 the information under the Evidence Act? Does
 14 that jog your memory about what's happening
 15 here?
 16 DR. HOWELL:
 17 A. It certainly sounds like there was concern
 18 about what do you release considering these
 19 two other factors, but beyond that I can't for
 20 the life of me think of what it was that, even
 21 that I was being asked to talk to Mr. Boone
 22 about.
 23 CHAYTOR, Q.C.:
 24 Q. And you have no recollection of any follow-up
 25 discussion with Mr. Boone on it?

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1 DR. HOWELL:
 2 A. On that particular item, no.
 3 CHAYTOR, Q.C.:
 4 Q. Now, you're both in the room?
 5 DR. HOWELL:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. And it appears that in terms of being tasked
 9 with this, you're to go away and discuss
 10 further before making any decision.
 11 DR. HOWELL:
 12 A. The only other part to this would be that,
 13 whether this is referring to the fact that we
 14 are looking at that the quality folks have now
 15 finished their analysis with whatever data
 16 that they have and that we're looking at--and
 17 I think that'll come through further down, at
 18 putting together a--the technical briefing for
 19 the press, for the media. And whether that's
 20 referring to what can you use -
 21 CHAYTOR, Q.C.:
 22 Q. Well, it talks about the public is the first
 23 sentence.
 24 DR. HOWELL:
 25 A. Yeah.

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1 CHAYTOR, Q.C.:
 2 Q. In terms of what can be released to the
 3 public.
 4 DR. HOWELL:
 5 A. Yeah.
 6 CHAYTOR, Q.C.:
 7 Q. But I think in terms of my line of questioning
 8 here perhaps the more important piece is the
 9 actual getting the information out into the
 10 hands of the pathologists who are doing this
 11 work so that they can ensure that they are
 12 doing the best work possible, in the best
 13 interests of patient care.
 14 DR. HOWELL:
 15 A. And as you rightly point out, it certainly was
 16 my understanding that that had been done the
 17 evening before.
 18 CHAYTOR, Q.C.:
 19 Q. For those who were in attendance?
 20 DR. HOWELL:
 21 A. And my recollection is it was--I can't say
 22 with certainty that every region was
 23 represented, but I think that there seemed to
 24 be a lot of people on that call.
 25 CHAYTOR, Q.C.:

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1 Q. So it that happened the day before, there was
 2 certainly not that concern the day before, but
 3 the next day there's a concern being raised
 4 about getting information out and how far that
 5 can go. And that's being raised in this
 6 executive management meeting. And do you know
 7 why or who would have raised that as a
 8 concern?
 9 DR. HOWELL:
 10 A. I cannot expand on any more than what is
 11 written there.
 12 THE COMMISSIONER:
 13 Q. Dr. Howell, can you just clarify one thing you
 14 said a little earlier for me? You were saying
 15 that there were two pieces to be considered in
 16 the matter of what information was to be
 17 released. One was your view that the external
 18 reviews had been done as peer reviews; and the
 19 second was the existence of the class action
 20 suit. Is there, in your view, any difference
 21 in the result, whether one or both of those
 22 applied? To be perhaps more clear about it,
 23 would the fact that it was peer review allow
 24 you, as an organization, to reveal more or
 25 less information than it would have if you

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1 were dealing with a class action suit? Is
 2 there really any difference in the end from
 3 the perspective of your organization? Because
 4 as I understood it, the view of Eastern Health
 5 was, well what was done under peer review
 6 remained a closely guarded secret, if you
 7 will, available only to a handful of people,
 8 the original reports were revealed, as I
 9 understood it, to maybe four--there were four
 10 or five copies made, perhaps other people
 11 heard about it in different ways, but there
 12 were initially at least only a few copies even
 13 made of the reports when they came in.
 14 DR. HOWELL:
 15 A. That's correct.
 16 THE COMMISSIONER:
 17 Q. And up to this point I had gotten the
 18 impression that Eastern Health's position was
 19 that because of the nature of these reports,
 20 they were not to go any further. And I'm
 21 wondering how could you give out less
 22 information than that, because of the
 23 existence of a class action suit?
 24 DR. HOWELL:
 25 A. What I had been told, Commissioner, is that

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1 those that participated in that external
 2 review understood that it was done under the
 3 protection of the Evidence Act and therefore,
 4 the contents would not be released.
 5 THE COMMISSIONER:
 6 Q. Yes.
 7 DR. HOWELL:
 8 A. Beyond a very few people.
 9 THE COMMISSIONER:
 10 Q. Uh-hm.
 11 DR. HOWELL:
 12 A. And remembering that much of this was rather
 13 new to me coming into the job, but that I did
 14 somewhere along the way have the understanding
 15 that recommendations though could be put
 16 forward and in terms of where the class action
 17 lawsuit fit, I would not profess to have the
 18 legal knowledge--I would have to take the
 19 advice of others.
 20 THE COMMISSIONER:
 21 Q. So from--your understanding would be had there
 22 not been a class action suit, Eastern Health
 23 could have been free to discuss openly all
 24 recommendations--could have and would have
 25 discussed openly all recommendations made by

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1 the peer review?
 2 DR. HOWELL:
 3 A. My understanding was that the actual contents
 4 and the report itself would not be shared, but
 5 recommendations could be.
 6 CHAYTOR, Q.C.:
 7 Q. And where did you get that information?
 8 DR. HOWELL:
 9 A. I'm darned if I know, it was information
 10 coming from any different sources and that is
 11 an understanding that I was--I couldn't tell
 12 you how that understanding evolved.
 13 THE COMMISSIONER:
 14 Q. Okay, and is it further--do I take from what
 15 you're saying then that further, your
 16 understanding would be the existence of a
 17 class action suit would prohibit even the
 18 sharing of the recommendations?
 19 DR. HOWELL:
 20 A. I don't think I knew or even today understand
 21 for sure how that works.
 22 THE COMMISSIONER:
 23 Q. Okay, thank you.
 24 CHAYTOR, Q.C.:
 25 Q. And are you concerned about it?

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1 DR. HOWELL:
 2 A. I'm concerned when I now am wearing a mantle
 3 of responsibility for the laboratory,
 4 absolutely.
 5 CHAYTOR, Q.C.:
 6 Q. And what concerns you?
 7 DR. HOWELL:
 8 A. Well, you know, I guess for me it's making
 9 sure that and we will get there, that all
 10 actions arising out of those external reviews
 11 have been taken and that we have the processes
 12 in place, including the proficiency testing,
 13 that ensures that the quality of the product
 14 that we give to the ordering physician is at
 15 the highest level.
 16 CHAYTOR, Q.C.:
 17 Q. And in order for that to happen, there would
 18 have to be this knowledge transfer.
 19 DR. HOWELL:
 20 A. That's correct.
 21 CHAYTOR, Q.C.:
 22 Q. And before I leave that, Doctor, while Dr.
 23 Carter's presentation would have referred to a
 24 number of issues certainly raised through the
 25 external reviews, could it be that the broader

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1 information to be shared would be the actual
 2 findings in the report, findings for example
 3 for a test failure that Dr. Banerjee had
 4 found, perhaps the discussion was more to
 5 actually let pathologists know what went wrong
 6 so that they will indeed pay the appropriate
 7 attention to the points that were raised.
 8 It's one thing to have a PowerPoint
 9 presentation and say here's what you should do
 10 and here are, you know, the best ways to get,
 11 as she calls it, the perfect test result. But
 12 to actually tell people that this is what we
 13 didn't do so well the first time round, do you
 14 agree that that would be important to put it
 15 in that context and actually say that these
 16 are the findings of the reviewers?
 17 DR. HOWELL:
 18 A. Yes, but you know, that presentation, to my
 19 understanding, was as much designed as a
 20 general education for all parties as it was
 21 maybe more so than specifically dealing with
 22 the recommendations arising out of the--at
 23 least that's, as I saw those folks get up
 24 there and do their presentations, it was much
 25 as I would have anticipated if I went to a

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1 grand round where that was to be discussed and
 2 we had one of the academic physicians talking
 3 about a particular health problem or process,
 4 it was delivered in that kind of -
 5 CHAYTOR, Q.C.:
 6 Q. Right, and that's my point really, that it was
 7 done as a general educational session and not
 8 tied to the findings or to the actual outcomes
 9 of the peer reviews or external reviews. And
 10 what I'm saying to you is that it certainly
 11 didn't cover everything, there was, you know,
 12 while there's many points raised, it certainly
 13 didn't cover anything and if people are being
 14 told here's a general educational session, as
 15 opposed to we really need to pay attention to
 16 this because this is what, in fact, we didn't
 17 do so well the first time round, that would
 18 have much more impact in terms of getting the
 19 message out to others?
 20 DR. HOWELL:
 21 A. But I think that all that participated in that
 22 evening event were aware of the ER/PR issue
 23 and in general that something major was afoot
 24 here, so I think they would have significant
 25 interest and be at least linking the two as

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1 part of knowledge transfer and quality
 2 learning.
 3 THE COMMISSIONER:
 4 Q. So the people who met were the surgeons--or
 5 who were invited were surgeons, oncologists,
 6 pathologists and lab techs?
 7 DR. HOWELL:
 8 A. That's correct.
 9 THE COMMISSIONER:
 10 Q. As I understand it all of whom have a part,
 11 some greater, some lesser, to play in the
 12 process from the obtaining of a specimen to
 13 the eventual decisions about treatment of a
 14 patient.
 15 DR. HOWELL:
 16 A. That's correct.
 17 THE COMMISSIONER:
 18 Q. There's certain steps along the way and all of
 19 the people who would be involved in those
 20 steps were in that room.
 21 DR. HOWELL:
 22 A. That's correct, that was the goal.
 23 THE COMMISSIONER:
 24 Q. So I suppose you would not expect that a
 25 surgeon would necessarily have the knowledge

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1 of all the details that a pathologist does,
 2 but wouldn't a surgeon understand that what
 3 happened in that room when the specimen was
 4 being taken was an important step in making
 5 sure that at the end of the day, the advice
 6 that was given to the patient was as good as
 7 advice as we could possibly arrange for in the
 8 circumstance? I mean, everybody had a part to
 9 play, the surgeon did, the pathologist did,
 10 the lab techs did and the oncologist did and
 11 if they all applied their mind and did the
 12 best they could do, then that's the best hope
 13 that the patient is going to get the best
 14 advice.
 15 DR. HOWELL:
 16 A. Correct.
 17 THE COMMISSIONER:
 18 Q. And it seems to me that if you look at the
 19 recommendations coming out of the external
 20 reports, while they concentrate on the role of
 21 a laboratory technologist and the pathologist,
 22 they're certainly lessons to be learned by the
 23 two groups who are on the external ends of
 24 that process, i.e. the surgeons and the
 25 oncologists.

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

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

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

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1 A. Well, I, you know, the only great feedback
 2 that I can give you from that meeting was I
 3 remember going up to speak to Dr. Denic after
 4 and Dr. Felix, who does a lot of breast
 5 surgery coming up to Dr. Denic and
 6 congratulating him on the presentation and
 7 that he felt that it was an excellent learning
 8 opportunity for him. And that's about the
 9 only feedback of any substantive nature that I
 10 heard, but that was heartening to me.
 11 COMMISSIONER:
 12 Q. Okay.
 13 CHAYTOR, Q.C.:
 14 Q. Did you have the impression it was the first
 15 time Dr. Felix was hearing those things about,
 16 particularly about fixation issue?
 17 DR. HOWELL:
 18 A. No, I really -
 19 CHAYTOR, Q.C.:
 20 Q. But he indicated it was a great learning -
 21 DR. HOWELL:
 22 A. I think he--I don't know if he used the word
 23 "learning" but he certainly seemed to be
 24 genuinely pleased with the presentation.
 25 CHAYTOR, Q.C.:

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1 Q. Doctor, before we leave the minutes, the third
 2 bullet says, "We have to position ourselves
 3 appropriately so the public has confidence in
 4 the laboratory and that the people who have
 5 been waiting for information have confidence
 6 and understanding of the events related to ER
 7 and PR testing. A subgroup will be
 8 established to identify key messages to be
 9 delivered and develop a strategic
 10 communication plan" and you in conjunction
 11 with Susan Bonnell is to lead that subgroup to
 12 develop the communication strategy. Had you
 13 had experience with developing key messages?
 14 DR. HOWELL:
 15 A. No, no, that would not--I had had media
 16 training in my prior lives, both involved with
 17 the Newfoundland and Labrador Medical
 18 Association and with the large corporate
 19 client I worked for, but certainly key
 20 massaging along this line would be a new
 21 endeavour for me.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And did you do that then, did you and
 24 Ms. Bonnell lead the subgroup? I take it this
 25 is the communication strategy that went

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1 forward then on December 11th, 2006 in
 2 communicating on this issue? This is all part
 3 of the ER/PR presentation in the meeting so
 4 this was to put together a communication
 5 strategy, I take it, for disclosure to the
 6 public on December 11th?
 7 DR. HOWELL:
 8 A. This was to do that technical briefing, that's
 9 correct.
 10 CHAYTOR, Q.C.:
 11 Q. Yes, okay. And so then you, in conjunction
 12 with Susan Bonnell, lead that process?
 13 DR. HOWELL:
 14 A. That was the direction.
 15 CHAYTOR, Q.C.:
 16 Q. Is that what happened?
 17 DR. HOWELL:
 18 A. There--in preparation for my testimony I mean,
 19 it's so long ago I had to go back and I had to
 20 call Ms. Bonnell and get her to refresh my
 21 memory as to how we actually did that and then
 22 go back and find my journals which I had
 23 forgotten all about, as you know, and -
 24 CHAYTOR, Q.C.:
 25 Q. That's why we got them yesterday.

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1 DR. HOWELL:
 2 A. And refresh my memory as to so what as this
 3 subgroup. And in my notes, as you've seen,
 4 there really is only the one note of a meeting
 5 that was held with Dr. Denic, Ms. Predham, Mr.
 6 Boone -
 7 CHAYTOR, Q.C.:
 8 Q. And yourself?
 9 DR. HOWELL:
 10 A. And myself and Ms. Bonnell.
 11 CHAYTOR, Q.C.:
 12 Q. So that's the subgroup?
 13 DR. HOWELL:
 14 A. But along that way I, while I have no notes,
 15 it seems to me there were a number of people
 16 that were involved other than that in making
 17 contributions, but I can only speak to what I
 18 had recorded.
 19 CHAYTOR, Q.C.:
 20 Q. Yes. Well, there are other notes, too, and
 21 perhaps when we get to them, you can tell me,
 22 but there are certainly other notes. But
 23 you're right, there is the one meeting in late
 24 November of the individuals that you just
 25 noted. So you think that must be the subgroup

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1 that was formed?
 2 DR. HOWELL:
 3 A. That's what I'm -
 4 CHAYTOR, Q.C.:
 5 Q. To deal with it?
 6 DR. HOWELL:
 7 A. - I'm guessing.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Did anyone ever suggest to you that
 10 they weren't convinced errors had taken place
 11 in the hormone receptor testing?
 12 DR. HOWELL:
 13 A. This is why I say I believe there was a lot
 14 more involvement in putting the presentation
 15 together. Through all of this there--as I was
 16 trying to understand the even what ER/PR was
 17 all about, let along the technical science
 18 behind it, I was also being introduced to the
 19 ideas of the Swiss cheese model that I've hear
 20 you've all spent some time maybe in the
 21 symposium talking about and that there was
 22 considerable discussion, whether, in fact,
 23 there was an error, per se, that had occurred.
 24 And I was shown the picture of the Swiss
 25 cheese model and that this, there was great

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1 discussion as to this being a systems event.
 2 CHAYTOR, Q.C.:
 3 Q. And who was saying this, who was telling you
 4 this?
 5 DR. HOWELL:
 6 A. This would be in meetings that I would have
 7 had with Mr. Gulliver, Dr. Denic, Dr. Laing,
 8 Ms. Predham, those would be the principal and
 9 Ms. Bonnell would have been there for those
 10 discussions. That would be the group that we
 11 would be talking about that.
 12 CHAYTOR, Q.C.:
 13 Q. And so those individuals weren't convinced
 14 that, in fact, errors had been made in the
 15 testing process?
 16 DR. HOWELL:
 17 A. It was that if one thought about an error, one
 18 thought about that is--that thing there, that
 19 event there, that person there made a mistake
 20 and that fix that and that's where this broke
 21 down.
 22 CHAYTOR, Q.C.:
 23 Q. That's not what the Swiss cheese model is
 24 saying, is that there are a number of
 25 different holes and you line them all up and

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1 you get through and then there's an error that
 2 happens -
 3 DR. HOWELL:
 4 A. That's correct.
 5 CHAYTOR, Q.C.:
 6 Q. - because everything lined up.
 7 DR. HOWELL:
 8 A. So that's when they were talking to me about
 9 this being a systems issue, that there were--
 10 it wasn't one thing, that there were many
 11 different things.
 12 CHAYTOR, Q.C.:
 13 Q. So nobody was suggesting that an error hadn't
 14 taken place, they were suggesting no one
 15 individual or no one event can be solely,
 16 solely pointed at and attributed to make that
 17 error, is that what it is? I mean, it's
 18 different to say no error took place as
 19 opposed to, well, we can't point to one person
 20 or one thing.
 21 DR. HOWELL:
 22 A. Yeah. It was more than that, that they were
 23 talking to me about the fact that this was not
 24 a great test, that if you looked at the
 25 literature, that there was a significant false

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

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

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1 want to ask you now to step back, because
 2 that's what you heard from all the people who
 3 were entrenched in the issue for over a year
 4 through some stressful times as we talked
 5 about earlier, and step back with that fresh
 6 perspective. You read Dr. Banerjee's report,
 7 how did what you were hearing jive with what
 8 you read in Dr. Banerjee's report?
 9 DR. HOWELL:
 10 A. I think when I read Dr. Banerjee's report, I
 11 really took more of that forward vision as to,
 12 okay, what needs to be done here? And I tried
 13 to take the report and, you know, my way of
 14 remembering things is to try to segment it
 15 into categories and I was looking at fixation,
 16 optimization of staining, controls, and
 17 documentation. So, I was really looking, in
 18 all those recommendations, have we done those?
 19 CHAYTOR, Q.C.:
 20 Q. If we could have P-0046 please, page 3. This
 21 is Dr. Banerjee's report, Doctor. I bought
 22 you to this earlier today. Under his review
 23 of cases, "I reviewed a number of cases from
 24 the retrospect of testing set with Dr. Donald
 25 Cook, all of the cases that had converted from

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

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1 there is no standardized fixation protocol
 2 that everyone adheres to. Four, inadequate or
 3 not attention paid to the status of internal
 4 controls" which we also saw in the first part
 5 I bought you to. And then six, which should
 6 be five, "inappropriate choice of blocks with
 7 no representative normal ductal epithelium"
 8 and seven, "better education is required" and
 9 then there's a list of other system flaws that
 10 he observed.
 11 So my question to you was, coming at this
 12 with a fresh perspective, having read Dr.
 13 Banerjee's report, hearing the long list of
 14 things that people were presenting to you as
 15 somewhat of disbelief on their part, that an
 16 error actually could have occurred, were you
 17 concerned that this did not seem consistent
 18 with what Dr. Banerjee had said?
 19 DR. HOWELL:
 20 A. There are significant deficiencies identified
 21 here and that my understanding when I arrived
 22 on the scene, that all of those deficiencies
 23 were being worked.
 24 CHAYTOR, Q.C.:
 25 Q. Yes.

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1 DR. HOWELL:
 2 A. And I had a forward looking view.
 3 CHAYTOR, Q.C.:
 4 Q. Yes. And that list that you gave me in
 5 answering the question, I didn't hear, we
 6 weren't paying attention to fixation, there
 7 were issues with our fixation, we weren't
 8 paying adequate attention to internal
 9 controls. Those things weren't in the list
 10 that you gave. And I'm just wondering, having
 11 read it and coming at this from a fresh
 12 perspective, were you concerned that perhaps
 13 there was something not connecting with what
 14 you read here and what you were being told by
 15 those involved?
 16 DR. HOWELL:
 17 A. My approach was to read that and then to look
 18 at the list and say, so, where are we on
 19 correcting this.
 20 CHAYTOR, Q.C.:
 21 Q. I understand that, but do you understand how
 22 that's not my question? My question is what
 23 you were told by those involved as to whether
 24 or not, in fact, there was errors made and
 25 whether or not what you were told in response

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1 to that--and what I was hearing you say,
 2 because my original question was, were there
 3 people who weren't convinced that, in fact,
 4 any errors had been made, was my original
 5 question, and what you were told by those
 6 people involved versus what you read in Dr.
 7 Banerjee's and did you see a disconnect.
 8 DR. HOWELL:
 9 A. They certainly were not talking to me about,
 10 that there were errors made. That is not what
 11 they were talking to me about.
 12 CHAYTOR, Q.C.:
 13 Q. And did you, in fact, get the impression that
 14 there were people who weren't convince that,
 15 in fact, errors had happened?
 16 DR. HOWELL:
 17 A. There was--at not point did anyone say to me,
 18 we made a mistake here, we made a mistake
 19 there. I had people say to me, you know, we
 20 did a lot of things, but we didn't have the
 21 documentation to support it. But I wasn't
 22 getting from anyone, that's correct, that
 23 these are the errors. Nobody has talked to me
 24 about there are errors.
 25 CHAYTOR, Q.C.:

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1 Q. Did anyone ever tell you that Dr. Carter has
 2 set out on an investigation in the early days
 3 which was abandoned around the beginning of
 4 August 2005?
 5 DR. HOWELL:
 6 A. No, I'm unsure when that letter first came to
 7 my attention, but it was--somewhere along the
 8 way I became aware of the fact that Dr. Carter
 9 had expressed concern.
 10 CHAYTOR, Q.C.:
 11 Q. And I take it that was much further along the
 12 way?
 13 DR. HOWELL:
 14 A. I don't know what--it certainly wasn't early
 15 on in the time that I was there.
 16 CHAYTOR, Q.C.:
 17 Q. And could that have, in fact, been through the
 18 process coming on through to 2007 and
 19 ultimately into this process?
 20 DR. HOWELL:
 21 A. It could be.
 22 CHAYTOR, Q.C.:
 23 Q. That you became aware that she had even set
 24 out on that.
 25 DR. HOWELL:

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1 A. Yes, it very well could be.
 2 THE COMMISSIONER:
 3 Q. Wherever you can find a convenient place to
 4 break, Ms. Chaytor.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, perhaps this would be a good place then.
 7 THE COMMISSIONER:
 8 Q. All right then, 9:30 in the morning.
 9 CHAYTOR, Q.C.:
 10 Q. Thank you.
 11 THE COMMISSIONER:
 12 Q. Thank you.
 13 Upon conclusion at 4:51 p.m

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1 CERTIFICATE
 2 I, Judy Moss, hereby certify that the foregoing is
 3 a true and correct transcript in the matter of the
 4 Commission of Inquiry on Hormone Receptor Testing,
 5 heard on the 22nd day of May, A.D., 2008 before the
 6 Honourable Justice Margaret A. Cameron,
 7 Commissioner, at the Commission of Inquiry, St.
 8 John's, Newfoundland and Labrador and was
 9 transcribed by me to the best of my ability by
 10 means of a sound apparatus.
 11 Dated at St. John's, Newfoundland and Labrador
 12 this 22nd day of May, A.D., 2008
 13 Judy Moss

<p>-\$-</p> <p>\$1000 [1] 133:10 \$2000 [1] 133:10</p> <hr/> <p>-'-</p> <p>' [1] 279:25 '05 [1] 285:4 '06 [2] 85:10 268:24 '07 [3] 185:5 294:11,22 'group' [2] 259:3,6</p> <hr/> <p>---</p> <p>-a [1] 243:16 -and [1] 60:6 -just [1] 315:20 -or [1] 283:17 -sorry [1] 290:11 -to [1] 261:14</p> <hr/> <p>-0-</p> <p>0044 [1] 106:5 0422 [1] 265:15 0479 [1] 187:19</p> <hr/> <p>-1-</p> <p>1 [4] 71:2 159:9 188:25 192:7 10 [1] 223:5 100 [1] 104:5 10th [2] 180:13 181:24 11 [1] 166:6 11th [3] 283:10 318:1,6 12st [1] 272:5 13 [9] 181:11 182:4,4,6,6 182:7,14 185:17 266:4 14 [1] 225:13 1400 [1] 83:16 1401 [1] 143:12 1402 [1] 246:24 1403 [1] 4:22 1405 [1] 4:22 1410 [1] 4:22 1412 [3] 4:23 5:1,3 1414 [3] 4:23 5:5 185:4 1422 [2] 198:19 277:16 1424 [2] 4:23 5:6 14th [1] 235:19 15 [5] 110:19 188:18 189:6 192:9 264:21 15th [4] 31:4 180:22 223:4 268:23 16 [2] 189:6 192:8 17th [1] 71:3 18 [1] 23:13 18th [1] 144:22 19 [14] 23:14 88:1 181:12 185:17,18 186:7 188:18 188:19 189:10,11,12</p>	<p>192:6 193:22 274:15 1975 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